Pfizer Logo

Pfizer to Showcase Progress of Broad-Based Oncology Portfolio at European Society for Medical Oncology (ESMO) 2016 Congress

Wednesday, September 28, 2016 - 02:00am

20 abstracts across multiple tumor types; unique mechanisms of action address the diverse needs of people living with cancer New combination study data in renal cell carcinoma and first-in-human results for OX40 agonist provide new insights in immuno-oncology

“Pfizer looks forward to sharing news from our diverse and growing oncology portfolio, particularly in the area of novel immunotherapies and combination approaches.”

Pfizer Inc. (NYSE:PFE) today announced that it will be presenting data from 20 abstracts, including three late-breakers, at the European Society for Medical Oncology (ESMO) 2016 Congress in Copenhagen from October 7-11, 2016. The presentations demonstrate progress addressing cancer’s complex challenges through our work across 11 tumor types and eight distinct mechanisms of action, including two immuno-oncology/targeted therapy combination studies in renal cell carcinoma (RCC).

“Pfizer looks forward to sharing news from our diverse and growing oncology portfolio, particularly in the area of novel immunotherapies and combination approaches,” said Liz Barrett, global president and general manager, Pfizer Oncology. “We are also particularly pleased to present new data from our RCC franchise, where Pfizer has established itself as a leader in driving meaningful progress through significant contributions in RCC research and development.”

Pfizer will present data from three late-breaker abstracts at this year’s ESMO, including results from the S-TRAC clinical trial (Sunitinib Trial in Adjuvant Renal Cancer), a Phase 3 study of SUTENT® (sunitinib) versus placebo in the adjuvant setting, during a Presidential Symposium. Other late-breakers include early data from a Phase 1 study of PF-06647020, a novel antibody-drug conjugate (ADC) candidate targeting PTK7, a receptor tyrosine kinase associated with poorer prognosis that is expressed in many tumor types, and a biomarker analysis from the Phase 3 PALOMA-2 trial of IBRANCE® (palbociclib) in combination with letrozole in postmenopausal women with estrogen receptor-positive, human epidermal growth factor 2-negative (ER+/HER2–) metastatic breast cancer. These data for IBRANCE as well as health-related quality of life data from PALOMA-2 being presented as a poster discussion add to the growing body of evidence supporting the use of IBRANCE in this patient population.

Among six abstracts selected for poster discussion presentation at the meeting, four will address development efforts from Pfizer’s growing immuno-oncology pipeline. Highlights include data from two advanced RCC studies of INLYTA® (axitinib) in combination with different checkpoint inhibitors, including one study in

combination with avelumab, an anti-PD-L1 IgG1 monoclonal antibody being developed through an Alliance between Pfizer and Merck KGaA, Darmstadt, Germany. Pfizer will also present the latest safety, anti-tumor activity and biomarker data from the first-in-human single-agent study of Pfizer's investigational immunotherapy PF-04518600, an OX40 agonist, in a variety of advanced cancers. These preliminary results evaluating 25 patients suggest that PF-04518600 is tolerated up to 3 mg/kg and showed early anti-tumor activity.

Additionally, an updated data set from PROFILE 1001, a multicenter, single-arm Phase 1 study that examined use of XALKORI® (crizotinib) in patients with ROS1-positive advanced non-small cell lung cancer (NSCLC), will be presented. This analysis was used to support the recent approval of XALKORI in the European Union for patients with advanced NSCLC whose tumors are ROS1-positive.

A full list of the Pfizer-sponsored late-breaker and poster discussions at ESMO is included below.

Pfizer-sponsored late-breakers at ESMO include:

Abstract Number/Title/Presenter	**Presentation Type**	**Date/Time (All Times CEST)**	**Location**
(Abstract LBA11_PR) Phase III trial of sunitinib (SU) vs placebo (PBO) as adjuvant treatment for high-risk renal cell carcinoma (RCC) after nephrectomy (S-TRAC) Ravaud A	Presidential Symposium	Monday, October 10 16:30-18:10	Copenhagen
(Abstract LBA15) Biomarker analyses from the Phase 3 PALOMA-2 trial of palbociclib (P) with letrozole (L) compared with placebo (PLB) plus L in postmenopausal women with ER+/HER2- advanced breast cancer (ABC) Finn R	Proffered Paper	Saturday, October 8 11:00-12:30	Vienna
(Abstract LBA35) A Phase 1 study of PF-06647020, an antibody-drug conjugate (ADC) targeting protein tyrosine kinase 7 (PTK7), in patients with advanced solid tumors including platinum resistant ovarian cancer (OVCA) Sachdev J	Poster Discussion	Saturday, October 8 9:30-10:30	Bern

Pfizer-sponsored poster discussions at ESMO include:

Abstract Number/Title/Presenter	Date/Time (All Times CEST)	Location
(Abstract 1206PD) Crizotinib in advanced ROS1-rearranged non-small cell lung cancer (NSCLC): updated results from PROFILE 1001 Shaw A	Sunday, October 9 14:45-16:15	Oslo
(Abstract 225PD) Impact of palbociclib plus letrozole on health related quality of life (HRQOL) compared with letrozole alone in treatment naïve postmenopausal patients with ER+ HER2- metastatic breast cancer (MBC): results from PALOMA-2 Rugo H	Sunday, October 9 16:30-17:30	Brussels
(Abstract 773PD) Axitinib in combination with pembrolizumab in patients (pts) with advanced renal cell carcinoma (aRCC): preliminary safety and efficacy results Atkins M	Sunday, October 9 16:30-17:30	Athens
(Abstract 775PD) Phase 1b dose-finding study of avelumab (anti-PD-L1) + axitinib in treatment-naïve patients with advanced renal cell carcinoma Larkin J	Sunday, October 9 16:30-17:30	Athens
(Abstract 777PD) Avelumab (MSB0010718C; anti-PD-L1) in patients with metastatic urothelial carcinoma progressed after platinum-based therapy or platinum ineligible Patel M	Sunday, October 9 16:30-17:30	Athens
(Abstract 1053PD) A first-in-human (FIH) study of PF-04518600 (PF-8600) OX40 agonist in adult patients (pts) with select advanced malignancies Diab A	Monday, October 10 9:30-10:30	Berlin

For a complete list of Pfizer-sponsored abstracts featuring data on our broad oncology pipeline of biologics, small molecules and immunotherapies, please visit: http://www.pfizer.com/files/news/esmo/Pfizer_Oncology_Data_Presentations_at_ESMO_2016.pdf

Learn more about how Pfizer Oncology is applying innovative approaches to improve the outlook for people living with cancer at http://www.pfizer.com/research/therapeutic_areas/oncology.

About IBRANCE® (palbociclib)

IBRANCE is an oral inhibitor of cyclin dependent kinases (CDKs) 4 and 6,[i] which are key regulators of the cell cycle that trigger cellular progression.[ii,iii] In the U.S., IBRANCE is indicated for the treatment of hormone receptor-positive (HR+), HER2- advanced or metastatic breast cancer in combination with letrozole as initial endocrine based therapy in postmenopausal women, or fulvestrant in women with disease progression following endocrine therapy.[i] The indication in combination with letrozole is approved under accelerated approval based on progression-free survival (PFS). Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.[i]

IBRANCE Important Safety Information

Neutropenia was the most frequently reported adverse reaction in Study 1 (PALOMA-1) (75%) and Study 2 (PALOMA-3) (83%). In Study 1, Grade 3 (57%) or 4 (5%) decreased neutrophil counts were reported in patients receiving IBRANCE plus letrozole. In Study 2, Grade 3 (56%) or Grade 4 (11%) decreased neutrophil counts were reported in patients receiving IBRANCE plus fulvestrant. Febrile neutropenia has been reported in about 1% of patients exposed to IBRANCE. One death due to neutropenic sepsis was observed in Study 2. Inform patients to promptly report any fever.

Monitor complete blood count prior to starting IBRANCE, at the beginning of each cycle, on Day 14 of first 2 cycles, and as clinically indicated. Dose interruption, dose reduction, or delay in starting treatment cycles is recommended for patients who develop Grade 3 or 4 neutropenia.

Pulmonary embolism (PE) has been reported at a higher rate in patients treated with IBRANCE plus letrozole in Study 1 (5%) and in patients treated with IBRANCE plus fulvestrant in Study 2 (1%) compared with no cases in patients treated either with letrozole alone or fulvestrant plus placebo. Monitor for signs and symptoms of PE and treat as medically appropriate.

Based on the mechanism of action, IBRANCE can cause **fetal harm**. Advise females of reproductive potential to use effective contraception during IBRANCE treatment and for at least 3 weeks after the last dose. IBRANCE may **impair fertility in males** and has the potential to cause genotoxicity. Advise male patients with female partners of reproductive potential to use effective contraception during IBRANCE treatment and for 3 months after the last dose. Advise females to inform their healthcare provider of a known or suspected pregnancy. Advise women **not to breastfeed** during IBRANCE treatment and for 3 weeks after the last dose because of the potential for serious adverse reactions in nursing infants.

The **most common adverse reactions (?10%)** of any grade reported in **Study 1** of IBRANCE plus letrozole vs letrozole alone included neutropenia (75% vs 5%), leukopenia (43% vs 3%), fatigue (41% vs 23%), anemia (35% vs 7%), upper respiratory infection (31% vs 18%), nausea (25% vs 13%), stomatitis (25% vs 7%), alopecia (22% vs 3%), diarrhea (21% vs 10%), thrombocytopenia (17% vs 1%), decreased appetite (16% vs 7%), vomiting (15% vs 4%), asthenia (13% vs 4%), peripheral neuropathy (13% vs 5%), and epistaxis (11% vs 1%).

Grade 3/4 adverse reactions (?10%) in **Study 1** reported at a higher incidence in the IBRANCE plus letrozole group vs the letrozole alone group included neutropenia (54% vs 1%) and leukopenia (19% vs 0%). The most frequently reported serious adverse events in patients receiving IBRANCE plus letrozole were pulmonary embolism (4%) and diarrhea (2%).

Lab abnormalities occurring in **Study 1** (all grades, IBRANCE plus letrozole vs letrozole alone) were decreased WBC (95% vs 26%), decreased neutrophils (94% vs 17%), decreased lymphocytes (81% vs 35%), decreased hemoglobin (83% vs 40%), and decreased platelets (61% vs 16%).

The **most common adverse reactions (?10%)** of any grade reported in **Study 2** of IBRANCE plus fulvestrant vs fulvestrant plus placebo included neutropenia (83% vs 4%), leukopenia (53% vs 5%), infections (47% vs 31%), fatigue (41% vs 29%), nausea (34% vs 28%), anemia (30% vs 13%), stomatitis (28% vs 13%), headache (26% vs 20%), diarrhea (24% vs 19%), thrombocytopenia (23% vs 0%), constipation (20% vs 16%), vomiting (19% vs 15%), alopecia (18% vs 6%), rash (17% vs 6%), decreased appetite (16% vs 8%), and pyrexia (13% vs 5%).

Grade 3/4 adverse reactions (?10%) in **Study 2** reported at a higher incidence in the IBRANCE plus fulvestrant group vs the fulvestrant plus placebo group included neutropenia (66% vs 1%) and leukopenia (31% vs 2%). The most frequently reported serious adverse reactions in patients receiving IBRANCE plus fulvestrant were infections (3%), pyrexia (1%), neutropenia (1%), and pulmonary embolism (1%).

Lab abnormalities occurring in **Study 2** (all grades, IBRANCE plus fulvestrant vs fulvestrant plus placebo) were decreased WBC (99% vs 26%), decreased neutrophils (96% vs 14%), anemia (78% vs 40%), and decreased platelets (62% vs 10%).

Avoid concurrent use of **strong CYP3A inhibitors**. If patients must be administered a strong CYP3A inhibitor, reduce the IBRANCE dose to 75 mg/day. If the strong inhibitor is discontinued, increase the IBRANCE dose (after 3-5 half-lives of the inhibitor) to the dose used prior to the initiation of the strong CYP3A inhibitor. Grapefruit or grapefruit juice may increase plasma concentrations of IBRANCE and should be avoided. Avoid concomitant use of **strong CYP3A inducers**. The dose of **sensitive CYP3A substrates** with a narrow therapeutic index may need to be reduced as IBRANCE may increase their exposure.

IBRANCE **has not been studied** in patients with **moderate to severe hepatic impairment** or in patients with **severe renal impairment** (CrCl <30 mL/min).

The full prescribing information for IBRANCE can be found at www.pfizer.com.

About INLYTA® (axitinib)

INLYTA, a kinase inhibitor, is an oral therapy that is designed to inhibit tyrosine kinases, including vascular endothelial growth factor (VEGF) receptors 1, 2 and 3; these receptors can influence tumor growth, vascular angiogenesis and progression of cancer (the spread of tumors). In the U.S., INLYTA is approved for the treatment of advanced renal cell carcinoma (RCC) after failure of one prior systemic therapy.

INLYTA Important Safety Information

Hypertension including hypertensive crisis has been observed. Blood pressure should be well controlled prior to initiating INLYTA. Monitor for hypertension and treat as needed. For persistent hypertension, despite use of antihypertensive medications, reduce the dose. Discontinue INLYTA if hypertension is severe and persistent despite use of antihypertensive therapy and dose reduction of INLYTA, and discontinuation should be considered if there is evidence of hypertensive crisis.

Arterial and venous thrombotic events have been observed and can be fatal. Use with caution in patients who are at increased risk or who have a history of these events.

Hemorrhagic events, including fatal events, have been reported. INLYTA has not been studied in patients with evidence of untreated brain metastasis or recent active gastrointestinal bleeding and should not be used in those patients. If any bleeding requires medical intervention, temporarily interrupt the INLYTA dose.

Cardiac failure has been observed and can be fatal. Monitor for signs or symptoms of cardiac failure throughout treatment with INLYTA. Management of cardiac failure may require permanent discontinuation of INLYTA.

Gastrointestinal perforation and fistula, including death, have occurred. Use with caution in patients at risk for gastrointestinal perforation or fistula. Monitor for symptoms of gastrointestinal perforation or fistula periodically throughout treatment.

Hypothyroidism requiring thyroid hormone replacement has been reported. Monitor thyroid function before initiation of, and periodically throughout, treatment.

No formal studies of the effect of INLYTA on wound healing have been conducted. Stop INLYTA at least 24 hours prior to scheduled surgery.

Reversible Posterior Leukoencephalopathy Syndrome (RPLS) has been observed. If signs or symptoms occur, permanently discontinue treatment.

Monitor for proteinuria before initiation of, and periodically throughout, treatment. For moderate to severe proteinuria, reduce the dose or temporarily interrupt treatment.

Liver enzyme elevation has been observed during treatment with INLYTA. Monitor ALT, AST, and bilirubin before initiation of, and periodically throughout, treatment.

For patients with moderate hepatic impairment, the starting dose should be decreased. INLYTA has not been studied in patients with severe hepatic impairment.

Women of childbearing potential should be advised of potential hazard to the fetus and to avoid becoming pregnant while receiving INLYTA.

Avoid strong CYP3A4/5 inhibitors. If unavoidable, reduce the dose. Grapefruit or grapefruit juice may also increase INLYTA plasma concentrations and should be avoided.

Avoid strong CYP3A4/5 inducers and, if possible, avoid moderate CYP3A4/5 inducers.

The most common (?20%) adverse events (AEs) occurring in patients receiving INLYTA (all grades, vs sorafenib) were diarrhea (55% vs 53%), hypertension (40% vs 29%), fatigue (39% vs 32%), decreased appetite (34% vs 29%), nausea (32% vs 22%), dysphonia (31% vs 14%), hand-foot syndrome (27% vs 51%), weight decreased (25% vs 21%), vomiting (24% vs 17%), asthenia (21% vs 14%), and constipation (20% vs 20%).

The most common (?10%) grade 3/4 AEs occurring in patients receiving INLYTA (vs sorafenib) were hypertension (16% vs 11%), diarrhea (11% vs 7%), and fatigue (11% vs 5%).

The most common (?20%) lab abnormalities occurring in patients receiving INLYTA (all grades, vs sorafenib) included increased creatinine (55% vs 41%), decreased bicarbonate (44% vs 43%), hypocalcemia (39% vs 59%), decreased hemoglobin (35% vs 52%), decreased lymphocytes (absolute) (33% vs 36%), increased ALP (30% vs 34%), hyperglycemia (28% vs 23%), increased lipase (27% vs 46%), increased amylase (25% vs 33%), increased ALT (22% vs 22%), and increased AST (20% vs 25%).

For more information and full Prescribing Information, visit www.pfizer.com.

About SUTENT® (sunitinib malate)

SUTENT is an oral multi-kinase inhibitor that works by blocking multiple molecular targets implicated in the growth, proliferation and spread of cancer. Two important SUTENT targets, vascular endothelial growth factor receptor (VEGFR) and platelet-derived growth factor receptor (PDGFR) are expressed by many types of solid tumors and are thought to play a crucial role in angiogenesis, the process by which tumors acquire blood vessels, oxygen and nutrients needed for growth. SUTENT also inhibits other targets important to tumor growth, including KIT, FLT3 and RET.

SUTENT is indicated for the treatment of advanced renal cell carcinoma (RCC), gastrointestinal stromal tumor (GIST) after disease progression on or intolerance to imatinib mesylate, and progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) in patients with unresectable locally advanced or metastatic disease.

SUTENT Important Safety Information

Boxed Warning/Hepatotoxicity: **Hepatotoxicity has been observed in clinical trials and post-marketing experience. This hepatotoxicity may be severe, and deaths have been reported.** Monitor liver function tests before initiation of treatment, during each cycle of treatment, and as clinically indicated. SUTENT should be interrupted for Grade 3 or 4 drug-related hepatic adverse events and discontinued if there is no resolution. Do not restart SUTENT if patients subsequently experience severe changes in liver function tests or have other signs and symptoms of liver failure.

Pregnancy: Women of childbearing potential should be advised of the potential hazard to the fetus and to avoid becoming pregnant.

Nursing mothers: Given the potential for serious adverse reactions (ARs) in nursing infants, a decision should be made whether to discontinue nursing or SUTENT.

Cardiovascular events: Cardiovascular events, including heart failure, cardiomyopathy, myocardial ischemia, and myocardial infarction, some of which were fatal, have been reported. Use SUTENT with caution in patients who are at risk for, or who have a history of, these events. Monitor patients for signs and symptoms of congestive heart failure (CHF) and, in the presence of clinical manifestations, discontinuation is recommended. Patients who presented with cardiac events, pulmonary embolism, or cerebrovascular events within the previous 12 months were excluded from clinical studies.

QT interval prolongation and Torsades de Pointes: SUTENT has been shown to prolong QT interval in a dose-dependent manner, which may lead to an increased risk for ventricular arrhythmias including Torsades de Pointes, which has been seen in <0.1% of patients. Monitoring with on-treatment electrocardiograms and electrolytes should be considered.

Hypertension: Hypertension may occur. Monitor blood pressure and treat as needed with standard antihypertensive therapy. In cases of severe hypertension, temporary suspension of SUTENT is recommended until hypertension is controlled.

Reversible posterior leukoencephalopathy syndrome (RPLS): There have been (<1%) reports, some fatal, of subjects presenting with seizures and radiological evidence of RPLS.

Hemorrhagic events: Hemorrhagic events, including tumor-related hemorrhage such as pulmonary hemorrhage, have occurred. Some of these events were fatal. Perform serial complete blood counts (CBCs) and physical examinations.

Tumor lysis syndrome (TLS): Cases of TLS have been reported primarily in patients with high tumor burden. Monitor these patients closely and treat as clinically indicated.

Thrombotic microangiopathy (TMA): TMA, including thrombotic thrombocytopenic purpura and hemolytic uremic syndrome, sometimes leading to renal failure or a fatal outcome, has been reported in patients who received SUTENT as monotherapy and in combination with bevacizumab. Discontinue SUTENT in patients developing TMA. Reversal of the effects of TMA has been observed after treatment was discontinued.

Proteinuria: Proteinuria and nephrotic syndrome have been reported. Some of these cases have resulted in renal failure and fatal outcomes. Perform baseline and periodic urinalysis during treatment, with follow-up measurement of 24-hour urine protein as clinically indicated. Interrupt SUTENT and dose reduce if 24-hour urine protein is ?3 g; discontinue SUTENT in cases of nephrotic syndrome or repeat episodes of urine protein ?3 g despite dose reductions.

Dermatologic toxicities: Severe cutaneous reactions have been reported, including cases of erythema multiforme (EM), Stevens-Johnson syndrome (SJS), and toxic epidermal necrolysis (TEN), some of which were fatal. If signs or symptoms of EM, SJS, or TEN are present, SUTENT treatment should be discontinued. If a diagnosis of SJS or TEN is suspected, treatment must not be re-started. Necrotizing fasciitis, including fatal cases, has been reported, including of the perineum and secondary to fistula formation. Discontinue SUTENT in patients who develop necrotizing fasciitis.

Thyroid dysfunction: Thyroid dysfunction may occur. Monitor thyroid function in patients with signs and/or symptoms of thyroid dysfunction, including hypothyroidism, hyperthyroidism, and thyroiditis, and treat per standard medical practice.

Hypoglycemia: SUTENT has been associated with symptomatic hypoglycemia, which may result in loss of consciousness or require hospitalization. Reductions in blood glucose levels may be worse in patients with diabetes. Check blood glucose levels regularly during and after discontinuation of SUTENT. Assess whether anti-diabetic drug dosage needs to be adjusted to minimize the risk of hypoglycemia.

Osteonecrosis of the jaw (ONJ): ONJ has been reported. Consider preventive dentistry prior to treatment with SUTENT. If possible, avoid invasive dental procedures, particularly in patients receiving bisphosphonates.

Wound healing: Cases of impaired wound healing have been reported. Temporary interruption of therapy with SUTENT is recommended in patients undergoing major surgical procedures.

Adrenal function: Adrenal hemorrhage was observed in animal studies. Monitor adrenal function in case of stress such as surgery, trauma, or severe infection.

Laboratory tests: CBCs with platelet count and serum chemistries including phosphate should be performed at the beginning of each treatment cycle for patients receiving treatment with SUTENT.

CYP3A4 coadministration: Dose adjustments are recommended when SUTENT is administered with CYP3A4 inhibitors or inducers. During treatment with SUTENT, patients should not drink grapefruit juice, eat grapefruit, or take St John's Wort.

Most common ARs & most common grade 3/4 ARs (advanced RCC): The most common ARs occurring in ? 20% of patients receiving SUTENT for treatment-naïve metastatic RCC (all grades, vs IFN?) were diarrhea (66% vs 21%), fatigue (62% vs 56%), nausea (58% vs 41%), anorexia (48% vs 42%), altered taste (47% vs 15%), mucositis/stomatitis (47% vs 5%), pain in extremity/limb discomfort (40% vs 30%), vomiting (39% vs

17%), bleeding, all sites (37% vs 10%), hypertension (34% vs 4%), dyspepsia (34% vs 4%), arthralgia (30% vs 19%), abdominal pain (30% vs 12%), rash (29% vs 11%), hand-foot syndrome (29% vs 1%), back pain (28% vs 14%), cough (27% vs 14%), asthenia (26% vs 22%), dyspnea (26% vs 20%), skin discoloration/yellow skin (25% vs 0%), peripheral edema (24% vs 5%), headache (23% vs 19%), constipation (23% vs 14%), dry skin (23% vs 7%), fever (22% vs 37%), and hair color changes (20% vs <1%). The most common grade 3/4 ARs (occurring in ?5% of patients with RCC receiving SUTENT vs IFN?) were fatigue (15% vs 15%), hypertension (13% vs <1%), asthenia (11% vs 6%), diarrhea (10% vs <1%), hand-foot syndrome (8% vs 0%), dyspnea (6% vs 4%), nausea (6% vs 2%), back pain (5% vs 2%), pain in extremity/limb discomfort (5% vs 2%), vomiting (5% vs 1%), and abdominal pain (5% vs 1%).

Most common grade 3/4 lab abnormalities (advanced RCC): The most common grade 3/4 lab abnormalities (occurring in ?5% of patients with RCC receiving SUTENT vs IFN?) included lymphocytes (18% vs 26%), lipase (18% vs 8%), neutrophils (17% vs 9%), uric acid (14% vs 8%), platelets (9% vs 1%), hemoglobin (8% vs 5%), sodium decreased (8% vs 4%), leukocytes (8% vs 2%), glucose increased (6% vs 6%), phosphorus (6% vs 6%), and amylase (6% vs 3%).

Most common ARs & most common grade 3/4 ARs (imatinib-resistant or -intolerant GIST): The most common ARs occurring in ?20% of patients with GIST and more commonly with SUTENT than placebo (all grades, vs placebo) were diarrhea (40% vs 27%), anorexia (33% vs 29%), skin discoloration (30% vs 23%), mucositis/stomatitis (29% vs 18%), asthenia (22% vs 11%), altered taste (21% vs 12%), and constipation (20% vs 14%). The most common grade 3/4 ARs (occurring in ?4% of patients with GIST receiving SUTENT vs placebo) were asthenia (5% vs 3%), hand-foot syndrome (4% vs 3%), diarrhea (4% vs 0%), and hypertension (4% vs 0%).

Most common grade 3/4 lab abnormalities (imatinib-resistant or -intolerant GIST): The most common grade 3/4 lab abnormalities (occurring in ?5% of patients with GIST receiving SUTENT vs placebo) included lipase (10% vs 7%), neutrophils (10% vs 0%), amylase (5% vs 3%), and platelets (5% vs 0%).

Most common ARs & most common grade 3/4 ARs (advanced pNET): The most common ARs occurring in ?20% of patients with advanced pNET and more commonly with SUTENT than placebo (all grades, vs placebo) were diarrhea (59% vs 39%), stomatitis/oral syndromes (48% vs 18%), nausea (45% vs 29%), abdominal pain (39% vs 34%), vomiting (34% vs 31%), asthenia (34% vs 27%), fatigue (33% vs 27%), hair color changes (29% vs 1%), hypertension (27% vs 5%), hand-foot syndrome (23% vs 2%), bleeding events (22% vs 10%), epistaxis (21% vs 5%), and dysgeusia (21% vs 5%). The most commonly reported grade 3/4 ARs (occurring in ?5% of patients with advanced pNET receiving SUTENT vs placebo) were hypertension (10% vs 1%), hand-foot syndrome (6% vs 0%), stomatitis/oral syndromes (6% vs 0%), abdominal pain (5% vs 10%), fatigue (5% vs 9%), asthenia (5% vs 4%), and diarrhea (5% vs 2%).

Most common grade 3/4 lab abnormalities (advanced pNET): The most common grade 3/4 lab abnormalities (occurring in ?5% of patients with advanced pNET receiving SUTENT vs placebo) included decreased neutrophils (16% vs 0%), increased glucose (12% vs 18%), increased alkaline phosphatase (10% vs 11%), decreased phosphorus (7% vs 5%), decreased lymphocytes (7% vs 4%), increased creatinine (5% vs 5%), increased lipase (5% vs 4%), increased AST (5% vs 3%), and decreased platelets (5% vs 0%).

Please see ***full Prescribing Information***, **including BOXED WARNING and Medication Guide, for SUTENT® (sunitinib malate)**.

About XALKORI® (crizotinib)

XALKORI is indicated for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test. XALKORI is also indicated for the treatment of patients with metastatic NSCLC whose tumors are ROS1-positive.

XALKORI Important Safety Information

Hepatotoxicity: Drug-induced hepatotoxicity with fatal outcome occurred in 0.1% of patients treated with XALKORI across clinical trials (n=1719). Transaminase elevations generally occurred within the first 2 months. Monitor with liver function tests including ALT, AST, and total bilirubin every 2 weeks during the first 2 months of treatment, then once a month and as clinically indicated, with more frequent repeat testing for increased liver transaminases, alkaline phosphatase, or total bilirubin in patients who develop transaminase elevations. Permanently discontinue for ALT/AST elevation >3 times ULN with concurrent total bilirubin elevation >1.5 times ULN (in the absence of cholestasis or hemolysis); otherwise, temporarily suspend and dose-reduce XALKORI as indicated.

Interstitial Lung Disease (Pneumonitis): Severe, life-threatening, or fatal interstitial lung disease (ILD)/pneumonitis can occur. Across clinical trials (n=1719), 2.9% of XALKORI-treated patients had any grade ILD, 1.0% had Grade 3/4, and 0.5% had fatal ILD. ILD generally occurred within 3 months after initiation of treatment. Monitor for pulmonary symptoms indicative of ILD/pneumonitis. Exclude other potential causes and permanently discontinue XALKORI in patients with drug-related ILD/pneumonitis.

QT Interval Prolongation: QTc prolongation can occur. Across clinical trials (n=1616), 2.1% of patients had QTcF (corrected QT by the Fridericia method) ?500 ms and 5.0% had an increase from baseline QTcF ?60 ms by automated machine-read evaluation of ECGs. Avoid use in patients with congenital long QT syndrome. Monitor with ECGs and electrolytes in patients with congestive heart failure, bradyarrhythmias, electrolyte abnormalities, or who are taking medications that prolong the QT interval. Permanently discontinue XALKORI in patients who develop QTc >500 ms or ?60 ms change from baseline with Torsade de pointes, polymorphic ventricular tachycardia, or signs/symptoms of serious arrhythmia. Withhold XALKORI in patients who develop QTc >500 ms on at least 2 separate ECGs until recovery to a QTc ?480 ms, then resume at a reduced dose.

Bradycardia: Symptomatic bradycardia can occur. Across clinical trials, bradycardia occurred in 12.7% of patients treated with XALKORI (n=1719). Avoid use in combination with other agents known to cause bradycardia. Monitor heart rate and blood pressure regularly. In cases of symptomatic bradycardia that is not life-threatening, hold XALKORI until recovery to asymptomatic bradycardia or to a heart rate of ?60 bpm, re-evaluate the use of concomitant medications, and adjust the dose of XALKORI. Permanently discontinue for life-threatening bradycardia due to XALKORI; however, if associated with concomitant medications known to cause bradycardia or hypotension, hold XALKORI until recovery to asymptomatic bradycardia or to a heart rate of ?60 bpm. If concomitant medications can be adjusted or discontinued, restart XALKORI at 250 mg once daily with frequent monitoring.

Severe Visual Loss: Across clinical trials, the incidence of Grade 4 visual field defect with vision loss was 0.2% (n=1719). Discontinue XALKORI in patients with new onset of severe visual loss (best corrected vision less than 20/200 in one or both eyes). Perform an ophthalmological evaluation. There is insufficient information to characterize the risks of resumption of XALKORI in patients with a severe visual loss; a decision to resume should consider the potential benefits to the patient.

Vision Disorders: Most commonly visual impairment, photopsia, blurred vision or vitreous floaters, occurred in 63.1% of 1719 patients. The majority (95%) of these patients had Grade 1 visual adverse reactions. 0.8% of patients had Grade 3 and 0.2% had Grade 4 visual impairment. The majority of patients on the XALKORI arms in Studies 1 and 2 (>50%) reported visual disturbances which occurred at a frequency of 4-7 days each week,

lasted up to 1 minute, and had mild or no impact on daily activities.

Embryo-Fetal Toxicity: XALKORI can cause fetal harm when administered to a pregnant woman. Advise of the potential risk to the fetus. Advise females of reproductive potential and males with female partners of reproductive potential to use effective contraception during treatment and for at least 45 days (females) or 90 days (males) respectively, following the final dose of XALKORI.

ROS1-positive Metastatic NSCLC: Safety was evaluated in 50 patients with ROS1-positive metastatic NSCLC from a single-arm study, and was generally consistent with the safety profile of XALKORI evaluated in patients with ALK-positive metastatic NSCLC. Vision disorders occurred in 92% of patients in the ROS1 study; 90% of patients had Grade 1 vision disorders and 2% had Grade 2.

Adverse Reactions: Safety was evaluated in a phase 3 study in previously untreated patients with ALK-positive metastatic NSCLC randomized to XALKORI (n=171) or chemotherapy (n=169). Serious adverse events were reported in 34% of patients treated with XALKORI, the most frequent were dyspnea (4.1%) and pulmonary embolism (2.9%). Fatal adverse events in XALKORI-treated patients occurred in 2.3% of patients, consisting of septic shock, acute respiratory failure, and diabetic ketoacidosis. Common adverse reactions (all grades) occurring in ?25% and more commonly (?5%) in patients treated with XALKORI vs chemotherapy were vision disorder (71% vs 10%), diarrhea (61% vs 13%), edema (49% vs 12%), vomiting (46% vs 36%), constipation (43% vs 30%), upper respiratory infection (32% vs 12%), dysgeusia (26% vs 5%), and abdominal pain (26% vs 12%). Grade 3/4 reactions occurring at a ?2% higher incidence with XALKORI vs chemotherapy were QT prolongation (2% vs 0%), and constipation (2% vs 0%). In patients treated with XALKORI vs chemotherapy, the following occurred: elevation of ALT (any grade [79% vs 33%] or Grade 3/4 [15% vs 2%]); elevation of AST (any grade [66% vs 28%] or Grade 3/4 [8% vs 1%]); neutropenia (any grade [52% vs 59%] or Grade 3/4 [11% vs 16%]); lymphopenia (any grade [48% vs 53%] or Grade 3/4 [7% vs 13%]); hypophosphatemia (any grade [32% vs 21%] or Grade 3/4 [10% vs 6%]). In patients treated with XALKORI vs chemotherapy, renal cysts occurred (5% vs 1%). Nausea (56%), decreased appetite (30%), fatigue (29%), and neuropathy (21%) also occurred in patients taking XALKORI.

Drug Interactions: Exercise caution with concomitant use of moderate CYP3A inhibitors. Avoid grapefruit or grapefruit juice which may increase plasma concentrations of crizotinib. Avoid concomitant use of strong CYP3A inducers and inhibitors. Avoid concomitant use of CYP3A substrates with narrow therapeutic range in patients taking XALKORI. If concomitant use of CYP3A substrates with narrow therapeutic range is required in patients taking XALKORI, dose reductions of the CYP3A substrates may be required due to adverse reactions.

Lactation: Because of the potential for adverse reactions in breastfed infants, advise females not to breast feed during treatment with XALKORI and for 45 days after the final dose.

Hepatic Impairment: XALKORI has not been studied in patients with hepatic impairment. As crizotinib is extensively metabolized in the liver, hepatic impairment is likely to increase plasma crizotinib concentrations. Use caution in patients with hepatic impairment.

Renal Impairment: Decreases in estimated glomerular filtration rate occurred in patients treated with XALKORI. Administer XALKORI at a starting dose of 250 mg taken orally once daily in patients with severe renal impairment (CLcr <30 mL/min) not requiring dialysis. No starting dose adjustment is needed for patients with mild and moderate renal impairment.

For more information and full Prescribing Information, visit www.XALKORI.com.

About Pfizer Oncology

Pfizer Oncology is committed to pursuing innovative treatments that have a meaningful impact on those living with cancer. As a leader in oncology speeding cures and accessible breakthrough medicines to patients, Pfizer Oncology is helping to redefine life with cancer. Our strong pipeline of biologics, small molecules and immunotherapies, one of the most robust in the industry, is studied with precise focus on identifying and translating the best scientific breakthroughs into clinical application for patients across a wide range of cancers. By working collaboratively with academic institutions, individual researchers, cooperative research groups, governments and licensing partners, Pfizer Oncology strives to cure or control cancer with its breakthrough medicines. Because Pfizer Oncology knows that success in oncology is not measured solely by the medicines you manufacture, but rather by the meaningful partnerships you make to have a more positive impact on people's lives.

Pfizer Inc.: Working together for a healthier world™

At Pfizer, we apply science and our global resources to bring therapies to people that extend and significantly improve their lives. We strive to set the standard for quality, safety and value in the discovery, development and manufacture of healthcare products. Our global portfolio includes medicines and vaccines as well as many of the world's best-known consumer healthcare products. Every day, Pfizer colleagues work across developed and emerging markets to advance wellness, prevention, treatments and cures that challenge the most feared diseases of our time. Consistent with our responsibility as one of the world's premier innovative biopharmaceutical companies, we collaborate with health care providers, governments and local communities to support and expand access to reliable, affordable health care around the world. For more than 150 years, Pfizer has worked to make a difference for all who rely on us. For more information, please visit us at www.pfizer.com. In addition, to learn more, follow us on Twitter at @Pfizer and @Pfizer_News, LinkedIn, YouTube, and like us on Facebook at Facebook.com/Pfizer.

DISCLOSURE NOTICE: The information contained in this release is as of September 28, 2016. Pfizer assumes no obligation to update forward-looking statements contained in this release as the result of new information or future events or developments.

This release contains forward-looking information about Pfizer's oncology portfolio, including avelumab (MSB0010718C), IBRANCE (palbociclib), INLYTA (axitinib), SUTENT (sunitinib), XALKORI (crizotinib), PF-06647020 and PF-04518600, including their potential benefits that involves substantial risks and uncertainties that could cause actual results to differ materially from those expressed or implied by such statements. Risks and uncertainties include, among other things, uncertainties regarding the commercial success of Pfizer's oncology products; the uncertainties inherent in research and development, including the ability to meet anticipated clinical study commencement and completion dates as well as the possibility of unfavorable study results, including unfavorable new clinical data and additional analyses of existing clinical data; risks associated with interim data; the risk that clinical trial data are subject to differing interpretations, and, even when we view data as sufficient to support the safety and/or effectiveness of a product candidate, regulatory authorities may not share our views and may require additional data or may deny approval altogether; whether regulatory authorities will be satisfied with the design of and results from our clinical studies; whether and when drug applications may be filed in any jurisdictions for any potential indications for Pfizer's oncology products and product candidates; whether and when any such applications may be approved by regulatory authorities, which will depend on the assessment by such regulatory authorities of the benefit-risk profile suggested by the totality of the efficacy and safety information submitted; decisions by regulatory authorities regarding labeling and other matters that could affect the availability or commercial potential of Pfizer's oncology products and product candidates; and competitive developments.

A further description of risks and uncertainties can be found in Pfizer's Annual Report on Form 10-K for the fiscal year ended December 31, 2015 and in its subsequent reports on Form 10-Q, including in the sections thereof captioned "Risk Factors" and "Forward-Looking Information and Factors That May Affect Future Results", as well as in its subsequent reports on Form 8-K, all of which are filed with the U.S. Securities and Exchange Commission and available at www.sec.gov and www.pfizer.com.

[i] IBRANCE® (palbociclib) Prescribing Information. New York. NY: Pfizer Inc: 2016.

[ii] Weinberg RA. pRb and Control of the Cell Cycle Clock. In: Weinberg RA, ed. *The Biology of Cancer*. 2nd ed. New York, NY: Garland Science; 2014:275-329.

[iii] Sotillo E, Grana X. Escape from Cellular Quiescence. In: Enders GH, ed. Cell Cycle Deregulation in Cancer. New York, NY: Humana Press; 2010:3-22.

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