A treatment guide to help your patients

START & STAY on KISQALI

NCCN CATEGORY 1 PREFERRED

National Comprehensive Cancer Network® (NCCN®) **differentiates ribociclib (KISQALI®) as the first and only Category 1 Preferred treatment option when used in combination with an AI** for appropriate patients with HR+/HER2- mBC in 1L and for appropriate patients with HR+/HER2- eBC, including those with high-risk node-negative disease.[1]

In HR+/HER2- eBC, high-risk node-negative disease is defined as either tumor size >5 cm, or if tumor size 2-5 cm, either grade 2 (with high genomic risk or Ki-67 ≥20%), or grade 3.[1]
There is controversy on the choice of CDK4/6 inhibitor as there are no head-to-head comparisons between the agents and there are some differences in the study populations in the phase III randomized studies.[1]
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.[1]
Category 1: Based upon high-level evidence (≥1 randomized phase III trials or high-quality, robust meta-analyses), there is uniform NCCN consensus (≥85% support of the Panel) that the intervention is appropriate.[1]

1L, first line; AI, aromatase inhibitor; CDK, cyclin-dependent kinase; eBC, early breast cancer; HER2-, human epidermal growth factor receptor 2-negative; HR+, hormone receptor-positive; mBC, metastatic breast cancer.

Indications

KISQALI is indicated:

- in combination with an aromatase inhibitor for the adjuvant treatment of adults with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative stage II and III early breast cancer (eBC) at high risk of recurrence
- for the treatment of adults with HR-positive, HER2-negative advanced or metastatic breast cancer (mBC) in combination with:
  - an aromatase inhibitor as initial endocrine-based therapy; or
  - fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy

IMPORTANT SAFETY INFORMATION

Interstitial lung disease/pneumonitis. Severe, life-threatening, or fatal interstitial lung disease (ILD) and/or pneumonitis can occur in patients treated with KISQALI and other CDK4/6 inhibitors.

In patients with eBC (NATALEE) who received 400 mg KISQALI plus a nonsteroidal aromatase inhibitor (NSAI), 1.5% of patients had ILD/pneumonitis (grade 1/2).

In patients with advanced or mBC (MONALEESA-2, MONALEESA-3, MONALEESA-7), 1.6% of patients had ILD/pneumonitis of any grade, 0.4% had grade 3/4, and 0.1% had a fatal outcome. Additional cases of ILD/pneumonitis have occurred in the postmarketing setting, some resulting in death.

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

TRIAL DESIGNS
STARTING KISQALI
SAFETY PROFILE
DOSING ADJUSTMENTS
SUPPORT & RESOURCES

In stage II/III HR+/HER2- eBC,

NATALEE—a positive study of KISQALI efficacy and safety in the broadest range of patients at risk of recurrence, including those with no nodal involvement

NATALEE was a randomized, multicenter, open-label, phase III clinical trial of KISQALI + AI (n=2549) vs AI alone* (n=2552) in the adjuvant treatment of HR+/HER2- eBC[2,3]

Study population[2,4]

- Adults with HR+/HER2- eBC
- Pre- and postmenopausal women, men
- Diagnosed ≤18 months prior
- Anatomic stage II or III
- All high-risk node-negative or node-positive
  - N0: T2 (G2 + high genomic risk or Ki-67 ≥20% or G3), T3, T4
  - All N1
  - All N2
  - All N3

Key end points[3]

Primary

- Invasive disease-free survival (iDFS)

Secondary

- Distant disease-free survival (DDFS)
- Health-related quality of life (HRQOL)
- Overall survival (OS) (ongoing)

Select exclusion criteria[4]

- Prior treatment with a CDK4/6 inhibitor
- ECOG performance status ≥2
- Major surgery, chemotherapy, or radiotherapy within 14 days prior to randomization
- Treatment with tamoxifen, raloxifene, or AIs for reduction in risk of breast cancer and/or treatment for osteoporosis within the last 2 years

*Men and premenopausal women also received goserelin.[3]
ECOG, Eastern Cooperative Oncology Group; G, grade; N, nodal status; T, tumor size.

IMPORTANT SAFETY INFORMATION (continued)

Interstitial lung disease/pneumonitis (continued). Monitor patients for pulmonary symptoms indicative of ILD/pneumonitis, which may include hypoxia, cough, and dyspnea. In patients who have new or worsening respiratory symptoms suspected to be due to ILD or pneumonitis, interrupt KISQALI immediately and evaluate the patient. Permanently discontinue treatment with KISQALI in patients with severe ILD/pneumonitis or any recurrent symptomatic ILD/pneumonitis.

Severe cutaneous adverse reactions. Severe cutaneous adverse reactions (SCARs), including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), and drug-induced hypersensitivity syndrome (DiHS)/drug reaction with eosinophilia and systemic symptoms (DRESS) can occur in patients treated with KISQALI.

If signs or symptoms of SCARs occur, interrupt KISQALI until the etiology of the reaction has been determined. Early consultation with a dermatologist is recommended to ensure greater diagnostic accuracy and appropriate management.

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In stage II/III HR+/HER2- eBC,

The NATALEE trial was designed to help patients START & STAY on KISQALI + AI—whether new to adjuvant therapy or already on ET

Patients were eligible for KISQALI even with up to 1 year of prior ET—the most inclusive ET eligibility window of any positive CDK4/6 inhibitor trial in eBC[4-6]

- NATALEE is the only positive trial of a CDK4/6 inhibitor to allow endocrine-based therapy for up to 1 year prior to randomization, so patients who began ET within the last year may still be candidates for treatment with KISQALI

Dosing was intentionally chosen for the adjuvant setting with the goal of balancing efficacy and safety[4]

- The **once-daily** 400-mg starting dose and 3-year duration were studied with the goal of minimizing dose-dependent adverse reactions and adherence issues related to tolerability—with the least possible impact on efficacy

ET, endocrine therapy.

IMPORTANT SAFETY INFORMATION (continued)

Severe cutaneous adverse reactions (continued). If SJS, TEN, or DiHS/DRESS is confirmed, permanently discontinue KISQALI. Do not reintroduce KISQALI in patients who have experienced SCARs or other life-threatening cutaneous reactions during KISQALI treatment.

QT interval prolongation. KISQALI has been shown to prolong the QT interval in a concentration-dependent manner.

Avoid KISQALI in patients who are at significant risk of developing torsades de pointes (TdP), including those with:

- congenital long QT syndrome;
- uncontrolled or significant cardiac disease, recent myocardial infarction, heart failure, unstable angina, bradyarrhythmias, uncontrolled hypertension, high degree atrioventricular block, severe aortic stenosis, or uncontrolled hypothyroidism;
- electrolyte abnormalities;
- taking drugs known to prolong QT interval and/or strong CYP3A inhibitors as this may lead to prolongation of the QTcF interval.

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In HR+/HER2- mBC,

KISQALI + AI or fulvestrant has been studied across 3 phase III trials

KISQALI is the only CDK4/6 inhibitor with a clinical trial dedicated to premenopausal patients[2]

Patient portrayal.

MONALEESA-2

1L postmenopausal patients with an AI

MONALEESA-2 was a randomized, double-blind, placebo-controlled, phase III study of KISQALI + letrozole (n=334) vs placebo + letrozole (n=334) in postmenopausal patients with HR+/HER2- mBC who received no prior therapy for advanced breast cancer. OS was a secondary end point; PFS was the primary end point.[2,7]

Patient portrayal.

MONALEESA-3

1L and 2L postmenopausal patients with fulvestrant

MONALEESA-3 was a randomized, double-blind, placebo-controlled, phase III study of KISQALI + fulvestrant (n=484) vs placebo + fulvestrant (n=242) in postmenopausal patients with HR+/HER2- mBC who received no or only 1 line of prior ET for advanced breast cancer. OS was a secondary end point; PFS was the primary end point.[2,8]

Patient portrayal.

MONALEESA-7

1L premenopausal patients with ET + goserelin

MONALEESA-7 was a randomized, double-blind, placebo-controlled, phase III study of KISQALI + ET (NSAI or tamoxifen) + goserelin (n=335) vs placebo + ET (NSAI or tamoxifen) + goserelin (n=337) (ITT) in premenopausal patients with HR+/HER2- mBC who received no prior ET for advanced breast cancer. **KISQALI is not indicated for concomitant use with tamoxifen.** Results are from a prespecified subgroup analysis of 495 patients who received KISQALI (n=248) or placebo (n=247) with an NSAI + goserelin. OS was a secondary end point; PFS was the primary end point.[2,9,10]

2L, second line; ITT, intent to treat; NSAI, nonsteroidal aromatase inhibitor; PFS, progression-free survival.

IMPORTANT SAFETY INFORMATION (continued)

QT interval prolongation (continued). Based on the observed QT prolongation during treatment, KISQALI may require dose interruption, reduction, or discontinuation.

In patients with eBC (NATALEE) who received 400 mg KISQALI plus NSAI, 8 out of 2494 patients (0.3%) had > 500 ms post-baseline QTcF interval value and 50 out of 2494 patients (2%) had > 60 ms QTcF increase from baseline. QTcF prolongation was reversible with dose interruption. The majority of QTcF prolongation occurred within the first 4 weeks of KISQALI. There were no reported cases of torsades de pointes.

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For your patients with HR+/HER2- eBC or mBC,

Start with a few baselines, then complete most scheduled assessments within the first 2 months of therapy—with none beyond Cycle 6

Assessment[2]	Baseline	Cycle 1	Cycle 2		Cycles 3-6
		Day 14	Day 1	Day 14	Day 1
CBC and LFT	✓	✓	✓	✓	✓
Electrolytes	✓	–	✓	–	✓
ECG	✓	✓	–	–	–

Monitoring requirements based on a 28-day treatment cycle.

Routine monitoring for lab abnormalities[2]

- Blood tests are performed at baseline, on Day 14 of Cycle 1, on Days 1 and 14 of Cycle 2, on Day 1 of Cycles 3 through 6, and as clinically indicated
- For LFTs, if grade ≥2 abnormalities are noted, more frequent monitoring is recommended
- Correct any electrolyte abnormalities prior to treatment
- Additional monitoring may be required as clinically indicated

2 required ECG assessments completed within the first 2 weeks of treatment[2]

- ECGs are performed at baseline, on Day 14 of Cycle 1, and as clinically indicated
- KISQALI should only be initiated in patients with QTcF <450 ms
- In case of QTcF prolongation during therapy, more frequent assessments are recommended
- Additional assessments may be required as clinically indicated

CBC, complete blood count; ECG, electrocardiogram; LFT, liver function test; QTcF, QT interval corrected by Fridericia's formula.

IMPORTANT SAFETY INFORMATION (continued)

QT interval prolongation (continued). In patients with advanced or mBC (MONALEESA-2, MONALEESA-3, and MONALEESA-7) who received 600 mg KISQALI plus NSAI or fulvestrant, 15 of 1054 patients (1.4%) had >500 ms postbaseline QTcF value, and 61 of 1054 (6%) had a >60 ms QTcF increase from baseline. QTcF prolongation was reversible with dose interruption. The majority of QTcF prolongation occurred within the first 4 weeks of KISQALI. There were no reported cases of torsades de pointes. In MONALEESA-2, in the KISQALI + letrozole treatment arm, there was 1 (0.3%) sudden death in a patient with grade 3 hypokalemia and grade 2 QT prolongation. No cases of sudden death were reported in MONALEESA-7 or MONALEESA-3.

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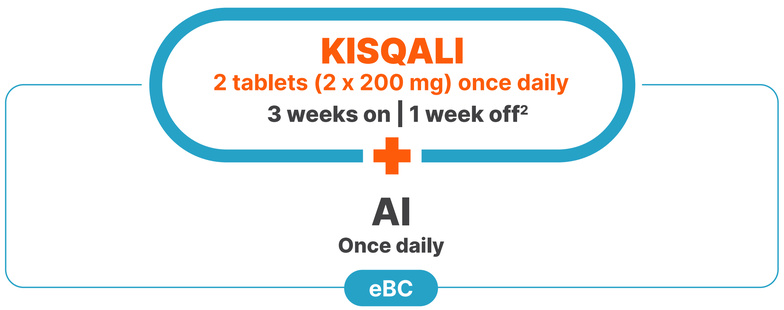
In HR+/HER2- eBC (stage II/III) and mBC,

Start with the dose that was studied and proven in patients like yours: 400 mg for eBC and 600 mg for mBC

The 400-mg starting dose was intentionally chosen for the adjuvant setting with the goal of balancing efficacy and safety[2,4]



- KISQALI is given as 400 mg (2 x 200-mg tablets) orally, once daily (3 weeks on, 1 week off) for 36 months with an AI
  - Review the full Prescribing Information for recommended dosing of selected AI
  - An LHRH agonist should be used concomitantly with AI in men and premenopausal women
- Patients should continue treatment for 3 years or until disease recurrence or unacceptable toxicity

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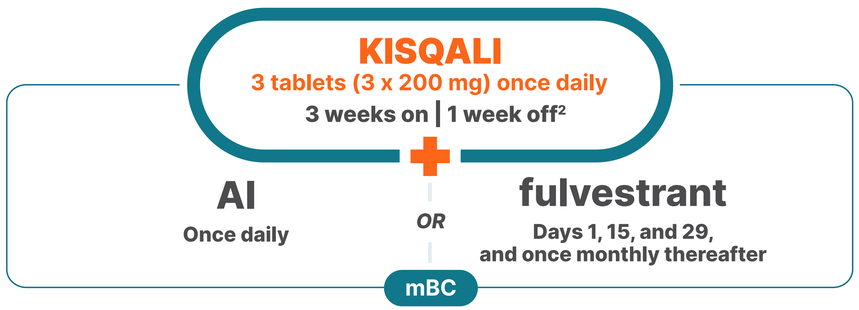
- KISQALI can be taken with or without food
- Store at room temperature at 20°C to 25°C (68°F to 77°F); excursions permitted between 15°C and 30°C (59°F and 86°F)
- Store tablets in the original blister package in order to protect from moisture

LHRH, luteinizing hormone-releasing hormone.

The 600-mg starting dose was studied in patients with mBC across 3 phase III trials[2]



- KISQALI is given as 600 mg (3 x 200-mg tablets) orally, once daily (3 weeks on, 1 week off) with either:
  - An AI once daily (continuously); in men and premenopausal women, an LHRH agonist should also be administered according to current clinical practice guidelines; or
  - Fulvestrant 500 mg intramuscularly on Days 1, 15, and 29, and once monthly thereafter; in men and premenopausal women, an LHRH agonist should also be administered according to current clinical practice guidelines
- Patients should continue treatment until disease progression or unacceptable toxicity

Regardless of indication or combination partner, KISQALI is taken once daily for 3 weeks on, 1 week off

IMPORTANT SAFETY INFORMATION (continued)

QT interval prolongation (continued). Perform electrocardiogram (ECG) in all patients prior to starting KISQALI. Initiate treatment with KISQALI only in patients with QTcF values <450 ms. Repeat ECG at approximately Day 14 of the first cycle, and as clinically indicated.

Monitor serum electrolytes (including potassium, calcium, phosphorus and magnesium) prior to the initiation of KISQALI, at the beginning of the first 6 cycles, and as clinically indicated. Correct any abnormality before starting KISQALI.

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Considerations for KISQALI dosing and administration

SELECT DRUG INTERACTIONS[2]	
Strong CYP3A4 inhibitors	• Avoid concomitant use • If coadministration cannot be avoided, in patients with eBC, reduce the KISQALI dose to 200 mg once daily. In patients with mBC, reduce the KISQALI dose to 400 mg once daily
Strong CYP3A4 inducers	• Avoid concomitant use
CYP3A substrates	• For CYP3A substrates where minimal increases in the concentration may increase CYP3A substrate adverse reactions, monitor for increased adverse reactions of the CYP3A substrate during treatment with KISQALI • The dose of the sensitive CYP3A substrate may need to be reduced as KISQALI can increase its exposure
Drugs known to prolong QT interval	• Avoid concomitant use of drugs such as antiarrhythmic medicines and other drugs that are known to prolong the QT interval • If concomitant use cannot be avoided, monitor ECG when initiating, during concomitant use, and as clinically indicated

CYP3A, cytochrome P450, family 3, subfamily A.

DOSE MODIFICATION FOR HEPATIC IMPAIRMENT[2]		
Indication	**Mild hepatic impairment (Child-Pugh class A)**	**Moderate and severe hepatic impairment (Child-Pugh class B or C)**
Early breast cancer	No dose adjustment is necessary	No dose adjustment is necessary
Advanced or metastatic breast cancer	No dose adjustment is necessary	KISQALI 400 mg once daily

No dose adjustment is necessary in patients with breast cancer who have mild to moderate [30 mL/min to 89 mL/min/1.73 m^2 ≤ estimated glomerular filtration rate (eGFR)] renal impairment. A reduced starting dose of 200 mg is recommended in patients with breast cancer who have severe renal impairment.[2]

IMPORTANT SAFETY INFORMATION (continued)

Increased QT prolongation with concomitant use of tamoxifen. KISQALI is not indicated for concomitant use with tamoxifen. Avoid use of tamoxifen with KISQALI. In MONALEESA-7, the observed mean QTcF increase from baseline was >10 ms higher in the tamoxifen + placebo subgroup compared with the nonsteroidal aromatase inhibitor (NSAI) + placebo subgroup. In the placebo arm, an increase of >60 ms from baseline occurred in 6/90 (7%) of patients receiving tamoxifen, and in no patients receiving an NSAI. An increase of >60 ms from baseline in the QTcF interval was observed in 14/87 (16%) of patients in the KISQALI and tamoxifen combination and in 18/245 (7%) of patients receiving KISQALI plus an NSAI.

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With 33.3 months of follow-up, in the adjuvant setting, for patients with stage II/III HR+/HER2- eBC,

No new safety signals were observed with KISQALI

ADVERSE REACTIONS (≥10% AND ≥2% HIGHER THAN AI-ALONE ARM) IN NATALEE[2]

	KISQALI + AI (n=2526)		AI alone (n=2441)	
	All grades (%)	Grade 3 or 4 (%)	All grades (%)	Grade 3 or 4 (%)
INFECTIONS AND INFESTATIONS				
Infections[a]	37	2	27	0.9
NERVOUS SYSTEM DISORDERS				
Headache	23	0.4[b]	17	0.2[b]
GASTROINTESTINAL DISORDERS				
Nausea	23	0.2[b]	8	0.1[b]
Diarrhea	15	0.6[b]	6	0.1[b]
Constipation	13	0.2[b]	5	0
Abdominal pain	11	0.5[b]	7	0.4[b]
GENERAL DISORDERS AND ADMINISTRATION-SITE CONDITIONS				
Fatigue	22	0.8[b]	13	0.2[b]
Asthenia	17	0.6[b]	12	0.1[b]
Pyrexia	11	0.2[b]	6	0.1[b]
SKIN AND SUBCUTANEOUS TISSUE DISORDERS				
Alopecia	15	0	4.6	0
RESPIRATORY, THORACIC, AND MEDIASTINAL DISORDERS				
Cough	13	0.1[b]	8	0.1[b]

ALT, alanine aminotransferase; AR, adverse reaction; AST aspartate aminotransferase; CTCAE, Common Terminology Criteria for Adverse Events; ILD, interstitial lung disease; SCAR, severe cutaneous adverse reaction.

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

The NATALEE trial was designed to maximize the efficacy benefit of KISQALI while minimizing dose-dependent ARs and adherence issues related to tolerability[4]

- The most common ARs (occurring in ≥20% of patients treated with KISQALI), including laboratory abnormalities, were decrease in lymphocytes, decrease in leukocytes, decrease in neutrophils, decrease in hemoglobin, increase in ALT, increase in AST, infections, increase in creatinine, decrease in platelets, headache, nausea, and fatigue[2]
- The most common grade ≥3 ARs, including laboratory abnormalities, occurring in ≥5% of patients were decrease in neutrophils, decrease in leukocytes, decrease in lymphocytes, increase in ALT, and increase in AST[2]
- Fatal ARs occurred in 0.6% of patients who received KISQALI. Fatal ARs in ≥0.1% of patients receiving KISQALI included COVID-19 or COVID-19 pneumonia (0.2%) and pulmonary embolism (0.1%)[2]
- Patients may require dose interruption, reduction, or discontinuation for ARs. Monitoring should include pulmonary symptoms, ECGs, serum electrolytes, LFTs, and CBCs. See Warnings and Precautions for risk of ILD/pneumonitis, SCARs, QT prolongation, hepatotoxicity, neutropenia, and embryo-fetal toxicity[2]
- In the NATALEE trial, no new safety signals were observed at 5 years of follow-up[11]

Grading according to CTCAE version 4.03.
[a]Infections included urinary and respiratory tract infections.[2]
[b]Only includes grade 3 ARs.[2]

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With 33.3 months of follow-up, in the adjuvant setting, for patients with stage II/III HR+/HER2- eBC,

No new lab abnormalities were observed with KISQALI

SELECT LABORATORY ABNORMALITIES (≥10%) IN NATALEE[2]

	KISQALI + AI (n=2526)		AI alone (n=2441)	
	All grades (%)	Grade 3 or 4 (%)	All grades (%)	Grade 3 or 4 (%)
HEMATOLOGY				
Lymphocyte count decreased	97	19	88	6
Leukocyte count decreased	95	27	45	0.6
Neutrophil count decreased	94	45	35	1.7
Hemoglobin decreased	47	0.6	26	0.3
Platelet count decreased	28	0.4	13	0.3
CHEMISTRY				
ALT increased	45	8	35	1
AST increased	44	5	33	1
Creatinine increased	33	0.3	11	0

- Grade 4 increases in ALT (1.5%) and AST (0.8%) were reported in the KISQALI + AI arm[2]
- Drug-induced liver injury was reported in 9 patients (0.4%), of which 5 were grade ≥3, and 8 had resolved as of the data cutoff. There were 8 (0.3%) clinically confirmed Hy's Law cases (including 4 out of 9 drug-induced liver injury mentioned above), 6 of which had resolved within 303 days and 2 of which were improving, all after discontinuation of KISQALI[2]
- In the NATALEE trial, no new lab abnormalities were observed at 5 years of follow-up[11]

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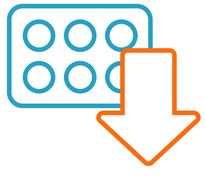
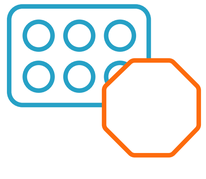
In stage II/III HR+/HER2- eBC,

With KISQALI, most adverse reactions were manageable and reversible with dose reduction, which may have helped patients remain on therapy



Rate of dose reductions due to ARs[12]

KISQALI + AI: 23.2% | **AI alone: 0%**



Rate of discontinuation due to ARs[12]

KISQALI + AI: 20.8% | **AI alone: 5.5%**

- Median time to KISQALI discontinuation was 4.2 months[13]

In NATALEE, the leading cause of discontinuation was asymptomatic laboratory findings such as increases in ALT or AST, not symptomatic ARs such as diarrhea, fatigue, and nausea

In NATALEE, the leading causes of KISQALI + AI discontinuation (occurring in ≥2% of patients) were increases in ALT or AST (8%).[2]

IMPORTANT SAFETY INFORMATION (continued)

Hepatotoxicity. In patients with eBC and advanced or mBC, drug-induced liver injury and increases in transaminases occurred with KISQALI.

In patients with eBC (NATALEE) treated with KISQALI, drug-induced liver injury was reported in 9 patients (0.4%), of which 5 were grade ≥3 and 8 had resolved as of the data cutoff. There were 8 (0.3%) clinically confirmed Hy's Law cases (including 4 out of 9 drug-induced liver injury mentioned above), 6 of which had resolved within 303 days and 2 were resolving, all after discontinuation of KISQALI. Grade 3/4 increases in alanine aminotransferase (ALT) and aspartate aminotransferase (AST) occurred in 8% and 4.7%, respectively, and grade 4 increases in ALT (1.5%) and AST (0.8%).

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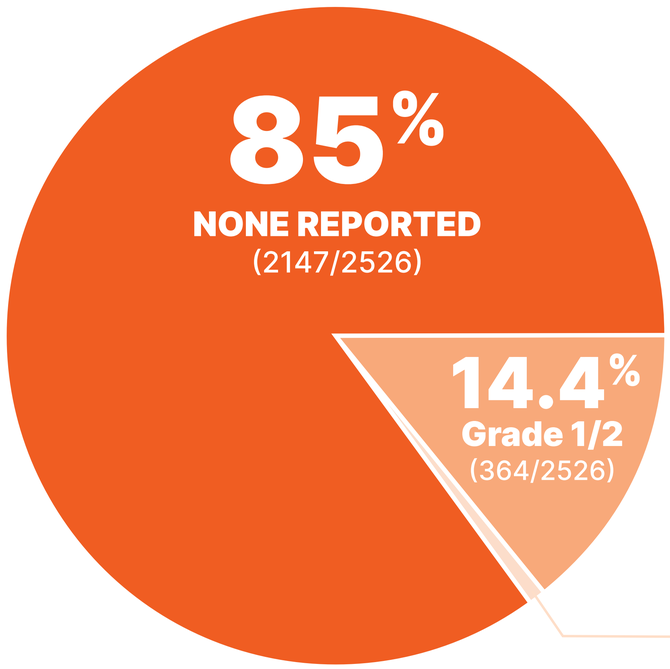
In the NATALEE clinical trial,

Reported rates of diarrhea were low with KISQALI

Diarrhea rates in NATALEE[2]



ADL, activities of daily living.

Diarrhea can be disruptive in many ways—from a daily, unpredictable inconvenience to a debilitating, even life-threatening condition[14]

- **Grade 1:** <4 stools/day over baseline; mild increase in ostomy output
- **Grade 2:** 4 to 6 stools per day over baseline; moderate increase in ostomy output; limiting instrumental ADL
- **Grade 3**: ≥7 stools per day over baseline; hospitalizations indicated; severe increase in ostomy output; limiting self-care ADL
- **Grade 4:** Life-threatening; urgent intervention indicated
- **Grade 5:** Death

IMPORTANT SAFETY INFORMATION (continued)

Hepatotoxicity (continued). In patients with advanced or mBC (MONALEESA-2, MONALEESA-7, and MONALEESA-3) treated with KISQALI, grade 3 or 4 increases in ALT and AST occurred in 11% and 8%, respectively. Among the patients who had grade ≥3 ALT/AST elevation, the median time to onset was 92 days for the KISQALI plus aromatase inhibitor or fulvestrant treatment arms. The median time to resolution to grade ≤2 was 21 days in the KISQALI plus aromatase inhibitor or fulvestrant treatment arms. In MONALEESA-2 and MONALEESA-3, concurrent elevations in ALT or AST >3x ULN and total bilirubin >2x ULN, with normal alkaline phosphatase, in the absence of cholestasis (Hy's Law) occurred in 6 (1%) patients and all patients recovered after discontinuation of KISQALI.

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In patients with stage II/III HR+/HER2- eBC,

Incidence of QT prolongation observed with KISQALI was low

INCIDENCE OF QT PROLONGATION IN THE NATALEE TRIAL[2,12]

All grades: **4.3%**

Grade ≥3: **0.3%**

Most cases of QT prolongation were moderate and reversible, and the majority occurred within the first 4 weeks of treatment

Among cases of QT prolongation[2]:

- **0.3%** had a >500 ms postbaseline QTcF value
- **2%** had a >60 ms increase from baseline in QTcF interval
- There were **no reported cases** of torsades de pointes

IMPORTANT SAFETY INFORMATION (continued)

Hepatotoxicity (continued). Perform liver function tests (LFTs) before initiating KISQALI. Monitor LFTs every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, and as clinically indicated. Based on the severity of the transaminase elevations, KISQALI may require dose interruption, reduction, or discontinuation.

Neutropenia. KISQALI causes concentration-dependent neutropenia. In patients with eBC (NATALEE) who received KISQALI plus NSAI, 94%, including 45% of grade 3/4, had a decrease in neutrophil counts (based on laboratory findings), 63% had an adverse drug reaction of neutropenia, and 0.3% had febrile neutropenia. The median time to grade ≥2 neutropenia was 18 days. The median time to resolution of grade ≥3 neutropenia to grade <3 was 10 days. Treatment discontinuation due to neutropenia was required in 1.1% of patients.

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KISQALI + letrozole safety profile

MONALEESA-2: KISQALI + letrozole in 1L postmenopausal patients

ADVERSE REACTIONS OCCURRING IN ≥10% AND ≥2% HIGHER THAN PLACEBO[2]

	KISQALI + letrozole (n=334)		Placebo + letrozole (n=330)	
	All grades (%)	Grade 3 or 4 (%)	All grades (%)	Grade 3 or 4 (%)
GASTROINTESTINAL DISORDERS				
Nausea	52	2.4[a]	29	0.6[a]
Diarrhea	35	1.2[a]	22	0.9[a]
Vomiting	29	3.6[a]	16	0.9[a]
Constipation	25	1.2[a]	19	0
Stomatitis	12	0.3[a]	7	0
Abdominal pain	11	1.2[a]	8	0
GENERAL DISORDERS AND ADMINISTRATION-SITE CONDITIONS				
Fatigue	37	2.4	30	0.9
Pyrexia	13	0.3[a]	6	0
Peripheral edema	12	0	10	0
SKIN AND SUBCUTANEOUS TISSUE DISORDERS				
Alopecia	33	0	16	0
Rash	17	0.6[a]	8	0
Pruritus	14	0.6[a]	6	0
NERVOUS SYSTEM DISORDERS				
Headache	22	0.3[a]	19	0.3[a]
Insomnia	12	0.3[a]	9	0
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS				
Back pain	20	2.1[a]	18	0.3[a]
METABOLISM AND NUTRITION DISORDERS				
Decreased appetite	19	1.5[a]	15	0.3[a]
RESPIRATORY, THORACIC, AND MEDIASTINAL DISORDERS				
Dyspnea	12	1.2[a]	9	0.6[a]
INFECTIONS AND INFESTATIONS				
Urinary tract infection	11	0.6[a]	8	0

- Dose reductions due to ARs: 45% with KISQALI + letrozole
- Permanent discontinuations: 7% with KISQALI + letrozole
- The most common ARs (≥20% on the KISQALI arm and ≥2% higher than placebo), including laboratory abnormalities, were decrease in neutrophils, decrease in leukocytes, decrease in hemoglobin, nausea, decrease in lymphocytes, increase in ALT, increase in AST, fatigue, diarrhea, alopecia, vomiting, decrease in platelets, constipation, headache, and back pain
- Fatal ARs occurred in 1.8% of patients who received KISQALI. Fatal ARs in ≥0.1% of patients receiving KISQALI included acute respiratory failure (0.6%), acute myocardial infarction, sudden death (with grade 3 hypokalemia and grade 2 QT prolongation), unknown cause, and pneumonia (0.3% each)

Grading according to CTCAE version 4.03.
[a]Only includes grade 3 ARs.

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

KISQALI + fulvestrant safety profile

MONALEESA-3: KISQALI + fulvestrant in 1L/2L postmenopausal patients

ADVERSE REACTIONS OCCURRING IN ≥10% AND ≥2% HIGHER THAN PLACEBO[2]

	KISQALI + fulvestrant (n=483)		Placebo + fulvestrant (n=241)	
	All grades (%)	Grade 3 or 4 (%)	All grades (%)	Grade 3 or 4 (%)
GASTROINTESTINAL DISORDERS				
Nausea	45	1.4[c]	28	0.8[c]
Diarrhea	29	0.6[c]	20	0.8[c]
Vomiting	27	1.4[c]	13	0
Constipation	25	0.8[c]	12	0
Abdominal pain	17	1.4[c]	13	0.8[c]
INFECTIONS AND INFESTATIONS				
Infections[a,b]	42	4.6[c]	30	1.7[c]
SKIN AND SUBCUTANEOUS TISSUE DISORDERS				
Rash	23	0.8[c]	8	0
Pruritus	20	0.2[c]	7	0
Alopecia	19	0	5	0
RESPIRATORY, THORACIC, AND MEDIASTINAL DISORDERS				
Cough	22	0	15	0
Dyspnea	15	1.4	12	1.7
METABOLISM AND NUTRITION DISORDERS				
Decreased appetite	16	0.2[c]	13	0
GENERAL DISORDERS AND ADMINISTRATION-SITE CONDITIONS				
Peripheral edema	15	0	7	0
Pyrexia	11	0.2[c]	7	0
NERVOUS SYSTEM DISORDERS				
Dizziness	13	0.2[c]	8	0

- Dose reductions due to ARs: 32% with KISQALI + fulvestrant
- Permanent discontinuations: 8% with KISQALI + fulvestrant
- The most common ARs (≥20% on the KISQALI arm and ≥2% higher than placebo), including laboratory abnormalities, were decrease in leukocytes, decrease in neutrophils, decrease in lymphocytes, increase in creatinine, decrease in hemoglobin, increase in AST, nausea, increase in ALT, infections, decrease in platelets, diarrhea, vomiting, constipation, decrease in glucose serum, cough, rash, and pruritus
- Fatal ARs occurred in 1.2% of patients who received KISQALI. Fatal ARs in ≥0.1% of patients receiving KISQALI included cardiac failure, ventricular arrhythmia, pneumonia, acute respiratory distress, pulmonary embolism, and hemorrhagic shock (0.2% each)

Grading according to CTCAE version 4.03.
[a]Infections included urinary and respiratory tract infections, gastroenteritis, and sepsis (1%).
[b]Includes the following fatal adverse reactions: pneumonia (n=1).
[c]Only includes grade 3 ARs.

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

KISQALI + NSAI + goserelin safety profile

MONALEESA-7: KISQALI + NSAI + goserelin in 1L premenopausal patients

ADVERSE REACTIONS OCCURRING IN ≥10% AND ≥2% HIGHER THAN PLACEBO[2]

	KISQALI + NSAI + goserelin (n=248)		Placebo + NSAI + goserelin (n=247)	
	All grades (%)	Grade 3 or 4 (%)	All grades (%)	Grade 3 or 4 (%)
INFECTIONS AND INFESTATIONS				
Infections[a]	36	1.6[b]	24	0.4[b]
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS				
Arthralgia	34	0.8[b]	29	1.2[b]
GASTROINTESTINAL DISORDERS				
Nausea	32	0	20	0
Constipation	16	0	12	0
Stomatitis	10	0	8	0.4[b]
SKIN AND SUBCUTANEOUS TISSUE DISORDERS				
Alopecia	21	0	13	0
Rash	17	0.4[b]	9	0
Pruritus	11	0	4	0
GENERAL DISORDERS AND ADMINISTRATION-SITE CONDITIONS				
Pyrexia	17	0.8[b]	7	0
Pain in extremity	10	0	8	1.2[b]
RESPIRATORY, THORACIC, AND MEDIASTINAL DISORDERS				
Cough	15	0	10	0

- Dose reductions due to ARs: 33% with KISQALI + NSAI + goserelin
- Permanent discontinuations: 3% with KISQALI + NSAI + goserelin
- The most common ARs (≥20% on the KISQALI arm and ≥2% higher than placebo), including laboratory abnormalities, were decrease in leukocytes, decrease in neutrophils, decrease in hemoglobin, decrease in lymphocytes, increase in gamma-glutamyl transferase, increase in AST, infections, arthralgia, increase in ALT, nausea, decrease in platelets, and alopecia

Grading according to CTCAE version 4.03.
[a]Infections included urinary and respiratory tract infections, gastroenteritis, and sepsis (<1%).
[b]Only includes grade 3 ARs.

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

KISQALI + letrozole safety profile

MONALEESA-2: KISQALI + letrozole in 1L postmenopausal patients

LABORATORY ABNORMALITIES OCCURRING IN ≥10% OF PATIENTS[2]				
	KISQALI + letrozole (n=334)		Placebo + letrozole (n=330)	
	All grades (%)	Grade 3 or 4 (%)	All grades (%)	Grade 3 or 4 (%)
HEMATOLOGY				
Leukocyte count decreased	93	34	29	1.5
Neutrophil count decreased	93	60	24	1.2
Hemoglobin decreased	57	1.8	26	1.2
Lymphocyte count decreased	51	14	22	3.9
Platelet count decreased	29	0.9	6	0.3
CHEMISTRY				
ALT increased	46	10	36	1.2
AST increased	44	7	32	1.5
Creatinine increased	20	0.6	6	0
Phosphorus decreased	13	5	4	0.6
Potassium decreased	11	1.2	7	1.2

- Patients may require dose interruption, reduction, or discontinuation for ARs. Monitoring should include pulmonary symptoms, ECGs, serum electrolytes, LFTs, and CBCs. See Warnings and Precautions for risk of ILD/pneumonitis, SCARs, QT prolongation, hepatotoxicity, neutropenia, and embryo-fetal toxicity

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

KISQALI + fulvestrant safety profile

MONALEESA-3: KISQALI + fulvestrant in 1L/2L postmenopausal patients

LABORATORY ABNORMALITIES OCCURRING IN ≥10% OF PATIENTS[2]

	KISQALI + fulvestrant (n=483)		Placebo + fulvestrant (n=241)	
	All grades (%)	Grade 3 or 4 (%)	All grades (%)	Grade 3 or 4 (%)
HEMATOLOGY				
Leukocyte count decreased	95	26	26	0.4
Neutrophil count decreased	92	53	21	0.8
Lymphocyte count decreased	69	16	35	4.1
Hemoglobin decreased	60	4.3	35	2.9
Platelet count decreased	33	1.9	11	0
CHEMISTRY				
Creatinine increased	65	1	33	0.4
GGT increased	52	8	49	10
AST increased	50	7	43	2.9
ALT increased	44	11	37	1.7
Glucose serum decreased	23	0	18	0
Phosphorus decreased	18	4.6	8	0.8
Albumin decreased	12	0	8	0

GGT, gamma-glutamyl transferase.

- Patients may require dose interruption, reduction, or discontinuation for ARs. Monitoring should include pulmonary symptoms, ECGs, serum electrolytes, LFTs, and CBCs. See Warnings and Precautions for risk of ILD/pneumonitis, SCARs, QT prolongation, hepatotoxicity, neutropenia, and embryo-fetal toxicity

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

KISQALI + NSAI + goserelin safety profile

MONALEESA-7: KISQALI + NSAI + goserelin in 1L premenopausal patients

LABORATORY ABNORMALITIES OCCURRING IN ≥10% OF PATIENTS[2]

	KISQALI + NSAI + goserelin (n=248)		Placebo + NSAI + goserelin (n=247)	
	All grades (%)	Grade 3 or 4 (%)	All grades (%)	Grade 3 or 4 (%)
HEMATOLOGY				
Leukocyte count decreased	93	36	30	0.8
Neutrophil count decreased	92	63	27	2.4
Hemoglobin decreased	84	2.4	51	0.4
Lymphocyte count decreased	55	14	18	2.8
Platelet count decreased	26	0.4	9	0.4
CHEMISTRY				
GGT increased	42	7	42	9
AST increased	37	4.8	35	1.6
ALT increased	33	6	31	1.6
Phosphorus decreased	14	1.6	11	0.8
Potassium decreased	11	1.2	14	1.2
Glucose serum decreased	10	0.4	10	0.4
Creatinine increased	8	0	2	0

- Patients may require dose interruption, reduction, or discontinuation for ARs. Monitoring should include pulmonary symptoms, ECGs, serum electrolytes, LFTs, and CBCs. See Warnings and Precautions for risk of ILD/pneumonitis, SCARs, QT prolongation, hepatotoxicity, neutropenia, and embryo-fetal toxicity

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

In patients with HR+/HER2- mBC,

Incidence of QT prolongation observed with KISQALI was low

The average incidence of QTcF >480 ms across all 3 trials was 5.4% for patients taking KISQALI[8,10,15]

IN A POOLED ANALYSIS ACROSS 3 PHASE III TRIALS OF 1054 PRE- AND POSTMENOPAUSAL PATIENTS TREATED WITH KISQALI + AN AI OR FULVESTRANT[2]:

1.4% (15/1054) had a >500 ms postbaseline QTcF value

6% (61/1054) experienced a >60 ms increase from baseline in QTcF interval

Most cases of QT prolongation were moderate and reversible with dose interruption and reduction

- There were no reported cases of torsades de pointes
- KISQALI has been shown to prolong the QT interval in a concentration-dependent manner
- In MONALEESA-2, there was 1 (0.3%) sudden death in a patient with grade 3 hypokalemia and grade 2 QT prolongation
- Based on the observed QT prolongation during treatment, KISQALI may require dose interruption, reduction, or discontinuation
- **In case of QTcF prolongation at any given time during treatment, more frequent ECG monitoring is recommended**

In the subgroup of patients who received tamoxifen, an increased risk for QT prolongation was observed. KISQALI is not indicated for concomitant use with tamoxifen.

IMPORTANT SAFETY INFORMATION (continued)

Neutropenia (continued). In patients with advanced or metastatic breast cancer (MONALEESA-2, MONALEESA-7, and MONALEESA-3) who received KISQALI plus NSAI or fulvestrant, 75% had neutropenia, 62% had grade 3/4 decrease in neutrophil count (based on laboratory findings), and 1.7% had febrile neutropenia. The median time to grade ≥2 neutropenia was 17 days. The median time to resolution of grade ≥3 neutropenia to grade <3 was 12 days. Treatment discontinuation due to neutropenia was required in 1% of patients.

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

Help your patients with HR+/HER2- eBC or mBC

START & STAY on KISQALI with simple dose reductions

Dose reductions with KISQALI mean no need for new mid-cycle prescriptions or additional costs[2]

	eBC	mBC
Starting dose	2 200-mg TABLETS (400 mg)	3 200-mg TABLETS (600 mg)
1st reduction	1 200-mg TABLET (200 mg)	2 200-mg TABLETS (400 mg)
2nd reduction	—	1 200-mg TABLET (200 mg)

- Dose adjustments for ARs should be made stepwise by reducing the number of tablets taken
- Dose modification is recommended based on individual safety and tolerability
- If dose reduction below 200 mg/day is required, discontinue treatment

- **KISQALI is given as 400 mg (2 x 200-mg tablets) and 600 mg (3 x 200-mg tablets) orally once daily (3 weeks on, 1 week off) for HR+/HER2- eBC and HR+/HER2- mBC, respectively, with either:**
  - An AI once daily (continuously); in men and premenopausal women, an LHRH agonist should also be administered according to current clinical practice guidelines; or
  - In mBC only: fulvestrant 500 mg intramuscularly on Days 1, 15, and 29, and once monthly thereafter; in men and premenopausal women, an LHRH agonist should also be administered according to current clinical practice guidelines
- Early breast cancer patients should continue treatment for 3 years or until disease recurrence or unacceptable toxicity
- Metastatic breast cancer patients should continue treatment until disease progression or unacceptable toxicity
- KISQALI can be taken with or without food
- Store at room temperature at 20°C to 25°C (68°F to 77°F); excursions permitted between 15°C and 30°C (59°F and 86°F)
- Store in the original blister package in order to protect from moisture

IMPORTANT SAFETY INFORMATION (continued)

Adverse reactions in advanced or metastatic breast cancer patients. Most common (incidence ≥20%) adverse reactions include infections, nausea, fatigue, diarrhea, vomiting, headache, constipation, alopecia, cough, rash, and back pain.

Laboratory abnormalities. Across clinical trials of patients with advanced or metastatic breast cancer, the most common laboratory abnormalities reported in the KISQALI arm (all grades, pooled incidence ≥20%) **were leukocytes decreased, neutrophils decreased, hemoglobin decreased, lymphocytes decreased, AST increased, gamma-glutamyl transferase increased, ALT increased, creatinine increased, platelets decreased, and glucose serum decreased**.

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

In HR+/HER2- eBC or mBC,

Straightforward dose adjustments may help manage ARs so patients can stay on treatment

ILD/PNEUMONITIS[2]	
Grade 1 (asymptomatic)	No dose interruption or adjustment is required • Initiate appropriate medical therapy and monitor as clinically indicated
Grade 2 (symptomatic)	Interrupt dose until recovery to grade ≤1, then consider resuming KISQALI at the next lower dose level • If grade 2 recurs, discontinue
Grade 3 (severe symptomatic) **or grade 4**	Discontinue

- For grade 2 ILD/pneumonitis, an individualized benefit-risk assessment should be performed when considering resuming KISQALI

CUTANEOUS ADVERSE REACTIONS, INCLUDING SCARs[2]	
Grade 1 or grade 2 (<10% or 10%-30% of BSA, respectively, with active skin toxicity, no signs of systemic involvement)	No dose adjustment is required • Initiate appropriate medical therapy and monitor as clinically indicated
Grade 3 (severe rash not responsive to medical management; >30% BSA with active skin toxicity, signs of systemic involvement present; SJS)	Interrupt KISQALI until the etiology of the reaction has been determined If etiology is not a SCAR, • Interrupt dose until recovery to grade ≤1; resume at same dose level • If grade 3 reaction recurs, resume at next lower dose level If etiology is a SCAR, permanently discontinue KISQALI
Grade 4 (any % BSA associated with extensive superinfection, with IV antibiotics indicated; life-threatening consequences; TEN)	Permanently discontinue

BSA, body surface area; IV, intravenous; SJS, Stevens-Johnson syndrome; TEN, toxic epidermal necrolysis.

- SJS (grades 3 and 4) is skin sloughing covering <10% BSA and 10%-30% BSA, respectively, with associated signs. TEN (grade 4) is defined as skin sloughing covering ≥30% BSA with associated symptoms
  - Signs and symptoms of SJS and TEN include erythema, purpura, epidermal detachment, and mucous membrane detachment

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

In HR+/HER2- eBC or mBC,

Straightforward dose adjustments may help manage ARs so patients stay on treatment (continued)

NEUTROPENIA[2]	
Grade 1 or grade 2 (ANC 1000/mm^3 - < LLN)	No dose adjustment required
Grade 3 (afebrile) (ANC 500/mm^3 - <1000/mm^3)	Interrupt dose until recovery to grade ≤2; resume at same dose level • If grade 3 recurs, interrupt dose until recovery; resume at next lower dose level
Grade 3 (febrile) **or grade 4** (ANC <500/mm^3)	Interrupt dose until recovery to grade ≤2; resume at next lower dose level

ANC, absolute neutrophil count; LLN, lower limit of normal.

- Grade 3 febrile neutropenia is defined as a single episode of fever >38.3°C or ≥38°C for more than 1 hour and/or concurrent infection
- CBCs should be assessed prior to initiation of treatment. Repeat CBCs every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, and as clinically indicated

QT PROLONGATION[2]	
QTcF prolongation >480 ms and ≤500 ms	Interrupt treatment until recovery to ≤480 ms; in patients with eBC, resume at same dose level. In patients with mBC, reduce to the next lower dose level • If QTcF >480 ms recurs, interrupt dose until recovery; resume at next lower dose level
QTcF prolongation >500 ms	Interrupt treatment until recovery to ≤480 ms; resume at next lower dose level • If QTcF >500 ms recurs, discontinue KISQALI • Permanently discontinue KISQALI if QTcF interval prolongation is either >500 ms or >60 ms change from baseline AND associated with torsades de pointes, polymorphic ventricular tachycardia, syncope, or signs/symptoms of serious arrhythmia

- ECGs should be assessed prior to initiation of treatment. Initiate treatment with KISQALI only in patients with QTcF values less than 450 ms. Repeat ECGs at approximately Day 14 of the first cycle and as clinically indicated. In case of QTcF prolongation at any given time during treatment, more frequent ECG monitoring is recommended
- Serum electrolytes (including potassium, calcium, phosphorus, and magnesium) should be assessed prior to the initiation of treatment, at the beginning of each of the first 6 cycles, and as clinically indicated. Correct any abnormality before starting KISQALI therapy

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

In HR+/HER2- eBC or mBC,

Straightforward dose adjustments may help manage ARs so patients stay on treatment (continued)

ALT AND/OR AST ELEVATION[2]	
Grade 1 (> ULN - 3 × ULN) or **grade 2 at baseline** (>3 - 5 × ULN)	No dose adjustment required
New grade 2 (>3 - 5 × ULN)	Interrupt dose until recovery to ≤ baseline grade; resume at same dose level • If grade 2 recurs, resume at next lower dose level
Grade 3 (>5 - 20 × ULN)	Interrupt dose until recovery to ≤ baseline grade; resume at next lower dose level • If grade 3 recurs, discontinue
Grade 4 (>20 × ULN) **or any grade with TB >2 × ULN without cholestasis**	Discontinue

TB, total bilirubin; ULN, upper limit of normal.

- LFTs should be assessed prior to initiation of treatment. Repeat LFTs every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, and as clinically indicated. If grade ≥2 abnormalities are noted, more frequent monitoring is recommended

OTHER TOXICITIES[2]	
Grade 1 or grade 2	No dose adjustment required • Initiate appropriate medical therapy and monitor as clinically indicated
Grade 3	Interrupt dose until recovery to grade ≤1; resume at same dose level • If grade 3 recurs, resume at next lower dose level
Grade 4	Discontinue

- Grading criteria from CTCAE v4.03. Adverse reactions not requiring a dose adjustment are not shown. Initiate appropriate medical therapy as clinically indicated
- Clinical judgment of the treating physician should guide the management plan of each patient based on individual benefit-risk assessment

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

KISQALI—broad access and coverage to help make treatment available for more of your patients

For the majority of patients with prescription drug insurance coverage, all or nearly all of the cost of KISQALI is covered, and prior authorizations are approved within 1 day

For Medicare members, nearly

90% of KISQALI out-of-pocket costs were between **$0** and **$20** per month[16]

For patients with commercial insurance, approximately

80% of KISQALI out-of-pocket costs were between **$0** and **$50** per month[16]

More than

90% of KISQALI PAs are approved in less than **24 hours**[17]

More than 9 out of 10 patients have preferred formulary coverage for KISQALI[18]

Unrestricted or single-step edit coverage from MMIT data as of February 2026.

PA, prior authorization.
Novartis does not guarantee payment or coverage for any product or service. Actual coverage and reimbursement decisions are made by individual payers following receipt of claims. Coverage is subject to change by the relevant payer.

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

Novartis Patient Support™—a dedicated team for your patients

Novartis Patient Support is a comprehensive program that is designed to help your eligible patients start, stay, and save on KISQALI

We support your patient's journey with:

Insurance Support

Help navigating the insurance process, including benefits verification

Financial Support

Assistance with connecting patients to relevant savings options, including $0 Co-Pay Plus* offer and affordability programs

Electrocardiogram (ECG) Testing Support

Guidance on workflow and options for testing

Ongoing Support

Dedicated assistance from our team and educational resources to help your patients get started on treatment and guide them along the way

Visit Novartis Patient Support to learn more OR fill out the electronic Start Form on the CoverMyMeds® portal by visiting CoverMyMeds.health

To learn more, contact your dedicated Novartis Patient Support team at 866-433-8000,
Monday-Friday, 8:00 AM - 8:00 PM ET, excluding holidays

***Limitations apply.** Subject to annual co-pay benefit limit. Offer not valid under Medicare, Medicaid, or any other federal or state programs. Novartis reserves the right to rescind, revoke, or amend this program without notice. Additional limitations may apply. See complete Terms & Conditions at support.kisqali.com for details.

CoverMyMeds is a registered trademark of CoverMyMeds LLC.

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

Downloadable resources

Access tools and resources for stage II and III HR+/HER2- early breast cancer

Access tools and resources for HR+/HER2- metastatic breast cancer

Visit KISQALI-HCP.com to download indication-specific and dual-indication resources for KISQALI, such as:

- Assessments and dosing tools
- KISQALI EHR tools
- Patient resources
- Access, coding, and reimbursement guides

EHR, electronic health record.

Please see additional Important Safety Information throughout and click here for full Prescribing Information for KISQALI.

KISQALI® ribociclib 200 mg tablets

Indications

KISQALI is indicated:

- in combination with an aromatase inhibitor for the adjuvant treatment of adults with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative stage II and III early breast cancer (eBC) at high risk of recurrence
- for the treatment of adults with HR-positive, HER2-negative advanced or metastatic breast cancer (mBC) in combination with:
  - an aromatase inhibitor as initial endocrine-based therapy; or
  - fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy

IMPORTANT SAFETY INFORMATION

Interstitial lung disease/pneumonitis. Severe, life-threatening, or fatal interstitial lung disease (ILD) and/or pneumonitis can occur in patients treated with KISQALI and other CDK4/6 inhibitors.

In patients with eBC (NATALEE) who received 400 mg KISQALI plus a nonsteroidal aromatase inhibitor (NSAI), 1.5% of patients had ILD/pneumonitis (grade 1/2).

In patients with advanced or mBC (MONALEESA-2, MONALEESA-3, MONALEESA-7), 1.6% of patients had ILD/pneumonitis of any grade, 0.4% had grade 3/4, and 0.1% had a fatal outcome. Additional cases of ILD/pneumonitis have occurred in the postmarketing setting, some resulting in death.

Monitor patients for pulmonary symptoms indicative of ILD/pneumonitis, which may include hypoxia, cough, and dyspnea. In patients who have new or worsening respiratory symptoms suspected to be due to ILD or pneumonitis, interrupt KISQALI immediately and evaluate the patient. Permanently discontinue treatment with KISQALI in patients with severe ILD/pneumonitis or any recurrent symptomatic ILD/pneumonitis.

Severe cutaneous adverse reactions. Severe cutaneous adverse reactions (SCARs), including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), and drug-induced hypersensitivity syndrome (DiHS)/drug reaction with eosinophilia and systemic symptoms (DRESS) can occur in patients treated with KISQALI.

If signs or symptoms of SCARs occur, interrupt KISQALI until the etiology of the reaction has been determined. Early consultation with a dermatologist is recommended to ensure greater diagnostic accuracy and appropriate management.

If SJS, TEN, or DiHS/DRESS is confirmed, permanently discontinue KISQALI. Do not reintroduce KISQALI in patients who have experienced SCARs or other life-threatening cutaneous reactions during KISQALI treatment.

QT interval prolongation. KISQALI has been shown to prolong the QT interval in a concentration-dependent manner.

Avoid KISQALI in patients who are at significant risk of developing torsades de pointes (TdP), including those with:

- congenital long QT syndrome;
- uncontrolled or significant cardiac disease, recent myocardial infarction, heart failure, unstable angina, bradyarrhythmias, uncontrolled hypertension, high degree atrioventricular block, severe aortic stenosis, or uncontrolled hypothyroidism;
- electrolyte abnormalities;
- taking drugs known to prolong QT interval and/or strong CYP3A inhibitors as this may lead to prolongation of the QTcF interval.

Based on the observed QT prolongation during treatment, KISQALI may require dose interruption, reduction, or discontinuation.

In patients with eBC (NATALEE) who received 400 mg KISQALI plus NSAI, 8 out of 2494 patients (0.3%) had > 500 ms post-baseline QTcF interval value and 50 out of 2494 patients (2%) had > 60 ms QTcF increase from baseline. QTcF prolongation was reversible with dose interruption. The majority of QTcF prolongation occurred within the first 4 weeks of KISQALI. There were no reported cases of torsades de pointes.

In patients with advanced or mBC (MONALEESA-2, MONALEESA-3, and MONALEESA-7) who received 600 mg KISQALI plus NSAI or fulvestrant, 15 of 1054 patients (1.4%) had >500 ms postbaseline QTcF value, and 61 of 1054 (6%) had a >60 ms QTcF increase from baseline. QTcF prolongation was reversible with dose interruption. The majority of QTcF prolongation occurred within the first 4 weeks of KISQALI. There were no reported cases of torsades de pointes. In MONALEESA-2, in the KISQALI + letrozole treatment arm, there was 1 (0.3%) sudden death in a patient with grade 3 hypokalemia and grade 2 QT prolongation. No cases of sudden death were reported in MONALEESA-7 or MONALEESA-3.

Perform electrocardiogram (ECG) in all patients prior to starting KISQALI. Initiate treatment with KISQALI only in patients with QTcF values <450 ms. Repeat ECG at approximately Day 14 of the first cycle, and as clinically indicated.

Monitor serum electrolytes (including potassium, calcium, phosphorus and magnesium) prior to the initiation of KISQALI, at the beginning of the first 6 cycles, and as clinically indicated. Correct any abnormality before starting KISQALI.

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IMPORTANT SAFETY INFORMATION (continued)

Increased QT prolongation with concomitant use of tamoxifen. KISQALI is not indicated for concomitant use with tamoxifen. Avoid use of tamoxifen with KISQALI. In MONALEESA-7, the observed mean QTcF increase from baseline was >10 ms higher in the tamoxifen + placebo subgroup compared with the nonsteroidal aromatase inhibitor (NSAI) + placebo subgroup. In the placebo arm, an increase of >60 ms from baseline occurred in 6/90 (7%) of patients receiving tamoxifen, and in no patients receiving an NSAI. An increase of >60 ms from baseline in the QTcF interval was observed in 14/87 (16%) of patients in the KISQALI and tamoxifen combination and in 18/245 (7%) of patients receiving KISQALI plus an NSAI.

Hepatotoxicity. In patients with eBC and advanced or mBC, drug-induced liver injury and increases in transaminases occurred with KISQALI.

In patients with eBC (NATALEE) treated with KISQALI, drug-induced liver injury was reported in 9 patients (0.4%), of which 5 were grade ≥3 and 8 had resolved as of the data cutoff. There were 8 (0.3%) clinically confirmed Hy's Law cases (including 4 out of 9 drug-induced liver injury mentioned above), 6 of which had resolved within 303 days and 2 were resolving, all after discontinuation of KISQALI. Grade 3/4 increases in alanine aminotransferase (ALT) and aspartate aminotransferase (AST) occurred in 8% and 4.7%, respectively, and grade 4 increases in ALT (1.5%) and AST (0.8%).

In patients with advanced or mBC (MONALEESA-2, MONALEESA-7, and MONALEESA-3) treated with KISQALI, grade 3 or 4 increases in ALT and AST occurred in 11% and 8%, respectively. Among the patients who had grade ≥3 ALT/AST elevation, the median time to onset was 92 days for the KISQALI plus aromatase inhibitor or fulvestrant treatment arms. The median time to resolution to grade ≤2 was 21 days in the KISQALI plus aromatase inhibitor or fulvestrant treatment arms. In MONALEESA-2 and MONALEESA-3, concurrent elevations in ALT or AST >3x ULN and total bilirubin >2x ULN, with normal alkaline phosphatase, in the absence of cholestasis (Hy's Law) occurred in 6 (1%) patients and all patients recovered after discontinuation of KISQALI.

Perform liver function tests (LFTs) before initiating KISQALI. Monitor LFTs every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, and as clinically indicated. Based on the severity of the transaminase elevations, KISQALI may require dose interruption, reduction, or discontinuation.

Neutropenia. KISQALI causes concentration-dependent neutropenia. In patients with eBC (NATALEE) who received KISQALI plus NSAI, 94%, including 45% of grade 3/4, had a decrease in neutrophil counts (based on laboratory findings), 63% had an adverse drug reaction of neutropenia, and 0.3% had febrile neutropenia. The median time to grade ≥2 neutropenia was 18 days. The median time to resolution of grade ≥3 neutropenia to grade <3 was 10 days. Treatment discontinuation due to neutropenia was required in 1.1% of patients.

Neutropenia (continued). In patients with advanced or metastatic breast cancer (MONALEESA-2, MONALEESA-7, and MONALEESA-3) who received KISQALI plus NSAI or fulvestrant, 75% had neutropenia, 62% had grade 3/4 decrease in neutrophil count (based on laboratory findings), and 1.7% had febrile neutropenia. The median time to grade ≥2 neutropenia was 17 days. The median time to resolution of grade ≥3 neutropenia to grade <3 was 12 days. Treatment discontinuation due to neutropenia was required in 1% of patients.

Perform complete blood count (CBC) before initiating therapy with KISQALI. Monitor CBC every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, and as clinically indicated. Based on the severity of the neutropenia, KISQALI may require dose interruption, reduction, or discontinuation.

Embryo-fetal toxicity. Based on findings from animal studies and the mechanism of action, KISQALI can cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to a fetus. Advise women of reproductive potential to use effective contraception during therapy with KISQALI and for at least 3 weeks after the last dose.

Adverse reactions in early breast cancer patients. Most common (incidence ≥20%) adverse reactions include infections, nausea, headache, and fatigue.

Laboratory abnormalities. In a clinical trial of patients with early breast cancer, the most common laboratory abnormalities reported in the KISQALI arm (all grades, pooled incidence ≥20%) **were lymphocytes decreased, leukocyte decreased, neutrophil decreased, hemoglobin decreased, alanine aminotransferase increased, aspartate aminotransferase increased, creatinine increased, and platelets decreased**.

Adverse reactions in advanced or metastatic breast cancer patients. Most common (incidence ≥20%) adverse reactions include infections, nausea, fatigue, diarrhea, vomiting, headache, constipation, alopecia, cough, rash, and back pain.

Laboratory abnormalities. Across clinical trials of patients with advanced or metastatic breast cancer, the most common laboratory abnormalities reported in the KISQALI arm (all grades, pooled incidence ≥20%) **were leukocytes decreased, neutrophils decreased, hemoglobin decreased, lymphocytes decreased, AST increased, gamma-glutamyl transferase increased, ALT increased, creatinine increased, platelets decreased, and glucose serum decreased**.

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1. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Breast Cancer V.2.2026. © National Comprehensive Cancer Network, Inc. 2026. All rights reserved. Accessed March 4, 2026. To view the most recent and complete version of the guideline, go online to NCCN.org. **2.** Kisqali. Prescribing information. Novartis Pharmaceuticals Corp. **3.** Slamon D, Lipatov O, Nowecki Z, et al. Ribociclib plus endocrine therapy in early breast cancer. *N Engl J Med*. 2024;390(12):1080-1091. doi:10.1056/NEJMoa2305488 **4.** Slamon DJ, Fasching PA, Hurvitz S, et al. Rationale and trial design of NATALEE: a phase III trial of adjuvant ribociclib + endocrine therapy versus endocrine therapy alone in patients with HR+/HER2- early breast cancer. *Ther Adv Med Oncol.* 2023;15:1-16. doi:10.1177/17588359231178125 **5.** Mayer EL, Dueck AC, Martin M, et al. Palbociclib with adjuvant endocrine therapy in early breast cancer (PALLAS): interim analysis of a multicentre, open-label, randomised, phase 3 study. *Lancet Oncol.* 2021;22(2):212-222. doi:10.1016/S1470-2045(20)30642-2 **6.** Johnston SRD, Toi M, O'Shaughnessy J, et al. Abemaciclib plus endocrine therapy for hormone receptor-positive, HER2-negative, node-positive, high-risk early breast cancer (monarchE): results from a preplanned interim analysis of a randomised, open-label, phase 3 trial. *Lancet Oncol.* 2023;24(1):77-90. doi:10.1016/S1470-2045(22)00694-5 **7.** Hortobagyi GN, Stemmer SM, Burris HA, et al. Overall survival with ribociclib plus letrozole in advanced breast cancer. *N Engl J Med.* 2022;386(10):942-950. doi:10.1056/NEJMoa2114663 **8.** Slamon DJ, Neven P, Chia S, et al. Phase III randomized study of ribociclib and fulvestrant in hormone receptor–positive, human epidermal growth factor receptor 2–negative advanced breast cancer: MONALEESA-3. *J Clin Oncol.* 2018;36(24):2465-2472. doi:10.1200/JCO.2018.78.9909 **9.** Im S-A, Lu Y-S, Bardia A, et al. Overall survival with ribociclib plus endocrine therapy in breast cancer. *N Engl J Med.* 2019;381(4):307-316. doi:10.1056/NEJMoa1903765 **10.** Tripathy D, Im S-A, Colleoni M, et al. Ribociclib plus endocrine therapy for premenopausal women with hormone-receptor-positive, advanced breast cancer (MONALEESA-7): a randomised phase 3 trial. *Lancet Oncol.* 2018;19(7):904-915. doi:10.1016/S1470-2045(18)30292-4 **11.** Crown J, Stroyakovskii D, Yardley DA, et al. Adjuvant ribociclib plus nonsteroidal aromatase inhibitor therapy in patients with HR-positive/HER2-negative early breast cancer: 5-year follow-up of NATALEE efficacy outcomes and updated overall survival. *ESMO Open.* 2025;10(11):105858. doi:10.1016/j.esmoop.2025.105858 **12.** Data on file. CLEE011O12301C (NATALEE) final iDFS analysis CSR. Novartis Pharmaceuticals Corp; 2023. **13.** Barrios C, Harbeck N, Hortobagyi G, et al. NATALEE update: safety and treatment duration of ribociclib + nonsteroidal aromatase inhibitor in patients with HR+/HER2- early breast cancer. Presented at: ESMO Breast Cancer 2024; May 15-17, 2024; Berlin, Germany. **14.** US Department of Health and Human Services. Common Terminology Criteria for Adverse Events (CTCAE), Version 5.0. Published November 27, 2017. Accessed March 13, 2026. https://dctd.cancer.gov/research/ctep-trials/for-sites/adverse-events/ctcae-v5-8x11.pdf **15.** Hortobagyi GN, Stemmer SM, Burris HA, et al. Updated results from MONALEESA-2, a phase III trial of first-line ribociclib plus letrozole versus placebo plus letrozole in hormone receptor-positive, HER2-negative advanced breast cancer. *Ann Oncol.* 2018;29(7):1541-1547. doi:10.1093/annonc/mdy155 **16.** Data on file. Kisqali IQVIA data through November 2025. Novartis Pharmaceuticals Corp; 2025. **17.** Data on file. Kisqali CMM AMP data review February 2026. Novartis Pharmaceuticals Corp; 2026. **18.** Data on file. Kisqali MMIT data February 2026. Novartis Pharmaceuticals Corp; 2026.

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