

May 8, 2017

European Commission Approves Bristol-Myers Squibb's Opdivo (nivolumab) for Squamous Cell Cancer of the Head and Neck in Adults Progressing On or After Platinum-based Therapy

(PRINCETON, NJ, April 28, 2017) – Bristol-Myers Squibb Company (NYSE: BMY) announced that the European Commission (EC) has approved Opdivo (nivolumab) as monotherapy for the treatment of squamous cell cancer of the head and neck (SCCHN) in adults progressing on or after platinum-based therapy. Opdivo is the first and only Immuno-Oncology (I-O) treatment that demonstrated in a Phase 3 trial a significant improvement in overall survival (OS) for these patients.

Bristol-Myers Squibb (BMS) has a robust clinical development program in Opdivo monotherapy and in combination therapy with other therapeutic drugs in a variety of tumor types overseas, including glioblastoma, small cell lung cancer, urothelial cancer, hepatocellular carcinoma, esophageal cancer, colorectal cancer, gastric cancer, blood cancer, etc.

In Japan, Ono Pharmaceutical Co., Ltd. (ONO) launched Opdivo for the treatment of unresectable melanoma in September 2014. ONO received an approval for additional indication of unresectable, advanced or recurrent non-small cell lung cancer in December 2015 and unresectable or metastatic renal cell cancer in August 2016, relapsed or refractory classical Hodgkin lymphoma in December 2016 and recurrent or metastatic head and neck cancer in March 2017. In addition, ONO has submitted supplemental application for additional indication of gastric cancer, and is conducting clinical development program including esophageal cancer, gastro-esophageal junction cancer, small cell lung cancer, hepatocellular carcinoma, glioblastoma, urothelial cancer, malignant pleural mesothelioma, ovarian cancer, biliary tract cancer, etc.

In Japan, ONO and BMS (and BMS Japan subsidiary BMSKK) have formed a strategic partnership that includes co-development, co-commercialization, and co-promotion of multiple immunotherapies for patients with cancer.

Attached from the following page is the press release made by BMS for your information.

Contact

ONO PHARMACEUTICAL CO., LTD.

Corporate Communications

public_relations@ono.co.jp

European Commission Approves Bristol-Myers Squibb's *Opdivo* (nivolumab) for Squamous Cell Cancer of the Head and Neck in Adults Progressing On or After Platinum-based Therapy

Opdivo is the first and only Immuno-Oncology agent to receive European approval for the treatment of squamous cell cancer of the head and neck in adults progressing on or after platinum-based therapy

Opdivo is now approved by the EC for seven indications in five distinct tumor types

This is the first approval in Europe of a treatment for squamous cell cancer of the head and neck in more than a decade

(PRINCETON, NJ, April 28, 2017) – [Bristol-Myers Squibb Company](#) (NYSE: BMY) today announced that the European Commission (EC) has approved *Opdivo* (nivolumab) as monotherapy for the treatment of squamous cell cancer of the head and neck (SCCHN) in adults progressing on or after platinum-based therapy. *Opdivo* is the first and only Immuno-Oncology (I-O) treatment that demonstrated in a Phase 3 trial a significant improvement in overall survival (OS) for these patients.

“Adult patients with squamous cell cancer of the head and neck that progresses on or after platinum-based therapy are fighting a debilitating and hard-to-treat disease that is associated with a very poor prognosis,” said Kevin Harrington, M.D., Ph.D., professor in Biological Cancer Therapies at The Institute of Cancer Research, London, and a consultant clinical oncologist at The Royal Marsden NHS Foundation Trust in London. “As an oncologist who helps patients deal with navigate this terrible disease, I hope that nivolumab will now be made available as widely as possible, offering this group of patients a new treatment option that can potentially improve their overall survival.”

The approval was based on results from CheckMate -141, a global Phase 3, open-label, randomized trial, first published in *The New England Journal of Medicine* last October, which evaluated *Opdivo* versus investigator's choice of therapy in patients aged 18 years and above with recurrent or metastatic, platinum-refractory SCCHN who had tumor progression during or within six months of receiving platinum-based therapy administered in the adjuvant, neo-adjuvant, primary or metastatic setting. Investigator's choice of therapy included methotrexate, docetaxel, or cetuximab. The primary endpoint was OS. The trial's secondary endpoints included progression-free survival (PFS) and objective response rate (ORR).

“The European Commission's approval of *Opdivo* marks not only the first new treatment option in 10 years for patients with advanced cancers of the head and neck, but also the first Immuno-Oncology treatment for SCCHN,” said Murdo Gordon, executive vice

president and chief commercial officer, Bristol-Myers Squibb. “Bristol-Myers Squibb remains committed to redefining survival for patients with cancer, and now that *Opdivo* is approved in Europe, we will work collaboratively with EU health authorities to ensure it is available for these patients as quickly as possible.”

In the interim analysis of the pivotal trial, *Opdivo* demonstrated statistically significant improvement in OS with a 30% reduction in the risk of death (HR=0.70 [95% CI: 0.53-0.92; $p=0.0101$]), and a median OS of 7.5 months (95% CI: 5.5-9.1) for *Opdivo* compared with 5.1 months (95% CI: 4.0-6.0) for the investigator’s choice arm. There were no statistically significant differences between the two arms for PFS (HR=0.89; 95% CI: 0.70, 1.13) or ORR (13.3% [95% CI: 9.3, 18.3] vs 5.8% [95% CI: 2.4, 11.6] for *Opdivo* and investigator’s choice, respectively. The EC approval was based on updated study results, which will be presented at the 53rd Annual Meeting of the American Society of Clinical Oncology (ASCO).

Patient reported outcomes (PROs) were evaluated using the following European Organization for Research and Treatment of Cancer (EORTC) quality-of-life assessments: EORTC QLQ-C30, EORTC QLQ-H&N35, and 3-level EQ-5D instruments. Patients treated with *Opdivo* exhibited stable PROs, while those assigned to investigator’s choice therapy exhibited significant declines in functioning (e.g., physical, role, social) and health status as well as increased symptomatology (e.g., fatigue, dyspnoea, appetite loss, pain and sensory problems).

The safety profile of *Opdivo* in CheckMate -141 was consistent with prior studies in patients with melanoma and non-small cell lung cancer. Serious adverse reactions occurred in 49% of patients receiving *Opdivo*. The most frequent serious adverse reactions reported in at least 2% of patients receiving *Opdivo* were pneumonia, dyspnea, aspiration pneumonia, respiratory failure, respiratory tract infection, and sepsis.

About Head & Neck Cancer

Cancers that are known as head and neck cancers usually begin in the squamous cells that line the moist mucosal surfaces inside the head and neck, such as inside the mouth, the nose and the throat. Head and neck cancer is the seventh most common cancer globally, with an estimated 400,000 to 600,000 new cases per year and 223,000 to 300,000 deaths per year. The five-year survival rate is reported as less than 4% for metastatic Stage IV disease. Squamous cell cancer of the head and neck (SCCHN) accounts for approximately 90% of all head and neck cancers with global incidence expected to increase by 17% between 2012 and

2022. Risk factors for SCCHN include tobacco and alcohol consumption. Human Papilloma Virus (HPV) infection is also a risk factor leading to rapid increase in oropharyngeal SCCHN in Europe and North America.

About Opdivo

Opdivo is a programmed death-1 (PD-1) immune checkpoint inhibitor that is designed to uniquely harness the body's own immune system to help restore anti-tumor immune response. By harnessing the body's own immune system to fight cancer, *Opdivo* has become an important treatment option across multiple cancers.

Opdivo's leading global development program is based on Bristol-Myers Squibb's scientific expertise in the field of Immuno-Oncology and includes a broad range of clinical trials across all phases, including Phase 3, in a variety of tumor types. To date, the *Opdivo* clinical development program has enrolled more than 25,000 patients. The *Opdivo* trials have contributed to gaining a deeper understanding of the potential role of biomarkers in patient care, particularly regarding how patients may benefit from *Opdivo* across the continuum of PD-L1 expression.

In July 2014, *Opdivo* was the first PD-1 immune checkpoint inhibitor to receive regulatory approval anywhere in the world. *Opdivo* is currently approved in more than 60 countries, including the United States, the European Union and Japan. In October 2015, the company's *Opdivo* and *Yervoy* combination regimen was the first Immuno-Oncology combination to receive regulatory approval for the treatment of metastatic melanoma and is currently approved in more than 50 countries, including the United States and the European Union.

U. S. FDA APPROVED INDICATIONS FOR OPDIVO®

OPDIVO® (nivolumab) as a single agent is indicated for the treatment of patients with BRAF V600 mutation-positive unresectable or metastatic melanoma. This indication is approved under accelerated approval based on progression-free survival. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

OPDIVO® (nivolumab) as a single agent is indicated for the treatment of patients with BRAF V600 wild-type unresectable or metastatic melanoma.

OPDIVO® (nivolumab), in combination with YERVOY® (ipilimumab), is indicated for the treatment of patients with unresectable or metastatic melanoma. This indication is approved under accelerated approval based on progression-free survival. Continued approval for this

indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

OPDIVO[®] (nivolumab) is indicated for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with progression on or after platinum-based chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving OPDIVO.

OPDIVO[®] (nivolumab) is indicated for the treatment of patients with advanced renal cell carcinoma (RCC) who have received prior anti-angiogenic therapy.

OPDIVO[®] (nivolumab) is indicated for the treatment of patients with classical Hodgkin lymphoma (cHL) that has relapsed or progressed after autologous hematopoietic stem cell transplantation (HSCT) and post-transplantation brentuximab vedotin. This indication is approved under accelerated approval based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

OPDIVO[®] (nivolumab) is indicated for the treatment of patients with recurrent or metastatic squamous cell carcinoma of the head and neck (SCCHN) with disease progression on or after platinum-based therapy.

OPDIVO[®] (nivolumab) is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy. This indication is approved under accelerated approval based on tumor response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

IMPORTANT SAFETY INFORMATION

WARNING: IMMUNE-MEDIATED ADVERSE REACTIONS

YERVOY can result in severe and fatal immune-mediated adverse reactions. These immune-mediated reactions may involve any organ system; however, the most common severe immune-mediated adverse reactions are enterocolitis, hepatitis, dermatitis (including toxic epidermal necrolysis), neuropathy, and endocrinopathy. The majority of these immune-mediated reactions initially manifested during treatment; however, a minority occurred weeks to months after discontinuation of YERVOY.

Assess patients for signs and symptoms of enterocolitis, dermatitis, neuropathy, and endocrinopathy and evaluate clinical chemistries including liver function tests (LFTs), adrenocorticotrophic hormone (ACTH) level, and thyroid function tests at baseline and before each dose.

Permanently discontinue YERVOY and initiate systemic high-dose corticosteroid therapy for severe immune-mediated reactions.

Immune-Mediated Pneumonitis

OPDIVO can cause immune-mediated pneumonitis. Fatal cases have been reported. Monitor patients for signs with radiographic imaging and for symptoms of pneumonitis. Administer corticosteroids for Grade 2 or more severe pneumonitis. Permanently discontinue for Grade 3 or 4 and withhold until resolution for Grade 2. In patients receiving OPDIVO monotherapy, fatal cases of immune-mediated pneumonitis have occurred. Immune-mediated pneumonitis occurred in 3.1% (61/1994) of patients. In patients receiving OPDIVO with YERVOY, immune-mediated pneumonitis occurred in 6% (25/407) of patients.

In Checkmate 205 and 039, pneumonitis, including interstitial lung disease, occurred in 4.9% (13/263) of patients receiving OPDIVO. Immune-mediated pneumonitis occurred in 3.4% (9/263) of patients receiving OPDIVO: Grade 3 (n=1) and Grade 2 (n=8).

Immune-Mediated Colitis

OPDIVO can cause immune-mediated colitis. Monitor patients for signs and symptoms of colitis. Administer corticosteroids for Grade 2 (of more than 5 days duration), 3, or 4 colitis. Withhold OPDIVO monotherapy for Grade 2 or 3 and permanently discontinue for Grade 4 or recurrent colitis upon re-initiation of OPDIVO. When administered with YERVOY, withhold OPDIVO and YERVOY for Grade 2 and permanently discontinue for Grade 3 or 4 or recurrent colitis. In patients receiving OPDIVO monotherapy, immune-mediated colitis occurred in 2.9% (58/1994) of patients. In patients receiving OPDIVO with YERVOY, immune-mediated colitis occurred in 26% (107/407) of patients including three fatal cases.

In a separate Phase 3 study of YERVOY 3 mg/kg, severe, life-threatening, or fatal (diarrhea of ≥ 7 stools above baseline, fever, ileus, peritoneal signs; Grade 3-5) immune-mediated enterocolitis occurred in 34 (7%) patients. Across all YERVOY-treated patients in that study (n=511), 5 (1%) developed intestinal perforation, 4 (0.8%) died as a result of complications, and 26 (5%) were hospitalized for severe enterocolitis.

Immune-Mediated Hepatitis

OPDIVO can cause immune-mediated hepatitis. Monitor patients for abnormal liver tests prior to and periodically during treatment. Administer corticosteroids for Grade 2 or greater transaminase elevations. Withhold for Grade 2 and permanently discontinue for Grade 3 or 4 immune-mediated hepatitis. In patients receiving OPDIVO monotherapy, immune-mediated hepatitis occurred in 1.8% (35/1994) of patients. In patients receiving OPDIVO with YERVOY, immune-mediated hepatitis occurred in 13% (51/407) of patients.

In a separate Phase 3 study of YERVOY 3 mg/kg, severe, life-threatening, or fatal hepatotoxicity (AST or ALT elevations $>5x$ the ULN or total bilirubin elevations $>3x$ the ULN; Grade 3-5) occurred in 8 (2%) patients, with fatal hepatic failure in 0.2% and hospitalization in 0.4%.

Immune-Mediated Neuropathies

In a separate Phase 3 study of YERVOY 3 mg/kg, 1 case of fatal Guillain-Barré syndrome and 1 case of severe (Grade 3) peripheral motor neuropathy were reported.

Immune-Mediated Endocrinopathies

OPDIVO can cause immune-mediated hypophysitis, immune-mediated adrenal insufficiency, autoimmune thyroid disorders, and Type 1 diabetes mellitus. Monitor patients for signs and symptoms of hypophysitis, signs and symptoms of adrenal insufficiency, thyroid function prior to and periodically during treatment, and hyperglycemia. Administer hormone replacement as clinically indicated and corticosteroids for Grade 2 or greater hypophysitis. Withhold for Grade 2 or 3 and permanently discontinue for Grade 4 hypophysitis. Administer corticosteroids for Grade 3 or 4 adrenal insufficiency. Withhold for Grade 2 and permanently discontinue for Grade 3 or 4 adrenal insufficiency. Administer hormone-replacement therapy for hypothyroidism. Initiate medical management for control of hyperthyroidism. Withhold OPDIVO for Grade 3 and permanently discontinue for Grade 4 hyperglycemia.

In patients receiving OPDIVO monotherapy, hypophysitis occurred in 0.6% (12/1994) of patients. In patients receiving OPDIVO with YERVOY, hypophysitis occurred in 9% (36/407) of patients. In patients receiving OPDIVO monotherapy, adrenal insufficiency occurred in 1% (20/1994) of patients. In patients receiving OPDIVO with YERVOY, adrenal insufficiency occurred in 5% (21/407) of patients. In patients receiving OPDIVO monotherapy, hypothyroidism or thyroiditis resulting in hypothyroidism occurred in 9% (171/1994) of patients. Hyperthyroidism occurred in 2.7% (54/1994) of patients receiving OPDIVO monotherapy. In patients receiving OPDIVO with YERVOY, hypothyroidism or thyroiditis resulting in hypothyroidism occurred in 22% (89/407) of patients. Hyperthyroidism occurred in 8% (34/407) of patients receiving OPDIVO with YERVOY. In patients receiving OPDIVO monotherapy, diabetes occurred in 0.9% (17/1994) of patients. In patients receiving OPDIVO with YERVOY, diabetes occurred in 1.5% (6/407) of patients.

In a separate Phase 3 study of YERVOY 3 mg/kg, severe to life-threatening immune-mediated endocrinopathies (requiring hospitalization, urgent medical intervention, or interfering with activities of daily living; Grade 3-4) occurred in 9 (1.8%) patients. All 9 patients had hypopituitarism, and some had additional concomitant endocrinopathies such as adrenal insufficiency, hypogonadism, and hypothyroidism. 6 of the 9 patients were hospitalized for severe endocrinopathies.

Immune-Mediated Nephritis and Renal Dysfunction

OPDIVO can cause immune-mediated nephritis. Monitor patients for elevated serum creatinine prior to and periodically during treatment. Administer corticosteroids for Grades 2-4 increased serum creatinine. Withhold OPDIVO for Grade 2 or 3 and permanently discontinue for Grade 4 increased serum creatinine. In patients receiving OPDIVO monotherapy, immune-mediated nephritis and renal dysfunction occurred in 1.2% (23/1994) of patients. In patients receiving OPDIVO with YERVOY, immune-mediated nephritis and renal dysfunction occurred in 2.2% (9/407) of patients.

Immune-Mediated Skin Adverse Reactions and Dermatitis

OPDIVO can cause immune-mediated rash, including Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN), some cases with fatal outcome. Administer corticosteroids for Grade 3 or 4 rash. Withhold for Grade 3 and permanently discontinue for Grade 4 rash. For symptoms or signs of SJS or TEN, withhold OPDIVO and refer the patient for specialized care for assessment and treatment; if confirmed, permanently discontinue. In patients receiving OPDIVO monotherapy, immune-mediated rash occurred in 9% (171/1994)

of patients. In patients receiving OPDIVO with YERVOY, immune-mediated rash occurred in 22.6% (92/407) of patients.

In a separate Phase 3 study of YERVOY 3 mg/kg, severe, life-threatening, or fatal immune-mediated dermatitis (eg, Stevens-Johnson syndrome, toxic epidermal necrolysis, or rash complicated by full thickness dermal ulceration, or necrotic, bullous, or hemorrhagic manifestations; Grade 3-5) occurred in 13 (2.5%) patients. 1 (0.2%) patient died as a result of toxic epidermal necrolysis. 1 additional patient required hospitalization for severe dermatitis.

Immune-Mediated Encephalitis

OPDIVO can cause immune-mediated encephalitis. Evaluation of patients with neurologic symptoms may include, but not be limited to, consultation with a neurologist, brain MRI, and lumbar puncture. Withhold OPDIVO in patients with new-onset moderate to severe neurologic signs or symptoms and evaluate to rule out other causes. If other etiologies are ruled out, administer corticosteroids and permanently discontinue OPDIVO for immune-mediated encephalitis. In patients receiving OPDIVO monotherapy, encephalitis occurred in 0.2% (3/1994) of patients. Fatal limbic encephalitis occurred in one patient after 7.2 months of exposure despite discontinuation of OPDIVO and administration of corticosteroids. Encephalitis occurred in one patient receiving OPDIVO with YERVOY (0.2%) after 1.7 months of exposure.

Other Immune-Mediated Adverse Reactions

Based on the severity of adverse reaction, permanently discontinue or withhold treatment, administer high-dose corticosteroids, and, if appropriate, initiate hormone-replacement therapy. Across clinical trials of OPDIVO the following clinically significant immune-mediated adverse reactions occurred in <1.0% of patients receiving OPDIVO: uveitis, iritis, pancreatitis, facial and abducens nerve paresis, demyelination, polymyalgia rheumatica, autoimmune neuropathy, Guillain-Barré syndrome, hypopituitarism, systemic inflammatory response syndrome, gastritis, duodenitis, sarcoidosis, histiocytic necrotizing lymphadenitis (Kikuchi lymphadenitis), myositis, myocarditis, rhabdomyolysis, motor dysfunction, vasculitis, and myasthenic syndrome.

Infusion Reactions

OPDIVO can cause severe infusion reactions, which have been reported in <1.0% of patients in clinical trials. Discontinue OPDIVO in patients with Grade 3 or 4 infusion reactions. Interrupt or slow the rate of infusion in patients with Grade 1 or 2. In patients receiving OPDIVO monotherapy, infusion-related reactions occurred in 6.4% (127/1994) of patients. In patients receiving OPDIVO with YERVOY, infusion-related reactions occurred in 2.5% (10/407) of patients.

Complications of Allogeneic HSCT after OPDIVO

Complications, including fatal events, occurred in patients who received allogeneic HSCT after OPDIVO. Outcomes were evaluated in 17 patients from Checkmate 205 and 039, who underwent allogeneic HSCT after discontinuing OPDIVO (15 with reduced-intensity conditioning, 2 with myeloablative conditioning). Thirty-five percent (6/17) of patients died from complications of allogeneic HSCT after OPDIVO. Five deaths occurred in the setting of

severe or refractory GVHD. Grade 3 or higher acute GVHD was reported in 29% (5/17) of patients. Hyperacute GVHD was reported in 20% (n=2) of patients. A steroid-requiring febrile syndrome, without an identified infectious cause, was reported in 35% (n=6) of patients. Two cases of encephalitis were reported: Grade 3 (n=1) lymphocytic encephalitis without an identified infectious cause, and Grade 3 (n=1) suspected viral encephalitis. Hepatic veno-occlusive disease (VOD) occurred in one patient, who received reduced-intensity conditioned allogeneic HSCT and died of GVHD and multi-organ failure. Other cases of hepatic VOD after reduced-intensity conditioned allogeneic HSCT have also been reported in patients with lymphoma who received a PD-1 receptor blocking antibody before transplantation. Cases of fatal hyperacute GVHD have also been reported. These complications may occur despite intervening therapy between PD-1 blockade and allogeneic HSCT.

Follow patients closely for early evidence of transplant-related complications such as hyperacute GVHD, severe (Grade 3 to 4) acute GVHD, steroid-requiring febrile syndrome, hepatic VOD, and other immune-mediated adverse reactions, and intervene promptly.

Embryo-Fetal Toxicity

Based on their mechanisms of action, OPDIVO and YERVOY can cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with an OPDIVO- or YERVOY- containing regimen and for at least 5 months after the last dose of OPDIVO.

Lactation

It is not known whether OPDIVO or YERVOY is present in human milk. Because many drugs, including antibodies, are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from an OPDIVO-containing regimen, advise women to discontinue breastfeeding during treatment. Advise women to discontinue nursing during treatment with YERVOY and for 3 months following the final dose.

Serious Adverse Reactions

In Checkmate 037, serious adverse reactions occurred in 41% of patients receiving OPDIVO (n=268). Grade 3 and 4 adverse reactions occurred in 42% of patients receiving OPDIVO. The most frequent Grade 3 and 4 adverse drug reactions reported in 2% to <5% of patients receiving OPDIVO were abdominal pain, hyponatremia, increased aspartate aminotransferase, and increased lipase. In Checkmate 066, serious adverse reactions occurred in 36% of patients receiving OPDIVO (n=206). Grade 3 and 4 adverse reactions occurred in 41% of patients receiving OPDIVO. The most frequent Grade 3 and 4 adverse reactions reported in $\geq 2\%$ of patients receiving OPDIVO were gamma-glutamyltransferase increase (3.9%) and diarrhea (3.4%). In Checkmate 067, serious adverse reactions (73% and 37%), adverse reactions leading to permanent discontinuation (43% and 14%) or to dosing delays (55% and 28%), and Grade 3 or 4 adverse reactions (72% and 44%) all occurred more frequently in the OPDIVO plus YERVOY arm (n=313) relative to the OPDIVO arm (n=313). The most frequent ($\geq 10\%$) serious adverse reactions in the OPDIVO plus YERVOY arm and the OPDIVO arm, respectively, were diarrhea (13% and 2.6%), colitis (10% and 1.6%), and pyrexia (10% and 0.6%). In Checkmate 017 and 057, serious adverse reactions occurred in

46% of patients receiving OPDIVO (n=418). The most frequent serious adverse reactions reported in at least 2% of patients receiving OPDIVO were pneumonia, pulmonary embolism, dyspnea, pyrexia, pleural effusion, pneumonitis, and respiratory failure. In Checkmate 025, serious adverse reactions occurred in 47% of patients receiving OPDIVO (n=406). The most frequent serious adverse reactions reported in $\geq 2\%$ of patients were acute kidney injury, pleural effusion, pneumonia, diarrhea, and hypercalcemia. In Checkmate 205 and 039, among all patients (safety population [n=263]), adverse reactions leading to discontinuation (4.2%) or to dosing delays (23%) occurred. The most frequent serious adverse reactions reported in $\geq 1\%$ of patients were infusion-related reaction, pneumonia, pleural effusion, pyrexia, rash and pneumonitis. Ten patients died from causes other than disease progression, including 6 who died from complications of allogeneic HSCT. Serious adverse reactions occurred in 21% of patients in the safety population (n=263) and 27% of patients in the subset of patients evaluated for efficacy (efficacy population [n=95]). In Checkmate 141, serious adverse reactions occurred in 49% of patients receiving OPDIVO. The most frequent serious adverse reactions reported in at least 2% of patients receiving OPDIVO were pneumonia, dyspnea, respiratory failure, respiratory tract infections, and sepsis. In Checkmate 275, serious adverse reactions occurred in 54% of patients receiving OPDIVO (n=270). The most frequent serious adverse reactions reported in at least 2% of patients receiving OPDIVO were urinary tract infection, sepsis, diarrhea, small intestine obstruction, and general physical health deterioration.

Common Adverse Reactions

In Checkmate 037, the most common adverse reaction ($\geq 20\%$) reported with OPDIVO (n=268) was rash (21%). In Checkmate 066, the most common adverse reactions ($\geq 20\%$) reported with OPDIVO (n=206) vs dacarbazine (n=205) were fatigue (49% vs 39%), musculoskeletal pain (32% vs 25%), rash (28% vs 12%), and pruritus (23% vs 12%). In Checkmate 067, the most common ($\geq 20\%$) adverse reactions in the OPDIVO plus YERVOY arm (n=313) were fatigue (59%), rash (53%), diarrhea (52%), nausea (40%), pyrexia (37%), vomiting (28%), and dyspnea (20%). The most common ($\geq 20\%$) adverse reactions in the OPDIVO (n=313) arm were fatigue (53%), rash (40%), diarrhea (31%), and nausea (28%). In Checkmate 017 and 057, the most common adverse reactions ($\geq 20\%$) in patients receiving OPDIVO (n=418) were fatigue, musculoskeletal pain, cough, dyspnea, and decreased appetite. In Checkmate 025, the most common adverse reactions ($\geq 20\%$) reported in patients receiving OPDIVO (n=406) vs everolimus (n=397) were asthenic conditions (56% vs 57%), cough (34% vs 38%), nausea (28% vs 29%), rash (28% vs 36%), dyspnea (27% vs 31%), diarrhea (25% vs 32%), constipation (23% vs 18%), decreased appetite (23% vs 30%), back pain (21% vs 16%), and arthralgia (20% vs 14%). In Checkmate 205 and 039, among all patients (safety population [n=263]) and the subset of patients in the efficacy population (n=95), respectively, the most common adverse reactions ($\geq 20\%$) were fatigue (32% and 43%), upper respiratory tract infection (28% and 48%), pyrexia (24% and 35%), diarrhea (23% and 30%), and cough (22% and 35%). In the subset of patients in the efficacy population (n=95), the most common adverse reactions also included rash (31%), musculoskeletal pain (27%), pruritus (25%), nausea (23%), arthralgia (21%), and peripheral neuropathy (21%). In Checkmate 141, the most common adverse reactions ($\geq 10\%$) in patients receiving OPDIVO were cough and dyspnea at a higher incidence than investigator's choice. In Checkmate 275, the most common adverse reactions ($\geq 20\%$) reported in patients receiving OPDIVO (n=270) were fatigue (46%), musculoskeletal pain (30%), nausea (22%), and decreased appetite (22%).

In a separate Phase 3 study of YERVOY 3 mg/kg, the most common adverse reactions ($\geq 5\%$) in patients who received YERVOY at 3 mg/kg were fatigue (41%), diarrhea (32%), pruritus (31%), rash (29%), and colitis (8%).

Checkmate Trials and Patient Populations

Checkmate 067 - advanced melanoma alone or in combination with YERVOY; **Checkmate 037 and 066** - advanced melanoma; **Checkmate 017** - squamous non-small cell lung cancer (NSCLC); **Checkmate 057** - non-squamous NSCLC; **Checkmate 025** - renal cell carcinoma; **Checkmate 205/039** - classical Hodgkin lymphoma; **Checkmate 141** – squamous cell carcinoma of the head and neck; **Checkmate 275** - urothelial carcinoma.

Please see U.S. Full Prescribing Information for [OPDIVO](#) and [YERVOY](#), including **Boxed WARNING** regarding immune-mediated adverse reactions for YERVOY.

About the Bristol-Myers Squibb and Ono Pharmaceutical Co., Ltd. Collaboration

In 2011, through a collaboration agreement with Ono Pharmaceutical Co., Ltd (Ono), Bristol-Myers Squibb expanded its territorial rights to develop and commercialize *Opdivo* globally except in Japan, South Korea and Taiwan, where Ono had retained all rights to the compound at the time. On July 23, 2014, Bristol-Myers Squibb and Ono further expanded the companies' strategic collaboration agreement to jointly develop and commercialize multiple immunotherapies – as single agents and combination regimens – for patients with cancer in Japan, South Korea and Taiwan.

About Bristol-Myers Squibb

Bristol-Myers Squibb is a global biopharmaceutical company whose mission is to discover, develop and deliver innovative medicines that help patients prevail over serious diseases. For more information about Bristol-Myers Squibb, visit us at BMS.com or follow us on [LinkedIn](#), [Twitter](#), [YouTube](#) and [Facebook](#).

Bristol-Myers Squibb Forward-Looking Statement

This press release contains "forward-looking statements" as that term is defined in the Private Securities Litigation Reform Act of 1995 regarding the research, development and commercialization of pharmaceutical products. Such forward-looking statements are based on current expectations and involve inherent risks and uncertainties, including factors that could delay, divert or change any of them, and could cause actual outcomes and results to differ materially from current expectations. No forward-looking statement can be guaranteed.



Forward-looking statements in this press release should be evaluated together with the many uncertainties that affect Bristol-Myers Squibb's business, particularly those identified in the cautionary factors discussion in Bristol-Myers Squibb's Annual Report on Form 10-K for the year ended December 31, 2016 in our Quarterly Reports on Form 10-Q and our Current Reports on Form 8-K. Bristol-Myers Squibb undertakes no obligation to publicly update any forward-looking statement, whether as a result of new information, future events or otherwise.

###

Contacts

Media:

Audrey Abernathy, 919-605-4521
audrey.abernathy@bms.com

Investors:

Tim Power, 609-252-7509
timothy.power@bms.com

Bill Szablewski, 609-252-5894
william.szablewski@bms.com