

Johnson & Johnson Announces U.S. FDA Approval of TECVAYLI® plus DARZALEX FASPRO® for Relapsed/Refractory Multiple Myeloma, Offering a Potential New Standard of Care as Early as Second Line

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Approval based on unprecedented Phase 3 data demonstrating statistically significant improvements in progression-free survival and overall survival versus standard of care regimens

83.3% of patients were alive at three years, indicating durable clinical benefit

HORSHAM, Pa., March 5, 2026 /PRNewswire/ -- Johnson & Johnson (NYSE:JNJ), a worldwide leader in multiple myeloma therapies, today announced that the U.S. Food and Drug Administration (FDA) approved TECVAYLI® (teclistamab-cqyv) plus DARZALEX FASPRO® (daratumumab and hyaluronidase-fihj) for the treatment of adults with relapsed or refractory multiple myeloma (RRMM) who have received at least one prior line of therapy, including a proteasome inhibitor and an immunomodulatory agent.¹ TECVAYLI® and DARZALEX FASPRO® work synergistically to prime and activate the immune system to eradicate myeloma cells that express the BCMA protein.¹ This approval offers a potential new standard of care (SOC) as early as second line and brings a novel treatment approach for the 40% of patients with multiple myeloma who experience disease relapse.²

Multimedia assets for media are available [here](#).

Perspectives on Expanding Multiple Myeloma Treatment Options

"This new treatment option can redefine how we approach RRMM treatment by giving healthcare providers a

regimen with improvement in PFS and OS and a well-characterized safety profile," said Dr. Luciano J. Costa, Professor of Multiple Myeloma and Director of the Multiple Myeloma Research and Treatment Program at the University of Alabama at Birmingham, and Primary Investigator of MajesTEC-3*. "The option to use this regimen as early as second line is particularly important because patients with RRMM often experience multiple relapses and reduced responsiveness to therapy over time, which makes earlier treatment with the most effective therapies critical. In addition, the steroid-sparing approach may reduce toxicity and improve tolerability."

"There is a critical need to expand community-based treatment options for multiple myeloma patients, allowing them to receive care closer to home while respecting their individual treatment preferences," said Heather Ortnor Cooper, President & CEO of the International Myeloma Foundation**. "This approval enhances the therapeutic landscape, giving oncologists diverse options to personalize treatment plans for each patient."

"As the leader in hematology, we have a proud history of transforming the treatment landscape for multiple myeloma. This approval represents another pivotal milestone in improving outcomes for patients living with this disease, with a unique regimen accessible to patients across all practice settings," said Imran Khan, M.D., Ph.D., Vice President, U.S. Hematology Medical Affairs, Johnson & Johnson. "The FDA approval of TECVAYLI plus DARZALEX FASPRO adds a powerful new treatment option to our multiple myeloma portfolio, moving us closer to our ambition of one day curing this disease."

Unprecedented MajesTEC-3 Study Results

The approval is based on data from the Phase 3 MajesTEC-3 study, an ongoing, Phase 3 randomized study evaluating the safety and efficacy of teclistamab plus daratumumab versus investigator's choice of daratumumab and dexamethasone with either pomalidomide or bortezomib in patients with RRMM who have received at least one prior line of therapy. TECVAYLI® in combination with DARZALEX FASPRO® demonstrated statistically significant improvements in PFS and OS in patients with RRMM compared to standard treatment after a median follow-up of three years in patients with RRMM. Results show an 83% reduction in the risk of disease progression or death compared to standard regimens (hazard ratio [HR], 0.17; 95 percent confidence interval [CI], 0.12-0.23; P<0.0001).³ The three-year PFS rate was 83% compared to 30% in the control arm, underscoring a durable benefit.³ The results were presented in December 2025 as a late-breaking oral presentation at the American Society of Hematology (ASH) Annual Meeting with simultaneous publication in **The New England Journal of Medicine**.

Significant improvements compared to SOC were observed across key secondary endpoints, including treatment response rates, minimal residual disease (MRD)-negativity, OS, and time to worsening of symptoms – revealing the impact of the regimen across varied patient measures.³ TECVAYLI® plus DARZALEX FASPRO® showed higher rates

of overall response (ORR) (89.0% vs. 75.3%; OR, 2.65; 95% CI, 1.68-4.18), complete response (\geq CR) (81.8% vs. 32.1%; odds ratio [OR], 9.56; 95% CI, 6.47-14.14), and MRD-negativity (58.4% vs. 17.1%; OR, 6.78; 95% CI, 4.53-10.15, $P < 0.0001$; evaluable rate of 89.3% vs. 63.0%) at three-years follow-up.³ OS favored TECVAYLI[®] plus DARZALEX FASPRO[®] (HR, 0.46; 95% CI, 0.32-0.65; $P < 0.0001$) across all prespecified subgroups. At three years, OS rates were 83.3% and 65.0% for the TECVAYLI[®] plus DARZALEX FASPRO[®] arm and the control arm, respectively.³

In the MajesTEC-3 study, TECVAYLI[®] plus DARZALEX FASPRO[®] and SOC comparators had similar rates of Grade 3/4 (95.1% vs. 96.6%) treatment-emergent adverse events (TEAE).³ Most Grade 3/4 events were due to cytopenias and infection.³ Infections were observed with TECVAYLI[®] and DARZALEX FASPRO[®] (any grade, 96.5%; Grade 3/4, 54.1%) and DPd/DVd control (any grade 84.1%; Grade 3/4 43.4%). Grade 3 or higher infections with TECVAYLI[®] and DARZALEX FASPRO[®] declined after the first 6 months of treatment consistent with use of established immunoglobulin supplementation and infection prophylaxis protocols, along with switch to monthly dosing.³ Cytokine release syndrome occurred in 60.1% of patients; all cases were Grade 1/2, did not lead to treatment discontinuation and were effectively managed using standard guidelines.³ Immune effector cell-associated neurotoxicity syndrome was rare and occurred in 1.1% of patients.³ Serious adverse events occurred in 70.7% of patients compared to 62.4% of patients treated with the control regimen, while treatment discontinuations due to adverse events were low (4.6% vs. 5.5%).³ Grade 5 TEAEs were 7.1% and 5.9% with TECVAYLI[®] plus DARZALEX FASPRO[®] and DPd/DVd control, respectively.³

The FDA proactively selected the teclistamab MajesTEC-3 supplemental Biologics License Application (sBLA) to participate in the Commissioner's National Priority Voucher (CNPV) Pilot Program as it aligns with the program's priority to deliver more innovative therapies for American people. The FDA also granted the application Breakthrough Therapy Designation and Real-Time Oncology Review.

Access to TECVAYLI[®] plus DARZALEX FASPRO[®]

Johnson & Johnson offers comprehensive access and support information and resources to assist patients in gaining access to our multiple myeloma therapies. Our patient support program, TECVAYLI[®] withMe⁺, is available to provide personalized support to help patients start and stay on their Johnson & Johnson medicines once the clinical decision has been made to prescribe. TECVAYLI[®] withMe helps providers support their patients by verifying patients' insurance coverage, providing information on Prior Authorization and Appeals processes and educating on reimbursement processes. Patients can connect to TECVAYLI[®] withMe to receive cost support, regardless of insurance type, free, personalized one-on-one support from a Care Navigator, and resources and community connections. Learn more at [TECVAYLI.com](https://www.tecvayli.com) or by calling 833-JNJ-wMe1 (833-565-9631).

About MajesTEC-3

MajesTEC-3 is an ongoing, Phase 3 randomized study evaluating the safety and efficacy of teclistamab plus

daratumumab versus investigator's choice of daratumumab and dexamethasone with either pomalidomide or bortezomib in patients with relapsed/refractory multiple myeloma who have received at least one prior line of therapy. The primary endpoint is PFS and secondary endpoints include complete response or better, overall response rate, minimal residual disease negativity, overall survival, time to worsening of symptoms (MySI-m-Q), and safety. The MajesTEC-3 study is a part of the MajesTEC clinical program, which includes exploring the potential of TECVAYLI[®] as a combination regimen.⁴ It is the first randomized Phase 3 trial using a bispecific antibody in relapsed/refractory multiple myeloma and confirmatory trial after the initial FDA approval.

About TECVAYLI[®]

TECVAYLI[®] (teclistamab-cqyv) is a first-in-class, bispecific T-cell engager antibody therapy that uses innovative science to activate the immune system by binding to the CD3 receptor expressed on the surface of T-cells and to the B-cell maturation antigen (BCMA) expressed on the surface of multiple myeloma cells and some healthy B-lineage cells. TECVAYLI[®] received accelerated **approval** from the U.S. FDA in October 2022 as an off-the-shelf (or ready-to-use) antibody that is administered as a subcutaneous treatment for adult patients with relapsed or refractory multiple myeloma (RRMM) who have received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 antibody.⁵

In February 2024, the U.S. FDA **approved** the supplemental Biologics License Application (sBLA) for TECVAYLI[®] for a reduced dosing frequency of 1.5 mg/kg every two weeks in patients with relapsed or refractory multiple myeloma who have achieved and maintained a CR or better for a minimum of six months. Since FDA approval, more than 23,000 patients have been treated worldwide with TECVAYLI[®].

The European Commission (EC) granted TECVAYLI[®] **conditional marketing authorization** in August 2022 as monotherapy for the treatment of adult patients with RRMM who have received at least three prior therapies, including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 antibody, and have demonstrated disease progression since the last therapy. In August 2023, the EC **granted the approval** of a Type II variation application for TECVAYLI[®], providing the option for a reduced dosing frequency of 1.5 mg/kg every two weeks (Q2W) in patients who have achieved a complete response or better for a minimum of six months.

For more information, visit www.TECVAYLI.com.

About DARZALEX FASPRO[®] and DARZALEX[®]

DARZALEX FASPRO[®] (daratumumab and hyaluronidase-fihj) **received** U.S. FDA approval in May 2020 and is approved for 11 indications in multiple myeloma, four of which are for frontline treatment in newly diagnosed patients who are transplant eligible or ineligible.⁶ It is the only subcutaneous CD38-directed antibody approved to treat patients with multiple myeloma. 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.⁷ In 2025, DARZALEX FASPRO[®] was approved by the U.S. FDA and EMA as the first and only treatment for patients with high-risk smoldering multiple myeloma.

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 618,000 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 Biotech, Inc. an exclusive license to develop, manufacture and commercialize daratumumab.

For more information, visit www.DARZALEX.com.

About Multiple Myeloma

Multiple myeloma is an incurable blood cancer that affects a type of white blood cell called plasma cells, which are found in the bone marrow.⁸ In multiple myeloma, these plasma cells proliferate and spread rapidly and replace normal cells in the bone marrow with tumors.⁹ Multiple myeloma is the third most common blood cancer worldwide and remains an incurable disease.¹⁰ In 2024, it was estimated that more than 35,000 people will be diagnosed with multiple myeloma in the U.S. and more than 12,000 people would die from the disease.¹¹ People living with multiple myeloma have a 5-year survival rate of 59.8 percent.¹² 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 and kidney problems or infections.^{13,14}

TECVAYLI[®] INDICATIONS AND IMPORTANT SAFETY INFORMATION

INDICATIONS AND USAGE

TECVAYLI[®] (teclistamab-cqyv) is a bispecific B-cell maturation antigen (BCMA)-directed CD3 T-cell engager indicated for the treatment of adult patients with relapsed or refractory multiple myeloma:

- in combination with daratumumab and hyaluronidase-fihj in patients who have received at least one prior line of therapy, including a proteasome inhibitor and an immunomodulatory agent.
- as monotherapy, in patients who have received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 monoclonal antibody.

IMPORTANT SAFETY INFORMATION

WARNING: CYTOKINE RELEASE SYNDROME and NEUROLOGIC TOXICITY including IMMUNE EFFECTOR CELL-ASSOCIATED NEUROTOXICITY SYNDROME

Cytokine release syndrome (CRS), including life-threatening or fatal reactions, can occur in patients receiving TECVAYLI. Initiate treatment with TECVAYLI step-up dosing schedule to reduce risk of CRS. Withhold TECVAYLI until CRS resolves or permanently discontinue based on severity.

Neurologic toxicity, including Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS) and serious, life-threatening, or fatal reactions, can occur in patients receiving TECVAYLI. Monitor patients for signs or symptoms of neurologic toxicity, including ICANS, during treatment. Withhold TECVAYLI until neurologic toxicity resolves or permanently discontinue based on severity.

TECVAYLI is available only through a restricted program called the TECVAYLI and TALVEY[®] Risk Evaluation and Mitigation Strategy (REMS).

WARNINGS AND PRECAUTIONS

Cytokine Release Syndrome - TECVAYLI can cause cytokine release syndrome (CRS), including life-threatening or fatal reactions.

In the clinical trials (monotherapy and combination therapy; N=448), CRS occurred in 64% of patients who received TECVAYLI at the recommended dose, with Grade 1 CRS occurring in 46% of patients, Grade 2 in 18%, and Grade 3 in 0.2%. Recurrent CRS occurred in 27% of patients. Most patients experienced CRS during the initial step-up dosing schedule (step-up dose 1 [37%], step-up dose 2 [32%], or the initial treatment dose [20%]). CRS first occurred following subsequent doses of TECVAYLI in 2.5% of patients. The median time to onset of CRS was 2 (range: 1 to 9) days after the most recent dose and the median duration of CRS was 2 (range: 1 to 22) days.

Clinical signs and symptoms of CRS included, but were not limited to, fever, hypoxia, chills, hypotension, sinus tachycardia, headache, and elevated liver enzymes (aspartate aminotransferase and alanine aminotransferase elevation).

Initiate therapy according to TECVAYLI step-up dosing schedule to reduce risk of CRS. Administer pretreatment medications to reduce risk of CRS and monitor patients following administration of TECVAYLI accordingly.

At the first sign of CRS, immediately evaluate patient for hospitalization. Administer supportive care based on severity and consider further management per current practice guidelines. Withhold until CRS resolves or permanently discontinue TECVAYLI based on severity.

TECVAYLI is available only through a restricted program under a REMS.

Neurologic Toxicity including Immune Effector Cell-Associated Neurotoxicity

Syndrome - TECVAYLI can cause serious, life-threatening, or fatal neurologic toxicity, including immune effector cell-associated neurotoxicity syndrome (ICANS).

In the clinical trials (monotherapy and combination therapy trials; N=448), neurologic toxicity occurred in 60% of patients who received TECVAYLI at the recommended dosage, with Grade 3 or 4 neurologic toxicity in 6%. Neurologic toxicities reported in ≥5% of patients included headache (27%), sensory neuropathy (16%), motor dysfunction (15%), insomnia (12%), encephalopathy (11%), and dizziness (8%). Fatal neurologic toxicity occurred in 0.4% of patients, including Guillain-Barré syndrome and status epilepticus (one patient each).

In MajesTEC-1, ICANS was reported in 6% of patients who received TECVAYLI as monotherapy at the recommended dosage. Recurrent ICANS occurred in 1.8% of patients. Most patients experienced ICANS following step-up dose 1 (1.2%), step-up dose 2 (0.6%), or the initial treatment dose (1.8%). Less than 3% of patients developed first occurrence of ICANS following subsequent TECVAYLI doses. The median time to onset of ICANS was 4 (range: 2 to 8) days after the most recent dose with a median duration of 3 (range: 1 to 20) days. The most frequent clinical manifestations of ICANS reported were confusional state and dysgraphia.

In MajesTEC-3, ICANS was reported in 1.1% of patients who received the recommended TECVAYLI dosage in combination with daratumumab and hyaluronidase-fihj, including Grade 4 ICANS in 1 patient. All events of ICANS occurred during the step-up dosing schedule. The median time to onset of ICANS was 2 (range: 1 to 3) days after the most recent dose and the median duration of ICANS was 2 (range: 1 to 2) days. The clinical manifestations of ICANS reported were amnesia, encephalopathy and delirium.

The onset of ICANS can be concurrent with CRS, following resolution of CRS, or in the absence of CRS.

Monitor patients for signs and symptoms of neurologic toxicity, including ICANS during TECVAYLI treatment. At the first sign of neurologic toxicity, including ICANS, immediately evaluate patient and provide supportive therapy based on severity. Withhold until neurologic toxicity resolves or permanently discontinue TECVAYLI based on severity per recommendations and consider further management per current practice guidelines.

Due to the potential for neurologic toxicity, patients receiving TECVAYLI are at risk of depressed level of

consciousness. Advise patients to refrain from driving or operating heavy or potentially dangerous machinery during and for 48 hours after completion of TECVAYLI step-up dosing schedule and in the event of new onset of any neurologic toxicity symptoms until neurologic toxicity resolves.

TECVAYLI is available only through a restricted program under a REMS.

TECVAYLI and TALVEY REMS - TECVAYLI is available only through a restricted program under a REMS called the TECVAYLI and TALVEY REMS because of the risks of CRS and neurologic toxicity, including ICANS.

Hepatotoxicity - TECVAYLI can cause hepatotoxicity, including fatalities. There was one fatal case of hepatic failure in MajesTEC-1. In patients who received TECVAYLI at the recommended dose in the clinical trials (monotherapy and combination therapy trials; N=448) elevated aspartate aminotransferase (AST) occurred in 47% of patients, with Grade 3 or 4 elevations in 2.9%. Elevated alanine aminotransferase (ALT) occurred in 48% of patients, with Grade 3 or 4 elevations in 3.8%. Elevated total bilirubin occurred in 10% of patients with Grade 3 or 4 elevations in 0.7%. Liver enzyme elevation can occur with or without concurrent CRS.

Monitor liver enzymes and bilirubin at baseline and during treatment as clinically indicated. Withhold TECVAYLI or consider permanent discontinuation of TECVAYLI based on severity.

Infections - TECVAYLI can cause severe, life-threatening, or fatal infections.

In MajesTEC-1 (N=165), in patients who received the recommended TECVAYLI dosage, serious infections, including opportunistic infections, occurred in 30% of patients, Grade 3 or 4 infections in 35% of patients, and fatal infections in 4.2% of patients.

In MajesTEC-3 (N=283), in patients who received TECVAYLI in combination with daratumumab and hyaluronidase-fihj at the recommended dosage, serious infections, including opportunistic infections, occurred in 54% of patients, Grade 3 or Grade 4 infections in 54% of patients, and fatal infections in 4.6% of patients.

Monitor patients for signs and symptoms of infection prior to and during treatment with TECVAYLI and treat appropriately. Administer prophylactic antimicrobials according to current practice guidelines.

Withhold TECVAYLI or consider permanent discontinuation of TECVAYLI based on severity.

Monitor immunoglobulin levels prior to and during treatment with TECVAYLI and administer subcutaneous or intravenous immunoglobulin (IVIG) to maintain the serum levels >400 mg/dL.

Neutropenia - TECVAYLI can cause neutropenia and febrile neutropenia. In patients who received TECVAYLI at the recommended dose in the clinical trials (monotherapy and combination therapy trials; N=448), decreased neutrophils occurred in 88% of patients, with Grade 3 or 4 decreased neutrophils in 70%. Febrile neutropenia occurred in 6% of patients.

Monitor complete blood cell counts at baseline and periodically during treatment and provide supportive care per local institutional guidelines.

Monitor patients with neutropenia for signs of infection.

Withhold TECVAYLI based on severity.

Hypersensitivity and Other Administration Reactions - TECVAYLI can cause both systemic administration-related and local injection-site reactions.

Systemic Reactions - In patients who received the recommended TECVAYLI dosage in the clinical trials (monotherapy and combination therapy trials; N=448), 2.5% of patients experienced systemic-administration reactions, which included recurrent pyrexia and rash.

Local Reactions - In patients who received TECVAYLI at the recommended dosage in the clinical trials (monotherapy and combination therapy trials; N=448), injection-site reactions occurred in 37% of patients, with Grade 1 injection-site reactions in 29% and Grade 2 in 9%.

Withhold TECVAYLI or consider permanent discontinuation of TECVAYLI based on severity.

Embryo-Fetal Toxicity - Based on its mechanism of action, TECVAYLI may cause fetal harm when administered to a pregnant patient. Advise pregnant patients of the potential risk to the fetus. Advise females of reproductive potential to use effective contraception during treatment with TECVAYLI and for 5 months after the last dose.

ADVERSE REACTIONS

The most common adverse reactions ($\geq 20\%$) in patients who received TECVAYLI monotherapy were pyrexia, CRS, musculoskeletal pain, injection site reaction, fatigue, upper respiratory tract infection, nausea, headache, pneumonia, and diarrhea. The most common adverse reactions ($\geq 20\%$) in patients who received TECVAYLI in combination with daratumumab and hyaluronidase-fihj were hypogammaglobulinemia, upper respiratory tract infection, CRS, cough, diarrhea, musculoskeletal pain, COVID-19, pneumonia, injection site reaction, fatigue, pyrexia, headache, nausea, gastroenteritis, and weight decreased.

The most common Grade 3 to 4 laboratory abnormalities ($\geq 20\%$) with TECVAYLI (as monotherapy or in combination with daratumumab and hyaluronidase-fihj) were decreased lymphocytes, decreased neutrophils, decreased white blood cells, decreased hemoglobin, and decreased platelets.

Please read full **Prescribing Information**, including **Boxed WARNING**, for TECVAYLI.

cp-322928v6

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, lenalidomide, and dexamethasone in newly diagnosed patients who are ineligible 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

DARZALEX FASPRO[®] as monotherapy is indicated for the treatment of adult patients with high-risk smoldering multiple myeloma.

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 1446 patients with multiple myeloma (N=1235) or light chain (AL) amyloidosis (N=193) who received DARZALEX FASPRO[®] as monotherapy or as part of a combination therapy, 7% of patients experienced a systemic administration-related reaction (Grade 2: 3%, Grade 3: 0.8%, Grade 4: 0.1%). In patients with high-risk smoldering multiple myeloma (N=193), systemic administration-related reactions occurred in 17% of patients in AQUILA (Grade 2: 7%, Grade 3: 1%).

In all patients (N=1639), systemic administration-related reactions occurred in 7% of patients with the first injection, 0.5% with the second injection, and cumulatively 1% with subsequent injections. The median time to onset was 3.2 hours (range: 4 minutes to 3.5 days). Of the 283 systemic administration-related reactions that occurred in 135 patients, 240 (85%) 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 of 1446 patients with multiple myeloma (N=1253) or light chain amyloidosis (N=193), injection-site reactions occurred in 8% of patients, including Grade 2 reactions in 1.1%. The most frequent (>1%) injection-site reactions were injection site erythema and injection site rash. In patients with high-risk smoldering multiple myeloma (N=193), injection-site reactions occurred in 28% of patients, including Grade 2 reactions in 3%. These local reactions occurred a median of 6 minutes (range: 0 minutes to 6.5 days) after starting administration of DARZALEX FASPRO[®]. Monitor for local reactions and consider symptomatic management.

Infections

DARZALEX FASPRO[®] can cause serious, life-threatening, or fatal infections. In patients who received DARZALEX FASPRO[®] in a pooled safety population including patients with smoldering multiple myeloma and light chain (AL) amyloidosis (N=1639), serious infections, including opportunistic infections, occurred in 24% of patients, Grade 3 or 4 infections occurred in 22%, and fatal infections occurred in 2.5%. The most common type of serious infection reported was pneumonia (8.5%).

Monitor patients for signs and symptoms of infection prior to and during treatment with DARZALEX FASPRO[®] and treat appropriately. Administer prophylactic antimicrobials according to guidelines.

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 ($\geq 20\%$) with DARZALEX FASPRO[®] monotherapy is upper respiratory tract infection. The most common adverse reactions with combination therapy ($\geq 20\%$ for any combination) include fatigue, nausea, diarrhea, dyspnea, sleep disorder, headache, rash, renal impairment, motor dysfunction, pyrexia, cough, muscle spasms, back pain, vomiting, hypertension, musculoskeletal pain, decreased appetite, urinary tract infection, abdominal pain, upper respiratory tract infection, peripheral neuropathy, peripheral sensory neuropathy, constipation, pneumonia, edema, dizziness, bruising, and COVID-19.

The most common adverse reactions ($\geq 20\%$) in patients with high-risk smoldering multiple myeloma who received DARZALEX FASPRO[®] monotherapy are upper respiratory tract infection, musculoskeletal pain, fatigue, diarrhea, rash, sleep disorder, sensory neuropathy, and injection site reactions.

The most common hematology laboratory abnormalities ($\geq 40\%$) with DARZALEX FASPRO[®] are decreased

leukocytes, decreased lymphocytes, decreased neutrophils, decreased platelets, and decreased hemoglobin.

Please [click here](#) to read full Prescribing Information for DARZALEX FASPRO®.

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

IMPORTANT SAFETY INFORMATION

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 life threatening, 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 $\geq 20\%$) were upper respiratory infection, neutropenia, infusion-related reactions, thrombocytopenia, diarrhea, constipation, anemia, peripheral sensory neuropathy, fatigue, peripheral edema, nausea, cough, pyrexia, dyspnea, and asthenia. The most common hematologic

laboratory abnormalities ($\geq 40\%$) with DARZALEX[®] are neutropenia, lymphopenia, thrombocytopenia, leukopenia, and anemia.

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

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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.

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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 TECVAYLI[®] (teclistamab-cqyv) and DARZALEX FASPRO[®] (daratumumab and hyaluronidase-fihj). 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 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 most recent Annual Report on Form 10-K, 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 on request from Johnson & Johnson. Johnson & Johnson does not undertake to update any forward-looking statement as a result of new information or future events or developments.

FOOTNOTES

*Dr. Luciano J. Costa, Professor of Multiple Myeloma and Director of the Multiple Myeloma Research and Treatment Program at the University of Alabama at Birmingham, and Primary Investigator of MajesTEC-3, has provided consulting, advisory, and speaking services to Johnson & Johnson. He has not been paid for any media work.

**Heather Ortner Cooper, President & CEO of the International Myeloma Foundation, has provided consulting, advisory, and speaking services to Johnson & Johnson. She has not been paid for any media work.

†The patient support and resources provided by J&J withMe are not intended to give medical advice, replace a treatment plan from the patient's healthcare provider, offer services that would normally be performed by the provider's office, or serve as a reason to prescribe a Johnson & Johnson medicine.

References

¹ TECVAYLI® U.S. Prescribing Information.

² Kumar, S. K., et al. (2021). Prognostic factors for early (<2 years) and late (>2 years) relapse after initial therapy in multiple myeloma. *Blood*, 138(Supplement 1), 3761. <https://doi.org/10.1182/blood-2021-151249>

³ Maria-Victoria Mateos, et. al., Phase 3 Randomized Study of Teclistamab Plus Daratumumab Versus Investigator's Choice of Daratumumab and Dexamethasone With Either Pomalidomide or Bortezomib (DPd/DVd) in Patients With Relapsed Refractory Multiple Myeloma (RRMM): Results of MajesTEC-3, 2025 American Society of Hematology Annual Meeting. Accessed December 2025.

⁴ MajesTEC-3, NCT05083169. A Phase 3 Randomized Study Comparing Teclistamab + Subcutaneous Daratumumab (Tec-Dara) Versus Daratumumab SC + Pomalidomide + Dexamethasone (DPd) or Daratumumab SC + Bortezomib + Dexamethasone (DVd). <https://clinicaltrials.gov/study/NCT05083169>. Accessed December 2025.

⁵ U.S. FDA Approves TECVAYLI® (teclistamab-cqyv), the First Bispecific T-cell Engager Antibody for the Treatment of Patients with Relapsed or Refractory Multiple Myeloma. <https://www.jnj.com/u-s-fda-approves-tecvayli-teclistamab-cqyv-the-first-bispecific-t-cell-engager-antibody-for-the-treatment-of-patients-with-relapsed-or-refractory-multiple-myeloma>. Accessed December 2025.

⁶ DARZALEX FASPRO® U.S. Prescribing Information.

⁷ DARZALEX® U.S. Prescribing Information.

⁸ Rajkumar SV. Multiple Myeloma: 2020 Update on Diagnosis, Risk-Stratification and Management. *Am J Hematol*. 2020;95(5):548-567. <http://www.ncbi.nlm.nih.gov/pubmed/32212178>.

⁹ National Cancer Institute. Plasma cell neoplasms. National Institutes of Health.

<https://www.cancer.gov/types/myeloma/patient/myeloma-treatment-pdq>. Accessed October 2025.

¹⁰ City of Hope. Multiple myeloma: Causes, symptoms & treatments. <https://www.cancercenter.com/cancer-types/multiple-myeloma>. Accessed December 2025.

¹¹ American Cancer Society. Myeloma cancer statistics. <https://cancerstatisticscenter.cancer.org/types/myeloma>.

Accessed December 2025.

¹² SEER Explorer: An interactive website for SEER cancer statistics [Internet]. Surveillance Research Program, National Cancer Institute. <https://seer.cancer.gov/explorer/>. Accessed December 2025.

¹³ American Cancer Society. What is multiple myeloma? <https://www.cancer.org/cancer/multiple-myeloma/about/what-is-multiple-myeloma.html>. Accessed December 2025.

¹⁴ American Cancer Society. Multiple myeloma early detection, diagnosis, and staging. <https://www.cancer.org/cancer/types/multiple-myeloma/detection-diagnosis-staging/detection.html>. Accessed December 2025.

<https://clinicaltrials.gov/study/NCT05083169>

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