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NEWS RELEASE

DARZALEX® (daratumumab)-based maintenance regimens show clinically meaningful deep and durable responses in transplant-eligible patients with newly diagnosed multiple myeloma

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Minimal residual disease (MRD)-negativity rate of 10^{-5} more than doubled by 12 months with DARZALEX FASPRO® in maintenance therapy compared to lenalidomide alone, resulting in improvement in 30-month progression-free survival

RIO DE JANEIRO, Sept. 27, 2024 /PRNewswire/ -- Johnson & Johnson (NYSE: JNJ) today announced data from three studies highlighting clinical efficacy of DARZALEX® (daratumumab) and DARZALEX FASPRO® (daratumumab and hyaluronidase-fihj) in maintenance regimens. Data from the Phase 3 AURIGA study show DARZALEX FASPRO® plus lenalidomide (D-R) maintenance therapy following autologous stem cell transplant (ASCT) significantly increases MRD-negative conversion rates at 12 months compared to lenalidomide (R) maintenance alone in patients with newly diagnosed multiple myeloma (NDMM). DARZALEX FASPRO® plus lenalidomide maintenance therapy also demonstrated a potential benefit in progression-free survival (PFS) with no new safety concerns.[1] Data were featured in an oral presentation at the **2024 International Myeloma Society (IMS) Annual Meeting** (Abstract #OA – 45).

"The significant improvement in MRD-negative conversion rates and the promising progression-free survival data suggest that this maintenance regimen has the potential to improve longer-term outcomes for patients with newly diagnosed multiple myeloma who are transplant-eligible," said Dr. Ashraf Badros, professor of medicine at the University of Maryland School of Medicine and Director of the Multiple Myeloma Service at the University of Maryland Greenebaum Comprehensive Cancer Center within University of Maryland Medical Center in

Maryland.* "Combining DARZALEX FASPRO with lenalidomide in the maintenance setting offers an advantage over lenalidomide alone for patients who are newly diagnosed with multiple myeloma and anti-CD38 naïve."

In the AURIGA study, the D-R arm demonstrated a higher MRD-negative (10^{-5}) conversion rate by 12 months compared to the R arm (50.5 percent vs 18.8 percent, odds ratio [OR] 4.51, P<0.0001) and a superior ≥6-month sustained MRD-negative rate (35.4 percent vs 13.9 percent, OR 3.40, P=0.0005). Complete response (CR) or better rates were also higher with D-R: 75.8 percent vs 61.4 percent (P=0.0255). The increased MRD-negative conversion rate resulted in a PFS favoring D-R (hazard ratio 0.53; 95% CI, 0.29-0.97) with an estimated 30-month rate of 82.7 percent compared to 66.4 percent for the R arm.[1]

"MRD-negativity is an important predictor of long-term progression-free survival for patients with multiple myeloma, and the FDA Oncologic Drugs Advisory Committee emphasized the value of this when it unanimously decided that MRD could be used as a primary endpoint in multiple myeloma clinical trials as a surrogate for PFS," said Imran Khan, Vice President, Medical Affairs, Hematology, Innovative Medicine, Johnson & Johnson. "These results, along with the data being presented from the Phase 3 CEPHEUS study, further underscore the promising potential of DARZALEX FASPRO for newly diagnosed patients, regardless of their transplant status."

Grade 3/4 treatment-related adverse events (TRAEs) occurred in 74 percent of patients treated with D-R and 67.3 percent of patients treated with R; infections (18.8 percent and 13.3 percent) and neutropenia (46.9 percent and 41.8 percent) were most common.[1]

Additional data from Phase 3 PERSEUS study demonstrate benefit of DARZALEX FASPRO®-based induction, consolidation and maintenance regimens across cytogenetic risk populations

Expanded analyses of the Phase 3 PERSEUS study show that DARZALEX FASPRO® in combination with bortezomib, lenalidomide and dexamethasone (D-VRd) in induction/consolidation followed by a maintenance regimen of D-R induced deep and sustained MRD-negativity compared to VRd regardless of disease stage based on the second revised International Staging System (R2-ISS). In the revised high-risk subgroup, treatment with D-VRd followed by D-R maintenance results in higher rates of overall MRD-negativity at 10^{-6} with complete response or better compared to VRd (63.1 percent vs 32.4 percent; P<0.0001) with sustained MRD-negativity status for at least 12 months (42.3 percent vs 15.5 percent; P=0.0007).[2]

These data, including high-risk cytogenetic abnormalities (HRCAs), including gain(1q21) and amp(1q21), will be presented in an oral presentation at IMS (Abstract #OA – 48).

Phase 3 CASSIOPEIA MRD update shows deep and durable responses with DARZALEX® in

maintenance therapy

Updated MRD data from the Phase 3 CASSIOPEIA study demonstrate that including DARZALEX® in both induction/consolidation and maintenance regimens resulted in deeper and more durable MRD-negative responses at 10^{-5} level vs bortezomib/thalidomide/dexamethasone (VTd) and observation: 77 percent vs 71 percent (P=0.0417). The benefit of DARZALEX® monotherapy maintenance was demonstrated in both patients who received VTd induction and consolidation, as well as those who received DARZALEX® and VTd. DARZALEX® maintenance reduced the risk of progression or death by 24% in patients who received DARZALEX® and VTd as induction and consolidation. These results will be presented in an oral presentation at IMS (Abstract #OA – 47).[3]

In the AURIGA, PERSEUS and CASSIOPEIA studies, the safety profiles were consistent with the known safety profiles for DARZALEX® and DARZALEX FASPRO®.

About the AURIGA Study

The randomized study (**NCT03901963**) included 200 patients aged 18-79 years with newly diagnosed multiple myeloma who are minimal residual disease (MRD)-positive after frontline autologous stem cell transplant. Patients received 1800 milligram (mg) daratumumab by subcutaneous (SC) injection in combination with lenalidomide (orally) as maintenance therapy for a maximum of 36 cycles. Each cycle is 28 days. Patients in the comparative arm will receive lenalidomide (orally) alone as maintenance therapy for a maximum of 36 cycles. Each cycle is 28 days.[4]

About the CEPHEUS Study

CEPHEUS (**NCT03652064**) is an ongoing, multicenter, randomized, open-label, Phase 3 study comparing the efficacy and safety of D-VRd vs VRd in patients with newly diagnosed multiple myeloma who are transplant-ineligible or for whom transplant is not intended as initial therapy. Primary endpoint is MRD-negativity rate at 10^{-5} sensitivity threshold. Secondary endpoints include PFS, MRD-negative rate at 1 year, durable MRD negativity, ORR, time to and duration of response, PFS on next line of therapy, overall survival and safety. The trial has enrolled 396 patients in 13 countries.

About the PERSEUS Study

The PERSEUS study (**NCT03710603**) is being conducted in collaboration with the European Myeloma Network as the sponsor. PERSEUS is an ongoing, randomized, open-label, Phase 3 study comparing the efficacy and safety of DARZALEX FASPRO® -VRd during induction and consolidation versus VRd during induction and consolidation in patients with NDMM eligible for ASCT. Following consolidation, patients received an investigational treatment regimen for maintenance that included DARZALEX FASPRO® in combination with lenalidomide or lenalidomide alone. The trial was not designed to isolate the effect of DARZALEX FASPRO® in the maintenance phase of treatment. The efficacy of DARZALEX FASPRO® in combination with lenalidomide for maintenance has not been

established. The primary endpoint is PFS, and secondary endpoints include overall CR or better rate, and overall MRD-negativity (in patients with CR or better). The median age is 61.0 (range, 32-70) years for patients in the D-VRd arm and 59.0 (range, 31-70) years for patients in the VRd arm.[5] The study is being conducted in 14 countries in Europe and Australia.

About the CASSIOPEIA Study

The randomized, open-label, multicenter, Phase 3 (**NCT02541383**) study is sponsored by the French Intergroupe Francophone du Myelome in collaboration with the Dutch-Belgian Cooperative Trial Group for Hematology Oncology and Janssen Research & Development, LLC. This Phase 3 study included 1,085 newly diagnosed patients with previously untreated, symptomatic multiple myeloma who were eligible for high-dose chemotherapy and stem cell transplant. Part one of the study compared DARZALEX® (D) in combination with bortezomib, thalidomide and dexamethasone (VTd) versus VTd induction and consolidation therapy in patients with NDMM who were eligible for autologous stem cell transplantation (ASCT) and demonstrated that D-VTd yielded deeper responses and improved PFS. Part two of the study compared D-maintenance therapy given every 8 weeks (at a reduced frequency treatment schedule compared to the standard long-term dosing frequency of every 4 weeks) versus observation. The primary endpoint in this part of the study is the proportion of patients who achieve a stringent complete response (sCR) 100 days after transplant. In the second part of the study, which is ongoing, patients who achieved a partial response or better in part one will undergo a second randomization to receive maintenance treatment with DARZALEX® 16 mg/kg every eight weeks for up to two years or will be observed with no further treatment. The primary endpoint in this part of the study is PFS.[6]

About Multiple Myeloma

Multiple myeloma is a blood cancer that affects a type of white blood cell called plasma cells, which are found in the bone marrow.[7] In multiple myeloma, these malignant plasma cells proliferate and replace normal cells in the bone marrow.[8] Multiple myeloma is the second most common blood cancer worldwide and remains an incurable disease.[9] In 2024, it is estimated that more than 35,000 people will be diagnosed with multiple myeloma in the U.S. and more than 12,000 will die from the disease. People with multiple myeloma have a 5-year survival rate of 59.8 percent.[10] While some people diagnosed with multiple myeloma initially have no symptoms, most patients are diagnosed due to symptoms that can include bone fracture or pain, low red blood cell counts, tiredness, high calcium levels, kidney problems or infections.[11,12]

About DARZALEX FASPRO® and DARZALEX®

DARZALEX FASPRO® (daratumumab and hyaluronidase-fihj) **received** U.S. FDA approval in May 2020 and is approved for nine indications in multiple myeloma, four of which are for frontline treatment in newly diagnosed patients who are transplant eligible or ineligible.[14] It is the only subcutaneous CD38-directed antibody approved to treat patients with MM. DARZALEX FASPRO® is co-formulated with recombinant human hyaluronidase PH20

(rHuPH20), Halozyme's ENHANZE® drug delivery technology.

DARZALEX® (daratumumab) received **U.S. FDA approval** in November 2015 and is approved in eight indications, three of which are in the frontline setting, including newly diagnosed patients who are transplant-eligible and ineligible.[6]

DARZALEX® is the first CD38-directed antibody approved to treat multiple myeloma.[6] DARZALEX®-based regimens have been used in the treatment of more than 518,000 patients worldwide and more than 68,000 patients in the U.S. alone.

In **August 2012**, Janssen Biotech, Inc. and Genmab A/S entered a worldwide agreement, which granted Janssen an exclusive license to develop, manufacture and commercialize daratumumab.

Since 2020, the National Comprehensive Cancer Network® (NCCN®) has recommended daratumumab-based combination regimens for the treatment of newly diagnosed multiple myeloma and relapsed and refractory multiple myeloma.† For newly diagnosed multiple myeloma in non-transplant candidates, the NCCN® guidelines recommend daratumumab in combination with lenalidomide and dexamethasone as a Category 1 preferred regimen; daratumumab in combination with bortezomib, melphalan, and prednisone as another recommended Category 1 regimen; and daratumumab in combination with bortezomib, cyclophosphamide, and prednisone as another recommended Category 2A regimen. For newly diagnosed multiple myeloma in transplant candidates, the NCCN® guidelines recommend daratumumab in combination with bortezomib, lenalidomide and dexamethasone as another recommended Category 2A regimen; daratumumab in combination with bortezomib, thalidomide and dexamethasone as a Category 2A regimen useful in certain circumstances; daratumumab in combination with carfilzomib, lenalidomide and dexamethasone as a Category 2A regimen useful in certain circumstances; and daratumumab in combination with cyclophosphamide, bortezomib and dexamethasone as a Category 2A regimen useful in certain circumstances. For maintenance in transplant candidates, the NCCN guidelines recommend daratumumab in combination with lenalidomide as useful in certain circumstances. In relapsed/refractory myeloma, four daratumumab regimens are listed as Category 1 preferred regimens for early relapses (1-3 prior therapies): daratumumab in combination with lenalidomide and dexamethasone; daratumumab in combination with bortezomib and dexamethasone; daratumumab in combination with carfilzomib and dexamethasone; and daratumumab in combination with pomalidomide and dexamethasone [after one prior therapy including lenalidomide and a proteasome inhibitor (PI)]. The NCCN® also recommends daratumumab in combination with cyclophosphamide, bortezomib and dexamethasone as another Category 2A regimen for early relapses (1-3 prior therapies) and as monotherapy as a Category 2A regimen useful in certain circumstances for early relapse patients after at least three prior therapies, including a PI and an immunomodulatory agent, or for patients who are double refractory to a PI and an immunomodulatory agent.

For more information, visit **www.DARZALEX.com**.

DARZALEX® INDICATIONS AND IMPORTANT SAFETY INFORMATION

INDICATIONS

DARZALEX® (daratumumab) is indicated for the treatment of adult patients with multiple myeloma:

- In combination with bortezomib, melphalan, and prednisone in newly diagnosed patients who are ineligible for autologous stem cell transplant
- In combination with lenalidomide and dexamethasone in newly diagnosed patients who are ineligible for autologous stem cell transplant and in patients with relapsed or refractory multiple myeloma who have received at least one prior therapy
- In combination with bortezomib, thalidomide, and dexamethasone in newly diagnosed patients who are eligible for autologous stem cell transplant
- In combination with pomalidomide and dexamethasone in patients who have received at least one prior line of therapy including lenalidomide and a proteasome inhibitor
- In combination with carfilzomib and dexamethasone in patients with relapsed or refractory multiple myeloma who have received one to three prior lines of therapy
- In combination with bortezomib and dexamethasone in patients who have received at least one prior therapy
- As monotherapy in patients who have received at least three prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent or who are double-refractory to a PI and an immunomodulatory agent

CONTRAINDICATIONS

DARZALEX® is contraindicated in patients with a history of severe hypersensitivity (eg, anaphylactic reactions) to daratumumab or any of the components of the formulation.

WARNINGS AND PRECAUTIONS

Infusion-Related Reactions

DARZALEX® can cause severe and/or serious infusion-related reactions including anaphylactic reactions. These reactions can be lifethreatening, and fatal outcomes have been reported. In clinical trials (monotherapy and combination: N=2066), infusion-related reactions occurred in 37% of patients with the Week 1 (16 mg/kg) infusion, 2% with the Week 2 infusion, and cumulatively 6% with subsequent infusions. Less than 1% of patients had a Grade 3/4 infusion-related reaction at Week 2 or subsequent infusions. The median time to onset was 1.5 hours (range: 0 to 73 hours). Nearly all reactions occurred during infusion or within 4 hours of completing DARZALEX®. Severe reactions have occurred, including bronchospasm, hypoxia, dyspnea, hypertension, tachycardia, headache,

laryngeal edema, pulmonary edema, and ocular adverse reactions, including choroidal effusion, acute myopia, and acute angle closure glaucoma. Signs and symptoms may include respiratory symptoms, such as nasal congestion, cough, throat irritation, as well as chills, vomiting, and nausea. Less common signs and symptoms were wheezing, allergic rhinitis, pyrexia, chest discomfort, pruritus, hypotension and blurred vision.

When DARZALEX® dosing was interrupted in the setting of ASCT (CASSIOPEIA) for a median of 3.75 months (range: 2.4 to 6.9 months), upon re-initiation of DARZALEX®, the incidence of infusion-related reactions was 11% for the first infusion following ASCT. Infusion-related reactions occurring at re-initiation of DARZALEX® following ASCT were consistent in terms of symptoms and severity (Grade 3 or 4: <1%) with those reported in previous studies at Week 2 or subsequent infusions. In EQUULEUS, patients receiving combination treatment (n=97) were administered the first 16 mg/kg dose at Week 1 split over two days, ie, 8 mg/kg on Day 1 and Day 2, respectively. The incidence of any grade infusion-related reactions was 42%, with 36% of patients experiencing infusion-related reactions on Day 1 of Week 1, 4% on Day 2 of Week 1, and 8% with subsequent infusions.

Pre-medicate patients with antihistamines, antipyretics, and corticosteroids. Frequently monitor patients during the entire infusion. Interrupt DARZALEX® infusion for reactions of any severity and institute medical management as needed. Permanently discontinue DARZALEX® therapy if an anaphylactic reaction or life-threatening (Grade 4) reaction occurs and institute appropriate emergency care. For patients with Grade 1, 2, or 3 reactions, reduce the infusion rate when re-starting the infusion.

To reduce the risk of delayed infusion-related reactions, administer oral corticosteroids to all patients following DARZALEX® infusions. Patients with a history of chronic obstructive pulmonary disease may require additional post-infusion medications to manage respiratory complications. Consider prescribing short- and long-acting bronchodilators and inhaled corticosteroids for patients with chronic obstructive pulmonary disease.

Ocular adverse reactions, including acute myopia and narrowing of the anterior chamber angle due to ciliochoroidal effusions with potential for increased intraocular pressure or glaucoma, have occurred with DARZALEX® infusion. If ocular symptoms occur, interrupt DARZALEX® infusion and seek immediate ophthalmologic evaluation prior to restarting DARZALEX®.

Interference With Serological Testing

Daratumumab binds to CD38 on red blood cells (RBCs) and results in a positive indirect antiglobulin test (indirect Coombs test). Daratumumab-mediated positive indirect antiglobulin test may persist for up to 6 months after the last daratumumab infusion. Daratumumab bound to RBCs masks detection of antibodies to minor antigens in the patient's serum. The determination of a patient's ABO and Rh blood type is not impacted. Notify blood transfusion centers of this interference with serological testing and inform blood banks that a patient has received DARZALEX®. Type and screen patients prior to starting DARZALEX®.

Neutropenia and Thrombocytopenia

DARZALEX® may increase neutropenia and thrombocytopenia induced by background therapy. Monitor complete blood cell counts periodically during treatment according to manufacturer's prescribing information for background therapies. Monitor patients with neutropenia for signs of infection. Consider withholding DARZALEX® until recovery of neutrophils or for recovery of platelets.

Interference With Determination of Complete Response

Daratumumab is a human immunoglobulin G (IgG) kappa monoclonal antibody that can be detected on both the serum protein electrophoresis (SPE) and immunofixation (IFE) assays used for the clinical monitoring of endogenous M-protein. This interference can impact the determination of complete response and of disease progression in some patients with IgG kappa myeloma protein.

Embryo-Fetal Toxicity

Based on the mechanism of action, DARZALEX® can cause fetal harm when administered to a pregnant woman. DARZALEX® may cause depletion of fetal immune cells and decreased bone density. Advise pregnant women of the potential risk to a fetus. Advise females with reproductive potential to use effective contraception during treatment with DARZALEX® and for 3 months after the last dose.

The combination of DARZALEX® with lenalidomide, pomalidomide, or thalidomide is contraindicated in pregnant women because lenalidomide, pomalidomide, and thalidomide may cause birth defects and death of the unborn child. Refer to the lenalidomide, pomalidomide, or thalidomide prescribing information on use during pregnancy.

ADVERSE REACTIONS

The most frequently reported adverse reactions (incidence ≥20%) were: upper respiratory infection, neutropenia, infusionrelated reactions, thrombocytopenia, diarrhea, constipation, anemia, peripheral sensory neuropathy, fatigue, peripheral edema, nausea, cough, pyrexia, dyspnea, and asthenia. The most common hematologic laboratory abnormalities (≥40%) with DARZALEX® are: neutropenia, lymphopenia, thrombocytopenia, leukopenia, and anemia.

Please **click here** to see the full Prescribing Information.

DARZALEX FASPRO® INDICATIONS AND IMPORTANT SAFETY INFORMATION

INDICATIONS

DARZALEX FASPRO® (daratumumab and hyaluronidase-fihj) is indicated for the treatment of adult patients with

multiple myeloma:

- In combination with bortezomib, lenalidomide, and dexamethasone for induction and consolidation in newly diagnosed patients who are eligible for autologous stem cell transplant
- In combination with bortezomib, melphalan, and prednisone in newly diagnosed patients who are ineligible for autologous stem cell transplant
- In combination with lenalidomide and dexamethasone in newly diagnosed patients who are ineligible for autologous stem cell transplant and in patients with relapsed or refractory multiple myeloma who have received at least one prior therapy
- In combination with bortezomib, thalidomide, and dexamethasone in newly diagnosed patients who are eligible for autologous stem cell transplant
- In combination with pomalidomide and dexamethasone in patients who have received at least one prior line of therapy including lenalidomide and a proteasome inhibitor (PI)
- In combination with carfilzomib and dexamethasone in patients with relapsed or refractory multiple myeloma who have received one to three prior lines of therapy
- In combination with bortezomib and dexamethasone in patients who have received at least one prior therapy
- As monotherapy in patients who have received at least three prior lines of therapy including a PI and an immunomodulatory agent or who are double refractory to a PI and an immunomodulatory agent

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

DARZALEX FASPRO® is contraindicated in patients with a history of severe hypersensitivity to daratumumab, hyaluronidase, or any of the components of the formulation.

WARNINGS AND PRECAUTIONS

Hypersensitivity and Other Administration Reactions

Both systemic administration-related reactions, including severe or life-threatening reactions, and local injection-site reactions can occur with DARZALEX FASPRO®. Fatal reactions have been reported with daratumumab-containing products, including DARZALEX FASPRO®.

Systemic Reactions

In a pooled safety population of 1249 patients with multiple myeloma (N=1056) or light chain (AL) amyloidosis (N=193) who received DARZALEX FASPRO® as monotherapy or in combination, 7% of patients experienced a systemic administration-related reaction (Grade 2: 3.2%, Grade 3: 0.7%, Grade 4: 0.1%). Systemic administration-related reactions occurred in 7% of patients with the first injection, 0.2% with the second injection, and cumulatively

1% with subsequent injections. The median time to onset was 2.9 hours (range: 5 minutes to 3.5 days). Of the 165 systemic administration-related reactions that occurred in 93 patients, 144 (87%) occurred on the day of DARZALEX FASPRO® administration. Delayed systemic administration-related reactions have occurred in 1% of the patients.

Severe reactions included hypoxia, dyspnea, hypertension, tachycardia, and ocular adverse reactions, including choroidal effusion, acute myopia, and acute angle closure glaucoma. Other signs and symptoms of systemic administration-related reactions may include respiratory symptoms, such as bronchospasm, nasal congestion, cough, throat irritation, allergic rhinitis, and wheezing, as well as anaphylactic reaction, pyrexia, chest pain, pruritus, chills, vomiting, nausea, hypotension, and blurred vision.

Pre-medicate patients with histamine-1 receptor antagonist, acetaminophen, and corticosteroids. Monitor patients for systemic administration-related reactions, especially following the first and second injections. For anaphylactic reaction or life-threatening (Grade 4) administration-related reactions, immediately and permanently discontinue DARZALEX FASPRO®. Consider administering corticosteroids and other medications after the administration of DARZALEX FASPRO® depending on dosing regimen and medical history to minimize the risk of delayed (defined as occurring the day after administration) systemic administration-related reactions.

Ocular adverse reactions, including acute myopia and narrowing of the anterior chamber angle due to ciliochoroidal effusions with potential for increased intraocular pressure or glaucoma, have occurred with daratumumab-containing products. If ocular symptoms occur, interrupt DARZALEX FASPRO® and seek immediate ophthalmologic evaluation prior to restarting DARZALEX FASPRO®.

Local Reactions
In this pooled safety population, injection-site reactions occurred in 7% of patients, including Grade 2 reactions in 0.8%. The most frequent (>1%) injection-site reaction was injection-site erythema. These local reactions occurred a median of 5 minutes (range: 0 minutes to 6.5 days) after starting administration of DARZALEX FASPRO®. Monitor for local reactions and consider symptomatic management.

Neutropenia

Daratumumab may increase neutropenia induced by background therapy. Monitor complete blood cell counts periodically during treatment according to manufacturer's prescribing information for background therapies. Monitor patients with neutropenia for signs of infection. Consider withholding DARZALEX FASPRO® until recovery of neutrophils. In lower body weight patients receiving DARZALEX FASPRO®, higher rates of Grade 3-4 neutropenia were observed.

Thrombocytopenia

Daratumumab may increase thrombocytopenia induced by background therapy. Monitor complete blood cell

counts periodically during treatment according to manufacturer's prescribing information for background therapies. Consider withholding DARZALEX FASPRO® until recovery of platelets.

Embryo-Fetal Toxicity

Based on the mechanism of action, DARZALEX FASPRO® can cause fetal harm when administered to a pregnant woman. DARZALEX FASPRO® may cause depletion of fetal immune cells and decreased bone density. Advise pregnant women of the potential risk to a fetus. Advise females with reproductive potential to use effective contraception during treatment with DARZALEX FASPRO® and for 3 months after the last dose.

The combination of DARZALEX FASPRO® with lenalidomide, thalidomide, or pomalidomide is contraindicated in pregnant women because lenalidomide, thalidomide, and pomalidomide may cause birth defects and death of the unborn child. Refer to the lenalidomide, thalidomide, or pomalidomide prescribing information on use during pregnancy.

Interference With Serological Testing

Daratumumab binds to CD38 on red blood cells (RBCs) and results in a positive indirect antiglobulin test (indirect Coombs test). Daratumumab-mediated positive indirect antiglobulin test may persist for up to 6 months after the last daratumumab administration. Daratumumab bound to RBCs masks detection of antibodies to minor antigens in the patient's serum. The determination of a patient's ABO and Rh blood type are not impacted.

Notify blood transfusion centers of this interference with serological testing and inform blood banks that a patient has received DARZALEX FASPRO®. Type and screen patients prior to starting DARZALEX FASPRO®.

Interference With Determination of Complete Response

Daratumumab is a human immunoglobulin G (IgG) kappa monoclonal antibody that can be detected on both the serum protein electrophoresis (SPE) and immunofixation (IFE) assays used for the clinical monitoring of endogenous M-protein. This interference can impact the determination of complete response and of disease progression in some DARZALEX FASPRO®-treated patients with IgG kappa myeloma protein.

ADVERSE REACTIONS

In multiple myeloma, the most common adverse reaction (≥20%) with DARZALEX FASPRO® monotherapy is upper respiratory tract infection. The most common adverse reactions with combination therapy (≥20% for any combination) include fatigue, nausea, diarrhea, dyspnea, insomnia, headache, pyrexia, cough, muscle spasms, back pain, vomiting, hypertension, upper respiratory tract infection, peripheral sensory neuropathy, constipation, pneumonia, and peripheral edema.

The most common hematology laboratory abnormalities (≥40%) with DARZALEX FASPRO® are decreased leukocytes, decreased lymphocytes, decreased neutrophils, decreased platelets, and decreased hemoglobin.

Please **click here** to see the full Prescribing Information for DARZALEX FASPRO®.

About Johnson & Johnson

At Johnson & Johnson, we believe health is everything. Our strength in healthcare innovation empowers us to build a world where complex diseases are prevented, treated, and cured, where treatments are smarter and less invasive, and solutions are personal. Through our expertise in Innovative Medicine and MedTech, we are uniquely positioned to innovate across the full spectrum of healthcare solutions today to deliver the breakthroughs of tomorrow, and profoundly impact health for humanity. Learn more at **https://www.jnj.com/** or at **www.janssen.com/johnson-johnson-innovative-medicine**. Follow us at **@JanssenUS** and **@JNJInnovMed**. Janssen Research & Development, LLC and Janssen Biotech, Inc., Janssen Global Services, LLC and Janssen Scientific Affairs, LLC are Johnson & Johnson companies.

Cautions Concerning Forward-Looking Statements

This press release contains "forward-looking statements" as defined in the Private Securities Litigation Reform Act of 1995 regarding product development and the potential benefits and treatment impact of DARZALEX® and DARZALEX FASPRO®. The reader is cautioned not to rely on these forward-looking statements. These statements are based on current expectations of future events. If underlying assumptions prove inaccurate or known or unknown risks or uncertainties materialize, actual results could vary materially from the expectations and projections of Janssen Research & Development, LLC, Janssen Biotech, Inc. Janssen Global Services, LLC, Janssen Scientific Affairs, LLC and/or Johnson & Johnson. Risks and uncertainties include, but are not limited to: challenges and uncertainties inherent in product research and development, including the uncertainty of clinical success and of obtaining regulatory approvals; uncertainty of commercial success; manufacturing difficulties and delays; competition, including technological advances, new products and patents attained by competitors; challenges to patents; product efficacy or safety concerns resulting in product recalls or regulatory action; changes in behavior and spending patterns of purchasers of health care products and services; changes to applicable laws and regulations, including global health care reforms; and trends toward health care cost containment. A further list and descriptions of these risks, uncertainties and other factors can be found in Johnson & Johnson's Annual Report on Form 10-K for the fiscal year ended December 31, 2023, including in the sections captioned "Cautionary Note Regarding Forward-Looking Statements" and "Item 1A. Risk Factors," and in Johnson & Johnson's subsequent Quarterly Reports on Form 10-Q and other filings with the Securities and Exchange Commission. Copies of these filings are available online at **www.sec.gov**, **www.jnj.com** or on request from Johnson & Johnson. None of Janssen Research & Development, LLC, Janssen Biotech, Inc., Janssen Global Services, LLC, Janssen Scientific Affairs, LLC nor Johnson & Johnson undertake to update any forward-looking statement as a result of new information or future

events or developments.

Source: Johnson & Johnson

* Dr. Ashraf Badros, University of Maryland Medical Center in Maryland has provided consulting, advisory, and speaking services to Johnson & Johnson; he has not been paid for any media work.

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[3] Corre, J., et al. Daratumumab (DARA) + Bortezomib/Thalidomide/ Dexamethasone (D-VTd) and DARA Maintenance in Transplanteligible Newly Diagnosed Multiple Myeloma (NDMM): CASSIOPEIA Minimal Residual Disease (MRD) Update. IMS 2024. September 27, 2024.
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