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Trodelvy® (sacituzumab govitecan-hziy) Impact of *UGT1A1* Status on Safety Profile in Patients With mBC

This document is in response to your request for information regarding the impact of uridine diphosphate glucuronosyl transferase family 1 member A1 (*UGT1A1*) status on the safety profile of Trodelvy® (sacituzumab govitecan-hziy [SG]) in patients with metastatic breast cancer (mBC).

This document summarizes data from phase 2 and phase 3 clinical studies of SG monotherapy (10 mg/kg IV on Days 1 and 8 of a 21-d treatment cycle) and real-world 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]

Do NOT substitute SG for or use with other drugs containing irinotecan or its active metabolite SN-38.

Warnings and Precautions: Neutropenia

Neutropenia occurred earlier in patients with reduced UGT1A1 activity.

Primary prophylaxis with G-CSF is recommended starting in the first cycle of treatment in all patients at increased risk of febrile neutropenia, including older patients, patients with previous neutropenia, poor performance status, organ dysfunction, or multiple comorbidities.

Warnings and Precautions: Increased Risk of Adverse Reactions in Patients with Reduced *UGT1A1* Activity

Patients homozygous for the *UGT1A1*28* allele are at increased risk for neutropenia, febrile neutropenia, and anemia; and may be at increased risk for other adverse reactions when treated with SG.

The incidence of neutropenia and anemia was analyzed in 1202 patients who received SG and had *UGT1A1* GT results. In patients homozygous for the *UGT1A1*28* allele (n=138), the incidence of Grade 3 to 4 neutropenia was 57%. In patients heterozygous for the *UGT1A1*28* allele (n=531), the incidence of Grade 3 to 4 neutropenia was 48%. In patients homozygous for the WT allele (n=533), the incidence of Grade 3 to 4 neutropenia was 41%. In patients homozygous for the *UGT1A1*28* allele, the incidence of Grade 3 to 4 anemia was 17%. In patients heterozygous for the *UGT1A1*28* allele, the incidence of Grade 3 to 4 anemia was 9%. In patients homozygous for the WT allele, the incidence of Grade 3 to 4 anemia was 8%.

The median time to first neutropenia including febrile neutropenia was 9 days in patients homozygous for the *UGT1A1*28* allele, 19 days in patients heterozygous for the *UGT1A1*28* allele, and 21 days in patients homozygous for the WT allele. The median time to first anemia was 22 days in patients homozygous for the *UGT1A1*28* allele, 29 days in patients heterozygous for the *UGT1A1*28* allele, and 29 days in patients homozygous for the WT allele.

Closely monitor patients with known reduced UGT1A1 activity for adverse reactions. Withhold or permanently discontinue SG based on clinical assessment of the onset, duration, and severity of the observed adverse reactions in patients with evidence of acute early-onset or unusually severe adverse reactions, which may indicate reduced UGT1A1 enzyme activity.

Drug Interactions: Effect of Other Drugs on SG

UGT1A1 Inhibitors

Avoid administering UGT1A1 inhibitors with SG. SN-38 is a UGT1A1 substrate. Concomitant administration of SG with inhibitors of UGT1A1 may increase the incidence of adverse reactions due to potential increase in systemic exposure to SN-38.

UGT1A1 Inducers

Avoid administering UGT1A1 inducers with SG. SN-38 is a UGT1A1 substrate. Concomitant administration of SG with inducers of UGT1A1 may reduce exposure to SN-38.

Pharmacokinetics

Metabolism

No metabolism studies with SG have been conducted. SN-38 (the small molecule moiety of SG) is metabolized via UGT1A1. The glucuronide metabolite of SN-38 (SN-38G) was detectable in the serum of patients.

Drug Interaction Studies

No drug-drug interaction studies were conducted with SG or its components. Inhibitors or inducers of UGT1A1 may increase or decrease SN-38 exposure, respectively.

Pharmacogenomics

SN-38 is metabolized via UGT1A1. Genetic variants of the *UGT1A1* gene such as the *UGT1A1*28* allele lead to reduced UGT1A1 enzyme activity. Individuals who are homozygous or heterozygous for the *UGT1A1*28* allele are at increased risk for neutropenia, febrile neutropenia, and anemia from SG compared to individuals who are WT (**1/*1*).

Approximately 20% of the Black or African American population, 10% of the White population, and 2% of the East Asian population are homozygous for the *UGT1A1*28* allele

(**28/*28*). Approximately 40% of the Black or African American population, 50% of the White population, and 25% of the East Asian population are heterozygous for the *UGT1A1*28* allele (**1/*28*). Decreased function alleles other than *UGT1A1*28* may be present in certain populations.

SG Clinical Studies: Impact of *UGT1A1* Status on SG Safety Profile

In ASCENT,[2] a study in 2L+ mTNBC, SG treated patients with the homozygous *UGT1A1* polymorphism *(*28/*28)* GT had higher rates of Grade ≥3 TRAEs vs those with heterozygous (**1/*28)* and WT (**1/*1)* GTs, including neutropenia (59% vs 47% vs 53%), febrile neutropenia (18% vs 5% vs 3%), anemia (15% vs 6% vs 4%), and diarrhea (15% vs 9% vs 10%).[3]

In TROPiCS-02,[4] a study in pretreated HR+/HER2- mBC, SG treated patients with the homozygous *UGT1A1* polymorphism *(*28/*28)* GT vs those with heterozygous (*1/*28)* and WT (**1/*1*) GTs had higher rates of Grade ≥3 TEAEs (92% vs 75% vs 67%, respectively), Grade ≥3 neutropenia (64% vs 57% vs 45%), and Grade ≥3 diarrhea (24% vs 13% vs 6%), and higher rates of any-grade (but not Grade ≥3) anemia (48% vs 36% vs 33%), respectively.[5,6]

In ASCENT-03, an ongoing study in 1L PD-(L)1 inhibitor ineligible mTNBC[7], and ASCENT-04, an ongoing study in 1L PD-(L)1+ mTNBC,[8] exploratory safety analyses by *UGT1A1* GT status in patients treated with SG are planned[9,10]; however, this data is not yet available.

In IMMU-132-01, in patients with metastatic epithelial cancers (including patients with mTNBC and HR+/HER2- mBC), patients with the homozygous *UGT1A1*28* polymorphism (**28/*28*) had higher rates of neutropenia (60.9%) vs patients with the heterozygous *UGT1A1 (*1/*28;* 38.3%) or the WT (**1/*1;* 33.3%) alleles. Higher rates of diarrhea were also observed in the patients with the **28/*28* allele (60.9%) vs patients with the *1/*28 (*51.7%) or the WT (**1/*1;* 54.8%) alleles.[11]

SG Real-World Studies: Impact of *UGT1A1* Status on SG Safety Profile

A retrospective analysis of 68 patients with metastatic and locally recurrent HER2- BC (52 [76.5%] patients had TNBC) was conducted to evaluate the association between *UGT1A1* status and safety in patients who underwent GT testing for *UGT1A1* alleles. An increased risk of discontinuation for toxicity was observed in patients homozygous for *UGT1A1*28* (HR, 5.52; 95% CI: 1.15–26.49; *P*=0.03). No events of discontinuation for toxicity were observed in patients with a heterozygous GT (HR, 0; 95% CI: 0; *P*≤0.0001). However, 76% of patients with the *UGT1A1*28* homozygous GT either started on a lower dose, had a dose reduction, or were intolerant. Treatment alterations and discontinuations for intolerance were observed in 71% and 56% of patients in the heterozygous and WT groups, respectively.[12]

In a retrospective analysis in patients with advanced BC treated with SG, rates of any Grade ≥2 AEs were similar between patients with the **1/*1* GT and those with *1/*28 or *28/*28 GTs (42.9% vs 44.4%). Compared with patients with the *1/*1 GT, a higher proportion of patients with *1/*28 or *28/*28 GTs experienced Grade ≥3 AEs (28.6% vs 44.4%), Grade ≥3 neutropenia (28.6% vs 33.3%), and dose reductions due to toxicity (37.5% vs 66.7%).[13]

SG Clinical Studies: Impact of *UGT1A1* Status on SG Safety Profile

ASCENT Study in 2L+ mTNBC

ASCENT, an open-label, randomized, phase 3 study (N=529), compared the efficacy and safety of SG 10 mg/kg IV on Days 1 and 8 of a 21-d cycle (n=267) vs chemotherapy treatment of physician's choice (TPC [n=262; eribulin, vinorelbine, gemcitabine, or capecitabine]) in patients with refractory or relapsed mTNBC who had received ≥2 prior chemotherapies for unresectable, locally advanced, or metastatic disease.[2] Patients in the SG arm received a median of 7 treatment cycles (range: 1–33), with a median (range) treatment duration of 4.4 (0.03–22.9) mo.[14]

An exploratory safety subgroup analysis of 243 SG treated patients with known UGT1A1 status at baseline (**1/*1*, n=113; **1/*28*, n=96; **28/*28*, n=34) was performed. The median SG relative dose intensity was 99.8%, 99.5%, and 99.8%, and mean time to first dose reduction was 2.7, 2.4, and 1.8 months in the**1/*1*, **1/*28*, and **28/*28* groups, respectively. Patients with the **28/*28* allele had a higher incidence of Grade ≥3 TRAEs, including neutropenia, febrile neutropenia, anemia, and diarrhea, vs patients with the **1/*1* or **1/*28* alleles. The rate of treatment discontinuation due to TRAEs was greater among those with the**28/*28* (6%) GT vs those with the **1/*1* (2%) or **1/*28* (1%) alleles. TEAEs leading to dose reductions were greater among those with the **28/*28* (35%) GT vs those with the **1/*1* (18%) or **1/*28* (19%) GT. Further details can be found in Table 1.[3]

Table 1. ASCENT: Key TRAEs by UGT1A1 GT[3]

TRAEs, n (%)		SG (n=243)[a]					
		**1/*1* (n=113)		**1/*28* (n=96)		**28/*28* (n=34)	
		All Grade	Grade ≥3	All Grade	Grade ≥3	All Grade	Grade ≥3
Hematologic	Neutropenia[b]	76 (67)	60 (53)	55 (57)	45 (47)	24 (71)	20 (59)
	Anemia[c]	37 (33)	5 (4)	29 (30)	6 (6)	16 (47)	5 (15)
	Leukopenia[d]	18 (16)	10 (9)	13 (14)	9 (9)	8 (24)	5 (15)
	Lymphopenia[e]	10 (9)	1 (1)	5 (5)	1 (1)	4 (12)	2 (6)
	Febrile neutropenia	3 (3)	3 (3)	5 (5)	5 (5)	6 (18)	6 (18)
	Thrombocytopenia[f]	3 (3)	0	6 (6)	0	4 (12)	4 (12)
GI	Diarrhea	65 (58)	11 (10)	57 (59)	9 (9)	21 (62)	5 (15)

Abbreviation: GI=gastrointestinal.
[a]Patients with *UGT1A1* GT in the safety population of the SG arm. *UGT1A1* GTs were not listed for 7 patients.
[b]Neutropenia and decreased neutrophil count were combined.
[c]Anemia and decreased hemoglobin were combined.
[d]Leukopenia and decreased WBC count were combined.
[e]Lymphopenia and decreased lymphocyte count were combined.
[f]Thrombocytopenia and decreased platelet count were combined.
Note: Patients could have reported ≥1 TRAE per preferred term.

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

TROPiCS-02, an open-label, randomized, multicenter, phase 3 study (N=543), compared the efficacy and safety of SG 10 mg/kg IV on Days 1 and 8 of a 21-d cycle (n=272) vs TPC (n=271; eribulin, gemcitabine, capecitabine, or vinorelbine) in patients with HR+/HER2- mBC who were previously treated with ≥1 taxane, ≥1 endocrine therapy, and ≥1 cyclin-

dependent kinase 4/6 inhibitor therapy in any setting, and who had received ≥2 and ≤4 prior chemotherapy regimens for metastatic disease. In the OSP (n=517), patients received a mean of 8.2 SG cycles (range: 1–35) over a median (range) duration of 4.1 (0.03–24.2) mo.[4]

An exploratory safety analysis by UGT1A1 GT status was conducted in patients treated with SG; 38% had WT (**1/*1*; n=103), 44% had heterozygous (**1/*28*; n=119) and 9% had homozygous (**28/*28*; n=25) *UGT1A1* GT. Three patients (1%) treated with SG had other GTs, one each of **1/*36*, **1/*37*, and **28/*36*.[5,6] Median relative dose intensity (cumulative dosage received divided by total assigned dosage) was 99%, 98%, and 94% for patients with WT (**1/*1*), heterozygous (**1/*28*), and homozygous (**28/*28)* UGT1A1 GTs, respectively, and the median duration of exposure was 3.9, 4.8, and 2.8 mo, respectively.[15] Patients with homozygous (**28/*28* allele) GT had higher rates of Grade ≥3 TEAEs and TEAEs leading to discontinuation vs patients with WT (**1/*1*) or heterozygous (**1/*28*) GT. Patients with heterozygous (**1/*28*) or homozygous (**28/*28* allele) GT had higher rates of TEAEs leading to dose reduction vs those with WT (**1/*1*) GT. Further details can be found in Table 2.[5,6]

Table 2. TROPiCS-02: TEAEs by *UGT1A1* GT[5,6]

TEAEs, n (%)		SG (n=268)					
		**1/*1* (n=103)		**1/*28* (n=119)		**28/*28* (n=25)	
		All Grade	Grade ≥3	All Grade	Grade ≥3	All Grade	Grade ≥3
All TEAEs		103 (100)	69 (67)	119 (100)	89 (75)	25 (100)	23 (92)
That led to dose reduction		26 (25)	NR	49 (41)	NR	10 (40)	NR
That led to treatment interruption		70 (68)	NR	76 (64)	NR	19 (76)	NR
That led to dose discontinuation		5 (5)	NR	7 (6)	NR	3 (12)	NR
Special interest TEAEs	Neutropenia[a]	73 (71)	46 (45)	86 (72)	68 (57)	19 (76)	16 (64)
	Diarrhea	60 (58)	6 (6)	77 (65)	15 (13)	17 (68)	6 (24)
	Anemia[b]	34 (33)	6 (6)	43 (36)	10 (8)	12 (48)	2 (8)
	Febrile neutropenia	6 (6)	6 (6)	8 (7)	8 (7)	1 (4)	1 (4)

Abbreviation: NR=not reported.
[a]Combined preferred terms of neutropenia and neutrophil count decreased.
[b]Combined preferred terms of anemia, hemoglobin decreased, and red blood cell count decreased.

ASCENT-03 Study in 1L PD-(L)1 Inhibitor Ineligible mTNBC

ASCENT-03, an ongoing, global, open-label, randomized, phase 3 study (N=558), is comparing the efficacy and safety of SG (n=279) vs TPC (n=279; gemcitabine + carboplatin, paclitaxel, or nab-paclitaxel) as 1L treatment in patients with previously untreated, locally advanced, inoperable or mTNBC who are not candidates for PD-(L)1 inhibitor therapy.[7]

An exploratory safety analysis by *UGT1A1* GT status in patients treated with SG is planned;[9] however, this data is not yet available.

ASCENT-04 Study in 1L PD-L1+ mTNBC

ASCENT-04, an ongoing, global, open-label, randomized, phase 3 study (N=443), is comparing the efficacy and safety of SG + pembrolizumab (n=221) vs TPC (gemcitabine + carboplatin, paclitaxel, or nab-paclitaxel) + pembrolizumab (n=222) as 1L treatment in patients with PD-L1+ (combined positive score ≥10) inoperable, locally advanced or mTNBC.[8]

An exploratory safety analysis by *UGT1A1* GT status in patients treated with SG is planned;[10] however, this data is not yet available.

IMMU-132-01 Study in Metastatic Epithelial Cancer

IMMU-132-01, a phase 1/2, single-arm, open-label basket study investigated the efficacy and safety of SG IV on Days 1 and 8 of a 21-d cycle in patients with metastatic epithelial cancers (including patients with mTNBC and HR+/HER2- mBC) who had relapsed after or were refractory to ≥1 prior therapy for metastatic disease. *UGT1A1* testing was performed in all patients.[11]

Impact of *UGT1A1* status on safety

The OSP (N=495) included all patients who received ≥1 dose of SG. Descriptive analysis was performed to analyze the incidence of AEs in 81.4% of patients in the OSP who had *UGT1A1* GT data available (n=403).[11]

The pattern and incidence of AEs were broadly similar between patients who were heterozygous (**1/*28)* and those who had the WT allele. Safety outcomes according to *UGT1A1* status can be found in Table 3.[16]

Table 3. IMMU-132-01: Safety Outcomes According to *UGT1A1* Status[16]

Safety Outcomes, n (%)		*UGT1A1* Status		
		****1/*1*** **(n=177)**	****1/*28*** **(n=180)**	****28/*28*** **(n=46)**
Any-grade TEAE		177 (100)	179 (99.4)	46 (100)
Grade ≥3 TEAE		121 (68.4)	141 (78.3)	41 (89.1)
Any-grade TRAE		175 (98.9)	173 (96.1)	44 (95.7)
Grade ≥3 TRAE		95 (53.7)	110 (61.1)	38 (82.6)
SAE		64 (36.2)	66 (36.7)	27 (58.7)
Treatment-related SAE		25 (14.1)	18 (10)	19 (41.3)
TEAE that led to discontinuation of SG		12 (6.8)	12 (6.7)	2 (4.3)
TEAE that led to dose interruption		82 (46.3)	87 (48.3)	33 (71.7)
TEAE that led to on-treatment death[a]		5 (2.8)	8 (4.4)	1 (2.2)
Most common TRAEs (≥30% of patients in any *UGT1A1* status group)	Nausea	112 (63.3)	103 (57.2)	31 (67.4)
	Diarrhea	97 (54.8)	93 (51.7)	28 (60.9)
	Fatigue	80 (45.2)	80 (44.4)	21 (45.7)
	Alopecia	74 (41.8)	73 (40.6)	15 (32.6)
	Vomiting	72 (40.7)	56 (31.1)	23 (50)
	Anemia	66 (37.3)	57 (31.7)	23 (50)
	Neutropenia	59 (33.3)	69 (38.3)	28 (60.9)
	Decreased appetite	39 (22)	50 (27.8)	18 (39.1)

Abbreviations: SAE=serious adverse event.
[a]Defined as death that occurred between the start of SG treatment and 30 d after the last dose.

SG Real-World Studies: Impact of *UGT1A1* Status on SG Safety Profile

Retrospective Analysis of Patients With the *UGT1A1*28* Polymorphism[12]

A retrospective analysis of patients (N=68) with metastatic and locally recurrent HER2- BC (52 [76.5%] patients had TNBC) was conducted to evaluate the association between *UGT1A1* status and safety in patients who underwent GT testing for *UGT1A1* alleles. The

most common polymorphism was *UGT1A1*28*, which was homozygous in 17 (25%) patients and heterozygous in 24 patients (35.3%; including one patient with **1/*37 UGT1A1* polymorphism). The remaining 27 (39.7%) patients had the WT GT. Patients received a median (range) of 8.5 (1–54) doses of SG and were observed for a median (range) of 3.9 (0.9–23.7) mo. Fifty-eight patients started treatment with SG 10 mg/kg and 10 patients started at reduced doses of SG 7–8 mg/kg.

Results

An increased risk of discontinuation for toxicity was observed in patients homozygous for *UGT1A1*28* (HR 5.52 [95% CI 1.15–26.49], *P*=0.03). No events of discontinuation for toxicity were observed in patients with a heterozygous GT (HR, 0; 95% CI: 0; *P*≤0.0001). However, 76% of patients with a *UGT1A1*28* homozygous GT either started on a lower dose, had a dose reduction, or were intolerant. Treatment alterations and discontinuations for intolerance were observed in 71% and 56% of patients in the heterozygous and WT groups, respectively.

Retrospective, Observational Study in Advanced BC[13]

An ongoing, single-center, study is evaluating the safety and tolerability of SG according to *UGT1A1* polymorphism in patients with advanced BC. Patients were grouped as the normal group, comprising individuals with the **1/*1* GT, or the risk group, comprising carriers of the **28* allele (**1/*28* or **28/*28* GTs). A total of 17 patients were included; 8 patients had the *UGT1A1 *1/*1* GT and 9 had *UGT1A1*28* alleles (Table 4).

Table 4. Select Baseline Characteristics and Disease Characteristics[13]

Key Demographics and Characteristics		UGT1A1 Status	
		***1/*1* GT (n=8)**	***1/*28 or *28/*28 GT (n=9)**
Age, median, y		48	55
HER2 status, 0/low, n (%)		3 (37.5)/5 (62.5)	5 (55.6)/4 (44.4)
ECOG PS 0/≥1, n (%)		7 (87.5)/1 (12.5)	4 (44.4)/5 (55.6)
Metastatic sites, n (%)	<3	4 (50)	5 (55.6)
	≥3	4 (50)	4 (44.4)
Hepatic metastases, n (%)		6 (75)	6 (66.7)
Line of therapy of SG, n (%)	2L or 3L	6 (75)	7 (77.8)
	≥4L	2 (25)	2 (22.2)

Abbreviations: ECOG PS=Eastern Cooperative Oncology Group performance status; 2L=second-line; 3L=third-line; 4L=fourth-line.

Patients with the **1/*1* GT received more cycles of SG than those with **1/*28* or **28/*28* GTs (mean rank: 10.19 vs 6.81).

Rates of Grade ≥2 AEs were similar between patients with the **1/*1* GT and those with **1/*28* or **28/*28* GTs (42.9% vs 44.4%), and most patients in both groups received G-CSF (83.3% vs 88.9%) during treatment. Compared with patients with the **1/*1* GT, a higher proportion of patients with the **1/*28* or **28/*28* GT experienced Grade ≥3 AEs (28.6% vs 44.4%), Grade ≥3 neutropenia (28.6% vs 33.3%), and dose reductions due to toxicity (37.5% vs 66.7%).

References

1. TRODELVY® Gilead Sciences Inc. Trodelvy (sacituzumab govitecan-hziy) for injection, for intravenous use. U.S. Prescribing Information. Foster City, CA.
2. Bardia A, Hurvitz SA, Tolaney SM, et al. Sacituzumab govitecan in metastatic triple-negative breast cancer. *N Engl J Med.* 2021;384(16):1529-1541.
3. 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).
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. *J Clin Oncol.* 2022;40(29):3365-3376.
5. Rugo HS, Bardia A, Marmé F, et al. Overall survival with sacituzumab govitecan in hormone receptor-positive and human epidermal growth factor receptor 2-negative metastatic breast cancer (TROPiCS-02): a randomised, open-label, multicentre, phase 3 trial [Supplementary Appendix]. *The Lancet.* 2023;402(10411):1423-1433.
6. Rugo HS, Bardia A, Marmé F, et al. Overall survival with sacituzumab govitecan in hormone receptor-positive and human epidermal growth factor receptor 2-negative metastatic breast cancer (TROPiCS-02): a randomised, open-label, multicentre, phase 3 trial. *The Lancet.* 2023;402(10411):1423-1433.
7. Cortés J, Punie K, Barrios C, et al. Sacituzumab govitecan in untreated, advanced triple-negative breast cancer. *N Engl J Med.* 2025;393(19):1912-1925.
8. Tolaney S, De Azambuja E, Kalinsky K, et al. Sacituzumab govitecan plus pembrolizumab for advanced triple-negative breast cancer. *N Engl J Med.* 2026;394:354-366.
9. Cortés J, Punie K, Barrios C, et al. Sacituzumab govitecan in untreated, advanced triple-negative breast cancer [Protocol]. *N Engl J Med.* 2025;393(19):1912-1925.
10. Tolaney S, De Azambuja E, Kalinsky K, et al. Sacituzumab govitecan plus pembrolizumab for advanced triple-negative breast cancer [Protocol]. *N Engl J Med.* 2026;394:354-366.
11. Bardia A, Messersmith WA, Kio EA, et al. Sacituzumab govitecan, a Trop-2-directed antibody-drug conjugate, for patients with epithelial cancer: final safety and efficacy results from the phase I/II IMMU-132-01 basket trial. *Ann Oncol.* 2021;32(6):746-756.
12. Wong MH, Jones VC, Yu W, et al. UGT1A1*28 polymorphism and the risk of toxicity and disease progression in patients with breast cancer receiving sacituzumab govitecan. *Cancer Med.* 2024;13:e70096.
13. Blancas I, Gonzalez-Rivas L, Legeren M, Moron R, Rodriguez-Serrano F. Impact of UGT1A1 polymorphism on safety and dose management of sacituzumab govitecan in the treatment of advanced breast cancer patients [Abstract #e15143]. Presented at: American Society of Clinical Oncology (ASCO) Annual Meeting; May 29-June 2, 2026; Chicago, IL.
14. 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.
15. Marme F, Rugo H, Tolaney S, et al. Safety outcomes by UGT1A1 status in the phase 3 TROPiCS-02 study of sacituzumab govitecan in HR+/HER2- metastatic breast cancer [Poster 194P]. Presented at: European Society for Medical Oncology Breast Cancer (ESMO BC); 11-13 May, 2023; Berlin, Germany.
16. Bardia A, Messersmith WA, Kio EA, et al. Sacituzumab govitecan, a Trop-2-directed antibody-drug conjugate, for patients with epithelial cancer: final safety and efficacy results from the phase I/II IMMU-132-01 basket trial [Supplementary Appendix]. *Ann Oncol.* 2021;32(6):746-756.

Abbreviations

1L=first-line
2L+=second-line and later
AE=adverse event
BC=breast cancer
G-CSF=granulocyte colony-stimulating factor
GT=genotype
HER2=human epidermal growth factor receptor 2
HR=hazard ratio
HR+/HER2-=hormone receptor-positive/human epidermal growth factor receptor 2-negative
mBC=metastatic breast cancer
mTNBC=metastatic triple-negative breast cancer
OSP=overall safety population
PD-(L)1=programmed death-(ligand)1
SG=sacituzumab govitecan-hziy
TEAE=treatment-emergent adverse event
TNBC=triple-negative breast cancer
TPC=treatment of physician's choice
TRAE=treatment-related adverse event
UGT1A1=uridine diphosphate glucuronosyl transferase family 1 member A1
WT=wild type

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 Global Patient Safety ☎ 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

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