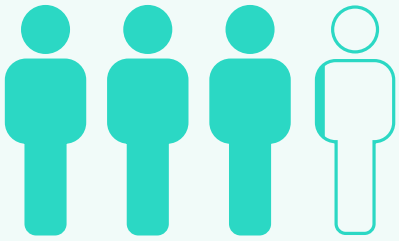
When it comes to treating MDS and CMML, what is your patients' preferred treatment method?



In a noninterventional survey of patients with MDS (n=184),

76.6% OF PATIENTS

would prefer to switch to oral treatment when offered alongside other options[1]*

A forecast of predicted treatment choices among patients with MDS found[1]:

- **Only 4.3% to 5.6% would choose IV administration based on the number of infusion** visits
- **Only 11.3% would choose SC administration** if a decitabine and cedazuridine oral combination tablet were an option

Are there patients with MDS in your practice who would prefer an oral treatment?

*Since data are not from a well-controlled clinical trial, they should be interpreted cautiously. Comparisons of efficacy and safety between or among agents should not be drawn or inferred based on these data.[1]

STUDY DESIGN

A noninterventional, cross-sectional, mixed-methods study of patients with MDS using qualitative and quantitative methods to develop a survey and analyze responses. The objective of the study was to show preferences of patients with MDS in the United States and Canada for hypomethylating agents' benefits, risks, and burden of administration through an online and discrete-choice experiment. Statistical significance was defined with a threshold of 5% of type I error. The survey was completed by 184 of the 275 individuals who initially responded to the invitation.[1]

INDICATIONS

INQOVI is indicated for treatment of adult patients with myelodysplastic syndromes (MDS), including previously treated and untreated, de novo and secondary MDS with the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups.

SELECTED IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Myelosuppression: Fatal and serious myelosuppression can occur with INQOVI. Based on laboratory values, new or worsening thrombocytopenia occurred in 82% of patients, with Grade 3 or 4 occurring in 76%. Neutropenia occurred in 73% of patients, with Grade 3 or 4 occurring in 71%. Anemia occurred in 71% of patients, with Grade 3 or 4 occurring in 55%.

CMML=chronic myelomonocytic leukemia; IV=intravenous; MDS=myelodysplastic syndromes; SC=subcutaneous.

Please see additional Important Safety Information throughout and full Prescribing Information in pocket.

INQOVI®
(decitabine and cedazuridine) tablets

MDS can require lifelong treatment[2,3]*

Receiving treatment for MDS, including CMML, can be challenging for some patients and caregivers, requiring[3,4]:

- Additional travel to and from chemotherapy infusion centers or hospitals for IV infusions or SC injections[3,5]

- Venous access and parenteral administration[4,6]

Gaining back time and overcoming treatment administration hurdles are patient priorities[1]

- Most patients prefer simpler treatment administration and shorter and fewer treatment visits[1]

An oral treatment may be more convenient for patients and caregivers, particularly patients who may remain on treatment for an extended period of time, even years.[3,6]

*Especially in the case of transplant-ineligible patients.[2-4]

SELECTED IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Myelosuppression (continued): Febrile neutropenia occurred in 33% of patients, with Grade 3 or 4 occurring in 32%. Myelosuppression (thrombocytopenia, neutropenia, anemia, and febrile neutropenia) is the most frequent cause of INQOVI dose reduction or interruption, occurring in 36% of patients. Permanent discontinuation due to myelosuppression (febrile neutropenia) occurred in 1% of patients. Myelosuppression and worsening neutropenia may occur more frequently in the first or second treatment cycles and may not necessarily indicate progression of underlying MDS.

Fatal and serious infectious complications can occur with INQOVI. Pneumonia occurred in 21% of patients, with Grade 3 or 4 occurring in 15%. Sepsis occurred in 14% of patients, with Grade 3 or 4 occurring in 11%. Fatal pneumonia occurred in 1% of patients, fatal sepsis in 1%, and fatal septic shock in 1%.

Obtain complete blood cell counts prior to initiation of INQOVI, prior to each cycle, and as clinically indicated to monitor response and toxicity. Administer growth factors and anti-infective therapies for treatment or prophylaxis as appropriate. Delay the next cycle and resume at the same or reduced dose as recommended.

Embryo-Fetal Toxicity: INQOVI can cause fetal harm. Advise pregnant women of the potential risk to a fetus. Advise patients to use effective contraception during treatment and for 6 months (females) or 3 months (males) after last dose.

Only ONE oral HMA has been approved for MDS and CMML[7]

The ONLY oral HMA with equivalent systemic exposure to IV decitabine[7]*

99% RATIO OF ORAL TO IV 5-DAY DECITABINE AUC

(90% CI: 93, 106)†

INQOVI® (decitabine and cedazuridine) tablets is indicated for treatment of adult patients with myelodysplastic syndromes (MDS), including previously treated and untreated, de novo and secondary MDS with the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups.

As the only once-daily oral HMA for the treatment of MDS and CMML, INQOVI tablets allow patients to take their treatment in the comfort of their own home.[7]

*INQOVI was studied in a phase 3 crossover trial designed to assess systemic decitabine exposure, demethylation activity, and safety between IV decitabine and INQOVI tablets. The trial allowed for reliable intrapatient comparison in the first 2 randomized treatment cycles, and then assessment of the long-term efficacy and safety of INQOVI as a single arm.[7]

†This ratio is the geometric mean of the 5-day cumulative decitabine AUC between INQOVI tablets and IV-administered decitabine when administered once daily for 5 consecutive days.[7]

AUC=area under the curve; CI=confidence interval; HMA=hypomethylating agent.

SELECTED IMPORTANT SAFETY INFORMATION

ADVERSE REACTIONS

Serious adverse reactions in > 5% of patients included febrile neutropenia (30%), pneumonia (14%), and sepsis (13%). Fatal adverse reactions included sepsis (1%), septic shock (1%), pneumonia (1%), respiratory failure (1%), and one case each of cerebral hemorrhage and sudden death.

The most common adverse reactions (≥ 20%) were fatigue (55%), constipation (44%), hemorrhage (43%), myalgia (42%), mucositis (41%), arthralgia (40%), nausea (40%), dyspnea (38%), diarrhea (37%), rash (33%), dizziness (33%), febrile neutropenia (33%), edema (30%), headache (30%), cough (28%), decreased appetite (24%), upper respiratory tract infection (23%), pneumonia (21%), and transaminase increased (21%). The most common Grade 3 or 4 laboratory abnormalities (≥ 50%) were leukocytes decreased (81%), platelet count decreased (76%), neutrophil count decreased (71%), and hemoglobin decreased (55%).

Please see additional Important Safety Information throughout and full Prescribing Information in pocket.

INQOVI®
(decitabine and cedazuridine) tablets

Your patients may be appropriate for INQOVI, the only oral HMA approved for MDS and CMML[7]

- Diagnosed with de novo or secondary MDS and CMML
- Classified as intermediate- or high-risk MDS
- Have not received prior treatment or have previously been treated

Additional patient considerations[3,7]:

- Wish to take their HMA therapy in the comfort of their own home
- Unable to have, or do not wish to have, infusion port placement
- Do not have regular support to manage travel to the infusion center

Visit **INQOVI.com/hcp** to learn more

SELECTED IMPORTANT SAFETY INFORMATION

USE IN SPECIFIC POPULATIONS

Lactation: Because of the potential for serious adverse reactions in the breastfed child, advise women not to breastfeed during treatment with INQOVI and for 2 weeks after the last dose.

Renal Impairment: No dosage modification of INQOVI is recommended for patients with mild or moderate renal impairment (creatinine clearance [CLcr] of 30 to 89 mL/min based on Cockcroft-Gault). Due to the potential for increased adverse reactions, monitor patients with moderate renal impairment (CLcr 30 to 59 mL/min) frequently for adverse reactions. INQOVI has not been studied in patients with severe renal impairment (CLcr 15 to 29 mL/min) or end-stage renal disease (ESRD: CLcr <15 mL/min).

References: 1. Zeidan AM, Tsai JH, Karimi M, et al. Patient preferences for benefits, risks, and administration route of hypomethylating agents in myelodysplastic syndromes. *Clin Lymphoma Myeloma Leuk*. 2022;22(9):e853-e866. doi:10.106/j.clml.2022.04.023. **2.** Platzbecker U. Treatment of MDS. *Blood*. 2019;133(10):1096-1107. **3.** Savona MR, Odenike O, Amrein PC, et al. An oral fixed-dose combination of decitabine and cedazuridine in myelodysplastic syndromes: a multicentre, open-label, dose-escalation, phase 1 study. *Lancet Haematol*. 2019;6(4):e194-e203. doi:10.1016/S2352-3026(19)30030-4. **4.** Steensma DP, Komrokji RS, Stone RM, et al. Disparity in perceptions of disease characteristics, treatment effectiveness, and factors influencing treatment adherence between physicians and patients with myelodysplastic syndromes. *Cancer*. 2014;120(11):1670-1676. **5.** Vidaza [package insert]. Summit, NJ: Celgene Corporation; 2020. **6.** Leveque D. Subcutaneous administration of anticancer agents. *Anticancer Res*. 2014;34(4):1579-1586. **7.** INQOVI [package insert]. Princeton, NJ: Taiho Oncology, Inc.; 2022.

Please see additional Important Safety Information throughout and full Prescribing Information in pocket.

TAIHO ONCOLOGY

 10/2022 INQ-PM-US-0480

INQOVI®
(decitabine and cedazuridine) tablets