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Trodelvy® (sacituzumab govitecan-hziy) Sequencing With Other ADCs in HER2- mBC

This document is in response to your request for information regarding Trodelvy® (sacituzumab govitecan-hziy [SG]) and sequencing with other antibody-drug conjugates (ADCs) in the treatment of human epidermal growth factor receptor 2-negative (HER2-) metastatic breast cancer (mBC).

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Summary

Retrospective observational studies including ≤780 patients have evaluated the safety and efficacy of sequential ADC use in patients with HER2- mBC. Studies of ≤40 patients are excluded from this document.

Real-World Data on Sequential ADC Use in mBC

A retrospective study of breast tumor specimens and insurance claim data compared clinical outcomes in patients treated with SG, T-DXd, or both in sequential order (ie, SG→T-DXd [n=360] and T-DXd→SG [n=420]).[1]

- The overall median (95% CI) TOT2 for patients who received both ADCs was similar regardless of sequence order: SG→T-DXd, 10.8 (10.1–11.7) mo; T-DXd→SG, 10.4 (9.74–10.9) mo (*P*=0.356). Within the HER2-null group, SG→T-DXd was associated with a longer TOT2 than T-DXd→SG. Safety data were not reported.

A retrospective study in France evaluated the efficacy of sequential SG and T-DXd in patients (N=179) with HR+ or HR-/HER2-low mBC.[2]

- Median PFS2 (PFS with ADC2) in the overall population was 2.7 mo (95% CI, 2.4–3.3).[2]
- In patients who received SG prior to T-DXd (n=115), median PFS2 (95% CI) was 3.1 (2.6–3.6) mo vs 2.2 (1.9–2.7) mo in patients who received T-DXd prior to SG (n=64).[2]

- ORR was 35.4% for ADC1 and 19% for ADC2. For ADC1, 40.4% and 59.6% of patients were considered to have primary and secondary resistance (PR1 and SR1), respectively; for ADC2, 54.4% and 45.6% of patients were considered to have primary and secondary resistance (PR2 and SR2), respectively.[2]
- In a later analysis, after a median follow-up of 20.2 mo, the overall median PFS2 was 2.7 (95% CI: 2.3–3.1) mo, and the mOS was 7.3 (95% CI: 6.3–8.9) mo. In a multivariate analysis, T-DXd use as ADC2 was associated with improved PFS2 relative to SG use as ADC2 (HR: 0.53; 95% CI: 0.32–0.89; *P*=0.015).[3,4]
- Safety data were not reported.

A retrospective study at MD Anderson Cancer Center compared survival outcomes of sequential SG→T-DXd (n=87) and T-DXd→SG (n=77) in patients with HER2-low mBC.[5]

- The overall PFS1 was 5.1 mo and was longer in patients who received SG→T-DXd than in those who received T-DXd→SG (5.4 vs 4.8 mo, respectively; HR: 1.38; 95% CI: 1–1.89; *P*=0.049).
- The overall PFS2 was 5.4 mo and was longer in patients who received SG→T-DXd than in those who received T-DXd→SG (6.3 vs 4.3 mo; HR: 1.51; 95% CI: 1.07–2.12; *P*=0.018).
- The overall OS was 21.6 mo and was similar between the SG→T-DXd and T-DXd→SG groups (21.9 vs 21.6 mo; HR: 1.34; 95% CI: 0.82–2.18; *P*=0.24).
- Safety data were not reported.

A retrospective study in the US evaluated the efficacy and safety of sequential SG and T-DXd monotherapy in patients (N=84) with HR+ or HR-/HER2-low mBC.[6]

- In the HR+/HER2-low cohort, median TTFs were: for SG→T-DXd (n=24), 6.3 mo and 3.6 mo, respectively; for T-DXd→SG (n=32), 5.3 mo and 2.1 mo.
- In the HR-/HER2-low cohort, median TTFs were: for SG→T-DXd (n=25), 7.5 mo and 2.8 mo, respectively; for T-DXd→SG (n=3), undetermined due to small sample size.
- Eight patients (9.5%) treated with SG discontinued SG due to toxicity vs 10 patients (11.9%) treated with T-DXd due to toxicity. Dose reductions were required in 41 patients (48.8%) treated with SG and 15 patients (17.9%) treated with T-DXd.
- ILD incidence was 16.7% (n=14) in the T-DXd group; there were no reports with SG.

A retrospective single-center study reported real-world outcomes with sequential SG and T-DXd (given in either order ± intermediary LoT) in patients with mBC (N=85).[7]

- mPFS (95% CI) with ADC2 by ADC sequence was 3.5 (2.67–7.7) mo when SG was given first and 2.83 (2.57–3.73) mo when T-DXd was given first (HR: 1.69; *P*=0.06).
- SG mPFS (95% CI) before vs after T-DXd was 5.13 (3.27–7.27) mo with ADC1 (SG first) and 4.9 (3.5–5.6) mo with ADC2 (T-DXd first; HR: 2.11, *P*=0.006).
- T-DXd mPFS (95% CI) before vs after SG was 4.9 (3.3–5.6) mo with ADC1 (T-DXd first) and 3.5 (2.67–7.7) mo with ADC2 (SG first; HR: 1.25, *P*=0.38).
- Safety data were not reported.

A retrospective study in the US evaluated efficacy and cross-resistance with sequential use of ≥2 ADCs in patients (N=68) with HR+/HER2- mBC or mTNBC.[8]

- In the overall population, the mPFS (95% CI) with ADC1 was 161 (131–224) d vs 77 (51–112) d with ADC2 (*P*<0.01).
- In subgroup analyses, mPFS decreased with ADC2 regardless of sequence (SG prior to T-DXd or T-DXd prior to SG) or mBC subtype.
- Cross-resistance was present in 36 patients and absent in 38 patients.

- Safety data were not reported.

A retrospective real-world study using an EHR-derived database evaluated patients with mTNBC who received T-DXd after SG (n=58) or T-DXd without prior SG (n=61).[9]

- In patients who received T-DXd after SG, mPFS and mOS (95% CI) were 3.4 (2–4.5) mo and 9 (5.9–10.5) mo, respectively. In patients treated with T-DXd without prior SG, mPFS and mOS (95% CI) were 5.7 (4.3–9) mo and 14.52 (9.9–N/A) mo, respectively.
- Safety data were not reported.

A retrospective study in China evaluated patients with locally advanced or mBC (N=79; n=64 with HER2+ disease) who received ≥2 different types of ADC. Among those who were HER2-low, SG was received as ADC1 in 6 patients and as ADC2 in 1 patient.[10]

- mPFS with SG-containing regimens vs HER2 ADCs was 9.10 vs 6.35 mo, respectively (HR: 0.5; *P*=0.207). There was no difference in mPFS between patients treated with RC48 and T-Dxd who progressed after SG; an analysis of patients progressing after HER2 ADC was not reported, as only 1 patient was treated with RC48 prior to SG.
- Safety data were not reported.

Clinical Trial Data on Sequential ADC Use in mBC

TROPION-PanTumor01, a phase 1 study, is evaluating the safety and efficacy of Dato-DXd in relapsed/refractory metastatic solid tumors and includes 44 patients with advanced TNBC. In the TOP1 inhibitor-naive cohort[11]:

- mPFS (95% CI) in all patients was 4.4 (3–7.3) mo vs 7.3 (3–18) mo.
- mOS (95% CI) in all patients was 13.5 (10.1–16.3) mo vs 14.3 (10.5–NE) mo.
- Safety data were not reported.

NCCN Clinical Practice Guidelines in Oncology for Breast Cancer[12]

SG is listed as a Category 1 preferred 2L treatment option for patients with recurrent unresectable or metastatic HR+/HER2- breast cancer with visceral crisis or endocrine refractory breast cancer who are not candidates for T-DXd (T-DXd is recommended as a Category 1 preferred treatment option for patients who test HER2 IHC 1+ or 2+/ISH-). SG may be used in adult patients after prior treatment that includes ET, CDK4/6is, and ≥2 lines of chemotherapy, 1 of which was a taxane, and ≥1 of which was in the metastatic setting. SG and T-DXd may be considered for later line if not used as 2L therapy.

SG is listed as a Category 1 preferred 2L treatment option for patients with recurrent unresectable or mTNBC who have received ≥1 prior regimen in the metastatic setting. SG may be considered for later line if not used as 2L therapy. T-DXd is listed as a second-line treatment option for patients with recurrent unresectable or mTNBC who test HER2 IHC 1+ or 2+/ISH-. T-DXd can be considered for later line if not used in 2L.

Real-World Data on Sequential ADC Use in mBC

Retrospective Study of mBC and HER2 Expression[1]

A retrospective analysis of breast tumor specimens that underwent profiling compared clinical outcomes in patients treated with SG, T-DXd, or in both in sequential order (ie, SG→T-DXd [n=360] and T-DXd→SG [n=420]). Of the patients treated with both ADCs, the TOT2 was calculated from the beginning of ADC1 treatment to the end of ADC2 treatment.

OS data were determined from the time of ADC initiation to the last date or known clinical activity (per insurance claims). See Table 1 for select patient and treatment characteristics.

Table 1. Select Baseline Demographics and Disease Characteristics of Patients Treated With Both ADCs (Sledge et al)[1]

Select Patient Demographics and Characteristics		SG→T-DXd (n=360)	T-DXd→SG (n=420)	*P*-Value
Age, median (IQR), y		58 (47–65)	57.5 (50–66)	0.1
Female, n (%)		355 (99)	416 (99)	0.8
Specimen site, n (%)	Primary/local	129 (39)	128 (30)	<0.001
	Non-visceral	125 (35)	118 (28)	
	Visceral	92 (26)	170 (40)	
	Unclear/other	4 (1)	4 (1)	
HER2 category,[a] n (%)	HER2-low	126 (35)	190 (45)	0.0021
	HER2-ultra-low	83 (23)	103 (25)	
	HER2-null	151 (42)	127 (30)	

[a]HER2-low: IHC 1+ and >10% positive cells or IHC 2+ with >10% positive cells and chromogenic ISH-. HER2-ultra-low: IHC 1+, 2+, or 3+ and ≤10% positive cells. HER2-null: IHC 0+.

Study results

The overall median (95% CI) TOT2 for patients who received both ADCs was similar regardless of sequence: SG→T-DXd, 10.8 (10.1–11.7) mo; T-DXd→SG, 10.4 (9.74–10.9) mo (*P*=0.356). Within the HER2-null group, the use of SG→T-DXd was associated with a longer TOT2 among patients than the use of T-DXd→SG; the sequence of ADC treatment did not impact TOT2 in other HER2 groups (Table 2).

Table 2. TOT2 Outcomes According to ADC Sequence Overall and by HER2 Category (Sledge et al)[1]

T-DXd→SG vs SG→T-DXd	HR (95% CI); *P*-Value
All HER2- mBC patients	1.062 (0.935–1.206); 0.356
HER2-null	0.66 (0.519–0.839); <0.001
HER2-ultra-low	0.926 (0.692–1.24); 0.604
HER2-low	1.041 (0.829–1.308); 0.737

Note: HRs <1 favor SG before T-DXd, and HRs >1 favor T-DXd before SG.

Outcomes in patients within the HER2-null group according to HR+/- status are shown in Table 3.

Table 3. Outcomes Among Patients With HER2-Null Tumors According to ADC Sequence and HR+/- Status (Sledge et al)[1]

	ADC Sequence	n	TOT2		OS	
			Median (95% CI), Mo	HR (95% CI); *P*-Value	Median (95% CI), Mo	HR (95% CI); *P*-Value
HR+	SG→T-DXd	36	10.6 (8–11.7)	1.04 (0.699–1.55); 0.921	14.7 (12.8–22.4)	1.16 (0.67–1.99); 0.602
	T-DXd→SG	82	9.67 (7.73–11.2)		19 (15.1–24.5)	
HR-	SG→T-DXd	114	11.7 (10.2–13)	0.478 (0.333–0.685); <0.0001	19.7 (16.8–23)	0.478 (0.303–0.756); 0.001
	T-DXd→SG	45	7.43 (6.68–8.88)		11.8 (10.5–18)	

In additional analyses of efficacy according to HR- status, among all patients with HR- mBC, SG treatment prior to T-DXd was associated with significantly longer TOT2 relative to the opposite sequence (HR: 0.643 95% CI: 0.504–0.82; *P*<0.001). This treatment benefit was

also observed for OS: HR, 0.646 (95% CI: 0.471–0.887; *P*=0.006); this observation was noted in the subgroup of patients with HR-/HER2-null mBC (Table 3).

In an analysis among patients with HR+/HER2-low mBC, treatment with T-DXd prior to SG was associated with significantly longer TOT2 relative to the opposite sequence (HR: 1.43; 95% CI: 1.01–2.03; *P*=0.044); however, the sequence of T-DXd→SG did not result in a significantly longer OS (HR: 0.957; 95% CI: 0.539–1.7; *P*=0.88).

Safety data were not reported.

ADC-Low: Retrospective Multicenter Study in France

A retrospective multicenter study in women with HR+ or HR-/HER2-low mBC evaluated the efficacy of sequential SG and T-DXd given in either order (Table 4) ± intermediary LoT. Of those who received SG or T-DXd as ADC1, 57 (SG→T-DXd for HR-, n=49; SG→T-DXd for HR+, n=8;) and 18 (T-DXd→SG for HR-, n=4; T-DXd→SG for HR+, n=14) patients, respectively, received intermediary LoT before ADC2. See Table 4 for select patient and treatment characteristics.[2]

Table 4. Select Baseline Demographics and Disease and Treatment Characteristics (Poumeaud et al)[2]

Select Patient Demographics and Characteristics		Overall (N=179)	
Age, median (range), y		54 (30–80)	
De novo mBC, (n) %		39 (21.8)	
HR+ (estrogen receptor or progesterone receptor ≥10%)/HR-, n (%)		71 (39.7)/108 (60.3)	
Prior CDK4/6i for patients with HR+ mBC, n/N (%)		65/71 (91.5)	
Metastases, visceral/CNS, n (%)		111 (62)/25 (14.1)	
Received intermediary LoT, n		75	
Line of administration, median (range)		4 (2–11)	
Most common (>5 patients) first intermediary therapies,[a] n	Eribulin	23	
	Carbo	6	
	Cape	6	
	Gemcitabine	5	
Treatment Characteristics		**ADC1**	**ADC2**
ADC sequence for all patients, n (%)	SG	115 (64.2)[b]	64 (35.8)[c]
	T-DXd	64 (35.8)[d]	115 (64.2)[e]
Prior chemotherapy regimens in metastatic setting, median (range)		2 (0–9)	4 (1–11)
Dose reduction after Cycle 1, n (%) or n/N (%)		43 (24.3)	33/172 (19.2)
ECOG PS 0–1, n (%)		166 (93.8)	137 (77)

[a]Data were not available for 13 patients. Other regimens were as follows: paclitaxel, Navelbine, vinorelbine, doxorubicin (each, n=2); PARP inhibitor, cyclophosphamide + methotrexate, Navelbine + thiotepa, other (each, n=1). [b]HR-, n=100; HR+, n=15. [c]HR-, n=8; HR+, n=56. [d]HR-, n=8; HR+, n=56. [e]HR-, n=100; HR+, n=15.

Preliminary results[2]

The primary endpoint was median PFS2 in the overall population; other endpoints were median PFS2 by subgroups, median PFI1 (PFI with ADC1; Table 5), and mOS in the whole population and subgroups. The median follow-up duration was 5.3 mo.

Table 5. PFS2 and PFI1 by mBC Subtype and ADC Sequence (Poumeaud et al)[2]

Population and ADC Sequence, Median (95% CI), Mo		PFS2	PFI1
All patients	Overall population (N=179)	2.7 (2.4–3.3)	4.3 (3.5–5.1)
	SG followed by T-DXd (n=115)	3.1 (2.6–3.6)	Not reported
	T-DXd followed by SG (n=64)	2.2 (1.9–2.7)	Not reported
HR+/HER2-low	T-DXd followed by SG (n=56)	2.3 (1.8–2.8)	2.7 (2.3–3.5)
TNBC	SG followed by T-DXd (n=100)	3.2 (2.6–3.8)	4.9 (3.9–5.5)

Median PFS2 (95% CI) for patients with intermediary LoT (n=75) was 2.6 (2–3.1) mo, vs 3.1 (2.4–3.6) mo for patients with no intermediary LoT (n=104). After a median follow-up of 5.3 mo, there were no significant differences in mOS by HR status (*P*=0.616).

Clinical cross-resistance was defined as primary resistance to ADC2 after secondary resistance to ADC1. The ORR for ADC1 was 35.4% (9 CR and 54 PR) and 19% (1 CR and 27 PR) for ADC2. For ADC1 (n=178), 72 (40.4%) and 106 (59.6%) patients were considered to have PR1 and SR1, respectively. For ADC2 (n=147), 80 (54.4%) and 67 (45.6%) patients were considered to have PR2 and SR2, respectively. PR2 was more frequent than PR1.

Primary and secondary resistance for both ADCs were reported in 40/147 (27%) and 41/147 patients (27.9%), respectively. However, 40/81 patients (49.4%) with SR1 who were evaluable for ADC2 were considered to have PR2, and 26/66 patients (39.4%) considered PR1 who were evaluable for ADC2 were considered to have SR2. Treatment duration was, however, short, with a median (range) of 4.1 (0.7–7.7) mo for patients with SR2.

Extended follow-up results

At a later data cutoff date, with a median follow-up of 20.2 mo, 170 patients discontinued ADC2; tumor progression was the cause of death in 140 patients (78.2%).[3,4] Safety data were not reported.

First intermediary treatment after ADC1[3]

The median (95% CI) PFI1 of the 62 patients for whom the type of intermediate treatment was available was 2.6 (2.3–3.3) mo; of the 23 patients who received eribulin as the first intermediate treatment after ADC1, the median (95% CI) PFI1 was 3.5 (2.5–4.1) mo.

Additional subgroup analyses

The overall median PFS2 was 2.7 (95% CI: 2.3–3.1) mo.[4] Median (95% CI) PFS2 in patients with HR+ mBC who received SG and in patients with HR- mBC who received T-DXd was 2.1 (1.8–2.7) mo and 3.1 (2.6–3.7) mo, respectively. In a multivariate analysis of SG vs T-DXd as ADC2 that adjusted for ECOG PS, HR+/- status, sequential ADC use, histologic subtype, and number of LoTs in the metastatic setting, PFS2 was improved with T-DXd (HR: 0.53; 95% CI: 0.32–0.89; *P*=0.015).[3]

The overall mOS was 7.3 (95% CI: 6.3–8.9) mo. Among those with HR+ and HR- mBC, mOS was 8 (95% CI: 6.3–9.5) mo and 7.3 (95% CI: 5.3–10.2) mo, respectively. The PR1 rate was 40.4%, and PR2 rate was 59.4%.[3]

An additional analysis of ADC2 use as ≤3L treatment (n=35) included 31 patients with HR- mBC, including 29 who received SG→T-DXd and 2 who received T-DXd→SG, and 4 patients with HR+ mBC, each of whom received T-DXd→SG. Administration of ADC2 as ≤3L vs >3L (n=144) resulted in a longer median (95% CI) PFS2: 3.1 (2–5.4) mo vs 2.6 (2.1–3) mo, respectively. Within the subgroup of patients who received early ADC2, the PR1 rate was 37.1%, and the PR2 rate was 55.9%.[3]

Retrospective Study at MD Anderson Cancer Center in the US[5]

A retrospective study of patients with HER2-low mBC in the US evaluated survival outcomes with sequential SG and T-DXd given in either order. Overall, 98% of patients were female, and the median age was 52 y. See Table 6 for select patient and treatment characteristics.

Table 6. Select Baseline Demographics and Disease Characteristics Overall and by ADC Sequence (Valero et al)[5]

Select Patient Demographics and Characteristics		Overall (N=164)	SG→T-DXd (n=87)	T-DXd→SG (n=77)	*P*-Value
Age at onset of metastatic disease, n (%)	18–40 y	24 (15)	11 (13)	13 (17)	0.64
	41–60 y	96 (59)	53 (61)	43 (56)	
	61–70 y	37 (23)	20 (23)	17 (22	
	71–80 y	5 (3)	3 (3)	2 (3)	
	>80 y	2 (1)	0	2 (3)	
Prior lines of treatment, n (%)	<3/≥3	107 (65)/57 (35)	69 (79)/18 (21)	38 (49)/39 (51)	<0.001
HR+ at any time, n (%)		97 (59)	36 (41)	61 (79)	<0.001
Sequential ADC treatment, n (%)	Yes	121 (74)	68 (78)	53 (69)	0.21
	No	43 (26)	19 (22)	24 (31)	
Duration of follow-up, median (range), mo		14.5 (1.9–51.4)	15.4 (1.9–51.4)	13.3 (2.4–27.6)	–

Study results

After an overall median follow-up duration of 14.5 mo, there were marginally greater improvements in PFS1 and PFS2 with SG→T-DXd relative to the opposite sequence; there was no difference in OS between ADC sequences (Table 7). In a subgroup analysis, there were no significant differences in PFS or OS between ADC sequences among patients who had HR+ mBC. No safety data were reported.

Table 7. Univariate Analysis: Survival Outcomes Overall and by ADC Sequence (Valero et al)[5]

Outcomes		Overall	SG→T-DXd	T-DXd→SG
PFS1	Median (95% CI), mo	5.1 (4.5–6)	5.4 (4.6–6.4)	4.8 (3.1–6.1)
	HR (95% CI)	–	Reference	1.38 (1–1.89); *P*=0.049
PFS2	Median (95% CI), mo	5.4 (4–6.3)	6.3 (4–6.9)	4.3 (3.6–6.1)
	HR (95% CI)	–	Reference	1.51 (1.07–2.12); *P*=0.018
OS[a]	Median (95% CI), mo	21.6 (18.1–26)	21.9 (20.2–NE)	21.6 (16–NE)
	HR (95% CI)	–	Reference	1.34 (0.82–2.18); *P*=0.24

[a]Defined as survival from first ADC to death or last follow-up.

Retrospective, Multicenter Cohort Study in the US[6]

A retrospective cohort study that included patients (most were female) with HER2-low and HR+ or HR- mBC from 5 academic centers evaluated the efficacy and safety of sequential SG and T-DXd monotherapy (in either order ± intervening LoT). See Table 8 for select baseline demographics, disease characteristics, and treatment history.

Table 8. Select Baseline Demographics, Disease Characteristics, and Treatment History by mBC Subtype (Huppert et al)[6]

Select Demographics, Characteristics, and Treatment History		HR+/HER2-Low mBC (n=56)	HR-/HER2-Low mBC (n=28)
Age at start of ADC1, median (range), y		60.4 (23–81.7)	54 (37.5–79.1)
De novo mBC, n (%)		12 (21.4)	7 (25)
Visceral disease prior to ADC1, n (%)		47 (83.9)	18 (64.3)
Time from mBC diagnosis to ADC1, median (range), mo		44 (0.7–199.3)	10.2 (0.5–59.6)
Total LoTs prior to ADC1, median (range), n		4 (0–10)	2 (0–5)
LoT prior to ADC1 by type, median (range),	Lines of chemotherapy	2 (0–7)	1 (0–4)
	Lines of ET	2 (0–6)	0 (0–1)
Prior therapy, CDK4/6i/immunotherapy, n (%)		45 (80.4)/13 (23.2)	N/A/18 (64.3)
Time on ET for mBC, median (range), mo		30.6 (0–145)	N/A

Efficacy results

Percentages of patients who received SG and T-DXd as ADC1 or ADC2, intervening therapies between ADCs, and outcomes by mBC subtype are shown in Table 9. TTFs were generally longer with ADC1 than with ADC2 (77.4%; n=65), but 19 patients (22.6%) had longer TTF with ADC2 than with ADC1. In these 19 patients, TTF was 6.9 mo with ADC2 and 2.5 mo with ADC1; 13 patients discontinued their ADC1 due to disease progression and 6 due to toxicity, including ILD during T-DXd treatment (n=3).

Table 9. Prior and Intervening Therapies, Efficacy, and Survival Status by mBC Subtype and ADC Sequence (Huppert et al)[6]

ADC Sequence, Intervening Therapy, and Efficacy and Survival Outcomes		HR+/HER2-Low mBC (n=56)		HR-/HER2-Low mBC (n=28)	
		SG→T-DXd (n=24)	T-DXd→SG (n=32)	SG→T-DXd (n=25)	T-DXd→SG (n=3)
LoT prior to ADC1, median (range), n	Total therapies	3 (0–9)	4.5 (2–10)	2 (0–5)	3 (1–5)
	Lines of chemotherapy	2 (0–7)	2 (0–6)	1 (0–4)	2 (0–3)
Intervening therapies between ADCs,[a] n (%)		12 (50)	13 (40.6)	9 (36)	2 (66.7)
RR,[b] n/N (%)	ADC1	17/22 (77.3)	15/32 (46.9)	17/25 (68)	1/3 (33.3)
	ADC2[c]	8/23 (34.8)	5/29 (17.2)	7/21 (33.3)	0/2 (0)
TTF,[d] median, mo	ADC1	6.3	5.3	7.5	Not determined[e]
	ADC2	3.6	2.1	2.8	Not determined[e]
OS, median,[f] mo	ADC1	22.8	17.7	16.5	Not determined[e]
	ADC2	7.8	5.8	6.5	Not determined[e]

[a]Intervening therapies were as follows: eribulin (n=13), liposomal doxorubicin (n=10), gemcitabine + carbo (n=9), cape (n=6), paclitaxel (n=6), vinorelbine (n=4), olaparib (n=3), and fulvestrant (n=3).
[b]Assessed by investigator. Defined as the proportion of patients with responding disease at the first provider-ordered scan.
[c]Responses were not available for all patients, as several patients discontinued treatment prior to the first scan; thus, the denominators are different.
[d]Defined as the time from the start of ADC to the time of discontinuation due to any reason (eg, disease progression, toxicity due to treatment, or death).
[e]Not determined due to the small size of the subgroup.
[f]Defined as the date from the start of the ADC to the date of death or the last follow-up.

Among patients with HR+/HER2-low mBC and either ADC sequence, there was no difference in the median TTF between ADC1 and ADC2 in prespecified subgroups (eg, age ≤65 y/>65 y, visceral metastasis pre-ADC1, CNS metastases pre-ADC1, and de novo/non-de novo mBC). In this mBC subset, for mOS, there were no differences between ADC1 and ADC2 by subgroup, except according to age among those who received SG prior to T-DXd: ≤65 y, 26 mo; >65 y, 15.7 mo (*P*=0.05).

Among patients with HR-/HER2-low mBC treated with SG before T-DXd, there was no difference in the median TTF between ADC1 and ADC2 in age, de novo/non-de novo mBC, or visceral metastases pre-ADC1 subgroups. Patients without CNS disease (n=19) vs with CNS disease (n=6) pre-ADC1 had a significantly longer median TTF (7.9 vs 5.2 mo, respectively; *P*=0.047) and a longer mOS (19.3 vs 11.6 mo; *P*<0.0001). No comparisons could be made for the patients with HR-/HER2-low mBC treated with T-DXd before SG due to the small subgroup size.

No significant difference in the TTF of ADC2 was observed between patients who received an intervening therapy and those who did not (HR: 1.497; 95% CI: 0.921–2.434; *P*=0.104). The time on treatment with ADC1 vs ADC2 was not significantly different in those who did not receive an intervening therapy (HR: 0.978; 95% CI: 0.618–1.547; *P*=0.923).

Several factors were associated with a significantly longer OS from the start of ADC1 in a multivariate analysis: use of SG→T-DXd vs T-DXd→SG (HR: 0.461; 95% CI: 0.246–0.864; *P*=0.016); age at ADC1 (HR: 0.864; 95% CI: 0.746–1; *P*=0.05); and time from diagnosis of mBC to the start of ADC1 (HR: 0.985; 95% CI: 0.974–0.997; *P*=0.012).

Safety results

With SG treatment, there was no significant difference in the proportion of patients who required dose reduction according to HR+/HR- status, regardless of SG as ADC1 or ADC2, presence or absence of visceral metastases, or age ≤65 y/>65 y. Seven patients with HR+/HER2-low mBC and 1 patient with HR-/HER2-low mBC discontinued treatment due to toxicity (overall, n=8 [9.5%]); 41 patients (48.8%) required dose reduction. Similar rates of patients with HR+/HER2-low and HR-/HER2-low mBC received growth factor support (62.5% [35/56] vs 64.3% [18/28]). Overall, 16 patients (19%) treated with SG had delays in ADC treatment due to neutropenia. See Table 10 for further details.

With T-DXd treatment, no significant difference was seen in rates of dose reduction according to HR+/HR- status or according to treatment as ADC1 vs ADC2; 10 patients (11.9%) discontinued treatment due to toxicities, and 15 (17.9%) required dose reductions. Additional safety outcomes for T-DXd are shown in Table 10.

ILD was reported in 14 patients (16.7%) in the T-DXd group; 7 received T-DXd as ADC1 and 7 as ADC2, and 9 and 5 patients were in the HR+/HER2-low mBC and HR-/HER2-low mBC groups, respectively. The median (range) time to ILD onset was 3.8 (0.3–22.9) mo. Steroids were used to manage ILD in all patients, and 9 patients required hospitalization.
Two patients with Grade 1 ILD were rechallenged with T-DXd after ground glass opacities resolved on imaging; neither patient had a recurrence of ILD. Three patients (3.6%) died due to ILD-related complications.

Table 10. Dose Reductions, Discontinuations, Growth Factor Support, and ILD/Pneumonitis by mBC Status and ADC Sequence (Huppert et al)[6]

Safety Outcomes, %	HR+/HER2-Low mBC (n=56)				HR-/HER2-Low mBC (n=28)			
	SG→T-DXd (n=24)		T-DXd→SG (n=32)		SG→T-DXd (n=25)		T-DXd→SG (n=3)	
	SG[a]	T-DXd[b]	T-DXd[a]	SG[b]	SG[a]	T-DXd[b]	T-DXd[a]	SG[b]
Required dose reduction	41.6	16.7	25	59.4	44	12	0	33.3
Due to lab abnormalities	25	0	6.3	37.5	28	8	0	33.3
Due to symptoms	16.7	8.3	9.4	12.5	16	0	0	0
Due to other reasons	0	8.3	9.4	9.4	0	4	0	0
Discontinued ADC due to toxicity	12.5	8.3	12.5	12.5	4	16	0	0

Safety Outcomes, %	HR+/HER2-Low mBC (n=56)				HR-/HER2-Low mBC (n=28)			
	SG→T-DXd (n=24)		T-DXd→SG (n=32)		SG→T-DXd (n=25)		T-DXd→SG (n=3)	
	SG[a]	T-DXd[b]	T-DXd[a]	SG[b]	SG[a]	T-DXd[b]	T-DXd[a]	SG[b]
Received growth factor support	58.3	12.5	9.4	65.6	68	8	0	33.3
Primary prophylaxis	29.2	12.5	6.3	40.6	40	8	0	0
Secondary prophylaxis	29.2	0	3.1	25	28	0	0	33.3
Delayed treatment due to neutropenia	16.7	0	6.3	18.8	24	0	0	0
Any-grade ILD/pneumonitis	0	8.3[c]	21.9[d]	0	0	20[e]	0	0

[a]Treatment as ADC1. [b]Treatment as ADC2. [c]Grade 3–4, 4.2%; Grade 5, 4.2%. [d]Grade 1–2, 21.9%. [e]Grade 3–4, 12%; Grade 5, 8%.

Retrospective Single-Center Study in the US

A retrospective single-center study reported real-world effectiveness with sequential SG and T-DXd (given in either order ± intermediary LoT) in patients with mBC between June 2018 and January 2024.[7] ADC1 sequencing for patients with HR+ mBC (n=54) was as follows: SG, n=14; T-DXd, n=40; of the 31 patients with mTNBC, 19 received SG as ADC1, and 12 received T-DXd.[7,13] See Table 11 for additional patient characteristics.

Table 11. Select Patient Demographics and Disease Characteristics by ADC1 (Mai et al)[7]

Select Demographics and Characteristic	SG (n=33)	T-DXd (n=52)	*P*-Value
Age, median (IQR), y	62 (51–68)	58 (53–63)	0.32
Age >50 y, n (%)	25 (76)	43 (83)	0.44
ER+ mBC, n (%)	14 (42)	40 (77)	0.001
Metastases at ADC2, brain/bone-only, n (%)	10 (30)/4 (12)	4 (7.7)/4 (7.7)	0.006/0.71
Treatment lines prior to ADC1, median (IQR)	5 (3–7)	6 (4–8)	0.15
Treatment lines prior to ADC2, median (IQR)	7 (5–9)	8 (6–10)	0.12
Treatment lines between ADC1 and ADC2, 0/1/2, n (%)	14 (42)/12 (36)/ 7 (21)	23 (44)/18 (35)/ 11 (21)	0.98
Reason for stopping ADC1, disease progression/toxicity/other, n (%)	29 (88)/3 (9.1)/ 1 (3)	47 (90)/5 (9.6)/ 0	0.54
Reason for stopping ADC2, disease progression/toxicity/other, n (%)	24 (73)/1 (3)/ 2 (6.1)	34 (65)/6 (12)/ 4 (7.7)	0.62
Ongoing ADC2 treatment, n (%)	6 (18)	8 (15)	0.73

Study results[7]

The mPFS (95% CI) with ADC2 was 3.5 (2.67–7.7) mo when SG was given first and 2.83 (2.57–3.73) mo when T-DXd was given first (HR: 1.69; 95% CI: 0.98–2.94; *P*=0.06). See Table 12 for PFS by ADC sequence and Table 13 for results of a multivariable analysis.

Table 12. mPFS of SG and T-DXd as ADC1 or ADC2 (Mai et al)[7]

	SG→T-DXd vs T-DXd→SG		T-DXd→SG vs SG→T-DXd	
	SG as ADC1	SG as ADC2	T-DXd as ADC1	T-DXd as ADC2
mPFS (95% CI), mo	5.13 (3.27–7.27)	2.83 (2.57–3.73)	4.9 (3.3–5.6)	3.5 (2.67–7.7)
HR for progression or death (95% CI)	2.11 (1.25–3.77); *P*=0.006		1.25 (0.76–2.06); *P*=0.38	

Table 13. Multivariable Analysis of ADC2 PFS (Mai et al)[7]

Variable		HR (95% CI)	*P*-Value
Baseline clinical data	Age	0.98 (0.96–1.01)	0.2
	Treatment lines preceding ADC2	1.1 (1.01–1.21)	0.034
	ADC1 TTF	0.94 (0.89–1)	0.044
ADC1	T-DXd vs SG	1.23 (0.68–2.24)	0.5
mBC subtype	TNBC vs ER+	1 (0.52–1.9)	0.99

Across the entire cohort, regardless of which ADC was used first, mPFS with ADC2 was shorter than with ADC1 in 75% of patients, with 14 patients remaining on treatment at the data cutoff. Fourteen patients had a PFS2 >6 mo, which was longer than PFS1 in 9 patients. Within this subgroup of patients, 2 patients who received T-DXd as ADC1 had a loss in HER2 expression from before T-DXd treatment (HER2 IHC 1–2+ and 1+) to after T-DXd treatment (HER2 IHC 0). Safety data were not reported.

A3 Retrospective Multicenter Study in the US

A retrospective study across three academic medical centers evaluated efficacy and cross-resistance with the sequential use of ≥2 ADCs between August 2014 and June 2023.[8,14] Patients with mBC (N=68) received ≥2 ADCs; of those, 30 (44.1%) had HR+/HER2- mBC, 38 (55.9%) had TNBC, and 50 (73.5%) had HER2-low. ADC2 was received at a median (range) age of 59.6 (29.9–88.6) y, and the median number of prior LoTs in the metastatic setting before ADC2 was 4. Sixty patients received 2 ADCs, and 8 received 3 ADCs.[8]

Study results[8]

In the overall population, mPFS (95% CI) with ADC1 was 161 (131–224) d and with ADC2 was 77 d (51–112; *P*<0.01). See Table 14 for mPFS by mBC subtype and ADC sequence.

Table 14. A3 Study: mPFS by mBC Subtype and ADC Sequence[8]

mBC Subtype	PFS1, Median (95% CI), d → PFS2, Median (95% CI), d			
	SG Prior to T-DXd	*P*-Value	T-DXd Prior to SG	*P*-Value
HR+/HER2-	n=7: 249 (128–590) → 168 (45–168)	0.09	n=11: 147 (131–210) → 50 (41–72)	0.03
TNBC	n=14: 231 (98–400) → 84 (48–126)	0.01	n=7: 42 (21–133) → 93 (58–N/A)	0.16

Cross-resistance, defined as progressive disease on ADC2 at the time of first restaging or <60 d of treatment on ADC2, was present in 36 patients and absent in 38 patients. When only the payload of ADC2 was changed, cross-resistance was seen in 57.1% of patients (8/14); when both the antibody target and the payload were changed, cross-resistance was seen in 48.9% of patients (23/47). When ADC2 had the same payload but a different antibody target, cross-resistance was seen in 30% of patients (3/10). In 3 patients, neither the antibody target nor the payload was changed in ADC2, and 66.7% of patients (2/3) showed cross-resistance.

No safety data were reported.

EHR Retrospective Study in the US[9]

A retrospective study of the Flatiron Health EHR database evaluated the efficacy of T-DXd in patients with mTNBC (N=119; December 2019 to January 2023). See Table 15 for outcomes by prior SG use. Safety data were not reported.

Table 15. T-DXd Outcomes by Prior Use of SG (Tarantino et al)[9]

	Prior SG (n=58)	No Prior SG (n=61)	*P*-Value
Prior LoT, median (range)	3 (1–11)	2 (0–9)	-
mPFS (95% CI), mo	3.4 (2–4.5)	5.7 (4.3–9)	0.005
mOS (95% CI), mo	9 (5.9–10.5)	14.52 (9.9–not reached)	<0.001

Retrospective Multicenter Study in China[10]

A retrospective study across three hospitals evaluated female patients (N=79; July 2017 to May 2023) with locally advanced or mBC who received ≥2 different types of ADC (T-DM1, T-DXd, RC48, and SG). A total of 64 (81%), 35 (44.3%), and 8 (10.1%) patients had HER2+, HR+, or TNBC, respectively. SG was received as ADC1 (n=6) or ADC2 (n=1) in patients with HER2-low.

mPFS was numerically longer with SG-containing regimens than with HER2 ADCs (9.1 vs 6.35 mo; HR: 0.5; 95% CI: 0.15–1.6; *P*=0.207). Among those who progressed after SG, no significant difference in mPFS was seen between patients treated with RC48 or T-DXd. Progression after HER2 ADC was not reported because only 1 patient was treated with RC48 prior to SG. Safety data were not reported.

Clinical Trial Data on Sequential ADC Use in mBC

TROPION-PanTumor01 Study in Advanced TNBC[11]

A phase 1, multicenter, open-label study is evaluating the safety and efficacy of Dato-DXd in relapsed/refractory metastatic solid tumors, including in 44 patients with advanced TNBC. The median (range) number of prior therapies in the metastatic setting was 3 (1–10). Eleven patients, 2 patients, and 1 patient had previously received SG, T-DXd, and patritumab deruxtecan, respectively.

Study results

Survival rates and ORRs were reported for all patients and among patients who were naive to treatment with TOP1 inhibitors (Table 16). Safety outcomes by prior ADC use and outcomes specific to sequencing with SG were not reported.

Table 16. TROPION-PanTumor01: Survival and RRs[11]

Survival and RR	All Patients (N=44)	TOP1 Inhibitor-Naive Patients (n=30)
mPFS (95% CI), mo	4.4 (3–7.3)	7.3 (3–18)
mOS (95%CI), mo	13.5 (10.1–16.3)	14.3 (10.5–NE)
Confirmed ORR, % (95% CI)	31.8 (18.6–47.6)	40 (22.7–59.4)

Ongoing Prospective Sequencing ADC Studies

Multicenter Registry Study: ENCORE[15]

A multicohort real-world study (NCT06774027) will evaluate the safety and efficacy of sequential ADCs. Cohorts 1 and 2 will evaluate sequential ADCs per SoC and will enroll ~35 patients with HR+/HER2- mBC and ~25 patients with mTNBC, respectively, prior to

ADC1. Cohorts 3 and 4 will evaluate sequential ADCs per SoC and will enroll ~25 patients with HR+/HER2- mBC and ~15 patients with mTNBC, respectively, prior to ADC2. Intervening therapies between ADC1 and ADC2 are permitted.

Phase 2, Multicenter SERIES Study

A phase 2, single-arm, multicenter, open-label study (NCT06263543) is evaluating the efficacy and safety of SG in patients with HR+/HER2-low mBC who progressed on T-DXd.

References

1. Sledge GW, Xiu J, Solzak JP, et al. Comparing clinical benefit of trastuzumab deruxtecan (T-DXd) and sacituzumab govitecan (SG) in a large cohort of HER2-negative metastatic breast cancer (MBC) [Poster 1076]. Presented at: American Society of Clinical Oncology (ASCO) Annual Meeting; May 30-June 3, 2025; Chicago, IL.
2. Poumeaud F, Morisseau M, Cabel L, et al. Efficacy of administration sequence: sacituzumab govitecan and trastuzumab deruxtecan in HER2-low metastatic breast cancer. *Br J Cancer.* 2024;131(4):702-708.
3. Pomeaud F, Morisseau M, Reich M, et al. Efficacy of sequential antibody-drug conjugates (ADCs) targeting topoisomerase-1 in HER2-low metastatic breast cancer (MBC): updated results and additional analyses from the French Multicenter Retrospective ADC-Low Cohort [Poster 312P]. Presented at: European Society for Medical Oncology (ESMO) Congress; May 14-17, 2025; Munich, Germany.
4. Pomeaud F, Morisseau M, Reich M, et al. Efficacy of sequential antibody-drug conjugates (ADCs) targeting topoisomerase-1 in HER2-low metastatic breast cancer (MBC): updated results and additional analyses from the French Multicenter Retrospective ADC-Low Cohort [Astract 312P]. Presented at: European Society for Medical Oncology (ESMO) Congress; May 14-17, 2025; Munich, Germany.
5. Valero V, Wang Z, Damodaran S, Bassett Jr R, Tripathy D, Raghavendra A. Outcomes of subsequent antibody drug conjugate (ADC) regimen in ADC-resistant HER2 low metastatic breast cancer [Poster 605P]. Presented at: European Society for Medical Oncology (ESMO) Congress; October 17-21, 2025; Berlin, Germany.
6. Huppert LA, Mahtani R, Fisch S, et al. Multicenter retrospective cohort study of the sequential use of the antibody-drug conjugates (ADCs) trastuzumab deruxtecan (T-DXd) and sacituzumab govitecan (SG) in patients with HER2-low metastatis breast cancer (MBC). *NPJ Breast Cancer.* 2025;11(1):34.
7. Mai N, Klar Lieberman MM, Ferraro E, et al. Sequential Antibody-Drug Conjugate Therapy in Patients With Metastatic Breast Cancer Treated With Sacituzumab Govitecan and Trastuzumab Deruxtecan. *JCO Precis Oncol.* 2025;9:e2400898.
8. Abelman RO, Spring LM, Fell G, et al. Sequencing antibody-drug conjugate after antibody-drug conjugate in metastatic breast cancer (A3 study): multi-institution experience and biomariker analysis [Poster]. Presented at: San Antonio Breast Cancer Symposium; December 5-9, 2023; San Antonio, TX.
9. Tarantino P, Lee D, Foldi J, et al. Outcomes with trastuzumab deruxtecan by HER2 status and line of treatment in a large real-world database of patients with metastatic breast cancer [Poster]. Presented at: American Society of Clinical Oncology (ASCO) Annual Meeting; May 31-June 4, 2024; Chicago, IL.
10. Chen M, Huang R, Chen R, et al. Optimal sequential strategies for antibody-drug conjugate in metastatic breast cancer: evaluating efficacy and cross-resistance. *Oncologist.* 2024;5;29(8):e957-e966.
11. Bardia A, Krop IE, Kogawa T, et al. Datopotamab deruxtecan in advanced or metastatic HR+/HER2- and triple-negative breast cancer: results from the phase I TROPION-PanTumor01 study. *J Clin Oncol.* 2024:Jco2301909.

12. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Breast Cancer Version 4.2025. April 17, 2025.
13. Mai N, Klar M, Ferraro E, et al. Real world outcomes of sequential ADC therapy in metastatic breast cancer: Patients treated with sacituzumab govitecan and trastuzumab deruxtecan [Abstract]. Presented at: American Society of Clinical Oncology (ASCO) Annual Meeting; May 31-June 4, 2024; Chicago, IL.
14. Abelman RO, Spring LM, Fell G, et al. Sequencing antibody-drug conjugate after antibody-drug conjugate in metastatic breast cancer (A3 study): multi-institution experience and biomariker analysis [Abstract]. Presented at: San Antonio Breast Cancer Symposium; December 5-9, 2023; San Antonio, TX.
15. Huppert LA, Ellisen L, Anders C, et al. ENCORE: Multicenter prospectivE registry of sequential aNtibody drug COnjugates in HER2 negative metastatic bREast cancer trial [Poster TPS1137]. Presented at: American Society of Clinical Oncology (ASCO) Annual Meeting; May 30-June 3, 2025; Chicago, IL.

Abbreviations

2L/3L=second/third-line
ADC=antibody-drug conjugate
ADC1/ADC2=first/second antibody-drug conjugate
cape=capecitabine
carbo=carboplatin
CDK4/6i=cyclin-dependent kinase 4/6 inhibitor
CNS=central nervous system
CR=complete response
Dato-DXd=datopotamab deruxtecan
ECOG PS=Eastern Cooperative Oncology Group Performance Status
EHR=electronic health record
ENCORE=multicenter prospectivE registry of sequential aNtibody drug COnjugates in HER2 negative metastatic bREast cancer
ER=estrogen receptor
ET=endocrine therapy
HER2=human epidermal growth factor receptor 2
HR=hazard ratio
HR+/-=hormone receptor-positive/negative
IHC=immunohistochemistry
ILD=interstitial lung disease
ISH=in situ hybridization
LoT=line(s) of therapy
mBC=metastatic breast cancer
mPFS=median progression-free survival
mOS=median overall survival
mTNBC=metastatic triple-negative breast cancer
NCCN=National Comprehensive Cancer Network
NE=not evaluable
ORR=objective response rate
OS=overall survival
PFI=progression-free interval
PFI1=progression-free interval with first antibody-drug conjugate
PFS=progression-free survival
PFS1/PFS2=progression-free survival with first/second antibody-drug conjugate
PR=partial response
PR1/PR2=primary resistance with antibody-drug conjugate 1/2
RC48=disitamab vedotin
RR=response rate
SG=sacituzumab govitecan-hziy
SERIES=SEquencing sacituzumab govitecan afteR T-DXd In ER+/HER2 low metaStatic breast cancer
SoC=standard of care
SR1/SR2=secondary resistance with antibody-drug conjugate 1/2
T-DM1=trastuzumab emtansine
T-DXd=trastuzumab deruxtecan
TNBC=triple-negative breast cancer
TOP1=topoisomerase I
TOT2=time on treatment from the start of ADC1 to the last of ADC2 among those treated with 2 ADCs
TTF=time to treatment failure

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