

November 25, 2015

New Long-Term Data on *Opdivo* and the *Opdivo* + *Yervoy* Regimen Shows Survival Benefit Across Lines of Therapy in Advanced Melanoma

(PRINCETON, NJ, November 18, 2015) – Bristol-Myers Squibb Company (NYSE:BMJ) announced new long-term data of *Opdivo* in treatment-naïve BRAF wild-type advanced melanoma from CheckMate -066.

In USA, *Opdivo* was approved under accelerated approval for the treatment of unresectable or metastatic melanoma and disease progression following *Yervoy* and, if BRAF V600 mutation positive, a BRAF inhibitor in December 2014 and approved for the treatment of metastatic squamous NSCLC with progression on or after platinum-based chemotherapy in March 2015. Also, *Opdivo* in combination with *Yervoy* for the treatment of patients with BRAF V600 wild-type unresectable or metastatic melanoma received the approval in October 2015. *Opdivo* received expanded FDA approval in previously-treated metastatic non-small cell lung cancer in the same month. In EU, *Opdivo* was approved for the treatment of advanced (unresectable or metastatic) melanoma in adults regardless of BRAF status in June 2015. European Commission approved Nivolumab BMS for the treatment of locally advanced or metastatic squamous NSCLC after prior chemotherapy in July 2015.

Also, BMS has a robust clinical development program in a variety of tumor types overseas, including: Renal Cell Carcinoma (RCC), Head and Neck Cancer, Blood Cancer, Glioblastoma, Colorectal Cancer, Pancreatic Cancer, Gastric Cancer, Hepatocellular Carcinoma, Triple-Negative Breast Cancer, Small-Cell Lung Cancer, Urothelial Cancer, etc. In Japan, ONO launched it for the treatment of unresectable melanoma in September 2014. Also, ONO is conducting clinical development programs including RCC, NSCLC, Head and Neck Cancer, Gastric Cancer, Esophageal Cancer, Hepatocellular Carcinoma, Hodgkin Lymphoma, Urothelial Cancer, Glioblastoma and Ovarian Cancer, etc.

Attached from the following page is the press release made by BMS for your information.

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New Long-Term Data on *Opdivo* and the *Opdivo* + *Yervoy* Regimen Shows Survival Benefit Across Lines of Therapy in Advanced Melanoma

First and only PD-1 checkpoint inhibitor to demonstrate two-year overall survival data in a Phase 3 trial, CheckMate -066, with nearly 60% of patients still alive at two years

Longest follow-up for the *Opdivo* + *Yervoy* Regimen from Study 004 shows three-year overall survival rate of 68% across Phase 1 dosing cohorts

(PRINCETON, NJ, November 18, 2015) – [Bristol-Myers Squibb Company](#) (NYSE:BMJ) today announced new long-term data of *Opdivo* in treatment-naïve *BRAF* wild-type advanced melanoma from CheckMate -066. In the trial, *Opdivo* continued to demonstrate superior overall survival versus dacarbazine with 57.7% of patients alive at two years compared to 26.7% of patients treated with dacarbazine. The safety profile of *Opdivo* was consistent with prior studies. The two-year survival and safety data from CheckMate -066 represent the longest follow-up from a randomized study of any PD-1 immune checkpoint inhibitor in the first-line setting of advanced melanoma. These data will be presented as a late-breaking presentation at the Society for Melanoma Research (SMR) 2015 International Congress in San Francisco, CA from November 18 to 21.

Bristol-Myers Squibb is also presenting updated data from various Phase 1 cohorts of Study 004 evaluating the *Opdivo* + *Yervoy* Regimen in patients with unresectable or metastatic melanoma, including up to three-year overall survival. The Phase 1b Study 004 is a dose-finding study on which the proof of concept for *Opdivo* + *Yervoy* Regimen approval was based.

“The long-term survival data for our Immuno-Oncology agent, *Opdivo*, as a single agent and in combination with *Yervoy* presented at SMR shows our continued commitment to improve outcomes for patients with advanced melanoma,” said Michael Giordano, M.D., senior vice president, head of Oncology Development, Bristol-Myers Squibb. “The *Opdivo* + *Yervoy* Regimen has shown compelling potential for providing improved duration of response and long-term survival for some patients, and, as single agents, *Opdivo* and *Yervoy* continue to play a critical role as core components of the treatment continuum for advanced melanoma in appropriate patients.”

The global incidence of melanoma has been increasing over the past three decades, and despite recent advances in treatment, patients with advanced or metastatic disease often have a poor prognosis. Currently, five-year survival rates for advanced melanoma are between 5% and 19%.

Opdivo Associated with a Doubling of Overall Survival in CheckMate -066

CheckMate -066 is a Phase 3, randomized study which evaluated *Opdivo* as a single agent (n=210) versus dacarbazine (n=208) in patients with previously untreated, *BRAF* wild-type unresectable or metastatic melanoma. The primary endpoint of the trial was overall survival (OS). Secondary endpoints included progression-free survival (PFS) and objective response rate (ORR).

In the trial, patients administered *Opdivo* demonstrated increased OS compared to dacarbazine. With a minimum follow-up of 15.1 months, *Opdivo* continued to demonstrate significantly improved OS with the median OS not reached (NR) (95% CI: 23.1, NR) versus 11.2 months with dacarbazine (95% CI: 9.6, 13.0) (hazard ratio [HR]=0.43; 95% CI: 0.33, 0.57; p<0.001). Overall survival rates were 70.7% and 57.7% for *Opdivo* and 46.3% and 26.7% for dacarbazine at 12 and 24 months, respectively. Subsequent treatment was used in 72.1% of patients in the dacarbazine arm, with 27 (13%) patients receiving *Opdivo* as the subsequent therapy. ORR and PFS also continued to be significantly greater with *Opdivo*. Objective response rate was 42.9% for *Opdivo* with 11% of patients achieving a complete response, compared to a 14.4% ORR for dacarbazine with 1% of patients achieving a complete response. Of 90 responders, 81% experienced ongoing responses with *Opdivo*. Median PFS was 5.4 months for *Opdivo* versus 2.2 months for dacarbazine (HR=0.42; 95% CI: 0.32, 0.53; p<0.0001). At one and two years, PFS was 44.3% and 39.2% for those patients administered *Opdivo*, respectively.

The safety profile of *Opdivo* in CheckMate -066 was consistent with prior studies and continued to be acceptable at two years. Incidences of treatment-related adverse events (AE) of any grade were similar between treatment arms, with Grade 3-4 AEs occurring in 13% and 17% of patients. Treatment-related select AEs reported in $\geq 10\%$ of patients treated with *Opdivo* included pruritus (22%), diarrhea (18%) and rash (18%). Treatment-related AEs led to discontinuation in 6% of patients treated with *Opdivo*.

Opdivo + Yervoy Regimen Shows Improved Overall Survival Across Dosing Cohorts

Study 004 (CA209-004) is a Phase 1b, open-label, multicenter, multidose, dose-finding study of *Opdivo* in combination with *Yervoy* in patients with unresectable or metastatic melanoma. The trial evaluated different dosing schedules for the *Opdivo* + *Yervoy* Regimen, including *Opdivo* + *Yervoy* every three weeks for 12 weeks, followed by *Opdivo* every three weeks for 12 weeks (Cohorts 1, 2, 2a, and 3) (n=53), or *Opdivo* 1 mg/kg and *Yervoy* 3 mg/kg every three weeks for 12 weeks followed by *Opdivo* 3 mg/kg every two weeks (Cohort 8) (n=41). Forty percent of patients in Cohorts 1-3 and 51% of patients in Cohort 8 were previously treated.

For Cohorts 1-3, median duration of follow-up was 32.7 months (range 2.5 to 61.4). At 36 months (three years), the OS rate was 68% for patients in Cohorts 1-3 treated with the combination of *Opdivo* and *Yervoy*. Objective response rate was 42% with a 22.3 month median duration of response (95% CI: 12.09-NR). Complete responses were seen in 21% of patients in Cohorts 1-3. Rates of ongoing response were similar between Cohorts 1-3 and Cohort 8 (55% and 56%, respectively). These data represent the longest follow-up of the combination of *Opdivo* and *Yervoy*.

Patients included in Cohort 8 had poor prognostic factors at baseline, including ECOG performance status, history of brain metastases, prior systemic therapy and PD-L1 expression. At 18 months, 68% of patients were alive, with a median duration of follow-up of 19.9 months (range 0.9 to 24.0). Objective response rate was 44% with a median duration of response of 13.7 months (95% CI: 5.59-NR). Complete responses were seen in 17% of patients. In the study, high response rates and durable tumor response were observed in patients with or without poor prognostic factors at baseline.

The frequency of treatment-related AEs in the study were similar between Cohorts 1-3 and Cohort 8, and was consistent with the Phase 2 and 3 trials for the combination therapy. Across all concurrent cohorts, the incidence of treatment-related Grade 3-4 AEs was 56% and the incidence of treatment-related AEs leading to discontinuation was 27%.

About *Opdivo*

Bristol-Myers Squibb has a broad, global development program to study *Opdivo* in multiple tumor types consisting of more than 50 trials – as monotherapy or in combination with other therapies – in which more than 8,000 patients have been enrolled worldwide. *Opdivo* is the first PD-1 immune checkpoint inhibitor to receive regulatory approval anywhere in the world in July 2014, and currently has regulatory approval in more than 37 countries including the United States, Japan, and in the European Union.

About *Yervoy*

Yervoy is a recombinant, human monoclonal antibody that binds to the cytotoxic T-lymphocyte-associated antigen-4 (CTLA-4). CTLA-4 is a negative regulator of T-cell activity. *Yervoy* binds to CTLA-4 and blocks the interaction of CTLA-4 with its ligands, CD80/CD86. Blockade of CTLA-4 has been shown to augment T-cell activation and proliferation, including the activation and proliferation of tumor infiltrating T-effector cells. Inhibition of CTLA-4 signaling can also reduce T-regulatory cell function, which may contribute to a general increase in T-cell responsiveness, including the anti-tumor

immune response. *Yervoy* is now approved in more than 40 countries. There is a broad, ongoing development program in place for *Yervoy* spanning multiple tumor types.

Indications and Important Safety Information for YERVOY[®] (ipilimumab)

Indications

YERVOY[®] (ipilimumab) is indicated for the treatment of unresectable or metastatic melanoma.

YERVOY[®] (ipilimumab) is indicated for the adjuvant treatment of patients with cutaneous melanoma with pathologic involvement of regional lymph nodes of more than 1 mm who have undergone complete resection, including total lymphadenectomy.

Important Safety Information

WARNING: IMMUNE-MEDIATED ADVERSE REACTIONS

YERVOY (ipilimumab) can result in severe and fatal immune-mediated adverse reactions. These immune-mediated reactions may involve any organ system; however, the most common severe immune-mediated adverse reactions are enterocolitis, hepatitis, dermatitis (including toxic epidermal necrolysis), neuropathy, and endocrinopathy. The majority of these immune-mediated reactions initially manifested during treatment; however, a minority occurred weeks to months after discontinuation of YERVOY.

Permanently discontinue YERVOY and initiate systemic high-dose corticosteroid therapy for severe immune-mediated reactions.

Assess patients for signs and symptoms of enterocolitis, dermatitis, neuropathy, and endocrinopathy and evaluate clinical chemistries including liver function tests (LFTs), adrenocorticotropic hormone (ACTH) level, and thyroid function tests, at baseline and before each dose.

Recommended Dose Modifications

Endocrine: Withhold YERVOY for systemic endocrinopathy. Resume YERVOY in patients with complete or partial resolution of adverse reactions (Grade 0-1) and who are receiving <7.5 mg prednisone or equivalent per day. Permanently discontinue YERVOY for symptomatic reactions lasting 6 weeks or longer or an inability to reduce corticosteroid dose to 7.5 mg prednisone or equivalent per day.

Ophthalmologic: Permanently discontinue YERVOY for Grade 2-4 reactions not improving to Grade 1 within 2 weeks while receiving topical therapy or requiring systemic treatment.

All Other Organ Systems: Withhold YERVOY for Grade 2 adverse reactions. Resume YERVOY in patients with complete or partial resolution of adverse reactions (Grade 0-1) and who are receiving <7.5 mg prednisone or equivalent per day. Permanently discontinue YERVOY for Grade 2 reactions lasting 6 weeks or longer, an inability to reduce corticosteroid dose to 7.5 mg prednisone or equivalent per day, and Grade 3 or 4 adverse reactions.

Immune-mediated Enterocolitis:

Immune-mediated enterocolitis, including fatal cases, can occur with YERVOY. Monitor patients for signs and symptoms of enterocolitis (such as diarrhea, abdominal pain, mucus or blood in stool, with or without fever) and of bowel perforation (such as peritoneal signs and ileus). In symptomatic patients, rule out infectious etiologies and consider endoscopic evaluation for persistent or severe symptoms. Withhold YERVOY for moderate enterocolitis; administer anti-diarrheal treatment and, if persistent for >1 week, initiate systemic corticosteroids (0.5 mg/kg/day prednisone or equivalent). Permanently discontinue YERVOY in patients with severe enterocolitis and initiate systemic corticosteroids (1-2 mg/kg/day of prednisone or equivalent). Upon improvement to \leq Grade 1, initiate corticosteroid taper and continue over at least 1 month. In clinical trials, rapid corticosteroid tapering resulted in recurrence or worsening symptoms of enterocolitis in some patients. Consider adding anti-TNF or other immunosuppressant agents for management of immune-mediated enterocolitis unresponsive to systemic corticosteroids within 3-5 days or recurring after symptom improvement. In patients receiving YERVOY 3 mg/kg in Trial 1, severe, life-threatening, or fatal (diarrhea of ≥ 7 stools above baseline, fever, ileus, peritoneal signs; Grade 3-5) immune-mediated enterocolitis occurred in 34 YERVOY-treated patients (7%) and moderate (diarrhea with up to 6 stools above baseline, abdominal pain, mucus or blood in stool; Grade 2) enterocolitis occurred in 28 YERVOY-treated patients (5%). Across all YERVOY-treated patients (n=511), 5 (1%) developed intestinal perforation, 4 (0.8%) died as a result of complications, and 26 (5%) were hospitalized for severe enterocolitis. Infliximab was administered to 5 (8%) of the 62 patients with moderate, severe, or life-threatening immune-mediated enterocolitis following inadequate response to corticosteroids. In patients receiving YERVOY 10 mg/kg in Trial 2, Grade 3-5 immune-mediated enterocolitis occurred in 76 patients (16%) and Grade 2 enterocolitis occurred in 68 patients (14%). Seven (1.5%) developed intestinal perforation and 3 patients (0.6%) died as a result of complications.

Immune-mediated Hepatitis:

Immune-mediated hepatitis, including fatal cases, can occur with YERVOY. Monitor LFTs (hepatic transaminase and bilirubin levels) and assess patients for signs and symptoms of hepatotoxicity before each dose of YERVOY. In patients with hepatotoxicity, rule out infectious or malignant causes and increase frequency of LFT monitoring until resolution. Withhold YERVOY in patients with Grade 2 hepatotoxicity. Permanently discontinue YERVOY in patients with Grade 3-4 hepatotoxicity and administer systemic corticosteroids (1-2 mg/kg/day of prednisone or equivalent). When LFTs show sustained improvement or return to baseline, initiate corticosteroid tapering and continue over 1 month. Across the clinical development program for YERVOY, mycophenolate treatment has been administered in patients with persistent severe hepatitis despite high-dose corticosteroids. In patients receiving YERVOY 3 mg/kg in Trial 1, severe, life-threatening, or fatal hepatotoxicity (AST or ALT elevations $>5\times$ the ULN or total bilirubin elevations $>3\times$ the ULN; Grade 3-5) occurred in 8 YERVOY-treated patients (2%), with fatal hepatic failure in 0.2% and hospitalization in 0.4%. An additional 13 patients (2.5%) experienced moderate hepatotoxicity manifested by LFT abnormalities (AST or ALT elevations $>2.5\times$ but $\leq 5\times$ the ULN or total bilirubin elevation $>1.5\times$ but $\leq 3\times$ the ULN; Grade 2). In a dose-finding trial, Grade 3 increases in transaminases with or without concomitant increases in total bilirubin occurred in 6 of 10 patients who received concurrent YERVOY (3 mg/kg) and vemurafenib (960 mg BID or 720 mg BID). In patients receiving YERVOY 10 mg/kg in Trial 2, Grade 3-4 immune-mediated hepatitis occurred in 51 patients (11%) and moderate Grade 2 immune-mediated hepatitis occurred in 22 patients (5%). Liver biopsy performed in 6 patients with Grade 3-4 hepatitis showed evidence of toxic or autoimmune hepatitis.

Immune-mediated Dermatitis:

Immune-mediated dermatitis, including fatal cases, can occur with YERVOY. Monitor patients for signs and symptoms of dermatitis such as rash and pruritus. Unless an alternate etiology has been identified, signs or symptoms of dermatitis should be considered immune-mediated. Treat mild to moderate dermatitis (e.g., localized rash and pruritus) symptomatically; administer topical or systemic corticosteroids if there is no improvement within 1 week. Withhold YERVOY in patients with moderate to severe signs and symptoms. Permanently discontinue YERVOY in patients with severe, life-threatening, or fatal immune-mediated dermatitis (Grade 3-5). Administer systemic corticosteroids (1-2 mg/kg/day of prednisone or equivalent). When dermatitis is controlled, corticosteroid tapering should occur over a period of at least 1 month. In patients receiving YERVOY 3 mg/kg in Trial 1, severe, life-threatening, or fatal immune-mediated dermatitis (e.g., Stevens-Johnson syndrome, toxic epidermal necrolysis, or rash complicated by full thickness dermal ulceration, or necrotic, bullous, or hemorrhagic manifestations; Grade 3-5) occurred in 13 YERVOY-treated patients (2.5%); 1 patient (0.2%) died as a result of toxic epidermal necrolysis and 1 additional patient required hospitalization for severe dermatitis. There were 63 patients (12%) with moderate (Grade 2) dermatitis. In patients receiving YERVOY 10 mg/kg in Trial 2, Grade 3-4 immune-mediated dermatitis occurred in 19 patients (4%). There were 99 patients (21%) with moderate Grade 2 dermatitis.

Immune-mediated Neuropathies:

Immune-mediated neuropathies, including fatal cases, can occur with YERVOY. Monitor for symptoms of motor or sensory neuropathy such as unilateral or bilateral weakness, sensory alterations, or paresthesia. Withhold YERVOY in patients with moderate neuropathy (not interfering with daily activities). Permanently discontinue YERVOY in patients with severe neuropathy (interfering with daily activities), such as Guillain-Barre-like syndromes. Institute medical intervention as appropriate for management for severe neuropathy. Consider initiation of systemic corticosteroids (1-2 mg/kg/day of prednisone or equivalent) for severe neuropathies. In patients receiving YERVOY 3 mg/kg in Trial 1, 1 case of fatal Guillain-Barré syndrome and 1 case of severe (Grade 3) peripheral motor neuropathy were reported. Across the clinical development program of YERVOY, myasthenia gravis and additional cases of Guillain-Barré syndrome have been reported. In patients receiving YERVOY 10 mg/kg in Trial 2, Grade 3-5 immune-mediated neuropathy occurred in 8 patients (2%); the sole fatality was due to complications of Guillain-Barré syndrome. Moderate Grade 2 immune-mediated neuropathy occurred in 1 patient (0.2%).

Immune-mediated Endocrinopathies:

Immune-mediated endocrinopathies, including life-threatening cases, can occur with YERVOY. Monitor patients for clinical signs and symptoms of hypophysitis, adrenal insufficiency (including adrenal crisis), and hyper- or hypothyroidism. Patients may present with fatigue, headache, mental status changes, abdominal pain, unusual bowel habits, and hypotension, or nonspecific symptoms which may resemble other causes such as brain metastasis or underlying disease. Unless an alternate etiology has been identified, signs or symptoms should be considered immune-mediated. Monitor clinical chemistries, adrenocorticotropic hormone (ACTH) level, and thyroid function tests at the start of treatment, before each dose, and as clinically indicated based on symptoms. In a limited number of patients, hypophysitis was diagnosed by imaging studies through enlargement of the pituitary gland. Withhold YERVOY in symptomatic patients and consider referral to an endocrinologist. Initiate systemic corticosteroids (1-2 mg/kg/day of prednisone or equivalent) and initiate appropriate hormone replacement therapy. In patients receiving YERVOY 3 mg/kg in Trial 1, severe to life-threatening immune-mediated endocrinopathies (requiring hospitalization, urgent medical intervention, or interfering with activities of daily living; Grade 3-4) occurred in 9 YERVOY-treated patients (1.8%). All 9 patients had hypopituitarism, and some had additional concomitant endocrinopathies such as adrenal insufficiency, hypogonadism, and hypothyroidism. Six of the 9 patients were hospitalized for severe endocrinopathies.

Moderate endocrinopathy (requiring hormone replacement or medical intervention; Grade 2) occurred in 12 patients (2.3%) and consisted of hypothyroidism, adrenal insufficiency, hypopituitarism, and 1 case each of hyperthyroidism and Cushing's syndrome. The median time to onset of moderate to severe immune-mediated endocrinopathy was 2.5 months and ranged up to 4.4 months after the initiation of YERVOY. In patients receiving YERVOY 10 mg/kg in Trial 2, Grade 3-4 immune-mediated endocrinopathies occurred in 39 patients (8%) and Grade 2 immune-mediated endocrinopathies occurred in 93 patients (20%). Of the 39 patients with Grade 3-4 immune-mediated endocrinopathies, 35 patients had hypopituitarism (associated with 1 or more secondary endocrinopathies, e.g., adrenal insufficiency, hypogonadism, and hypothyroidism), 3 patients had hyperthyroidism, and 1 had primary hypothyroidism. The median time to onset of Grade 3-4 immune-mediated endocrinopathy was 2.2 months (range: 2 days-8 months). Twenty-seven (69.2%) of the 39 patients were hospitalized for immune-mediated endocrinopathies. Of the 93 patients with Grade 2 immune-mediated endocrinopathy, 74 had primary hypopituitarism (associated with 1 or more secondary endocrinopathy, e.g., adrenal insufficiency, hypogonadism, and hypothyroidism), 9 had primary hypothyroidism, 3 had hyperthyroidism, 3 had thyroiditis with hypo- or hyperthyroidism, 2 had hypogonadism, 1 had both hyperthyroidism and hypopituitarism, and 1 subject developed Graves' ophthalmopathy. The median time to onset of Grade 2 immune-mediated endocrinopathy was 2.1 months (range: 9 days-19.3 months).

Other Immune-mediated Adverse Reactions, Including Ocular Manifestations:

Permanently discontinue YERVOY for clinically significant or severe immune-mediated adverse reactions. Initiate systemic corticosteroids (1-2 mg/kg/day of prednisone or equivalent) for severe immune-mediated adverse reactions. Administer corticosteroid eye drops for uveitis, iritis, or episcleritis. Permanently discontinue YERVOY for immune-mediated ocular disease unresponsive to local immunosuppressive therapy. In Trial 1, the following clinically significant immune-mediated adverse reactions were seen in <1% of YERVOY-treated patients: nephritis, pneumonitis, meningitis, pericarditis, uveitis, iritis, and hemolytic anemia. In Trial 2, the following clinically significant immune-mediated adverse reactions were seen in <1% of YERVOY-treated patients unless specified: eosinophilia (2.1%), pancreatitis (1.3%), meningitis, pneumonitis, sarcoidosis, pericarditis, uveitis and fatal myocarditis. Across 21 dose-ranging trials administering YERVOY at doses of 0.1 to 20 mg/kg (n=2478), the following likely immune-mediated adverse reactions were also reported with <1% incidence: angiopathy, temporal arteritis, vasculitis, polymyalgia rheumatica, conjunctivitis, blepharitis, episcleritis, scleritis, iritis, leukocytoclastic vasculitis, erythema multiforme, psoriasis, arthritis, autoimmune thyroiditis, neurosensory hypoacusis, autoimmune central neuropathy (encephalitis), myositis, polymyositis, ocular myositis, hemolytic anemia, and nephritis.

Embryo-fetal Toxicity

Based on its mechanism of action, YERVOY can cause fetal harm when administered to a pregnant woman. The effects of YERVOY are likely to be greater during the second and third trimesters of pregnancy. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with a YERVOY-containing regimen and for 3 months after the last dose of YERVOY.

Lactation

It is not known whether YERVOY is secreted in human milk. Advise women to discontinue nursing during treatment with YERVOY and for 3 months following the final dose.

Common Adverse Reactions:

The most common adverse reactions ($\geq 5\%$) in patients who received YERVOY at 3 mg/kg were fatigue (41%), diarrhea (32%), pruritis (31%), rash (29%), and colitis (8%). The most common adverse

reactions ($\geq 5\%$) in patients who received YERVOY at 10 mg/kg were rash (50%), diarrhea (49%), fatigue (46%), pruritus (45%), headache (33%), weight loss (32%), nausea (25%), pyrexia (18%), colitis (16%), decreased appetite (14%), vomiting (13%), and insomnia (10%).

Please see U.S. Full Prescribing Information, including **Boxed WARNING regarding immune-mediated adverse reactions**.

Indications and Important Safety Information for OPDIVO[®] (nivolumab)

Indications

OPDIVO[®] (nivolumab) is indicated for the treatment of unresectable or metastatic melanoma as a single agent in patients with disease progression following ipilimumab and, if BRAF V600 mutation positive, a BRAF inhibitor and in combination with ipilimumab in patients with BRAF V600 wild-type melanoma.

These indications are approved under accelerated approval based on tumor response rate and durability of response. Continued approval for these indications may be contingent upon verification and description of clinical benefit in the confirmatory trials.

OPDIVO[®] (nivolumab) is indicated for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with progression on or after platinum-based chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving OPDIVO.

IMPORTANT SAFETY INFORMATION

WARNING: IMMUNE-MEDIATED ADVERSE REACTIONS

Immune-Mediated Pneumonitis

Immune-mediated pneumonitis or interstitial lung disease, including fatal cases, occurred with OPDIVO treatment. Across the clinical trial experience with solid tumors, fatal immune-mediated pneumonitis occurred in 0.5% (5/978) of patients receiving OPDIVO as a single agent. Monitor patients for signs with radiographic imaging and symptoms of pneumonitis. Administer corticosteroids for Grade 2 or greater pneumonitis. Permanently discontinue for Grade 3 or 4 and withhold until resolution for Grade 2. In Checkmate 037, pneumonitis, including interstitial lung disease, occurred in 3.4% (9/268) of patients receiving OPDIVO and none of the 102 patients receiving chemotherapy. Immune-mediated pneumonitis occurred in 2.2% (6/268) of patients receiving OPDIVO; Grade 3 (n=1) and Grade 2 (n=5). In Checkmate 057, immune-mediated pneumonitis, including interstitial lung disease, occurred in 3.4% (10/287) of patients receiving OPDIVO as a single agent: Grade 3 (n=5), Grade 2 (n=2), and Grade 1 (n=3). Across the clinical trial experience in 188 patients with melanoma who received OPDIVO in combination with YERVOY, in Checkmate 069 (n=94) and an additional dose-finding study (n=94), fatal immune-mediated pneumonitis occurred in 0.5% (1/188) of patients. In Checkmate 069, there were six additional patients who died without resolution of abnormal respiratory findings. In Checkmate 069, pneumonitis, including interstitial lung disease, occurred in 10% (9/94) of patients receiving OPDIVO in combination with YERVOY and 2.2% (1/46) of patients receiving YERVOY. Immune-mediated pneumonitis occurred in 6% (6/94) of patients receiving OPDIVO in combination with YERVOY: Grade 5 (n=1), Grade 3 (n=2) and Grade 2 (n=3).

Immune-Mediated Colitis

Immune-mediated colitis can occur with OPDIVO treatment. Monitor patients for signs and symptoms of colitis. Administer corticosteroids for Grade 2 (of more than 5 days duration), 3, or 4 colitis. As a single agent, withhold OPDIVO for Grade 2 or 3 and permanently discontinue for Grade 4 or recurrent colitis upon restarting OPDIVO. In combination with YERVOY, withhold OPDIVO for Grade 2 and permanently discontinue for Grade 3 or 4 or recurrent colitis upon restarting OPDIVO. In Checkmate 037, diarrhea or colitis occurred in 21% (57/268) of patients receiving OPDIVO and 18% (18/102) of patients receiving chemotherapy. Immune-mediated colitis occurred in 2.2% (6/268) of patients receiving OPDIVO; Grade 3 (n=5) and Grade 2 (n=1). In Checkmate 057, diarrhea or colitis occurred in 17% (50/287) of patients receiving OPDIVO as a single agent. Immune-mediated colitis occurred in 2.4% (7/287) of patients: Grade 3 (n=3), Grade 2 (n=2), and Grade 1 (n=2). In Checkmate 069, diarrhea or colitis occurred in 57% (54/94) of patients receiving OPDIVO in combination with YERVOY and 46% (21/46) of patients receiving YERVOY. Immune-mediated colitis occurred in 33% (31/94) of patients receiving OPDIVO in combination with YERVOY: Grade 4 (n=1), Grade 3 (n=16), Grade 2 (n=9), and Grade 1 (n=5).

In a separate Phase 3 study of YERVOY 3 mg/kg, severe, life-threatening, or fatal (diarrhea of ≥ 7 stools above baseline, fever, ileus, peritoneal signs; Grade 3-5) immune-mediated enterocolitis occurred in 34 (7%) patients. Across all YERVOY-treated patients in that study (n=511), 5 (1%) developed intestinal perforation, 4 (0.8%) died as a result of complications, and 26 (5%) were hospitalized for severe enterocolitis.

Immune-Mediated Hepatitis

Immune-mediated hepatitis can occur with OPDIVO treatment. Monitor patients for abnormal liver tests prior to and periodically during treatment. Administer corticosteroids for Grade 2 or greater transaminase elevations. Withhold for Grade 2 and permanently discontinue for Grade 3 or 4 immune-mediated hepatitis. In Checkmate 037, there was an increased incidence of liver test abnormalities in the OPDIVO-treated group as compared to the chemotherapy-treated group, with increases in AST (28% vs 12%), alkaline phosphatase (22% vs 13%), ALT (16% vs 5%), and total bilirubin (9% vs 0). Immune-mediated hepatitis occurred in 1.1% (3/268) of patients receiving OPDIVO; Grade 3 (n=2) and Grade 2 (n=1). In Checkmate 057, one patient (0.3%) developed immune-mediated hepatitis. In Checkmate 069, immune-mediated hepatitis occurred in 15% (14/94) of patients receiving OPDIVO in combination with YERVOY: Grade 4 (n=3), Grade 3 (n=9), and Grade 2 (n=2).

In a separate Phase 3 study of YERVOY 3 mg/kg, severe, life-threatening, or fatal hepatotoxicity (AST or ALT elevations $>5x$ the ULN or total bilirubin elevations $>3x$ the ULN; Grade 3-5) occurred in 8 (2%) patients, with fatal hepatic failure in 0.2% and hospitalization in 0.4%.

Immune-Mediated Dermatitis

In a separate Phase 3 study of YERVOY 3 mg/kg, severe, life-threatening, or fatal immune-mediated dermatitis (eg, Stevens-Johnson syndrome, toxic epidermal necrolysis, or rash complicated by full thickness dermal ulceration, or necrotic, bullous, or hemorrhagic manifestations; Grade 3-5) occurred in 13 (2.5%) patients. 1 (0.2%) patient died as a result of toxic epidermal necrolysis. 1 additional patient required hospitalization for severe dermatitis.

Immune-Mediated Neuropathies

In a separate Phase 3 study of YERVOY 3 mg/kg, 1 case of fatal Guillain-Barré syndrome and 1 case of severe (Grade 3) peripheral motor neuropathy were reported.

Immune-Mediated Endocrinopathies

Hypophysitis, adrenal insufficiency, and thyroid disorders can occur with OPDIVO treatment. Monitor patients for signs and symptoms of hypophysitis, signs and symptoms of adrenal insufficiency during and after treatment, and thyroid function prior to and periodically during treatment. Administer corticosteroids for Grade 2 or greater hypophysitis. Withhold for Grade 2 or 3 and permanently discontinue for Grade 4 hypophysitis. Administer corticosteroids for Grade 3 or 4 adrenal insufficiency. Withhold for Grade 2 and permanently discontinue for Grade 3 or 4 adrenal insufficiency. Administer hormone replacement therapy for hypothyroidism. Initiate medical management for control of hyperthyroidism.

In Checkmate 069, hypophysitis occurred in 13% (12/94) of patients receiving OPDIVO in combination with YERVOY: Grade 3 (n=2) and Grade 2 (n=10). Adrenal insufficiency occurred in 1% (n=555) of patients receiving OPDIVO as a single agent. In Checkmate 069, adrenal insufficiency occurred in 9% (8/94) of patients receiving OPDIVO in combination with YERVOY: Grade 3 (n=3), Grade 2 (n=4), and Grade 1 (n=1). In Checkmate 069, hypothyroidism occurred in 19% (18/94) of patients receiving OPDIVO in combination with YERVOY. All were Grade 1 or 2 in severity except for one patient who experienced Grade 3 autoimmune thyroiditis. Grade 1 hyperthyroidism occurred in 2.1% (2/94) of patients receiving OPDIVO in combination with YERVOY. In Checkmate 037, Grade 1 or 2 hypothyroidism occurred in 8% (21/268) of patients receiving OPDIVO and none of the 102 patients receiving chemotherapy. Grade 1 or 2 hyperthyroidism occurred in 3% (8/268) of patients receiving OPDIVO and 1% (1/102) of patients receiving chemotherapy. In Checkmate 057, Grade 1 or 2 hypothyroidism, including thyroiditis, occurred in 7% (20/287) and elevated TSH occurred in 17% of patients receiving OPDIVO as a single agent. Grade 1 or 2 hyperthyroidism occurred in 1.4% (4/287) of patients.

In a separate Phase 3 study of YERVOY 3 mg/kg, severe to life-threatening immune-mediated endocrinopathies (requiring hospitalization, urgent medical intervention, or interfering with activities of daily living; Grade 3-4) occurred in 9 (1.8%) patients. All 9 patients had hypopituitarism, and some had additional concomitant endocrinopathies such as adrenal insufficiency, hypogonadism, and hypothyroidism. 6 of the 9 patients were hospitalized for severe endocrinopathies.

Immune-Mediated Nephritis and Renal Dysfunction

Immune-mediated nephritis can occur with OPDIVO treatment. Monitor patients for elevated serum creatinine prior to and periodically during treatment. For Grade 2 or 3 increased serum creatinine, withhold and administer corticosteroids; if worsening or no improvement occurs, permanently discontinue. Administer corticosteroids for Grade 4 serum creatinine elevation and permanently discontinue. In Checkmate 037, there was an increased incidence of elevated creatinine in the OPDIVO-treated group as compared to the chemotherapy-treated group (13% vs 9%). Grade 2 or 3 immune-mediated nephritis or renal dysfunction occurred in 0.7% (2/268) of patients. In Checkmate 057, Grade 2 immune-mediated renal dysfunction occurred in 0.3% (1/287) of patients receiving OPDIVO as a single agent. In Checkmate 069, Grade 2 or higher immune-mediated nephritis or renal dysfunction occurred in 2.1% (2/94) of patients. One patient died without resolution of renal dysfunction.

Immune-Mediated Rash

Immune-mediated rash can occur with OPDIVO treatment. Monitor patients for rash. Administer corticosteroids for Grade 3 or 4 rash. Withhold for Grade 3 and permanently discontinue for Grade 4. In Checkmate 037 (n=268), the incidence of rash was 21%; the incidence of Grade 3 or 4 rash was 0.4%. In Checkmate 057, immune-mediated rash occurred in 6% (17/287) of patients receiving OPDIVO as a

single agent including four Grade 3 cases. In Checkmate 069, immune-mediated rash occurred in 37% (35/94) of patients receiving OPDIVO in combination with YERVOY: Grade 3 (n=6), Grade 2 (n=10), and Grade 1 (n=19).

Immune-Mediated Encephalitis

Immune-mediated encephalitis can occur with OPDIVO treatment. Withhold OPDIVO in patients with new-onset moderate to severe neurologic signs or symptoms and evaluate to rule out other causes. If other etiologies are ruled out, administer corticosteroids and permanently discontinue OPDIVO for immune-mediated encephalitis. Across clinical trials of 8490 patients receiving OPDIVO as a single agent or in combination with YERVOY, <1% of patients were identified as having encephalitis. In Checkmate 057, fatal limbic encephalitis occurred in one patient (0.3%) receiving OPDIVO as a single agent.

Other Immune-Mediated Adverse Reactions

Based on the severity of adverse reaction, permanently discontinue or withhold treatment, administer high-dose corticosteroids, and, if appropriate, initiate hormone-replacement therapy. The following clinically significant immune-mediated adverse reactions occurred in <2% (n=555) of single-agent OPDIVO-treated patients: uveitis, pancreatitis, abducens nerve paresis, demyelination, polymyalgia rheumatica, and autoimmune neuropathy. Across clinical trials of OPDIVO administered as a single agent at doses 3 mg/kg and 10 mg/kg, additional clinically significant, immune-mediated adverse reactions were identified: facial nerve paralysis, motor dysfunction, vasculitis, diabetic ketoacidosis, and myasthenic syndrome. In Checkmate 069, the following additional immune-mediated adverse reactions occurred in 1% of patients treated with OPDIVO in combination with YERVOY: Guillain-Barré syndrome and hypopituitarism. Across clinical trials of OPDIVO in combination with YERVOY, the following additional clinically significant, immune-mediated adverse reactions were identified: uveitis, sarcoidosis, duodenitis, pancreatitis, and gastritis.

Infusion Reactions

Severe infusion reactions have been reported in <1% of patients in clinical trials of OPDIVO as a single agent. In Checkmate 057, Grade 2 infusion reactions occurred in 1% (3/287) of patients receiving OPDIVO as a single agent. In Checkmate 069, Grade 2 infusion reactions occurred in 3% (3/94) of patients receiving OPDIVO in combination with YERVOY. Discontinue OPDIVO in patients with severe or life-threatening infusion reactions. Interrupt or slow the rate of infusion in patients with mild or moderate infusion reactions.

Embryofetal Toxicity

Based on their mechanisms of action, OPDIVO and YERVOY can cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with an OPDIVO- or YERVOY-containing regimen and for at least 5 months after the last dose of OPDIVO.

Lactation

It is not known whether OPDIVO or YERVOY is present in human milk. Because many drugs, including antibodies, are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from OPDIVO-containing regimen, advise women to discontinue breastfeeding during treatment. Advise women to discontinue nursing during treatment with YERVOY and for 3 months following the final dose.

Serious Adverse Reactions

In Checkmate 037, serious adverse reactions occurred in 41% of patients receiving OPDIVO. Grade 3 and 4 adverse reactions occurred in 42% of patients receiving OPDIVO. The most frequent Grade 3 and 4 adverse drug reactions reported in 2% to <5% of patients receiving OPDIVO were abdominal pain, hyponatremia, increased aspartate aminotransferase, and increased lipase. In Checkmate 057, serious adverse reactions occurred in 47% of patients receiving OPDIVO as a single agent. The most frequent serious adverse reactions reported in $\geq 2\%$ of patients were pneumonia, pulmonary embolism, dyspnea, pleural effusion, and respiratory failure. In Checkmate 069, serious adverse reactions occurred in 62% of patients receiving OPDIVO; the most frequent serious adverse events with OPDIVO in combination with YERVOY, as compared to YERVOY alone, were colitis (17% vs 9%), diarrhea (9% vs 7%), pyrexia (6% vs 7%), and pneumonitis (5% vs 0).

Common Adverse Reactions

In Checkmate 037, the most common adverse reaction ($\geq 20\%$) reported with OPDIVO was rash (21%). In Checkmate 057, the most common adverse reactions ($\geq 20\%$) reported with OPDIVO as a single agent were fatigue (49%), musculoskeletal pain (36%), cough (30%), decreased appetite (29%), and constipation (23%). In Checkmate 069, the most common adverse reactions ($\geq 20\%$) reported in patients receiving OPDIVO in combination with YERVOY vs YERVOY alone were rash (67% vs 57%), pruritus (37% vs 26%), headache (24% vs 20%), vomiting (23% vs 15%), and colitis (22% vs 11%).

In a separate Phase 3 study of YERVOY 3 mg/kg, the most common adverse reactions ($\geq 5\%$) in patients who received YERVOY at 3 mg/kg were fatigue (41%), diarrhea (32%), pruritus (31%), rash (29%), and colitis (8%).

Please see U.S. Full Prescribing Information, including **Boxed WARNING regarding immune-mediated adverse reactions**, for YERVOY.

Please see U.S. Full Prescribing Information for OPDIVO.

Immuno-Oncology at Bristol-Myers Squibb

Surgery, radiation, cytotoxic or targeted therapies have represented the mainstay of cancer treatment over the last several decades, but long-term survival and a positive quality of life have remained elusive for many patients with advanced disease.

To address this unmet medical need, Bristol-Myers Squibb is leading research in an innovative field of cancer research and treatment known as Immuno-Oncology, which involves agents whose primary mechanism is to work directly with the body's immune system to fight cancer. The company is exploring a variety of compounds and immunotherapeutic approaches for patients with different types of cancer, including researching the potential of combining Immuno-Oncology agents that target different pathways in the treatment of cancer.

Bristol-Myers Squibb is committed to advancing the science of Immuno-Oncology, with the goal of changing survival expectations and the way patients live with cancer.

About the Bristol-Myers Squibb and Ono Pharmaceutical Collaboration

In 2011, through a collaboration agreement with Ono Pharmaceutical Co., Bristol-Myers Squibb expanded its territorial rights to develop and commercialize *Opdivo* globally except in Japan, South Korea and Taiwan, where Ono had retained all rights to the compound at the time. On July 23, 2014, Bristol-Myers Squibb and Ono Pharmaceutical further expanded the companies' strategic collaboration agreement to jointly develop and commercialize multiple immunotherapies – as single agents and combination regimens – for patients with cancer in Japan, South Korea and Taiwan.

About Bristol-Myers Squibb

Bristol-Myers Squibb is a global biopharmaceutical company whose mission is to discover, develop and deliver innovative medicines that help patients prevail over serious diseases. For more information about Bristol-Myers Squibb, visit www.bms.com, or follow us on Twitter at <http://twitter.com/bmsnews>.

Bristol-Myers Squibb Forward-Looking Statement

This press release contains "forward-looking statements" as that term is defined in the Private Securities Litigation Reform Act of 1995 regarding the research, development and commercialization of pharmaceutical products. Such forward-looking statements are based on current expectations and involve inherent risks and uncertainties, including factors that could delay, divert or change any of them, and could cause actual outcomes and results to differ materially from current expectations. No forward-looking statement can be guaranteed. Forward-looking statements in this press release should be evaluated together with the many uncertainties that affect Bristol-Myers Squibb's business, particularly those identified in the cautionary factors discussion in Bristol-Myers Squibb's Annual Report on Form 10-K for the year ended December 31, 2014 in our Quarterly Reports on Form 10-Q and our Current Reports on Form 8-K. Bristol-Myers Squibb undertakes no obligation to publicly update any forward-looking statement, whether as a result of new information, future events or otherwise.

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