

REDEFINE YOUR APPROACH

to MSI-H/dMMR locally
advanced rectal cancer (LARC)

JEMPERLI is the **FIRST AND ONLY**
FDA-approved immunotherapy for
patients with MSI-H/dMMR LARC^{1*}

^{*}Stage II/III.¹

INDICATION

JEMPERLI, as a single agent, is indicated for the treatment of adult patients with Stage II/III, locally advanced rectal cancer (LARC) that is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), as determined by an FDA-authorized test for solid tumors. This indication is approved under accelerated approval based on sustained clinical complete response for 12 months. The long-term risk of relapse is unknown, with additional follow-up expected. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

IMPORTANT SAFETY INFORMATION

Severe and Fatal Immune-Mediated Adverse Reactions

- Immune-mediated adverse reactions, which can be severe or fatal, can occur in any organ system or tissue and can occur at any time during or after treatment with a PD-1/PD-L1-blocking antibody, including JEMPERLI.
- Monitor closely for signs and symptoms of immune-mediated adverse reactions. Evaluate liver enzymes, creatinine, and thyroid function tests at baseline and periodically during treatment. For suspected immune-mediated adverse reactions, initiate appropriate workup to exclude alternative etiologies, including infection. Institute medical management promptly, including specialty consultation as appropriate.

Please see additional Important Safety Information throughout and full Prescribing Information, including Medication Guide.

Though Multimodal Treatment Is Effective, Clinical Challenges Persist in Rectal Cancer^{2,3}

Multimodal treatment for rectal cancer, which may include surgery, can be associated with long-term treatment-related morbidities, such as^{2,4-8}:

Permanent stoma^{2,4} | Urinary & GI dysfunction^{2,4,5} | Sexual dysfunction^{4,6} | Reduced fertility^{4,7,8}

In previous studies in locally advanced rectal cancer (LARC), **complete response rates of 15-30% have been observed with multimodal treatment³**

15-30%

For patients with MSI-H/dMMR LARC, early clinical evidence supported further evaluation of JEMPERLI in a curative-intent treatment setting^{9,10*}

- Up to 10% of LARC cases are MSI-H/dMMR, which makes them more likely to respond to anti-PD-1 therapies, like JEMPERLI^{11,12†}



For patients with MSI-H/dMMR LARC, starting with JEMPERLI may help avoid the need for multimodal treatment and preserve the rectum¹

JEMPERLI has its own treatment considerations. Learn more about the cCR12 data on page 6 and JEMPERLI safety profile on page 9.

Multimodal treatment combines radiotherapy, chemotherapy, and/or surgery.⁹

*Curative intent reflects the treatment setting and is not an established outcome of therapy.

†Increased mutations promote antitumor immune cell reaction and increased tumor-infiltrating lymphocytes.¹²

IMPORTANT SAFETY INFORMATION (CONT'D)

Severe and Fatal Immune-Mediated Adverse Reactions (cont'd)

- Based on the severity of the adverse reaction, withhold or permanently discontinue JEMPERLI. In general, if JEMPERLI requires interruption or discontinuation, administer systemic corticosteroids (1 to 2 mg/kg/day prednisone or equivalent) until improvement to ≤Grade 1. Upon improvement to ≤Grade 1, initiate corticosteroid taper and continue to taper over at least 1 month. Consider administration of other systemic immunosuppressants in patients whose immune-mediated adverse reaction is not controlled with corticosteroids.

Immune-Mediated Pneumonitis

- JEMPERLI can cause immune-mediated pneumonitis, which can be fatal. In patients treated with other PD-1/PD-L1-blocking antibodies, the incidence of pneumonitis is higher in patients who have received prior thoracic radiation. Pneumonitis occurred in 2% (15/759) of patients, including Grade 2 (1.2%), Grade 3 (0.7%), and Grade 4 (0.1%) pneumonitis.

Please see additional Important Safety Information throughout and full Prescribing Information, including Medication Guide.

Jemperli 
(dostarlimab-gxly) Injection 500 mg

JEMPERLI Is the Only FDA-Approved Immunotherapy for MSI-H/dMMR LARC Backed by Evidence From 2 Trials¹



Initial results from MSKCC 19-288

*a single-center, supported
collaborative trial^{1,9,13}*



Further evidence from AZUR-1

*a global, multicenter,
registrational trial^{1,14}*



FDA approval

*with Breakthrough
Therapy Designation¹*

Dostarlimab-gxly (JEMPERLI) is the only FDA-approved immunotherapy for patients with dMMR/MSI-H LARC recommended by the National Comprehensive Cancer Network® (NCCN®)^{1,15}

NCCN

CATEGORY 2A
PREFERRED OPTION

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) recommend dostarlimab-gxly (JEMPERLI) as an immunotherapy option for patients with previously untreated dMMR/MSI-H locally advanced rectal cancer (NCCN category 2A, preferred)¹⁵

Category 2A – Based upon lower-level evidence, there is uniform NCCN consensus (≥85% support of the Panel) that the intervention is appropriate.¹⁵

Preferred intervention – Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability.¹⁵

IMPORTANT SAFETY INFORMATION (CONT'D)

Immune-Mediated Colitis

- Colitis occurred in 1.2% (9/759) of patients, including Grade 2 (0.7%) and Grade 3 (0.5%) adverse reactions. Cytomegalovirus infection/reactivation have occurred in patients with corticosteroid-refractory immune-mediated colitis. In such cases, consider repeating infectious workup to exclude alternative etiologies.

Immune-Mediated Hepatitis

- JEMPERLI can cause immune-mediated hepatitis, which can be fatal. Grade 3 hepatitis occurred in 0.5% (4/759) of patients.

Immune-Mediated Endocrinopathies

- Adrenal Insufficiency
 - Adrenal insufficiency occurred in 1.1% (8/759) of patients, including Grade 2 (0.4%) and Grade 3 (0.7%). For Grade 2 or higher adrenal insufficiency, initiate symptomatic treatment per institutional guidelines, including hormone replacement as clinically indicated. Withhold or permanently discontinue JEMPERLI depending on severity.

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Clinical Complete Response (cCR) Is a Recognized Measure That Was a Key Endpoint in AZUR-1 and MSKCC 19-288^{1,13,16}

cCR Absence of residual cancer upon clinical examination of patient by endoscopic, imaging, and physical examination techniques^{14,15}

pCR Absence of residual cancer upon histological examination of excised surgical specimens¹⁷

cCR is used in prospective clinical trials and its relationship to long-term outcomes is being studied^{16,18}

Assessment of cCR with immunotherapy may be complicated by atypical response¹⁹⁻²³

- **Immune-mediated inflammation as a response to treatment can look like progression on clinical evaluation.** This can occur early in treatment and may raise concerns about obstruction
- **Persistent mucinous or fibrotic findings after treatment may mimic a residual tumor**
- **Regular monitoring can help distinguish atypical treatment response from progression and enable early detection of adverse reactions**

IMPORTANT SAFETY INFORMATION (CONT'D)

Immune-Mediated Endocrinopathies (cont'd)

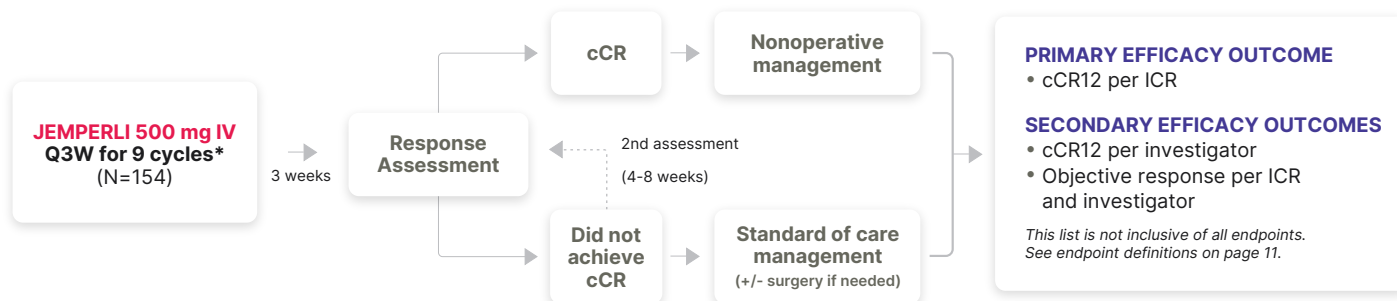
- Hypophysitis
 - JEMPERLI can cause immune-mediated hypophysitis. Grade 2 hypophysitis occurred in 0.3% (2/759) of patients. Initiate hormone replacement as clinically indicated. Withhold or permanently discontinue JEMPERLI depending on severity.
- Thyroid Disorders
 - Grade 2 thyroiditis occurred in 0.4% (3/759) of patients. Grade 2 hypothyroidism occurred in 8% (58/759) of patients. Hyperthyroidism occurred in 2.2% (17/759) of patients, including Grade 2 (2.1%) and Grade 3 (0.1%). Initiate thyroid hormone replacement or medical management of hyperthyroidism as clinically indicated. Withhold or permanently discontinue JEMPERLI depending on severity.
- Type 1 Diabetes Mellitus, Which Can Present with Diabetic Ketoacidosis
 - JEMPERLI can cause type 1 diabetes mellitus, which can present with diabetic ketoacidosis. Grade 3 type 1 diabetes mellitus occurred in 0.1% (1/759) of patients. Monitor patients for hyperglycemia or other signs and symptoms of diabetes. Initiate treatment with insulin as clinically indicated. Withhold or permanently discontinue JEMPERLI depending on severity.

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AZUR-1 Evaluated the Efficacy and Safety Profile of JEMPERLI as a Single Agent^{1,14}

AZUR-1 enrolled 154 patients in a multicenter, single-arm, open-label, phase 2 study^{1,14}



All analyses are descriptive.

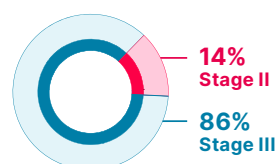
*Unless unacceptable toxicity or disease progression occurred.¹

- If cCR was not achieved at the first response assessment after treatment with JEMPERLI, a second response assessment per investigator was conducted 4 to 8 weeks later¹⁴

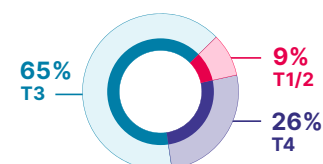
Baseline patient characteristics (N=154)¹:

61.5 years median age	62% Male	71% ECOG PS 0
42% aged ≥65 years	38% Female	29% ECOG PS 1
88% White	7% Asian	4% Black
1% Unknown	95% Not Hispanic or Latino	5% Hispanic or Latino

Rectal Cancer Stage

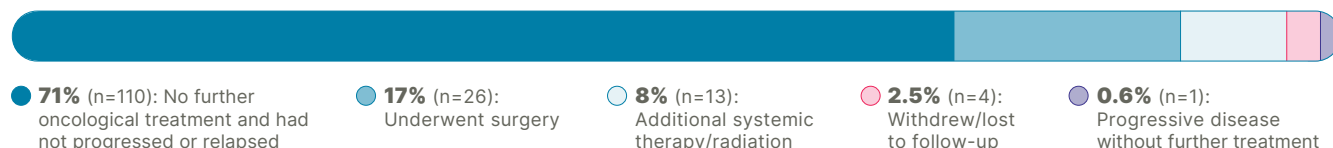


Tumor Size



Eligible patients had previously untreated, histologically confirmed, MSI-H/dMMR, Stage II (T3–T4, N0) or III (any T, N+) LARC with evaluable disease at baseline (by radiology and endoscopy).¹

Patient disposition (N=154)¹:



Six patients died including 4 in the setting of progressive disease without initial response to JEMPERLI, 1 due to sepsis following treatment for intestinal obstruction, and 1 died after withdrawal from the study.

IMPORTANT SAFETY INFORMATION (CONT'D)

Immune-Mediated Nephritis with Renal Dysfunction

- JEMPERLI can cause immune-mediated nephritis, which can be fatal. Grade 2 nephritis, including tubulointerstitial nephritis, occurred in 0.4% (3/759) of patients.

Immune-Mediated Dermatologic Adverse Reactions

- JEMPERLI can cause immune-mediated rash or dermatitis. Bullous and exfoliative dermatitis, including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), and drug rash with eosinophilia and systemic symptoms (DRESS), have occurred with PD-1/PD-L1-blocking antibodies. One patient receiving JEMPERLI experienced Grade 3 SJS, which resolved. Topical emollients and/or topical corticosteroids may be adequate to treat mild to moderate non-bullous/exfoliative rashes. Withhold or permanently discontinue JEMPERLI depending on severity.

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In AZUR-1, Many Patients Achieved Complete Responses That Were Sustained For 12 Months With JEMPERLI¹

At this pre-specified interim analysis, some patients who achieved cCR12 per investigator assessment were not yet evaluable by ICR^{1*}

PRIMARY EFFICACY OUTCOME

47% cCR12
per ICR¹

(n=54/116; 95% CI: 37, 56)

SECONDARY EFFICACY OUTCOME

68% cCR12
per investigator¹

(n=98/144; 95% CI: 60, 76)

ICR assessment strives to remove bias by standardizing review with predefined imaging and endoscopic assessments. Investigator assessment is performed collaboratively with the MDT and also includes clinical context which is reflective of clinical practice. Some differences between assessments are anticipated, but results are complementary.^{24,25} At data cutoff, cCR12 results have 87% concordance.²⁶

SECONDARY EFFICACY OUTCOMES

- **79% (n=121/154; 95% CI: 71, 85) objective response at the first or second assessment after JEMPERLI per ICR**, including cCR, nCR, and PR rates of 28%, 29%, and 22%, respectively, and **82% (n=126/154; 95% CI: 75, 88) per investigator**, including cCR, nCR, and PR rates of 66%, 6%, and 10%, respectively¹

PATHOLOGICAL COMPLETE RESPONSE

- **80% of the patients (n=12/15) who underwent rectal cancer surgery after treatment with JEMPERLI alone were found to have pCR** without additional prior chemotherapy and radiation therapy¹

Data were collected on whether patients were able to avoid rectal cancer surgery and preserve their rectum¹

- 83% of patients did not undergo surgery (n=128/154), while 17% (n=26/154) underwent surgery (with or without additional systemic therapy or radiation)

Median follow-up of 26 months for the overall population. Data cutoff April 20, 2026. Confidence intervals determined using Clopper-Pearson method.¹

*Patients with an opportunity for at least 12 months of follow-up from the date at which cCR was first observed. Non-evaluable patients include those who achieved cCR and had <12 months of follow-up at data cutoff. 38 patients who achieved cCR per ICR are still being followed for cCR12.¹

IMPORTANT SAFETY INFORMATION (CONT'D)

Other Immune-Mediated Adverse Reactions

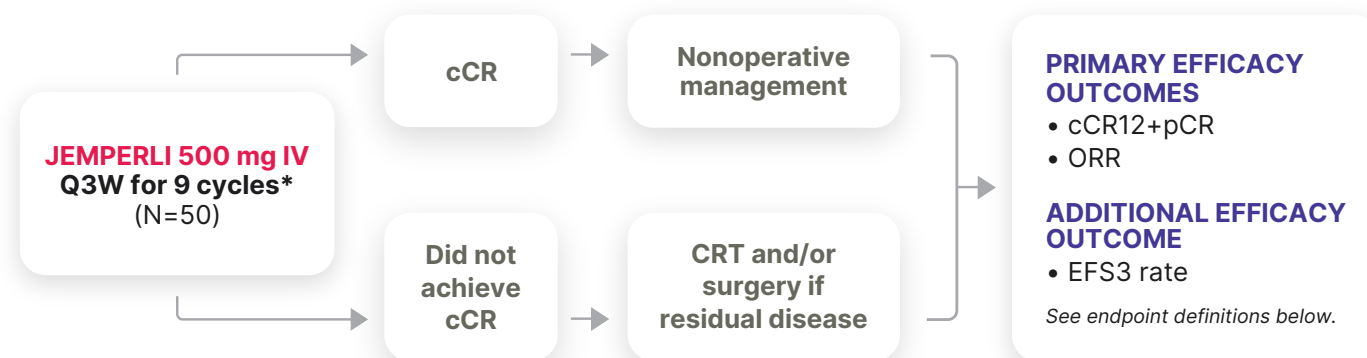
- The following clinically significant immune-mediated adverse reactions occurred in <1% of the 759 patients treated with JEMPERLI or were reported with the use of other PD-1/PD-L1-blocking antibodies. Severe or fatal cases have been reported for some of these adverse reactions.
 - *Nervous System*: Meningitis, encephalitis, myelitis and demyelination, myasthenic syndrome/myasthenia gravis, Guillain-Barré syndrome, nerve paresis, autoimmune neuropathy

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The MSKCC 19-288 Trial Laid the Groundwork for AZUR-1^{1,14}

MSKCC 19-288 enrolled 50 patients in a single-center, single-arm, open-label, phase 2 study^{1,9,13,26-28}



All analyses are descriptive.

cCR: The absence of residual disease on digital and endoscopic rectal examination and rectal MRI with no restricted diffusion on T2-weighted imaging. **cCR12+pCR:** Patients who achieved cCR after treatment with JEMPERLI and maintained it for at least 12 months, or pCR after treatment with JEMPERLI and rectal cancer surgery, with or without chemoradiation. **ORR:** Overall response rate.

EFS3 rate: Binary endpoint defined as the rate of participants who remained alive and free of disease progression precluding surgery, local recurrence, and distant recurrence at 3 years.^{9,28}

*Unless unacceptable toxicity or disease progression occurred.¹

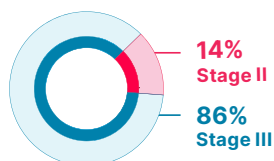
- Tumor response was assessed using MRI, endoscopy, and digital rectal examination at baseline, 6 weeks (endoscopy and digital rectal examination only), 3 months, 6 months, and then every 4 months⁹

Baseline patient characteristics (N=50)¹:

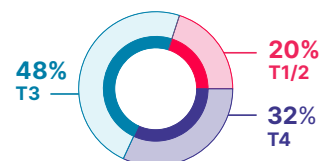
51 years median age	44% Male	82% ECOG PS 0
16% aged ≥65 years	56% Female	18% ECOG PS 1
78% White	12% Black	10% Asian
88% Not Hispanic or Latino	12% Hispanic or Latino	

Eligible patients had previously untreated MSI-H/dMMR Stage II/III LARC.¹

Rectal Cancer Stage



Tumor Size



IMPORTANT SAFETY INFORMATION (CONT'D)

Other Immune-Mediated Adverse Reactions (cont'd)

- Cardiac/Vascular:** Myocarditis, pericarditis, vasculitis
- Ocular:** Uveitis, iritis, other ocular inflammatory toxicities. Some cases can be associated with retinal detachment. Various grades of visual impairment to include blindness can occur
- Gastrointestinal:** Pancreatitis, including increases in serum amylase and lipase levels, gastritis, duodenitis
- Musculoskeletal and Connective Tissue:** Myositis/polymyositis, rhabdomyolysis and associated sequelae including renal failure, arthritis, polymyalgia rheumatica

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The Results From MSKCC 19-288 Led to FDA Breakthrough Therapy Designation for JEMPERLI

- All patients achieved cCR; therefore, the ORR reflects the cCR rate¹
- No patients proceeded to CRT and/or rectal cancer surgery; therefore, the cCR12 rate reflects the cCR12+pCR rate¹

EFFICACY
OUTCOME

100% ORR (100% cCR)¹
(n=50/50; 95% CI: 93, 100)

EFFICACY
OUTCOME

93% cCR12^{1,26}
(n=42/45; 95% CI: 82, 99)*

**EFS3
RATE**

89% of evaluable patients were alive and free of disease progression at 3 years (n=24/27)^{1,26†}

- 1 patient had a local recurrence treated with lymphadenectomy
- 1 patient withdrew and 1 patient died unrelated to disease under study

Median follow-up of 41 months for the overall population. Data cutoff January 28, 2026.²⁶

*Patients with an opportunity for at least 12 months of follow-up on nonoperative management. Median follow-up of 43 months.²⁶ †Binary endpoint. Patients with an opportunity for at least 3 years of follow-up from the first dose of JEMPERLI. Median follow-up of 36 months.²⁶

IMPORTANT SAFETY INFORMATION (CONT'D)

Other Immune-Mediated Adverse Reactions (cont'd)

- *Endocrine*: Hypoparathyroidism
- *Hematologic/Immune*: Autoimmune hemolytic anemia, aplastic anemia, hemophagocytic lymphohistiocytosis, systemic inflammatory response syndrome, histiocytic necrotizing lymphadenitis (Kikuchi lymphadenitis), sarcoidosis, immune thrombocytopenia, solid organ transplant rejection, other transplant (including corneal graft) rejection
- *Other*: Myocarditis-Myositis-Myasthenia Gravis (or Myasthenia-Like) Overlap Syndrome, reported as the co-occurrence of either two or all three adverse reactions.

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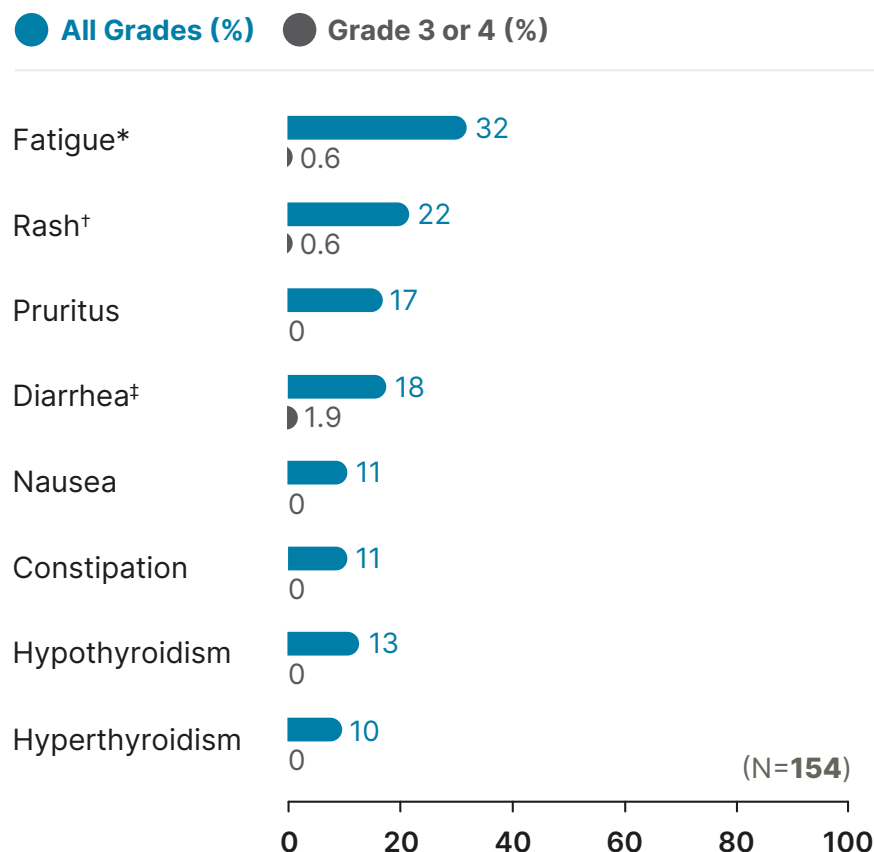
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Safety Profile in AZUR-1

Of the 154 patients in AZUR-1¹:

- **3% of patients permanently discontinued JEMPERLI due to adverse reactions.** Adverse reactions leading to discontinuation occurred in 1 patient each and include lichen planus, hepatitis, increased amylase, and intestinal obstruction occurring at the tumor site¹
- Serious adverse reactions occurred in 20% of patients, including (in $\geq 1\%$ of patients) colitis (1.9%), gastritis, rectal stenosis, and intestinal obstruction occurring at the tumor site (1.3% each)¹
- The most common adverse reactions ($\geq 15\%$) were fatigue, rash, diarrhea, and pruritus¹

Adverse Reactions ($\geq 10\%$) in AZUR-1¹



Graded per National Cancer Institute Common Terminology Criteria for Adverse Events Version 5.0.¹

*Includes fatigue, asthenia, and malaise.¹ †Includes rash, rash maculo-papular, rash pruritic, erythema, lichen planus, rash erythematous, and rash papular.¹ ‡Includes diarrhea and colitis.¹

IMPORTANT SAFETY INFORMATION (CONT'D)

Infusion-Related Reactions

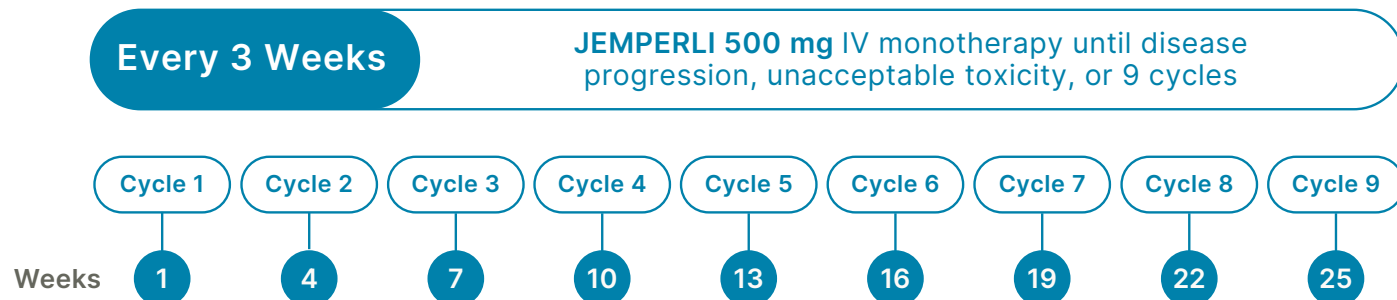
- Severe or life-threatening infusion-related reactions have been reported with PD-1/PD-L1-blocking antibodies. Severe infusion-related reactions (Grade 3) occurred in 0.1% (1/759) of patients. Monitor patients for signs and symptoms of infusion-related reactions. Interrupt or slow the rate of infusion or permanently discontinue JEMPERLI based on severity of reaction.

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JEMPERLI Is a Single-Agent Treatment Administered Over ~6 Months¹

30-minute IV infusion every 3 weeks for 9 cycles¹



Monitoring during and after treatment can help evaluate response to JEMPERLI²²

- Regular monitoring can help distinguish atypical treatment response from progression and enable early detection of adverse reactions^{19,22}

In AZUR-1, patients were assessed* at defined timepoints^{1,14}:

During treatment:

- Week 6 (endoscopy only)
- Week 12

After treatment:

- ~3 weeks after last dose
- 4-8 weeks later if cCR was not achieved

Throughout nonoperative management:

- Every 4 months (Years 1-2)
- Every 6 months (Years 3+)

Additional monitoring may be required per clinical discretion.¹

*Patients were assessed for response or progression using endoscopy, rectal MRI, and CT of the chest, abdomen, and pelvis.¹

IMPORTANT SAFETY INFORMATION (CONT'D)

Complications of Allogeneic HSCT

- Fatal and other serious complications can occur in patients who receive allogeneic hematopoietic stem cell transplantation (HSCT) before or after treatment with a PD-1/PD-L1-blocking antibody, which may occur despite intervening therapy. Monitor patients closely for transplant-related complications and intervene promptly.

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IMPORTANT SAFETY INFORMATION (CONT'D)

Embryo-Fetal Toxicity and Lactation

- Based on its mechanism of action, JEMPERLI can cause fetal harm. Advise pregnant women of the potential risk to a fetus. Advise women of reproductive potential to use effective contraception during treatment with JEMPERLI and for 4 months after their last dose. Because of the potential for serious adverse reactions from JEMPERLI in a breastfed child, advise women not to breastfeed during treatment with JEMPERLI and for 4 months after their last dose.

Common Adverse Reactions

The most common adverse reactions ($\geq 15\%$) were fatigue, rash, diarrhea, and pruritus. The most common Grade 3 or 4 laboratory abnormalities ($\geq 2\%$) were decreased lymphocytes, decreased hemoglobin, and increased AST.

References: 1. JEMPERLI. Prescribing Information. GSK; 2026. 2. Cerdan-Santacruz C, et al. *J Clin Med*. 2023;12(8):2873. 3. Kasi A, et al. *JAMA Netw Open*. 2020;3(12):e2030097. 4. Hupkens BJP, et al. *Dis Colon Rectum*. 2017;60(10):1032-1040. 5. Olopade FA, et al. *Br J Cancer*. 2005;92(9):1663-1670. 6. Hansen SB, et al. *Curr Oncol*. 2023;30(10):9317-9326. 7. Anthon C, et al. *Cancers (Basel)*. 2024;16(23):4005. 8. Jiang Q, Hua H. *Oncologist*. 2024;29(10):e1237-e1245. 9. Cercek A, et al. *N Engl J Med*. 2022;386(25):2363-2376. 10. Tosi F, et al. *ESMO Open*. 2024;9(10):103929. 11. Clerick J, et al. *Cancer Treat Res Commun*. 2024;39:100807. 12. Le DT, et al. *N Engl J Med*. 2015;372(26):2509-2520. 13. Cercek A, et al. *N Engl J Med*. 2025;392(23):2297-2308. 14. Cercek A, et al. *Clin Colorectal Cancer*. 2025;24(2):325-330. 15. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Rectal Cancer V.2.2026. © National Comprehensive Cancer Network; 2026. All rights reserved. Accessed May 1, 2026. To view the most recent and complete version of the guideline, go online to NCCN.org.* 16. Thompson HM, et al. *JAMA Netw Open*. 2024;7(1):e2350903. 17. National Cancer Institute. Pathologic complete response. Accessed March 4, 2026. <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/pathologic-complete-response> 18. Verheij FS, et al. *J Clin Oncol*. 2024;42(5):500-506. 19. Beer L, et al. *Memo*. 2018;11(2):138-143. 20. Dromain C, et al. *Eur Radiol Exp*. 2020;4(1):2. 21. Ma Y, et al. *Am J Cancer Res*. 2019;9(8):1546-1553. 22. Xie Y, et al. *J Natl Compr Canc Netw*. 2023;21(2):133-142.e3. 23. Vanderbecq Q, et al. *ESMO Open*. 2026;11(1):106020. 24. Ford R, et al. *Eur J Cancer*. 2009;45(2):268-274. 25. Zettler ME. *Cancers (Basel)*. 2025;17(7):1096. 26. Data on file, GSK. 27. Cercek A, et al. *N Engl J Med*. 2025;392(23)(suppl):2297-2308. 28. Cercek A, et al. *N Engl J Med*. 2025;392(23)(protocol):2297-2308. 29. ClinicalTrials.gov. A study of dostarlimab in untreated dMMR/MSI-H locally advanced rectal cancer (AZUR-1). Accessed August 19, 2026. <https://clinicaltrials.gov/study/NCT05723562>

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

cCR=clinical complete response; cCR12=clinical complete response for 12 months; CI=confidence interval; CRT=chemoradiotherapy; CT=computed tomography; dMMR=mismatch repair deficient; ECOG PS=Eastern Cooperative Oncology Group Performance Status; EFS3=event-free survival at 3 years; GI=gastrointestinal; ICR=independent central review; IV=intravenous; LARC=locally advanced rectal cancer; MDT=multidisciplinary team; MRI=magnetic resonance imaging; MSI-H=microsatellite instability-high; MSKCC=Memorial Sloan Kettering Cancer Center; NCCN=National Comprehensive Cancer Network; nCR=clinical near-complete response; ORR=overall response rate; pCR=pathological complete response; PD-1=programmed death receptor-1; PR=clinical partial response; Q3W=every 3 weeks.

AZUR-1 Endpoint Definitions

cCR: No clinical evidence of residual tumor. **cCR12:** cCR sustained for 12 months, beginning from the first disease assessment after the last dose of JEMPERLI where cCR was observed. **Objective response:** Patients who achieved cCR, clinical near-complete response (nCR), or clinical partial response (PR) as their best overall response at the first or second response assessments after treatment with JEMPERLI. **nCR:** Clinical near-complete response by the following findings on (1) MRI: mostly dark T2 signal with some remaining intermediate signal; significant regression of signal on diffusion weighted imaging b800 - b1000 with minimal residual focus or foci or bright signal (confirmed with some remaining dark signal in tumor bed on the apparent diffusion coefficient map); partial regression of enlarged lymph nodes (if any at baseline); and/or (2) endoscopic visualization: irregular mucosa; small mucosal nodules, or minor mucosal abnormality; superficial ulceration; or mild persisting erythema of the scar.^{1,14,29}

Please see additional Important Safety Information throughout and full Prescribing Information, including Medication Guide.

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Choose JEMPERLI—the First and Only FDA-Approved Immunotherapy for Patients With MSI-H/dMMR LARC¹



FDA approval

with Breakthrough Therapy Designation¹



Evidence of sustained cCRs

47% cCR12 per ICR and 68% cCR12 per investigator in AZUR-1 interim analysis¹



Clinically meaningful results over 3+ years median follow-up

100% ORR (all cCR), 93% cCR12, and 89% EFS3 rate in MSKCC 19-288^{1,26}

IMPORTANT SAFETY INFORMATION

Severe and Fatal Immune-Mediated Adverse Reactions

- Immune-mediated adverse reactions, which can be severe or fatal, can occur in any organ system or tissue and can occur at any time during or after treatment with a PD-1/PD-L1-blocking antibody, including JEMPERLI.
- Monitor closely for signs and symptoms of immune-mediated adverse reactions. Evaluate liver enzymes, creatinine, and thyroid function tests at baseline and periodically during treatment. For suspected immune-mediated adverse reactions, initiate appropriate workup to exclude alternative etiologies, including infection. Institute medical management promptly, including specialty consultation as appropriate.

Visit JEMPERLIHCP.com/redefine-options to learn more about JEMPERLI in MSI-H/dMMR LARC and download resources for you and your patients



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