HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use ENHERTU safely and effectively. See full prescribing information for ENHERTU.
ENHERTU® (fam-trastuzumab deruxtecan-nxki) for injection, for intravenous use

WARNING: INTERSTITIAL LUNG DISEASE and EMBRYO-FETAL TOXICITY
See full prescribing information for complete boxed warning.

• Interstitial lung disease (ILD) and pneumonitis, including fatal cases, have been reported with ENHERTU. Monitor for and promptly investigate signs and symptoms including cough, dyspnea, fever, and other new or worsening respiratory symptoms. Permanently discontinue ENHERTU in all patients with Grade 2 or higher ILD/pneumonitis. Advise patients of the risk and to immediately report symptoms. (2.3, 5.1)
• Exposure to ENHERTU during pregnancy can cause embryo-fetal harm. Advise patients of these risks and the need for effective contraception. (5.4, 8.1, 8.3)

RECENT MAJOR CHANGES
Indications and Usage (1.1) 05/2022
Indications and Usage (1.2) 11/2022
Indications and Usage (1.3) 08/2022
Dosage and Administration (2.1) 08/2022
Dosage and Administration (2.2) 05/2022
Dosage and Administration (2.3) 08/2022
Dosage and Administration (2.4) 08/2022
Dosage and Administration (2.5) 08/2022

INDICATIONS AND USAGE
ENHERTU is a HER2-directed antibody and topoisomerase inhibitor conjugate indicated for the treatment of:
• adult patients with unresectable or metastatic HER2-positive breast cancer who have received a prior anti-HER2-based regimen either:
  o in the metastatic setting, or
  o in the neoadjuvant or adjuvant setting and have developed disease recurrence during or within six months of completing therapy. (1.1)
• adult patients with unresectable or metastatic HER2-low (IHC 1+ or IHC 2+/ISH-) breast cancer, as determined by an FDA-approved test, who have received a prior chemotherapy in the metastatic setting or developed disease recurrence during or within 6 months of completing adjuvant chemotherapy. (1.2)
• adult patients with unresectable or metastatic non-small cell lung cancer (NSCLC) whose tumors have activating HER2 (ERBB2) mutations, as detected by an FDA-approved test, and who have received a prior systemic therapy. (1.3)

This indication is approved under accelerated approval based on objective response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial. (1.3, 14.5)
• adult patients with locally advanced or metastatic HER2-positive gastric or gastroesophageal junction adenocarcinoma who have received a prior trastuzumab-based regimen. (1.4)

Do not substitute ENHERTU for or with trastuzumab or ado-trastuzumab emtansine. (2.2, 2.4)

DOSE AND ADMINISTRATION

• For intravenous infusion only. Do not administer as an intravenous push or bolus. DO NOT use Sodium Chloride Injection, USP. (2.4)
• Premedicate for prevention of chemotherapy-induced nausea and vomiting. (2.2)
• The recommended dosage of ENHERTU for breast cancer is 5.4 mg/kg given as an intravenous infusion once every 3 weeks (21-day cycle) until disease progression or unacceptable toxicity. (2.2, 2.3)
• The recommended dosage of ENHERTU for lung cancer is 5.4 mg/kg given as an intravenous infusion once every 3 weeks (21-day cycle) until disease progression or unacceptable toxicity. (2.2, 2.3)
• The recommended dosage of ENHERTU for gastric cancer is 6.4 mg/kg given as an intravenous infusion once every 3 weeks (21-day cycle) until disease progression or unacceptable toxicity. (2.2, 2.3)
• Management of adverse reactions (ILD, neutropenia, thrombocytopenia, or left ventricular dysfunction) may require temporary interruption, dose reduction, or discontinuation of ENHERTU. (2.3)

DOSE FORMS AND STRENGTHS
For injection: 100 mg lyophilized powder in a single-dose vial (3)

CONTRAINDICATIONS
None. (4)

WARNINGS AND PRECAUTIONS
• Neutropenia: Monitor complete blood counts prior to initiation of ENHERTU and prior to each dose, and as clinically indicated. Manage through treatment interruption or dose reduction. (2.3, 5.2)
• Left Ventricular Dysfunction: Assess LVEF prior to initiation of ENHERTU and at regular intervals during treatment as clinically indicated. Manage through treatment interruption or discontinuation. Permanently discontinue ENHERTU in patients with symptomatic congestive heart failure (CHF). (2.3, 5.3)

ADVERSE REACTIONS
The most common adverse reactions (≥20%), including laboratory abnormalities, in patients with:
• metastatic breast cancer and HER2-mutant NSCLC were nausea, decreased white blood cell count, decreased hemoglobin, decreased neutrophil count, decreased lymphocyte count, fatigue, decreased platelet count, increased aspartate aminotransferase, vomiting, increased alanine aminotransferase, alopecia, increased blood alkaline phosphatase, constipation, musculoskeletal pain, decreased appetite, hypokalemia, diarrhea, and respiratory infection. (6.1)
• gastric cancer were decreased hemoglobin, decreased white blood cell count, decreased neutrophil count, decreased lymphocyte count, decreased platelet count, nausea, decreased appetite, increased aspartate aminotransferase, fatigue, increased blood alkaline phosphatase, increased alanine aminotransferase, diarrhea, hypokalemia, vomiting, constipation, increased blood bilirubin, pyrexia, and alopecia. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Daiichi Sankyo, Inc. at 1-877-437-7763 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

USE IN SPECIFIC POPULATIONS
• Lactation: Advise not to breastfeed. (8.2)
• Females and Males of Reproductive Potential: Verify pregnancy status of females prior to initiation of ENHERTU. (8.3)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 11/2022

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1 INDICATIONS AND USAGE

1.1 HER2-Positive Metastatic Breast Cancer
ENHERTU is indicated for the treatment of adult patients with unresectable or metastatic HER2-positive breast cancer who have received a prior anti-HER2-based regimen either:
• in the metastatic setting, or
• in the neoadjuvant or adjuvant setting and have developed disease recurrence during or within six months of completing therapy.

1.2 HER2-Low Metastatic Breast Cancer
ENHERTU is indicated for the treatment of adult patients with unresectable or metastatic HER2-low (IHC 1+ or IHC 2+/ISH-) breast cancer, as determined by an FDA-approved test, who have received a prior chemotherapy in the metastatic setting or developed disease recurrence during or within 6 months of completing adjuvant chemotherapy [see Dosage and Administration (2.1)].

1.3 Unresectable or Metastatic HER2-Mutant Non-Small Cell Lung Cancer
ENHERTU is indicated for the treatment of adult patients with unresectable or metastatic non-small cell lung cancer (NSCLC) whose tumors have activating HER2 (ERBB2) mutations, as detected by an FDA-approved test, and who have received a prior systemic therapy.

This indication is approved under accelerated approval based on objective response rate and duration of response [see Clinical Studies (14.3)]. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

1.4 Locally Advanced or Metastatic Gastric Cancer
ENHERTU is indicated for the treatment of adult patients with locally advanced or metastatic HER2-positive gastric or gastroesophageal junction (GEJ) adenocarcinoma who have received a prior trastuzumab-based regimen.

2 DOSAGE AND ADMINISTRATION

2.1 Patient Selection
Unresectable or Metastatic HER2-Low Breast Cancer
Select patients for treatment of unresectable or metastatic HER2-low breast cancer with ENHERTU based on HER2 expression (IHC 1+ or IHC 2+/ISH-) [see Clinical Studies (14.2)].

Unresectable or Metastatic HER2-Mutant NSCLC
Select patients for treatment of unresectable or metastatic HER2-mutant NSCLC with ENHERTU based on the presence of activating HER2 (ERBB2) mutations in tumor or plasma specimens [see Clinical Studies (14.3)]. If no mutation is detected in a plasma specimen, test tumor tissue.

Locally Advanced or Metastatic Gastric Cancer
Select patients with locally advanced or metastatic gastric cancer based on HER2 protein overexpression or HER2 gene amplification. Reassess HER2 status if it is feasible to obtain a new tumor specimen after prior trastuzumab-based therapy and before treatment with ENHERTU.

Additional Patient Selection Information
Information on FDA-approved tests for the detection of HER2 protein expression, HER2 gene amplification, and activating HER2 mutations is available at: http://www.fda.gov/CompanionDiagnostics.

2.2 Recommended Dosage and Schedules
Do not substitute ENHERTU for or with trastuzumab or ado-trastuzumab emtansine.

Recommended Dosage for Locally Advanced or Metastatic Gastric Cancer
The recommended dosage of ENHERTU is 5.4 mg/kg given as an intravenous infusion once every 3 weeks (21-day cycle) until disease progression or unacceptable toxicity.

2.3 Dosage Modifications
Management of adverse reactions may require temporary interruption, dose reduction, or treatment discontinuation of ENHERTU as described in Tables 1 and 2. Do not re-escalate the ENHERTU dose after a dose reduction is made.

Table 1: Dosage Reduction Schedule

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>Severity</th>
<th>Treatment Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interstitial Lung Disease (ILD)/Pneumonitis</td>
<td>Asymptomatic ILD/pneumonitis (Grade 1)</td>
<td>Continue treatment with ENHERTU.</td>
</tr>
<tr>
<td></td>
<td>Symptomatic ILD/pneumonitis (Grade 2 or greater)</td>
<td>Interrupt ENHERTU until resolved to Grade 0, then:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• if resolved in 28 days or less from date of onset, resume dose.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• if resolved greater than 28 days, continue with treatment and do not re-escalate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• permanently discontinue ENHERTU.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• promptly initiate corticosteroid treatment as soon as ILD/pneumonitis is suspected.</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>Grade 3 (less than 1.0 to 0.5 x 10^9/L)</td>
<td>Interrupt ENHERTU until resolved to Grade 2 or less, then maintain dose.</td>
</tr>
<tr>
<td></td>
<td>Grade 4 (less than 0.5 x 10^9/L)</td>
<td>Reduce dose by one level (see Table 1).</td>
</tr>
<tr>
<td>Febrile Neutropenia</td>
<td>Absolute neutrophil count of less than 1.0 x 10^9/L and temperature greater than 38°C or a sustained temperature of 38°C or greater for more than one hour</td>
<td>Interrupt ENHERTU until resolved.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduce dose by one level (see Table 1).</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>Platelet count less than 50 to 25 x 10^9/L</td>
<td>Interrupt ENHERTU until resolved to Grade 1 or less, then maintain dose.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduce dose by one level (see Table 1).</td>
</tr>
<tr>
<td>Left Ventricular Dysfunction</td>
<td>LVEF greater than 45% and absolute decrease from baseline is 10% to 20%</td>
<td>Continue treatment with ENHERTU.</td>
</tr>
<tr>
<td></td>
<td>LVEF 40% to 45% and absolute decrease from baseline is less than 10%</td>
<td>Interrupt ENHERTU.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Repeat LVEF assessment within 3 weeks.</td>
</tr>
</tbody>
</table>

Table 2: Dosage Modifications for Adverse Reactions

Recommended Dosage for Locally Advanced or Metastatic Gastric Cancer
The recommended dosage of ENHERTU is 6.4 mg/kg given as an intravenous infusion once every 3 weeks (21-day cycle) until disease progression or unacceptable toxicity.

Recommended Dosage for Locally Advanced or Metastatic Gastric Cancer

<table>
<thead>
<tr>
<th>Dose Reduction Schedule</th>
<th>Breast Cancer and NSCLC</th>
<th>Gastric Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended starting dose</td>
<td>5.4 mg/kg</td>
<td>6.4 mg/kg</td>
</tr>
<tr>
<td>First dose reduction</td>
<td>4.4 mg/kg</td>
<td>5.4 mg/kg</td>
</tr>
<tr>
<td>Second dose reduction</td>
<td>3.2 mg/kg</td>
<td>4.4 mg/kg</td>
</tr>
</tbody>
</table>

Recommended Dosage for Locally Advanced or Metastatic Gastric Cancer

ENHERTU is indicated for the treatment of adult patients with unresectable or metastatic HER2-mutant NSCLC who have received a prior chemotherapy in the metastatic setting, or developed disease recurrence during or within 6 months of completing therapy.

Recommended Dosage for Locally Advanced or Metastatic Gastric Cancer

Recommended Dosage for Locally Advanced or Metastatic Gastric Cancer

ENHERTU is indicated for the treatment of adult patients with unresectable or metastatic HER2-mutant NSCLC who have received a prior chemotherapy in the metastatic setting, or developed disease recurrence during or within 6 months of completing therapy.

Recommended Dosage for Locally Advanced or Metastatic Gastric Cancer

ENHERTU is indicated for the treatment of adult patients with unresectable or metastatic HER2-mutant NSCLC who have received a prior chemotherapy in the metastatic setting, or developed disease recurrence during or within 6 months of completing therapy.

Recommended Dosage for Locally Advanced or Metastatic Gastric Cancer

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Recommended Dosage for Locally Advanced or Metastatic Gastric Cancer

ENHERTU is indicated for the treatment of adult patients with unresectable or metastatic HER2-mutant NSCLC who have received a prior chemotherapy in the metastatic setting, or developed disease recurrence during or within 6 months of completing therapy.

Recommended Dosage for Locally Advanced or Metastatic Gastric Cancer

ENHERTU is indicated for the treatment of adult patients with unresectable or metastatic HER2-mutant NSCLC who have received a prior chemotherapy in the metastatic setting, or developed disease recurrence during or within 6 months of completing therapy.
Toxicity grades are in accordance with National Cancer Institute Common Terminology Criteria for Adverse Events Version 5.0 (NCI CTCAE v5.0).

### 2.4 Preparation and Administration

In order to prevent medication errors, check the vial labels to ensure that the drug is being prepared and administered as ENHERTU (fam-trastuzumab deruxtecan-nkx) and not trastuzumab or ado-trastuzumab emtansine. Reconstitute and further dilute ENHERTU prior to intravenous infusion. Use appropriate aseptic technique.

ENHERTU (fam-trastuzumab deruxtecan-nkx) is a hazardous drug. Follow applicable special handling and disposal procedures.1

#### Reconstitution

- Reconstitute immediately before dilution.
- More than one vial may be needed for a full dose. Calculate the dose (mg), the total volume of reconstituted ENHERTU solution required, and the number of vial(s) of ENHERTU needed [see Dosage and Administration (2.2)].
- Reconstitute each 100 mg vial by using a sterile syringe to slowly inject 5 mL of Sterile Water for Injection, USP into each vial to obtain a final concentration of 20 mg/mL.
- Swirl the vial gently until completely dissolved. Do not shake.
- Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit. The solution should be clear and colorless to light yellow. Do not use if visible particles are observed or if the solution is cloudy or discolored.
- If not used immediately, store the reconstituted ENHERTU vials in a refrigerator at 2°C to 8°C (36°F to 46°F) for up to 24 hours from the time of reconstitution, protected from light. Do not freeze.
- The product does not contain a preservative. Discard unused ENHERTU after 24 hours refrigerated.

#### Dilution

- Dilute the calculated volume of reconstituted ENHERTU in an intravenous infusion bag containing 100 mL of 5% Dextrose Injection, USP. DO NOT use Sodium Chloride Injection, USP. ENHERTU is compatible with an infusion bag made of polyvinylchloride or polyolefin (copolymer of ethylene and polypropylene).
- Gently invert the infusion bag to thoroughly mix the solution. Do not shake.
- Cover the infusion bag to protect from light.
- If not used immediately, store at room temperature for up to 4 hours including preparation and infusion, or in a refrigerator at 2°C to 8°C (36°F to 46°F) for up to 24 hours, protected from light. Do not freeze.
- Discard any unused portion left in the vial.

#### Administration

- If the prepared infusion solution was stored refrigerated (2°C to 8°C [36°F to 46°F]), allow the solution to reach room temperature prior to administration. Cover the infusion bag to protect from light.
- Administer ENHERTU as an intravenous infusion only with an infusion set made of polyolefin or polybutadiene.
- Administer ENHERTU with a 0.20 or 0.22 micron in-line polysulfonate (PES) filter. Do NOT administer as an intravenous push or bolus.
- Cover the infusion bag to protect from light during administration.
- Do not mix ENHERTU with other drugs or administer other drugs through the same intravenous line.
- First infusion: Administer infusion over 90 minutes.
- Subsequent infusions: Administer over 30 minutes if prior infusions were well tolerated.

### 3 DOSAGE FORMS AND STRENGTHS

For injection: 100 mg of fam-trastuzumab deruxtecan-nkx as a white to yellowish white lyophilized powder in a single-dose vial for reconstitution and further dilution

### 4 CONTRAINDICATIONS

None.

### 5 WARNINGS AND PRECAUTIONS

#### 5.1 Interstitial Lung Disease/Pneumonitis

Severe, life-threatening, or fatal interstitial lung disease (ILD), including pneumonitis, can occur in patients treated with ENHERTU [see Adverse Reactions (6.1)]. A higher incidence of Grade 1 and 2 ILD/pneumonitis has been observed in patients with moderate renal impairment.

Advise patients to immediately report cough, dyspnea, fever, and/or any new or worsening respiratory symptoms. Monitor patients for signs and symptoms of ILD. Promptly investigate evidence of ILD. Evaluate patients with suspected ILD by radiographic imaging. Consider consultation with a pulmonologist. For asymptomatic (Grade 1) ILD, consider corticosteroid treatment (e.g., ≥0.5 mg/kg/day prednisone or equivalent). Withhold ENHERTU until recovery [see Dosage and Administration (2.3)]. In cases of symptomatic ILD (Grade 2 or greater), promptly initiate systemic corticosteroid treatment (e.g., ≥1 mg/kg/day prednisone or equivalent) and continue for at least 14 days followed by gradual taper for at least 4 weeks. Permanently discontinue ENHERTU in patients who are diagnosed with symptomatic (Grade 2 or greater) ILD [see Dosage and Administration (2.3)].

#### Metastatic Breast Cancer and HER2-Mutant NSCLC (5.4 mg/kg)

In patients with metastatic breast cancer and HER2-mutant NSCLC treated with ENHERTU 5.4 mg/kg, ILD occurred in 12% of patients. Fatal outcomes due to ILD and/or pneumonitis occurred in 1.0% of patients treated with ENHERTU. Median time to first onset was 5 months (range: 0.9 to 23).

Locally Advanced or Metastatic Gastric Cancer (6.4 mg/kg)

In patients with locally advanced or metastatic HER2-positive gastric or GEJ adenocarcinoma treated with ENHERTU 6.4 mg/kg, ILD occurred in 10% of patients. Median time to first onset was 2.8 months (range: 1.2 to 21).

#### 5.2 Neutropenia

Severe neutropenia, including febrile neutropenia, can occur in patients treated with ENHERTU. Monitor complete blood counts prior to initiation of ENHERTU and prior to each dose, and as clinically indicated. Based on the severity of neutropenia, ENHERTU may require dose interruption or reduction [see Dosage and Administration (2.3)].

#### Metastatic Breast Cancer and HER2-Mutant NSCLC (5.4 mg/kg)

In patients with metastatic breast cancer and HER2-mutant NSCLC treated with ENHERTU 5.4 mg/kg, a decrease in neutrophil count was reported in 65% of patients. Sixteen percent had Grade 3 or 4 decreased neutrophil count. Median time to first onset of decreased neutrophil count was 22 days (range: 2 to 664). Febrile neutropenia was reported in 1.1% of patients.

Locally Advanced or Metastatic Gastric Cancer (6.4 mg/kg)

In patients with locally advanced or metastatic HER2-positive gastric or GEJ adenocarcinoma treated with ENHERTU 6.4 mg/kg, a decrease in neutrophil count was reported in 72% of patients. Fifty-one percent had Grade 3 or 4 decreased neutrophil count. Median time to first onset of decreased neutrophil count was 22 days (range: 2 to 187). Febrile neutropenia was reported in 4.8% of patients. 

#### 5.3 Left Ventricular Dysfunction

Patients treated with ENHERTU may be at increased risk of developing left ventricular dysfunction. Left ventricular ejection fraction (LVEF) decrease has been observed with anti-HER2 therapies, including ENHERTU. Assess LVEF prior to initiation of ENHERTU and at regular intervals during treatment as clinically indicated. Manage LVEF decrease through treatment interruption. Permanently discontinue ENHERTU if LVEF of less than 40% or absolute decrease from baseline of greater than 20% is confirmed. Permanently discontinue ENHERTU in patients with symptomatic congestive heart failure (CHF) [see Dosage and Administration (2.3)].

Treatment with ENHERTU has not been studied in patients with a history of clinically significant cardiac disease or LVEF less than 50% prior to initiation of treatment.

#### Metastatic Breast Cancer and HER2-Mutant NSCLC (5.4 mg/kg)

In patients with metastatic breast cancer and HER2-mutant NSCLC treated with ENHERTU 5.4 mg/kg, LVEF decrease was reported in 3.6% of patients, of which 0.4% were Grade 3.

Locally Advanced or Metastatic Gastric Cancer (6.4 mg/kg)

In patients with locally advanced or metastatic HER2-positive gastric or GEJ adenocarcinoma treated with ENHERTU 6.4 mg/kg, no clinical adverse events of heart failure were reported; however, echocardiography, 8% were found to have asymptomatic Grade 2 decrease in LVEF.

#### 5.4 Embryo-Fetal Toxicity

Based on its mechanism of action, ENHERTU can cause fetal harm when administered to a pregnant woman. In postmarketing reports, use of a HER2-directed antibody during pregnancy resulted in cases of oligohydramnios manifesting as fatal pulmonary hypoplasia, skeletal abnormalities, and neonatal death. Based on its mechanism of action, the topoisomerase inhibitor component of ENHERTU, DXd, can also cause embryo-fetal toxicity when administered to a pregnant woman because it is genotoxic and targets actively dividing cells [see Use in Specific Populations (8.1), Clinical Pharmacology (12.1), Nonclinical Toxicology (13.1)]. Advise patients of the potential risks to a fetus.

Verify the pregnancy status of females of reproductive potential prior to the initiation of ENHERTU. Advise females of reproductive potential to use effective contraception during treatment and for 7 months after the last dose of ENHERTU. Advise male patients with female partners of reproductive potential to use effective contraception during treatment with ENHERTU and for 4 months after the last dose of ENHERTU [see Use in Specific Populations (8.1, 8.3)].
6 ADVERSE REACTIONS

The following clinically significant adverse reactions are described elsewhere in the labeling:
- Interstitial Lung Disease/Pneumonitis [see Warnings and Precautions (5.1)]
- Neutropenia [see Warnings and Precautions (5.2)]
- Left Ventricular Dysfunction [see Warnings and Precautions (5.3)]

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.

Metastatic Breast Cancer and HER2-Mutant NSCLC (5.4 mg/kg)

The pooled safety population described in WARNINGS AND PRECAUTIONS reflects exposure to ENHERTU 5.4 mg/kg intravenously every 3 weeks in 384 patients in Study DS8201-A-J101 (NCT02564900), DESTINY-Breast01, DESTINY-Breast03, DESTINY-Breast04, and DESTINY-Lung02. Among these patients, 65% were exposed for greater than 6 months and 39% were exposed for greater than one year. In this pooled safety population, the most common (>20%) adverse reactions (including laboratory abnormalities) were nausea (76%), decreased white blood cell count (71%), decreased hemoglobin (66%), decreased neutrophil count (65%), decreased lymphocyte count (55%), fatigue (54%), decreased platelet count (47%), increased aspartate aminotransferase (48%), vomiting (44%), increased alanine aminotransferase (42%), alopecia (39%), increased blood alkaline phosphatase (39%), constipation (34%), musculoskeletal pain (32%), decreased appetite (32%), hypokalemia (28%), diarrhea (28%), and respiratory infection (24%).

Locally Advanced or Metastatic Gastric Cancer (6.4 mg/kg)

The data described in WARNINGS and PRECAUTIONS reflect exposure to ENHERTU 6.4 mg/kg intravenously every 3 weeks in 125 patients in DESTINY-Gastric01.

HER2-Positive Metastatic Breast Cancer

DESTINY-Breast03

The safety of ENHERTU was evaluated in 257 patients with unresectable or metastatic HER2-positive breast cancer who received at least one dose of ENHERTU 5.4 mg/kg in DESTINY-Breast03 [see Clinical Studies (14.1)]. ENHERTU was administered by intravenous infusion once every three weeks. The median duration of treatment was 14 months (range: 0.7 to 30) for patients who received ENHERTU and 7 months (range: 0.7 to 25) for patients who received ado-trastuzumab emtansine.

Serious adverse reactions occurred in 19% of patients receiving ENHERTU. Serious adverse reactions in >1% of patients who received ENHERTU were vomiting, interstitial lung disease, pneumonia, pyrexia, and urinary tract infection. Fatalities due to adverse reactions occurred in 0.8% of patients including COVID-19 and sudden death (one patient each).

ENHERTU was permanently discontinued in 14% of patients, of which ILD/pneumonitis accounted for 8%. Dose interruptions due to adverse reactions occurred in 44% of patients treated with ENHERTU. The most frequent adverse reactions (>2%) associated with dose interruption were neutropenia, leukopenia, anemia, thrombocytopenia, pneumonia, nausea, fatigue, and ILD/pneumonitis. Dose reductions occurred in 21% of patients treated with ENHERTU. The most frequent adverse reactions (>2%) associated with dose reduction were nausea, neutropenia, and fatigue.

The most common (>20%) adverse reactions, including laboratory abnormalities, were nausea, decreased white blood cell count, decreased neutrophil count, increased aspartate aminotransferase, decreased hemoglobin, decreased lymphocyte count, increased alanine aminotransferase, decreased platelet count, fatigue, vomiting, increased blood alkaline phosphatase, alopecia, hypokalemia, constipation, musculoskeletal pain, diarrhea, decreased appetite, headache, respiratory infection, abdominal pain, increased blood bilirubin, and stomatitis.

Table 3 and 4 summarize common adverse reactions and laboratory abnormalities observed in DESTINY-Breast03.

### Table 3: Common Adverse Reactions (>10% All Grades or ≥2% Grades 3-4) in Patients Treated with ENHERTU in DESTINY-Breast03

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>ENHERTU 5.4 mg/kg</th>
<th>ENHERTU 5.4 mg/kg</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Grades</td>
<td>N=257</td>
<td>N=261</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Grades 3-4</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>All Grades</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Grades 3-4</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

#### Gastrointestinal Disorders

- Nausea: 76% (30% 0.4)
- Vomiting: 49 (10 0.8)
- Constipation: 34 (20 0)
- Diarrhea: 29 (7 0.4)
- Abdominal pain: 21 (8 0.4)
- Stomatitis: 20 (5 0)
- Dyspepsia: 11 (0 0)

#### General Disorders and Administration Site Conditions

- Fatigue: 49 (35 0.8)

### Table 3: Common Adverse Reactions (>10% All Grades or ≥2% Grades 3-4) in Patients Treated with ENHERTU in DESTINY-Breast03

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>ENHERTU 5.4 mg/kg</th>
<th>ENHERTU 5.4 mg/kg</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Grades</td>
<td>N=257</td>
<td>N=261</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Grades 3-4</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>All Grades</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Grades 3-4</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

#### Blood and Lymphatic System Disorders

- Anemia: 33 (17 6)

#### Skin and Subcutaneous Tissue Disorders

- Alopecia: 37 (3.1 0)

#### Musculoskeletal and Connective Tissue Disorders

- Musculoskeletal pain: 31 (25 0.4)

#### Metabolism and Nutrition Disorders

- Decreased appetite: 29 (1.6 0.4)

#### Respiratory, Thoracic and Mediastinal Disorders

- Decreased weight: 17 (6 0.4)

#### Nervous System Disorders

- Headache: 22 (16 0)
- Peripheral neuropathy: 13 (14 0.4)
- Dizziness: 13 (8 0)

Events were graded using NCI CTCAE version 5.0.

- a Including abdominal pain, abdominal discomfort, lower abdominal pain, and upper abdominal pain
- b Including stomatitis, aphthous ulcer, mouth ulceration, oral mucosa erosion, and oral mucosal erosion
- c Including fatigue, asthenia, malaise, and lethargy
- d Including anemia, decreased hemoglobin, and decreased red blood cell count
- e This Grade 3 event was reported by the investigator. Per NCI CTCAE v5.0, the highest NCI CTCAE grade for alopecia is Grade 2.
- f Including back pain, myalgia, pain in extremity, musculoskeletal pain, muscle spasms, bone pain, neck pain, musculoskeletal chest pain, and limb discomfort
- g Including respiratory tract infection, lower and upper respiratory tract infection, pneumonia, influenza, influenza-like illness, viral upper respiratory infection, bronchitis, and respiratory syncytial virus infection
- h Interstitial lung disease includes events that were adjudicated as ILD for ENHERTU: pneumonitis, interstitial lung disease, organizing pneumonia, pneumonia, and pulmonary mass.
- i Including headache and migraine
- j Including peripheral neuropathy, peripheral sensory neuropathy, and paresthesia

Other clinically relevant adverse reactions reported in less than 10% of patients in the ENHERTU-treated group were:
- Respiratory, Thoracic and Mediastinal Disorders: dyspnea (8%)
- Skin and Subcutaneous Tissue Disorders: pruritus (8%) and skin hyperpigmentation (6%) [including skin hyperpigmentation, skin discoloration, and pigmentation disorder]
- Nervous System Disorders: dysgeusia (6%)
- Metabolism and Nutrition Disorders: dehydration (4.3%)
- Eye Disorders: blurred vision (3.5%)
- Cardiac Disorders: asymptomatic left ventricular ejection fraction decrease (2.7%)
- Injury, Poisoning and Procedural Complications: infusion-related reactions (2.3%) [including hypersensitivity and infusion-related reactions]
- Blood and Lymphatic System Disorders: febrile neutropenia (0.8%)
The safety of ENHERTU was evaluated in a pooled analysis of 234 patients with unresectable or metastatic HER2-positive breast cancer who received at least one dose of ENHERTU 5.4 mg/kg in DESTINY-Breast01 and Study DS8201-A-J101 (NCT02564900). [see Clinical Studies (14.1)]. ENHERTU was administered by intravenous infusion once every three weeks. The median duration of treatment was 7 months (range: 0.7 to 31).

In the pooled 234 patients, the median age was 56 years (range: 28-96), 74% of patients were <65 years, 99.6% of patients were female, and the majority were White (51%) or Asian (42%). Patients had an Eastern Cooperative Oncology Group (ECOG) performance status of 0 (58%) or 1 (42%) at baseline. Ninety-four percent had visceral disease, 31% had bone metastases, and 13% had brain metastases.

Serious adverse reactions occurred in 20% of patients receiving ENHERTU. Serious adverse reactions in >1% of patients who received ENHERTU were interstitial lung disease, pneumonia, vomiting, nausea, cellulitis, hypokalemia, and intestinal obstruction. Fatalities due to adverse reactions occurred in 4.3% of patients. The most common (>10%) adverse reactions were interstitial lung disease, respiratory failure, organizing pneumonia, acute respiratory failure, lung infiltration, lymphangitis, and alveolitis.

ENHERTU was permanently discontinued in 9% of patients, of which ILD accounted for 6%. Dose interruptions due to adverse reactions occurred in 33% of patients treated with ENHERTU. The most frequent adverse reactions (>2%) associated with dose interruption were neutropenia, anemia, thrombocytopenia, leukopenia, upper respiratory tract infection, fatigue, nausea, and ILD. Dose reductions occurred in 18% of patients treated with ENHERTU. The most frequent adverse reactions (>2%) associated with dose reduction were fatigue, nausea, and neutropenia.

The most common (>20%) adverse reactions, including laboratory abnormalities, were nausea, decreased white blood cell count, decreased hemoglobin, decreased neutrophil count, fatigue, vomiting, alopecia, increased aspartate aminotransferase, increased alanine aminotransferase, decreased platelet count, constipation, decreased appetite, diarrhea, hypokalemia, and cough.

Tables 5 and 6 summarize common adverse reactions and laboratory abnormalities observed in ENHERTU-treated patients in DESTINY-Breast01 and Study DS8201-A-J101.
Frequencies were based on NCI CTCAE v.4.03 grade-derived laboratory abnormalities. Percentages were calculated using patients with worsening laboratory values from baseline and the number of patients with both baseline and post-treatment measurements as the denominator. Frequencies were based on NCI CTCAE v.4.03 grade-derived laboratory abnormalities.

**HER2-Low Metastatic Breast Cancer**

The safety of ENHERTU was evaluated in 371 patients with unresectable or metastatic HER2-low (IHC 1+ or IHC 2+/ISH-) breast cancer who received ENHERTU 5.4 mg/kg in DESTINY-Breast04 (see Clinical Studies [14.2]). ENHERTU was administered by intravenous infusion once every three weeks. The median duration of treatment was 8 months (range: 0.2 to 33) for patients who received ENHERTU.

Serious adverse reactions occurred in 28% of patients receiving ENHERTU. Serious adverse reactions in >1% of patients who received ENHERTU were ILD/pneumonitis, pneumonia, dyspnea, musculoskeletal pain, sepsis, anemia, febrile neutropenia, hypercalcemia, nausea, pyrexia, and vomiting. Fatalities due to adverse reactions occurred in 4.0% of patients including ILD/pneumonitis (3 patients); sepsis (2 patients); and ischemic colitis, disseminated intravascular coagulation, dyspnea, febrile neutropenia, general physical health deterioration, pleural effusion, and respiratory failure (1 patient each).

ENHERTU was permanently discontinued in 16% of patients, of which ILD/pneumonitis accounted for 8%. Dose interruptions due to adverse reactions occurred in 39% of patients treated with ENHERTU. The most frequent adverse reactions (>2%) associated with dose interruption were neutropenia, fatigue, anemia, leukopenia, COVID-19, ILD/pneumonitis, increased transaminases, and hyperbilirubinemia. Dose reductions occurred in 23% of patients treated with ENHERTU. The most frequent adverse reactions (>2%) associated with dose reduction were fatigue, nausea, thrombocytopenia, and neutropenia.

The most common (>20%) adverse reactions, including laboratory abnormalities, were nausea, decreased white blood cell count, decreased hemoglobin, decreased neutrophil count, decreased lymphocyte count, fatigue, decreased platelet count, alopecia, vomiting, increased aspartate aminotransferase, increased alanine aminotransferase, constipation, increased blood alkaline phosphatase, decreased appetite, musculoskeletal pain, diarrhea, and pyrexia.

Tables 7 and 6 summarize common adverse reactions and laboratory abnormalities observed in DESTINY-Breast04.

### Table 6: Selected Laboratory Abnormalities in Patients with Unresectable or Metastatic HER2-positive Breast Cancer Treated with ENHERTU in DESTINY-Breast01 and Study DS8201-A-J101

<table>
<thead>
<tr>
<th>Laboratory Parameter</th>
<th>ENHERTU 5.4 mg/kg N=234</th>
<th>Chemotherapy</th>
<th>All Grades</th>
<th>Grades 3 or 4</th>
<th>All Grades</th>
<th>Grades 3 or 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hematology</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased white blood cell count</td>
<td>70%</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased hemoglobin</td>
<td>70%</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased neutrophil count</td>
<td>62%</td>
<td>16%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased platelet count</td>
<td>37%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chemistry</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased aspartate aminotransferase</td>
<td>41%</td>
<td>0.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased alanine aminotransferase</td>
<td>38%</td>
<td>0.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypokalemia</td>
<td>26%</td>
<td>3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Percentages were calculated using patients with worsening laboratory values from baseline and the number of patients with both baseline and post-treatment measurements as the denominator.

### Table 7: Common Adverse Reactions (>10% All Grades or ≥2%, Grades 3 or 4) in Patients Treated with ENHERTU in DESTINY-Breast04

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>ENHERTU 5.4 mg/kg N=371</th>
<th>Chemotherapy N=172</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gastrointestinal Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>76%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Vomiting</td>
<td>40%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Constipation</td>
<td>34%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>27%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>18%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Stomatitis</td>
<td>13%</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>General Disorders and Administration Site Conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>54%</td>
<td>9%</td>
</tr>
<tr>
<td>Pyrexia</td>
<td>12%</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Skin and Subcutaneous Tissue Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alopecia</td>
<td>40%</td>
<td>0%</td>
</tr>
<tr>
<td>Rash</td>
<td>13%</td>
<td>0%</td>
</tr>
</tbody>
</table>

(continued)

Events were graded using NCI CTCAE version 5.0.

- a Including abdominal pain, abdominal discomfort, lower abdominal pain, and upper abdominal pain
- b Including stomatitis, aphthous ulcer, mouth ulceration, and pharyngeal inflammation
- c Including fatigue, asthenia, and malaise
- d Including rash, pruritic rash, pruritic rash, muculo-papular rash, palmar-plantar erythrodysthesia syndrome, papular rash, macular rash, eczema, erythema multiforme, dermatitis, urticarial dermatitis, drug eruption, and dermatitis bullous
- e Including anemia, decreased hemoglobin, and decreased red blood cell count
- f Including back pain, myalgia, pain in extremity, musculoskeletal pain, bone pain, musculoskeletal chest pain, arthralgia, noncardiac chest pain, musculoskeletal stiffness, arthritis, spinal pain, and neck pain
- g Including esophageal varices, hemorrhage, hemorrhoidal hemorrhage, epistaxis, hematuria, conjunctival hemorrhage, vaginal hemorrhage, gingival bleeding, genital hemorrhage, eye hemorrhage, hemothysis, hemorrhagic cystitis, pharyngeal hemorrhage, rectal hemorrhage, upper gastrointestinal hemorrhage, and esophageal hemorrhage
- h Including headache and migraine
- i Including peripheral neuropathy, peripheral sensory neuropathy, peripheral motor neuropathy, polyneuropathy, paresthesia, hypoesthesia, dysesthesia, and neuralgia
- j Including dizziness, postural dizziness, and vertigo
- k Including upper respiratory tract infection, influenza, influenza-like illness, nasopharyngitis, pharyngitis, sinusitis, and rhinitis
- l Interstitial lung disease includes events that were adjudicated as ILD for ENHERTU: interstitial lung disease, pneumonitis, organizing pneumonia, pneumonia, and radiation pneumonitis.

Other clinically relevant adverse reactions reported in less than 10% of patients treated with ENHERTU:

- **Nervous System Disorders:** dysgeusia (10%)
- **Respiratory, Thoracic and Mediastinal Disorders:** cough (10%)
- **Gastrointestinal Disorders:** abdominal distension (5%), gastritis (2.7%), flatulence (2.4%)
- **Eye Disorders:** blurred vision (4.9%) [including blurred vision and visual impairment]
- **Skin and Subcutaneous Tissue Disorders:** pruritus (3.2%) and skin hyperpigmentation (2.7%) [including skin hyperpigmentation, skin discoloration, and pigmentation disorder]
- **Metabolism and Nutrition Disorders:** dehydration (1.9%)
- **Blood and Lymphatic System Disorders:** febrile neutropenia (1.1%)
- **Injury, Poisoning and Procedural Complications:** infusion-related reactions (0.5%) [including injection site reaction and chills]
Frequencies were based on NCI CTCAE v.5.0 grade-derived laboratory abnormalities. Baseline and the number of patients with both baseline and post-treatment measurements as the denominator. Percentages were calculated using patients with worsening laboratory values from baseline.

### Table 8: Selected Laboratory Abnormalities in Patients in DESTINY-Breast04

<table>
<thead>
<tr>
<th>Laboratory Parameter</th>
<th>ENHERTU 5.4 mg/kg N=371</th>
<th>Chemotherapy N=172</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades %</td>
<td>Grades 3 or 4 %</td>
</tr>
<tr>
<td><strong>Hematology</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased white blood cell count</td>
<td>70</td>
<td>9</td>
</tr>
<tr>
<td>Decreased hemoglobin</td>
<td>64</td>
<td>8</td>
</tr>
<tr>
<td>Decreased neutrophil count</td>
<td>64</td>
<td>14</td>
</tr>
<tr>
<td>Decreased lymphocyte count</td>
<td>55</td>
<td>18</td>
</tr>
<tr>
<td>Decreased platelet count</td>
<td>44</td>
<td>6</td>
</tr>
<tr>
<td><strong>Chemistry</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased aspartate aminotransferase</td>
<td>38</td>
<td>2.2</td>
</tr>
<tr>
<td>Increased alanine aminotransferase</td>
<td>36</td>
<td>0.8</td>
</tr>
<tr>
<td>Increased blood alkaline phosphatase</td>
<td>34</td>
<td>0.3</td>
</tr>
<tr>
<td>Hypokalemia</td>
<td>25</td>
<td>3.3</td>
</tr>
<tr>
<td>Increased blood bilirubin</td>
<td>16</td>
<td>2.7</td>
</tr>
<tr>
<td>Increased blood creatinine</td>
<td>15</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Percentages were calculated using patients with worsening laboratory values from baseline and the number of patients with both baseline and post-treatment measurements as the denominator.

### Table 9: Common Adverse Reactions (≥10% All Grades or ≥2% Grades 3 or 4) in Patients with Unresectable or Metastatic HER2-Mutant NSCLC in DESTINY-Lung02

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>ENHERTU 5.4 mg/kg N=101</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades %</td>
</tr>
<tr>
<td><strong>Gastrointestinal Disorders</strong></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>61</td>
</tr>
<tr>
<td>Constipation</td>
<td>31</td>
</tr>
<tr>
<td>Vomiting</td>
<td>26</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>19</td>
</tr>
<tr>
<td>Stomatitis</td>
<td>12</td>
</tr>
<tr>
<td><strong>Blood and Lymphatic System Disorders</strong></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>34</td>
</tr>
</tbody>
</table>

### Table 10: Select Laboratory Abnormalities in Patients with Unresectable or Metastatic HER2-Mutant NSCLC in DESTINY-Lung02

<table>
<thead>
<tr>
<th>Laboratory Parameter</th>
<th>ENHERTU 5.4 mg/kg N=101</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades %</td>
</tr>
<tr>
<td><strong>Hematology</strong></td>
<td></td>
</tr>
<tr>
<td>Decreased white blood cell count</td>
<td>60</td>
</tr>
<tr>
<td>Decreased hemoglobin</td>
<td>58</td>
</tr>
<tr>
<td>Decreased neutrophil count</td>
<td>52</td>
</tr>
<tr>
<td>Decreased lymphocyte count</td>
<td>43</td>
</tr>
<tr>
<td>Decreased platelet count</td>
<td>40</td>
</tr>
<tr>
<td><strong>Chemistry</strong></td>
<td></td>
</tr>
<tr>
<td>Decreased albumin</td>
<td>39</td>
</tr>
<tr>
<td>Increased aspartate aminotransferase</td>
<td>35</td>
</tr>
<tr>
<td>Increased alanine aminotransferase</td>
<td>34</td>
</tr>
<tr>
<td>Increased alkaline phosphatase</td>
<td>22</td>
</tr>
<tr>
<td>Hypokalemia</td>
<td>17</td>
</tr>
</tbody>
</table>

Events were graded using NCI CTCAE version 5.0.

- a Including vomiting and retching
- b Including mucosal inflammation and stomatitis
- c Including asthenia, fatigue, and malaise
- d Including back pain, musculoskeletal stiffness, musculoskeletal chest pain, arthralgia, musculoskeletal pain, myalgia, and pain in extremity

Other clinically relevant adverse reactions reported in less than 10% of patients were:
- Respiratory, Thoracic and Mediastinal Disorders: interstitial lung disease (6%) [including interstitial lung disease that was adjudicated as ILD including pneumonitis, interstitial lung disease, pulmonary toxicity, and respiratory failure], dyspnea (5%), and epistaxis (3%)
- Gastrointestinal Disorders: abdominal pain (9%) [including abdominal discomfort, abdominal pain, and upper abdominal pain]
- Skin and Subcutaneous Disorders: rash (3%) [including rash and maculo-papular rash]
- Infections and Infestations: upper respiratory tract infection (4%) [including upper respiratory tract infection, pharyngitis, and laryngitis]
- Nervous System Disorders: headache (4%) [including headache and migraine]

### Table 9: Common Adverse Reactions (≥10% All Grades or ≥2% Grades 3 or 4) in Patients with Unresectable or Metastatic HER2-Mutant NSCLC in DESTINY-Lung02

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>ENHERTU 5.4 mg/kg N=101</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades %</td>
</tr>
<tr>
<td><strong>General Disorders and Administration Site Conditions</strong></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>32</td>
</tr>
<tr>
<td><strong>Metabolism and Nutrition Disorders</strong></td>
<td></td>
</tr>
<tr>
<td>Decreased appetite</td>
<td>30</td>
</tr>
<tr>
<td><strong>Skin and Subcutaneous Tissue Disorders</strong></td>
<td></td>
</tr>
<tr>
<td>Alopecia</td>
<td>21</td>
</tr>
<tr>
<td><strong>Musculoskeletal and Connective Tissue Disorders</strong></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal pain</td>
<td>15</td>
</tr>
</tbody>
</table>

- a Including vomiting and retching
- b Including mucosal inflammation and stomatitis
- c Including asthenia, fatigue, and malaise
- d Including back pain, musculoskeletal stiffness, musculoskeletal chest pain, arthralgia, musculoskeletal pain, myalgia, and pain in extremity

- a Percentages were calculated using patients with worsening laboratory values from baseline and the number of patients with both baseline and post-treatment measurements as the denominator.
- b Frequencies were based on NCI CTCAE v.5.0 grade-derived laboratory abnormalities.
- c The denominator used to calculate the rate varied from 98 to 99 based on the number of patients with a baseline value and at least one post-treatment value.

**Locally Advanced or Metastatic Gastric Cancer**

The safety of ENHERTU was evaluated in 187 patients with locally advanced or metastatic HER2-positive gastric or GEJ adenocarcinoma in DESTINY-Gastric01 [see Clinical Studies (14.4)]. Patients intravenously received at least one dose of either ENHERTU (N=125) 6.4 mg/kg once every three weeks or either irinotecan (N=7) 150 mg/m² biweekly or paclitaxel (N=7) 80 mg/m² weekly for 3 weeks. The median duration of treatment was 4.6 months (range: 0.7 to 22.3) in the ENHERTU group and 2.8 months (range: 0.5 to 13.1) in the irinotecan/paclitaxel group.

Serious adverse reactions occurred in 44% of patients receiving ENHERTU 6.4 mg/kg. Serious adverse reactions in ≥2% of patients who received ENHERTU included pneumonia (6%), respiratory, thoracic and mediastinal disorders (5%), interstitial lung disease (6%), and pleural effusion (3%).
ENHERTU was permanently discontinued in 15% of patients, of which ILD accounted for 6%. Dose interruptions due to adverse reactions occurred in 62% of patients treated with ENHERTU. The most frequent adverse reactions (≥2%) associated with dose interruption were neutropenia, anemia, decreased appetite, leukopenia, fatigue, thrombocytopenia, ILD, pneumonia, lymphopenia, upper respiratory tract infection, diarrhea, and hypokalemia. Dose reductions occurred in 32% of patients treated with ENHERTU. The most frequent adverse reactions (≥2%) associated with dose reduction were neutropenia, decreased appetite, fatigue, nausea, and febrile neutropenia.

The most common (≥20%) adverse reactions, including laboratory abnormalities, were decreased hemoglobin, decreased white blood cell count, decreased neutrophil count, decreased lymphocyte count, decreased platelet count, nausea, decreased appetite, increased aspartate aminotransferase, fatigue, increased blood alkaline phosphatase, increased alanine aminotransferase, diarrhea, hypokalemia, vomiting, constipation, increased blood bilirubin, pyrexia, and alopecia.

Tables 11 and 12 summarize adverse reactions and laboratory abnormalities observed in patients receiving ENHERTU 6.4 mg/kg in DESTINY-Gastric01.

### Table 11: Adverse Reactions in ≥10% All Grades or ≥2% Grades 3 or 4 of Patients Receiving ENHERTU in DESTINY-Gastric01

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>ENHERTU 6.4 mg/kg N=125</th>
<th>Irinotecan or Paclitaxel N=62</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades %</td>
<td>Grades 3 or 4 %</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>63</td>
<td>4.8</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>32</td>
<td>2.4</td>
</tr>
<tr>
<td>Vomiting</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>Constipation</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Abdominal pain&lt;sup&gt;a&lt;/sup&gt;</td>
<td>14</td>
<td>0.8</td>
</tr>
<tr>
<td>Stomatitis&lt;sup&gt;b&lt;/sup&gt;</td>
<td>11</td>
<td>1.6</td>
</tr>
<tr>
<td>Metabolism and Nutrition Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased appetite</td>
<td>60</td>
<td>17</td>
</tr>
<tr>
<td>Dehydration</td>
<td>6</td>
<td>2.4</td>
</tr>
<tr>
<td>Blood and Lymphatic System Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia&lt;sup&gt;a&lt;/sup&gt;</td>
<td>58</td>
<td>38</td>
</tr>
<tr>
<td>Febrile neutropenia</td>
<td>4.8</td>
<td>4.8</td>
</tr>
<tr>
<td>General Disorders and Administration Site Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue&lt;sup&gt;d&lt;/sup&gt;</td>
<td>55</td>
<td>9</td>
</tr>
<tr>
<td>Pyrexia</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Peripheral edema</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Skin and Subcutaneous Tissue Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alopecia</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>Respiratory, Thoracic and Mediastinal Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interstitial lung disease&lt;sup&gt;e&lt;/sup&gt;</td>
<td>10</td>
<td>2.4</td>
</tr>
<tr>
<td>Hepatobiliary Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal hepatic function</td>
<td>8</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Events were graded using NCI CTCAE version 4.03.

<sup>a</sup> Including abdominal discomfort, gastrointestinal pain, abdominal pain, lower abdominal pain, and upper abdominal pain
<sup>b</sup> Including stomatitis, aphthous ulcer, mouth ulceration, oral mucosa erosion, and oral mucosal blistering
<sup>c</sup> Including anemia, decreased hemoglobin, decreased red blood cell count, and decreased hematocrit
<sup>d</sup> Including fatigue, asthenia, and malaise
<sup>e</sup> Interstitial lung disease includes events that were adjudicated as ILD: pneumonitis, interstitial lung disease, respiratory failure, organzng pneumonia, acute respiratory failure, lung infiltration, lymphangitis, and alveolitis.

### Table 12: Selected Laboratory Abnormalities Occurring in Patients Receiving ENHERTU in DESTINY-Gastric01

<table>
<thead>
<tr>
<th>Laboratory Parameter</th>
<th>ENHERTU 6.4 mg/kg N=125</th>
<th>Irinotecan or Paclitaxel N=62</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades %</td>
<td>Grades 3 or 4 %</td>
</tr>
<tr>
<td>Hematology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased hemoglobin</td>
<td>75</td>
<td>38</td>
</tr>
<tr>
<td>Decreased white blood cell count</td>
<td>74</td>
<td>29</td>
</tr>
<tr>
<td>Decreased neutrophil count</td>
<td>72</td>
<td>51</td>
</tr>
<tr>
<td>Decreased lymphocyte count</td>
<td>70</td>
<td>28</td>
</tr>
<tr>
<td>Decreased platelet count</td>
<td>68</td>
<td>12</td>
</tr>
<tr>
<td>Chemistry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased aspartate aminotransferase</td>
<td>58</td>
<td>9</td>
</tr>
<tr>
<td>Increased blood alkaline phosphatase</td>
<td>54</td>
<td>8</td>
</tr>
<tr>
<td>Increased alanine aminotransferase</td>
<td>47</td>
<td>9</td>
</tr>
<tr>
<td>Hypokalemia</td>
<td>30</td>
<td>4.8</td>
</tr>
<tr>
<td>Increased blood bilirubin</td>
<td>24</td>
<td>7</td>
</tr>
</tbody>
</table>

Percentages were calculated using patients with worsening laboratory values from baseline and the number of patients with both baseline and post-treatment measurements as the denominator.

### 8 USE IN SPECIFIC POPULATIONS

#### 8.1 Pregnancy

**Risk Summary**

Based on its mechanism of action, ENHERTU can cause fetal harm when administered to a pregnant woman. There are no available data on the use of ENHERTU in pregnant women. In postmarketing reports, use of a HER2-directed antibody during pregnancy resulted in cases of oligohydramnios manifesting as fetal pulmonary hypoplasia, skeletal abnormalities, and neonatal death (see Data). Based on its mechanism of action, the topoisomerase inhibitor component of ENHERTU, DXd, can also cause embryo-fetal harm when administered to a pregnant woman because.seti is genotoxic and targets actively dividing cells (see Clinical Pharmacology (12.1), Nonclinical Toxicology (13.1)). Advise patients of the potential risks to a fetus.

There are clinical considerations if ENHERTU is used in pregnant women, or if a patient becomes pregnant within 7 months after the last dose of ENHERTU (see Clinical Considerations).

The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2 to 4% and 15 to 20%, respectively.

**Clinical Considerations**

Fetal/Neonatal Adverse Reactions

Monitor women who received ENHERTU during pregnancy or within 7 months prior to conception for oligohydramnios. If oligohydramnios occurs, perform fetal testing that is appropriate for gestational age and consistent with community standards of care.

### Data

**Human Data**

There are no available data on the use of ENHERTU in pregnant women. In postmarketing reports in pregnant women receiving a HER2-directed antibody, cases of oligohydramnios manifesting as fetal pulmonary hypoplasia, skeletal abnormalities, and neonatal death have been reported. These case reports described oligohydramnios in pregnant women who received a HER2-directed antibody either alone or in combination with chemotherapy. In some case reports, amniotic fluid index increased after use of a HER2-directed antibody was stopped.

**Animal Data**

There were no animal reproductive or developmental toxicity studies conducted with fam-trastuzumab deruxtecan-nxki.

#### 8.2 Lactation

**Risk Summary**

There is no data regarding the presence of fam-trastuzumab deruxtecan-nxki in human milk, the effects on the breastfed child, or the effects on milk production. Because of the potential for serious adverse reactions in a breastfed child, advise women not to breastfeed during treatment with ENHERTU and for 7 months after the last dose.
8.3 Females and Males of Reproductive Potential
Pregnancy Testing
Verify pregnancy status of females of reproductive potential prior to initiation of ENHERTU.

Contraception

Females
ENHERTU can cause fetal harm when administered to a pregnant woman [see Use in Specific Populations (8.1)]. Advise females of reproductive potential to use effective contraception during treatment with ENHERTU and for 4 months after the last dose [see Nonclinical Toxicology (13.1)].

Males
Because of the potential for genotoxicity, advise male patients with female partners of reproductive potential to use effective contraception during treatment with ENHERTU and for 4 months after the last dose [see Nonclinical Toxicology (13.1)].

Infertility
Based on findings in animal toxicity studies, ENHERTU may impair male reproductive function and fertility [see Nonclinical Toxicology (13.1)].

8.4 Pediatric Use
Safety and effectiveness of ENHERTU have not been established in pediatric patients.

8.5 Geriatric Use
Of the 883 patients with breast cancer treated with ENHERTU 5.4 mg/kg, 22% were 66 years or older and 3.6% were 75 years or older. No overall differences in efficacy within clinical studies were observed between patients ≥65 years of age compared to younger patients (48%).

Of the 101 patients with unresectable or metastatic HER2-mutant NSCLC treated with ENHERTU 5.4 mg/kg, 40% were 65 years or older and 8% were 75 years or older. No overall differences in efficacy or safety were observed between patients ≥65 years of age compared to younger patients.

Of the 125 patients with locally advanced or metastatic HER2-positive gastric or GEJ adenocarcinoma treated with ENHERTU 6.4 mg/kg in DESTINY-Gastric01, 56% were 66 years or older and 14% were 75 years or older. No overall differences in efficacy or safety were observed between patients ≥65 years of age compared to younger patients.

8.6 Renal Impairment
No dose adjustment of ENHERTU is required in patients with mild (creatinine clearance [CLcr] ≥60 and <90 mL/min) or moderate (CLcr ≥30 and <60 mL/min) renal impairment [see Clinical Pharmacology (12.3)]. A higher incidence of Grade 3–4 adverse reactions observed in patients aged 65 years or older (60%) as compared to younger patients (48%).

Of the 101 patients with unresectable or metastatic HER2-mutant NSCLC treated with ENHERTU 5.4 mg/kg, 40% were 65 years or older and 8% were 75 years or older. No overall differences in efficacy or safety were observed between patients ≥65 years of age compared to younger patients.

8.7 Hepatic Impairment
No dose adjustment of ENHERTU is required in patients with mild (total bilirubin ≤ULN and any AST >ULN or total bilirubin >1.5 times ULN and any AST) or moderate (total bilirubin >1.5 to 3 times ULN and any AST) hepatic impairment. In patients with moderate hepatic impairment, due to potentially increased exposure, closely monitor for increased toxicities related to the topoisomerase inhibitor, DXd [see Dosage and Administration (2.3)]. The recommended dosage of ENHERTU has not been established for patients with severe hepatic impairment (CLcr <30 mL/min) [see Clinical Pharmacology (12.3)].

11 DESCRIPTION
Fam-trastuzumab deruxtecan-nxki is a HER2-directed antibody and topoisomerase inhibitor conjugate. Fam-trastuzumab deruxtecan-nxki is an antibody-drug conjugate (ADC) composed of three components: 1) a humanized anti-HER2 IgG1 monoclonal antibody (mAb), covalently linked to 2) a topoisomerase inhibitor, via 3) a tetrapeptide-based cleavable linker. Deruxtecan is composed of a protease-cleavable maleimide tetrapeptide linker and the topoisomerase inhibitor, DXd, which is an exetane derivative.

The antibody is produced in Chinese hamster ovary cells by recombinant DNA technology, and the topoisomerase inhibitor and linker are produced by chemical synthesis. Approximately 8 molecules of deruxtecan are attached to each antibody molecule. Fam-trastuzumab deruxtecan-nxki has the following structure:

![Diagram](image)

ENHERTU (fam-trastuzumab deruxtecan-nxki) is a sterile, white to yellowish white, preservative-free lyophilized powder in single-dose vials. Each vial delivers 100 mg of fam-trastuzumab deruxtecan-nxki, L-histidine (4.45 mg), L-histidine hydrochloride monohydrate (20.2 mg), polysorbate 80 (1.5 mg), and sucrose (450 mg). Following reconstitution with 5 mL of Sterile Water for Injection, USP, the resulting concentration of fam-trastuzumab deruxtecan-nxki is 20 mg/mL with a pH of 5.5. The resulting solution is administered by intravenous infusion following dilution.

12 CLINICAL PHARMACOLOGY
12.1 Mechanism of Action
Fam-trastuzumab deruxtecan-nxki is a HER2-directed antibody-drug conjugate. The antibody is a humanized anti-HER2 IgG1. The small molecule, DXd, is a topoisomerase I inhibitor attached to the antibody by a cleavable linker. Following binding to HER2 on tumor cells, fam-trastuzumab deruxtecan-nxki undergoes internalization and intracellular linker cleavage by lysosomal enzymes. Upon release, the membrane-permeable DXd causes DNA damage and apoptotic cell death.

12.2 Pharmacodynamics
Cardiac Electrophysiology
The administration of multiple doses of ENHERTU 6.4 mg/kg every 3 weeks did not show a large mean effect (i.e., >20 ms) on the QT interval in an open-label, single-arm study in 51 patients with metastatic HER2-positive cancer.

12.3 Pharmacokinetics
The pharmacokinetics of fam-trastuzumab deruxtecan-nxki was evaluated in patients with cancer. Following a single dose, exposures (Cmax, AUC) of fam-trastuzumab deruxtecan-nxki and released topoisomerase inhibitor (DXd) increased proportionally over a dose range of 3.2 mg/kg to 8 mg/kg (approximately 0.6 to 1.5 times the recommended dose in breast cancer and NSCLC and 0.5 to 1.25 times the recommended dose in gastric cancer).

Metastatic Breast Cancer
At the recommended dosage of ENHERTU for patients with metastatic breast cancer, the geometric mean (coefficient of variation [CV%]) Cmax of fam-trastuzumab deruxtecan-nxki and DXd was 133 μg/mL (19%) and 4.7 ng/mL (43%), respectively, and the AUC of fam-trastuzumab deruxtecan-nxki and DXd were 780 μg-day/mL (27%) and 29 ng-day/mL (42%), respectively, based on population pharmacokinetic analysis. Accumulation of fam-trastuzumab deruxtecan-nxki was approximately 35% at steady-state (Cycle 3).

Unresectable or Metastatic HER2-Mutant NSCLC
At the recommended dosage of ENHERTU for patients with HER2-mutant NSCLC, the geometric mean (CV%) Cmax of fam-trastuzumab deruxtecan-nxki and DXd were 141 μg/mL (21%) and 7.2 ng/mL (44%), respectively, and the AUC of fam-trastuzumab deruxtecan-nxki and DXd were 775 μg-day/mL (33%) and 40.9 ng-day/mL (43%), respectively, based on population pharmacokinetic analysis. Accumulation of fam-trastuzumab deruxtecan-nxki was approximately 31% at steady-state based on population pharmacokinetic analysis.

Locally Advanced or Metastatic Gastric Cancer
At the recommended dosage of ENHERTU for patients with HER2-positive gastric cancer, the geometric mean (CV%) Cmax of fam-trastuzumab deruxtecan-nxki and DXd were 141 μg/mL (18%) and 7.2 ng/mL (44%), respectively, and the AUC of fam-trastuzumab deruxtecan-nxki and DXd were 743 μg-day/mL (26%) and 33 ng-day/mL (43%), respectively, based on population pharmacokinetic analysis. Accumulation of fam-trastuzumab deruxtecan-nxki was approximately 39% at steady-state (Cycle 3).

Distribution
Based on population pharmacokinetic analysis, the estimated volume of distribution of the central compartment (Vc) of fam-trastuzumab deruxtecan-nxki was 2.68 L. For humans, DXd plasma protein binding is approximately 97% and the blood-to-plasma ratio is approximately 0.6, in vitro.

Elimination
The median elimination half-life (t1/2) of fam-trastuzumab deruxtecan-nxki in patients with HER2-positive metastatic breast cancer, HER2-mutant NSCLC, and HER2-positive gastric cancer was approximately 5.4-5.7 days. Based on population pharmacokinetic analysis, the estimated systemic clearance of fam-trastuzumab deruxtecan-nxki was 0.41 L/day.

The median apparent elimination half-life (t1/2) of DXd in patients with HER2-positive metastatic breast cancer, HER2-mutant NSCLC, and HER2-positive gastric cancer was approximately 5.4-6.1 days. Based on population pharmacokinetic analysis, the estimated apparent systemic clearance of DXd was 18.3 L/h.

Metabolism
The humanized HER2 IgG1 monoclonal antibody is expected to be degraded into small peptides and amino acids via catabolic pathways in the same manner as endogenous IgG.

In vitro, DXd is primarily metabolized by CYP3A4.

Specific Populations
No clinically significant differences in the pharmacokinetics of fam-trastuzumab deruxtecan-nxki or DXd were observed for age (20-96 years); race (Asian [n=906] vs Non-Asian [n=763]), including White [n=619], Black or African American [n=36], and Other [n=108]; sex; body weight (27.3-125.4 kg); mild (total bilirubin ≤ULN and any AST >ULN or total bilirubin >1.5 times ULN and any AST) or moderate (CLcr ≤30 and <60 mL/min, n=251) renal impairment based on population pharmacokinetic analysis.
The pharmacokinetics of fam-trastuzumab deruxtecan-nxki or DXd in patients with moderate to severe hepatic impairment (total bilirubin >1.5 ULN with any AST) or severe renal impairment (CrCl <30 mL/min) is unknown.

### Drug Interaction Studies

#### Clinical Studies

**Effect of CYP3A4 Inhibitors on DXd:** Coadministration of itraconazole, a strong CYP3A4 inhibitor, with multiple doses of ENHERTU increased steady state AUC_{0-17} days of fam-trastuzumab deruxtecan-nxki by 11% and DXd by 18%. The impact of these changes is not clinically meaningful.

**Effect of OATP Inhibitors on DXd:** Coadministration of ritonavir, a dual inhibitor of OATP1B1/CYP3A, with multiple doses of ENHERTU increased steady state AUC_{0-17} days of fam-trastuzumab deruxtecan-nxki by 19% and DXd by 22%. The impact of these changes is not clinically meaningful.

#### In Vitro Studies

**Effects of DXd on CYP Enzymes:** DXd does not inhibit CYP1A2, CYP2B6, CYP2C9, CYP2C19, CYP2D6, and CYP3A nor induce CYP1A2, CYP2B6, or CYP3A.

**Effects of DXd on Transporters:** At clinically relevant concentrations (steady-state C_{max} <0.2 μmol/L), DXd has a low potential to inhibit OAT1 (IC_{50} value of 12.7 μmol/L), OAT3, OCT1, OCT2, OATP1B1 (IC_{50} value of 14.4 μmol/L), OATP1B3, MATE1, MATE2-K, P-gp, BCRP, or BSEP transporters.

### 12.6 Immuneogenicity

The observed incidence of anti-drug antibodies (ADA) is highly dependent on the sensitivity and specificity of the assay. Differences in assay methods preclude meaningful comparisons of the incidence of ADA in the studies described below with the incidence of ADA in other studies, including those of ENHERTU or of other anti-HER2 products.

During the median 14-month treatment period in HER2-positive breast cancer patients in DESTINY-Breast03 with a median ADA sampling period of 13 months, treatment-emergent ADA (or anti-fam-trastuzumab deruxtecan-nxki antibodies) developed in 1.6% (4/256) of patients who received ENHERTU. The incidence of treatment-emergent neutralizing antibodies against fam-trastuzumab deruxtecan-nxki was 0.4% (1/256).

During the median 7-month treatment period in HER2-positive breast cancer patients in DESTINY-Breast01 with a median ADA sampling period of 9 months, treatment-emergent ADA developed in 1.2% (3/249) of patients who received ENHERTU. The incidence of treatment-emergent neutralizing antibodies against fam-trastuzumab deruxtecan-nxki was 0% (0/249).

During the median 6-month treatment period in HER2-low breast cancer patients in DESTINY-Breast04 with a median ADA sampling period of 8 months, treatment-emergent ADA developed in 2.0% (7/357) of patients who received ENHERTU. The incidence of treatment-emergent neutralizing antibodies against fam-trastuzumab deruxtecan-nxki was 0% (0/357).

During the median 3.5-month treatment period in HER2-mutant NSCLC patients in DESTINY-Lung02 with median ADA sampling period of 2.2 months, treatment-emergent ADA developed in 0.7% (1/143) of patients who received ENHERTU. The incidence of treatment-emergent neutralizing antibodies against fam-trastuzumab deruxtecan-nxki was 0% (0/143).

During the median 4.6-month treatment period in HER2-positive gastric or GEJ adenocarcinoma patients in DESTINY-Gastr01 with a median ADA sampling period of 4.6 months, treatment-emergent ADA developed in 7.3% (9/123) of patients who received ENHERTU. The incidence of treatment-emergent neutralizing antibodies against fam-trastuzumab deruxtecan-nxki was 0% (0/123).

Due to the limited number of patients who tested positive for ADA, the effect of treatment-emergent ADAs and treatment-emergent neutralizing antibodies on the pharmacokinetics, pharmacodynamics, safety and/or effectiveness of fam-trastuzumab deruxtecan-nxki is unknown.

### 13 NONCLINICAL TOXICOLOGY

#### 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenicity studies have not been conducted with fam-trastuzumab deruxtecan-nxki.

The topoisomerase inhibitor component of fam-trastuzumab deruxtecan-nxki, DXd, was clastogenic in both an in vivo rat bone marrow micronucleus assay and an in vitro Chinese hamster lung chromosome aberration assay and was not mutagenic in an in vitro bacterial reverse mutation assay.

Fertility studies have not been conducted with fam-trastuzumab deruxtecan-nxki. In a six-week repeat-dose toxicity study in rats, intravenous administration of fam-trastuzumab deruxtecan-nxki resulted in spermatid retention at 20 mg/kg and 60 mg/kg (approximately 4 and 9 times the human recommended dose of 5.4 mg/kg based on AUC, respectively). Decreased testes and epididymides weights, tubular atrophy/regeneration in tests, and reduced sperm count in epididymides were observed at a dose of 197 mg/kg (19 times the human recommended dose of 5.4 mg/kg based on AUC). In a three-month repeat-dose toxicity study in monkeys, intravenous administration of fam-trastuzumab deruxtecan-nxki resulted in decreased numbers of round spermatids in the testes at seminiferous tubule stages V to VI at ≥30 mg/kg (≥7 times the human recommended dose of 5.4 mg/kg based on AUC).

Evidence of reversibility was observed in monkeys by the end of a three-month recovery period.

### 14 CLINICAL STUDIES

#### 14.1 HER2-Positive Metastatic Breast Cancer

**DESTINY-Breast03**

The efficacy of ENHERTU was evaluated in study DESTINY-Breast03 (NCT03529110), a multicenter, open-label, randomized trial that enrolled 524 patients with HER2-positive, untreated and/or metastatic breast cancer who received prior trastuzumab and taxane therapy for metastatic disease or developed disease recurrence within 6 months of completing adjuvant therapy. HER2 expression was based on archival tissue tested at a central laboratory prior to enrollment with HER2 positivity defined as HER2 IHC 3+ or ISH positive. Patients were excluded for a history of IBD/pneumonitis requiring treatment with steroids, IBD/pneumonitis at screening, or clinically significant cardiac disease. Patients were also excluded for untreated and symptomatic brain metastases. ECOG performance status <1, or prior treatment with an anti-HER2 antibody-drug conjugate in the metastatic setting.

Patients were randomized 1:1 to receive either ENHERTU 5.4 mg/kg (N=261) or ado-trastuzumab emtansine 3.6 mg/kg (N=263) by intravenous infusion every 3 weeks until unacceptable toxicity or disease progression. Randomization was stratified by hormone receptor status, prior treatment with pertuzumab, and visceral versus non-visceral disease. Tumor imaging was obtained every 6 weeks and CT/MRI of the brain was mandatory for all patients at baseline. The major efficacy outcomes were progression-free survival (PFS) as assessed by blinded independent central review (BICR) based on Response Evaluation Criteria in Solid Tumors (RECIST) v.1.1 and overall survival (OS). Confirmed objective response rate (ORR) was an additional outcome measure.

The median age was 54 years (range: 20-83); 80% were <65 years and 99.6% were female. The majority of patients were Asian (60%), White (27%) and Black (3.6%). Eleven percent (11%) of patients were of Hispanic/Latino ethnicity. Patients had an ECOG performance status of 0 (63%) or 1 (37%) at baseline. Seventy-three percent had visceral disease, 16% had brain metastases at baseline. 52% were hormone receptor positive (HR+) and 48% of patients had received one line of prior systemic therapy in the metastatic setting. The percentage of patients who had not received prior treatment for metastatic disease was 10%.

Efficacy results are summarized in Table 13 and Figure 1. At the time of the PFS analysis, 16% of patients had died and overall survival (OS) was immature.

<table>
<thead>
<tr>
<th>Efficacy Parameter</th>
<th>ENHERTU 5.4 mg/kg</th>
<th>Ado-trastuzumab emtansine 3.6 mg/kg</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Progression-Free Survival (PFS) per BICR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>261</td>
<td>263</td>
</tr>
<tr>
<td>Number of events (%)</td>
<td>87 (33.3)</td>
<td>158 (60.1)</td>
</tr>
<tr>
<td>Median, months (95% CI)</td>
<td>NR (18.5, NE)</td>
<td>6.8 (5.6, 8.2)</td>
</tr>
<tr>
<td>Hazard ratio (95% CI)</td>
<td>0.28 (0.22, 0.37)</td>
<td>p-value &lt; 0.0001</td>
</tr>
<tr>
<td><strong>Confirmed Objective Response Rate (ORR) per BICR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>248</td>
<td>241</td>
</tr>
<tr>
<td>n (%)</td>
<td>205 (82.7)</td>
<td>87 (36.1)</td>
</tr>
<tr>
<td>95% CI</td>
<td>(77.4, 87.2)</td>
<td>(30.0, 42.5)</td>
</tr>
<tr>
<td>Complete response (%)</td>
<td>39 (15.7)</td>
<td>20 (8.3)</td>
</tr>
<tr>
<td>Partial response (%)</td>
<td>166 (66.9)</td>
<td>67 (27.8)</td>
</tr>
</tbody>
</table>

CI = confidence interval; NR = not reached; NE=not estimable

*Analysis was performed based on the patients with measurable disease assessed by BICR at baseline.

**DESTINY-Breast01**

The efficacy of ENHERTU was evaluated in study DESTINY-Breast01 (NCT03248492), a multicenter, single-arm, trial that enrolled 184 female patients with HER2-positive, untreated and/or metastatic breast cancer who had received two or more prior anti-HER2 therapies. Patients were excluded for a history of treated IBD or current...
ILD at screening. Patients were also excluded for history of clinically significant cardiac disease, active brain metastases, and ECOG performance status >1. HER2 expression was based on archival tissue tested at a central laboratory prior to enrollment with HER2 positivity defined as HER2 IHC 3+ or ISH positive.

Patients received ENHERTU 5.4 mg/kg by intravenous infusion every 3 weeks until unacceptable toxicity or disease progression. Tumor imaging was obtained every 6 weeks and CT/MRI of the brain was mandatory for patients with brain metastases at baseline. The major efficacy outcomes were confirmed objective response rate (ORR) assessed by independent central review (ICR) using RECIST v1.1 and duration of response (DOR).

The median age was 55 years (range: 28-96); 76% of patients were <65 years. All 184 patients were female, and the majority were White (55%) or Asian (38%). Patients had an ECOG performance status of 0 (55%) or 1 (44%) at baseline. Ninety-two percent had visceral disease, 29% had bone metastases, and 13% had brain metastases. Fifty-three percent were HR+. Sum of diameters of target lesions were <5 cm in 42%, and ≥5 cm in 50% (not evaluable by central review in 8% of patients).

The median number of prior cancer regimens in the locally advanced/metastatic setting was 5 (range: 2-17). All patients received prior trastuzumab, ado-trastuzumab emtansine, and 66% had prior pertuzumab.

Efficacy results are summarized in Table 14.

Table 14: Efficacy Results by Independent Central Review in DESTINY-Breast01

<table>
<thead>
<tr>
<th>Efficacy Parameter</th>
<th>DESTINY-Breast01</th>
<th>Overall Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=184</td>
<td>HR+ and HR-</td>
</tr>
<tr>
<td>DOR (95% CI)</td>
<td>60.3% (52.9, 67.4)</td>
<td>60.3% (52.9, 67.4)</td>
</tr>
<tr>
<td>Complete Response</td>
<td>4.3%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Partial Response</td>
<td>56.0%</td>
<td>56.0%</td>
</tr>
<tr>
<td>Duration of Response*</td>
<td>14.8 (13.8, 16.9)</td>
<td>14.8 (13.8, 16.9)</td>
</tr>
</tbody>
</table>

ORR 95% CI calculated using Clopper-Pearson method
* DOR is based on median duration of follow-up of 11.1 months.
† Median DOR based on Kaplan-Meier estimate; 95% CI calculated using Brookmeyer-Crowley method

14.2 HER2-Low Metastatic Breast Cancer

The efficacy of ENHERTU was evaluated in study DESTINY-Breast04 (NCT03734029), a randomized, multicenter, open-label study that enrolled 557 adult patients with unresectable or metastatic HER2-low breast cancer. The study included 2 cohorts: 494 hormone receptor-positive (HR+) patients and 63 hormone receptor-negative (HR-) patients. HER2-low expression was defined as IHC 1+ or IHC 2+/ISH-, as determined at a central laboratory using Ventana’s PATHWAY anti-HER-2/neu (48S) Rabbit Monoclonal Primary Antibody assay. Patients must have received chemotherapy in the metastatic setting or have developed disease recurrence during or within 6 months of completing adjuvant chemotherapy. Patients who were HR+ must have received at least one endocrine therapy or be ineligible for endocrine therapy. Patients were randomized 2:1 to receive either ENHERTU 5.4 mg/kg (N=373) by intravenous infusion every 3 weeks or physician’s choice of chemotherapy (N=184, eribulin, capcitabine, gemcitabine, nab paclitaxel, or paclitaxel). Randomization was stratified by HER2 IHC status of tumor samples (IHC 1+ or IHC 2+/ISH+), number of prior lines of chemotherapy in the metastatic setting (1 or 2), and HR status/prior CDK4/6i treatment (HR+ with prior CDK4/6i inhibitor treatment, HR- without prior CDK4/6i inhibitor treatment, or HR-). Treatment was administered until disease progression, death, withdrawal of consent, or unacceptable toxicity. The study excluded patients with a history of ILD/pneumonitis requiring treatment with steroids or ILD/pneumonitis at screening and clinically significant cardiac disease. Patients were also excluded for untreated or symptomatic brain metastases or ECOG performance status >1.

The major efficacy outcome measure was PFS in patients with HR+ breast cancer assessed by BICR based on RECIST v1.1. Additional efficacy outcome measures were PFS assessed by BICR based on RECIST v1.1 in the overall population (all randomized HR+ and HR- patients), OS in HR+ patients, and OS in the overall population.

The median age was 57 years (range: 28 to 81); 24% were age 65 or older; 99.6% were female; 48% were White; 40% were Asian; and 2% were Black or African American. 18% of patients were Hispanic/Latino ethnicity. Patients had an ECOG performance status of 0 (55%) or 1 (45%) at baseline; 58% were IHC 1+, 42% were IHC 2+/ISH-; 70% had liver metastases, 33% had lung metastases, and 6% had brain metastases. In the metastatic setting, patients had a median of 3 prior lines of systemic therapy (range: 1 to 9) with 58% having 1 and 41% having 2 prior chemotherapy regimens. 3.9% were early progressors (progression in the neo-adjuvant setting). In HR+ patients, the median number of prior lines of endocrine therapy was 2 (range: 0 to 9) and 70% had prior CDK4/6i treatment.

Efficacy results are summarized in Table 15 and Figures 2 and 3.

Table 15: Efficacy Results in DESTINY-Breast04

<table>
<thead>
<tr>
<th>Efficacy Parameter</th>
<th>HR+ Cohort</th>
<th>Overall Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ENHERTU (N=331)</td>
<td>Chemotherapy (N=163)</td>
</tr>
<tr>
<td>Overall Survival</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of events (%)</td>
<td>126 (38.1%)</td>
<td>73 (44.8%)</td>
</tr>
<tr>
<td>Median, months (95% CI)</td>
<td>23.4 (20.8, 24.8)</td>
<td>17.5 (15.2, 22.4)</td>
</tr>
<tr>
<td>Hazard ratio (95% CI)</td>
<td>0.64 (0.48, 0.86)</td>
<td>0.64 (0.49, 0.84)</td>
</tr>
<tr>
<td>p-value</td>
<td>0.0028</td>
<td>0.001</td>
</tr>
<tr>
<td>Progression-Free Survival per BICR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of events (%)</td>
<td>211 (63.7%)</td>
<td>110 (67.5%)</td>
</tr>
<tr>
<td>Median, months (95% CI)</td>
<td>10.1 (9.5, 11.5)</td>
<td>5.4 (4.4, 7.1)</td>
</tr>
<tr>
<td>Hazard ratio (95% CI)</td>
<td>0.51 (0.40, 0.64)</td>
<td>0.50 (0.40, 0.63)</td>
</tr>
<tr>
<td>p-value</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

14.3 Unresectable or Metastatic HER2-Mutant Non-Small Cell Lung Cancer

ENHERTU was evaluated in DESTINY-Lung01 (NCT03550710) and at two dose levels in DESTINY-Lung02 (NCT04644237). Patients were prospectively selected for treatment with ENHERTU based on the presence of activating HER2 (ERBB2) mutations by local testing using tissue. Samples from DESTINY-Lung01 were retrospectively tested using Oncomine™ Dx Target Test (Life Technologies Corporation, Tissue-test) and Guardant360® CDx test (Guardant Health Inc., Plasma test). Demographic and baseline disease characteristics were similar for patients in DESTINY-Lung01 and DESTINY-Lung02, except for race (34% Asian vs 79% Asian, respectively). Response rates were consistent across dose levels. Increased rates of ILD/pneumonitis were observed at the higher dose. The approved recommended dose of 5.4 mg/kg.
intravenously every 3 weeks in the DESTINY-Lung02 study is described below [see Adverse Reactions (6.1)].

The efficacy of ENHERTU was evaluated in DESTINY-Lung02, a multicenter, multi-cohort, randomized, blinded, dose-optimization trial. Eligible patients were required to have unresectable or metastatic HER2-mutant non-squamous NSCLC with disease progression after one prior systemic therapy. Patients with a history of steroid dependent ILD/pneumonitis, clinically significant cardiac disease, clinically active brain metastases; and ECOG performance status >1 were excluded. Patients received ENHERTU 5.4 mg/kg by intravenous infusion every 3 weeks until disease progression or unacceptable toxicity. Tumor imaging was obtained every 6 weeks and CT/MRI of the brain was mandatory for patients with stable brain metastases at baseline.

Results from an interim efficacy analysis in a pre-specified patient cohort are described below. The major efficacy outcomes were confirmed ORR as assessed by BICR using RECIST v1.1 and DOR.

The median age was 56 years (range 30 to 78); 69% were female; 79% were Asian; 12% were White, and 10% were other races; 29% had an ECOG performance status of 0 and 71% had 1; 33% had stable brain metastases; 94% had a mutation in the EGFR exon 19 or 21; 61% had stable lung metastases; 29% had prior brain metastases; and 45% had three or more prior regimens in the metastatic setting. A total of 30% of patients were identified as having a history of smoking. The median number of prior regimens was 2 (range: 1 to 12); 100% of patients received prior platinum therapy, 71% received prior immunotherapy, and 44% received both in combination. Fifty percent of patients were never-smokers and 50% were former smokers; 96% of patients had adenocarcinoma histology.

Efficacy results are provided in Table 16.

Table 16: Efficacy Results for DESTINY-Lung02

<table>
<thead>
<tr>
<th>Efficacy Parameter</th>
<th>DESTINY-Lung02 N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Confirmed Objective Response Rate (95% CI)</strong></td>
<td>57.7% (43.2, 71.3)</td>
</tr>
<tr>
<td>Complete Response</td>
<td>1.9%</td>
</tr>
<tr>
<td>Partial Response</td>
<td>55.8%</td>
</tr>
<tr>
<td><strong>Duration of Response</strong></td>
<td>8.7 (7.1, NE)</td>
</tr>
</tbody>
</table>

ORR 95% CI calculated using Clopper-Pearson method
NE=not estimable

*Data cut-off: 22 June 2022
†Median DOR based on Kaplan-Meier estimate; 95% CI calculated using Brookmeyer-Crowley method

14.4 Locally Advanced or Metastatic Gastric Cancer

The efficacy of ENHERTU was evaluated in study DESTINY-Gastric01 (NCT03329690), a multicenter, open-label, randomized trial conducted in Japan and South Korea that enrolled 188 adult patients with HER2-positive (IHC 3+ or IHC 2+/ISH positive), locally advanced or metastatic gastric or GEJ adenocarcinoma who had progressed on at least two prior regimens including trastuzumab, a fluoropyrimidine- and a platinum-containing chemotherapy. HER2 expression was determined by a central lab on tissue obtained either before or after prior trastuzumab treatment. Patients were excluded for a history of treated or current ILD, a history of clinically significant cardiac disease, active brain metastases, or ECOG performance status >1.

Patients were randomized 2:1 to receive ENHERTU (N=126) 6.4 mg/kg intravenously every 3 weeks or physician’s choice of chemotherapy: irinotecan monotherapy (N=55) 150 mg/m² intravenously every 2 weeks or paclitaxel monotherapy (N=7) 80 mg/m² intravenously weekly. Randomization was stratified by HER2 status (IHC 3+ or IHC 2+/ISH+), ECOG performance status 0 or 1, and region (Japan or South Korea). Tumor imaging assessments were performed at screening and every 6 weeks from the first treatment dose. Treatment was administered until unacceptable toxicity or disease progression. The major efficacy outcomes were ORR assessed by ICR according to RECIST v1.1 and OS in the intent-to-treat population. Additional efficacy outcomes were PFS and DOR.

The median age was 66 years (range 28 to 82); 76% were male; and 100% were Asian. All patients received a trastuzumab product. Patients had an ECOG performance status of either 0 (4%) or 1 (51%); 87% had gastric adenocarcinoma and 13% had GEJ adenocarcinoma; 76% were IHC 3+ and 23% were IHC 2+/ISH+ 65% had inoperable advanced cancer; 35% had postoperative recurrent cancer; 54% had liver metastases; 25% had lung metastases; 45% had three or more prior regimens in the locally advanced or metastatic setting. A total of 30% of patients were identified as HER2-positive using tissue obtained following prior treatment with a trastuzumab product.

Efficacy results are summarized in Table 17, and the Kaplan-Meier curve for OS is shown in Figure 4.

15 REFERENCES

1. OSHA Hazardous Drugs. OSHA.
http://www.osha.gov/SLTC/hazardousdrugs/index.html

16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 How Supplied/Storage

ENHERTU (fam-trastuzumab deruxtecan-nxki) for injection is a white to yellowish white lyophilized powder supplied as:

<table>
<thead>
<tr>
<th>Carton Contents</th>
<th>NDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>One 100 mg single-dose vial</td>
<td>65597-406-01</td>
</tr>
</tbody>
</table>

Store vials in a refrigerator at 2°C to 8°C (36°F to 46°F) in the original carton to protect from light until time of reconstitution. Do not freeze. Do not shake the reconstituted or diluted solution [see Dosage and Administration (2.4)].

16.2 Special Handling

ENHERTU (fam-trastuzumab deruxtecan-nxki) is a hazardous drug. Follow applicable special handling and disposal procedures.³
17 PATIENT COUNSELING INFORMATION

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

Interstitial Lung Disease
- Inform patients of the risks of severe or fatal ILD. Advise patients to contact their healthcare provider immediately for any of the following: cough, shortness of breath, fever, or other new or worsening respiratory symptoms [see Warnings and Precautions (5.1)].

Neutropenia
- Advise patients of the possibility of developing neutropenia and to immediately contact their healthcare provider should they develop a fever, particularly in association with any signs of infection [see Warnings and Precautions (5.2)].

Left Ventricular Dysfunction
- Advise patients to contact their healthcare provider immediately for any of the following: new onset or worsening shortness of breath, cough, fatigue, swelling of ankles/legs, palpitations, sudden weight gain, dizziness, loss of consciousness [see Warnings and Precautions (5.3)].

Embryo-Fetal Toxicity
- Inform female patients of the potential risk to a fetus. Advise female patients to contact their healthcare provider of a known or suspected pregnancy [see Warnings and Precautions (5.4), Use in Specific Populations (8.1)].
- Advise females of reproductive potential to use effective contraception during treatment with ENHERTU and for 7 months after the last dose [see Use in Specific Populations (8.3)].
- Advise male patients with female partners of reproductive potential to use effective contraception during treatment with ENHERTU and for 4 months after the last dose [see Use in Specific Populations (8.3)].

Lactation
- Advise women not to breastfeed during treatment and for 7 months after the last dose of ENHERTU [see Use in Specific Populations (8.2)].

Infertility
- Advise males of reproductive potential that ENHERTU may impair fertility [see Use in Specific Populations (8.3)].
What is the most important information I should know about ENHERTU?

ENHERTU can cause serious side effects, including:
- Lung problems that may be severe, life-threatening or that may lead to death. If you develop lung problems your healthcare provider may treat you with corticosteroid medicines. Tell your healthcare provider right away if you get any of the following signs and symptoms:
  - cough
  - trouble breathing or shortness of breath
  - fever
  - other new or worsening breathing symptoms (e.g., chest tightness, wheezing)
- Low white blood cell count (neutropenia). Low white blood cell counts are common with ENHERTU and can sometimes be severe. Your healthcare provider will check your white blood cell counts before starting ENHERTU and before starting each dose. Tell your healthcare provider right away if you develop any signs or symptoms of an infection or have fever or chills during treatment with ENHERTU.
- Heart problems that may affect your heart's ability to pump blood. Your healthcare provider will check your heart function before starting treatment with ENHERTU. Tell your healthcare provider right away if you get any of the following signs and symptoms:
  - new or worsening shortness of breath
  - coughing
  - feeling tired
  - swelling of your ankles or legs
  - loss of consciousness
- Your healthcare provider will check you for these side effects during your treatment with ENHERTU. Your healthcare provider may reduce your dose, delay treatment or completely stop treatment with ENHERTU if you have severe side effects.
- Harm to your unborn baby. Tell your healthcare provider right away if you become pregnant or think you might be pregnant during treatment with ENHERTU.
  - If you are able to become pregnant, your healthcare provider should do a pregnancy test before you start treatment with ENHERTU.
  - Females who are able to become pregnant should use effective birth control (contraception) during treatment with ENHERTU and for 7 months after the last dose.
  - Males who have female partners that are able to become pregnant should use effective birth control (contraception) during treatment with ENHERTU and for 4 months after the last dose.

See “What are the possible side effects of ENHERTU?” for more information about side effects.

What is ENHERTU?

ENHERTU is a prescription medicine used to treat adults who have:
- human epidermal growth factor receptor 2 (HER2)-positive breast cancer that cannot be removed by surgery or that has spread to other parts of the body (metastatic), and who have received a prior anti-HER2 breast cancer treatment:
  - for metastatic disease, or
  - have breast cancer that has come back during or within 6 months of completing treatment for their early-stage breast cancer.
- HER2-low breast cancer that cannot be removed by surgery or that has spread to other parts of your body (metastatic), and who have received a prior chemotherapy:
  - for metastatic disease, or
  - your disease has returned during or within 6 months of completing adjuvant chemotherapy (after surgery). Your healthcare provider will perform a test to make sure ENHERTU is right for you.
- non-small cell lung cancer (NSCLC) that has a certain mutation in the HER2 gene and cannot be removed by surgery or has spread to other parts of your body (metastatic), and who have received a prior treatment. Your healthcare provider will perform a test to make sure ENHERTU is right for you.
- stomach cancer called gastric or gastroesophageal junction (GEJ) adenocarcinoma that is HER2-positive and has spread to areas near your stomach (locally advanced) or that has spread to other parts of your body (metastatic), and who have received a prior trastuzumab-based regimen.

It is not known if ENHERTU is safe and effective in children.

Before you receive ENHERTU, tell your healthcare provider about all of your medical conditions, including if you:
- have lung or breathing problems.
- have signs or symptoms of an infection.
- have or have had any heart problems.
- are breastfeeding or plan to breastfeed. It is not known if ENHERTU passes into your breast milk. Do not breastfeed during treatment with ENHERTU and for 7 months after the last dose.

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

How will I receive ENHERTU?

- You will receive ENHERTU into your vein through an intravenous (IV) line by your healthcare provider.
- ENHERTU is given 1 time every three weeks (21-day treatment cycle).
- Your healthcare provider will decide how many treatments you need.
- Your healthcare provider will give you medicines before your infusion to help prevent nausea and vomiting.
- Your healthcare provider may slow down or temporarily stop your infusion of ENHERTU if you have an infusion-related reaction, or permanently stop ENHERTU if you have severe infusion reactions.
- If you miss a planned dose of ENHERTU, call your healthcare provider right away to schedule an appointment. Do not wait until the next planned treatment cycle.

What are the possible side effects of ENHERTU?

ENHERTU can cause serious side effects. See “What is the most important information I should know about ENHERTU?”

The most common side effects of ENHERTU, when used in people with metastatic breast cancer and HER2-mutant non-small cell lung cancer include:
- nausea
- low white blood cell counts
- low red blood cell counts
- feeling tired
- low platelet counts
- increased liver function tests
- vomiting
- diarrhea
- cough

The most common side effects of ENHERTU, when used in people with HER2-positive gastric or GEJ adenocarcinoma, include:
- low red blood cell counts
- low white blood cell counts
- low platelet counts
- nausea
- decreased appetite
- increased liver function tests
- feeling tired

ENHERTU may cause fertility problems in males, which may affect the ability to father children. Talk to your healthcare provider if you have concerns about fertility.

These are not all of the possible side effects of ENHERTU. 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 ENHERTU.

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. You can ask your pharmacist or healthcare provider for information about ENHERTU that is written for healthcare professionals.

What are the ingredients in ENHERTU?

Active Ingredient: fam-trastuzumab deruxtecan-nxki.

Inactive Ingredients: L-histidine, L-histidine hydrochloride monohydrate, polysorbate 80, and sucrose.

Manufactured by: Daiichi Sankyo, Inc., Basking Ridge, NJ 07920
U.S. License No. 2128

Marketed by: Daiichi Sankyo, Inc., Basking Ridge, NJ 07920 and AstraZeneca Pharmaceuticals LP, Wilmington, DE 19850

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For more information, call 1-877-437-7763 or go to https://www.ENHERTU.com

This Medication Guide has been approved by the U.S. Food and Drug Administration.

Revised: 08/2022