KEYTRUDA® (pembrolizumab)

KEYTRUDA® (pembrolizumab) in combination with enfortumab vedotin▼ as a treatment option for patients with unresectable or metastatic urothelial carcinoma (u/mUC)

KEYTRUDA, in combination with enfortumab vedotin, is indicated for the first-line treatment of unresectable or metastatic urothelial carcinoma in adults.[1]

Please refer to the appropriate Summary of Product Characteristics and Risk Minimisation Materials for Patients before making any prescribing decisions.

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk/ or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to MSD (Tel: 020 8154 8000). By clicking the above link you will leave the MSD website and be taken to the MHRA website.

For UK Healthcare professionals only.

MSD makes no warranties or representations of any kind as to the accuracy, completeness, reliability or usefulness of any information contained in third-party sites and shall have no liability for any loss or damage of any kind that may arise from your use of such content or information. The inclusion of any third-party link does not imply an endorsement or recommendation by MSD.

Prescribing information for KEYTRUDA

MSD ONCOLOGY

1. KEYTRUDA Summary of Product Characteristics. MSD. Available at: https://www.medicines.org.uk/emc/product/2498. Accessed: May 2025.

GB-PDO-03486 | Date of preparation: May 2025

MSD

KEYTRUDA® (pembrolizumab)

DOSING PI

Contents page

Click on the links below to navigate to any of the pages in this deck.
To access this page from any of the other pages in the deck, please press the ‘Home’ icon.

DoR, duration of response; ESMO, European Society for Medical Oncology; ORR, overall response rate; OS, overall survival; PFS, progression-free survival; TRAE, treatment-related adverse event; u/mUC, unresectable/metastatic urothelial carcinoma; UC, urothelial carcinoma.

There is a significant unmet need in patients with unresectable/metastatic UC

For decades, platinum-based chemotherapy has been the first-line standard therapy for unresectable or metastatic UC;[1] however, treatment outcomes remain poor.[1,2]

Around 10% of patients with u/mUC will survive their cancer for 5 years or more after diagnosis*[3]

New treatments are needed to improve outcomes for these patients

*Data is from 2019 and pertains to patients in England only.[3]
u/mUC, unresectable/metastatic urothelial carcinoma; UC, urothelial carcinoma.

1. Powles T, *et al. N Engl J Med* 2024;390:875–888. **2.** SEER cancer stat facts: Bladder cancer. Available at: https://seer.cancer.gov/statfacts/html/urinb.html. Accessed: May 2025. **3.** Cancer Research UK. Survival for bladder cancer. Available at: https://www.cancerresearchuk.org/about-cancer/bladder-cancer/survival. Accessed: May 2025.

KEYTRUDA in combination with enfortumab vedotin

For the first-line treatment of adult patients with unresectable or metastatic urothelial carcinoma.[1,2]

Indication

KEYTRUDA, in combination with enfortumab vedotin, is indicated for the first-line treatment of unresectable or metastatic urothelial carcinoma in adults.[1]

Enfortumab vedotin is an antibody–drug conjugate (ADC) composed of an anti-nectin-4 monoclonal antibody with payload monomethyl auristatin E (MMAE) attached via a protease-cleavable linker.[3]

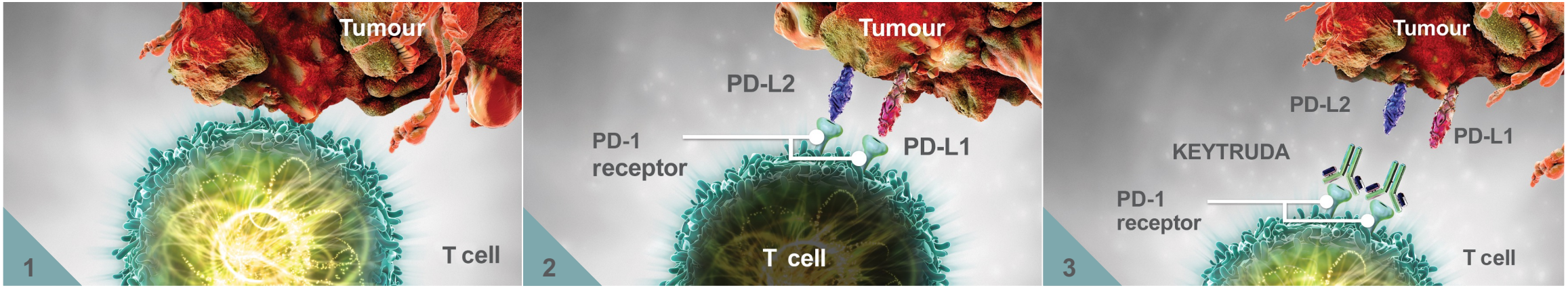
Refer to the Summary of Product Characteristics and Risk Minimisation Materials available on the EMC website before prescribing, in order to help reduce the risks associated with KEYTRUDA.

ADC, antibody–drug conjugate; EMC, Electronic Medicines Compendium; MMAE, monomethyl auristatin E.

1. KEYTRUDA Summary of Product Characteristics. MSD. Available at: https://www.medicines.org.uk/emc/product/2498. Accessed: May 2025. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888. **3.** Heath EI & Rosenberg JE. *Nat Rev Urol* 2021;18:93–103.

KEYTRUDA mechanism of action[1]

- KEYTRUDA binds to the PD-1 receptor, blocking both PD-L1 and PD-L2 from interacting with PD-1 to help restore T-cell and immune response[1]
- **Restoring active T-cell response could affect both normal healthy cells and tumour cells[1]**



Normal immune response[2,3]

When functioning properly, T cells are activated and can attack tumour cells or antigen-presenting cells.

Tumour evasion and T-cell deactivation[3,4]

Some tumours can evade the immune system through the PD-1 pathway. The PD-L1 and PD-L2 ligands on tumours can bind with the PD-1 receptors on T cells to inactivate the T cells.

T-cell reactivation with KEYTRUDA[1,4]

KEYTRUDA binds the PD-1 receptor and blocks the interaction with PD-L1 and PD-L2, which helps restore the immune response. While affecting the tumour, this could also affect normal, healthy cells.

- EV is an antibody–drug conjugate composed of an anti-nectin-4 monoclonal antibody with payload monomethyl auristatin E (MMAE) attached via a protease-cleavable linker[5]

Adapted from KEYTRUDA SmPC; Chen DS, *et al.* 2013 & Pardoll DM. 2012.[1,3,4]

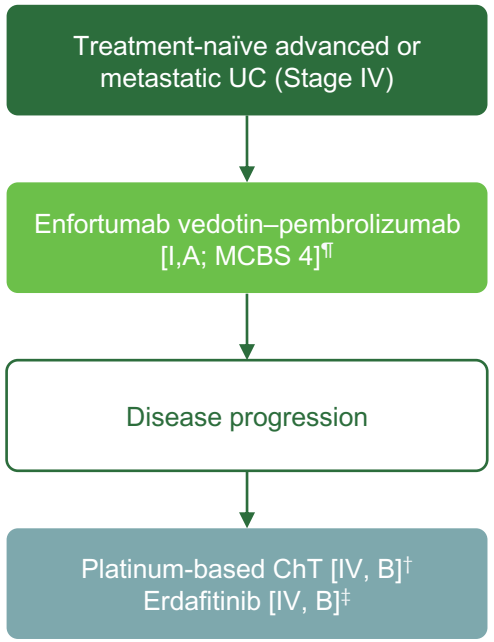
EV, enfortumab vedotin; PD-1, programmed death receptor-1; PD-L1, programmed death-ligand 1; PD-L2, programmed death-ligand 2; SmPC, Summary of Product Characteristics.

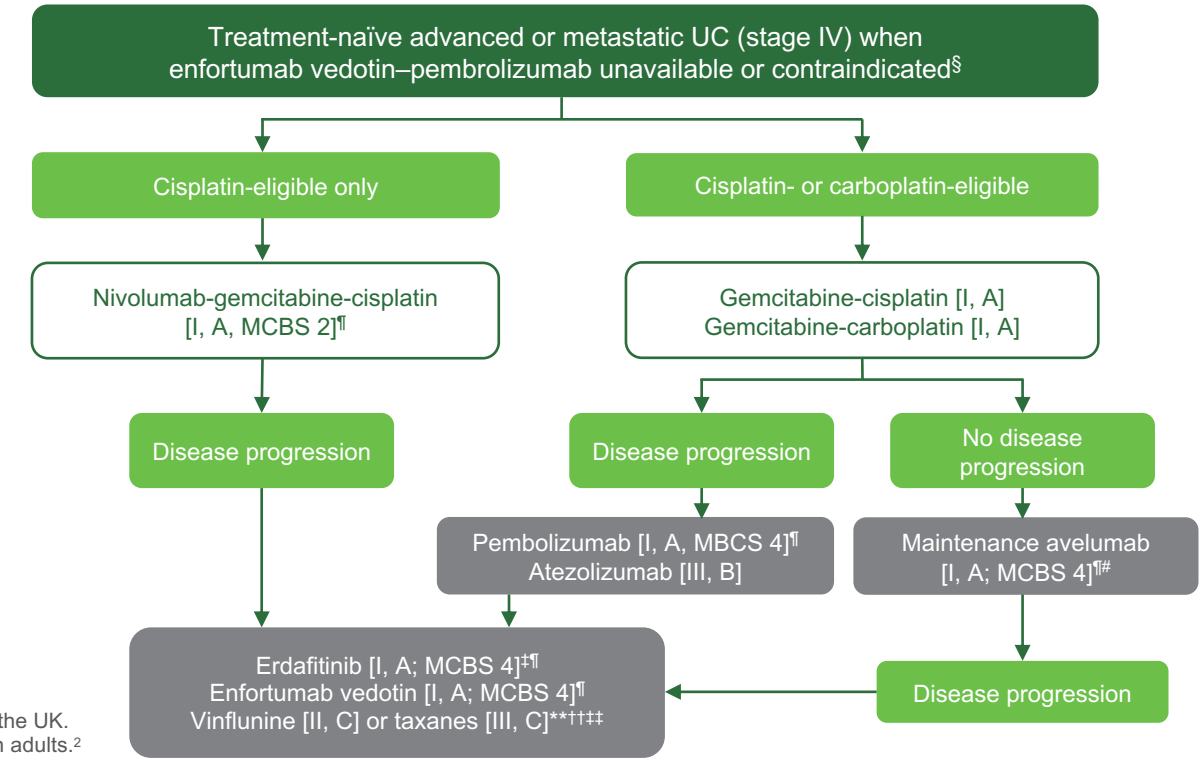
1. KEYTRUDA Summary of Product Characteristics. MSD. Available at: https://www.medicines.org.uk/emc/product/2498. Accessed: May 2025. **2.** May KF, *et al.* Chapter 8 – Immunosurveillance: innate and adaptive antitumor immunity. In: Cancer Immunotherapy (Second Edition) 2013. Academic Press. Cambridge, MA, USA. **3.** Chen DS, *et al. Immunity* 2013;39:1–10. **4.** Pardoll DM. *Nat Rev Cancer* 2012;12:252–264. **5.** Heath EI & Rosenberg JE. *Nat Rev Urol* 2021;18:93–103.

ESMO now recommends KEYTRUDA, in combination with enfortumab vedotin, as SOC for first-line treatment of advanced or metastatic UC[1]

ESMO Clinical Practice Guideline interim update on first-line therapy in advanced/metastatic UC:

Management of patients with advanced/metastatic UC





Adapted from ESMO Guidelines.[1]
Please note that this diagram has been adapted to remove guidance on any products not licensed in the UK.
The indication of KEYTRUDA is for the treatment of unresectable or metastatic urothelial carcinoma in adults.[2]

†Rechallenge with single-agent ICI is not encouraged without further evidence [V, D]. ‡In tumours with selected *FGFR* DNA fusions and mutations. §Enfortumab vedotin–pembrolizumab is preferred over platinum-based ChT irrespective of platinum eligibility. ¶ESMO-MCBS v1.1 was used to calculate scores for new therapies/indications approved by the EMA or FDA. The scores have been calculated and validated by the ESMO-MCBS Working Group and reviewed by the authors. #This should be assessed within 10 weeks of completion of ChT. **Rechallenge with platinum-based ChT may be considered if progression occurred 12 months after the end of previous platinum-based ChT or 12 months after the end of previous platinum-based ChT and maintenance avelumab. ††Platinum doublets to be considered if the treatment-free interval from the last platinum-based ChT is >1 year. ‡‡To be considered when other therapies are not available.[1] ChT, chemotherapy; DNA, deoxyribonucleic acid; EGFR, epidermal growth factor receptor; EMA, European Medicines Agency; ESMO, European Society for Medical Oncology; FDA, Food and Drug Administration; ICI, immune checkpoint inhibitor; MCBS, Magnitude of Clinical Benefit Scale; SOC, standard of care; UC, urothelial carcinoma.

1. Powles T, *et al. Ann Oncol* 2024;35:485–490. **2.** KEYTRUDA Summary of Product Characteristics. MSD. Available at: https://www.medicines.org.uk/emc/product/2498. Accessed: May 2025.

KEYNOTE-A39 / EV-302

An open-label, multicentre, randomised, active-controlled Phase III study of KEYTRUDA + EV vs platinum-based chemotherapy (gemcitabine + either cisplatin or carboplatin) in previously untreated, locally advanced or metastatic UC[1]

The indication of KEYTRUDA in combination with enfortumab vedotin, is for the treatment of unresectable or metastatic urothelial carcinoma in adults.[2]

EV, enfortumab vedotin; UC, urothelial carcinoma.

1. Powles T, *et al. N Engl J Med* 2024;390:875–888. **2.** KEYTRUDA Summary of Product Characteristics. MSD. Available at: https://www.medicines.org.uk/emc/product/2498. Accessed: May 2025.

KEYNOTE-A39 data presentation overview

Powles T, *et al. N Engl J Med*[1]

Abstract presented at ESMO Annual Congress 2023

7 March 2024

Final analysis
with 17.2 months median follow-up

Data cut-off: 8 August 2023

Because the results of the interim analysis of overall survival were significant, the interim analysis was considered to be the final analysis.

ASCO Genitourinary Cancers Symposium[2]

13–15 February 2025

Exploratory analysis
with 1 year of additional follow-up
(29.1 months median follow-up)

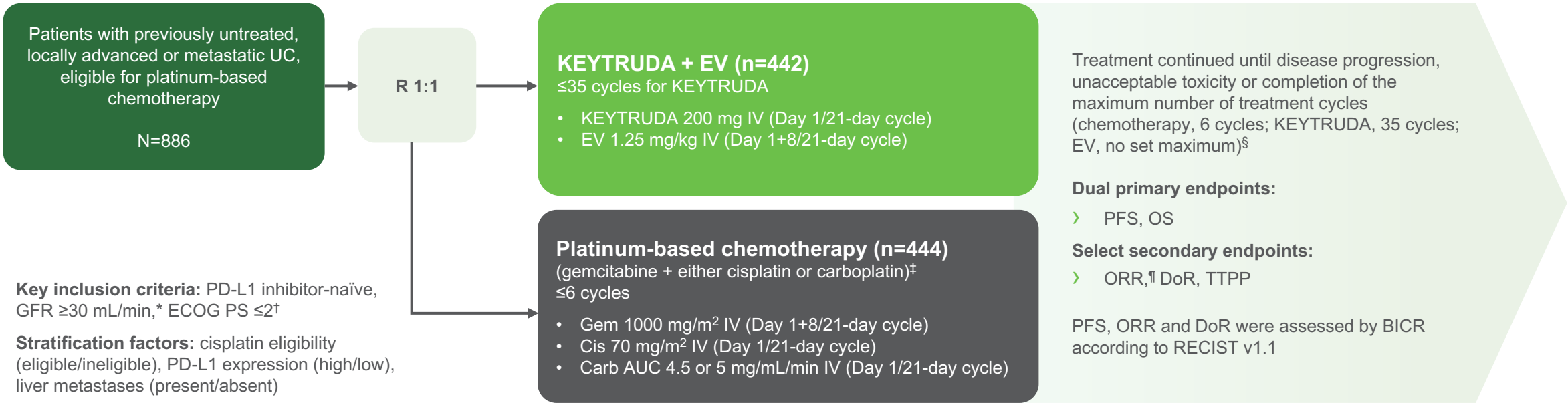
Data cut-off: 8 August 2024

ASCO, American Society of Clinical Oncology; ESMO, European Society of Medical Oncology; EV, enfortumab vedotin.

1. Powles T, *et al. N Engl J Med*. 2024;390:875–888 (plus supplementary appendix and protocol); 2. Powles T, *et al.* Abstract 664. Presented at ASCO GU 2025, 13–15 February. San Francisco, CA.

Study design[1–3]

A randomised, multicentre, open-label, active-controlled Phase III trial across 25 countries.



Adapted from Powles T, *et al.* 2024.[1–3]

The indication of KEYTRUDA in combination with enfortumab vedotin, is for the treatment of unresectable or metastatic urothelial carcinoma in adults.[4]

*Measured by the Cockcroft-Gault formula, Modification of Diet in Renal Disease, or 24-hour urine.[2] †Patients with ECOG PS of 2 were required to also meet the additional criteria: haemoglobin ≥10 g/dL and GFR ≥50 mL/min but may not have NYHA Class III heart failure.[2] ‡Maintenance therapy could be used following completion and/or discontinuation of platinum-containing therapy.[2] §Treatment continuation was permitted beyond RECIST v1.1, defined progression if the treating investigator considered the patient to be deriving clinical benefit and the treatment was tolerated.[3] ¶Defined as a a complete or partial response according to RECIST, version 1.1.[1]

AUC, area under curve; BICR, blinded independent central review; carb, carboplatin; cis, cisplatin; DoR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; gem, gemcitabine; GFR, glomerular filtration rate; IV, intravenous; NYHA, New York Heart Association; ORR, overall response rate; OS, overall survival; PD-L1, programmed death-ligand 1; PFS, progression-free survival; R, randomised; RECIST, Response Evaluation Criteria In Solid Tumours; TTPP, time to pain progression; UC, urothelial carcinoma.

1. Powles T, *et al. N Engl J Med* 2024;390:875–888. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888. Supplementary appendix. **3**. Powles T, *et al. N Engl J Med* 2024;390:875–888. Protocol. **4.** KEYTRUDA Summary of Product Characteristics. MSD. Available at: https://www.medicines.org.uk/emc/product/2498. Accessed: May 2025.

Dosing schedule[1]

KEYNOTE-A39: KEYTRUDA in combination with enfortumab vedotin
21-DAY DOSING CYCLE[1]

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Enfortumab vedotin 1.25 mg/kg	✔							✔													
KEYTRUDA, 200 mg Q3W	✔																				

Patients received enfortumab vedotin 1.25 mg/kg as an IV infusion over 30 minutes on Days 1 and 8 of a 21-day cycle, followed by KEYTRUDA 200 mg as an IV infusion on Day 1 of a 21-day cycle approximately 30 minutes after enfortumab vedotin. Patients were treated until disease progression or unacceptable toxicity. In the absence of disease progression or unacceptable toxicity, KEYTRUDA was continued for up to 2 years.

IV, intravenous; Q3W, every 3 weeks.

1. Powles T, *et al. N Engl J Med* 2024;390:875–888.

Baseline patient population[1,2]

Both treatment arms were well-balanced for key baseline demographic and disease characteristics.

Characteristic		KEYTRUDA + EV (n=442)	Platinum-based chemotherapy (n=444)
Median age, years (range)		69 (37–87)	69 (22–91)
Male, n (%)		344 (77.8)	336 (75.7)
White, n (%)		308 (69.7)	290 (65.3)
Geographic region, n (%)	North America	103 (23.3)	85 (19.1)
	Europe	172 (38.9)	197 (44.4)
	Rest of the world	167 (37.8)	162 (36.5)
ECOG PS n (%)*	0	223 (50.5)	215 (48.4)
	1	204 (46.2)	216 (48.6)
	2	15 (3.4)	11 (2.5)
Creatinine clearance, n (%)†	≥60 ml/min	249 (56.3)	257 (57.9)
	<60 ml/min	193 (43.7)	187 (42.1)
Metastatic disease at randomisation, n (%)		421 (95.2)	420 (94.6)
Lower tract as primary source of disease origin, n (%)		305 (69.0)	339 (76.4)
Upper tract as primary source of disease origin, n (%)		135 (30.5)	104 (23.4)

Characteristic		KEYTRUDA + EV (n=442)	Platinum-based chemotherapy (n=444)
Histologic type, n (%)	UC	379 (85.7)	373 (84.0)
	UC, mixed types	50 (11.3)	53 (11.9)
	Variant UC only	4 (0.9)	7 (1.6)
Site of metastasis	Lymph node only	103 (23.3)	104 (23.4)
	Visceral site	318 (71.9)	318 (71.6)
	Bone	81 (18.3)	102 (23.0)
	Liver	100 (22.6)	99 (22.3)
	Lung	170 (38.5)	157 (35.4)
PD-L1 CPS ≥10 (high), n (%)‡		254/438 (58.0)	254/439 (57.9)
Cisplatin eligible, n (%)		240 (54.3)	242 (54.5)

In the platinum-chemotherapy arm, those who were cisplatin-ineligible received carboplatin-based chemotherapy instead.

Adapted from Powles T, *et al.* 2024.[1,2]

*ECOG PS scores range from 0–5, with higher scores indicating greater disability.[1] †Renal function criteria: normal (GFR ≥90 ml/min per 1.73 m^2); mild impairment (GFR 60–89 ml/min per 1.73 m^2); moderate impairment (GFR 45–59 ml/min per 1.73 m^2); severe impairment (GFR 15–29 ml/min per 1.73 m^2).[3] ‡High PD-L1 expression was defined as CPS ≥10.[4]
CPS, combined positive score; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; GFR, glomerular filtration rate; PD-L1, programmed death-ligand 1; UC, urothelial carcinoma.
1. Powles T, *et al. N Engl J Med* 2024;390:875–888. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888. Supplementary appendix. **3**. Levey AS, *et al. Kidney Int* 2020;97:1117–1129. **4**. Powles T, *et al. N Engl J Med* 2024;390:875–888. Protocol.

How does ‘platinum-eligibility’ differ from ‘cisplatin-eligibility’?

- Although the pivotal KEYNOTE-A39 trial excluded patients ineligible for platinum-based therapies, it included individuals eligible for cisplatin and/or carboplatin. This means that some participants were ineligible for cisplatin but still eligible for carboplatin.[1]
- Patients in the comparator arm received either cisplatin- or carboplatin-based chemotherapy, depending on whether they were eligible for cisplatin therapy or not[1,2]

KEYNOTE-A39 protocol: criteria for cisplatin-ineligibility[2]

Renal function	GFR <60 mL/min but ≥30 mL/min*
Prognostic factors	ECOG or WHO PS 2
NCI CTCAE	Grade ≥2 audiometric hearing loss
Heart failure classification	NYHA Class III heart failure

If a patient is eligible for either cisplatin or carboplatin, then they are potentially eligible for treatment with combination KEYTRUDA + EV[1–3]

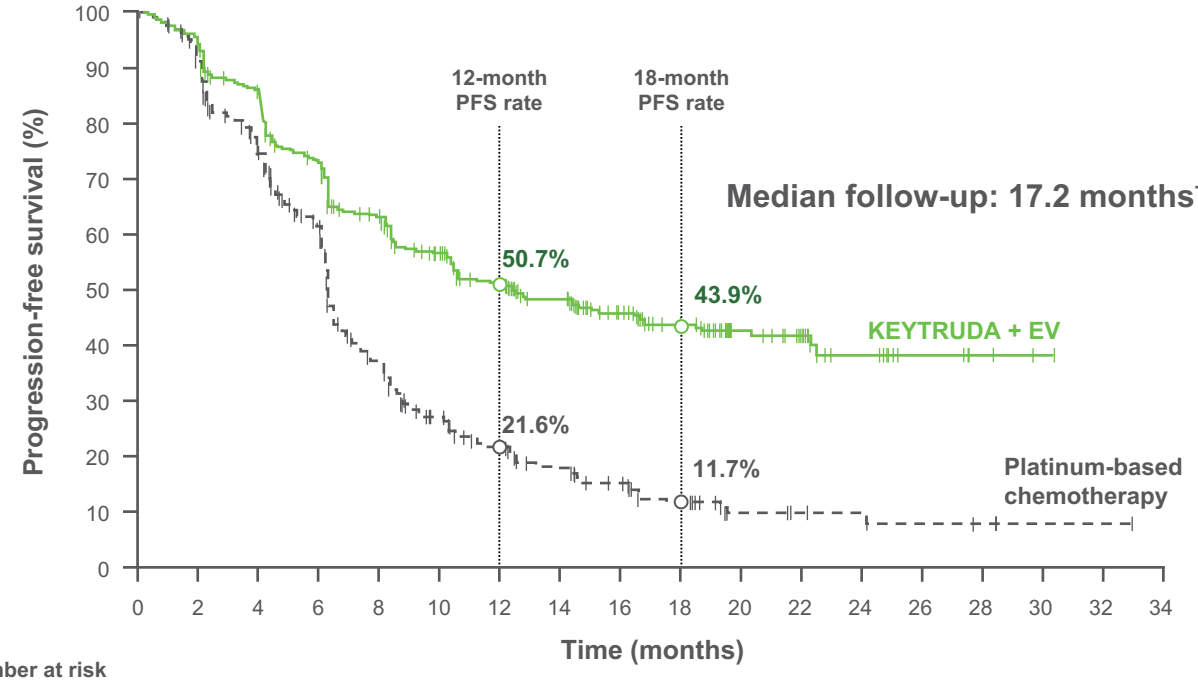
*Subjects with GFR ≥50 mL/min and no other cisplatin ineligibility criteria may be considered cisplatin-eligible based on the investigator's clinical judgement.[2]

CTCAE, Common Terminology Criteria for Adverse Events; ECOG, Eastern Cooperative Oncology Group; EV, enfortumab vedotin; GFR, glomerular filtration rate; NCI, National Cancer Institute; NYHA, New York Heart Association; PS, performance status; WHO, World Health Organisation.

1. Powles T, *et al. N Engl J Med* 2024;390:875–888. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888. Supplementary appendix. **3.** KEYTRUDA Summary of Product Characteristics. MSD. Available at: https://www.medicines.org.uk/emc/product/2498. Accessed: May 2025.

In the KEYNOTE-A39 final analysis, KEYTRUDA + EV significantly reduced the risk of disease progression or death vs platinum-based chemotherapy[1]

Kaplan-Meier estimates of PFS* (dual primary endpoint in the ITT population)



Number at risk

KEYTRUDA + EV	442	409	361	303	253	204	167	132	102	73	45	33	17	6	3	1	0
Platinum-based chemotherapy	444	380	297	213	124	78	56	41	30	19	8	6	5	3	2	1	1	0

Adapted from Powles T, *et al.* 2024.[1]

KEYTRUDA + EV nearly doubled the median PFS vs platinum-based chemotherapy in the 1L treatment of u/mUC

55%

RELATIVE REDUCTION IN RISK OF DISEASE PROGRESSION OR DEATH with KEYTRUDA + EV vs platinum-based chemotherapy

Events: 50.5% (223/442) vs 69.1% (307/444)

HR: 0.45;‡ 95% CI: 0.38–0.54; p<0.001§

Median PFS

KEYTRUDA + EV
12.5 months
(95% CI: 10.4–16.6)

vs

Platinum-based chemotherapy
6.3 months
(95% CI: 6.2–6.5)

*As assessed by BICR according to RECIST v1.1.[1] †**Cut-off date: 8 August 2023.**[1] ‡Based on the stratified Cox proportional hazard regression model.[1] §Two-sided p-value based on stratified log-rank test.[1]

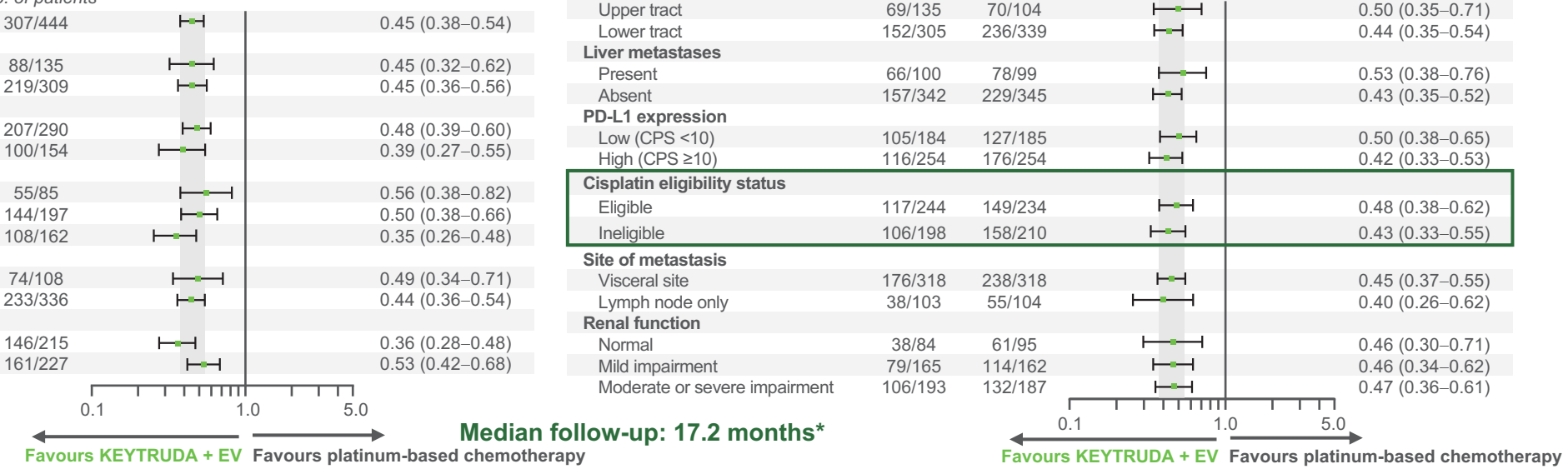
1L, first-line; BICR, blinded independent central review; CI, confidence interval; EV, enfortumab vedotin; HR, hazard ratio; ITT, intention-to-treat; PFS, progression-free survival; RECIST, Response Evaluation Criteria in Solid Tumours; u/mUC, unresectable/metastatic urothelial carcinoma.

1. Powles T, *et al. N Engl J Med* 2024;390:875–888.

In the KEYNOTE-A39 final analysis, PFS favoured KEYTRUDA + EV across all prespecified patient subgroups[1]

Exploratory subgroup analysis of PFS within the ITT population

Subgroup	KEYTRUDA + EV	Platinum-based chemotherapy	HR (95% CI)
	no. of events/no. of patients		
Overall	223/442	307/444	0.45 (0.38–0.54)
Age			
<65 years	75/144	88/135	0.45 (0.32–0.62)
≥65 years	148/298	219/309	0.45 (0.36–0.56)
Race			
White	168/308	207/290	0.48 (0.39–0.60)
Other	55/134	100/154	0.39 (0.27–0.55)
Geographic region			
North America	58/103	55/85	0.56 (0.38–0.82)
Europe	94/172	144/197	0.50 (0.38–0.66)
Rest of the world	71/167	108/162	0.35 (0.26–0.48)
Sex			
Female	55/98	74/108	0.49 (0.34–0.71)
Male	168/344	233/336	0.44 (0.36–0.54)
ECOG PS score			
0	93/223	146/215	0.36 (0.28–0.48)
1 or 2	130/219	161/227	0.53 (0.42–0.68)
Primary site of origin of disease			
Upper tract	69/135	70/104	0.50 (0.35–0.71)
Lower tract	152/305	236/339	0.44 (0.35–0.54)
Liver metastases			
Present	66/100	78/99	0.53 (0.38–0.76)
Absent	157/342	229/345	0.43 (0.35–0.52)
PD-L1 expression			
Low (CPS <10)	105/184	127/185	0.50 (0.38–0.65)
High (CPS ≥10)	116/254	176/254	0.42 (0.33–0.53)
Cisplatin eligibility status			
Eligible	117/244	149/234	0.48 (0.38–0.62)
Ineligible	106/198	158/210	0.43 (0.33–0.55)
Site of metastasis			
Visceral site	176/318	238/318	0.45 (0.37–0.55)
Lymph node only	38/103	55/104	0.40 (0.26–0.62)
Renal function			
Normal	38/84	61/95	0.46 (0.30–0.71)
Mild impairment	79/165	114/162	0.46 (0.34–0.62)
Moderate or severe impairment	106/193	132/187	0.47 (0.36–0.61)



In KEYNOTE-A39, formal statistical testing for these subgroups was not conducted. The study was not powered to detect differences in the treatment effect in these subgroups. **Therefore, results should be interpreted with caution and no conclusions should be drawn**

Adapted from Powles T, *et al.* 2024.[1]

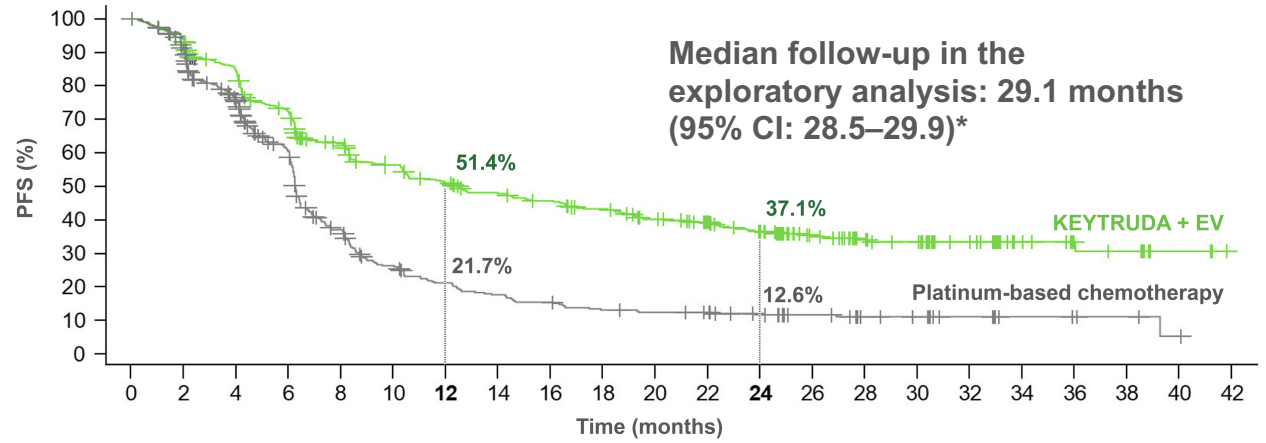
***Cut-off date: 8 August 2023.**[1]

CI, confidence interval; CPS, combined positive score; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; HR, hazard ratio; ITT, intention-to-treat; no, number; PD-L1, programmed death-ligand 1; PFS, progression-free survival.

1. Powles T, *et al. N Engl J Med* 2024;390:875–888.

An exploratory analysis of the KEYNOTE-A39 trial data showed that the PFS benefit was maintained with KEYTRUDA + EV vs platinum-based chemotherapy[1,2]

Kaplan-Meier estimates of PFS* (dual primary endpoint in the ITT population)[1]



52%

RELATIVE REDUCTION IN RISK OF DISEASE PROGRESSION OR DEATH with KEYTRUDA + EV vs platinum-based chemotherapy

Events: 59.0% (262/444) vs 71.4% (317/444)

HR: 0.48; 95% CI: 0.41–0.57; p<0.00001†

Median PFS

KEYTRUDA + EV	vs	Platinum-based chemotherapy
12.5 months (95% CI: 10.4–16.6)		**6.3 months** (95% CI: 6.2–6.5)

Adapted from Powles T, *et al.* 2025.[1]

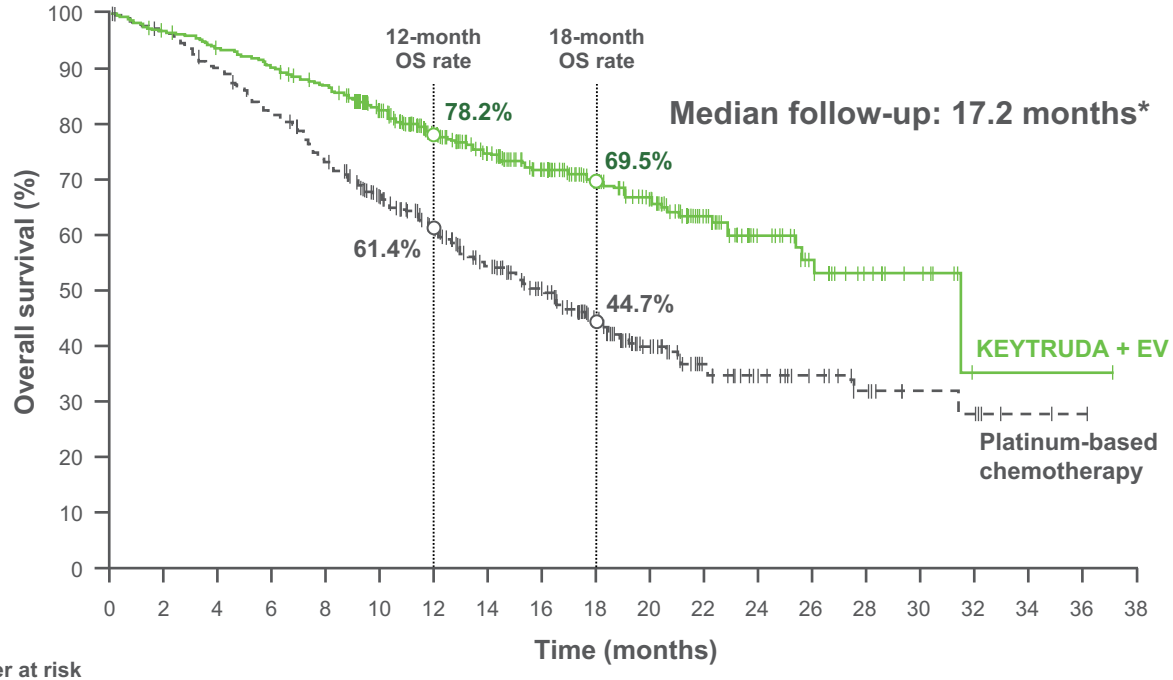
*1 year additional follow-up from final analysis (~2.5 years of median follow-up). **Cut-off date: 8 August 2024.**[1] †P-value is nominal and descriptive.[1]

BICR, blinded independent central review; CI, confidence interval; EV, enfortumab vedotin; HR, hazard ratio; ITT, intention-to-treat; PFS, progression-free survival; RECIST, Response Evaluation Criteria in Solid Tumours.

1. Powles T, *et al.* EV-302: Updated Analysis from the Phase 3 Global Study of Enfortumab Vedotin in Combination with Pembrolizumab (EV+P) vs Chemotherapy (Chemo) in Previously Untreated Locally Advanced or Metastatic Urothelial Carcinoma (la/mUC). ASCO GU Annual Symposium. 13–15 February 2025. San Francisco, CA, USA. Oral presentation. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888.

In the KEYNOTE-A39 final analysis, there was a significant OS benefit with KEYTRUDA + EV vs platinum-based chemotherapy[1]

Kaplan-Meier estimates of OS (dual primary endpoint in the ITT population)



Number at risk

KEYTRUDA + EV	442	426	409	394	376	331	270	222	182	141	108	67	36	22	12	8	1	1	1	0
Platinum-based chemotherapy	444	423	393	356	317	263	209	164	125	90	60	37	25	18	12	7	6	2	1	0

Adapted from Powles T, *et al.* 2024.[1]

KEYTRUDA + EV nearly doubled the median OS vs platinum-based chemotherapy in the 1L treatment of patients with u/mUC

53%

RELATIVE REDUCTION IN RISK OF DEATH
with KEYTRUDA + EV
vs platinum-based chemotherapy

Events: 30.1% (133/442) vs 50.9% (226/444)

HR: 0.47;† 95% CI: 0.38–0.58; p<0.001‡

Median OS

KEYTRUDA + EV
31.5 months
(95% CI: 25.4–NR)

vs

Platinum-based chemotherapy
16.1 months
(95% CI: 13.9–18.3)

***Cut-off date: 8 August 2023.**[1] †Based on the stratified Cox proportional hazard regression model.[1] ‡Two-sided p-value based on stratified log-rank test.[1]

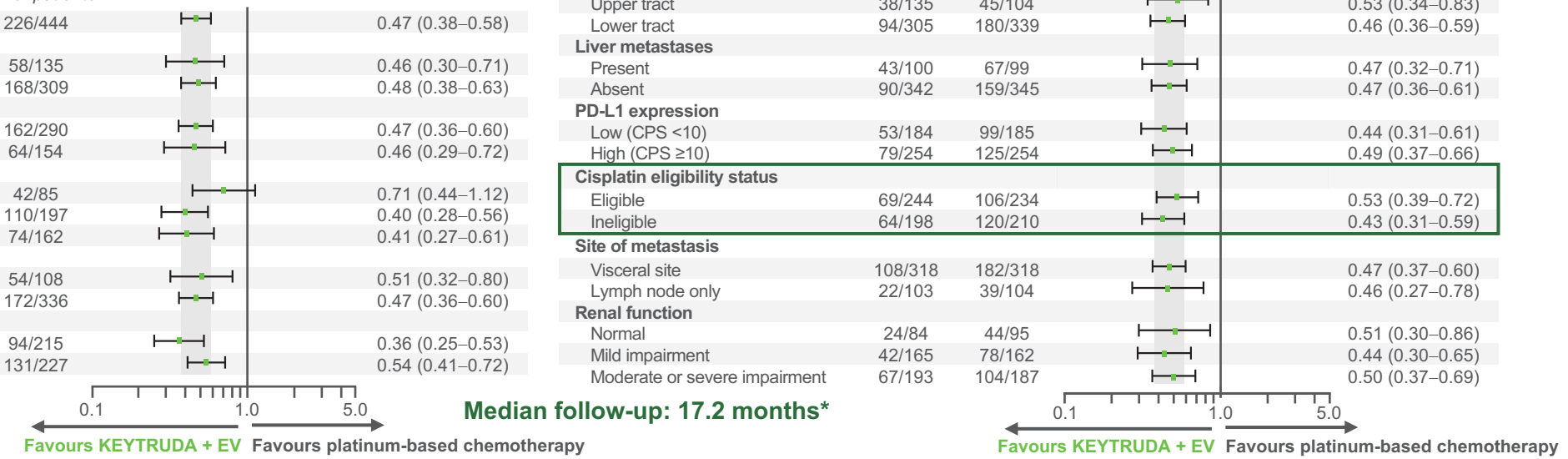
1L, first-line; CI, confidence interval; EV, enfortumab vedotin; HR, hazard ratio; ITT, intention-to-treat; NR, not reached; OS, overall survival; u/mUC, unresectable/metastatic urothelial carcinoma.

1. Powles T, *et al. N Engl J Med* 2024;390:875–888.

In the KEYNOTE-A39 final analysis, OS favoured KEYTRUDA + EV across all prespecified patient subgroups[1]

Exploratory subgroup analysis of OS within the ITT population

Subgroup	KEYTRUDA + EV	Platinum-based chemotherapy	HR (95% CI)
	no. of events/no. of patients		
Overall	133/442	226/444	0.47 (0.38–0.58)
Age			
<65 years	39/144	58/135	0.46 (0.30–0.71)
≥65 years	94/298	168/309	0.48 (0.38–0.63)
Race			
White	104/308	162/290	0.47 (0.36–0.60)
Other	29/134	64/154	0.46 (0.29–0.72)
Geographic region			
North America	40/103	42/85	0.71 (0.44–1.12)
Europe	56/172	110/197	0.40 (0.28–0.56)
Rest of the world	37/167	74/162	0.41 (0.27–0.61)
Sex			
Female	32/98	54/108	0.51 (0.32–0.80)
Male	101/344	172/336	0.47 (0.36–0.60)
ECOG PS score			
0	44/223	94/215	0.36 (0.25–0.53)
1 or 2	89/219	131/227	0.54 (0.41–0.72)
Primary site of origin of disease			
Upper tract	38/135	45/104	0.53 (0.34–0.83)
Lower tract	94/305	180/339	0.46 (0.36–0.59)
Liver metastases			
Present	43/100	67/99	0.47 (0.32–0.71)
Absent	90/342	159/345	0.47 (0.36–0.61)
PD-L1 expression			
Low (CPS <10)	53/184	99/185	0.44 (0.31–0.61)
High (CPS ≥10)	79/254	125/254	0.49 (0.37–0.66)
Cisplatin eligibility status			
Eligible	69/244	106/234	0.53 (0.39–0.72)
Ineligible	64/198	120/210	0.43 (0.31–0.59)
Site of metastasis			
Visceral site	108/318	182/318	0.47 (0.37–0.60)
Lymph node only	22/103	39/104	0.46 (0.27–0.78)
Renal function			
Normal	24/84	44/95	0.51 (0.30–0.86)
Mild impairment	42/165	78/162	0.44 (0.30–0.65)
Moderate or severe impairment	67/193	104/187	0.50 (0.37–0.69)



In KEYNOTE-A39, formal statistical testing for these subgroups was not conducted. The study was not powered to detect differences in the treatment effect in these subgroups. **Therefore, results should be interpreted with caution and no conclusions should be drawn**

Adapted from Powles T, *et al.* 2024.[1]

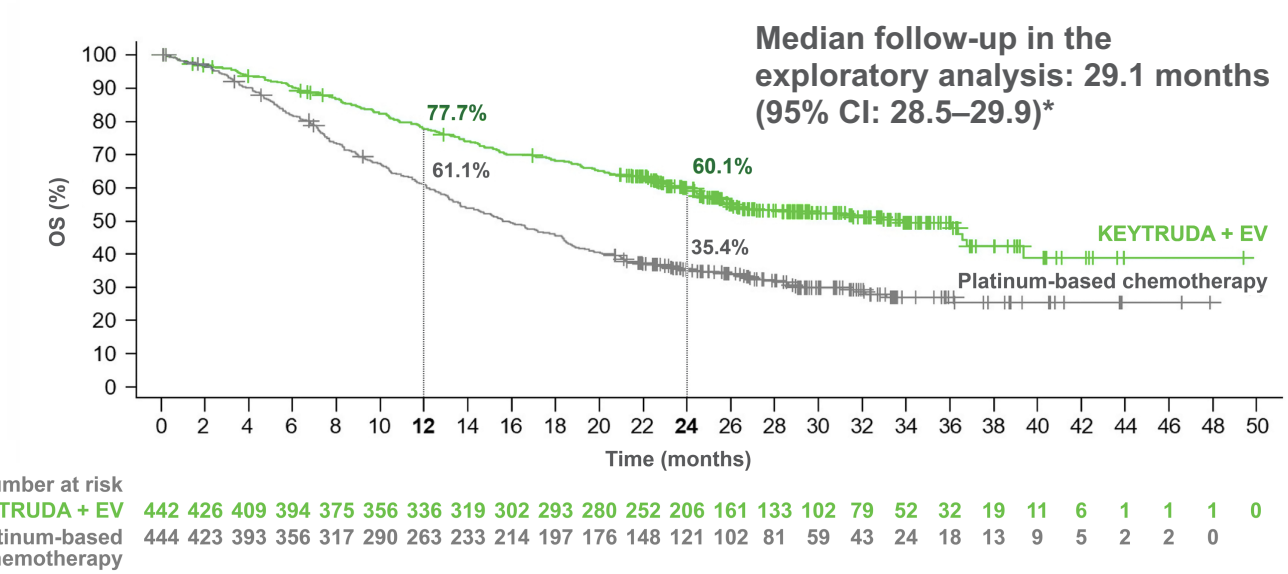
***Cut-off date: 8 August 2023.**[1]

CI, confidence interval; CPS, combined positive score; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; HR, hazard ratio; ITT, intention-to-treat; no, number; OS, overall survival; PD-L1, programmed death-ligand 1.

1. Powles T, *et al. N Engl J Med* 2024;390:875–888.

An exploratory analysis of the KEYNOTE-A39 trial data showed that the OS benefit was maintained with KEYTRUDA + EV vs platinum-based chemotherapy[1,2]

Kaplan-Meier estimates of OS (dual primary endpoint in the ITT population)[1]



49%

RELATIVE REDUCTION IN RISK OF DEATH
with KEYTRUDA + EV
vs platinum-based chemotherapy

Events: 45.8% (203/444) vs 66.9% (297/444)

HR: 0.51; 95% CI: 0.43–0.61; p<0.00001†

Median OS

KEYTRUDA + EV
33.8 months
(95% CI: 26.1–39.3)

vs

Platinum-based chemotherapy
15.9 months
(95% CI: 13.6–18.3)

Adapted from Powles T, *et al.* 2025.[1]

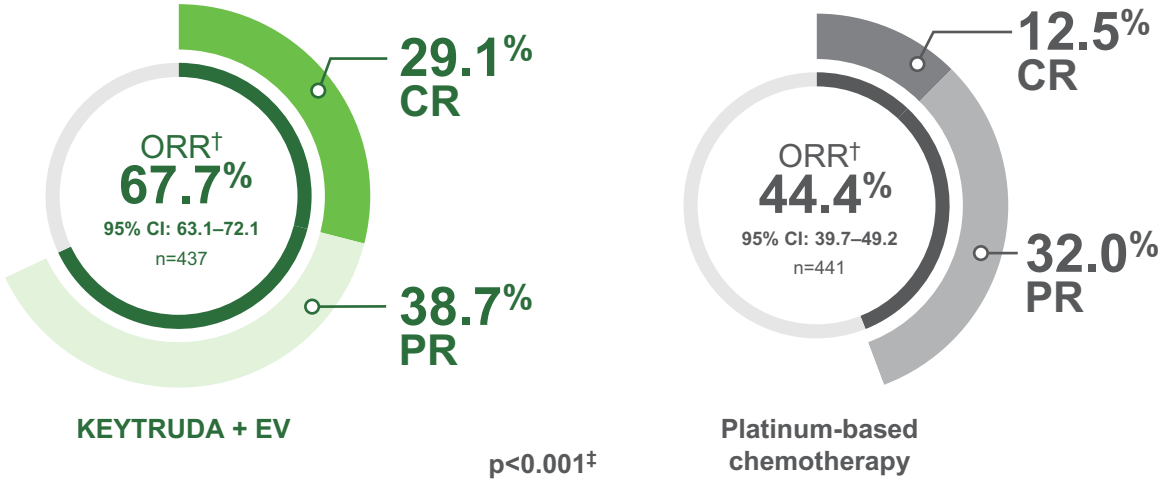
*1 year additional follow-up from final analysis (~2.5 years of median follow-up). **Cut-off date: 8 August 2024.**[1] †P-value is nominal and descriptive.[1]
CI, confidence interval; EV, enfortumab vedotin; HR, hazard ratio; ITT, intention-to-treat; OS, overall survival.

1. Powles T, *et al.* EV-302: Updated Analysis from the Phase 3 Global Study of Enfortumab Vedotin in Combination with Pembrolizumab (EV+P) vs Chemotherapy (Chemo) in Previously Untreated Locally Advanced or Metastatic Urothelial Carcinoma (la/mUC). ASCO GU Annual Symposium. 13–15 February 2025. San Francisco, CA, USA. Oral presentation. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888.

In the KEYNOTE-A39 final analysis, a significant ORR benefit was demonstrated with KEYTRUDA + EV vs platinum-based chemotherapy*[1,2]

Secondary endpoint

Treatment response rates within the ITT population



ORRs favoured KEYTRUDA + EV across all prespecified patient subgroups[4]

Median follow-up: 17.2 months§

29.1% had a complete response with KEYTRUDA + EV
vs **12.5%** with platinum-based chemotherapy

Events: 29.1% (127/437) vs 12.5% (55/441)

Disease control rate (achieved stable disease or better)[1,3]

KEYTRUDA + EV	vs	Platinum-based chemotherapy
86.0%		78.0%

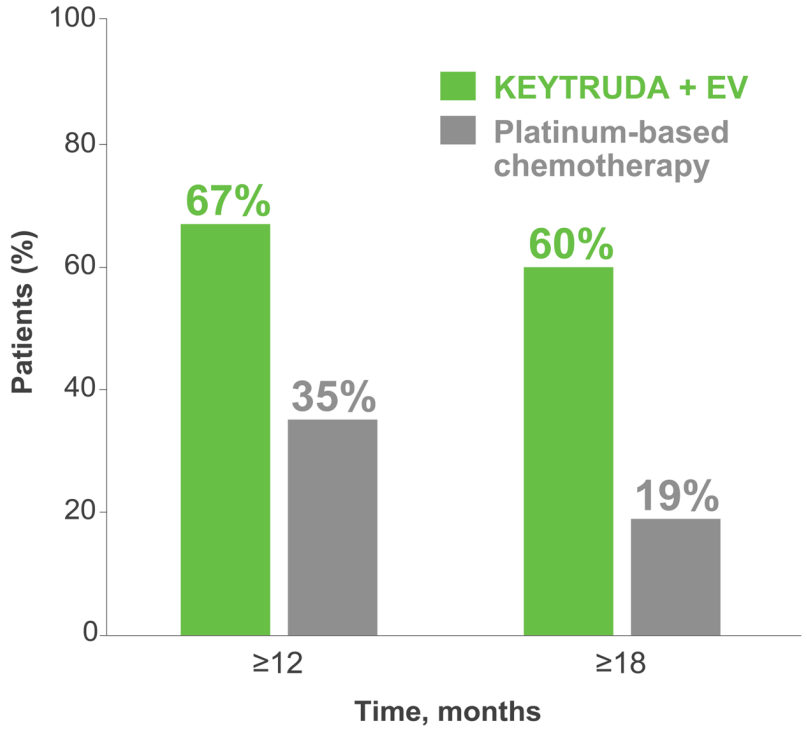
KEYTRUDA + EV **more than doubled the complete response rate** vs platinum-based chemotherapy

Adapted from Powles T, *et al.* 2024.[1]

*As assessed by BICR according to RECIST v1.1.[1] †Includes only patients with measurable disease at baseline. Based on patients with a best overall response as confirmed complete or partial response.[1] ‡Two-sided p-value based on Cochran-Mantel-Haenszel test stratified by PD-L1 expression, cisplatin eligibility and liver metastases.[1] §**Cut-off date: 8 August 2023.**[1]
BICR, blinded independent central review; CI, confidence interval; CR, complete response; EV, enfortumab vedotin; ITT, intention-to-treat; ORR, objective response rate; PD-L1, programmed death-ligand 1; PR, partial response; RECIST, Response Evaluation Criteria in Solid Tumours.
1. Powles T, *et al. N Engl J Med* 2024;390:875–888. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888. Protocol. **3.** MSD. Company Core Data Sheet. S-CCDS-MK3475-IV-072024. **4.** Powles T, *et al. N Engl J Med* 2024;390:875–888. Supplementary appendix.

In the KEYNOTE-A39 final analysis, KEYTRUDA + EV extended the median DoR vs platinum-based chemotherapy*†[1,2]

Proportion of patients who were still in remission at 12 months and 18 months



Median follow-up: 17.2 months‡

Median duration of response[3]

KEYTRUDA + EV	vs	Platinum-based chemotherapy
NR (range: 2.0+ to 28.3+)		7.0 months (range: 1.5+ to 30.9+)

Adapted from Powles T, *et al.* 2024.[1]

*As assessed by BICR according to RECIST v1.1.[1] †Based on Kaplan-Meier estimaion.[1] ‡**Cut-off date: 8 August 2023.**[1]

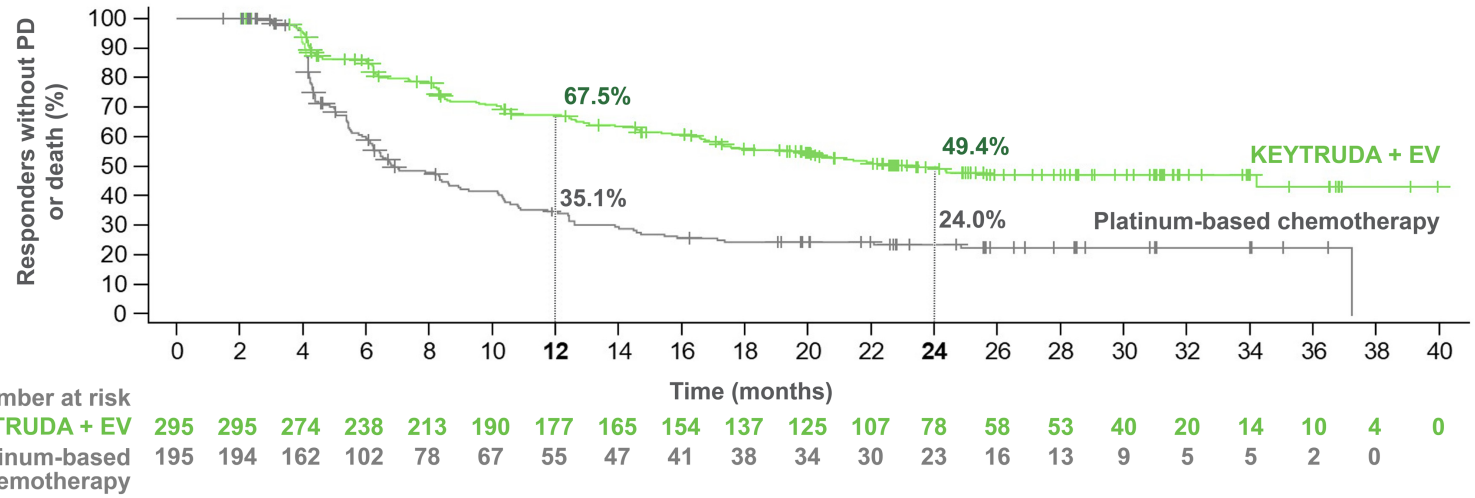
BICR, blinded independent central review; CI, confidence interval; DoR, duration of response; EV, enfortumab vedotin; NE, non-estimable; NR, not reached; RECIST v1.1, Response Evaluation Criteria in Solid Tumours v1.1.

1. Powles T, *et al. N Engl J Med* 2024;390:875–888. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888. Supplementary appendix. **3.** MSD. Company Core Data Sheet. S-CCDS-MK3475-IV-070224. July 2024.

An exploratory analysis of the KEYNOTE-A39 trial data showed that the DoR benefit of KEYTRUDA + EV vs platinum-based chemotherapy* was maintained[1,2]

Secondary endpoint analysis

Duration of response (CR or PR) by BICR



Median follow-up in the exploratory analysis: 29.1 months (95% CI: 28.5–29.9)†

Among responders, the probability of maintained response at 24 months was **~50% with KEYTRUDA + EV[1]**

Median DoR:

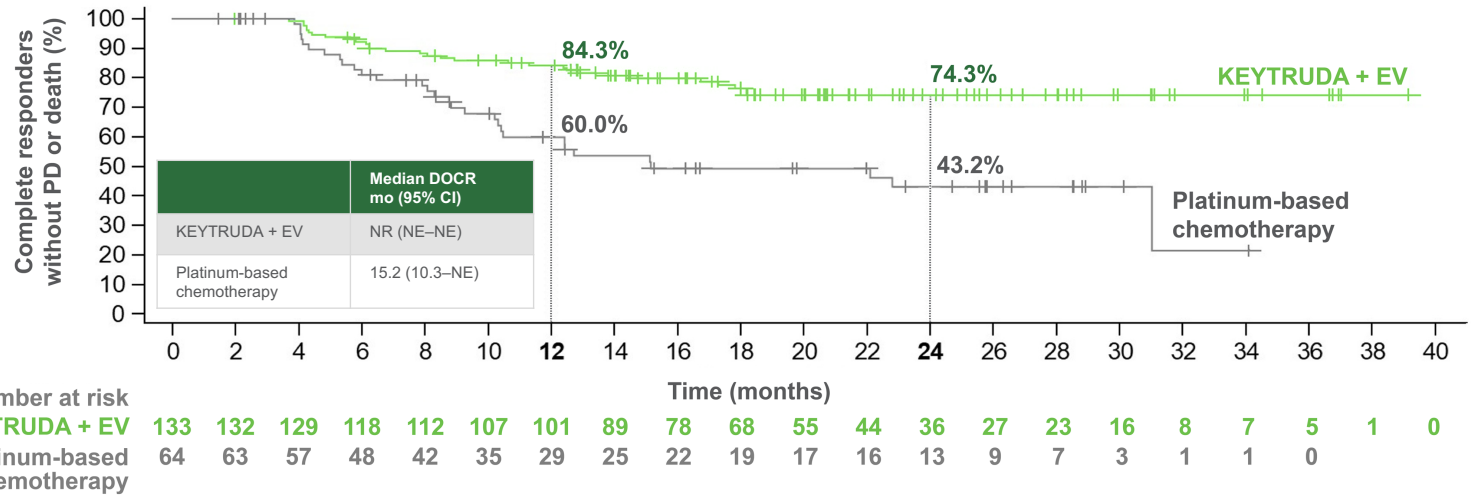
- **KEYTRUDA + EV: 23.3 months (17.8–NE)**
- **Platinum-based chemotherapy: 7.0 months (6.2–9.0)[1]**

Adapted from Powles T, *et al.* 2025.[1]

*As assessed by BICR according to RECIST v1.1.[1] †1 year additional follow-up from final analysis (~2.5 years of median follow-up). **Cut-off date: 8 August 2024.**[1] ‡P-value is nominal and descriptive.[1]
BICR, blinded independent central review; DoR, duration of response; EV, enfortumab vedotin; NE, non-estimable.
1. Powles T, *et al.* EV-302: Updated Analysis from the Phase 3 Global Study of Enfortumab Vedotin in Combination with Pembrolizumab (EV+P) vs Chemotherapy (Chemo) in Previously Untreated Locally Advanced or Metastatic Urothelial Carcinoma (la/mUC). ASCO GU Annual Symposium. 13–15 February 2025. San Francisco, CA, USA. Oral presentation. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888.

In the exploratory analysis, the probability of a maintained CR at 24 months was higher with KEYTRUDA + EV vs platinum-based chemotherapy*[1,2]

Duration of confirmed CR† by BICR



For patients who had a cCR:
Estimated 24-month PFS rate: 78.2% for KEYTRUDA + EV vs 53.7% for platinum-based chemotherapy
Estimated 24-month OS rate: 95.4% for KEYTRUDA + EV vs 85.8% for platinum-based chemotherapy

With 29.1 months (95% CI: 28.5–29.9) of median follow-up:‡

Probability of maintained CR at 24 months was 74.3% with KEYTRUDA + EV vs 43.2% with platinum-based chemotherapy[1]

Median DoCR:

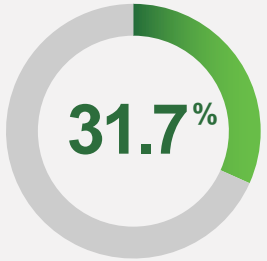
- **KEYTRUDA + EV: NR (NE–NE)**
- **Platinum-based chemotherapy: 15.2 months (10.3–NE)**
- **Events: 22.6% (30/133) vs 46.9% (30/64)**

Adapted from Powles T, *et al.* 2025.[1]

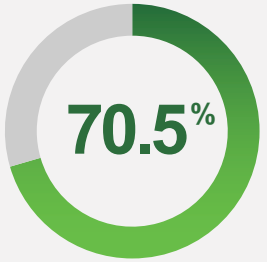
*As assessed by BICR according to RECIST v1.1.[1] †For patients with a best overall response of confirmed CR.[1] ‡1 year additional follow-up from final analysis (~2.5 years of median follow-up). **Cut-off date: August 8 2024.[1]**
BICR, blinded independent central review; cCR, confirmed complete response; CI, confidence interval; CR, complete response; DoCR, duration of complete response; EV, enfortumab vedotin; NE, non-estimable; NR, not reached; OS, overall survival; PD, progressive disease; PFS, progression-free survival; RECIST, Response Evaluation Criteria in Solid Tumours.

1. Powles T, *et al.* EV-302: Updated Analysis from the Phase 3 Global Study of Enfortumab Vedotin in Combination with Pembrolizumab (EV+P) vs Chemotherapy (Chemo) in Previously Untreated Locally Advanced or Metastatic Urothelial Carcinoma (la/mUC). ASCO GU Annual Symposium. 13–15 February 2025. San Francisco, CA, USA. Oral presentation. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888.

KEYNOTE-A39: Subsequent therapy*[1,2]

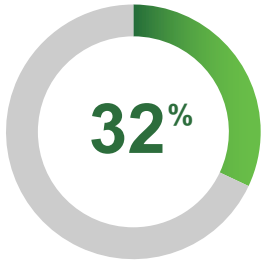


of patients receiving KEYTRUDA + EV went on to receive subsequent cancer-related therapies[1]

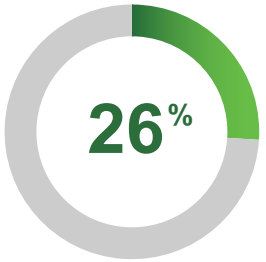


of patients receiving platinum-based chemotherapy went onto receive subsequent cancer-related therapies[1]

Of the patients who received platinum-based chemotherapy:[2]



received maintenance immunotherapy[2]



received immunotherapy as first subsequent therapy after disease progression[3]

***Cut-off date: August 8 2023.**[1]
EV, enfortumab vedotin.
1. Powles T, *et al. N Engl J Med* 2024;390:875–888. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888. Supplementary appendix. **3.** MSD. Company Core Data Sheet. S-CCDS-MK3475-IV-072024. July 2024.

KEYNOTE-A39 final analysis: Summary of AEs in the as-treated population (final analysis)[1,2]

The safety analysis included all patients who received any dose of trial treatment.

Summary of adverse events (AEs)* **Median follow-up: 17.2 months†**

AE, % (n)	KEYTRUDA + EV (n=440)	Platinum-based chemotherapy (n=433)
Any grade, any cause	99.8 (439)	98.6 (427)
Treatment-related	97 (427)	95.6 (414)
Grade ≥3	55.9 (246)	69.5 (301)
Grade 5	0.9 (4)‡	0.9 (4)§
Serious, treatment-related	27.7 (122)	19.6 (85)
Led to dose interruption	68.0 (299)	52.9 (229)
Led to discontinuation	35.0 (154)	18.5 (80)

AEs experienced by patients treated with combination KEYTRUDA + EV during KEYNOTE-A39 were generally similar to those observed in patients receiving either component as a monotherapy[1,2]

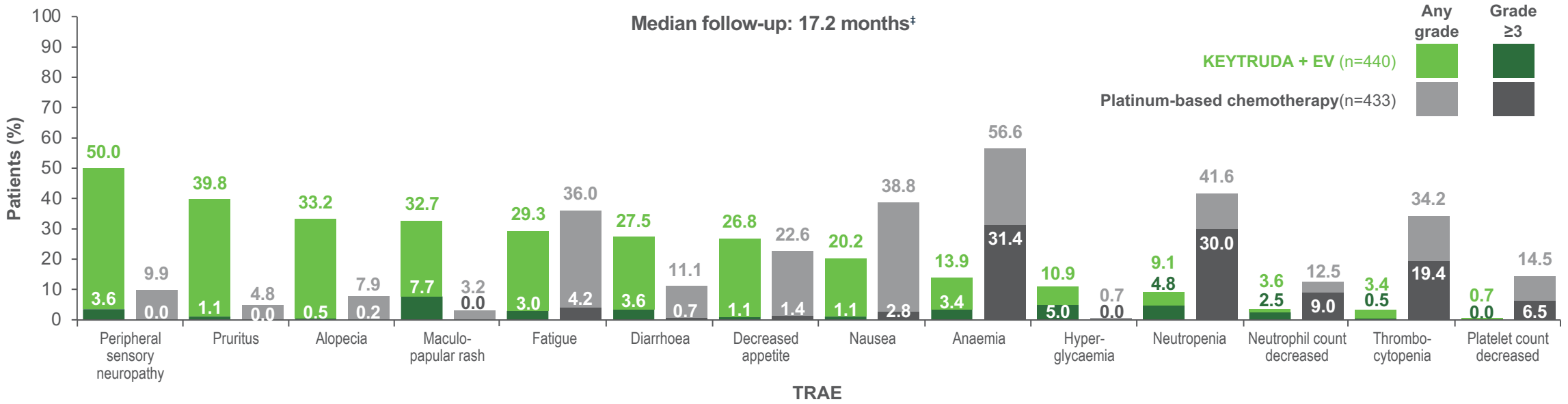
Adapted from Powles T, *et al.* 2024.[1,2]

*Determined by the investigator as reasonably related to treatment. AEs were graded according to the NCI CTCAE v4.03.[1,2] †**Cut-off date: 8 August 2023.**[1] ‡Multiple organ dysfunction syndrome, immune-mediated lung disease, diarrhoea and asthenia; 1 patient each.[1]
§Sepsis, febrile neutropenia, neutropenic sepsis and myocardial infarction; 1 patient each.[1]
AE, adverse event; CTCAE, Common Terminology Criteria for Adverse Events; EV, enfortumab vedotin; NCI, National Cancer Institute.
1. Powles T, *et al. N Engl J Med* 2024;390:875–888. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888. Supplementary appendix.

KEYNOTE-A39 final analysis: Treatment-related adverse events (TRAEs)[1,2]

The safety analysis included all patients who received any dose of trial treatment.

Any grade TRAEs occurring in ≥20% of patients and Grade ≥3 TRAEs occurring in ≥5% of patients in either treatment group*†



Adapted from Powles T, *et al.* 2024.[1]

*TRAEs are those for which there is a reasonable possibility that they were caused by the trial treatment, as assessed by the investigator. This analysis included all the patients who had received any dose of the trial treatment.[1] †Adverse events were graded according to the NCI CTCAE, version 4.03.[1] ‡**Cut-off date: 8 August 2023.**[1]
CTCAE, Common Terminology Criteria for Adverse Events; EV, enfortumab vedotin; NCI, National Cancer Institute; TRAE, treatment-related adverse event.
1. Powles T, *et al. N Engl J Med* 2024;390:875–888. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888. Supplementary appendix.

KEYTRUDA TRAEs of special interest[1]

	KEYTRUDA + EV (N=440) n (%)		Platinum-based chemotherapy (N=433) n (%)	
	Any grade	Grade ≥3	Any grade	Grade ≥3
Severe skin reactions	75 (17.0)	52 (11.8)	2 (0.5)	0
Hypothyroidism	47 (10.7)	2 (0.5)	3 (0.7)	0
Pneumonitis	42 (9.5)	16 (3.6)	1 (0.2)	1 (0.2)
Hyperthyroidism	20 (4.5)	1 (0.2)	2 (0.5)	0
Hepatitis	14 (3.2)	8 (1.8)	2 (0.5)	0
Colitis	12 (2.7)	7 (1.6)	0	0
Gastritis	9 (2.0)	0	3 (0.7)	0
Adrenal insufficiency	7 (1.6)	2 (0.5)	0	0
Infusion reactions	6 (1.4)	0	6 (1.4)	1 (0.2)
Pancreatitis	5 (1.1)	4 (0.9)	1 (0.2)	1 (0.2)
Myositis	4 (0.9)	1 (0.2)	2 (0.5)	2 (0.5)
Nephritis	4 (0.9)	1 (0.2)	0	0
Myocarditis	3 (0.7)	1 (0.2)	0	0
Hypophysitis	3 (0.7)	0	0	0
Thyroiditis	3 (0.7)	0	0	0
Arthritis	2 (0.5)	0	0	0
Optic neuritis	2 (0.5)	0	0	0
Cholangitis sclerosing	1 (0.2)	1 (0.2)	0	0
Encephalitis	1 (0.2)	1 (0.2)	0	0
Sarcoidosis	1 (0.2)	1 (0.2)	0	0
Type 1 diabetes mellitus	1 (0.2)	1 (0.2)	0	0
Uveitis	1 (0.2)	0	0	0

Adapted from Powles T, *et al. N Engl J Med* 2024 (plus supplementary appendix).

EV, enfortumab vedotin; TRAEs, treatment-related adverse events.

1. Powles T, *et al. N Engl J Med.* 2024;390:875–888 (plus supplementary appendix).

EV TRAEs of special interest[1]

In the KEYTRUDA + EV arm, the most common TRAEs of special interest of Grade ≥3 that have been previously associated with EV were skin reactions (15.5%), peripheral neuropathy (6.8%) and hyperglycaemia (6.1%)

	KEYTRUDA + EV (N=440) n (%)		Platinum-based chemotherapy (N=433) n (%)	
	Any grade	Grade ≥3	Any grade	Grade ≥3
Skin reactions	294 (66.8)	68 (15.5)	60 (13.9)	1 (0.2)
Peripheral neuropathy	278 (63.2)	30 (6.8)	53 (12.2)	0 (0.0)
Sensory events	260 (59.1)	19 (4.3)	51 (11.8)	0 (0.0)
Motor events	44 (10.0)	12 (2.7)	5 (1.2)	0 (0.0)
Ocular disorders	94 (21.4)	0 (0.0)	12 (2.8)	0 (0.0)
Dry eye	82 (18.6)	0 (0.0)	8 (1.8)	0 (0.0)
Hyperglycaemia	57 (13.0)	27 (6.1)	3 (0.7)	0 (0.0)
Infusion-related reactions	9 (2.0)	0 (0.0)	9 (2.1)	0 (0.0)

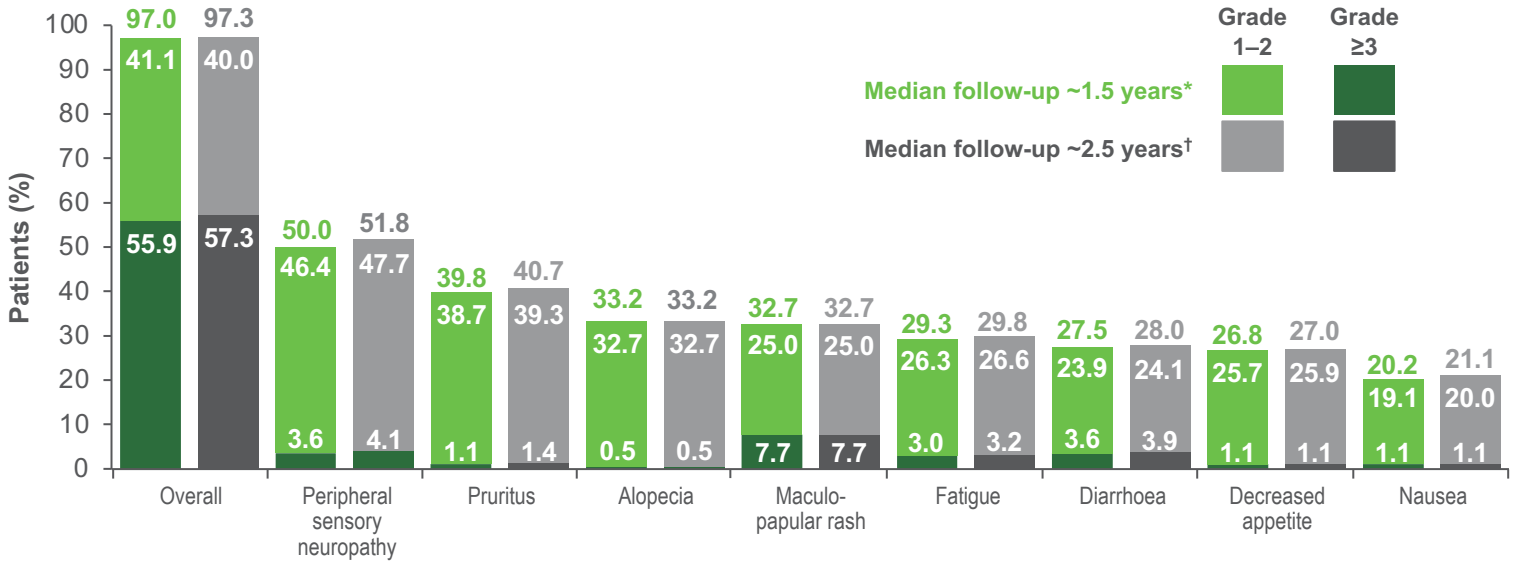
Adapted from Powles T, *et al. N Engl J Med* 2024 (plus supplementary appendix).

EV, enfortumab vedotin; TRAEs, treatment-related adverse events.

1. Powles T, *et al. N Engl J Med.* 2024;390:875–888 (plus supplementary appendix).

With an additional year of follow-up, TRAEs in KEYNOTE-A39 remained consistent with the final analysis[1,2]

Most frequent (≥20%) TRAEs with KEYTRUDA + EV[1]



- No new safety signals were observed with KEYTRUDA + EV after an additional 1-year follow-up[1]
- Frequency and grade of TRAEs remained consistent with the final analysis[2]
- Rates of TRAEs of special interest for KEYTRUDA + EV were consistent with those in the final KEYNOTE-A39 analysis[1,2]

Adapted from Powles T, *et al.* 2025.[1]

***Cut-off date: 8 August 2023.[1]** †1 year additional follow-up from final analysis. **Cut-off date: 8 August 2024.[1]**
EV, enfortumab vedotin; TRAE, treatment-related adverse event.
1. Powles T, *et al.* EV-302: Updated Analysis from the Phase 3 Global Study of Enfortumab Vedotin in Combination with Pembrolizumab (EV+P) vs Chemotherapy (Chemo) in Previously Untreated Locally Advanced or Metastatic Urothelial Carcinoma (la/mUC). ASCO GU Annual Symposium. 13–15 February 2025. San Francisco, CA, USA. Oral presentation. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888.

SUMMARY: First-line KEYTRUDA + EV significantly improved OS, PFS and ORR vs platinum-based chemotherapy in patients with locally advanced or metastatic UC[1–3]

Improved efficacy in the final analysis was maintained with 1 year additional follow-up (~2.5 years median follow-up):

- KEYTRUDA + EV extended OS and PFS vs platinum-based chemotherapy, including across prespecified subgroups
- The chance of achieving a CR more than doubled with KEYTRUDA + EV vs platinum-based chemotherapy

Manageable safety profile

- Frequency and grade of TRAEs and AEs of special interest with KEYTRUDA + EV remained consistent with previously observed AEs
- **No new safety signals identified** during an extended follow-up analysis (median follow-up ~2.5 years)

These data support the use of KEYTRUDA + EV for the first-line treatment of patients with u/mUC[4]

The indication of KEYTRUDA in combination with enfortumab vedotin, is for the treatment of unresectable or metastatic urothelial carcinoma in adults.[4]

AE, adverse event; CR, complete response; EV, enfortumab vedotin; ORR, objective response rate; OS, overall survival; PFS, progression-free survival; SOC, standard of care; TRAE, treatment-related adverse event; u/mUC, unresectable/metastatic urothelial carcinoma; UC, urothelial carcinoma.

1. Powles T, *et al. N Engl J Med* 2024;390:875–888. **2.** Powles T, *et al. N Engl J Med* 2024;390:875–888. Supplementary appendix. **3.** Powles T, *et al.* EV-302: Updated Analysis from the Phase 3 Global Study of Enfortumab Vedotin in Combination with Pembrolizumab (EV+P) vs Chemotherapy (Chemo) in Previously Untreated Locally Advanced or Metastatic Urothelial Carcinoma (la/mUC). ASCO GU Annual Symposium. 13–15 February 2025. San Francisco, CA, USA. Oral presentation. **4.** KEYTRUDA Summary of Product Characteristics. MSD. Available at: https://www.medicines.org.uk/emc/product/2498. Accessed: May 2025.

Meet Victor*

Victor

69-year-old retired shop owner

Victor first noticed he had less energy when he was gardening. He reached out to his doctor when he noticed pain while urinating. After a diagnostic work-up from his GP and urologist, a diagnosis of mUC (with metastases to the liver) was made.[1]

Presentation

Upper abdominal pain, pain with urination, unintentional weight loss[1]

Diagnosis

- Stage IVB (T3, N1, M1b) mUC[1,2]
- ECOG PS: 1[1]
- CrCl: 70 mL/min[1]
- **Treatment eligibility: platinum-eligible**

Comorbidities

Hypertension, hypercholesterolemia, controlled type 2 diabetes (HbA1c: 6.7%)

Victor may benefit from KEYTRUDA + EV

How would you manage this patient with metastatic UC?

***Patient cases are fictitious, based on clinical examples. Images are illustrative of the range of patients diagnosed with UC.**

CrCl, creatinine clearance; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; GP, general practitioner; HbA1c, glycated haemoglobin; N1, single regional lymph node metastasis in the true pelvis (perivesical, obturator, internal and external iliac, or sacral lymph node);[3] M1b, non–lymph node distant metastases;[3] mUC, metastatic urothelial carcinoma; T3, tumour invades perivesical tissue;[3] UC, urothelial carcinoma.

1. Witjes JA, *et al. Eur Urol* 2024;85:17–31. **2.** Leslie SW, Soon-Sutton TL, *et al.* Bladder cancer. NCBI Bookshelf. Last updated 15 August 2024. Available at: https://www.ncbi.nlm.nih.gov/books/NBK536923/. Accessed: May 2025. **3.** Steinberg GB, *et al.* Bladder Cancer Staging. Medscape. Last updated 21 September 2023. Available at: https://emedicine.medscape.com/article/2006834-overview. Accessed: May 2025.

KEYTRUDA® (pembrolizumab)

DOSING PI

Meet Darlene*

Darlene

71-year-old retired teacher

Darlene noticed she was slowing down and getting tired more frequently. She contacted her doctor after she noticed blood in her urine – her mUC diagnosis followed less than a month later.[1]

Presentation

Unintentional weight loss, painless visible haematuria, pelvic pain[1]

Diagnosis

- Stage IVA (T3, N1, M1a) mUC, in lymph nodes only[1,2]
- ECOG PS: 2[1]
- CrCl: 61 mL/min[1]
- **Treatment eligibility: platinum-eligible**

Comorbidities

Depression, controlled hypertension

Darlene may benefit from KEYTRUDA + EV

How would you manage this patient with metastatic UC?

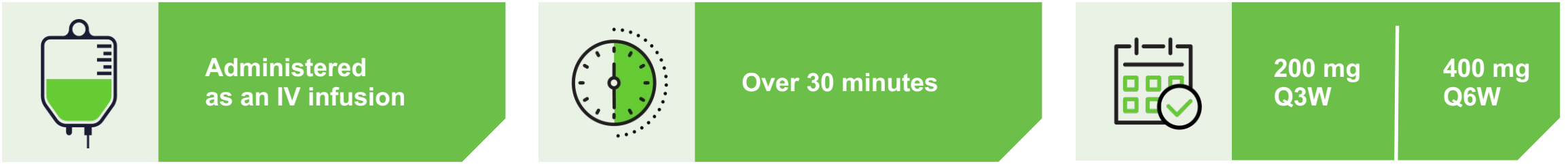
***Patient cases are fictitious, based on clinical examples. Images are illustrative of the range of patients diagnosed with UC.**

CrCl, creatinine clearance; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; N1, single regional lymph node metastasis in the true pelvis (perivesical, obturator, internal and external iliac, or sacral lymph node);[3] M1a, distant metastasis limited to lymph nodes beyond the common iliacs;[3] mUC, metastatic urothelial carcinoma; T3, tumour invades perivesical tissue;[3] UC, urothelial carcinoma.

1. Witjes JA, *et al. Eur Urol* 2024;85:17–31. **2.** Leslie SW, Soon-Sutton TL, *et al.* Bladder cancer. NCBI Bookshelf. Last updated 15 August 2024. Available at: https://www.ncbi.nlm.nih.gov/books/NBK536923/. Accessed: May 2025. **3.** Steinberg GB, *et al.* Bladder Cancer Staging. Medscape. Last updated 21 September 2023. Available at: https://emedicine.medscape.com/article/2006834-overview. Accessed: May 2025.

KEYTRUDA offers flexibility of dosing[1]

KEYTRUDA should be administered after EV when given on the same day[1]



Assessment of regimens

The 200 mg Q3W regimen has been assessed in Phase II and III registration studies across a multitude of indications of KEYTRUDA.
An exposure-response evaluation, using modelling and simulation, led to the approval of the 400 mg Q6W dosing for monotherapy and combination therapy.

What does the flexibility of dosing mean for you and your patients?

Refer to the Summary of Product Characteristics and Risk Minimisation Materials available on the EMC website before prescribing, to help reduce the risks associated with KEYTRUDA.

IV, intravenous; EMC, Electronic Medicines Compendium; Q3W, every 3 weeks; Q6W, every 6 weeks.

1. KEYTRUDA Summary of Product Characteristics. MSD. Available at: https://www.medicines.org.uk/emc/product/2498. Accessed: May 2025.