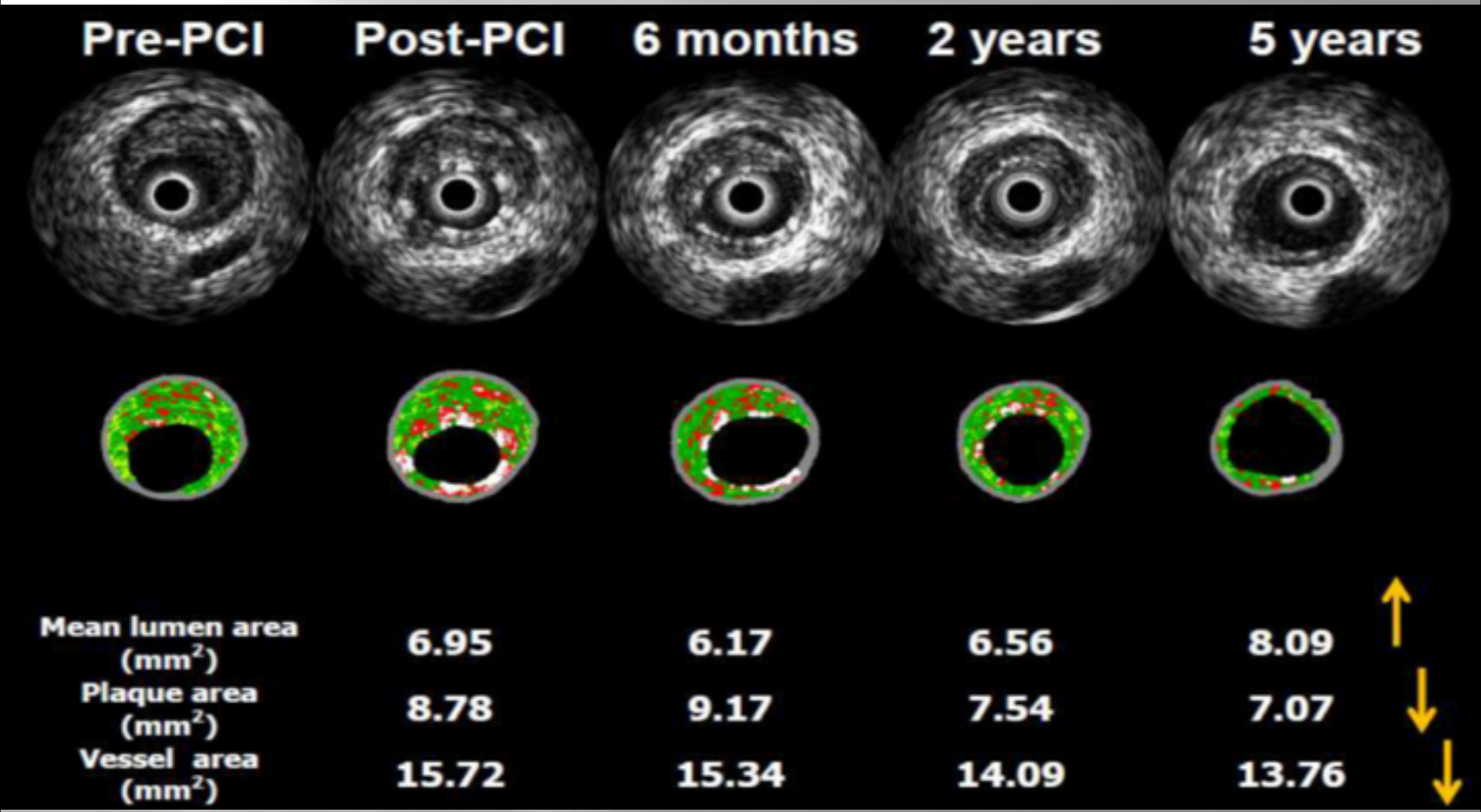
IVUS through 5 years



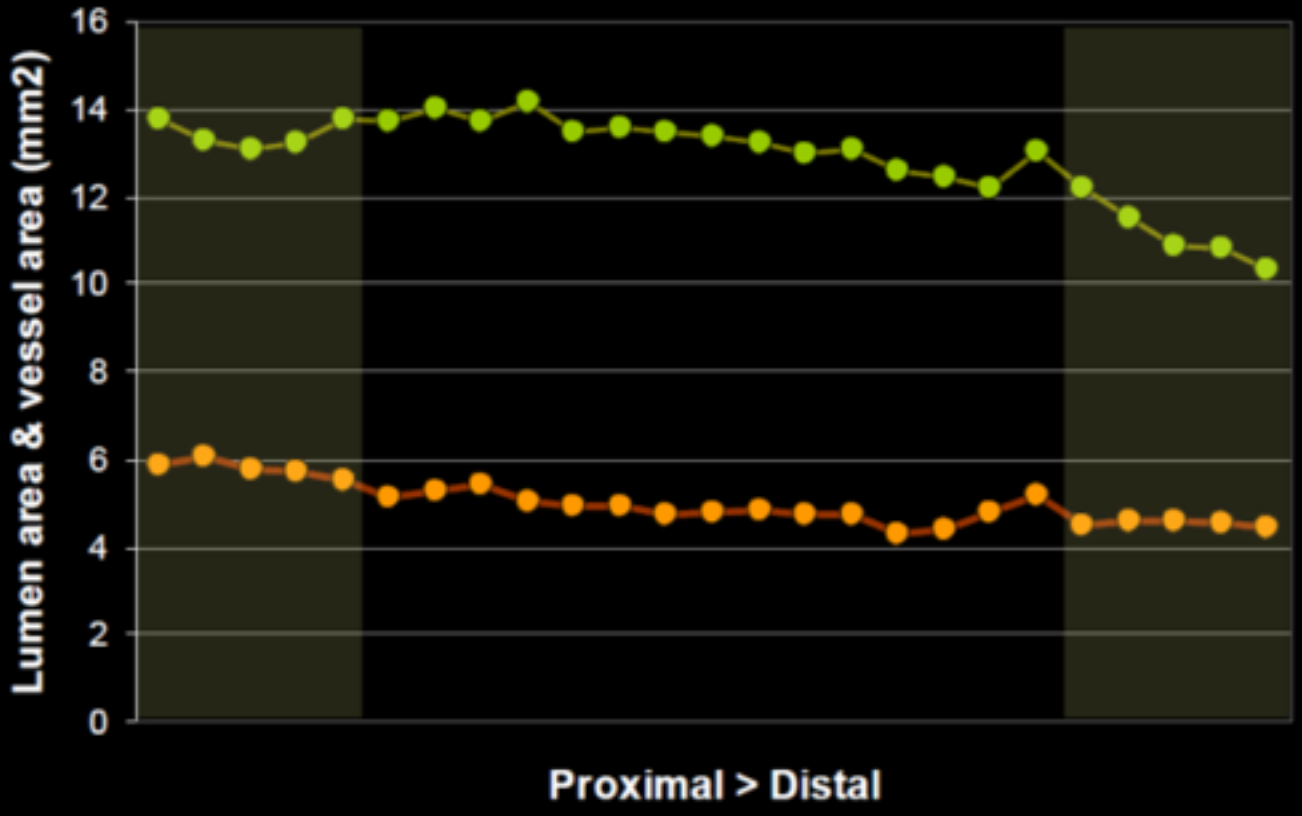
Koen Nieman, et al. *Circulation. 2011,124: A10570*

MSCT through 5 years

Vessel Area:
13.2 ± 4.6 mm2
[7.1 - 22.6]

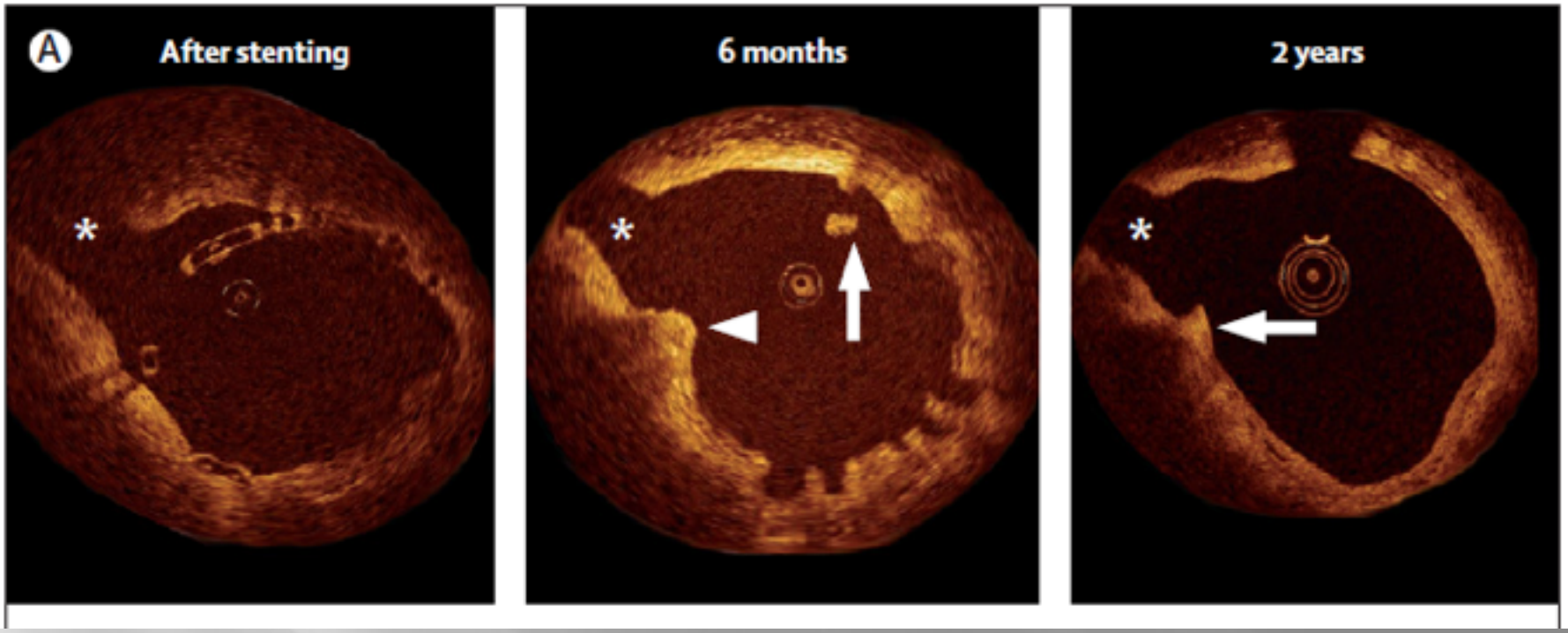
Plaque Area:
8.4 ± 3.9 mm2
[3.0 - 17.3]

Lumen Area:
4.7 ± 1.8 mm2
[2.7 - 9.9]



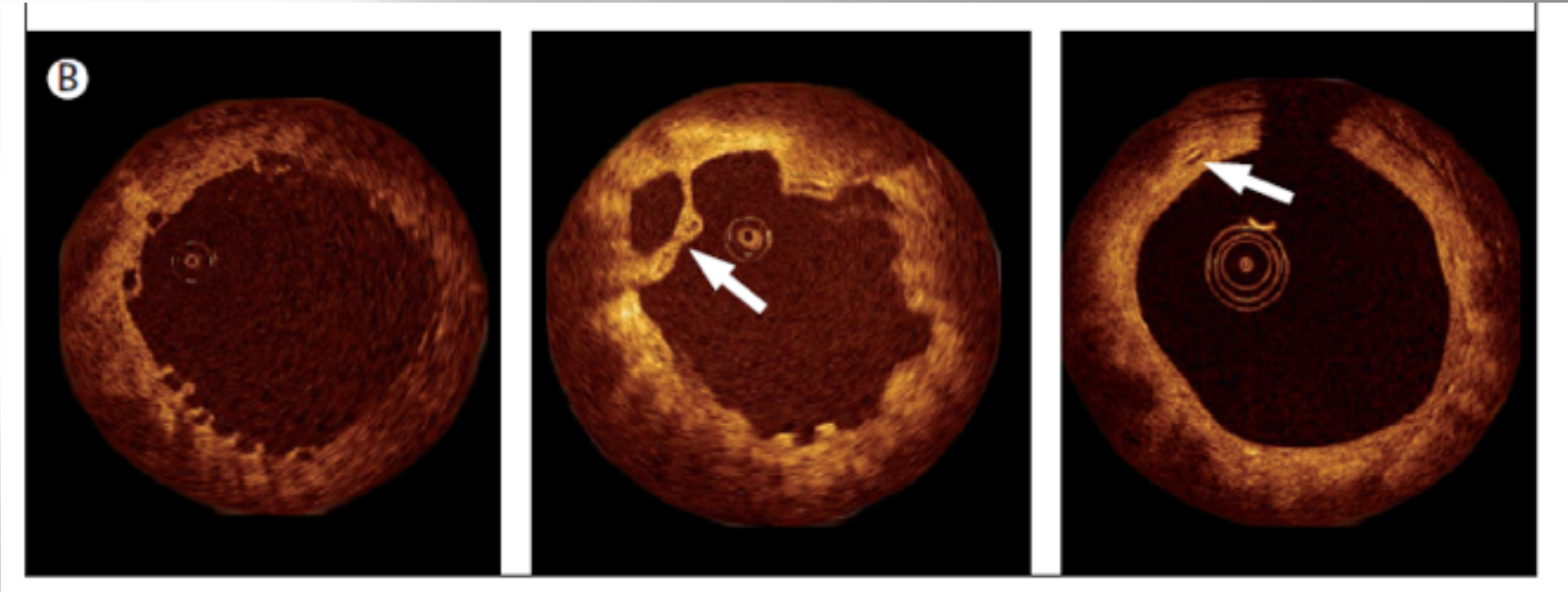
Nieman et al. TCT 2011

OCT through 2 years



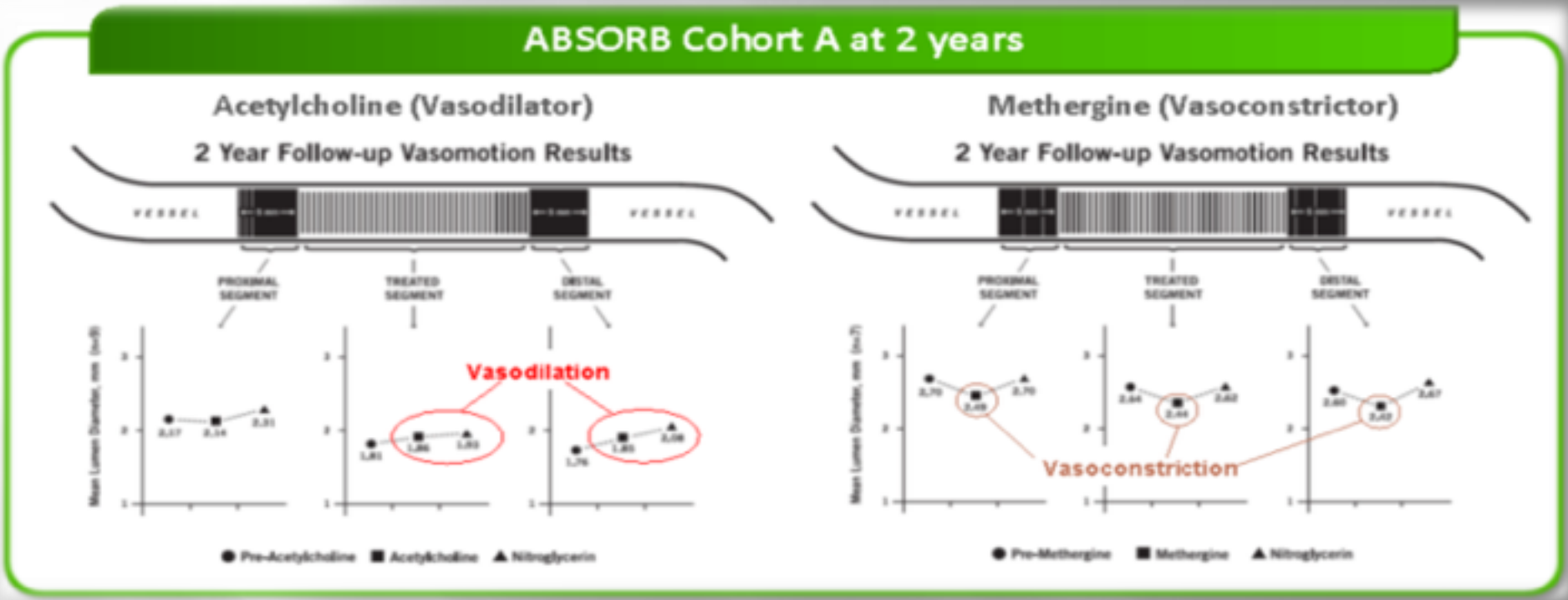
After stenting, incomplete stent apposition(ISA) in front of a side-branch ostium.
At 6 mos,persistent ISA and resolved ISA.
At 2yrs,there is now smooth appearance of the endoluminal lining without ISA since struts have been absorbed.

OCT through 2 years



Complete apposition of strut after the procedure.
At 6 mos, there is late acquired ISA with tissue bridging connecting the struts. The endoluminal lining is corrugated.
At 2 yrs, smooth endothelial lining with almost circular cross section. Generally, the struts are no longer discernible, although there is a bright reflection that could indicate a strut. Asterisk indicates a side branch.

Vasomotor function testing at 2 year



The reappearance of vasomotion in the proximal, distal, as well as treated segments in response to methergine or acetylcholine suggests that vessel vasoreactivity has been restored and that a physiological response to vasoactive stimulus might occur anew.

Serruy PW, et al. Lancet.2009,373:897-910

ABSORB Cohort A
Excellent Long-Term Data Out to 5 Years

	RESTORATION		RESORPTION	
Hierarchical	6 Months 30 Patients	1 year 29 Patients**	2 Year 29 Patients**	5 Year 29 Patients**
Ischemia Driven MACE***	1 (3.3%)*	1 (3.4%)*	1 (3.4%)*	1 (3.4%)*
Cardiac Death	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
MI	1 (3.3%)*	1 (3.4%)*	1 (3.4%)*	1 (3.4%)*
Q-Wave MI	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Non Q-Wave MI	1 (3.3%)*	1 (3.4%)*	1 (3.4%)*	1 (3.4%)*
Ischemia Driven TLR	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
by PCI	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.%)
by CABG	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.%)

No new MACE events between 6 months and 5 years
No scaffold thrombosis up to 5 years

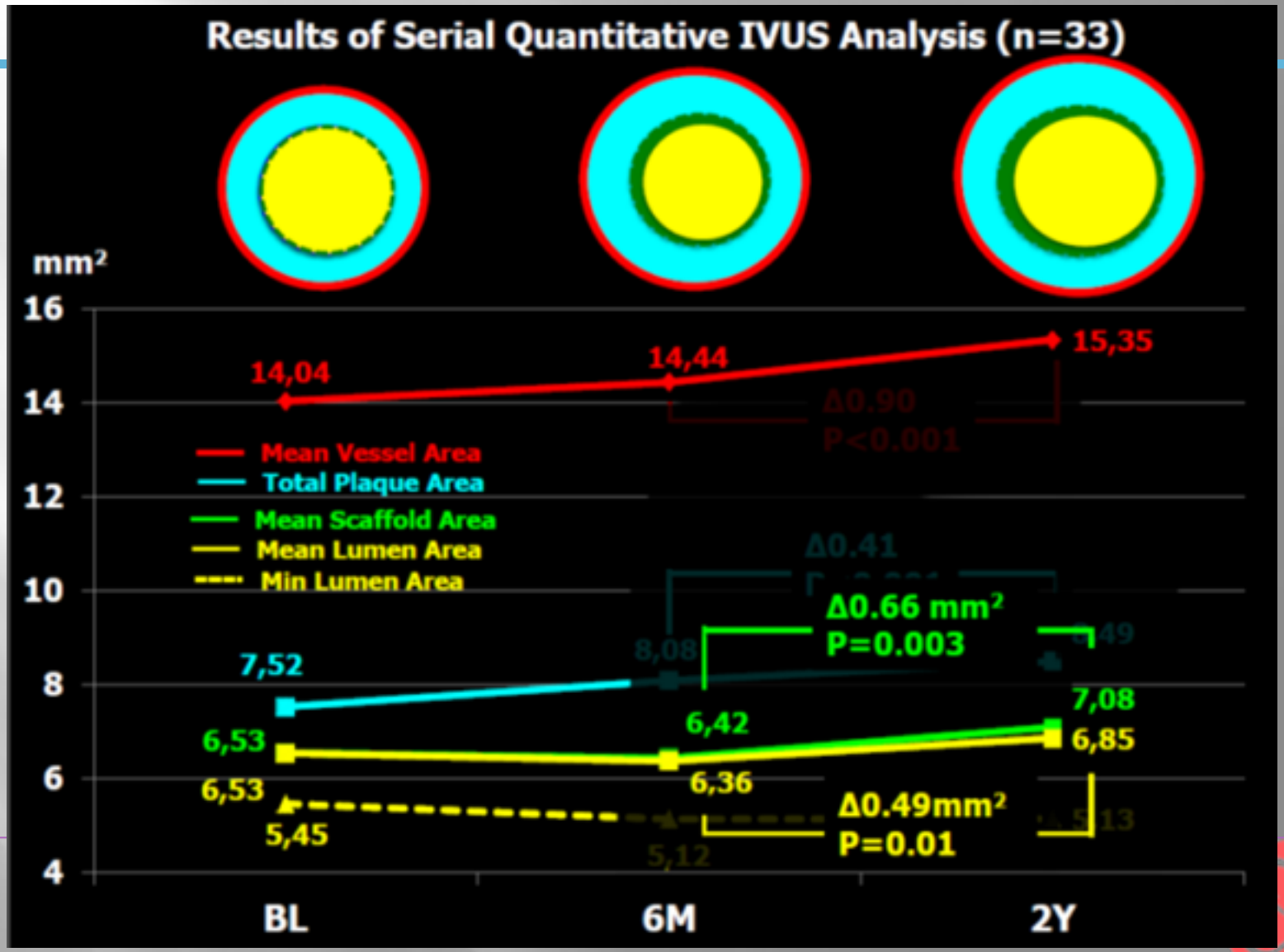
Absorb Cohort B

Absorb Cohort B

101 subjects
(Non-randomized) 12 sites in Europe, Australia, New Zealand

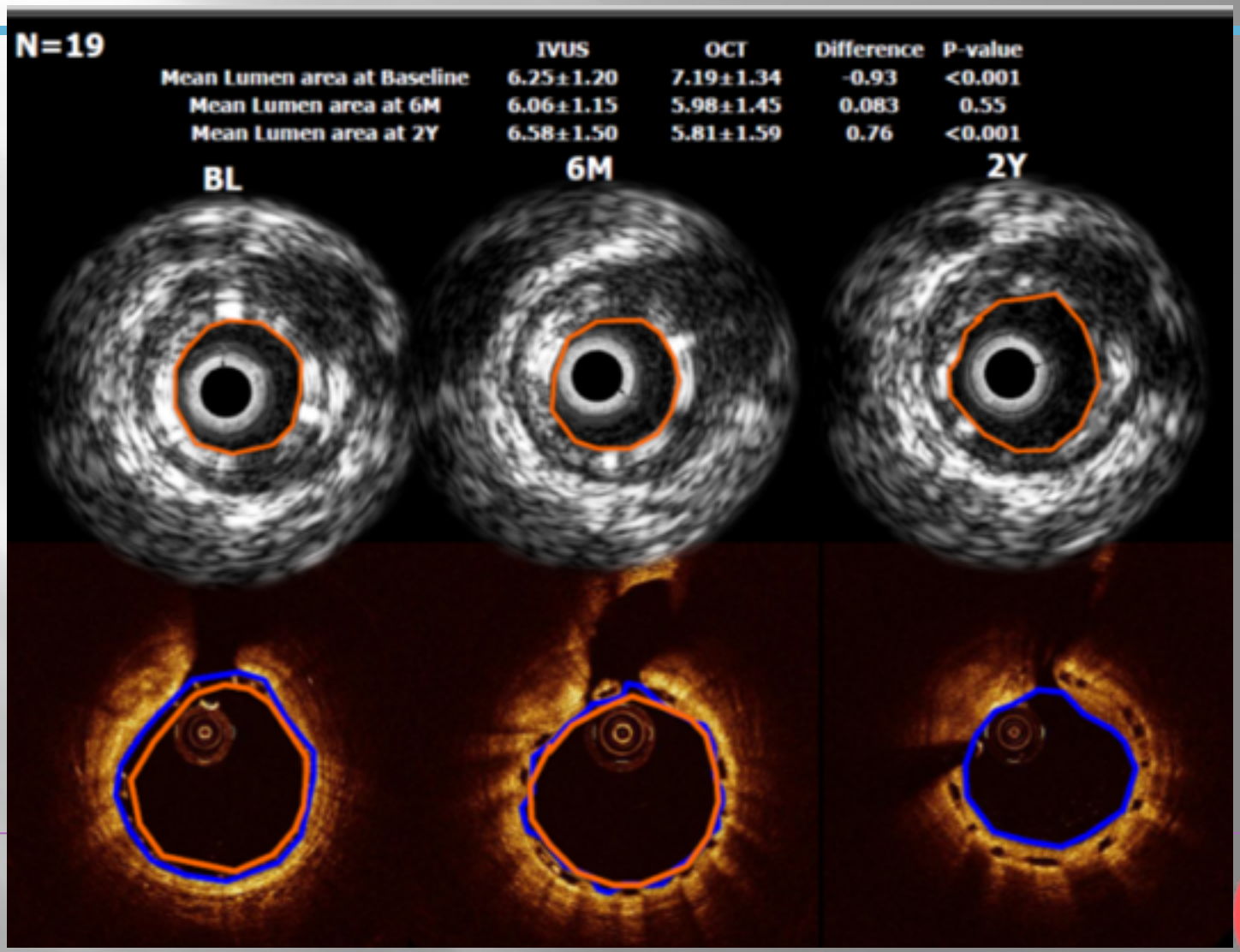
Study Objective	First In Man, Single Arm – safety/performance
Endpoints	Typical PCI clinical and imaging endpoints
Treatment	Up to 2 *de novo* lesions in different epicardial vessels Reference vessel diameter of 3.0 mm, lesions ≤ 14 mm in length
Device Sizes	3.0 x 18 mm devices

IVUS through 2 years



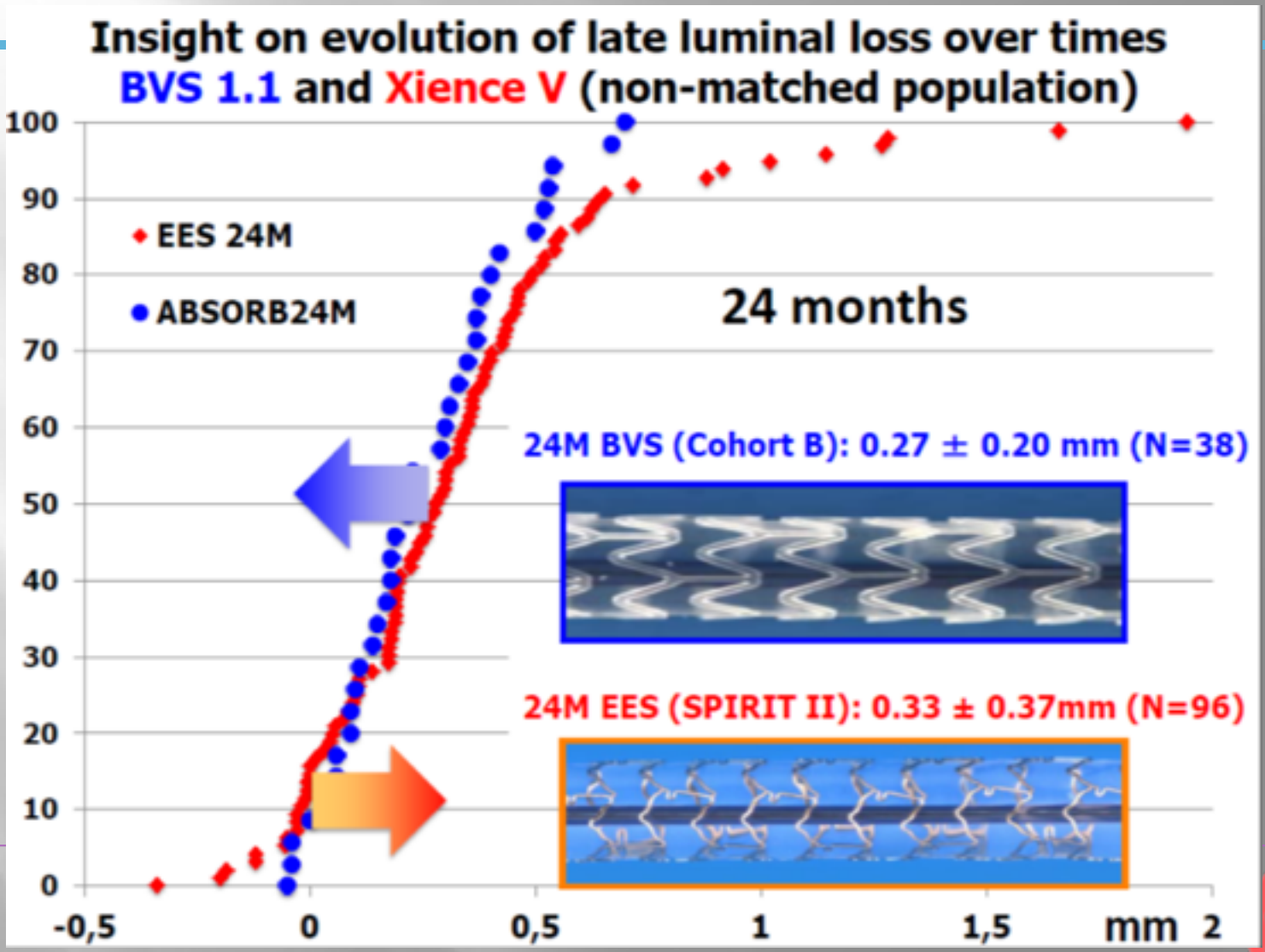
Patrick W, et al. PCR, March 9, 2012

Mean Lumen Area



Patrick W, et al. PCR, March 9, 2012

BVS vs. Xience V



Patrick W, et al. PCR, March 9, 2012

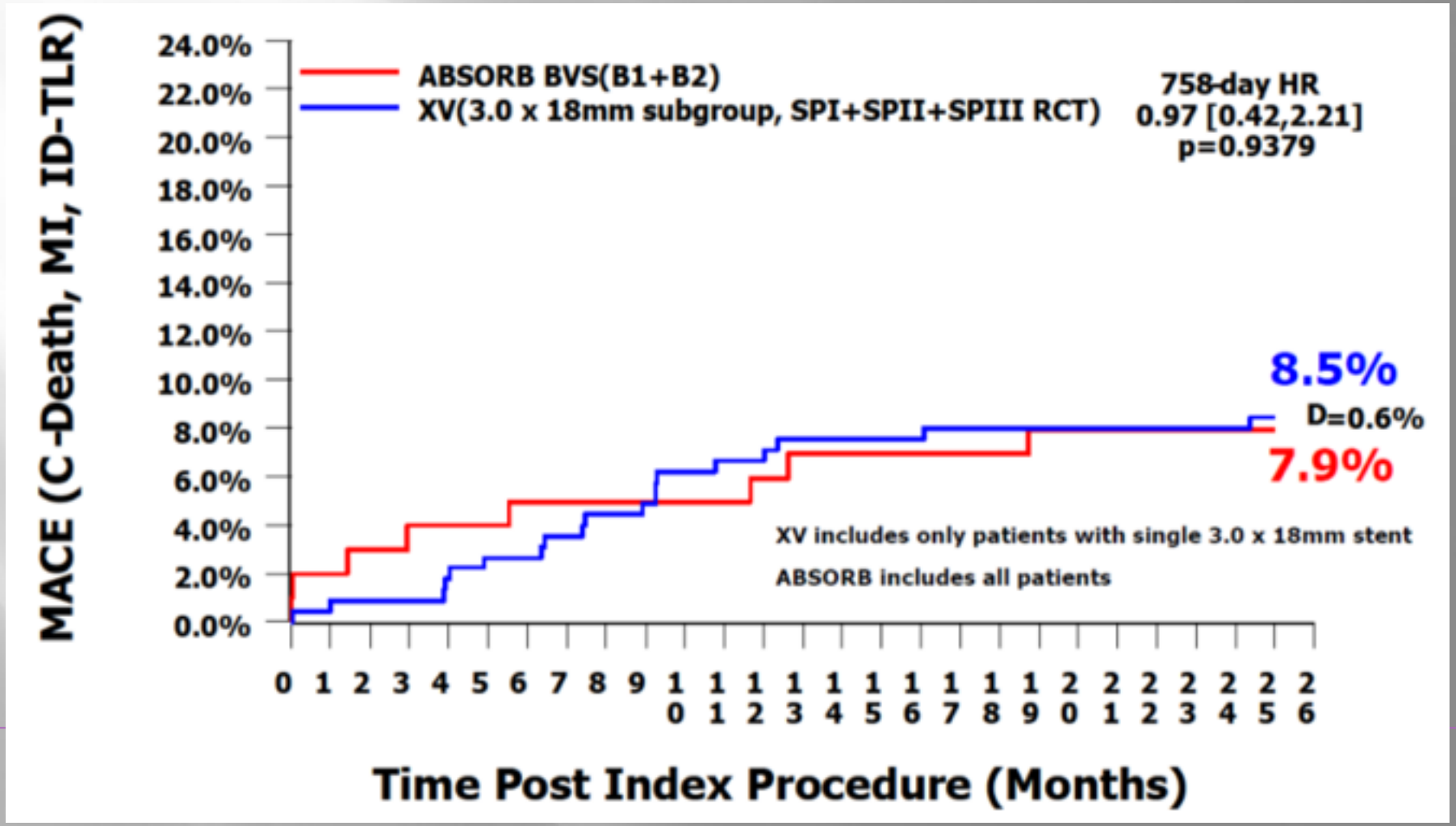
ABSORB Cohort B
Excellent Data Out to 2 Years

	30 Days	6 Months	1 Year	2 Years
Non -Hierarchical	n = 101	n = 101	n = 101	n = 100*
Cardiac Death %	0	0	0	0
Myocardial Infarction % (n)	2.0 (2)	3.0 (3)	3.0 (3)	3.0 (3)
Q-wave MI	0	0	0	0
Non Q -wave MI	2.0 (2)	3.0 (3)	3.0 (3)	3.0 (3)
Ischemia driven TLR % (n)	0	2.0 (2)	4.0 (4)	6.0 (6)
CABG	0	0	0	0
PCI	0	2.0 (2)	4.0 (4)	6.0 (6)
Hierarchical MACE % (n)	2.0 (2)	5.0 (5)	6.9 (7)	9.0 (9)

No scaffold thrombosis by ARC or Protocol out to 2-year
only 2 additional TLR events between 1 year and 2 year

Dudek,D. ACC 2012.

MACE rate in patients treated with BVS (n=101) Vs. Xience V (n=227)



Patrick W, et al. PCR, March 9, 2012

Why Absorb?
Near & Long Term Results Similar to XIENCE & Unique Benefits Emerging

Similar Results vs. XIENCE → Unique Benefits Emerging

- **Near term** results, measured in traditional endpoints, indicate Absorb performs as well as the standard of care (XIENCE V)*
  - 12 month MACE: 4.2% EXTEND vs. 5.3% SPIRIT II/III; Chevalier, EXTEND 1 year 450 Pt follow-up, Rotterdam, PCR

- **Longer term** data demonstrates a numerical difference in favor of Absorb vs. the standard of care (XIENCE V)*
  - 3 year MACE: 9.9% vs. 11.4% SPIRIT I/II/III; Serruys, Cohort B2 3 year Follow-up, Rotterdam PCR Focus on BVS, 2013

- The most **unique benefits** of Absorb are the results that would not be expected with a metallic implant

Clinical

Patients
  - 12-Month significant difference in favor of Absorb vs. XIENCE in reducing reported angina*†
  - Long-term lumen enlargement
  - Reduced plaque area with Absorb over the long-term
  - More treatment options
  - Scaffold breaks down into water and carbon dioxide unlike a permanent implant‡

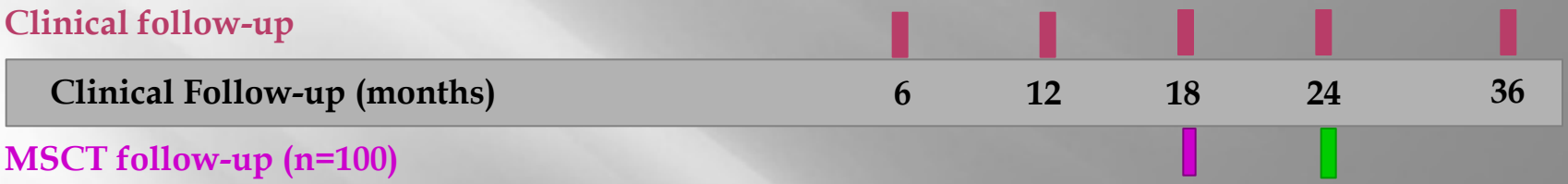
*Data sets are from different trials and displayed for descriptive purposes only.
†ABSORB EXTEND vs. SPIRIT IV. Presented at EuroPCR 2013.
‡Small platinum markers at scaffold edges remain for fluoroscopic landmarking

Absorb Extend

ABSORB EXTEND
Non-Randomized, Single-Arm, Continued Access Trial

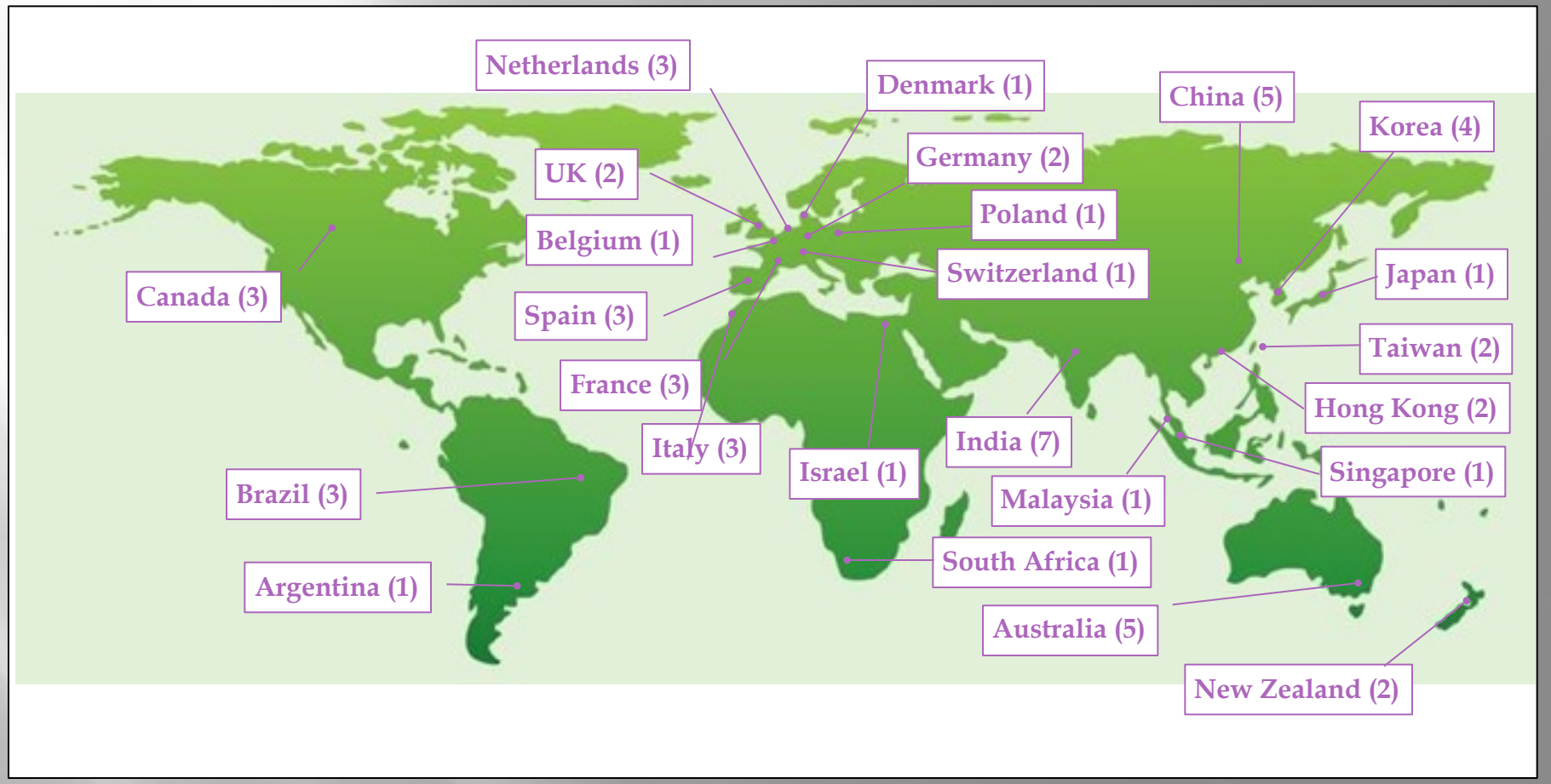
~1000 subjects

Up to 100 global sites (non-US)



Study Objective	Continued Access trial. FPI: Jan 11, 2011
Endpoints	Typical PCI clinical endpoints
Treatment	Up to 2 *de novo* lesions in different epicardial vessels Planned overlapping allowed in lesions >22 and ≤ 28 mm
Device Sizes	Scaffold diameters: 2.5, 3.0 mm Scaffold lengths: 18, 28 mm

ABSORB EXTEND
Planned Clinical Sites



- Up to two *de novo* lesions can be treated, each located in a separate native epicardial vessel
- Target vessel diameter range is ≥ 2.0 mm and ≤ 3.3 mm
- Target lesion length is ≤ 28 mm (planned overlapping allowed in lesions >22 and ≤ 28 mm)
- Target lesion(s) meeting any of the following criteria are excluded:
  - Left main location;
  - Located within an arterial or saphenous vein graft or distal to a diseased arterial or saphenous vein graft;
  - Involves a bifurcation with a side branch ≥ 2 mm in diameter and ostial lesion > 40% stenosed or side branch requiring predilatation;
  - Total occlusion (TIMI flow 0), prior to wire crossing;
  - Excessive tortuosity proximal to or within the lesion;
  - Heavy calcification.

ABSORB EXTEND

Preliminary Data from ABSORB EXTEND: A Report of the 6-month Clinical Outcomes from the First 269 Patients Registered

Robert Jan van Geuns, MD, PhD, FACC
on behalf of the ABSORB EXTEND Investigators

EuroPCR Focus on BVS 2012
Rotterdam, The Netherlands

Quantitative Vessel Sizing - Online QCA

- The recommended range for target vessel diameter is assessed in terms of the online QCA parameters distal D_{max} and proximal D_{max}, which refer to maximum lumen diameter evaluated at the distal and proximal ends of the target segment to be scaffolded, respectively.

Target Vessel Diameter Distal and Proximal	ABSORB BVS Diameter to be Used
≥ 2.0 mm and ≤ 3.0 mm	2.5 mm
≥ 2.5 mm and ≤ 3.3 mm	3.0 mm

As of CIP Rev. 3.0, IVUS is now also permitted as a modality for vessel sizing.