

## A guide to help your patients with HR+/HER2- eBC or mBC

# START & STAY on KISQALI

### NCCN CATEGORY 1 UPDATE

National Comprehensive Cancer Network® (NCCN®) differentiates ribociclib (KISQALI®) as the first and only Category 1 Preferred treatment option when used in combination with an AI for appropriate patients with HR+/HER2- mBC in 1L and for appropriate patients with HR+/HER2- eBC, including those with high-risk node-negative disease.<sup>1</sup>

In HR+/HER2- eBC, high-risk node-negative disease is defined as either tumor size >5 cm, or if tumor size 2-5 cm, either grade 2 (with high genomic risk or Ki-67 ≥20%), or grade 3.<sup>1,2</sup>

There is controversy on the choice of CDK4/6i as there are no head-to-head comparisons between the agents and there are some differences in the study populations in the phase III randomized studies.<sup>1</sup>

NCCN makes no warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application or use in any way.<sup>1</sup>



**KISQALI—the #1 prescribed CDK4/6 inhibitor in new-to-brand prescriptions in both HR+/HER2- eBC and mBC<sup>3</sup>**

November 2024 IQVIA custom breast cancer market sizing report.

### Indications

KISQALI is indicated:

- in combination with an aromatase inhibitor for the adjuvant treatment of adults with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative stage II and III early breast cancer (eBC) at high risk of recurrence
- for the treatment of adults with HR-positive, HER2-negative advanced or metastatic breast cancer (mBC) in combination with:
  - an aromatase inhibitor as initial endocrine-based therapy; or
  - fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy

### IMPORTANT SAFETY INFORMATION

**Interstitial lung disease/pneumonitis.** Severe, life-threatening, or fatal interstitial lung disease (ILD) and/or pneumonitis can occur in patients treated with KISQALI and other CDK4/6 inhibitors.

In patients with eBC (NATALEE) who received 400 mg KISQALI plus a nonsteroidal aromatase inhibitor (NSAI), 1.5% of patients had ILD/pneumonitis (grade 1/2).

In patients with advanced or mBC (MONALEESA-2, MONALEESA-3, MONALEESA-7), 1.6% of patients had ILD/pneumonitis of any grade, 0.4% had grade 3/4, and 0.1% had a fatal outcome. Additional cases of ILD/pneumonitis have occurred in the postmarketing setting, some resulting in death.

Please see additional Important Safety Information throughout and [click here](#) for full Prescribing Information for KISQALI.



ASSESSMENTS

DOSING & DOSE REDUCTIONS

NOVARTIS PATIENT SUPPORT

LEARN MORE

For your patients with HR+/HER2- eBC or mBC,

ABBREVIATIONS  
& REFERENCES

# Complete most of the scheduled assessments for KISQALI within the first 2 months of therapy—with none beyond Cycle 6

ISI

Assessment <sup>2</sup>	Baseline	Cycle 1	Cycle 2		Cycles 3-6
		Day 14	Day 1	Day 14	Day 1
CBC and LFT	✓	✓	✓	✓	✓
Electrolytes	✓	-	✓	-	✓
ECG	✓	✓	-	-	-

### Routine monitoring for lab abnormalities<sup>2</sup>

- Blood tests are performed at baseline, on Day 14 of Cycle 1, on Days 1 and 14 of Cycle 2, on Day 1 of Cycles 3 through 6, and as clinically indicated
- Additional monitoring may be required as clinically indicated

### 2 required ECG assessments for eBC and mBC, completed within the first 2 weeks of treatment<sup>2</sup>

- ECGs are performed at baseline, on Day 14 of Cycle 1, and as clinically indicated
- KISQALI should only be initiated in patients with QTcF <450 ms
- In case of QTcF prolongation during therapy, more frequent assessments are recommended
- Additional monitoring may be required as clinically indicated

**If you are unable to perform ECGs in office, speak with your Novartis Oncology Specialist or Clinical Educator about a simple solution for fast, easy, and accurate ECG testing**

### IMPORTANT SAFETY INFORMATION (continued)

**Interstitial lung disease/pneumonitis (continued).** Monitor patients for pulmonary symptoms indicative of ILD/pneumonitis, which may include hypoxia, cough, and dyspnea. In patients who have new or worsening respiratory symptoms suspected to be due to ILD or pneumonitis, interrupt KISQALI immediately and evaluate the patient. Permanently discontinue treatment with KISQALI in patients with severe ILD/pneumonitis or any recurrent symptomatic ILD/pneumonitis.

Please see additional Important Safety Information throughout and [click here](#) for full Prescribing Information for KISQALI.

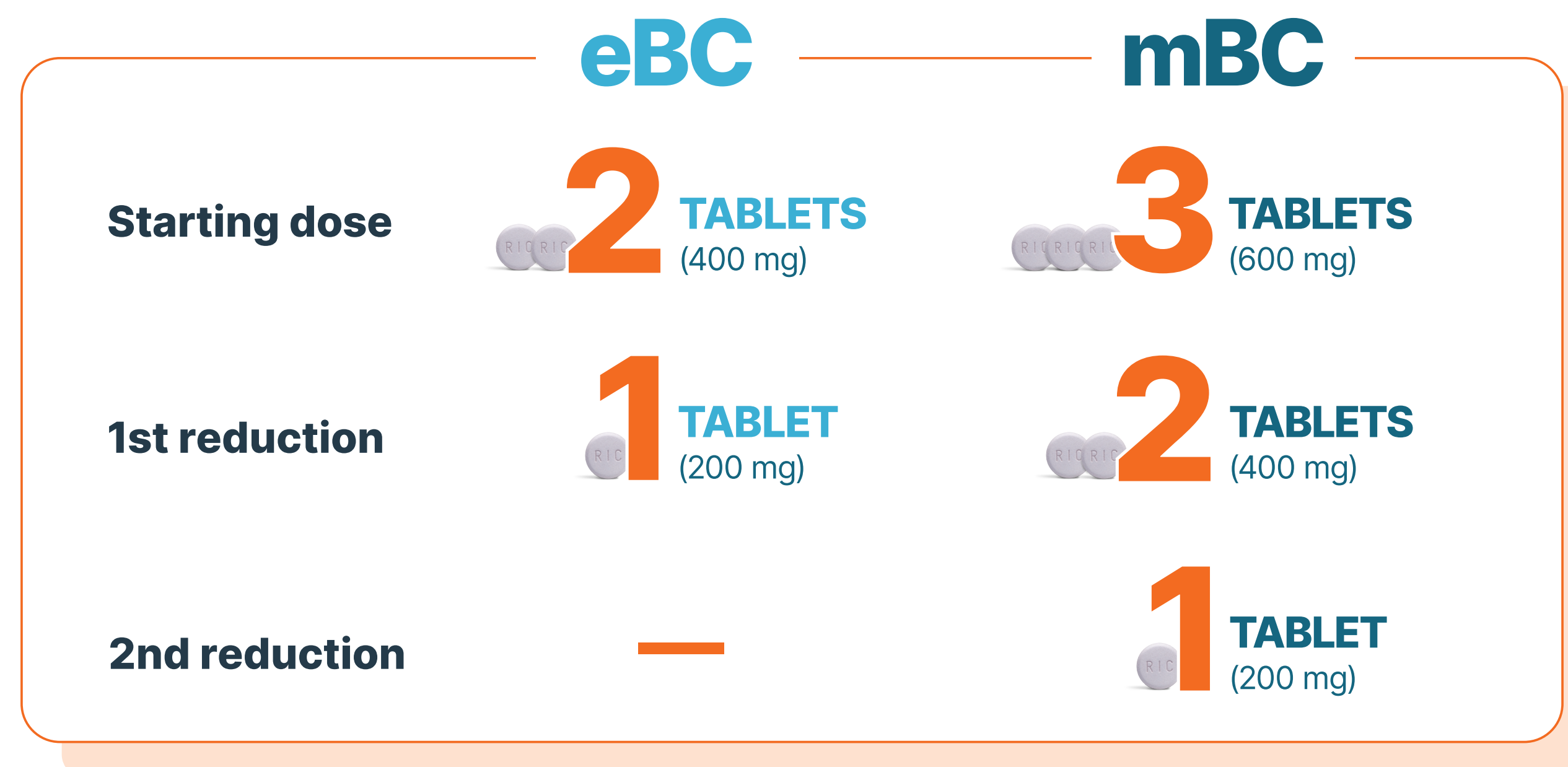
 **KISQALI**<sup>®</sup>  
ribociclib 200 mg  
tablets



For your patients with HR+/HER2- eBC or mBC,

# KISQALI single-strength tablets make dose reduction simple and convenient

Dose reductions with KISQALI mean no need for new mid-cycle prescriptions or additional costs<sup>2</sup>



KISQALI is given as 400 mg (2 x 200-mg tablets) and 600 mg (3 x 200-mg tablets) orally once daily (3 weeks on, 1 week off) for HR+/HER2- eBC and HR+/HER2- mBC, respectively, with either:

- An AI once daily (continuously); in men and premenopausal women, an LHRH agonist should also be administered according to current clinical practice guidelines; or
- In mBC only: fulvestrant 500 mg intramuscularly on Days 1, 15, and 29, and once monthly thereafter; in men and premenopausal women, an LHRH agonist should also be administered according to current clinical practice guidelines
- Metastatic breast cancer patients should continue treatment until disease progression or unacceptable toxicity
- Early breast cancer patients should continue treatment for 3 years or until disease recurrence or unacceptable toxicity
- Dose adjustments for ARs should be made stepwise by reducing the number of tablets taken
- Dose modification is recommended based on individual safety and tolerability
- If dose reduction below 200 mg/day is required, discontinue treatment
- KISQALI can be taken with or without food
- Store refrigerated at 2°C to 8°C (36°F to 46°F). Excursions permitted between 2°C and 15°C (36°F and 59°F)
- After dispensing, patients may store at room temperature at 20°C to 25°C (68°F to 77°F) for up to 2 months
- Store tablets in the original blister pack

## IMPORTANT SAFETY INFORMATION (continued)

**Severe cutaneous adverse reactions.** Severe cutaneous adverse reactions (SCARs), including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), and drug-induced hypersensitivity syndrome (DiHS)/drug reaction with eosinophilia and systemic symptoms (DRESS) can occur in patients treated with KISQALI.

Please see additional Important Safety Information throughout and [click here](#) for full Prescribing Information for KISQALI.



# Novartis Patient Support™—a dedicated team for you and your patients

Novartis Patient Support is a comprehensive program that is designed to help your eligible patients start, stay, and save on KISQALI

Your practice and patients will have access to a Novartis Patient Support team committed to providing the support you need, including:



### Insurance Support

Help navigating the insurance process, including benefits verification



### Financial Support

Assistance with relevant savings options for your eligible patients



### Clinical Testing and Support

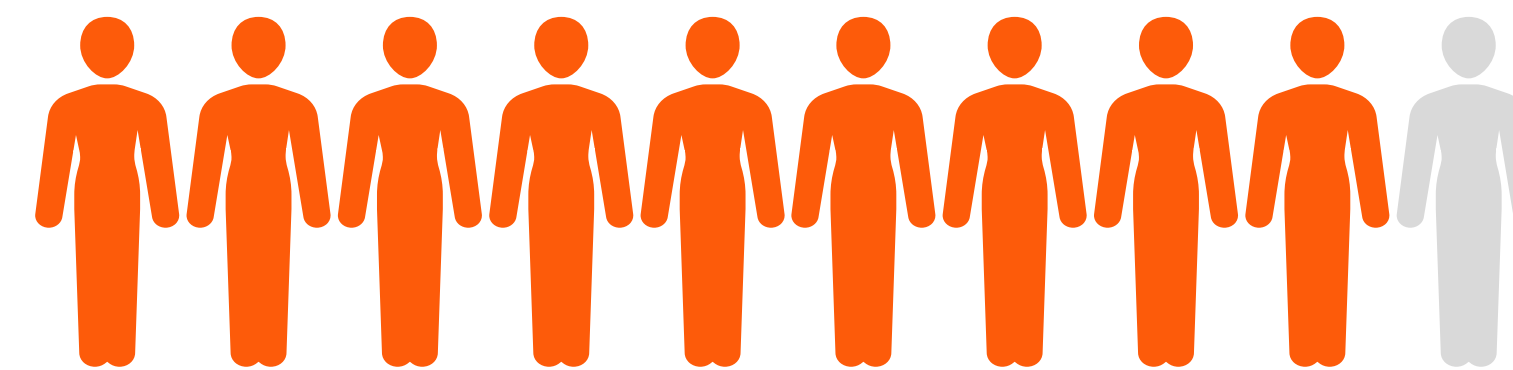
Workflow support and options for testing



### Ongoing Support

Dedicated assistance from our team and educational resources

**9 out of 10 patients** have favorable coverage for KISQALI for approved metastatic indications<sup>4</sup>



Unrestricted or single-step edit coverage from MMIT data as of June 2024.

**To learn more, contact your dedicated Novartis Patient Support team at 1-866-433-8000**

Monday-Friday, 8:00 AM - 8:00 PM ET, excluding holidays

#### IMPORTANT SAFETY INFORMATION (continued)

**Severe cutaneous adverse reactions (continued).** If signs or symptoms of SCARs occur, interrupt KISQALI until the etiology of the reaction has been determined. Early consultation with a dermatologist is recommended to ensure greater diagnostic accuracy and appropriate management.

If SJS, TEN, or DiHS/DRESS is confirmed, permanently discontinue KISQALI. Do not reintroduce KISQALI in patients who have experienced SCARs or other life-threatening cutaneous reactions during KISQALI treatment.

Please see additional Important Safety Information throughout and [click here](#) for full Prescribing Information for KISQALI.



# MORE

## support

[Click here](#) to contact your local Novartis representative  
and learn more about treating with KISQALI

### IMPORTANT SAFETY INFORMATION (continued)

**QT interval prolongation.** KISQALI has been shown to prolong the QT interval in a concentration-dependent manner.

Avoid KISQALI in patients who are at significant risk of developing torsades de pointes (TdP), including those with:

- congenital long QT syndrome;
- uncontrolled or significant cardiac disease, recent myocardial infarction, heart failure, unstable angina, bradyarrhythmias, uncontrolled hypertension, high degree atrioventricular block, severe aortic stenosis, or uncontrolled hypothyroidism;
- electrolyte abnormalities;
- taking drugs known to prolong QT interval and/or strong CYP3A inhibitors as this may lead to prolongation of the QTcF interval.

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 **KISQALI**<sup>®</sup>  
ribociclib 200 mg  
tablets



# Abbreviations and references

**Abbreviations:** 1L, first line; AI, aromatase inhibitor; AR, adverse reaction; CBC, complete blood count; CDK, cyclin-dependent kinase; eBC, early breast cancer; ECG, electrocardiogram; LFT, liver function test; LHRH, luteinizing hormone-releasing hormone; mBC, metastatic breast cancer; QTcF, QT interval corrected by Fridericia's formula.

**References:** **1.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Breast Cancer V.1.2025. © National Comprehensive Cancer Network, Inc. 2025. All rights reserved. Accessed February 5, 2025. To view the most recent and complete version of the guideline, go online to NCCN.org. **2.** Kisqali. Prescribing information. Novartis Pharmaceuticals Corp. **3.** Data on file. mBC and eBC NBRx share data from IQVIA market sizing report. Novartis Pharmaceuticals Corp; 2024. **4.** Data on file. Kisqali MMIT data June 2024. Novartis Pharmaceuticals Corp; 2024.

## IMPORTANT SAFETY INFORMATION (continued)

**QT interval prolongation (continued).** Based on the observed QT prolongation during treatment, KISQALI may require dose interruption, reduction, or discontinuation.

In patients with eBC (NATALEE) who received 400 mg KISQALI plus NSAID, 8 out of 2494 patients (0.3%) had > 500 ms post-baseline QTcF interval value and 50 out of 2494 patients (2%) had > 60 ms QTcF increase from baseline. QTcF prolongation was reversible with dose interruption. The majority of QTcF prolongation occurred within the first 4 weeks of KISQALI. There were no reported cases of torsades de pointes.

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In patients with advanced or mBC (MONALEESA-2, MONALEESA-3, MONALEESA-7), 1.6% of patients had ILD/pneumonitis of any grade, 0.4% had grade 3/4, and 0.1% had a fatal outcome. Additional cases of ILD/pneumonitis have occurred in the postmarketing setting, some resulting in death.

Monitor patients for pulmonary symptoms indicative of ILD/pneumonitis, which may include hypoxia, cough, and dyspnea. In patients who have new or worsening respiratory symptoms suspected to be due to ILD or pneumonitis, interrupt KISQALI immediately and evaluate the patient. Permanently discontinue treatment with KISQALI in patients with severe ILD/pneumonitis or any recurrent symptomatic ILD/pneumonitis.

**Severe cutaneous adverse reactions.** Severe cutaneous adverse reactions (SCARs), including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), and drug-induced hypersensitivity syndrome (DiHS)/drug reaction with eosinophilia and systemic symptoms (DRESS) can occur in patients treated with KISQALI.

If signs or symptoms of SCARs occur, interrupt KISQALI until the etiology of the reaction has been determined. Early consultation with a dermatologist is recommended to ensure greater diagnostic accuracy and appropriate management.

If SJS, TEN, or DiHS/DRESS is confirmed, permanently discontinue KISQALI. Do not reintroduce KISQALI in patients who have experienced SCARs or other life-threatening cutaneous reactions during KISQALI treatment.

**QT interval prolongation.** KISQALI has been shown to prolong the QT interval in a concentration-dependent manner.

Avoid KISQALI in patients who are at significant risk of developing torsades de pointes (TdP), including those with:

- congenital long QT syndrome;
- uncontrolled or significant cardiac disease, recent myocardial infarction, heart failure, unstable angina, bradyarrhythmias, uncontrolled hypertension, high degree atrioventricular block, severe aortic stenosis, or uncontrolled hypothyroidism;
- electrolyte abnormalities;
- taking drugs known to prolong QT interval and/or strong CYP3A inhibitors as this may lead to prolongation of the QTcF interval.

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ribociclib 200 mg  
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## IMPORTANT SAFETY INFORMATION (continued)

**QT interval prolongation (continued).** Based on the observed QT prolongation during treatment, KISQALI may require dose interruption, reduction, or discontinuation.

In patients with eBC (NATALEE) who received 400 mg KISQALI plus NSAI, 8 out of 2494 patients (0.3%) had > 500 ms post-baseline QTcF interval value and 50 out of 2494 patients (2%) had > 60 ms QTcF increase from baseline. QTcF prolongation was reversible with dose interruption. The majority of QTcF prolongation occurred within the first 4 weeks of KISQALI. There were no reported cases of torsades de pointes.

In patients with advanced or mBC (MONALEESA-2, MONALEESA-3, and MONALEESA-7) who received 600 mg KISQALI plus NSAI or fulvestrant, 15 of 1054 patients (1.4%) had >500 ms postbaseline QTcF value, and 61 of 1054 (6%) had a >60 ms QTcF increase from baseline. QTcF prolongation was reversible with dose interruption. The majority of QTcF prolongation occurred within the first 4 weeks of KISQALI. There were no reported cases of torsades de pointes. In MONALEESA-2, in the KISQALI + letrozole treatment arm, there was 1 (0.3%) sudden death in a patient with grade 3 hypokalemia and grade 2 QT prolongation. No cases of sudden death were reported in MONALEESA-7 or MONALEESA-3.

Perform electrocardiogram (ECG) in all patients prior to starting KISQALI. Initiate treatment with KISQALI only in patients with QTcF values <450 ms. Repeat ECG at approximately Day 14 of the first cycle, and as clinically indicated.

Monitor serum electrolytes (including potassium, calcium, phosphorus and magnesium) prior to the initiation of KISQALI, at the beginning of the first 6 cycles, and as clinically indicated. Correct any abnormality before starting KISQALI.

**Increased QT prolongation with concomitant use of tamoxifen.** KISQALI is not indicated for concomitant use with tamoxifen. Avoid use of tamoxifen with KISQALI. In MONALEESA-7, the observed mean QTcF increase from baseline was >10 ms higher in the tamoxifen + placebo subgroup compared with the nonsteroidal aromatase inhibitor (NSAI) + placebo subgroup. In the placebo arm, an increase of >60 ms from baseline occurred in 6/90 (7%) of patients receiving tamoxifen, and in no patients receiving an NSAI. An increase of >60 ms from baseline in the QTcF interval was observed in 14/87 (16%) of patients in the KISQALI and tamoxifen combination and in 18/245 (7%) of patients receiving KISQALI plus an NSAI.

**Hepatotoxicity.** In patients with eBC and advanced or mBC, drug-induced liver injury and increases in transaminases occurred with KISQALI.

In patients with eBC (NATALEE) treated with KISQALI, drug-induced liver injury was reported in 9 patients (0.4%), of which 5 were grade  $\geq 3$  and 8 had resolved as of the data cutoff. There were 8 (0.3%) clinically confirmed Hy's Law cases (including 4 out of 9 drug-induced liver injury mentioned above), 6 of which had resolved within 303 days and 2 were resolving, all after discontinuation of KISQALI. Grade 3/4 increases in alanine aminotransferase (ALT) and aspartate aminotransferase (AST) occurred in 8% and 4.7%, respectively, and grade 4 increases in ALT (1.5%) and AST (0.8%).

In patients with advanced or mBC (MONALEESA-2, MONALEESA-7, and MONALEESA-3) treated with KISQALI, grade 3 or 4 increases in ALT and AST occurred in 11% and 8%, respectively. Among the patients who had grade  $\geq 3$  ALT/AST elevation, the median time to onset was 92 days for the KISQALI plus aromatase inhibitor or fulvestrant treatment arms. The median time to resolution to grade  $\leq 2$  was 21 days in the KISQALI plus aromatase inhibitor or fulvestrant treatment arms. In MONALEESA-2 and MONALEESA-3, concurrent elevations in ALT or AST >3x ULN and total bilirubin >2x ULN, with normal alkaline phosphatase, in the absence of cholestasis (Hy's Law) occurred in 6 (1%) patients and all patients recovered after discontinuation of KISQALI.

Perform liver function tests (LFTs) before initiating KISQALI. Monitor LFTs every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, and as clinically indicated. Based on the severity of the transaminase elevations, KISQALI may require dose interruption, reduction, or discontinuation.

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## IMPORTANT SAFETY INFORMATION (continued)

**Neutropenia.** KISQALI causes concentration-dependent neutropenia. In patients with eBC (NATALEE) who received KISQALI plus NSAID, 94%, including 45% of grade 3/4, had a decrease in neutrophil counts (based on laboratory findings), 63% had an adverse drug reaction of neutropenia, and 0.3% had febrile neutropenia. The median time to grade  $\geq 2$  neutropenia was 18 days. The median time to resolution of grade  $\geq 3$  neutropenia to grade  $< 3$  was 10 days. Treatment discontinuation due to neutropenia was required in 1.1% of patients.

In patients with advanced or metastatic breast cancer (MONALEESA-2, MONALEESA-7, and MONALEESA-3) who received KISQALI plus NSAID or fulvestrant, 75% had neutropenia, 62% had grade 3/4 decrease in neutrophil count (based on laboratory findings), and 1.7% had febrile neutropenia. The median time to grade  $\geq 2$  neutropenia was 17 days. The median time to resolution of grade  $\geq 3$  neutropenia to grade  $< 3$  was 12 days. Treatment discontinuation due to neutropenia was required in 1% of patients.

Perform complete blood count (CBC) before initiating therapy with KISQALI. Monitor CBC every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, and as clinically indicated. Based on the severity of the neutropenia, KISQALI may require dose interruption, reduction, or discontinuation.

**Embryo-fetal toxicity.** Based on findings from animal studies and the mechanism of action, KISQALI can cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to a fetus. Advise women of reproductive potential to use effective contraception during therapy with KISQALI and for at least 3 weeks after the last dose.

**Adverse reactions in early breast cancer patients. Most common (incidence  $\geq 20\%$ ) adverse reactions include infections, nausea, headache, and fatigue.**

**Laboratory abnormalities.** In a clinical trial of patients with early breast cancer, the most common laboratory abnormalities reported in the KISQALI arm (all grades, pooled incidence  $\geq 20\%$ ) were **lymphocytes decreased, leukocyte decreased, neutrophil decreased, hemoglobin decreased, alanine aminotransferase increased, aspartate aminotransferase increased, creatinine increased, and platelets decreased.**

**Adverse reactions in advanced or metastatic breast cancer patients. Most common (incidence  $\geq 20\%$ ) adverse reactions include infections, nausea, fatigue, diarrhea, vomiting, headache, constipation, alopecia, cough, rash, and back pain.**

**Laboratory abnormalities.** Across clinical trials of patients with advanced or metastatic breast cancer, the most common laboratory abnormalities reported in the KISQALI arm (all grades, pooled incidence  $\geq 20\%$ ) were **leukocytes decreased, neutrophils decreased, hemoglobin decreased, lymphocytes decreased, AST increased, gamma-glutamyl transferase increased, ALT increased, creatinine increased, platelets decreased, and glucose serum decreased.**

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