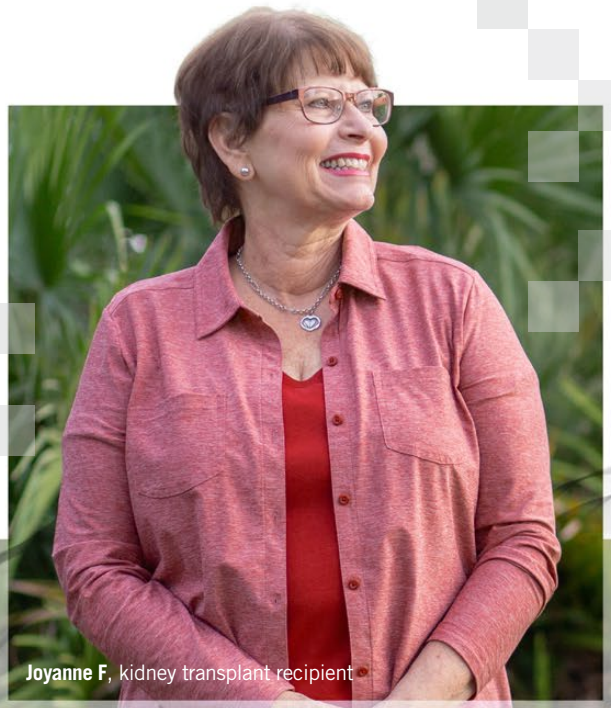
CareDx®
Your Partner in Transplant Care™



Join CareDx at the 2023 ASTS Winter Symposium

Save the dates and join us in Miami to hear the latest on transplant innovation.

Dates: January 12-15, 2023
Location: Loews Miami Beach

Sign Up to Receive Updates

SIGN UP

https://caredx.link/3Whrlig

Thursday, Jan 12

7:30–10:30 PM
Byblos Miami, 1545 Collins Ave
Miami Beach, FL 33139

Molecular Surveillance and Innovation for Improved Patient Support and Allograft Outcomes

Panel discussion and dinner program highlighting how we should utilize molecular and digital tools for clinical care.

Friday, Jan 13

11:00 AM–12:00 PM
Loews Miami - 2nd Floor
Americana Room

From Benchtop to Bedside: Clinical Utility of Multi-Modal Molecular and Digital Tools

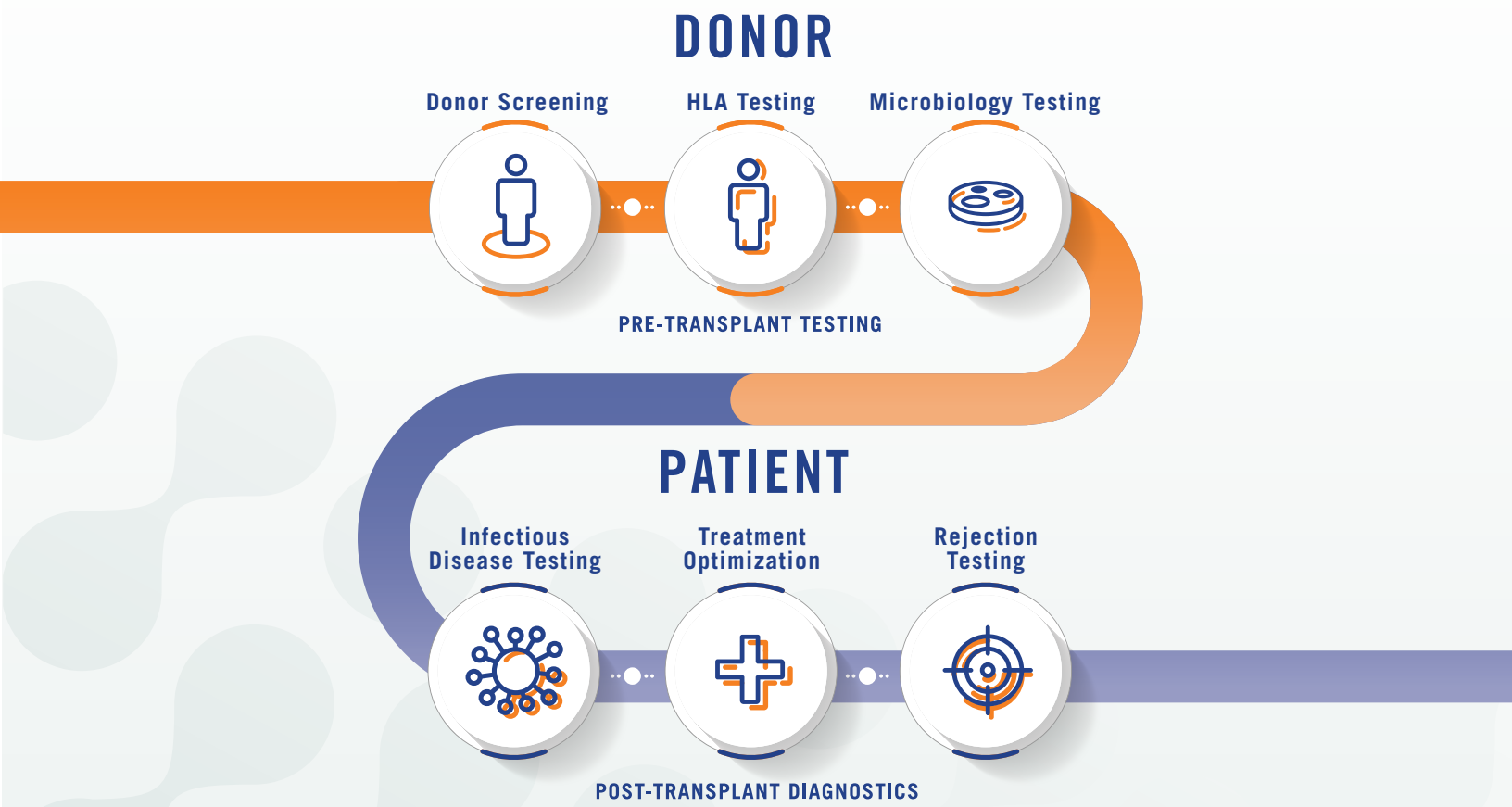
Sponsored lunch symposium highlighting the latest data on AlloMap Kidney, AlloSure for immuno-optimization, and AiKidney

Thurs – Sat

All Day
Loews Miami - 2nd Floor
Americana Room

Visit Our Booth

Learn more about personalized care for every step of the transplant journey



From Pre-Tranplant to Post Recovery

WE'RE YOUR PARTNER THROUGH ALL OF IT

From donor to recipient, the transplant journey requires precision testing every step of the way. That's exactly what we deliver. Diagnostics that inform, monitor and lead to improved long-term outcomes for patients and clinicians by providing personalized insights that can answer life and organ saving transplant questions.

eurofins | Transplant Diagnostics

Three Leaders in Transplant Testing.

ONE NAME.

eurofins | Donor & Product Testing

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Enhancing Living Donor Kidney Transplantation Opportunities

Saturday, January 14, 2023 • 11:00 AM - 12:00 PM EST

Loews Miami Beach Hotel
Poinciana Room
Miami, Florida

Matthew Cooper, MD
Chief, Division of Transplant Surgery
Professor of Surgery
Medical College of Wisconsin
Mark B. Adams Chair in Transplant Surgery
Milwaukee, Wisconsin

Amit Govil, MD
Medical Director, Kidney Transplant Program
University of Cincinnati
Cincinnati, Ohio

Alexander Wiseman, MD
Executive Director, Kidney Transplantation
Centura Health
Denver, Colorado

Program Description
Please join us for a discussion on the current state of living donor kidney transplantation in the United States. This program will highlight current trends and policies that seek to address gaps in equity and access. The evolution and expansion of kidney paired donation, strategies to engage living donors, and removal of financial disincentives will also be discussed.

This is an industry-sponsored session. CE/CME credit will not be available.

In compliance with PhRMA and AMA guidelines, only healthcare professionals and office personnel may attend this program. Spouses or other guests are not permitted. This session is brought to you by Veloxis Pharmaceuticals, Inc. The speakers are presenting on behalf of Veloxis Pharmaceuticals, Inc., and must present information in compliance with FDA requirements.

If you are licensed in any state or other jurisdiction (eg, DC, ME, MN, NJ, VT) or are an employee or contractor of any organization or governmental entity that limits or prohibits meals from pharmaceutical companies, please identify yourself so that you (and we) are able to comply with such requirements. Your name, the value, and the purpose of any educational item, meal, or other items of value you receive may be reported as required by state or federal law. Once reported, this information may be publicly accessible.

This symposium is not part of the ASTS Winter Symposium educational program, and the session and content are not endorsed by ASTS. Sponsored by Veloxis Pharmaceuticals, Inc.

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natera™ | Prospera™ Kidney

Now published!

> The combination of dd-cfDNA fraction and quantity was found to be significantly more predictive than either variable alone.
>
> – HALLORAN, ET AL[1]

Real-world performance of Prospera's two-threshold algorithm for kidney transplant assessment

Evaluated in the Trifecta study, an innovative cfDNA test with a two-threshold algorithm demonstrated exceptional performance in discriminating between active rejection and non-rejection in kidney transplant recipients.

Scan the QR code to read the study

The Trifecta study represents the largest multisite, prospective, fully biopsy-matched cohort with dd-cfDNA analysis for kidney transplant recipients conducted to date, involving:

25
international and US sites

367
biopsy-matched plasma samples from adult kidney transplant recipients

125
histology-confirmed rejections in an indication biopsy cohort

Reference: Halloran, Philip F. MD, PhD, et al. Combining Donor-derived Cell-free DNA Fraction and Quantity to Detect Kidney Transplant Rejection Using Molecular Diagnoses and Histology as Confirmation. Transplantation: June 29, 2022 - Volume - Issue - 10.1097/TP.0000000000004212 doi: 10.1097/TP.0000000000004212

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Visit us at ASTS Winter Symposium

Induction Therapy for Kidney Transplant: Protection in a Hostile Environment

Thymoglobulin®
Anti-thymocyte Globulin (Rabbit)

Thymoglobulin Induction Demonstrated Superiority to Basiliximab in Reducing Treatment Failure[1]

Brennan et al: Open-Label, Randomized, Active-Controlled Trial[1,2]

Deceased-donor kidney transplant patients
at increased risk for acute rejection or delayed graft function (DGF) (N=278)

1:1 R

Thymoglobulin
1.5 mg/kg on Days 0-4
(n=141)

Basiliximab
20 mg on Days 0 and 4
(n=137)

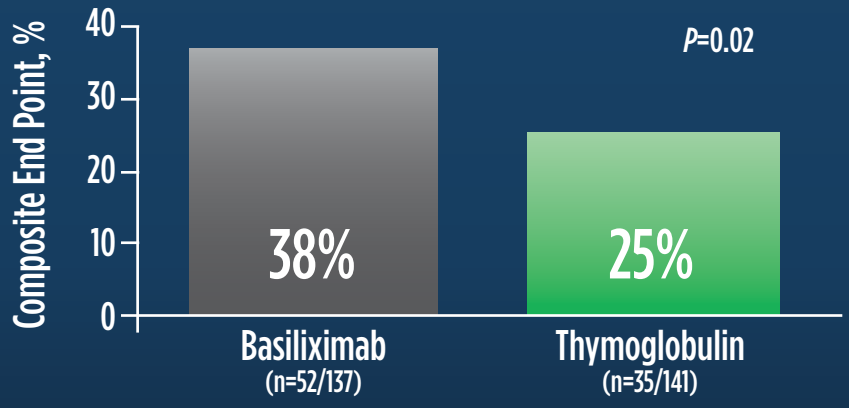
Primary End Point[a]
Composite of biopsy-proven acute rejection (BPAR) (grade I-III), graft loss, death, and lost to follow-up (considered treatment failure)

UNOS Analysis

Today, ~80% of deceased-donor kidney transplant patients would be considered at increased risk for acute rejection[3,4]

Based on the inclusion criteria of the 1010 Study in an exploratory analysis of the OPTN/UNOS database during the period of 1999-2021. Analysis performed December 3, 2021.

Treatment Failure at 12 Months[1]



34% relative reduction in treatment failure associated with Thymoglobulin compared with basiliximab

Infections occurred in 76% of Thymoglobulin-treated patients (23% severe) and 63% of basiliximab-treated patients (15% severe)[1]

[a] The original primary end point of the trial published by Brennan et al was a composite of the first occurrence of BPAR, DGF, graft loss, or death.[2] The FDA filing used a new composite end point, which removed DGF and included lost to follow-up, accounting for differences in the Brennan et al data compared with the Thymoglobulin label.[3] The composite end point is defined as the occurrence of any of the following: BPAR (grade I-III), graft loss, death, or lost to follow-up. A patient can be counted in more than 1 category with the exception of lost to follow-up. First induction treatment was initiated prior to the reperfusion of the kidney and all patients received triple-maintenance immunosuppression involving cyclosporine, MMF, and corticosteroids. Patients were followed for 12 months or until they were withdrawn from the study or lost to follow-up.[1]

Thymoglobulin® (anti-thymocyte globulin (rabbit)) is indicated for the prophylaxis and treatment of acute rejection in patients receiving a kidney transplant. Thymoglobulin is to be used in conjunction with concomitant immunosuppression.

Important Safety Information

WARNING: IMMUNOSUPPRESSION.
Thymoglobulin should only be used by physicians experienced in immunosuppressive therapy in transplantation.

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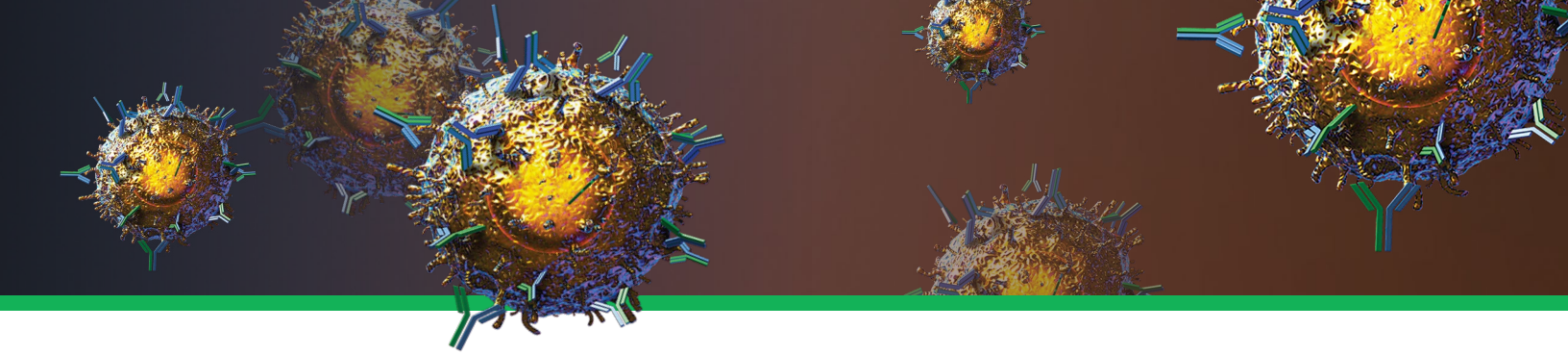

Important Safety Information (cont)

- **Contraindications.** Thymoglobulin is contraindicated in patients with a history of allergy or anaphylaxis to rabbit proteins or to any product excipients, or who have active acute or chronic infections which contraindicate any additional immunosuppression.
- **Management of Immunosuppression.** To prevent over-immunosuppression, physicians may wish to decrease the dose of the maintenance immunosuppression regimen during the period of Thymoglobulin use. Dosing for Thymoglobulin is different from dosing for other ATG products, because protein composition and concentrations vary depending on the source of ATG. Thymoglobulin should be used under strict medical supervision in a hospital setting, and patients should be carefully monitored during the infusion.
- **Immune Mediated Reactions.** Serious immune-mediated reactions, including anaphylaxis or severe cytokine release syndrome (CRS), have been reported with the use of Thymoglobulin. Fatal anaphylaxis has been reported. If an anaphylactic reaction occurs, the infusion should be terminated immediately.
- **Infusion-Associated Reactions.** Cases consistent with cytokine release syndrome (CRS) have been reported with rapid infusion rates. CRS is attributed to the release of cytokines by activated monocytes and lymphocytes. Severe acute CRS can cause serious cardiorespiratory events and/or death. Close compliance with the recommended dosage and infusion time may reduce the incidence and severity of infusion-associated reactions (IARs). Slowing the infusion rate may minimize many of these IARs. Reactions at the infusion site may include pain, swelling, and redness of the skin.
- **Hematologic Effects.** Low counts of platelets and white blood cells (including low counts of lymphocytes and neutrophils) have been identified and are reversible following dose adjustments. Total white blood cell and platelet counts should be monitored.
- **Infection and Malignancy.** Infections, reactivation of infection, febrile neutropenia, sepsis, malignancies including lymphoproliferative disorders (LPD) and other lymphomas as well as solid tumors have been reported after Thymoglobulin administration in combination with multiple immunosuppressive agents. These events can be fatal.
- **Immunization.** The safety of immunization with attenuated live vaccines following Thymoglobulin therapy has not been studied; therefore, immunization with attenuated live vaccines is not recommended for patients who have recently received Thymoglobulin.
- **Overdosage.** Thymoglobulin overdosage may result in leukopenia (including lymphopenia and neutropenia) and/ or thrombocytopenia, which can be managed with dose reduction.
- **Adverse Reactions.** The most common adverse reactions and laboratory abnormalities (incidence >5% higher than comparator) are urinary tract infection, abdominal pain, hypertension, nausea, shortness of breath, fever, headache, anxiety, chills, increased potassium levels in the blood, and low counts of platelets and white blood cells.
- During post-marketing surveillance, arthralgia/myalgia, lymphadenopathy, proteinuria, and decreased oxygen saturation tend to occur 5 to 15 days after Thymoglobulin infusion and are consistent with serum sickness. Symptoms are manageable with corticosteroid treatment.

Visit the Thymoglobulin Website to Learn More

Click here for full Prescribing Information, including Boxed WARNING.

FDA, Food and Drug Administration; MMF, mycophenolate mofetil; OPTN, Organ Procurement and Transplantation Network; R, randomization; UNOS, United Network for Organ Sharing.

References: 1. Thymoglobulin [prescribing information]. Cambridge, MA: Genzyme Corporation; 2020. **2.** Brennan DC, et al. *N Engl J Med.* 2006;355(19): 1967-1977. **3.** Data on file. sBLA Section 2.5. Sanofi Genzyme, 2015. **4.** Data on file. Induction use by Brennan at-risk groups. Sanofi Genzyme, 2021. **5.** Data on file. Induction use by Brennan at-risk groups. Sanofi Genzyme, 2021.

Thymoglobulin®
Anti-thymocyte Globulin (Rabbit)

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American Journal of Transplantation

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#8 in Surgery

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