Gilead Sciences, Inc. is providing this document to you, a US Healthcare Professional, in response to your unsolicited request for medical information.

GILEAD | Medical Information

Trodelvy® (sacituzumab govitecan-hziy) Impact of Dose Modifications on Outcomes in mBC Studies

This document is in response to your request for information regarding Trodelvy® (sacituzumab govitecan-hziy [SG]) monotherapy and the impact of dose modifications on outcomes in metastatic breast cancer (mBC) studies.

Gilead continually assesses safety data from all sources for unidentified drug reactions and updates the product label information accordingly to reflect the safety profile of SG. Because case reports of potential adverse reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish causal relationship to drug exposure. For this reason, Gilead does not provide information from post-marketing spontaneous reports.

Some data may be outside of the US FDA-approved prescribing information. In providing this data, Gilead Sciences, Inc. is not making any representation as to its clinical relevance or to the use of any Gilead product(s). For information about the approved conditions of use of any Gilead drug product, please consult the FDA-approved prescribing information.

The full indication, important safety information, and boxed warnings for neutropenia and diarrhea are available at: www.gilead.com/-/media/files/pdfs/medicines/oncology/trodelvy/trodelvy_pi.

Summary

Relevant Product Labeling[1]

Dosage and Administration: Recommended Dosage

The recommended dosage of SG as a single agent or in combination with pembrolizumab is 10 mg/kg administered as an IV infusion on Days 1 and 8 of each 21-day cycle. Continue SG until disease progression or unacceptable toxicity. Do not administer SG at doses >10 mg/kg.

Dosage and Administration: Dosage Modifications for Adverse Reactions

Management of adverse reactions may require temporary interruption, dose reduction, or permanent discontinuation of SG as described in Tables 1 and 2 of the US FDA-approved Prescribing Information. Do not re-escalate the SG dose after a dose reduction for adverse reactions has been made.

Monitor patients during the infusion and for at least 30 minutes after completion of infusion. Treatment interruption and/or dose reduction may be needed to manage adverse reactions; see Tables 1 and 2 of the US FDA-approved Prescribing Information.

Clinical mBC Studies: Impact of Dose Modifications on Outcomes

In ASCENT, a study of patients with mTNBC in a 2L+ setting, 61% and 33% of patients in the SG and TPC groups, respectively, had a dose interruption. Dose reductions occurred in 26% and 22% of patients in the SG and TPC groups, respectively.[2]

- Patients in the SG group had improved ORR, CBR, and PFS vs patients in the TPC group, regardless of these dose modifications.

In TROPiCS-02, a study of patients with pretreated HR+/HER2- mBC, AEs that led to dose delays and dose reductions occurred in 66% and 33% of patients in the SG group vs 44% and 33% of patients in the TPC group, respectively.[3,4]

- In the SG group, rates of PFS, OS, CR, and CBR declined with decreases in RDI.[5]

In an exposure-response analysis of patients with mTNBC (N=277), the risk of dose reductions, dose delays, any-grade AEs of vomiting, diarrhea, nausea, or neutropenia, and Grade ≥3 neutropenia increased as the $CAVG_{SG}$ increased. The likelihood of continuing SG without requiring a dose reduction or delay was lower with an SG 10 mg/kg starting dose than with SG 8 mg/kg.[6]

Real-World mBC Studies: Impact of Dose Modifications on Outcomes

A database study (N=433) found that patients who received an SG starting dose of 10 mg/kg had a median DoT of 136 d vs 77 d for patients with a starting dose of ≤7.5 mg/kg (*P*=0.012). Additionally, dose reductions resulted in a DoT of 172 d vs 89 d for those without dose reductions (*P*<0.001).[7]

A single-center, retrospective chart review of 128 patients with mTNBC and HR+/HER2- mBC found that PFS was improved (*P*=0.018) in patients who had dose reductions. Multivariate analysis supported improved PFS, which was observed in patients who had dose reductions (HR 0.67; 95% CI: 0.46–0.99; *P*=0.044).[8]

A multi-institution retrospective study of patients (N=115) with mTNBC evaluated RDI and starting dose of SG on outcomes. The median (range) RDI and starting dose (range) of SG was 92% (33-100%) and 10 mg/kg (5-10 mg/kg), respectively. The median (range) starting dose for patients who had an objective response, SD, and PD was 10 (5-10) mg/kg. There was no statistical difference between RDI, median starting dose, and ORR or CBR. RDI did not affect the response rates; median RDI in the PR/CR/SD vs PD groups was 0.88 vs 0.91; *P*=0.3.[9,10]

A retrospective cohort study of four oncology centers analyzed data from 83 patients with mTNBC. Initial dose reductions of SG ≥10% were reported in 16 patients (9 patients received a ≥20% dose reduction). There were no statistical differences in PFS or OS in patients who received an initial SG dose reduction of ≥10% (n=16) vs those who received <10% dose reduction; log-rank *P*=0.3 and *P*=0.09, respectively; a trend toward worse outcomes was noted. Conversely, patients who had an initial dose reduction ≥20% reported significantly shorter PFS (log-rank *P*=0.03) and OS (log-rank *P*<0.001) vs those who had an initial dose reduction <20%. mPFS (95% CI) in the initial <20% dose-reduced group was 4.4 (2.6–6.5) mo vs 2.2 (2.1–2.3) mo in the initial ≥20% dose reduction group; the corresponding mOS (95% CI) were 10.3 (6.8–13.8) mo and 3.9 (1.7–6) mo, respectively.[11]

- In patients who received an initial ≥20% dose reduction vs those who did not, hazard ratios for PFS and OS in a univariate Cox regression analysis were, 2.3 (95% CI: 1.1–4.9; *P*=0.03) and, 4.8 (95% CI: 2.1–11.3; *P*<0.001), respectively. After adjusting for clinically relevant factors in a multivariate Cox regression analysis, an initial ≥20% dose

reduction remained an independent predictor of shorter PFS (HR 2.6; 95% CI: 1.1–6.6; *P*=0.04) and shorter OS (HR 6; 95% CI: 2–17.5; *P*=0.001). The initial ≥20% dose reduction had no significant impact on the incidence of Grade ≥2 AEs (n=3 [66.7%] vs n=63 [85.1%]; *P*=0.17), Grade ≥3 AEs (n=4 [44.4%] vs n=43 [58.1%]; *P*=0.49), or on the frequency of G-CSF use (n=8 [88.9%] vs n=62 [83.8%]; *P*=1).

A single-center, retrospective mBC cohort study compared outcomes with SG 10 mg/kg (n=24) vs SG 8 mg/kg (n=24). Subsequent dose reductions were reported in 54.2% and 37.5% of patients who received SG 10 mg/kg and 8 mg/kg, respectively. There was no statistical difference in mPFS and mOS between patients in the two groups; mPFS (95% CI) in the SG 10 mg/kg and 8 mg/kg groups, respectively, was 3.4 (2.6–9.5) mo vs 3.5 (1.9–7.7) mo; *P*=0.9; mOS (95% CI) was 10.6 (7.6–13.3) mo vs 11.1 (5.4–30.5) mo; *P*=0.4. Hospitalization due to SG toxicity was reported in 20.8% of patients who received SG 10 mg/kg and in 4.3% of patients who received SG 8 mg/kg (*P*=0.2).[12]

Clinical mBC Studies: Impact of Dose Modifications on Outcomes

ASCENT Study in 2L+ mTNBC

In ASCENT, a study of patients with mTNBC in a 2L+ setting, patients in the SG group (n=258) received a median (range) of 7 (1–33) treatment cycles, with a median (range) treatment duration of 4.4 (0.03–22.9) mo.[13]

Results[2]

The primary analysis assessed efficacy in patients who were BMNeg and who received ≥1 dose of SG or TPC. A post hoc analysis evaluated efficacy in patients who were BMNeg and who required dose interruption or dose reduction, compared with the overall BMNeg population. SG improved ORR, CBR, and PFS vs TPC, regardless of dose modifications. Additionally, patients in the SG group who had dose interruption(s) or reduction(s) experienced similar efficacy outcomes vs patients without dose modifications (Table 1).

Table 1. ASCENT: Efficacy Outcomes by Dose Reduction and Interruption (BMNeg Population)[2]

		ORR,[a] n (%)	CBR,[a] n (%)	Best Overall Response, n (%)		mPFS,[a] (95% CI), Mo
				CR	Partial Response	
Overall BMNeg population	SG (n=235)	82 (35)	105 (45)	10 (4)	72 (31)	5.6 (4.3–6.3)
	TPC (n=233)	11 (5)	20 (9)	2 (1)	9 (4)	1.7 (1.5–2.6)
Dose reductions	SG (n=62)	29 (47)	37 (60)	5 (8)	24 (39)	8.3 (5.4–10.3)
	TPC (n=52)	7 (13)	11 (21)	1 (2)	6 (12)	2.9 (2.7–4.3)
No dose reductions	SG (n=173)	53 (31)	68 (39)	5 (3)	48 (28)	4.6 (3.5–5.7)
	TPC (n=181)	4 (2)	9 (5)	1 (1)	3 (2)	1.5 (1.4–1.7)
Dose interruptions	SG (n=144)	56 (39)	71 (49)	7 (5)	49 (34)	5.7 (4.3–7)
	TPC (n=78)	5 (6)	12 (15)	0	5 (6)	2.7 (1.7–3)
No dose interruptions	SG (n=91)	26 (29)	34 (37)	3 (3)	23 (25)	4.2 (2.9–6.8)
	TPC (n=155)	6 (4)	8 (5)	2 (1)	4 (3)	1.6 (1.5–2.2)

[a]Assessed via BICR.

TROPiCS-02 Study in Pretreated HR+/HER2- mBC

In the OSP (n=517), a study of patients with pretreated HR+/HER2- mBC, patients received a mean (range) of 8.2 (1–35) SG treatment cycles over a median (range) duration of 4.1 (0.03–24.2) mo. Efficacy specific to patients who required dose interruption(s) or reduction(s), was not reported.[3]

A post hoc subgroup analysis found that ORR, CBR, PFS, and OS results in the SG group decreased numerically as RDI decreased (Table 2).[5]

Table 2. TROPiCS-02: Efficacy Outcomes (per BICR) According to RDI of SG[5]

Subgroup		ORR, n (%)	CBR, n (%)	mPFS, (95% CI), mo	mOS, (95% CI), mo
ITT population (n=272)		57 (21)	92 (34)	5.5 (4.2–7)	14.4 (13–15.7)
RDI[a]	>90% (n=88)	25 (28)	37 (42)	7.3 (4.4–8.9)	16.5 (13.9–19.1)
	>74–90% (n=89)	17 (19)	29 (33)	5.3 (4.1–7)	15.2 (11.9–18.7)
	≤74% (n=88)	13 (15)	24 (27)	4.2 (2.8–5.7)	13.1 (11.6–15.3)

[a]RDI accounted for dose reductions and delays; calculated as actual cumulative dose/total planned dose.

Exposure-Response Analyses of Outcomes in mTNBC[6]

The relationship between exposure to SG and outcomes was assessed in 277 patients with mTNBC from ASCENT (n=253 [8 mg/kg, n=4; 10 mg/kg, n=249]) and IMMU-132-01 (n=24 [8 mg/kg, n=16; 10 mg/kg, n=5; 12 mg/kg, n=3]) who received SG starting doses of 8 or 10 mg/kg. Measures of exposure, such as CAVG (defined as the CAVG [eg, for SG, free SN-38, and total antibody] between the first SG dose and the time of event, and accounted for dose reductions and delays), were assessed. Models were used to predict response outcomes for SG 8 mg/kg and 10 mg/kg starting doses which included the following covariates: body weight, age, race, region, study (safety only), prior treatment, prior lines of treatment, ECOG PS status, *UGT1A1* GT, and use of UGT1A1 inhibitors/inducers; lactate dehydrogenase and baseline trophoblast cell-surface antigen 2 (efficacy assessments only); and G-CSF (neutropenia assessment only).

Results

In this dataset, the median (range) age and body weight were 54 (27–82) y and 66.7 (37.2–132) kg, respectively; 99.3% were female, 80.5% were White, and 67.9% were from North America.

As $CAVG_{SG}$ increased, the probability of any-grade AEs of vomiting, diarrhea, nausea, or neutropenia, and Grade ≥3 neutropenia were increased. Within the SG 10 mg/kg starting dose group, the model-predicted proportions of patients with any-grade AE vomiting, diarrhea, nausea, and neutropenia were 35.9%, 67.4%, 64.7%, and 67.1%, respectively; the model-predicted rate of Grade ≥3 neutropenia in this group was 54.3%.

$CAVG_{SG}$ was the most statistically significant exposure metric that correlated with the time to first dose reduction and time to first dose delay (P<0.001); as $CAVG_{SG}$ increased, the risk of dose reductions and delays increased (Table 3).

None of the evaluated covariates had a significant effect on the time to first dose reduction, after adjusting for the effect of $CAVG_{SG}$. Patient body weight had a significant effect on the probability of dose delays (P<0.001); patients with a higher body weight were estimated to have a lower risk of dose delays than those with a lower body weight. The likelihood of continuing SG without requiring a dose reduction or delay was lower with SG 10 mg/kg than with SG 8 mg/kg.

Table 3. Exposure-Response Analysis for IMMU-132-01 and ASCENT: Model-Predicted Probability of Dose Modifications Over 12 mo According to CAVG by Starting Dose[6]

Endpoint	Probability at Mean 8 mg/kg $CAVG_{SG}$ (95% CI)	Probability at Mean 10 mg/kg $CAVG_{SG}$ (95% CI)
Dose reduction	0.0674 (0.0356–0.0993)	0.212 (0.148–0.276)
Dose delay[a]	0.512 (0.43–0.594)	0.886 (0.831–0.941)

[a]Based on a median body weight of 66.7 kg.

Real-World mBC Studies: Impact of Dose Modifications on Outcomes

Impact of Starting Dose and Dose Reductions on DoT[7]

A real-world study utilizing the Integra Connect PrecisionQ database evaluated how SG starting dose and rate of dose reduction impacted DoT in patients with ≥12 mo of follow-up (N=433). Average (median) patient age was 59.6 y (61 y). Patient diagnosis was not specified in the study.

Results

Three SG starting doses were evaluated: 10 mg/kg (n=358 [83%]), 7.5 mg/kg (n=57 [13%]), and ≤5 mg/kg (n=18 [4%]).

The overall dose reduction rate was 37% (n=159). The rate of dose reduction for patients who started on SG 10 mg/kg was 35% and was not significantly different vs those who started SG ≤7.5 mg/kg (43%; *P*>0.05). The dose reduction rate was also not significantly different for patients who started SG 7.5 mg/kg (39%) vs those who started SG ≤5 mg/kg (56%; *P*>0.05).

The median DoT overall was 116 d (n=336). Patients who started on SG 10 mg/kg (n=254) had a longer DoT vs those who started on ≤7.5 mg/kg (n=61): 136 d vs 77 d, respectively (*P*=0.012). Additionally, patients who had a dose reduction (n=125) had a longer DoT vs those (n=190) who did not have a dose reduction: 172 d vs 89 d, respectively (*P*<0.001). Efficacy and safety outcomes were not reported in this study.

Impact of SG Dose Reductions on PFS[8]

A single-center, retrospective chart review of patients (N=128) with mTNBC (74.2%) and HR+/HER2- mBC explored associations between patient/tumor characteristics and SG response.

Results

Patients received SG as median (range) 4L therapy (1–13). Improved PFS (*P*=0.018) was demonstrated in patients who had dose reductions. Multivariate analysis supported improved PFS, which was observed in patients who had dose reductions (HR, 0.67; 95%

CI:0.46-0.99; *P*=0.044). Safety data specific to patients who had dose reductions was not reported.

Impact of RDI on Outcomes

A multi-institution retrospective study of patients (N=115) with mTNBC was conducted. The median (range) age at SG initiation was 60 (31-85) y.[9]

Results

The median (range) RDI of SG was 92% (33-100%). The median starting dose of SG was 10 mg/kg, with a range of 5-10 mg/kg (Table 4). The median (range) starting dose for patients who had an objective response, SD, and PD was 10 (5-10) mg/kg. There was no statistical difference between RDI, median starting dose, and ORR or CBR.[9,10]

RDI did not affect the response rates; median RDI in the PR/CR/SD vs PD groups was 0.88 vs 0.91; *P*=0.3.[9]

Table 4. RDI and Starting Dose by Clinical Outcomes[10]

		PR/CR/SD (Duration ≥6 Mo)	All Others (PD/SD, Duration <6 Mo/Death)	*P*-value
RDI	Mean/ Std/ N	0.84/ 0.15/ 45	0.87/ 0.15/ 54	0.29
	Median/ Min/ Max	0.88/ 0.53/ 1	0.91/ 0.33/ 1	
Starting Dose, mg/kg	Mean/ Std/ N	9.52/ 1.34/ 45	9.31/ 1.36/ 54	0.157
	Median/ Min/ Max	10/ 5/ 10	10/ 5/ 10	

Abbreviation: Std=standard deviation.

Impact of Initial SG Dose Reduction on Outcomes[11]

A retrospective cohort study analyzed data from medical records of 83 patients with mTNBC in four oncology centers in Poland. The impact of initial SG dose reduction on clinical outcomes and tolerability was assessed. Median (range) age was 55 (30–86) y.

Results

Initial dose reductions of SG ≥10% were reported in 16 patients (19.3%), including 9 patients (10.8%) who received a dose reduction ≥20%. A total of 18.1% of patients had administrative adjustments (defined as reductions >10% to flat doses of 200, 400, 600, or 800 mg). Other reasons for dose modification included anticipated or pre-existing toxicities. Overall dose reductions due to toxicity after treatment initiation and treatments delays occurred in 24.1% and 68.7% of patients, respectively.

There were no statistical differences in PFS or OS in patients who received an initial SG dose reduction of ≥10% (n=16) vs those who received <10% dose reduction; log-rank *P*=0.3 and *P*=0.09, respectively; a trend toward worse outcomes was noted. In contrast, patients who had an initial dose reduction ≥20% (n=9) experienced significantly shorter PFS (log-rank *P*=0.03) and OS (log-rank *P*<0.001) vs patients who had an initial dose reduction <20%. mPFS (95% CI) in the <20% dose-reduced group was 4.4 (2.6–6.5) mo vs 2.2 (2.1–2.3) mo in the ≥20% dose reduction group; the corresponding mOS (95% CI) were 10.3 (6.8–13.8) mo and 3.9 (1.7–6) mo, respectively.

In patients who received an initial ≥20% dose reduction vs those who did not, hazard ratios for PFS and OS in a univariate Cox regression analysis were, 2.3 (95% CI: 1.1–4.9; *P*=0.03)

and, 4.8 (95% CI: 2.1–11.3; *P*<0.001), respectively. After adjusting for clinically relevant factors in a multivariate Cox regression analysis, a ≥20% initial dose reduction remained an independent predictor of shorter PFS (HR 2.6; 95% CI: 1.1–6.6; *P*=0.04) and shorter OS (HR 6; 95% CI: 2–17.5; *P*=0.001).

The initial ≥20% dose reduction had no significant impact on the incidence of Grade ≥2 AEs (n=3 [66.7%] vs n=63 [85.1%]; *P*=0.17), Grade ≥3 AEs (n=4 [44.4%] vs n=43 [58.1%]; *P*=0.49), or on the frequency of G-CSF use (n=8 [88.9%] vs n=62 [83.8%]; *P*=1). In addition, the rates of all-grade hematologic AEs were not significantly different between the ≥20% and <20% dose reduction groups; neutropenia occurred in 5 (55.6%) vs 48 (64.9%) patients; *P*=0.72, anemia occurred in 3 (33.3%) vs 27 (36.5%) patients; *P*=1, and thrombocytopenia occurred in one (11.1%) vs 9 (12.2%) patients; *P*=1, respectively.

Impact of Standard vs Reduced SG Dose on Outcomes[12]

A single-center, retrospective mBC cohort study of patients with mTNBC (n=34) and ER+/HER2- mBC (n=14) compared outcomes of patients who received ≥1 cycle of an initial dose of either SG 10 mg/kg (n=24) or 8 mg/kg (n=24). The median (IQR) age of patients at SG initiation was 63 (50–70) y and they were followed for a median (IQR) of 10.5 (5.33–15.38) mo from initiation of the first SG dose.

Results

There were no statistical differences in mPFS or mOS in patients in the overall SG 10 mg/kg vs 8 mg/kg initial treatment groups; similarly, there were no statistical differences between SG 10 mg/kg vs 8 mg/kg for either outcome in patients with mTNBC and ER+/HER2- mBC (Table 5).

Table 5: mPFS and mOS for the Overall Cohort and Subgroups Stratified by Dose[12]

	Overall	SG 10 mg/kg	SG 8 mg/kg	P-value
SG	n=48	n=24	n=24	
mPFS (95% CI)	3.4 (2.6–5.7)	3.4 (2.6–9.5)	3.5 (1.9–7.7)	0.9
mOS (95% CI)	10.6 (8–14.1)	10.6 (7.6–13.3)	11.1 (5.4–30.5)	0.4
TNBC (n=34)				
mPFS (95% CI)	3.2 (2.6–7.8)	3.2 (2.4–9.8)	3.9 (2.6–NA)	0.1
mOS (95% CI)	11.5 (8.6–25.4)	10.9 (8–17.2)	25.4 (8.4–NA)	0.2
ER + (n=14) and ER+/HER2 low (n=14)				
mPFS (95% CI)	3.5 (1.6–10.7)	5.7 (4.9–NA)	1.6 (1.4–NA)	0.09
mOS (95% CI)	6.4 (4.3–NA)	6.7 (6–NA)	4.9 (3.7–NA)	0.8
ER+/HER2 low (n=14)				
mPFS (95% CI)	3.5 (1.6–10.7)	5.7 (4.9–NA)	1.6 (1.4–NA)	0.09
mOS (95% CI)	6.4 (4.3–NA)	6.7 (6–NA)	4.9 (3.7–NA)	0.8

The overall response rate for the entire SG cohort was 20.8%. Patients treated with SG 10 mg/kg and 8 mg/kg had an overall response rates of 16.7% vs 25%; *P*=0.72. Overall response rates for patients with TNBC were 23.5% (SG 10 mg/kg, 15.8% vs SG 8 mg/kg, 33.3%; *P*=0.42) and 14.3% (SG 10 mg/kg, 20% vs SG 8 mg/kg, 11.1%, *P*=1) for patients with ER+/HER2- mBC.

The median time (IQR) on SG treatment was 3.3 (2.3–8.1) mo for patients treated with SG 10 mg/kg and 3.5 (1.5–7.2) mo for patients treated with SG 8 mg/kg, *P*=0.42.

From Day 8 of Cycle 1, a total of 13 of 24 (54.2%) and 9 of 24 (37.5%) patients experienced subsequent dose reductions in the SG 10 mg/kg and 8 mg/kg groups, respectively. The

difference in dose reduction rates between groups was not statistically significant (*P*=0.38). Myeloid growth factor use was significantly higher in patients receiving SG 10 mg/kg (58% vs 0%; *P*<0.01). Hospitalization due to SG toxicity was reported in 20.8% of patients who received SG 10 mg/kg and in 4.3% of patients who received SG 8 mg/kg (*P*=0.2).

Ongoing Clinical Study

A phase 1/2, open label study of SG (NCT06926920) is evaluating the efficacy and safety of an alternative SG dose and schedule in patients with advanced TNBC. A total of 100 patients are expected to be enrolled.

References

1. TRODELVY® Gilead Sciences Inc. Trodelvy (sacituzumab govitecan-hziy) for injection, for intravenous use. U.S. Prescribing Information. Foster City, CA.
2. Rugo HS, Tolaney SM, Loirat D, et al. Safety analyses from the phase 3 ASCENT trial of sacituzumab govitecan in metastatic triple-negative breast cancer. *NPJ Breast Cancer.* 2022;98(8).
3. Rugo HS, Bardia A, Marme F, et al. Sacituzumab govitecan in hormone receptor-positive/human epidermal growth factor receptor 2-negative metastatic breast cancer. *J Clin Oncol.* 2022;40(29):3365-3376.
4. Rugo HS, Bardia A, Marme F, et al. Sacituzumab govitecan in hormone receptor-positive/human epidermal growth factor receptor 2-negative metastatic breast cancer [Supplementary Appendix]. *J Clin Oncol.* 2022;40(29):3365-3376.
5. Bardia A, Schmid P, Tolaney SM, et al. Clinical outcomes by age subgroups in the phase 3 TROPiCS-02 study of sacituzumab govitecan vs treatment of physician's choice in HR+/HER2− metastatic breast cancer. Presented at: Florida Society of Clinical Oncology; May 4-5, 2024; Kissimmee, FL.
6. Sathe AG, Diderichsen PM, Fauchet F, Phan SC, Girish S, Othman AA. Exposure-response analyses of sacituzumab govitecan efficacy and safety in patients with metastatic triple-negative breast cancer. *Clin Pharmacol Ther.* 2025;117(2):570-578.
7. Gorantla V, Erin A, Mike G, et al. Assessment of initial dosing and dose management of sacituzumab govitecan-hziy and how dosing practices impact duration of therapy (DOT) [Poster P02-18-01]. Presented at: San Antonio Breast Cancer Symposium (SABCS); December 5-9, 2023; San Antonio, TX.
8. Wong M, LeVee A, Ruel N, McArthur H, Mortimer JE. Characteristics associated with sacituzumab govitecan response in the real-world setting [Abstract P1-09-30]. Presented at: San Antonio Breast Cancer Symposium (SABCS); December 10-14, 2024; San Antonio, TX.
9. Alaklabi S, Roy AM, Zagami P, et al. Real-world clinical outcomes with sacituzumab govitecan in metastatic triple-negative breast cancer. *JCO Oncol Pract.* 2025;21(5):620-628.
10. Alaklabi S, Roy AM, Zagami P, et al. Real-world clinical outcomes with sacituzumab govitecan in metastatic triple-negative breast cancer [Supplement]. *JCO Oncol Pract.* 2025;21(5):620-628.
11. Pieniążek M, Kubeczko M, Las-Jankowska M, et al. Sacituzumab Govitecan initial dose reduction in polish patients with metastatic triple-negative breast cancer: impact on efficacy and safety. *Cancer Chemother Pharmacol.* 2025;95(1):97. doi: 10.1007/s00280-025-04823-3.
12. Stabellini N, Kaur J, Owusu C, et al. Real-world outcomes of reduced-dose versus standard-dose antibody drug conjugates in metastatic breast cancer: a retrospective cohort study. *Breast Cancer Res Treat.* 2026;215(2):59. doi: 10.1007/s10549-025-07891-4.
13. Bardia A, Hurvitz SA, Tolaney SM, et al. Sacituzumab govitecan in metastatic triple-negative breast cancer [Supplementary Appendix]. *N Engl J Med.* 2021;384(16):1529-1541.

Abbreviations

2L+=second line and later
4L=fourth line
AE=adverse event
BICR=blinded independent central review
BMNeg=negative for brain metastasis
CAVG=average concentration
CBR=clinical benefit rate
CR=complete response
DoT=duration of therapy
ECOG PS=Eastern Cooperative Oncology Group Performance Status
G-CSF=granulocyte colony-stimulating factor
HER2-=human epidermal growth factor receptor 2-negative
HR=hazard ratio
HR+=hormone receptor-positive
mBC=metastatic breast cancer
mOS=median overall survival
mPFS=median progression-free survival
mTNBC=metastatic triple-negative breast cancer
OR=odds ratio
ORR=objective response rate
OS=overall survival
OSP=overall safety population
PD=progressive disease
PFS=progression-free survival
PR=partial response
RDI=relative dose intensity
SD=stable disease
SG=sacituzumab govitecan-hziy
SN-38=active metabolite of irinotecan
TPC=treatment of physician's choice
UGT1A1=uridine diphosphate-glucuronosyl transferase 1A1

Product Label

For the full indication, important safety information, and boxed warning(s), please refer to the Trodelvy US Prescribing Information available at: www.gilead.com/-/media/files/pdfs/medicines/oncology/trodelvy/trodelvy_pi.

Follow-Up

For any additional questions, please contact Trodelvy Medical Information at:

☎ 1-888-983-4668 or 🖱 www.askgileadmedical.com

Adverse Event Reporting

Please report all adverse events to:

Gilead Pharmacovigilance and Epidemiology ☎ 1-800-445-3235, option 3 or 🖱 www.gilead.com/utility/contact/report-an-adverse-event

FDA MedWatch Program by ☎ 1-800-FDA-1088 or ✉MedWatch, FDA, 5600 Fishers Ln, Rockville, MD 20852 or 🖱 www.accessdata.fda.gov/scripts/medwatch

Data Privacy

The Medical Information service at Gilead Sciences may collect, store, and use your personal information to provide a response to your medical request. We may share your information with other Gilead Sciences colleagues to ensure that your request is addressed appropriately. If you report an adverse event or concern about the quality of a Gilead or Kite product, we will need to use the information you have given us in order to meet our regulatory requirements in relation to the safety of our medicines.

It may be necessary for us to share your information with Gilead's affiliates, business partners, service providers, and regulatory authorities located in countries besides your own. Gilead Sciences has implemented measures to protect the personal information you provide. Please see the Gilead Privacy Statement (www.gilead.com/privacy-statements) for more information about how Gilead handles your personal information and your rights. If you have any further questions about the use of your personal information, please contact gilead.privacy@gilead.com.

TRODELVY, GILEAD, and the GILEAD logo are registered trademarks of Gilead Sciences, Inc., or its related companies.
© 2026 Gilead Sciences, Inc.