FOR TODAY

Heart failure and chronic kidney disease in T2DM remains a substantial unmet need

The heart and kidneys are **interlinked.** **3 in 5** of the earliest complications in T2DM patients are heart failure and chronic kidney disease[1].

Your treatment choice today can change your patients' outcomes tomorrow

Early

Heart failure is one of the **earliest CV complications** in T2DM[2]

Frequent

Over 2 in 3 T2DM patients will develop heart damage within 5 years of their diagnosis[3]

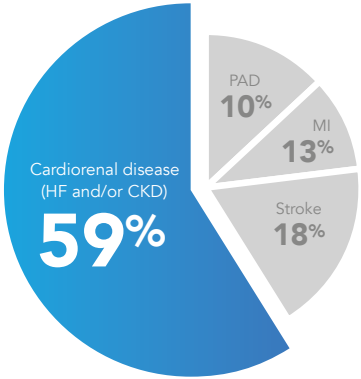
Fatal

Only 1 in 8 T2DM patients with heart failure will survive for 5 years or more[4]

Over 2 in 5 T2DM patients will develop chronic kidney disease (CKD)[5]

Patients with CKD are **6 times more likely to die from heart disease** than developing ESRD[6]

INITIAL CV DISEASE MANIFESTATION IN T2DM PATIENTS[1]



Adapted from Birkeland KI et al. 2019.

forxiga®
dapagliflozin

FOR TOMORROW

DECLARE A BETTER TOMORROW

Forxiga® – Your Cardio-renal Guardian

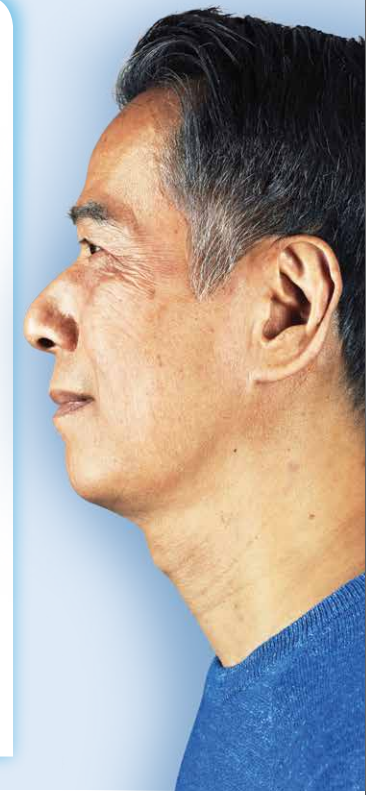
Reduction in cardiorenal events observed in T2DM patients[7]

↓17%
CV death or hospitalisation for HF*

↓24%
Cardiorenal composite endpoint†

↓47%
Renal-specific composite endpoint‡

Reassured safety profile of Forxiga®[7]



* hHF alone was a separate, nominally significant exploratory endpoint in the DECLARE trial – the primary endpoint composite of CV death/hHF was driven by hHF.

† Composite of cardiorenal events (≥40% decrease in eGFR to <60 ml/min/1.73 m², new end-stage renal disease, or death from renal or cardiovascular causes). Nominally significant, prespecified exploratory outcome.

‡ Composite of renal events (≥40% decrease in eGFR to <60 ml/min/1.73 m², new end-stage renal disease, or death from renal causes). Nominally significant, prespecified exploratory outcome.

CKD=chronic kidney disease. CV=cardiovascular. CVD=cardiovascular disease. ESRD=end-stage renal disease. HF=heart failure. MI=myocardial infarction. PAD=peripheral arterial disease. SGLT2i=sodium-glucose cotransporter 2 inhibitors. T2DM=type 2 diabetes mellitus.

Reference: 1. Birkeland KI et al. Presented at: 79th American Diabetes Association's Scientific Sessions 2019. **2.** Shah AD, et al. Lancet Diabetes Endocrinol 2015;3:105–13. **3.** Faden G, et al. Diabetes Res Clin Pract 2013;101:309–16. **4.** Bertoni AG, et al. Diabetes Care 2004;27:699–703. **5.** Alicic RZ, et al. Clin J Am Soc Nephrol 2017;12:2032–45. **6.** Dalrymple L, et al. J Gen Intern Med 2011;26:379–85. **7.** Wiviott SD, et al. N Engl J Med 2019;380:347-57.

Abridged Prescribing Information (API)
FORXIGA® (dapagliflozin)
Composition: Dapagliflozin propanediol monohydrate film coated tablet, 5 mg or 10 mg. **Therapeutic Indications:** For the treatment of insufficiently controlled type 2 diabetes mellitus in adults as an adjunct to diet and exercise, either as monotherapy when metformin is considered inappropriate due to intolerance, or in addition to other medicinal products for the treatment of type 2 diabetes. **Dosage and Administration:** Recommended dose is 10 mg to be taken orally once daily at any time of day with or without food. Tablets are to be swallowed whole. In patients with severe hepatic impairment, a starting dose of 5 mg is recommended. **Contraindications:** Hypersensitivity to the active substance or to any of its excipients. **Warnings and Precautions:** Renal function, risk of volume depletion and/or hypotension should be taken into account in patients. Dosage of insulin and sulphonyluerea (SU) may need to be readjusted to reduce the risk of hypoclycaemia. May add to the diuretic effect of thiazide and loop diuretics and may increase the risk of dehydration and hypotension. Use with caution in patients with increased risk of diabetic ketoacidosis; on anti-hypertensive therapy with a history of hypotension; elderly (≥ 65 years). Treatment should be temporarily interrupted when volume depleted; when treating pyelonephritis or urosepsis; in patients who are hospitalized for major surgical procedures or acute serious medical illnesses, until ketone values are normal. Should not be initiated in patients with a GFR < 60 ml/min; with type 1 diabetes; with hereditary problems of galactose intolerance, the total lactase deficiency, or glucose-galactose malabsorption. Discontinue if GFR is persistently below 45 ml/min; if suspected or diagnosed diabetic ketoacidosis; if Fournier's gangrene is suspected; when pregnancy is detected; while breast-feeding. Limited or no data in cardiac failure; pregnancy; and paediatric population. **Adverse Reactions:** Very common: hypoglycaemia when used with SU or insulin. Common: vulvovaginitis, balanitis and related genital infections, urinary tract infection, dizziness, rash, back pain, dysuria, polyuria, dyslipidaemia, decreased creatinine renal clearance (during initial treatment), and increased haematocrit. Uncommon: Fungal infection, volume depletion, thirst, constipation, dry mouth, nocturia, vulvovaginal and genital pruritus, increased blood creatinine (during initial treatment), increased blood urea, and decreased weight. Rare: diabetic ketoacidosis. Very rare: necrotising fasciitis of the perineum (Fournier's gangrene), angioedema. Not known: acute kidney injury. **Drug interaction:** Coadministration with rifampicin may reduce dapagliflozin systemic exposure; coadministration with mefenamic acid may increase dapagliflozin systemic exposure. Monitoring glycaemic control with 1,5-AG assay is not recommended in patients taking SGLT2 inhibitors. **Storage:** Store below 30 ˚C. **Local prescribing information is available upon request. API.HK.FOR.0720**

Please contact HKPatientSafety@astrazeneca.com for reporting of Individual Case Safety Report (ICSR) to AstraZeneca Hong Kong Limited.
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