You are cordially invited to attend

MONJUVI tafasitamab-cxix rituximab & lenalidomide

Monjuvi + Rituximab & Lenalidomide: The First and Only CD19- and CD20-targeted Immunotherapy Combination Approved for 2L+ Follicular Lymphoma Patients

Wednesday, October 1, 2025 at 6:30 PM

The program will begin at 6:30 PM. Please plan to arrive 15 minutes early to sign in.

Featured Speaker

M. Yair Levy, MD
Texas Oncology - Baylor
Dallas, TX

Location

Las Brisas Steakhouse
4701 112th Street
Lubbock, TX 79424

Appropriate attendees include licensed HCPs with a direct role in patient care.
Due to a change in Policy, Incyte will no longer provide or pay for alcohol at Speaker Programs.

Registration

Register by Wednesday, September 24th
https://sphase.info/inc12790

To register manually, please contact your Incyte representative Steve Wohnoutka at (972) 529-8982 or swohnoutka@incyte.com with the following information: name, title/degree, state(s) and state license #(s), affiliation, address, phone, and e-mail.

INDICATIONS & USAGE

MONJUVI (tafasitamab-cxix), in combination with lenalidomide and rituximab, is indicated for the treatment of adult patients with relapsed or refractory follicular lymphoma (FL).

Limitations of Use: MONJUVI is not indicated and is not recommended for the treatment of patients with relapsed or refractory marginal zone lymphoma outside of controlled clinical trials.

Please see Important Safety Information on reverse and accompanying Full Prescribing Information.

Please note this program is intended for US healthcare professionals (HCPs) who practice in a specialty relevant to the program's FDA-approved indication or disease state. This program is sponsored by Incyte and is not eligible for CE credits.

This is an educational event intended only for appropriate healthcare professionals. Spouses, guests, and other individuals who are not the intended audience of this educational program are not permitted to attend. Healthcare professionals who are subject to federal, state or local laws or government ethics restrictions may not attend this event. Incyte will report the cost of any meals provided at this event as required by federal, state or local law requirements.

Incyte and its representatives will process your personal information that you provide when you register in order to attend an educational event presented by Incyte. You can learn more about Incyte's privacy practices at the following site: **https://www.incyte.com/privacy-policy**. Please contact **privacy@incyte.com** if you have any questions or concerns.

IMPORTANT SAFETY INFORMATION

MONJUVI®
tafasitamab-cxix | 200mg
for injection, for intravenous use

CONTRAINDICATIONS

None.

WARNINGS AND PRECAUTIONS

Infusion-Related Reactions

MONJUVI (tafasitamab-cxix) can cause infusion-related reactions (IRRs).

In inMIND, infusion-related reactions occurred in 16% of the 274 patients with FL who received MONJUVI in combination with lenalidomide and rituximab. Signs and symptoms included fever, chills, rash, flushing, dyspnea, and hypertension. These reactions were generally managed with temporary interruption of the infusion and/or with supportive medication.

Premedicate patients prior to starting MONJUVI infusion. Monitor patients frequently during infusion. Based on the severity of the infusion-related reaction, interrupt or discontinue MONJUVI. Institute appropriate medical management.

Myelosuppression

MONJUVI can cause serious or severe myelosuppression, including neutropenia, lymphopenia, thrombocytopenia, and anemia.

In inMIND, among 274 patients with FL who received MONJUVI in combination with lenalidomide and rituximab, new or worse Grade 3 or 4 cytopenias included decreased neutrophils in 48% (Grade 4, 19%), decreased lymphocytes in 22% (Grade 4, 1.8%), decreased hemoglobin in 9%, and decreased platelets in 8% (Grade 4, 4%). Febrile neutropenia occurred in 4.4%.

Monitor complete blood counts (CBCs) before each treatment cycle and throughout treatment. Monitor patients with neutropenia for signs of infection. Consider granulocyte colony-stimulating factor (G-CSF) administration. Withhold MONJUVI based on the severity of the adverse reaction. Refer to the lenalidomide prescribing information for dosage modifications.

Infections

Fatal and serious infections, including opportunistic infections, occurred in patients during treatment with MONJUVI and following the last dose.

Among 274 patients with FL who received MONJUVI in combination with lenalidomide and rituximab in inMIND, Grade 3 or higher infections occurred in 24%, including fatal infections in 1.1% of patients. The most frequent Grade ≥ 3 infections were respiratory tract infections (19%), including Grade 3 or higher pneumonia (14%) and COVID-19 infection (11%). Opportunistic infections of any grade occurred in 6% of patients including herpes simplex or zoster infection (5%), fungal pneumonia (1.1%, including *Pneumocystis jirovecii* pneumonia in 0.4%), and cytomegalovirus (CMV) reactivation (0.4%).

Monitor patients for signs and symptoms of infection and manage infections as appropriate. Consider infection prophylaxis per institutional guidelines. Consider treatment with subcutaneous or intravenous immunoglobulin (IVIG) as appropriate.

Embryo-Fetal Toxicity

Based on its mechanism of action, MONJUVI may cause fetal B-cell depletion when administered to a pregnant woman. Advise pregnant women of the potential risk to a fetus. Advise women of reproductive potential to use effective contraception during treatment with MONJUVI and for 3 months after the last dose.

The combination of MONJUVI with lenalidomide and rituximab is contraindicated in pregnant women because lenalidomide can cause birth defects and death of the unborn child. Refer to the lenalidomide prescribing information on use during pregnancy.

ADVERSE REACTIONS

In the MONJUVI arm, serious adverse reactions occurred in 33% of patients, including serious infections in 24% of patients (including pneumonia and COVID-19 infection). Other serious adverse reactions in ≥ 2% of patients included renal insufficiency (3.3%), second primary malignancies (2.9%), and febrile neutropenia (2.6%). Fatal adverse reactions occurred in 1.5% of patients, including from COVID-19, sepsis, and adenocarcinoma.

Adverse reactions led to permanent discontinuation of MONJUVI in 11% of patients and dosage interruptions in 74%. The most frequent adverse reactions leading to dosage interruptions of MONJUVI were neutropenia (37% of all patients), COVID-19 (22%), pneumonia (11%), and infusion-related reaction (8%).

The most common adverse reactions (≥ 20%) in patients receiving MONJUVI were respiratory tract infections (56%) (including COVID-19 infection and pneumonia), diarrhea (38%), rash (37%), fatigue (34%), constipation (29%), musculoskeletal pain (24%), and cough (21%). The most common Grade 3 or 4 laboratory abnormalities (≥ 20%) were decreased neutrophils (48%) and decreased lymphocytes (22%).

Please see the accompanying Full Prescribing Information for more information about MONJUVI.

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