LATEST CV OUTCOMES DATA INSIDE:
A FOURIER subanalysis of recent MI patients

FOR PATIENTS WHO HAVE RECENTLY SUFFERED AN MI,

Add Repatha® today to help

PREVENT ANOTHER MI[1]

Indications

Prevention of Cardiovascular Events: In adults with established cardiovascular disease, Repatha® is indicated to reduce the risk of myocardial infarction, stroke, and coronary revascularization.

Primary Hyperlipidemia (including Heterozygous Familial Hypercholesterolemia): Repatha® is indicated as an adjunct to diet, alone or in combination with other lipid-lowering therapies (e.g., statins, ezetimibe), for the treatment of adults with primary hyperlipidemia to reduce low-density lipoprotein cholesterol (LDL-C).

Important Safety Information

Contraindication: Repatha® is contraindicated in patients with a history of a serious hypersensitivity reaction to Repatha®.
Serious hypersensitivity reactions including angioedema have occurred in patients treated with Repatha®.

Please see Important Safety Information throughout and click here for full Prescribing Information.

Repatha® (evolocumab) injection 140 mg/mL

FOR PATIENTS WITH ESTABLISHED CVD,

REPATHA® ADDED TO A STATIN *reduced the risk of composite CV events more than statins alone*[2,3]

Repatha® added to a statin was proven to reduce the risk of composite CV events by 20% in a median of only 2.2 years of follow-up, and the benefit improved over time[3]

FOURIER was a double-blind, randomized, placebo-controlled, event-driven trial in 27,564 adult patients with established cardiovascular disease and with LDL-C ≥70 mg/dL and/or non-HDL-C ≥100 mg/dL despite high- or moderate-intensity statin therapy. Patients received either subcutaneous injections of Repatha® (140 mg every 2 weeks or 420 mg once monthly) or placebo. On stable background lipid-lowering therapy, median LDL-C at baseline was 92 mg/dL.[3]

MI
27 % *RRR*[3]

Revascularization
22 % *RRR*[3]

- Primary composite endpoint of time to CV death, MI, hospitalization for unstable angina, stroke, or coronary revascularization: HR 0.85 (95% CI, 0.79-0.92; *P*<0.0001)[3]
- **Stroke = 21% RRR**[3]
- Key secondary composite endpoint of time to CV death, MI, or stroke: HR 0.80 (95% CI, 0.73-0.88).[3]
- Relative risk reductions for the primary and secondary composite endpoints were driven by a reduction in the risk of MI: HR 0.73 (95% CI, 0.65-0.82), stroke: HR 0.79 (95% CI, 0.66-0.95), and coronary revascularization: HR 0.78 (95% CI, 0.71-0.86)[3]
- **ARR of 2.0% in the overall Repatha CV Outcomes Trial study population was evaluated at 36 months**[2]
- **Observed HR for CV death: 1.05 (95% CI, 0.88-1.25) and hospitalizations due to unstable angina: 0.99 (95% CI, 0.82-1.18)**[3]

Important Safety Information

Allergic Reactions: Hypersensitivity reactions (e.g. angioedema, rash, urticaria) have been reported in patients treated with Repatha®, including some that led to discontinuation of therapy. If signs or symptoms of serious allergic reactions occur, discontinue treatment with Repatha®, treat according to the standard of care, and monitor until signs and symptoms resolve.

Adverse Reactions in Primary Hyperlipidemia (including HeFH): The most common adverse reactions (>5% of patients treated with Repatha® and occurring more frequently than placebo) were: nasopharyngitis, upper respiratory tract infection, influenza, back pain, and injection site reactions.

From a pool of the 52-week trial and seven 12-week trials: Local injection site reactions occurred in 3.2% and 3.0% of Repatha®-treated and placebo-treated patients, respectively. The most common injection site reactions were erythema, pain, and bruising.

Allergic reactions occurred in 5.1% and 4.7% of Repatha®-treated and placebo-treated patients, respectively. The most common allergic reactions were rash (1.0% versus 0.5% for Repatha® and placebo, respectively), eczema (0.4% versus 0.2%), erythema (0.4% versus 0.2%), and urticaria (0.4% versus 0.1%).

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HELP PREVENT A FUTURE CV EVENT TODAY

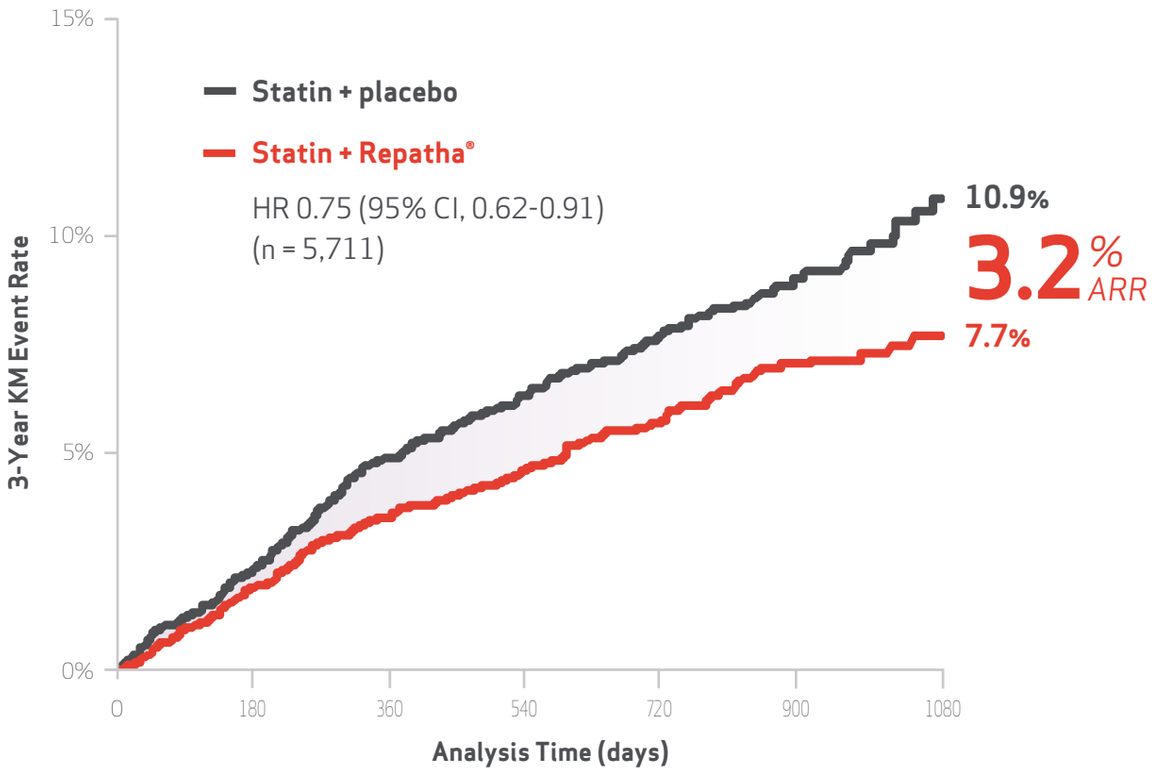
Patients **WITHIN 1 YEAR** *of their most recent MI are exposed to higher CV risk*[1,4,5]

LATEST CV OUTCOMES DATA

In a FOURIER subanalysis, statin + Repatha® provided greater ARR for patients who suffered an MI within 1 year compared to patients with a more distant MI[1]

RECENT MI

Key secondary endpoint: composite of CV death, MI, or stroke



For recent MI patients

ARR=**3.2%**

For distant MI patients

ARR=**1.3%**

ARR of 2.0% in the overall Repatha® CV Outcomes Trial study population was evaluated at 36 months[2]

- Analysis of 81% (N = 22,320) of patients in Repatha® CV Outcomes Trial with a prior MI[1,2]
- 5,711 patients who experienced an MI within 1 to 12 months of randomization were compared to 16,609 patients with a more distant MI (more than 12 months prior to randomization)[1]

Important Safety Information

Adverse Reactions in the Cardiovascular Outcomes Trial: The most common adverse reactions (>5% of patients treated with Repatha® and occurring more frequently than placebo) were: diabetes mellitus (8.8% Repatha®, 8.2% placebo), nasopharyngitis (7.8% Repatha®, 7.4% placebo), and upper respiratory tract infection (5.1% Repatha®, 4.8% placebo).

Among the 16,676 patients without diabetes mellitus at baseline, the incidence of new-onset diabetes mellitus during the trial was 8.1% in patients assigned to Repatha® compared with 7.7% in those assigned to placebo.

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RECENT MI PATIENTS ARE **COUNTING ON YOU**

Patients within 1 year of their most recent MI are exposed to higher CV risk[1,4,5]

1 yr

***Repatha® added to a statin* provided a *greater ARR* in patients who suffered a recent MI compared to those with a more distant MI.**[1]

For very high-risk* patients who have suffered a recent MI,

ACC/AHA guidelines consider an LDL-C of 70 mg/dL or greater as the threshold to trigger action and recommend the addition of a PCSK9 inhibitor like Repatha® to further lower LDL-C and future CV risk.[6†]

THE TIME TO DO MORE IS NOW.

ADD REPATHA® today to help prevent a future MI.[1]

*Very high risk includes a history of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions.[6]

†Class I: Add ezetimibe to maximal statin before adding a PCSK9 inhibitor; Class IIa: If on a clinically judged maximal LDL–C-lowering therapy and LDL-C ≥70 mg/dL, or non-HDL-C ≥100 mg/dL, adding a PCSK9 inhibitor is reasonable.[6]

Important Safety Information

Immunogenicity: Repatha® is a human monoclonal antibody. As with all therapeutic proteins, there is potential for immunogenicity with Repatha®.

ACC /AHA=American College of Cardiology/American Heart Association; **ARR**=absolute risk reduction; **ASCVD**=atherosclerotic cardiovascular disease; **CI**=confidence interval; **CV**=cardiovascular; **CVD**=cardiovascular disease; **HDL-C**=high-density lipoprotein cholesterol; **HR**=hazard ratio; **KM**=Kaplan-Meier; **LDL-C**=low-density lipoprotein cholesterol; **MI**=myocardial infarction; **PCSK9**=proprotein convertase subtilisin/kexin type 9; **RRR**=relative risk reduction.

References: 1. Gencer B, Mach F, Murphy SA, et al. Evolocumab and cardiovascular outcomes in patients with recent myocardial infarction: analysis from FOURIER. Poster presented at: American Heart Association Scientific Sessions; November 16-18, 2019; Philadelphia, PA. **2.** Sabatine MS, Giugliano RP, Keech AC, et al; for FOURIER Steering Committee and Investigators. Evolocumab and clinical outcomes in patients with cardiovascular disease. *N Engl J Med*. 2017;376:1713-1722. **3.** Repatha® (evolocumab) prescribing information, Amgen. **4.** Wang Y, Li J, Zheng X, et al. Risk factors associated with major cardiovascular events 1 year after acute myocardial infarction. *JAMA Netw Open*. 2018;1:e181079. doi:10.1001/jamanetworkopen.2018.1079 **5.** Jernberg T, Hasvold P, Henriksson M, Hjelm H, Thuresson M, Janzon M. Cardiovascular risk in post-myocardial infarction patients: nationwide real world data demonstrate the importance of a long-term perspective. *Eur Heart J*. 2015;36:1163-1170. **6.** Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA guideline on the management of blood cholesterol: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *J Am Coll Cardiol*. 2018: https://doi.org/10.1016/j.jacc.2018.11.003.

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