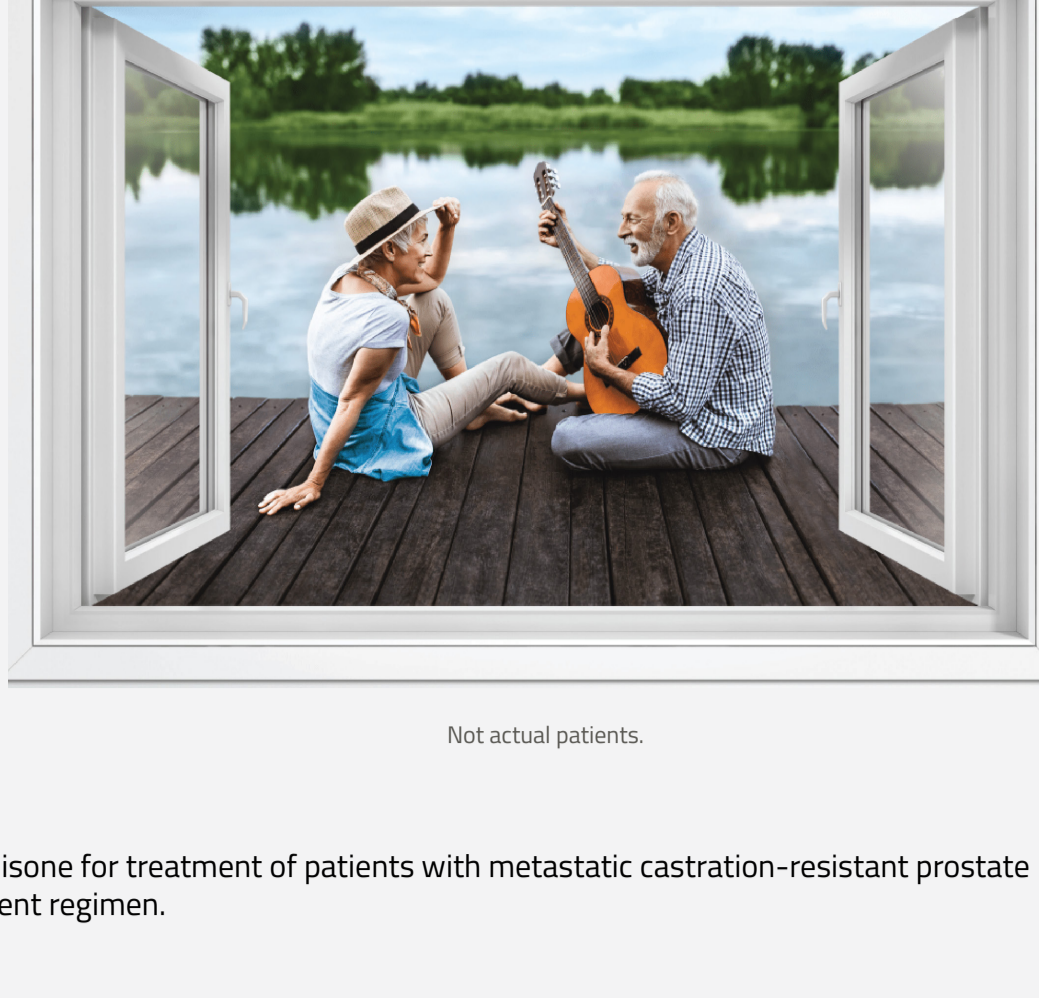


Do you have mCRPC patients with disease progression after docetaxel?

Seize The Window of Opportunity

When you see disease progression, you have another option, reach for JEVTANA^{1,2}



Not actual patients.

INDICATION

JEVTANA is a microtubule inhibitor indicated in combination with prednisone for treatment of patients with metastatic castration-resistant prostate cancer (mCRPC) previously treated with a docetaxel-containing treatment regimen.

IMPORTANT SAFETY INFORMATION

WARNING: NEUTROPENIA AND HYPERSENSITIVITY

Neutropenia: Neutropenic deaths have been reported. Monitor for neutropenia with frequent blood cell counts. JEVTANA is contraindicated in patients with neutrophil counts of $\leq 1,500$ cells/mm³. Primary prophylaxis with G-CSF is recommended in patients with high-risk clinical features. Consider primary prophylaxis with G-CSF in all patients receiving a dose of 25 mg/m².

Severe hypersensitivity: Severe hypersensitivity reactions can occur and may include generalized rash/erythema, hypotension and bronchospasm. Severe hypersensitivity reactions require immediate discontinuation of the JEVTANA infusion and administration of appropriate therapy. Patients should receive premedication. JEVTANA is contraindicated in patients who have a history of severe hypersensitivity reactions to cabazitaxel or to other drugs formulated with polysorbate 80.

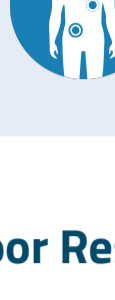
Please see additional Important Safety Information throughout and please [click here](#) for full Prescribing Information, including **Boxed WARNING**.

About mCRPC

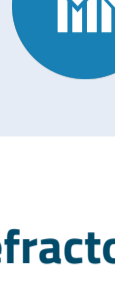
Early Identification of Clinical Factors Associated with High-Risk mCRPC May Help Guide Treatment Decisions

Patients With mCRPC May Present With Clinical Factors That Can Affect Treatment Outcomes

These Clinical Factors Include:



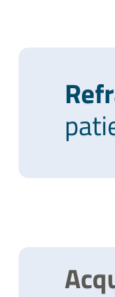
Presence of visceral metastases with or without concomitant bone metastases^{3,4}



Rapid disease progression⁴



Multiple sites of metastases (>2)^{3,4}

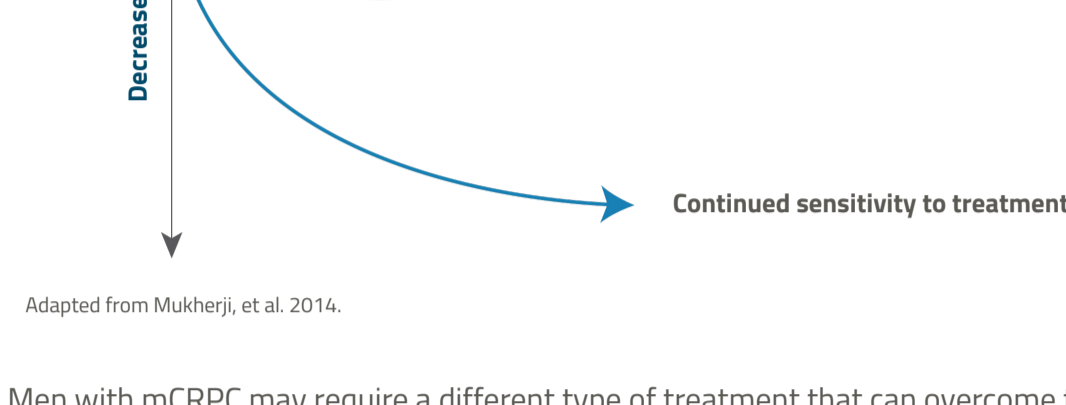


Poor response to initial therapies, which may be a sign of refractory disease or acquired resistance^{5,6}

A Poor Response to Initial Therapies May Be a Sign of Refractory Disease or Acquired Resistance^{5,7,8}

Patients May Develop Resistance to Medications

Response Patterns to Treatment in Advanced Prostate Cancer



Adapted from Mukherji, et al. 2014.

Men with mCRPC may require a different type of treatment that can overcome this resistance.⁹

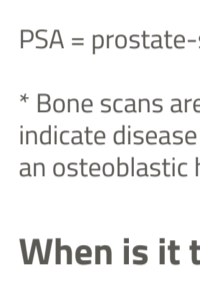
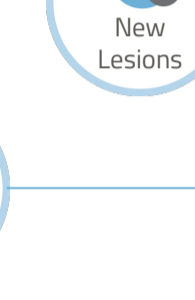
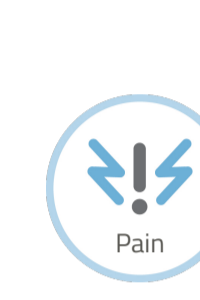
It may be important to take into account a patient's unique clinical factors and response to prior lines of therapy when deciding on subsequent treatment.⁹

When deciding what's next, do you consider a patient's unique clinical factors and response to prior therapy?

Progression

Early Detection of Disease Progression May Enable a Timely Change in Treatment Strategy

Indicators of disease progression^{6,10}



Monitoring recommendations and guidelines for metastatic disease¹⁰

• PSA measurement every 3-6 months based on clinical judgement
• Increased risk for bone metastasis or death with a PSA doubling time of <8 months

• New Lesions: Frequency of imaging should be based on individual risk, age, PSA doubling time, Gleason score, and overall health:
• Bone scans¹¹ every 8-12 weeks
• PSA doubling time <8 months: perform bone imaging more frequently

• History and physical examination every 3-6 months

PSA = prostate-specific antigen. PSA doubling time = PSA doubling time.

* Bone scans are useful to monitor mCRPC to determine the clinical benefit of systemic therapy. However, new lesions comprising pre- and post-treatment bone scans may not indicate disease progression. New lesions in the setting of a falling PSA or soft tissue response and in the absence of pain progression at the site may indicate bone scan flare or an osteoblastic healing reaction.

When is it time to consider another option for men like James, William or Darryl?

Hypothetical cases



James, 76
Has a rising PSA two months after his last cycle of docetaxel. He also mentions new discomfort in his shoulder. Previously, he progressed on LHRH + abiraterone within 12 months and scans revealed multiple bone lesions in his ribs, right arm and shoulder.



William, 66
Is experiencing tolerability issues after his 4th cycle of docetaxel. Presents with multiple bone lesions and recent CT scan revealed multiple new 1.5 mm liver lesions.



Darryl, 72
Presents with a rising PSA after 8 months on abiraterone. Previously, he progressed during his 3rd cycle of docetaxel with a rising PSA and two new bone lesions in his humerus and ribs.

LHRH+abiraterone → docetaxel → ?

Enzalutamide → docetaxel → ?

Docetaxel → abiraterone → ?

LHRH = luteinizing hormone-releasing hormone

JEVTANA Studies

The efficacy and safety of JEVTANA were evaluated in the TROPIC, PROSELICA and CARD trials.

Results from the CARD study were published in the *New England Journal of Medicine* and presented at 2019 ESMO, and 2020 ASCO GU & ASCO.

Data from the TROPIC, PROSELICA and CARD studies are included in the US Prescribing Information.

TROPIC Study (n=755) ¹	PROSELICA Study (n=1200) ¹	CARD Study (n=255) ⁹
Validated JEVTANA as treatment in mCRPC after docetaxel	Established the recommended starting dose for JEVTANA	The first comparative, prospective, phase 4 trial evaluating JEVTANA versus abiraterone or enzalutamide
A randomized, open-label, international, multi-center study of JEVTANA 25mg/m ² (n=378) vs mitoxantrone 12 mg/m ² (n=377) in patients with mCRPC previously treated with a docetaxel-containing regimen.	A noninferiority, randomized, open-label, multi-center study of JEVTANA 20 mg/m ² (n=598) vs 25 mg/m ² (n=602) in patients with mCRPC previously treated with a docetaxel-containing regimen.	A randomized, open-label, multicenter study of JEVTANA 25 mg/m ² vs an androgen receptor (AR)-targeted agent (abiraterone or enzalutamide) in patients with mCRPC who had previously received docetaxel and had disease progression within 12 months on an alternative AR-targeted agent.
Primary endpoint: Overall survival	Primary endpoint: Overall survival	Primary endpoint: Radiographic progression free survival

ESMO = European Society of Medical Oncology, ASCO = American Society of Clinical Oncology, GU = Genitourinary.

SEE RESULTS AT:
JEVTANApro.com

Important Safety Information (cont'd)

CONTRAINDICATIONS

JEVTANA is contraindicated in patients with neutrophil counts of $\leq 1,500$ /mm³, patients with a history of severe hypersensitivity reactions to cabazitaxel or to other drugs formulated with polysorbate 80, and patients with severe hepatic impairment (total bilirubin >3x upper limit of normal (ULN)).

WARNINGS AND PRECAUTIONS

Bone Marrow Suppression (BMS): BMS manifested as neutropenia, anemia, thrombocytopenia and/or pancytopenia may occur. Neutropenic deaths have been reported. Monitor blood counts frequently to determine if initiation of G-CSF and/or dosage modification is needed. Monitoring of complete blood counts is essential on a weekly basis during cycle 1 and before each treatment cycle thereafter so that the dose can be adjusted, if needed. Caution is recommended in patients with hemoglobin < 10 g/dl.

Please see additional Important Safety Information throughout and please [click here](#) for full Prescribing Information, including **Boxed WARNING**.

Patients

Over 2,200 mCRPC patients were studied, including men 75 years of age and older with high disease burden.

Patients presented with a diversity of metastatic sites.

TROPIC Study (n=755) ^{1,11,12}	PROSELICA Study (n=1200) ^{1,13}	CARD Study (n=255) ^{1,14}
Median age (range): ~68 years (46-92); ~18% were ≥ 75 years	Median age (range): ~68 years (45-89); ~20% were ≥ 75 years	Median age (range): ~70 years (45-88); ~31% were ≥ 75 years
ECOG PS: 0-1: 92% and 2: 8%	ECOG PS: 0-1: 90% and 2: 10%	ECOG PS: 0-1: 95% and 2: 5%
Disease burden: Visceral: 25% Bone: 84% Distant Lymph Nodes: 35% 45% had pain at baseline	Disease burden: Lung: 16% Liver: 15% Bone: 94% Distant Lymph Nodes: 49% ~44% had pain at baseline	Disease burden: Lung: 7% Liver: 11% Bone (+/- lymph nodes): 59% Distant Lymph Nodes: 6% 69% had pain at baseline
Speed of progression: 72% of patients (n=378) progressed during or within 3 months from last docetaxel dose	Speed of progression: 69% of patients progressed during or within 3 months from last docetaxel dose	Speed of progression: All patients had disease progression within 12 months on abiraterone or enzalutamide either before or after docetaxel (at least 3 cycles)

ECOG PS = Eastern Cooperative Oncology Group performance status.

CARD Study Disease History at Baseline ⁹	Median duration	Prior AR-targeted agent	Timing of prior AR-targeted agent
43% M1	~13 months [*] on first androgen-deprivation therapy	48% abiraterone	39% before docetaxel
60% Gleason score 8-10	All patients progressed within: ≤ 12 months on prior AR-targeted agent	51% enzalutamide	61% after docetaxel

M1 disease = metastatic disease (distant metastases).

*Median duration (range) - months, cabazitaxel 13.7 (2-114); abiraterone/enzalutamide 12.6 (3-179)

JEVTANA is an option for your appropriate patients with mCRPC after docetaxel



JEVTANA has been studied in a broad and diverse population across 2 phase 3 trials and 1 phase 4 trial. It has been evaluated in over 2,200 mCRPC patients previously treated with docetaxel, including men 75 years of age and older with high disease burden.^{2,13}



JEVTANA does not require companion diagnostic testing.¹



JEVTANA has been an FDA approved therapy for more than 15 years.¹

After docetaxel and before a second ASTI (abiraterone or enzalutamide), consider JEVTANA¹

ASTI= Androgen-signaling-targeted inhibitor

Important Safety Information (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

Increased Toxicities in Elderly Patients: Patients ≥ 65 years of age were more likely to experience fatal outcomes not related to disease progression and certain adverse reactions, including neutropenia and febrile neutropenia. Monitor closely.

Hypersensitivity Reactions: Severe hypersensitivity reactions can occur. Premedicate all patients with antihistamines, corticosteroids and H2 antagonists prior to JEVTANA. Observe patients closely, especially during the first and second infusions. Discontinue JEVTANA immediately if severe hypersensitivity occurs and treat as indicated.

Gastrointestinal (GI) Adverse Reactions: Nausea, vomiting, and severe diarrhea may occur. Death related to diarrhea and electrolyte imbalance occurred in the randomized clinical trials and mortality related to diarrhea has been reported. Intensive measures may be required for severe diarrhea and electrolyte imbalance. Rehydrate and treat with antiemetics and antidiarrheals as needed. If experiencing grade ≥ 3 diarrhea, dosage should be modified.

GI hemorrhage and perforation, ileus, enterocolitis, neutropenic enterocolitis, including diarrhea and electrolyte imbalance, have been reported. Risk may be increased with neutropenia, age, steroid use, concomitant use of NSAIDs, antiplatelet therapy or anticoagulants, and prior history of pelvic radiotherapy, adhesions, ulceration and GI bleeding. Abdominal pain and tenderness, fever, persistent constipation, diarrhea, with or without neutropenia, may be early manifestations of serious GI toxicity and should be evaluated and treated promptly. JEVTANA treatment delay or discontinuation may be necessary.

Please see additional Important Safety Information throughout and please [click here](#) for full Prescribing Information, including **Boxed WARNING**.

NCCN CATEGORY 1

Cabazitaxel is a NCCN Category 1 preferred regimen following docetaxel and novel hormonal therapy for patients with metastatic castration-resistant prostate cancer (mCRPC).¹⁰

Identify the Right Patient, at the Right Moment

Consider JEVTANA for your mCRPC patients who previously received docetaxel, including those with high disease burden.^{5,9,11}

Prescribed to over 47,000 men*

*estimate based on US sales & IQVIA data. 06/2010-11/2024. Sanofi[®]

Important Safety Information (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

Renal Failure: Cases, including those with fatal outcomes, have been reported. Identify cause and manage aggressively.

Urinary Disorders including Cystitis: Cystitis, radiation cystitis, and hematuria, including that requiring hospitalization, has been reported with JEVTANA in patients who previously received pelvic radiation. Cystitis from radiation recall may occur late in treatment with JEVTANA. Monitor patients who previously received pelvic radiation for signs and symptoms of cystitis while on JEVTANA. Interrupt or discontinue JEVTANA in patients experiencing severe hemorrhagic cystitis. Medical and/or surgical supportive therapy may be required to treat severe hemorrhagic cystitis.

Respiratory Disorders: Interstitial pneumonia/pneumonitis, interstitial lung disease and acute respiratory distress syndrome have been reported and may be associated with the setting of outcome. Patients with underlying lung disease may be at higher risk for these events. Acute respiratory distress syndrome may occur in the fatal of infection. Interrupt JEVTANA if new or worsening pulmonary symptoms develop. Closely monitor, promptly investigate, and appropriately treat patients receiving JEVTANA. Consider discontinuation. The benefit of resuming JEVTANA treatment must be carefully evaluated.

Use in Patients with Hepatic Impairment: JEVTANA dose should be reduced for patients with mild (total bilirubin > 1 to ≤ 1.5 x ULN or AST > 1.5 x ULN) and moderate (total bilirubin > 1.5 to ≤ 3.0 x ULN and any AST) hepatic impairment, based on tolerability data in these patients. Administer JEVTANA 20 mg/m² for mild hepatic impairment. Administer JEVTANA 15 mg/m² for moderate hepatic impairment. Monitor closely.

Embryo-Fetal Toxicity: JEVTANA can cause fetal harm and loss of pregnancy. Advise males with female partners of reproductive potential to use effective contraception during treatment and for 4 months after the last dose of JEVTANA.

ADVERSE REACTIONS (ARs)

The most common all grades adverse reactions and laboratory abnormalities ($\geq 10\%$) with JEVTANA 20 mg/m² or 25 mg/m² are neutropenia, anemia, diarrhea, nausea, fatigue, asthenia, vomiting, hematuria, constipation, decreased appetite, back pain, and abdominal pain.

DRUG INTERACTIONS

Avoid coadministration of JEVTANA with strong CYP3A inhibitors. If patients require coadministration of a strong CYP3A inhibitor, consider a 25% JEVTANA dose reduction.

USE IN SPECIFIC POPULATIONS

• **Pregnancy:** The safety and efficacy of JEVTANA have not been established in females. There are no human data on the use of JEVTANA in pregnant women to inform the drug-associated risk.

• **Lactation:** The safety and efficacy of JEVTANA have not been established in females. There is no information available on the presence of JEVTANA in human milk, the effects of the drug on the breastfed infant, or the effects of the drug on milk production.

• **Females and Males of Reproductive Potential:** Advise male patients with female partners of reproductive potential to use effective contraception during treatment and for 4 months after the last dose of JEVTANA.

Please see full Prescribing Information, including **Boxed WARNING**.

Prescribers and other Healthcare Professionals may go to <https://www.sanofi.us/en/our-company/governance/state-disclosure> for Price Disclosure Information.

References: 1. JEVTANA Prescribing Information. Bridgewater, NJ: sanofi-aventis U.S. LLC, 2023. 2. Data on file. Bridgewater, NJ: sanofi-aventis U.S. LLC. 3. Halabi S, Lin CY, Small EJ, et al. Prognostic model predicting metastatic castration-resistant prostate cancer survival in men treated with second-line chemotherapy. *J Natl Cancer Inst.* 2013;105(22):1729-1737. doi:10.1093/jnci/djt306. 4. Armstrong AL, Garrett-Mayer ES, Yang JC, et al. A contemporary prognostic model in metastatic castration-resistant prostate cancer (mCRPC) incorporating PSA kinetics. *Clin Cancer Res.* 2007;13(21):6396-6403. doi:10.1158/1078-0432.CCR-07-1033. 5. Mukherji D, Ormlin A, Pezaro C, et al. Metastatic castration-resistant prostate cancer (CRPC): preclinical and clinical evidence for the sequential use of novel therapeutics. *Cancer Metastasis Rev.* 2014;33(2-3):555-566. doi:10.1007/s10555-013-9476-7. 6. Scher HI, Morris MJ, Stadler WM, et al. Trial design and objectives for castration resistant prostate cancer: Updated recommendations from the Prostate Cancer Clinical Trials Working Group 3. *J Clin Oncol.* 2016;34(12):1402-1418. 7. Holohan C, Van Schaeybroeck S, Longley DB, Johnston PG. Cancer drug resistance: an evolving paradigm. *Nat Rev Cancer.* 2013;13(10):714-726. doi:10.1038/nrc3599. 8. Rebuticni M, Michiels C. Molecular aspects of cancer cell resistance to chemotherapy. *Biochem Pharmacol.* 2013;85(9):1219-1226. doi:10.1016/j.bcp.2013.02.017. 9. de Wit R, de Bono J, Sternberg CN, et al; CARD Investigators. Cabazitaxel versus abiraterone or enzalutamide in metastatic prostate cancer. *N Engl J Med.* 2019;381(26):2506-2518. doi:10.1056/NEJMoa1911206. 10. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines[®]) for Prostate Cancer, V.2.2025. 11. National Comprehensive Cancer Network, Inc. 2025. All rights reserved. Accessed February 6, 2025. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way. 11. de Bono JS, Oudard S, Ozguroglu M, et al. Prednisone plus cabazitaxel or mitoxantrone for metastatic castration-resistant prostate cancer progressing after docetaxel treatment: a randomised open-label trial. *Lancet.* 2010;376(9747):1147-1154. 12. Oudard S, TROPIC: Phase III trial of cabazitaxel for the treatment of metastatic castration-resistant prostate cancer. *Future Oncol.* 2011;7(4):497-506. 13. Eisenberger M, Hardy-Bessard AC, Kim CS, et al. Phase III Study Comparing a Reduced Dose of Cabazitaxel (20 mg/m²) and the Currently Approved Dose (25 mg/m²) in Postdocetaxel Patients With Metastatic Castration-Resistant Prostate Cancer-PROSELICA. *J Clin Oncol.* 2017;35(28):3198-3206. 14. de Wit R, de Bono J, Sternberg CN, et al; CARD Investigators. Cabazitaxel versus abiraterone or enzalutamide in metastatic prostate cancer. *Supplementary Appendix. N Engl J Med.* 2019;381(26):2506-2518. 15. Sanofi, Data on file. 06/2010-11/2024.