Indication: VENCLEXTA is indicated in combination with azacitidine, or decitabine, or low-dose cytarabine for the treatment of newly diagnosed acute myeloid leukemia (AML) in adults 75 years or older, or who have comorbidities that preclude use of intensive induction chemotherapy.

IN A PHASE 3 TRIAL
VENCLEXTA + AZACITIDINE WAS PROVEN TO HELP
NEWLY DIAGNOSED AML PATIENTS LIVE LONGER

VIALE-A: A randomized (2:1), double-blind, placebo-controlled, multicenter, phase 3 study that evaluated the efficacy and safety of VENCLEXTA in combination with azacitidine (VEN+AZA; N=286) vs placebo with azacitidine (PBO+AZA; N=145) in adults with newly diagnosed AML who were ≥75 years of age, or had comorbidities that precluded the use of intensive induction chemotherapy.

National Comprehensive Cancer Network® (NCCN®) Recommendations* for Venetoclax Combination-Based Regimens2

For patients ≥60 years of age who are not candidates for intensive induction chemotherapy in first-line AML:

- VENETOCLAX + DECITABINE: CATEGORY 2A PREFERRED
- VENETOCLAX + LOW-DOSE CYTARABINE: CATEGORY 2A RECOMMENDED
- VENETOCLAX + AZACITIDINE: THE ONLY CATEGORY 1 PREFERRED

Important Safety Information

Tumor Lysis Syndrome

- Tumor lysis syndrome (TLS), including fatal events and renal failure requiring dialysis, has occurred in patients treated with VENCLEXTA.
- VENCLEXTA can cause rapid reduction in tumor and thus poses a risk for TLS at initiation and during the ramp-up phase in all patients. Changes in blood chemistries consistent with TLS that require prompt management can occur as early as 6 to 8 hours following the first dose of VENCLEXTA and at each dose increase.
- In patients with AML who followed the current 3-day ramp-up dosing schedule and the TLS prophylaxis and monitoring measures, the rate of TLS was 1.1% in patients who received VENCLEXTA in combination with azacitidine. In patients with AML who followed a 4-day ramp-up dosing schedule and the TLS prophylaxis and monitoring measures, the rate of TLS was 5.6% and included deaths and renal failure in patients who received VENCLEXTA in combination with low-dose cytarabine.
- The risk of TLS is a continuum based on multiple factors, particularly reduced renal function, tumor burden, and type of malignancy.
- Assess all patients for risk and provide appropriate prophylaxis for TLS, including hydration and anti-hyperuricemics. Monitor blood chemistries and manage abnormalities promptly. Employ more intensive measures (IV hydration, frequent monitoring, hospitalization) as overall risk increases. Interrupt dosing if needed; when restarting VENCLEXTA follow dose modification guidance in the Prescribing Information.
- Concomitant use of VENCLEXTA with P-gp inhibitors or strong or moderate CYP3A inhibitors increases venetoclax exposure, which may increase the risk of TLS at initiation and during the ramp-up phase, and requires VENCLEXTA dose adjustment.

Median Overall Survival1

<table>
<thead>
<tr>
<th>VEN+AZA</th>
<th>VS</th>
<th>PBO+AZA</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.7 months</td>
<td>9.6 months</td>
<td></td>
</tr>
</tbody>
</table>

95% CI: (11.9, 18.7) 95% CI: (7.4, 12.7)

OS: HR=0.66; 95% CI: (0.52, 0.85); P<0.001

*See NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for AML, Version 2.2021, for complete recommendations. 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.

†Actionable mutations include IDH1/2 and FLT3.

CI=confidence interval; OS=overall survival; HR=hazard ratio; IDH=isocitrate dehydrogenase; FLT=fms-like tyrosine kinase.

©2022 AbbVie. VENCLEXTA is a registered trademark of AbbVie Inc. Please see additional Important Safety Information on pages 16 and 17. Please see accompanying full Prescribing Information or visit www.rxabbvie.com/pdf/venclexta.pdf.
Efficacy and safety of VENCLEXTA + azacitidine (VEN+AZA) was evaluated in a pivotal phase 3 trial. VIALE-A studied newly diagnosed AML patients who were ≥75 years of age or had comorbidities that precluded the use of intensive induction chemotherapy. Efficacy was based on overall survival (OS), measured from the date of randomization to death from any cause. Select clinical endpoints included complete remission (CR) and complete remission with partial hematologic recovery (CRh). Additional baseline characteristics are summarized in the table below.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>VEN+AZA (N=286)</th>
<th>PBO+AZA (N=145)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years; median (range)</td>
<td>76 (49, 91)</td>
<td>76 (60, 90)</td>
</tr>
<tr>
<td>Race; %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>76</td>
<td>75</td>
</tr>
<tr>
<td>Black or African American</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Asian</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Male; %</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>ECOG performance status; %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-1</td>
<td>55</td>
<td>56</td>
</tr>
<tr>
<td>2</td>
<td>40</td>
<td>41</td>
</tr>
<tr>
<td>3</td>
<td>5.6</td>
<td>3.4</td>
</tr>
<tr>
<td>Bone marrow blast; %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;30%</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>≥30% to &lt;50%</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>≥50%</td>
<td>49</td>
<td>49</td>
</tr>
<tr>
<td>Disease history; %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De novo AML</td>
<td>75</td>
<td>76</td>
</tr>
<tr>
<td>Secondary AML</td>
<td>25</td>
<td>24</td>
</tr>
<tr>
<td>Cyto genetic risk detected*; %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate</td>
<td>64</td>
<td>61</td>
</tr>
<tr>
<td>Poor</td>
<td>36</td>
<td>39</td>
</tr>
<tr>
<td>Mutation analyses detected; n/N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IDH1 or IDH2</td>
<td>61/245 (25)</td>
<td>28/127 (22)</td>
</tr>
<tr>
<td>IDH1</td>
<td>23/245 (9.4)</td>
<td>11/127 (8.7)</td>
</tr>
<tr>
<td>IDH2</td>
<td>40/245 (16)</td>
<td>18/127 (14)</td>
</tr>
<tr>
<td>FLT3</td>
<td>29/206 (14)</td>
<td>22/108 (20)</td>
</tr>
<tr>
<td>NPM1</td>
<td>27/163 (17)</td>
<td>17/86 (20)</td>
</tr>
<tr>
<td>TP53</td>
<td>38/163 (23)</td>
<td>14/86 (16)</td>
</tr>
</tbody>
</table>

Important Safety Information

Neutropenia
In patients with AML, baseline neutrophil counts worsened in 95% to 100% of patients treated with VENCLEXTA in combination with azacitidine or decitabine or low-dose cytarabine. Neutropenia may recur with subsequent cycles.

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In patients with AML, baseline neutrophil counts worsened in 95% to 100% of patients treated with VENCLEXTA in combination with azacitidine or decitabine or low-dose cytarabine. Neutropenia may recur with subsequent cycles.
VEN+AZA demonstrated superior overall survival vs PBO+AZA

Median OS was extended by 5.1 months in patients treated with VEN+AZA vs PBO+AZA

### Important Safety Information

**Infections**
- Fatal and serious infections such as pneumonia and sepsis have occurred in patients treated with VENCLEXTA. Monitor patients for signs and symptoms of infection and treat promptly. Withhold VENCLEXTA for Grade 3 and 4 infection until resolution and resume at same or reduced dose based on occurrence.

**Immune-related Mild to Moderate Reactions**
- Do not administer live attenuated vaccines prior to, during, or after treatment with VENCLEXTA until B-cell recovery occurs.

**Embryo-Fetal Toxicity**
- Do not administer VENCLEXTA to pregnant women. Advise females of reproductive potential to use effective contraception during treatment with VENCLEXTA and for at least 30 days after the last dose.

**Transfusion Independence Conversion and/or Maintenance**

#### Powerlaw, durable remissions

- Median follow-up for VEN+AZA was approximately 20.5 months (range: <0.1-30.7 months)
- Number of patients at risk

<table>
<thead>
<tr>
<th>Number of patients at risk</th>
<th>VEN+AZA</th>
<th>PBO+AZA</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=286</td>
<td>219</td>
<td>198</td>
</tr>
<tr>
<td>N=145</td>
<td>109</td>
<td>92</td>
</tr>
</tbody>
</table>

**Adverse Reactions**

- Patients with AML receiving combination therapy with azacitidine, the most frequent serious adverse reactions (≥5%) were febrile neutropenia (30%), pneumonia (22%), sepsis (excluding fungal; 19%), and hemorrhage (8%). The most common adverse reactions (≥30%) of any grade were neutrophils decreased (98%), platelets decreased (94%), lymphocytes decreased (91%), hemoglobin decreased (81%), nausea (44%), diarrhea (43%), febrile neutropenia (42%), musculoskeletal pain (36%), pneumonia (33%), fatigue (31%), and vomiting (29%). Fatal adverse reactions occurred in 23% of patients who received VENCLEXTA in combination with azacitidine, with the most frequent (≥4%) being pneumonia (9%), sepsis (excluding fungal; 3%), and hemorrhage (2%).

**Key Trials**

- **BELLINI Trial** (NCT02755597): In a randomized trial in patients with relapsed or refractory multiple myeloma, the addition of VENCLEXTA to bortezomib plus dexamethasone, a use for which VENCLEXTA is not indicated, resulted in increased mortality.

- **REBIND-01 Trial**: In a phase 3 trial (NCT02929592) in patients with relapsed or refractory multiple myeloma, treatment with VENCLEXTA and dexamethasone demonstrated superior overall survival compared to bortezomib plus dexamethasone. Median overall survival was extended by 5.1 months in patients treated with VENCLEXTA vs bortezomib plus dexamethasone.

- **VEN-0006 Trial**: In a phase 3 trial (NCT02375597), the addition of VENCLEXTA to azacitidine in patients with AML resulted in increased mortality.

**For more information, please see the full Prescribing Information or visit www.rxabbvie.com/pdf/venclexta.pdf.**
Overall survival outcomes in different mutational subgroups

Overall survival was statistically significant in the consolidated IDH1/IDH2 group of patients in the VEN+AZA arm.

- In the VEN+AZA arm, median OS in the IDH1/IDH2 group (N=61) was not reached (95% CI: 12.2, -).
- In the PBO+AZA arm, median OS in the IDH1/IDH2 group (N=28) was 6.2 months (95% CI: 2.3, 12.7).

Subgroup analyses of prespecified exploratory endpoints were not powered or tested to demonstrate a statistically significant difference in OS for any subgroup examined.

Remission was achieved in different mutational subgroups, including IDH1/2 and FLT3.

More than half of patients with an IDH1/2 or FLT3 mutation achieved remission in the VEN+AZA group.

- CR+CRh rates for IDH1/2 and FLT3 were prespecified secondary endpoints.

Important Safety Information

Drug Interactions (cont’d)

- Concomitant use with a P-gp inhibitor or a strong or moderate CYP3A inhibitor increases VENCLEXTA exposure, which may increase VENCLEXTA toxicities, including the risk of TLS. Consider alternative medications or adjust VENCLEXTA dosage and monitor more frequently for adverse reactions. Resume the VENCLEXTA dosage that was used prior to concomitant use of a P-gp inhibitor or a strong or moderate CYP3A inhibitor 2 to 3 days after discontinuation of the inhibitor.

- Avoid concomitant use of VENCLEXTA with a P-gp substrate. If concomitant use is unavoidable, separate dosing of the P-gp substrate at least 6 hours before VENCLEXTA.

- Advise nursing women not to breastfeed during treatment with VENCLEXTA and for 1 week after the last dose.

Please see additional Important Safety Information on pages 16 and 17.
Please see accompanying full Prescribing Information or visit www.rxabbvie.com/pdf/venclexta.pdf.
A tolerable, manageable, and predictable adverse reaction profile

No additional warnings or precautions for VENCLEXTA were observed in the AML trials.

The safety profile of VEN+AZA was consistent with the known side effect profile of both agents.

Adverse reactions (≥10%) in patients with AML who received VEN+AZA with a difference between arms of ≥5% for all grades or ≥2% for Grade 3 or 4 reactions compared with PBO+AZA.

Hematologic laboratory abnormalities

No additional warnings or precautions for VENCLEXTA were observed in the AML trials.

The safety profile of VEN+AZA was consistent with the known side effect profile of both agents.

VIALE-A: VEN+AZA vs PBO+AZA

Assessment

*Patients who received at least one dose of either treatment.
†Includes multiple adverse reaction terms.

Adverse reaction by body system

<table>
<thead>
<tr>
<th>Body system</th>
<th>Adverse reaction</th>
<th>VEN+AZA (N=283)</th>
<th>PBO+AZA (N=144)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal disorders</td>
<td>Nausea</td>
<td>44</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Diarrhea</td>
<td>43</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Vomiting</td>
<td>30</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Stomatitis</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Abdominal pain</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Blood and lymphatic system disorders</td>
<td>Febrile neutropenia</td>
<td>42</td>
<td>19</td>
</tr>
<tr>
<td>Musculoskeletal and connective tissue disorders</td>
<td>Musculoskeletal pain</td>
<td>36</td>
<td>28</td>
</tr>
<tr>
<td>General disorders and administration site conditions</td>
<td>Fatigue</td>
<td>31</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Edema</td>
<td>27</td>
<td>19</td>
</tr>
<tr>
<td>Vascular disorders</td>
<td>Hemorrhage</td>
<td>27</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Hypertension</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Metabolism and nutrition disorders</td>
<td>Decreased appetite</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue disorders</td>
<td>Rash</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>Infections and infestations</td>
<td>Sepsis (excluding fungal)</td>
<td>22</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Urinary tract infection</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>Respiratory, thoracic and mediastinal disorders</td>
<td>Dyspnea</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>Nervous system disorders</td>
<td>Dizziness</td>
<td>17</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>

Duration of exposure and occurrence of adverse reactions

Patients maintained treatment with VEN in the VEN+AZA arm for a median of 7.6 months

| Rate of serious adverse reactions |
|----------------------------------|-------------------------------|-----------------|-----------------|
| VEN+AZA (N=283)                  |                               | PBO+AZA (N=144)|               |
| (%) occurrence                   | Most frequent adverse reaction(s) | (%) occurrence | Most frequent adverse reaction(s) |
| Serious ARs                      | ≥5%: febrile neutropenia      | 83              | ≥5%: pneumonia (22%), febrile neutropenia (20%), pneumonia (22%), sepsis (excluding fungal; 19%), hemoglobin (6%) |
| Fatal ARs                        | ≥2%: pneumonia (4%), sepsis      | 73              | ≥2%: pneumonia (4%), sepsis (4%), hemorrhage (2%) |

Discontinuation, reduction, and interruption rates of VEN or PBO

- In the VEN+AZA arm, among patients who achieved bone marrow clearance of leukemia, 53% (114/216)* underwent dose interruptions for ANC <500/microliter.
- Once bone marrow assessment confirmed a remission, defined as less than 5% leukemia blasts with cytopenia, VENCLEXTA or placebo was interrupted up to 14 days or until ANC ≥300/microliter and platelet count ≥50 x 10³/microliter.
- Azacitidine was resumed on the same day as VENCLEXTA or placebo following interruption.
- Azacitidine dose reduction was implemented in the clinical trial for management of hematologic toxicity.

Please see Important Safety Information on pages 16 and 17. Please see accompanying full Prescribing Information or visit www.rxabbvie.com/pdf/venclexta.pdf.

NEW ORCHID

SAFETY
Dose ramp-up is designed to allow patients to safely attain the recommended daily dose.

- Assess patient-specific factors for level of risk of tumor lysis syndrome (TLS) and provide prophylactic hydration and anti-hyperuricemics to patients prior to first dose of VENCLEXTA to reduce risk of TLS.
- Instruct patients to take VENCLEXTA tablets with a meal and water at approximately the same time each day. VENCLEXTA tablets should be swallowed whole and not chewed, crushed, or broken prior to swallowing.

Pretreatment TLS risk assessment and prophylaxis

- All patients should have white blood cell count less than 25 × 10^9/L prior to initiation of VENCLEXTA. Cytoreduction prior to treatment may be required.
- Prior to first VENCLEXTA dose, provide all patients with prophylactic measures including adequate hydration and anti-hyperuricemic agents and continue during ramp-up phase.
- Assess blood chemistry and correct pre-existing abnormalities prior to initiation of treatment with VENCLEXTA.
- Monitor blood chemistries for TLS at pre-dose, 6 to 8 hours after each new dose during ramp-up, and 24 hours after reaching final dose.
- For patients with risk factors for TLS, consider additional measures, including increased laboratory monitoring and reducing VENCLEXTA starting dose.

TLS in clinical trials

- With implementation of dosing ramp-up plus standard TLS prophylaxis and monitoring:
  - In VIALE-A, the rate of TLS was 1.1% (3/283) in patients who received VENCLEXTA in combination with azacitidine. All events were laboratory TLS.
  - In VIALE-C, the rate of TLS was 5.6% (8/142) in patients who received VENCLEXTA in combination with low-dose cytarabine. There were 4 events of laboratory TLS and 4 events of clinical TLS, which included 2 deaths and cases of renal failure.

VENCLEXTA is taken orally in combination with AZA

- VENCLEXTA dose should be modified for concomitant use with certain medications.
  - VENCLEXTA is metabolized by the CYP3A enzyme; the dose should be reduced when used with P-gp inhibitors or strong or moderate CYP3A inhibitors.

Dose modifications for managing potential interactions

<table>
<thead>
<tr>
<th>Coadministered drug</th>
<th>Initiation and ramp-up phase</th>
<th>Steady daily dose after ramp-up phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posaconazole</td>
<td>Day 1: 10 mg Day 2: 20 mg Day 3: 50 mg Day 4: 70 mg</td>
<td>Reduce the VENCLEXTA dose to 70 mg</td>
</tr>
<tr>
<td>Other strong CYP3A inhibitor</td>
<td>Day 1: 10 mg Day 2: 20 mg Day 3: 50 mg Day 4: 100 mg</td>
<td>Reduce the VENCLEXTA dose to 100 mg</td>
</tr>
<tr>
<td>Moderate CYP3A inhibitor</td>
<td>Aprepitant, ciprofloxacin, conivaptan, cyclosporine, diltiazem, dronedarone, erythromycin, fluconazole, isavuconazole, voriconazole*</td>
<td>Reduce the VENCLEXTA dose by at least 50%</td>
</tr>
<tr>
<td>P-gp inhibitor</td>
<td>Amiodarone, carbamazepine, clarithromycin, cyclosporine, diltiazem, dronedarone, itraconazole, ketoconazole, quinidine, ranolazine, ritonavir, verapamil*</td>
<td>Reduce the VENCLEXTA dose to 100 mg</td>
</tr>
</tbody>
</table>

- Concomitant use of VENCLEXTA with strong CYP3A inducers decreases VENCLEXTA exposure, which may decrease VENCLEXTA efficacy. Avoid concomitant use of VENCLEXTA with strong CYP3A inducers or moderate CYP3A inhibitors.
- Concomitant use of VENCLEXTA increases warfarin exposure, which may increase the risk of bleeding. Monitor international normalized ratio (INR) more frequently in patients using warfarin concomitantly with VENCLEXTA.
- Concomitant use of VENCLEXTA increases exposure of P-gp substrates, which may increase toxicities of these substrates. Avoid concomitant use of VENCLEXTA with a P-gp substrate. If concomitant use is unavoidable, separate dosing of the P-gp substrate at least 6 hours before VENCLEXTA.

Dose modifications for patients with severe hepatic impairment:

- Reduce the VENCLEXTA once daily dose by 50% for patients with severe hepatic impairment (Child-Pugh C); monitor these patients more closely for adverse reactions.

- Adjust the VENCLEXTA dose and monitor more frequently for adverse reactions. Resumes the VENCLEXTA dosage that was used prior to concomitant use of a strong or moderate CYP3A inhibitor or a P-gp inhibitor 2 to 3 days after discontinuation of the inhibitor.
- Avoid grapefruit products, Seville oranges, and starfruit during treatment with VENCLEXTA, as they contain inhibitors of CYP3A.
- Concomitant use of VENCLEXTA increases exposure of P-gp substrates, which may increase toxicities of these substrates. Avoid concomitant use of VENCLEXTA with a P-gp substrate. If concomitant use is unavoidable, separate dosing of the P-gp substrate at least 6 hours before VENCLEXTA.

*This is not an exhaustive list and is intended only to complement, not replace, clinical judgment during treatment of patients with VENCLEXTA.

Please see Important Safety Information on pages 16 and 17. Please see accompanying full Prescribing Information or visit www.rxabbvie.com/pdf/venclexta.pdf.
Responses for CR and CRh were reached at different times throughout treatment; management of Grade 4 neutropenia or thrombocytopenia may differ before and after remission is achieved1

In VIALE-A, bone marrow assessment was conducted following Cycle 1 treatment. Once bone marrow assessment confirmed a remission, VENCLEXTA or placebo was interrupted up to 14 days or until ANC ≥500/microliter and platelet count ≥50 × 10^3/microliter. For patients with resistant disease at the end of Cycle 1, a bone marrow assessment was performed after Cycle 2 or 3 and as clinically indicated.1

<table>
<thead>
<tr>
<th>Select secondary endpoints: CR, CR+CRh1,3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Endpoint</td>
<td>VEN+AZA (N=286)</td>
</tr>
<tr>
<td>CR, n (%), (95% CI)</td>
<td>105 (37), (31, 43)</td>
</tr>
<tr>
<td>P value</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Median DOCR (months), (95% CI)</td>
<td>18 (15.3, -)</td>
</tr>
<tr>
<td>CR+CRh, n (%), (95% CI)</td>
<td>185 (65), (59, 70)</td>
</tr>
<tr>
<td>P value</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Median DOCR+CRh (months), (95% CI)</td>
<td>17.8 (15.3, -)</td>
</tr>
</tbody>
</table>

The median time to first response of CR or CRh was 1.0 months (range: 0.6-14.3 months) with VEN+AZA treatment; some patients achieved CR/CRh in later cycles1,4

Secondary endpoint: CR+CRh by initiation of Cycle 2

* 40% (n=114/286) with VEN+AZA (95% CI: [34, 46]; P<0.001)

In an exploratory post hoc analysis of CR+CRh in the VEN+AZA ITT population:4

* 47% (134/286) achieved CR+CRh by the beginning of Cycle 3
* 50% (143/286) achieved CR+CRh by the beginning of Cycle 4

*Defined as less than 5% leukemia blasts with cytopenia.

**ITT=intention to treat.

Important Safety Information

Females and Males of Reproductive Potential

* Advise females of reproductive potential to use effective contraception during treatment with VENCLEXTA and for at least 30 days after the last dose.
* Based on findings in animals, VENCLEXTA may impair male fertility.

Hepatic Impairment

* Reduce the dose of VENCLEXTA for patients with severe hepatic impairment (Child-Pugh C); monitor these patients more frequently for signs of adverse reactions. No dose adjustment is recommended for patients with mild (Child-Pugh A) or moderate (Child-Pugh B) hepatic impairment.

In VIALE-A:

* In the VEN+AZA arm, among patients who achieved bone marrow clearance of leukemia, 53% (114/216) underwent dose interruptions for ANC <500/microliter1,6
* Once bone marrow assessment confirmed a remission, defined as less than 5% leukemia blasts with cytopenia, VENCLEXTA or placebo was interrupted up to 14 days or until ANC ≥500/microliter and platelet count ≥50 × 10^3/microliter.

*Of patients who achieved a morphologic leukemia-free state of response or better.6

Recommendations for dose modifications for chemotherapeutic toxicities

In an exploratory post hoc analysis of VIALE-A:

* 75% of patients in remission (139/186) had at least 1 pause in dosing lasting 7+ days4

AR=adverse reaction.

Please see additional Important Safety Information on pages 16 and 17.
Please see accompanying full Prescribing Information or visit www.rxabbvie.com/pdf/venclexta.pdf.
Additional efficacy from a phase 3 clinical trial of VEN+LDAC vs PBO+LDAC

VIALE-C: VENCLEXTA in combination with LDAC vs PBO+LDAC

- The efficacy and safety of VENCLEXTA in combination with low-dose cytarabine (VEN+LDAC) (N=143) versus placebo with low-dose cytarabine (PBO+LDAC) (N=68) was evaluated in VIALE-C, a double-blind randomized trial in patients with newly diagnosed AML.
- At baseline, patients were ≥75 years of age, or had comorbidities that precluded the use of intensive induction chemotherapy based on at least one of the following criteria: baseline ECOG performance status of ≥2, severe cardiac or pulmonary comorbidity, moderate hepatic impairment, Clcr <45 ml/min, or other comorbidity.

Dosing in VIALE-C

- Patients received VENCLEXTA 600 mg orally once daily on Days 1-28 following completion of the ramp-up dosing schedule or placebo in combination with LDAC 20 mg/m² subcutaneously once daily on Days 1-10 of each 28-day cycle beginning on Cycle 1, Day 1.
- During the 4-day ramp-up phase, patients received TSL prophylaxis and were hospitalized for monitoring.
- For patients with resistant disease at the end of Cycle 1, a bone marrow assessment was performed after Cycle 2 or 3 and continued to receive treatment until disease progression or unacceptable toxicity.
- LDAC was resumed on the same day as VENCLEXTA or placebo following interruption.

Bone marrow assessment in VIALE-C

- A bone marrow assessment was performed following Cycle 1 of treatment. If bone marrow assessment confirmed a remission, defined as less than 5% leukemia blasts with cytopenia, VENCLEXTA or placebo was interrupted up to 14 days or until ANC ≥500/microliter and platelet count ≥50 × 10^9/microliter.
- For patients with resistant disease at the end of Cycle 1, a bone marrow assessment was performed after Cycle 2 and as clinically indicated.
- LDAC was resumed on the same day as VENCLEXTA or placebo following interruption.
- Patients continued to receive treatment until disease progression or unacceptable toxicity.

Baseline characteristics

VEN+LDAC: (N=143)
- The median age of patients treated with VEN+LDAC was 76 years (range: 36-93 years). ECOG performance status at baseline was 0.1 for 52% of patients, 0.2 for 44% of patients, and 3 for 4.2% of patients.
- Mutations identified were as follows: TSP53—20% (22/112), IDH1 or IDH2—19% (21/112), FLT3/ITD—18% (20/112); and NPM1—16% (18/112). Intermediate or poor cytogenetic risk was present in 63% and 33% of patients, respectively.

PBO+LDAC: (N=68)
- The median age of patients treated with PBO+LDAC was 76 years (range: 41-88 years). ECOG performance status at baseline was 0.1 for 50% of patients, 0.2 for 37% of patients, and 3 for 13% of patients.
- Mutations identified were as follows: TSP53—17% (9/52); IDH1 or IDH2—22% (12/52); FLT3/ITD—17% (9/52); and NPM1—13% (7/52). Intermediate or poor cytogenetic risk was present in 63% and 29% of patients, respectively.

Efficacy was based on the rate of CR and duration of CR with supportive evidence of rate of CR+RCh, duration of CR+RCh, and the rate of conversion from transfusion dependence to transfusion independence.

<table>
<thead>
<tr>
<th>CR</th>
<th>VEN+LDAC: 27% (95% CI: 20, 35)</th>
<th>PBO+LDAC: 7.4% (95% CI: 3.4, 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>mDOCR: 11.1 months (95% CI: 6.1, -)</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>mDOCR: 8.3 months (95% CI: 3.1, -)</td>
<td>---</td>
<td></td>
</tr>
</tbody>
</table>

VEN+LDAC did not significantly improve OS versus PBO+LDAC. HR for OS was 0.75 (95% CI: 0.52, 1.07); P=0.114. The median OS for the VEN+LDAC arm was 7.2 months (95% CI: 5.6, 10.1) and for the PBO+LDAC arm was 4.1 months (95% CI: 3.1, 8.8).

<table>
<thead>
<tr>
<th>CR+RCh</th>
<th>VEN+LDAC: 47% (95% CI: 39, 55)</th>
<th>PBO+LDAC: 15% (95% CI: 7.3, 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>mDOCR: 11.1 months (95% CI: 6.1, -)</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>mDOCR: 6.2 months (95% CI: 3.1, -)</td>
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<td></td>
</tr>
</tbody>
</table>

Safety information from VIALE-C

A predictable, tolerable, and manageable safety profile

- No additional warnings or precautions for VENCLEXTA were observed in the AML trials.

Serious adverse reactions (ARs)

- Serious adverse reactions were reported in 65% of patients who received VEN+LDAC, with the most frequent (≥10%) being pneumonia (17%), febrile neutropenia (16%), and sepsis (excluding fungal; 12%).

Fatal ARs

- Fatal adverse reactions occurred in 23% of patients who received VENCLEXTA in combination with the most frequent (≥5%) being pneumonia (6%) and sepsis (excluding fungal; 7%).

Adverse reactions leading to discontinuation, dose reductions, and dose interruptions

- Adverse reactions leading to permanent discontinuation of VENCLEXTA in 25% of patients, dose reductions in 9%, and dose interruptions in 63%. Among patients who achieved bone marrow clearance of leukemia, 32% underwent dose interruptions for ANC ≤500/microliter. The most frequent adverse reaction (>2%) which resulted in permanent discontinuation of VENCLEXTA was pneumonia (6%). Adverse reactions which required a dose reduction in ≥1% of patients were pneumonia (1%) and thrombocytopenia (1%), and the adverse reactions which required a dose interruption in ≥5% of patients included neutropenia (20%), thrombocytopenia (15%), pneumonia (8%), febrile neutropenia (6%) and sepsis (excluding fungal; 6%).

Adverse reactions (≥10%) in patients with AML who received VEN+LDAC with a difference between arms of ≥5% for all grades or ≥2% for Grade 3 or 4 compared with PBO+LDAC in VIALE-C

<table>
<thead>
<tr>
<th>Adverse reaction</th>
<th>VEN+LDAC (N=142)</th>
<th>PBO+LDAC (N=68)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse reaction</td>
<td>All Grades (%)</td>
<td>Grade 3 or 4 (%)</td>
</tr>
<tr>
<td>Nausea</td>
<td>42</td>
<td>1</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>28</td>
<td>3</td>
</tr>
<tr>
<td>Vomiting</td>
<td>25</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Abdominal pain†</td>
<td>15</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Stomatitis†</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Febrile neutropenia</td>
<td>32</td>
<td>29</td>
</tr>
<tr>
<td>Pneumonia†</td>
<td>29</td>
<td>19</td>
</tr>
<tr>
<td>Hemorrhage†</td>
<td>27</td>
<td>16</td>
</tr>
<tr>
<td>Hypotension†</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Musculoskeletal and connective tissue disorders</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>Fatigue†</td>
<td>22</td>
<td>21</td>
</tr>
</tbody>
</table>

†Includes multiple adverse reaction terms.

Hematologic laboratory abnormalities

- New or worsening Grade 3 or 4 hematologic laboratory abnormalities in VIALE-C with a difference between arms of ≥2% for VEN+LDAC vs PBO+LDAC, respectively: platelets decreased 95% vs 90%, neutrophils decreased 92% vs 71%, lymphocytes decreased 69% vs 24%, hemoglobin decreased 57% vs 54%.

For dose modifications for drug-drug interactions and management of adverse reactions specific to VEN+LDAC regimen, please refer to section 2 of the full Prescribing Information.

Please refer to insert for additional efficacy data.

Please see additional Important Safety Information on pages 16 and 17. Please see accompanying full Prescribing Information or visit www.rxabbvie.com/pdf/venclexta.pdf.
Additional efficacy from a phase 1b trial of VEN+AZA or DEC\textsuperscript{1,9}

Study M14-358: VENCLEXTA in combination with AZA or DEC\textsuperscript{1}
- VENCLEXTA was studied in a non-randomized, open-label trial (NCT02203773) that evaluated the efficacy of VENCLEXTA in combination with AZA (N=84) or decitabine (DEC) (N=31) in patients with newly diagnosed AML.
- Of those patients, 67 who received AZA combination and 13 who received DEC combination were 75 years or older, or had comorbidities that precluded the use of intensive induction chemotherapy based on at least one of the following criteria: baseline ECOG performance status of 2-3, severe cardiac or pulmonary comorbidity, moderate hepatic impairment, CLcr <45 mL/min, or other comorbidity.

Dosing in M14-358\textsuperscript{1}
- Patients received VENCLEXTA 400 mg orally once daily following completion of the ramp-up dosing schedule in combination with AZA (75 mg/m\textsuperscript{2} either intravenously or subcutaneously once daily on Days 1-7 of each 28-day cycle beginning on Cycle 1, Day 1) or DEC (20 mg/m\textsuperscript{2} was administered intravenously once daily on Days 1-5 of each 28-day cycle beginning on Cycle 1, Day 1).
- During the ramp-up phase, patients received TLS prophylaxis and were hospitalized for monitoring.
- Treatment was continued until disease progression or unacceptable toxicity.

Baseline characteristics\textsuperscript{1}
- The median age of patients treated with VEN+DEC was 75 years (range: 68-86 years). ECOG performance status at baseline was 0-1 for 92% of patients and 2 for 7.7% of patients.
- Of the 13 patients in the VEN+DEC arm, those who had mutations identified were as follows: 31% with TP53, 15% with NPM1, 23% with FLT3, and no patients with IDH1 or IDH2. Intermediate or poor cytogenetic risk was present in 38% and 62% of patients, respectively.

First-line efficacy and fast remissions with VEN+DEC\textsuperscript{1}
- CR was 54% (n=7); 95% CI: (25, 81).
- CRh was 7.7% (n=1); 95% CI: (0.2, 36).
- Median duration of response of CR was 12.7 months (95% CI: [1.4, –]).
- Median time to first response (CR or CRh) was 1.9 months (range: 0.8-4.2).

Descriptive prespecified exploratory analysis of CR+CRh rates in different mutational and cytogenetic risk subgroups\textsuperscript{9}
- CR+CRh rates were 33% (n=1/3; 95% CI: [0.8, 91]) for FLT3, 100% (n=2/2; 95% CI: [16, 100]) for NPM1, 75% (n=3/4; 95% CI: [19, 99]) for TP53, 60% (n=3/5; 95% CI: [15, 95]) for the intermediate cytogenetic risk group, and 63% (n=5/8; 95% CI: [25, 92]) for the poor cytogenetic risk group.
- CR rates were 50% (n=2/4; 95% CI: [7, 93]) for TP53 and 50% (n=4/8; 95% CI: [16, 84]) for the poor cytogenetic risk group.
- CR rates for FLT3, NPM1, and the intermediate cytogenetic risk group were the same as rates seen for CR+CRh.
- No patients had an IDH1/2 mutation.
- 4 patients had insufficient sample for analysis. Patients could have expressed one or more, or none, of the identified mutations.
- The subgroup analyses were not powered or tested to demonstrate a statistically significant difference in outcomes for any subgroup examined.

Important Safety Information

Tumor Lysis Syndrome
- Tumor lysis syndrome (TLS), including fatal events and renal failure requiring dialysis, has occurred in patients treated with VENCLEXTA.

Adverse Reactions
- In patients with AML receiving combination therapy with decitabine, the most frequent serious adverse reactions (≥10%) were sepsis (excluding fungal; 46%), febrile neutropenia (38%), and pneumonia (31%). The most common adverse reactions (≥30%) of any grade were febrile neutropenia (69%), fatigue (62%), constipation (62%), musculoskeletal pain (54%), dizziness (54%), nausea (54%), abdominal pain (46%), diarrhea (46%), pneumonia (46%), sepsis (excluding fungal; 46%), cough (38%), pyrexia (31%), hypotension (31%), oropharyngeal pain (31%), edema (31%), and vomiting (31%). One (8%) fatal adverse reaction of bacteremia occurred within 30 days of starting treatment.

Please see additional Important Safety Information on pages 16 and 17. Please see accompanying full Prescribing Information or visit www.rxabbvie.com/pdf/venclexta.pdf.
A predictable, tolerable, and manageable safety profile

No additional warnings or precautions for VENCLEXTA were observed in the AML trials.

Adverse reactions reported in ≥30% (any grade)

- The most common adverse reactions (≥30%) were febrile neutropenia (69%), fatigue (62%), constipation (62%), musculoskeletal pain (54%), dizziness (54%), nausea (54%), abdominal pain (46%), diarrhea (46%), pneumonia (46%), sepsis (excluding fungal; 46%), cough (38%), pyrexia (31%), hypotension (31%), oropharyngeal pain (31%), edema (31%), and vomiting (31%)
- The most common hematologic laboratory abnormalities (≥30%) were neutrophils decreased (100%), lymphocytes decreased (100%), white blood cells decreased (100%), platelets decreased (92%), and hemoglobin decreased (69%)
- The median duration of exposure for patients taking VEN+DEC was 8.4 months (range: 0.5-39.0 months)

Treatment events and occurrence rates

- Serious adverse reactions were reported in 85% of patients
- The most frequent serious adverse reactions (≥10%) were sepsis (excluding fungal; 46%), febrile neutropenia (38%), and pneumonia (31%)
- One (8%) fatal adverse reaction of bacteremia occurred within 30 days of starting treatment
- Permanent discontinuation due to adverse reactions occurred in 38% of patients
- The most frequent adverse reaction leading to permanent discontinuation (≥5%) was pneumonia (8%)
- Dosage interruptions due to adverse reactions occurred in 69% of patients
- The most frequent adverse reactions leading to dose interruption (≥10%) were:
  - neutropenia (38%), febrile neutropenia (23%), leukopenia (15%), and pneumonia (15%)
- Dosage reductions due to adverse reactions occurred in 15% of patients
- The most frequent adverse reaction leading to dose reduction (≥5%) was neutropenia (15%)

For dose modifications for drug-drug interactions and management of adverse reactions specific to VEN+DEC regimen, please see section 2 of the full Prescribing Information.
Important Safety Information

Tumor Lysis Syndrome
• Tumor lysis syndrome (TLS), including fatal events and renal failure requiring dialysis, has occurred in patients treated with VENCLEXTA.

• VENCLEXTA can cause rapid reduction in tumor and thus poses a risk for TLS at initiation and during the ramp-up phase in all patients. Changes in blood chemistries consistent with TLS that require prompt management can occur as early as 6 to 8 hours following the first dose of VENCLEXTA and at each dose increase.

• In patients with AML who followed the current 3-day ramp-up dosing schedule and the TLS prophylaxis and monitoring measures, the rate of TLS was 5% in patients who received VENCLEXTA in combination with azacitidine. In patients with AML who followed a 4-day ramp-up dosing schedule and the TLS prophylaxis and monitoring measures, the rate of TLS was 6.5% and included deaths and renal failure in patients who received VENCLEXTA in combination with low-dose cytarabine.

• The risk of TLS is a continuum based on multiple factors, particularly reduced renal function, tumor burden, and type of malignancy.

• Assess all patients for risk and provide appropriate prophylaxis for TLS, including hydration and anti-hyperuricemic. Monitor blood chemistries and manage abnormally elevated bases promptly. Employ more intense measures (IV hydration, frequent monitoring, hospitalization) as overall risk increases. Interrupt dosing if needed; when restarting VENCLEXTA follow dose modification guidance in the Prescribing Information.

• Concomitant use of VENCLEXTA with P-gp inhibitors or strong or moderate CYP3A inhibitors increases venetoclax exposure, which may increase the risk of TLS at initiation and during the ramp-up phase, and requires VENCLEXTA dose adjustment.

• Neutropenia

• In patients with AML, baseline neutrophil counts worsened in 95% to 100% of patients treated with VENCLEXTA in combination with azacitidine or decitabine or low-dose cytarabine. Neutropenia can recur with subsequent cycles.

• Monitor complete blood counts throughout the treatment period. For severe neutropenia, interrupt dosing or reduce duration based on remission status and occurrence. Consider supportive measures including antimicrobials and growth factors (e.g., G-CSF).

• Infections

• Fatal and serious infections such as pneumonia and sepsis have occurred in patients treated with VENCLEXTA. Monitor patients for signs and symptoms of infection and treat promptly. Withhold VENCLEXTA for Grade 3 and 4 infection until resolution and resume at same or reduced dose based on occurrence.

• Immunization

• Do not administer live attenuated vaccines prior to, during, or after treatment with VENCLEXTA until B-cell recovery occurs. Advise patients that vaccinations may be less effective.

• Embryo-Fetal Toxicity

• VENCLEXTA may cause embryo-fetal harm when administered to a pregnant woman. Advise females of reproductive potential to avoid pregnancy within 30 days after the last dose.

• Males and females of reproductive potential should use effective contraception during treatment with VENCLEXTA and for at least 30 days after the last dose.

• Advise patients who are or may become pregnant that there is a potential for tumor lysis syndrome in the early postpartum period.

• Advise patients to use effective contraception during treatment with VENCLEXTA and for at least 30 days after the last dose.

• Based on findings in animals, VENCLEXTA may impair male fertility.

• Lactation

• Advise nursing women not to breastfeed during treatment with VENCLEXTA and for 1 week after the last dose.

Females and Males of Reproductive Potential

• Advise females of reproductive potential to use effective contraception during treatment with VENCLEXTA and for at least 30 days after the last dose.

• Advise patients and their partners to avoid conception during VENCLEXTA treatment and for at least 30 days after the last dose.

• Avoid concomitant use of strong or moderate CYP3A inducers.

• Monitor international normalized ratio (INR) more frequently in patients receiving warfarin.

• Avoid concomitant use of VENCLEXTA with a P-gp substrate. If concomitant use is unavoidable, separate dosing of the P-gp substrate by at least 6 hours before VENCLEXTA.

Lactation

• Advise nursing women not to breastfeed during treatment with VENCLEXTA and for 1 week after the last dose.

• Advise males to use effective contraceptive measures during treatment with VENCLEXTA and for at least 30 days after the last dose.

• Based on findings in animals, VENCLEXTA may impair male fertility.

Hepatic Impairment

• Reduce the dose of VENCLEXTA for patients with severe hepatic impairment (Child-Pugh C), monitor these patients more frequently for signs of adverse reactions. No dose adjustment is recommended for patients with mild (Child-Pugh A) or moderate (Child-Pugh B) hepatic impairment.

References: 1. VENCLEXTA [package insert]. North Chicago, IL: AbbVie Inc. 2. References with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Acute Myeloid Leukemia V.2 2021 © National Comprehensive Cancer Network, Inc 2020. All rights reserved. Accessed November 19, 2020. To view the most recent and complete version of the guideline, go online to NCCN.org. NATIONAL COMPREHENSIVE CANCER NETWORK®. NCCN GUIDELINES®, and all other NCCN Content are trademarks owned by the National Comprehensive Cancer Network, Inc.
In a phase 3 trial, VEN+AZA was proven to help newly diagnosed AML patients live longer
In patients who were ≥75 years of age or had comorbidities that precluded the use of intensive induction chemotherapy¹

FDA-approved regardless of mutation status. No need to wait for biomarker test results.

### LONGER OVERALL SURVIVAL¹

<table>
<thead>
<tr>
<th></th>
<th>VEN+AZA</th>
<th>PBO+AZA</th>
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<tbody>
<tr>
<td>mOS</td>
<td>14.7 months</td>
<td>9.6 months</td>
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<tr>
<td>95% CI: (11.9, 18.7)</td>
<td>95% CI: (7.4, 12.7)</td>
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</table>

### LASTING IMPACT¹

<table>
<thead>
<tr>
<th></th>
<th>VEN+AZA</th>
<th>PBO+AZA</th>
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<tbody>
<tr>
<td>CR</td>
<td>37%</td>
<td>18%</td>
</tr>
<tr>
<td>*P&lt;0.001</td>
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</tr>
<tr>
<td>105/286 patients</td>
<td>26/145 patients</td>
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</tr>
<tr>
<td>95% CI: (31, 43)</td>
<td>95% CI: (12, 25)</td>
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<tr>
<td>mDOCR</td>
<td>18 months</td>
<td>13.4 months</td>
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<td>95% CI: (15.3, –)</td>
<td>95% CI: (8.7, 17.6)</td>
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</tr>
<tr>
<td>CR+CRh</td>
<td>65%</td>
<td>23%</td>
</tr>
<tr>
<td>*P&lt;0.001</td>
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</tr>
<tr>
<td>185/286 patients</td>
<td>33/145 patients</td>
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</tr>
<tr>
<td>95% CI: (59, 70)</td>
<td>95% CI: (16, 30)</td>
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<tr>
<td>mDOCR+CRh</td>
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<td>13.9 months</td>
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<tr>
<td>95% CI: (15.3, –)</td>
<td>95% CI: (10.4, 15.7)</td>
<td></td>
</tr>
</tbody>
</table>

### LEVERAGE 3-STEP APPROACH FOR TREATMENT WITH VENCLEXTA¹

**Initiation**
- Evaluate TLS risk in all patients and provide prophylactic measures
- 3-day dose ramp-up and monitor blood chemistries
- Dose-reduce for concomitant use with P-gp inhibitors or strong or moderate CYP3A inhibitors or for severe hepatic impairment

**Assessment**
- Assess and monitor for common and serious adverse reactions (ARs)
- Bone marrow assessment as clinically indicated
  - In VIALE-A, bone marrow assessment was conducted following Cycle 1 treatment to assess for remission

**Management**
- Manage hematologic ARs with dose modifications based on remission status*
  - May include VENCLEXTA pause or change in VENCLEXTA duration
- Manage non-hematologic ARs with dose modifications*

*See Table 6 in the full Prescribing Information for dose modifications.

Select Important Safety Information

- Tumor lysis syndrome (TLS), including fatal events and renal failure requiring dialysis, has occurred in patients treated with VENCLEXTA. Assess all patients for risk, including evaluation of tumor burden and comorbidities, and provide prophylaxis for TLS, including hydration and anti-hyperuricemics. Monitor blood chemistries and manage abnormalities promptly. Employ more intensive measures (IV hydration, frequent monitoring, hospitalization) as overall risk increases. Interrupt dosing if needed; when restarting VENCLEXTA follow dose modification guidance in the Prescribing Information.
- Concomitant use of VENCLEXTA with P-gp inhibitors or strong or moderate CYP3A inhibitors increases venetoclax exposure, which may increase the risk of TLS at initiation and during ramp-up phase, and requires VENCLEXTA dose adjustment.
- Grade 3 or 4 neutropenia occurred in patients treated with VENCLEXTA. Monitor blood counts and for signs of infection; manage as medically appropriate.
- Baseline neutrophil counts worsened in 95% to 100% of patients treated with VENCLEXTA in combination with azacitidine or decitabine or low-dose cytarabine. Neutropenia can recur with subsequent cycles.
- Fatal and serious infections such as pneumonia and sepsis have occurred in patients with VENCLEXTA. Monitor patients for signs and symptoms of infection and treat promptly. Withhold VENCLEXTA for Grade 3 and 4 infection until resolution.
- Do not administer live attenuated vaccines prior to, during, or after treatment until B-cell recovery occurs.
- VENCLEXTA may cause embryo-fetal harm. Advise females of reproductive potential to use effective contraception during treatment and for at least 30 days after the last dose.

Please see additional Important Safety Information on pages 16 and 17.