Gilead and Kite to Share Latest Scientific Advances in Hematologic Malignancies at ASH 2020

November 5, 2020

-- 16 Abstracts, Including Three Oral Presentations, Highlight Breadth of Company’s Innovation in Immuno-Oncology for Patients with Blood Cancers --

-- Kite Data Highlight Yescarta® Long-Term Efficacy in Relapsed/Refractory Large B-Cell Lymphoma, its Potential as An Earlier Line of Therapy in DLBCL, as well as Results in Other Cancers, and One-Year Follow-up Results for Tecartus™ in Relapsed Mantle Cell Lymphoma --

-- Magrolimab Demonstrates Continued Response Rates in Updated Results of Phase 1b Study of Acute Myeloid Leukemia Patients, Including Those with TP53 Mutation --

FOSTER CITY, Calif. & SANTA MONICA, Calif.--(BUSINESS WIRE)--Nov. 5, 2020-- Gilead Sciences, Inc. (Nasdaq: GILD) and Kite, a Gilead Company, today announced that 16 abstracts, including three oral presentations from the companies’ combined immuno-oncology research and development programs, have been accepted for presentation at the 62nd American Society of Hematology (ASH) Annual Meeting and Exposition. The meeting, which is being held virtually on December 5-8, 2020, will feature presentations on Yescarta® (axicabtagene ciloleucel), Tecartus™ (brexucabtagene autoleucel, KTE-X19) and other ongoing research from Kite’s chimeric antigen receptor (CAR) T cell therapy development program, as well as magrolimab, Gilead’s first-in-class, investigational anti-CD47 monoclonal antibody.

This press release features multimedia. View the full release here: https://www.businesswire.com/news/home/20201105005130/en/

“The evidence supporting our innovation in hematologic malignancies continues to grow, providing assurance of the lasting and positive impact our diverse oncology pipeline could achieve over time,” said Merdad Parsey, MD, PhD, Chief Medical Officer, Gilead Sciences. “We continue to see broad potential across our oncology portfolio – anchored by Kite in cell therapy and Gilead’s anti-CD47 monoclonal antibody – to transform care for patients with hard-to-treat blood cancers.”

New Long-Term Efficacy Data and the Potential of CAR T Therapy for More Patients

Building on three-year data presented at ASH 2019, overall survival results at four years from the pivotal ZUMA-1 trial of Yescarta in patients with refractory large B-cell lymphoma will be presented (Abstract #1187). Additionally, new data include one-year follow-up results from the ZUMA-2 study evaluating KTE-X19 in relapsed or refractory mantle cell lymphoma (Abstract #1120), as well as several studies evaluating the potential of Yescarta in new indications include an interim analysis of ZUMA-12 in first-line large B-cell lymphoma among patients with high-risk features (Abstract #405) and the ZUMA-5 primary analysis in relapsed or refractory indolent non-Hodgkin lymphoma (NHL), including follicular lymphoma (FL) and marginal zone lymphoma (MZL; Abstract #700).

Data from the ZUMA-5 primary analysis form the basis for the supplemental Biologics License Application (sBLA) for Yescarta currently under review by the U.S. Food & Drug Administration (FDA). Yescarta has previously been granted a Breakthrough Therapy Designation by the FDA for relapsed or refractory large B-cell lymphoma (Abstract #1120), as well as several studies evaluating the potential of Yescarta in new indications include an interim analysis of ZUMA-12 in first-line large B-cell lymphoma among patients with high-risk features (Abstract #405) and the ZUMA-5 primary analysis in relapsed or refractory indolent non-Hodgkin lymphoma (NHL), including follicular lymphoma (FL) and marginal zone lymphoma (MZL; Abstract #700).

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Harnessing Potential First-in-Class Anti-CD47 Antibody in Difficult-to-Treat Malignancies

Researchers will give an oral presentation of updated results from the Phase 1b study of magrolimab in patients with previously-untreated acute myeloid leukemia (AML) who cannot undergo treatment with intensive chemotherapy, including patients with TP53-mutant AML (Abstract #330). The FDA recently assigned Breakthrough Designation to magrolimab, in combination with azacitidine for the treatment of adult patients with newly-diagnosed MDS including intermediate-, high-, or very high-risk tumor types to expedite the development and regulatory review of this investigational treatment. Magrolimab also received PRIME Designation for treatment of MDS from the European Medicines Agency (EMA).

Dates and times for all accepted abstracts are as follows:

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<tr>
<th>Area of Focus, Presentation Number and Date/Time</th>
<th>Abstract Title</th>
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<td>Oral Presentations</td>
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<td><strong>Acute Myeloid Leukemia</strong></td>
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<tr>
<td>Abstract #330</td>
<td>The First-in-Class Anti-CD47 Antibody Magrolimab Combined with Azacitidine Is Well-Tolerated and Effective in AML Patients: Phase 1b Results</td>
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Interim Analysis of ZUMA-12: A Phase 2 Study of Axicabtagene Cilooleucel (Axi-Cel) as First-Line Therapy in Patients (Pts) with High-Risk Large B Cell Lymphoma (LBCL)

Primary Analysis of ZUMA-5: A Phase 2 Study of Axicabtagene Cilooleucel (Axi-Cel) in Patients With Relapsed/Refractory (R/R) Indolent Non-Hodgkin Lymphoma (iNHL)

Safety Profile of Idelalisib in Patients with Refractory Follicular Lymphoma: Interim Analysis of a Noninterventional Study

Long-Term Survival and Gradual Recovery of B Cells in Patients With Refractory Large B Cell Lymphoma Treated With Axicabtagene Cilooleucel (Axi-Cel)


The First Retrospective Commercial Claims-Based Analysis of CAR T Treated Patients With Relapsed or Refractory Large B-Cell Lymphoma (R/R LBCL)

Cost and Healthcare Utilization in Relapsed/Refractory Diffuse Large B-Cell Lymphoma: A Real-World Analysis of Medicare Beneficiaries Receiving Chimeric Antigen Receptor T-Cell Vs. Autologous and Allogeneic Hematopoietic Stem Cell Transplants

Burden of Illness and Outcomes in the 2nd Line Treatment of Large B-Cell Lymphoma: A Real-World Comparison of Medicare Beneficiaries with and without Stem Cell Transplants

Lines of Therapy in Patients with Relapsed or Refractory Large B-Cell Lymphoma and Stem Cell Transplant-Intended Treatment
One-Year Follow-Up of ZUMA-2, the Multicenter, Registrational Study of KTE-X19 in Patients With Relapsed/Refractory Mantle Cell Lymphoma

Pharmacological Profile and Clinical Outcomes of KTE-X19 by Prior Bruton Tyrosine Kinase Inhibitors (BTKi) Exposure or Mantle Cell Lymphoma (MCL) Morphology in Patients With Relapsed/Refractory (R/R) MCL in the ZUMA-2 Trial

Retreatment With Axicabtagene Ciloleucel (Axi-Cel) in Patients With Relapsed/Refractory Indolent Non-Hodgkin Lymphoma in ZUMA-5

ZUMA-4: A Phase 1/2 Multicenter Study of KTE-X19 in Pediatric and Adolescent Patients With Relapsed/Refractory B Cell Acute Lymphoblastic Leukemia or Non-Hodgkin Lymphoma

ZUMA-19: A Phase 1/2 Multicenter Study of Lenzilumab Use with Axicabtagene Ciloleucel (Axi-Cel) in Patients (Pts) With Relapsed or Refractory Large B Cell Lymphoma (R/R LBCL)

Efficacy Outcomes of Treatments for Double Relapsed/Refractory Follicular Lymphoma (R/R FL): A Systematic Literature Review

Yescarta was the first CAR T cell therapy to be approved by the FDA for the treatment of adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, and high grade B-cell lymphoma and DLBCL arising from FL. Yescarta is not indicated for the treatment of patients with primary central nervous system lymphoma. In July, Tecartus became the first CAR T cell therapy to receive accelerated approval from the FDA for the treatment of relapsed or refractory mantle cell lymphoma, based on overall response rate and durability of response. Continued approval for this indication may be contingent upon additional data from a confirmatory trial. The U.S. Prescribing Information for Yescarta and Tecartus each have BOXED WARNINGS for the risks of CRS and neurologic toxicities, and Yescarta and Tecartus are each approved with a risk evaluation and mitigation strategy (REMS) due to these risks; see below for Important Safety Information.

The uses of Yescarta in relapsed or refractory FL or MZL or as a first-line treatment for patients with large B-cell lymphoma and high-risk genetics are investigational and not approved anywhere globally. Its efficacy and safety have not been established for these indications.

Magrolimab is investigational and not approved anywhere globally. Its efficacy and safety have not been established. More information about clinical trials with magrolimab is available at [www.clinicaltrials.gov](http://www.clinicaltrials.gov).

**ABOUT MAGROLIMAB**

Magrolimab is a first-in-class, investigational monoclonal antibody against CD47 and macrophage checkpoint inhibitor that is designed to interfere with recognition of CD47 by the SIRPα receptor on macrophages, thus blocking the “don’t eat me” signal used by cancer cells to avoid being ingested by macrophages. Magrolimab is being developed in several hematologic and solid tumor malignancies, including MDS. Magrolimab has been granted
About Yescarta

Yescarta is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including DLBCL not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma.

Limitation of Use: Yescarta is not indicated for the treatment of patients with primary central nervous system lymphoma.

U.S. Important Safety Information for Yescarta

BOXED WARNING: CYTOKINE RELEASE SYNDROME AND NEUROLOGIC TOXICITIES

- Cytokine Release Syndrome (CRS), including fatal or life-threatening reactions, occurred in patients receiving Yescarta. Do not administer Yescarta to patients with active infection or inflammatory disorders. Treat severe or life-threatening CRS with tocilizumab or tocilizumab and corticosteroids.
- Neurologic toxicities, including fatal or life-threatening reactions, occurred in patients receiving Yescarta, including concurrently with CRS or after CRS resolution. Monitor for neurologic toxicities after treatment with Yescarta. Provide supportive care and/or corticosteroids as needed.
- Yescarta is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Yescarta and Tecartus REMS Program.

CYTOKINE RELEASE SYNDROME (CRS) occurred in 94% of patients, with 13% ≥ Grade 3. Among patients who died after receiving Yescarta, 4 had ongoing CRS at death. The median time to onset was 2 days (range: 1-12 days) and median duration was 7 days (range: 2-58 days). Key manifestations include fever (78%), hypotension (41%), tachycardia (28%), hypoxia (22%), and chills (20%). Serious events that may be associated with CRS include cardiac arrhythmias (including atrial fibrillation and ventricular tachycardia), cardiac arrest, cardiac failure, renal insufficiency, capillary leak syndrome, hypotension, hypoxia, and hemophagocytic lymphohistiocytosis/macrophage activation syndrome. Ensure that 2 doses of tocilizumab are available prior to Yescarta infusion. Following infusion, monitor patients for signs and symptoms of CRS at least daily for 7 days at the certified healthcare facility, and for 4 weeks thereafter. Counsel patients to seek immediate medical attention should signs or symptoms of CRS occur at any time. At the first sign of CRS, institute treatment with supportive care, tocilizumab or tocilizumab and corticosteroids as indicated.

NEUROLOGIC TOXICITIES occurred in 87% of patients, 98% of which occurred within the first 8 weeks with a median time to onset of 4 days (range: 1-43 days) and a median duration of 17 days. Grade ≥3 occurred in 31% of patients. The most common neurologic toxicities included encephalopathy (57%), headache (44%), tremor (31%), dizziness (21%), aphasia (18%), delirium (17%), insomnia (9%), and anxiety (9%). Prolonged encephalopathy lasting up to 173 days was noted. Serious events including leukoencephalopathy and seizures, as well as fatal and serious cases of cerebral edema have occurred. Following Yescarta infusion, monitor patients for signs and symptoms of neurologic toxicities at least daily for 7 days at the certified healthcare facility, and for 4 weeks thereafter, and treat promptly.

REMS: Because of the risk of CRS and neurologic toxicities, Yescarta is available only through a restricted program called the Yescarta and Tecartus REMS Program which requires that: Healthcare facilities that dispense and administer Yescarta must be enrolled and comply with the REMS requirements and must have on-site, immediate access to a minimum of 2 doses of tocilizumab for each patient for infusion within 2 hours after Yescarta infusion, if needed for treatment of CRS. Certified healthcare facilities must ensure that healthcare providers who prescribe, dispense, or administer Yescarta are trained about the management of CRS and neurologic toxicities. Further information is available at www.YescartaTecartusREMS.com or 1-844-454-KITE (5483).

HYPERSENSITIVITY REACTIONS: Allergic reactions, including serious hypersensitivity reactions or anaphylaxis, may occur with the infusion of Yescarta.

SERIOUS INFECTIONS: Severe or life-threatening infections occurred. Infections (all grades) occurred in 38% of patients. Grade ≥3 infections occurred in 23% of patients; those due to an unspecified pathogen occurred in 16% of patients, bacterial infections in 9%, and viral infections in 4%. Yescarta should not be administered to patients with clinically significant active systemic infections. Monitor patients for signs and symptoms of infection before and after infusion and treat appropriately. Administer prophylactic anti-microbials according to local guidelines. Febrile neutropenia was observed in 36% of patients and may be concurrent with CRS. In the event of febrile neutropenia, evaluate for infection and manage with broad spectrum antibiotics, fluids, and other supportive care as medically indicated. Hepatitis B virus (HBV) reactivation, in some cases resulting in fulminant hepatitis, hepatic failure, and death, can occur in patients treated with drugs directed against B cells. Perform screening for HBV, HCV, and HIV in accordance with clinical guidelines before collection of cells for manufacturing.

PROLONGED CYTOPENIAS: Patients may exhibit cytopenias for several weeks following lymphodepleting chemotherapy and Yescarta infusion. Grade ≥3 cytopenias not resolved by Day 30 following Yescarta infusion occurred in 28% of patients and included thrombocytopenia (18%), neutropenia (15%), and anemia (3%). Monitor blood counts after infusion.

HYPOGAMMAGLOBULINEMIA and B-cell aplasia can occur. Hypogammaglobulinemia occurred in 15% of patients. Monitor immunoglobulin levels after treatment and manage using infection precautions, antibiotic prophylaxis, and immunoglobulin replacement. The safety of immunization with live viral vaccines during or following Yescarta treatment has not been studied. Vaccination with live virus vaccines is not recommended for at least 6 weeks prior to the start of lymphodepleting chemotherapy, during Yescarta treatment, and until immune recovery following treatment.

SECONDARY MALIGNANCIES may develop. Monitor life-long for secondary malignancies. In the event that one occurs, contact Kite at 1-844-454-KITE (5483) to obtain instructions on patient samples to collect for testing.

EFFECTS ON ABILITY TO DRIVE AND USE MACHINES: Due to the potential for neurologic events, including altered mental status or seizures, patients are at risk for altered or decreased consciousness or coordination in the 8 weeks following Yescarta infusion. Advise patients to refrain from...
driving and engaging in hazardous occupations or activities, such as operating heavy or potentially dangerous machinery, during this initial period.

**ADVERSE REACTIONS:** The most common (incidence ≥20%) include CRS, fever, hypotension, encephalopathy, tachycardia, fatigue, headache, decreased appetite, chills, diarrhea, febrile neutropenia, infections-pathogen unspecified, nausea, hypoxia, tremor, cough, vomiting, dizziness, constipation, and cardiac arrhythmias.

Please see accompanying full Prescribing Information, including **BOXED WARNING** and Medication Guide.

**About Tecartus**

Tecartus is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of adult patients with relapsed or refractory mantle cell lymphoma (MCL).

This indication is approved under accelerated approval based on overall response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

**U.S. Important Safety Information for Tecartus**

**BOXED WARNING:** CYTOKINE RELEASE SYNDROME and NEUROLOGIC TOXICITIES

- Cytokine Release Syndrome (CRS), including life-threatening reactions, occurred in patients receiving Tecartus. Do not administer Tecartus to patients with active infection or inflammatory disorders. Treat severe or life-threatening CRS with tocilizumab or tocilizumab and corticosteroids.
- Neurologic toxicities, including life-threatening reactions, occurred in patients receiving Tecartus, including concurrently with CRS or after CRS resolution. Monitor for neurologic toxicities after treatment with Tecartus. Provide supportive care and/or corticosteroids as needed.
- Tecartus is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Yescarta and Tecartus REMS Program.

**Cytokine Release Syndrome (CRS),** including life-threatening reactions, occurred following treatment with Tecartus. In ZUMA-2, CRS occurred in 91% (75/82) of patients receiving Tecartus, including ≥ Grade 3 CRS in 18% of patients. Among the patients who died after receiving Tecartus, one had a fatal CRS event. The median time to onset of CRS was three days (range: 1 to 13 days) and the median duration of CRS was ten days (range: 1 to 50 days). Among patients with CRS, key manifestations (>10%) included fever (99%), hypotension (60%), hypoxia (37%), chills (33%), tachycardia (37%), headache (24%), fatigue (19%), nausea (13%), alanine aminotransferase increased (13%), aspartate aminotransferase increased (12%), and diarrhea (11%). Serious events associated with CRS included hypotension, fever, hypoxia, acute kidney injury, and tachycardia.

Ensure that a minimum of two doses of tocilizumab are available for each patient prior to infusion of Tecartus. Following infusion, monitor patients for signs and symptoms of CRS daily for at least seven days at the certified healthcare facility, and for four weeks thereafter. Counsel patients to seek immediate medical attention should signs or symptoms of CRS occur at any time. At the first sign of CRS, institute treatment with supportive care, tocilizumab, or tocilizumab and corticosteroids as indicated.

**Neurologic Toxicities,** including those that were life-threatening, occurred following treatment with Tecartus. In ZUMA-2, neurologic events occurred in 81% of patients, 37% of whom experienced Grade ≥3 adverse reactions. The median time to onset for neurologic events was six days (range: 1 to 32 days). Neurologic events resolved for 52 out of 66 (79%) patients with a median duration of 21 days (range: 2 to 454 days). Three patients had ongoing neurologic events at the time of death, including one patient with serious encephalopathy. The remaining unresolved neurologic events were either Grade 1 or Grade 2. Fifty-four (66%) patients experienced CRS by the onset of neurological events. Five (6%) patients did not experience CRS with neurologic events and eight patients (10%) developed neurological events after the resolution of CRS. 85% of all treated patients experienced the first CRS or neurological event within the first seven days after Tecartus infusion.

The most common neurologic events (>10%) included encephalopathy (51%), headache (35%), tremor (38%), aphasia (23%), and delirium (16%). Serious events including encephalopathy, aphasia, and seizures occurred.

Monitor patients daily for at least seven days at the certified healthcare facility and for four weeks following infusion for signs and symptoms of neurologic toxicities and treat promptly.

**REMS Program:** Because of the risk of CRS and neurologic toxicities, Tecartus is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Yescarta and Tecartus REMS Program which requires that:

- Healthcare facilities that dispense and administer Tecartus must be enrolled and comply with the REMS requirements. Certified healthcare facilities must have on-site, immediate access to tocilizumab, and ensure that a minimum of two doses of tocilizumab are available for each patient for infusion within two hours after Tecartus infusion, if needed for treatment of CRS.
- Certified healthcare facilities must ensure that healthcare providers who prescribe, dispense, or administer Tecartus are trained in the management of CRS and neurologic toxicities. Further information is available at [www.YescartaTecartusREMS.com](http://www.YescartaTecartusREMS.com) or 1-844-454-KITE (5483).

**Hypersensitivity Reactions:** Serious hypersensitivity reactions, including anaphylaxis, may occur due to dimethyl sulfoxide (DMSO) or residual gentamicin in Tecartus.

**Severe Infections:** Severe or life-threatening infections occurred in patients after Tecartus infusion. In ZUMA-2, infections (all grades) occurred in 56% of patients. Grade 3 or higher infections, including bacterial, viral, and fungal infections, occurred in 30% of patients. Tecartus should not be administered to patients with clinically significant active systemic infections. Monitor patients for signs and symptoms of infection before and after
Febrile neutropenia was observed in 6% of patients after Tecartus infusion and may be concurrent with CRS. In the event of febrile neutropenia, evaluate for infection and manage with broad-spectrum antibiotics, fluids, and other supportive care as medically indicated.

**Viral Reactivation**

Hepatitis B virus (HBV) reactivation, in some cases resulting in fulminant hepatitis, hepatic failure, and death, can occur in patients treated with drugs directed against B cells. Perform screening for HBV, HCV, and HIV in accordance with clinical guidelines before collection of cells for manufacturing.

**Prolonged Cytopenias:** Patients may exhibit cytopenias for several weeks following lymphodepleting chemotherapy and Tecartus infusion. In ZUMA-2, Grade ≥3 cytopenias not resolved by Day 30 following Tecartus infusion occurred in 55% of patients and included thrombocytopenia (38%), neutropenia (37%), and anemia (17%). Monitor blood counts after infusion.

**Hypogammaglobulinemia** and B-cell aplasia can occur in patients receiving treatment with Tecartus. In ZUMA-2, hypogammaglobulinemia occurred in 16% of patients. Monitor immunoglobulin levels after treatment with Tecartus and manage using infection precautions, antibiotic prophylaxis, and immunoglobulin replacement. The safety of immunization with live viral vaccines during or following Tecartus treatment has not been studied. Vaccination with live virus vaccines is not recommended for at least six weeks prior to the start of lymphodepleting chemotherapy, during treatment, and until immune recovery following treatment with Tecartus.

**Secondary Malignancies** may develop. Monitor life-long for secondary malignancies. In the event that it occurs, contact Kite at 1-844-454-KITE (5483) to obtain instructions on patient samples to collect for testing.

**Effects on Ability to Drive and Use Machines:** Due to the potential for neurologic events, including altered mental status or seizures, patients are at risk for altered or decreased consciousness or coordination in the 8 weeks following Tecartus infusion. Advise patients to refrain from driving and engaging in hazardous activities, such as operating heavy or potentially dangerous machinery, during this period.

**Adverse Reactions:** The most common adverse reactions (incidence ≥ 20%) were pyrexia, CRS, hypotension, encephalopathy, fatigue, tachycardia, arrhythmia, infection – pathogen unspecified, chills, hypoxia, cough, tremor, musculoskeletal pain, headache, nausea, edema, motor dysfunction, constipation, diarrhea, decreased appetite, dyspnea, rash, insomnia, pleural effusion, and aphasia. Serious adverse reactions occurred in 66% of patients. The most common serious adverse reactions (> 2%) were encephalopathy, pyrexia, infection – pathogen unspecified, CRS, hypoxia, aphasia, renal insufficiency, pleural effusion, respiratory failure, bacterial infections, dyspnea, fatigue, arrhythmia, tachycardia, and viral infections.

Please see full Prescribing Information, including BOXED WARNING and Medication Guide.

**About Gilead Sciences**

Gilead Sciences, Inc. is a research-based biopharmaceutical company that discovers, develops and commercializes innovative medicines in areas of unmet medical need. The company strives to transform and simplify care for people with life-threatening illnesses around the world. Gilead has operations in more than 35 countries worldwide, with headquarters in Foster City, California. For more information on Gilead Sciences, please visit the company’s website at www.gilead.com.

**About Kite**

Kite, a Gilead Company, is a biopharmaceutical company based in Santa Monica, California, with commercial manufacturing operations in North America and Europe. Kite is engaged in the development of innovative cancer immunotherapies. The company is focused on chimeric antigen receptor and T cell receptor engineered cell therapies. For more information on Kite, please visit www.kitepharma.com.

**Gilead and Kite Forward-Looking Statements**

This press release includes forward-looking statements, within the meaning of the Private Securities Litigation Reform Act of 1995 that are subject to risks, uncertainties and other factors, including the possibility of unfavorable results from ongoing and additional clinical studies involving Yescarta, Tecartus and magrolimab and the possibility that Gilead and Kite may be unable to initiate or complete one or more of such studies in the currently anticipated timelines or at all. There is also the risk that the FDA may not approve Yescarta for the treatment of relapsed or refractory FL or MZL after at least two prior therapies in the anticipated timelines or at all, and any marketing approvals if granted, may have significant limitations on its use. Further, it is possible that Gilead may make a strategic decision to discontinue development of magrolimab or that the FDA and other regulatory agencies may not approve magrolimab for the treatment of MDS and other indications, and any marketing approvals, if granted, may have significant limitations on its use. All statements other than statements of historical fact are statements that could be deemed forward-looking statements. These risks, uncertainties and other factors could cause actual results to differ materially from those referred to in the forward-looking statements. The reader is cautioned not to rely on these forward-looking statements. These and other risks are described in detail in Gilead’s Quarterly Report on Form 10-Q for the quarter ended September 30, 2020, as filed with the U.S. Securities and Exchange Commission. All forward-looking statements are based on information currently available to Gilead and Kite, and Gilead and Kite assume no obligation to update any such forward-looking statements.


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Learn more about Gilead at www.gilead.com; follow Gilead on Twitter (@GileadSciences) or call Gilead Public Affairs at 1-800-GILEAD-5 or 1-650-574-3000. For more information on Kite, please visit the company’s website at www.kitepharma.com. Follow Kite on social media on Twitter (@KitePharma) and LinkedIn.

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