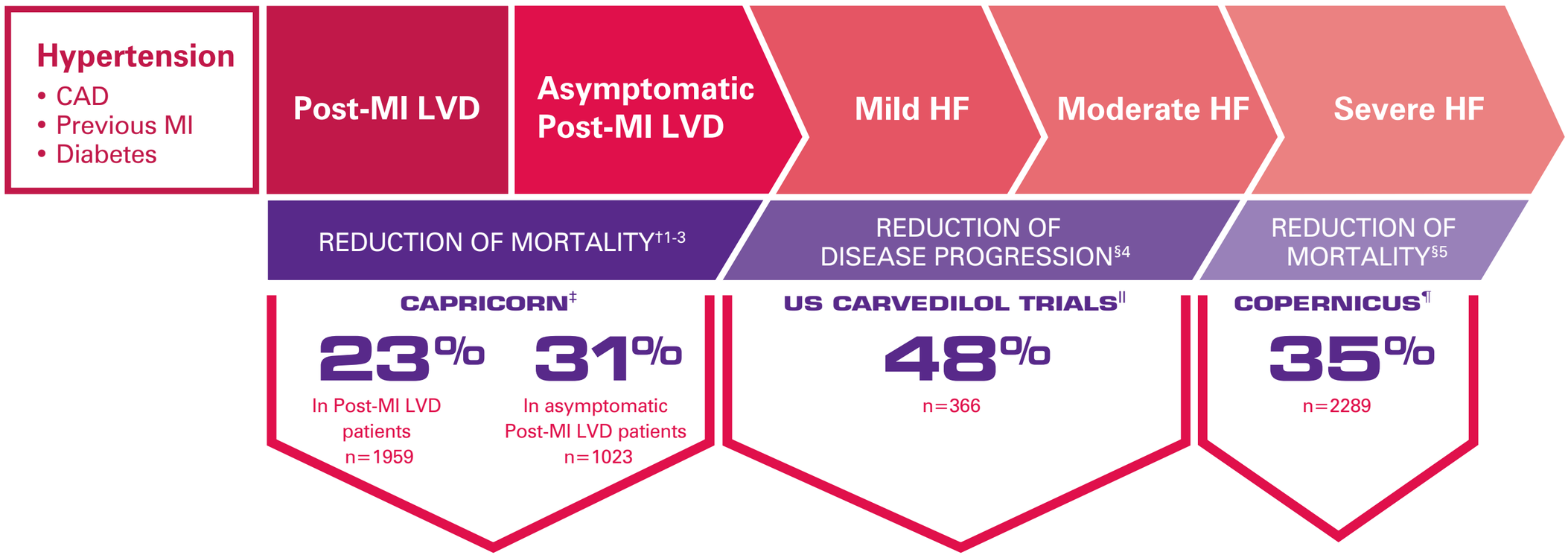
Broad-spectrum blockade,* proven cardioprotection

COREG reduces mortality in Post-MI LVD and in mild to severe HF

COREG provides broad-spectrum blockade, proven cardioprotection



HYPERTENSION: COREG is indicated for the management of essential hypertension. COREG can be used alone or in combination with other antihypertensive agents, especially thiazide-type diuretics.

LEFT VENTRICULAR DYSFUNCTION (LVD) FOLLOWING MYOCARDIAL INFARCTION (MI): COREG is indicated to **reduce cardiovascular (CV) mortality** in clinically stable patients who have survived the acute phase of an MI and have a left ventricular ejection fraction (LVEF) ≤40% **(with or without symptomatic heart failure [HF]).**

CONGESTIVE HF: COREG is indicated for the treatment of **mild to severe HF** of ischemic or cardiomyopathic origin, usually in addition to diuretics, angiotensin-converting enzyme (ACE) inhibitor, and digitalis, to **increase survival** and, also, to reduce the risk of hospitalization.

* β_1-, β_2-, and α_1-adrenergic receptor blockade. The bases (mechanisms of action) for the beneficial effects of COREG in hypertension, HF, and Post MI-LVD have not been established.

† Patients were receiving ACE inhibitors or angiotensin receptor blockers (97%), aspirin (85%), diuretics (34%), lipid-lowering agents (23%), and anticoagulants (20%).[1]

‡ CAPRICORN was a double-blind study comparing COREG and placebo in 1959 patients with a recent MI (within 21 days) and LVEF ≤ 40%, with (47%) or without (53%) symptoms of HF. Patients given COREG received 6.25 mg bid, titrated as tolerated to 25 mg bid. Entry criteria included a systolic blood pressure >90 mm Hg, a sitting heart rate >60 beats/minute, and no contraindication to β-blocker use. All-cause mortality was 15% in the placebo group and 12% in the COREG group, indicating a 23% risk reduction in patients treated with COREG (95% CI, 2% to 40%; *P*=.031). All-cause mortality in asymptomatic HF patients was 12% in the placebo group and 8% in the COREG group, indicating a 31% risk reduction in patients treated with COREG (95% CI, –3% to 53%).[1,3]

§ Reduction vs placebo in addition to the benefits of ACE-based therapy (ACE inhibitor, diuretics, +/– digoxin).

‖ Duration of study was up to 15 months. The risk of disease progression was defined as the triple endpoint of HF death, HF hospitalization, or the need for sustained increase in medications for HF. Disease progression was 21% in the placebo group and 11% in the carvedilol group, indicating a 48% risk reduction in patients treated with COREG (95% CI, 15% to 68%; *P*=.008).

¶ A double-blind, randomized, placebo-controlled study of 2289 euvolemic patients with symptoms of HF at rest or on minimal exertion for at least 2 months and an LVEF<25%. All-cause mortality was 19.7% in the placebo group and 12.8% in the carvedilol group, indicating a 35% risk reduction in patients treated with COREG (95% CI, 19% to 48%; *P*=.0014).

Please see complete Prescribing Information available at this exhibit.

References: 1. Prescribing Information for COREG. GlaxoSmithKline. **2.** The CAPRICORN Investigators. Effect of carvedilol on outcome after myocardial infarction in patients with left-ventricular dysfunction: the CAPRICORN randomised trial. *Lancet.* 2001;357:1385-1390. **3.** Data on file, GlaxoSmithKline. **4.** Colucci WS, Packer M, Bristow MR, et al, for the US Carvedilol Heart Failure Study Group. Carvedilol inhibits clinical progression in patients with mild symptoms of heart failure. *Circulation.* 1996;94:2800-2806. **5.** Packer M, Coats AJS, Fowler MB, et al, for the Carvedilol Prospective Randomized Cumulative Survival Study Group. Effect of carvedilol on survival in severe chronic heart failure. *N Engl J Med.* 2001;344:1651-1658.

GlaxoSmithKline

COREG® Carvedilol®

Benefits Beyond β_1-blockade

ADA	6/5-7/04	Orlando, FL	CRG905R0A	18x24/36x48	First Used