The **ONLY** FDA-approved treatment for reducing excess abdominal fat in adults with HIV and lipodystrophy.[1]

EGRIFTA WR™
(tesamorelin) for injection

There is more to treating people with HIV than viral suppression

REDUCE THE IMPACT of central adiposity[1]

***EGRIFTA WR™* is indicated for the reduction of excess abdominal fat in HIV-infected adult patients with lipodystrophy.**[1]

- The impact and safety of *EGRIFTA WR™* on cardiovascular health have not been studied.
- *EGRIFTA WR™* is not indicated for weight loss management.
- It is not known whether taking *EGRIFTA WR™* helps improve compliance with anti-retroviral medications.

Discover EVAF and how *EGRIFTA WR™* can help manage this condition in your patients.

The safety and effectiveness of *EGRIFTA WR™* have been established based on adequate and well-controlled studies with *EGRIFTA®*. *EGRIFTA®* was approved in 2010, *EGRIFTA SV®* in 2019, and *EGRIFTA WR™* in 2025.

Understanding Central Adiposity and EVAF

With advancements in antiretroviral therapy (ART), people with HIV (PWH) now enjoy much the same life expectancy as those without the virus, making long-term health management a priority.

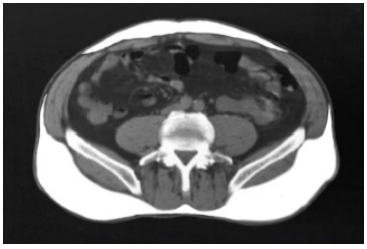
- However, even in the era of modern ART, studies show that the condition of **central adiposity** remains a common side effect.[2]

What is central adiposity?

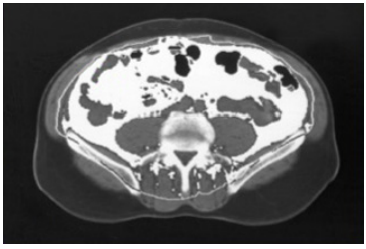
Central adiposity refers to the localized accumulation of both subcutaneous and visceral adipose tissue (VAT) in and around the abdomen. In PWH, this is often characterized by a buildup of VAT—a condition known as excess visceral abdominal fat (EVAF).

- **EVAF is an abnormal buildup of VAT within the abdominal cavity surrounding the internal organs.**[3]

Fat tissues involved in central adiposity



Subcutaneous abdominal fat



Visceral abdominal fat

In typical obesity (BMI >30), weight is carried throughout the body and fat accumulates primarily as subcutaneous adipose tissue[4,5]

Just beneath the skin[4,5]

Poor indicator of EVAF as it is prevalent *even* in PWH with normal BMI, with rates of:[6*]

- **43%** in people with BMI 20–25 kg/m^2 (normal weight)
- **47%** in people with BMI 25–29.9 kg/m^2 (overweight)

Deep within the abdominal cavity, surrounding the internal organs[3,4]

Surface area: 155 cm^2*

Visceral fat surface area in an actual patient. Surface area above 130 cm^2 is indicative of lipohypertrophy.[3]

IMPORTANT SAFETY INFORMATION

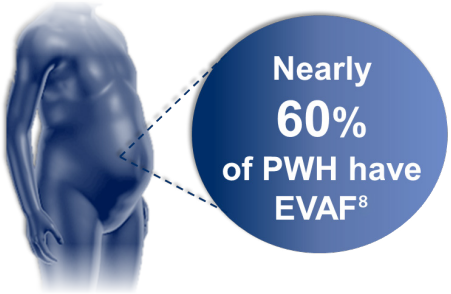
Contraindications:

Do not use *EGRIFTA WR*™ if patient:

- Has a pituitary gland tumor, has had pituitary gland surgery, has other problems related to their pituitary gland, or has had radiation treatment to their head or a head injury.
- Has active cancer.
- Is allergic to tesamorelin or any of the ingredients in *EGRIFTA WR*™.
- Is pregnant or planning to become pregnant.

ART, antiretroviral therapy; BMI, body mass index; EVAF, excess visceral abdominal fat; PWH, people with HIV; VAT, visceral adipose tissue.

EVAF Remains Prevalent in the Modern ART Era[7,8]



Studies show that up to 60% of PWH on modern ARTs with virological suppression for over a year were found to have EVAF.[8]*

Recognizing EVAF as Part of Comprehensive Care for PWH

DHHS Guidelines Update (September 2025)[7]

HIV has been **recognized as an ASCVD risk amplifier**, imposing a **2x risk for ASCVD** vs. the general population

Lipohypertrophy is **associated with additional risk** and has been identified as a **key modifiable risk factor**

Access a section of the Cardiovascular and Metabolic Complications in People with HIV chapter of the DHHS recommendations

IMPORTANT SAFETY INFORMATION

Drug Interactions

- *EGRIFTA WR*™ had no significant impact on the pharmacokinetic profiles of simvastatin in healthy subjects.
- Monitor patients for potential interactions when administering *EGRIFTA WR*™ in combination with other drugs known to be metabolized by CYP450 liver enzyme.
- Patients on glucocorticoids may require dosage adjustment upon initiation of *EGRIFTA WR*™.

* Based on a multi-center observational study in PWH.[4]

ART, antiretroviral therapy; EVAF, excess visceral abdominal fat; GH, growth hormone; GHRH, growth hormone-releasing hormone; PWH, people with HIV; VAT, visceral adipose tissue.

Recognizing and Diagnosing EVAF in Practice

Start identifying EVAF with this one simple step:[3]

Measure waist circumference (WC)

If WC meets the threshold for EVAF, proceed to measure hip circumference and **calculate** the **waist-to-hip ratio** (WHR)‡

EVAF Indicators*†

	Males	Females
WC:	≥37.4 in (95 cm)	≥37 in (94 cm)
WHR:	≥0.94	≥0.88

Studies show that WC is the most reliable predictor of EVAF, outperforming weight and BMI.[1,2]

* Based on a multi-center observational study in PWH.[4]
† Reference values are based on inclusion criteria in clinical trials.
‡ Waist-to-hip ratio = waist circumference/hip circumference.
ART, antiretroviral therapy; ASCVD, atherosclerotic cardiovascular disease; BMI, body mass index; EVAF, excess visceral abdominal fat; HC, hip circumference; PWH, people with HIV; WC, waist circumference; WHR, waist-to-hip ratio.

IMPORTANT SAFETY INFORMATION

Use in Specific Populations

Lactation: Mothers should not breastfeed if they receive *EGRIFTA WR*™.
Pediatric Use: Safety and effectiveness in pediatric patients have not been established.
Geriatric Use: There is no information on the use of *EGRIFTA WR*™ in patients greater than 65 years of age.
Renal and Hepatic Impairment: Use in renal and hepatic impairment has not been studied.

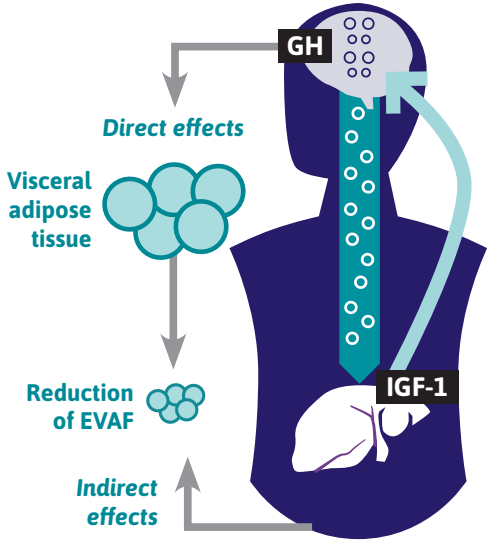
Managing EVAF in PWH with *EGRIFTA WR*™

A unique mechanism of action to address GH reductions and EVAF in PWH

There is a significant inverse relationship between GH levels and VAT surface area in PWH[8*]

EGRIFTA WR™ is an **analog of GHRH** that stimulates the body to secrete its own GH in a pulsatile manner, resulting in **both anabolic and lipolytic effects.**[1]

- By supporting endogenous GH release without altering pulse frequency, *EGRIFTA WR*™ mimics the body's natural hormone rhythm.[9]



Pharmacological agents targeting the GH axis to reduce EVAF may help mitigate EVAF-associated health risk in PWH.

EGRIFTA WR™ is the **ONLY** FDA-approved treatment for reducing excess abdominal fat in adults with HIV and lipodystrophy.[1]

* Based on a multi-center observational study in PWH.[4]

ART, antiretroviral therapy; EVAF, excess visceral abdominal fat; GH, growth hormone; GHRH, growth hormone-releasing hormone; PWH, people with HIV; VAT, visceral adipose tissue.

IMPORTANT SAFETY INFORMATION

Warnings and Precautions

- **Increased risk of neoplasms:** Preexisting malignancy should be inactive, and its treatment complete prior to starting *EGRIFTA WR*™. *EGRIFTA WR*™ should be discontinued if the patient has evidence of recurrent malignancy.
- **Elevated IGF-1:** Monitor regularly IGF-1 levels in all patients during *EGRIFTA WR*™ therapy. Consider discontinuing in patients with persistent elevations (e.g., >3 SDS).
- **Fluid retention:** May include edema, arthralgia, and carpal tunnel syndrome.

In two multicenter, randomized, double-blind, placebo-controlled clinical trials,

Patients who received EGRIFTA® experienced:

Main Phase 26 weeks — **16%** — **Average reduction in EVAF***† — **Extension Phase** 52 weeks — **18%**

In a post-hoc responder analysis*‡ of data from two multicenter, randomized, double-blind, placebo-controlled clinical trials,

EGRIFTA® responders experienced:[11]

Main Phase 26 weeks — **27%** — **Average reduction in EVAF***† — **Extension Phase** 52 weeks — **31%**

Main Phase 26 weeks — **1.65" (4.2 cm)** — **Average reduction in waist circumference***‡ — **Extension Phase** 52 weeks — **1.85" (4.7 cm)**

* The primary outcome for these trials was change in VAT from Week 0 to 26 by treatment group.
† A single-slice CT scan was used to quantify VAT.
‡ A ≥8% decrease in VAT area was determined to be clinically significant and used to define responders *a priori*.

An expert panel in agreement with the FDA determined that a **≥8% decrease in EVAF was clinically significant.**[10]

- At Week 52, average VAT was within normal range (mean EVAF: 129 ± 48 cm^2).

IMPORTANT SAFETY INFORMATION

Warnings and Precautions

- **Glucose intolerance or diabetes mellitus:** May develop with *EGRIFTA WR*™ use. Evaluate glucose status prior to and during therapy with *EGRIFTA WR*™.
- **Hypersensitivity reactions:** Advise patients to seek immediate medical attention and discontinue treatment if suspected.
- **Injection-site reactions:** Advise patients to rotate injection sites to different areas of the abdomen to decrease injection-site reactions.
- **Increased mortality in patients with acute critical illness:** Consider discontinuation in critically ill patients.

EGRIFTA® effects on secondary metabolic outcome measures in PWH, WC, lean body mass, and trunk fat[1,11]*

Outcome	Change from Week 0–26 (n=232)		Change from Week 0–52 (n=110)	
	Baseline	Change	Baseline	Change
WC (cm)	103.7 ± 8.6	-4.2 ± 5.7†	103.6 ± 8.2	-4.7 ± 6.4‡
Lean body mass (kg)	62.2 ± 9.6	1.6 ± 2.4†	62.1 ± 9.1	1.2 ± 2.8‡
Trunk fat (kg)	14.4 ± 4.7	-1.8 ± 2.0†	14.4 ± 4.4	-2.2 ± 2.3‡

***EGRIFTA WR*™ may increase lean body mass by up to 5 lb.**[1,11§]

Measures of glucose homeostasis[1,11]	Other outcomes[1,11]
• Fasting glucose levels¶ • Fasting insulin levels‖ • HbA1c levels** • HOMA-IR score†† • 2-hour glucose levels‡‡	• Triglyceride levels§§ • Adiponectin levels¶¶

The results of the post-hoc analysis were not part of the NDA, and therefore were not reviewed by the FDA to support the approval of *EGRIFTA*®.

The safety and effectiveness of *EGRIFTA WR*™ have been established based on adequate and well-controlled studies with *EGRIFTA*® (tesamorelin for injection).[1]

EGRIFTA WR™ is not indicated for weight loss management.[1]

EGRIFTA WR™ is not approved for use in clinical conditions other than the reduction of excess abdominal fat.[1]

EVAF, excess visceral abdominal fat; MetS, metabolic syndrome; NDA, New Drug Application; VAT, visceral adipose tissue.
* All data presented as mean ± SD, unless stated otherwise. † Indicates $p<0.05$ for within-group comparison of baseline vs. 26 weeks, using a mixed repeated measure model. ‡ Indicates $p<0.05$ for within-group comparison of baseline vs. 52 weeks, using a mixed repeated measure model. § EGRIFTA WR™ has a weight-neutral effect. ¶ Mean change (±SD) in fasting glucose levels between tesamorelin responders and non-responders: Week 0–26: 1 ± 16 mg/dL vs. 5 ± 14 mg/dL ($p=0.010$); Week 0–52: -1 ± 14 mg/dL vs. 8 ± 14 mg/dL ($p<0.001$). || Mean change (±SD) in fasting insulin levels between tesamorelin responders and non-responders: Week 0–26: -1.1 ± 25.2 µIU/mL vs. 5.7 ± 13.5 µIU/mL ($p=0.011$); Week 0–52: -2.5 ± 19.1 µIU/mL vs. 4.9 ± 17.9 µIU/mL ($p=0.002$). ** Mean change (±SD) in HbA1c levels between tesamorelin responders and non-responders: Week 0–26: 0.1 ± 0.3 % vs. 0.3 ± 0.4% ($p<0.001$); Week 0–52: 0.0 ± 0.3 % vs. 0.2 ± 0.5 % ($p=0.003$). †† Mean change (±SD) in HOMA-IR score between tesamorelin responders and non-responders: Week 0–26: -0.4 ± 7.9 vs. 1.8 ± 4.3 ($p=0.006$); Week 0–52: -0.7 ± 5.2 vs. 1.6 ± 5.5 ($p<0.001$). ‡‡ Mean change (±SD) in 2-hour glucose levels between tesamorelin responders and non-responders: Week 0–26: -1 ± 34 mg/dL vs. 10 ± 44 mg/dL ($p=0.009$); Week 0–52: -5 ± 37 mg/dL vs. 10 ± 31 mg/dL ($p=0.006$). §§ Mean change (±SD) in triglyceride levels between tesamorelin responders and non-responders: Week 0–26: -0.6 ± 1.7 mmol/L vs. -0.1 ± 1.2 mmol/L ($p=0.005$); Week 0-52: -0.8 ± 1.8 mmol/L vs. 0.0 ± 1.1 mmol/L ($p=0.003$). ¶¶ Mean change (±SD) in adiponectin levels between tesamorelin responders and non-responders: Week 0–26: 1.0 ± 3.0 µg/mL vs. -0.3 ± 1.8 µg/mL ($p=0.011$); Week 0–52: 2.3 ± 3.2 µg/mL vs. 0.3 ± 1.6 mmol/L ($p=0.008$).

Building on 15+ years of established safety with EGRIFTA®1*

EGRIFTA WR™ is generally well tolerated[1]

Within the Phase 3 studies, 740 people with HIV who had lipodystrophy and EVAF received *EGRIFTA*®; of these, 543 received *EGRIFTA*® during the initial 26-week placebo-controlled Main Phase studies.[1]

The most commonly reported adverse events were:[1]

- Hypersensitivity reactions (rash, urticaria)
- Edema-related reactions (e.g., arthralgia, pain in extremity, peripheral edema, and carpal tunnel syndrome)
- Hyperglycemia
- Injection-site reactions (e.g., injection-site erythema, pruritus, pain, urticaria, irritation, swelling, and hemorrhage)

* The safety of *EGRIFTA WR*™ (11.6 mg/vial formulation) has been established based on clinical trials conducted with *EGRIFTA*® (1 mg/vial formulation). Adverse events for the 1.28 mg dose (11.6 mg/vial formulation) of *EGRIFTA WR*™ are expected to be similar to those observed with the 2 mg dose (1 mg/vial formulation) of *EGRIFTA*®.[1]

IMPORTANT SAFETY INFORMATION

Adverse Reactions

The most commonly reported adverse reactions include injection-site reactions, arthralgia, pain in extremity, myalgia, and peripheral edema.

For complete disclosure of *EGRIFTA WR*™ product information, please read the Full Prescribing Information, available at www.egriftawr.com.

For more information about *EGRIFTA WR*™, contact THERA patient support® toll free at 1-833-23-THERA (1-833-238-4372). To report suspected adverse reactions, contact THERA patient support® toll free or the FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

EGRIFTA WR™ Dosing and Administration

A once-weekly reconstitution for simpler daily administration

Key features include:[1,12]

- Once-daily dosing of 1.28 mg
- Concentrated for small daily injection volumes (0.16 mL)
- Stored at room temperature (no refrigeration required before or after reconstitution)
- Comes with BD SafetyGlide™ syringes for injection (with needle attached; orange cap)

Access resources online to educate your patients about the reconstitution and administration of *EGRIFTA WR*™.

Contact THERA patient support® to get your patients started with *EGRIFTA WR*™ today!

Your dedicated resource, there for you and your patients every step of the way, providing personalized assistance to help them:

Start therapy quickly by minimizing barriers to access, including insurance approval (e.g., prior authorization, appeals)

Save on treatment-associated costs through reimbursement navigation and other financial assistance programs

Stay on *EGRIFTA WR*™ treatment with ongoing, personalized, one-on-one support

Scan the QR code to download the *EGRIFTA WR*™ enrollment form and get your patients started with *EGRIFTA WR*™ today!

Have questions?

Visit www.THERApatientsupportUS.com online

OR

Call THERA patient support® toll free at 1-833-23-THERA (1-833-238-4372) and a THERA Patient Care Coordinator will assist you and your office staff. Available Monday to Friday from 8:30 a.m. to 8:00 p.m. ET.

The **ONLY** FDA-approved treatment for reducing excess abdominal fat in adults with HIV and lipodystrophy.[1]

EGRIFTA WR™
(tesamorelin) for injection

A Targeted Treatment to Reduce EVAF in PWH

- Responders achieved a **31% reduction in EVAF** after 52 weeks of treatment, returning the **average VAT surface area to within the normal range** (mean VAT: 129 ± 48 cm^2).[11]
- May increase lean body mass by up to 5 lb.*[1]

* *EGRIFTA WR*™ has a weight-neutral effect.

Building on 15+ years of established safety.[1]

Once-weekly reconstitution for simpler daily administration.[1]

References:
1. Theratechnologies Inc. *EGRIFTA WR*™ (tesamorelin) for injection Prescribing Information. March 2025. **2.** Koethe JR, et al. *Nat Rev Dis Primers*. 2020;6(1):48. **3.** Lake JE. *Curr HIV/AIDS Rep*. 2017;14(6):211-219. **4.** Ibrahim MM. *Obes Rev*. 2010;11(1):11-18. **5.** NIH & NHLBI. Assessing your weight and health risks. Accessed September 2025. https://www.nhlbi.nih.gov/health/heart-healthy-living/healthy-weight. **6.** Mounzer K. Presented at: CROI; March 9–12, 2025; San Francisco, California. **7.** DHHS guidelines for the use of antiretroviral agents in adults and adolescents with HIV. September 2025. **8.** Mounzer K, et al. Presented at IDWeek; October 16–19; Los Angeles, California. **9.** Stanley TL, et al. *J Clin Endocrinol Metab*. 2011;96(1):150-158. **10.** Snyder SW. Regulatory considerations for the treatment of lipodystrophy. Forum for Collaborative HIV Research Roundtable Discussion. October 25, 2004; Washington, DC. **11.** Stanley TL, et al. *Clin Infect Dis*. 2012;54(11):1642-1651. **12.** Zogheib M, et al. Presented at IDWeek; October 16–19; Los Angeles, California. **13.** Bedimo R, et al. Presented at CROI 2025; March 9–12; San Francisco, California.

THERA technologies

EGRIFTA WR™
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