I r e n e C o x

Sample Work: p r i n t

Extensive experience in the DTC, DTP, and the Managed Markets space, planning and writing resources including vis aids, monographs, message platforms, patient brochures and DVDs, print ads, storyboards for TV commercials, slide decks, brochures, slim jims, reprint carriers, sell sheets, direct mail, starter kits, budget impact models, and playbooks

Type 2 diabetes is a major health and economic crisis

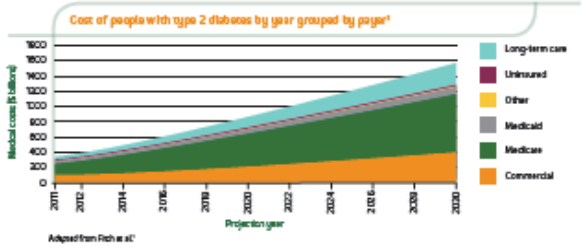
Increasing prevalence of type 2 diabetes

The number of US adults currently diagnosed with type 2 diabetes is approximately 22 million, and it is estimated to increase by 46% to nearly 32 million by 2031.[1] An estimated 79 million US adults aged 20 years or older have prediabetes.[2]

Healthcare costs are more than double for people with type 2 diabetes

- A study conducted by UnitedHealth Group of over 10 million commercial health plan members revealed the annual healthcare costs reported for a member with diabetes are more than double that of the overall member population. Additionally, for members with type 2 diabetes, healthcare costs nearly tripled.[1]

Overall costs for type 2 diabetes are predicted to increase significantly over the next 20 years[1]



Adapted from Fitch et al[1]

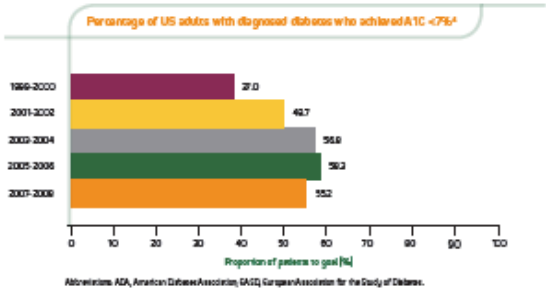
BOXED WARNING: RISK OF THYROID C-CELL TUMORS

Exenatide extended-release causes an increased incidence in thyroid C-cell tumors at clinically relevant exposures in rats compared to controls. It is unknown whether BYDUREON causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as human relevance could not be determined by clinical or nonclinical studies. BYDUREON is contraindicated in patients with a personal or family history of MTC and in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Routine serum calcitonin or thyroid ultrasound monitoring is of uncertain value in patients treated with BYDUREON. Patients should be counseled regarding the risk and symptoms of thyroid tumors.

Please see Important Safety Information throughout and the accompanying Prescribing Information and Medication Guide.

Treating type 2 diabetes continues to be a challenge

Approximately 45% of US adults aged 20 years or older with type 2 diabetes are not achieving the ADA/EASD-recommended A1C goal of <7%[4]



Abbreviations: ADA, American Diabetes Association; EASD, European Association for the Study of Diabetes.

- Despite the increase in the number and types of pharmacotherapies for type 2 diabetes over the past 2 decades, many patients are still not achieving recommended A1C goals[4]

The ADA recommends a GLP-1 receptor agonist, second oral agent, or insulin as second-line therapy for patients who do not achieve or maintain the A1C target over 3 to 6 months on noninsulin monotherapy at maximal doses[5]

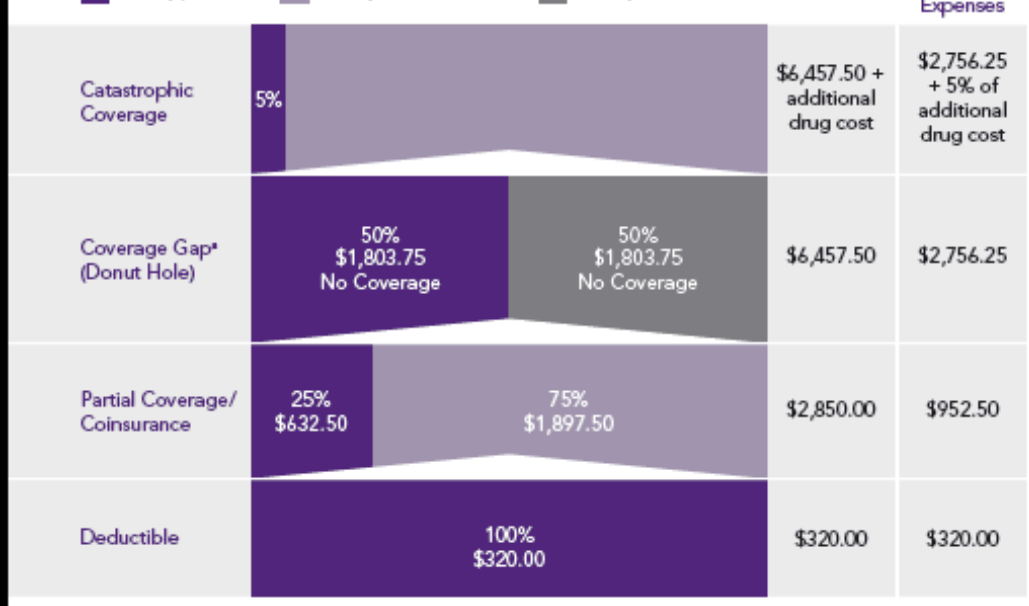
Once-weekly
BYDUREON™
exenatide extended-release for injectable suspension

Materials for the Managed Markets audience,
Including pharmacists, hospital formulary committees, payors, and employers

Medicare Part D

Overview of 2012 Standard Coverage Guidelines[1]

The 4 Stages of Medicare Part D Coverage for 2012



[a]Under the Patient Protection and Affordable Care Act of 2010, the coverage gap will be gradually eliminated, phasing out entirely by 2020.

Catastrophic coverage: Once cumulative drug cost expenses reach $6,457.50, catastrophic coverage begins. In this stage, 95% of the drug prescription is paid by the insurer/ Medicare, and 5% is paid by the patient for the remainder of the calendar year.

Coverage gap (or donut hole): Medicare Part D does not provide prescription coverage during the coverage gap stage. In this stage, a 50% manufacturer's discount is available for brand-name drugs. Patients are responsible for the remaining 50% of the prescription cost. Manufacturer and patient contributions are both applied toward the annual cumulative drug cost expenses up to $6,457.50.

Partial coverage/coinsurance: Medicare drug plans have different levels or "tiers" of partial coverage/ coinsurance. After the deductible is met and the patient enters this stage, 75% of the cost of a drug may be paid by insurer/Medicare and 25% paid by the patient. In 2012, the partial coverage/coinsurance stage ends when cumulative drug cost expenses reach $2,850.

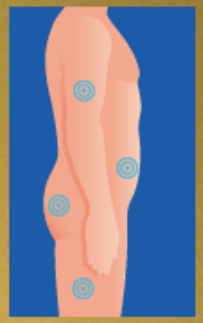
Deductible: Deductibles vary between Medicare drug plans, with some having no deductible. In the 2012 benefit, no Medicare drug plan can have a deductible greater than $320.

for the nurse audience

For the palliative treatment of advanced prostate cancer

Tips to enhance the administration of ELIGARD[1-4]

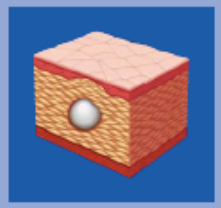
- You can remove enough ELIGARD from the refrigerator for the entire day if you check your patient schedule in advance, since ELIGARD must be brought to room temperature before administration.
- ELIGARD can be left at room temperature for up to 120 hours, including shipping time,[5] so any doses that are not used (if, for example, a patient misses an appointment) can be safely returned to the refrigerator at the end of the day as long as the 120-hour limit has not been exceeded.
- ELIGARD can be mixed quickly (in less than a minute) and must be administered within 30 minutes or discarded, so you can wait until the patient is in the treatment room before mixing it.
- ELIGARD can be administered in multiple locations such as the abdomen, upper buttocks, upper arm, thigh, or anywhere on the body where there is an adequate amount of subcutaneous tissue that does not have excessive pigment, nodules, lesions, or hair.

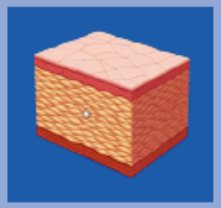


Subcutaneous delivery system

Because ELIGARD is a subcutaneous injection, the needle should be inserted quickly at an angle and withdrawn quickly at the same angle.

Once injected, ELIGARD forms a pellet that will dissolve over time (1, 3, 4, or 6 months, depending on dose), providing continuous, controlled release of medication.





Important Safety Information

ELIGARD is contraindicated in women, pediatric patients, and patients with hypersensitivity to GnRH, GnRH agonists, or any of the components of ELIGARD.

ELIGARD, like other LHRH agonists, causes a transient increase in serum testosterone during the first 2 weeks of treatment. Patients may experience worsening of symptoms or onset of new symptoms during the first weeks of treatment, including bone pain, neuropathy, hematuria, spinal compression, or bladder outlet obstruction. The most common side effects are hot flashes, injection site pain (including burning and stinging), fatigue, and testicular atrophy.

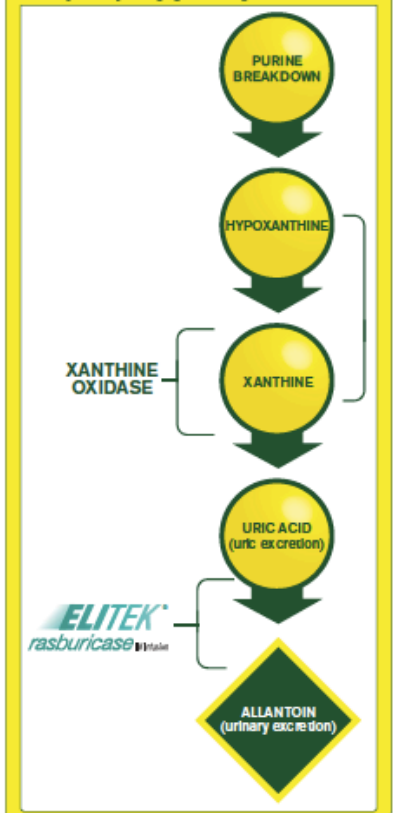
Please see accompanying full prescribing information in pocket for complete preparation and administration information.

Eligard®
(leuprolide acetate for injectable suspension)

Virtually the full range of therapeutic categories,
including oncology, CNS, diabetes, hematology, chronic pain, COPD, and vaccines

ELITEK® *(Rasburicase): Mechanism of Action*

Figure 3. ELITEK *Avoids Xanthine Accumulation by Directly Managing Circulating Uric Acid*[1]



ELITEK reduces circulating uric acid levels, while even maximized allopurinol therapy has no effect on uric acid formed.

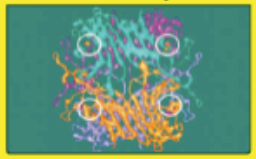
Mechanism of Action of ELITEK

In most mammalian species, the enzyme urate oxidase catabolizes the breakdown of uric acid to allantoin (see *Figure 2*), which is far more soluble (10 times) at normal urinary pH than is uric acid.[10] In humans, urate oxidase is not present, and uric acid is the final step in purine catabolism. *ELITEK* catalyzes the oxidation of uric acid to its far more soluble metabolite, allantoin, facilitating elimination by the kidneys in hyperuricemic patients. Because *ELITEK* acts at the end of the purine catabolic pathway, it does not modify earlier steps in purine metabolism, nor does it induce accumulation of upstream metabolites such as xanthine or hypoxanthine.[1,11] Moreover, unlike xanthine oxidase inhibitors that cannot modify existing high levels of uric acid, *ELITEK* directly decreases such levels. Finally, *ELITEK* does not interfere with any anabolic pathway involved in the synthesis of nucleic acids (*Figure 3*).[1]

Product Information

ELITEK is a recombinant form of the enzyme urate oxidase produced by a genetically modified strain of *Saccharomyces cerevisiae* expressing cDNA cloned from a strain of *Aspergillus flavus*. *ELITEK* is a tetrameric protein with identical subunits of a molecular mass of approximately 34 kDa (*Figure 4*).[1] The molecular formula is $C_{1550}H_{2388}N_{414}O_{456}S_7$. The monomer, made up of a single 301 amino-acid polypeptide chain, has no intra- or interdisulfide bridges, and each is N-terminal acetylated. The drug product (each 3-mL vial contains 1.5 mg rasburicase, 10.6 mg mannitol, 15.9 mg L-alanine, 12.6-14.3 mg dibasic sodium phosphate; each 10-mL vial contains 7.5 mg rasburicase, 53 mg mannitol, 79.5 mg L-alanine, and between 63 and 71.5 mg dibasic sodium phosphate) is a sterile, white to off-white, lyophilized powder intended for intravenous administration after reconstitution with sterile water and Poloxamer 188.[1]

Figure 4. Structure of ELITEK



Clinical Development of ELITEK

Clinical Studies Overview

Table 7 lists the 4 clinical studies conducted using *ELITEK*.

Table 7. Studies Providing Approval Basis for ELITEK[1,2,11,20-22]

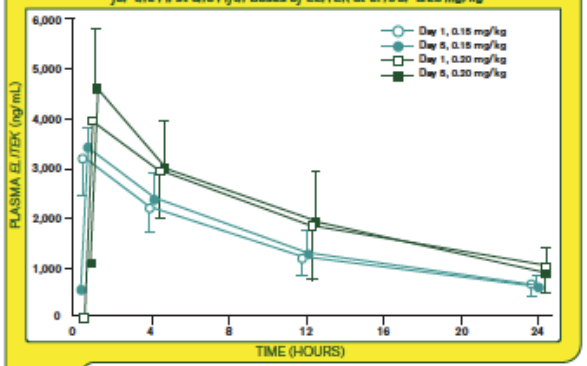
Study	Locations	Design	Population	No. of Subjects/Patients
Phase II (Study 2)	Multicenter—Europe	Pharmacokinetics, efficacy, and safety; dose selection for treatment and prophylaxis	Adults (18) and children (80) with leukemia or lymphoma	107
Phase II (Study 3)	Multicenter—International	Pharmacokinetics, efficacy, and safety; dose selection for treatment and prophylaxis	Children with leukemia or lymphoma	130
Phase III (Study 1)	Multicenter—US	Efficacy and safety vs allopurinol	Children with leukemia or lymphoma	27 *ELITEK* 25 Allopurinol
Phase II	Multicenter—International	Long-term safety and tolerability	Children with cancer	173

Pharmacokinetics

The pharmacokinetics of *ELITEK* were examined in 2 Phase II studies in patients with lymphoid leukemia (B cell and T cell), non-Hodgkin's lymphoma (including Burkitt's lymphoma), or acute myelogenous leukemia.[1,11,21] *ELITEK* exposure, as measured by $AUC_{0\text{-}24}$ and C_{max}, tended to increase linearly with dose over a limited dose range in patients (0.15-0.20 mg/kg).[1]

ELITEK plasma concentrations declined slowly (*Figure 5*), giving a mean elimination half-life of approximately 18 hours.[1]

Figure 5. Mean(SD) Plasma Concentration-vs-Time Plots for the First and Fifth Doses of ELITEK *at 0.15 or 0.20 mg/kg*[11]



Phase II study in patients receiving *ELITEK* on Days 1 and 5 with doses of 0.15 mg/kg (n=11) or 0.20 mg/kg (n=10).[11] All data points are shifted to the right of those for Day 1, 0.15 mg/kg, to avoid excessive overlap of the plot.

Please see accompanying full Prescribing Information including Boxed Warnings in pocket.
Please see Important Safety Information including Boxed Warnings on cover.