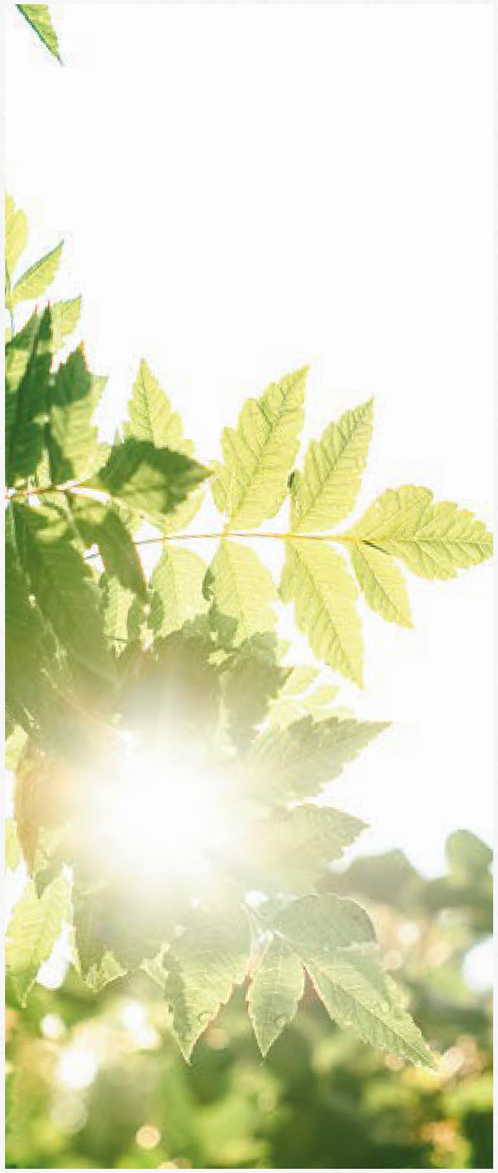
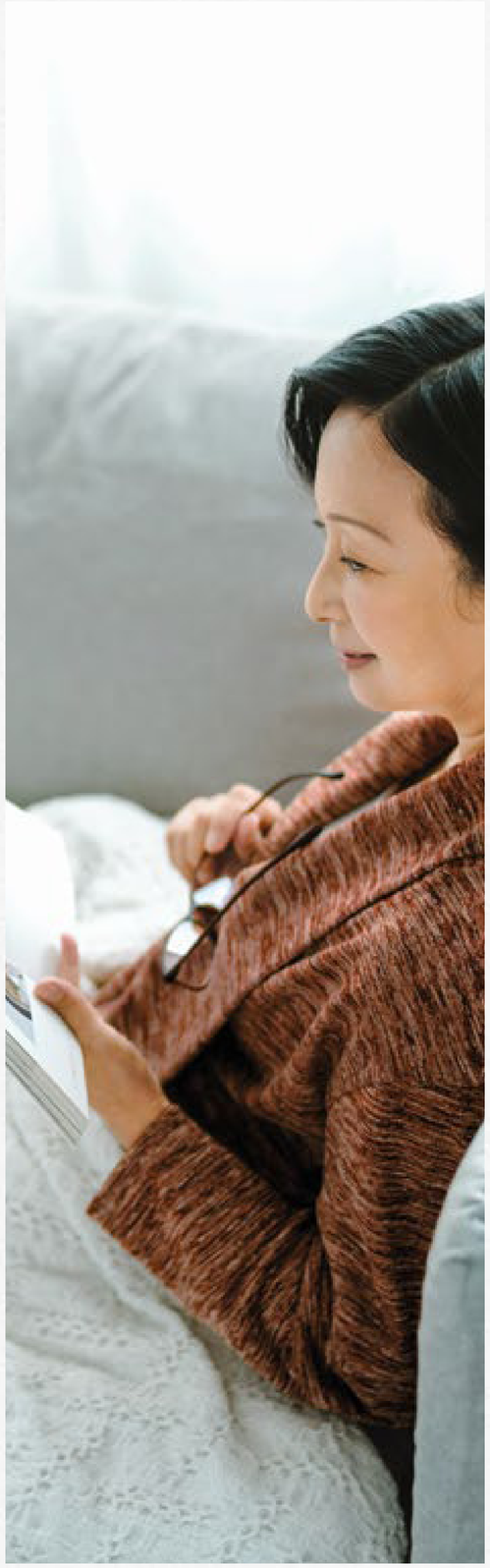




Eliquis™
apixaban

#1 OAC Globally[1–3]#

ELIQUIS™: THE EFFICACY AND SAFETY† I WOULD CHOOSE

Only Eliquis™ delivered both superior risk reduction in stroke/SE and major bleeding vs warfarin in AF[4,5‡]

Accounting for more patient treatment days prescribed* around the world than any other OAC within NVAF & VTE indications**

* Patient treatment days prescribed estimated based on the latest six month period, IQVIA MIDAS Q4'21 Sell-In/Sell-Out data. Standard Units divided by recommended administration of each NOAC within 24 hours. [apixaban BID, dabigatran BID, edoxaban QD, rivaroxaban QD]. VKA drugs treatment days estimated based on standard units divided by IQVIA MIDAS Medical average daily dose

** Indications accounted for by factoring standard unit volume based on IQVIA medical audit data and relevant WHO ICD10 codes

† Based on clinical trial data vs warfarin in patients with NVAF

‡ There are no head-to-head trials comparing NOACs

PP-ELI-HKG-1092 NOV 2022

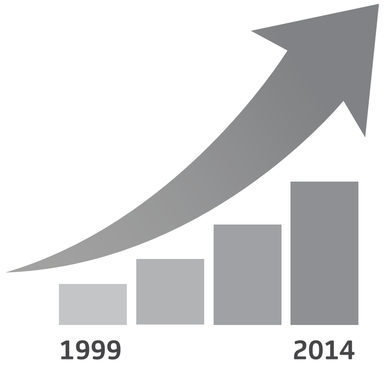
Atrial fibrillation (AF): Leading causes of stroke & a growing burden[6]

Approximately
33 million
people worldwide
suffer from AF[7]

In 2050, Asia will have ***72 million*** AF patients[8]

More than the combined numbers of patients from EU and USA[8]

About ***1 in 4*** Hong Kong stroke cases are AF-related[9]



AF-related stroke in Hong Kong increased by more than ***2.5-fold*** between 1999 and 2014[9]

In Hong Kong, about one-fourth of stroke cases are AF-related, which is more severe and has a higher mortality rate than other types of stroke.[9]

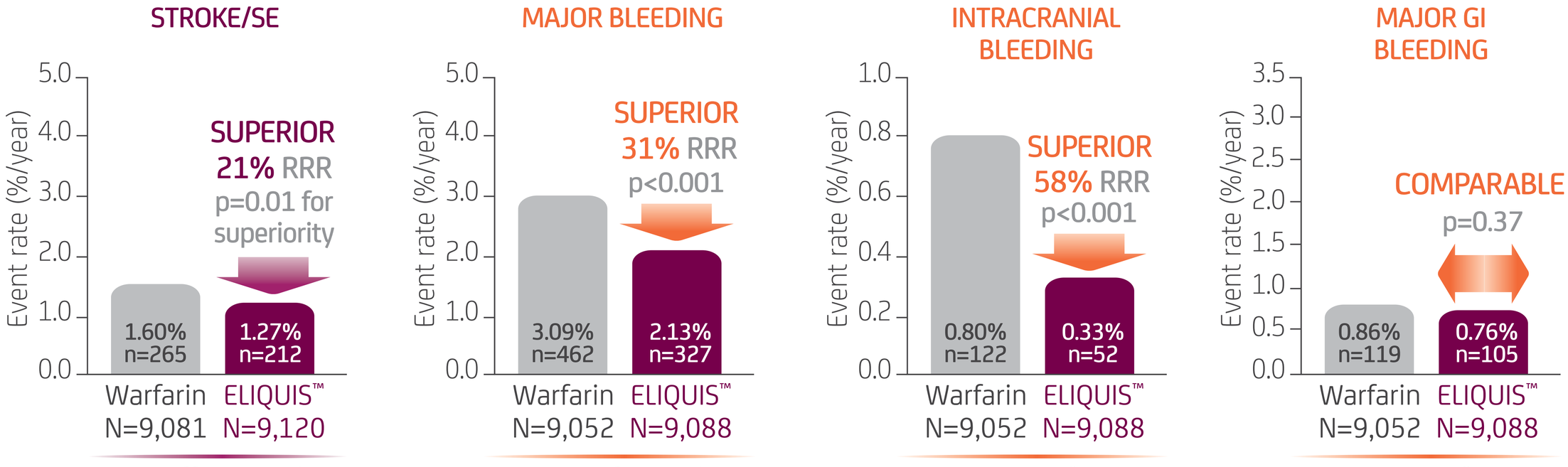
The term “AF” used in this document excludes moderate-severe mitral stenosis and mechanical heart valves.

International guidelines recommend NOACs for stroke prevention in AF

	ESC (2020)[10]	CHEST (2018)[11]	AHA/ACC/HRS (2019)[12]
Stroke risk prediction in AF	The **CHA_2DS_2-VASc score** is recommended *(Grade IA)*	The **CHA_2DS_2-VASc score** is recommended *(Strong recommendation, moderate quality evidence)*	The **CHA_2DS_2-VASc score** is recommended, except in patients with moderate-to-severe mitral stenosis or a mechanical heart valve *(Grade IB)*
Pharmacologic therapy	• In eligible patients, **NOACs are preferred over warfarin** *(Grade IA)* • For CHA_2DS_2-VASc score of ≥2 in men or ≥3 in women, **OACs are recommended** *(Grade IA)* • **Antiplatelet monotherapy is not recommended** for stroke prevention *(Grade IIIA)*	• **NOACs are recommended over VKA** in eligible patients *(Strong recommendation, moderate quality evidence)* • In patients on VKAs with consistently low time in INR TTR, **switching to a NOAC is recommended** *(Strong recommendation, moderate quality evidence)*	• **NOACs are recommended over warfarin** in eligible patients *(Grade IA)* • For patients unable to maintain a therapeutic INR level with warfarin, **NOACs are recommended** *(Grade IC-EO*)*

* C-EO, consensus of expert opinion

ARISTOTLE trial[4]: ELIQUIS™ provides superior stroke protection and major bleeding profile versus warfarin in patients with AF



Adapted from Granger et al. 2011[4]

In addition to superior stroke and major bleeding protection, ELIQUIS™ significantly reduced mortality versus warfarin in AF patients (11% RRR; p=0.047).[4,13]

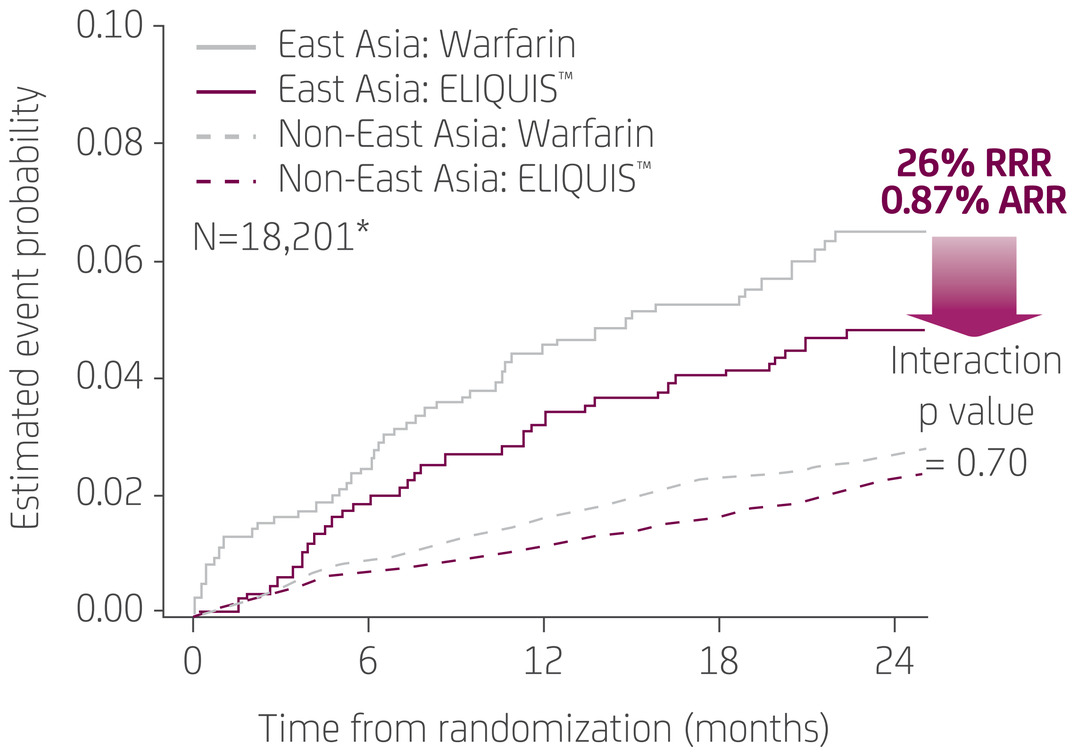
GI bleeding is one of the most frequent adverse events associated with OAC use.[14]
ELIQUIS™ is the only factor Xa inhibitor that does not increase GI bleeding versus warfarin.[4,10]*

*There are no head-to-head trials comparing NOACs

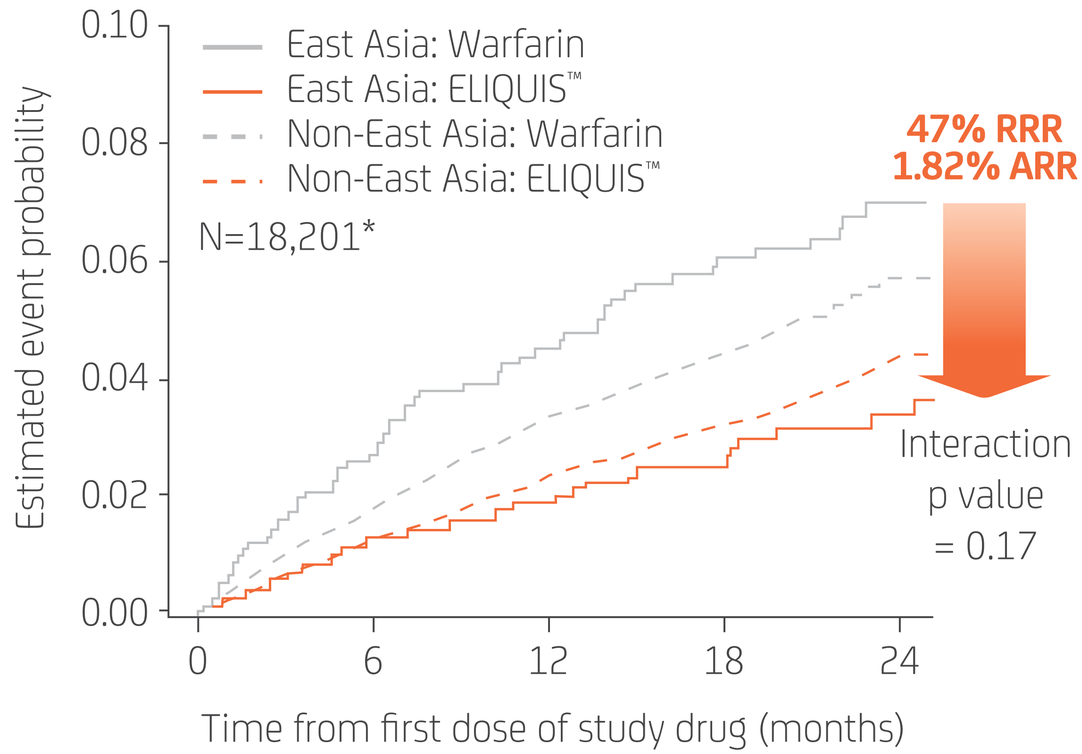
ELIQUIS™ provides consistent benefits in East Asian AF patients

- The efficacy and safety of ELIQUIS™ over warfarin were at least similar in magnitude for East Asian versus non-East Asian patients with NVAF.[15]
- There was a **greater reduction in major bleeding** with ELIQUIS™ versus warfarin in East Asian compared with non-East Asian patients.[15]

PRIMARY EFFICACY ENDPOINT: STROKE/SE



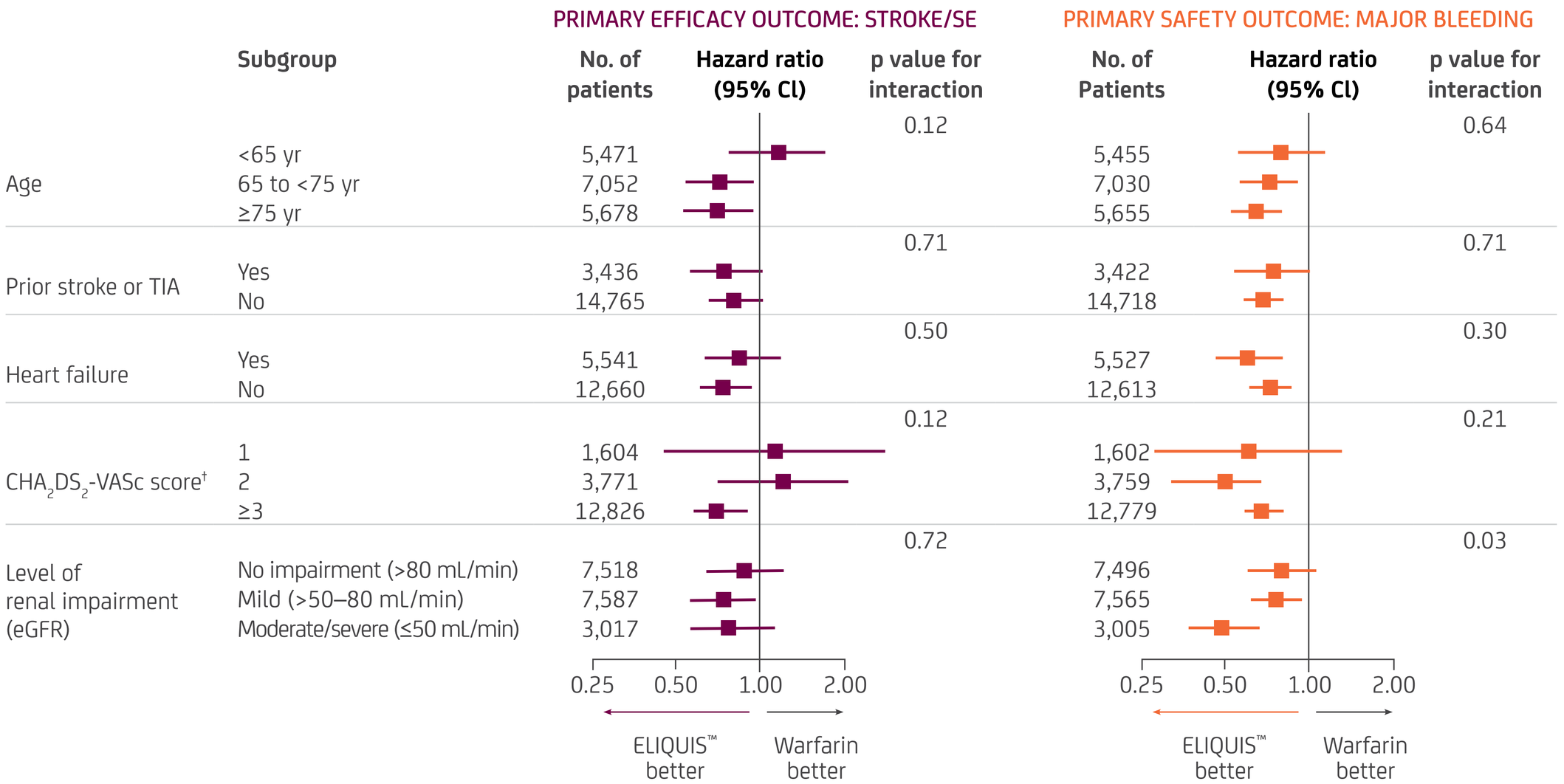
PRIMARY SAFETY ENDPOINT: MAJOR BLEEDING



* Of the 18,201 patients enrolled in ARISTOTLE, 1,993 patients were recruited from East Asia.
Adapted from Goto et al. 2014[15]

ELIQUIS™ provides consistent benefits across a variety of AF patients

The ARISTOTLE trials showed that AF patients treated with ELIQUIS™ had **consistently fewer strokes and bleeds** versus warfarin **across a variety of subgroup populations and risk profiles**.[4,16]*



* As assessed by CHA_2DS_2-VASc scores[16]

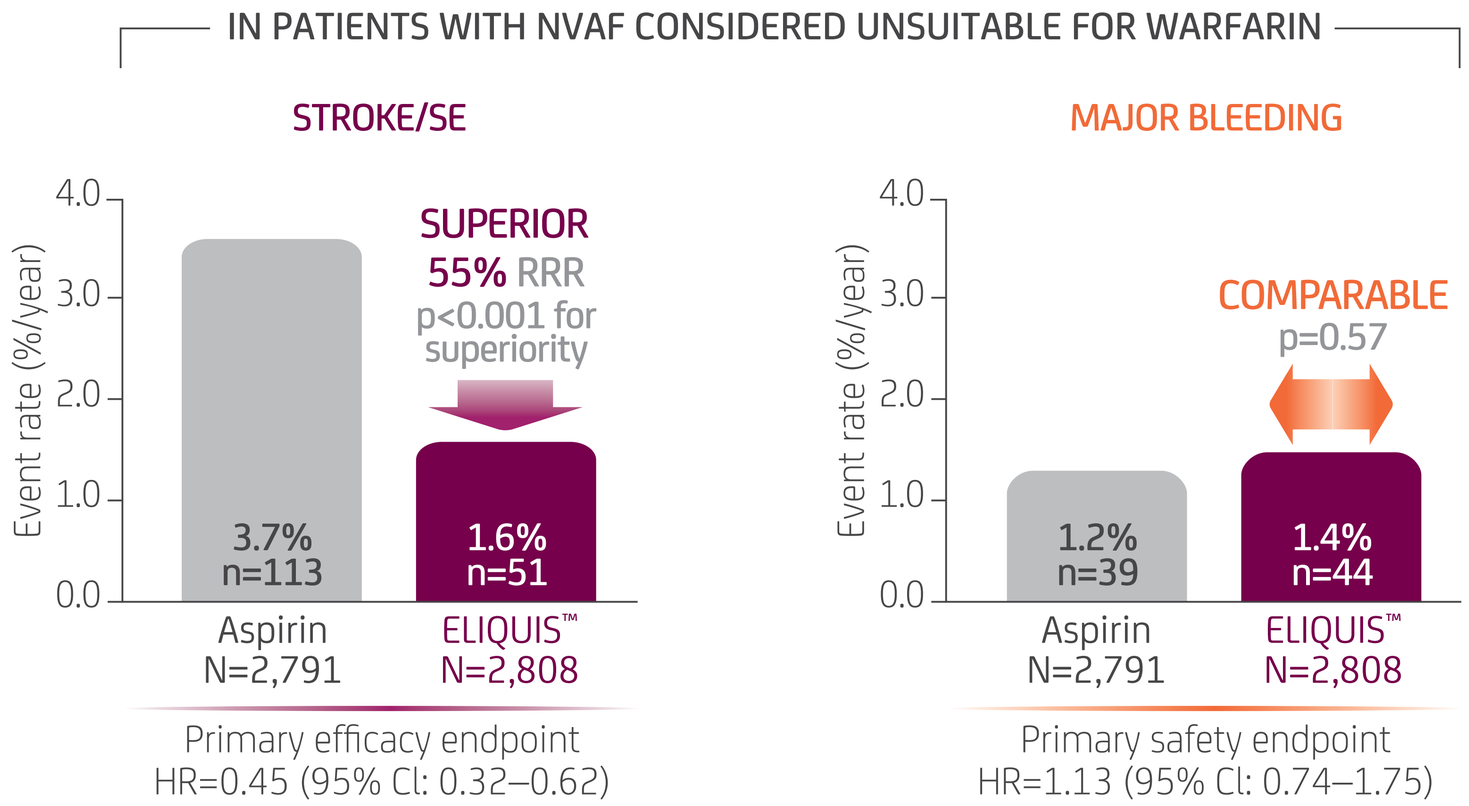
† The ARISTOTLE trial was not designed or powered to detect interactions between study drug and CHA_2DS_2-VASc score subgroups. This was because the date of CHA_2DS_2-VASc score validation was not until February 2010 after the initiation of ARISTOTLE[16]

Adapted from Granger et al. 2011[4] and Lopes et al. 2012[16]

ELIQUIS™ provides clear benefit versus aspirin in AF patients unsuitable for warfarin

ELIQUIS™ is the only NOAC compared with aspirin for stroke prevention in AF.[17]*

- AVERROES was terminated early due to clear benefit in favor of ELIQUIS™ for the primary endpoint.[17]
- In a subgroup analysis, ELIQUIS™ provided **greater relative and absolute benefits in stroke/SE risk reduction in the elderly (≥75 years)** with no greater risk of bleeding, compared with younger patients.[18]

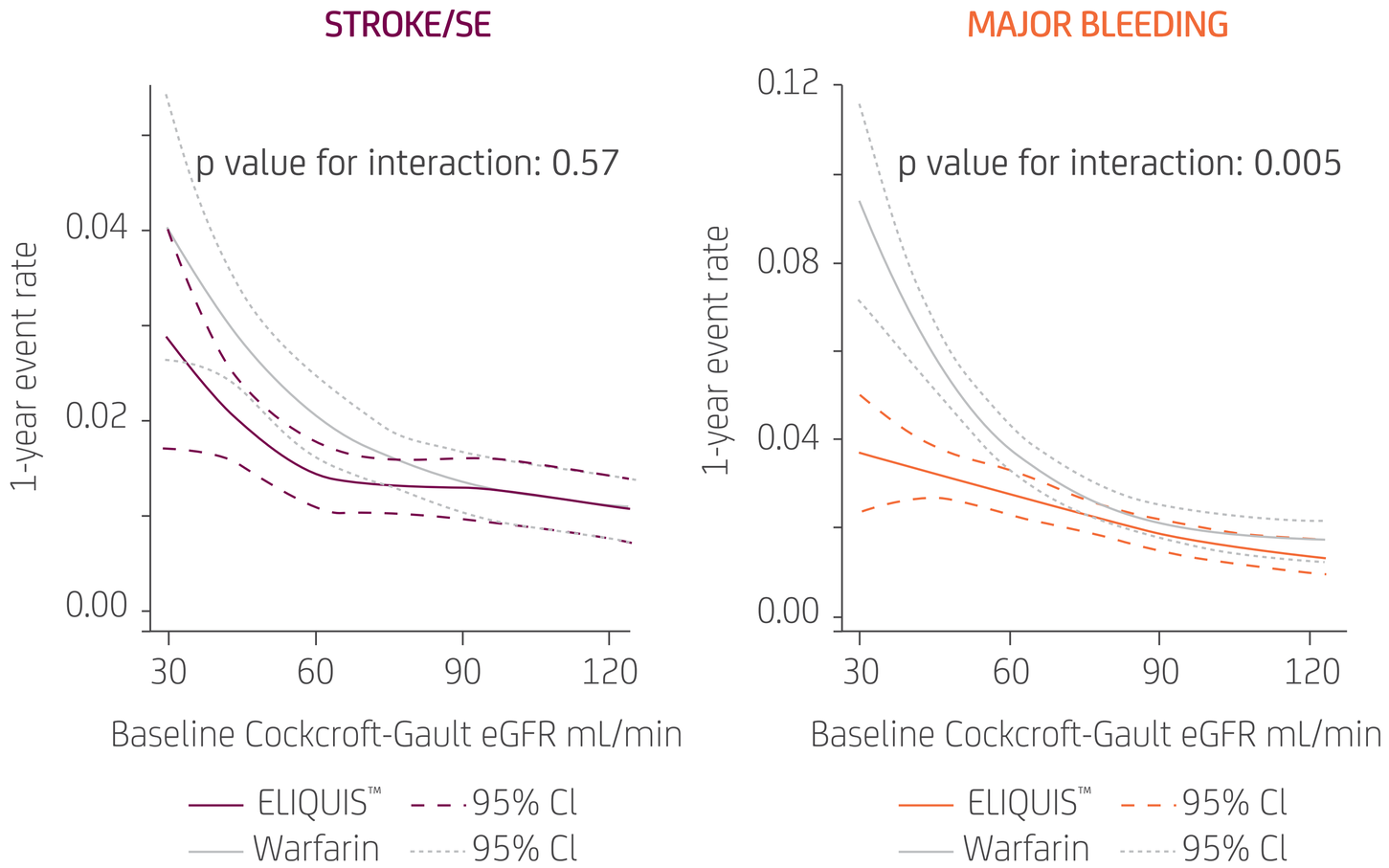


Adapted from Connolly et al. 2011[17]

* There are no head-to-head trials comparing NOACs.

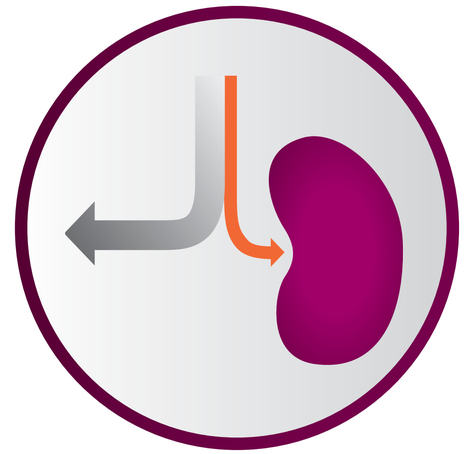
ELIQUIS™ is effective and well tolerated across AF patients with eGFR of ≥30 mL/min[19]

- ELIQUIS™ reduced the rate of stroke, death, and major bleeding versus warfarin, regardless of renal function.[19]
- The RRR in major bleeding was greater in patients with moderate-to-severe renal impairment than in those with no or mild renal impairment.[4,19]



ELIQUIS™ has the lowest renal excretion among NOACs[10]

27% renally cleared



Adapted from Hohnloser et al. 2012[19]

Choosing the right dose[20,21]

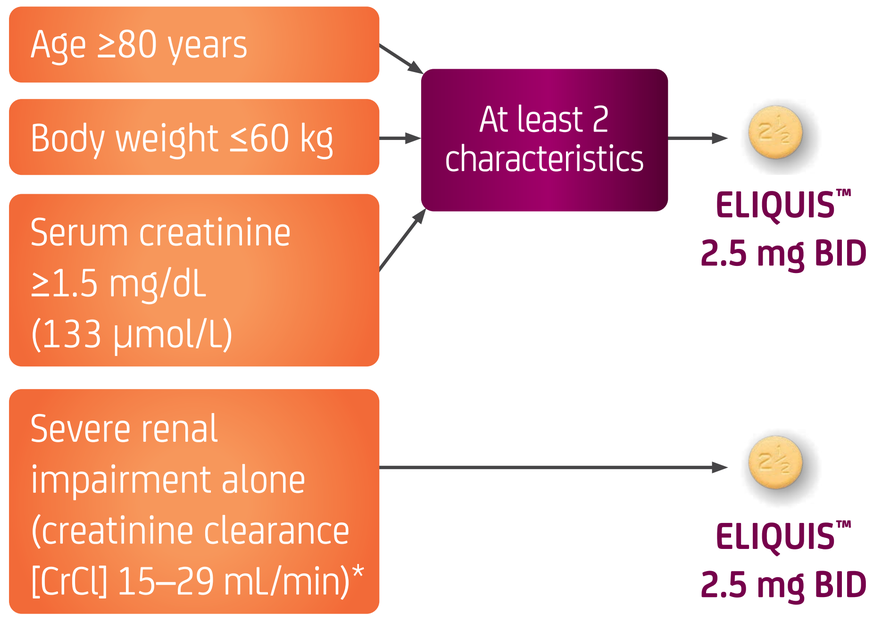
For prevention of stroke/SE in patients with NVAF, with one or more risk factors

The recommended dose of ELIQUIS™ for NVAF is **5 mg BID** taken orally with water

MORNING
ELIQUIS™ 5 mg

EVENING
ELIQUIS™ 5 mg

ELIQUIS™ dosage should be reduced to **2.5 mg BID** in patients with the following:



Tablets shown are not actual size.
* No dosing adjustment for patients with mild (CrCl 51–80 mL/min) or moderate (CrCl 30–50 mL/min) renal impairment

Adapted from ELIQUIS™ Prescribing Information 2021[20,21]

ELIQUIS™: The safer choice[4*]

Only ELIQUIS™ delivered superior risk reduction in stroke/SE and major bleeding versus warfarin in AF.[4,5#]

ELIQUIS™ 5 mg BID:

Demonstrates **superior stroke prevention and bleeding risk reduction** over warfarin.[4]

Has consistent efficacy and safety data in both **Asian and non-Asian** patients with AF.[4,13,15]

Provides **consistent benefits** across a variety of AF patients.[4]

Is recommended as the preferred agent in patients with **advanced age** (>75 years).[22]

Is recommended as one of the preferred agents in patients with **renal impairment** (CrCl 30–49 mL/min).[22]

Is recommended as one of the preferred agents in patients with **high GI bleeding risk**.[22]

* ELIQUIS™ significantly lowers the risk of major bleeding in AF compared to warfarin.
\# There are no head-to-head trials comparing NOACs

Eliquis™ apixaban

ACC, American College of Cardiology; AF, atrial fibrillation; AHA, American Heart Association; ARR, absolute risk reduction; BID, twice daily; CI, confidence interval; CrCl, creatinine clearance; eGFR, estimated glomerular filtration rate; ESC, European Society of Cardiology; ESRD, end-stage renal disease; GI, gastrointestinal; HR, hazard ratio; HRS, Heart Rhythm Society; INR, international normalized ratio; MS, mitral stenosis; NOAC, non-VKA oral anticoagulant; NVAF, non-valvular atrial fibrillation; OAC, oral anticoagulant; RRR, relative risk reduction; SE, systemic embolism; TIA, transient ischemic attack; TTR, time in therapeutic range; VKA, vitamin K antagonist

References 1. IQVIA MIDAS Sales Data Q4'21 Sell-In/Sell-Out data. **2.** IQVIA MIDAS Summary and Detailed Medical Data Q4'21. **3.** NOAC recommended administration within 24 hour period [apixaban BID, dabigatran BID, edoxaban QD, rivaroxaban QD] **4.** Granger CB, et al. *N Engl J Med* 2011;365:981-992. **5.** Ruff CT, et al. *Lancet* 2014;383:955-962. **6.** Lippi G, et al. *Int J Stroke* 2021;16:217-221. **7.** Aggarwal N, et al. *Neurol Res Int* 2015;2015:374352. **8.** Chiang CE, et al. *EP Europace* 2015;17(Suppl 2):ii31-ii39. **9.** Soo Y, et al. *J Neurol Neurosurg Psychiatry* 2017;0:1-5. **10.** Hindricks G, et al. *Eur Heart J* 2021;42:373-498. **11.** Lip GYH, et al. *Chest* 2018;154:1121-1201. **12.** January CT, et al. *Heart Rhythm* 2019;pii:S1547-5271(19)30037-2. **13.** Hylek EM, et al. *J Am Coll Cardiol* 2014;63:2141-2147. **14.** Caldeira D, et al. *Aliment Pharmacol Ther* 2015;42:1239-1249. **15.** Goto S, et al. *Am Heart J* 2014;168:303-309. **16.** Lopes RD, et al. *Lancet* 2012;380:1749-1758. **17.** Connolly SJ, et al. *N Engl J Med* 2011;364:806-817. **18.** Ng KH, et al. *Age Ageing* 2016;45:77-83. **19.** Hohnloser SH, et al. *Eur Heart J* 2012;33:2821-2830. **20.** ELIQUIS™ (apixaban) 2.5 mg Prescribing Information. Pfizer Corporation Hong Kong Limited. Version: Jun 2021. **21.** ELIQUIS™ (apixaban) 5 mg Prescribing Information. Pfizer Corporation Hong Kong Limited. Version: Sep 2021. **22.** Diener HC, et al. *Eur Heart J* 2017;38:860-868.

Scan the QR codes or type the URLs in your browser to find the full Prescribing Information of apixaban:

Apixaban (2.5 mg)

https://www.pfi.sr/Jzi

Apixaban (5 mg)

https://www.pfi.sr/JzT

The QR codes/URL links to the latest Prescribing Information approved by the Department of Health in Hong Kong and may not be effective and the same as presented in the actual product package.

21/F, Kerry Centre, 683 King's Road, Quarry Bay, Hong Kong
Tel: (852) 2811 9711 Fax: (852) 2579 0599
Website: www.Pfizer.com.hk | HCP Portal: www.PfizerPro.com.hk
Copyright © 2022 Pfizer Corporation Hong Kong Limited. All Rights Reserved.
PP-ELI-HKG-1092 NOV 2022

Pfizer