INQOVI®
(decitabine and cedazuridine)
35mg / 100mg tablets

Minimize your patients' out-of-pocket expenses for INQOVI

INQOVI is the only oral hypomethylating agent (HMA) for the treatment of myelodysplastic syndromes (MDS) and chronic myelomonocytic leukemia[1]

If all other outcomes were similar,

77% **of patients with MDS said they would switch to an oral pill if available to them, according to an HMA treatment preference study[2,a,b]**

[a]When HMA treatments were assumed to be associated with the same risk of acute myeloid leukemia and level of fatigue but to differ in terms of mode and frequency of administration.[2]

[b]A preference study was conducted using the discrete-choice experiment method in collaboration with patient organizations to understand HMA preferences for United States and Canadian patients with MDS. Eligibility included being a patient with MDS or a caregiver of a patient with MDS and being 18 years of age or older. The study was comprised of two phases. Phase 1 was qualitative and included a literature review, interviews with clinicians, patients, and caregivers, and input from patient organizations. Phase 2 was quantitative, during which survey participants indicated their preference between different hypothetical HMA profiles that varied in attributes. Sixteen participants completed Phase 1, and 184 (158 patients and 26 caregivers) completed Phase 2.[2]

INDICATIONS

INQOVI is indicated for treatment of adult patients with myelodysplastic syndromes (MDS), including previously treated and untreated, de novo and secondary MDS with the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Myelosuppression

Fatal and serious myelosuppression can occur with INQOVI. Based on laboratory values, new or worsening thrombocytopenia occurred in 82% of patients, with Grade 3 or 4 occurring in 76%. Neutropenia occurred in 73% of patients, with Grade 3 or 4 occurring in 71%. Anemia occurred in 71% of patients, with Grade 3 or 4 occurring in 55%. Febrile neutropenia occurred in 33% of patients, with Grade 3 or 4 occurring in 32%.

Please see additional Important Safety Information on the last page and full Prescribing Information.

TAIHO ONCOLOGY

The Taiho Oncology Patient Support Program

TAIHO ONCOLOGY PATIENT SUPPORT
Supporting your treatment journey

To determine patient eligibility for the Co-Pay Program, visit **TaihoOncologyCopay.com.**

Taiho Oncology Patient Support™ offers personalized services to help patients, caregivers, and healthcare professionals (HCPs) access Taiho Oncology medications. This includes insurance verification, help with medication costs, and treatment plan support. For patients with commercial insurance coverage, the Taiho Oncology Co-Pay Assistance Program may help reduce out-of-pocket (OOP) costs to $0.[a]

The Taiho Oncology Patient Assistance Program provides free medication to patients who are uninsured or underinsured. Assistance is based on eligibility and additional criteria.

HOW TO ENROLL–We offer 2 convenient ways to enroll in Taiho Oncology Patient Support services:

Download, Print, and Fax
Download and fill in the **Enrollment Form** from **TaihoPatientSupport.com**. Print it out and fax the completed form to **1-844-287-2559**.

By Phone
Call **1-844-TAIHO-4U** (1-844-824-4648) for help with enrollment.

Patient Support Website
Scan the QR code to visit **TaihoPatientSupport.com**.

FOUNDATION FINANCIAL ASSISTANCE[b]

FundFinder (fundfinder.panfoundation.org)

FundFinder is a free resource that provides information—all in one place—about various available patient assistance programs and notifies you when a disease fund opens at any of the charitable patient assistance foundations.

[a]Restrictions and eligibility: Offer valid in the US, Puerto Rico, and US territories only. Only valid for patients with private insurance. Offer not valid for prescriptions reimbursed under Medicaid, a Medicare drug benefit plan, TRICARE, or other federal or state programs (such as medical assistance programs). If the patient is eligible for drug benefits under any such program, this offer is not valid and the patient cannot use this offer. By presenting or accepting this benefit, patient and pharmacist agree not to submit claim for reimbursement under the above programs. Patient further agrees to comply with any and all terms of his or her health insurance contract requiring notification to his or her payer of the existence and/or value of this offer. It is illegal to or offer to sell, purchase, or trade this benefit. Maximum reimbursement limits apply; patient out-of-pocket expense may vary. Taiho Oncology, Inc., reserves the right to rescind, revoke, or amend this offer at any time without notice.

[b]Taiho Oncology does not influence or control the decisions of independent co-pay assistance foundations; each co-pay assistance foundation has its own criteria for patient eligibility. We cannot guarantee financial assistance.

Medicare beneficiaries will continue to see OOP costs capped at ~$2000 in 2026

TOTAL OOP COSTS BY YEAR[3-6]

	2024	2025	2026
Deductible	100% of drug costs up to $545	100% of drug costs up to $590	**100% up to $615**
Initial Coverage	25% of drug costs up to $5029 in total drug costs ($1121 OOP)	25% of drug costs up to $2000 OOP	**25% of drug costs up to $2100 OOP**
Coverage Gap	25% of drug costs up to ~$3300 OOP	None	**None**
Catastrophic Phase	None	None	**None**

[a]Assuming INQOVI or a similarly priced medication is taken the full calendar year.

Your patients may be eligible for financial assistance through the Medicare Extra Help program

Extra Help can help patients with limited income pay for medications and other related costs[7]

To qualify for Extra Help, annual income must be ≤150% of the federal poverty level (FPL).[8] This means **individuals must have an annual income ≤$23,475 and resources ≤$17,600 per year**. For **married couples, the annual income limit is ≤$31,725 and resources ≤$35,130 per year**.[7,8,a,b,c]

Everyone who qualifies for Extra Help will pay[5,9]:

- No monthly premium
- No Part D late enrollment penalty
- No annual deductible
- Reduced amount for generic and brand name drugs (see table below)

Extra Help Category[5]	Generic	Brand
Non–Dual-Eligible Beneficiaries	**$5.10**	**$12.65**
Dual-Eligible Beneficiaries With Income **≤100% FPL**	**$1.60**	**$4.90**
Dual-Eligible Beneficiaries With Income **>100% but ≤150% FPL**	**$5.10**	**$12.65**

How can you identify dual-eligible patients?

These patients carry cards for Medicare and Medicaid, as well as their prescription drug card.

Sample Medicaid State-Specific Card | Sample Medicare Card | Sample Prescription Drug Card

[a]FPL is as of 2025 and may increase in 2026. Annual income limits are higher in Alaska and Hawaii.[8]

[b]Income and resource limits vary according to the number of dependents living with the Medicare beneficiary and whether the beneficiary has income from work.[7]

[c]Resource limits are as of 2025 and may change in 2026. Resources include money in a checking or savings account, stocks, bonds, mutual funds, and Individual Retirement Accounts (IRAs). Resources do not include a primary residence, vehicles, household items, burial plots, up to $1500 for burial expenses (per person), or life insurance policies.[7,8]

References: 1. INQOVI. Prescribing Information. Taiho Oncology. Inc; 2022. **2.** Zeidan AM, Tsai JH, Karimi M, et al. Understanding what matters to myelodysplastic syndrome patients–a study of preferences for treatments with hypomethylating agents. Poster presented at: ASH (American Society of Hematology) Annual Meeting 2022; December 10-13, 2022; New Orleans, Louisiana. **3.** Final CY 2025 Part D Redesign Program Instructions. US Department of Health and Human Services. Accessed May 2, 2025. https://www.cms.gov/files/document/final-cy-2025-part-d-redesign-program-instructions.pdf **4.** Kaiser Family Foundation. Changes to Medicare Part D in 2024 and 2025 under the Inflation Reduction Act and how enrollees will benefit. Issue brief. April 20, 2023. Accessed July 8, 2024. https://www.kff.org/medicare/issue-brief/changes-to-medicare-part-d-in-2024-and-2025-under-the-inflation-reduction-act-and-how-enrollees-will-benefit/ **5.** Announcement of Calendar Year (CY) 2026 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. US Department of Health and Human Services. Accessed May 2, 2025. https://www.cms.gov/files/document/2026-announcement.pdf **6.** 2025 Medicare Part D Outlook. Q1Medicare. Accessed May 2, 2025. https://q1medicare.com/PartD-The-2025-Medicare-Part-D-Outlook.php **7.** Social Security Administration. Understanding the Extra Help With Your Medicare Prescription Drug Plan. Accessed May 2, 2025. https://www.ssa.gov/pubs/EN-05-10508.pdf **8.** 2025 Federal Poverty Level Guidelines (FPL): 2025/2026 LIS Qualifications and Benefits. Q1Medicare. January 13, 2024. Accessed April 22, 2025. https://q1medicare.com/news/Article.php?article=lis-extrahelp-qualifications-and-benefits-2025-fpl&article_id=1054&category_id=8 **9.** Medicare and You 2025. US Department of Health and Human Services. January 2025. Accessed May 2, 2025. https://www.medicare.gov/publications/10050-medicare-and-you.pdf

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IMPORTANT SAFETY INFORMATION (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

Myelosuppression (cont'd)

Myelosuppression (thrombocytopenia, neutropenia, anemia, and febrile neutropenia) is the most frequent cause of INQOVI dose reduction or interruption, occurring in 36% of patients. Permanent discontinuation due to myelosuppression (febrile neutropenia) occurred in 1% of patients. Myelosuppression and worsening neutropenia may occur more frequently in the first or second treatment cycles and may not necessarily indicate progression of underlying MDS.

Fatal and serious infectious complications can occur with INQOVI. Pneumonia occurred in 21% of patients, with Grade 3 or 4 occurring in 15%. Sepsis occurred in 14% of patients, with Grade 3 or 4 occurring in 11%. Fatal pneumonia occurred in 1% of patients, fatal sepsis in 1%, and fatal septic shock in 1%.

Obtain complete blood cell counts prior to initiation of INQOVI, prior to each cycle, and as clinically indicated to monitor response and toxicity. Administer growth factors and anti-infective therapies for treatment or prophylaxis as appropriate. Delay the next cycle and resume at the same or reduced dose as recommended.

Embryo-Fetal Toxicity

INQOVI can cause fetal harm. Advise pregnant women of the potential risk to a fetus. Advise patients to use effective contraception during treatment and for 6 months (females) or 3 months (males) after last dose.

ADVERSE REACTIONS

Serious adverse reactions in > 5% of patients included febrile neutropenia (30%), pneumonia (14%), and sepsis (13%). Fatal adverse reactions included sepsis (1%), septic shock (1%), pneumonia (1%), respiratory failure (1%), and one case each of cerebral hemorrhage and sudden death.

The most common adverse reactions (≥ 20%) were fatigue (55%), constipation (44%), hemorrhage (43%), myalgia (42%), mucositis (41%), arthralgia (40%), nausea (40%), dyspnea (38%), diarrhea (37%), rash (33%), dizziness (33%), febrile neutropenia (33%), edema (30%), headache (30%), cough (28%), decreased appetite (24%), upper respiratory tract infection (23%), pneumonia (21%), and transaminase increased (21%). The most common Grade 3 or 4 laboratory abnormalities (≥ 50%) were leukocytes decreased (81%), platelet count decreased (76%), neutrophil count decreased (71%), and hemoglobin decreased (55%).

USE IN SPECIFIC POPULATIONS

Lactation

Because of the potential for serious adverse reactions in the breastfed child, advise women not to breastfeed during treatment with INQOVI and for 2 weeks after the last dose.

Renal Impairment

No dosage modification of INQOVI is recommended for patients with mild or moderate renal impairment (creatinine clearance [CLcr] of 30 to 89 mL/min based on Cockcroft-Gault). Due to the potential for increased adverse reactions, monitor patients with moderate renal impairment (CLcr 30 to 59 mL/min) frequently for adverse reactions. INQOVI has not been studied in patients with severe renal impairment (CLcr 15 to 29 mL/min) or end-stage renal disease (ESRD: CLcr <15 mL/min).

Please see full Prescribing Information.

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