

October 11, 2016

**Bristol-Myers Squibb Presents Results From CheckMate -026, a Phase 3 Study of
Opdivo (nivolumab) Monotherapy Versus Chemotherapy as First-Line Therapy
in a Broad PD-L1 Positive Population With Advanced Lung Cancer**

(PRINCETON, NJ, October 9, 2016) – Bristol-Myers Squibb Company (NYSE: BMY) announced the final primary analysis of CheckMate -026, a trial investigating the use of Opdivo (nivolumab) monotherapy as first-line therapy in patients with advanced non-small cell lung cancer (NSCLC) whose tumors expressed PD-L1 $\geq 1\%$. The study was powered to assess progression-free survival (PFS) for patients with $\geq 5\%$ PD-L1 expression. The topline results from this study were previously disclosed and showed CheckMate -026 did not meet the primary endpoint of superior PFS compared to chemotherapy. In patients with $\geq 5\%$ PD-L1 expression, the median PFS was 4.2 months with Opdivo and 5.9 months with platinum-based doublet chemotherapy (stratified hazard ratio [HR]=1.15 [95% CI: 0.91, 1.45, p=0.25]). Overall survival was 14.4 months for Opdivo versus 13.2 months for chemotherapy (HR=1.02 [95% CI: 0.80, 1.30]), and 60% of patients on the chemotherapy arm received subsequent Opdivo use after progression either through crossover or commercial access.

The safety of Opdivo was consistent with the known safety profile of the drug in previous studies. Among all-treated patients, treatment-related adverse events (AE) of any grade and Grade 3/4 occurred in 71% and 18% of Opdivo-treated patients and 92% and 51% of chemotherapy-treated patients, respectively.

Bristol-Myers Squibb (BMS) has a robust clinical development program in Opdivo monotherapy and in combination therapy with other therapeutic drugs in a variety of tumor types overseas, including Glioblastoma, Small Cell Lung Cancer, Urothelial Cancer, Hepatocellular Carcinoma, Esophageal Cancer, Colorectal Cancer, Gastric Cancer, Blood Cancer, etc.

In Japan, Ono Pharmaceutical Co., Ltd. (ONO) launched Opdivo for the treatment of unresectable melanoma in September 2014. ONO received an approval for additional indication of unresectable, advanced or recurrent non-small cell lung cancer in December 2015 and unresectable or metastatic renal cell cancer in August 2016. In addition, ONO has submitted supplemental applications for additional indications of Hodgkin Lymphoma and Head and Neck Cancer, and is conducting clinical development program including Gastric Cancer, Esophageal Cancer, Small Cell Lung Cancer, Hepatocellular Carcinoma, Glioblastoma, Ovarian Cancer, Urothelial Cancer, Malignant Pleural Mesothelioma, Biliary Tract Cancer, etc.

In Japan, ONO and BMS (and BMS Japan subsidiary BMSKK) have formed a strategic partnership that includes co-development, co-commercialization, and co-promotion of multiple immunotherapies for patients with cancer.

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

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Bristol-Myers Squibb Presents Results From CheckMate -026, a Phase 3 Study of *Opdivo* (nivolumab) Monotherapy Versus Chemotherapy as First-Line Therapy in a Broad PD-L1 Positive Population With Advanced Lung Cancer

(PRINCETON, N.J., October 9, 2016) – [Bristol-Myers Squibb Company](#) (NYSE: BMY) announced today the final primary analysis of CheckMate -026, a trial investigating the use of *Opdivo* (nivolumab) monotherapy as first-line therapy in patients with advanced non-small cell lung cancer (NSCLC) whose tumors expressed PD-L1 $\geq 1\%$. The study was powered to assess progression-free survival (PFS) for patients with $\geq 5\%$ PD-L1 expression. The topline results from this study were previously disclosed and showed CheckMate -026 did not meet the primary endpoint of superior PFS compared to chemotherapy. In patients with $\geq 5\%$ PD-L1 expression, the median PFS was 4.2 months with *Opdivo* and 5.9 months with platinum-based doublet chemotherapy (stratified hazard ratio [HR]=1.15 [95% CI: 0.91, 1.45, $p=0.25$]). Overall survival was 14.4 months for *Opdivo* versus 13.2 months for chemotherapy (HR=1.02 [95% CI: 0.80, 1.30]), and 60% of patients on the chemotherapy arm received subsequent *Opdivo* use after progression either through crossover or commercial access.

The safety of *Opdivo* was consistent with the known safety profile of the drug in previous studies. Among all-treated patients, treatment-related adverse events (AE) of any grade and Grade 3/4 occurred in 71% and 18% of *Opdivo*-treated patients and 92% and 51% of chemotherapy-treated patients, respectively.

“*Opdivo* has replaced the standard of care in previously treated metastatic NSCLC patients regardless of PD-L1 expression, and this study aimed to answer an important clinical question of whether this PD-1 inhibitor could provide superior benefit over chemotherapy in a broad patient population in the first-line setting,” said Mark Socinski, M.D., executive medical director, Florida Hospital Cancer Institute, Orlando, and lead author of the study. “These findings provide additional understanding of the role of PD-1 monotherapy in treatment-naïve patients and confirm there is still a significant opportunity for improving outcomes for the majority of these patients.”

These data will be presented today, October 9, during a Presidential Symposium at the 2016 European Society for Medical Oncology (ESMO) Congress from 5:35-5:50 p.m. CEST (Abstract #LBA7_PR).

“The CheckMate -026 trial results strengthen our belief that the majority of previously untreated NSCLC patients may require combination therapy in order to experience an improved benefit versus chemotherapy,” said Fouad Namouni, M.D., head of development, Oncology, Bristol-Myers Squibb. “With our broad lung cancer development program, which includes a robust Phase 3 trial evaluating the combination of *Opdivo* and *Yervoy* as first-line therapy, we will continue to aim for transformative options for the majority of lung cancer patients.”

About CheckMate -026

CheckMate -026 is a Phase 3, open-label, randomized study of *Opdivo* as monotherapy versus investigator’s choice chemotherapy in patients with advanced non-small cell lung cancer (NSCLC). Patients enrolled in the trial had received no prior systemic treatment for advanced disease and tested positive for PD-L1 expression ($\geq 1\%$). The trial randomized 541 patients to receive either *Opdivo* 3 mg/kg intravenously every two weeks or investigator’s choice platinum-based doublet chemotherapy in squamous patients (gemcitabine with cisplatin/gemcitabine with carboplatin/paclitaxel with carboplatin, followed by optional pemetrexed maintenance) and non-squamous patients (pemetrexed with cisplatin/pemetrexed with carboplatin) until disease progression, unacceptable toxicity or completion of six cycles. The primary endpoint is progression-free survival (PFS), as assessed by the Independent Radiology Review Committee, in patients with $\geq 5\%$ PD-L1 tumor expression.

About Lung Cancer

Lung cancer is the leading cause of cancer deaths globally, resulting in more than 1.5 million deaths each year, according to the World Health Organization. Non-small cell lung cancer is one of the most common types of the disease and accounts for approximately 85% of cases. About 25% to 30% of all lung cancers are squamous cell carcinomas, and non-squamous NSCLC accounts for approximately 50% to 65% of all lung cancer cases. Survival rates vary depending on the stage and type of the cancer when it is diagnosed. Globally, the five-year survival rate for Stage I NSCLC is between 47% and 50%; for Stage IV NSCLC, the five-year survival rate drops to 2%.

Bristol-Myers Squibb & Immuno-Oncology: Advancing Oncology Research

At Bristol-Myers Squibb, patients are at the center of everything we do. Our vision for the future of cancer care is focused on researching and developing transformational Immuno-

Oncology (I-O) medicines that will raise survival expectations in hard-to-treat cancers and will change the way patients live with cancer.

We are leading the scientific understanding of I-O through our extensive portfolio of investigational and approved agents, including the first combination of two I-O agents in metastatic melanoma, and our differentiated clinical development program, which is studying broad patient populations across more than 20 types of cancers with 11 clinical-stage molecules designed to target different immune system pathways. Our deep expertise and innovative clinical trial designs uniquely position us to advance the science of combinations across multiple tumors and potentially deliver the next wave of I-O combination regimens with a sense of urgency. We also continue to pioneer research that will help facilitate a deeper understanding of the role of immune biomarkers and inform which patients will benefit most from I-O therapies.

We understand making the promise of I-O a reality for the many patients who may benefit from these therapies requires not only innovation on our part but also close collaboration with leading experts in the field. Our partnerships with academia, government, advocacy and biotech companies support our collective goal of providing new treatment options to advance the standards of clinical practice.

About Opdivo

Opdivo is a programmed death-1 (PD-1) immune checkpoint inhibitor that is designed to uniquely harness the body's own immune system to help restore anti-tumor immune response. By harnessing the body's own immune system to fight cancer, *Opdivo* has become an important treatment option across multiple cancers.

Opdivo's leading global development program is based on Bristol-Myers Squibb's scientific expertise in the field of Immuno-Oncology and includes a broad range of clinical trials across all phases, including Phase 3, in a variety of tumor types. To date, the *Opdivo* clinical development program has enrolled more than 25,000 patients. The *Opdivo* trials have contributed to gaining a deeper understanding of the potential role of biomarkers in patient care, particularly regarding how patients may benefit from *Opdivo* across the continuum of PD-L1 expression.

In July 2014, *Opdivo* was the first PD-1 immune checkpoint inhibitor to receive regulatory approval anywhere in the world. *Opdivo* is currently approved in more than 57 countries, including the United States, the European Union and Japan. In October 2015, the company's *Opdivo* and *Yervoy* combination regimen was the first Immuno-Oncology

combination to receive regulatory approval for the treatment of metastatic melanoma and is currently approved in more than 47 countries, including the United States and the European Union.

U.S. FDA-APPROVED INDICATIONS FOR OPDIVO®

OPDIVO® (nivolumab) as a single agent is indicated for the treatment of patients with BRAF V600 wild-type unresectable or metastatic melanoma.

OPDIVO® (nivolumab) as a single agent is indicated for the treatment of patients with BRAF V600 mutation-positive unresectable or metastatic melanoma. This indication is approved under accelerated approval based on progression-free survival. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

OPDIVO® (nivolumab), in combination with YERVOY® (ipilimumab), is indicated for the treatment of patients with unresectable or metastatic melanoma. This indication is approved under accelerated approval based on progression-free survival. Continued approval for this indication 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.

OPDIVO® (nivolumab) is indicated for the treatment of patients with advanced renal cell carcinoma (RCC) who have received prior anti-angiogenic therapy.

OPDIVO® (nivolumab) is indicated for the treatment of patients with classical Hodgkin lymphoma (cHL) that has relapsed or progressed after autologous hematopoietic stem cell transplantation (HSCT) and post-transplantation brentuximab vedotin. This indication is approved under accelerated approval based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

Please refer to the end of the Important Safety Information for a brief description of the patient populations studied in the CheckMate trials.

IMPORTANT SAFETY INFORMATION

WARNING: IMMUNE-MEDIATED ADVERSE REACTIONS

YERVOY 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.

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

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

Immune-Mediated Pneumonitis

Immune-mediated pneumonitis, including fatal cases, occurred with OPDIVO treatment. Across the clinical trial experience with solid tumors, fatal immune-mediated pneumonitis occurred with OPDIVO. In addition, in CheckMate 069, there were six patients who died without resolution of abnormal respiratory findings. 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 069 and 067, immune-mediated pneumonitis occurred in 6% (25/407) of patients receiving OPDIVO with YERVOY: Fatal (n=1), Grade 3 (n=6), Grade 2 (n=17), and Grade 1 (n=1). In CheckMate 037, 066, and 067, immune-mediated pneumonitis occurred in 1.8% (14/787) of patients receiving OPDIVO: Grade 3 (n=2) and Grade 2 (n=12). In CheckMate 057, immune-mediated pneumonitis, including interstitial lung disease, occurred in 3.4% (10/287) of patients: Grade 3 (n=5), Grade 2 (n=2), and Grade

1 (n=3). In CheckMate 025, pneumonitis, including interstitial lung disease, occurred in 5% (21/406) of patients receiving OPDIVO and 18% (73/397) of patients receiving everolimus. Immune-mediated pneumonitis occurred in 4.4% (18/406) of patients receiving OPDIVO: Grade 4 (n=1), Grade 3 (n=4), Grade 2 (n=12), and Grade 1 (n=1). In CheckMate 205 and 039, pneumonitis, including interstitial lung disease, occurred in 4.9% (13/263) of patients receiving OPDIVO. Immune-mediated pneumonitis occurred in 3.4% (9/263) of patients receiving OPDIVO: Grade 3 (n=1) and Grade 2 (n=8).

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. When administered with YERVOY, withhold OPDIVO for Grade 2 and permanently discontinue for Grade 3 or 4 or recurrent colitis upon restarting OPDIVO. In CheckMate 069 and 067, diarrhea or colitis occurred in 56% (228/407) of patients receiving OPDIVO with YERVOY. Immune-mediated colitis occurred in 26% (107/407) of patients: Grade 4 (n=2), Grade 3 (n=60), Grade 2 (n=32), and Grade 1 (n=13). In CheckMate 037, 066, and 067, diarrhea or colitis occurred in 31% (242/787) of patients receiving OPDIVO. Immune-mediated colitis occurred in 4.1% (32/787) of patients: Grade 3 (n=20), Grade 2 (n=10), and Grade 1 (n=2). In CheckMate 057, diarrhea or colitis occurred in 17% (50/287) of patients receiving OPDIVO. 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 025, diarrhea or colitis occurred in 25% (100/406) of patients receiving OPDIVO and 32% (126/397) of patients receiving everolimus. Immune-mediated diarrhea or colitis occurred in 3.2% (13/406) of patients receiving OPDIVO: Grade 3 (n=5), Grade 2 (n=7), and Grade 1 (n=1). In CheckMate 205 and 039, diarrhea or colitis occurred in 30% (80/263) of patients receiving OPDIVO. Immune-mediated diarrhea (Grade 3) occurred in 1.1% (3/263) of patients.

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 069 and 067, immune-mediated hepatitis occurred in 13% (51/407) of patients receiving OPDIVO with YERVOY: Grade 4 (n=8), Grade 3 (n=37), Grade 2 (n=5), and Grade 1 (n=1). In CheckMate 037, 066, and 067, immune-mediated hepatitis occurred in 2.3% (18/787) of patients receiving OPDIVO: Grade 4 (n=3), Grade 3 (n=11), and Grade 2 (n=4). In CheckMate 057, one patient (0.3%) developed immune-mediated hepatitis. In CheckMate 025, there was an increased incidence of liver test abnormalities compared to baseline in AST (33% vs 39%), alkaline phosphatase (32% vs 32%), ALT (22% vs 31%), and total bilirubin (9% vs 3.5%) in the OPDIVO and everolimus arms, respectively. Immune-mediated hepatitis requiring systemic immunosuppression occurred in 1.5% (6/406) of patients receiving OPDIVO: Grade 3 (n=5) and Grade 2 (n=1). In CheckMate 205 and 039, hepatitis occurred in 11% (30/263) of patients receiving OPDIVO. Immune-mediated hepatitis occurred in 3.4% (9/263): Grade 3 (n=7) 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, thyroid disorders, and type 1 diabetes mellitus can occur with OPDIVO treatment. Monitor patients for signs and symptoms of hypophysitis, signs and symptoms of adrenal insufficiency during and after treatment, thyroid function prior to and periodically during treatment, and hyperglycemia. 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. Administer insulin for type 1 diabetes. Withhold OPDIVO for Grade 3 and permanently discontinue for Grade 4 hyperglycemia.

In CheckMate 069 and 067, hypophysitis occurred in 9% (36/407) of patients receiving OPDIVO with YERVOY: Grade 3 (n=8), Grade 2 (n=25), and Grade 1 (n=3). In CheckMate 037, 066, and 067, hypophysitis occurred in 0.9% (7/787) of patients receiving OPDIVO: Grade 3 (n=2), Grade 2 (n=3), and Grade 1 (n=2). In CheckMate 025, hypophysitis occurred in 0.5% (2/406) of patients receiving OPDIVO: Grade 3 (n=1) and Grade 1 (n=1). In CheckMate 069 and 067, adrenal insufficiency occurred in 5% (21/407) of patients receiving OPDIVO with YERVOY: Grade 4 (n=1), Grade 3 (n=7), Grade 2 (n=11), and Grade 1 (n=2). In CheckMate 037, 066, and 067, adrenal insufficiency occurred in 1% (8/787) of patients receiving OPDIVO: Grade 3 (n=2), Grade 2 (n=5), and Grade 1 (n=1). In CheckMate 057, 0.3% (1/287) of OPDIVO-treated patients developed adrenal insufficiency. In CheckMate 025, adrenal insufficiency occurred in 2.0% (8/406) of patients receiving OPDIVO: Grade 3 (n=3), Grade 2 (n=4), and Grade 1 (n=1). In CheckMate 205 and 039, adrenal insufficiency (Grade 2) occurred in 0.4% (1/263) of patients receiving OPDIVO. In CheckMate 069 and 067, hypothyroidism or thyroiditis occurred in 22% (89/407) of patients receiving OPDIVO with YERVOY: Grade 3 (n=6), Grade 2 (n=47), and Grade 1 (n=36). Hyperthyroidism occurred in 8% (34/407) of patients: Grade 3 (n=4), Grade 2 (n=17), and Grade 1 (n=13). In CheckMate 037, 066, and 067, hypothyroidism or thyroiditis occurred in 9% (73/787) of patients receiving OPDIVO: Grade 3 (n=1), Grade 2 (n=37), Grade 1 (n=35). Hyperthyroidism occurred in 4.4% (35/787) of patients receiving OPDIVO: Grade 3 (n=1), Grade 2 (n=12), and Grade 1 (n=22). In CheckMate 057, Grade 1 or 2 hypothyroidism, including thyroiditis, occurred in 7% (20/287) and elevated thyroid stimulating hormone

occurred in 17% of patients receiving OPDIVO. Grade 1 or 2 hyperthyroidism occurred in 1.4% (4/287) of patients. In CheckMate 025, thyroid disease occurred in 11% (43/406) of patients receiving OPDIVO, including one Grade 3 event, and in 3.0% (12/397) of patients receiving everolimus. Hypothyroidism/thyroiditis occurred in 8% (33/406) of patients receiving OPDIVO: Grade 3 (n=2), Grade 2 (n=17), and Grade 1 (n=14). Hyperthyroidism occurred in 2.5% (10/406) of patients receiving OPDIVO: Grade 2 (n=5) and Grade 1 (n=5). In CheckMate 205 and 039, hypothyroidism/thyroiditis occurred in 12% (32/263) of patients receiving OPDIVO: Grade 2 (n=18) and Grade 1: (n=14). Hyperthyroidism occurred in 1.5% (4/263) of patients receiving OPDIVO: Grade 2: (n=3) and Grade 1 (n=1). In CheckMate 069 and 067, diabetes mellitus or diabetic ketoacidosis occurred in 1.5% (6/407) of patients: Grade 4 (n=3), Grade 3 (n=1), Grade 2 (n=1), and Grade 1 (n=1). In CheckMate 037, 066, and 067, diabetes mellitus or diabetic ketoacidosis occurred in 0.8% (6/787) of patients receiving OPDIVO: Grade 3 (n=2), Grade 2 (n=3), and Grade 1 (n=1). In CheckMate 025, hyperglycemic adverse events occurred in 9% (37/406) patients. Diabetes mellitus or diabetic ketoacidosis occurred in 1.5% (6/406) of patients receiving OPDIVO: Grade 3 (n=3), Grade 2 (n=2), and Grade 1 (n=1). In CheckMate 205 and 039, diabetes mellitus occurred in 0.8% (2/263) of patients receiving OPDIVO: Grade 3 (n=1) and Grade 1 (n=1).

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 069 and 067, immune-mediated nephritis and renal dysfunction occurred in 2.2% (9/407) of patients: Grade 4 (n=4), Grade 3 (n=3), and Grade 2 (n=2). In CheckMate 037, 066, and 067, nephritis and renal dysfunction of any grade occurred in 5% (40/787) of patients receiving OPDIVO. Immune-mediated nephritis and

renal dysfunction occurred in 0.8% (6/787) of patients: Grade 3 (n=4) and Grade 2 (n=2). In CheckMate 057, Grade 2 immune-mediated renal dysfunction occurred in 0.3% (1/287) of patients receiving OPDIVO. In CheckMate 025, renal injury occurred in 7% (27/406) of patients receiving OPDIVO and 3.0% (12/397) of patients receiving everolimus. Immune-mediated nephritis and renal dysfunction occurred in 3.2% (13/406) of patients receiving OPDIVO: Grade 5 (n=1), Grade 4 (n=1), Grade 3 (n=5), and Grade 2 (n=6). In CheckMate 205 and 039, nephritis and renal dysfunction occurred in 4.9% (13/263) of patients treated with OPDIVO. This included one reported case (0.3%) of Grade 3 autoimmune nephritis.

Immune-Mediated Rash

Immune-mediated rash can occur with OPDIVO treatment. Severe rash (including rare cases of fatal toxic epidermal necrolysis) occurred in the clinical program of OPDIVO. Monitor patients for rash. Administer corticosteroids for Grade 3 or 4 rash. Withhold for Grade 3 and permanently discontinue for Grade 4. In CheckMate 069 and 067, immune-mediated rash occurred in 22.6% (92/407) of patients receiving OPDIVO with YERVOY: Grade 3 (n=15), Grade 2 (n=31), and Grade 1 (n=46). In CheckMate 037, 066, and 067, immune-mediated rash occurred in 9% (72/787) of patients receiving OPDIVO: Grade 3 (n=7), Grade 2 (n=15), and Grade 1 (n=50). In CheckMate 057, immune-mediated rash occurred in 6% (17/287) of patients receiving OPDIVO including four Grade 3 cases. In CheckMate 025, rash occurred in 28% (112/406) of patients receiving OPDIVO and 36% (143/397) of patients receiving everolimus. Immune-mediated rash, defined as a rash treated with systemic or topical corticosteroids, occurred in 7% (30/406) of patients receiving OPDIVO: Grade 3 (n=4), Grade 2 (n=7), and Grade 1 (n=19). In CheckMate 205 and 039, rash occurred in 22% (58/263) of patients receiving OPDIVO. Immune-mediated rash occurred in 7% (18/263) of patients on OPDIVO: Grade 3 (n=4), Grade 2 (n=3), and Grade 1 (n=11).

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. In CheckMate 067, encephalitis was identified in one patient (0.2%) receiving OPDIVO with YERVOY. In CheckMate 057, fatal limbic encephalitis occurred in one patient (0.3%) receiving OPDIVO.

In CheckMate 205 and 039, encephalitis occurred in 0.8% (2/263) of patients after allogeneic HSCT after OPDIVO.

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. In < 1.0% of patients receiving OPDIVO, the following clinically significant, immune-mediated adverse reactions occurred: uveitis, iritis, pancreatitis, facial and abducens nerve paresis, demyelination, polymyalgia rheumatica, autoimmune neuropathy, Guillain-Barré syndrome, hypopituitarism, systemic inflammatory response syndrome, gastritis, duodenitis, and sarcoidosis. Across clinical trials of OPDIVO as a single agent administered at doses of 3 mg/kg and 10 mg/kg, additional clinically significant, immune-mediated adverse reactions were identified: motor dysfunction, vasculitis, and myasthenic syndrome.

Infusion Reactions

Severe infusion reactions have been reported in <1.0% of patients in clinical trials of OPDIVO. Discontinue OPDIVO in patients with Grade 3 or 4 infusion reactions. Interrupt or slow the rate of infusion in patients with Grade 1 or 2. In CheckMate 069 and 067, infusion-related reactions occurred in 2.5% (10/407) of patients receiving OPDIVO with YERVOY: Grade 2 (n=6) and Grade 1 (n=4). In CheckMate 037, 066, and 067, Grade 2 infusion related reactions occurred in 2.7% (21/787) of patients receiving OPDIVO: Grade 3 (n=2), Grade 2 (n=8), and Grade 1 (n=11). In CheckMate 057, Grade 2 infusion reactions requiring corticosteroids occurred in 1.0% (3/287) of patients receiving OPDIVO. In CheckMate 025, hypersensitivity/infusion-related reactions occurred in 6% (25/406) of patients receiving OPDIVO and 1.0% (4/397) of patients receiving everolimus. In CheckMate 205 and 039, hypersensitivity/infusion-related reactions occurred in 16% (42/263) of patients receiving OPDIVO: Grade 3 (n=2), Grade 2 (n=24), and Grade 1 (n=16).

Complications of Allogeneic HSCT after OPDIVO

Complications, including fatal events, occurred in patients who received allogeneic HSCT after OPDIVO. Outcomes were evaluated in 17 patients from CheckMate 205 and 039, who underwent allogeneic HSCT after discontinuing OPDIVO (15 with reduced-intensity conditioning, 2 with myeloablative conditioning). Thirty-five percent (6/17) of patients died from complications of allogeneic HSCT after OPDIVO. Five deaths occurred in the setting of

severe or refractory GVHD. Grade 3 or higher acute GVHD was reported in 29% (5/17) of patients. Hyperacute GVHD was reported in 20% (n=2) of patients. A steroid-requiring febrile syndrome, without an identified infectious cause, was reported in 35% (n=6) of patients. Two cases of encephalitis were reported: Grade 3 (n=1) lymphocytic encephalitis without an identified infectious cause, and Grade 3 (n=1) suspected viral encephalitis. Hepatic veno-occlusive disease (VOD) occurred in one patient, who received reduced-intensity conditioned allogeneic SCT and died of GVHD and multi-organ failure. Other cases of hepatic VOD after reduced-intensity conditioned allogeneic HSCT have also been reported in patients with lymphoma who received a PD-1 receptor blocking antibody before transplantation. Cases of fatal hyperacute GVHD have also been reported. These complications may occur despite intervening therapy between PD-1 blockade and allogeneic HSCT.

Follow patients closely for early evidence of transplant-related complications such as hyperacute GVHD, severe (Grade 3 to 4) acute GVHD, steroid-requiring febrile syndrome, hepatic VOD, and other immune-mediated adverse reactions, and intervene promptly.

Embryo-fetal 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 an 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 067, serious adverse reactions (73% and 37%), adverse reactions leading to permanent discontinuation (43% and 14%) or to dosing delays (55% and 28%), and Grade 3

or 4 adverse reactions (72% and 44%) all occurred more frequently in the OPDIVO plus YERVOY arm relative to the OPDIVO arm. The most frequent ($\geq 10\%$) serious adverse reactions in the OPDIVO plus YERVOY arm and the OPDIVO arm, respectively, were diarrhea (13% and 2.6%), colitis (10% and 1.6%), and pyrexia (10% and 0.6%). 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 066, serious adverse reactions occurred in 36% of patients receiving OPDIVO. Grade 3 and 4 adverse reactions occurred in 41% of patients receiving OPDIVO. The most frequent Grade 3 and 4 adverse reactions reported in $\geq 2\%$ of patients receiving OPDIVO were gamma-glutamyltransferase increase (3.9%) and diarrhea (3.4%). In CheckMate 057, serious adverse reactions occurred in 47% of patients receiving OPDIVO. The most frequent serious adverse reactions reported in $\geq 2\%$ of patients were pneumonia, pulmonary embolism, dyspnea, pleural effusion, and respiratory failure. In CheckMate 025, serious adverse reactions occurred in 47% of patients receiving OPDIVO. The most frequent serious adverse reactions reported in $\geq 2\%$ of patients were acute kidney injury, pleural effusion, pneumonia, diarrhea, and hypercalcemia. In CheckMate 205 and 039, among all patients (safety population [n=263]), adverse reactions leading to discontinuation (4.2%) or to dosing delays (23%) occurred. The most frequent serious adverse reactions reported in $\geq 1\%$ of patients were infusion-related reaction, pneumonia, pleural effusion, pyrexia, rash and pneumonitis. Ten patients died from causes other than disease progression, including 6 who died from complications of allogeneic HSCT. Serious adverse reactions occurred in 21% of patients in the safety population (n=263) and 27% of patients in the subset of patients evaluated for efficacy (efficacy population [n=95]).

Common Adverse Reactions

In CheckMate 067, the most common ($\geq 20\%$) adverse reactions in the OPDIVO plus YERVOY arm were fatigue (59%), rash (53%), diarrhea (52%), nausea (40%), pyrexia (37%), vomiting (28%), and dyspnea (20%). The most common ($\geq 20\%$) adverse reactions in the OPDIVO arm were fatigue (53%), rash (40%), diarrhea (31%), and nausea (28%). In CheckMate 037, the most common adverse reaction ($\geq 20\%$) reported with OPDIVO was rash (21%). In CheckMate 066, the most common adverse reactions ($\geq 20\%$) reported with OPDIVO vs dacarbazine were fatigue (49% vs 39%), musculoskeletal pain (32% vs 25%),

rash (28% vs 12%), and pruritus (23% vs 12%). In CheckMate 057, the most common adverse reactions ($\geq 20\%$) reported with OPDIVO were fatigue (49%), musculoskeletal pain (36%), cough (30%), decreased appetite (29%), and constipation (23%). In CheckMate 025, the most common adverse reactions ($\geq 20\%$) reported in patients receiving OPDIVO vs everolimus were asthenic conditions (56% vs 57%), cough (34% vs 38%), nausea (28% vs 29%), rash (28% vs 36%), dyspnea (27% vs 31%), diarrhea (25% vs 32%), constipation (23% vs 18%), decreased appetite (23% vs 30%), back pain (21% vs 16%), and arthralgia (20% vs 14%). In CheckMate 205 and 039, among all patients (safety population [n=263]) and the subset of patients in the efficacy population (n=95), respectively, the most common adverse reactions (reported in at least 20%) were fatigue (32% and 43%), upper respiratory tract infection (28% and 48%), pyrexia (24% and 35%), diarrhea (23% and 30%), and cough (22% and 35%). In the subset of patients in the efficacy population (n=95), the most common adverse reactions also included rash (31%), musculoskeletal pain (27%), pruritus (25%), nausea (23%), arthralgia (21%), and peripheral neuropathy (21%).

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%).

CheckMate Trials and Patient Populations

CheckMate 069 and 067 – advanced melanoma alone or in combination with YERVOY; **CheckMate 037 and 066** – advanced melanoma; **CheckMate 057** – non-squamous non-small cell lung cancer (NSCLC); **CheckMate 025** – renal cell carcinoma; **CheckMate 205/039** – classical Hodgkin lymphoma

About the Bristol-Myers Squibb and Ono Pharmaceutical Co., Ltd. Collaboration

In 2011, through a collaboration agreement with Ono Pharmaceutical Co., Ltd (Ono), 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 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 us at BMS.com or follow us on [LinkedIn](#), [Twitter](#), [YouTube](#) and [Facebook](#).

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, 2015 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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