

First and only mIDH1 inhibitor for R/R MDS[1,2]

LASER-FOCUSED ON REMISSION

39% Complete Remission (95% CI, 17.3-64.3)[1,a]

69% Remission at 6 Years per Kaplan-Meier estimation[3,b]

67% Transfusion Independence of patients who were transfusion-dependent at BL[1,c]

TIBSOVO® ivosidenib tablets 250mg

Ivosidenib (TIBSOVO) is recommended by the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) as a targeted treatment option for certain patients with R/R MDS with *IDH1* mutations[4,d]

[a]CR was defined as BM ≤5% myeloblasts with normal maturation of all cell lines, hemoglobin ≥11 g/dL, platelets ≥100 x 10^9/L, neutrophils ≥1.0 x 10^9/L, and response lasting at least 4 weeks.[3,5] 43% of CR responders had baseline BM blasts <5%.[1]

[b]The percentage of patients that were estimated to remain in remission at 6 years is based on the total number of patients who achieved CR.[3]

[c]Six out of 9 patients who were transfusion-dependent at baseline achieved transfusion independence.[1] Postbaseline transfusion independence was defined as a period of ≥56 days with no RBC and/or platelet transfusions after the start of study treatment and on or before the end of study treatment.[3,5]

[d]Category 2A recommendation for lower-risk disease with symptomatic anemia, or with clinically relevant thrombocytopenia or neutropenia when used in the third line after immunosuppressive therapy (+/- eltrombopag), azacitidine, or decitabine, and for higher-risk disease in transplant patients when used as a single agent following no response to initial treatment, or in non-transplant patients when used following no response, intolerance, or relapse to initial treatment.[4] Category 2B recommendation for lower-risk disease with clinically relevant thrombocytopenia and neutropenia when used in the second line following disease progression, no response, or relapse.

BL, baseline; BM, bone marrow; CI, confidence interval; CR, complete remission; mIDH1, mutated IDH1; MDS, myelodysplastic syndromes; NCCN, National Comprehensive Cancer Network® (NCCN®); RBC, red blood cell; R/R, relapsed or refractory.

INDICATION

TIBSOVO is indicated for the treatment of adult patients with relapsed or refractory myelodysplastic syndromes (MDS) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test.

IMPORTANT SAFETY INFORMATION

WARNING: DIFFERENTIATION SYNDROME IN MDS

Patients treated with TIBSOVO have experienced symptoms of differentiation syndrome, which can be fatal. Symptoms may include fever, dyspnea, hypoxia, pulmonary infiltrates, pleural or pericardial effusions, rapid weight gain or peripheral edema, hypotension, and hepatic, renal, or multi-organ dysfunction. If differentiation syndrome is suspected, initiate corticosteroid therapy and hemodynamic monitoring until symptom resolution.

Please see Important Safety Information on page 13 and Full Prescribing Information, including BOXED WARNING for MDS patients, accompanying this material or at TibsovoPro.com.

TIBSOVO HELPS FILL AN IMPORTANT TREATMENT GAP IN R/R MDS

Treatment options are limited in MDS[6]

First-line therapies for MDS often result in relapse or a lack of response.[7,8] Historically, patients with R/R MDS have had limited therapeutic options.[7]

Supportive care agents

- **ESAs and EMAs** are used to treat anemia in MDS, but **primary resistance to ESA is common, and 70% of patients relapse**[8]
- **~90% of MDS patients develop chronic anemia and may require long-term transfusion dependence**, which can lead to long-term complications such as iron toxicity[9-11]

HMA therapy

- Although HMAs are widely used in MDS, **patients rarely achieve CR, and most experience HMA failure**[6,12]
- **Outcomes for patients after HMA failure are poor,** with a median survival of less than 6 months[13]

HCT

- HCT is the only curative option for MDS, but **only around one-third of higher-risk patients are eligible**[6,14]
- **Relapse occurs in 20% to 50%** of patients[15]

m*IDH1* is an early driver mutation in the progression of MDS[16,17]

- *IDH1* mutations are recurring molecular abnormalities that can **occur in up to 4% of patients, and the mutation rate may double in patients who progress to AML**[6,18]
- **m*IDH1* MDS is associated with a higher incidence of neutropenia, higher rate of transformation to AML, and poorer overall and leukemia-free survival**[18-20]
  - 2-year survival rate for patients with m*IDH1* MDS was 14% (n=7) compared to 52% of patients with wt*IDH1* MDS (n=146)[18]
  - 67% of patients with m*IDH1* MDS (4/7) transformed to AML compared to 28% of patients with wt*IDH1* MDS (41/145)[18]

NCCN Guidelines® recommend genetic testing for somatic mutations (ie, acquired mutations) in genes associated with MDS[4]

- **NCCN Guidelines recommend retesting if there is disease progression, no response following initial treatment, or relapse** in patients with lower-risk MDS with clinically relevant thrombocytopenia or neutropenia
- **NCCN Guidelines also recommend retesting in R/R MDS patients** with lower-risk disease with symptomatic anemia or higher-risk disease

Retest your patients for *IDH1* mutations at the first suspicion of clinical change.[6]
Consider TIBSOVO for patients with m*IDH1* MDS experiencing their first relapse[1]

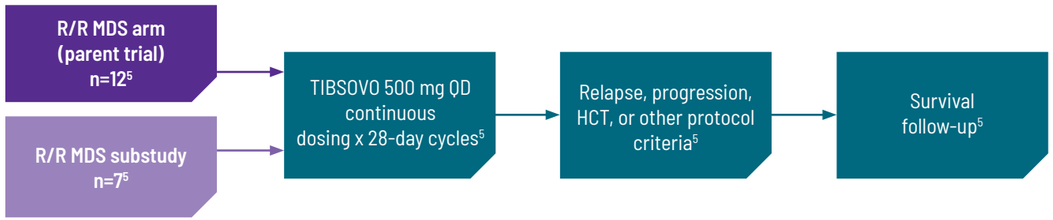
AML, acute myeloid leukemia; CR, complete remission; EMA, erythroid maturation agent; ESA, erythropoiesis-stimulating agent; HCT, hematopoietic cell transplantation; HMA, hypomethylating agent; wtIDH1, wild-type IDH1.

Please see Important Safety Information on page 13 and Full Prescribing Information, including BOXED WARNING for MDS patients, accompanying this material or at TibsovoPro.com.

TIBSOVO WAS STUDIED IN THE FIRST CLINICAL TRIAL SPECIFICALLY FOR PATIENTS WITH m*IDH1* MDS

TIBSOVO was evaluated in an open-label, single-arm, multicenter study[1]

IDH1 mutations were detected in peripheral blood or bone marrow[1,a]



Efficacy was established on the basis of rate of CR + partial remission (PR),[b] duration of CR + PR (DOCR+PR), and rate of conversion from transfusion dependence to transfusion independence.[1] All observed responses were CRs

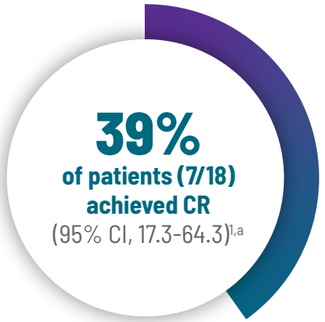
Selected baseline demographics and disease characteristics[1]

	TIBSOVO (N=18)
Median age, years (min, max)	74 (61, 82)
ECOG PS, %	
0	28
1	56
2	17
Cytogenic risk status, %	
Good	22
Intermediate	44
Poor	28
Missing	6
Baseline BM blasts, %	
<5%	39
≥5%	61
Prior therapies, %	
Intensive chemotherapy	17
Nonintensive chemotherapy	83
1 line of HMA-based therapy	78
2 lines of HMA-based therapy	6

[a]Identified by a local or central diagnostic test and confirmed retrospectively using the Abbott RealTime IDH1 Assay.[1]
[b]Rate of CR or PR per 2006 Working Group response criteria for MDS.[1]
ECOG PS, Eastern Cooperative Oncology Group Performance Status; QD, once a day.

TIBSOVO® ivosidenib tablets 250mg

TIBSOVO DEMONSTRATED DEEP AND DURABLE REMISSIONS



39%
of patients (7/18) achieved CR
(95% CI, 17.3-64.3)[1,a]

Rapid remissions: median time to CR was 1.9 months (range, 1.0-5.6)[1]



69% **of patients who achieved CR were estimated to remain in remission at 6 years**[3,b]



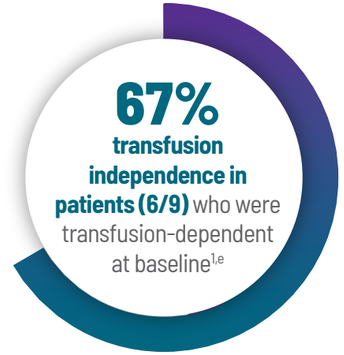
NR **Median DOCR was not reached** by data cutoff (range, 1.9-80.8+ months; 95% CI, 1.9-NE)[1,5,c]

Patients treated with TIBSOVO achieved hematologic improvements, including rapid neutrophil recovery[3,5]

- **Rapid and sustained neutrophil recovery** was seen in patients, regardless of the treatment response status[3,21]
  - Among patients who didn't achieve CR, more than half (4/7) experienced rapid neutrophil recovery in a **median time of 0.97 months**[d]

Please see Important Safety Information on page 13 and Full Prescribing Information, including BOXED WARNING for MDS patients, accompanying this material or at TibsovoPro.com.

MAJORITY OF PATIENTS ACHIEVED OR MAINTAINED TRANSFUSION INDEPENDENCE WITH TIBSOVO



67%
transfusion independence in patients (6/9) who were transfusion-dependent at baseline[1,e]

Median time to transfusion independence was 2.43 months in patients who were transfusion-dependent at baseline[3,5]



78% **of patients (7/9)** who were transfusion-independent at baseline **maintained transfusion independence**[1]



100% **of patients** who were platelet transfusion-independent at baseline **maintained transfusion independence**[5]

TIBSOVO delivered sustained transfusion independence[3]

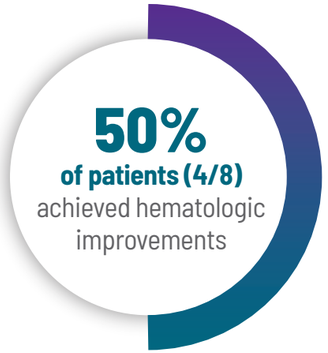
- 67% of patients (4/6) who were transfusion-dependent at baseline and achieved transfusion independence **had a duration of transfusion independence >4 months**, with the longest lasting 272+ days and maintained it through the end of treatment[3]
- Of the 72% of patients (13/18) who achieved or maintained transfusion independence, **median duration of transfusion independence was not reached, but ranged between 1.9 and 78.8 months**[3,5,e,f]

[a]CR was defined as bone marrow ≤5% myeloblasts with normal maturation of all cell lines, hemoglobin ≥11 g/dL, platelets ≥100 x 10^9/L, neutrophils ≥1.0 x 10^9/L, and response lasting at least 4 weeks.[3,5] 43% of CR responders had baseline bone marrow blasts <5%.[1]
[b]Per Kaplan-Meier estimation.[3]
[c]DOCR was derived based on Kaplan-Meier method and is the date of the first documented CR (lasting ≥4 weeks) to the date of the first documented relapse or death, whichever was earlier.[1] Plus sign (+) indicates a censored observation.
[d]Based on patients with mCR and pretreatment absolute neutrophil count <1.0 x 10^9/L (n=7)[5]
[e]Postbaseline transfusion independence was defined as a period of ≥56 days with no RBC and/or platelet transfusions after the start of study treatment and on or before the end of study treatment.[3,5]
[f]Nine observations were censored.[3]
NE, not estimable.

TIBSOVO® ivosidenib tablets 250mg

REMISSION & TRANSFUSION INDEPENDENCE

83% OVERALL RESPONSE RATE WITH TIBSOVO[a]



Of the 8 patients who experienced marrow CR, **50% experienced hematologic improvements in ≥1 lineage,** including RBC, platelet, and/or neutrophil

6% **of patients (1/18) went on to receive stem cell transplantation** following treatment with TIBSOVO[5]

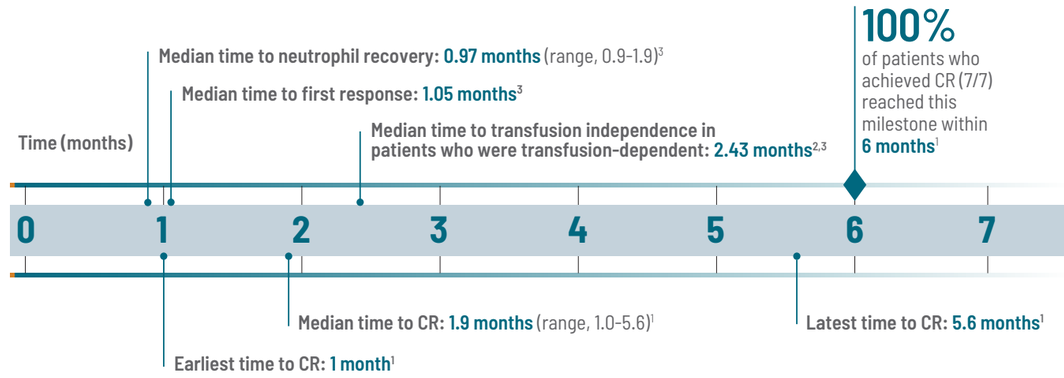
11% **of patients (2/18)** progressed from MDS to AML[5]

Responses to TIBSOVO in patients with R/R MDS[5]

	TIBSOVO (N=18)	95% CI
Probability of patients maintaining CR + PR,[c] %		
At 3 months	86	
At 24 months	69	
At 60 months	69	
Best overall response, %		
ORR[a]	83	58.6-96.4
CR	39	17.3-64.3
PR	0	0.0-18.5
mCR	44	21.5-96.2
Time to OR,[a] median, months (min, max)	1, 5	
HI in non-CR/PR patients, %		
Erythrocyte lineage	18[d]	
Platelet lineage	25[e]	
Neutrophil lineage	57[f]	
Any HI lineage	36[g]	

Please see Important Safety Information on page 13 and Full Prescribing Information, including BOXED WARNING for MDS patients, accompanying this material or at TibsovoPro.com.

PATIENTS WHO ACHIEVED CR REACHED KEY MILESTONES WITHIN 6 MONTHS WITH TIBSOVO



For patients without disease progression or unacceptable toxicity, treat for a minimum of 6 months to allow time for clinical response[1]

[a]Overall response rate was defined as CR + PR+mCR.[5]

[b]Of those experiencing hematologic improvements in >1 lineage , 25% (2/8) had improved RBC counts, 25% (2/8) had improved platelet counts, and 50% (4/8) had improved neutrophil counts.[5]

[c]Kaplan-Meier estimate of duration of CR + PR.[5]

[d]Percentage based on number of patients with mCR and pretreatment hemoglobin <11 g/dL (n=11).[5]

[e]Percentage based on number of patients with mCR and pretreatment platelet count <100 × 10^9/L (n=8).[5]

[f]Percentage based on patients with mCR and pretreatment absolute neutrophil count <1.0 × 10^9/L (n=7).[5]

[g]Percentage based on patients with mCR and who satisfied the pretreatment criteria for HI-erythrocyte, HI-platelet, or HI-neutrophil (n=11).[5]

CI, confidence interval; CR, complete remission; HI, hematologic improvement; INV, investigational agent; mCR, marrow CR;MDS, myelodysplastic syndrome; OR, overall response; ORR, overall response rate; PD, progressive disease; PR, partial remission; PT, prior therapy; RBC, red blood cell;R/R, relapsed or refractory; SD, stable disease.

TIBSOVO® ivosidenib tablets 250mg

TIBSOVO IS NONMYELOSUPPRESSIVE, WITH A WELL-CHARACTERIZED SAFETY PROFILE

- The majority of adverse reactions with TIBSOVO were Grades 1 or 2[1]
- Serious adverse reactions in ≥5% of patients included differentiation syndrome (11%), fatigue (5%), and rash (5%)[1]

Adverse reactions ≥10% in patients with R/R MDS[1]

	TIBSOVO (N=19)	
Body system Adverse reaction	All grades, %	Grade 3 or 4, %
Musculoskeletal and connective tissue disorders		
Arthralgia	42	16
Myalgia	26	0
General disorders and administration site conditions		
Fatigue	37	11
Respiratory, thoracic, and mediastinal disorders		
Cough	32	0
Dyspnea	21	0
Gastrointestinal disorders		
Diarrhea	32	0
Mucositis	26	5
Constipation	16	0
Nausea	16	0
Skin and subcutaneous tissue disorders		
Pruritus	26	0
Rash	26	0
Metabolism and nutrition disorders		
Decreased appetite	26	0
Blood system and lymphatic system disorders		
Leukocytosis	16	5
Differentiation syndrome	11	0
Nervous system disorders		
Headache	16	0
Vascular disorders		
Hypertension	16	16
Investigations		
ECG QT prolonged	11	0

ECG, electrocardiogram.

Please see Important Safety Information on page 13 and Full Prescribing Information, including BOXED WARNING for MDS patients, accompanying this material or at TibsovoPro.com.

LABORATORY ASSESSMENTS AND DOSE MODIFICATIONS

Select laboratory abnormalities (≥15%) that worsened from baseline in patients with R/R MDS[1,a]

	TIBSOVO (N=19)	
Laboratory abnormality	All grades, %	Grade 3 or 4, %
Creatinine increased	95	5
Hemoglobin decreased	42	32
Albumin decreased	37	0
Aspartate aminotransferase increased	37	5
Sodium decreased	32	5
Phosphate decreased	26	5
Alanine aminotransferase increased	21	5
Bilirubin increased	21	0
Magnesium decreased	21	0
Alkaline phosphatase increased	16	0
Potassium increased	16	0

[a]Laboratory abnormality is defined as new or worsened by at least one grade from baseline, or if baseline is unknown.[1]

Dose modifications seen with TIBSOVO[1]

- Permanent discontinuation of TIBSOVO due to an adverse reaction occurred in 1 (5%) patient. The adverse reaction that resulted in permanent discontinuation was fatigue
- Adverse reactions leading to dose interruption of TIBSOVO occurred in 16% of patients. Adverse reactions that required dose interruption in ≥5% were differentiation syndrome, leukocytosis, and rash
- Dose reductions of TIBSOVO due to an adverse reaction occurred in 16% of patients. Adverse reactions that required a dose reduction in ≥5% included differentiation syndrome, fatigue, and rash

TIBSOVO OFFERS CONVENIENT, ONCE-DAILY ORAL DOSING

The recommended dosage for TIBSOVO is 500 mg taken orally once daily with or without food[1]



500 mg
(2 x 250-mg film-coated tablets)



Tablets not shown at actual size.

Dosing guidance for TIBSOVO[1]

- TIBSOVO can be taken with or without food but should not be taken with a high-fat meal (approximately 1000 calories and 58 grams of fat)
- TIBSOVO tablets should not be split, crushed, or chewed
- If a dose is vomited, patients should not take a replacement dose; they should wait until the next scheduled dose is due
- If a dose is missed or not taken at the usual time, patients should take the missed dose as soon as possible and at least 12 hours prior to the next scheduled dose. They should return to the normal schedule the following day. Patients should not take 2 doses within 12 hours
- Store TIBSOVO at room temperature from 20 to 25 °C (68-77 °F)

Monitoring and dose modifications[1]

- Obtain an ECG prior to treatment initiation. Monitor ECGs at least once weekly for the first 3 weeks of therapy and then at least once monthly for the duration of therapy. Manage any abnormalities promptly
- Assess blood counts and blood chemistries prior to the initiation of TIBSOVO at least once weekly for the first month, once every other week for the second month, and once monthly for the duration of therapy
- Monitor blood creatine phosphokinase weekly for the first month of therapy
- Interrupt dosing or reduce dose for toxicities. See Full Prescribing Information for dose modification guidelines

For patients without disease progression or unacceptable toxicity, treat for a minimum of 6 months to allow time for clinical response[1]

Please see Important Safety Information on page 13 and Full Prescribing Information, including BOXED WARNING for MDS patients, accompanying this material or at TibsovoPro.com.

TIBSOVO IS THE FIRST AND ONLY DIFFERENTIATION THERAPY APPROVED TO TARGET mIDH1 IN R/R MDS

TIBSOVO targets the mIDH1 enzyme to restore myeloid differentiation[1,3,5,22]

- In patients with MDS with mutated *IDH1*, TIBSOVO decreased 2-HG levels ex vivo, reduced blast counts, and increased percentages of mature myeloid cells[1,3,5,22]
- TIBSOVO was shown to inhibit selected IDH1 R132 mutants at much lower concentrations than wild-type IDH1 in vitro[1]
- Susceptible *IDH1* mutations are defined as those leading to increased levels of 2-HG in the leukemia cells and where efficacy is predicted by (1) clinically meaningful remissions with the recommended dose of ivosidenib and/or (2) inhibition of mutant IDH1 enzymatic activity at concentrations of ivosidenib sustainable at the recommended dosage according to validated methods[1]
  - Susceptible *IDH1* mutations are R132C and R132H

Ivosidenib (TIBSOVO) is a recommended treatment option for MDS[4]

NCCN
CATEGORY 2A & 2B

As a Category 2A treatment option for certain patients with R/R MDS with *IDH1* mutations for the management of lower-risk MDS with symptomatic anemia and higher-risk MDS, and as a Category 2B option for certain patients with lower-risk MDS with clinically relevant thrombocytopenia or neutropenia[a]

TIBSOVO is the only therapy approved by the FDA to target mIDH1 R/R MDS.[1,2]
Retest your patients for *IDH1* mutations at the first suspicion of clinical change to determine if TIBSOVO may be right for them if and when they relapse[1,6]

[a]Category 2A recommendation for lower-risk disease with symptomatic anemia, or with clinically relevant thrombocytopenia or neutropenia when used in the third line after immunosuppressive therapy (+/- eltrombopag), azacitidine, or decitabine, and for higher-risk disease in transplant patients when used as a single agent following no response to initial treatment, or in non-transplant patients when used following no response, intolerance, or relapse to initial treatment.[4] Category 2B recommendation for lower-risk disease with clinically relevant thrombocytopenia and neutropenia when used in the second line following disease progression, no response, or relapse.

References: 1. Tibsovo. Package insert. Servier Pharmaceuticals LLC; 2023. **2.** Servier announces FDA approval of TIBSOVO® (ivosidenib tablets) for the treatment of IDH1-mutated relapsed or refractory (R/R) myelodysplastic syndromes (MDS). Servier Pharmaceuticals LLC. 2023. Accessed February 20, 2024. https://servier.us/blog/servier-announces-fda-approval-of-tibsovo-ivosidenib-tablets-for-the-treatment-of-idh1-mutated-relapsed-or-refractory-r-r-myelodysplastic-syndromes-mds/ **3.** Data on file. Servier Pharmaceuticals LLC. **4.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Myelodysplastic Syndromes Version 2.2025. © National Comprehensive Cancer Network, Inc. 2025. All rights reserved. Accessed March 13, 2025. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way. **5.** DiNardo CD et al. *Blood Adv*. 2024;8(15):4209-4220. doi:10.1182/bloodadvances.2023012302 **6.** Platzbecker U et al. *Leukemia*. 2021;35(8):2182-2198. doi:10.1038/s41375-021-01265-7 **7.** Rodriguez-Sevilla JJ et al. *Cell Rep Med*. 2023;4(2):100940. doi:10.1016/j.xcrm.2023.100940 **8.** Kubasch AS et al. *Int J Mol Sci*. 2019;20(16):3853. doi:10.3390/ijms20163853 **9.** Gangat N et al. *Am J Hematol*. 2016;91(1):76-89. doi:10.1002/ajh.24253 **10.** Balducci L. *Cancer*. 2006;106(10):2087-2094. doi:10.1002/cncr.21860

TIBSOVO® ivosidenib tablets 250mg

MDS EXISTS ON A BIOLOGICAL CONTINUUM WITH AML

Updated classifications redefined the blast count cutoff in the absence of genetic abnormalities[23,24]

WHO 2022 guidance for MDS-IB2[23,a]



blasts in the bone marrow

ICC 2022 guidance for MDS/AML[24]



blasts in the blood or bone marrow

Patients classified as MDS-IB2 or MDS/AML may have poorer outcomes

- **Approximately 1 in 5 MDS patients classify as MDS/AML** and may have poorer overall survival outcomes and a greater possibility of progressing to AML

Updated classifications redefined the diagnosis of AML in the presence of genetic abnormalities[23,24]

WHO 2022 guidance[23,a]	ICC 2022 guidance[24,c]
AML with defining genetic abnormalities	**AML with recurrent genetic abnormalities**
AML can be diagnosed in the presence of certain mutations and/or defined genetic abnormalities **irrespective of blast count**	All entities defined by the presence of certain recurrent genetic abnormalities and other genetically related entities can be diagnosed as **AML if ≥10% blasts are present**

- National Comprehensive Cancer Network® (NCCN®) recognizes that patients with **certain genetic abnormalities are considered to have AML** even if the marrow blast count **is less than 20%**[4,d]

Consider how updated classifications may impact how your patients are diagnosed and managed[23,24]

[a]The WHO 2022 guidance for MDS-IB2 includes 5% to 19% blasts in the peripheral blood or Auer rods.[23]

[b]*RUNX1::RUNX1T1* fusion, *CBFB::MYH11* fusion, *DEK::NUP214* fusion, *RBM15::MRTFA* fusion, *BCR::ABL1* fusion, *KMT2A* rearrangement, *MECOM* rearrangement, *NUP98* rearrangement, *NPM1* mutation, *CEBPA* mutation, myelodysplasia-related genetic abnormalities, and other defined genetic alterations.[23]

[c]t(8;21)(q22;q22.1)/*RUNX1::RUNX1T1*, inv(16)(p13.1q22) or t(16;16)(p13.1;q22)/*CBFB::MYH11*, t(6;9)(p22.3;q34.1)/*DEK::NUP214*, t(9;11)(p21.3;q23.3)/*MLLT3::KMT2A*, other *KMT2A* rearrangements, inv(3)(q21.3q26.2) or t(3;3)(q21.3;q26.2)/*GATA2; MECOM(EVI1)*, other *MECOM* rearrangements, other rare recurring translocations, mutated *NPM1*, and in-frame bZIP *CEBPA* mutations.[23]

[d]t(8;21)(q22;q22.1)/*RUNX1::RUNX1T1*, inv(16)(p13.1q22) or t(16;16)(p13.1;q22)/*CBFB::MYH11*, t(9;11)(p21.3;q23.3)/*MLLT3::KMT2A*, other *KMT2A* rearrangements, t(6;9)(p22.3;q34.1)/*DEK::NUP214*, inv(3)(q21.3q26.2), t(3;3)(q21.3;q26.2)/*GATA2; MECOM(EVI1)*, other *MECOM* rearrangements, mutated *NPM1*, *CEBPA* (WHO), in-frame bZIP *CEBPA* mutations (ICC), *RBM15::MRTFA* fusion, *NUP98* rearrangement.[4]

ICC, International Consensus Classification; MDS-IB2, MDS with increased blasts 2; WHO, World Health Organization.

References (cont'd): **11.** Germing U et al. *Hemasphere*. 2019;3(6):e314. doi:10.1097/HS9.0000000000000314 **12.** Gangat N et al. *Am J Hematol*. 2023;98(2):225-228. doi:10.1002/ajh.26781 **13.** Steensma DP. *Blood Cancer J*. 2018;8(5):47. doi:10.1038/s41408-018-0085-4 **14.** Bhatt VR et al. *J Oncol Pract*. 2016;12(9):786-792. doi:10.1200/JOP.2016.015214 **15.** Courville EL et al. *BMC Clin Pathol*. 2017;17:28. doi:10.1186/s12907-017-0066-8 **16.** Guess T et al. *Blood Cancer Discov*. 2022;3(4):316-329. doi:10.1158/2643-3230.BCD-21-0128 **17.** DiNardo CD et al. *Leukemia*. 2016;30(4):980-984. doi:10.1038/leu.2015.211 **18.** Thol F et al. *Haematologica*. 2010;95(10):1668-1674. doi:10.3324/haematol.2010.025494 **19.** Jin J et al. *PLoS One*. 2014;9(6):e100206. doi:10.1371/journal.pone.0100206 **20.** Komrokji R et al. *Haematologica*. 2023;108(4):1168-1172. doi:10.3324/haematol.2022.281607 **21.** Prince GT, Baratam P, Garcia-Manero G, et al. Improved hematologic recovery with ivosidenib in patients with mIDH1 relapsed or refractory MDS: Results from a Phase 1 substudy. Presented at: American Society of Hematologists Annual Meeting and Exposition; December 7-10, 2024; San Diego, CA. **22.** Molenaar RJ, Wilmink JW. IDH1/2 mutations in cancer stem cells and their implications for differentiation therapy. *J Histochem Cytochem*. 2022;70(1):83-97. doi:10.1369/00221554211062499 **23.** Khoury JD et al. *Leukemia*. 2022;36(7):1703-1719. doi:10.1038/s41375-022-01613-1 **24.** Arber DA et al. *Blood*. 2022;140(11):1200-1228. doi:10.1182/blood.2022015850

Please see Important Safety Information on page 13 and Full Prescribing Information, including BOXED WARNING for MDS patients, accompanying this material or at TibsovoPro.com.

IMPORTANT SAFETY INFORMATION

INDICATION

TIBSOVO is indicated for the treatment of adult patients with relapsed or refractory myelodysplastic syndromes (MDS) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test.

WARNING: DIFFERENTIATION SYNDROME IN MDS
Patients treated with TIBSOVO have experienced symptoms of differentiation syndrome, which can be fatal. Symptoms may include fever, dyspnea, hypoxia, pulmonary infiltrates, pleural or pericardial effusions, rapid weight gain or peripheral edema, hypotension, and hepatic, renal, or multi-organ dysfunction. If differentiation syndrome is suspected, initiate corticosteroid therapy and hemodynamic monitoring until symptom resolution.

WARNINGS AND PRECAUTIONS

Differentiation Syndrome in MDS: Differentiation syndrome is associated with rapid proliferation and differentiation of myeloid cells and may be life-threatening or fatal. Symptoms of differentiation syndrome in patients treated with TIBSOVO included noninfectious leukocytosis, peripheral edema, pyrexia, dyspnea, pleural effusion, hypotension, hypoxia, pulmonary edema, pneumonitis, pericardial effusion, rash, fluid overload, tumor lysis syndrome, and creatinine increased.

If differentiation syndrome is suspected, initiate dexamethasone 10 mg IV every 12 hours (or an equivalent dose of an alternative oral or IV corticosteroid) and hemodynamic monitoring until improvement. If concomitant noninfectious leukocytosis is observed, initiate treatment with hydroxyurea or leukapheresis, as clinically indicated. Taper corticosteroids and hydroxyurea after resolution of symptoms and administer corticosteroids for a minimum of 3 days. Symptoms of differentiation syndrome may recur with premature discontinuation of corticosteroid and/or hydroxyurea treatment. If severe signs and/or symptoms persist for more than 48 hours after initiation of corticosteroids, interrupt TIBSOVO until signs and symptoms are no longer severe.

QTc Interval Prolongation: Patients treated with TIBSOVO can develop QT (QTc) prolongation and ventricular arrhythmias. Concomitant use of TIBSOVO with drugs known to prolong the QTc interval (eg, anti-arrhythmic medicines, fluoroquinolones, triazole anti-fungals, 5-HT_3 receptor antagonists) and CYP3A4 inhibitors may increase the risk of QTc interval prolongation. Conduct monitoring of electrocardiograms (ECGs) and electrolytes. In patients with congenital long QTc syndrome, congestive heart failure, electrolyte abnormalities, or those who are taking medications known to prolong the QTc interval, more frequent monitoring may be necessary.

Interrupt TIBSOVO if QTc increases to greater than 480 msec and less than 500 msec. Interrupt and reduce TIBSOVO if QTc increases to greater than 500 msec. Permanently discontinue TIBSOVO in patients who develop QTc interval prolongation with signs or symptoms of life-threatening arrhythmia.

Guillain-Barré Syndrome: Guillain-Barré syndrome can develop in patients treated with TIBSOVO. Monitor patients taking TIBSOVO for onset of new signs or symptoms of motor and/or sensory neuropathy such as unilateral or bilateral weakness, sensory alterations, paresthesias, or difficulty breathing. Permanently discontinue TIBSOVO in patients who are diagnosed with Guillain-Barré syndrome.

ADVERSE REACTIONS

The most common adverse reactions including laboratory abnormalities (≥25%) in patients with relapsed or refractory MDS are creatinine increased, hemoglobin decreased, arthralgia, albumin decreased, aspartate aminotransferase increased, fatigue, diarrhea, cough, sodium decreased, mucositis, decreased appetite, myalgia, phosphate decreased, pruritus, and rash.

DRUG INTERACTIONS

Strong or Moderate CYP3A4 Inhibitors: Reduce TIBSOVO dose with strong CYP3A4 inhibitors. Monitor patients for increased risk of QTc interval prolongation.

Strong CYP3A4 Inducers: Avoid concomitant use with TIBSOVO.

Sensitive CYP3A4 Substrates: Avoid concomitant use with TIBSOVO.

QTc Prolonging Drugs: Avoid concomitant use with TIBSOVO. If co-administration is unavoidable, monitor patients for increased risk of QTc interval prolongation.

LACTATION

Advise women not to breastfeed.

TIBSOVO® ivosidenib tablets 250mg

TIBSOVO IS BUILT ON EXPERIENCE



- **39% of patients achieved CR** (95% CI, 17.3-64.3)[1,b]
- **Of patients who achieved CR, 69% were estimated to remain in remission at 6 years**[3,c]
- **67% transfusion independence in patients** who were transfusion-dependent at baseline[1,d]
- **Nonmyelosuppressive, with a well-characterized** safety profile[1,3]
- **First and only FDA-approved therapy** to target mIDH1 in R/R MDS[1,2]
- **Over 7 years of real-world experience** with more than 3700 patients treated across multiple indications[1,3]

NCCN Guidelines recommend ivosidenib (TIBSOVO) as a targeted treatment option for certain patients with R/R MDS with *IDH1* mutations[4,e]

Scan here or visit TibsovoPro.com/mds to learn more

[a]Claims data as of 01/2026.[3]
[b]CR was defined as bone marrow ≤5% myeloblasts with normal maturation of all cell lines, hemoglobin ≥11 g/dL, platelets ≥100 x 10^9/L, neutrophils ≥1.0 x 10^9/L, and response lasting at least 4 weeks.[3,5] 43% of CR responders had baseline bone marrow blasts <5%.[1]
[c]Per Kaplan-Meier estimation.[3]
[d]Postbaseline transfusion independence was defined as a period of ≥56 days with no RBC and/or platelet transfusions after the start of study treatment and on or before the end of study treatment.[3,5]
[e]Category 2A recommendation for lower-risk disease with symptomatic anemia, or with clinically relevant thrombocytopenia or neutropenia when used in the third line after immunosuppressive therapy (+/- eltrombopag), azacitidine, or decitabine, and for higher-risk disease in transplant patients when used as a single agent following no response to initial treatment, or in non-transplant patients when used following no response, intolerance, or relapse to initial treatment.[4] Category 2B recommendation for lower-risk disease with clinically relevant thrombocytopenia and neutropenia when used in the second line following disease progression, no response, or relapse.

INDICATION

TIBSOVO is indicated for the treatment of adult patients with relapsed or refractory myelodysplastic syndromes (MDS) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test.

IMPORTANT SAFETY INFORMATION

WARNING: DIFFERENTIATION SYNDROME IN MDS
Patients treated with TIBSOVO have experienced symptoms of differentiation syndrome, which can be fatal. Symptoms may include fever, dyspnea, hypoxia, pulmonary infiltrates, pleural or pericardial effusions, rapid weight gain or peripheral edema, hypotension, and hepatic, renal, or multi-organ dysfunction. If differentiation syndrome is suspected, initiate corticosteroid therapy and hemodynamic monitoring until symptom resolution.

Please see Important Safety Information on page 13 and Full Prescribing Information, including BOXED WARNING for MDS patients, accompanying this material or at TibsovoPro.com.

SERVIER

© 2026 Servier Pharmaceuticals LLC. Boston, MA 02210. Customer Service: 1-800-807-6124. Servier and the Servier Logo are registered trademarks of LES LABORATOIRES SERVIER. TIBSOVO is a registered trademark of SERVIER PHARMACEUTICALS LLC, a wholly owned, indirect subsidiary of LES LABORATOIRES SERVIER.
US-02934 v3 01/2026

TIBSOVO® ivosidenib tablets 250mg