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HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use KEYTRUDA safely and effectively. See full prescribing information for KEYTRUDA.

KEYTRUDA® (pembrolizumab) for injection, for intravenous use
KEYTRUDA® (pembrolizumab) injection, for intravenous use
Initial U.S. Approval: 2014

----------RECENT MAJOR CHANGES----------

Indications and Usage (1)	05/2017
Dosage and Administration (2)	05/2017
Warnings and Precautions (5)	05/2017

----------INDICATIONS AND USAGE----------

KEYTRUDA is a programmed death receptor-1 (PD-1)-blocking antibody indicated in:

Melanoma
- for the treatment of patients with unresectable or metastatic melanoma. (1.1)

Non-Small Cell Lung Cancer (NSCLC)
- as a single agent for the first-line treatment of patients with metastatic NSCLC whose tumors have high PD-L1 expression [(Tumor Proportion Score (TPS) ≥50%)] as determined by an FDA-approved test, with no EGFR or ALK genomic tumor aberrations. (1.2)
- as a single agent for the treatment of patients with metastatic NSCLC whose tumors express PD-L1 (TPS ≥1%) as determined by an FDA-approved test, with disease progression on or after platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving KEYTRUDA. (1.2)
- in combination with pemetrexed and carboplatin, as first-line treatment of patients with metastatic nonsquamous NSCLC. This indication is approved under accelerated approval based on tumor response rate and progression-free survival. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials. (1.2)

Head and Neck Squamous Cell Cancer (HNSCC)
- for the treatment of patients with recurrent or metastatic HNSCC with disease progression on or after platinum-containing chemotherapy.
  This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials. (1.3)

Classical Hodgkin Lymphoma (cHL)
- for the treatment of adult and pediatric patients with refractory cHL, or who have relapsed after 3 or more prior lines of therapy. This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials. (1.4)

Urothelial Carcinoma
- for the treatment of patients with locally advanced or metastatic urothelial carcinoma who are not eligible for cisplatin-containing chemotherapy. This indication is approved under accelerated approval based on tumor response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials. (1.5)
- for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy. (1.5)

Microsatellite Instability-High Cancer
- for the treatment of adult and pediatric patients with unresectable or metastatic, microsatellite instability-high (MSI-H) or mismatch repair deficient
  - o solid tumors that have progressed following prior treatment and who have no satisfactory alternative treatment options, or
  - o colorectal cancer that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan.

  This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials. (1.6)
- Limitation of Use: The safety and effectiveness of KEYTRUDA in pediatric patients with MSI-H central nervous system cancers have not been established. (1.6)

----------DOSAGE AND ADMINISTRATION----------
- Melanoma: 200 mg every 3 weeks. (2.2)
- NSCLC: 200 mg every 3 weeks. (2.3)
- HNSCC: 200 mg every 3 weeks. (2.4)
- cHL: 200 mg every 3 weeks for adults; 2 mg/kg (up to 200 mg) every 3 weeks for pediatrics. (2.5)
- Urothelial Carcinoma: 200 mg every 3 weeks. (2.6)
- MSI-H Cancer: 200 mg every 3 weeks for adults and 2 mg/kg (up to 200 mg) every 3 weeks for children. (2.7)

Administer KEYTRUDA as an intravenous infusion over 30 minutes.

----------DOSAGE FORMS AND STRENGTHS----------
- For injection: 50 mg lyophilized powder in single-dose vial for reconstitution (3)
- Injection: 100 mg/4 mL (25 mg/mL) solution in a single-dose vial (3)

----------CONTRAINDICATIONS----------

None. (4)

----------WARNINGS AND PRECAUTIONS----------
- Immune-mediated Pneumonitis: Withhold for moderate, and permanently discontinue for severe, life-threatening or recurrent moderate pneumonitis. (5.1)
- Immune-mediated Colitis: Withhold for moderate or severe, and permanently discontinue for life-threatening colitis. (5.2)
- Immune-mediated Hepatitis: Monitor for changes in hepatic function. Based on severity of liver enzyme elevations, withhold or discontinue. (5.3)
- Immune-mediated Endocrinopathies (5.4):
  - o Hypophysitis: Withhold for moderate and withhold or permanently discontinue for severe or life-threatening hypophysitis.
  - o Thyroid disorders: Monitor for changes in thyroid function. Withhold or permanently discontinue for severe or life-threatening hyperthyroidism.
  - o Type 1 diabetes mellitus: Monitor for hyperglycemia. Withhold KEYTRUDA in cases of severe hyperglycemia.
- Immune-mediated nephritis: Monitor for changes in renal function. Withhold for moderate, and permanently discontinue for severe or life-threatening nephritis. (5.5)
- Infusion-related reactions: Stop infusion and permanently discontinue KEYTRUDA for severe or life-threatening infusion reactions. (5.7)
- Complications of allogeneic HSCT after KEYTRUDA: Monitor for hepatic veno-occlusive disease, grade 3-4 acute GVHD including hyperacute GVHD, steroid-requiring febrile syndrome, and other immune-mediated adverse reactions. Transplant-related mortality has occurred. (5.8)
- Embryofetal toxicity: KEYTRUDA can cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus. (5.9)

----------ADVERSE REACTIONS----------

Most common adverse reactions (reported in ≥20% of patients) were fatigue, pruritus, diarrhea, decreased appetite, rash, pyrexia, cough, dyspnea, musculoskeletal pain, constipation, and nausea. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., at 1-877-888-4231 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

----------USE IN SPECIFIC POPULATIONS----------

Lactation: Discontinue nursing or discontinue KEYTRUDA. (8.2)

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See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 05/2017

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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

1.1 Melanoma

KEYTRUDA® (pembrolizumab) is indicated for the treatment of patients with unresectable or metastatic melanoma *[see Clinical Studies (14.1)]*.

1.2 Non-Small Cell Lung Cancer

KEYTRUDA, as a single agent, is indicated for the first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have high PD-L1 expression [Tumor Proportion Score (TPS) ≥50%)] as determined by an FDA-approved test, with no EGFR or ALK genomic tumor aberrations *[see Clinical Studies (14.2)]*.

KEYTRUDA, as a single agent, is indicated for the treatment of patients with metastatic NSCLC whose tumors express PD-L1 (TPS ≥1%) as determined by an FDA-approved test, with disease progression on or after platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving KEYTRUDA *[see Clinical Studies (14.2)]*.

KEYTRUDA, in combination with pemetrexed and carboplatin, is indicated for the first-line treatment of patients with metastatic nonsquamous NSCLC *[see Clinical Studies (14.2)]*. This indication is approved under accelerated approval based on tumor response rate and progression-free survival. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

1.3 Head and Neck Cancer

KEYTRUDA is indicated for the treatment of patients with recurrent or metastatic head and neck squamous cell carcinoma (HNSCC) with disease progression on or after platinum-containing chemotherapy *[see Clinical Studies (14.3)]*.

This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

1.4 Classical Hodgkin Lymphoma

KEYTRUDA is indicated for the treatment of adult and pediatric patients with refractory classical Hodgkin lymphoma (cHL), or who have relapsed after 3 or more prior lines of therapy *[see Clinical Studies (14.4)]*.

This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

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1.5 Urothelial Carcinoma

KEYTRUDA is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who are not eligible for cisplatin-containing chemotherapy *[see Clinical Studies (14.5)].*

This indication is approved under accelerated approval based on tumor response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

KEYTRUDA is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy *[see Clinical Studies (14.5)].*

1.6 Microsatellite Instability-High Cancer

KEYTRUDA is indicated for the treatment of adult and pediatric patients with unresectable or metastatic, microsatellite instability-high (MSI-H) or mismatch repair deficient

- solid tumors that have progressed following prior treatment and who have no satisfactory alternative treatment options, or
- colorectal cancer that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan *[see Clinical Studies (14.5)]*.

This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

Limitation of Use: The safety and effectiveness of KEYTRUDA in pediatric patients with MSI-H central nervous system cancers have not been established.

2 DOSAGE AND ADMINISTRATION

2.1 Patient Selection for Treatment of NSCLC

Select patients for treatment of metastatic NSCLC with KEYTRUDA as a single agent based on the presence of positive PD-L1 expression *[see Clinical Studies (14.2)]*. Information on FDA-approved tests for the detection of PD-L1 expression in NSCLC is available at: http://www.fda.gov/CompanionDiagnostics.

2.2 Recommended Dosage for Melanoma

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity *[see Clinical Studies (14.1)]*.

2.3 Recommended Dosage for NSCLC

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression *[see Clinical Studies (14.2)]*.

When administering KEYTRUDA in combination with chemotherapy, KEYTRUDA should be administered prior to chemotherapy when given on the same day *[see Clinical Studies (14.2)]*. See also the Prescribing Information for pemetrexed and carboplatin.

2.4 Recommended Dosage for HNSCC

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression *[see Clinical Studies (14.3)]*.

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2.5 Recommended Dosage for cHL

The recommended dose of KEYTRUDA in adults is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity, or up to 24 months in patients without disease progression *[see Clinical Studies (14.4)]*.

The recommended dose of KEYTRUDA in pediatric patients is 2 mg/kg (up to a maximum of 200 mg), administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity, or up to 24 months in patients without disease progression.

2.6 Recommended Dosage for Urothelial Carcinoma

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity, or up to 24 months in patients without disease progression *[see Clinical Studies (14.5)]*.

2.7 Recommended Dosage for MSI-H Cancer

The recommended dose of KEYTRUDA in adults is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression *[see Clinical Studies (14.5)].*

The recommended dose of KEYTRUDA in children is 2 mg/kg (up to a maximum of 200 mg), administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity, or up to 24 months in patients without disease progression.

2.8 Dose Modifications

Withhold KEYTRUDA for any of the following:

- Grade 2 pneumonitis *[see Warnings and Precautions (5.1)]*
- Grade 2 or 3 colitis *[see Warnings and Precautions (5.2)]*
- Grade 3 or 4 endocrinopathies *[see Warnings and Precautions (5.4)]*
- Grade 4 hematological toxicity in cHL patients
- Grade 2 nephritis *[see Warnings and Precautions (5.5)]*
- Aspartate aminotransferase (AST) or alanine aminotransferase (ALT) greater than 3 and up to 5 times upper limit of normal (ULN) or total bilirubin greater than 1.5 and up to 3 times ULN
- Any other severe or Grade 3 treatment-related adverse reaction *[see Warnings and Precautions (5.6)]*

Resume KEYTRUDA in patients whose adverse reactions recover to Grade 0-1.

Permanently discontinue KEYTRUDA for any of the following:

- Any life-threatening adverse reaction (excluding endocrinopathies controlled with hormone replacement therapy, or hematological toxicity in patients with cHL)
- Grade 3 or 4 pneumonitis or recurrent pneumonitis of Grade 2 severity *[see Warnings and Precautions (5.1)]*
- Grade 3 or 4 nephritis *[see Warnings and Precautions (5.5)]*
- AST or ALT greater than 5 times ULN or total bilirubin greater than 3 times ULN
  - For patients with liver metastasis who begin treatment with Grade 2 AST or ALT, if AST or ALT increases by greater than or equal to 50% relative to baseline and lasts for at least 1 week
- Grade 3 or 4 infusion-related reactions *[see Warnings and Precautions (5.7)]*
- Inability to reduce corticosteroid dose to 10 mg or less of prednisone or equivalent per day within 12 weeks
- Persistent Grade 2 or 3 adverse reactions (excluding endocrinopathies controlled with hormone replacement therapy) that do not recover to Grade 0-1 within 12 weeks after last dose of KEYTRUDA

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- Any severe or Grade 3 treatment-related adverse reaction that recurs *[see Warnings and Precautions (5.6)]*

2.9 Preparation and Administration

Reconstitution of KEYTRUDA for Injection (Lyophilized Powder)

- Add 2.3 mL of Sterile Water for Injection, USP by injecting the water along the walls of the vial and not directly on the lyophilized powder (resulting concentration 25 mg/mL).
- Slowly swirl the vial. Allow up to 5 minutes for the bubbles to clear. Do not shake the vial.

Preparation for Intravenous Infusion

- Visually inspect the solution for particulate matter and discoloration prior to administration. The solution is clear to slightly opalescent, colorless to slightly yellow. Discard the vial if visible particles are observed.
- Dilute KEYTRUDA injection (solution) or reconstituted lyophilized powder prior to intravenous administration.
- Withdraw the required volume from the vial(s) of KEYTRUDA and transfer into an intravenous (IV) bag containing 0.9% Sodium Chloride Injection, USP or 5% Dextrose Injection, USP. Mix diluted solution by gentle inversion. The final concentration of the diluted solution should be between 1 mg/mL to 10 mg/mL.
- Discard any unused portion left in the vial.

Storage of Reconstituted and Diluted Solutions

The product does not contain a preservative.

Store the reconstituted and diluted solution from the KEYTRUDA 50 mg vial either:

- At room temperature for no more than 6 hours from the time of reconstitution. This includes room temperature storage of reconstituted vials, storage of the infusion solution in the IV bag, and the duration of infusion.
- Under refrigeration at 2°C to 8°C (36°F to 46°F) for no more than 24 hours from the time of reconstitution. If refrigerated, allow the diluted solution to come to room temperature prior to administration.

Store the diluted solution from the KEYTRUDA 100 mg/4 mL vial either:

- At room temperature for no more than 6 hours from the time of dilution. This includes room temperature storage of the infusion solution in the IV bag, and the duration of infusion.
- Under refrigeration at 2°C to 8°C (36°F to 46°F) for no more than 24 hours from the time of dilution. If refrigerated, allow the diluted solution to come to room temperature prior to administration.

Do not freeze.

Administration

- Administer infusion solution intravenously over 30 minutes through an intravenous line containing a sterile, non-pyrogenic, low-protein binding 0.2 micron to 5 micron in-line or add-on filter.
- Do not co-administer other drugs through the same infusion line.

3 DOSAGE FORMS AND STRENGTHS

- For injection: 50 mg lyophilized powder in a single-dose vial for reconstitution
- Injection: 100 mg/4 mL (25 mg/mL) solution in a single-dose vial

4 CONTRAINDICATIONS

None.

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5 WARNINGS AND PRECAUTIONS

5.1 Immune-Mediated Pneumonitis

KEYTRUDA can cause immune-mediated pneumonitis, including fatal cases. Monitor patients for signs and symptoms of pneumonitis. Evaluate patients with suspected pneumonitis with radiographic imaging and administer corticosteroids (initial dose of 1 to 2 mg/kg/day prednisone or equivalent followed by a taper) for Grade 2 or greater pneumonitis. Withhold KEYTRUDA for moderate (Grade 2) pneumonitis, and permanently discontinue KEYTRUDA for severe (Grade 3), life-threatening (Grade 4), or recurrent moderate (Grade 2) pneumonitis *[see Dosage and Administration (2.8) and Adverse Reactions (6.1)].*

Pneumonitis occurred in 94 (3.4%) of 2799 patients receiving KEYTRUDA, including Grade 1 (0.8%), Grade 2 (1.3%), Grade 3 (0.9%), Grade 4 (0.3%), and Grade 5 (0.1%) pneumonitis. The median time to onset was 3.3 months (range: 2 days to 19.3 months), and the median duration was 1.5 months (range: 1 day to 17.2+ months). Sixty-three (67%) of the 94 patients received systemic corticosteroids, with 50 of the 63 receiving high-dose corticosteroids for a median duration of 8 days (range: 1 day to 10.1 months) followed by a corticosteroid taper. Pneumonitis occurred more frequently in patients with a history of prior thoracic radiation (6.9%) than in patients who did not receive prior thoracic radiation (2.9%). Pneumonitis led to discontinuation of KEYTRUDA in 36 (1.3%) patients. Pneumonitis resolved in 55 (59%) of the 94 patients.

5.2 Immune-Mediated Colitis

KEYTRUDA can cause immune-mediated colitis. Monitor patients for signs and symptoms of colitis. Administer corticosteroids (initial dose of 1 to 2 mg/kg/day prednisone or equivalent followed by a taper) for Grade 2 or greater colitis. Withhold KEYTRUDA for moderate (Grade 2) or severe (Grade 3) colitis, and permanently discontinue KEYTRUDA for life-threatening (Grade 4) colitis *[see Dosage and Administration (2.8) and Adverse Reactions (6.1)].*

Colitis occurred in 48 (1.7%) of 2799 patients receiving KEYTRUDA, including Grade 2 (0.4%), Grade 3 (1.1%), and Grade 4 (<0.1%) colitis. The median time to onset was 3.5 months (range: 10 days to 16.2 months), and the median duration was 1.3 months (range: 1 day to 8.7+ months). Thirty-three (69%) of the 48 patients received systemic corticosteroids, with 27 of the 33 requiring high-dose corticosteroids for a median duration of 7 days (range: 1 day to 5.3 months) followed by a corticosteroid taper. Colitis led to discontinuation of KEYTRUDA in 15 (0.5%) patients. Colitis resolved in 41 (85%) of the 48 patients.

5.3 Immune-Mediated Hepatitis

KEYTRUDA can cause immune-mediated hepatitis. Monitor patients for changes in liver function. Administer corticosteroids (initial dose of 0.5 to 1 mg/kg/day [for Grade 2 hepatitis] and 1 to 2 mg/kg/day [for Grade 3 or greater hepatitis] prednisone or equivalent followed by a taper) and, based on severity of liver enzyme elevations, withhold or discontinue KEYTRUDA *[see Dosage and Administration (2.8) and Adverse Reactions (6.1)].*

Hepatitis occurred in 19 (0.7%) of 2799 patients receiving KEYTRUDA, including Grade 2 (0.1%), Grade 3 (0.4%), and Grade 4 (<0.1%) hepatitis. The median time to onset was 1.3 months (range: 8 days to 21.4 months), and the median duration was 1.8 months (range: 8 days to 20.9+ months). Thirteen (68%) of the 19 patients received systemic corticosteroids, with 12 of the 13 receiving high-dose corticosteroids for a median duration of 5 days (range: 1 to 26 days) followed by a corticosteroid taper. Hepatitis led to discontinuation of KEYTRUDA in 6 (0.2%) patients. Hepatitis resolved in 15 (79%) of the 19 patients.

5.4 Immune-Mediated Endocrinopathies

Hypophysitis

KEYTRUDA can cause hypophysitis. Monitor for signs and symptoms of hypophysitis (including hypopituitarism and adrenal insufficiency). Administer corticosteroids and hormone replacement as clinically indicated. Withhold KEYTRUDA for moderate (Grade 2) hypophysitis and withhold or

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discontinue KEYTRUDA for severe (Grade 3) or life-threatening (Grade 4) hypophysitis *[see Dosage and Administration (2.8) and Adverse Reactions (6.1)].*

Hypophysitis occurred in 17 (0.6%) of 2799 patients receiving KEYTRUDA, including Grade 2 (0.2%), Grade 3 (0.3%), and Grade 4 (<0.1%) hypophysitis. The median time to onset was 3.7 months (range: 1 day to 11.9 months), and the median duration was 4.7 months (range: 8+ days to 12.7+ months). Sixteen (94%) of the 17 patients received systemic corticosteroids, with 6 of the 16 receiving high-dose corticosteroids. Hypophysitis led to discontinuation of KEYTRUDA in 4 (0.1%) patients. Hypophysitis resolved in 7 (41%) of the 17 patients.

Thyroid Disorders
KEYTRUDA can cause thyroid disorders, including hyperthyroidism, hypothyroidism and thyroiditis. Monitor patients for changes in thyroid function (at the start of treatment, periodically during treatment, and as indicated based on clinical evaluation) and for clinical signs and symptoms of thyroid disorders. Administer replacement hormones for hypothyroidism and manage hyperthyroidism with thionamides and beta-blockers as appropriate. Withhold or discontinue KEYTRUDA for severe (Grade 3) or life-threatening (Grade 4) hyperthyroidism *[see Dosage and Administration (2.8) and Adverse Reactions (6.1)].*

Hyperthyroidism occurred in 96 (3.4%) of 2799 patients receiving KEYTRUDA, including Grade 2 (0.8%) and Grade 3 (0.1%) hyperthyroidism. The median time to onset was 1.4 months (range: 1 day to 21.9 months), and the median duration was 2.1 months (range: 3 days to 15.0+ months). Hyperthyroidism led to discontinuation of KEYTRUDA in 2 (<0.1%) patients. Hyperthyroidism resolved in 71 (74%) of the 96 patients.

Hypothyroidism occurred in 237 (8.5%) of 2799 patients receiving KEYTRUDA, including Grade 2 (6.2%) and Grade 3 (0.1%) hypothyroidism. The median time to onset was 3.5 months (range: 1 day to 18.9 months), and the median duration was not reached (range: 2 days to 27.7+ months). Hypothyroidism led to discontinuation of KEYTRUDA in 1 (<0.1%) patient. Hypothyroidism resolved in 48 (20%) of the 237 patients. The incidence of new or worsening hypothyroidism was higher in patients with HNSCC occurring in 28 (15%) of 192 patients receiving KEYTRUDA, including Grade 3 (0.5%) hypothyroidism. Of these 28 patients, 15 had no prior history of hypothyroidism.

Thyroiditis occurred in 16 (0.6%) of 2799 patients receiving KEYTRUDA, including Grade 2 (0.3%) thyroiditis. The median time of onset was 1.2 months (range: 0.5 to 3.5 months).

Type 1 Diabetes mellitus
KEYTRUDA can cause type 1 diabetes mellitus, including diabetic ketoacidosis, which have been reported in 6 (0.2%) of 2799 patients receiving KEYTRUDA. Monitor patients for hyperglycemia or other signs and symptoms of diabetes. Administer insulin for type 1 diabetes, and withhold KEYTRUDA and administer anti-hyperglycemics in patients with severe hyperglycemia *[see Dosage and Administration (2.8) and Adverse Reactions (6.1)]*.

5.5 Immune-Mediated Nephritis and Renal Dysfunction
KEYTRUDA can cause immune-mediated nephritis. Monitor patients for changes in renal function. Administer corticosteroids (initial dose of 1 to 2 mg/kg/day prednisone or equivalent followed by a taper) for Grade 2 or greater nephritis. Withhold KEYTRUDA for moderate (Grade 2), and permanently discontinue KEYTRUDA for severe (Grade 3) or life-threatening (Grade 4) nephritis *[see Dosage and Administration (2.8) and Adverse Reactions (6.1)].*

Nephritis occurred in 9 (0.3%) of 2799 patients receiving KEYTRUDA, including Grade 2 (0.1%), Grade 3 (0.1%), and Grade 4 (<0.1%) nephritis. The median time to onset was 5.1 months (range: 12 days to 12.8 months), and the median duration was 3.3 months (range: 12 days to 8.9+ months). Eight (89%) of the 9 patients received systemic corticosteroids, with 7 of the 8 receiving high-dose corticosteroids for a

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median duration of 15 days (range: 3 days to 4.0 months) followed by a corticosteroid taper. Nephritis led to discontinuation of KEYTRUDA in 3 (0.1%) patients. Nephritis resolved in 5 (56%) of the 9 patients.

5.6 Other Immune-Mediated Adverse Reactions

KEYTRUDA can cause other clinically important immune-mediated adverse reactions. These immune-mediated reactions may involve any organ system.

For suspected immune-mediated adverse reactions, ensure adequate evaluation to confirm etiology or exclude other causes. Based on the severity of the adverse reaction, withhold KEYTRUDA and administer corticosteroids. Upon improvement to Grade 1 or less, initiate corticosteroid taper and continue to taper over at least 1 month. Based on limited data from clinical studies in patients whose immune-related adverse reactions could not be controlled with corticosteroid use, administration of other systemic immunosuppressants can be considered. Resume KEYTRUDA when the immune-mediated adverse reaction remains at Grade 1 or less following corticosteroid taper. Permanently discontinue KEYTRUDA for any Grade 3 immune-mediated adverse reaction that recurs and for any life-threatening immune-mediated adverse reaction *[see Dosage and Administration (2.8) and Adverse Reactions (6.1)].*

The following clinically significant, immune-mediated adverse reactions occurred in less than 1% (unless otherwise indicated) of 2799 patients treated with KEYTRUDA: arthritis (1.5%), exfoliative dermatitis, bullous pemphigoid, rash (1.4%), uveitis, myositis, Guillain-Barré syndrome, myasthenia gravis, vasculitis, pancreatitis, hemolytic anemia, and partial seizures arising in a patient with inflammatory foci in brain parenchyma. In addition, myelitis and myocarditis were reported in other clinical trials, including cHL, and post-marketing use.

5.7 Infusion-Related Reactions

KEYTRUDA can cause severe or life-threatening infusion-related reactions, including hypersensitivity and anaphylaxis, which have been reported in 6 (0.2%) of 2799 patients receiving KEYTRUDA. Monitor patients for signs and symptoms of infusion-related reactions including rigors, chills, wheezing, pruritus, flushing, rash, hypotension, hypoxemia, and fever. For severe (Grade 3) or life-threatening (Grade 4) infusion-related reactions, stop infusion and permanently discontinue KEYTRUDA *[see Dosage and Administration (2.8)]*.

5.8 Complications of Allogeneic HSCT after KEYTRUDA

Immune-mediated complications, including fatal events, occurred in patients who underwent allogeneic hematopoietic stem cell transplantation (HSCT) after being treated with KEYTRUDA. Of 23 patients with cHL who proceeded to allogeneic HSCT after treatment with KEYTRUDA on any trial, 6 patients (26%) developed graft-versus-host-disease (GVHD), one of which was fatal, and 2 patients (9%) developed severe hepatic veno-occlusive disease (VOD) after reduced-intensity conditioning, one of which was fatal. Cases of fatal hyperacute GVHD after allogeneic HSCT have also been reported in patients with lymphoma who received a PD-1 receptor blocking antibody before transplantation. These complications may occur despite intervening therapy between PD-1 blockade and allogeneic HSCT. Follow patients closely for early evidence of transplant-related complications such as hyperacute GVHD, severe (Grade 3 to 4) acute GVHD, steroid-requiring febrile syndrome, hepatic VOD, and other immune-mediated adverse reactions, and intervene promptly.

5.9 Embryofetal Toxicity

Based on its mechanism of action, KEYTRUDA can cause fetal harm when administered to a pregnant woman. Animal models link the PD-1/PD-L1 signaling pathway with maintenance of pregnancy through induction of maternal immune tolerance to fetal tissue. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, apprise the patient of the potential hazard to a fetus. Advise females of reproductive potential to use highly effective contraception during treatment with KEYTRUDA and for 4 months after the last dose of KEYTRUDA *[see Use in Specific Populations (8.1, 8.3)].*

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6 ADVERSE REACTIONS

The following adverse reactions are discussed in greater detail in other sections of the labeling.

- Immune-mediated pneumonitis *[see Warnings and Precautions (5.1)].*
- Immune-mediated colitis *[see Warnings and Precautions (5.2)]*.
- Immune-mediated hepatitis *[see Warnings and Precautions (5.3)]*.
- Immune-mediated endocrinopathies *[see Warnings and Precautions (5.4)]*.
- Immune-mediated nephritis and renal dysfunction *[see Warnings and Precautions (5.5)]*.
- Other immune-mediated adverse reactions *[see Warnings and Precautions (5.6)]*.
- Infusion-related reactions *[see Warnings and Precautions (5.7)].*

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The data described in the WARNINGS AND PRECAUTIONS section reflect exposure to KEYTRUDA in 2799 patients in three randomized, open-label, active-controlled clinical trials (KEYNOTE-002, KEYNOTE-006, and KEYNOTE-010), which enrolled 912 patients with melanoma and 682 patients with NSCLC, and one single-arm trial (KEYNOTE-001) which enrolled 655 patients with melanoma and 550 patients with NSCLC. In addition, these data reflect exposure to KEYTRUDA in a non-randomized, open-label, multi-cohort trial (KEYNOTE-012) which enrolled 192 patients with HNSCC and 241 cHL patients in two non-randomized, open-label trials (KEYNOTE-013 and KEYNOTE-087). Across all studies, KEYTRUDA was administered at doses of 2 mg/kg intravenously every 3 weeks, 10 mg/kg intravenously every 2 weeks, 10 mg/kg intravenously every 3 weeks, or 200 mg intravenously every 3 weeks. Among the 2799 patients, 41% were exposed for 6 months or more and 21% were exposed for 12 months or more.

The data described in this section were obtained in five randomized, open-label, active-controlled clinical trials (KEYNOTE-002, KEYNOTE-006, KEYNOTE-010, KEYNOTE-021, and KEYNOTE-045) in which KEYTRUDA was administered to 912 patients with melanoma, 741 patients with NSCLC, and 542 patients with urothelial carcinoma, and three non-randomized, open-label trials (KEYNOTE-012, KEYNOTE-087, and KEYNOTE-052) in which KEYTRUDA was administered to 192 patients with HNSCC, 210 patients with cHL, and 370 patients with urothelial carcinoma. In these trials, KEYTRUDA was administered at 2 mg/kg every 3 weeks, 200 mg every 3 weeks, or 10 mg/kg every 2 or 3 weeks.

Melanoma

<u>Ipilimumab-Naive Melanoma</u>

The safety of KEYTRUDA for the treatment of patients with unresectable or metastatic melanoma who had not received prior ipilimumab and who had received no more than one prior systemic therapy was investigated in Study KEYNOTE-006. KEYNOTE-006 was a multicenter, open-label, active-controlled trial where patients were randomized (1:1:1) and received KEYTRUDA 10 mg/kg every 2 weeks (n=278) or KEYTRUDA 10 mg/kg every 3 weeks (n=277) until disease progression or unacceptable toxicity or ipilimumab 3 mg/kg every 3 weeks for 4 doses unless discontinued earlier for disease progression or unacceptable toxicity (n=256) *[see Clinical Studies (14.1)]*. Patients with autoimmune disease, a medical condition that required systemic corticosteroids or other immunosuppressive medication; a history of interstitial lung disease; or active infection requiring therapy, including HIV or hepatitis B or C, were ineligible.

The median duration of exposure was 5.6 months (range: 1 day to 11.0 months) for KEYTRUDA and similar in both treatment arms. Fifty-one and 46% of patients received KEYTRUDA 10 mg/kg every 2 or 3 weeks, respectively, for ≥6 months. No patients in either arm received treatment for more than one year.

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The study population characteristics were: median age of 62 years (range: 18 to 89 years), 60% male, 98% White, 32% had an elevated lactate dehydrogenase (LDH) value at baseline, 65% had M1c stage disease, 9% with history of brain metastasis, and approximately 36% had been previously treated with systemic therapy which included a BRAF inhibitor (15%), chemotherapy (13%), and immunotherapy (6%).

In KEYNOTE-006, the adverse reaction profile was similar for the every 2 week and every 3 week schedule, therefore summary safety results are provided in a pooled analysis (n=555) of both KEYTRUDA arms. Adverse reactions leading to permanent discontinuation of KEYTRUDA occurred in 9% of patients. Adverse reactions leading to discontinuation of KEYTRUDA in more than one patient were colitis (1.4%), autoimmune hepatitis (0.7%), allergic reaction (0.4%), polyneuropathy (0.4%), and cardiac failure (0.4%). Adverse reactions leading to interruption of KEYTRUDA occurred in 21% of patients; the most common (≥1%) was diarrhea (2.5%). The most common adverse reactions (reported in at least 20% of patients) were fatigue and diarrhea. Table 1 and Table 2 summarize the incidence of selected adverse reactions and laboratory abnormalities that occurred in patients receiving KEYTRUDA.

Table 1: Selected* Adverse Reactions Occurring in ≥10% of Patients Receiving KEYTRUDA in KEYNOTE-006

	KEYTRUDA 10 mg/kg every 2 or 3 weeks n=555		Ipilimumab n=256	
Adverse Reaction	**All Grades† (%)**	**Grade 3-4 (%)**	**All Grades (%)**	**Grade 3-4 (%)**
General Disorders and Administration Site Conditions				
Fatigue	28	0.9	28	3.1
Skin and Subcutaneous Tissue Disorders				
Rash‡	24	0.2	23	1.2
Vitiligo§	13	0	2	0
Musculoskeletal and Connective Tissue Disorders				
Arthralgia	18	0.4	10	1.2
Back pain	12	0.9	7	0.8
Respiratory, Thoracic and Mediastinal Disorders				
Cough	17	0	7	0.4
Dyspnea	11	0.9	7	0.8
Metabolism and Nutrition Disorders				
Decreased appetite	16	0.5	14	0.8
Nervous System Disorders				
Headache	14	0.2	14	0.8

* Adverse reactions occurring at same or higher incidence than in the ipilimumab arm
† Graded per NCI CTCAE v4.0
‡ Includes rash, rash erythematous, rash follicular, rash generalized, rash macular, rash maculo-papular, rash papular, rash pruritic, and exfoliative rash.
§ Includes skin hypopigmentation

Other clinically important adverse reactions occurring in ≥10% of patients receiving KEYTRUDA were diarrhea (26%), nausea (21%), and pruritus (17%).

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Table 2: Selected* Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of Melanoma Patients Receiving KEYTRUDA in KEYNOTE-006

	KEYTRUDA 10 mg/kg every 2 or 3 weeks		Ipilimumab	
Laboratory Test†	**All Grades‡ %**	**Grades 3-4 %**	**All Grades %**	**Grades 3-4 %**
Chemistry				
Hyperglycemia	45	4.2	45	3.8
Hypertriglyceridemia	43	2.6	31	1.1
Hyponatremia	28	4.6	26	7
Increased AST	27	2.6	25	2.5
Hypercholesterolemia	20	1.2	13	0
Hematology				
Anemia	35	3.8	33	4.0
Lymphopenia	33	7	25	6

* Laboratory abnormalities occurring at same or higher incidence than in ipilimumab arm
† Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA (520 to 546 patients) and ipilimumab (237 to 247 patients); hypertriglyceridemia: KEYTRUDA n=429 and ipilimumab n=183; hypercholesterolemia: KEYTRUDA n=484 and ipilimumab n=205.
‡ Graded per NCI CTCAE v4.0

Other laboratory abnormalities occurring in ≥20% of patients receiving KEYTRUDA were increased hypoalbuminemia (27% all Grades; 2.4% Grades 3-4), increased ALT (23% all Grades; 3.1% Grades 3-4), and increased alkaline phosphatase (21% all Grades, 2.0% Grades 3-4).

Ipilimumab-Refractory Melanoma

The safety of KEYTRUDA in patients with unresectable or metastatic melanoma with disease progression following ipilimumab and, if BRAF V600 mutation positive, a BRAF inhibitor, was evaluated in Study KEYNOTE-002. KEYNOTE-002 was a multicenter, partially blinded (KEYTRUDA dose), randomized (1:1:1), active-controlled trial in which 528 patients received KEYTRUDA 2 mg/kg (n=178) or 10 mg/kg (n=179) every 3 weeks or investigator's choice of chemotherapy (n=171), consisting of dacarbazine (26%), temozolomide (25%), paclitaxel and carboplatin (25%), paclitaxel (16%), or carboplatin (8%) *[see Clinical Studies (14.1)]*. The trial excluded patients with autoimmune disease, severe immune-related toxicity related to ipilimumab, defined as any Grade 4 toxicity or Grade 3 toxicity requiring corticosteroid treatment (greater than 10 mg/day prednisone or equivalent dose) for greater than 12 weeks; medical conditions that required systemic corticosteroids or other immunosuppressive medication; a history of interstitial lung disease; or an active infection requiring therapy, including HIV or hepatitis B or C.

The median duration of exposure to KEYTRUDA 2 mg/kg every 3 weeks was 3.7 months (range: 1 day to 16.6 months) and to KEYTRUDA 10 mg/kg every 3 weeks was 4.8 months (range: 1 day to 16.8 months). The data described below reflect exposure to KEYTRUDA 2 mg/kg in 36% of patients exposed to KEYTRUDA for ≥6 months and in 4% of patients exposed for ≥12 months. In the KEYTRUDA 10 mg/kg arm, 41% of patients were exposed to KEYTRUDA for ≥6 months and 6% of patients were exposed to KEYTRUDA for ≥12 months.

The study population characteristics were: median age of 62 years (range: 15 to 89 years), 61% male, 98% White, 41% with an elevated LDH value at baseline, 83% with M1c stage disease, 73% received two or more prior therapies for advanced or metastatic disease (100% received ipilimumab and 25% a BRAF inhibitor), and 15% with history of brain metastasis.

In KEYNOTE-002, the adverse reaction profile was similar for the 2 mg/kg dose and 10 mg/kg dose, therefore summary safety results are provided in a pooled analysis (n=357) of both KEYTRUDA arms. Adverse reactions resulting in permanent discontinuation occurred in 12% of patients receiving

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KEYTRUDA; the most common (≥1%) were general physical health deterioration (1%), asthenia (1%), dyspnea (1%), pneumonitis (1%), and generalized edema (1%). Adverse reactions leading to interruption of KEYTRUDA occurred in 14% of patients; the most common (≥1%) were dyspnea (1%), diarrhea (1%), and maculo-papular rash (1%). The most common adverse reactions (reported in at least 20% of patients) of KEYTRUDA were fatigue, pruritus, rash, constipation, nausea, diarrhea, and decreased appetite.

Table 3 summarizes the incidence of adverse reactions occurring in at least 10% of patients receiving KEYTRUDA.

Table 3: Selected* Adverse Reactions Occurring in ≥10% of Patients Receiving KEYTRUDA in KEYNOTE-002

	KEYTRUDA 2 mg/kg or 10 mg/kg every 3 weeks n=357		Chemotherapy† n=171	
Adverse Reaction	**All Grades‡ (%)**	**Grade 3-4 (%)**	**All Grades (%)**	**Grade 3-4 (%)**
General Disorders and Administration Site Conditions				
Pyrexia	14	0.3	9	0.6
Asthenia	10	2.0	9	1.8
Skin and Subcutaneous Tissue Disorders				
Pruritus	28	0	8	0
Rash§	24	0.6	8	0
Gastrointestinal Disorders				
Constipation	22	0.3	20	2.3
Diarrhea	20	0.8	20	2.3
Abdominal pain	13	1.7	8	1.2
Respiratory, Thoracic and Mediastinal Disorders				
Cough	18	0	16	0
Musculoskeletal and Connective Tissue Disorders				
Arthralgia	14	0.6	10	1.2

* Adverse reactions occurring at same or higher incidence than in chemotherapy arm
† Chemotherapy: dacarbazine, temozolomide, carboplatin plus paclitaxel, paclitaxel, or carboplatin
‡ Graded per NCI CTCAE v4.0
§ Includes rash, rash erythematous, rash generalized, rash macular, rash maculo-papular, rash papular, and rash pruritic

Other clinically important adverse reactions occurring in patients receiving KEYTRUDA were fatigue (43%), nausea (22%), decreased appetite (20%), vomiting (13%), and peripheral neuropathy (1.7%).

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Table 4: Selected* Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of Melanoma Patients Receiving KEYTRUDA in KEYNOTE-002

	KEYTRUDA 2 mg/kg or 10 mg/kg every 3 weeks		Chemotherapy	
Laboratory Test†	**All Grades‡ %**	**Grades 3-4 %**	**All Grades %**	**Grades 3-4 %**
Chemistry				
Hyperglycemia	49	6	44	6
Hypoalbuminemia	37	1.9	33	0.6
Hyponatremia	37	7	24	3.8
Hypertriglyceridemia	33	0	32	0.9
Increased Alkaline Phosphatase	26	3.1	18	1.9
Increased AST	24	2.2	16	0.6
Bicarbonate Decreased	22	0.4	13	0
Hypocalcemia	21	0.3	18	1.9
Increased ALT	21	1.8	16	0.6

* Laboratory abnormalities occurring at same or higher incidence than in chemotherapy arm.
† Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA (range: 320 to 325 patients) and chemotherapy (range: 154 to 161 patients); hypertriglyceridemia: KEYTRUDA n=247 and chemotherapy n=116; bicarbonate decreased: KEYTRUDA n=263 and chemotherapy n=123.
‡ Graded per NCI CTCAE v4.0

Other laboratory abnormalities occurring in ≥20% of patients receiving KEYTRUDA were anemia (44% all Grades; 10% Grades 3-4) and lymphopenia (40% all Grades; 9% Grades 3-4).

NSCLC

Previously Treated NSCLC

The safety of KEYTRUDA was investigated in Study KEYNOTE-010, a multicenter, open-label, randomized (1:1:1), active-controlled trial, in patients with advanced NSCLC who had documented disease progression following treatment with platinum-based chemotherapy and, if positive for EGFR or ALK genetic aberrations, appropriate therapy for these aberrations. A total of 991 patients received KEYTRUDA 2 mg/kg (n=339) or 10 mg/kg (n=343) every 3 weeks or docetaxel (n=309) at 75 mg/m^2 every 3 weeks. Patients with autoimmune disease, medical conditions that required systemic corticosteroids or other immunosuppressive medication, or who had received more than 30 Gy of thoracic radiation within the prior 26 weeks were ineligible.

The median duration of exposure to KEYTRUDA 2 mg/kg every 3 weeks was 3.5 months (range: 1 day to 22.4 months) and to KEYTRUDA 10 mg/kg every 3 weeks was 3.5 months (range 1 day to 20.8 months). The data described below reflect exposure to KEYTRUDA 2 mg/kg in 31% of patients exposed to KEYTRUDA for ≥6 months. In the KEYTRUDA 10 mg/kg arm, 34% of patients were exposed to KEYTRUDA for ≥6 months.

The study population characteristics were: median age of 63 years (range: 20 to 88), 42% age 65 years or older, 61% male, 72% white and 21% Asian, 8% with advanced localized disease, 91% with metastatic disease, and 15% with history of brain metastases. Twenty-nine percent received two or more prior systemic treatments for advanced or metastatic disease.

In KEYNOTE-010, the adverse reaction profile was similar for the 2 mg/kg and 10 mg/kg dose, therefore summary safety results are provided in a pooled analysis (n=682). Treatment was discontinued for adverse reactions in 8% of patients receiving KEYTRUDA. The most common adverse events resulting in permanent discontinuation of KEYTRUDA was pneumonitis (1.8%). Adverse reactions leading to interruption of KEYTRUDA occurred in 23% of patients; the most common (≥1%) were diarrhea (1%), fatigue (1.3%), pneumonia (1%), liver enzyme elevation (1.2%), decreased appetite (1.3%), and pneumonitis (1%).

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Table 5 summarizes the adverse reactions that occurred in at least 10% of patients treated with KEYTRUDA.

Table 5: Selected* Adverse Reactions Occurring in ≥10% of Patients Receiving KEYTRUDA in KEYNOTE-010

	KEYTRUDA 2 or 10 mg/kg every 3 weeks n=682		Docetaxel 75 mg/m^2 every 3 weeks n=309	
Adverse Reaction	**All Grades† (%)**	**Grade 3-4 (%)**	**All Grades† (%)**	**Grade 3-4 (%)**
Metabolism and Nutrition Disorders				
Decreased appetite	25	1.5	23	2.6
Gastrointestinal Disorders				
Nausea	20	1.3	18	0.6
Constipation	15	0.6	12	0.6
Vomiting	13	0.9	10	0.6
Respiratory, Thoracic and Mediastinal Disorders				
Dyspnea	23	3.7	20	2.6
Cough	19	0.6	14	0
Musculoskeletal and Connective Tissue Disorders				
Arthralgia	11	1.0	9	0.3
Back pain	11	1.5	8	0.3
Skin and Subcutaneous Tissue Disorders				
Rash‡	17	0.4	8	0
Pruritus	11	0	3	0.3

* Adverse reactions occurring at same or higher incidence than in docetaxel arm
† Graded per NCI CTCAE v4.0
‡ Includes rash, rash erythematous, rash macular, rash maculo-papular, rash papular, and rash pruritic

Other clinically important adverse reactions occurring in patients receiving KEYTRUDA were fatigue (25%), diarrhea (14%), asthenia (11%) and pyrexia (11%).

Table 6: Selected* Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of NSCLC Patients Receiving KEYTRUDA in KEYNOTE-010

	KEYTRUDA 2 or 10 mg/kg every 3 weeks		Docetaxel 75 mg/m^2 every 3 weeks	
Laboratory Test†	**All Grades‡ %**	**Grades 3-4 %**	**All Grades‡ %**	**Grades 3-4 %**
Chemistry				
Hyponatremia	32	8	27	2.9
Alkaline phosphatase increased	28	3.0	16	0.7
Aspartate aminotransferase increased	26	1.6	12	0.7
Alanine aminotransferase increased	22	2.7	9	0.4

* Laboratory abnormalities occurring at same or higher incidence than in docetaxel arm.
† Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA (range: 631 to 638 patients) and docetaxel (range: 274 to 277 patients).
‡ Graded per NCI CTCAE v4.0

Other laboratory abnormalities occurring in ≥20% of patients receiving KEYTRUDA were hyperglycemia (44% all Grades; 4.1% Grades 3-4), anemia (37% all Grades; 3.8% Grades 3-4), hypertriglyceridemia (36% all Grades; 1.8% Grades 3-4), lymphopenia (35% all Grades; 9% Grades 3-4), hypoalbuminemia (34% all Grades; 1.6% Grades 3-4), and hypercholesterolemia (20% all Grades; 0.7% Grades 3-4).

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Previously Untreated Nonsquamous NSCLC, in Combination with Chemotherapy
The safety of KEYTRUDA in combination with pemetrexed and carboplatin was investigated in a randomized (1:1) open-label cohort in Study KEYNOTE-021. Patients with previously untreated, metastatic nonsquamous NSCLC received KEYTRUDA 200 mg with pemetrexed and carboplatin (n=59), or pemetrexed and carboplatin alone (n=62). Patients with autoimmune disease that required systemic therapy within 2 years of treatment; a medical condition that required immunosuppression; or who had received more than 30 Gy of thoracic radiation within the prior 26 weeks were ineligible *[see Clinical Studies (14.2)]*.

The median duration of exposure to KEYTRUDA was 8 months (range: 1 day to 16 months). Sixty-eight percent of patients in the KEYTRUDA arm were exposed to KEYTRUDA 200 mg for ≥6 months. The study population characteristics were: median age of 64 years (range: 37 to 80), 48% age 65 years or older, 39% male, 87% White and 8% Asian, 97% with metastatic disease, and 12% with brain metastases.

KEYTRUDA was discontinued for adverse reactions in 10% of patients. The most common adverse reaction resulting in discontinuation of KEYTRUDA (≥ 2%) was acute kidney injury (3.4%). Adverse reactions leading to interruption of KEYTRUDA occurred in 39% of patients; the most common (≥ 2%) were fatigue (8%), neutrophil count decreased (8%), anemia (5%), dyspnea (3.4%), and pneumonitis (3.4%).

Table 7 summarizes the adverse reactions that occurred in at least 20% of patients treated with KEYTRUDA. KEYNOTE-021 was not designed to demonstrate a statistically significant difference in adverse reaction rates for pembrolizumab plus chemotherapy, as compared to chemotherapy alone, for any specified adverse reaction listed in Table 7.

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Table 7: Adverse Reactions Occurring in ≥20% of Patients in KEYNOTE-021

	KEYTRUDA Pemetrexed Carboplatin n=59		Pemetrexed Carboplatin n=62	
Adverse Reaction	**All Grades* (%)**	**Grade 3-4 (%)**	**All Grades (%)**	**Grade 3-4 (%)**
General Disorders and Administration Site Conditions				
Fatigue	71	3.4	50	0
Peripheral Edema	22	0	18	0
Gastrointestinal Disorders				
Nausea	68	1.7	56	0
Constipation	51	0	37	1.6
Vomiting	39	1.7	27	0
Diarrhea	37	1.7	23	1.6
Skin and Subcutaneous Tissue Disorders				
Rash†	42	1.7	21	1.6
Pruritus	24	0	4.8	0
Alopecia	20	0	3.2	0
Respiratory, Thoracic and Mediastinal Disorders				
Dyspnea	39	3.4	21	0
Cough	24	0	18	0
Metabolism and Nutrition Disorders				
Decreased Appetite	31	0	23	0
Nervous System Disorders				
Headache	31	0	16	1.6
Dizziness	24	0	16	0
Dysgeusia	20	0	11	0
Psychiatric Disorders				
Insomnia	24	0	15	0
Infections and Infestations				
Upper respiratory tract infection	20	0	3.2	0
Musculoskeletal and Connective Tissue Disorders				
Arthralgia	15	0	24	1.6

* Graded per NCI CTCAE v4.0
† Includes rash, rash generalized, rash macular, rash maculo-papular, and rash pruritic.

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Table 8: Laboratory Abnormalities Worsened from Baseline in ≥20% of Patients in KEYNOTE-021

	KEYTRUDA Pemetrexed Carboplatin		Pemetrexed Carboplatin	
Laboratory Test*	**All Grades† %**	**Grades 3-4 %**	**All Grades %**	**Grades 3-4 %**
Chemistry				
Hyperglycemia	74	9	61	5
Lymphocytes decreased	53	23	60	28
Aspartate aminotransferase increased	51	3.5	46	1.7
Hypertriglyceridemia	50	0	43	0
Alanine aminotransferase increased	40	3.5	32	1.7
Creatinine increased	34	3.4	19	1.7
Hyponatremia	33	5	35	3.5
Hypoalbuminemia	32	0	31	0
Hypocalcemia	30	5	19	1.7
Hypokalemia	29	5	22	1.7
Hypophosphatemia	29	5	24	11
Alkaline phosphatase increased	28	0	9	0
Hematology				
Hemoglobin decreased	83	17	84	19
Neutrophils decreased	47	14	43	8
Platelets decreased	24	9	36	10

* Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA pemetrexed carboplatin (range: 56 to 58 patients) and pemetrexed carboplatin (range: 55 to 61 patients).
† Graded per NCI CTCAE v4.0

HNSCC
Among the 192 patients with HNSCC enrolled in Study KEYNOTE-012, the median duration of exposure to KEYTRUDA was 3.3 months (range: 1 day to 27.9 months). Patients with autoimmune disease or a medical condition that required immunosuppression were ineligible for KEYNOTE-012. The median age of patients was 60 years (range: 20 to 84), 35% were age 65 years or older, 83% were male, 77% were White, 15% were Asian, and 5% were Black. Sixty-one percent of patients had two or more lines of therapy in the recurrent or metastatic setting, and 95% had prior radiation therapy. Baseline ECOG PS was 0 (30%) or 1 (70%) and 86% had M1 disease.

KEYTRUDA was discontinued due to adverse reactions in 17% of patients. Serious adverse reactions occurred in 45% of patients receiving KEYTRUDA. The most frequent serious adverse reactions reported in at least 2% of patients were pneumonia, dyspnea, confusional state, vomiting, pleural effusion, and respiratory failure. The incidence of adverse reactions, including serious adverse reactions, was similar between dosage regimens (10 mg/kg every 2 weeks or 200 mg every 3 weeks); these data were pooled. The most common adverse reactions (occurring in ≥ 20% of patients) were fatigue, decreased appetite, and dyspnea. Adverse reactions occurring in patients with HNSCC were generally similar to those occurring in patients with melanoma or NSCLC, with the exception of increased incidences of facial edema (10% all Grades; 2.1% Grades 3-4) and new or worsening hypothyroidism *[see Warnings and Precautions (5.4)]*.

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cHL
Among the 210 patients with cHL enrolled in Study KEYNOTE-087 *[see Clinical Studies (14.4)]*, the median duration of exposure to KEYTRUDA was 8.4 months (range: 1 day to 15.2 months). KEYTRUDA was discontinued due to adverse reactions in 5% of patients, and treatment was interrupted due to adverse reactions in 26%. Fifteen percent (15%) of patients had an adverse reaction requiring systemic corticosteroid therapy. Serious adverse reactions occurred in 16% of patients. The most frequent serious adverse reactions (≥1%) included pneumonia, pneumonitis, pyrexia, dyspnea, graft versus host disease and herpes zoster. Two patients died from causes other than disease progression; one from GVHD after subsequent allogeneic HSCT and one from septic shock.

Table 9 summarizes the adverse reactions that occurred in at least 10% of patients treated with KEYTRUDA.

Table 9: Adverse Reactions in ≥10% of Patients with cHL in KEYNOTE-087

	KEYTRUDA 200 mg every 3 weeks N=210	
Adverse Reaction	All Grades* (%)	Grade 3 (%)
General Disorders and Administration Site Conditions		
Fatigue[†]	26	1.0
Pyrexia	24	1.0
Respiratory, Thoracic and Mediastinal Disorders		
Cough[‡]	24	0.5
Dyspnea[§]	11	1.0
Musculoskeletal and Connective Tissue Disorders		
Musculoskeletal pain[¶]	21	1.0
Arthralgia	10	0.5
Gastrointestinal Disorders		
Diarrhea[#]	20	1.4
Vomiting	15	0
Nausea	13	0
Skin and Subcutaneous Tissue Disorders		
Rash[Þ]	20	0.5
Pruritus	11	0
Endocrine Disorders		
Hypothyroidism	14	0.5
Infections and Infestations		
Upper respiratory tract infection	13	0
Nervous System Disorders		
Headache	11	0.5
Peripheral neuropathy[β]	10	0

* Graded per NCI CTCAE v4.0
† Includes fatigue, asthenia
‡ Includes cough, productive cough
§ Includes dyspnea, dyspnea exertional, wheezing
¶ Includes back pain, myalgia, bone pain, musculoskeletal pain, pain in extremity, musculoskeletal chest pain, musculoskeletal discomfort, neck pain
\# Includes diarrhea, gastroenteritis, colitis, enterocolitis
Þ Includes rash, rash maculo-papular, drug eruption, eczema, eczema asteatotic, dermatitis, dermatitis acneiform, dermatitis contact, rash erythematous, rash macular, rash papular, rash pruritic, seborrhoeic dermatitis, dermatitis psoriasiform
β Includes neuropathy peripheral, peripheral sensory neuropathy, hypoesthesia, paresthesia, dysesthesia, polyneuropathy

Other clinically important adverse reactions that occurred in less than 10% of patients on KEYNOTE-087 included infusion reactions (9%), hyperthyroidism (3%), pneumonitis (3%), uveitis and myositis (1% each), myelitis and myocarditis (0.5% each).

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Table 10: Selected Laboratory Abnormalities Worsened from Baseline Occurring in ≥15% of cHL Patients Receiving KEYTRUDA in KEYNOTE-087

	KEYTRUDA 200 mg every 3 weeks	
Laboratory Test*	All Grades† (%)	Grade 3-4 (%)
Chemistry		
Hypertransaminasemia‡	34%	2%
Alkaline phosphatase increased	17%	0%
Creatinine increased	15%	0.5%
Hematology		
Anemia	30%	6%
Thrombocytopenia	27%	4%
Neutropenia	24%	7%

* Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA (range: 208 to 209 patients)
† Graded per NCI CTCAE v4.0
‡ Includes elevation of AST or ALT

Hyperbilirubinemia occurred in less than 15% of patients on KEYNOTE-087 (10% all Grades, 2.4% Grade 3-4).

Urothelial Carcinoma

Cisplatin Ineligible Patients with Urothelial Carcinoma

The safety of KEYTRUDA was investigated in Study KEYNOTE-052, a single-arm trial that enrolled 370 patients with locally advanced or metastatic urothelial carcinoma who were not eligible for cisplatin-containing chemotherapy. Patients with autoimmune disease or medical conditions that required systemic corticosteroids or other immunosuppressive medications were ineligible. Patients received KEYTRUDA 200 mg every 3 weeks until unacceptable toxicity or either radiographic or clinical disease progression. The median duration of exposure to KEYTRUDA was 2.8 months (range: 1 day to 15.8 months).

The most common adverse reactions (reported in at least 20% of patients) were fatigue, musculoskeletal pain, decreased appetite, constipation, rash and diarrhea. KEYTRUDA was discontinued due to adverse reactions in 11% of patients. Eighteen patients (5%) died from causes other than disease progression. Five patients (1.4%) who were treated with KEYTRUDA experienced sepsis which led to death, and three patients (0.8%) experienced pneumonia which led to death. Adverse reactions leading to interruption of KEYTRUDA occurred in 22% of patients; the most common (≥1%) were liver enzyme increase, diarrhea, urinary tract infection, acute kidney injury, fatigue, joint pain, and pneumonia. Serious adverse reactions occurred in 42% of patients. The most frequent serious adverse reactions (≥2%) were urinary tract infection, hematuria, acute kidney injury, pneumonia, and urosepsis.

Immune-related adverse reactions that required systemic glucocorticoids occurred in 8% of patients, use of hormonal supplementation due to an immune-related adverse reaction occurred in 8% of patients, and 5% of patients required at least one steroid dose ≥ 40 mg oral prednisone equivalent.

Table 11 summarizes the incidence of adverse reactions occurring in at least 10% of patients receiving KEYTRUDA.

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Table 11: Adverse Reactions Occurring in ≥10% of Patients Receiving KEYTRUDA in KEYNOTE-052

	KEYTRUDA 200 mg every 3 weeks N=370	
Adverse Reaction	**All Grades*** (%)	**Grades 3 – 4** (%)
All Adverse Reactions	96	49
Blood and Lymphatic System Disorders		
Anemia	17	7
Gastrointestinal Disorders		
Constipation	21	1.1
Diarrhea†	20	2.4
Nausea	18	1.1
Abdominal pain‡	18	2.7
Elevated LFTs§	13	3.5
Vomiting	12	0
General Disorders and Administration Site Conditions		
Fatigue¶	38	6
Pyrexia	11	0.5
Weight decreased	10	0
Infections and Infestations		
Urinary tract infection	19	9
Metabolism and Nutrition Disorders		
Decreased appetite	22	1.6
Hyponatremia	10	4.1
Musculoskeletal and Connective Tissue Disorders		
Musculoskeletal pain#	24	4.9
Arthralgia	10	1.1
Renal and Urinary Disorders		
Blood creatinine increased	11	1.1
Hematuria	13	3.0
Respiratory, Thoracic, and Mediastinal Disorders		
Cough	14	0
Dyspnea	11	0.5
Skin and Subcutaneous Tissue Disorders		
Rash⊳	21	0.5
Pruritis	19	0.3
Edema peripheral	14	1.1

* Graded per NCI CTCAE v4.0
† Includes diarrhea, colitis, enterocolitis, gastroenteritis, frequent bowel movements
‡ Includes abdominal pain, pelvic pain, flank pain, abdominal pain lower, tumor pain, bladder pain, hepatic pain, suprapubic pain, abdominal discomfort, abdominal pain upper
§ Includes autoimmune hepatitis, hepatitis, hepatitis toxic, liver injury, transaminases increased, hyperbilirubinemia, blood bilirubin increased, alanine aminotransferase increased, aspartate aminotransferase increased, hepatic enzymes increased, liver function tests increased
¶ Includes fatigue, asthenia
\# Includes back pain, bone pain, musculoskeletal chest pain, musculoskeletal pain, myalgia, neck pain, pain in extremity, spinal pain
⊳ Includes dermatitis, dermatitis bullous, eczema, erythema, rash, rash macular, rash maculo-papular, rash pruritic, rash pustular, skin reaction, dermatitis acneform, seborrheic dermatitis, palmar-plantar erythrodysesthesia syndrome, rash generalized

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Previously Treated Urothelial Carcinoma

The safety of KEYTRUDA for the treatment of patients with locally advanced or metastatic urothelial carcinoma with disease progression following platinum-containing chemotherapy was investigated in Study KEYNOTE-045. KEYNOTE-045 was a multicenter, open-label, randomized (1:1), active-controlled trial in which 266 patients received KEYTRUDA 200 mg every 3 weeks or investigator's choice of chemotherapy (n=255), consisting of paclitaxel (n=84), docetaxel (n=84) or vinflunine (n=87) *[see Clinical Studies (14.5)]*. Patients with autoimmune disease or a medical condition that required systemic corticosteroids or other immunosuppressive medications were ineligible. The median duration of exposure was 3.5 months (range: 1 day to 20 months) in patients who received KEYTRUDA and 1.5 months (range: 1 day to 14 months) in patients who received chemotherapy.

KEYTRUDA was discontinued due to adverse reactions in 8% of patients. The most common adverse reaction resulting in permanent discontinuation of KEYTRUDA was pneumonitis (1.9%). Adverse reactions leading to interruption of KEYTRUDA occurred in 20% of patients; the most common (≥1%) were urinary tract infection (1.5%), diarrhea (1.5%), and colitis (1.1%). The most common adverse reactions (occurring in at least 20% of patients who received KEYTRUDA) were fatigue, musculoskeletal pain, pruritus, decreased appetite, nausea and rash. Serious adverse reactions occurred in 39% of KEYTRUDA-treated patients. The most frequent serious adverse reactions (≥2%) in KEYTRUDA-treated patients were urinary tract infection, pneumonia, anemia, and pneumonitis.

Table 12 summarizes the incidence of adverse reactions occurring in at least 10% of patients receiving KEYTRUDA. Table 13 summarizes the incidence of laboratory abnormalities that occurred in at least 20% of patients receiving KEYTRUDA.

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Table 12: Adverse Reactions Occurring in ≥10% of Patients Receiving KEYTRUDA in KEYNOTE-045

	KEYTRUDA 200 mg every 3 weeks n=266		Chemotherapy* n=255	
Adverse Reaction	**All Grades† (%)**	**Grade 3-4 (%)**	**All Grades† (%)**	**Grade 3-4 (%)**
Gastrointestinal Disorders				
Nausea	21	1.1	29	1.6
Constipation	19	1.1	32	3.1
Diarrhea‡	18	2.3	19	1.6
Vomiting	15	0.4	13	0.4
Abdominal pain	13	1.1	13	2.7
General Disorders and Administration Site Conditions				
Fatigue§	38	4.5	56	11
Pyrexia	14	0.8	13	1.2
Infections and Infestations				
Urinary tract infection	15	4.9	14	4.3
Metabolism and Nutrition Disorders				
Decreased appetite	21	3.8	21	1.2
Musculoskeletal and Connective Tissue Disorders				
Musculoskeletal pain¶	32	3.0	27	2.0
Renal and Urinary Disorders				
Hematuria#	12	2.3	8	1.6
Respiratory, Thoracic and Mediastinal Disorders				
Cough Þ	15	0.4	9	0
Dyspnea ß	14	1.9	12	1.2
Skin and Subcutaneous Tissue Disorders				
Pruritus	23	0	6	0.4
Rash à	20	0.4	13	0.4

* Chemotherapy: paclitaxel, docetaxel, or vinflunine
† Graded per NCI CTCAE v4.0
‡ Includes diarrhea, gastroenteritis, colitis, enterocolitis
§ Includes asthenia, fatigue, malaise lethargy
¶ Includes back pain, myalgia, bone pain, musculoskeletal pain, pain in extremity, musculoskeletal chest pain, musculoskeletal discomfort, neck pain
\# Includes blood urine present, hematuria, chromaturia
Þ Includes cough, productive cough
ß Includes dyspnea, dyspnea exertional, wheezing
à Includes rash maculo-papular, rash genital rash, rash erythematous, rash papular, rash pruritic, rash pustular, erythema, drug eruption, eczema, eczema asteatotic, dermatitis contact, dermatitis acneiform, dermatitis, seborrhoeic keratosis, lichenoid keratosis

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Table 13: Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of Urothelial Carcinoma Patients Receiving KEYTRUDA in KEYNOTE-045

	KEYTRUDA 200 mg every 3 weeks		Chemotherapy	
Laboratory Test*	**All Grades† %**	**Grades 3-4 %**	**All Grades† %**	**Grades 3-4 %**
Chemistry				
Glucose increased	52	8	60	7
Hemoglobin decreased	52	13	68	18
Lymphocytes decreased	45	15	53	25
Albumin decreased	43	1.7	50	3.8
Sodium decreased	37	9	47	13
Alkaline phosphatase increased	37	7	33	4.9
Creatinine increased	35	4.4	28	2.9
Phosphate decreased	29	8	34	14
Aspartate aminotransferase increased	28	4.1	20	2.5
Potassium increased	28	0.8	27	6
Calcium decreased	26	1.6	34	2.1

* Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA (range: 240 to 248 patients) and chemotherapy (range: 238 to 244 patients); phosphate decreased: KEYTRUDA n=232 and chemotherapy n=222.
† Graded per NCI CTCAE v4.0

6.2 Immunogenicity

As with all therapeutic proteins, there is the potential for immunogenicity. Trough levels of pembrolizumab interfere with the electrochemiluminescent (ECL) assay results; therefore, a subset analysis was performed in the patients with a concentration of pembrolizumab below the drug tolerance level of the anti-product antibody assay. In clinical studies in patients treated with pembrolizumab at a dose of 2 mg/kg every 3 weeks, 200 mg every 3 weeks, or 10 mg/kg every 2 or 3 weeks, 26 (2.0%) of 1289 evaluable patients tested positive for treatment-emergent anti-pembrolizumab antibodies. Among the 26 patients who tested positive for treatment emergent anti-pembrolizumab antibodies, only 4 patients were tested for neutralizing antibodies and one was positive. There was no evidence of an altered pharmacokinetic profile or increased infusion reactions with anti-pembrolizumab binding antibody development.

The detection of antibody formation is highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody (including neutralizing antibody) positivity in an assay may be influenced by several factors including assay methodology, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of incidence of antibodies to KEYTRUDA with the incidences of antibodies to other products may be misleading.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

Based on its mechanism of action, KEYTRUDA can cause fetal harm when administered to a pregnant woman. In animal models, the PD-1/PD-L1 signaling pathway is important in the maintenance of pregnancy through induction of maternal immune tolerance to fetal tissue *[see Data]*. Human IgG4 (immunoglobulins) are known to cross the placenta; therefore, pembrolizumab has the potential to be transmitted from the mother to the developing fetus. There are no available human data informing the risk of embryo-fetal toxicity. Apprise pregnant women of the potential risk to a fetus.

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.

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Data

Animal Data

Animal reproduction studies have not been conducted with KEYTRUDA to evaluate its effect on reproduction and fetal development, but an assessment of the effects on reproduction was provided. A central function of the PD-1/PD-L1 pathway is to preserve pregnancy by maintaining maternal immune tolerance to the fetus. Blockade of PD-L1 signaling has been shown in murine models of pregnancy to disrupt tolerance to the fetus and to result in an increase in fetal loss; therefore, potential risks of administering KEYTRUDA during pregnancy include increased rates of abortion or stillbirth. As reported in the literature, there were no malformations related to the blockade of PD-1 signaling in the offspring of these animals; however, immune-mediated disorders occurred in PD-1 knockout mice. Based on its mechanism of action, fetal exposure to pembrolizumab may increase the risk of developing immune-mediated disorders or of altering the normal immune response.

8.2 Lactation

Risk Summary

It is not known whether KEYTRUDA is excreted in human milk. No studies have been conducted to assess the impact of KEYTRUDA on milk production or its presence in breast milk. Because many drugs are excreted in human milk, instruct women to discontinue nursing during treatment with KEYTRUDA and for 4 months after the final dose.

8.3 Females and Males of Reproductive Potential

Contraception

Based on its mechanism of action, KEYTRUDA can cause fetal harm when administered to a pregnant woman *[see Warnings and Precautions (5.9) and Use in Specific Populations (8.1)].* Advise females of reproductive potential to use effective contraception during treatment with KEYTRUDA and for at least 4 months following the final dose.

8.4 Pediatric Use

There is limited experience with KEYTRUDA in pediatric patients. In a study, 40 pediatric patients (16 children ages 2 years to less than 12 years and 24 adolescents ages 12 years to 18 years) with advanced melanoma, lymphoma, or PD-L1 positive advanced, relapsed, or refractory solid tumors were administered KEYTRUDA 2 mg/kg every 3 weeks. Patients received KEYTRUDA for a median of 3 doses (range 1-17 doses), with 34 patients (85%) receiving KEYTRUDA for 2 doses or more. The concentrations of pembrolizumab in pediatric patients were comparable to those observed in adult patients at the same dose regimen of 2 mg/kg every 3 weeks.

The safety profile in these pediatric patients was similar to that seen in adults treated with pembrolizumab; toxicities that occurred at a higher rate (≥15% difference) in pediatric patients when compared to adults under 65 years of age were fatigue (45%), vomiting (38%), abdominal pain (28%), hypertransaminasemia (28%) and hyponatremia (18%).

Efficacy for pediatric patients with cHL or MSI-H cancers is extrapolated from the results in the respective adult populations *[see Clinical Studies (14.4, 14.5)].*

8.5 Geriatric Use

Of 3991 patients with melanoma, NSCLC, HNSCC, cHL or urothelial carcinoma who were treated with KEYTRUDA in clinical studies, 46% were 65 years and over and 16% were 75 years and over. No overall differences in safety or effectiveness were observed between elderly patients and younger patients.

10 OVERDOSAGE

There is no information on overdosage with KEYTRUDA.

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11 DESCRIPTION

Pembrolizumab is a humanized monoclonal antibody that blocks the interaction between PD-1 and its ligands, PD-L1 and PD-L2. Pembrolizumab is an IgG4 kappa immunoglobulin with an approximate molecular weight of 149 kDa.

KEYTRUDA for injection is a sterile, preservative-free, white to off-white lyophilized powder in single-dose vials. Each vial is reconstituted and diluted for intravenous infusion. Each 2 mL of reconstituted solution contains 50 mg of pembrolizumab and is formulated in L-histidine (3.1 mg), polysorbate 80 (0.4 mg), and sucrose (140 mg). May contain hydrochloric acid/sodium hydroxide to adjust pH to 5.5.

KEYTRUDA injection is a sterile, preservative-free, clear to slightly opalescent, colorless to slightly yellow solution that requires dilution for intravenous infusion. Each vial contains 100 mg of pembrolizumab in 4 mL of solution. Each 1 mL of solution contains 25 mg of pembrolizumab and is formulated in: L-histidine (1.55 mg), polysorbate 80 (0.2 mg), sucrose (70 mg), and Water for Injection, USP.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Binding of the PD-1 ligands, PD-L1 and PD-L2, to the PD-1 receptor found on T cells, inhibits T cell proliferation and cytokine production. Upregulation of PD-1 ligands occurs in some tumors and signaling through this pathway can contribute to inhibition of active T-cell immune surveillance of tumors. Pembrolizumab is a monoclonal antibody that binds to the PD-1 receptor and blocks its interaction with PD-L1 and PD-L2, releasing PD-1 pathway-mediated inhibition of the immune response, including the anti-tumor immune response. In syngeneic mouse tumor models, blocking PD-1 activity resulted in decreased tumor growth.

12.2 Pharmacodynamics

Based on dose/exposure efficacy and safety relationships, there are no clinically significant differences in efficacy and safety between pembrolizumab doses of 200 mg or 2 mg/kg every 3 weeks in patients with melanoma or NSCLC.

12.3 Pharmacokinetics

The pharmacokinetics (PK) of pembrolizumab was characterized using a population PK analysis with concentration data collected from 2841 patients with various cancers who received pembrolizumab doses of 1 to 10 mg/kg every 2 weeks or 2 to 10 mg/kg every 3 weeks. Pembrolizumab clearance (CV%) is approximately 21% lower [geometric mean, 196 mL/day (41%)] at steady state than that after the first dose [249 mL/day (38%)]; this decrease in clearance with time is not considered clinically important. The geometric mean value (CV%) for volume of distribution at steady state is 6.0 L (21%) and for terminal half-life ($t_{1/2}$) is 22 days (32%).

Steady-state concentrations of pembrolizumab were reached by 16 weeks of repeated dosing with an every 3-week regimen and the systemic accumulation was 2.2-fold. The peak concentration (C_{max}), trough concentration (C_{min}), and area under the plasma concentration versus time curve at steady state (AUC_{ss}) of pembrolizumab increased dose proportionally in the dose range of 2 to 10 mg/kg every 3 weeks.

Specific Populations: The following factors had no clinically important effect on the CL of pembrolizumab: age (range: 15 to 94 years), sex, race (94% White), renal impairment (eGFR greater than or equal to 15 mL/min/1.73 m^2), mild hepatic impairment (total bilirubin less than or equal to upper limit of normal (ULN) and AST greater than ULN or total bilirubin between 1 and 1.5 times ULN and any AST), or tumor burden. There is insufficient information to determine whether there are clinically important differences in the CL of pembrolizumab in patients with moderate or severe hepatic impairment. Pembrolizumab concentrations with weight-based dosing at 2 mg/kg every 3 weeks in pediatric patients (2 to 17 years) are comparable to those of adults at the same dose.

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13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

No studies have been performed to test the potential of pembrolizumab for carcinogenicity or genotoxicity.

Fertility studies have not been conducted with pembrolizumab. In 1-month and 6-month repeat-dose toxicology studies in monkeys, there were no notable effects in the male and female reproductive organs; however, most animals in these studies were not sexually mature.

13.2 Animal Toxicology and/or Pharmacology

In animal models, inhibition of PD-1 signaling resulted in an increased severity of some infections and enhanced inflammatory responses. M. tuberculosis-infected PD-1 knockout mice exhibit markedly decreased survival compared with wild-type controls, which correlated with increased bacterial proliferation and inflammatory responses in these animals. PD-1 knockout mice have also shown decreased survival following infection with lymphocytic choriomeningitis virus (LCMV). Administration of pembrolizumab in chimpanzees with naturally occurring chronic hepatitis B infection resulted in two out of four animals with significantly increased levels of serum ALT, AST, and GGT, which persisted for at least 1 month after discontinuation of pembrolizumab.

14 CLINICAL STUDIES

14.1 Melanoma

Ipilimumab-Naive Melanoma

The safety and efficacy of KEYTRUDA were evaluated in Study KEYNOTE-006 (NCT01866319), a randomized (1:1:1), open-label, multicenter, active-controlled trial. Patients were randomized to receive KEYTRUDA at a dose of 10 mg/kg every 2 weeks or 10mg/kg every 3 weeks as an intravenous infusion until disease progression or unacceptable toxicity or to ipilimumab 3 mg/kg every 3 weeks as an intravenous infusion for 4 doses unless discontinued earlier for disease progression or unacceptable toxicity. Patients with disease progression could receive additional doses of treatment unless disease progression was symptomatic, was rapidly progressive, required urgent intervention, occurred with a decline in performance status, or was confirmed at 4 to 6 weeks with repeat imaging. Randomization was stratified by line of therapy (0 vs. 1), ECOG PS (0 vs. 1), and PD-L1 expression (≥1% of tumor cells [positive] vs. <1% of tumor cells [negative]) according to an investigational use only (IUO) assay. Key eligibility criteria were unresectable or metastatic melanoma; no prior ipilimumab; and no more than one prior systemic treatment for metastatic melanoma. Patients with BRAF V600E mutation-positive melanoma were not required to have received prior BRAF inhibitor therapy. Patients with autoimmune disease; a medical condition that required immunosuppression; previous severe hypersensitivity to other monoclonal antibodies; and HIV, hepatitis B or hepatitis C infection, were ineligible. Assessment of tumor status was performed at 12 weeks, then every 6 weeks through Week 48, followed by every 12 weeks thereafter. The major efficacy outcome measures were overall survival (OS) and progression-free survival (PFS; as assessed by blinded independent central review (BICR) using Response Evaluation Criteria in Solid Tumors [RECIST v1.1]). Additional efficacy outcome measures were overall response rate (ORR) and response duration.

A total of 834 patients were randomized: 277 patients to the KEYTRUDA 10 mg/kg every 3 weeks arm, 279 to the KEYTRUDA 10 mg/kg every 2 weeks arm, and 278 to the ipilimumab arm. The study population characteristics were: median age of 62 years (range: 18 to 89 years), 60% male, 98% White, 66% had no prior systemic therapy for metastatic disease , 69% ECOG PS of 0, 80% had PD-L1 positive melanoma, 18% had PD-L1 negative melanoma, and 2% had unknown PD-L1 status using the IUO assay, 65% had M1c stage disease, 68% with normal LDH, 36% with reported BRAF mutation-positive melanoma, and 9% with a history of brain metastases. Among patients with BRAF mutation-positive melanoma, 139 (46%) were previously treated with a BRAF inhibitor.

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The study demonstrated statistically significant improvements in OS and PFS for patients randomized to KEYTRUDA as compared to ipilimumab (Table 14 and Figure 1).

Table 14: Efficacy Results in KEYNOTE-006

	KEYTRUDA 10 mg/kg every 3 weeks n=277	KEYTRUDA 10 mg/kg every 2 weeks n=279	Ipilimumab 3 mg/kg every 3 weeks n=278
OS			
Deaths (%)	92 (33%)	85 (30%)	112 (40%)
Hazard ratio* (95% CI)	0.69 (0.52, 0.90)	0.63 (0.47, 0.83)	---
p-Value (stratified log-rank)	0.004	<0.001	---
PFS by BICR			
Events (%)	157 (57%)	157 (56%)	188 (68%)
Median in months (95% CI)	4.1 (2.9, 6.9)	5.5 (3.4, 6.9)	2.8 (2.8, 2.9)
Hazard ratio* (95% CI)	0.58 (0.47, 0.72)	0.58 (0.46, 0.72)	---
p-Value (stratified log-rank)	<0.001	<0.001	---
Best overall response by BICR			
ORR (95% CI)	33% (27, 39)	34% (28, 40)	12% (8, 16)
Complete response rate	6%	5%	1%
Partial response rate	27%	29%	10%

* Hazard ratio (KEYTRUDA compared to ipilimumab) based on the stratified Cox proportional hazard model

Among the 91 patients randomized to KEYTRUDA 10 mg/kg every 3 weeks with an objective response, response durations ranged from 1.4+ to 8.1+ months. Among the 94 patients randomized to KEYTRUDA 10 mg/kg every 2 weeks with an objective response, response durations ranged from 1.4+ to 8.2 months.

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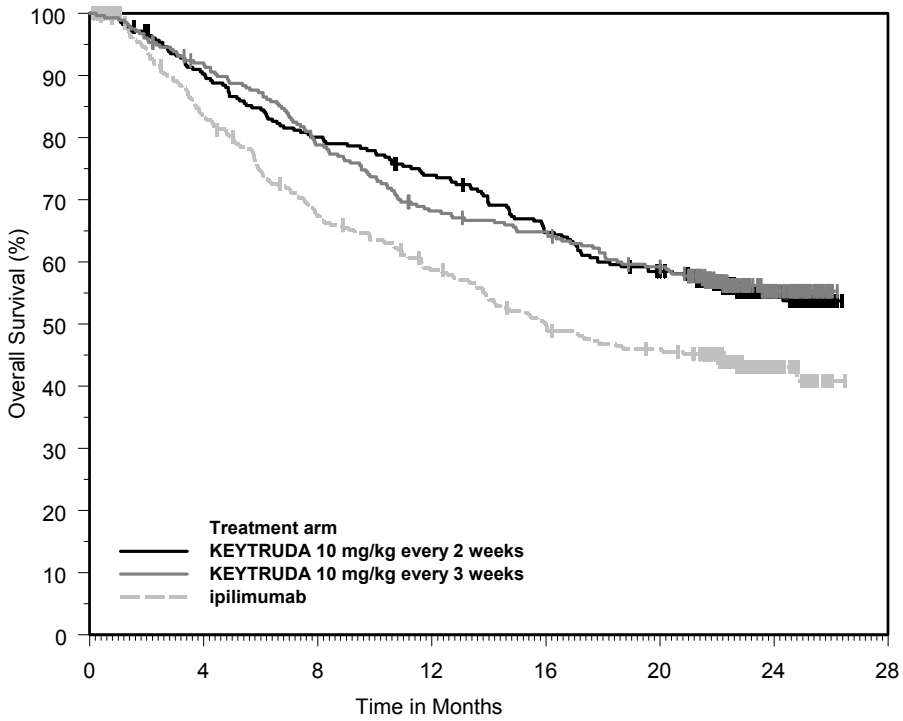
Figure 1: Kaplan-Meier Curve for Overall Survival in KEYNOTE-006*



Number at Risk								
KEYTRUDA 10 mg/kg every 2 weeks:	279	249	221	202	176	156	44	0
KEYTRUDA 10 mg/kg every 3 weeks:	277	251	215	184	174	156	43	0
ipilimumab:	278	213	170	145	122	110	28	0

**based on the final analysis with an additional follow-up of 9 months (total of 383 deaths as pre-specified in the protocol)*

Ipilimumab-Refractory Melanoma

The safety and efficacy of KEYTRUDA were evaluated in Study KEYNOTE-002 (NCT01704287), a multicenter, randomized (1:1:1), active-controlled trial. Patients were randomized to receive one of two doses of KEYTRUDA in a blinded fashion or investigator's choice chemotherapy. The treatment arms consisted of KEYTRUDA 2 mg/kg or 10 mg/kg intravenously every 3 weeks or investigator's choice of any of the following chemotherapy regimens: dacarbazine 1000 mg/m^2 intravenously every 3 weeks (26%), temozolomide 200 mg/m^2 orally once daily for 5 days every 28 days (25%), carboplatin AUC 6 intravenously plus paclitaxel 225 mg/m^2 intravenously every 3 weeks for four cycles then carboplatin AUC of 5 plus paclitaxel 175 mg/m^2 every 3 weeks (25%), paclitaxel 175 mg/m^2 intravenously every 3 weeks (16%), or carboplatin AUC 5 or 6 intravenously every 3 weeks (8%). Randomization was stratified by ECOG performance status (0 vs. 1), LDH levels (normal vs. elevated [≥110% ULN]) and BRAF V600 mutation status (wild-type [WT] or V600E). The trial included patients with unresectable or metastatic melanoma with progression of disease; refractory to two or more doses of ipilimumab (3 mg/kg or higher) and, if BRAF V600 mutation-positive, a BRAF or MEK inhibitor; and disease progression within 24 weeks following the last dose of ipilimumab. The trial excluded patients with uveal melanoma and active brain metastasis. Patients received KEYTRUDA until unacceptable toxicity; disease progression that was symptomatic, was rapidly progressive, required urgent intervention, occurred with a decline in performance status, or was confirmed at 4 to 6 weeks with repeat imaging; withdrawal of consent; or physician's decision to stop therapy for the patient. Assessment of tumor status was performed at 12 weeks after randomization, then every 6 weeks through week 48, followed by every 12 weeks thereafter. Patients on chemotherapy who experienced progression of disease were offered KEYTRUDA. The major efficacy outcomes were progression-free survival (PFS) as assessed by BICR per RECIST

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v1.1 and overall survival (OS). Additional efficacy outcome measures were confirmed overall response rate (ORR) as assessed by BICR per RECIST v1.1 and duration of response.

The treatment arms consisted of KEYTRUDA 2 mg/kg (n=180) or 10 mg/kg (n=181) every 3 weeks or investigator's choice chemotherapy (n=179). Among the 540 randomized patients, the median age was 62 years (range: 15 to 89 years), with 43% age 65 or older; 61% male; 98% White; and ECOG performance score was 0 (55%) and 1 (45%). Twenty-three percent of patients were BRAF V600 mutation positive, 40% had elevated LDH at baseline, 82% had M1c disease, and 73% had two or more prior therapies for advanced or metastatic disease.

The study demonstrated a statistically significant improvement in PFS for patients randomized to KEYTRUDA as compared to control arm (Table 15). There was no statistically significant difference between KEYTRUDA 2 mg/kg and chemotherapy or between KEYTRUDA 10 mg/kg and chemotherapy in the OS analysis in which 55% of the patients who had been randomized to receive chemotherapy had crossed over to receive KEYTRUDA.

Table 15: Efficacy Results in KEYNOTE-002

	KEYTRUDA 2 mg/kg every 3 weeks n=180	**KEYTRUDA 10 mg/kg every 3 weeks n=181**	**Chemotherapy n=179**
Progression-Free Survival			
Number of Events, n (%)	129 (72%)	126 (70%)	155 (87%)
Progression, n (%)	105 (58%)	107 (59%)	134 (75%)
Death, n (%)	24 (13%)	19 (10%)	21 (12%)
Median in months (95% CI)	2.9 (2.8, 3.8)	2.9 (2.8, 4.7)	2.7 (2.5, 2.8)
P Value (stratified log-rank)	<0.001	<0.001	---
Hazard ratio* (95% CI)	0.57 (0.45, 0.73)	0.50 (0.39, 0.64)	---
Overall Survival†			
Deaths (%)	123 (68%)	117 (65%)	128 (72%)
Hazard ratio* (95% CI)	0.86 (0.67, 1.10)	0.74 (0.57, 0.96)	---
p-Value (stratified log-rank)	0.117	0.011‡	---
Median in months (95% CI)	13.4 (11.0, 16.4)	14.7 (11.3, 19.5)	11.0 (8.9, 13.8)
Objective Response Rate			
ORR (95% CI)	21% (15, 28)	25% (19, 32)	4% (2, 9)
Complete response rate	2%	3%	0%
Partial response rate	19%	23%	4%

* Hazard ratio (KEYTRUDA compared to chemotherapy) based on the stratified Cox proportional hazard model
† With additional follow-up of 18 months after the PFS analysis
‡ Not statistically significant compared to multiplicity adjusted significance level of 0.01

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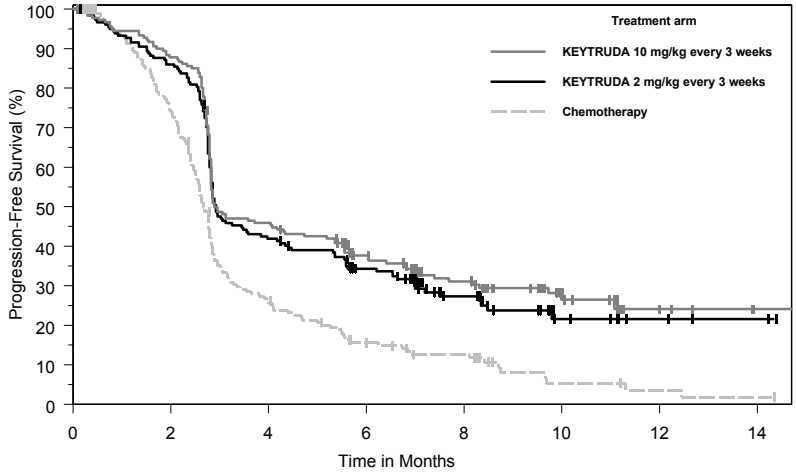
Figure 2: Kaplan-Meier Curve for Progression-Free Survival in KEYNOTE-002



Number at Risk								
KEYTRUDA 10 mg/kg:	181	158	82	55	39	15	5	1
KEYTRUDA 2 mg/kg:	180	153	74	53	26	9	4	2
Chemotherapy:	179	128	43	22	15	4	2	1

Among the 38 patients randomized to KEYTRUDA 2 mg/kg with an objective response, response durations ranged from 1.3+ to 11.5+ months. Among the 46 patients randomized to KEYTRUDA 10 mg/kg with an objective response, response durations ranged from 1.1+ to 11.1+ months.

14.2 Non-Small Cell Lung Cancer

First-line treatment of metastatic NSCLC as a single agent

Study KEYNOTE-024 (NCT02142738) was a randomized, multicenter, open-label, active-controlled trial in patients with metastatic NSCLC, whose tumors had high PD-L1 expression [tumor proportion score (TPS) of 50% or greater] by an immunohistochemistry assay using the PD-L1 IHC 22C3 pharmDx Kit, and had not received prior systemic treatment for metastatic NSCLC. Patients with EGFR or ALK genomic tumor aberrations; autoimmune disease that required systemic therapy within 2 years of treatment; a medical condition that required immunosuppression; or who had received more than 30 Gy of radiation in the thoracic region within the prior 26 weeks of initiation of study were ineligible. Randomization was stratified by ECOG performance status (0 vs. 1), histology (squamous vs. nonsquamous), and geographic region (East Asia vs. non-East Asia). Patients were randomized (1:1) to receive KEYTRUDA 200 mg intravenously every 3 weeks or investigator's choice of any of the following platinum-containing chemotherapy regimens:

- Pemetrexed 500 mg/m^2 every 3 weeks and carboplatin AUC 5 to 6 mg/mL/min every 3 weeks on Day 1 for 4 to 6 cycles followed by optional pemetrexed 500 mg/m^2 every 3 weeks for patients with nonsquamous histologies;
- Pemetrexed 500 mg/m^2 every 3 weeks and cisplatin 75 mg/m^2 every 3 weeks on Day 1 for 4 to 6 cycles followed by optional pemetrexed 500 mg/m^2 every 3 weeks for patients with nonsquamous histologies;
- Gemcitabine 1250 mg/m^2 on days 1 and 8 and cisplatin 75 mg/m^2 every 3 weeks on Day 1 for 4 to 6 cycles;
- Gemcitabine 1250 mg/m^2 on Days 1 and 8 and carboplatin AUC 5 to 6 mg/mL/min every 3 weeks on Day 1 for 4 to 6 cycles;
- Paclitaxel 200 mg/m^2 every 3 weeks and carboplatin AUC 5 to 6 mg/mL/min every 3 weeks on Day 1 for 4 to 6 cycles followed by optional pemetrexed maintenance (for nonsquamous histologies).

Treatment with KEYTRUDA continued until RECIST 1.1-defined progression of disease as determined by an independent radiology committee, unacceptable toxicity, or for up to 24 months. Treatment could continue beyond disease progression if the patient was clinically stable and was considered to be deriving

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clinical benefit by the investigator. Patients randomized to chemotherapy were offered KEYTRUDA at the time of disease progression.

Assessment of tumor status was performed every 9 weeks. The main efficacy outcome measure was PFS as assessed by a blinded independent central radiologists' (BICR) review according to RECIST 1.1. Additional efficacy outcome measures were OS and ORR as assessed by the BICR according to RECIST 1.1.

A total of 305 patients were randomized: 154 patients to the KEYTRUDA arm and 151 to the chemotherapy arm. The study population characteristics were: median age of 65 years (range: 33 to 90), 54% age 65 or older; 61% male; 82% white and 15% Asian; 65% ECOG performance status of 1; 18% with squamous and 82% with nonsquamous histology and 9% with history of brain metastases. A total of 66 patients in the chemotherapy arm received KEYTRUDA at the time of disease progression.

The trial demonstrated a statistically significant improvement in PFS for patients randomized to KEYTRUDA as compared with chemotherapy. Additionally, a pre-specified interim OS analysis at 108 events (64% of the events needed for final analysis) also demonstrated statistically significant improvement of OS for patients randomized to KEYTRUDA as compared with chemotherapy. Table 16 summarizes key efficacy measures for KEYNOTE-024.

Table 16: Efficacy Results in KEYNOTE-024

Endpoint	**KEYTRUDA 200 mg every 3 weeks n=154**	**Chemotherapy n=151**
PFS		
Number (%) of patients with event	73 (47%)	116 (77%)
Median in months (95% CI)	10.3 (6.7, NR)	6.0 (4.2, 6.2)
Hazard ratio* (95% CI)	0.50 (0.37, 0.68)	
p-Value (stratified log-rank)	<0.001	
OS		
Number (%) of patients with event	44 (29%)	64 (42%)
Median in months (95% CI)	NR (NR, NR)	NR (9.4, NR)
Hazard ratio* (95% CI)	0.60 (0.41, 0.89)	
p-Value (stratified log-rank)	0.005†	
Objective Response Rate		
ORR (95% CI)	45% (37, 53)	28% (21, 36)
Complete response rate	4%	1%
Partial response rate	41%	27%
p-Value (Miettinen-Nurminen)	0.001	
Median duration of response in months (range)	NR (1.9+, 14.5+)	6.3 (2.1+, 12.6+)

* Based on the stratified Cox proportional hazard model
† P-value is compared with 0.0118 of the allocated alpha for this interim analysis.
NR = not reached

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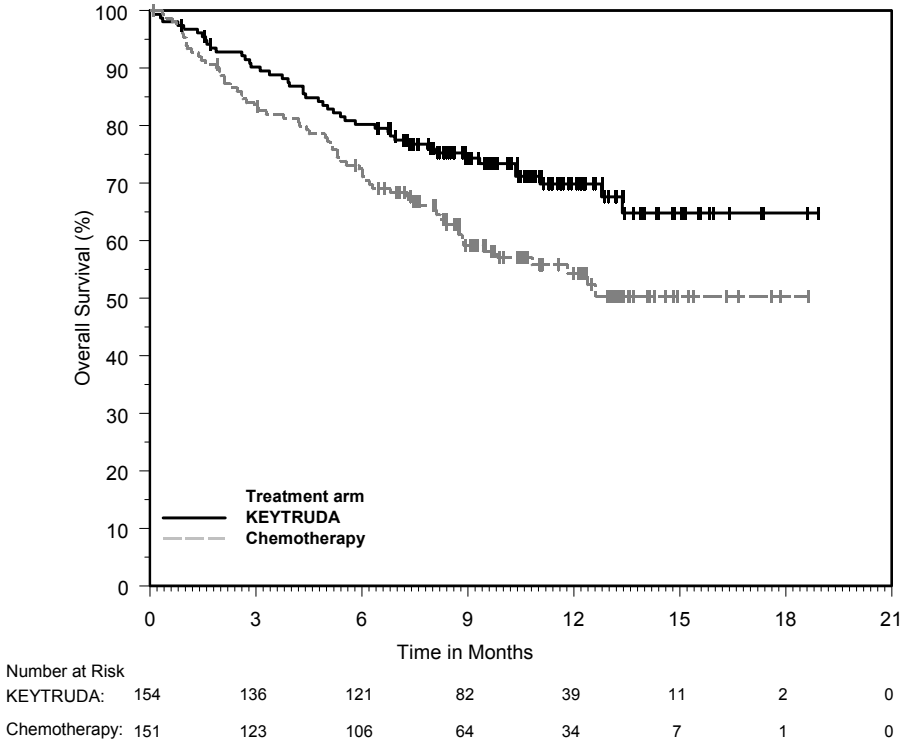
Figure 3: Kaplan-Meier Curve for Overall Survival in KEYNOTE-024



First-line treatment of metastatic nonsquamous NSCLC in combination with pemetrexed and carboplatin
The efficacy of KEYTRUDA was investigated in patients enrolled in an open-label, multicenter, multi-cohort study, Study KEYNOTE-021 (NCT02039674); the efficacy data are limited to patients with metastatic nonsquamous NSCLC randomized within a single cohort (Cohort G1). The key eligibility criteria for this cohort were locally advanced or metastatic nonsquamous NSCLC, regardless of tumor PD-L1 expression status, and no prior systemic treatment for metastatic disease. Patients with autoimmune disease that required systemic therapy within 2 years of treatment; a medical condition that required immunosuppression; or who had received more than 30 Gy of thoracic radiation within the prior 26 weeks were ineligible. Randomization was stratified by PD-L1 tumor expression (TPS <1% vs. TPS ≥1%). Patients were randomized (1:1) to one of the following treatment arms:

- KEYTRUDA 200 mg, pemetrexed 500 mg/m^2, and carboplatin AUC 5 mg/mL/min intravenously on Day 1 of each 21-day cycle for 4 cycles followed by KEYTRUDA 200 mg intravenously every 3 weeks. KEYTRUDA was administered prior to chemotherapy on Day 1.
- Pemetrexed 500 mg/m^2 and carboplatin AUC 5 mg/mL/min intravenously on Day 1 of each 21-day cycle for 4 cycles.

At the investigator's discretion, maintenance pemetrexed 500 mg/m^2 every 3 weeks was permitted in both treatment arms.

Treatment with KEYTRUDA continued until RECIST 1.1-defined progression of disease as determined by blinded independent central review (BICR), unacceptable toxicity, or a maximum of 24 months. Administration of KEYTRUDA was permitted beyond RECIST-defined disease progression if the patient was clinically stable and deriving clinical benefit as determined by the investigator.

Patients on chemotherapy were offered KEYTRUDA as a single agent at the time of disease progression.

Assessment of tumor status was performed every 6 weeks through Week 18 and every 9 weeks thereafter. The major efficacy outcome measure was objective response rate (ORR) as assessed by

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BICR using RECIST 1.1. Additional efficacy outcome measures were progression-free survival (PFS) as assessed by BICR using RECIST 1.1, duration of response, and overall survival (OS).

A total of 123 patients were randomized: 60 patients to the KEYTRUDA and chemotherapy arm and 63 to the chemotherapy arm. The study population characteristics were: median age of 64 years (range: 37 to 80); 48% age 65 or older; 39% male; 87% White and 8% Asian; ECOG performance status of 0 (41%) and 1 (56%); 97% had metastatic disease; and 12% had brain metastases. Thirty-six percent had tumor PD-L1 expression TPS <1%; no patients had sensitizing EGFR or ALK genomic aberrations. A total of 20 (32%) patients in the chemotherapy arm received KEYTRUDA at the time of disease progression and 12 (19%) additional patients received a checkpoint inhibitor as subsequent therapy.

In Cohort G1 of KEYNOTE-021, there was a statistically significant improvement in ORR in patients randomized to KEYTRUDA in combination with pemetrexed and carboplatin compared with pemetrexed and carboplatin alone (see Table 17).

Table 17: Efficacy Results in Cohort G1 of KEYNOTE-021

Endpoint	KEYTRUDA Pemetrexed Carboplatin n=60	Pemetrexed Carboplatin n=63
Overall Response Rate		
Overall Response Rate	55%	29%
(95% CI)	(42, 68)	(18, 41)
Complete Response	0%	0%
Partial Response	55%	29%
p-value*	0.0032	
Duration of Response		
% with duration ≥ 6 months†	93%	81%
Range (months)	1.4+ to 13.0+	1.4+ to 15.2+
PFS		
Number of events (%)	23 (38%)	33 (52%)
Progressive Disease	15 (25%)	27 (43%)
Death	8 (13%)	6 (10%)
Median in months (95% CI)	13.0 (8.3, NE)	8.9 (4.4, 10.3)
Hazard ratio‡ (95% CI)	0.53 (0.31, 0.91)	
p-value§	0.0205	

* Based on Miettinen-Nurminen method stratified by PD-L1 status (TPS <1% vs. TPS ≥1%).
† Based on Kaplan-Meier estimation
‡ Based on the Cox proportional hazard model stratified by PD-L1 status (TPS <1% vs. TPS ≥1%).
§ Based on the log-rank test stratified by PD-L1 status (TPS <1% vs. TPS ≥1%).
NE = not estimable

Exploratory analyses for ORR were conducted in subgroups defined by the stratification variable, PD-L1 tumor expression (TPS <1% and TPS ≥1%). In the TPS <1% subgroup, the ORR was 57% in the KEYTRUDA-containing arm and 13.0% in the chemotherapy arm. In the TPS ≥1% subgroup, the ORR was 54% in the KEYTRUDA-containing arm and 38% in the chemotherapy arm.

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Previously treated NSCLC
The efficacy of KEYTRUDA was investigated in Study KEYNOTE-010 (NCT01905657), a randomized, multicenter, open-label, active-controlled trial conducted in patients with metastatic NSCLC that had progressed following platinum-containing chemotherapy, and if appropriate, targeted therapy for EGFR or ALK genomic tumor aberrations. Eligible patients had PD-L1 expression TPS of 1% or greater by an immunohistochemistry assay using the PD-L1 IHC 22C3 pharmDx Kit. Patients with autoimmune disease; a medical condition that required immunosuppression; or who had received more than 30 Gy of thoracic radiation within the prior 26 weeks were ineligible. Randomization was stratified by tumor PD-L1 expression (PD-L1 expression TPS ≥50% vs. PD-L1 expression TPS=1-49%), ECOG performance scale (0 vs. 1), and geographic region (East Asia vs. non-East Asia). Patients were randomized (1:1:1) to receive KEYTRUDA 2 mg/kg intravenously every 3 weeks, KEYTRUDA 10 mg/kg intravenously every 3 weeks or docetaxel intravenously 75 mg/m^2 every 3 weeks until unacceptable toxicity or disease progression. Patients randomized to KEYTRUDA were permitted to continue until disease progression that was symptomatic, rapidly progressive, required urgent intervention, occurred with a decline in performance status, or confirmation of progression at 4 to 6 weeks with repeat imaging or for up to 24 months without disease progression.

Assessment of tumor status was performed every 9 weeks. The main efficacy outcome measures were OS and PFS as assessed by the BICR according to RECIST 1.1 in the subgroup of patients with TPS ≥50% and the overall population with TPS ≥1%. Additional efficacy outcome measures were ORR and response duration in the subgroup of patients with TPS ≥50% and the overall population with TPS ≥1%.

A total of 1033 patients were randomized: 344 to the KEYTRUDA 2 mg/kg arm, 346 patients to the KEYTRUDA 10 mg/kg arm, and 343 patients to the docetaxel arm. The study population characteristics were: median age 63 years (range: 20 to 88), 42% age 65 or older; 61% male; 72% White and 21% Asian; 66% ECOG performance status 1; 43% with high PD-L1 tumor expression; 21% with squamous, 70% with nonsquamous, and 8% with mixed, other or unknown histology; 91% metastatic (M1) disease; 15% with history of brain metastases; and 8% and 1% with EGFR and ALK genomic aberrations, respectively. All patients had received prior therapy with a platinum-doublet regimen, 29% received two or more prior therapies for their metastatic disease.

Tables 18 and 19 summarize key efficacy measures in the subgroup with TPS ≥50% population and in all patients, respectively. The Kaplan-Meier curve for OS (TPS ≥1%) is shown in Figure 4.

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Table 18: Efficacy Results of the Subgroup of Patients with TPS ≥50% in KEYNOTE-010

Endpoint	KEYTRUDA 2 mg/kg every 3 weeks n=139	KEYTRUDA 10 mg/kg every 3 weeks n=151	Docetaxel 75 mg/m^2 every 3 weeks n=152
OS			
Deaths (%)	58 (42%)	60 (40%)	86 (57%)
Median in months (95% CI)	14.9 (10.4, NR)	17.3 (11.8, NR)	8.2 (6.4, 10.7)
Hazard ratio* (95% CI)	0.54 (0.38, 0.77)	0.50 (0.36, 0.70)	---
p-Value (stratified log-rank)	<0.001	<0.001	---
PFS			
Events (%)	89 (64%)	97 (64%)	118 (78%)
Median in months (95% CI)	5.2 (4.0, 6.5)	5.2 (4.1, 8.1)	4.1 (3.6, 4.3)
Hazard ratio* (95% CI)	0.58 (0.43, 0.77)	0.59 (0.45, 0.78)	---
p-Value (stratified log-rank)	<0.001	<0.001	---
Objective response rate			
ORR† (95% CI)	30% (23, 39)	29% (22, 37)	8% (4, 13)
p-Value (Miettinen-Nurminen)	<0.001	<0.001	---
Median duration of response in months (range)	NR (0.7+, 16.8+)	NR (2.1+, 17.8+)	8.1 (2.1+, 8.8+)

* Hazard ratio (KEYTRUDA compared to docetaxel) based on the stratified Cox proportional hazard model
† All responses were partial responses
NR = not reached

Table 19: Efficacy Results of All Randomized Patients (TPS ≥1%) in KEYNOTE-010

Endpoint	KEYTRUDA 2 mg/kg every 3 weeks n=344	KEYTRUDA 10 mg/kg every 3 weeks n=346	Docetaxel 75 mg/m^2 every 3 weeks n=343
OS			
Deaths (%)	172 (50%)	156 (45%)	193 (56%)
Median in months (95% CI)	10.4 (9.4, 11.9)	12.7 (10.0, 17.3)	8.5 (7.5, 9.8)
Hazard ratio* (95% CI)	0.71 (0.58, 0.88)	0.61 (0.49, 0.75)	---
p-Value (stratified log-rank)	<0.001	<0.001	---
PFS			
Events (%)	266 (77%)	255 (74%)	257 (75%)
Median in months (95% CI)	3.9 (3.1, 4.1)	4.0 (2.6, 4.3)	4.0 (3.1, 4.2)
Hazard ratio* (95% CI)	0.88 (0.73, 1.04)	0.79 (0.66, 0.94)	---
p-Value (stratified log-rank)	0.068	0.005	---
Objective response rate			
ORR† (95% CI)	18% (14, 23)	19% (15, 23)	9% (7, 13)
p-Value (Miettinen-Nurminen)	<0.001	<0.001	---
Median duration of response in months (range)	NR (0.7+, 20.1+)	NR (2.1+, 17.8+)	6.2 (1.4+, 8.8+)

* Hazard ratio (KEYTRUDA compared to docetaxel) based on the stratified Cox proportional hazard model
† All responses were partial responses
NR = not reached

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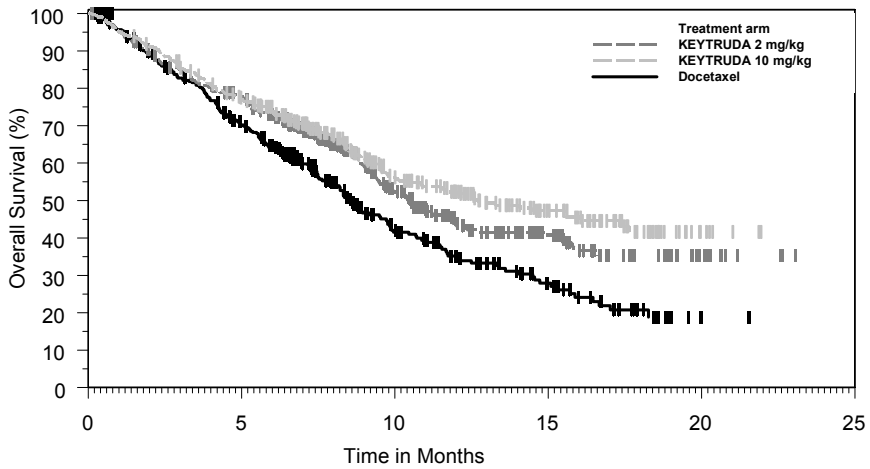
Figure 4: Kaplan-Meier Curve for Overall Survival in all Randomized Patients in KEYNOTE-010 (TPS ≥1%)



Number at Risk						
KEYTRUDA 2 mg/kg:	344	259	115	49	12	0
KEYTRUDA 10 mg/kg:	346	255	124	56	6	0
Docetaxel:	343	212	79	33	1	0

14.3 Head and Neck Cancer

The efficacy of KEYTRUDA was investigated in Study KEYNOTE-012 (NCT01848834), a multicenter, non-randomized, open-label, multi-cohort study that enrolled 174 patients with recurrent or metastatic HNSCC who had disease progression on or after platinum-containing chemotherapy administered for recurrent or metastatic HNSCC or following platinum-containing chemotherapy administered as part of induction, concurrent, or adjuvant therapy. Patients with active autoimmune disease, a medical condition that required immunosuppression, evidence of interstitial lung disease, or ECOG PS ≥2 were ineligible.

Patients received KEYTRUDA 10 mg/kg every 2 weeks (n=53) or 200 mg every 3 weeks (n=121) until unacceptable toxicity or disease progression that was symptomatic, was rapidly progressive, required urgent intervention, occurred with a decline in performance status, or was confirmed at least 4 weeks later with repeat imaging. Patients without disease progression were treated for up to 24 months. Treatment with pembrolizumab could be reinitiated for subsequent disease progression and administered for up to 1 additional year. Assessment of tumor status was performed every 8 weeks. The major efficacy outcome measures were ORR according to RECIST 1.1, as assessed by blinded independent central review, and duration of response.

Among the 174 patients, the baseline characteristics were median age 60 years (32% age 65 or older); 82% male; 75% White, 16% Asian, and 6% Black; 87% had M1 disease; 33% had HPV positive tumors; 63% had prior cetuximab; 29% had an ECOG PS of 0 and 71% had an ECOG PS of 1; and the median number of prior lines of therapy administered for the treatment of HNSCC was 2.

The ORR was 16% (95% CI: 11, 22) with a complete response rate of 5%. The median follow-up time was 8.9 months. Among the 28 responding patients, the median duration of response had not been reached (range 2.4+ to 27.7+ months), with 23 patients having responses of 6 months or longer. The ORR and duration of response were similar irrespective of dosage regimen (10 mg/kg every 2 weeks or 200 mg every 3 weeks) or HPV status.

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14.4 Classical Hodgkin Lymphoma

The efficacy of KEYTRUDA was investigated in 210 patients with relapsed or refractory cHL, enrolled in a multicenter, non-randomized, open-label study (KEYNOTE-087; NCT02453594). Patients with active, non-infectious pneumonitis, an allogeneic HSCT within the past 5 years (or greater than 5 years but with symptoms of GVHD), active autoimmune disease, a medical condition that required immunosuppression, or an active infection requiring systemic therapy were ineligible for the trial. Patients received KEYTRUDA at a dose of 200 mg every 3 weeks until unacceptable toxicity or documented disease progression, or for up to 24 months in patients that did not progress. Disease assessment was performed every 12 weeks. The major efficacy outcome measures (ORR, CRR, and duration of response) were assessed by blinded independent central review according to the 2007 revised International Working Group (IWG) criteria.

Among the 210 patients, the baseline characteristics were: median age of 35 years (range: 18 to 76), 9% age 65 or older; 54% male; 88% White; 49% had an ECOG performance status (PS) of 0 and 51% had an ECOG PS of 1. The median number of prior lines of therapy administered for the treatment of cHL was 4 (range 1 to 12). Fifty-eight percent were refractory to the last prior therapy, including 35% with primary refractory disease and 14% whose disease was chemo-refractory to all prior regimens. Sixty-one percent of patients had undergone prior auto-HSCT, 83% had received prior brentuximab vedotin and 36% of patients had prior radiation therapy.

Efficacy results for KEYNOTE-087 are summarized in Table 20.

Table 20: Efficacy Results in KEYNOTE-087

	KEYNOTE-087*
Endpoint	N=210
Overall Response Rate	
ORR %, (95% CI)	69% (62, 75)
Complete Remission	22%
Partial Remission	47%
Response Duration	
Median in months (range)	11.1 (0.0+, 11.1)†

* Median follow-up time of 9.4 months
† Based on patients (n=145) with a response by independent review

14.5 Urothelial Carcinoma

Cisplatin Ineligible Patients with Urothelial Carcinoma

The efficacy of KEYTRUDA was investigated in Study KEYNOTE-052 (NCT02335424), a multicenter, open-label, single-arm trial in 370 patients with locally advanced or metastatic urothelial carcinoma who were not eligible for cisplatin-containing chemotherapy. The trial excluded patients with autoimmune disease or a medical condition that required immunosuppression.

Patients received KEYTRUDA 200 mg every 3 weeks until unacceptable toxicity or disease progression. Patients with initial radiographic disease progression could receive additional doses of treatment during confirmation of progression unless disease progression was symptomatic, was rapidly progressive, required urgent intervention, or occurred with a decline in performance status. Patients without disease progression could be treated for up to 24 months. Tumor response assessments were performed at 9 weeks after the first dose, then every 6 weeks for the first year, and then every 12 weeks thereafter. The major efficacy outcome measures were ORR according to RECIST 1.1 as assessed by independent radiology review and duration of response.

In this trial, the median age was 74 years, 77% were male, and 89% were White. Eighty-seven percent had M1 disease, and 13% had M0 disease. Eighty-one percent had a primary tumor in the lower tract, and 19% of patients had a primary tumor in the upper tract. Eighty-five percent of patients had visceral metastases, including 21% with liver metastases. Reasons for cisplatin ineligibility included: 50% with baseline creatinine clearance of <60 mL/min, 32% with ECOG performance status of 2, 9% with ECOG 2

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and baseline creatinine clearance of <60 mL/min, and 9% with other reasons (Class III heart failure, Grade 2 or greater peripheral neuropathy, and Grade 2 or greater hearing loss). Ninety percent of patients were treatment naïve, and 10% received prior adjuvant or neoadjuvant platinum-based chemotherapy.

The median follow-up time for 370 patients treated with KEYTRUDA was 7.8 months (range 0.1 to 20 months). Efficacy results are summarized in Table 21.

Table 21: Efficacy Results in KEYNOTE-052

Endpoint	KEYTRUDA 200 mg every 3 weeks n=370
Objective Response Rate	
ORR (95% CI)	29% (24, 34)
Complete Response Rate	7%
Partial Response Rate	22%
Duration of Response	
Median in months (range)	NR (1.4+, 17.8+)

\+ Denotes ongoing
NR = not reached

Previously Treated Urothelial Carcinoma
The efficacy of KEYTRUDA was evaluated in Study KEYNOTE-045 (NCT02256436), a multicenter, randomized (1:1), active-controlled trial in patients with locally advanced or metastatic urothelial carcinoma with disease progression on or after platinum-containing chemotherapy. The trial excluded patients with autoimmune disease or a medical condition that required immunosuppression.

Patients were randomized to receive either KEYTRUDA 200 mg every 3 weeks (n=270) or investigator's choice of any of the following chemotherapy regimens all given intravenously every 3 weeks (n=272): paclitaxel 175 mg/m^2 (n=84), docetaxel 75 mg/m^2 (n=84), or vinflunine 320 mg/m^2 (n=87). Treatment continued until unacceptable toxicity or disease progression. Patients with initial radiographic disease progression could receive additional doses of treatment during confirmation of progression unless disease progression was symptomatic, was rapidly progressive, required urgent intervention, or occurred with a decline in performance status. Patients without disease progression could be treated for up to 24 months. Assessment of tumor status was performed at 9 weeks after randomization, then every 6 weeks through the first year, followed by every 12 weeks thereafter. The major efficacy outcomes were OS and PFS as assessed by BICR per RECIST 1.1. Additional efficacy outcome measures were ORR as assessed by BICR per RECIST 1.1 and duration of response.

Among the 542 randomized patients, the study population characteristics were: median age 66 years (range: 26 to 88), 58% age 65 or older; 74% male; 72% White and 23% Asian; 42% ECOG status of 0 and 56% ECOG performance status of 1; and 96% M1 disease and 4% M0 disease. Eighty-seven percent of patients had visceral metastases, including 34% with liver metastases. Eighty-six percent had a primary tumor in the lower tract and 14% had a primary tumor in the upper tract. Fifteen percent of patients had disease progression following prior platinum-containing neoadjuvant or adjuvant chemotherapy. Twenty-one percent had received 2 or more prior systemic regimens in the metastatic setting. Seventy-six percent of patients received prior cisplatin, 23% had prior carboplatin, and 1% were treated with other platinum-based regimens.

Table 22 and Figure 5 summarize the key efficacy measures for KEYNOTE-045. The study demonstrated statistically significant improvements in OS and ORR for patients randomized to KEYTRUDA as compared to chemotherapy. There was no statistically significant difference between KEYTRUDA and

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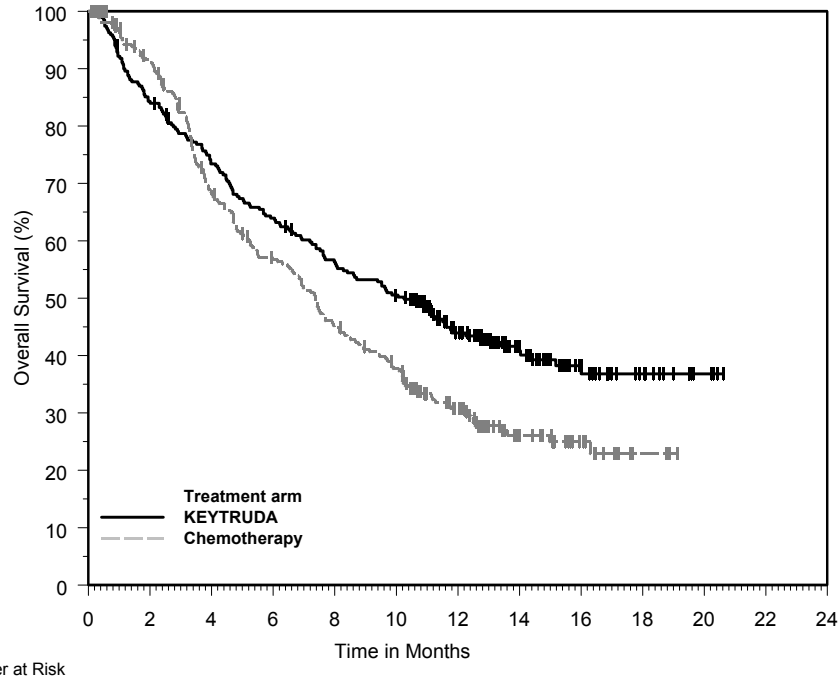
chemotherapy with respect to PFS. The median follow-up time for this trial was 9.0 months (range: 0.2 to 20.8 months).

Table 22: Efficacy Results in KEYNOTE-045

	KEYTRUDA 200 mg every 3 weeks n=270	Chemotherapy n=272
OS		
Deaths (%)	155 (57%)	179 (66%)
Median in months (95% CI)	10.3 (8.0, 11.8)	7.4 (6.1, 8.3)
Hazard ratio* (95% CI)	0.73 (0.59, 0.91)	
p-Value (stratified log-rank)	0.004	
PFS by BICR		
Events (%)	218 (81%)	219 (81%)
Median in months (95% CI)	2.1 (2.0, 2.2)	3.3 (2.3, 3.5)
Hazard ratio* (95% CI)	0.98 (0.81, 1.19)	
p-Value (stratified log-rank)	0.833	
Objective Response Rate		
ORR (95% CI)	21% (16, 27)	11% (8, 16)
Complete Response Rate	7%	3%
Partial Response Rate	14%	8%
p-Value (Miettinen-Nurminen)	0.002	
Median duration of response in months (range)	NR (1.6+, 15.6+)	4.3 (1.4+, 15.4+)

* Hazard ratio (KEYTRUDA compared to chemotherapy) based on the stratified Cox proportional hazard model
\+ Denotes ongoing
NR = not reached

Figure 5: Kaplan-Meier Curve for Overall Survival in KEYNOTE-045



Number at Risk

KEYTRUDA:	270	226	194	169	147	131	87	54	27	13	4	0	0
Chemotherapy:	272	232	171	138	109	89	55	27	14	3	0	0	0

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14.6 Microsatellite Instability-High Cancer

The efficacy of KEYTRUDA was evaluated in patients with MSI-H or mismatch repair deficient (dMMR), solid tumors enrolled in one of five uncontrolled, open-label, multi-cohort, multi-center, single-arm trials. Patients with active autoimmune disease or a medical condition that required immunosuppression were ineligible across the five trials. Patients received either KEYTRUDA 200 mg every 3 weeks or KEYTRUDA 10 mg/kg every 2 weeks. Treatment continued until unacceptable toxicity or disease progression that was either symptomatic, rapidly progressive, required urgent intervention, or occurred with a decline in performance status. A maximum of 24 months of treatment with KEYTRUDA was administered. For the purpose of assessment of anti-tumor activity across these 5 trials, the major efficacy outcome measures were ORR as assessed by blinded independent central radiologists' (BICR) review according to RECIST 1.1 and duration of response.

Table 23: MSI-H Trials

Study	Design and Patient Population	Number of patients	MSI-H/dMMR testing	Dose	Prior therapy
KEYNOTE-016 NCT01876511	• prospective, investigator-initiated • 6 sites • patients with CRC and other tumors	28 CRC 30 non-CRC	local PCR or IHC	10 mg/kg every 2 weeks	• CRC: ≥ 2 prior regimens • Non-CRC: ≥1 prior regimen
KEYNOTE-164 NCT02460198	• prospective international multi-center • CRC	61	local PCR or IHC	200 mg every 3 weeks	Prior fluoropyrimidine, oxaliplatin, and irinotecan +/- anti-VEGF/EGFR mAb
KEYNOTE-012 NCT01848834	• retrospectively identified patients with PD-L1-positive gastric, bladder, or triple-negative breast cancer	6	central PCR	10 mg/kg every 2 weeks	≥1 prior regimen
KEYNOTE-028 NCT02054806	• retrospectively identified patients with PD-L1-positive esophageal, biliary, breast, endometrial, or CRC	5	central PCR	10 mg/kg every 2 weeks	≥1 prior regimen
KEYNOTE-158 NCT02628067	• prospective international multi-center enrollment of patients with MSI-H/dMMR non-CRC • retrospectively identified patients who were enrolled in specific rare tumor non-CRC cohorts	19	local PCR or IHC (central PCR for patients in rare tumor non-CRC cohorts)	200 mg every 3 weeks	≥1 prior regimen
Total		**149**			

CRC = colorectal cancer
PCR = polymerase chain reaction
IHC = immunohistochemistry

A total of 149 patients with MSI-H or dMMR cancers were identified across the five clinical trials. Among these 149 patients, the baseline characteristics were: median age 55 years (36% age 65 or older); 56% male; 77% White, 19% Asian, 2% Black; and ECOG PS 0 (36%) or 1 (64%). Ninety-eight percent of patients had metastatic disease and 2% had locally advanced, unresectable disease. The median number of prior therapies for metastatic or unresectable disease was two. Eighty-four percent of patients with metastatic CRC and 53% of patients with other solid tumors received two or more prior lines of therapy.

The identification of MSI-H or dMMR tumor status for the majority of patients (135/149) was prospectively determined using local laboratory-developed, polymerase chain reaction (PCR) tests for MSI-H status or immunohistochemistry (IHC) tests for dMMR. Fourteen of the 149 patients were retrospectively identified as MSI-H by testing tumor samples from a total of 415 patients using a central laboratory developed PCR

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test. Forty-seven patients had dMMR cancer identified by IHC, 60 had MSI-H identified by PCR, and 42 were identified using both tests.

Efficacy results are summarized in Table 24.

Table 24: Efficacy Results for Patients with MSI-H/dMMR Cancer

Endpoint	n=149
Objective response rate	
ORR (95% CI)	39.6% (31.7, 47.9)
Complete response rate	7.4
Partial response rate	32.2
Response duration	
Median in months (range)	NR (1.6+, 22.7+)
% with duration ≥6 months	78%

NR = not reached

Table 25: Response by Tumor Type

	N	Objective response rate n (%)	95% CI	DOR range (months)
CRC	90	32 (36%)	(26%, 46%)	(1.6+, 22.7+)
Non-CRC	59	27 (46%)	(33%, 59%)	(1.9+, 22.1+)
Endometrial cancer	14	5 (36%)	(13%, 65%)	(4.2+, 17.3+)
Biliary cancer	11	3 (27%)	(6%, 61%)	(11.6+, 19.6+)
Gastric or GE junction cancer	9	5 (56%)	(21%, 86%)	(5.8+, 22.1+)
Pancreatic cancer	6	5 (83%)	(36%, 100%)	(2.6+, 9.2+)
Small intestinal cancer	8	3 (38%)	(9%, 76%)	(1.9+, 9.1+)
Breast cancer	2	PR, PR		(7.6, 15.9)
Prostate cancer	2	PR, SD		9.8+
Bladder cancer	1	NE		
Esophageal cancer	1	PR		18.2+
Sarcoma	1	PD		
Thyroid cancer	1	NE		
Retroperitoneal adenocarcinoma	1	PR		7.5+
Small cell lung cancer	1	CR		8.9+
Renal cell cancer	1	PD		

CR = complete response
PR = partial response
SD = stable disease
PD = progressive disease
NE = not evaluable

16 HOW SUPPLIED/STORAGE AND HANDLING

KEYTRUDA for injection (lyophilized powder): carton containing one 50 mg single-dose vial (NDC 0006-3029-02).

Store vials under refrigeration at 2°C to 8°C (36°F to 46°F).

KEYTRUDA injection (solution): carton containing one 100 mg/4 mL (25 mg/mL), single-dose vial (NDC 0006-3026-02)

Store vials under refrigeration at 2°C to 8°C (36°F to 46°F) in original carton to protect from light. Do not freeze. Do not shake.

17 PATIENT COUNSELING INFORMATION

Advise the patient to read the FDA-approved patient labeling (Medication Guide).

- Inform patients of the risk of immune-mediated adverse reactions that may require corticosteroid treatment and interruption or discontinuation of KEYTRUDA, including:

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- Pneumonitis: Advise patients to contact their healthcare provider immediately for new or worsening cough, chest pain, or shortness of breath *[see Warnings and Precautions (5.1)]*.
- Colitis: Advise patients to contact their healthcare provider immediately for diarrhea or severe abdominal pain *[see Warnings and Precautions (5.2)]*.
- Hepatitis: Advise patients to contact their healthcare provider immediately for jaundice, severe nausea or vomiting, or easy bruising or bleeding *[see Warnings and Precautions (5.3)]*.
- Hypophysitis: Advise patients to contact their healthcare provider immediately for persistent or unusual headache, extreme weakness, dizziness or fainting, or vision changes *[see Warnings and Precautions (5.4)]*.
- Hyperthyroidism and Hypothyroidism: Advise patients to contact their healthcare provider immediately for signs or symptoms of hyperthyroidism and hypothyroidism *[see Warnings and Precautions (5.4)].*
- Type 1 Diabetes Mellitus: Advise patients to contact their healthcare provider immediately for signs or symptoms of type 1 diabetes *[see Warnings and Precautions (5.4)].*
- Nephritis: Advise patients to contact their healthcare provider immediately for signs or symptoms of nephritis *[see Warnings and Precautions (5.5)]*.

- Advise patients to contact their healthcare provider immediately for signs or symptoms of infusion-related reactions *[see Warnings and Precautions (5.7)]*.
- Advise patients of potential risk of post-transplant complications *[see Warnings and Precautions (5.8)].*
- Advise patients of the importance of keeping scheduled appointments for blood work or other laboratory tests *[see Warnings and Precautions (5.3, 5.4, 5.5)]*.
- Advise females that KEYTRUDA can cause fetal harm. Instruct females of reproductive potential to use highly effective contraception during and for 4 months after the last dose of KEYTRUDA *[see Warnings and Precautions (5.9) and Use in Specific Populations (8.1, 8.3)]*.
- Advise nursing mothers not to breastfeed while taking KEYTRUDA and for 4 months after the final dose *[see Use in Specific Populations (8.2)]*.

Manufactured by: Merck Sharp & Dohme Corp., a subsidiary of
MERCK & CO., INC., Whitehouse Station, NJ 08889, USA
U.S. License No. 0002

For KEYTRUDA for injection, at:
MSD International GmbH,
County Cork, Ireland

For KEYTRUDA injection, at:
MSD Ireland (Carlow)
County Carlow, Ireland

For patent information: www.merck.com/product/patent/home.html

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MEDICATION GUIDE

KEYTRUDA® (key-true-duh) (pembrolizumab) for injection	**KEYTRUDA® (key-true-duh) (pembrolizumab) injection**

What is the most important information I should know about KEYTRUDA?

KEYTRUDA is a medicine that may treat certain cancers by working with your immune system. KEYTRUDA can cause your immune system to attack normal organs and tissues in any area of your body and can affect the way they work. These problems can sometimes become serious or life-threatening and can lead to death.

Call or see your doctor right away if you develop any symptoms of the following problems or these symptoms get worse:

Lung problems (pneumonitis). Symptoms of pneumonitis may include:
- shortness of breath
- chest pain
- new or worse cough

Intestinal problems (colitis) that can lead to tears or holes in your intestine. Signs and symptoms of colitis may include:
- diarrhea or more bowel movements than usual
- stools that are black, tarry, sticky, or have blood or mucus
- severe stomach-area (abdomen) pain or tenderness

Liver problems (hepatitis). Signs and symptoms of hepatitis may include:
- yellowing of your skin or the whites of your eyes
- nausea or vomiting
- pain on the right side of your stomach area (abdomen)
- dark urine
- feeling less hungry than usual
- bleeding or bruising more easily than normal

Hormone gland problems (especially the thyroid, pituitary, adrenal glands, and pancreas). Signs and symptoms that your hormone glands are not working properly may include:
- rapid heart beat
- weight loss or weight gain
- increased sweating
- feeling more hungry or thirsty
- urinating more often than usual
- hair loss
- feeling cold
- constipation
- your voice gets deeper
- muscle aches
- dizziness or fainting
- headaches that will not go away or unusual headache

Kidney problems, including nephritis and kidney failure. Signs of kidney problems may include:
- change in the amount or color of your urine

Problems in other organs. Signs of these problems may include:
- rash
- changes in eyesight
- severe or persistent muscle or joint pains
- severe muscle weakness
- low red blood cells (anemia)
- shortness of breath, irregular heartbeat, feeling tired, or chest pain (myocarditis)

Infusion (IV) reactions, that can sometimes be severe and life-threatening. Signs and symptoms of infusion reactions may include:
- chills or shaking

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- shortness of breath or wheezing
- itching or rash
- flushing
- dizziness
- fever
- feeling like passing out

Complications of stem cell transplantation that uses donor stem cells (allogeneic) after treatment with KEYTRUDA. These complications can be severe and can lead to death. Your doctor will monitor you for signs of complications if you are an allogeneic stem cell transplant recipient.

Getting medical treatment right away may help keep these problems from becoming more serious. Your doctor will check you for these problems during treatment with KEYTRUDA. Your doctor may treat you with corticosteroid or hormone replacement medicines. Your doctor may also need to delay or completely stop treatment with KEYTRUDA, if you have severe side effects.

What is KEYTRUDA?

KEYTRUDA is a prescription medicine used to treat:

- a kind of skin cancer called melanoma that has spread or cannot be removed by surgery (advanced melanoma).
- a kind of lung cancer called non-small cell lung cancer (NSCLC).
  - KEYTRUDA may be used alone when your lung cancer:
    - has spread (advanced NSCLC) **and,**
    - tests positive for “PD-L1” **and,**
      - as your first treatment if you have not received chemotherapy to treat your advanced NSCLC and your tumor does not have an abnormal “EGFR” or “ALK” gene,

      or
      - you have received chemotherapy that contains platinum to treat your advanced NSCLC, and it did not work or it is no longer working, **and**
      - if your tumor has an abnormal “EGFR” or “ALK” gene, you have also received an EGFR or ALK inhibitor medicine and it did not work or is no longer working.
  - KEYTRUDA may be used with the chemotherapy medicines pemetrexed and carboplatin as your first treatment when your lung cancer:
    - has spread (advanced NSCLC) **and**
    - is a type of lung cancer called “nonsquamous”.
- a kind of cancer called head and neck squamous cell cancer (HNSCC) that:
    - has returned or spread **and**
    - you have received chemotherapy that contains platinum and it did not work or is no longer working.
- a kind of cancer called classical Hodgkin lymphoma (cHL) in adults and children when:
    - you have tried a treatment and it did not work **or**
    - your cHL has returned after you received 3 or more types of treatment.
- a kind of bladder and urinary tract cancer called urothelial carcinoma. KEYTRUDA may be used when your bladder or urinary tract cancer:
    - has spread or cannot be removed by surgery (advanced urothelial cancer) **and**,
    - you are not able to receive chemotherapy that contains a medicine called cisplatin, **or**
    - you have received chemotherapy that contains platinum, and it did not work or is no longer working.
- a kind of cancer that is shown by a laboratory test to be a microsatellite instability-high (MSI-H) or a mismatch repair deficient (dMMR) solid tumor. KEYTRUDA may be used in adults and children to treat:
    - cancer that has spread or cannot be removed by surgery (advanced cancer), **and**
    - has progressed following treatment, and you have no satisfactory treatment options, **or**
    - you have colon or rectal cancer, and you have received chemotherapy with fluoropyrimidine, oxaliplatin, and irinotecan but it did not work or is no longer working.

  It is not known if KEYTRUDA is safe and effective in children with MSI-H cancers of the brain or spinal cord (central nervous system cancers).

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What should I tell my doctor before receiving KEYTRUDA?

Before you receive KEYTRUDA, tell your doctor if you:

- have immune system problems such as Crohn's disease, ulcerative colitis, or lupus
- have had an organ transplant
- have lung or breathing problems
- have liver problems
- have any other medical problems
- are pregnant or plan to become pregnant
  - KEYTRUDA can harm your unborn baby.
  - Females who are able to become pregnant should use an effective method of birth control during and for at least 4 months after the final dose of KEYTRUDA. Talk to your doctor about birth control methods that you can use during this time.
  - Tell your doctor right away if you become pregnant during treatment with KEYTRUDA.
- are breastfeeding or plan to breastfeed.
  - It is not known if KEYTRUDA passes into your breast milk.
  - Do not breastfeed during treatment with KEYTRUDA and for 4 months after your final dose of KEYTRUDA.

Tell your doctor about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

Know the medicines you take. Keep a list of them to show your doctor and pharmacist when you get a new medicine.

How will I receive KEYTRUDA?

- Your doctor will give you KEYTRUDA into your vein through an intravenous (IV) line over 30 minutes.
- KEYTRUDA is usually given every 3 weeks.
- Your doctor will decide how many treatments you need.
- Your doctor will do blood tests to check you for side effects.
- If you miss any appointments, call your doctor as soon as possible to reschedule your appointment.

What are the possible side effects of KEYTRUDA?

KEYTRUDA can cause serious side effects. See "What is the most important information I should know about KEYTRUDA?"

Common side effects of KEYTRUDA when used alone include: feeling tired, itching, diarrhea, decreased appetite, rash, fever, cough, shortness of breath, pain in muscles, bones or joints, constipation, and nausea.

In children, feeling tired, vomiting and stomach-area (abdominal) pain, and increased levels of liver enzymes and decreased levels of salt (sodium) in the blood are more common than in adults.

These are not all the possible side effects of KEYTRUDA. For more information, ask your doctor or pharmacist.

Tell your doctor if you have any side effect that bothers you or that does not go away.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

General information about the safe and effective use of KEYTRUDA

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. If you would like more information about KEYTRUDA, talk with your doctor. You can ask your doctor or nurse for information about KEYTRUDA that is written for healthcare professionals. For more information, go to www.keytruda.com.

What are the ingredients in KEYTRUDA?

Active ingredient: pembrolizumab

Inactive ingredients:

KEYTRUDA for injection: L-histidine, polysorbate 80, and sucrose. May contain hydrochloric acid/sodium hydroxide.

KEYTRUDA injection: L-histidine, polysorbate 80, sucrose, and Water for Injection, USP.

Manufactured by: Merck Sharp & Dohme Corp., a subsidiary of
MERCK & CO., INC., Whitehouse Station, NJ 08889, USA

For KEYTRUDA for injection, at:
MSD International GmbH, County Cork, Ireland
For KEYTRUDA injection, at:
MSD Ireland (Carlow), County Carlow, Ireland
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