In advanced* G/GEJ cancer,

Detect CLDN18.2 and reveal a **predictive biomarker** for a **targeted therapy**.[1,2]

*Locally advanced unresectable or metastatic.[1]
CLDN18.2=claudin 18.2; **G/GEJ**=gastric/gastroesophageal junction.

INDICATION

VYLOY® (zolbetuximab-clzb), in combination with fluoropyrimidine- and platinum-containing chemotherapy, is indicated for the first-line treatment of adults with locally advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-negative gastric or gastroesophageal junction (GEJ) adenocarcinoma whose tumors are claudin (CLDN) 18.2 positive as determined by an FDA-approved test.

SELECT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Hypersensitivity reactions, including serious anaphylaxis reactions, and serious and fatal infusion-related reactions (IRR) have been reported in clinical studies when VYLOY has been administered. **Any grade hypersensitivity reactions,** including anaphylactic reactions, occurring with VYLOY in combination with mFOLFOX6 or CAPOX was 18%. **Severe (Grade 3 or 4) hypersensitivity reactions,** including anaphylactic reactions, occurred in 2% of patients. Seven patients (1.3%) permanently discontinued VYLOY for hypersensitivity reactions, including two patients (0.4%) who permanently discontinued VYLOY due to anaphylactic reactions. Seventeen (3.2%) patients required dose interruption, and three patients (0.6%) required infusion rate reduction due to hypersensitivity reactions. **All grade IRRs** occurred in 3.2% in patients administered VYLOY in combination with mFOLFOX6 or CAPOX. Severe (Grade 3) IRRs occurred in 2 (0.4%) patients who received VYLOY. An IRR led to permanent discontinuation of VYLOY in 2 (0.4%) patients and dose interruption in 7 (1.3%) patients. The infusion rate was reduced for VYLOY for 2 (0.4%) patients due to an IRR. Monitor patients during infusion with VYLOY and for 2 hours after completion of infusion or longer if clinically indicated, for hypersensitivity reactions with symptoms and signs that are highly suggestive of anaphylaxis (urticaria, repetitive cough, wheeze and throat tightness/change in voice). Monitor patients for signs and symptoms of IRRs including nausea, vomiting, abdominal pain, salivary hypersecretion, pyrexia, chest discomfort, chills, back pain, cough and hypertension. If a severe or life-threatening hypersensitivity or IRR reaction occurs, discontinue VYLOY permanently, treat symptoms according to standard medical care, and monitor until symptoms resolve. For any Grade 2 hypersensitivity or IRR, interrupt the VYLOY infusion until Grade ≤1, then resume at a reduced infusion rate for the remaining infusion. Follow Grade 2 management for Grade 3 infusion-related nausea and vomiting. Premedicate the patient with antihistamines for the subsequent infusions, and closely monitor the patient for symptoms and signs of a hypersensitivity reaction. The infusion rate may be gradually increased as tolerated.

Please see Important Safety Information throughout and on page 6, and full Prescribing Information.

VYLOY®
zolbetuximab-clzb
for injection 100mg and 300mg vials

According to estimates from two global Phase 3 studies:

38% of patients with advanced* G/GEJ adenocarcinoma are CLDN18.2+[3,4†‡]

Data estimated from 2 global randomized Phase 3 studies: SPOTLIGHT, which included 2,403 assessable patients, of which 922 were CLDN18.2 positive; and GLOW, which included 2,104 assessable patients, of which 808 were CLDN18.2 positive as determined by IHC in a central laboratory using the investigational VENTANA CLDN18 (43-14A) RxDx Assay.[3,4]

Claudin 18.2 is one of the most highly prevalent biomarkers in advanced G/GEJ adenocarcinoma[3-13]

Biomarker prevalence estimates from select studies are reported below. Prevalence data can vary among studies due to tumor heterogeneity, differences in patient population, clinical trial methodology, and diagnostic assays used.[3-13]

CLDN18.2[3,4] (positive)[†‡]	PD-L1[5,9-12] (variable due to multiple factors)[§]	HER2[6-8] (positive)	MMR or MSI[11-13] (MSI-high)[‖]
38%	CPS ≥1: 67-82% CPS ≥5: 29-60% CPS ≥10: 16-49%	14-22%	3-7%

Published studies have shown no significant correlation between CLDN18.2 positivity and the expression of biomarkers such as PD-L1, MMR/MSI, and HER2.[14-16]

*Locally advanced unresectable or metastatic.[3,4]

† CLDN18.2+ (claudin 18.2 positive) is defined as ≥75% of tumor cells demonstrating moderate to strong membranous CLDN18 staining by IHC.[3,4]

‡ Data from 2 global randomized Phase 3 studies: SPOTLIGHT, which included 2,403 assessable patients, of which 922 were CLDN18.2 positive; and GLOW, which included 2,104 assessable patients, of which 808 were CLDN18.2 positive.[3,4]

§ CPS thresholds are still being explored. Data are from randomized controlled trials and real-world retrospective medical records studies.[5,9-12]

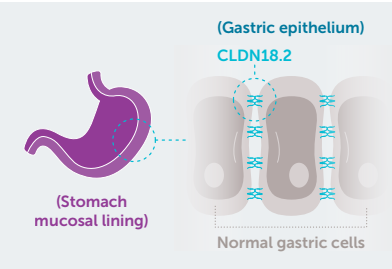
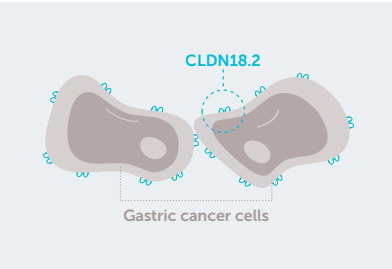
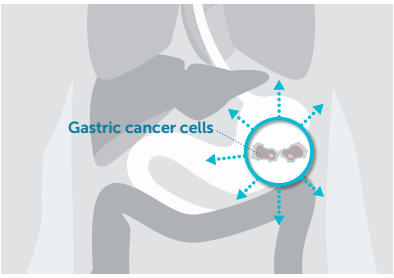
‖ MSI-high prevalence varies by stage of disease. Data shown are from patients with advanced disease.[11-13]

CPS=combined positive score; **IHC**=immunohistochemistry; **MMR**=mismatch repair; **MSI**=microsatellite instability; **PD-L1**=programmed death-ligand 1.

Please see Important Safety Information throughout and on page 6, and full Prescribing Information.

Claudin 18.2 is a predictive and actionable biomarker in gastric tumors[1,2]*

CLDN18.2 is typically confined within healthy gastric mucosa; however, it may become exposed, and thus more accessible to VYLOY as tumors develop.[17,18]

CONFINED IN HEALTHY TISSUE	RETAINED AND EXPOSED IN MALIGNANT TRANSFORMATION	MAINTAINED IN METASTATIC PROGRESSION
		
In normal gastric mucosa, CLDN18.2 is typically buried within tight junctions.[17,18] As a component of tight junctions, claudins are involved in the regulation of permeability, barrier function, and polarity of epithelial layers.[19-21]	CLDN18.2 is often retained during malignant transformation. CLDN18.2 may be more exposed and accessible to antibodies when cell polarity disruptions and structure loss occur.[17,18,22]	CLDN18.2 may also be expressed in lymph node metastases of gastric adenocarcinoma as well as other distant metastatic sites.[14,17,23,24]

- **Claudins are found throughout the body, but CLDN18.2 is the dominant CLDN18 isoform in gastric tissue[17,25]**
- VYLOY specifically targets CLDN18.2[1]

*Advanced G/GEJ adenocarcinoma.[1]

VYLOY IS AN FDA-APPROVED FIRST-LINE TREATMENT THAT TARGETS CLAUDIN 18.2

SELECT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Severe Nausea and Vomiting. VYLOY is emetogenic. Nausea and vomiting occurred more often during the first cycle of treatment. **All grade nausea and vomiting** occurred in 82% and 67% respectively of patients treated with VYLOY in combination with mFOLFOX6 and 69% and 66% in combination with CAPOX, respectively. **Severe (Grade 3) nausea** occurred in 16% and 9% of patients treated with VYLOY in combination with mFOLFOX6 or CAPOX respectively. **Severe (Grade 3) vomiting** occurred in 16% and 12% of patients treated with VYLOY in combination with mFOLFOX6 or CAPOX. Nausea led to permanent discontinuation of VYLOY in combination with mFOLFOX6 or CAPOX in 18 (3.4%) patients and dose interruption in 147 (28%) patients. Vomiting led to permanent discontinuation of VYLOY in combination with mFOLFOX6 or CAPOX in 20 (3.8%) patients and dose interruption in 150 (28%) patients. Pretreat with antiemetics prior to each infusion of VYLOY. Manage patients during and after infusion with antiemetics or fluid replacement. Interrupt the infusion, or permanently discontinue VYLOY based on severity.

Please see Important Safety Information throughout and on page 6, and full Prescribing Information.

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) recommend CLDN18.2 testing at the time of diagnosis if advanced/metastatic disease/adenocarcinoma is documented/suspected[26,27]*

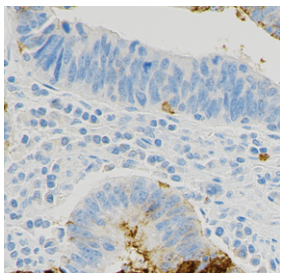
*This is a summary of relevant portions of the NCCN Guidelines®. Please see the full NCCN Guidelines for Gastric Cancer and Esophageal and Esophagogastric Junction Cancers at NCCN.org.[26,27]

The VENTANA CLDN18 (43-14A) RxDx Assay is FDA-approved as a companion diagnostic to identify patients for a first-line targeted treatment[28]

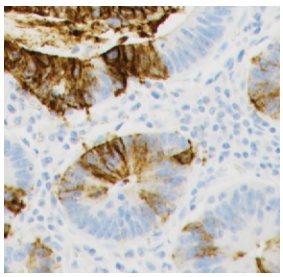
- This assay is used with OptiView DAB IHC Detection Kit for staining on a BenchMark ULTRA instrument

CLDN18.2 IS EVALUATED USING BOTH MEMBRANOUS STAINING INTENSITY AND PERCENTAGE OF VIABLE TUMOR CELLS STAINED[28]

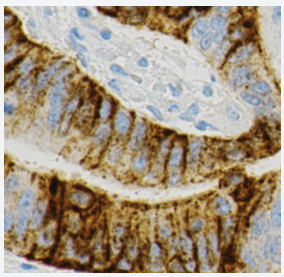
Membrane staining of tumor cells[29]



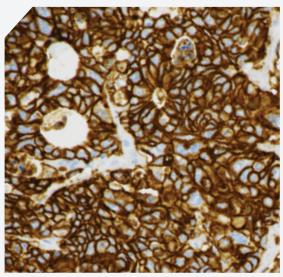
NO STAINING



WEAK STAINING



MODERATE STAINING



STRONG STAINING

†Test results of the VENTANA CLDN18 (43-14A) RxDx Assay should be interpreted by a qualified pathologist in conjunction with histological examination, relevant clinical information, and proper controls.[28]

VENTANA CLDN18 (43-14A) RxDx Assay and BenchMark ULTRA are registered trademarks of Roche Diagnostics.

The clinical cutoff is ≥75% viable tumor cells demonstrating moderate-to-strong membranous CLDN18 staining above background.[28†]

Please see Important Safety Information throughout and on page 6, and full Prescribing Information.

Testing is available throughout the United States

FIND TESTING SITES THAT OFFER THE VENTANA CLDN18 (43-14A) RXDX ASSAY AT VYLOYHCP.COM

Explore resources to help you begin testing

Assay Education

Learn how to detect CLDN18.2+ cells in G/GEJ tumors with the VENTANA CLDN18 (43-14A) RxDx Assay.[1,28] Explore the eLearning Module on cancerdiagnosticeducation.com.

Expand your lab's test offerings

Visit go.roche.com/CLDN18 to learn more about the FDA-approved assay indicated to help identify patients who may be candidates for VYLOY + chemo.[1,28]

References:

1. VYLOY [package insert]. Northbrook, IL: Astellas Pharma US, Inc; 2025. **2.** US Department of Health and Human Services. Understand translational research tools: biomarkers. Accessed August 30, 2023. https://toolkit.ncats.nih.gov/module/discovery/developing-translational-research-tools/biomarkers/. **3.** Shitara K, Lordick F, Bang YJ, et al. Zolbetuximab plus mFOLFOX6 in patients with CLDN18.2-positive, HER2-negative, untreated, locally advanced unresectable or metastatic gastric or gastro-oesophageal junction adenocarcinoma (SPOTLIGHT): a multicentre, randomised, double-blind, phase 3 trial. Lancet 2023;401(10389):1655-68. Errata in: Lancet 2023;402(10398):290; Lancet 2024;403(10421):30. **4.** Shah MA, Shitara K, Ajani JA, et al. Zolbetuximab plus CAPOX in CLDN18.2-positive gastric or gastroesophageal junction adenocarcinoma: the randomized, phase 3 GLOW trial. Nat Med 2023;29(8):2133-41. **5.** Fuchs CS, Özgüroğlu M, Bang YJ, et al. Pembrolizumab versus paclitaxel for previously treated PD-L1-positive advanced gastric or gastroesophageal junction cancer: 2-year update of the randomized phase 3 KEYNOTE-061 trial. Gastric Cancer 2022;25(1):197-206. **6.** Van Cutsem E, Bang YJ, Feng-Yi F, et al. HER2 screening data from ToGA: targeting HER2 in gastric and gastroesophageal junction cancer. Gastric Cancer 2015;18(3):476-84. **7.** Janjigian YY, Werner D, Pauligk C, et al. Prognosis of metastatic gastric and gastroesophageal junction cancer by HER2 status: a European and USA international collaborative analysis. Ann Oncol 2012;23(10):2656-62. **8.** Kim WH, Gomez-Izquierdo L, Vilardell F, et al. HER2 status in gastric and gastroesophageal junction cancer: results of the large, multinational HER-EAGLE study. Appl Immunohistochem Mol Morphol 2018;26(4):239-45. **9.** Mehta R, Liepa AM, Zheng S, Chatterjee A. Real-world molecular biomarker testing patterns and results for advanced gastroesophageal cancers in the United States. Curr Oncol 2023;30(2):1869-81. **10.** Schoemig-Markiefka B, Eschbach J, Scheel AH, et al. Optimized PD-L1 scoring of gastric cancer. Gastric Cancer 2021;24(5):1115-22. **11.** Shitara K, Ajani J, Moehler M, et al. Nivolumab plus chemotherapy or ipilimumab in gastro-oesophageal cancer. Nature 2022;603(7903):942-48. **12.** Rha SY, Oh D-Y, Yañez P, et al. Pembrolizumab plus chemotherapy versus placebo plus chemotherapy for HER2-negative advanced gastric cancer (KEYNOTE-859): a multicentre, randomised, double-blind, phase 3 trial. Lancet Oncol 2023;24(11):1181-95. **13.** Chao J, Fuchs CS, Shitara K, et al. Assessment of pembrolizumab therapy for the treatment of microsatellite instability-high gastric or gastroesophageal junction cancer among patients in the KEYNOTE-059, KEYNOTE-061, and KEYNOTE-062 clinical trials. JAMA Oncol 2021;7(6):895-902. **14.** Pellino A, Brignola S, Riello E, et al. Association of CLDN18 protein expression with clinicopathological features and prognosis in advanced gastric and gastroesophageal junction adenocarcinomas. J Pers Med 2021;11(11):1095. **15.** Kubota Y, Kawazoe A, Mishima S, et al. Comprehensive clinical and molecular characterization of claudin 18.2 expression in advanced gastric or gastroesophageal junction cancer. ESMO Open 2023;8(1):100762. Erratum in: ESMO Open 2024;9(1):102232. **16.** Waters R, Sewastjanow-Silva M, Yamashita K, et al. Retrospective study of claudin 18 isoform 2 prevalence and prognostic association in gastric and gastroesophageal junction adenocarcinoma. JCO Precis Oncol 2024;8:e2300543. **17.** Sahin U, Koslowski M, Dhaene K, et al. Claudin-18 splice variant 2 is a pan-cancer target suitable for therapeutic antibody development. Clin Cancer Res 2008;14(23):7624-34. **18.** Sahin U, Schuler M, Richly H, et al. A phase I dose-escalation study of IMAB362 (zolbetuximab) in patients with advanced gastric and gastro-oesophageal junction cancer. Eur J Cancer 2018;100:17-26. **19.** Turner JR, Buschmann MM, Romero-Calvo I, Sailer A, Shen L. The role of molecular remodeling in differential regulation of tight junction permeability. Semin Cell Dev Biol 2014;36:204-12. **20.** Tsukita S, Tanaka H, Tamura A. The claudins: from tight junctions to biological systems. Trends Biochem Sci 2019;44(2):141-52. **21.** Hu YJ, Wang YD, Tan FQ, Yang WX. Regulation of paracellular permeability: factors and mechanisms. Mol Biol Rep 2013;40(11):6123-42. **22.** Lamouille S, Xu J, Derynck R. Molecular mechanisms of epithelial-mesenchymal transition. Nat Rev Mol Cell Biol 2014;15(3):178-96. **23.** Coati I, Lotz G, Fanelli GN, et al. Claudin-18 expression in oesophagogastric adenocarcinomas: a tissue microarray study of 523 molecularly profiled cases. Br J Cancer 2019;121(3):257-63. **24.** Rohde C, Yamaguchi R, Mukhina S, Sahin U, Itoh K, Türeci Ö. Comparison of claudin 18.2 expression in primary tumors and lymph node metastases in Japanese patients with gastric adenocarcinoma. Jpn J Clin Oncol 2019;49(9):870-6. **25.** Niimi T, Nagashima K, Ward JM, et al. Claudin-18, a novel downstream target gene for the T/EBP/NKX2.1 homeodomain transcription factor, encodes lung- and stomach-specific isoforms through alternative splicing. Mol Cell Biol 2001;21(21):7380-90. **26.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Gastric Cancer V.1.2025. © National Comprehensive Cancer Network, Inc. 2025. All rights reserved. Accessed March 4, 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. **27.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Esophageal and Esophagogastric Junction Cancers V.1.2025. © National Comprehensive Cancer Network, Inc. 2025. All rights reserved. Accessed March 3, 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. **28.** Ventana CLDN18 (43-14A) RxDx assay. Package insert. Tucson, AZ: Ventana Medical Systems, Inc; 2024. **29.** VENTANA CLDN18 (43-14A) RxDx Assay Interpretation Guide for Gastric Adenocarcinoma including Gastroesophageal Junction (GEJ). Tucson, AZ; 2024.

Please see Important Safety Information throughout and on page 6, and full Prescribing Information.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Hypersensitivity reactions, including serious anaphylaxis reactions, and serious and fatal infusion-related reactions (IRR) have been reported in clinical studies when VYLOY has been administered. **Any grade hypersensitivity reactions,** including anaphylactic reactions, occurring with VYLOY in combination with mFOLFOX6 or CAPOX was 18%. **Severe (Grade 3 or 4) hypersensitivity reactions,** including anaphylactic reactions, occurred in 2% of patients. Seven patients (1.3%) permanently discontinued VYLOY for hypersensitivity reactions, including two patients (0.4%) who permanently discontinued VYLOY due to anaphylactic reactions. Seventeen (3.2%) patients required dose interruption, and three patients (0.6%) required infusion rate reduction due to hypersensitivity reactions. **All grade IRRs** occurred in 3.2% in patients administered VYLOY in combination with mFOLFOX6 or CAPOX. Severe (Grade 3) IRRs occurred in 2 (0.4%) patients who received VYLOY. An IRR led to permanent discontinuation of VYLOY in 2 (0.4%) patients and dose interruption in 7 (1.3%) patients. The infusion rate was reduced for VYLOY for 2 (0.4%) patients due to an IRR. Monitor patients during infusion with VYLOY and for 2 hours after completion of infusion or longer if clinically indicated, for hypersensitivity reactions with symptoms and signs that are highly suggestive of anaphylaxis (urticaria, repetitive cough, wheeze and throat tightness/change in voice). Monitor patients for signs and symptoms of IRRs including nausea, vomiting, abdominal pain, salivary hypersecretion, pyrexia, chest discomfort, chills, back pain, cough and hypertension. If a severe or life-threatening hypersensitivity or IRR reaction occurs, discontinue VYLOY permanently, treat symptoms according to standard medical care, and monitor until symptoms resolve. For any Grade 2 hypersensitivity or IRR, interrupt the VYLOY infusion until Grade ≤1, then resume at a reduced infusion rate for the remaining infusion. Follow Grade 2 management for Grade 3 infusion-related nausea and vomiting. Premedicate the patient with antihistamines for the subsequent infusions, and closely monitor the patient for symptoms and signs of a hypersensitivity reaction. The infusion rate may be gradually increased as tolerated.

Severe Nausea and Vomiting. VYLOY is emetogenic. Nausea and vomiting occurred more often during the first cycle of treatment. **All grade nausea and vomiting** occurred in 82% and 67% respectively of patients treated with VYLOY in combination with mFOLFOX6 and 69% and 66% in combination with CAPOX, respectively. **Severe (Grade 3) nausea** occurred in 16% and 9% of patients treated with VYLOY in combination with mFOLFOX6 or CAPOX respectively. **Severe (Grade 3) vomiting** occurred in 16% and 12% of patients treated with VYLOY in combination with mFOLFOX6 or CAPOX. Nausea led to permanent discontinuation of VYLOY in combination with mFOLFOX6 or CAPOX in 18 (3.4%) patients and dose interruption in 147 (28%) patients. Vomiting led to permanent discontinuation of VYLOY in combination with mFOLFOX6 or CAPOX in 20 (3.8%) patients and dose interruption in 150 (28%) patients. Pretreat with antiemetics prior to each infusion of VYLOY. Manage patients during and after infusion with antiemetics or fluid replacement. Interrupt the infusion, or permanently discontinue VYLOY based on severity.

ADVERSE REACTIONS

Most common adverse reactions (≥15%): Nausea, vomiting, fatigue, decreased appetite, diarrhea, peripheral sensory neuropathy, abdominal pain, constipation, decreased weight, hypersensitivity reactions, and pyrexia.

Most common laboratory abnormalities (≥15%): Decreased neutrophil count, decreased leucocyte count, decreased albumin, increased creatinine, decreased hemoglobin, increased glucose, decreased lymphocyte count, increased aspartate aminotransferase, decreased platelets, increased alkaline phosphatase, increased alanine aminotransferase, decreased glucose, decreased sodium, increased phosphate, decreased potassium, and decreased magnesium.

SPOTLIGHT Study: 279 patients with locally advanced unresectable or metastatic HER2-negative gastric or GEJ adenocarcinoma whose tumors were CLDN18.2 positive who received at least one dose of VYLOY in combination with mFOLFOX6

Serious adverse reactions occurred in 45% of patients treated with VYLOY in combination with mFOLFOX6; the **most common serious adverse reactions** (≥2%) were vomiting (8%), nausea (7%), neutropenia (2.9%), febrile neutropenia (2.9%), diarrhea (2.9%), intestinal obstruction (3.2%), pyrexia (2.5%), pneumonia (2.5%), respiratory failure (2.2%), pulmonary embolism (2.2%), decreased appetite (2.1%) and sepsis (2.0%). **Fatal adverse reactions** occurred in 5% of patients who received VYLOY in combination with mFOLFOX6 including sepsis (1.4%), pneumonia (1.1%), respiratory failure (1.1%), intestinal obstruction (0.7%), acute hepatic failure (0.4%), acute myocardial infarction (0.4%), death (0.4%), disseminated intravascular coagulation (0.4%), encephalopathy (0.4%), and upper gastrointestinal hemorrhage (0.4%). Permanent discontinuation of VYLOY due to an adverse reaction occurred in 20% of patients; the **most common adverse reactions leading to discontinuation** (≥2%) were nausea and vomiting. Dosage interruptions of VYLOY due to an adverse reaction occurred in 75% of patients; the **most common adverse reactions leading to dose interruption** (≥5%) were nausea, vomiting, neutropenia, abdominal pain, fatigue, and hypertension.

GLOW Study: 254 patients with locally advanced unresectable or metastatic HER2-negative gastric or GEJ adenocarcinoma whose tumors were CLDN18.2 positive who received at least one dose of VYLOY in combination with CAPOX

Serious adverse reactions occurred in 47% of patients treated with VYLOY in combination with CAPOX; the **most common serious adverse reactions** (≥2%) were vomiting (6%), nausea (4.3%), decreased appetite (3.9%), decreased platelet count (3.1%), upper gastrointestinal hemorrhage (2.8%), diarrhea (2.8%), pneumonia (2.4%), pulmonary embolism (2.3%), and pyrexia (2.0%). **Fatal adverse reactions** occurred in 8% of patients who received VYLOY in combination with CAPOX including sepsis (1.2%), pneumonia (0.4%), death (0.8%), upper gastrointestinal hemorrhage (0.8%), cerebral hemorrhage (0.8%), abdominal infection (0.4%), acute respiratory distress syndrome (0.4%), cardio-respiratory arrest (0.4%), decreased platelet count (0.4%), disseminated intravascular coagulation (0.4%), dyspnea (0.4%), gastric perforation (0.4%), hemorrhagic ascites (0.4%), procedural complication (0.4%), sudden death (0.4%), and syncope (0.4%). Permanent discontinuation of VYLOY due to an adverse reaction occurred in 19% of patients; the **most common adverse reaction leading to discontinuation** (≥2%) was vomiting. Dosage interruption of VYLOY due to an adverse reaction occurred in 55% of patients; the **most common adverse reactions leading to dose interruption** (≥2%) were nausea, vomiting, neutropenia, thrombocytopenia, anemia, fatigue, infusion-related reaction, and abdominal pain.

SPECIFIC POPULATIONS

Lactation Advise lactating women not to breastfeed during treatment with VYLOY and for 8 months after the last dose.

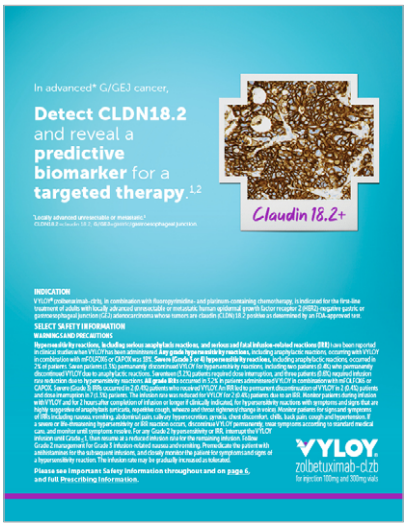
Please see full Prescribing Information.

astellas

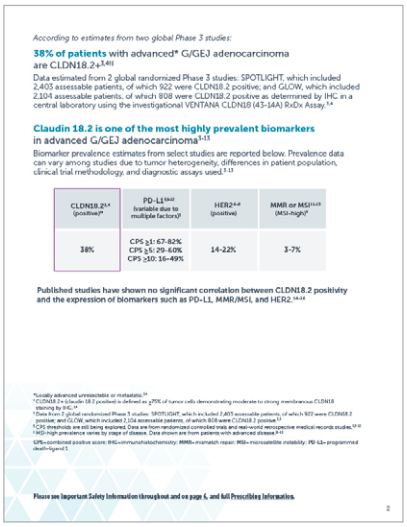
For US healthcare professionals only.

VYLOY®
zolbetuximab-clzb
for injection 100mg and 300mg vials

Digital pages

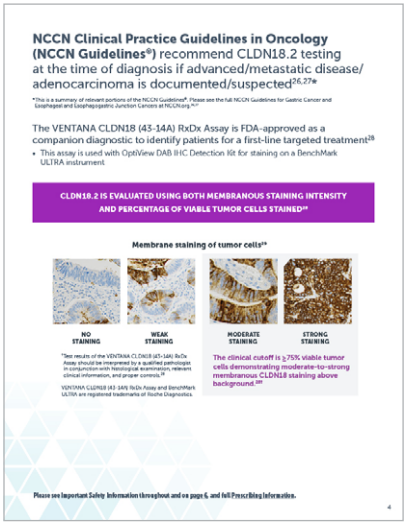


Page 1

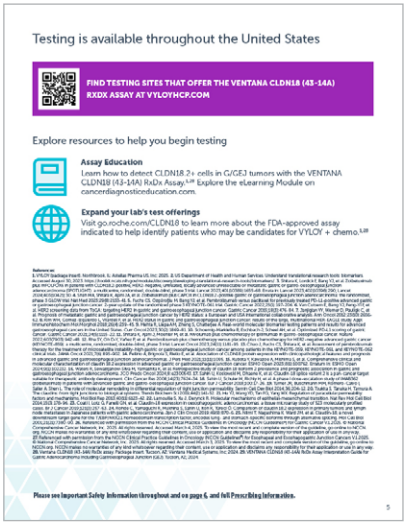


Page 2

Page 3



Page 4



Page 5

Page 6