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NEWS RELEASE

RYBREVANT FASPRO™ (amivantamab and hyaluronidase-lpuj) plus immunotherapy shows strong clinical benefit with 56 percent overall response rate in first-line recurrent or metastatic head and neck cancer

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Ten percent complete response and rapid, durable antitumor activity reported with RYBREVANT FASPRO™; results surpass current standards of care

RARITAN, N.J., Feb. 19, 2026 /PRNewswire/ -- Johnson & Johnson (NYSE:JNJ) today announced new results from the Phase 1b/2 OrigAMI-4 study showing that first-line treatment with investigational subcutaneous amivantamab and hyaluronidase-lpuj in combination with a PD-1 inhibitor delivered clinically meaningful and durable antitumor activity in patients with head and neck squamous cell carcinoma (HNSCC) that is recurrent or metastatic, PD-L1-positive, and human papillomavirus (HPV)-unrelated. Data were presented during a plenary session at the 2026 Multidisciplinary Head and Neck Cancers Symposium (MHNCS) (Abstract #2).[1]

Head and neck squamous cell carcinoma is an aggressive disease, and many patients see their cancer return or spread after their initial diagnosis. In the first-line recurrent or metastatic setting, outcomes remain poor with current standard of care. PD-1 monotherapy has historically achieved response rates of approximately 18 percent, and only modest improvements are seen when chemotherapy is added, leaving many patients without meaningful benefit.[2,3] This underscores the need for approaches that address additional drivers of disease including epidermal growth factor receptor (EGFR) and mesenchymal-epithelial transition (MET), which contribute to tumor growth and treatment resistance.[4,5,6] Data from lung cancer, where these same pathways have been well characterized, suggest that targeting both may change disease biology and improve outcomes.[7]

"From a clinical perspective, rapid and durable disease control is an important goal in the first-line treatment of head and neck cancer," said Ranee Mehra,* M.D., Director of Head and Neck Medical Oncology and Professor of Medicine at the Marlene and Stewart Greenebaum Comprehensive Cancer Center at the University of Maryland. "Combining subcutaneous amivantamab with immunotherapy is promising because it targets key drivers of tumor growth and resistance, which is resulting in deeper responses compared with current standards. Continued research will be important to build on these findings and better understand how this approach may fit into first-line treatment."

Detailed Study Results

In Cohort 2 of the OrigAMI-4 study, treatment with subcutaneous amivantamab plus pembrolizumab, administered every three weeks, demonstrated a confirmed overall response rate of 56 percent (22/39; 95 percent confidence interval [CI], 40-72), including six complete responses (four confirmed at the time of analysis, which represents a 10 percent complete response rate) and 18 partial responses (all confirmed). At a median follow-up of 10.4 months (range, 1.6-12.5), 46 percent of patients remained on treatment. Tumor shrinkage of target lesions was observed in 82 percent of patients. The clinical benefit rate, defined as confirmed response or durable stable disease, was 74 percent (29/39; 95 percent CI, 58-87). Responses occurred rapidly, with a median time to first response of 9.7 weeks, and treatment was ongoing in 64 percent of confirmed responders (14/22) at the time of data cutoff. Median progression-free survival was 7.7 months (95 percent CI, 5.0-not estimable). The median overall survival was not estimable.[1]

The safety profile of subcutaneous amivantamab and pembrolizumab was consistent with those of the individual agents, with no new safety signals identified. The most common treatment-emergent adverse events, occurring in more than 30 percent of patients, were rash (49 percent), paronychia (46 percent), hypoalbuminemia (41 percent), dermatitis acneiform (38 percent), increased aspartate aminotransferase (38 percent), increased alanine aminotransferase (36 percent), and stomatitis (36 percent). Administration-related reactions occurred in six (15 percent) patients, none of which were Grade 3 or higher. Treatment discontinuation due to treatment-related adverse events occurred in four patients.[1]

"The standard of care in the first-line treatment of recurrent or metastatic head and neck cancer is inadequate for many patients, with low response rates and short durations of benefit," said Joshua Bauml, M.D., Vice President, Lung and Head and Neck Cancer Disease Area Leader, Johnson & Johnson. "Seeing rapid and durable disease control at levels meaningfully higher than what has historically been achieved signals the potential to redefine what treatment can offer patients. Subcutaneous amivantamab is built on a mechanism of action that has already changed disease biology and improved outcomes in EGFR-mutated lung cancer, and these new results suggest we may be able to deliver more meaningful benefit for patients in another setting where the status quo is simply not

good enough and unmet need remains high."

These data support continued evaluation of RYBREVANT FASPRO™-based regimens in head and neck squamous cell carcinoma, including the ongoing Phase 3 OrigAMI-5 study (**NCT07276399**) assessing subcutaneous amivantamab with carboplatin and pembrolizumab as a first-line treatment in patients with HPV-unrelated recurrent or metastatic disease, regardless of PD-L1 expression, where significant unmet need persists.[8]

About the OrigAMI-4 Study

OrigAMI-4 (**NCT06385080**) is an open-label Phase 1b/2 study evaluating RYBREVANT FASPRO™ (amivantamab and hyaluronidase-lpuj) in recurrent or metastatic head and neck squamous cell carcinoma (R/M HNSCC). The study includes five cohorts exploring RYBREVANT FASPRO™ across different treatment settings and regimens.

Cohort 1 evaluated RYBREVANT FASPRO™ as monotherapy in patients with HPV-unrelated R/M HNSCC who had received prior platinum-based chemotherapy and PD-1/PD-L1 immunotherapy. Patients with prior anti-EGFR therapy were excluded. Cohort 2 is evaluating RYBREVANT FASPRO™ in combination with pembrolizumab in patients with HPV-unrelated recurrent or metastatic head and neck squamous cell carcinoma who have not yet received treatment for their advanced disease and whose tumors express PD-L1.

RYBREVANT FASPRO™ was administered on a weekly schedule during the initial treatment period followed by dosing every three weeks (Q3W), with weight-based dosing adjustments. The primary endpoint across cohorts is overall response rate (ORR), assessed by blinded independent central review (BICR) using RECIST v1.1**.[9]

About Head and Neck Squamous Cell Carcinoma

Head and neck squamous cell carcinoma (HNSCC) is the most common type of head and neck cancer, accounting for more than 90 percent of cases and approximately 4.5 percent of all cancers worldwide.[10] It develops in the mucosal linings of the oral cavity, oropharynx, hypopharynx, and larynx.[10] Major risk factors include tobacco and alcohol use, as well as infection with high-risk human papillomavirus (HPV).[10] Around 75 percent of cases are HPV-negative, which is typically associated with a poorer prognosis and reduced response to treatment.[10,11] Despite advances in surgery, radiation, chemotherapy, and immunotherapy, many patients ultimately progress to advanced, recurrent or metastatic disease.[4,12]

About RYBREVANT FASPRO™ and RYBREVANT®

In December 2025, the U.S. FDA **approved** RYBREVANT FASPRO™ (amivantamab and hyaluronidase-lpuj) across all indications of intravenous RYBREVANT® (amivantamab-vmjw). This subcutaneously administered therapy is also

approved in Europe, Japan, China, and other markets.

RYBREVANT FASPRO™ is co-formulated with recombinant human hyaluronidase PH20 (rHuPH20), Halozyme's ENHANZE® drug delivery technology.

The effectiveness of RYBREVANT FASPRO™ has been established based on adequate and well controlled studies of RYBREVANT®. Data across multiple Phase 3 studies, including MARIPOSA, have demonstrated the clinical benefit of RYBREVANT® in improving progression-free survival (PFS) and overall survival (OS) in advanced EGFR-mutated non-small cell lung cancer (NSCLC).

RYBREVANT® is approved in the U.S., Europe and other markets across four indications in EGFR-mutated NSCLC, including two in the first-line setting and two in the second-line, for patients with either exon 19 deletions, exon 21 L858R mutations, or exon 20 insertion mutations, as monotherapy or in combination with LAZCLUZE® (lazertinib) or chemotherapy.

RYBREVANT® is a first-in-class, fully-human bispecific antibody targeting EGFR and MET with immune cell-directing activity.

The National Comprehensive Cancer Network® (NCCN®) Clinical Practice Guidelines in Oncology (NCCN Guidelines®)[§13] include amivantamab-vmjw (RYBREVANT®) across multiple treatment settings, including its recent inclusion as a NCCN Category 1 preferred option when used with lazertinib (LAZCLUZE®) for first-line treatment of people with locally advanced or metastatic NSCLC with EGFR exon 19 deletions or exon 21 L858R mutations. Amivantamab and hyaluronidase-lpuj subcutaneous injection (RYBREVANT FASPRO™) may be substituted for IV amivantamab-vmjw (RYBREVANT®). See the latest NCCN Guidelines® for NSCLC for complete information.[†‡]

The NCCN Guidelines for Central Nervous System Cancers also identify amivantamab-vmjw (RYBREVANT®)-based regimens, including the combination with lazertinib (LAZCLUZE®), as the only NCCN-preferred combination options for patients with EGFR-mutated NSCLC and brain metastases.[†‡]

The legal manufacturer for RYBREVANT® is Janssen Biotech, Inc. For more information, visit: **https://www.RYBREVANT.com**.

INDICATIONS

RYBREVANT FASPRO™ (amivantamab and hyaluronidase-lpuj) and RYBREVANT® (amivantamab-vmjw) are indicated:

- in combination with LAZCLUZE® (lazertinib) for the first-line treatment of adult patients with locally advanced

or metastatic NSCLC with EGFR exon 19 deletions or exon 21 L858R substitution mutations, as detected by an FDA-approved test.

- in combination with carboplatin and pemetrexed for the treatment of adult patients with locally advanced or metastatic NSCLC with EGFR exon 19 deletions or exon 21 L858R substitution mutations, whose disease has progressed on or after treatment with an EGFR tyrosine kinase inhibitor.
- in combination with carboplatin and pemetrexed for the first-line treatment of adult patients with locally advanced or metastatic NSCLC with EGFR exon 20 insertion mutations, as detected by an FDA-approved test.
- as a single agent for the treatment of adult patients with locally advanced or metastatic NSCLC with EGFR exon 20 insertion mutations, as detected by an FDA approved test, whose disease has progressed on or after platinum-based chemotherapy.

IMPORTANT SAFETY INFORMATION FOR RYBREVANT FASPRO™ AND RYBREVANT® [14,15,16]

CONTRAINDICATIONS

RYBREVANT FASPRO™ is contraindicated in patients with known hypersensitivity to hyaluronidase or to any of its excipients.

WARNINGS AND PRECAUTIONS

Hypersensitivity and Administration-Related Reactions with RYBREVANT FASPRO™

RYBREVANT FASPRO™ can cause hypersensitivity and administration-related reactions (ARRs); signs and symptoms of ARR include dyspnea, flushing, fever, chills, chest discomfort, hypotension, and vomiting. The median time to ARR onset is approximately 2 hours.

RYBREVANT FASPRO™ with LAZCLUZE®

In PALOMA-3 (n=206), all Grade ARRs occurred in 13% of patients, including 0.5% Grade 3. Of the patients who experienced ARRs, 89% occurred with the initial dose (Week 1, Day 1).

Premedicate with antihistamines, antipyretics, and glucocorticoids and administer RYBREVANT FASPRO™ as recommended. Monitor patients for any signs and symptoms of administration-related reactions during injection in a setting where cardiopulmonary resuscitation medication and equipment are available. Interrupt RYBREVANT FASPRO™ injection if ARR is suspected. Resume treatment upon resolution of symptoms or permanently discontinue RYBREVANT FASPRO™ based on severity.

Infusion-Related Reactions with RYBREVANT®

RYBREVANT® can cause infusion-related reactions (IRR) including anaphylaxis; signs and symptoms of IRR include dyspnea, flushing, fever, chills, nausea, chest discomfort, hypotension, and vomiting. The median time to IRR onset is approximately 1 hour.

RYBREVANT® with LAZCLUZE®

In MARIPOSA (n=421), IRRs occurred in 63% of patients, including Grade 3 in 5% and Grade 4 in 1% of patients. IRR-related infusion modifications occurred in 54%, dose reduction in 0.7%, and permanent discontinuation of RYBREVANT® in 4.5% of patients.

RYBREVANT® with Carboplatin and Pemetrexed

Based on the pooled safety population (n=281), IRRs occurred in 50% of patients including Grade 3 (3.2%) adverse reactions. IRR-related infusion modifications occurred in 46%, and permanent discontinuation of RYBREVANT® in 2.8% of patients.

RYBREVANT® as a Single Agent

In CHRYSALIS (n=302), IRRs occurred in 66% of patients. IRRs occurred in 65% of patients on Week 1 Day 1, 3.4% on Day 2 infusion, 0.4% with Week 2 infusion, and were cumulatively 1.1% with subsequent infusions. 97% were Grade 1-2, 2.2% were Grade 3, and 0.4% were Grade 4. The median time to onset was 1 hour (range: 0.1 to 18 hours) after start of infusion. IRR-related infusion modifications occurred in 62%, and permanent discontinuation of RYBREVANT® in 1.3% of patients.

Premedicate with antihistamines, antipyretics, and glucocorticoids and infuse RYBREVANT® as recommended. Administer RYBREVANT® via a peripheral line on Week 1 and Week 2 to reduce the risk of IRRs. Monitor patients for signs and symptoms of IRRs in a setting where cardiopulmonary resuscitation medication and equipment are available. Interrupt infusion if IRR is suspected. Reduce the infusion rate or permanently discontinue RYBREVANT® based on severity. If an anaphylactic reaction occurs, permanently discontinue RYBREVANT®.

Interstitial Lung Disease/Pneumonitis

RYBREVANT FASPRO™ and RYBREVANT® can cause severe and fatal interstitial lung disease (ILD)/pneumonitis.

RYBREVANT FASPRO™ with LAZCLUZE®

In PALOMA-3, ILD/pneumonitis occurred in 6% of patients, including Grade 3 in 1%, Grade 4 in 1.5%, and fatal cases

in 1.9% of patients. 5% of patients permanently discontinued RYBREVANT FASPRO™ and LAZCLUZE® due to ILD/pneumonitis.

RYBREVANT® with LAZCLUZE®

In MARIPOSA, ILD/pneumonitis occurred in 3.1% of patients, including Grade 3 in 1.0% and Grade 4 in 0.2% of patients. There was one fatal case of ILD/pneumonitis and 2.9% of patients permanently discontinued RYBREVANT® and LAZCLUZE® due to ILD/pneumonitis.

RYBREVANT® with Carboplatin and Pemetrexed

Based on the pooled safety population, ILD/pneumonitis occurred in 2.1% of patients with 1.8% of patients experiencing Grade 3 ILD/pneumonitis. 2.1% discontinued RYBREVANT® due to ILD/pneumonitis.

RYBREVANT® as a Single Agent

In CHRYSALIS, ILD/pneumonitis occurred in 3.3% of patients, with 0.7% of patients experiencing Grade 3 ILD/pneumonitis. Three patients (1%) permanently discontinued RYBREVANT® due to ILD/pneumonitis.

Monitor patients for new or worsening symptoms indicative of ILD/pneumonitis (e.g., dyspnea, cough, fever). Immediately withhold RYBREVANT FASPRO™ or RYBREVANT® and LAZCLUZE® (when applicable) in patients with suspected ILD/pneumonitis and permanently discontinue if ILD/pneumonitis is confirmed.

Venous Thromboembolic (VTE) Events with Concomitant Use with LAZCLUZE®

RYBREVANT FASPRO™ and RYBREVANT® in combination with LAZCLUZE® can cause serious and fatal venous thromboembolic (VTE) events, including deep vein thrombosis and pulmonary embolism. Without prophylactic anticoagulation, the majority of these events occurred during the first four months of treatment.

RYBREVANT FASPRO™ with LAZCLUZE®

In PALOMA-3 (n=206), all Grade VTE occurred in 11% of patients and 1.5% were Grade 3. 80% (n=164) of patients received prophylactic anticoagulation at study entry, with an all Grade VTE incidence of 7%. In patients who did not receive prophylactic anticoagulation (n=42), all Grade VTE occurred in 17% of patients. In total, 0.5% of patients had VTE leading to dose reductions of RYBREVANT FASPRO™ and no patients required permanent discontinuation. The median time to onset of VTEs was 95 days (range: 17 to 390).

RYBREVANT® with LAZCLUZE®

In MARIPOSA, VTEs occurred in 36% of patients including Grade 3 in 10% and Grade 4 in 0.5% of patients. On-study VTEs occurred in 1.2% of patients (n=5) while receiving anticoagulation therapy. There were two fatal cases of VTE (0.5%), 9% of patients had VTE leading to dose interruptions of RYBREVANT®, and 7% of patients had VTE leading to dose interruptions of LAZCLUZE®; 1% of patients had VTE leading to dose reductions of RYBREVANT®, and 0.5% of patients had VTE leading to dose reductions of LAZCLUZE®; 3.1% of patients had VTE leading to permanent discontinuation of RYBREVANT®, and 1.9% of patients had VTE leading to permanent discontinuation of LAZCLUZE®. The median time to onset of VTEs was 84 days (range: 6 to 777).

Administer prophylactic anticoagulation for the first four months of treatment. The use of Vitamin K antagonists is not recommended.

Monitor for signs and symptoms of VTE events and treat as medically appropriate. Withhold RYBREVANT FASPRO™ or RYBREVANT® and LAZCLUZE® based on severity. Once anticoagulant treatment has been initiated, resume RYBREVANT FASPRO™ or RYBREVANT® and LAZCLUZE® at the same dose level at the discretion of the healthcare provider. In the event of VTE recurrence despite therapeutic anticoagulation, permanently discontinue RYBREVANT FASPRO™ or RYBREVANT®. Treatment can continue with LAZCLUZE® at the same dose level at the discretion of the healthcare provider. Refer to the LAZCLUZE® Prescribing Information for recommended LAZCLUZE® dosage modification.

Dermatologic Adverse Reactions

RYBREVANT FASPRO™ and RYBREVANT® can cause severe rash including toxic epidermal necrolysis (TEN), dermatitis acneiform, pruritus and dry skin.

RYBREVANT FASPRO™ with LAZCLUZE®

In PALOMA-3, rash occurred in 80% of patients, including Grade 3 in 17% and Grade 4 in 0.5% of patients. Rash leading to dose reduction occurred in 11% of patients, and RYBREVANT FASPRO™ was permanently discontinued due to rash in 1.5% of patients.

RYBREVANT® with LAZCLUZE®

In MARIPOSA, rash occurred in 86% of patients, including Grade 3 in 26% of patients. The median time to onset of rash was 14 days (range: 1 to 556 days). Rash leading to dose interruptions occurred in 37% of patients for RYBREVANT® and 30% for LAZCLUZE®, rash leading to dose reductions occurred in 23% of patients for RYBREVANT® and 19% for LAZCLUZE®, and rash leading to permanent discontinuation occurred in 5% of patients

for RYBREVANT® and 1.7% for LAZCLUZE®.

RYBREVANT® with Carboplatin and Pemetrexed

Based on the pooled safety population, rash occurred in 82% of patients, including Grade 3 (15%) adverse reactions. Rash leading to dose reductions occurred in 14% of patients, and 2.5% permanently discontinued RYBREVANT® and 3.1% discontinued pemetrexed.

RYBREVANT® as a Single Agent

In CHRYSALIS, rash occurred in 74% of patients, including Grade 3 in 3.3% of patients. The median time to onset of rash was 14 days (range: 1 to 276 days). Rash leading to dose reduction occurred in 5% and permanent discontinuation due to rash occurred in 0.7% of patients. Toxic epidermal necrolysis occurred in one patient (0.3%).

When initiating treatment with RYBREVANT FASPRO™ or RYBREVANT®, prophylactic and concomitant medications are recommended to reduce the risk and severity of dermatologic adverse reactions. Instruct patients to limit sun exposure during and for 2 months after treatment. Advise patients to wear protective clothing and use broad spectrum UVA/UVB sunscreen.

If skin reactions develop, administer supportive care including topical corticosteroids and topical and/or oral antibiotics. For Grade 3 reactions, add oral steroids and consider dermatologic consultation. Promptly refer patients presenting with severe rash, atypical appearance or distribution, or lack of improvement within 2 weeks to a dermatologist. For patients receiving RYBREVANT FASPRO™ or RYBREVANT® in combination with LAZCLUZE®, withhold, reduce the dose, or permanently discontinue both drugs based on severity. For patients receiving RYBREVANT FASPRO™ or RYBREVANT® as a single agent or in combination with carboplatin and pemetrexed, withhold, dose reduce or permanently discontinue RYBREVANT FASPRO™ or RYBREVANT® based on severity.

Ocular Toxicity

RYBREVANT FASPRO™ and RYBREVANT® can cause ocular toxicity including keratitis, blepharitis, dry eye symptoms, conjunctival redness, blurred vision, visual impairment, ocular itching, eye pruritus and uveitis.

RYBREVANT FASPRO™ with LAZCLUZE®

In PALOMA-3, all Grade ocular toxicity occurred in 13% of patients, including 0.5% Grade 3.

RYBREVANT® with LAZCLUZE®

In MARIPOSA, ocular toxicity occurred in 16%, including Grade 3 or 4 ocular toxicity in 0.7% of patients. Withhold, reduce the dose, or permanently discontinue RYBREVANT® and continue LAZCLUZE® based on severity.

RYBREVANT® with Carboplatin and Pemetrexed

Based on the pooled safety population, ocular toxicity occurred in 16% of patients. All events were Grade 1 or 2.

RYBREVANT® as a Single Agent

In CHRYSALIS, keratitis occurred in 0.7% and uveitis occurred in 0.3% of patients. All events were Grade 1-2.

Promptly refer patients presenting with new or worsening eye symptoms to an ophthalmologist. Withhold, dose reduce or permanently discontinue RYBREVANT FASPRO™ or RYBREVANT® based on severity.

Embryo-Fetal Toxicity

Based on animal models, RYBREVANT FASPRO™, RYBREVANT® and LAZCLUZE® can cause fetal harm when administered to a pregnant woman. Verify pregnancy status of females of reproductive potential prior to initiating RYBREVANT FASPRO™ and RYBREVANT®. Advise pregnant women and females of reproductive potential of the potential risk to the fetus. Advise patients of reproductive potential to use effective contraception during treatment and for 3 months after the last dose of RYBREVANT FASPRO™ or RYBREVANT®, and for 3 weeks after the last dose of LAZCLUZE®.

ADVERSE REACTIONS

RYBREVANT FASPRO™ with LAZCLUZE®

In PALOMA-3 (n=206), the most common adverse reactions (≥20%) were rash (80%), nail toxicity (58%), musculoskeletal pain (50%), fatigue (37%), stomatitis (36%), edema (34%), nausea (30%), diarrhea (22%), vomiting (22%), constipation (22%), decreased appetite (22%), and headache (21%). The most common Grade 3 or 4 laboratory abnormalities (≥2%) were decreased lymphocyte count (6%), decreased sodium (5%), decreased potassium (5%), decreased albumin (4.9%), increased alanine aminotransferase (3.4%), decreased platelet count (2.4%), increased aspartate aminotransferase (2%), increased gamma-glutamyl transferase (2%), and decreased hemoglobin (2%).

Serious adverse reactions occurred in 33% of patients, with those occurring in ≥2% of patients including ILD/pneumonitis (6%); and pneumonia, VTE and fatigue (2.4% each). Death due to adverse reactions occurred in 5% of patients treated with RYBREVANT FASPRO™, including ILD/pneumonitis (1.9%), pneumonia (1.5%), and

respiratory failure and sudden death (1% each).

RYBREVANT® with LAZCLUZE®

In MARIPOSA (n=421), the most common adverse reactions (ARs) (≥20%) were rash (86%), nail toxicity (71%), infusion-related reactions (IRRs) (RYBREVANT®) (63%), musculoskeletal pain (47%), stomatitis (43%), edema (43%), VTE (36%), paresthesia (35%), fatigue (32%), diarrhea (31%), constipation (29%), COVID-19 (26%), hemorrhage (25%), dry skin (25%), decreased appetite (24%), pruritus (24%), and nausea (21%). The most common Grade 3 or 4 laboratory abnormalities (≥2%) were decreased albumin (8%), decreased sodium (7%), increased ALT (7%), decreased potassium (5%), decreased hemoglobin (3.8%), increased AST (3.8%), increased GGT (2.6%), and increased magnesium (2.6%).

Serious ARs occurred in 49% of patients, with those occurring in ≥2% of patients including VTE (11%), pneumonia (4%), ILD/pneumonitis and rash (2.9% each), COVID-19 (2.4%), and pleural effusion and IRRs (RYBREVANT®) (2.1% each). Fatal ARs occurred in 7% of patients due to death not otherwise specified (1.2%); sepsis and respiratory failure (1% each); pneumonia, myocardial infarction, and sudden death (0.7% each); cerebral infarction, pulmonary embolism (PE), and COVID-19 infection (0.5% each); and ILD/pneumonitis, acute respiratory distress syndrome (ARDS), and cardiopulmonary arrest (0.2% each).

RYBREVANT® with Carboplatin and Pemetrexed

In MARIPOSA-2 (n=130), the most common ARs (≥20%) were rash (72%), IRRs (59%), fatigue (51%), nail toxicity (45%), nausea (45%), constipation (39%), edema (36%), stomatitis (35%), decreased appetite (31%), musculoskeletal pain (30%), vomiting (25%), and COVID-19 (21%). The most common Grade 3 to 4 laboratory abnormalities (≥2%) were decreased neutrophils (49%), decreased white blood cells (42%), decreased lymphocytes (28%), decreased platelets (17%), decreased hemoglobin (12%), decreased potassium (11%), decreased sodium (11%), increased alanine aminotransferase (3.9%), decreased albumin (3.8%), and increased gamma-glutamyl transferase (3.1%).

In MARIPOSA-2, serious ARs occurred in 32% of patients, with those occurring in >2% of patients including dyspnea (3.1%), thrombocytopenia (3.1%), sepsis (2.3%), and PE (2.3%). Fatal ARs occurred in 2.3% of patients; these included respiratory failure, sepsis, and ventricular fibrillation (0.8% each).

In PAPILLON (n=151), the most common ARs (≥20%) were rash (90%), nail toxicity (62%), stomatitis (43%), IRRs (42%), fatigue (42%), edema (40%), constipation (40%), decreased appetite (36%), nausea (36%), COVID-19 (24%), diarrhea (21%), and vomiting (21%). The most common Grade 3 to 4 laboratory abnormalities (≥2%) were decreased albumin (7%), increased alanine aminotransferase (4%), increased gamma-glutamyl transferase (4%), decreased sodium (7%), decreased potassium (11%), decreased magnesium (2%), and decreases in white blood cells (17%),

hemoglobin (11%), neutrophils (36%), platelets (10%), and lymphocytes (11%).

In PAPILLON, serious ARs occurred in 37% of patients, with those occurring in ≥2% of patients including rash, pneumonia, ILD, PE, vomiting, and COVID-19. Fatal adverse reactions occurred in 7 patients (4.6%) due to pneumonia, cerebrovascular accident, cardio-respiratory arrest, COVID-19, sepsis, and death not otherwise specified.

RYBREVANT® as a Single Agent

In CHRYSALIS (n=129), the most common ARs (≥20%) were rash (84%), IRR (64%), paronychia (50%), musculoskeletal pain (47%), dyspnea (37%), nausea (36%), fatigue (33%), edema (27%), stomatitis (26%), cough (25%), constipation (23%), and vomiting (22%). The most common Grade 3 to 4 laboratory abnormalities (≥2%) were decreased lymphocytes (8%), decreased albumin (8%), decreased phosphate (8%), decreased potassium (6%), increased alkaline phosphatase (4.8%), increased glucose (4%), increased gamma-glutamyl transferase (4%), and decreased sodium (4%).

Serious ARs occurred in 30% of patients, with those occurring in ≥2% of patients including PE, pneumonitis/ILD, dyspnea, musculoskeletal pain, pneumonia, and muscular weakness. Fatal adverse reactions occurred in 2 patients (1.5%) due to pneumonia and 1 patient (0.8%) due to sudden death.

LAZCLUZE® DRUG INTERACTIONS

Avoid concomitant use of LAZCLUZE® with strong and moderate CYP3A4 inducers. Consider an alternate concomitant medication with no potential to induce CYP3A4.

Monitor for adverse reactions associated with a CYP3A4 or BCRP substrate where minimal concentration changes may lead to serious adverse reactions, as recommended in the approved product labeling for the CYP3A4 or BCRP substrate.

Please see full Prescribing Information for **RYBREVANT FASPRO™**, **RYBREVANT®** and **LAZCLUZE®**.

cp-491009v1

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.innovativemedicine.jnj.com**. Follow us at **@JNJInnovMed**.

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 RYBREVANT®-based regimens. 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 http://**www.sec.gov**, http://**www.jnj.com**, or 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.

*Ranee Mehra, M.D., has served as a consultant to Johnson & Johnson; she has not been paid for any media work.

**RECIST (version 1.1) refers to Response Evaluation Criteria in Solid Tumors, which is a standard way to measure how well solid tumors respond to treatment and is based on whether tumors shrink, stay the same or get bigger.

[§] The NCCN content does not constitute medical advice and should not be used in place of seeking professional medical advice, diagnosis or treatment by licensed practitioners. 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.

[†] See the NCCN Guidelines for detailed recommendations, including other treatment options.

‡ The NCCN Guidelines for NSCLC provide recommendations for certain individual biomarkers that should be tested and recommend testing techniques but do not endorse any specific commercially available biomarker assays or commercial laboratories.

Source: Johnson & Johnson

[1] Mehra R, et al. Amivantamab Plus Pembrolizumab in Previously Untreated Recurrent/Metastatic Head and Neck Squamous Cell Cancer: Results From the Phase 1b/2 OrigAMI-4 Study [MHNCS Abstract 2]. Presented at: 2026 Multidisciplinary Head and Neck Cancers Symposium; February 19, 2026; Palm Desert, California.

[2] Burtness B, Harrington KJ, Greil R, et al. Pembrolizumab alone or with chemotherapy versus cetuximab with chemotherapy for recurrent or metastatic head and neck squamous cell carcinoma (KEYNOTE-048): a randomised, open-label, phase 3 study. Lancet. 2019;394(10212):1915–1928.

[3] Vermorken JB, Specenier P. Optimal treatment for recurrent/metastatic head and neck cancer. Ann Oncol. 2010;21 Suppl 7:vii252–vii261.

[4] Wise-Draper TM, Bahig H, Tonneau M, Karivedu V, Burtness B. Current Therapy for Metastatic Head and Neck Cancer: Evidence, Opportunities, and Challenges. American Society of Clinical Oncology Education Book. 2022;42:1-14. **https://doi.org/10.1200/edbk_350442**

[5] Rothenberger NJ, Stabile LP. Hepatocyte Growth Factor/c-Met Signaling in Head and Neck Cancer and Implications for Treatment. Cancers. 2017; 9(4):39. **https://doi.org/10.3390/cancers9040039**

[6] Hartmann S, et al. HGF/Met Signaling in Head and Neck Cancer: Impact on the Tumor Microenvironment. Clinical Cancer Research. 2016;22(16):4005-4013. **https://doi.org/10.1158/1078-0432.CCR-16-0951**

[7] Yang JCH, et al. Overall Survival with Amivantamab-Lazertinib in EGFR-mutant Advanced NSCLC. N Engl J Med. 2025.

[8] ClinicalTrials.gov. A Study of Amivantamab in Addition to Standard of Care Agents (SOC) Compared With SOC Alone in Participants With Recurrent/Metastatic Head and Neck Cancer (OrigAMI-5). **https://clinicaltrials.gov/study/NCT07276399**. Accessed February 2026.

[9] **ClinicalTrials.gov**. A Study of Amivantamab Alone or in Addition to Other Treatment Agents in Participants With Recurrent/ Metastatic Head and Neck Cancer (OrigAMI-4). **https://clinicaltrials.gov/study/NCT06385080?term=OrigAMI-4&limit=10&rank=1**. Accessed February 2026.

[10] Barsouk A, et al. Epidemiology, Risk Factors, and Prevention of Head and Neck Squamous Cell Carcinoma. Medical Sciences. 2023;11(2):42. **https://doi.org/10.3390/medsci11020042**

[11] Ghiani L, Chiocca S. High Risk-Human Papillomavirus in HNSCC: Present and Future Challenges for Epigenetic Therapies. International Journal of Molecular Sciences. 2022;23(7):3483. **https://doi.org/10.3390/ijms23073483**

[12] Ferris RL, Blumenschein G Jr, Fayette J, et al. Nivolumab for Recurrent Squamous-Cell Carcinoma of the Head and Neck. New England Journal of Medicine. 2016;375(19):1856-1867. doi:10.1056/NEJMoa1602252

[13] Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Non-Small Cell Lung Cancer V.3.2026 © National Comprehensive Cancer Network, Inc. All rights reserved. To view the most recent and complete version of the guideline, go online to **NCCN.org**. Accessed February 2026.

[14] RYBREVANT FASPRO™ Prescribing Information. Horsham, PA: Janssen Biotech, Inc.

[15] RYBREVANT® Prescribing Information. Horsham, PA: Janssen Biotech, Inc.

[16] LAZCLUZE® Prescribing Information. Horsham, PA: Janssen Biotech, Inc.

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