CEOP2019
CONTINUOUS EDUCATION FOR
ONCOLOGY PRACTITIONERS

THE 4TH CONTINUOUS EDUCATION FOR ONCOLOGY PRACTITIONERS

PATIENT JOURNEY

November 29 - 30, 2019
Hilton Metropolitan Hotel, Lebanon

HOPITAL HAYEK

Barbara Nassar
FOR CANCER PATIENT SUPPORT

In treating a broad range of women with HR+/HER2- mBC:[1]

CONFIDENCE BUILT ON STRENGTH

IBRANCE® palbociclib | 125 mg capsules

STRENGTH FROM...

Powerful clinical efficacy	A wealth of data from 2 large pivotal Phase III RCTs across lines and patient types studied, including visceral and bone-only[1-10]
Real-world experience	>4 years' real-world experience[11] complementing strong clinical data
Patient-reported outcomes	Health-related quality of life was maintained in both treatment arms in the 2 large pivotal Phase III RCTs*[12,13]
Established safety profile	Data from up to 50 months across RCTs[1-3,6-8,10,14,15]
One scheduled monitoring provision	CBCs are the only scheduled monitoring provision in the current SmPC†[1]
One pill, once daily	Convenient dosing with one pill once a day, regardless of dose strength‡[1]

*HRQoL as measured by the Functional Assessment of Cancer Therapy - Breast (FACT-B) total scores (PALOMA-2) and the European Organisation for Research and Treatment of Cancer Quality-of-Life (EORTC QLQ-C30) global QoL scores (PALOMA-3).
†Additional monitoring may be necessary based on the individual patient. ‡As part of combination therapy with an AI or fulvestrant. Dosing for these combination partners should follow the dosing indications in the respective SmPCs.

AI = aromatase inhibitor; **CBC** = complete blood count; **ET** = endocrine therapy; **HR+/HER2-** = hormone receptor-positive, human epidermal growth factor receptor 2-negative; **HRQoL** = health-related quality of life; **LHRH** = luteinising hormone-releasing hormone; **mBC** = metastatic breast cancer; **QoL** = quality of life; **RCT** = randomised controlled trial; **SmPC** = summary of product characteristics.

References:

1. IBRANCE Summary of Product Characteristics, September 2018. **2.** Rugo H, et al. Breast Cancer Res Treat. 2019;174(3):719-729. **3.** Finn RS, et al. *N Engl J Med*. 2016;375(20):1925-1936. **4.** Turner NC, et al. SABCS 2016; poster P 4-22-06. **5.** IBRANCE EPAR Public assessment report. 25 Nov 2016. Available at: http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Public_assessment_report/human/003853/WC500217198.pdf. Accessed October 2019. **6.** Cristofanilli M, et al. *Lancet Oncol*. 2016;17(4):425-439. **7.** Rugo H, et al. *Eur J Cancer*. 2018;101:123-133. **8.** Loibl S, et al. *Oncologist*. 2017;22(9):1028-1038. **9.** Turner NC, et al. *N Engl J Med*. 2018;379(20):1926-1936. **10.** Turner NC, et al. *Ann Oncol*. 2018;29(3):669-680. **11.** FDA Approved drugs. IBRANCE. https://search.usa.gov/search?query=IBRANCE&affiliate=fda1. Accessed October 2019. **12.** Harbeck N, et al. *Ann Oncol*. 2016;27(6):1047-1054. **13.** Rugo HS, et al. *Ann Oncol*. 2018;29(4):888-894. **14.** Dieras V, et al. *J Natl Cancer Inst*. 2019;111(4):419-430. **15.** Verma S, et al. *Oncologist*. 2016;21:1165-1175.

Indications:

IBRANCE is indicated for the treatment of HR+/HER2- locally advanced or mBC:[1]

- In combination with an AI as initial endocrine based therapy in postmenopausal women
- In combination with fulvestrant in women who have received prior ET

Pfizer

PP-IBR-LBN-0021

IBRANCE® Abbreviated Prescribing Information

IBRANCE® (palbociclib) capsules, for oral use. INDICATIONS AND USAGE: IBRANCE is a kinase inhibitor indicated for the treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in combination with: (1) an aromatase inhibitor as initial endocrine based therapy in postmenopausal women; or (2) fulvestrant in women with disease progression following endocrine therapy. DOSAGE FORMS AND STRENGTHS: Capsules 125 mg, 100 mg, and 75 mg. DOSAGE AND ADMINISTRATION: IBRANCE capsules are taken orally with food in combination with an aromatase inhibitor or fulvestrant. Recommended starting dose: 125 mg once daily taken with food for 21 days followed by 7 days off treatment. Dosing interruption and/or dose reductions are recommended based on individual safety and tolerability. CONTRAINDICATIONS: None. WARNINGS AND PRECAUTIONS: Neutropenia: Monitor complete blood count prior to start of IBRANCE therapy and at the beginning of each cycle, as well as on Day 15 of the first 2 cycles, and as clinically indicated. Embryo-Fetal Toxicity: IBRANCE can cause fetal harm. Advise patients of potential risk to a fetus and to use effective contraception. ADVERSE REACTIONS: Most common adverse reactions (incidence ≥10%) were neutropenia, infections, leukopenia, fatigue, nausea, stomatitis, anemia, alopecia, diarrhea, thrombocytopenia, rash, vomiting, decreased appetite, asthenia, and pyrexia. POSTMARKETING EXPERIENCE: The following adverse reactions have been identified during postapproval use of IBRANCE. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. Respiratory disorders: Interstitial lung disease (ILD)/non-infectious pneumonitis. DRUG INTERACTIONS: CYP3A Inhibitors: Avoid concurrent use of IBRANCE with strong CYP3A inhibitors. If the strong inhibitor cannot be avoided, reduce the IBRANCE dose. CYP3A Inducers: Avoid concurrent use of IBRANCE with strong CYP3A inducers. CYP3A Substrates: The dose of sensitive CYP3A4 substrates with narrow therapeutic indices may need to be reduced when given concurrently with IBRANCE. USE IN SPECIFIC POPULATIONS: Pregnancy: Based on findings in animals and mechanism of action, IBRANCE can cause fetal harm when administered to a pregnant woman. Lactation: There are no data on the presence of palbociclib in human milk, the effects of IBRANCE on the breastfed child, or the effects of IBRANCE on milk production. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from IBRANCE, advise a nursing woman to discontinue breastfeeding during treatment with IBRANCE. Pediatric Use: The safety and efficacy of IBRANCE in pediatric patients have not been studied. Geriatric Use: No overall differences in safety or effectiveness of IBRANCE were observed between these patients and younger patients but greater sensitivity of some older individuals cannot be ruled out. Hepatic Impairment: Based on a population pharmacokinetic analysis that included 183 patients, where 40 patients had mild hepatic impairment (total bilirubin = ULN and AST > ULN, or total bilirubin > 1.0 to 1.5 x ULN and any AST), mild hepatic impairment had no effect on the exposure of palbociclib. The pharmacokinetics of palbociclib have not been studied in patients with moderate or severe hepatic impairment (total bilirubin > 1.5 x ULN and any AST). Renal Impairment: Based on a population pharmacokinetic analysis that included 183 patients, where 73 patients had mild renal impairment (60 mUmin = CrCl <90 mUmin) and 29 patients had moderate renal impairment (30 ml1min = CrCl <60 mUmin), mild and moderate renal impairment had no effect on the exposure of palbociclib. The pharmacokinetics of palbociclib have not been studied in patients with severe renal impairment. OVERDOSAGE: There is no known antidote for IBRANCE. The treatment of overdose of IBRANCE should consist of general supportive measures.

Reference: Gulf/Levant LPD, Date of Revision (9/2019)

Date of this Document: 15/10/2019

Full prescribing information is available upon request

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Friday, November 29, 2019

13:00	**Registration**		
13:30 - 13:40	Introduction		Fadi Nasr
13:40 - 13:55	Barbara Nassar Association Achievement		Hani Nassar
13:55 - 14:05	Faire Face		Anne Frangieh
14:05 - 14:15	Said NGO		Hana Nimer
14:15 - 14:25	Sanad	President and founding member of SANAD	Lubna Izziddin
14:25 - 15:45	**AML**		
	Internal Medicine Point of View		Fadi Haddad
	Cytologist Point of View		Mirna Germanos
	Flow Cytometry		Hanadi Samaha
	Molecular Biology		Hampig Kourieh
	Nursing Point of View: Transfusion		Sahar Attieh
	Pharmacist Point of View:		
	- Vesanoid		Carole Dib
	- Arsenic Trioxide		Yasmina Yared
	- Venetoclax		Remie El Hajj
15:45 - 16:45	Living the Fear and Describing the Hope in Leukemia: " Changing Expectations in AML" | *Abbvie Symposium*		Georges Chahine
16:45 - 17:05	**Coffee Break**		

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17:05 - 17:35	The Unmet Need in the Treatment of R/R DLBCL: What Does the Future Hold? | *Roche Symposium*	Ahmad Ibrahim
17:35 - 17:55	**Update in Relapse All**	
	Oncologist Perspective	Colette Hanna
	Nursing: Febrile Neutropenia	Aida Bou Khalil
17:55 - 18:25	Novel Advances in the Management of R/R Acute Lymphoblastic Leukemia: Towards Improving Patients' Outcomes | *Pfizer Symposium*	Colette Hanna
18:25 - 18:45	**Update in Multiple Myeloma**	
	Oncologist Perspective: Daratumumab / Kyprolis / Imnovid / Ninlaro	Ahmad Ghoche
	Biologist Perspective: Daratumumab / Coombs	Emma Abboud
18:45 - 18:55	**Update in CLL**	
	Ibrutinib / Venetoclax	Jad Wakim
18:55 - 19:55	Living the Fear and Describing the Hope in Leukemia: " Breaking Free and Changing Treatment Paradigm in CLL" | *Abbvie Symposium*	Marwan Ghosn

Roche

Life

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An Evolving CLL Treatment Paradigm:
Venclexta™ in Relapsed/Refractory CLL

LB-VEN-190008

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08:30	**Registration**	
09:00 - 09:20	**Cancer & Thrombosis**	
	Clinical Cases Pharmacist: Complications of NOAC	Fadi Nasr May Fakhoury
09:20 - 09:50	Immune Therapy for Genitourinary Tumors | *MSD Symposium*	Georges Chahine
09:50 - 10:30	**Update in Breast Cancer**	
	Adjuvant TNBC Her (+) Neo/Adjuvant: Perjeta Metastatic ER/PR (+) TNBC: Tecentriq	Marcel Massoud Marwan Ghosn Georges Chahine Adel Tabchi
10:30 - 11:00	Updates in the Management of HR+ HER2- Advanced Breast Cancer | *Novartis Symposium*	Fadi Nasr
11:00 - 11:20	**Coffee Break**	
11:20 - 11:50	Post ESMO Updates in Management of Metastatic Breast Cancer Patients: Abemaciclib OS Benefits *Lilly Symposium*	Ghazi Nsouli

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11:50 - 12:20	Clinical implications of the evolving treatment paradigm of HR+/HER2- MBC | *Pfizer Symposium*	Fadi Nasr
12:20 - 12:50	Quality of Life and its Impact on MBC Patients | *Novartis Symposium*	Fadi El Karak
12:50 - 13:30	**Update in Lung Cancer**	
	ALK (+): Brigatinib, Ceritinib, Alectinib EFGR (+): Tagrisso Immunotherapy: - Update in 1st Line - Durvalumab Maintenance Immunotherapy Toxicity	Anthony Saroufim Abir Ahmadiyeh Fadi El Karak Noha Merhi
13:30 - 14:00	Practical Approaches to Optimizing the Clinical Outcomes of NSCLC Patients | *Pfizer Symposium*	Hampig Kourie
14:00 - 15:00	**Lunch Break**	
15:00 - 15:30	Pembrolizumab, Redefining the Survival Expectations in Metastatic Non-small Cell Lung Cancer *MSD Symposium*	Fadi Nasr
15:30 - 16:00	IO/IO Combination Therapy: What Have We Achieved so Fare | *BMS Symposium*	Georges Chahine

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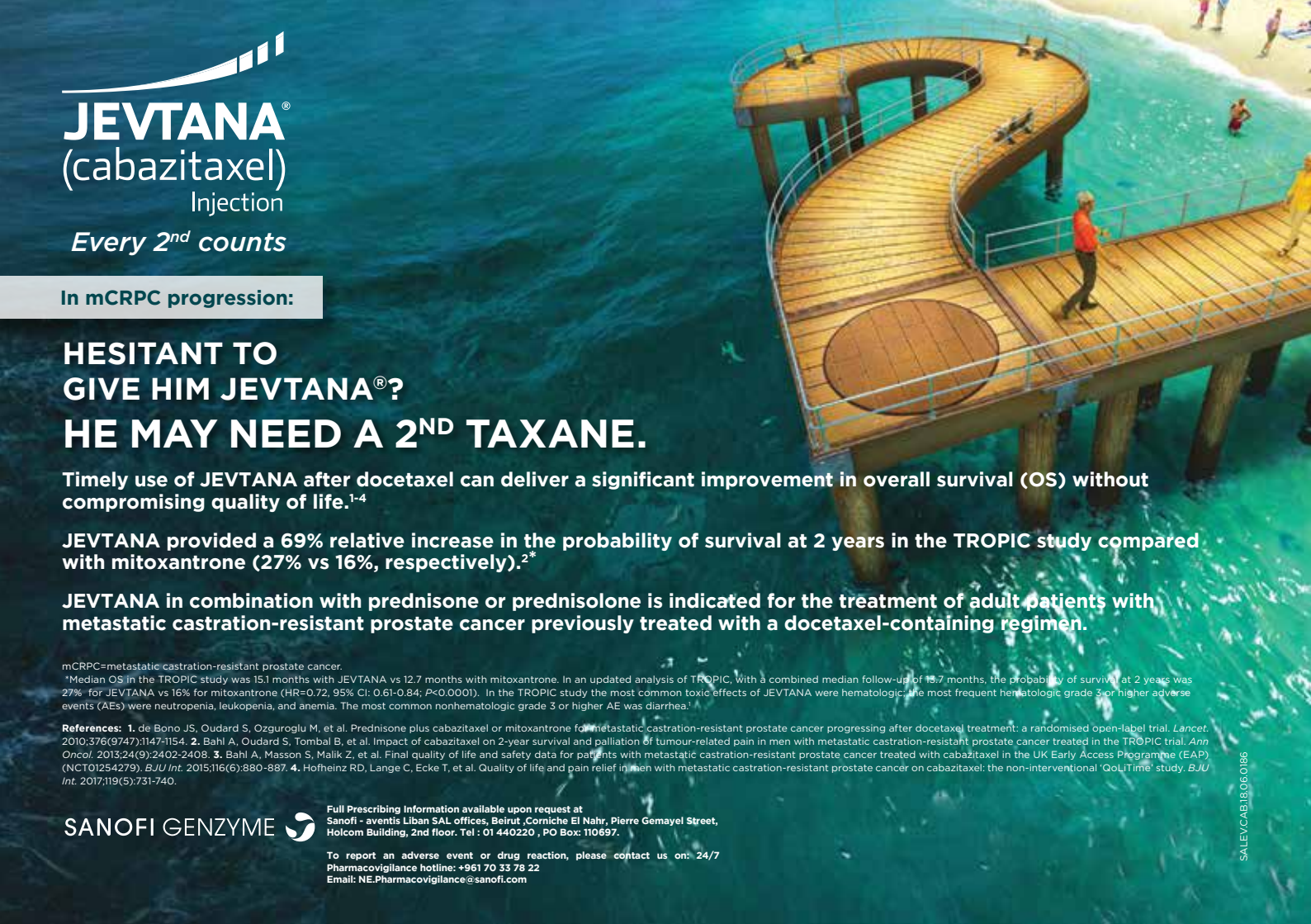
16:00 - 16:50	**Gastric Cancer**	
	Prevention	Antoine Geagea
	Surgery	Henri Bitar
	Locally Advanced	Rita Rizk
	Metastatic	Dany Gholam
	Radiotherapy	Caroline Jabbour
16:50 - 17:20	Maximizing Patients Outcome in Gastric Cancer: Case Discussion | *Lilly Symposium*	Joseph Kattan
17:20 - 17:40	**Coffee Break**	
17:40 - 18:40	**Bladder Cancer**	
	Urology Perspective:	
	- NMIBC	Alain Khalaf
	- Muscle Invasive	Maroun Serhal
	Neoadjuvant	Therese Abou Nasr
	Metastatic (Chemo/Immuno)	Joseph Kattan
	Update in Non-Metastatic Prostate Cancer M0	Fouad Aoun
	Update in Metastatic Prostate Cancer	Mansour Salem



JEVTANA®
(cabazitaxel)
Injection

Every 2nd counts

In mCRPC progression:

HESITANT TO GIVE HIM JEVTANA®?

HE MAY NEED A 2ND TAXANE.

Timely use of JEVTANA after docetaxel can deliver a significant improvement in overall survival (OS) without compromising quality of life.[1-4]

JEVTANA provided a 69% relative increase in the probability of survival at 2 years in the TROPIC study compared with mitoxantrone (27% vs 16%, respectively).[2*]

JEVTANA in combination with prednisone or prednisolone is indicated for the treatment of adult patients with metastatic castration-resistant prostate cancer previously treated with a docetaxel-containing regimen.

mCRPC=metastatic castration-resistant prostate cancer.
*Median OS in the TROPIC study was 15.1 months with JEVTANA vs 12.7 months with mitoxantrone. In an updated analysis of TROPIC, with a combined median follow-up of 13.7 months, the probability of survival at 2 years was 27% for JEVTANA vs 16% for mitoxantrone (HR=0.72, 95% CI: 0.61-0.84; *P*<0.0001). In the TROPIC study the most common toxic effects of JEVTANA were hematologic. The most frequent hematologic grade 3 or higher adverse events (AEs) were neutropenia, leukopenia, and anemia. The most common nonhematologic grade 3 or higher AE was diarrhea.[1]

References: 1. de Bono JS, Oudard S, Ozguroglu M, et al. Prednisone plus cabazitaxel or mitoxantrone for metastatic castration-resistant prostate cancer progressing after docetaxel treatment: a randomised open-label trial. *Lancet.* 2010;376(9747):1147-1154. **2.** Bahl A, Oudard S, Tombal B, et al. Impact of cabazitaxel on 2-year survival and palliation of tumour-related pain in men with metastatic castration-resistant prostate cancer treated in the TROPIC trial. *Ann Oncol.* 2013;24(9):2402-2408. **3.** Bahl A, Masson S, Malik Z, et al. Final quality of life and safety data for patients with metastatic castration-resistant prostate cancer treated with cabazitaxel in the UK Early Access Programme (EAP) (NCT01254279). *BJU Int.* 2015;116(6):880-887. **4.** Hofheinz RD, Lange C, Ecke T, et al. Quality of life and pain relief in men with metastatic castration-resistant prostate cancer on cabazitaxel: the non-interventional 'QoLiTime' study. *BJU Int.* 2017;119(5):731-740.

SANOFI GENZYME

Full Prescribing Information available upon request at
Sanofi - aventis Liban SAL offices, Beirut ,Corniche El Nahr, Pierre Gemayel Street, Holcom Building, 2nd floor. Tel : 01 440220 , PO Box: 110697.

To report an adverse event or drug reaction, please contact us on: 24/7 Pharmacovigilance hotline: +961 70 33 78 22
Email: NE.Pharmacovigilance@sanofi.com

SALEVCAB.18.06.0186

Notes

Notes

Notes

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sponsors for their contribution to the success of its annual congress

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KEYTRUDA APPROVED INDICATIONS [1]

ADVANCED MELANOMA

- FIRST-LINE AND LATER USE regardless of BRAF status

METASTATIC NSCLC:

- FIRST-LINE MONOTHERAPY for patients whose tumors express high PD-L1 (TPS ≥50%) that is negative for EGFR and ALK genomic tumor aberrations
- FIRST-LINE COMBINATION therapy with platinum-pemetrexed chemotherapy in nonsquamous metastatic NSCLC WITH OR WITHOUT PD-L1 EXPRESSION
- FIRST-LINE COMBINATION therapy with Carboplatin and either paclitaxel or nab-paclitaxel in squamous NSCLC WITH OR WITHOUT PD-L1 EXPRESSION
- SECOND-LINE MONOTHERAPY post-platinum failure for patients whose tumors express PD-L1 (TPS ≥1%)

CLASSICAL HODGKIN LYMPHOMA

- For the treatment of adult and pediatric patients with refractory cHL, or who have relapsed after 3 or more prior lines of therapy

PRIMARY MEDIASTINAL LARGE B-CELL LYMPHOMA

- For the treatment of adult and pediatric patients with refractory PMBCL, or who have relapsed after 2 or more prior lines of therapy.
- Limitation of Use: KEYTRUDA is not recommended for treatment of patients with PMBCL who require urgent cytoreductive therapy.

LOCALLY ADVANCED OR METASTATIC UROTHELIAL CARCINOMA

- FIRST-LINE CISPLATIN INELIGIBLE whose tumors express high PD-L1 (CPS≥10) or PLATINUM INELIGBLE
- SECOND-LINE post-platinum failure

RECURRENT OR METASTATIC HNSCC

- SECOND-LINE AND LATER USE post-platinum failure

ADVANCED MSI-H/dMMR CANCERS

- **CRC:** THIRD-LINE post Fluoropyrimidine, Oxaliplatin, and Irinotecan Failure for Adult and Pediatric Population with MSI-H or dMMR
- **Non-CRC:** SECOND-LINE post treatment for Adult and Pediatric Population with MSI-H or dMMR with no satisfactory alternative treatment options

ADVANCED GASTRIC OR GEJ CANCER

- THIRD-LINE AND LATER USE post fluoropyrimidine and platinum-containing chemotherapy Failure and if appropriate, HER2/neu-targeted therapy whose tumors express PD-L1 (CPS≥1)

ADVANCED CERVICAL CANCER

- SECOND-LINE AND LATER USE post chemotherapy Failure whose tumors express PD-L1 (CPS≥1)

HEPATOCELLULCAR CANCER

- SECOND-LINE post sorafenib treatment

BRAF =B-Raf proto-oncogene, serine/threonine kinase; NSCLC = non-small-cell lung cancer; PD-L1 = programmed death ligand 1; TPS = tumour proportion score; EGFR = epidermal growth factor receptor; ALK = anaplastic lymphoma kinase; cHL= Classical Hodgkin Lymphoma PMBCL: Primary Mediastinal Large B-Cell Lymphoma; CPS= combined positive score; HNSCC = head and neck squamous cell carcinom; MSI-H = microsatellite instability-high; dMMR = mismatch repair deficient; CRC = colorectal cancera; GEJ= gastroesophageal junction adenocarcinoma; HER2/Neu= human epidermal growth factor receptor 2

Reference: 1. Keytruda US Prescribing Information, November 2018

HR+/HER2- metastatic breast cancer is a

SHATTERING DIAGNOSIS

Now's the moment to decide... What comes next?

KISQALI® Important note: Before prescribing, consult full prescribing information. Presentation: Each film-coated tablet contains 200 mg of ribociclib free base. Indications: KISQALI® is indicated in combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of postmenopausal women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer. Dosage and administration: 2.1 Dosing and Administration The recommended dose of KISQALI is 600 mg (three 200 mg film-coated tablets) taken orally, once daily for 21 consecutive days followed by 7 days off treatment resulting in a complete cycle of 28 days. KISQALI can be taken with or without food . Coadminister KISQALI with letrozole 2.5 mg taken once daily throughout the 28day cycle. Refer to the full prescribing information of letrozole. For dosing and administration with other aromatase inhibitors refer to the applicable full prescribing information. Patients should take their dose of KISQALI and letrozole at approximately the same time each day, preferably in the morning. If the patient vomits after taking the dose, or misses a dose, no additional dose should be taken that day. The next prescribed dose should be taken at the usual time. KISQALI tablets should be swallowed whole (tablets should not be chewed, crushed or split prior to swallowing). No tablet should be ingested if it is broken, cracked, or otherwise not intact. Dose Modification for Use with Strong CYP3A Inhibitors Avoid concomitant use of KISQALI with strong CYP3A inhibitors and consider an alternative concomitant medication with less potential for CYP3A inhibition. If a strong CYP3A inhibitor must be coadministered, reduce the KISQALI dose to 400 mg once daily. If the strong inhibitor is discontinued, change the KISQALI dose (after at least 5 half-lives of the strong CYP3A inhibitor) to the dose used prior to the initiation of the strong CYP3A inhibitor. Dose Modification for Hepatic Impairment No dose adjustment is necessary in patients with mild hepatic impairment (Child-Pugh class A). The recommended starting dose is 400 mg KISQALI once daily for patients with moderate (Child-Pugh class B) and severe hepatic impairment (Child-Pugh class C). Review the Full Prescribing Information for the aromatase inhibitor for dose modifications related to hepatic impairment. Contraindications: • None. Warnings and precautions: •Neutropenia was most frequently reported. A complete blood count (CBC) should be performed before initiating therapy. CBC should be monitored every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, then as clinically indicated. Febrile neutropenia was reported in %1.5 of patients exposed to KisqalI and letrozole . Based on the severity of the neutropenia, KisqalI may require dose interruption, reduction, or discontinuation. •Increases in ALT and AST have been reported, with the majority of them without concurrent elevations of bilirubin. Concurrent elevations of ALT or AST >3 x ULN and of total bilirubin >2 x ULN, with normal alkaline phosphatase levels and no cholestasis occurred in %1.2 of patients; all patients returned to normal within 154 days after discontinuation of KisqalI. Liver function tests (LFTs) should be performed before initiating therapy with KisqalI. LFTs should be monitored every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, then as clinically indicated. Based on the severity of transaminase elevations, KisqalI may require dose interruption, reduction, or discontinuation. •QT interval prolongation has been reported with KisqalI. The use of KisqalI should be avoided in patients who have a heredity or who are at significant risk of developing QTc prolongation. The ECG should be assessed prior to initiation of treatment. Treatment with KisqalI should be initiated only in patients with QTcF values <450 msec. The ECG should be repeated at approximately Day 14 of the first cycle and at the beginning of the second cycle, then as clinically indicated. Appropriate monitoring of serum electrolytes (including potassium, calcium, phosphorous, and magnesium) should be performed prior to initiation of treatment, at the beginning of the first 6 cycles, and then as clinically indicated. Any abnormality should be corrected before the start of KisqalI therapy. Based on the observed QT prolongation during treatment, KisqalI may require dose interruption, reduction, or discontinuation. Pregnancy, lactation, females and males of reproductive potential. Pregnancy: It is possible that KisqalI can cause fetal harm when administered to a pregnant woman. The patient should be advised of the risk to a fetus if KisqalI is used during pregnancy or if the patient becomes pregnant while taking KisqalI. Lactation: A decision should be made whether to discontinue nursing or to discontinue KisqalI, taking into account the importance of KisqalI to the mother. It is recommended that women taking KisqalI should not breastfeed for at least 21 days after the last dose. Females and males of reproductive potential: •Pregnancy testing: For females of reproductive potential the pregnancy status should be verified prior to initiating treatment with KisqalI. •Contraception: Sexually active females of reproductive potential should use effective contraception (methods that result in < 1 % pregnancy rates) when using KisqalI during treatment and for 21 days after stopping treatment with KisqalI. • Infertility: Based on animal studies, KisqalI may impair fertility in males of reproductive potential. Adverse drug reactions: Very common (≥%10): Urinary tract infection, neutropenia, leukopenia, anaemia, lymphopenia, decreased appetite, headache, insomnia, dysgeusia, back pain, nausea, diarrhoea, vomiting, constipation, stomatitis, abdominal pain, alopecia, rash, pruritus, fatigue, peripheral oedema, asthenia, pyrexia, abnormal liver function tests, leukocyte count decreased, neutrophil count decreased, haemoglobin decreased, lymphocyte count decreased, platelet count decreased, alanine aminotransferase increased, aspartate aminotransferase increased, creatinine increased, phosphorous decreased, potassium decreased, . Interactions •Concomitant use of strong CYP3A inhibitors should be avoided, including but not limited to clarithromycin, indinavir, itraconazole, ketoconazole, lopinavir, ritonavir, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, and voriconazole. Alternative medications with less potential to inhibit CYP3A should be considered. Patients should be monitored for ADRs. If concomitant use of a strong CYP3A inhibitor cannot be avoided, the KisqalI dose should be reduced to 400 mg. Pomegranates or pomegranate juice and grapefruit or grapefruit juice should be avoided. •Concomitant use of strong CYP3A inducers should be avoided, including but not limited to phenytoin, rifampin, carbamazepine and St John's Wort (Hypericum perforatum). •Caution is advised when KisqalI is administered with CYP3A substrates with narrow therapeutic index (including but not limited to alfentanil, cyclosporine, dihydroergotamine, ergotamine, everolimus, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus), and their dose may need to be reduced. •Co-administration of KisqalI with medications with known potential to prolong the QT interval should be avoided such as anti-arrhythmic medicines (including but not limited to amiodarone, disopyramide, procainamide, quinidine, and sotalol), other medicinal products known to prolong the QT interval including but not limited to chloroquine, halofantrine, clarithromycin, haloperidol, methadone, moxifloxacin, bepridil, pimozide, and ondansetron (i.e. Paxlos and prices: Country-specific. Legal classification: Country-specific. Leaflet revision date: March 2017

March/2019/Kis-Leb/1/Adpage

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After diagnosis of HR+/HER2- metastatic breast cancer

STRENGTH COMES FIRST

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ribociclib

RAPID POWER THAT REDEFINES FIRST LINE IN...

POSTMENOPAUSAL

women **with an AI** as initial therapy