



FIRST-LINE ADVANCED OR UNRESECTABLE HCC^{1,2}



INCLUDED IN HELSEDIREKTORATET GUIDELINES FOR HCC⁶

HIMALAYA Study Presentation

STRIDE

With updated
5-YEAR results¹⁻⁴



THERAPEUTIC INDICATION:

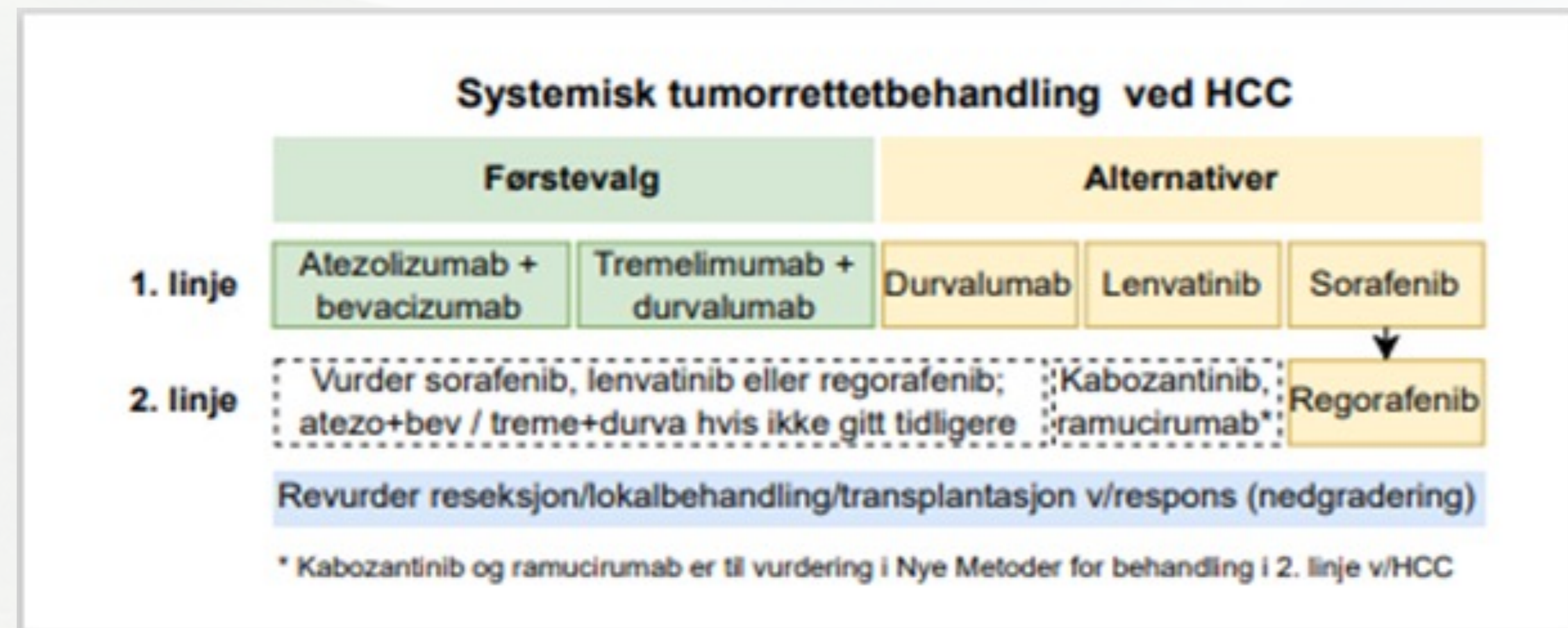
Imfinzi as monotherapy and in combination with Imjudo is indicated for the first line treatment of adults with advanced or unresectable hepatocellular carcinoma (HCC).

¹. IMFINZI Summary of Product Characteristics. ². IMJUDO Summary of Product Characteristics ³. Abou-Alfa GK et al. NEJM Evid. 2022;1(8) (including Supplementary Appendix and Protocol). ⁴. Rimassa L et al. Five-year overall survival update from the HIMALAYA study of tremelimumab plus durvalumab in unresectable HCC. J Hepatol. 2025 Oct;83(4):899-908. doi: 10.1016/j.jhep.2025.03.033. Epub 2025 Apr 11. ⁶. Levercellekreft (hepatocellulært karsinom (HCC)) – handlingsprogram (accessed 12th February 2025).



IMFINZI + IMJUDO FOR HCC – INCLUDED IN HELSEDIREKTORATET GUIDELINES⁶

SYSTEMISK TUMORRETTET BEHANDLING⁶



Figur 4. Skjematisk oversikt over aktuell systemisk tumorrettet behandling ved HCC⁶.

1. LINJE - FØRSTEVALG⁶

Immunterapi i form av PD-L1-hemmeren atezolizumab i kombinasjon med bevacizumab (atezo+bev), eller i form av **PD-L1-hemmeren durvalumab i kombinasjon med CTLA4-hemmeren tremelimumab**, er godkjent av Beslutningsforum til bruk i førstelinje for inoperabel HCC hos pasienter som ikke tidligere har mottatt systemisk behandling. (Atezolizumab (Tecentriq) - Indikasjon X - Nye metoder) (Durvalumab (Imfinzi) og tremelimumab (Imjudo) - Nye metoder)

(...)

For pasienter som er aktuelle for kombinasjonsbehandling med immunterapi bør man diskutere begge alternativer, og vektlegge både fordeler og ulemper ved hvert regime (risiko for blødning, kardiovaskulære hendelser, immunmedierte bivirkninger, tilgjengelighet av langtidsdata, hyppighet av behandlingsbesøk, behov for endoskopi osv.) for å avgjøre det mest passende alternativet for den enkelte pasient, basert på bivirkningsprofil, pasientpreferanser og behandlingsmål.

Behandlingen er innført av Beslutningsforum til voksne med avansert eller inoperabel hepatocellulært karsinom (HCC)*, og inngår i Helseforetakenes anbefaling for onkologiske legemidler. Rekvirering skal gjøres i tråd med disse: <https://www.sykehusinnkjop.no/avtaler-legemidler/onkologi/>

*Beslutningsforum for Nye Metoder, ID2022_115, 21.10.2024.

1. IMFINZI Summary of Product Characteristics. 2. IMJUDO Summary of Product Characteristics 6. Levercellekreft (hepatocellulært karsinom (HCC)) – handlingsprogram (accessed 12th February 2025).



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IMFINZI + single-dose IMJUDO was evaluated in 1L uHCC¹⁻³

Bringing together 2 complementary mechanisms of immune checkpoint inhibition

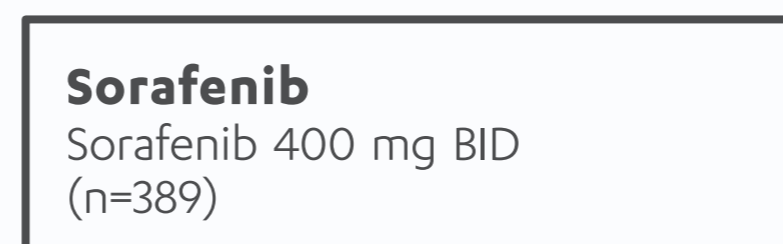
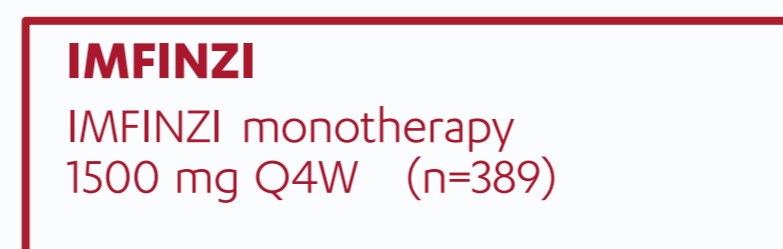
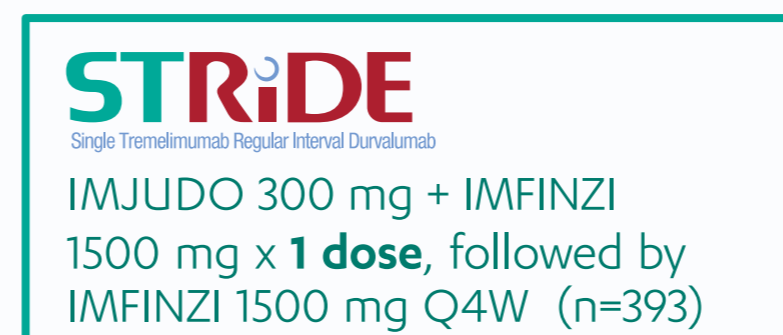
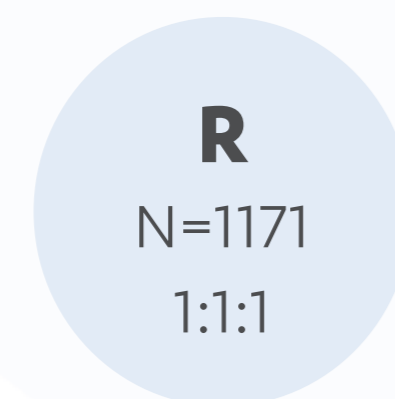
HIMALAYA: A GLOBAL, OPEN-LABEL, PHASE III STUDY³

Study population

- Adults with unresectable HCC, BCLC C or B (not eligible for locoregional therapy), CP-A score, and ECOG PS 0-1
- No prior systemic treatment

Stratification factors

- MVI, etiology of liver disease, and ECOG PS 0-1



Landmark OS was assessed in the HIMALAYA study at 3 years as a prespecified endpoint and beyond 3 years in exploratory analyses³

Primary endpoint: OS superiority of STRIDE vs sorafenib.³

Select secondary endpoints*: OS rates at 18, 24, and 36 months (primary analysis); PFS, ORR, DoR, safety, and PROs.³

Select exploratory endpoint: OS rates at 48 and 60 months (exploratory analyses).⁴

EGD screening for gastroesophageal varices was not an eligibility requirement

Key exclusion criteria^{1-3†}:

- HBV and HCV coinfection³
- Active or prior documented autoimmune/inflammatory disorders^{1,2}
- Active or prior GI bleeding (eg, ulcers, esophageal varices) within the past 12 months
- Thrombosis of the main trunk of the portal vein³
- Clinically meaningful ascites or hepatic encephalopathy within 12 months before start of treatment^{3†}
- Symptomatic or uncontrolled hypertension
- Brain metastases or a history of brain metastases

MVI=macrovascular invasion; ORR=objective response rate; PFS=progression-free survival; PROs=patient-reported outcomes; PS=performance status; Q4W=once every 4 weeks; R=randomized; RECIST=Response Evaluation Criteria in Solid Tumors.

The STRIDE Regimen (Single Tremelimumab Regular Interval Durvalumab): A single priming dose of IMJUDO 300 mg followed by IMFINZI 1500 mg on Day 1 of Cycle 1; continue IMFINZI 1500 mg as a single agent every 4 weeks.^{1,2}

*PFS, ORR, and DoR were investigator assessed according to RECIST v1.1.³

†For full eligibility criteria, refer to Sections 3.1 and 3.2 of the HIMALAYA protocol, available at evidence.nejm.org.

‡Ascites requiring nonpharmacologic intervention within 6 months, hepatic encephalopathy within 12 months.^{1,2}

HIMALAYA is a large positive Phase III trial to evaluate 1L treatment of uHCC³

The HIMALAYA trial included a diverse patient population, reflective of advanced or unresectable HCC globally³

➤ BASELINE DEMOGRAPHICS AND DISEASE CHARACTERISTICS (intent-to-treat population)³

Patient characteristics	STRIDE (n=393)	Sorafenib (n=389)
Median age, years (range)	65 (22-86)	64 (18-88)
Sex, n (%)		
Male	327 (83.2)	337 (86.6)
Female	66 (16.8)	52 (13.4)
Region, n (%)		
Asia (excluding Japan)	156 (39.7)	156 (40.1)
Rest of world (including Japan)*	237 (60.3)	233 (59.9)
Etiology, n (%)		
HBV	122 (31.0)	119 (30.6)
HCV	110 (28.0)	104 (26.7)
Nonviral†	161 (41.0)	166 (42.7)
ECOG PS, n (%)‡		
0	244 (62.1)	241 (62.0)
1	148 (37.7)	147 (37.8)
2	1 (0.3)	1 (0.3)
Child-Pugh classification, n (%)		
A/5	295 (75.1)	277 (71.2)
A/6	92 (23.4)	102 (26.2)
B/7	4 (1.0)	10 (2.6)
Others§	2 (0.5)	0

Patient characteristics	STRIDE (n=393)	Sorafenib (n=389)
BCLC stage, n (%)		
B	77 (19.6)	66 (17.0)
C	316 (80.4)	323 (83.0)
MVI, n (%)	103 (26.2)	100 (25.7)
EHS, n (%)	209 (53.2)	203 (52.2)
AFP ≥400 ng/mL, n (%)	145 (36.9)	124 (31.9)
PD-L1 status, n (%) 		
Positive	148 (37.7)	148 (38.0)
Negative	189 (48.1)	181 (46.5)
Missing	52 (13.2)	45 (11.6)

AFP=alpha-fetoprotein; EHS=extrahepatic spread; PD-L1=programmed death-ligand 1.

*Includes Brazil, Canada, France, Germany, Italy, Japan, Russia, Spain, Ukraine, and the United States.

†No active viral hepatitis identified.

‡The ECOG PS scale ranges from 0 to 5 with higher numbers corresponding to greater disability.

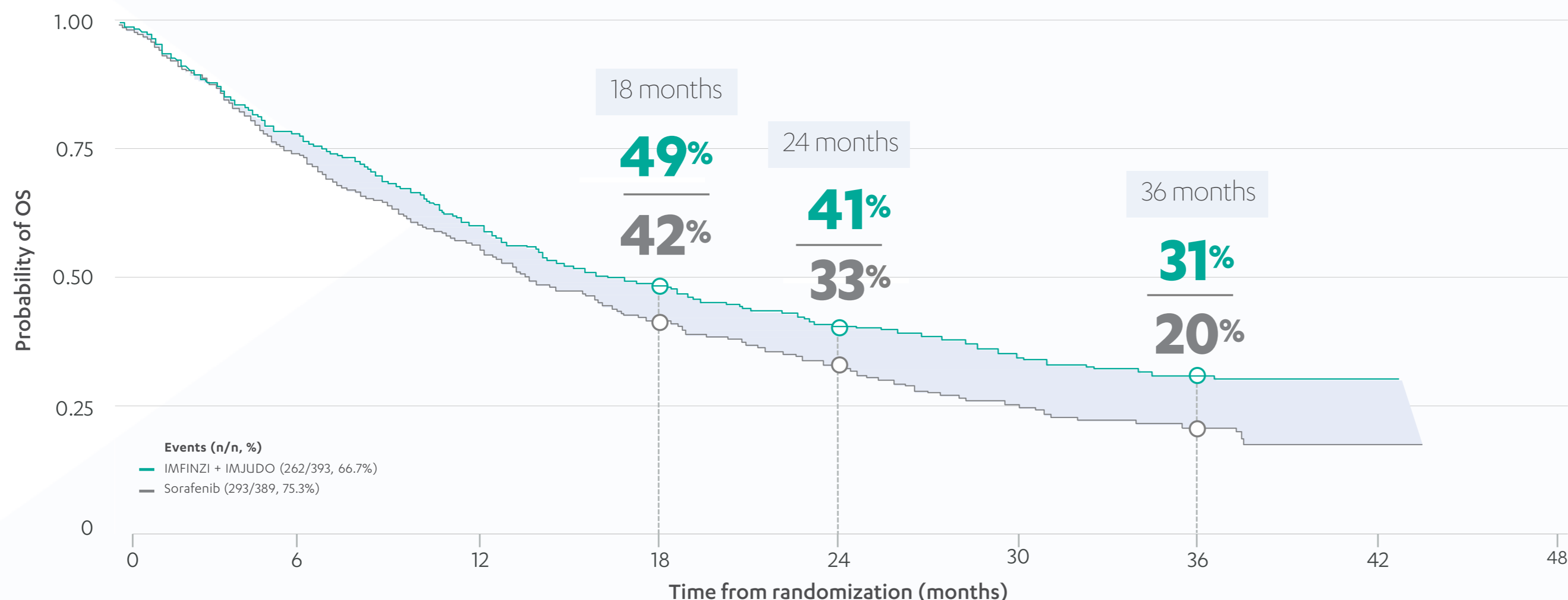
§None of the above.

||Baseline PD-L1 results were not available for patients who were randomized but not treated. PD-L1 expression level was based on the tumor and immune cell positivity score method as PD-L1 positive (≥1%) or negative (<1%).



First EMA-approved therapy to demonstrate 31% OS at 3 years in 1L advanced or unresectable HCC^{1-3, 7, 8}

OVERALL SURVIVAL IN THE INTENT-TO-TREAT POPULATION (PRIMARY ENDPOINT)³



Events (n/n, %)
 — IMFINZI + IMJUDO (262/393, 66.7%)
 — Sorafenib (293/389, 75.3%)

Number of patients at risk

	0	6	12	18	24	30	36	42	48
IMFINZI + IMJUDO	393	308	235	190	158	98	32	1	0
Sorafenib	389	283	211	155	121	62	21	1	0

Estimates of OS rates calculated using Kaplan-Meier technique. OS rates at 18, 24, and 36 months were secondary endpoints.

IMFINZI + IMJUDO: Statistically superior overall survival vs sorafenib^{1,2}

HR=0.78 (95% CI, 0.66-0.92);
P=0.0035*

16.4 MONTHS MEDIAN OS
 (95% CI, 14.2-19.6)
 with IMFINZI + IMJUDO

VS

13.8 MONTHS MEDIAN OS
 (95% CI, 12.3-16.1)
 with sorafenib

➤ Median duration of follow-up: 33.2 months (range, 31.7-34.5) for IMFINZI + IMJUDO and 32.2 months (range, 30.4-33.7) for sorafenib¹

Adapted from Abou-Alfa GK, et al. NEJM Evid. 2022. *Based on a Lan-DeMets alpha spending function with O'Brien-Fleming-type boundary and the actual number of events observed, the boundary for declaring statistical significance for IMFINZI + IMJUDO vs sorafenib was 0.0398.³

1. IMFINZI summary of product characteristics 2. IMJUDO summary of product characteristics 3. Abou-Alfa GK, Lau G, Kudo M, et al. NEJM Evid. 2022;1(8). doi:10.1056/EVIDoa2100070. 7. TECENTRIQ summary of product characteristics 8. OPDIVO summary of product characteristics



The only IO regimen with 5-year OS data from a Phase III study^{1,2,4,7,8}

OVERALL SURVIVAL AT 5 YEARS (exploratory analysis)*



Number at risk

	0	6	12	18	24	30	36	42	48	54	60	66	72
STRIDE	393	308	235	190	158	131	104	89	83	72	46	20	2
Sorafenib	389	283	211	155	121	84	66	51	45	37	18	6	0

	Primary analysis ¹⁻³	Exploratory 5-year analysis
Data cutoff	August 27, 2021	March 1, 2024
Median OS (95% CI)	16.4 months (14.2-19.6)	16.4 months (14.2-19.6)
	vs 13.8 months (12.3-16.1)	vs 13.8 months (12.3-16.1)
Hazard ratio (95% CI)	0.78 (95% CI, 0.66-0.92)	0.76 (95% CI, 0.65-0.89)
Pvalue	P=0.0035[†]	P=0.0008

Adapted from Figure 1 Rimassa L, et al⁴

* Estimate of OS rate calculated using Kaplan-Meier technique. OS rate at 60 months was an exploratory endpoint. At the 5-year analysis, OS data maturity across the IMFINZI + IMJUDO and sorafenib arms was 79% and 85%, respectively. Data cutoff: March 1, 2024.⁴

[†] Overall survival, the primary endpoint, met statistical significance at the primary analysis in accordance with the HIMALAYA trial design (66.7% maturity in the IMFINZI + IMJUDO arm and 75.3% maturity in the sorafenib arm). Data cutoff: August 27, 2021.³

1. IMFINZI summary of product characteristics **2.** IMJUDO summary of product characteristics **3.** Abou-Alfa GK, Lau G, Kudo M, et al. NEJM Evid. 2022;1(8). doi:10.1056/EVIDoa2100070. **4.** Rimassa L et al. Five-year overall survival update from the HIMALAYA study of tremelimumab plus durvalumab in unresectable HCC. J Hepatol. 2025 Oct;83(4):899-908. doi: 10.1016/j.jhep.2025.03.033. Epub 2025 Apr 11. **7.** TECENTRIQ summary of product characteristics **8.** OPDIVO summary of product characteristics



OS improvement with STRIDE was consistently observed across most subgroups vs sorafenib⁴

	Patients (n)	IMFINZI + IMJUDO events n/N (%)	Sorafenib events n/N (%)	Unstratified HR and 95% CI
All patients	782	309/393 (78.6%)	332/389 (85.3%)	
Sex	Male	257/327 (78.6%)	292/337 (86.6%)	
	Female	52/66 (78.8%)	40/52 (76.9%)	
Age	< 65 yr	158/195 (81.0%)	163/195 (83.6%)	
	≥ 65 yr	151/198 (76.3%)	169/194 (87.1%)	
PD-L1 expression	Positive	116/148 (78.4%)	126/148 (85.1%)	
	Negative	153/189 (81.0%)	156/181 (86.2%)	
Etiology*	HBV	101/122 (82.8%)	107/119 (89.9%)	
	HCV	80/110 (72.7%)	78/104 (75.0%)	
	Nonviral	128/161 (79.5%)	147/166 (88.6%)	
ECOG PS*	0	182/244 (74.6%)	199/241 (82.6%)	
	1	126/148 (85.1%)	132/147 (89.8%)	
MVI*/EHS	MVI=Yes	83/103 (80.6%)	90/100 (90.0%)	
	MVI=No	226/290 (77.9%)	242/289 (83.7%)	
	EHS=Yes	168/209 (80.4%)	175/203 (86.2%)	
	EHS=No	139/182 (76.4%)	157/185 (84.9%)	
	MVI=Yes and/or EHS = Yes	212/263 (80.6%)	216/251 (86.1%)	
	MVI=No and/or EHS=No	95/128 (74.2%)	116/137 (84.7%)	
Region	Asia (except Japan)	125/156 (80.1%)	141/156 (90.4%)	
	Rest of world (including Japan)	184/237 (77.6%)	191/233 (82.0%)	
AFP at baseline	< 400 ng/mL	130/167 (77.8%)	147/182 (80.8%)	
	≥ 400 ng/mL	76/98 (77.6%)	63/71 (88.7%)	
BCLC score	B	57/77 (74.0%)	54/66 (81.8%)	
	C	252/316 (79.7%)	278/323 (86.1%)	

A post-hoc analysis of baseline covariates in the HCV subgroup identified imbalances in other prognostic factors between arms, namely extrahepatic spread and albumin-bilirubin grade. Controlling for these factors led to an observed consistency of OS benefit³

OS subgroup analysis was not formally tested for statistical significance.

Long-term survivors were represented across all clinically relevant subgroups (exploratory analysis)⁴

Adapted from Rimassa L, et al⁴. **Exploratory analysis of prespecified subgroups. OS subgroup analysis was not powered to show differences between or within individual subgroups and was not formally tested for statistical significance.** For the subgroup analysis, the hazard ratio and 95% CI are estimated from an unstratified Cox proportional hazard model with treatment as the only covariate and using the Efron method to control for ties. Updated analysis data cutoff: March 1, 2024.⁴ The STRIDE Regimen (Single Tremelimumab Regular Interval Durvalumab): A single priming dose of IMJUDO 300 mg followed by IMFINZI 1500 mg on Day 1 of Cycle 1; continue IMFINZI 1500 mg as a single agent every 4 weeks.^{1,2} *Stratification factors.




Long-term (≥ 48 months) survivorship was observed with STRIDE regardless of RECIST v1.1 response⁴

BEST OBJECTIVE RESPONSE FOR THE FULL ANALYSIS SET AND LONG-TERM SURVIVORS (5-year exploratory analysis)^{4*}

BOR, n (%)	Full analysis set of patients (primary analysis) [†]		Long-term survivors (exploratory analysis) [*]	
	IMFINZI + IMJUDO (n=393)	Sorafenib (n=389)	IMFINZI + IMJUDO (n=83)	Sorafenib (n=45)
DCR	236 (60.1)	236 (60.7)	74 (89.2)	37 (82.2)
CR	12 (3.1)	0	10 (12)	0
PR	67 (17)	20 (5.1)	41 (49.4)	7 (15.6)
SD	157 (39.9)	216 (55.5)	23 (27.7)	30 (66.7)
PD	141 (35.9)	118 (30.3)	8 (9.6)	6 (13.3)
NE	16 (4.1)	35 (9)	1 (1.2)	2 (4.4)

- 1 in 4 (27.7%) long-term survivors had stable disease⁴
- 5-year OS rates in patients with disease control (CR/PR and SD) were 28.7% with STRIDE and 12.7% with sorafenib⁴

See more response data with STRIDE vs sorafenib 

> RECIST v1.1 response (CR/PR) did not fully capture the long-term survivorship associated with STRIDE⁴

The SmPC recommends treatment with STRIDE until disease progression or unacceptable toxicity.

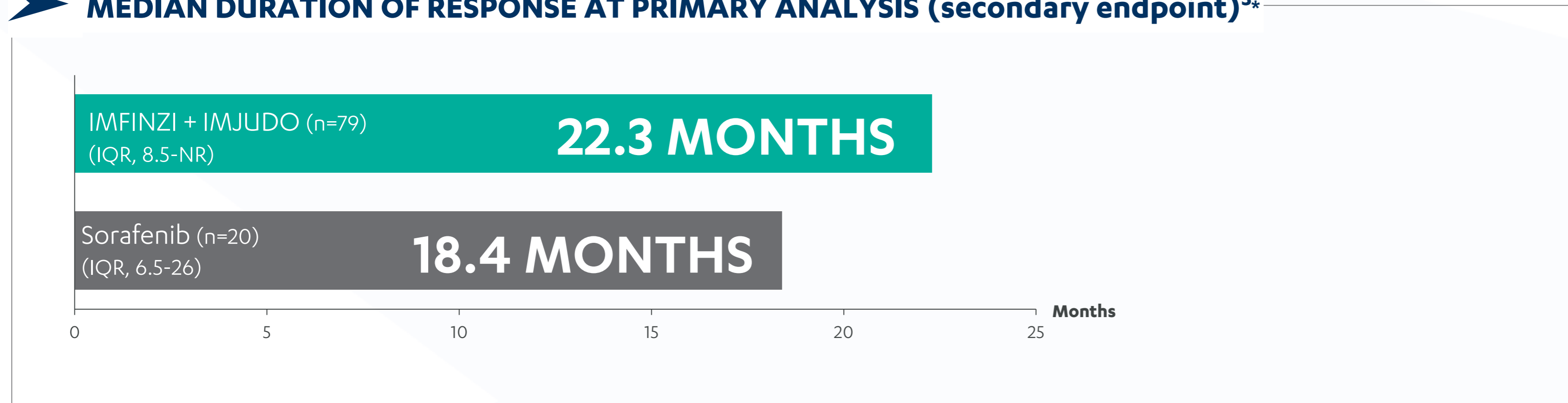
*Long-term survivors were defined as participants surviving ≥ 48 months beyond randomization. Not formally tested for statistical significance. Data cutoff: March 1, 2024 (exploratory analysis).⁴ †Data cutoff: August 27, 2021 (primary analysis).⁴ Stable disease (SD) is defined by RECIST v1.1 as neither meeting the criteria for PR ($\geq 30\%$ reduction) or PD ($\geq 20\%$ increase) in the sum of the diameter of target lesions compared to baseline.³ BOR=best objective response; CR=complete response; DCR=disease control rate; NE=not estimable; PD=progressive disease; PR=partial response; SD=stable disease.

4. Rimassa L et al. Five-year overall survival update from the HIMALAYA study of tremelimumab plus durvalumab in unresectable HCC. J Hepatol. 2025 Oct;83(4):899-908. doi: 10.1016/j.jhep.2025.03.033. Epub 2025 Apr 11.



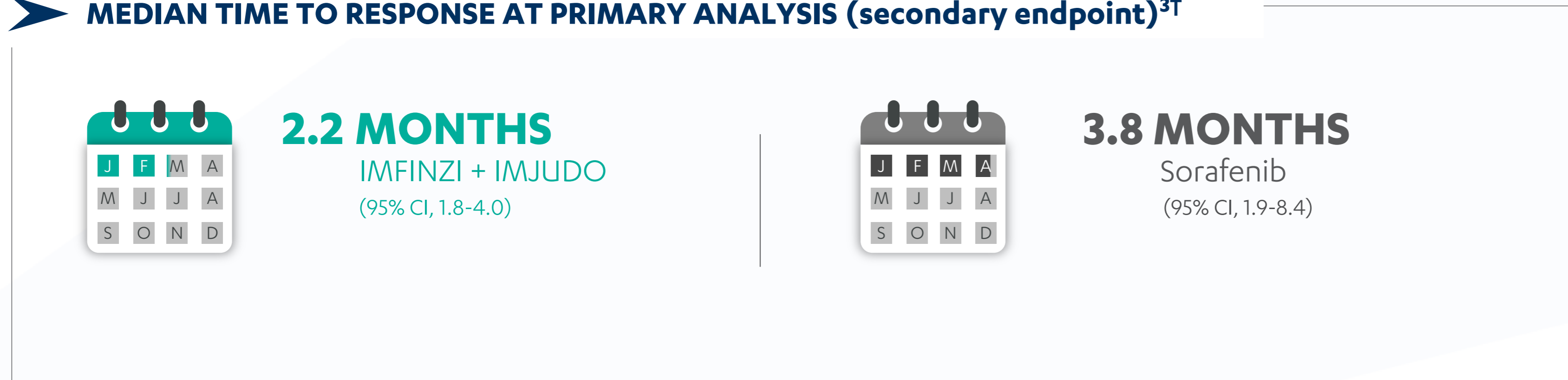
Responses with STRIDE were faster and more durable than with sorafenib¹⁻³

MEDIAN DURATION OF RESPONSE AT PRIMARY ANALYSIS (secondary endpoint)^{3*}



- ORR at primary analysis (secondary endpoint): 20.1% with IMFINZI + IMJUDO and 5.1% with sorafenib^{3*}
 - In an exploratory 5-year analysis, numerically more patients treated with STRIDE, compared with sorafenib, initially had SD and then went on to achieve subsequent tumor shrinkage in target lesions over the follow-up period⁴
- PFS at primary analysis: median PFS was 3.8 months (95% CI, 3.7-5.3) with IMFINZI + IMJUDO and 4.1 months (95% CI, 3.8-5.5) with sorafenib (HR=0.90 [95% CI, 0.77-1.05])^{1,2}

MEDIAN TIME TO RESPONSE AT PRIMARY ANALYSIS (secondary endpoint)^{3†}



*Time from the first documentation of a response until date of progression, death, or last evaluable RECIST v1.1 assessment. **Not formally tested for statistical significance.** Data cutoff: August 27, 2021.³

†Time from randomization to first confirmed response according to RECIST v1.1 assessment. **Not formally tested for statistical significance.** Data cutoff: August 27, 2021.³

³Confirmed responses by investigator assessment according to RECIST v1.1. **Not formally tested for statistical significance.** Data cutoff: August 27, 2021.³

IQR=interquartile range; NR=not reached.

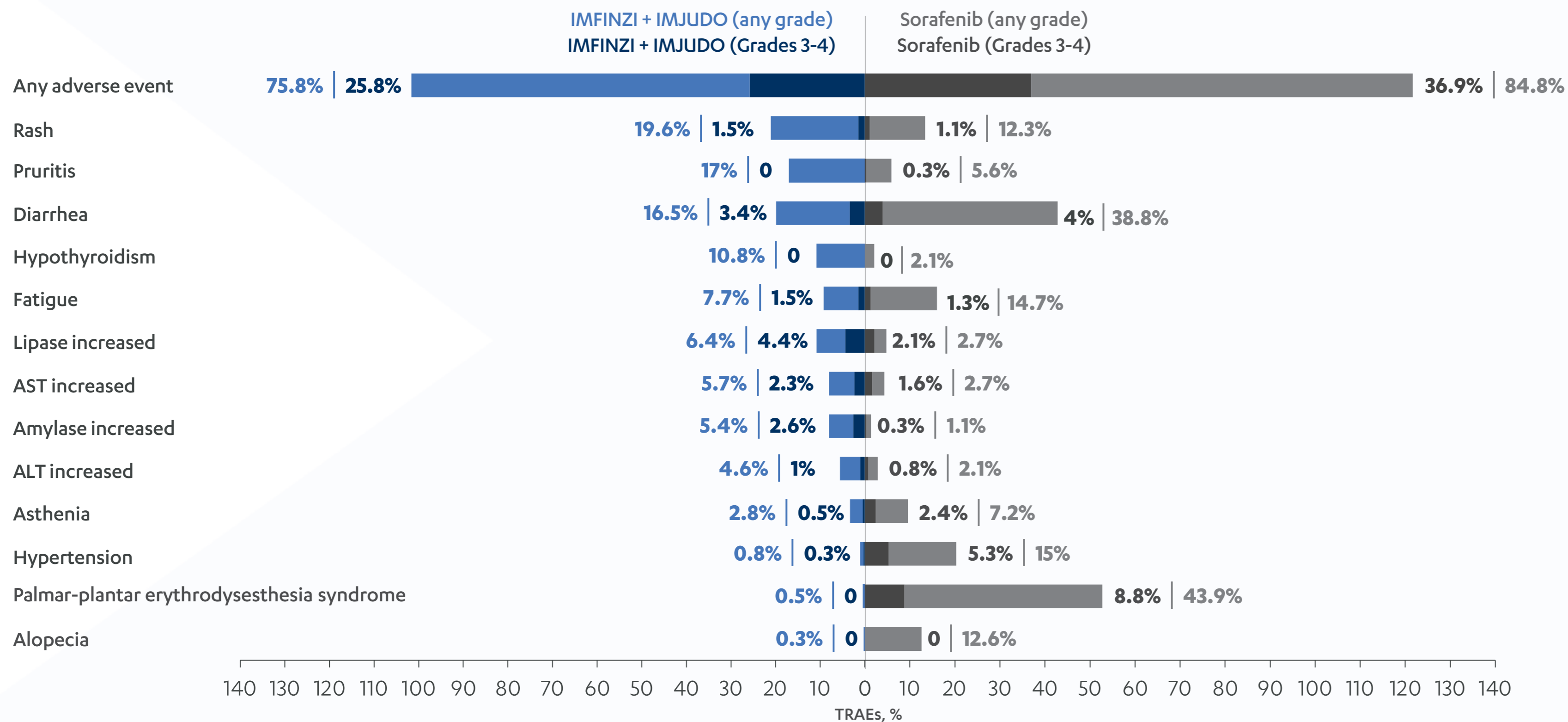
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Generally fewer TRAEs were observed with STRIDE than with sorafenib³

TRAEs led to discontinuation in 8.2% of patients treated with IMFINZI + IMJUDO and 11% of patients treated with sorafenib³

TRAEs REPORTED IN ≥10% (ANY GRADE) OR ≥2% (GRADE 3 OR 4) IN SAFETY ANALYSIS SET³



- Serious TRAEs occurred in 17.5% of patients (n=68) treated with IMFINZI + IMJUDO and 9.4% of patients (n=35) treated with sorafenib³
- TRAEs resulting in death occurred in 2.3% of patients (n=9) treated with IMFINZI + IMJUDO and 0.8% of patients (n=3) treated with sorafenib³

No new serious TRAEs occurred with STRIDE after the primary analysis⁴

Please refer to the SmPCs for IMFINZI and IMJUDO for full adverse event details^{1,2}.

■ IMFINZI + IMJUDO (n=388), any grade
 ■ IMFINZI + IMJUDO (n=388), Grades 3-4
 ■ Sorafenib (n=374), any grade
 ■ Sorafenib (n=374), Grades 3-4

Adapted from Abou-Alfa GK, et al. *NEJM Evid.* 2022.

Within the safety analysis set of the HIMALAYA study, the median duration of treatment for IMFINZI + IMJUDO (n=388) was 5.5 months (range, 0.4-42.7) and 4.1 months (range, 0.1-38.6) for sorafenib (n=374).

ALT=alanine aminotransferase; AST=aspartate aminotransferase; TRAEs=treatment-related adverse events.

The STRIDE Regimen (Single Tremelimumab Regular Interval Durvalumab): A single priming dose of IMJUDO 300 mg followed by IMFINZI 1500 mg on Day 1 of Cycle 1; continue IMFINZI 1500 mg as a single agent every 4 weeks.^{1,2}

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No treatment-related gastrointestinal or esophageal varices hemorrhage events were observed with the STRIDE Regimen³

SELECT HEPATIC AND HEMORRHAGE SMQ TREATMENT-RELATED ADVERSE EVENTS IN THE HIMALAYA STUDY³

Adverse event	Treatment-related AE, n (%)	
	IMFINZI + IMJUDO (n=388)	Sorafenib (n=374)
Any hepatic SMQ event	66 (17)	46 (12.3)
Grade 3 or 4 hepatic SMQ event	23 (5.9)	17 (4.5)
Hepatic failure, fibrosis, and cirrhosis/other liver damage-related conditions		
Any	3 (0.8)	6 (1.6)
Hepatic failure	1 (0.3)	2 (0.5)
Hepatic cirrhosis	0	0
Hepatic encephalopathy	0	2 (0.5)
Gastric varices hemorrhage	0	0
Esophageal varices	0	0
Esophageal varices hemorrhage	0	0
Hepatitis noninfectious		
Any	18 (4.6)	0
Immune-mediated hepatitis	4 (1)	0
Hemorrhage		
Any hemorrhage SMQ event	7 (1.8)	18 (4.8)
Grade 3 or 4 hemorrhage SMQ event	2 (0.5)	4 (1.1)
INR increased	4 (1)	0
Purpura	2 (0.5)	1 (0.3)
Activated partial thromboplastin time prolonged	1 (0.3)	0
Tumor hemorrhage	1 (0.3)	0
Gastrointestinal hemorrhage	0	3 (0.8)
Epistaxis	0	4 (1.1)
Gingival bleeding	0	2 (0.5)
Hemoptysis	0	1 (0.3)
Hematuria	0	2 (0.5)
Hemoglobin decreased	0	1 (0.3)

Adapted from Abou-Alfa GK, et al. NEJM Evid. 2022³. INR=international normalized ratio; SMQ=standardised MedDRA query. The STRIDE Regimen (Single Tremelimumab Regular Interval Durvalumab): A single priming dose of IMJUDO 300 mg followed by IMFINZI 1500 mg on Day 1 of Cycle 1; continue IMFINZI 1500 mg as a single agent every 4 weeks.^{1,2}

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The majority of imAEs associated with STRIDE were of low grade (Grade 1 or 2), and generally manageable per treatment guidelines³

➤ IMMUNE-MEDIATED ADVERSE EVENTS WITH STRIDE³

imAEs	IMFINZI + IMJUDO (n=388)
	Immune-mediated adverse events requiring high-dose steroids, %
Any	20.1
Hepatic events	7.5
Diarrhea/colitis*	5.2
Dermatitis/rash [†]	3.1
Pancreatic events	1.8
Renal events	0.8
Adrenal insufficiency	0.3
Hyperthyroid events	0.5
Hypothyroid events	0.3
Pneumonitis	1.0

- 5.7% of patients treated with IMFINZI + IMJUDO discontinued due to imAEs³
- Treatment-emergent fatal imAEs occurred in 6 patients (1.5%) treated with IMFINZI + IMJUDO³

Most imAEs occurred within the first 3 months of treatment (exploratory analysis)⁵



See OS results by imAE occurrence (exploratory analysis)⁵



IMFINZI + IMJUDO are associated with imARs. Routine monitoring of patients for signs and symptoms is advised.^{1,2}

The use of systemic corticosteroids or immunosuppressants before starting IMFINZI + IMJUDO, except physiological dose of systemic corticosteroids (≤10 mg/day prednisone or equivalent), is not recommended because of their potential interference with the pharmacodynamic activity and efficacy of IMFINZI and IMJUDO. Systemic corticosteroids or other immunosuppressants can be used after starting IMFINZI + IMJUDO to treat imARs.

imAEs=immune-mediated adverse events. Includes adverse events with onset or increase in severity on or after the date of the first dose through 90 days following the date of the last dose or the date of initiation of the first subsequent therapy. Patients may have had >1 event. Events include those that occurred in ≥1% of patients in either treatment arm. Data cutoff: August 27, 2021.

*Immune-mediated diarrhea/colitis was reported as a grouped term within the HIMALAYA study.

[†]Immune-mediated dermatitis/rash was reported as a grouped term within the HIMALAYA study. Other imAEs may include endocrinopathies, myasthenia gravis, myelitis transverse, myocarditis, myositis, polymyositis, rhabdomyolysis, meningitis, encephalitis, Guillain-Barré syndrome, immune thrombocytopenia, immune-mediated arthritis, uveitis and cystitis noninfective.^{1,2}

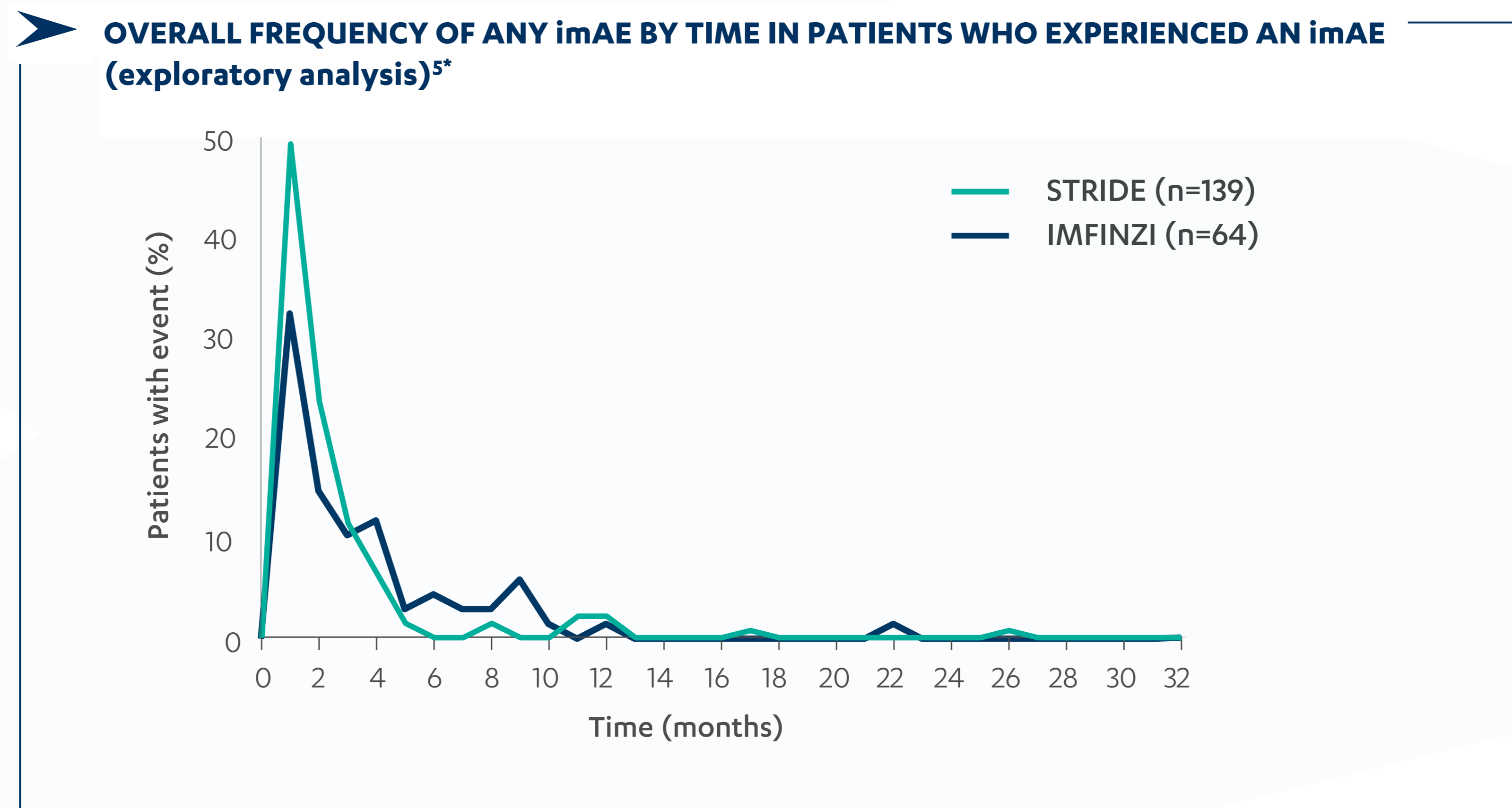
imARs=immune-mediated adverse reactions.

The STRIDE Regimen (Single Tremelimumab Regular Interval Durvalumab): A single priming dose of IMJUDO 300 mg followed by IMFINZI 1500 mg on Day 1 of Cycle 1; continue IMFINZI 1500 mg as a single agent every 4 weeks.^{1,2}

1. IMFINZI summary of product characteristics 2. IMJUDO summary of product characteristics 3. Abou-Alfa GK, Lau G, Kudo M, et al. NEJM Evid. 2022;1(8). doi:10.1056/EVIDoa2100070 5. Lau, George; Sangro, Bruno; Cheng, Ann-Lii; Kudo, Masatoshi; Kelley, Robin Kate et al (2025) Immune-mediated adverse events and overall survival with tremelimumab plus durvalumab and durvalumab monotherapy in unresectable HCC: HIMALAYA phase III randomized clinical trial. Hepatology ():10.1097/HEP.0000000000001385, May 16, 2025. | DOI: 10.1097/HEP.0000000000001385



For patients who experienced an imAE with STRIDE,
Most imAEs occurred within the first 3 months of treatment⁵



STRIDE

SmPC

> **Most imAEs resolved with a median time to resolution of <60 days with appropriate management strategies⁵**

The STRIDE Regimen (Single Tremelimumab Regular Interval Durvalumab): A single priming dose of IMJUDO 300 mg followed by IMFINZI 1500 mg on Day 1 of Cycle 1; continue IMFINZI 1500 mg as a single agent every 4 weeks.^{1,2}

*The percentage of patients with an event is the number of patients who experienced ≥1 imAE at each time interval divided by the number of patients who experienced ≥1 imAE at any time; includes first imAE only, regardless of grade. Data cutoff: August 27, 2021.

1. IMFINZI summary of product characteristics — 2. IMJUDO summary of product characteristics — 5. Lau, George; Sangro, Bruno; Cheng, Ann-Lii; Kudo, Masatoshi; Kelley, Robin Kate et al (2025) Immune-mediated adverse events and overall survival with tremelimumab plus durvalumab and durvalumab monotherapy in unresectable HCC: HIMALAYA phase III randomized clinical trial. Hepatology ():10.1097/HEP.0000000000001385, May 16, 2025. | DOI: 10.1097/HEP.0000000000001385

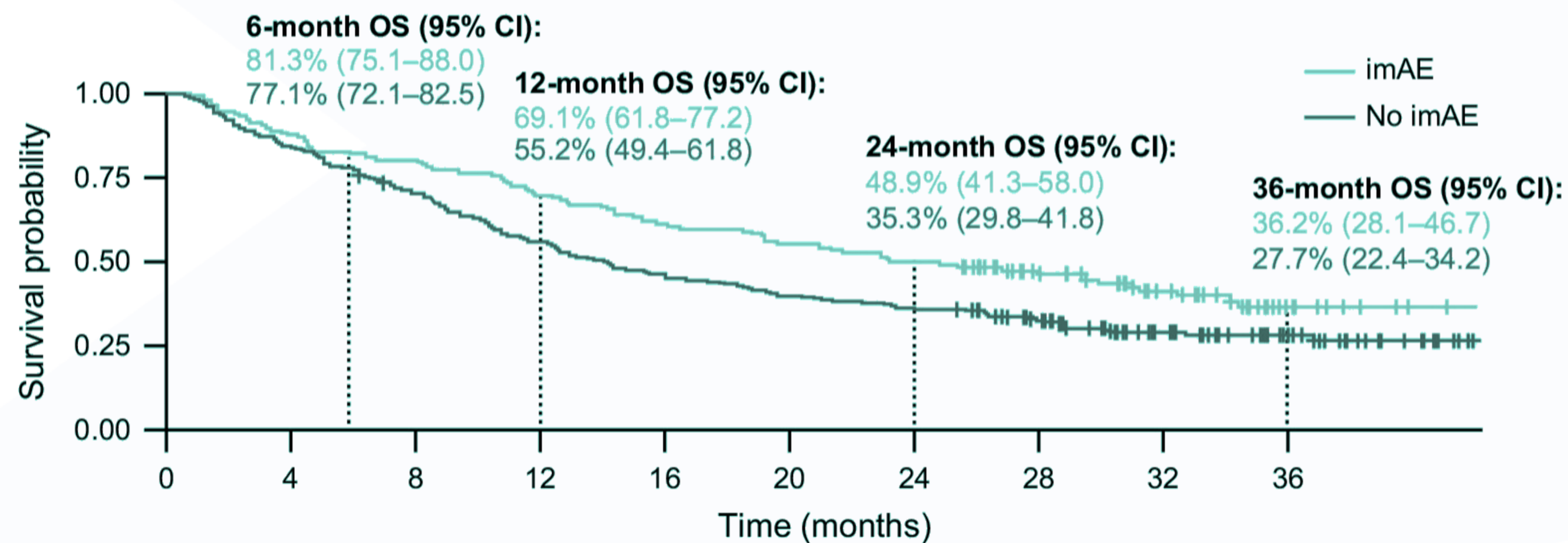
STRIDE 3-year OS data with STRIDE by imAE subgroup⁵

Single Tremelimumab Regular Interval Durvalumab

NUMERICALLY IMPROVED OS IN THE STRIDE ARM FOR PARTICIPANTS WHO EXPERIENCED imAE^{5*}

	imAE	No imAE
Median OS (95% CI), months	23.2 (19.1–32.4)	14.1 (11.6–17.9)
OS HR^a (95% CI)	0.73 (0.56–0.95)	

OS benefit with STRIDE was observed regardless of the use of high-dose steroids⁵



No. at risk (no. of events)

imAE	139 (0)	97 (42)	69 (70)	12 (82)
No imAE	249 (0)	137 (110)	88 (159)	20 (175)

The STRIDE Regimen (Single Tremelimumab Regular Interval Durvalumab): A single priming dose of IMJUDO 300 mg followed by IMFINZI 1500 mg on Day 1 of Cycle 1; continue IMFINZI 1500 mg as a single agent every 4 weeks.^{1,2}

*Data cutoff: August 27, 2021.⁵

1. IMFINZI summary of product characteristics 2. IMJUDO summary of product characteristics 5. Lau, George; Sangro, Bruno; Cheng, Ann-Lii; Kudo, Masatoshi; Kelley, Robin Kate et al (2025) Immune-mediated adverse events and overall survival with tremelimumab plus durvalumab and durvalumab monotherapy in unresectable HCC: HIMALAYA phase III randomized clinical trial. Hepatology ();10.1097/HEP.0000000000001385, May 16, 2025. | DOI: 10.1097/HEP.0000000000001385

Unique dual IO approach combines priming, single-dose IMJUDO with IMFINZI, followed by monthly (Q4W) IMFINZI monotherapy¹⁻³

SINGLE-PRIMING DOSE OF IMJUDO + IMFINZI ON DAY 1, FOLLOWED BY IMFINZI Q4W¹⁻³

For patients with body weight >40 kg



PRIME

IMJUDO
300-mg fixed-dose infusion*

+

IMFINZI
1500-mg fixed-dose infusion†



ENHANCE

IMFINZI
1500-mg fixed-dose infusion†

Same day administration
Continue until disease progression or unacceptable toxicity

- IMFINZI and IMJUDO are each administered as separate 60-minute IV infusions^{1,2}
- Administer IMJUDO prior to IMFINZI on the same day (Day 1)^{1,2}
- Prior to prescribing, please read the IMFINZI and IMJUDO SmPCs for full prescribing information, including important safety information on monitoring and management of imARs. Dose escalation or reduction is not recommended. Dose withholding or discontinuation may be required based on individual safety and tolerability.^{1,2}

*Patients with a body weight of ≤40 kg must receive weight-based dosing equivalent to 4 mg/kg of IMJUDO, until body weight is >40 kg.^{1,2}

†Patients with a body weight of ≤30 kg must receive weight-based dosing equivalent to 20 mg/kg of IMFINZI, until body weight is >30 kg.^{1,2}

IV=intravenous. The STRIDE Regimen (Single Tremelimumab Regular Interval Durvalumab): A single priming dose of IMJUDO 300 mg followed by IMFINZI 1500 mg on Day 1 of Cycle 1; continue IMFINZI 1500 mg as a single agent every 4 weeks.^{1,2} IMJUDO is supplied as single-use vials that contain either 25 mg/1.25 mL or 300 mg/15 mL. Refer to the IMJUDO SmPC for further information on storage, dilution, and administration instructions² IMFINZI is supplied as single-use vials that contain either 500 mg/10 mL or 120 mg/2.4 mL. Refer to the IMFINZI SmPC for further information on storage, dilution, and administration instructions¹ Treatment must be initiated and supervised by a physician experienced in the treatment of cancer. Infusion-related reactions with STRIDE were observed in 1.3% of patients.^{1,2}



IMFINZI + IMJUDO – The only IO regimen with 5-year OS data in 1L uHCC^{4,7,8}

EFFICACY



Statistically superior OS in a diverse patient population (ITT primary analysis)^{1,2}

22% reduction in risk of death with IMFINZI + IMJUDO vs sorafenib HR=0.78 (95% CI, 0.66-0.92); P=0.0035*

Median OS: 16.4 months with IMFINZI + IMJUDO (95% CI, 14.2-19.6) vs 13.8 months with sorafenib (95% CI, 12.3-16.1)



The only Phase III study with 5-year OS data (exploratory analysis)^{4†}

19.6% 5-YEAR OS RATE
IMFINZI + IMJUDO

Median duration of follow-up: 62.5 months (59.5-64.8)

24% reduction in risk of death with IMFINZI + IMJUDO vs sorafenib HR=0.76 (95% CI, 0.65-0.89); P=0.0008

9.4% 5-YEAR OS RATE
Sorafenib

Median duration of follow-up: 59.9 months (58.3-61.5)

SAFETY



Numerically fewer discontinuations due to TRAEs than sorafenib (8.2% vs 11%; primary analysis)³

The majority of imAEs with STRIDE were Grade 1 or 2 and generally manageable per treatment guidelines³



No EGD required to initiate therapy in the HIMALAYA study³

Grade 3 or 4 treatment-related hemorrhage events occurred in 0.5% of patients receiving STRIDE vs 1.1% of patients receiving sorafenib³

DOSING



Dual-IO approach combines a priming, single-dose of IMJUDO with IMFINZI, followed by monthly (Q4W) IMFINZI monotherapy^{1,2}

*The HR is based on the stratified Cox proportional hazard model. The boundary for declaring statistical significance for IMFINZI + IMJUDO vs sorafenib was 0.0398. Data cutoff: August 27, 2021.

†Estimates of OS rates calculated using Kaplan-Meier technique. OS data maturity across the IMFINZI + IMJUDO and sorafenib arms was 79% and 85%, respectively. Data cutoff: March 1, 2024.⁴

1. IMFINZI Summary of Product Characteristics. 2. IMJUDO Summary of Product Characteristics 3. Abou-Alfa GK et al. NEJM Evid. 2022;1(8) (including Supplementary Appendix and Protocol). 4. Rimassa L et al. Five-year overall survival update from the HIMALAYA study of tremelimumab plus durvalumab in unresectable HCC. J Hepatol. 2025 Oct;83(4):899-908. doi: 10.1016/j.jhep.2025.03.033. Epub 2025 Apr 11. 7. TECENTRIQ summary of product characteristics 8. OPDIVO summary of product characteristics



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VIKTIG INFORMASJON (UTVALG)

Imfinzi (durvalumab)

Konsentrat til infusjonsvæske, oppløsning 50 mg/ml

Indikasjoner:

Hepatocellulært karsinom (HCC; «Hepatocellular Carcinoma»):

IMFINZI i kombinasjon med tremelimumab er indisert som førstelinjebehandling hos voksne med avansert eller inoperabel hepatocellulært karsinom (HCC).

IMFINZI som monoterapi er indisert som førstelinjebehandling hos voksne med avansert eller inoperabel hepatocellulært karsinom (HCC).

For fullstendig indikasjonstekst, se SPC eller FK-tekst.

Dosering:

IMFINZI gis som i.v. infusjonsoppløsning i løpet av 1 time.

HCC:

Anbefalt dose for **IMFINZI i kombinasjon med tremelimumab**: 1 500 mg IMFINZI administrert i kombinasjon med 300 mg tremelimumab som en enkeltdose på syklus 1/dag 1, etterfulgt av IMFINZI monoterapi hver 4. uke. HCC pasienter med en kroppsvekt på 30 kg eller lavere må få vektbasert dosering, se SPC.

Anbefalt dose for **IMFINZI som monoterapi**: 1 500mg IMFINZI hver 4. uke. Pasienter med en kroppsvekt på 30 kg eller lavere må få vektbasert dosering, se SPC.

Behandlingsvarighet BTC og HCC: Inntil sykdomsprogresjon eller uakseptabel toksisitet.

UTVALGT SIKKERHETSINFORMASJON

Forsiktighetsregler: Behandling skal startes opp og overvåkes av en lege med erfaring i kreftbehandling.

Immunmedierte bivirkninger: Inkludert pneumonitt, myokarditt, hepatitt, kolitt, endokrinopatier, binyrebarksvikt, hypofysitt/hypopituitarisme, diabetes mellitus type 1, nefritt, utslett, pankreatitt, myasthenia gravis, transvers myelitt, myositt, polymyositt, rabdomyolyse, meningitt, encefalitt, Guillain-Barré syndrom, immunologisk trombocytopeni, immunmediert artritt, uveitt og ikke-infeksiøs cystitt har blitt observert, og pasienten bør overvåkes for tegn og symptomer. Ved mistanke om immunmedierte bivirkninger, bør tilstrekkelig evaluering utføres for å bekrefte etiologien. Retningslinjer for håndtering av immunmedierte bivirkninger er beskrevet i SPC.

Graviditet, amming og fertilitet: Ingen data fra bruk hos gravide. Durvalumab kan skade fosteret, og anbefales ikke under graviditet og til fertile kvinner som ikke bruker sikker prevensjon under og i minst 3 måneder etter behandling. Risiko for diende barn kan ikke utelukkes.

Hyppigst rapporterte bivirkninger i kombinasjon med kjemoterapi (> 10 %): Nøytropeni, anemi, kvalme, utmattelse/fatigue, trombocytopeni, forstoppelse, nedsatt appetitt, magesmerter, alopecia, leukopeni, oppkast, pyreksi, utslett, diaré, økt ASAT/ALAT, hoste/produktiv hoste og kløe.

De vanligste (> 10 %) bivirkninger i kombinasjon med tremelimumab: utslett, pruritus, diaré, abdominalsmerter, økt ASAT/ALAT, pyreksi, hypotyreose, hoste/produktiv hoste, perifert ødem, økt lipase.

De vanligste (> 10 %) bivirkningene med IMFINZI som monoterapi for pasienter behandlet for HCC: økt ASAT / økt ALAT, abdominalsmerter, diaré, pruritus og utslett.

Se SPC for utfyllende informasjon om dosering, forsiktighetsregler, interaksjoner og bivirkninger.

Utvalgt produktinformasjon:

PRIS, REFUSJON OG FORSKRIVNINGSGREGLER

Pakninger og priser (AUP) Konsentrat til infusjonsvæske.

Hetteglass: 2,4 ml (120 mg): kr 8 207,90. 10 ml (500 mg): kr 33 743,30 per 13.2.2026

Reseptgruppe C.

Markedsføringsinnehaver: AstraZeneca AS, Karvesvingen 7, 0579 Oslo, tel. 21006400

NO-15574-02-26-ONC

Før forskrivning av IMFINZI, se FK-tekst eller SPC på www.felleskatalogen.no eller

www.legemiddelsok.no

VIKTIG INFORMASJON (UTVALG)

▼ IMJUDO (TREMELIMUMAB)

Indikasjon: IMJUDO i kombinasjon med durvalumab er indisert som førstelinjebehandling hos voksne med avansert eller inoperabel hepatocellulært karsinom (HCC).

Dosering og administrasjonsmåte

Behandlingen må startes opp og overvåkes av en lege med erfaring i kreftbehandling.

IMJUDO administreres som en intravenøs infusjon i løpet av 1 time.

300 mg IMJUDO gis som en enkeltdose administrert i kombinasjon med 1500 mg durvalumab på syklus 1/dag 1, etterfulgt av durvalumab monoterapi hver 4. uke. Når IMJUDO gis i kombinasjon med durvalumab, gis IMJUDO først. Vektbasert dosering må gis ved kroppsvekt på 40 kg eller lavere. Behandlingsvarighet: Inntil sykdomsprogresjon eller uakseptabel toksisitet.

Utvalgt sikkerhetsinformasjon:

Forsiktighetsregler:

Immunmedierte bivirkninger har forekommet hos pasienter som fikk tremelimumab i kombinasjon med durvalumab. Basert på alvorlighetsgraden av bivirkningen bør durvalumab og/eller tremelimumab holdes tilbake og kortikosteroider administreres (se preparatomtalen for håndtering av immunmedierte bivirkninger).

Bivirkninger:

De vanligste bivirkninger (>10%) i kombinasjon med durvalumab var utslett, pruritus, diaré, abdominalsmerter, økt aspartat-aminotransferase/ økt alanin-aminotransferase, pyreksi, hypotyreose, hoste/produkt hoste og perifert ødem.

Følgende immunmedierte bivirkninger har blitt observert hos pasienter som har blitt behandlet med IMJUDO i kombinasjon med IMFINZI: pneumitt, hepatitt, kolitt, hypotyreose, hypertyreose, tyreoiditt, binyrebarksvikt, diabetes mellitus type 1, hypofysitt/hypopituitarisme, nefritt, utslett, myokarditt, myasthenia gravis.

Graviditet, amming og fertilitet: Ingen data fra bruk hos gravide. Tremelimumab har potensiale til å påvirke graviditeten og kan gi fosterskader. Amming skal opphøre ved behandling med IMJUDO.

Pris, pakning og refusjon:

300 mg tremelimumab (ett hetteglass på 15 ml): 208 874,80 NOK per 13.2.2026.

25 mg tremelimumab (ett hetteglass på 1,25 ml): 22 834,50 NOK per 13.2.2026.

Reseptgruppe C.

Markedsføringsinnehaver: AstraZeneca AS, Karvesvingen 7, 0579 Oslo, tel. 21006400

Se SPC for utfyllende informasjon om indikasjon, dosering, forsiktighetsregler, interaksjoner og bivirkninger på www.felleskatalogen.no

NO-15573-02-26-ONC

