

FUCASO (equecabtagne autoleucel)

Clinical Facts and Clinical Handling Guidance

Indications

Fucaso is indicated for the treatment of adult patients with relapsed or refractory multiple myeloma, after at least three lines of prior treatment (at least a proteasome inhibitor and an immunomodulatory agent).

WARNING: Cytokine Release Syndrome and Neurological Toxicities

- Patients receiving this product may experience Cytokine Release Syndrome (CRS), including fatal or life-threatening reactions. Do not administrate this product to patients with active infections or inflammatory disorders. Tocilizumab or tocilizumab and corticosteroid could be used to treat severe or life-threatening CRS.
- Patients receiving this product may experience fatal or life-threatening neurotoxicity concurrently with CRS or after CRS resolution. Neurologic events should be monitored after treatment with this product, and supportive care and/or corticosteroid should be provided as needed.

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WELCOME AND EXECUTIVE SUMMARY

Patients with refractory and relapsed multiple myeloma have suffered from the progressive disease burden and eventually exhausted all available treatment options with no improved clinical control and survival advantages. The substantial unmet clinical needs for these patients facilitated innovation of traditional anti-myeloma therapy into a new era of autogenous immunotherapy with introduction of BCMA-targeted chimeric antigen receptor T cells, providing those heavily treated patients with a new hope for disease alleviation.

Equecabtagene autoleucl (eque-cel), also known as FUCASO for its brand name, was developed by IASO Bio and was the first approved BCMA CAR-T cell product in China for treatment of patients with multiple myeloma. Explored and confirmed in two clinical studies, FUCASO demonstrated consistent and reliable clinical potency, efficacy, and safety in the targeted population. It can induce fast, durable, and deep response to ensure prolonged survival benefits with tolerable, manageable and expectable toxicities.

The document comprises two major chapters, introducing both the key highlights of FUCASO clinical data and the entire clinical process from preparation, infusion, to post-infusion safety monitoring. It is aimed to illustrate a concise but informative picture to healthcare professional, whose specialty mainly focuses on hematology and myeloma treatment, in peculiar whose patients have suffered from limited anti-myeloma treatment options after multiple lines of repeated treatment.

It is expected that this demonstration of study facts and clinical practice guidance of BCMA CAR-T therapy will shed new light onto the future of those miserable patients. We are hoping the upcoming collaboration would help patients blow away the obscured clouds of disease in the blue sky of their meaningful life in the near future.

02 | CLINICAL STUDY FACTS OF FUCASO

What is FUCASO?

Equecabtagene autoleucl (eque-cel), with brand name of FUCASO, is a biologically engineered cellular therapy with innovation of immunotherapeutic nature. This therapy, characterized as chimeric antigen receptor T cell (CAR-T), utilizes fully human single-chain antibodies to aim therapeutic targets on cell-membranes, B cell maturation antigen (BCMA). The intracellular part of chimeric antigen receptor from FUCASO consists of 4-1BB costimulatory domain and CD3- ζ activation domain, the activation of which lead to cytokine release and targeted cytotoxicity, thus achieving effective recognition and clearance of BCMA positive cancerous cells¹.

FUCASO received its conditional approval from regulatory authorities for the treatment of multiple myeloma in mainland China in June 2023. It is indicated for the treatment of adult patients with relapsed or refractory multiple myeloma, after at least three lines of prior treatment (at least a proteasome inhibitor and an immunomodulatory agent).

How does FUCASO Works?

Breakthroughs of anti-cancer treatment, like immunotherapy, utilizes T cell immunity to eliminate cancer cells. CAR-T cell therapy has emerged as a novel immunotherapy which modifies T cells with artificially engineered CAR, an intrinsic fusion protein that incorporates three key components. They consist of an extracellular antigen recognition domain, a transmembrane domain, and an intracellular domain including co-stimulation and signaling components. Extracellular domain recognizes and binds to the therapeutic target proteins, whereas intracellular components, called costimulatory

domain and activation domain, transduce external signals to operate cell proliferation and also initiate cytotoxicity to remove cancerous plasmic cells².

The choice of target is critical for CAR-T therapy. BCMA, a member of the tumor necrosis factor (TNF) superfamily, is exclusively expressed in a subpopulation of B cells, and especially malignant plasma cells, but not present on the surface of other hematopoietic or normal cells^{2,3}. BCMA protein plays a critical role in regulating B cell maturation and differentiation into plasma cells, facilitating B cell survival at different stages of development by engaging a proliferation-inducing ligand. The advantages of BCMA as an antigen for CAR-T therapy include the potential reduction of on-target/off-tumor effects, the focused consistency of therapeutic target for anti-tumor activity, regardless of disease stage of multiple myeloma and disease risk stratification, the feasibility of monitoring as clinical biomarker, and its prognostic nature even in low expression. The role of BCMA in the development of MM makes it the most popular target in MM CAR-T therapy, and thus selected as candidate of therapeutic target for development of FUCASO CAR-T therapy^{1,2}.

Following infusion into patients with multiple myeloma, the target domain of CAR-T cells of eque-cel recognizes and binds to the BCMA proteins on malignant plasma cell by identifying the target domain of chimeric antigen receptor on CAR-T cells, subsequently triggering the activation and expansion of those CAR-T cells, leading to cytokine release and targeted cytotoxicity, and thus achieving effective recognition and clearance of BCMA positive cells. These cascading biologic performances translate into substantial and profound anti-myeloma effects³.

What are the Clinical Benefits of FUCASO

Overview of Clinical Benefits of FUCASO

FUCASO (eque-cel) provides substantial clinical benefits to heavily treated patients with multiple myeloma who have previously failed at least three lines of anti-myeloma therapies:

- Fast, deep, and durable response
- Longer survival with no further repeated medical interventions.
- Manageable adverse events with no severe CRS or neurologic toxicities

The overall response rate (ORR) was

77.8%
two weeks after infusion

The ORR was

100%
for all patients with enhanced responses over time.

A total of

72.2%
(13 of 18) of the patients finally achieved a complete response (CR) or stringent CR (sCR)

Investigator-Initiated Study

FUCASO founded its clinical benefits first in an open-label, single-arm phase 1 clinical trial. This study evaluated the safety and preliminary efficacy of eque-cel for patients with refractory / relapse multiple myeloma (RRMM)¹. This dose-escalation study was conducted at a single medical center in China.

The study enrolled patients with the following major inclusion criteria: adult with age of 18 to 70 years, an Eastern Cooperative Oncology Group (ECOG) performance status (PS) score of 0 or 1, adequate major organ function, and at least 3 lines of prior therapies that must include a proteasome inhibitor (PI) and an immunomodulatory agent (iMiD).

All patients received the prescribed cell dose of eque-cel. At median follow-up period of 394 days by the cutoff date. The overall response rate (ORR) was 77.8% two weeks after infusion. The ORR was 100% for all patients with enhanced responses over time. A total of 72.2% (13 of 18) of the patients finally achieved a complete response (CR) or stringent CR (sCR). All 17 patients evaluated for MRD in the bone marrow were

MRD-negative at 10⁻⁴ nucleated cells by flow cytometry within 1 month. The median time to response (TTR) was 15 days (range, 14-62 days) for all patients. The median duration of response (DOR) was 325 days (range, 7-573 days) for all 18 patients and 412 days (range, 213-573 days) for the 13 patients with CR/sCR.

Survival analysis showed that the rates of PFS and OS at 1 year were 58.3% and 75%, respectively.

Long-term follow-up to study population showed that the median PFS was 22.64 months and the median OS was 41.97 months after median follow-up of 394 days⁴. The PFS and OS rates at 2 years were 50.0% and 72.2%, respectively. The patients without extramedullary multiple myeloma (EMM) had longer survival than those with EMM. The median PFS was 12.02 months, and the median OS was 28.52 months in patients with EMM, whereas the median PFS was 27.92 months, and the median OS was 41.97 months in patients without EMM.

The promising value of FUCASO against heavily disease of multiple myeloma warranted further investigation of eque-cel in a more stringent registration situation.

ORR was

96.1%

CR/sCR

77.7%
in 103 evaluable patients⁶

Pivotal and Registration Study: FUMANBA-1

After the first investigator-initiated study, a phase 1b/2, single-armed, multicentered study, FUMANBA-1 was initiated to further explore clinical efficacy and safety in patients with RRMM⁵. Participants were RRMM patients who had received at least three prior lines of therapy (with at least one PI and one iMiD) and whose disease had progressed after the last line of therapy. Patients with prior BCMA CAR T therapy were also included. Patients received a single infusion of eque-cel at a dose of 1×10⁶ cells/kg, following three consecutive days of lymphodepletion. The objective is to assess the efficacy, safety, and PK/PD characteristics of eque-cel in RRMM patients with failure of more than three-line therapies. The study was conducted in 14 medical centers in China and served as local registration study for market authorization of eque-cel into China market. The trial was registered both at ClinicalTrials.gov (NCT05066646) and the Chinese Clinical Trial Register (ChiCTR2000033946).

As cutoff date on December 31, 2022, the median follow-up was 18.07 months (IQR 12.6-21.8). A total of 105 patients received Eque-cel with a median of 4 lines of prior therapy (range 3-23), 32.4% of which had high risk (HR) cytogenetic abnormalities. ORR was 96.1%, CR/sCR 77.7% in 103 evaluable patients⁶. Median time to first response is 16 days (range 11-179) while median time to best response is 93 days (range 14-557).

Figure 2. Overall response rate

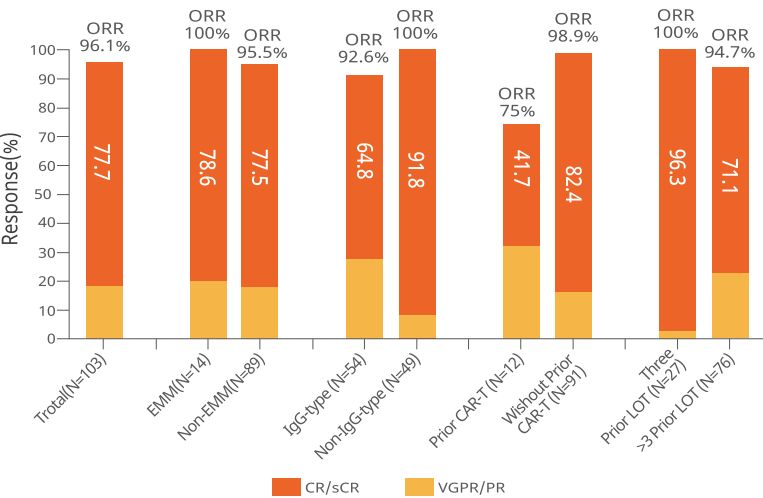


Figure: Overall response rate in overall and subgroup populations

The 12 month PFS rate was 80.0 (95% CI:70.33, 86.76). Even in patients with HR cytogenetic abnormalities, patients still benefited from eque-cel therapy with 12 month PFS of 58.1% (95% CI: 38.57, 73.36). Patients without HR cytogenetic abnormalities and without prior CAR T therapy had better PFS rate, and 12 m PFS rates were 92.0% (95% CI: 80.07, 96.92) and 85.5 (95% CI: 75.75, 91.51). Of the 94.2% (97/103) patients who achieved MRD negativity in FUMANBA-1, MRD negativity was sustained for ≥12 months in 80.8% (83/103) patients. Patients with sustained MRD negativity (≥6 months, and ≥12 months) had longer PFS (see Figure) compared with patients who did not (MRD negative <6 months).⁷ More specifically in patients without prior CAR-T exposure, 97.8% patients (89/91) achieved MRD negativity and 81.7% (74/91) maintained negative still 12 months following infusion.

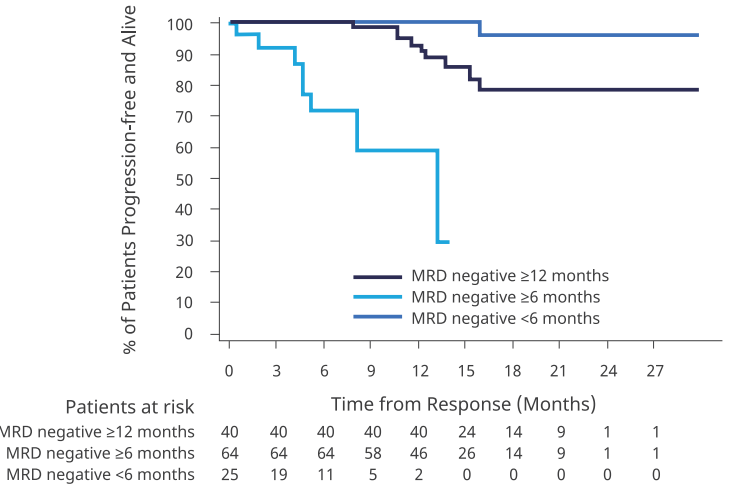
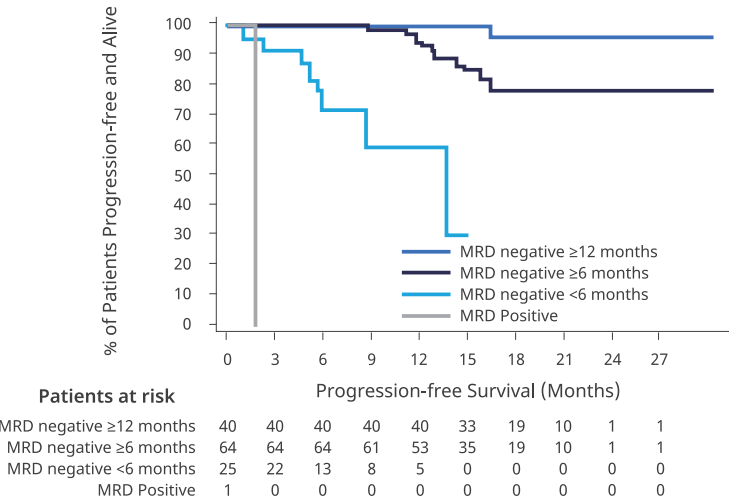


Figure: K-M curve on PFS and DOR probability sub-grouped by MRD negativity duration



In terms of drug persistence performance, after 24 months, the vector copy number (VCN) can still be detected in 40% of patients. The anti-drug antibody (ADA) was positive in only 19.2% (20/104) of patients. For safety analysis of eque-cel, the most common ≥ grade 3 treatment-related adverse events were hematologic toxicities⁶. CRS was found in 98 (93.3%) patients with most cases being grade 1~2. Neurologic toxicities including ICANS occurred in only 15.2% of patients, and all toxicities were only grade 1~2. FUMANBA-1 study demonstrated that a profound and durable response can be achieved in RRMM patients treated with eque-cel. Patients with clinical factors such as prior CAR-T therapy, and high-risk cytogenetic abnormality could still achieve substantial efficacy improvements from eque-cel therapy.

Other Exploratory and Ad-Hoc Analysis

Patients with multiple myeloma suffer from thrombocytopenia due to disease progression or treatment side-effects of anti-myeloma therapy. A retrospective analysis based on FUMANBA-1 trial was performed to predict association of high risk patients with baseline laboratory variables to suffer from prolonged thrombocytopenia after eque-cel treatment⁸. The aim is to impose a risk-adapted management strategy for hematologic toxicity. As result, it demonstrated that blood platelet (PLT), C reaction protein (CRP), plasma cells in bone marrow, hemoglobin and log of Ferritin at baseline was able to predict the recovery of thrombocytopenia (see Table). PLT and hemoglobin levels could partially reflect bone marrow reserve, while ferritin and plasma cells in bone marrow indirectly affect tumor burden. High risk patients with a model score of 5 or higher may require further intensive care including thrombopoietic growth factors and platelet transfusion, following eque-cel infusion.

Baseline Factors	0 Point	1 Point	2 Points
PLT	> 161.5 /uL	112.5 - 161.5 /uL	< 112.5 /uL
CRP	< 5.05 mg/L	5.05 – 23.95 mg/L	> 23.95 mg/L
Plasma cell	< 5.65%	5.65 – 51.05%	> 51.05%
Hemoglobin	> 94.00 g/L	< 94.00 g/L	
Ig(Ferritin)	< 2.800	> 2.800	

Table: Prolonged Thrombocytopenia Recovery Model

03 | PROCESS OVERVIEW OF CLINICAL USE WITH FUCASO

Unlike traditional treatment, the autogenous CAR-T product needs multiple steps in manufacturing and preparing the agent for final clinical infusion to eligible patients (see Figure). The entire process consists of three stages, among which there are different steps involved respectfully.

1 Prior-infusion stage:

Eligibility assessment, leukapheresis, bridging therapy and lymphodepleting chemotherapy. Simultaneously at certified manufacturing facility, CAR-T cells is being biologically engineered and amplified for final agent production under strict GMP supervision and quality assurance policy.

2 Infusion stage:

CAR-T cells is given to the patient under close attention and procedure control at the medical center and at bedside.

3 Post-infusion stage:

Both efficacy follow-up upon periodic tumor evaluation and closely monitoring and actively managing treatment related toxicities are vital to ensure the maximal clinical benefits for patients, outweighing the controllable risks.



04 | CLINICAL HANDLING GUIDANCE OF FUCASO

Selecting Eligible Patients to Use FUCASO

Based on released clinical data, FUCASO is capable of alleviating tumor burdens and disease disturbance in heavily treated patients with multiple myeloma. However, starting FUCASO treatment is suggested in selected patients with eligible clinical conditions for the purpose of maximizing patient well-beings, due to the nature of immunotherapy and the manufacturing process of CAR-T. Before making final decision, the patients are engaged to have comprehensive and in-depth discussion with their hematologists on their eligibility, preparation, whole treatment process, peri-infusion stage and post-infusion management, and thus fully understand the risks and benefits from FUCASO treatment.

Key Clinical Eligibility Criteria

The following conditions are recommended for healthcare professionals to initiate the discussion with patients on FUCASO therapy, in contexts of clinical eligibility:

- Adult patients diagnosed with multiple myeloma.
- Patients have previously failed three-lines of anti-myeloma therapies, assessed by hematologists. Patients intolerable to all or any of anti-myeloma therapeutic regimens may also be eligible, based on professional assessment by healthcare professionals.
- Patients have no evidence of uncontrolled diseases or conditions which demands continuous and systemic corticosteroid intervention.
- Patients have no evidence of previously severe hypersensitivity reactions, i.e. anaphylactic shock or worse.
- Patients have no evidence of being allergic or intolerable to fludarabine, cyclophosphamide, and tocilizumab.
- Patients have no evidence of no active and uncontrolled viral infection, including but not

limited to hepatitis B, hepatitis C and cytomegalovirus.

- Patients have no evidence of active pathogenic infection, under discrete judgment by medical doctors, including hepatitis B virus (HBV), hepatitis C virus (HCV), human immunodeficiency virus (HIV), syphilis and Cytomegalovirus (CMV)⁹⁻¹¹.
- Female patients who are pregnant or planning to be pregnant should be EXCLUDED from the discussion of FUCASO therapy.
- The expected life expectancy of patients is more than 2 months.

Contradictions

FUCASO is contradicted in patients who are allergic to the active ingredients or any excipients of eque-cel, including dimethyl sulfoxide (DMSO). Please see product label for more information.



Prior-Infusion and Preparation Stage

During prior-infusion stage, patients need to be collected for peripheral blood mononuclear cell (PBMC) through leukapheresis and ready for future FUCASO infusion. Unlike traditional therapies, the T cells within the final product of FUCASO are derived from the same patient to provide with PBMC for FUCASO and then manufactured ex-vivo in GMP-certified laboratory conditions. Prior to CAR-T infusion, the lymphodepleting chemotherapy will be given to patients to secure the suitable immune environment for further introduction and amplification of CAR-T cells in human body. The whole length of Prior-Infusion Stage lasts 3-4 weeks.

Criteria to Enter Leukapheresis

Hematologists or professionals with leukapheresis expertise are engaged to use the following checklist to confirm the suitable conditions of patients to enter leukapheresis process¹². The menu includes the following:

- Clinical check-up
 - * Medical history
 - * Current medication
 - * Physical examination
 - * Evaluation of potential comorbidities
- Report of venous access including skin status
- Blood counts in less than 5 days, especially lymphocyte count
- Screening for infectious diseases
- Informed consent of leukapheresis procedure

Patients are **NOT** allowed to enter leukapheresis stage if any of the following condition exists:

- Active and uncontrolled infection (<Grade 2 urogenital infection or upper respiratory tract infection per CTCAE criteria is allowed) within 7 days prior to leukapheresis.
- ECOG Performance Score > 2 or Karnofski Performance Score > 60%.
- Blood oxygen saturation < 92% without oxygen therapy.
- Active infection of HBV, HCV, HIV, CMV, human T-lymphotropic virus (HTLV)

or syphilis.

- Evidence of coronavirus disease 2019 (Covid-19) infection
- Clinical meaningful abnormalities in testing of electrolytes and renal function
- Abnormal results laboratory testing:
 - * Complete Blood Counting (CBC): Absolute lymphocyte counting (ALC) < 0.3 × 10⁹ /L, hemaglobin < 80 g/L, hematocrit < 0.24, platelets (PLT) < 30 × 10⁹ /L
 - * Coagulation: Clinical meaningful abnormalities with discrete consideration of benefits and risks by medical doctors
- Electrolytes and renal function: Clinical meaningful abnormalities.
- Other conditions which do not warrant leukapheresis, as determined by healthcare professionals.

Additionally, patients must complete the following wash-out period (indicated as minimal duration) or complete the following therapies prior to leukapheresis for CAR-T manufacturing¹³

- Hematopoietic stem cell transplantation (HSCT): 1 month. Immunosuppressive agents must be discontinued and there is no evidence of Graft vs. Host Disease (GVHD). The patients previously treated with high-dose melphalan and HSCT are eligible for FUCASO therapy once the required wash-out period is met.^{14,15}
- Donor lymphocyte infusion (DLI): 1 month. A longer interval of 6-8 weeks is preferable to exclude the possible safety concerns from GVHD.
- Cytotoxic chemotherapy or protease inhibitor (PI): 2 weeks for dose-dense chemotherapy; 3 days for short-acting cytotoxic / anti-proliferative agents. In any cases, patients must have recovered from cytopenia.
- Monoclonal antibody: 3 weeks
- Immunomodulatory drugs (iMiD): 1 week
- Corticosteroid: 3 days for systemic corticosteroid and 7 days recommended. However, physiological replacement, topical use, and inhaled steroids are allowed¹⁶.

CBC test should be repeated after the leukapheresis process, and PLT level should be monitored closely as the leukapheresis may eradicate at least 30% of peripheral PLT cells.

Leukapheresis

Leukapheresis involves collecting the patient's peripheral blood mononuclear cells (PBMC), after which they will be sent, cryopreserved, and sent to the CAR-T cell manufacturing facility. The recommended target collection cell number: 4×10⁹ PBMC.

Leukapheresis can take 3 to 6 hours and may need to be repeated, if indicated. The collected PBMC will be sent to the certified FUCASO manufacturing facility under the cryopreserved condition of 2-8°C, for further cell separation.

Bridging Therapy

Bridging therapy refers to anti-myeloma treatments given between apheresis and the initiation of lymphodepleting chemotherapy. The goal of bridging therapy is to prevent rapid disease progression during this waiting period and prior to CAR T cell infusion¹⁷.

In controlled clinical settings, patients were allowed to receive bridging therapy after leukapheresis, as shown in FUMANBA-1 study, 43.5% patients received bridging therapy between leukapheresis and FUCASO infusion (see Product label). However, the increased real-world use of CAR-T therapy has uncovered a number of barriers that can lead to significant delays in treatment. Therefore, bridging therapy has become a widely used tool to stabilize or debulk disease during the waiting period. Generally, bridging therapies involve chemotherapy, antibody, targeted therapy and even immunotherapy¹⁷. Much data of bridging therapy in CD19 CAR-T treatment for B cell lymphoma and leukemia is relatively solid, showing that bridge therapy is safe, and complete/partial response to it confers a 42% reduction in risk of progression/death after CD19 CAR-T therapy¹⁸. However, the experience with BCMA CAR-T is relatively sparse but in FUMANBA-1 study, patients were allowed to receive bridging therapy after leukapheresis and thus 43.5% patients received bridging therapy between leukapheresis and FUCASO infusion. Meanwhile, the bridging therapy did not significantly affect the Cmax and AUC of FUCASO, per pharmacokinetic data (see Product label).

Based on the discrete judgment by hematologists, the recommended

bridging therapy includes PAD (PI / anthracycline/ dexamethasone) or DECP (cisplatin / etoposide / ifosfamide /dexamethasone) regimens. The previously used regimen can also be considered, and however, it is not engaged to use the agents which have not be exposed to patients. In case that anthracycline is used, cardiac function must be carefully evaluated before starting lymphodepleting chemotherapy. For patients who completed bridging therapy during waiting period, they must be carefully re-assess for eligibility of lymphodepleting chemotherapy and then CAR-T infusion. Importantly, at least 14 days following bridging therapy must be spared with qualified clinical and laboratory indicators, to start subsequent lymphodepleting chemotherapy.

Lymphodepleting chemotherapy

Lymphodepleting regimens are given within 2-7 days before CAR T cell infusion to enable better expansion and engraftment of the transferred T cells through activation of antigen-presenting cells. In addition to direct anti-myeloma cytotoxicity, lymphodepletion can also activate innate immunity, improve the production of homeostatic cytokines, and remove immunoregulatory cells (like myeloid-derived suppressor cells and regulatory T cells). Therefore, it is intended to provide a suitable immune environment for CAR T cells, which improves their expansion, persistence and clinical activity while reducing the potential for anti-CAR immune responses¹⁷.

The recommended regimen to be used involves cyclophosphamide 500mg/m² and fludarabine 30mg/m² intravenously for injection in three consecutive days. Either infusion must be completed no less than 30 minutes, while fludarabine needs to be infused after cyclophosphamide in the same day. Dose modification is warranted per individual patient's conditions.

In the case that CAR-T infusion is delayed for more than 4 weeks, a second lymphodepleting chemotherapy process should be considered and recommended, based on patients' underlying conditions, complete blood counting and previous exposure to fludarabine.

To avoid toxicities to accumulate or overlap, the wash-out period for bridging therapy must be completed before lymphodepleting chemotherapy. Additionally, patients are requested to exempt from

the following clinical conditions before being given lymphodepleting chemotherapies. Otherwise, the infusion must be delayed or cancelled.

- Poor general condition
- Blood oxygen saturation < 92% without oxygen therapy
- Peripheral leukocytes: Lymphodepleting process must be operated regardless of leukocyte or lymphocyte counting. It is highly recommended to complete this process before CAR-T infusion in all patients.
- Active and uncontrolled severe infection: Refer to levels of CRP, ferritin, lactate dehydrogenase (LDH), metabolism, fibrinogen for confirmation.
- Liver dysfunction: Serum bilirubin, aminotransferase (ALT) and aspartate aminotransferase (AST): Based on discrete consideration by medical doctors.
- Renal malfunction: Creatinine Clearance (CrCl) < 30 mL/min
- Cardiac dysfunction: Cardiac echogram, electrocardiogram (ECG), and cardiac function evaluation are warranted and the decision should be made based on discrete consideration by medical doctors.
- High tumor burden: Based on discrete consideration by medical doctors.

Moreover, before initiating lymphodepleting chemotherapy, it is mandatory to recognize and confirm that FUCASO product has passed through manufacturing and quality check-ups and is ready for use per regulatory requirements.

How Long is Preparation Period and What might Accidentally Happen in Preparation Period?

- Duration of prepration period

The average interval between leukapheresis for successful PBMC collection and notification to initiate lymphodepleting chemotherapy is 3-4 weeks. In FUMANBA-1 trial, the median interval time (range) of leukapheresis to lymphodepletion, leukapheresis to infusion, and lymphodepletion to infusion are 31 (22-57), 35.5 (26-61) and 5.0 (5-7) days, respectively. During this period, the collected T cells will be prepared

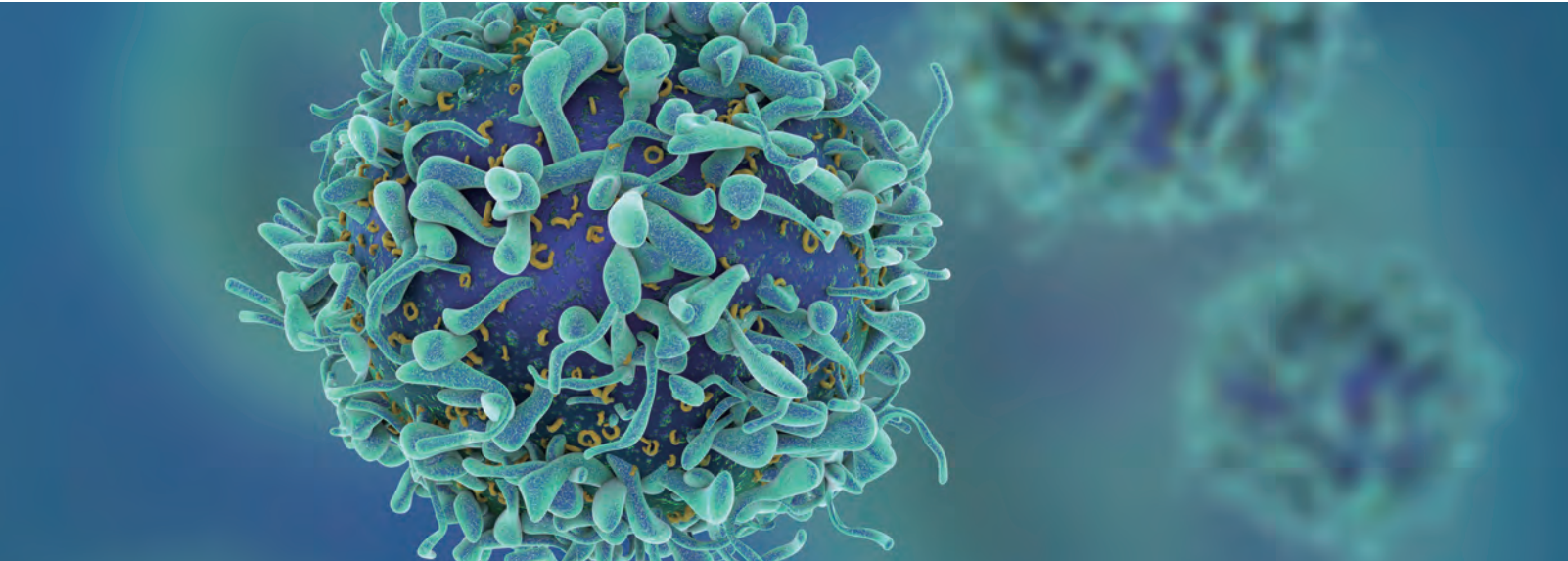
under bio-engineer process and quality control maneuvers into a formula of GMP-certified product for intravenous infusion back into the body of the patient.

- Delay on infusion

To ensure the best interest of patient benefits with lower risks, lymphodepletion and CAR-T infusion might be postponed under decisions by healthcare professionals or determined based upon objective situational changes. As mentioned above, there shall be many conditions to avoid prior to initiation of lymphodepletion before patients can be lymphodepleted to receive CAR-T cells. Please read the previous chapters on pre-requisitions before specific operations. FUCASO team will be working diligently with hematologists and healthcare professionals to make infusion happen as soon as it permits.

- Manufacturing failure

In small cases, the CAR-T cell manufacturing process may encounter with unexpected problems and the cells are unable to be ready for infusion in the desired timeframe. In such case, re-manufacturing will be scheduled using the backup PBMC stored at facility (if applicable), or using the PBMC sample to be re-collected from the patient in a second leukapheresis process.



Infusion Phase

No later than 7 days following the end of lymphodepleting chemotherapy, infusion of FUCASO must be scheduled and completed. However, to control the risks brought by CAR-T therapy, infusion should be delayed or even cancelled if any of the following conditions exists:

- Active and uncontrolled infection: Delay the infusion till infection is fully controlled.
- Body temperature within 48 hours prior to infusion is higher than 38 °C, which is relevant to the underlying disease
- Blood oxygen saturation < 92% without oxygen therapy

- Evidence of fluid burden or existing congestive heart failure
- Uncontrolled cardiac arrhythmia, which is strictly prohibited from FUCASO infusion.
- Hypotension which warrants vasopressors is strictly prohibited from FUCSO infusion. Further examinations and tests are desired to ascertain the causes. Infusion should be delayed till hypotension is reversed.
- Newly onset or other ≥grade 3 non-hematologic organ dysfunction worsening: Further examinations and tests are desired to ascertain the causes. Discrete clinical evaluation by medical doctors is expected.
- Worsening clinical condition after initiation of lymphodepletion: Further

examinations and tests are desired to ascertain the causes. Discrete clinical evaluation by medical doctors is expected.

- Neurologic evaluation should include ICE scoring result as baseline.

To minimize the risk of infusion delay after lymphodepletion, it is strongly advised for hematologists and healthcare professionals to actively ensure the patient is strictly eligible for lymphodepleting chemotherapy and the communication between FUCASO team and medical centers.

This CAR-T product of FUCASO is only for autologous use and cannot be given to any other patients in any case. Before infusion, the patient’s identity must match the patient’s identifier both on the cassette and on infusion bag. If a mismatch is found, FUCASO infusion must be discontinued and FUCASO support team must be reached for further actions immediately.

After receiving FUCASO, the patients should avoid donating blood, organs, tissues, or cells for transplantation.

Premedication

The common infusion reactions caused by CAR-T use include fever, chills, rash, urticaria, dyspnea, hypotension and/or nausea.

It is highly recommended that acetaminophen 450-650mg or diphenhydramine 25-50mg injected intramuscularly 30~60 minutes before FUCASO administration, reducing the risk of infusion reaction. In case of fever (not caused by infection), treat with non-steroidal anti-inflammatory drugs, while antihistamines and anti-emetic agents are also encouraged to deal with the other symptoms.

For the cause of possible influence on the activity of FUCASO, systematic corticosteroids and other immunosuppressive agents should be avoided. However, the physiologic replacement can be tolerated (hydrocortisone ≤ 12 mg/m2/d and equivalent as prednisone ≤ 3 mg/m2/d or dexamethasone ≤ 0.45 mg/m2/d).

Dosing and Administration

FUCASO is packaged in 20ml per bag. The recommended administration dose

is 1.0×106 CAR positive viable T cells per kg of body weight, in infusion only.

Before infusion and during recovery and observation period after infusion, corticosteroids, at least two doses of tocilizumab and rescue equipment shall be prepared and ready for emergency occasions. General clinical precautions and local biosafety guidelines shall be followed for handling and disposal of FUCASO, avoiding the potential transmission of infectious diseases.

Clinical Operating and Handling At Bedside Inside Medical Center

The entire infusion process should be carried out by qualified healthcare professional in accordance with the prescribed procedures.

Reception:

- It is mandatory to coordinate the timing of FUCASO thaw and infusion. The infusion time need to be confirmed in advance, adapting the start time for thaw to ensure that FUCASO is available when the patient is ready.
- Upon reception of FUCASO from delivery service, the identity information must be confirmed between product package and individual patient information.

Package and Storage:

- FUCASO has been stored at the temperature of low than -130°C in vapor phase of liquid nitrogen during shipment from certified FUCASO manufacturing facility to medical centers.
- Until it is confirmed that the patient is ready for infusion and the decision of infusion is cleared, it is required to keep the cassette of FUCASO in the nitrogen can.
- The disposable packaging material is a 50 ml cell cryopreservation bag, consisting of a freezing bag, a filling component, and an outer bag.

Handling and Preparation:

- This product is prepared from autologous T cells and shall only be infused

to the same individual patient who previously provided PMBC during leukapheresis at Prior-infusion Stage. Therefore prior to infusion, it is requested to confirm that the patient's identity matches the identifiers on the product label.

- Prepare the water bath device and measure the water temperature with validated thermometer. Ensure the temperature is within the range of 37 °C ± 1 °C, and record it on the document.
- Thermo-protection gloves must be worn by healthcare professional to handle with FUCASO. Take the aluminum cassette holding FUCASO infusion bag out of liquid nitrogen storage can, and then confirm the identifier on the aluminum cassette with the individual patient information. Record the information on the document. If they do not match, discontinue the infusion process and reach FUCASO team immediately.
- After confirming identity information on the aluminum cassette, remove

the product bag from the cassette and identify whether the patient information on the cassette label matches the patient information on the bag label. If the identity information does not match, discontinue the infusion process immediately and contact FUCASO team for supports. Check whether the solution within the infusion bag is white or slightly yellow colored solid ice.

- FUCASO has been stored in extremely low temperature so prior to infusion, it shall be thawed prior to infusion. Before thawing FUCASO in water bath, the integrity of the product package shall be checked for any breaks or cracks. If there are any issues with the product bag, please contact FUCASO team immediately for supports.
- Quickly immerse FUCASO infusion bag in the 37 °C water bath device with a pair of tweezers clamping the middle part of the long edge of the bag. During thaw, the infusion bag should not touch the bottom or walls of the water bath device. Gently shake it to thaw as soon as possible. The thawing time is about 3 minutes until there is no visible ice in the product

bag. The fully thawed solution is slightly yellow in color. It is requested to confirm that the cell preparation is completely melted and then gently mix the contents of the bag to disperse the aggregated cells. If there are still visible cell clumps, please continue to gently mix the contents of the bag. The honeycomb shaped small clumps can be scattered with a flick by hand. Do not wash, centrifuge, and/or resuspend FUCASO before infusion.

- In any cases, the thawed FUCASO product cannot be re-frozen.

Administration at Bedside:

- Before infusion, ensure the vital sign monitoring devices and rescue car are ready at bedside, while inform Intensive Care Unit of any resuscitation attempts and supports in advances. It is also required that two doses of tocilizumab are ready for use.
- Thawed FUCASO should be administered as soon as possible at room temperature. Infusion should begin within 20 minutes and be completed

within 40 minutes after thawing.

- Use 20G or larger needles for infusion. Infusion filters, i.e. leukocyte-depleting filters or submicron bacterial filters, are not allowed, and the infusion should flow through non-filtering tubing pathway only.
- Before infusion, prime the tubing of infusion set with 0.9% normal saline. It is recommended to complete the injection at a rate of 60-96 drops per minute throughout the entire administration process. After infusion, flush the administration line with 0.9% normal saline to ensure that all remaining cells in the line are delivered.
- Vital signs, including body temperature, respiration, heart rate, blood pressure, and blood oxygen saturation, must be carefully monitored from 4 hours before infusion. If unstable vital signs are observed after infusion, the patients need to be monitored further until their stable condition is reached.

Post-Infusion Phase

Although CAR-T therapy is a leaping breakthrough of innovation in the treatment of cancer, they have been associated with some adverse events (AEs), including CRS and neurologic events (e.g. immune effector cell-associated neurotoxicity syndrome [ICANS]). Some of these adverse events have been observed in patient with other immunotherapy, such as PD-1 therapy for solid tumors. But most of the others are unique but common AEs due to anti-tumor cytotoxic chemo-agents, like cytopenia and infection have also been observed. These AEs are treatable and reversible with appropriate treatment strategies but can become troublesome and even life-threatening if not managed early and properly¹⁹. To this end, it is vital for healthcare professionals taking care for patients undergoing CAR-T to have a comprehensive understanding of the associated AEs, in particular their grading, monitoring, and proper management.

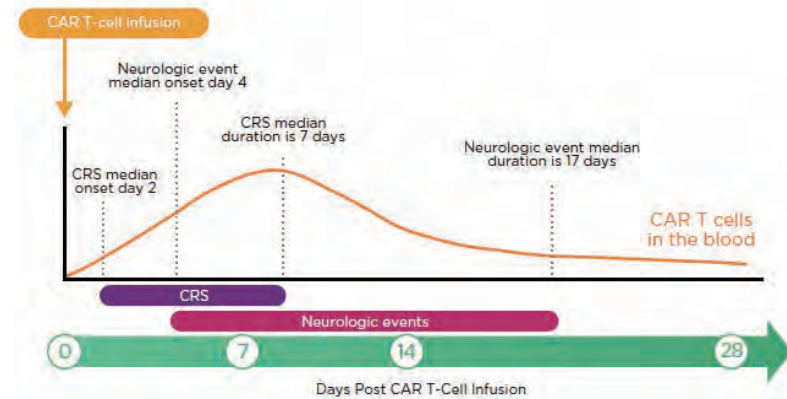


Figure: Illustrated chart showing Onset and resolution Trend of CRS and neurologic events.

Monitoring indicators

- Vital signs, including body temperature, respiration, heart rate, blood pressure, and blood oxygen saturation, must be carefully monitored till 4 hour after infusion. If unstable vital signs are observed after infusion, the patients need to be monitored further until their stable condition is reached. The vital signs are critical to early identify the patients who might suffer from CRS, and body temperature is also another indicator to track infection due to lymphodepleting chemotherapy and CAR-T treatment.
- Symptoms reported by patients who underwent CAR-T therapy are important for patients and healthcare professionals to keep close track to treatment related adverse reactions, in peculiar those reactions to be occurred when patients are discharge from hospitals. It is encouraged to educate patients on frequent monitoring their newly-onset and progressive-worsening symptoms. Those symptoms include but not limit to fever, chills, difficulty in breathing, chest tightness and palpitation, headache, dizziness, blurred vision, nausea and vomiting, muscle and joint pain, hypotension, bleeding in skin, mucous membranes, or other parts of the body.
- Peripheral blood cell counts are routine practice for patients to undergo anti-tumor therapies, and moreover, lymphocyte and neutrophil counting can

provide more information on existing infection from bacterial or viral source. Meanwhile, tracking on lymphocyte can facilitate a snap understanding of infused CAR-T cell in terms of their survival and expansion in the patient's body.

- Flow cytometry is an essential technology to elucidate both MRD negativity and CAR-T cells expansion level and velocity, as well as B cell recovery. B-cell recovery might be an indicator of functionally active CAR-T cells that deplete BCMA+ B cells and is associated with a sustained therapy response²⁰.
- Plasma gamma globulin is a useful index to indicate potential infections, as hypogammaglobulinemia caused by CAR-T infusion is associated with serious infection²¹.
- For patients susceptible to infection with possible clinical symptoms and / or signs, imaging technique and pathogen testing are helpful and warranted.
- It is also encouraged that patients remain living near the healthcare facility receiving infusion for at least 4 weeks after infusion, so they can receive timely medical attention and intervention in case of potential serious or life-threatening adverse reactions.

Acute Adverse Reactions During In-Patient Stay

It is recommended that the patients should be in hospital for at least 14 days after infusion to closely monitor and intervene any potential adverse reactions such as CRS and neurotoxicity in a timely manner, if those reactions arise.

CRS

The most common symptoms of CRS are high fevers, hypotension, tachycardia hypoxia and chills, and can include other organ toxicities while still, fever is the hallmark symptom of CRS onset. CRS may arise on the second day after infusion and has been mainly expected in patients within 14 days following CAR-T infusion. In FUMANBA-1 study, the median time for the first occurrence of CRS is 6.0 days after infusion (range: 1-13 days), and the median time for the duration of CRS is 5.0 days (range: 2-30 days). Also, 93.2% of the patients had CRS of any grades but there was no observed grade 3 or greater CRS.

If the patient has grade 2 or higher CRS, continuous ECG monitoring and blood oxygen saturation monitoring should be performed. Furthermore, patients with severe CRS should also consider conducting echocardiography to evaluate cardiac function. In the management of CRS, the use of corticosteroids and tocilizumab is preferred. Even for low-grade CRS, tocilizumab is still a reliable help for patients with significant symptoms, comorbidities with long duration. Intensive care is considered for severe or life-threatening CRS.

Please see product label for detailed instructions on how to grade and manage CRS.

Neurologic Toxicities

Neurologic toxicities (NT) can occur alongside with CRS, but also in a separate way, i.e. before or after CRS onset. The commonly observed neurologic toxicities arise with the popular symptoms of encephalopathy, tremor, dizziness, delirium, confusion and agitation. Based on experience of CD19 CAR-T, the median onset of NT is at Day 4 with a median duration of 17 days¹⁹. But similarly, in FUMANBA-1 study, 1.9% of the patients had NT of any grades and still there were no grade 3 or greater NT reported. It is recommended to monitor daily the patient's neurotoxicity (including ICANS) signs or symptoms within 14 days after Fucaso infusion. In occasions of NT onset, intensive care support is sought to be scheduled in a emergent fashion and the treatment for severe or

life-threatening ICANS following the recommendations per product label and / or other clinical guidelines are demanded. When NT occur along with CRS, tocilizumab is strongly encouraged in an early fashion.

Please see product label for detailed instructions on how to grade and manage NT (including ICANS).

Hematologic Adverse Events

In FUMANBA-1 study, the most common >= grade 3 treatment-relating adverse events were still hematologic. Leukocytopenia and thrombocytopenia are common due to lymphodepleting chemotherapy, CAR-T therapies and / or disease itself. Prolonged thrombocytopenia may be predicted using the exploratory model with four other factors, as described previously.

Most of hematologic adverse reactions are manageable and tolerable. Consultation with hematologists on how to manage these events are encouraged.

Delayed Adverse Reactions and Long-term Follow-up

CRS

Based on safety analysis from FUMANBA-1 study, CRS seldomly occur after 3 weeks after eque-cel infusion. Therefore, for patients who have fever two-three weeks after infusion, other overlapping susceptible cause, like active infection, must be taken into consideration, especially in those who had suspected symptoms and previous relating comorbidities.

Neurologic Toxicities

The risk of NT diminishes by time, but it is still suggested to continue monitoring these neurologic events in a nearby certificated healthcare facility within 4 weeks after infusion. Patients and their close relatives are highly encouraged to understand the importance of monitoring these suspected symptoms of NT, keep close look onto them, and report back to healthcare professionals, in case of occurrence.

Bacterial Infection

After CAR-T infusion, patients may experience serious or life-threatening infections. Before and after the infusion, the symptoms and signs of infection must be monitored.



However, antibacterial prophylaxis is not recommended by international clinical positioning paper⁹. If the patient develops fever or infectious symptoms, even if CRS is suspected, microbiological samples should be collected, and empiric antibiotic treatment initiated according to the local protocol.

The clinical situation should be reassessed 48 h after the onset of fever. If there is no sign of active infection, the cultures are negative, the diagnosis of CRS is highly probable and the patient is afebrile or stable, the withdrawal of the antibiotic should be considered.

Viral Infection

When plasma cell targeted therapy are administered, viral reactivation may occur, such as hepatitis B virus (HBV), cytomegalovirus, herpes simplex virus (HSV), etc. Patients with previous hepatitis B infection and positive hepatitis B core antibody should be carefully monitored and treated according to institution guidelines to prevent viral reactivation.

For HSV seropositive patients, it is advised to be given acyclovir 400-800 mg

every 12 h po (or 5 mg/kg every 12 h iv) for at least 60–100 days after CAR T-cell infusion⁹. The prophylaxis duration can be considered to extend even longer in high-risk patients, such as those who had recent allogenic HSCT, steroid/ tocilizumab therapies.

Long-term Follow-up

For patients with stable conditions after discharge from hospital following FUCASO infusion, it is suggested to:

- Weekly monitoring on peripheral blood counting, CRP and retest any deviated testing results.
- Monthly monitoring on CAR-T expansion and B-cell recovery
- Bi-monthly or quarterly monitoring for disease progression, tumor evaluation and MRD

05 | OTHER RELATING TOPICS OF FUCASO CLINICAL USE

Manufacturing Failure

In case of manufacturing failure of FUCASO at manufacturing facility, the rest from the last batch of PBMC collection sample may be used as backup (if applicable), or a new PBMC sample to be re-collected from the same patient, in order to initiate the production of a new batch of FUCASO. The consistent manufacturing and quality assurance requirement will be applied to the new batch.

Unable To Infuse Due to Clinical Concerns

In rare situation, the patient will be in emergent clinical condition and CAR-T infusion is not clinically indicated, after he/she undergoes lymphodepletion and FUCASO product is on delivery to medical center or has even been available in medical centers. FUCASO therapy shall be discontinued until the patient recovers from such emergency. Please immediately contact FUCASO team for supports.

If FUCASO has not been removed from shipment package and has not been thawed to ambient temperature, it might be possible to ship them back to manufacturing facility for storage until future use. This FUCASO product must be carefully checked when received by facility.

Accidental Exposure To FUCASO

If by any accident, any patient or individual who is not intended to receive this batch of product is exposed to FUCASO, please put the recipient under intensive care immediately and contact FUCASO team for supports.

Regulatory authority might be informed of this occasion under the required serious adverse reaction reporting policy.

06 | KEY SAFETY INFORMATION OF FUCASO

1. Safety Data Summary

The safety summary of equecabtagene autoleucel injection is based on the data of the 79 subjects included in the phase I/II relapsed/refractory multiple myeloma clinical trial (XL-LCYJ-0007), including 17 subjects in phase I trial and 62 subjects in phase II trial. The median follow-up time for safety data was 9.396 months.

In the clinical trial, the incidence of all levels of adverse drug reactions of the subjects after receiving the treatment of equecabtagene autoleucel injection was 100%. The incidence of grade 3 and above adverse drug reaction was 93.7%.

2. Adverse reactions in clinical study

A total of 79 subjects with relapsed/refractory multiple myeloma, aged ≥ 18 years, who had undergone ≥ 3 lines treatment (including chemotherapy based on proteasome inhibitors and immunomodulators), received this product for infusion.

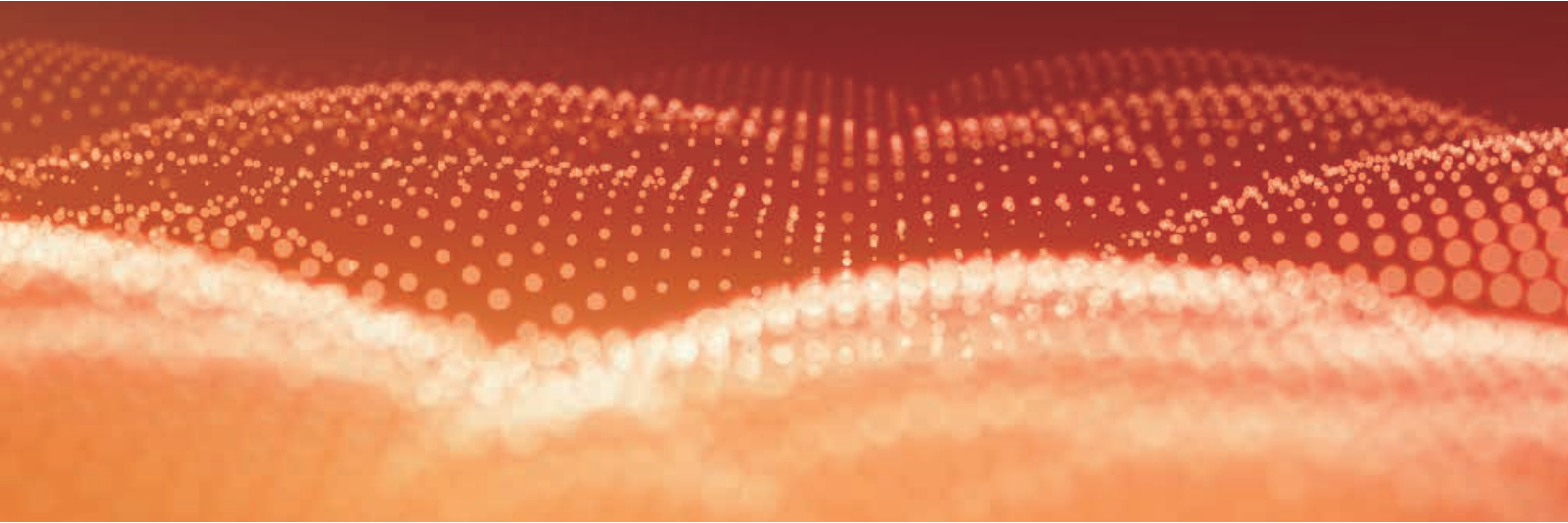
According to the incidence classification of adverse reactions recommended by the Council for International Organizations of Medical Sciences (CIOMS): very common ($\geq 10\%$), common ($1\%\sim 10\%$, including 1%), occasional ($0.1\%\sim 1\%$, including 0.1%), rare ($0.01\%\sim 0.1\%$, including 0.01%), very rare

(<0.01%). According to the CIOMS standard, all adverse reactions of this product have been summarized and provided below:

Very common adverse drug reaction (incidence $\geq 10\%$) includes pyrexia, cytokine release syndrome, hypogammaglobulinemia, decreased blood cell counting (including neutrophils, white blood cells, platelets, lymphocytes, red blood cells), hepatic function abnormal (aminotransferase increased), blood lactate dehydrogenase increased, hypoglobulinemia, electrolyte imbalance, infection, coagulopathy, vomiting, cough, diarrhoea, hypotension, cardiac function abnormal, edema.

Common adverse drug reaction (incidence of $1\%\sim 10\%$) includes fatigue, nausea, pain, blood cell counting abnormal, hypoxia, renal function abnormal (serum creatinine increased, proteinuria), metabolism abnormal (hyperuricemia, altered blood glucose and lipid metabolism), thrombin time prolonged, digestive system symptoms (constipation, abdominal bloating), neural system symptoms (insomnia, headache, dizziness), infectious complications, cardiovascular disorders (heart failure, hypertension, bradycardia, electrocardiogram abnormal), tumor lysis syndrome, sepsis, immune related adverse effects and other electrolyte dysfunction.

In the study, 52 subjects (65.8%) were treated with systemic corticosteroid



hormone and 22 subjects (27.8%) were treated with tocilizumab after receiving the treatment of Equecabtagene Autoleucl injection.
Please refer to the product label for the detailed incidence of any specific adverse event.

3. Adverse reactions/ adverse events of special concern

• Cytokine Release Syndrome (CRS)
In the XL-LCYJ-0007 study, 75/79 (94.9%) subjects who received treatment with Equecabtagene Autoleucl injection developed CRS, all were grade 1-2 CRS. The median time for the first occurrence of CRS is 6.0 days after infusion
(range: 1-13 days), and the median time for the duration of CRS is 5.0 days

(range: 2-30 days). The main CRS related adverse events (incidence ≥ 10%) included pyrexia (75/79, 94.9%), blood lactate dehydrogenase increased (13/79, 16.5%), hypotension (11/79, 13.9%), aspartate aminotransferase increased (9/79, 11.4%) and vomiting (8/79, 10.1%). 48/79 subjects (64.0%) were treated with corticosteroid, and 21/79 subjects (28.0%) were treated with tocilizumab.
The monitoring and management of CRS can be found in Warnings and Precautions.
Neurologic toxicitiesIn the XL-LCYJ-0007 study, 11/79 (13.9%) subjects who received treatment with Equecabtagene Autoleucl injection had adverse reactions of nervous system and psychosis related to the product, including headache and insomnia (each 4/79, 5.1%), lethargy, dizziness and post herpetic neuralgia (each 1/79, 1.3%), and 2/79 subjects (2.5%) had immune effector cell-associated neurotoxic syndrome (ICANS). Among them, 1/79 subject (1.3%) developed grade 2 ICANS 10 days after cell infusion, while the

main symptoms were lethargy and wakefulness after breathing and the lasting duration was 1 day. They received a dose of tocilizumab. Another 1/79 (1.3%) subject developed grade 1 ICANS 3 days after cell infusion, mainly manifested as mild drowsiness, lasting for 2 days. The ICANS outcomes of the two subjects mentioned above were all cured. Note: ICANS was graded according to the ASTCT standard (2019).
Monitoring and management of neurologic toxicities can be found in Warnings and Precautions.
• Hematological toxicity
Hematological toxicity includes persistent cytopenia and coagulation disorders. In the XL- LCYJ-0007 study, 79 subjects (100%) experienced grade 3 or higher blood cell count decreased that lasted for more than 30 days. The incidence included (ranged from high to low):
lymphocyte count decreased (79/79, 100%), white blood cell count decreased (76/79, 96.2%), neutrophil count decreased (75/79, 94.9%), hemoglobin decreased (55/79, 69.6%), and platelet count decreased (48/79, 60.8%). Coagulation disorders of grade 3 or above (5/79, 6.3%) included blood fibrinogen decreased (4/79, 5.1%) and activated partial thromboplastin time prolonged (1/79, 1.3%).
See Precautions for the monitoring and management of hematological toxicity.
• Severeinfections
In the XL-LCYJ-0007 study, 42/79 (53.2%) subjects developed cell infusion related infections andinfestation. Among them, 29/79 subjects (36.7%) were grade 3 or above, including: pneumonia (22/79, 27.8%), sepsis (4/79, 5.1%), upper respiratory tract infection (3/79, 3.8%), herpes zoster, febrile infection, infection, septic shock, enteritis infectious and bacterial infection (1/79, 1.3%). Among them, 3/79 (3.8%) of the subjects were level 5 infection, including pneumonia (3/79, 3.8%), sepsis, and septic shock (both 1/79, 1.3%).
Note: According to the CTCAE v5.0 standard, infections with grade ≥ 3 are defined as severe infections.
Some infections may be life-threatening or lead to death. The monitoring and management of severe infections can be found in Warnings and Precautions.

• Immunogenicity
This product is fully human autologous CAR-T cells, but it still has the possibility of inducing the production of antibodies against this product. The immunogenicity of this product is evaluated by using the electrochemiluminescence immunoassay technology to detect antibodies that can bind to CAR. In the XL-LCYJ-0007 study, 13/79 (16.5%) subjects developed anti-CAR antibodies after cell infusion, while 2 (2/76, 2.6%) subjects were detected within 3 months of infusion; 5 (5/61, 8.2%) subjects were detected at 6 months of infusion; 5 (5/15, 33.3%) subjects were detected at 12 months. At 6 months follow-up, the median VCN of 5 subjects who produced human anti-CAR antibodies was 0.000 copies/μg DNA, and the median VCN of 55 subjects who did not produce human anti-CAR antibodies was 254.590 copies/μg DNA; At 12 months follow-up, the median VCN of 5 subjects who produced human anti-CAR antibodies was 0.000 copies/μg DNA, and the median VCN of 10 subjects who did not produce human anti-CAR antibodies was 240.000 copies/μg DNA. The difference in VCN levels between the two visit points was statistically significant (P<0.05) by Wilcoxon's test, indicating that VCN levels in subjects who produced anti-CAR antibodies were significantly lower than those who did not produce anti-CAR antibodies during the 6 and 12 months follow-up.
• Tumor lysis syndrome (TLS)
In the XL-LCYJ-0007 study, 4/79 subjects (5.1%) developed tumor lysis syndrome, with 1/79 (1.3%) having a severity grade 4, 2/79 (2.5%) having a severity grade 3, and 1/79 (1.3%) having a severity grade 2. All of them were recovered. The monitoring and management of tumor lysis syndrome can be found in the Precautions.
• Hypogammaglobulinemia
In the XL-LCYJ-0007 study, 70/79 (88.6%) subjects developed hypogammaglobuline- mia (including diagnosis of hypogammaglobulinemia and laboratory IgG<500mg/dl). 64/79 subjects (81.0%) received immunoglobulin therapy during the study. The monitoring and management of hypogammaglobulinemia can be found in the Precautions.

07 | REPORTING ADVERSE REACTIONS TO IASO BIO

In case of possible adverse reactions and / or serious adverse reactions to your patients, you are obliged to report those actions to IASO Bio in a timely manner. For serious adverse reactions, you are required to report within 48 hours after first awareness of such incidence. Some of your professional information, patient identity information, key clinical information regarding such reactions will be needed for facilitating the subsequent reporting to regulatory authorities. During the process, those data you provide will be handled in a manner where privacy will be highly respected.



08 | CONTACT INFORMATION OF FUCASO TEAM

Marketing Authorization Holder

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Manufacturer

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