

EHR Support for KISQALI Treatment Monitoring

OncoEMR®

Maintaining up-to-date protocols in EHRs is an integral part of providing comprehensive, consistent care. OncoEMR may be able to support your EHR support or information technology department with developing, configuring, and modifying EHR components relevant to treatment with KISQALI, such as creating “Alerts” that will help health care professionals identify patients who need ECG and laboratory workup and monitoring once prescribed KISQALI.

- ✓ If you would like to **set up an Alert for KISQALI**, submit a request to OESupport@flatiron.com
- ✓ For more detail on **ECG monitoring, lab monitoring, and dosing** for KISQALI, see the following pages (the navigation tabs at the top of each page can also be used to easily navigate between information)
- ✓ For more information on **how the Novartis HIT Team can collaborate with your organization** to identify shared priorities please email: [HIT.Novartis@novartis.com]

ECG=electrocardiogram; EHR=Electronic Health Record.

Indications

KISQALI is indicated for the treatment of adults with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (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 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 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.



Upfront ECG Monitoring

ECG and QTcF Prolongation Overview

- **ECG** measures electrical impulses as 5 waves using the letters P, Q, R, S, and T¹
- **QT interval** is the space between the start of the Q wave and end of the T wave, characterizing the electrical depolarization and repolarization of the heart's ventricles^{1,2}
- **QTc** is a QT interval measurement corrected to compare QT intervals at different heart rates²
- **QTcF** is a QT interval corrected using the Fridericia formula³
- **Prolongation of the QTc interval** is a risk factor of developing torsades de pointes or other clinically significant arrhythmias⁴
- **Risk factors for QT interval prolongation** include medications with risk of lengthening the QT interval, 4 electrolyte imbalances (hypokalemia, hypomagnesemia, hypophosphatemia, and hypocalcemia), age, sex, bradycardia, and family/personal medical history⁴⁻⁶

KISQALI QTcF Prolongation Incidence³

Low incidence of QT prolongation across all KISQALI clinical trials, and most cases were moderate in nature

In a pooled analysis across 3 phase III trials of 1054 premenopausal and postmenopausal patients treated with KISQALI + an AI or fulvestrant:

1% had a >500 ms post baseline QTcF value

6% experienced a >60 ms increase from baseline in QTcF interval

- There were no reported cases of torsades de pointes

ECG changes were reversible with dose interruption and the majority occurred within the first 4 weeks of treatment.

AI=aromatase inhibitor.

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.

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.



Upfront ECG Monitoring (continued)³

ECG Monitoring		
Baseline		✓
Cycle 1	Day 14	✓

- KISQALI should only be initiated in patients with QTcF <450 ms. In case of QTcF prolongation during therapy, more frequent monitoring is recommended
- Any additional monitoring should be performed as clinically indicated
- Monitoring requirements based on a 28-day treatment cycle

Only 2 ECGs are required—and all are completed within the first 15 days of treatment.

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.

Based on the observed QT prolongation during treatment, KISQALI may require dose interruption, reduction, or discontinuation.

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



Routine Laboratory Monitoring³

		CBC/LFT	Electrolytes
Baseline		✓	✓
Cycle 1	Day 14	✓	
Cycle 2	Day 1	✓	✓
	Day 14	✓	
Cycle 3-6	Day 1	✓	✓

- For LFTs, if grade ≥ 2 abnormalities are noted, more frequent monitoring is recommended
- Correct any electrolyte abnormalities prior to treatment
- Additional monitoring may be required as clinically indicated
- Monitoring requirements based on a 28-day treatment cycle

The majority of scheduled monitoring occurs within the first 2 cycles of therapy and there is no scheduled monitoring beyond Cycle 6.

CBC=complete blood count; LFT=liver function test.

IMPORTANT SAFETY INFORMATION (continued)

QT interval prolongation (continued). In patients with advanced or mBC (MONALEESA-2, MONALEESA-3, and MONALEESA-7) who received 600 mg KISQALI plus NSAID 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.

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

Monitoring Summary³

		Upfront ECG Monitoring	Routine Laboratory Monitoring	
		ECG Monitoring	CBC/LFT	Electrolytes
Baseline		✓	✓	✓
Cycle 1	Day 14	✓	✓	
Cycle 2	Day 1		✓	✓
	Day 14		✓	
Cycle 3-6	Day 1		✓	✓

LAB

The majority of scheduled monitoring occurs **within the first 2 cycles of therapy** and there is **no scheduled monitoring beyond Cycle 6**.

ECG

Only 2 ECGs are required—and all are completed within the **first 15 days of treatment**.

IMPORTANT SAFETY INFORMATION (continued)

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.

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

mBC Dosing³

KISQALI—the only CDK4/6 inhibitor that offers one tablet strength for simple dose reductions

Recommended Dosing for mBC Indication



- KISQALI is given as 600 mg (3 x 200-mg tablets) orally once daily (3 weeks on, 1 week off) with either:
 - An AI once daily (continuously); in premenopausal patients and men, an LHRH agonist should be administered according to current clinical practice guidelines; or
 - Fulvestrant 500 mg intramuscularly on Days 1, 15, and 29, and once monthly thereafter for postmenopausal patients or men. In male patients, an LHRH agonist should be administered according to current clinical practice guidelines
- Dose adjustments for adverse reactions should be made in a stepwise order by reducing the number of tablets taken
- Dose modification of KISQALI 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

Simple dose reductions with no need for a new prescription or additional cost to patient mid-cycle

References: **1.** Mayo Clinic. Long QT syndrome diagnosis & treatment. <https://www.mayoclinic.org/diseases-conditions/long-qt-syndrome/diagnosis-treatment/drc-20352524>. Accessed July 27, 2023. **2.** Vandenberg B et al. *J Am Heart Assoc.* 2016;5(6):e003264. **3.** Kisqali. Prescribing information. Novartis Pharmaceuticals Corp. **4.** Mayo Clinic. Long QT syndrome symptoms & causes. <https://www.mayoclinic.org/diseases-conditions/long-qt-syndrome/symptoms-causes/syc-20352518>. Accessed July 27, 2023. **5.** Al-Khatib SM et al. *JAMA.* 2003;289(16):2120-2127. **6.** Vered I et al. *J Bone Miner Res.* 1990;5(5):469-474.

IMPORTANT SAFETY INFORMATION (continued)

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

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 ≥ 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 ≤ 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 $>3x$ the ULN and total bilirubin $>2x$ the 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 advanced or mBC (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 ≥ 2 neutropenia was 17 days. The median time to resolution of grade ≥ 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. 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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References: **1.** Mayo Clinic. Long QT syndrome diagnosis & treatment. <https://www.mayoclinic.org/diseases-conditions/long-qt-syndrome/diagnosis-treatment/drc-20352524>. Accessed July 27, 2023. **2.** Vandenberg B et al. *J Am Heart Assoc.* 2016;5(6):e003264. **3.** Kisqali. Prescribing information. Novartis Pharmaceuticals Corp. **4.** Mayo Clinic. Long QT syndrome symptoms & causes. <https://www.mayoclinic.org/diseases-conditions/longqt-syndrome/symptoms-causes/syc-20352518>. Accessed July 27, 2023. **5.** Al-Khatib SM et al. *JAMA.* 2003;289(16):2120-2127. **6.** Vered I et al. *J Bone Miner Res.* 1990;5(5):469-474.

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