For adults with **moderately to severely active UC** who are **ready for advanced therapy***[1]

VELSIPITY is an **oral first-line** advanced treatment* with **no boxed warning**[1]

Contraindicated in patients with specific cardiovascular conditions. Select Warnings & Precautions: Infections, Bradyarrhythmia & AV Conduction Delays, Liver Injury. See USPI.[1]

*Advanced therapies include S1P receptor modulators, biologics, and JAKi.[3]

Trial Design[1,3]: Adult patients with moderately to severely active UC (an mMS of 5 to 9) were randomized to VELSIPITY or placebo in 2 randomized, multicenter, double-blind, placebo-controlled, phase 3 trials after an inadequate response, a loss of response, or an intolerance to ≥1 predefined UC therapies (oral aminosalicylates [5-ASAs], corticosteroids, thiopurines, JAKi, and biologics) (N=741). A modified Mayo score (an mMS of 0 to 9) consists of stool frequency (0 to 3), rectal bleeding (0 to 3), and findings on a centrally read endoscopy score (0 to 3). Primary analyses were conducted at week 12 and at week 52 in UC-1 and at week 12 in UC-2. Concomitant use of stable doses of oral aminosalicylates and/or oral corticosteroids (≤20 mg/day prednisone, ≤9 mg/day budesonide, or equivalent steroid) was permitted. Concomitant therapies not permitted were immunomodulators, biologic therapies, JAKi, rectal 5-ASAs, or rectal corticosteroids.

†Co-primary endpoints: Clinical remission at week 12 and at week 52. Clinical remission was defined as a stool frequency (SF) subscore of 0 or 1, a rectal bleeding (RB) subscore of 0, and an endoscopy score (ES) ≤1 (excluding friability). Clinical remission: UC-1: At week 12, 27% (74/274) vs 7% (9/134) with placebo. At week 52, 32% (88/274) vs 7% (9/134) with placebo. UC-2: At week 12, 26% (57/221) vs 15% (17/112) with placebo.[1]

AV=atrioventricular.

INDICATION

VELSIPITY is indicated for the treatment of moderately to severely active ulcerative colitis (UC) in adults.

IMPORTANT SAFETY INFORMATION

Contraindications

- Patients in the last 6 months who experienced myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III or IV heart failure
- Patients with a history or presence of Mobitz type II second-degree or third-degree AV block, sick sinus syndrome, or sino-atrial block, unless the patient has a functioning pacemaker

Infections

VELSIPITY may increase the susceptibility to infections. Life-threatening and rare fatal infections have been reported in association with other sphingosine 1-phosphate (S1P) receptor modulators. Before starting VELSIPITY, obtain a recent (i.e., within 6 months) CBC, including lymphocyte count. Delay initiation of VELSIPITY in patients with an active infection until the infection is resolved. Consider interruption of treatment with VELSIPITY if a patient develops a serious infection. Continue monitoring for infections up to 5 weeks after discontinuing VELSIPITY.

- **Progressive multifocal leukoencephalopathy (PML)** is an opportunistic viral infection of the brain that typically occurs in patients who are immunocompromised, and usually leads to death or severe disability. PML has been reported in multiple sclerosis (MS) patients treated with S1P receptor modulators. If PML is suspected, suspend VELSIPITY and discontinue if PML is confirmed by appropriate diagnostic evaluation. Immune reconstitution inflammatory syndrome (IRIS) has been reported in patients with MS treated with S1P receptor modulators who developed PML and discontinued treatment. Clinical decline may be rapid, can lead to serious neurological complications or death, and is often associated with characteristic MRI changes. Onset was generally within a few months after S1P receptor modulator discontinuation. Monitoring for IRIS should be undertaken.

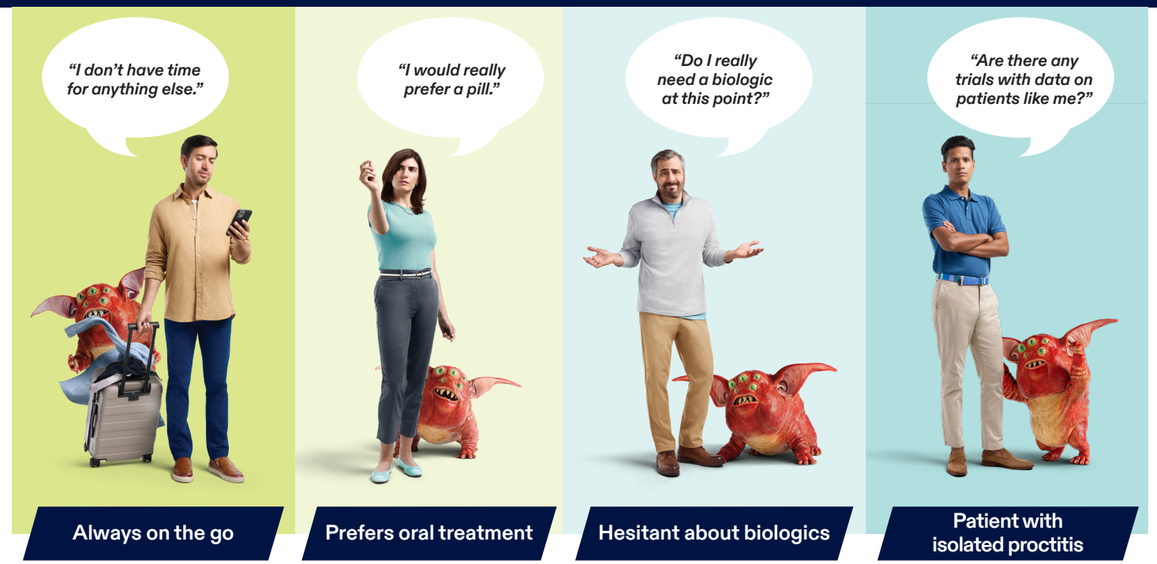
Visit **VELSIPITYhcp.com** to learn more.

Please see full Prescribing Information, including Medication Guide, in pocket.

Pfizer

For adults with moderately to severely active UC

What's next for these **patients** who are **ready for first-line advanced therapy***?



Not actual patients.

VELSIPITY—an S1P receptor modulator that is one pill, once daily, with no titration required—can offer your patients[1]:

- **Same dose from the start—no titration**; following baseline assessments[1†]
- **One 2-mg pill, taken once daily**[1]
- Periodic monitoring for certain potential safety signals, **with no required scheduled monitoring**[1‡]
- **Samples**[§]

*Advanced therapies include S1P receptor modulators, biologics, and JAKi.[3]
†Baseline assessments include blood work, electrocardiogram (ECG or EKG), ophthalmic assessment, current medications, prior vaccinations, and skin exam.[1]
‡Eg, infections, eye exam, blood pressure, and skin exam.[1]
§Upon request. Availability may vary.
S1P=sphingosine 1-phosphate.

IMPORTANT SAFETY INFORMATION (cont'd)

Infections (cont'd)

- **Herpes simplex encephalitis, varicella zoster meningitis, and localized herpes viral infections** have been reported with S1P receptor modulators. In UC-1, herpes zoster was reported in 0.7% of subjects treated with VELSIPITY and in none of the subjects who received placebo. Patients without a healthcare professional-confirmed history of varicella (chickenpox), or without documentation of a full course of vaccination against varicella zoster virus (VZV), should be tested for antibodies to VZV before initiating VELSIPITY. A full course of VZV vaccination for antibody-negative patients is recommended prior to commencing treatment with VELSIPITY.
- Cases of fatal **cryptococcal meningitis (CM) and disseminated cryptococcal infections** have been reported with S1P receptor modulators. VELSIPITY treatment should be suspended until a cryptococcal infection has been excluded. If CM is diagnosed, appropriate treatment should be initiated.
- VELSIPITY has not been studied in combination with anti-neoplastic, immune-modulating, or non-corticosteroid immunosuppressive therapies. Avoid concomitant administration of these therapies with VELSIPITY.
- Update immunizations according to current guidelines prior to VELSIPITY treatment. Avoid the use of live attenuated vaccines during and for 5 weeks after treatment with VELSIPITY. If live attenuated vaccine immunizations are required, administer at least 4 weeks prior to initiation of VELSIPITY.

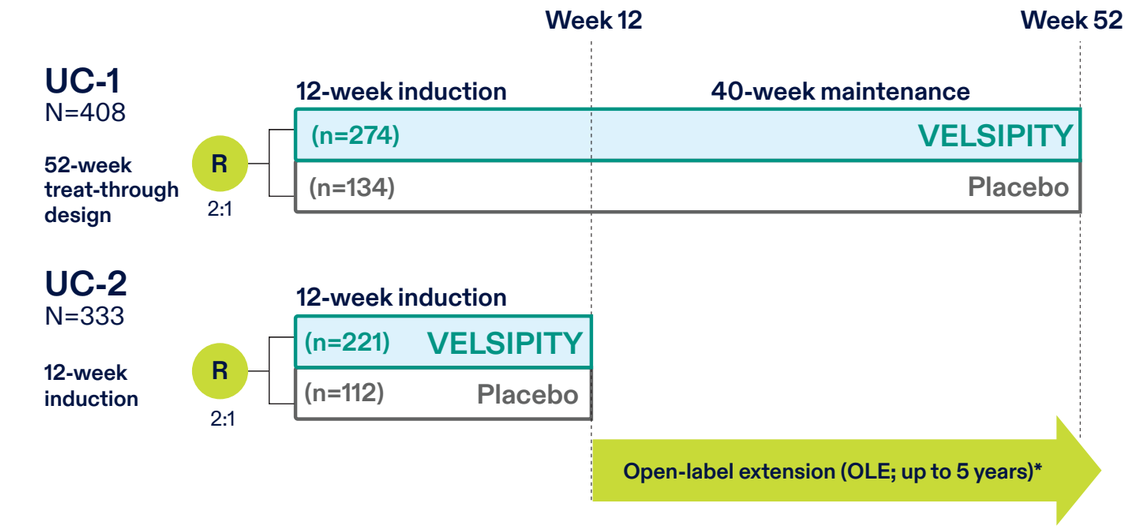
Please see full Prescribing Information, including Medication Guide, in pocket.

In adults with moderately to severely active UC

VELSIPITY was **evaluated for efficacy and safety** in two phase 3 trials

Velsipity® (etrasimod) 2mg tablets

UC-1 and UC-2 were randomized, double-blind, placebo-controlled trials[1,3]



Primary efficacy analysis was done in patients with an mMS† of 5 to 9.[1]

Primary endpoints[1]: Clinical remission at week 12 (UC-1 and UC-2) and at week 52 (UC-1)

Select key secondary endpoints[1,3]: Corticosteroid-free remission (UC-1), symptomatic remission, and endoscopic improvement

Other prespecified secondary endpoint[3]: Clinical response

Select inclusion criteria[1,3]**:**

- Adults with moderately to severely active UC with an inadequate response, a loss of response, or an intolerance to ≥1 treatment options: oral aminosalicylates, corticosteroids, thiopurines, JAKi, or biologics (eg, TNF blockers, anti-integrins, and anti-IL 12/23)
- Disease severity was assessed in patients with a modified Mayo score (mMS)† of 5 to 9 at baseline
- Concomitant use of select UC therapies‡ was permitted, including stable daily doses of oral 5-ASAs and/or oral corticosteroids
- Patients with isolated proctitis were allowed to enroll (<10 cm of rectal involvement at baseline and met all other criteria)

Select exclusion criteria[1]**:**

- Concomitant treatment with immunomodulators, biologics, JAKi, rectal 5-ASAs, or rectal corticosteroids

To see more information, including baseline characteristics, endpoint definitions, and inclusion and exclusion criteria, visit **VELSIPITYhcp.com/trial-design**.

*In UC-1, patients whose disease had not improved or had worsened vs baseline (per investigator judgment), could discontinue treatment and, if objective disease worsening criteria were met (having an RB subscore ≥2 or an RB subscore and an SF subscore ≥4 at 2 time points ≥7 and ≤14 days apart), enroll in the OLE. In UC-2, at the end of week 12, patients could enroll in the OLE. In both trials, patients who did not enroll in the OLE entered a 4-week follow-up period, with visits at week 2 and at week 4.[3]
†Modified Mayo score (an mMS of 0 to 9) consists of stool frequency (0 to 3), rectal bleeding (0 to 3), and findings on a centrally read endoscopy score (0 to 3).[1]
‡Oral aminosalicylates and/or oral corticosteroids (≤20 mg/day prednisone, ≤9 mg/day budesonide, or equivalent steroid). Therapies not permitted were immunomodulators, biologics, JAKi, rectal 5-ASAs, or rectal corticosteroids.[1]
OLE=open-label extension; R=randomization; TNF=tumor necrosis factor.

In adults with moderately to severely active UC

More patients achieved clinical remission with VELSIPITY vs placebo

Significant clinical remission in the overall population[1*]

Proportion of patients who achieved clinical remission in UC-1
Co-primary endpoints (*P*<0.001)

- In UC-2, 26% (57/221) of patients taking VELSIPITY achieved clinical remission at week 12 vs 15% (17/112) on placebo (*P*<0.05)[1]

Patients who were biologic/JAKi naive achieved clinical remission similar to the overall population[1]

Proportion of biologic/JAKi-naive patients who achieved clinical remission in UC-1
Subgroup population

- In UC-2, 30% (44/147) of biologic/JAKi-naive patients taking VELSIPITY achieved clinical remission at week 12 vs 16% (12/74) on placebo[1]

100% **of patients in clinical remission with VELSIPITY at week 52** (88/274) **were also corticosteroid free‡‡**

*Clinical remission was defined as an SF subscore of 0 or 1, an RB subscore of 0, and an ES ≤1 (excluding friability).[1]
†Advanced therapies include S1P receptor modulators, biologics, and JAKi.[3]
‡Corticosteroid-free clinical remission was defined as clinical remission at week 52 without receiving corticosteroids for ≥12 weeks prior to week 52.[1]

IMPORTANT SAFETY INFORMATION (cont'd)

Bradyarrhythmia and Atrioventricular (AV) Conduction Delays
Initiation of VELSIPITY may result in a transient decrease in heart rate and AV conduction delays. Before starting VELSIPITY, obtain an ECG to assess for preexisting cardiac conduction abnormalities. Before starting VELSIPITY, obtain an ECG to assess for preexisting cardiac conduction abnormalities. Seek advice of a cardiologist for patients with: significant QT prolongation; arrhythmia requiring treatment with Class Ia or Class III antiarrhythmic drugs or QT prolonging drugs; unstable ischemic heart disease, Class I or Class II heart failure, history of cardiac arrest, cerebrovascular disease, or uncontrolled hypertension; resting HR<50bpm; history of symptomatic bradycardia, recurrent cardiogenic syncope, or severe untreated sleep apnea; history of Mobitz type I second-degree AV block in the absence of a functioning pacemaker.

Liver Injury
Elevations of aminotransferases may occur in patients receiving VELSIPITY. Obtain transaminase and bilirubin levels, if not recently available (i.e., within the last 6 months), before initiation of VELSIPITY or in patients who develop symptoms suggestive of hepatic dysfunction. Discontinue VELSIPITY if significant liver injury is confirmed. Use of VELSIPITY in patients with severe hepatic impairment is not recommended.

Please see full Prescribing Information, including Medication Guide, in pocket.

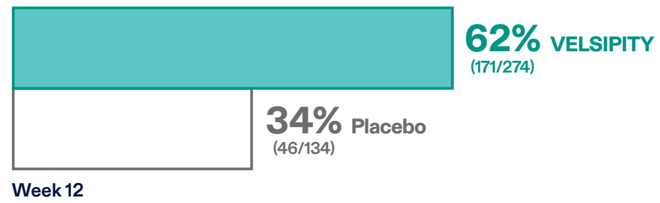
In adults with moderately to severely active UC

>60% of patients achieved clinical response with VELSIPITY vs placebo

Velsipity® (etrasimod) 2mg tablets

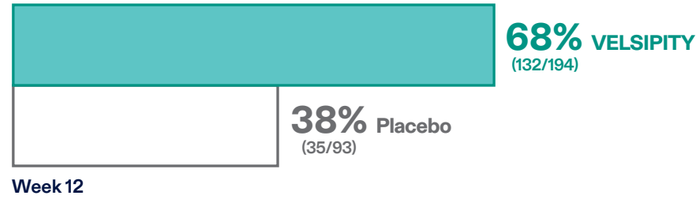
Higher clinical response with VELSIPITY vs placebo[1*]

Proportion of patients who achieved clinical response in UC-1[1,4,5†]
Other prespecified secondary endpoint



Clinical response in a subgroup population[5]

Proportion of biologic/JAKi-naive patients with clinical response in UC-1†
Post hoc subgroup analysis



To see clinical response at week 52, visit **VELSIPITYhcp.com/efficacy**.

*Clinical response was defined as a ≥2-point and a ≥30% decrease from baseline in an mMS and a ≥1-point decrease from baseline in an RB subscore or in an absolute RB subscore ≤1 at week 12.[1]
†In UC-2, 62% (137/221) of patients taking VELSIPITY achieved clinical response at week 12 vs 41% (46/112) on placebo. In a post hoc subgroup analysis, the proportion of biologic/JAKi-naive patients with clinical response was 65% (96/147) vs 43% (32/74) on placebo.[1,4,5]

IMPORTANT SAFETY INFORMATION (cont'd)

Macular Edema
S1P receptor modulators have been associated with an increased risk of macular edema. Obtain baseline evaluation of the fundus, including the macula near the start of VELSIPITY treatment. Periodically assess the fundus, including the macula, during treatment or if there is a change in vision. Consider discontinuing VELSIPITY if macular edema develops.

In adults with moderately to severely active UC

Symptomatic improvement with VELSIPITY vs placebo

Improvements in stool frequency and rectal bleeding subscores[1,3]

2 WEEKS

Stool frequency (SF)
subscores improved as early as **week 2** for VELSIPITY patients

4 WEEKS

Rectal bleeding (RB)
subscores improved as early as **week 4** for VELSIPITY patients

Nearly half of patients treated with VELSIPITY achieved symptomatic remission at week 12[3,5*]

Proportion of patients in symptomatic remission[3,5†]
Key secondary endpoint (P<0.001)

12 WEEKS

46% (126/274) VELSIPITY vs **22%** (29/134) Placebo

Week 12

*Symptomatic remission was defined as an SF subscore of 0 (or an SF subscore of 1 with a ≥1-point decrease from baseline) and an RB subscore of 0.[3]

†In UC-2, 47% (104/221) of patients taking VELSIPITY experienced symptomatic remission at week 12 vs 30% (33/112) on placebo (P=0.001).[3,5]

IMPORTANT SAFETY INFORMATION (cont'd)

Increased Blood Pressure
VELSIPITY patients in clinical trials had average increases of 1 to 4 mm Hg systolic and 1 to 2 mm Hg diastolic blood pressure (BP). Increases were first detected after 2 weeks of treatment and remained within the specified average range of BP increases throughout treatment. Monitor BP during treatment with VELSIPITY and manage appropriately.

Fetal Risk
Based on animal studies, VELSIPITY may cause fetal harm. Advise pregnant females and females of reproductive potential of the potential risk to a fetus and to use effective contraception to avoid pregnancy during and for one week after stopping VELSIPITY. Pregnant females exposed to VELSIPITY are encouraged to contact the pregnancy registry by calling 1-800-616-3791.

Malignancies
Cases of malignancies (including skin) have been reported in patients treated with S1P receptor modulators. Skin examinations are recommended prior to or shortly after the start of treatment and periodically thereafter for all patients, particularly those with risk factors for skin cancer. Monitor for suspicious skin lesions.

Posterior Reversible Encephalopathy Syndrome
Rare cases of posterior reversible encephalopathy syndrome (PRES) have been reported in patients receiving S1P receptor modulators. If a patient develops neurological or psychiatric symptoms/signs or any symptom/sign suggestive of an increase of intracranial pressure, or accelerated neurological deterioration, complete a physical and neurological examination promptly and consider an MRI. Symptoms of PRES are usually reversible but may evolve into ischemic stroke or cerebral hemorrhage. Delay in diagnosis and treatment may lead to permanent neurological sequelae. If PRES is suspected, discontinue treatment with VELSIPITY.

Please see full Prescribing Information, including Medication Guide, in pocket.

In adults with moderately to severely active UC

More patients achieved endoscopic improvement with VELSIPITY vs placebo

Velsipity® (etrasimod) 2mg tablets

Significant endoscopic improvement in the overall population[1*]

Proportion of patients who achieved endoscopic improvement in UC-1[†]
Key secondary endpoint (P<0.001)

Overall population

Patients who were biologic/JAKi naive achieved endoscopic improvement similar to the overall population[1]

Proportion of biologic/JAKi-naive patients who achieved endoscopic improvement in UC-1[†]

Subgroup population

First-line advanced treatment[‡]		First-line advanced treatment[‡]	
39% (76/194) VELSIPITY	vs **18%** (17/93) Placebo	**40%** (78/194) VELSIPITY	vs **13%** (12/93) Placebo
Week 12		Week 52	

Additionally, more patients achieved endoscopic remission[§] by week 12 (15% VELSIPITY vs 4% placebo) and week 52 (26% VELSIPITY vs 6% placebo)[1]

*Endoscopic improvement was defined as an ES ≤1 (excluding friability).[1]
†In UC-2, 30% (66/221) of patients taking VELSIPITY achieved endoscopic improvement at week 12 vs 19% (21/112) on placebo (P<0.05). In biologic/JAKi-naive patients, 34% (50/147) of patients taking VELSIPITY achieved endoscopic improvement at week 12 vs 19% (14/74) on placebo.[1]
‡Advanced therapies include S1P receptor modulators, biologics, and JAKi.[3]
§Normalization of the endoscopic appearance of the mucosa, or endoscopic remission, was defined as an ES of 0. At both week 12 and week 52, endoscopic normalization was seen in 11% of VELSIPITY patients vs 1% on placebo. In UC-2, improvements in endoscopic normalization were seen by week 12 (17% VELSIPITY vs 8% placebo).[1]

For adults with moderately to severely active UC

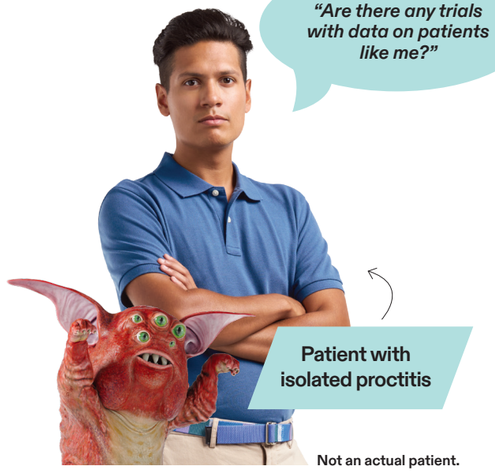
Do you see **patients with isolated proctitis** in your practice?

VELSIPITY is the first advanced therapy* to include patients with isolated proctitis in UC clinical trials[3]

- 8% of patients (n=56) in the VELSIPITY clinical trial program had isolated proctitis confirmed by centrally read colonoscopy or proctosigmoidoscopy at baseline[1,5]

According to an expert panel discussing their systematic literature review[6†]:

~1 out of 3 patients with UC has ulcerative proctitis



Not an actual patient.

LIMITATIONS: Systematic literature reviews include different trial designs and types, different practice types and regions (some ex-US), different definitions for and severity of ulcerative proctitis across the trials studied, and some missing trials during the selection process.

To see clinical remission data in the isolated proctitis subgroup population, visit **VELSIPITYhcp.com/efficacy**.

*Advanced therapies include S1P receptor modulators, biologics, and JAKi.[3]
†Based on a meeting of 35 IOIBD experts in September 2021. They convened to make recommendations from their recent systematic literature review to address the unmet needs of ulcerative proctitis because of its exclusion from UC RCTs to date. It is an expert consensus with recommendations as opposed to conclusions based on predefined study endpoints.[6]
IOIBD=International Organization for the Study of Inflammatory Bowel Diseases; RCTs=randomized controlled trials.

IMPORTANT SAFETY INFORMATION (cont'd)

Respiratory Effects
VELSIPITY may cause a decline in pulmonary function. Spirometric evaluation should be conducted during therapy if clinically indicated.

Unintended Additive Immune System Effects from Prior Treatment with Immunosuppressive or Immune-Modulating Drugs
When switching to VELSIPITY from drugs with prolonged immune effects, consider the half-life and mode of action of these drugs to avoid unintended additive immunosuppressive effects.

Immune System Effects After Stopping VELSIPITY
After stopping VELSIPITY, lymphocyte counts returned to the normal range in 90% of subjects within 4 to 5 weeks. Use of immunosuppressants within this period may lead to an additive effect on the immune system, and therefore monitor patients receiving concomitant immunosuppressants for infectious complications up to 5 weeks after the last dose of VELSIPITY.

Most Common Adverse Reactions
Most common adverse reactions reported in ≥ 2% of subjects and at a higher rate than placebo included: headache, elevated liver tests, dizziness, arthralgia, nausea, hypertension, bradycardia, UTI, hypercholesterolemia, and herpes viral infection.

Please see full Prescribing Information, including Medication Guide, in pocket.

Safety was evaluated in **three randomized, double-blind, placebo-controlled trials**

Velsipity® (etrasimod) 2mg tablets

Rates of serious infections and discontinuations with VELSIPITY

Serious infections[3]			
UC-1		UC-2	
1% VELSIPITY (n=289)	3% Placebo (n=144)	0% VELSIPITY (n=238)	0% Placebo (n=116)

Discontinuation due to treatment-emergent adverse events[3]			
UC-1		UC-2	
4% VELSIPITY (n=289)	5% Placebo (n=144)	5% VELSIPITY (n=238)	1% Placebo (n=116)

Adverse reactions with an incidence ≥2% in patients treated with VELSIPITY and at a higher rate than placebo in UC-1[1]

- Safety was evaluated in UC-1, UC-2, and a dose-finding phase 2 trial, UC-3 (n=577 treated with VELSIPITY; n=314 treated with placebo)[1*]

Adverse reactions	VELSIPITY 2 mg once daily (% of patients, n=289)	Placebo (% of patients, n=144)
Headache[†]	9	5
Elevated liver tests[‡]	6	5
Dizziness[§]	5	2
Arthralgia	4	2
Hypertension[‖]	3	1
Urinary tract infection[¶]	3	2
Nausea	3	1
Hypercholesterolemia[#]	3	0
Herpes viral infection[**]	2	1

[†]In UC-1, headache includes related terms headache, migraine, and tension headache. In UC-2 & UC-3, headache includes related terms headache, migraine, and sinus headache.[1]
[‡]In UC-1, elevated liver tests includes related terms ALT increased, AST increased, blood ALP increased, cholestasis, GGT increased, hepatic enzyme increased, hyperbilirubinemia, liver function test increased, and transaminases increased. In UC-2 & UC-3, elevated liver tests includes related terms ALT increased, AST increased, blood ALP increased, blood bilirubin increased, cholestasis, GGT increased, hepatic enzyme increased, hepatic function abnormal, liver function test abnormal, and transaminases increased.[1]
[§]Dizziness includes related terms dizziness, dizziness exertional, and dizziness postural.[1]
[‖]Hypertension includes related terms hypertension and blood pressure increased.[1]
[¶]In UC-1, urinary tract infection includes related terms urinary tract infection and cystitis. In UC-2 & UC-3, urinary tract infection includes related terms urinary tract infection, cystitis, and genitourinary tract infection.[1]
[#]Hypercholesterolemia includes related terms hypercholesterolemia and blood cholesterol increased.[1]
[**]Herpes viral infection includes related terms herpes zoster, oral herpes, and herpes simplex.[1]
[††]Bradycardia includes related terms bradycardia, sinus bradycardia, and heart rate decreased.[1]

- In UC-2 & UC-3, adverse reactions with an incidence ≥2% in patients treated with VELSIPITY (n=288) and at a higher rate than placebo (n=170) were headache (VELSIPITY 6%, placebo 4%), elevated liver tests (5% VELSIPITY, <1% placebo), nausea (4% VELSIPITY, 2% placebo), bradycardia[††] (3% VELSIPITY, 0% placebo), and urinary tract infection (3% VELSIPITY, 0% placebo)[1]

VELSIPITY has no boxed warning[1]

Contraindicated in patients with specific cardiovascular conditions. Select Warnings & Precautions: Infections, Bradyarrhythmia & AV Conduction Delays, Liver Injury. See USPI.[1]

*VELSIPITY-treated patients in UC-1 (n=289) and UC-2 & UC-3 (n=288).[1]
ALP=alkaline phosphatase; ALT=alanine aminotransferase; AST=aspartate aminotransferase; GGT=gamma-glutamyl transferase.

One pill, once daily—no injections, or titration required

Starting treatment[1]

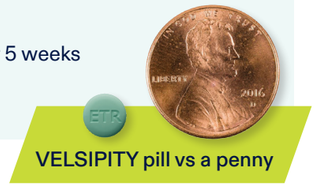
- Complete baseline assessments—see page 11
- Recommended dose: 2 mg orally, once daily, with or without food
- Initiation dose is the maintenance dose; no titration is required
- Exclude patients who:
  - Had certain cardiovascular conditions, including stroke, in the last 6 months
  - Are currently taking antineoplastic, immunomodulating, or non-corticosteroid immunosuppressive treatments, or drugs that could slow heart rate or AV conduction
  - Are or who plan to become pregnant

Drug-drug interactions[1]

- May impact concomitant medications that are also metabolized via CYP2C8, CYP2C9, and CYP3A4 pathways
- Avoid concomitant administration with fluconazole or rifampin
- No known interactions with monoamine oxidase (MAO) inhibitors or tyramine

Stopping treatment[1]

- The mean half-life of VELSIPITY is approximately 30 hours
- After the last dose:
  - Women of childbearing age should use contraception for 1 week
  - Patients should be monitored for signs and symptoms of infection for 5 weeks
  - Patients receiving concomitant immunosuppressants should be monitored for complications for 5 weeks



VELSIPITY pill vs a penny

CYP=cytochrome P450.

IMPORTANT SAFETY INFORMATION

Contraindications

- Patients in the last 6 months who experienced myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III or IV heart failure
- Patients with a history or presence of Mobitz type II second-degree or third-degree AV block, sick sinus syndrome, or sino-atrial block, unless the patient has a functioning pacemaker

Infections

VELSIPITY may increase the susceptibility to infections. Life-threatening and rare fatal infections have been reported in association with other sphingosine 1-phosphate (S1P) receptor modulators. Before starting VELSIPITY, obtain a recent (i.e., within 6 months) CBC, including lymphocyte count. Delay initiation of VELSIPITY in patients with an active infection until the infection is resolved. Consider interruption of treatment with VELSIPITY if a patient develops a serious infection. Consider monitoring for infections up to 5 weeks after discontinuing VELSIPITY.

- **Progressive multifocal leukoencephalopathy (PML)** is an opportunistic viral infection of the brain that typically occurs in patients who are immunocompromised, and usually leads to death or severe disability. PML has been reported in multiple sclerosis (MS) patients treated with S1P receptor modulators. If PML is suspected, suspend VELSIPITY and discontinue if PML is confirmed by appropriate diagnostic evaluation. Immune reconstitution inflammatory syndrome (IRIS) has been reported in patients with MS treated with S1P receptor modulators who developed PML and discontinued treatment. Clinical decline may be rapid, can lead to serious neurological complications or death, and is often associated with characteristic MRI changes. Onset was generally within a few months after S1P receptor modulator discontinuation. Monitoring for IRIS should be undertaken.

Please see full Prescribing Information, including Medication Guide, in pocket.

Baseline assessments help determine if VELSIPITY is appropriate for your patients

Velsipity® (etrasimod) 2mg tablets

Prior to treatment, complete these **one-time** assessments:

Blood work[1]

- Obtain a recent (ie, within the last 6 months or after discontinuation of prior UC therapy) complete blood count (CBC) with differential and liver function tests

ECG[1]

- Obtain a **one-time** ECG to determine whether preexisting cardiac abnormalities are present
  - Seek advice from a cardiologist if patients have a cardiac abnormality on ECG

It is also important to:

- **Review history for medications** that may affect heart rhythm or may have immunosuppressive effects[1]
- Confirm patient has a documented full course of VZV vaccination, a history of varicella (chickenpox), or is VZV antibody positive[1]

Near the start of treatment:

Ophthalmic assessment[1]

- Obtain baseline evaluation of the fundus, including the macula, **near the start** of treatment

Skin examination[1]

- Obtain a skin examination **prior to or shortly after** treatment initiation

Support for completing baseline assessments is available to eligible, commercially insured patients*

*See Terms and Conditions in pocket.

ECG=electrocardiogram; VZV=varicella-zoster virus.

Support and savings to **help eligible patients get started on** VELSIPITY

VelsipityForMe is committed to helping eligible patients receive their VELSIPITY treatment

FREE FOR UP TO 2 YRS

Interim Care Rx
Up to 2 years of VELSIPITY at no cost shipped through Interim Care Rx for eligible, commercially insured patients enrolled in VelsipityForMe who experience a delay or denial of coverage during the prior authorization or appeals process.*

Voucher Rx
A free, one-time, 30-day trial for new patients to get started.*

Copay Savings Program
Eligible patients may pay as little as $0 in out-of-pocket costs, with a maximum benefit of $16,000 per calendar year, with the Copay Savings Program.

Eligibility required. Commercially insured patients only. The maximum prescription benefit offer per patient is $16,000 per calendar year. Patients enrolled in a state or federally funded prescription health insurance program are not eligible. Available only to patients who have been diagnosed with an FDA-approved indication for VELSIPITY. No membership fees. This is not health insurance.*

Additional support

Baseline assessment support options for commercially insured patients. Eligibility required.*

- **Benefits investigation**
- **Prior authorization and appeals assistance**

The Dedicated Care Coordinator will be a consistent, primary point of contact to:

- **Welcome** enrolled patients into the program
- **Explain** insurance coverage and identify potential financial assistance options
- **Schedule** at-home assessments for eligible, commercially insured patients†
- **Communicate** patient status

*See Terms and Conditions in pocket.
†For commercially insured patients only who do not reside in MA, MI, MN, and RI.

Velsipityforme PATIENT SUPPORT PROGRAM | To learn more about VelsipityForMe, please visit **VELSIPITYhcp.com/PatientSupport**

IMPORTANT SAFETY INFORMATION (cont'd)

Infections (cont'd)

- **Herpes simplex encephalitis, varicella zoster meningitis, and localized herpes viral infections** have been reported with S1P receptor modulators. In UC-1, herpes zoster was reported in 0.7% of subjects treated with VELSIPITY and in none of the subjects who received placebo. Patients without a healthcare professional-confirmed history of varicella (chickenpox), or without documentation of a full course of vaccination against varicella zoster virus (VZV), should be tested for antibodies to VZV before initiating VELSIPITY. A full course of VZV vaccination for antibody-negative patients is recommended prior to commencing treatment with VELSIPITY.
- Cases of fatal **cryptococcal meningitis (CM) and disseminated cryptococcal infections** have been reported with S1P receptor modulators. VELSIPITY treatment should be suspended until a cryptococcal infection has been excluded. If CM is diagnosed, appropriate treatment should be initiated.
- VELSIPITY has not been studied in combination with anti-neoplastic, immune-modulating, or non-corticosteroid immunosuppressive therapies. Avoid concomitant administration of these therapies with VELSIPITY.
- Update immunizations according to current guidelines prior to VELSIPITY treatment. Avoid the use of live attenuated vaccines during and for 5 weeks after treatment with VELSIPITY. If live attenuated vaccine immunizations are required, administer at least 4 weeks prior to initiation of VELSIPITY.

Please see full Prescribing Information, including Medication Guide, in pocket.

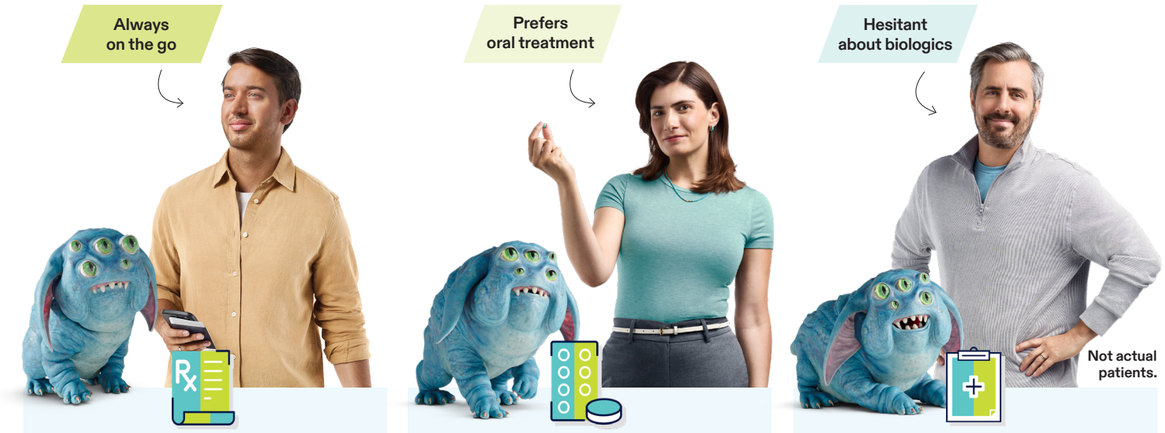
For adults with moderately to severely active UC

Help calm the chaos of UC with VELSIPITY[1]

Improvements were observed in stool frequency and rectal bleeding[1]

Velsipity® (etrasimod) 2mg tablets

Consider VELSIPITY as what's next for patients with UC who are ready for first-line advanced therapy*



A **first-line** advanced treatment*[1]

- Met key efficacy endpoints:
  - Significant clinical remission at week 12 and at week 52[1†]
  - Steroid freedom for patients in clinical remission at week 52[1‡]
  - Higher clinical response vs placebo at week 12[1,5§]

One pill, once daily, **no titration**[1]

- Same dose during treatment
- Complete baseline assessments—see full list on page 11

No boxed warning[1]

- Contraindicated in patients with specific cardiovascular conditions. Select Warnings & Precautions: Infections, Bradyarrhythmia & AV Conduction Delays, Liver Injury. See USPI[1]

*Advanced therapies include S1P receptor modulators, biologics, and JAKi.[3]
†Clinical remission was defined as an SF subscore of 0 or 1, an RB subscore of 0, and an ES ≤1 (excluding friability). In UC-1, proportion of patients in clinical remission at week 12 (27% [74/274] VELSIPITY, 7% [9/134] placebo) and at week 52 (32% [88/274] VELSIPITY, 7% [9/134] placebo). In UC-2, proportion of patients in clinical remission at week 12 (26% [57/221] VELSIPITY, 15% [17/112] placebo).[1]
‡Corticosteroid-free clinical remission was defined as clinical remission at week 52 without receiving corticosteroids for ≥12 weeks prior to week 52. In UC-1, proportion of patients in corticosteroid-free clinical remission at week 52 (32% [88/274] VELSIPITY, 7% [9/134] placebo).[1]
§Clinical response was defined as a ≥2-point and a ≥30% decrease from baseline in an mMS and a ≥1-point decrease from baseline in an RB subscore or an absolute RB subscore ≤1. In UC-1, proportion of patients with clinical response at week 12 (62% [171/274] VELSIPITY, 34% [46/134] placebo) and in UC-2 (62% [137/221] VELSIPITY, 41% [46/112] placebo).[1,5]

Discover more information by visiting **VELSIPITYhcp.com** or by scanning the QR code.

IMPORTANT SAFETY INFORMATION (cont'd)

Bradyarrhythmia and Atrioventricular (AV) Conduction Delays

Initiation of VELSIPITY may result in a transient decrease in heart rate and AV conduction delays. Before starting VELSIPITY, obtain an ECG to assess for preexisting cardiac conduction abnormalities. Seek advice of a cardiologist for patients with: significant QT prolongation; arrhythmia requiring treatment with Class Ia or Class III anti-arrhythmic drugs or QT prolonging drugs; unstable ischemic heart disease, Class I or Class II heart failure, history of cardiac arrest, cerebrovascular disease, or uncontrolled hypertension; resting HR<50bpm; history of symptomatic bradycardia, recurrent cardiogenic syncope, or severe untreated sleep apnea; history of Mobitz type I second-degree AV block in the absence of a functioning pacemaker.

Liver Injury

Elevations of aminotransferases may occur in patients receiving VELSIPITY. Obtain transaminase and bilirubin levels, if not recently available (i.e., within the last 6 months), before initiation of VELSIPITY or in patients who develop symptoms suggestive of hepatic dysfunction. Discontinue VELSIPITY if significant liver injury is confirmed. Use of VELSIPITY in patients with severe hepatic impairment is not recommended.

Macular Edema

S1P receptor modulators have been associated with an increased risk of macular edema. Obtain baseline evaluation of the fundus, including the macula near the start of VELSIPITY treatment. Periodically assess the fundus, including the macula, during treatment or if there is a change in vision. Consider discontinuing VELSIPITY if macular edema develops.

Increased Blood Pressure

VELSIPITY patients in clinical trials had average increases of 1 to 4 mm Hg systolic and 1 to 2 mm Hg diastolic blood pressure (BP). Increases were first detected after 2 weeks of treatment and remained within the specified average range of BP increases throughout treatment. Monitor BP during treatment with VELSIPITY and manage appropriately.

Fetal Risk

Based on animal studies, VELSIPITY may cause fetal harm. Advise pregnant females and females of reproductive potential of the potential risk to a fetus and to use effective contraception to avoid pregnancy during and for one week after stopping VELSIPITY. Pregnant females exposed to VELSIPITY are encouraged to contact the pregnancy registry by calling 1-800-616-3791.

Malignancies

Cases of malignancies (including skin) have been reported in patients treated with S1P receptor modulators. Skin examinations are recommended prior to or shortly after the start of treatment and periodically thereafter for all patients, particularly those with risk factors for skin cancer. Monitor for suspicious skin lesions.

Posterior Reversible Encephalopathy Syndrome

Rare cases of posterior reversible encephalopathy syndrome (PRES) have been reported in patients receiving S1P receptor modulators. If a patient develops neurological or psychiatric symptoms/signs or any symptom/sign suggestive of an increase of intracranial pressure, or accelerated neurological deterioration, complete a physical and neurological examination promptly and consider an MRI. Symptoms of PRES are usually reversible but may evolve into ischemic stroke or cerebral hemorrhage. Delay in diagnosis and treatment may lead to permanent neurological sequelae. If PRES is suspected, discontinue treatment with VELSIPITY.

Respiratory Effects

VELSIPITY may cause a decline in pulmonary function. Spirometric evaluation should be conducted during therapy if clinically indicated.

Unintended Additive Immune System Effects from Prior Treatment with Immunosuppressive or Immune-Modulating Drugs

When switching to VELSIPITY from drugs with prolonged immune effects, consider the half-life and mode of action of these drugs to avoid unintended additive immunosuppressive effects.

Immune System Effects After Stopping VELSIPITY

After stopping VELSIPITY, lymphocyte counts returned to the normal range in 90% of subjects within 4 to 5 weeks. Use of immunosuppressants within this period may lead to an additive effect on the immune system, and therefore monitor patients receiving concomitant immunosuppressants for infectious complications up to 5 weeks after the last dose of VELSIPITY.

Most Common Adverse Reactions

Most common adverse reactions reported in ≥ 2% of subjects and at a higher rate than placebo included: headache, elevated liver tests, dizziness, arthralgia, nausea, hypertension, bradycardia, UTI, hypercholesterolemia, and herpes viral infection.

References: 1. VELSIPITY [prescribing information]. New York, NY: Pfizer Inc.; November 2023. **2.** Kaplan GG, Ng SC. Epidemiology, pathogenesis, and diagnosis of inflammatory bowel diseases. In: Feldman M, Friedman LS, Brandt LJ, Chung RT, Rubin DT, Wilcox CM, eds. *Sleisenger and Fordtran's Gastrointestinal and Liver Disease: Pathophysiology, Diagnosis, Management*. 11th ed. Philadelphia, PA: Elsevier; 2021:1868-1897. **3.** Sandborn WJ, Vermeire S, Peyrin-Biroulet L, et al. Etrasimod as induction and maintenance therapy for ulcerative colitis (ELEVATE): two randomised, double-blind, placebo-controlled, phase 3 studies [published correction appears in *Lancet.* 2023;401(10381):1000]. *Lancet.* 2023;401(10383):1159-1171. **4.** Sandborn WJ, Vermeire S, Peyrin-Biroulet L, et al. Etrasimod as induction and maintenance therapy for ulcerative colitis (ELEVATE): two randomised, double-blind, placebo-controlled, phase 3 studies [published correction appears in *Lancet.* 2023;401(10381):1000]. *Lancet.* 2023;401(10383):1159-1171. Supplementary appendix available at: https://www.thelancet.com/cms/10.1016/S0140-6736(23)00061-2/attachment/cdbbc759-490f-4b2a-a3a2-93bc9918b29f/mmc1.pdf. Accessed March 20, 2024. **5.** Data on file. Pfizer Inc. **6.** Caron B, Abreu MT, Siegel CA, et al. IOIBD recommendations for clinical trials in ulcerative proctitis: the PROCTRIAL consensus. *Clin Gastroenterol Hepatol.* 2022;20(11):2619-2627.e1.

Please see full Prescribing Information, including Medication Guide, in pocket.