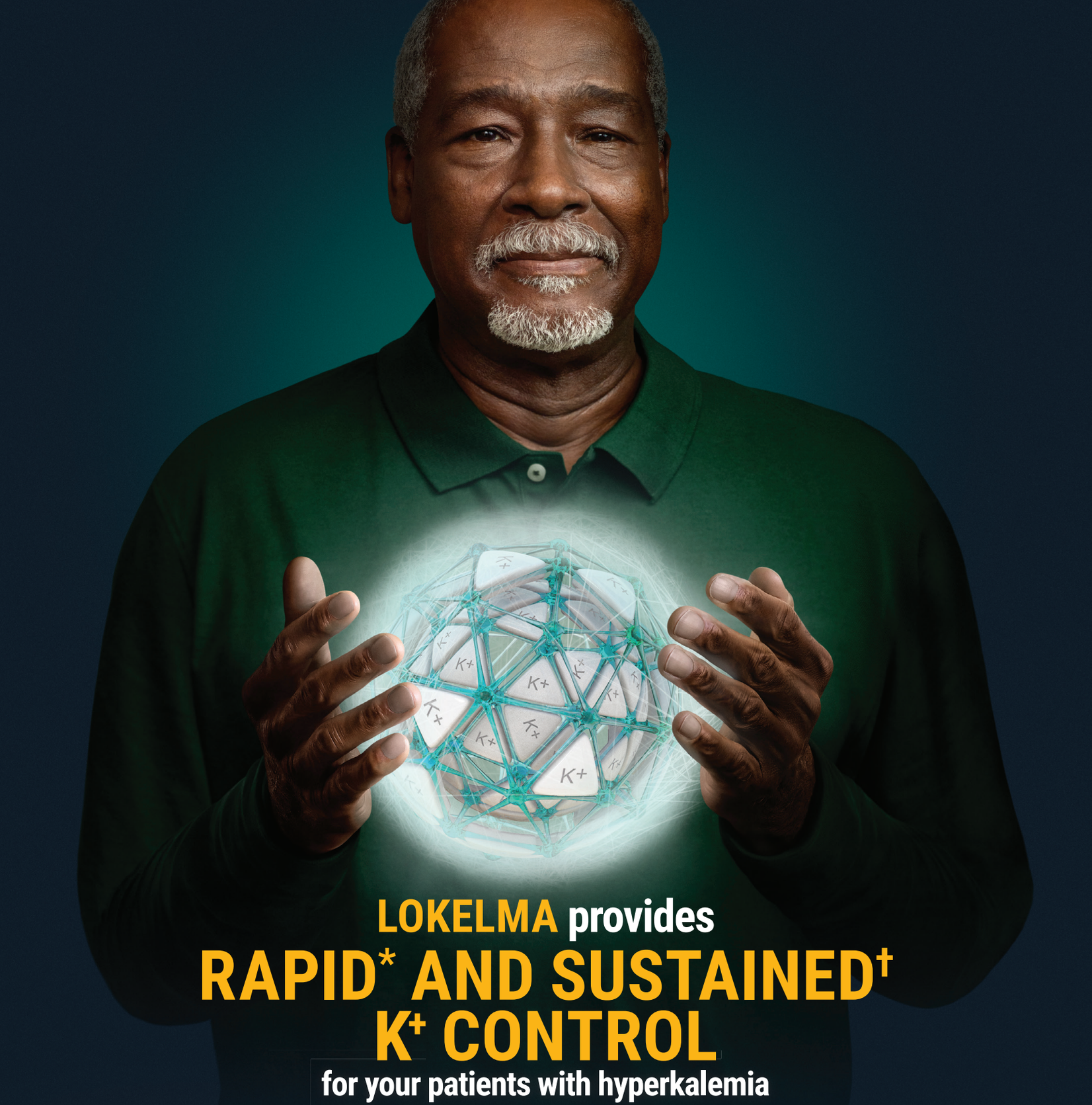


LOKELMA provides RAPID* AND SUSTAINED† K^+ CONTROL

for your patients with hyperkalemia

*In Study 1, LOKELMA 10 g tid demonstrated a greater reduction in serum K^+ levels vs placebo at 48 hours and started to work as early as 1 hour in patients with hyperkalemia not on dialysis.[1,2]

†In Study 2, LOKELMA-treated patients with hyperkalemia not on dialysis who achieved normokalemia at 48 hours maintained mean serum K^+ at lower levels than placebo at all 3 daily doses (5 g, 10 g, 15 g) in the 28-day randomized withdrawal phase. Patients in Study 2 who continued into the open-label, 11-month extension phase sustained normokalemia with continued LOKELMA dosing.[1,2]

K^+=potassium; tid=3 times a day.

Individual is a hypothetical patient, not an actual patient.

INDICATION AND LIMITATION OF USE

LOKELMA is indicated for the treatment of hyperkalemia in adults.

LOKELMA should not be used as an emergency treatment for life-threatening hyperkalemia because of its delayed onset of action.

Please read additional Important Safety Information on page 22 and accompanying full Prescribing Information.

LOKELMA®
(sodium zirconium cyclosilicate)
5 g | 10 g for oral suspension

Have you considered K^+ binders for your patients…

…across all settings?

NEW DATA: DIALYSIS

TIM

Age 58,* ESRD, diabetes

Pre-dialysis serum K^+ after the LIDI: 6.2 mEq/L

- On chronic hemodialysis with persistent hyperkalemia
- Previously hospitalized for hyperkalemia

EMERGENCY DEPARTMENT/INPATIENT

JULIA

Age 70,* CKD

Serum K^+: 6.1 mEq/L

- Received temporizing agent after admission to ED and is now stable but still hyperkalemic
- Previous episodes were treated with SPS, resulting in GI disturbances

OUTPATIENT

STEVEN

Age 62,* CHF

Serum K^+: 5.8 mEq/L

- Recurrent hyperkalemia over the past year requiring continued K^+ reduction
- Taking ACEi and MRA

LONG-TERM CARE

JOHN

Age 79,* CKD, CHF, T2D

Serum K^+: 5.7 mEq/L

- Discharged back to long-term care facility from ED after a K^+ spike
- Discontinued ACEi but still taking an MRA

*In LOKELMA clinical trials (Studies 1-4), the mean age of patients studied was 58-66 years.[1,3,4]

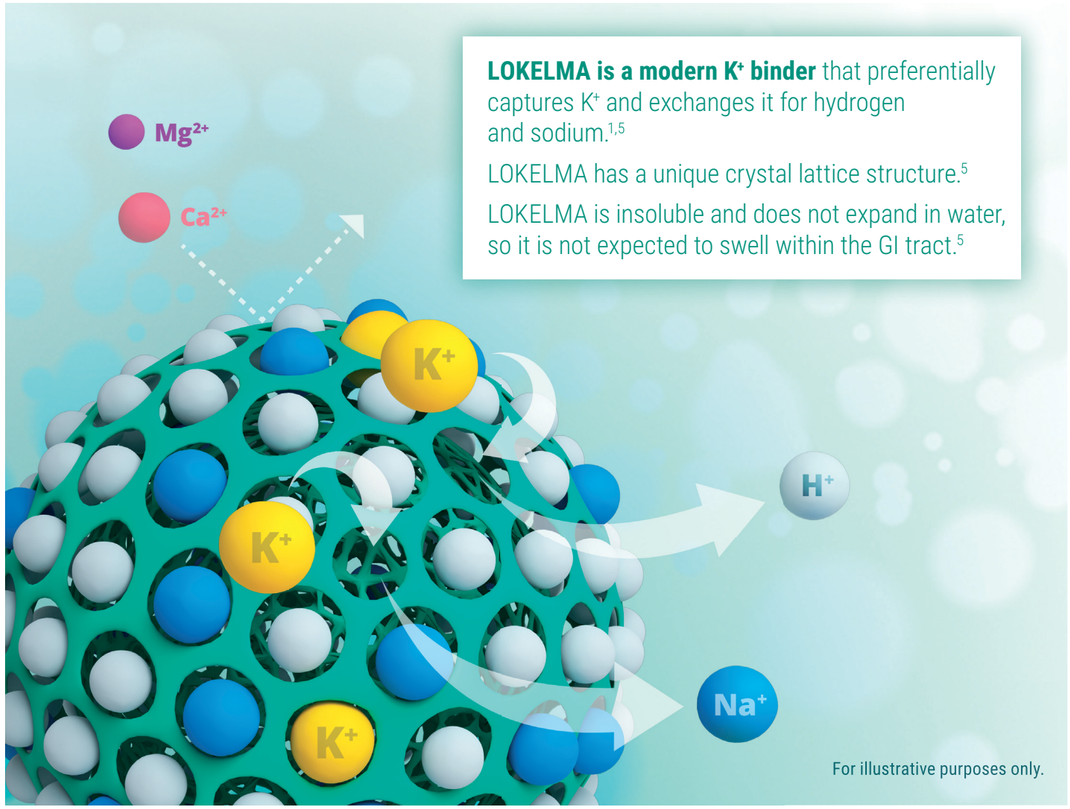
Individuals are hypothetical patients, not actual patients.

ACEi=angiotensin-converting enzyme inhibitor; CHF=congestive heart failure; ESRD=end-stage renal disease; LIDI=long interdialytic interval; MRA=mineralocorticoid receptor agonist.

Individuals are hypothetical patients, not actual patients.

ACEi=angiotensin-converting enzyme inhibitor; CHF=congestive heart failure; CKD=chronic kidney disease; ED=emergency department; GI=gastrointestinal; MRA=mineralocorticoid receptor agonist; SPS=sodium polystyrene sulfonate; T2D=type 2 diabetes.

LOKELMA is a highly selective, innovative K+ binder…



LOKELMA is a modern K+ binder that preferentially captures K+ and exchanges it for hydrogen and sodium.[1,5]

LOKELMA has a unique crystal lattice structure.[5]

LOKELMA is insoluble and does not expand in water, so it is not expected to swell within the GI tract.[5]

For illustrative purposes only.

IMPORTANT SAFETY INFORMATION FOR LOKELMA
WARNINGS AND PRECAUTIONS:

- **Gastrointestinal Adverse Events in Patients with Motility Disorders:** Avoid LOKELMA in patients with severe constipation, bowel obstruction or impaction, including abnormal post-operative bowel motility disorders. LOKELMA has not been studied in patients with these conditions and it may be ineffective and may worsen gastrointestinal conditions.
- **Edema:** Each 5-g dose of LOKELMA contains approximately 400 mg of sodium, but the extent of absorption by the patient is unknown. In clinical trials of LOKELMA in patients who were not on dialysis, edema was observed and was generally mild to moderate in severity and was more commonly seen in patients treated with 15 g once daily. Monitor for signs of edema, particularly in patients who should restrict their sodium intake or are prone to fluid overload (eg, heart failure or renal disease). Advise patients to adjust dietary sodium, if appropriate. Increase the dose of diuretics as needed.

  In a clinical trial of LOKELMA in patients on chronic hemodialysis in which most patients were treated with doses of 5 g to 10 g once daily on non-dialysis days, there was no difference in the mean change from baseline in interdialytic weight gain (a measure of fluid retention) between the LOKELMA and placebo groups.
- **Hypokalemia in Patients on Hemodialysis:** Patients on hemodialysis may be prone to acute illness that can increase the risk of hypokalemia on LOKELMA (eg, illnesses associated with decreased oral intake, diarrhea). Consider adjusting LOKELMA dose based on potassium levels in these settings.

…that is different than other K+ binders[1,5]

	LOKELMA®	SPS (sodium polystyrene sulfonate)*[6]	Veltassa® (patiromer) for oral suspension[7]
Selectivity	**Binds K+†[1]**	Binds K+, Ca+, and Mg+[6]	Binds K+ and Mg+[7]
Site of K+ capture in lumen of GI tract	**Small and large intestines‡[5]**	Primarily large intestine[8]	Primarily colon§[8]
Calcium content	**0 g[9]**	0 g[9]	1.6 g per 8.4 g of patiromer[10]
Sodium content for recommended maintenance dose range	**400 mg qod-1200 mg daily‖[1]**	1500 mg-6000 mg daily¶[11,12]	0[11,12]
Molecular composition	**Non-polymer[13]**	Polymer[13]	Polymer[13]

*Brand names for sodium polystyrene sulfonate (SPS) include Kayexalate® and Kionex®.

†In vitro, LOKELMA has a high affinity for K+, even in the presence of other cations such as calcium and magnesium.[1]

‡In vitro study; based on simulated intestinal fluid.[5]

§Based on nonclinical and early phase studies.[14]

‖The sodium content/unit dose of LOKELMA is 400 mg/5 g. The recommended maintenance dose range for non-dialysis patients is 5 g qod to 15 g daily (sodium content: 400 mg qod-1200 mg daily) and for dialysis patients is 5 g to 15 g once daily, on non-dialysis days (sodium content: 400 mg-1200 mg once daily on non-dialysis days).[1]

¶The sodium content/unit dose of SPS is 1500 mg/15 g. The in vivo efficiency of sodium-potassium exchange for SPS is approximately 33%; hence, about one-third of the actual sodium content is delivered to the body.[6] The recommended dose for SPS is 15 g 1 to 4 times daily.[6,11,12]

Clinical pharmacology does not correlate with efficacy or safety.

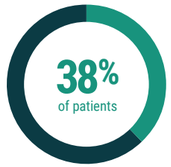
LOKELMA causes a small dose-dependent increase in serum bicarbonate concentrations (1.1 mEq/L at 5 g once daily, 2.3 mEq/L at 10 g once daily and 2.6 mEq/L at 15 g once daily as compared with a mean increase of 0.6 mEq/L in patients treated with placebo). The clinical significance of this finding is unclear.[1]

GI=gastrointestinal; qod=every other day.

Please read additional Important Safety Information on page 22 and accompanying full Prescribing Information.

LOKELMA®
(sodium zirconium cyclosilicate)
5 g | 10 g for oral suspension

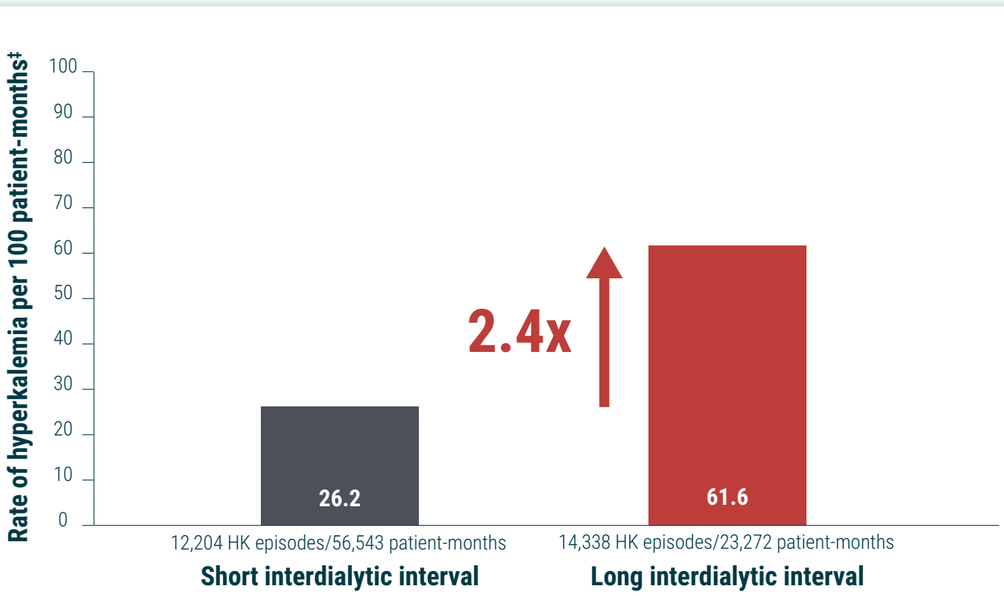
Hyperkalemia is **prevalent** in patients on hemodialysis…



Despite receiving in-center hemodialysis, 38% of patients presented at US dialysis centers in August 2019 with hyperkalemia (n=7938)*[15]

In a retrospective observational study, where hyperkalemia was defined as K^+ ≥5.5 mEq/L

Prevalence of hyperkalemia was found to be 2.4x higher in hemodialysis patients during the day after the long interdialytic interval vs the day after the short interdialytic interval†[17]



The short interdialytic interval was defined as a single day between sessions. The long interdialytic interval was defined as multiple days between sessions.

*Data from the DOPPS Practice Monitor using the most recent (single) monthly pre-dialysis values of serum potassium levels from the national sample of >11,000 patients in >200 US hemodialysis centers. Note: Hyperkalemia is defined as K^+ ≥ 5.0 mEq/L. Timing of K^+ measurement in relation to the hemodialysis schedule, whether after a long or short interdialytic interval, is unknown.[15]

†A retrospective observational study from the USRDS of hemodialysis patients (N=36,888) during 2010 with ≥6 hemodialysis sessions and ≥1 potassium measurement. Timing of K^+ measurement in relation to the hemodialysis cycle was not described in the study but was typically measured once a month during routine sessions. The hemodialysis schedule was defined as Monday-Wednesday-Friday (M-W-F) or Tuesday-Thursday-Saturday (T-Th-Sa). The day after the long 3-day interval between sessions (long interdialytic interval) was defined as Monday for patients on a M-W-F schedule and as Tuesday for patients on a T-Th-Sa schedule, and the other days were referred to as the short interdialytic interval.[17]

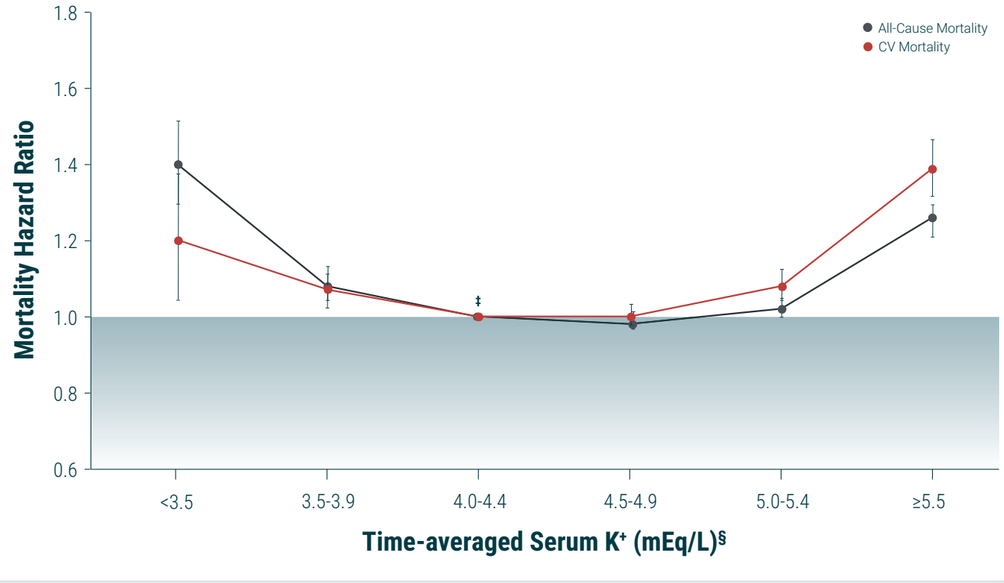
‡Rate of hyperkalemia was computed as a ratio of total number of hyperkalemia episodes and cumulative follow-up time in months. The LIDI rate was calculated based on hyperkalemia episodes identified on the day after the LIDI and the SIDI rate was calculated based on hyperkalemia episodes identified on the day after the SIDI.[17]

DOPPS=Dialysis Outcomes and Practice Patterns Study; HK=hyperkalemia; LIDI=long interdialytic interval; SIDI=short interdialytic interval; USRDS=United States Renal Data System.

…and poses risks of **hospitalization and mortality**[15,16]

In a retrospective observational study of ESRD patients receiving thrice-weekly hemodialysis (n=52,734), serum K^+ ≥5.5 mEq/L was associated with increased adjusted risk of all-cause hospitalization*[18]

Hyperkalemia is associated with an increased risk of all-cause and CV mortality in patients receiving hemodialysis†[16]



Graph reproduced from Torlén et al. 2012.

LOKELMA® (sodium zirconium cyclosilicate) is not indicated to reduce the risk of death or hospitalizations.[1]

*Based on an analysis of 533,889 qualifying serum K^+ measurements from US Medicare adult patients at a large dialysis organization with at least 1 potassium measurement between January 2010 and December 2011. Serum K^+ measurements were generally performed monthly immediately prior to HD on the first or second treatment day after the long weekend (ie, Monday or Wednesday for a Monday-Wednesday-Friday schedule). Analyses were adjusted for covariates including demographics, comorbidities, and laboratory values.[18]

†Analysis of 111,434 hemodialysis patients with follow-up data from an observational cohort study conducted in US DaVita facilities between July 2001 and June 2006. Hyperkalemia defined as K^+ ≥5.0 mEq/L. The timing of K^+ measurement in relation to the hemodialysis cycle and schedule was not described in the study. Data was adjusted for demographics, comorbidities, and laboratory values.[16]

‡Reference group was hemodialysis patients with serum K^+ between 4.0 and 4.5 mEq/L.[16]

§Each patient had K^+ measurements performed at least monthly. The average of all repeated measures was done quarterly for 20 calendar quarters to calculate the time-averaged serum K^+.[16]

CV=cardiovascular; ESRD=end-stage renal disease; HD=hemodialysis.

NEW DATA

LOKELMA is the only FDA-approved K^+ binder with results and dosing in the label...

...for adult patients with hyperkalemia on chronic hemodialysis[1]

STUDY 4: Met its primary endpoint of a proportion of patients classified as responders, defined as patients who maintained a pre-dialysis serum potassium between 4.0-5.0 mEq/L on at least 3 out of 4 dialysis treatments after the long interdialytic interval and who did not receive rescue therapy* during the evaluation period.[1]

41% of patients treated with LOKELMA (n=97) were responders compared to 1% of patients in the placebo group (n=99) (*P*<0.001)[1]

41% of patients

STUDY DESIGN 4: DIALIZE was a **double-blind, placebo-controlled trial** of 196 subjects (mean age 58 years, range 20 to 86 years) with end-stage renal disease on chronic hemodialysis for at least 3 months and persistent pre-dialysis hyperkalemia† who were randomized to receive LOKELMA 5 g or placebo once daily on non-dialysis days. At randomization, mean serum potassium levels were 5.8 mEq/L **(range 4.2-7.3 mEq/L)** in the LOKELMA group and 5.9 mEq/L (range 4.2-7.3 mEq/L) in the placebo group.[1,19]

To achieve pre-dialysis serum potassium level between 4.0 and 5.0 mEq/L during the dose adjustment period (initial 4 weeks), the dose could be adjusted weekly in 5-g increments up to 15 g once daily based on pre-dialysis serum potassium measurement after the LIDI. The dose reached at the end of the dose-adjustment period was maintained throughout the subsequent 4-week evaluation period.[1]

*Rescue therapy was defined as any urgent therapeutic intervention considered necessary to reduce serum K^+ in the setting of severe hyperkalemia (defined by protocol as >6.0 mEq/L). Use of rescue therapy was not strictly protocolized, and it was left to the investigator's clinical judgment to be given in accordance with local practice patterns.[19]

†Persistent hyperkalemia defined as predialysis serum K^+ >5.4 mEq/L after the LIDI.[19]

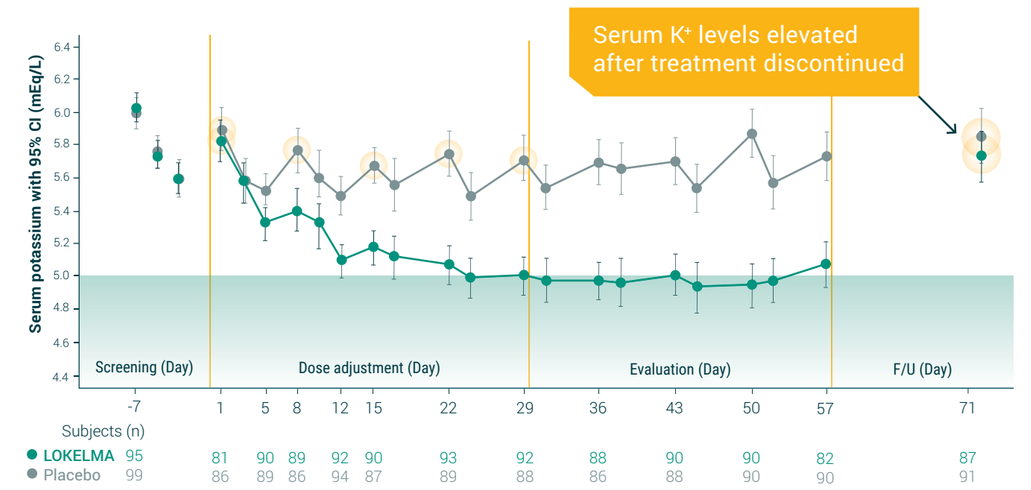
LIDI=long interdialytic interval.

IMPORTANT SAFETY INFORMATION FOR LOKELMA (cont'd)

ADVERSE REACTIONS: The most common adverse reaction in non-dialysis patients with LOKELMA was mild to moderate edema. In placebo-controlled trials up to 28 days, edema was reported in 4.4%, 5.9%, 16.1% of non-dialysis patients treated with 5 g, 10 g, and 15 g of LOKELMA once daily, respectively vs 2.4% of non-dialysis patients receiving placebo.

LOKELMA sustained pre-dialysis K^+ levels in patients on hemodialysis with continued treatment[1]

MEAN PRE-DIALYSIS SERUM POTASSIUM LEVELS OVER TIME IN PATIENTS ON CHRONIC HEMODIALYSIS[1]



F/U=follow-up period.
The displayed error bars correspond to 95% confidence intervals.
n=Number of patients with non-missing potassium measurements at a particular visit.

Please read additional Important Safety Information on page 22 and accompanying full Prescribing Information.

LOKELMA®
(sodium zirconium cyclosilicate)
5 g | 10 g for oral suspension

NEW DATA

In adult chronic hemodialysis patients with hyperkalemia,

In Study 4, the safety of LOKELMA was comparable to placebo[19]

Overall, 40 patients in the LOKELMA group (41.7%) reported adverse events, compared to 46 patients in the placebo group (46.5%)[1,19]

	LOKELMA (n=97)	Placebo (n=99)
GI disorders	19.8%	17.2%
Infections	12.5%	9.1%
Overall SAEs	7.3%	8.1%

- In Study 4 in which most patients were treated with doses of 5 g to 10 g once daily on non-dialysis days, there was **no difference in the mean change from baseline in interdialytic weight gain (a measure of fluid retention) between the LOKELMA and placebo groups**[1]
- 5% of patients developed pre-dialysis hypokalemia (serum K^+ <3.5 mEq/L) in both the LOKELMA and placebo groups; 3% and 1% of patients developed a serum K^+ <3.0 mEq/L in the LOKELMA and placebo groups, respectively[1]
- The most common SAEs were angina pectoris (2.1%) in the LOKELMA group and hyperkalemia requiring rescue therapy (3%)* and fluid overload (2%) in the placebo group[19]
  - None of the SAEs were related to study drug[19]

*Use of rescue therapy included but was not limited to insulin/glucose, sodium bicarbonate, β-adrenergic agonists, potassium binders (SPS, CPS, patiromer), and any other form of renal replacement therapy including additional dialysis or reduction in dialysate K^+ concentration.[19]

CPS=calcium polystyrene sulfonate; GI=gastrointestinal; IDWG=interdialytic weight gain; SAEs=serious adverse events; SPS=sodium polystyrene sulfonate.

IMPORTANT SAFETY INFORMATION FOR LOKELMA (cont'd)

DRUG INTERACTIONS: LOKELMA can transiently increase gastric pH. In general, oral medications with pH-dependent solubility should be administered at least 2 hours before or 2 hours after LOKELMA. Spacing is not needed if it has been determined the concomitant medication does not exhibit pH-dependent solubility.

WARNINGS AND PRECAUTIONS:

- **Hypokalemia in Patients on Hemodialysis:** Patients on hemodialysis may be prone to acute illness that can increase the risk of hypokalemia on LOKELMA (eg, illnesses associated with decreased oral intake, diarrhea). Consider adjusting LOKELMA dose based on potassium levels in these settings.

NEW DOSING

For patients on chronic hemodialysis, LOKELMA should only be dosed on non-dialysis days[1]

RECOMMENDED DOSE

TAKE ONE

5 g PACKET

1X/DAY

ON NON-DIALYSIS DAYS[1]

- The recommended starting dose is 5 g once daily on non-dialysis days[1]
- Consider a starting dose of 10 g once daily on non-dialysis days in patients with serum potassium >6.5 mEq/L[1]
- Monitor serum K^+ and adjust the dose of LOKELMA based on the pre-dialysis serum K^+ value after the LIDI and desired target range[1]
- During initiation and after a dose adjustment, assess serum potassium after 1 week[1]
- Recommended maintenance dose range is from 5 g to 15 g once daily, on non-dialysis days[1]
- Discontinue or decrease the dose of LOKELMA if:
  - Serum K^+ falls below the desired target range based on the pre-dialysis value after the LIDI,[1] or
  - The patient develops clinically significant hypokalemia[1]

Patients:

- Should be advised to adjust dietary sodium, if appropriate[1]
- Can take LOKELMA with or without food[1]
- Do not need to refrigerate LOKELMA[1]

3 tbsp of water

How to dose LOKELMA

- LOKELMA is a white powder available as 5 g or 10 g foil-lined packet for oral suspension[1]
- Administer LOKELMA orally as a suspension in water[1]
- Empty the entire contents of the packet(s) into a drinking glass containing approximately 3 tablespoons of water or more if desired[1]
- Stir well and drink immediately[1]
- If powder remains in the glass, add water, stir, and drink immediately. Repeat until no powder remains[1]
- In general, other oral medications should be administered at least 2 hours before or 2 hours after taking LOKELMA[1]

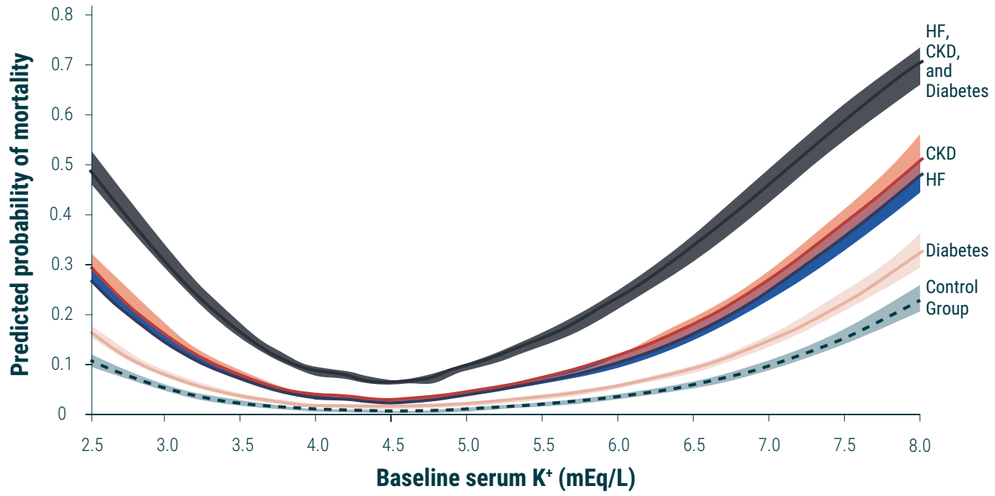
LIDI=long interdialytic interval.

Please read additional Important Safety Information on page 22 and accompanying full Prescribing Information.

LOKELMA®
(sodium zirconium cyclosilicate)
5 g | 10 g for oral suspension

Hyperkalemia poses an increased risk of mortality[20]

In a study of almost 1 million patients, hyperkalemia was an independent risk factor for all-cause mortality[20]



LOKELMA® (sodium zirconium cyclosilicate) is not indicated to reduce the risk of death.[1]

Serum K^+ ≥5.0 mEq/L was associated with an increased risk of all-cause mortality in patients with CKD, HF, diabetes, all 3, or none of these comorbidities[20]

- Even mild hyperkalemia (5.0-<5.5 mEq/L) was associated with increased all-cause mortality over an average 18-month follow-up[20]

Retrospective study of 911,698 patients from multiple integrated health delivery networks (Humedica). Control group included 338,297 individuals without known HF, CKD, diabetes, cardiovascular disease, or hypertension. Patient data came from private insurers, Medicare and Medicaid users, and uninsured individuals.[20]

CKD=chronic kidney disease; HF=heart failure.

Reducing or discontinuing RAAS inhibitor therapy to manage hyperkalemia may compromise guideline-recommended treatment[21]

The American Diabetes Association, KDIGO, and the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines/Heart Failure Society of America all recommend RAAS inhibitor therapy for patients with diabetes, CKD, and HF, respectively[22-24]

Despite guideline recommendations, RAAS inhibitor therapy was frequently reduced or discontinued to manage hyperkalemia[21]

~50%

- In 1 study, almost 50% of patients who experienced a moderate-to-severe* hyperkalemia event had their RAAS inhibitor stopped or reduced[21]

In this analysis from the Humedica database of health records, medical data were analyzed for 66,862 patients with hyperkalemia. Patients with at least 1 outpatient RAAS inhibitor prescription were included in the 12-month analysis. Patients with end-stage renal disease, CKD stage 5, and acute kidney injury were excluded.[21]

*Moderate-to-severe hyperkalemia was defined as serum potassium ≥5.5 mEq/L.[21]

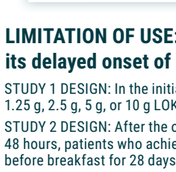
CKD=chronic kidney disease; HF=heart failure; KDIGO=Kidney Disease: Improving Global Outcomes; RAAS=renin-angiotensin-aldosterone system.

In adult patients with hyperkalemia who are not on dialysis,

LOKELMA led to rapid reduction in serum K+ levels[1]

STUDY 1: Reduction in serum K+ levels were observed in patients within 1 hour after initiation of LOKELMA 10 g tid and continued to decline over the 48-hour treatment period[1,2]

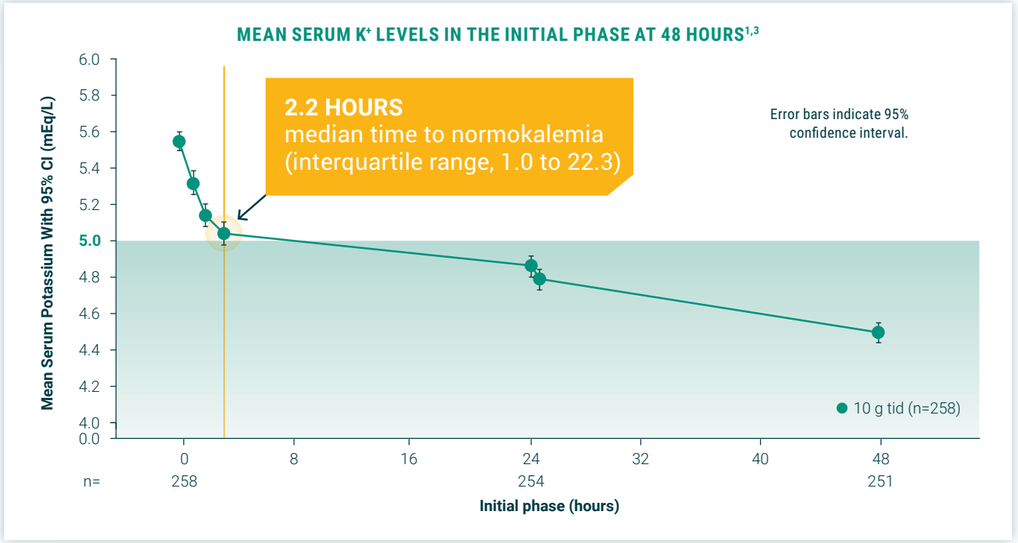
- The study met its primary endpoint: difference in exponential rate of change in serum K+ levels during the initial 48 hours of LOKELMA vs placebo[1]
- LOKELMA demonstrated a greater reduction in serum K+ levels compared to placebo (P<0.001)[1]



STUDY 2: Of the patients enrolled (n=258), 92% achieved normal K+ levels within 48 hours from baseline[1]

Average serum K+ levels decreased from 5.6 mEq/L to 4.5 mEq/L (with LOKELMA 10 g tid for 48 hours with meals)[1]

STUDY 2: Initial open-label phase[1,3]



LIMITATION OF USE: LOKELMA should not be used as an emergency treatment for life-threatening hyperkalemia because of its delayed onset of action.[1]

STUDY 1 DESIGN: In the initial phase of a multicenter, 2-part, double-blind, randomized, placebo-controlled, phase 3 trial, 753 patients received placebo or 1.25 g, 2.5 g, 5 g, or 10 g LOKELMA tid with meals for the initial 48 hours.[1,2]

STUDY 2 DESIGN: After the open-label initial phase of a multicenter, 2-part, phase 3 trial, in which 258 patients received 10 g LOKELMA administered tid with meals for 48 hours, patients who achieved a K+ level between 3.5 and 5.0 mEq/L were randomized (4:4:4:7) to receive 5 g, 10 g, or 15 g LOKELMA or placebo once daily taken just before breakfast for 28 days in the withdrawal phase. 123 patients who completed the withdrawal phase participated in the 11-month, open-label extension study.[1,3]

tid=3 times a day.

IMPORTANT SAFETY INFORMATION FOR LOKELMA (cont'd)

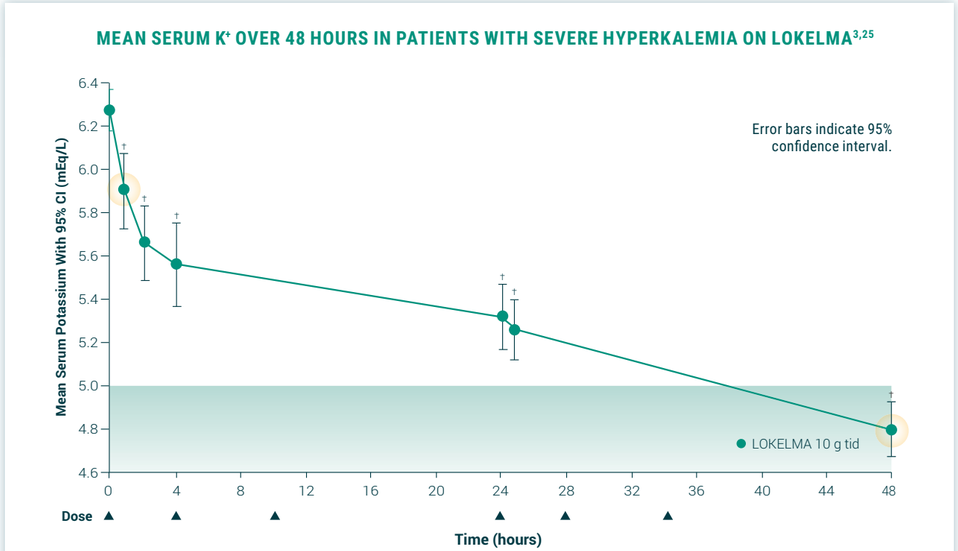
DRUG INTERACTIONS: LOKELMA can transiently increase gastric pH. In general, oral medications with pH-dependent solubility should be administered at least 2 hours before or 2 hours after LOKELMA. Spacing is not needed if it has been determined the concomitant medication does not exhibit pH-dependent solubility.

In adult patients with hyperkalemia who are not on dialysis,

Patients with severe hyperkalemia* exhibited a greater response to LOKELMA[1,25]

STUDY 1 AND STUDY 2: Post-hoc pooled analysis[25]

- 45 patients with baseline serum K+ ≥6.0 mEq/L received LOKELMA 10 g tid for 48 hours[25]
- The median time to K+ <6 mEq/L was **1.1 hours**, and the majority of patients achieved K+ levels ≤5.5 mEq/L by 4 hours[25]



- The mean baseline serum K+ level among patients with severe hyperkalemia (n=45) was 6.27 mEq/L[25]
- Serum K+ levels at 1, 2, 4, 24, and 48 hours were -0.4, -0.6, -0.7, -0.9, and -1.5 mEq/L, respectively[25]

This data analysis was for initial phase only. There is limited experience in 45 patients with serum K+ concentrations ≥6.0 mEq/L.[25]

Note: Normal serum potassium: 3.5-5.0 mEq/L.[1]

*Severe hyperkalemia was defined as serum K+ ≥6.0 mEq/L.[25]

†P<0.0001.[25]

tid=3 times a day.

Please read additional Important Safety Information on page 22 and accompanying full Prescribing Information.

LOKELMA®
(sodium zirconium cyclosilicate)
5 g | 10 g for oral suspension

In adult patients with hyperkalemia who are not on dialysis,

LOKELMA sustained normokalemia* for up to 1 year with continued treatment[1]

In a 1-month study, LOKELMA sustained mean K^+ at lower levels than placebo[1,3]

IN STUDY 2[1,3]:

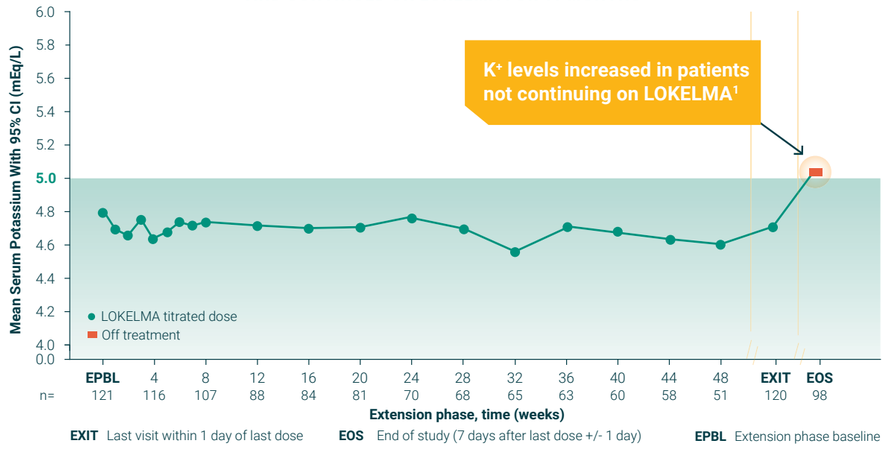
- LOKELMA-treated patients with hyperkalemia who achieved normokalemia at 48 hours were enrolled in the double-blind, randomized withdrawal phase of the study[1,3]
- Primary endpoint was met: mean serum K^+ value over Days 8-29 with LOKELMA 5 g, 10 g, and 15 g maintaining lower mean serum K^+ levels than placebo (4.8 mEq/L, 4.5 mEq/L, and 4.4 mEq/L vs 5.1 mEq/L, respectively; $P \leq 0.001$ for all doses)[1,3]

For maintenance treatment[1]:

- The recommended dose of LOKELMA is 10 g qd[1]
- Monitor serum potassium and adjust dose of LOKELMA at 1-week intervals or longer in increments of 5 g[1]
- The recommended maintenance dose range is from 5 g qod to 15 g qd[1]

STUDY 2 EXTENSION: For 11 months, LOKELMA sustained normal serum K^+ levels with continued treatment in patients who remained in the open-label extension phase.[1]

MEAN SERUM K^+ LEVELS IN PATIENTS WHO COMPLETED A 28-DAY RANDOMIZED WITHDRAWAL PHASE AND CONTINUED ON LOKELMA FOR 11 MONTHS[1]



- The mean dose of LOKELMA was 10 g qd in 73.2% (90/123) of patients; >10 g qd in 13.0% (16/123) of patients, and <10 g qd in 13.8% (17/123) of patients[26]

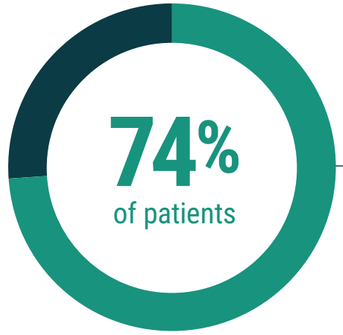
STUDY 2 EXTENSION DESIGN: 123 patients who were included in the 28-day randomized withdrawal phase of Study 2 had the option to continue treatment with LOKELMA, taken just before breakfast, in an open-label extension phase for up to 11 months (N=123). Patients who had i-STAT K^+ values between 3.5 and 5.5 mEq/L at Day 29 started on open-label LOKELMA at 10 g qd. Patients with i-STAT K^+ values >5.5 mEq/L at Day 29 received LOKELMA 10 g tid for up to 48 hours, and those who achieved normokalemia† entered into the open-label extended dosing phase and received LOKELMA at 10 g qd. Patients had their K^+ level monitored periodically during the study and the dose of LOKELMA was titrated in 5-g increments to 5 g qod up to 15 g qd, based on i-STAT K^+ values.[1,26]

*Normokalemia (normal serum K^+ levels) was defined as serum potassium levels between 3.5 mEq/L and 5 mEq/L.[1]
†Normokalemia was defined as iSTAT potassium levels between 3.5 mEq/L and 5.0 mEq/L.[1]
CI=confidence interval; qd=once daily; qod=every other day; tid=3 times a day.

In a retrospective analysis of Study 3,

A majority of patients maintained their RAAS inhibitor use*[4]

Among patients on RAAS inhibitor therapy (n=520) during the maintenance phase† of Study 3, a 12-month, open-label study evaluating LOKELMA in patients with hyperkalemia, 37 initiated therapy during the maintenance phase and 483 were on therapy at baseline. Of those 483 patients[4]:



No change in RAAS inhibitor therapy[4]

- 13% of patients increased their RAAS inhibitor dose‡[4]
- 14% of patients decreased their dose‡[4]
- 11% of patients discontinued their dose[4]

LOKELMA was administered in clinical trials without the requirement of low-potassium diet modification[1,2-4,26]

STUDY 3 DESIGN: LOKELMA was evaluated for long-term efficacy in 751 patients with hyperkalemia in an open-label, single-arm, 12-month, phase 3 study. Following the initial phase treatment of LOKELMA 10 g tid, patients who achieved normokalemia§ within 72 hours (n=746; 99%) entered the maintenance phase. For maintenance treatment, the initial dose of LOKELMA was 5 g qd and was adjusted to a minimum of 5 g qod up to a maximum of 15 g qd, based on serum potassium level. The primary endpoints included the percentage of patients who achieved normokalemia§ during the initial phase and the percentage of patients who maintained mean serum potassium ≤5.1 mEq/L during Months 3-12 of the maintenance phase.[1,4]

*Based on a retrospective analysis of the changes in RAAS inhibitor use during the maintenance phase of a 12-month, open-label study.[4]
†Excluded 5 patients who discontinued RAAS inhibitor therapy prior to their first dose of the study drug.[4]
‡Patients were counted more than once if they required more than 1 RAAS inhibitor adjustment, so the total percentage across all 4 categories may exceed 100%.[4]
§Normokalemia was defined as serum potassium levels between 3.5 and 5.0 mEq/L.[1]
qd=once daily; qod=every other day; RAAS=renin-angiotensin-aldosterone system; tid=3 times a day.

IMPORTANT SAFETY INFORMATION FOR LOKELMA
WARNINGS AND PRECAUTIONS:

- **Gastrointestinal Adverse Events in Patients with Motility Disorders:** Avoid LOKELMA in patients with severe constipation, bowel obstruction or impaction, including abnormal post-operative bowel motility disorders. LOKELMA has not been studied in patients with these conditions and it may be ineffective and may worsen gastrointestinal conditions.

Please read additional Important Safety Information on page 22 and accompanying full Prescribing Information.

LOKELMA®
(sodium zirconium cyclosilicate)
5 g | 10 g for oral suspension

LOKELMA was shown to be safe and generally well tolerated[1]

- Safety was evaluated in clinical trials with **more than 1700 patients not on dialysis with hyperkalemia** and comorbidities including CKD, DM, and CHF, with 507 patients **treated for at least 1 year**[1]
- There are **no GI side effects** listed in the LOKELMA Prescribing Information; however, there were GI adverse events observed in the clinical studies[1-4,26]

Adverse events in non-dialysis patients

Edema

- In clinical trials of LOKELMA, edema was generally mild to moderate in severity[1]
- In placebo-controlled trials in which patients were treated with once-daily doses of LOKELMA for up to 28 days:

LOKELMA			Placebo
5 g qd	10 g qd	15 g qd	
4.4%	5.9%	16.1%	2.4%

  - **0.2% of patients** (1/479) discontinued LOKELMA due to edema*[27]
- In longer-term, uncontrolled trials, in which most patients were maintained on doses <15 g qd, edema (including edema, generalized edema, and peripheral edema) was reported in 8% to 11% of patients[1]

Hypokalemia

- 4.1% of LOKELMA-treated patients developed hypokalemia with a serum K^+ value <3.5 mEq/L, which resolved with dose reduction or discontinuation of LOKELMA[1]

*During the maintenance phase, 1 patient who received 15 g LOKELMA qd was withdrawn due to general edema. There were no patient discontinuations due to edema for the initial phases of the trials.[27]

CHF=congestive heart failure; CKD=chronic kidney disease; DM=diabetes mellitus; GI=gastrointestinal; qd= once daily.

IMPORTANT SAFETY INFORMATION FOR LOKELMA
WARNINGS AND PRECAUTIONS:

- **Gastrointestinal Adverse Events in Patients with Motility Disorders:** Avoid LOKELMA in patients with severe constipation, bowel obstruction or impaction, including abnormal post-operative bowel motility disorders. LOKELMA has not been studied in patients with these conditions and it may be ineffective and may worsen gastrointestinal conditions.
- **Edema:** Each 5-g dose of LOKELMA contains approximately 400 mg of sodium, but the extent of absorption by the patient is unknown. In clinical trials of LOKELMA in patients who were not on dialysis, edema was observed and was generally mild to moderate in severity and was more commonly seen in patients treated with 15 g once daily. Monitor for signs of edema, particularly in patients who should restrict their sodium intake or are prone to fluid overload (eg, heart failure or renal disease). Advise patients to adjust dietary sodium, if appropriate. Increase the dose of diuretics as needed.

Please read additional Important Safety Information on page 22 and accompanying full Prescribing Information.

Treatment-emergent adverse events in LOKELMA Studies 1 and 2[27]

TEAEs in ≥2.0% of patients in the pooled analysis for the initial phases of Studies 1 and 2, in which patients were dosed with placebo or LOKELMA 10 g tid for 48 hours*†[27]

- The only TEAE reported by ≥2.0% of patients in any treatment group was diarrhea, which was experienced in 2.1% of patients in the placebo group and 1.2% of patients in the LOKELMA 10 g tid group[27]
- The overall incidence of gastrointestinal disorders experienced by patients was 5.3% in the placebo group and 4.5% in the LOKELMA 10 g tid treatment group[27]

*The initial phase of Study 2 was not placebo controlled.[1]

†In the pooled analysis for the initial phases of Studies 1 and 2, the overall incidence of TEAEs was 10.6% in the placebo group and 10.4% in the LOKELMA 10 g tid group.[27]

TEAEs REPORTED BY ≥2.0% OF PATIENTS IN ANY TREATMENT GROUP DURING THE WITHDRAWAL PHASE OF STUDIES 1 AND 2 FOR UP TO 28 DAYS‡§[27]

		STARTING DOSE OF LOKELMA DURING THE WITHDRAWAL PHASE		
	Placebo‖ (n=301)	5 g qd (n=110)	10 g qd (n=114)	15 g qd (n=56)
Any event	26.6%	34.5%	31.6%	44.6%
System organ class preferred term, (%)				
Blood and lymphatic system disorders	0.3%	3.6%	0.0%	5.4%
Anemia	0.0%	0.9%	0.0%	5.4%
Gastrointestinal disorders	6.6%	7.3%	3.5%	8.9%
Constipation	2.3%	0.0%	2.6%	1.8%
Diarrhea	2.0%	1.8%	0.0%	3.6%
Dyspepsia	0.0%	3.6%	0.0%	0.0%
Nausea	0.7%	0.0%	0.9%	1.8%
Vomiting	0.7%	3.6%	0.0%	0.0%
General disorders and administration site conditions	2.3%	1.8%	8.8%	17.9%
Fatigue	0.0%	0.0%	0.9%	3.6%
Generalized edema	0.0%	0.0%	0.0%	3.6%
Edema peripheral	1.7%	0.0%	4.4%	10.7%
Infections and infestations	7.3%	11.8%	7.9%	16.1%
Influenza	0.0%	0.0%	0.9%	3.6%
Nasopharyngitis	0.3%	0.0%	0.0%	5.4%
Upper respiratory tract infection	1.0%	2.7%	1.8%	1.8%
Urinary tract infection	1.3%	5.5%	3.5%	0.0%
Investigations	3.3%	3.6%	2.6%	3.6%
Electrocardiogram QT prolonged	0.0%	0.9%	0.0%	3.6%
Renal and urinary disorders	2.0%	6.4%	0.9%	3.6%
Renal failure	0.0%	2.7%	0.0%	0.0%
Vascular disorders	1.3%	2.7%	1.8%	5.4%
Hypertension	1.3%	1.8%	1.8%	3.6%

‡In a pooled analysis of Study 1 and Study 2 in which patients were treated across all LOKELMA doses for up to 28 days.[27]

§Study 1 was placebo controlled in the initial phase; in Study 2 all patients received LOKELMA 10 g tid for 48 hours in the initial phase.[27]

‖Following treatment with LOKELMA tid during the initial phase.[27]

qd=once daily; QT=QT interval; TEAE=treatment-emergent adverse event; tid=3 times a day.

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5 g | 10 g for oral suspension

LOKELMA is tasteless and odorless[1,3]

3 tbsp of water

Patients:

- Are not required to make changes in potassium-lowering diets[1-3]
  - Advise patients to adjust dietary sodium, if appropriate[1]
- Can take LOKELMA with or without food[1]
- Do not need to refrigerate LOKELMA[1]

How to dose LOKELMA

- LOKELMA is a white powder available as 5 g or 10 g foil-lined packet for oral suspension[1]
- Administer LOKELMA orally as a suspension in water[1]
- Empty the entire contents of the packet(s) into a drinking glass containing approximately 3 tablespoons of water or more if desired[1]
- Stir well and drink immediately[1]
- If powder remains in the glass, add water, stir, and drink immediately. Repeat until no powder remains[1]
- In general, other oral medications should be administered at least 2 hours before or 2 hours after taking LOKELMA[1]

IMPORTANT SAFETY INFORMATION FOR LOKELMA (cont'd)
WARNINGS AND PRECAUTIONS (cont'd):

- **Edema (cont'd):** In a clinical trial of LOKELMA in patients on chronic hemodialysis in which most patients were treated with doses of 5 g to 10 g once daily on non-dialysis days, there was no difference in the mean change from baseline in interdialytic weight gain (a measure of fluid retention) between the LOKELMA and placebo groups.
- **Hypokalemia in Patients on Hemodialysis:** Patients on hemodialysis may be prone to acute illness that can increase the risk of hypokalemia on LOKELMA (eg, illnesses associated with decreased oral intake, diarrhea). Consider adjusting LOKELMA dose based on potassium levels in these settings.

Following an initial treatment period of up to 48 hours, LOKELMA is a once-daily option[1]

Recommended dosing for initial treatment and maintenance therapy for hyperkalemia in non-dialysis patients[1]

RECOMMENDED STARTING DOSE
TAKE ONE
10 g PACKET
3X/DAY
FOR UP TO 48 HOURS (2 DAYS)

MAINTENANCE TREATMENT
TAKE ONE
10 g PACKET
1X/DAY

- Monitor serum potassium and adjust the dose of LOKELMA based on the serum potassium level and desired target range[1]
- During maintenance treatment, up-titrate based on the serum potassium level at intervals of 1 week or longer and in increments of 5 g[1]
- The recommended maintenance dose range is from 5 g qod to 15 g daily[1]
- Decrease the dose of LOKELMA or discontinue if the serum potassium is below the desired target range[1]

qod=every other day.

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LOKELMA®
(sodium zirconium cyclosilicate)
5 g | 10 g for oral suspension

Important Safety Information

IMPORTANT SAFETY INFORMATION FOR LOKELMA® (sodium zirconium cyclosilicate)

WARNINGS AND PRECAUTIONS:

- **Gastrointestinal Adverse Events in Patients with Motility Disorders:** Avoid LOKELMA in patients with severe constipation, bowel obstruction or impaction, including abnormal post-operative bowel motility disorders. LOKELMA has not been studied in patients with these conditions and it may be ineffective and may worsen gastrointestinal conditions.
- **Edema:** Each 5-g dose of LOKELMA contains approximately 400 mg of sodium, but the extent of absorption by the patient is unknown. In clinical trials of LOKELMA in patients who were not on dialysis, edema was observed and was generally mild to moderate in severity and was more commonly seen in patients treated with 15 g once daily. Monitor for signs of edema, particularly in patients who should restrict their sodium intake or are prone to fluid overload (eg, heart failure or renal disease). Advise patients to adjust dietary sodium, if appropriate. Increase the dose of diuretics as needed.

  In a clinical trial of LOKELMA in patients on chronic hemodialysis in which most patients were treated with doses of 5 g to 10 g once daily on non-dialysis days, there was no difference in the mean change from baseline in interdialytic weight gain (a measure of fluid retention) between the LOKELMA and placebo groups.
- **Hypokalemia in Patients on Hemodialysis:** Patients on hemodialysis may be prone to acute illness that can increase the risk of hypokalemia on LOKELMA (eg, illnesses associated with decreased oral intake, diarrhea). Consider adjusting LOKELMA dose based on potassium levels in these settings.

ADVERSE REACTIONS: The most common adverse reaction in non-dialysis patients with LOKELMA was mild to moderate edema. In placebo-controlled trials up to 28 days, edema was reported in 4.4%, 5.9%, 16.1% of non-dialysis patients treated with 5 g, 10 g, and 15 g of LOKELMA once daily, respectively vs 2.4% of non-dialysis patients receiving placebo.

DRUG INTERACTIONS: LOKELMA can transiently increase gastric pH. In general, oral medications with pH-dependent solubility should be administered at least 2 hours before or 2 hours after LOKELMA. Spacing is not needed if it has been determined the concomitant medication does not exhibit pH-dependent solubility.

INDICATION AND LIMITATION OF USE

LOKELMA is indicated for the treatment of hyperkalemia in adults.

LOKELMA should not be used as an emergency treatment for life-threatening hyperkalemia because of its delayed onset of action.

References

1. LOKELMA® (sodium zirconium cyclosilicate) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2020.

2. Packham DK, Rasmussen HS, Lavin PT, et al. Sodium zirconium cyclosilicate in hyperkalemia [article and supplementary material]. *N Engl J Med.* 2015;372(3):222-231.

3. Kosiborod M, Rasmussen HS, Lavin P, et al. Effect of sodium zirconium cyclosilicate on potassium lowering for 28 days among outpatients with hyperkalemia: the HARMONIZE randomized clinical trial. *JAMA.* 2014;312(21):2223-2233.

4. Spinowitz BS, Fishbane S, Pergola PE, et al; ZS-005 Study Investigators. Sodium zirconium cyclosilicate among individuals with hyperkalemia: a 12-month phase 3 study. *Clin J Am Soc Nephrol.* 2019;14(6):798-809.

5. Stavros F, Yang A, Leon A, Nuttall M, Rasmussen HS. Characterization of structure and function of ZS-9, a K^+ selective ion trap. *PLoS One.* 2014;9(12):e114686.

6. Kayexalate (sodium polystyrene sulfonate) [prescribing information]. St. Michael, Barbados: Concordia Pharmaceuticals Inc; 2017.

7. Veltassa® (patiromer) [prescribing information]. Redwood City, CA: Relypsa, Inc; 2018.

8. Pitt B, Bakris GL. New potassium binders for the treatment of hyperkalemia: current data and opportunities for the future. *Hypertension.* 2015;66(4):731-738.

9. Clegg DJ, Cody M, Palmer BF. Challenges in treating cardiovascular disease: restricting sodium and managing hyperkalemia. *Mayo Clin Proc.* 2017;92(8):1248-1260.

10. Lien YH. Patiromer: Can less be better than more? *Am J Med.* 2018;131(5):459-460.

11. Meaney CJ, Beccari MV, Yang Y, Zhao J. Systematic review and meta-analysis of patiromer and sodium zirconium cyclosilicate: a new armamentarium for the treatment of hyperkalemia. *Pharmacotherapy.* 2017;37(4):401-411.

12. Beccari MV, Meaney CJ. Clinical utility of patiromer, sodium zirconium cyclosilicate, and sodium polystyrene sulfonate for the treatment of hyperkalemia: an evidence-based review. *Core Evid.* 2017;12:11-24.

13. Palmer BF. Potassium binders for hyperkalemia in chronic kidney disease–diet, renin-angiotensin-aldosterone system inhibitor therapy, and hemodialysis. *Mayo Clin Proc.* 2020;95(2):339-354.

14. Li L, Harrison SD, Cope MJ, et al. Mechanism of action and pharmacology of patiromer, a nonabsorbed cross-linked polymer that lowers serum potassium concentration in patients with hyperkalemia. *J Cardiovasc Pharmacol Ther.* 2016;21(5):456-465.

15. The Dialysis Outcomes and Practice Patterns Study (DOPPS) Program. *DOPPS Practice Monitor.* April 2018 data. http://www.dopps.org/DPM. Accessed March 24, 2019.

16. Torlén K, Kalantar-Zadeh K, Molnar M, Vashistha T, Mehrotra R. Serum potassium and cause-specific mortality in a large peritoneal dialysis cohort. *Clin J Am Soc Nephrol.* 2012;7(8):1272-1284.

17. Yusuf AA, Hu Y, Singh B, Menoyo JA, Wetmore JB. Serum potassium levels and mortality in hemodialysis patients: a retrospective cohort study. *Am J Nephrol.* 2016;44(3):179-186.

18. Brunelli SM, Du Mond C, Oestreicher N, Rakov V, Spiegel DM. Serum potassium and short-term clinical outcomes among hemodialysis patients: impact of the long interdialytic interval. *Am J Kidney Dis.* 2017;70(1):21-29.

19. Fishbane S, Ford M, Fukagawa M, et al. A phase 3b, randomized, double-blind, placebo-controlled study of sodium zirconium cyclosilicate for reducing the incidence of predialysis hyperkalemia. *J Am Soc Nephrol.* 2019;30(9):1723-1733.

20. Collins AJ, Pitt B, Reaven N, et al. Association of serum potassium with all-cause mortality in patients with and without heart failure, chronic kidney disease, and/or diabetes. *Am J Nephrol.* 2017;46:213-221.

21. Epstein M, Reaven NL, Funk SE, McGaughey KJ, Oestreicher N, Knispel J. Evaluation of the treatment gap between clinical guidelines and the utilization of renin-angiotensin-aldosterone system inhibitors. *Am J Manag Care.* 2015;21(11 suppl):S212-S220.

22. Kidney Disease: Improving Global Outcomes (KDIGO) Blood Pressure Work Group. KDIGO clinical practice guideline for the management of blood pressure in chronic kidney disease. *Kidney Int Suppl.* 2012;2(5):337-414.

23. Yancy CW, Jessup M, Bozkurt B, et al. 2017 ACC/AHA/HFSA focused update of the 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice guidelines and the Heart Failure Society of America. *J Am Coll Cardiol.* 2017;70(6):776-803.

24. American Diabetes Association. Standards of medical care in diabetes—2013. *Diabetes Care.* 2013;36(suppl 1):S11-S66.

25. Kosiborod M, Peacock F, Lerma E, et al. Acute phase efficacy of sodium zirconium cyclosilicate (ZS-9) in patients with severe hyperkalaemia: analysis from two phase 3 studies. Poster presented at European Society of Cardiology Congress; Aug 29-Sep 2, 2015; London, UK.

26. Roger SD, Spinowitz BS, Lerma EV, et al. Efficacy and safety of sodium zirconium cyclosilicate for treatment of hyperkalemia: an 11-month open-label extension of HARMONIZE. *Am J Nephrol.* 2019;50(6):473-480.

27. U.S. Food & Drug Administration. Drug Approval Package: LOKELMA (sodium zirconium cyclosilicate) Medical Review(s). https://www.accessdata.fda.gov/drugsatfda_docs/nda/2018/207078Orig1s000MedR.pdf. Accessed May 10, 2019.

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LOKELMA®
(sodium zirconium cyclosilicate)
5 g | 10 g for oral suspension

Individual is a hypothetical patient, not an actual patient.

LOKELMA PROVIDES RAPID* AND SUSTAINED† K^+ CONTROL FOR YOUR PATIENTS WITH HYPERKALEMIA[1,2]

For patients not on dialysis:

RAPID*

Started to work in as early as 1 hour[1,2]

LIMITATION OF USE: LOKELMA should not be used as an emergency treatment for life-threatening hyperkalemia because of its delayed onset of action.[1]

SUSTAINED†[1]

Up to 1 year with continued treatment[1]

GENERALLY WELL TOLERATED[1]

- The AEs listed in the LOKELMA label were edema and hypokalemia[1]
- There are no GI side effects listed in the LOKELMA Prescribing Information; however, there were GI adverse events observed in the clinical studies[1-4,26]

Adverse reactions reported in LOKELMA label in non-dialysis patients

Edema

- In clinical trials of LOKELMA, edema was generally mild to moderate in severity[1]
- In placebo-controlled trials in which patients were treated with once-daily doses of LOKELMA for up to 28 days, edema was reported in 4.4%, 5.9%, and 16.1% of patients receiving 5 g, 10 g, and 15 g LOKELMA, respectively, compared with 2.4% of patients receiving placebo[1]
- In longer-term, uncontrolled trials, in which most patients were maintained on doses <15 g qd, edema (including edema, generalized edema, and peripheral edema) was reported in 8% to 11% of patients[1]
- In a pooled analysis of placebo-controlled trials in which patients were treated across all LOKELMA doses for up to 28 days, 0.2% of patients (1/479) discontinued LOKELMA due to edema‡[27]

Hypokalemia

- 4.1% of LOKELMA-treated patients developed hypokalemia with a serum K^+ value <3.5 mEq/L, which resolved with dose reduction or discontinuation of LOKELMA[1]

IMPORTANT SAFETY INFORMATION FOR LOKELMA

WARNINGS AND PRECAUTIONS:

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- **Edema:** Each 5-g dose of LOKELMA contains approximately 400 mg of sodium, but the extent of absorption by the patient is unknown. In clinical trials of LOKELMA in patients who were not on dialysis, edema was observed and was generally mild to moderate in severity and was more commonly seen in patients treated with 15 g once daily. Monitor for signs of edema, particularly in patients who should restrict their sodium intake or are prone to fluid overload (eg, heart failure or renal disease). Advise patients to adjust dietary sodium, if appropriate. Increase the dose of diuretics as needed.

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*In Study 1, LOKELMA 10 g tid demonstrated a greater reduction in serum K^+ levels vs placebo at 48 hours and started to work as early as 1 hour in patients with hyperkalemia not on dialysis.[1,2]

†In Study 2, LOKELMA-treated patients with hyperkalemia not on dialysis who achieved normokalemia at 48 hours maintained mean serum K^+ at lower levels than placebo at all 3 daily doses (5 g, 10 g, 15 g) in the 28-day randomized withdrawal phase. Patients in Study 2 who continued into the open-label, 11-month extension phase sustained normokalemia with continued LOKELMA dosing.[1,2]

‡Edema, in the discontinuation rate analysis, includes generalized edema, peripheral edema, fluid overload, and fluid retention. During the maintenance phase, 1 patient who received 15 g LOKELMA qd was withdrawn due to general edema. There were no patient discontinuations due to edema for the initial phases of the trials.[27]

AEs=adverse events; GI=gastrointestinal; qd=once daily; tid=3 times a day.

You are encouraged to report negative side effects of AstraZeneca prescription drugs by calling 1-800-236-9933. If you prefer to report these to the FDA, either visit www.FDA.gov/medwatch or call 1-800-FDA-1088.

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