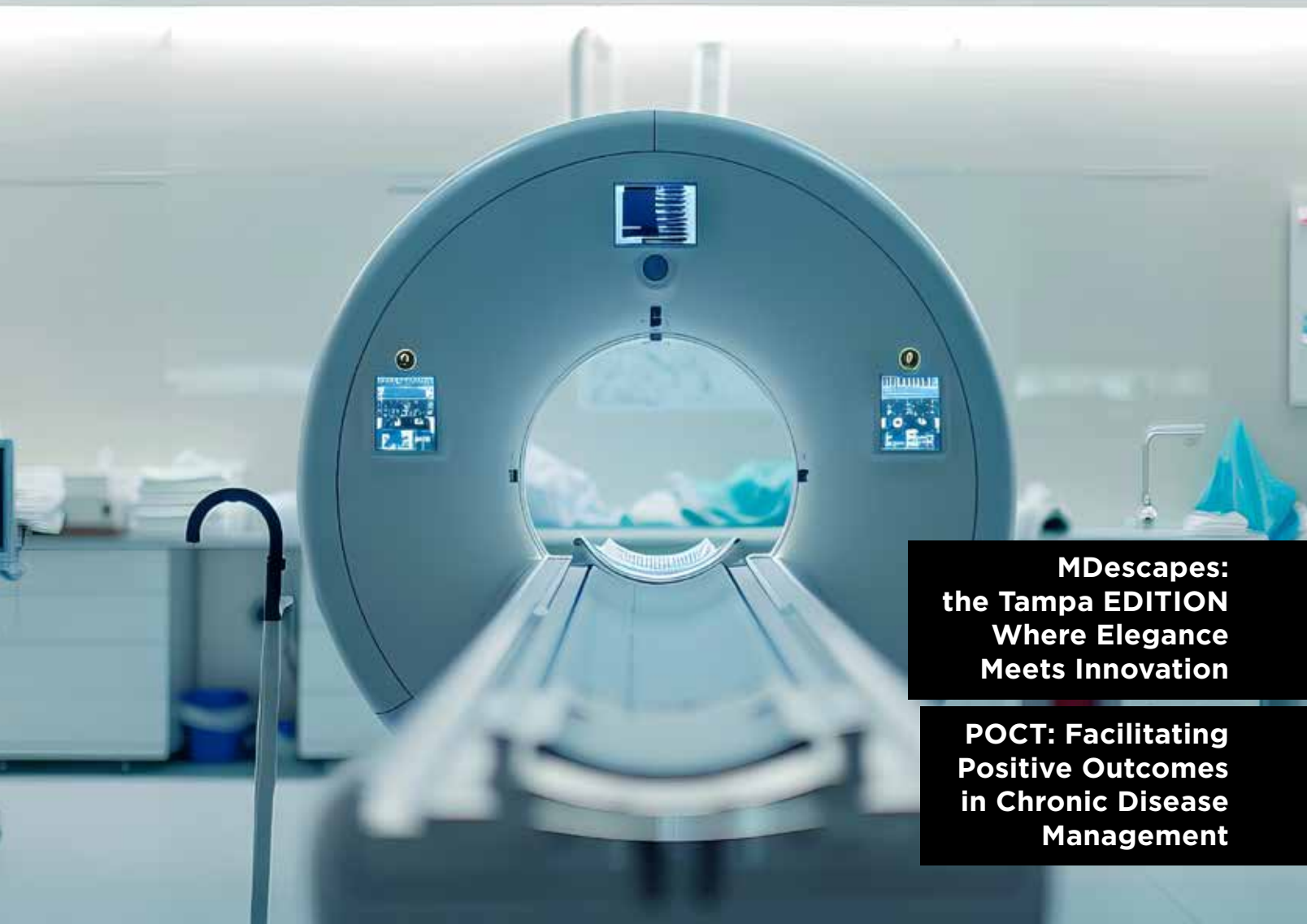
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Resources for You, Your Patients, & Your Practice

HOW TO CREATE A MEDICAL EMPIRE:

Imaging Centers



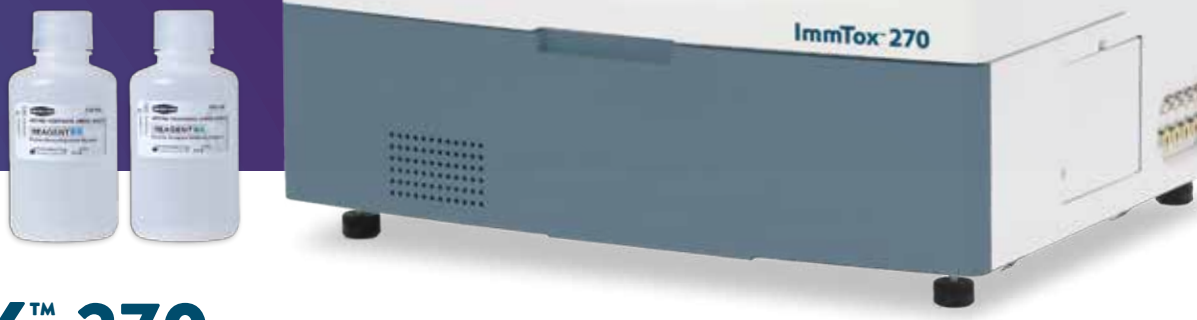
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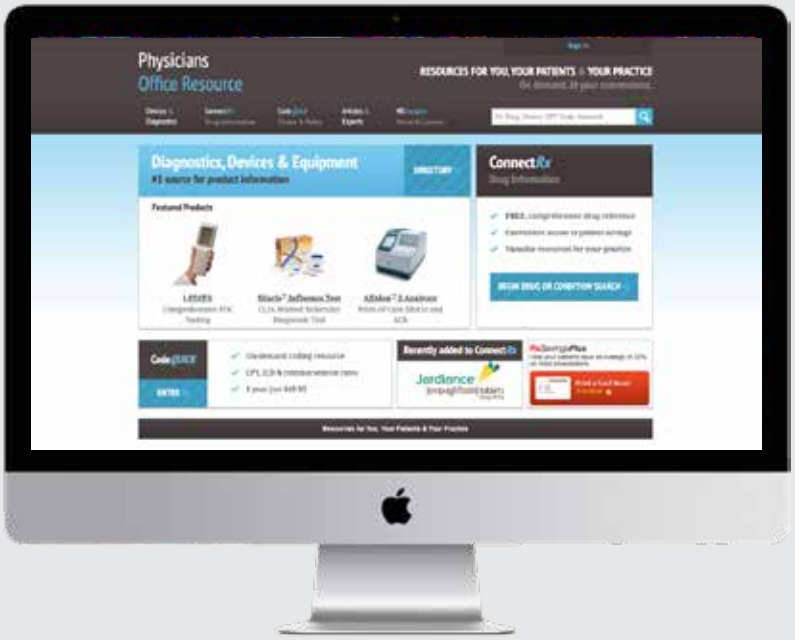
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6

How to Create a Medical Empire: Imaging Centers

Having discussed Ambulatory Surgery Centers in the last edition, it's time to move to a closely related entity, the Imaging Centers.

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Point of Care Testing: Facilitating positive outcomes in chronic disease management

Chronic diseases are the leading causes of death and disability in the U.S. and are leading drivers of the nation's healthcare costs.

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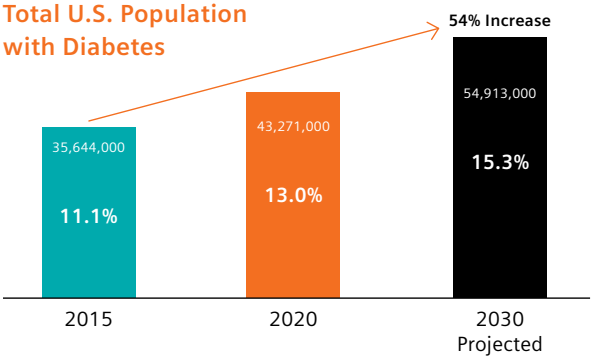
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1. Rowley, William R et al. "Diabetes 2030: Insights from Yesterday, Today, and Future Trends." Population health management vol. 20,1 (2017): 6-12. doi:10.1089/pop.2015.0181.

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PART 5 OF A 6 PART SERIES

HOW TO CREATE A MEDICAL EMPIRE:

Imaging Centers

BY DR. SHAKEEL AHMED

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"Do not follow where the path may lead. Go instead where there is no path and leave a trail."
- Ralph Waldo Emerson

This is the fifth installment in our series of articles on establishing a multi-business portfolio. Having discussed Ambulatory Surgery Centers in the last edition, it's time to move to a closely related entity, the Imaging Centers. Currently, there are approximately forty thousand medical imaging centers in the USA, performing more than a hundred million imaging procedures yearly. While tightly regulated by the same laws and forces that oversee the rest of healthcare, Imaging industry is unique in the sense that it allows a non-clinical person to have ownership in it. That opens the door to 300 plus million investors in the country.

Imaging, for the most part, is non-invasive. That allows the comfort factor to creep in when a patient chooses a center for their next test. While no one would opt for brain surgery at the cozy little office next to the mall, for an MRI that dogma flips on its head. Suddenly the imposing hospital seems overkill for a simple X-Ray. This convenience factor has created casualties for hospital departments witnessing hospital department "outmigration" to these independent diagnostic testing facilities, or IDTFs.

Covid helped turn the tables for IDTFs as well. I digress, but I will use a similar example to propound on that. Before the pandemic, telemedicine was seen as a vehicle for fraud. However, telemedicine has been legitimatized during the COVID-19 era. The same applies to all other healthcare concepts that seemed far-fetched previously, but now seem to be the norm. Outpatient procedures, convenient imaging and lab facilities far from the walls of the bug-infested hospitals, all are the rage now. Additionally, site-neutral policies of third-party payors have hit the profit margin of the larger hospitals, many of which can no longer compete and certainly won't see sense in upgrading their technology. The arrival of high deductible health plans and the regulation of price transparency will lower the costs further, and as out-of-pocket payments engender price-shopping, the elasticity of demand in the radiology and imaging healthcare areas will widen price discrepancies for a brisk competitive consumer landscape. In short, imaging centers are powerhouses. They are hard to compete with and hard to outperform. In terms of financial performance, IDTFs are astounding in their contributions to the US economy. They generate $25 billion in annual revenue and employ over one hundred thousand people. They also have maneuvered into having lower costs than hospital-based imaging centers. This translates into cost savings for both patients and payors. Having one seems to fit all the criteria for a win-win proposition.

Diagnostic centers are varied, from standalone endoscopy to pathology centers to yet-to-be-defined versions that will come with the evolution of medicine. Imaging centers may be the most expensive due to the sophisticated equipment that must be purchased and maintained via expensive subscription maintenance plans. As expensive as they are to build and run, it may be surprising that these are among the fastest-growing types in the industry. There are, however, aspects to imaging centers you can take advantage of that are more conservative (and financially viable). For example, you can start a center specializing in just MRI or one of a dozen other modalities, e.g., CT, PET scans, etc.

Cost

The beauty of imaging centers is, you can start small and then grow. Growing it over time is the best strategy, especially since some imaging technologies have yet to be invented, while the ever-expanding literature keeps coming up with new reasons to use the equipment that is already in place.

Regarding construction costs, you are a captive audience to your zip code. Certain parts of the country have reasonable construction fees and supply costs, but others don't. The following section on location discusses the desirability of where you will be located, but you have to balance what you can build and how much you can spend on where that is. And remember the mindset of excellence that must be part of your formula.

Fixed Costs

If you're playing imaging center Monopoly on Marvin Gardens instead of Baltic Avenue, your site will express a certain panache, but it will cost you more per square foot. These are fixed costs, determined by price per square foot based on industrial or retail zone pricing. If you're placing your center in a building already constructed, we're talking renovation. The amortization of your building over, say, thirty years is a fixed cost. So are the ten-year amortized big-ticket equipment items. Add the following:

- Building or renovation costs
- Architectural fees, which will likely be 20 percent of the building's cost. Add that into your fixed annual cost as amortized over ten years.
- Certifications and inspections, another 2 percent
- Equipment
  - · An MRI machine, at a bargain, will be $300,000; high-end ones can reach seven figures. A CT will be in the low- to mid-six-figure range. When the annual service contracts, which can be as much as $100,000 per machine per year, or amortized, it blurs the line between fixed and recurring costs.
  - · A mammography unit can cost $250,000, but you must add the yearly service contract of $50,000 per year to your 10-year amortization. X-ray is $100,000 per digital machine, with another $50,000 per year in contractual servicing.
- Cloud data storage, which will cost about $18,000 per year, but as your data accrues, so will your annual costs.
- Furniture is part of your marketing because patients don't

want scraggly chairs. Plus, remember the desks, office furniture, etc. A few hundred thousand dollars will drop to around $20,000 per year's amortization.

Annual Recurring Costs

- Salaries:
  - · radiologists (annually, each $400,000 + malpractice insurance + benefits)
  - · technologists, e.g., ultrasound tech, MRI tech, mammogram tech, CT/X-ray tech (at $70,000 per tech, per year)
  - · medical physicist for regulatory compliance ($60,000 to $180,000 depending on whether you share one or have them all to yourself)
  - · a couple of secretaries at $50,000 per year
  - · a business/marketing person for about $100,000 per year custodial personnel for about $40,000 per year
- Insurance, another 1 percent
- Property taxes are around 2 percent of your building's assessed value annually.
- Utilities ($40,000 annually):
  - · water
  - · heat
  - · electricity
- 5 percent of gross revenue to experts to maximize revenue while avoiding Medicare fraud. (It happens!)
- Consumables, e.g., toilet paper, stationery, contrast media, disposable medical items (syringes, etc.), another $35,000, perhaps.

So, now we're talking about up to $1.5 to $2 million a year to buy, build, renovate, and/or run it. Give or take. Amortized over ten or thirty years, depending on what's amortized.

Everything quoted here is an example, pulled from our own experience in the field.

Game-plan

Simple:

1. Get your money.
2. Just find a place to renovate or some land to build one.
3. Buy the equipment, then accommodate your site for the equipment (renovation).
4. Adhere to specifications for the diagnostic equipment requirements.
5. Meet building codes and regulations regarding every thing from lead-lined rooms and other shielding to parking spots allotted. Don't cut corners, or you'll pay later.
6. Get approval from your investors and the local, state, and federal agencies whose blessings you need. Obtain a CON, if required by your state.
7. Set a reasonable timeline.
8. Hire someone who builds imaging centers.
9. Hire the staff.
10. Turn the whole thing on.
11. And simply maintain profitability via patient satisfaction and marketing.

Caveats To Watch For

Some important points to consider when opening your own imaging center are;

- **Patient Convenience**: Your location must be visible; those who pass by and note your existence may contribute to your income someday. Visibility is the first (initial and innate) step in marketing. It must be easy to find, it must be easily accessible from major and recognizable roadways, and it must be easy to hop out of the car and walk right in. If failures in any of these merits occur, you may get a patient the first time (maybe), but you won't the second. (Remember step eleven above.) Don't forget public transportation considerations.
- **Provider Convenience**: Many IDTFs are located near hospitals, which offers benefits in subtle ways. First, referrals from adjacent office parks or the hospital can reach your facility easily. While this qualifies for the Patient Convenience bullet point above, the ease of patient compliance means physicians ordering the imaging are more likely to have their orders come to fruition. Chasing down noncompliant patients is a time- and money-waster. Also, if for any reason, the referring doctor needs to attend to the patient at the imaging center (e.g., allergic reaction, invasive procedures, etc.), a simple walk-to at lunch can prevent a provider from destroying their whole scheduled day. Additionally, if you're near the hospital, many of your competitors will be, too, who cannot tout *their* convenience to patients over your own.
- **Imaging Center Convenience**: While this heading implies a certain anthropomorphism, it lends itself well as a cautionary tale. You don't want to have to

literally fight tooth-and-nail to fit into, for example, an office park and become its problem child—i.e., noise, PR over hazardous waste, hogging up parking due to high appointment turn over, and other things the neighbors will torture you over. After all, unlike the pediatrician next door, you can't just pick up and move. Therefore, a stand alone facility avoids such intramural unpleasantness at the get-go.

Equipment

As a simplistic example, let's consider buying an MRI, a CT scanner, an ultrasound unit, a mammogram/tomography unit, and X-ray equipment. The type of imaging equipment you plan to have will determine the requirements of each room and the imaging center as a whole.

As a whole and in its entirety, your imaging center must be able to accommodate portable equipment. This means leeway for going down halls and making turns into separate rooms. It would be best to consider special traffic "lanes" so that equipment doesn't have to navigate through patients in the waiting or procedure rooms.

Imaging has advanced. Gone are the days of simple x-rays and ultrasounds. You now have behemoths that need to be transported, installed, and activated. The advances in imaging modalities are astounding. Where these advances fit into building imaging centers is flexibility. Walls, conduits, even Wi-Fi has to be considered, and while things are smaller and niftier, they still have to battle lead-lined walls and other obstacles. This means that hardwiring is still a necessity. And so are the attendant electrical, plumbing, and HVAC paraphernalia.

The requirements of your equipment mandate planning for them before building or renovation. Also, you must make room for the future, and there are those who can help predict—as best they can—what that future holds. MRI shielding should be adequate to reduce interference from the outside and reduce noise from the inside. Proper shielding can reduce the number of scans you might have to redo because of improper shielding.

As an example of cost outlay, as mentioned above, an MRI machine can cost between $300,000 to over a million dollars, depending on whether you begin with a refurbished one or an advanced model. The savings on a used machine can be significant, and even the added expense of a maintenance contract will not exceed what you save. Right now, MRI is the crown jewel of imaging, so you want to weigh in carefully on how you proceed with your preferences.

This includes materials intrinsic to MRI technology. What you choose for magnetic shielding is driven by its cost versus performance. You can use cheap metal, but you may not realize any savings if you need more of it to match what more expensive shielding material does.



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Magnetism, being so invisible (and powerful), can cause a broken machine, should someone blunder into the vicinity with metal. Expensive machines are also costly to fix, so a metal detector in the room's foyer might not be overreacting.

Specific shielding is also required for CT scanners and even X-ray procedures, but mainly to protect people from becoming unintended targets of X-radiation. OSHA will be watching.

The Digital

There is the hardware, and then there is the digital software. The flowsheet of how data and results will be stored, relayed, and collated is just as important in any construction. EMR (electronic medical records) is now reaching out to the patients to allow interactivity, so you'll have to be up to speed on center-patient interfaces just as much as center-hospital interfaces and center-provider interfaces. Your financial viability and success also depend on a reliable billing and coding system. You need a team knowledgeable in the billing and coding process, including insurance requirements, reimbursement rates, and regulatory rules and regulations. This will help increase revenue and reduce the risk of denied claims.

Time Money Coefficient

How many exits are there? How does your parking allotment jive with the expected patient turnover per hour? Will your sprinklers damage your MRI or CT? Will your place be ready for the fire inspector? Before it's over, you'll be familiar with the Americans with Disabilities Act (ADA). Among the governmental regulatory agencies, the ADA, the stakeholders' grumbling, the SEC, and your patient (tolerant, not sick person) banker, what will finally emerge is the go-ahead to break ground. Unless you have all the degrees to master these issues, you will be up to your neck in experts. Because only an expert can deal with the problems, and if there are no experts, now it's actually twice the problem.

Breaking Ground

Construction is not on autopilot. It requires time well spent at the site of construction—daily. You may have a foreman; you may have a contractor. But they need to be liable for the mistakes, like the wrong nails. True, the time you make to be there will take you away from your practice or what you usually do for a living, but it's time well spent, paying you a different way. And it's gold reimbursed if it means you open on the day initially set on the timeline.

Any sizable and new construction will attract a certain amount of rubbernecking, especially if your location is choice among traffic streams and thoroughfares. Marketing can begin the day you break ground with the right newspaper press releases and a picture. After that, an attractive sign that promises what's to come will jumpstart your marketing before you even get your first image.

Article continued at
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ABOUT THE AUTHOR:

Dr. Shakeel Ahmed

Spanning two decades, Dr. Shakeel Ahmed, a gastroenterologist turned healthcare mogul, has transformed his vision into the Midwest's leading Ambulatory Surgery Centers network. His dual expertise in medical administration and surgical execution-gained from years of frontline experience-has been pivotal in mastering the complexities of the healthcare sector. Dr. Ahmed's notable contributions extend beyond the ASC sphere; he has played a key role in developing a comprehensive healthcare network, including a range of medical facilities, diagnostic centers, and surgical establishments across several states. His literary contributions includes 6 published books alongside hundreds of articles in prestigious national and international journals. He is a consultant for multiple governments on healthcare development and works as an advisor to various governments across four continents in the establishment of outpatient surgery centers.

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1. Smolderen KG, Ameli O, Chaisson CE, Heath K, Mena-Hurtado C. Peripheral Artery Disease Screening in the Community and 1-Year Mortality, Cardiovascular Events, and Adverse Limb Events, AJPM Focus (2022), https://doi.org/10.1016/j.focus.2022.100016

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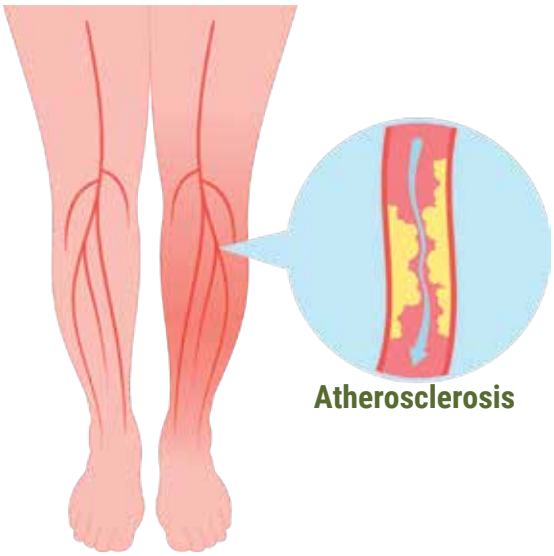
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FEATURE

Point-of-care Testing:

FACILITATING POSITIVE OUTCOMES IN CHRONIC DISEASE MANAGEMENT

BY SUSAN GARRAMONE
SENIOR CLINICAL MARKETING MANAGER
SIEMENS HEALTHINEERS

Introduction

Chronic diseases are the leading causes of death and disability in the U.S. and are leading drivers of the nation's rising healthcare costs.1 Chronic diseases are defined as conditions that last 1 year or more and require ongoing medical attention, limit activities of daily living, or both. Heart disease, cancer, chronic lung disease, stroke, Alzheimer's disease, diabetes, and chronic kidney disease are among the most common. A staggering 40% of adults in the U.S. have two or more chronic diseases.1 Unfortunately, chronic diseases are common, serious, and costly.

Common Comorbidities: Diabetes and Chronic Kidney Disease

Diabetes is the seventh-leading cause of death in the United States, affecting more than 37 million Americans.2,3 It is attributed to an estimated $327 billion in annual medical and lost productivity costs.2,3 Generally, care for patients with diabetes accounts for 1 in 4 healthcare dollars spent in the U.S., and a large portion of these costs results from diabetes-associated comorbidities that include potential neurological, cardiovascular, renal, and other chronic complications.3 In fact, diabetes is a risk factor for the development of chronic kidney disease (CKD); 1 in 3 adults with diabetes also have chronic kidney disease!4 In the U.S., where kidney disease is the tenth-leading cause of death, annual Medicare costs related to CKD are greater than $81 billion.[5,6]

Graphic 1



Graphic 2A



In addition to major healthcare cost implications, complications from diabetes and CKD may have significant impact on patient well-being and quality of life. Early recognition and management of diabetes and CKD enable timely intervention and greater opportunity to protect patient health. Tragically, 40% of patients with diabetes and 90% of patients with CKD are unaware that they have these conditions.[5,7]

With primary care being the first point of contact and foundation of a person's healthcare team, the ability to test, diagnose, consult, and manage diabetes and CKD in the primary care setting may provide the opportunity to prevent clinically worsening disease and improve patient outcomes and overall population health.[8,9]

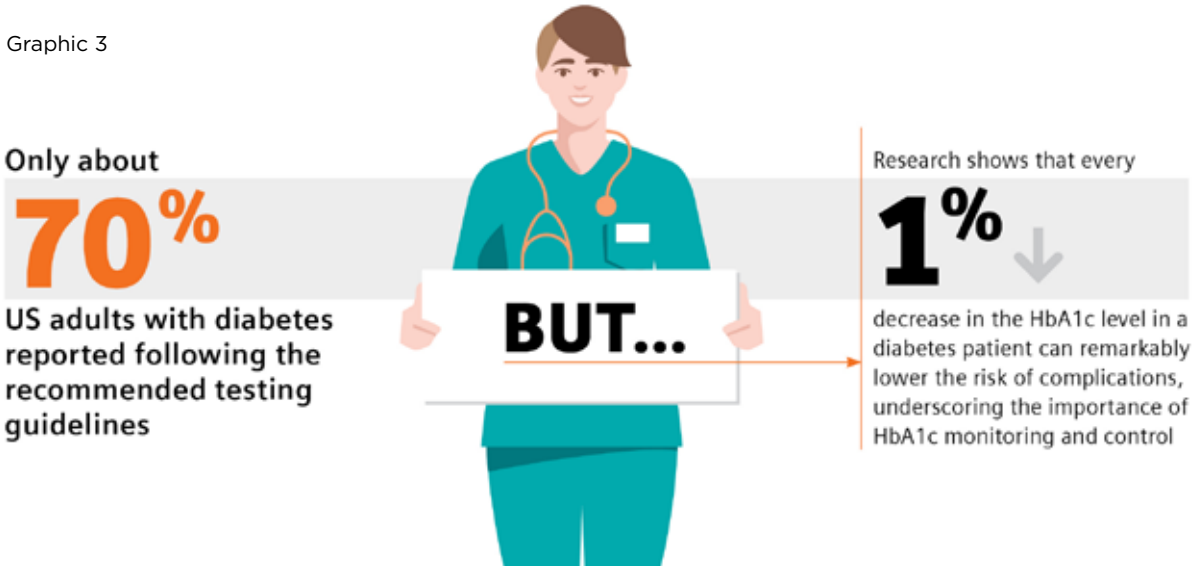
Diabetes and Hemoglobin A1c Testing

Glycated hemoglobin (A1c, hemoglobin A1c, HbA1c), which reflects average levels of blood glucose over the previous 2–3 months, is the most widely used test to monitor chronic glycemic control and the efficacy of treatment.10 In contrast to blood glucose levels, which fluctuate throughout the day based on diet and activity, the HbA1c level reflects a patient's glycemic control for the past 3 months.[10]

The American Diabetes Association (ADA) recommends the assessment of glycemic status (A1c or other glycemic measurement) at least two times per year in patients who are meeting treatment goals (and who have stable glycemic control) and at least quarterly, and as needed, in patients whose therapy has recently changed and/or who are not meeting glycemic goals.11 HbA1c testing can be performed in point-of-care (POC) settings such as a physician's office or laboratory, though the ADA states that POC testing for A1c provides opportunity for more timely treatment changes.[11]

According to the CDC, between 2011 and 2016, only 67.3–71.4% of U.S. adults with diabetes reported following the recommended testing guidelines.12 This statistic is very concerning from a population health perspective, as low adherence to HbA1c testing has been shown to lead to higher HbA1c levels, which in turn may lead to complications and comorbidities.13 Research shows that every 1% decrease in the HbA1c level in a diabetes patient can remarkably lower the risk of complications, underscoring the importance of HbA1c monitoring and control.[14]

Graphic 3

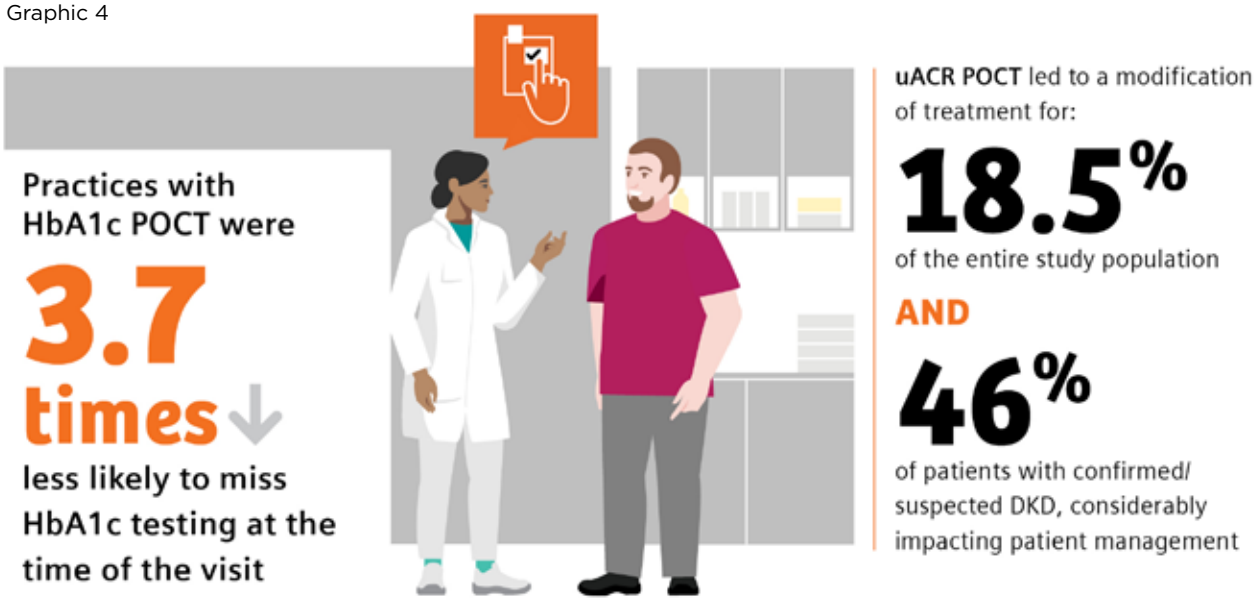


A review of the literature suggests that incorporating A1c testing into the patient visit and customizing the consultation to the patient's status appear to help physicians influence their patients to improve their glycemic control.[15]

The benefit of POC HbA1c testing has been widely reported in the literature.9,15-19 Of note is a study by Crocker et al. that demonstrated that POC HbA1c testing led to 3.7 times decreased likelihood of missing HbA1c testing.9 Nearly 1 in 4 of the individuals tested were found to have clinically worsening diabetes. Their diagnosis using POC testing enabled more timely intervention in diabetes management. A recent review by Rhyu et al. also highlighted the benefits of POC HbA1c testing in the physician's office, where the authors concluded that "POC A1c testing in primary care, if widely available and integrated into workflow, has the potential to positively impact diabetes care. Real-time feedback may change patient and physician behaviors, allowing earlier therapeutic intensification." [15]

In addition to addressing the clinical benefit, numerous studies have shown the cost-effectiveness of implementing POC HbA1c testing.16-20 Rosa et al. found that "compared to a centralized laboratory test, the use of the POC-A1c device in a healthcare unit increased the chance of the early control of type 2 diabetes and reduced costs in relation to DM-related outcomes."19 Crocker et al. reported that point-of-care HbA1c testing "can significantly improve clinical operations with cost reductions through improved practice efficiency," realizing a potential savings from improved efficiency of $24.64 per patient. This savings resulted from 89% and 85% decreases in follow-up phone calls and letters, respectively, and a 61% decrease in patient revisits.[17]

Graphic 4



CKD and Urinary Albumin-to-Creatinine Ratio (uACR)

The benefits of uACR testing at the point of care have similarly been studied, with findings of accuracy, convenience, improved patient access, and improvements in test adherence.21-25 The ADA recommends performing a spot uACR and estimated glomerular filtration rate (eGFR) test at least annually in patients with type 1 diabetes with duration of >5 years and in all patients with type 2 diabetes regardless of treatment. Patients with diabetes and urinary albumin >300 mg/g creatinine and/or an estimated glomerular filtration rate of 30–60 mL/min/1.73 m2 should be monitored twice annually to guide therapy.[26]

A recent study by Christofides and Desai discussed the importance of monitoring albuminuria in patients with type 2 diabetes as an essential tool in the detection of onset of CKD and monitoring disease progression. They stated, "Access to UACR testing may be improved by using Clinical Laboratory Improvements Amendments (CLIA)-waived point of care UACR testing options, that is, those approved for use closer to the patient and not necessarily in a central laboratory," and noted that using a CLIA-waived POC uACR option was a means to optimize test ordering. [21]

CLIA stands for Clinical Laboratory Improvement Amendments of 1988, a set of U.S. regulatory standards that apply to all clinical laboratory testing performed on humans (except for clinical trials and basic research), regardless of where the test is performed. A test system or product that is granted waived status is defined, in part, as a methodology that is simple and accurate to render negligible the likelihood of erroneous results.27 Many POC tests meet this classification, as they require no formal training, and operators must only follow the manufacturer's instructions for use. Waived POC tests are portable, easy to use, and offer accurate, quick near-patient results, making them particularly useful for testing in a physician's office. In this environment a physician can test a patient at the time of visit and obtain the result in real time, providing the opportunity to counsel the patient and make treatment adjustments at the time of the office visit. [28]

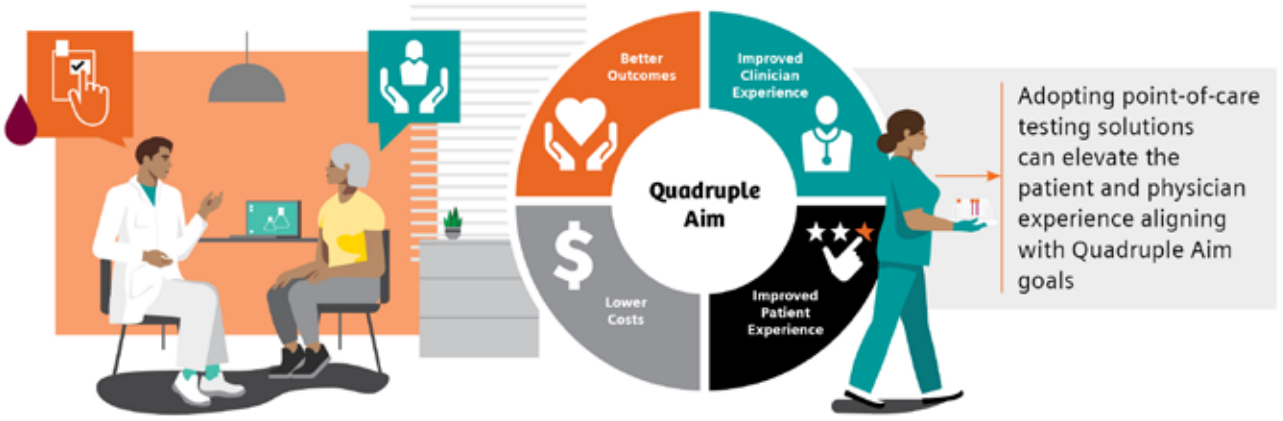
There is a documented need for strategies to improve routine CKD assessment nationwide and overcome testing barriers to increase test adherence.

A study by Folkherts et al. reported that physicians treating patients with diabetes are selectively adhering to chronic kidney disease screening guidelines where, despite recommendations to monitor both eGFR and urinary ACR, less than half of patients were screened for albuminuria during the 1-year follow-up.29 Additionally, a large retrospective study of patients at-risk for CKD by Alfego et al. found only 21% of adults at risk for CKD and 32.2% of patients with diabetes specifically had guideline-recommended uACR testing.30 Schultes et al. found that the implementation of ACR POCT in daily general practice can improve the diagnosis of diabetic kidney disease (DKD) in diabetes, which may support improved management of CKD.22 DKD was newly diagnosed in 8.6% of the entire study population and DKD was suspected in 9.9% based on their ACR POCT values. In 18.5% of the entire study population ACR POCT led to a change in medication, demonstrating a benefit in patient management. When surveyed regarding the relevance of the ACR POCT, 75% of physicians considered the test very important for people with diabetes; 25% rated it important.

Conclusion

Primary care physicians treat at least 90% of patients with diabetes in the United States.31 Patients with diabetes are at risk of developing CKD and monitoring for both conditions is important for disease management. Guidelines call for routine testing of HbA1c and uARC for disease monitoring and management.12,27 Adoption of in-office POC HbA1c and uACR testing may provide physicians an important tool toward the goal of closing the diabetes care gap, enabling convenient, efficient, cost-effective testing, and facilitating improved patient adherence to testing. Increased patient test adherence will enable faster intervention and treatment, leading to improved patient outcomes and decreased overall diabetes-related healthcare costs—a win for all in the fight against chronic disease.

Graphic 5



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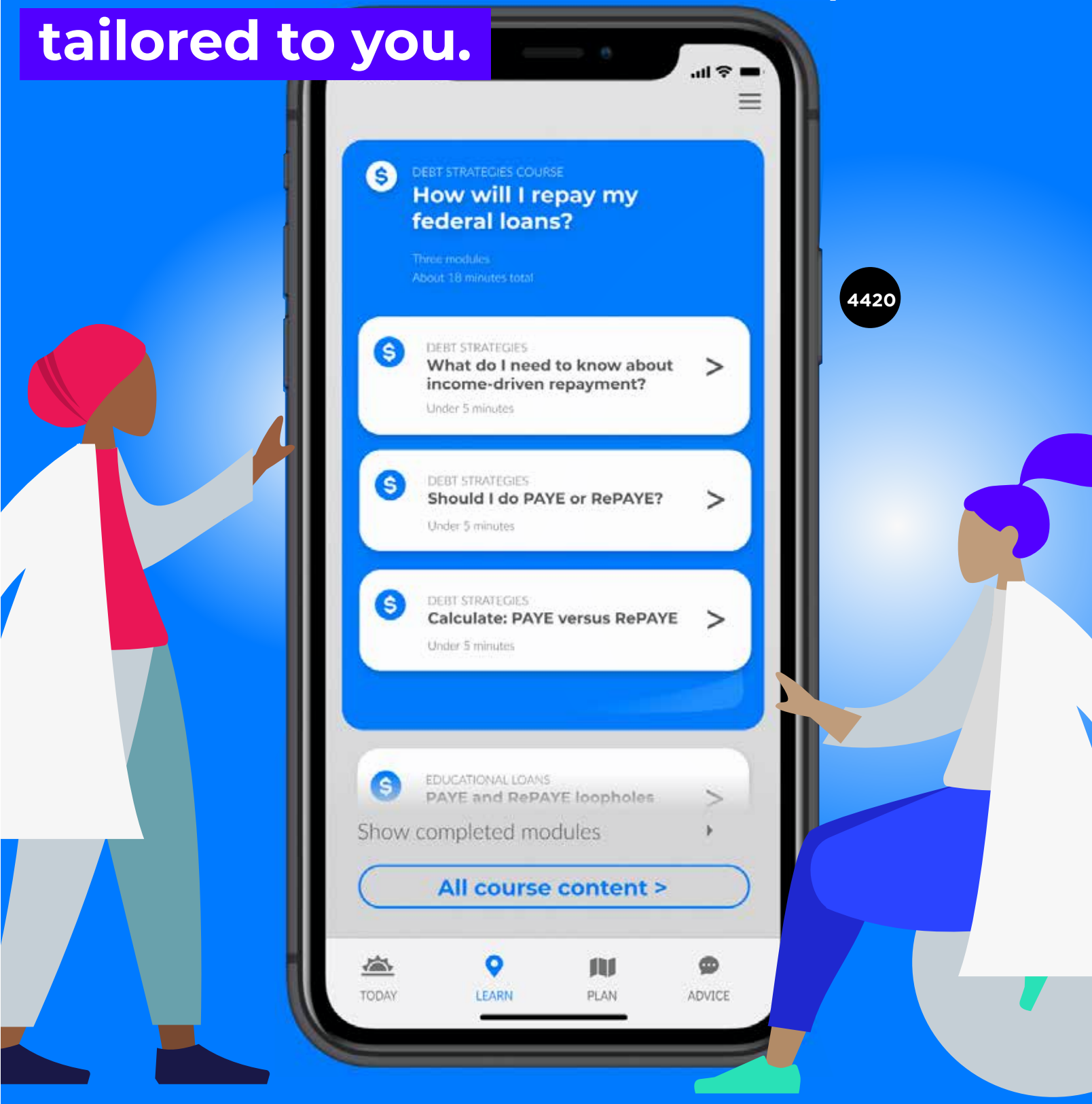
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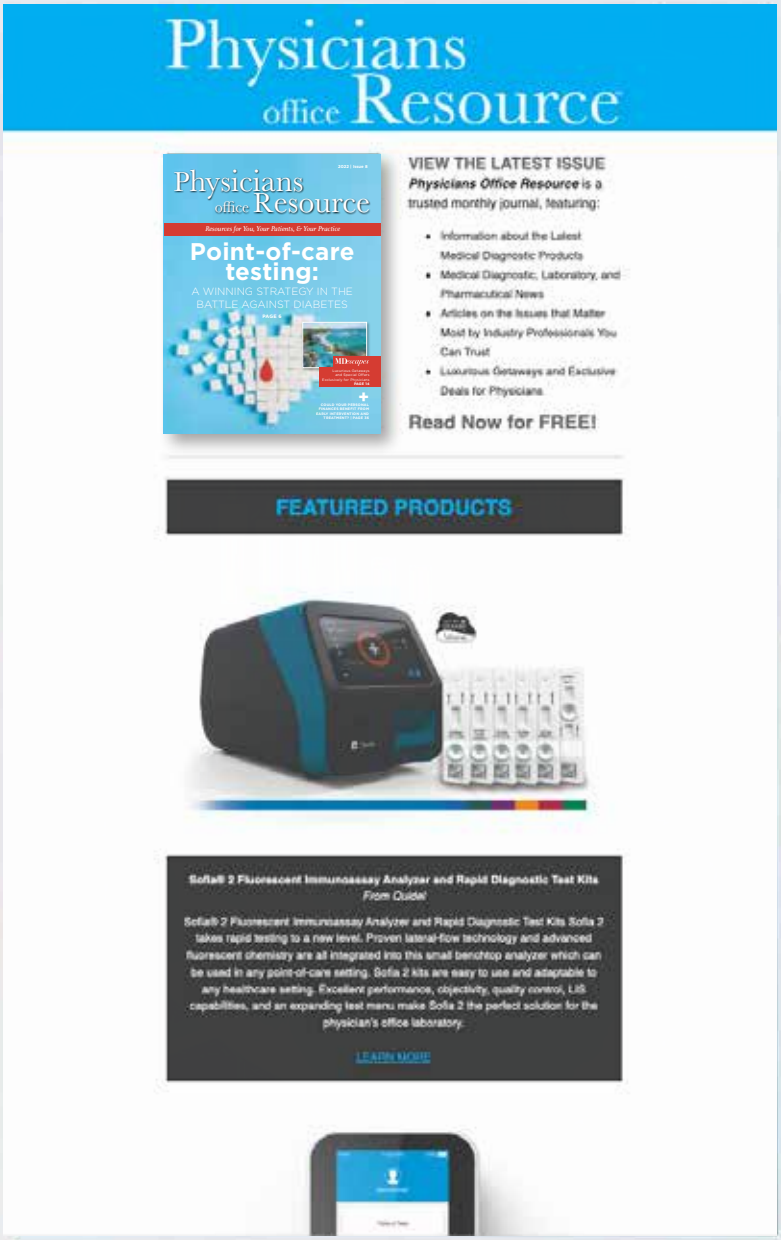
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- **Wegovy® is contraindicated in patients with a personal or family history of MTC or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Counsel patients regarding the potential risk for MTC with the use of Wegovy® and inform them of symptoms of thyroid tumors (e.g. a mass in the neck, dysphagia, dyspnea, persistent hoarseness). Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with Wegovy®**

Contraindications

- Wegovy® is contraindicated in patients with a personal or family history of MTC or in patients with MEN 2, and in patients with a prior serious hypersensitivity reaction to semaglutide or to any of the excipients in Wegovy®. Serious hypersensitivity reactions, including anaphylaxis and angioedema have been reported with Wegovy®

Warnings and Precautions

- **Risk of Thyroid C-Cell Tumors:** Patients should be further evaluated if serum calcitonin is measured and found to be elevated or thyroid nodules are noted on physical examination or neck imaging
- **Acute Pancreatitis:** Acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis, has been observed in patients treated with GLP-1 receptor agonists, including semaglutide. Acute pancreatitis was observed in patients treated with Wegovy® in clinical trials. Observe patients carefully for signs and symptoms of acute pancreatitis (including persistent severe abdominal pain, sometimes radiating to the back, and which may or may not be accompanied by vomiting). If acute pancreatitis is suspected, discontinue Wegovy® promptly, and if acute pancreatitis is confirmed, do not restart
- **Acute Gallbladder Disease:** Treatment with Wegovy® is associated with an increased occurrence of cholelithiasis and cholecystitis. The incidence of cholelithiasis and cholecystitis was higher in Wegovy® pediatric patients aged 12 years and older than in Wegovy® adults. In clinical trials in adult patients, cholelithiasis was reported by 1.6% of Wegovy® patients and 0.7% of placebo patients. Cholecystitis was reported by 0.6% of Wegovy® patients and 0.2% of placebo patients. In a clinical trial in pediatric patients aged 12 years and older, cholelithiasis was reported by 3.8% of Wegovy® patients and 0% placebo patients. Cholecystitis was reported by 0.8% of Wegovy® pediatric patients and 0% placebo patients. Substantial or rapid weight loss can increase the risk of cholelithiasis; however, the incidence of acute gallbladder disease was greater in Wegovy® patients than in placebo patients, even after accounting for the degree of weight loss. If cholelithiasis is suspected, gallbladder studies and appropriate clinical follow-up are indicated
- **Hypoglycemia:** Wegovy® lowers blood glucose and can cause hypoglycemia. In a trial of adult patients with type 2 diabetes, hypoglycemia was reported in 6.2% of Wegovy® patients versus 2.5% of placebo patients. Patients with diabetes taking Wegovy® with an insulin or insulin secretagogue (e.g. sulfonylurea) may have an increased risk of hypoglycemia, including severe hypoglycemia. The use of Wegovy® in patients with type 1 diabetes or in combination with insulin has not been evaluated. Inform patients of the risk of hypoglycemia and educate them on the signs and symptoms. Monitor blood glucose in patients with diabetes
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vs 2.6% with placebo†

77.1%

of patients taking Wegovy® achieved ≥5% weight loss vs 34.4% with placebo†§

Mean baseline body weight:
Wegovy®, 232.8 lb; placebo, 234.8 lb.
Mean baseline BMI: 38.5 kg/m².

Confirmatory secondary end points

≥10% weight loss: 61.8% with Wegovy®
vs 13.3% with placebo†
≥15% weight loss: 52.1% with Wegovy®
vs 7.0% with placebo†

Supportive secondary end point‡§

~1 out of 3 Wegovy® patients achieved

≥20%

Weight loss at 2 years

36.1% with Wegovy®
vs 2.3% with placebo

MACE risk reduction[1,3]

In adults with established CVD and either obesity or overweight, without diabetes:

When added to CV SOC

20%

RRR of MACE
1.5% ARR[4]‖

Event rates
Percent of patients with MACE:

Placebo + CV SOC (n=701 of 8,801)	vs	Wegovy® 2.4 mg + CV SOC (n=569 of 8,803)
8.0%		6.5%

HR, 0.80 (95% CI, 0.72-0.90)
p<0.001, one-sided *p*-value

STEP 5 Study Design: A 104-week trial of 304 adults with obesity (BMI ≥30 kg/m²) or with overweight (BMI 27 kg/m²-29.9 kg/m²) and at least one weight-related comorbid condition, such as treated or untreated dyslipidemia or hypertension, cardiovascular disease, or obstructive sleep apnea; patients with diabetes mellitus were excluded. Patients were randomized in a 1:1 ratio to either once-weekly Wegovy® 2.4 mg or placebo (with a 16-week dose escalation), both in conjunction with a reduced-calorie diet and increased physical activity. Discontinuation rate: 13% Wegovy®; 27% placebo.[2]

§Observed data include only patients who had a body weight assessment at week 104 (144 of 152 for Wegovy® arm and 128 of 152 for placebo arm) and do not include all randomized patients.
†*p*<0.0001 (unadjusted 2-sided) for superiority.
‡Supportive secondary end points were not included in the statistical testing hierarchy and, as such, not controlled for multiplicity.

SELECT Study Design: Multi-national, double-blind, placebo-controlled, event-driven superiority CVOT (N=17,604) for adults with BMI ≥27 kg/m² and established CVD (prior MI, prior stroke, or PAD), without diabetes, randomized 1:1 to receive once-weekly Wegovy® 2.4 mg or placebo. Both groups received SOC for CV risk reduction (medical management and individualized healthy lifestyle counseling, including diet and physical activity). Median duration of follow-up: 41.8 months. Discontinuation rate: 31% Wegovy®; 27% placebo. Adverse event discontinuation: 16% Wegovy®; 8% placebo.[1,3]

Primary composite end point: time from randomization to first occurrence of a 3-part composite MACE, defined as CV death, non-fatal MI, or non-fatal stroke.[3]

‖1.5% ARR at 40 months (mean duration of follow-up).

depletion. Monitor renal function when initiating or escalating doses of Wegovy® in patients reporting severe adverse gastrointestinal reactions and in patients with renal impairment reporting any adverse reactions that could lead to volume depletion

- **Hypersensitivity Reactions:** Serious hypersensitivity reactions (e.g., anaphylaxis, angioedema) have been reported with Wegovy®. If hypersensitivity reactions occur, discontinue use of Wegovy®, treat promptly per standard of care, and monitor until signs and symptoms resolve. Use caution in a patient with a history of anaphylaxis or angioedema with another GLP-1 receptor agonist
- **Diabetic Retinopathy Complications in Patients with Type 2 Diabetes:** In a trial of adult patients with type 2 diabetes, diabetic retinopathy was reported by 4.0% of Wegovy® patients and 2.7% of placebo patients. Rapid improvement in glucose control has been associated with a temporary worsening of diabetic retinopathy. Patients with a history of diabetic retinopathy should be monitored for progression of diabetic retinopathy
- **Heart Rate Increase:** Mean increases in resting heart rate of 1 to 4 beats per minute (bpm) were observed in Wegovy® adult patients compared to placebo in clinical trials. More Wegovy® adult patients compared with placebo had maximum changes from baseline of 10 to 19 bpm (41% versus 34%) and 20 bpm or more (26% versus 16%). In a clinical trial in pediatric patients aged 12 years and older with normal baseline heart rate, more patients treated with Wegovy® compared to placebo had maximum changes in heart rate of 20 bpm or more (54% versus 39%). Monitor heart rate at regular intervals and instruct patients to report palpitations or feelings of a racing heartbeat while at rest. If patients experience a sustained increase in resting heart rate, discontinue Wegovy®
- **Suicidal Behavior and Ideation:** Suicidal behavior and ideation have been reported in clinical trials with other weight management products. Monitor patients for depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior. Discontinue Wegovy® in patients who experience suicidal thoughts or behaviors and avoid in patients with a history of suicidal attempts or active suicidal ideation

Adverse Reactions

- Most common adverse reactions (incidence ≥5%) are: nausea, diarrhea, vomiting, constipation, abdominal pain, headache, fatigue, dyspepsia, dizziness, abdominal distention, eructation, hypoglycemia in patients with type 2 diabetes, flatulence, gastroenteritis, gastroesophageal reflux disease, and nasopharyngitis

Drug Interactions

- The addition of Wegovy® in patients treated with insulin has not been evaluated. When initiating Wegovy®, consider reducing the dose of concomitantly administered insulin secretagogues (such as sulfonylureas) or insulin to reduce the risk of hypoglycemia
- Wegovy® causes a delay of gastric emptying and has the potential to impact the absorption of concomitantly administered oral medications. Monitor the effects of oral medications concomitantly administered with Wegovy®

Use in Specific Populations

- **Pregnancy:** May cause fetal harm. When pregnancy is recognized, discontinue Wegovy®. Discontinue Wegovy® in patients at least 2 months before a planned pregnancy
- **Pediatric:** Adverse reactions with Wegovy® in pediatric patients aged 12 years and older were similar to those reported in adults. Pediatric patients ≥12 years of age treated with Wegovy® had greater incidences of cholelithiasis, cholecystitis, hypotension, rash, and urticaria compared to adults treated with Wegovy®. There are insufficient data in pediatric patients with type 2 diabetes treated with Wegovy® for obesity to determine if there is an increased risk of hypoglycemia with Wegovy® treatment similar to that reported in adults
- **Geriatric:** In the cardiovascular outcomes trial, patients aged 75 years and older reported more hip and pelvis fractures on Wegovy® than placebo. Patients aged 75 years and older (Wegovy® and placebo) reported more serious adverse reactions overall compared to younger adult patients

Please see the Brief Summary of Prescribing Information about Wegovy® on the following pages.

ARR, absolute risk reduction; BMI, body mass index; CI, confidence interval; CV, cardiovascular; CVD, cardiovascular disease; CVOT, cardiovascular outcomes trial; HR, hazard ratio; MACE, major adverse cardiovascular events; MI, myocardial infarction; PAD, peripheral arterial disease; RRR, relative risk reduction; SOC, standard of care.

References: 1. Wegovy® [package insert]. Plainsboro, NJ: Novo Nordisk Inc. **2.** Garvey WT, Batterham RL, Bhatta M, et al. Two-year effects of semaglutide in adults with overweight or obesity: the STEP 5 trial. *Nat Med*. 2022;28(10):2083-2091. **3.** Lincoff AM, Brown-Frandsen K, Colhoun HM, et al. Semaglutide and cardiovascular outcomes in obesity without diabetes. *N Engl J Med*. 2023;389(24):2221-2232. **4.** Data on file. Novo Nordisk Inc.; Plainsboro, NJ.

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novo nordisk®

WEGOVY® (semaglutide) injection

Rx Only

BRIEF SUMMARY: Please consult package insert for full prescribing information.

WARNING: RISK OF THYROID C-CELL TUMORS: In rodents, semaglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures. It is unknown whether WEGOVY® causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans as human relevance of semaglutide-induced rodent thyroid C-cell tumors has not been determined *[see Warnings and Precautions]*. WEGOVY® is contraindicated in patients with a personal or family history of MTC or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) *[see Contraindications]*. Counsel patients regarding the potential risk for MTC with the use of WEGOVY® and inform them of symptoms of thyroid tumors (e.g. a mass in the neck, dysphagia, dyspnea, persistent hoarseness). Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with WEGOVY® *[see Contraindications and Warnings and Precautions]*.

INDICATIONS AND USAGE: WEGOVY® is indicated in combination with a reduced calorie diet and increased physical activity: to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease and either obesity or overweight; to reduce excess body weight and maintain weight reduction long term in: Adults and pediatric patients aged 12 years and older with obesity; Adults with overweight in the presence of at least one weight-related comorbid condition. Limitations of Use: WEGOVY® contains semaglutide. Coadministration with other semaglutide-containing products or with any other GLP-1 receptor agonist is not recommended.

CONTRAINDICATIONS: WEGOVY® is contraindicated in the following conditions: A personal or family history of MTC or in patients with MEN 2 *[see Warnings and Precautions];* A prior serious hypersensitivity reaction to semaglutide or to any of the excipients in WEGOVY®. Serious hypersensitivity reactions, including anaphylaxis and angioedema, have been reported with WEGOVY® *[see Warnings and Precautions]*.

WARNINGS AND PRECAUTIONS: Risk of Thyroid C-Cell Tumors: In mice and rats, semaglutide caused a dose-dependent and treatment-duration-dependent increase in the incidence of thyroid C-cell tumors (adenomas and carcinomas) after lifetime exposure at clinically relevant plasma exposures. It is unknown whether WEGOVY® causes thyroid C-cell tumors, including MTC, in humans, as human relevance of semaglutide-induced rodent thyroid C-cell tumors has not been determined. Cases of MTC in patients treated with liraglutide, another GLP-1 receptor agonist, have been reported in the postmarketing period; the data in these reports are insufficient to establish or exclude a causal relationship between MTC and GLP-1 receptor agonist use in humans. WEGOVY® is contraindicated in patients with a personal or family history of MTC or in patients with MEN 2. Counsel patients regarding the potential risk for MTC with the use of WEGOVY® and inform them of symptoms of thyroid tumors (e.g. a mass in the neck, dysphagia, dyspnea, persistent hoarseness). Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with WEGOVY®. Such monitoring may increase the risk of unnecessary procedures, due to the low-test specificity for serum calcitonin and a high background incidence of thyroid disease. Significantly elevated serum calcitonin value may indicate MTC and patients with MTC usually have calcitonin values greater than 50 ng/L. If serum calcitonin is measured and found to be elevated, the patient should be further evaluated. Patients with thyroid nodules noted on physical examination or neck imaging should also be further evaluated. **Acute Pancreatitis:** Acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis, has been observed in patients treated with GLP-1 receptor agonists, including semaglutide. Acute pancreatitis was observed in patients treated with WEGOVY® in clinical trials *[see Adverse Reactions]*. After initiation of WEGOVY®, observe patients carefully for signs and symptoms of acute pancreatitis (including persistent severe abdominal pain, sometimes radiating to the back, and which may or may not be accompanied by vomiting). If acute pancreatitis is suspected, WEGOVY® should promptly be discontinued, and appropriate management should be initiated. If acute pancreatitis is confirmed, WEGOVY® should not be restarted. There is limited experience from clinical trials with WEGOVY® in patients with a history of pancreatitis. It is unknown if patients with a history of pancreatitis are at higher risk for development of pancreatitis on WEGOVY®. **Acute Gallbladder Disease:** Treatment with WEGOVY® is associated with an increased occurrence of cholelithiasis and cholecystitis. The incidence of cholelithiasis and cholecystitis was higher in WEGOVY®-treated pediatric patients aged 12 years and older than in WEGOVY®-treated adults. In randomized clinical trials in adult patients, cholelithiasis was reported by 1.6% of WEGOVY®-treated patients and 0.7% of placebo-treated patients. Cholecystitis was reported by 0.6% of WEGOVY®-treated adult patients and 0.2% of placebo-treated patients. In a clinical trial in pediatric patients aged 12 years and older, cholelithiasis was reported by 3.8% of WEGOVY®-treated patients and 0% placebo-treated patients. Cholecystitis was reported by 0.8% of WEGOVY®-treated pediatric patients and 0% placebo-treated patients *[see Adverse Reactions]*. Substantial or rapid weight loss can increase the risk of cholelithiasis; however, the incidence of acute gallbladder disease was greater in WEGOVY®-treated patients than in placebo-treated patients, even after accounting for the degree of weight loss. If cholelithiasis is suspected, gallbladder studies and appropriate clinical follow-up are indicated. **Hypoglycemia:** WEGOVY® lowers blood glucose and can cause hypoglycemia. In a trial of adult patients with type 2 diabetes and body mass index (BMI) greater than or equal to 27 kg/m^2, hypoglycemia (defined as a plasma glucose less than 54 mg/dL) was reported in 6.2% of WEGOVY®-treated patients versus 2.5% of placebo-treated patients. One episode of severe hypoglycemia (requiring the assistance of another person) was reported in one WEGOVY®-treated patient versus no placebo-treated patients. Patients with diabetes mellitus taking WEGOVY® in combination with insulin or an insulin secretagogue (e.g., sulfonylurea) may have an increased risk of hypoglycemia, including severe hypoglycemia. Hypoglycemia has been observed in patients treated with semaglutide at doses of 0.5 and 1 mg in combination with insulin. The use of WEGOVY® (semaglutide 2.4 mg or 1.7 mg once weekly) in patients with type 1 diabetes mellitus or in combination with insulin has not been evaluated. Inform patients of the risk of hypoglycemia and educate them on the signs and symptoms of hypoglycemia. In patients with diabetes, monitor blood glucose prior to starting WEGOVY® and during WEGOVY® treatment. When initiating WEGOVY®, consider reducing the dose of concomitantly administered insulin or insulin secretagogue (such as sulfonylureas) to reduce the risk of hypoglycemia *[see Drug Interactions]*. **Acute Kidney Injury:** There have been postmarketing reports of acute kidney injury and worsening of chronic renal failure, which have in some cases required hemodialysis, in patients treated with semaglutide. Patients with renal impairment may be at greater risk of acute kidney injury, but some of these events have been reported in patients without known underlying renal disease. A majority of the reported events occurred in patients who had experienced nausea, vomiting, or diarrhea, leading to volume depletion *[see Adverse Reactions]*. Monitor renal function when initiating or escalating doses of WEGOVY® in patients reporting severe adverse gastrointestinal reactions. Monitor renal function in patients with renal impairment reporting any adverse reactions that could lead to volume depletion. **Hypersensitivity Reactions:** Serious hypersensitivity reactions (e.g., anaphylaxis, angioedema) have been reported with WEGOVY®. If hypersensitivity reactions occur, discontinue use of WEGOVY®, treat promptly per standard of care, and monitor until signs and symptoms resolve. WEGOVY® is contraindicated in patients with a prior serious hypersensitivity reaction to semaglutide or to any of the excipients in WEGOVY® *[see Adverse Reactions]*. Anaphylaxis and angioedema have been reported with other GLP-1 receptor agonists. Use caution in a patient with a history of anaphylaxis or angioedema with another GLP-1 receptor agonist because it is unknown whether such patients will be predisposed to these reactions with WEGOVY®. **Diabetic Retinopathy Complications in Patients with Type 2 Diabetes:** In a trial of adult patients with type 2 diabetes and BMI greater than or equal to 27 kg/m^2, diabetic retinopathy was reported by 4.0% of WEGOVY®-treated patients and 2.7% placebo-treated patients. In a 2-year trial with semaglutide 0.5 mg and 1 mg once-weekly injection in adult patients with type 2 diabetes and high cardiovascular risk, diabetic retinopathy complications (which was a 4-component adjudicated endpoint) occurred in patients treated with semaglutide injection (3.0%) compared to placebo (1.8%). The absolute risk increase for diabetic retinopathy complications was larger among patients with a history of diabetic retinopathy at baseline (semaglutide injection 8.2%, placebo 5.2%) than among patients without a known history of diabetic retinopathy (semaglutide injection 0.7%, placebo 0.4%). Rapid improvement in glucose control has been associated with a temporary worsening of diabetic retinopathy. The effect of long-term glycemic control with semaglutide on diabetic retinopathy complications has not been studied. Patients with a history of diabetic retinopathy should be monitored for progression of diabetic retinopathy. **Heart Rate Increase:** Treatment with WEGOVY® was associated with increases in resting heart rate. Mean increases in resting heart rate of 1 to 4 beats per minute (bpm) were observed in WEGOVY®-treated adult patients compared to placebo in clinical trials. More adult patients treated with WEGOVY® compared with placebo had maximum changes from baseline at any visit of 10 to 19 bpm (41% versus 34%, respectively) and 20 bpm or more (26% versus 16%, respectively). In a clinical trial in pediatric patients aged 12 years and older with normal baseline heart rate, more patients treated with WEGOVY® compared to placebo had maximum changes in heart rate of 20 bpm or more (54% versus 39%) *[see Adverse Reactions]*. Monitor heart rate at regular intervals consistent with usual clinical practice. Instruct patients to inform their healthcare providers of palpitations or feelings of a racing heartbeat while at rest during WEGOVY® treatment. If patients experience a sustained increase in resting heart rate, discontinue WEGOVY®. **Suicidal Behavior and Ideation:** Suicidal behavior and ideation have been reported in clinical trials with other weight management products. Monitor patients treated with WEGOVY® for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior. Discontinue WEGOVY® in patients who experience suicidal thoughts or behaviors. Avoid WEGOVY® in patients with a history of suicidal attempts or active suicidal ideation.

ADVERSE REACTIONS: The following serious adverse reactions are described below or elsewhere in the prescribing information: Risk of Thyroid C-Cell Tumors *[see Warnings and Precautions];* Acute Pancreatitis *[see Warnings and Precautions];* Acute Gallbladder Disease *[see Warnings and Precautions];* Hypoglycemia *[see Warnings and Precautions];* Acute Kidney Injury *[see Warnings and Precautions];* Hypersensitivity Reactions *[see Warnings and Precautions];* Diabetic Retinopathy Complications in Patients with Type 2 Diabetes *[see Warnings and Precautions];* Heart Rate Increase *[see Warnings and Precautions];* Suicidal Behavior and Ideation *[see Warnings and Precautions]*. **Clinical Trials Experience:** Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice. **Adverse Reactions in Clinical Trials in Adults with Obesity or Overweight:** *WEGOVY® 2.4 mg Subcutaneous Weekly Dosage:* WEGOVY® was evaluated for safety in 3 randomized, double-blind, placebo-controlled trials that included 2,116 adult patients with obesity or overweight treated with 2.4 mg WEGOVY® for up to 68 weeks and a 7 week off-drug follow-up period. Baseline characteristics included a mean age of 48 years, 71% female, 72% White, 14% Asian, 9% Black or African American, and 5% reported as other or unknown; and 85% were not Hispanic or Latino ethnicity, 13% were Hispanic or Latino ethnicity, and

2% reported as unknown. The baseline characteristics were 42% with hypertension, 19% with type 2 diabetes, 43% with dyslipidemia, 28% with a BMI greater than 40 kg/m^2, and 4% with cardiovascular disease. In these clinical trials, 6.8% of patients treated with 2.4 mg WEGOVY® and 3.2% of patients treated with placebo permanently discontinued treatment as a result of adverse reactions. The most common adverse reactions leading to discontinuation were nausea (1.8% versus 0.2%), vomiting (1.2% versus 0%), and diarrhea (0.7% versus 0.1%) for WEGOVY® and placebo, respectively. Adverse reactions reported in clinical trials in adults and greater than or equal to 2% of WEGOVY®-treated patients and more frequently than in placebo-treated patients are shown in **Table 3**.

Table 3. Adverse Reactions (≥2% and Greater Than Placebo) in WEGOVY®-treated Adults with Obesity or Overweight

	Placebo N=1,261 %	WEGOVY® 2.4 mg N=2,116 %
Nausea	16	44
Diarrhea	16	30
Vomiting	6	24
Constipation	11	24
Abdominal Pain[a]	10	20
Headache	10	14
Fatigue[b]	5	11
Dyspepsia	3	9
Dizziness	4	8
Abdominal Distension	5	7
Eructation	<1	7
Hypoglycemia in T2DM[c]	2	6
Flatulence	4	6
Gastroenteritis	4	6
Gastroesophageal Reflux Disease	3	5
Gastritis[d]	1	4
Gastroenteritis Viral	3	4
Hair Loss	1	3
Dysesthesia[e]	1	2

[a]Includes abdominal pain, abdominal pain upper, abdominal pain lower, gastrointestinal pain, abdominal tenderness, abdominal discomfort and epigastric discomfort
[b]Includes fatigue and asthenia
[c]Defined as blood glucose <54 mg/dL with or without symptoms of hypoglycemia or severe hypoglycemia (requiring the assistance of another person) in patients with type 2 diabetes not on concomitant insulin (Study 3, WEGOVY® N=403, Placebo N=402). See text below for further information regarding hypoglycemia in patients with and without type 2 diabetes. T2DM = type 2 diabetes mellitus
[d]Includes chronic gastritis, gastritis, gastritis erosive, and reflux gastritis
[e]Includes paresthesia, hyperesthesia, burning sensation, allodynia, dysesthesia, skin burning sensation, pain of skin, and sensitive skin

In a cardiovascular outcomes trial, 8,803 patients were exposed to WEGOVY® for a median of 37.3 months and 8,801 patients were exposed to placebo for a median of 38.6 months. Safety data collection was limited to serious adverse events (including death), adverse events leading to discontinuation, and adverse events of special interest. Sixteen percent (16%) of WEGOVY®-treated patients and 8% of placebo-treated patients, respectively, discontinued study drug due to an adverse event. Additional information from this trial is included in subsequent sections below when relevant. **Adverse Reactions in a Clinical Trial of Pediatric Patients Aged 12 Years and Older with Obesity:** WEGOVY® was evaluated in a 68-week, double-blind, randomized, parallel group, placebo-controlled, multi-center trial in 201 pediatric patients aged 12 years and older with obesity. Baseline characteristics included a mean age of 15.4 years; 38% of patients were male; 79% were White, 8% were Black or African American, 2% were Asian, and 11% were of other or unknown race; and 11% were of Hispanic or Latino ethnicity. The mean baseline body weight was 107.5 kg, and mean BMI was 37 kg/m^2. **Table 4** shows adverse reactions reported in greater than or equal to 3% of WEGOVY®-treated pediatric patients and more frequently than in the placebo group from a study in pediatric patients aged 12 years and older.

Table 4. Adverse Reactions (≥3% and Greater than Placebo) in WEGOVY®-Treated Pediatric Patients Aged 12 Years and Older with Obesity

	Placebo N=67 %	WEGOVY® 2.4 mg N=133 %
Nausea	18	42
Vomiting	10	36
Diarrhea	19	22
Headache	16	17
Abdominal Pain	6	15
Nasopharyngitis	10	12
Dizziness	3	8
Gastroenteritis	3	7
Constipation	2	6
Gastroesophageal Reflux Disease	2	4
Sinusitis	2	4
Urinary tract infection	2	4
Ligament sprain	2	4
Anxiety	2	4
Hair Loss	0	4
Cholelithiasis	0	4
Eructation	0	4
Influenza	0	3
Rash	0	3
Urticaria	0	3

Other Adverse Reactions in Adults and/or Pediatric Patients: *Acute Pancreatitis:* In WEGOVY® clinical trials in adults, acute pancreatitis was confirmed by adjudication in 4 WEGOVY®-treated patients (0.2 cases per 100 patient years) versus 1 in placebo-treated patients (less than 0.1 cases per 100 patient years). One additional case of acute pancreatitis was confirmed in a patient treated with WEGOVY® in another clinical trial. *Acute Gallbladder Disease:* In WEGOVY® clinical trials in adults, cholelithiasis was reported by 1.6% of WEGOVY®-treated patients and 0.7% of placebo-treated patients. Cholecystitis was reported by 0.6% of WEGOVY®-treated adult patients and 0.2% of placebo-treated patients. In a clinical trial in pediatric patients aged 12 years and older, cholelithiasis was reported by 3.8% of WEGOVY®-treated patients and 0% placebo-treated patients. Cholecystitis was reported by 0.8% of WEGOVY®-treated pediatric patients and 0% placebo-treated patients. *Hypoglycemia:*
Patients with Type 2 Diabetes: In a trial of adult patients with type 2 diabetes and BMI greater than or equal to 27 kg/m^2, clinically significant hypoglycemia (defined as a plasma glucose less than 54 mg/dL) was reported in 6.2% of WEGOVY®-treated patients versus 2.5% of placebo-treated patients. A higher rate of clinically significant hypoglycemic episodes was reported with WEGOVY® (semaglutide 2.4 mg) versus semaglutide 1 mg (10.7 vs. 7.2 episodes per 100 patient years of exposure, respectively); the rate in the placebo-treated group was 3.2 episodes per 100 patient years of exposure. In addition, one episode of severe hypoglycemia requiring intravenous glucose was reported in a WEGOVY®-treated patient versus none in placebo-treated patients. The risk of hypoglycemia was increased when WEGOVY® was used with a sulfonylurea. *Patients without Type 2 Diabetes:* Episodes of hypoglycemia have been reported with GLP-1 receptor agonists in adult patients without type 2 diabetes mellitus. In WEGOVY® clinical trials in adult patients without type 2 diabetes mellitus, there was no systematic capturing or reporting of hypoglycemia. In a cardiovascular outcomes trial in adult patients without type 2 diabetes, 3 episodes of serious hypoglycemia were reported in WEGOVY®-treated patients versus 1 episode in placebo. Patients with a history of bariatric surgery (a risk factor for hypoglycemia) had more events of serious hypoglycemia while taking WEGOVY® (2.3%, 2/87) than placebo (0%, 0/97). *Acute Kidney Injury:* Acute kidney injury occurred in clinical trials in 7 adult patients (0.4 cases per 100 patient years) receiving WEGOVY® versus 4 patients (0.2 cases per 100 patient years of exposure) receiving placebo. Some of these adverse reactions occurred in association with gastrointestinal adverse reactions or dehydration. In addition, 2 patients treated with WEGOVY® had acute kidney injury with dehydration in other clinical trials. The risk of renal adverse reactions with WEGOVY® was increased in adult patients with a history of renal impairment (trials included 65 patients with a history of moderate or severe renal impairment at baseline), and occurred more frequently during dose titration. *Retinal Disorders in Patients with Type 2 Diabetes:* In a trial of adult patients with type 2 diabetes and BMI greater than or equal to 27 kg/m^2, retinal disorders were reported by 6.9% of patients treated with WEGOVY® (semaglutide 2.4 mg), 6.2% of patients treated with semaglutide 1 mg, and 4.2% of patients treated with placebo. The majority of events were reported as diabetic retinopathy (4.0%, 2.7%, and 2.7%, respectively) and non-proliferative retinopathy (0.7%, 0%, and 0%, respectively). *Increase in Heart Rate:* Mean increases in resting heart rate of 1 to 4 beats per minute (bpm) were observed with routine clinical monitoring in WEGOVY®-treated adult patients compared to placebo in clinical trials. In trials in which adult patients were randomized prior to dose-escalation, more patients treated with WEGOVY®, compared with placebo, had maximum changes from baseline at any visit of 10 to 19 bpm (41% versus 34%, respectively) and 20 bpm or more (26% versus 16%, respectively). In a clinical trial in pediatric patients aged 12 years and older with normal baseline heart rate, more patients treated with WEGOVY® compared to placebo had maximum changes in heart rate of 20 bpm or more (54% versus 39%). *Hypotension and Syncope:* Adverse reactions related to hypotension (hypotension, orthostatic hypotension, and decreased blood pressure) were reported in 1.3% of WEGOVY®-treated adult patients versus 0.4% of placebo-treated patients and syncope was reported in 0.8% of WEGOVY®-treated patients versus 0.2% of placebo-treated patients. Some reactions were related to gastrointestinal adverse reactions and volume loss associated with WEGOVY®. Hypotension and orthostatic hypotension were more frequently seen in patients on concomitant antihypertensive therapy. In a clinical trial in pediatric patients aged 12 years and older, hypotension was reported in 2.3% of WEGOVY®-treated patients versus 0% in placebo-treated patients. *Appendicitis:* Appendicitis (including perforated appendicitis) occurred in 10 (0.5%) WEGOVY®-treated adult patients and 2 (0.2%) patients receiving placebo. *Gastrointestinal Adverse Reactions:* In clinical trials in adults, 73% of WEGOVY®-treated patients and 47% of patients receiving placebo reported gastrointestinal adverse reactions, including severe reactions that were reported more frequently among patients receiving WEGOVY® (4.1%) than placebo (0.9%). The most frequently reported reactions were nausea (44% vs. 16%), vomiting (25% vs. 6%), and diarrhea (30% vs. 16%). Other reactions that occurred at a higher incidence among WEGOVY®-treated adult patients included dyspepsia, abdominal pain, abdominal distension, eructation, flatulence, gastroesophageal reflux disease, gastritis, hemorrhoids, and hiccups. These reactions increased during dose escalation. In the pediatric clinical trial, 62% of WEGOVY®-treated patients and 42% of placebo-treated patients reported gastrointestinal disorders. The most frequently reported reactions were nausea (42% vs. 18%), vomiting (36% vs. 10%), and diarrhea (22% vs. 19%). Other gastrointestinal-related reactions that occurred at a higher incidence than placebo among WEGOVY®-treated pediatric patients included abdominal pain, constipation, eructation, gastroesophageal reflux disease, dyspepsia, and flatulence. Permanent discontinuation of treatment as a result of a gastrointestinal adverse reaction occurred in 4.3% of WEGOVY®-treated adult patients versus 0.7% of placebo-treated patients. In a pediatric clinical trial, 2.3% of patients treated with WEGOVY® versus 1.5% of patients who received placebo discontinued treatment as a result of gastrointestinal adverse reactions. *Injection Site Reactions:* In clinical trials in adults, 1.4% of WEGOVY®-treated patients and 1.0% of patients receiving placebo experienced injection site reactions (including injection site pruritus, erythema, inflammation, induration, and irritation). *Hypersensitivity Reactions:* Serious hypersensitivity reactions (e.g., anaphylaxis, angioedema) have been reported with WEGOVY®. In a pediatric clinical trial, rash was reported in 3% of WEGOVY®-treated patients and 0% of placebo-treated patients, and urticaria was reported in 3% of WEGOVY®-treated patients and 0% of placebo-treated patients. In adult clinical trials, allergic reactions occurred in 16%

(8/50) of WEGOVY®-treated patients with anti-semaglutide antibodies and in 7% (114/1659) of WEGOVY®-treated patients who did not develop anti-semaglutide antibodies. *Fractures:* In the cardiovascular outcomes trial in adults, more fractures of the hip and pelvis were reported on WEGOVY® than on placebo in female patients: 1.0% (24/2448) vs. 0.2% (5/2424), and in patients ages 75 years and older: 2.4% (17/703) vs. 0.6% (4/663), respectively. *Urolithiasis:* In a cardiovascular outcomes trial, 1.2% of WEGOVY®-treated patients and 0.8% of patients receiving placebo reported urolithiasis, including serious reactions that were reported more frequently among patients receiving WEGOVY® (0.6%) than placebo (0.4%). *Dysgeusia:* In clinical trials in adults, 1.7% of WEGOVY®-treated patients and 0.5% of placebo-treated patients reported dysgeusia. *Laboratory Abnormalities: Amylase and Lipase:* Adult and pediatric patients treated with WEGOVY® had a mean increase from baseline in amylase of 15-16% and lipase of 39%. These changes were not observed in the placebo group. The clinical significance of elevations in lipase or amylase with WEGOVY® is unknown in the absence of other signs and symptoms of pancreatitis. *Liver Enzymes:* In a pediatric clinical trial, increases in alanine aminotransferase (ALT) greater than or equal to 5 times the upper limit of normal were observed in 4 (3%) WEGOVY®-treated patients compared with 0% of placebo-treated patients. In some patients, increases in ALT and AST were associated with other confounding factors (such as gallstones). In the cardiovascular outcomes trial in adults, increases in total bilirubin greater than or equal to 3 times the upper limit of normal were observed in 0.3% (30/8585) of WEGOVY®-treated patients versus 0.2% (14/8579) of placebo-treated patients. **Postmarketing Experience:** The following adverse reactions have been reported during post-approval use of semaglutide, the active ingredient of WEGOVY®. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. *Gastrointestinal Disorders:* acute pancreatitis and necrotizing pancreatitis, sometimes resulting in death; ileus *Hypersensitivity:* anaphylaxis, angioedema, rash, urticaria *Renal and Urinary Disorders:* acute kidney injury

DRUG INTERACTIONS: Concomitant Use with Insulin or an Insulin Secretagogue (e.g., Sulfonylurea): WEGOVY® lowers blood glucose and can cause hypoglycemia. The risk of hypoglycemia is increased when WEGOVY® is used in combination with insulin or insulin secretagogues (e.g., sulfonylureas). The addition of WEGOVY® in patients treated with insulin has not been evaluated. When initiating WEGOVY®, consider reducing the dose of concomitantly administered insulin secretagogue (such as sulfonylureas) or insulin to reduce the risk of hypoglycemia *[see Warnings and Precautions and Adverse Reactions]*. **Oral Medications:** WEGOVY® causes a delay of gastric emptying and thereby has the potential to impact the absorption of concomitantly administered oral medications. In clinical pharmacology trials with semaglutide 1 mg, semaglutide did not affect the absorption of orally administered medications. Nonetheless, monitor the effects of oral medications concomitantly administered with WEGOVY®.

USE IN SPECIFIC POPULATIONS: Pregnancy: Pregnancy Exposure Registry: There will be a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to semaglutide during pregnancy. Pregnant women exposed to WEGOVY® and healthcare providers are encouraged to contact Novo Nordisk at 1-877-390-2760 or www.wegovypregnancyregistry.com. Risk Summary: Based on animal reproduction studies, there may be potential risks to the fetus from exposure to semaglutide during pregnancy. Additionally, weight loss offers no benefit to a pregnant patient and may cause fetal harm. When a pregnancy is recognized, advise the pregnant patient of the risk to a fetus, and discontinue WEGOVY® *(see Clinical Considerations)*. Available pharmacovigilance data and data from clinical trials with WEGOVY® use in pregnant patients are insufficient to establish a drug-associated risk of major birth defects, miscarriage or adverse maternal or fetal outcomes. In pregnant rats administered semaglutide during organogenesis, embryofetal mortality, structural abnormalities and alterations to growth occurred at maternal exposures below the maximum recommended human dose (MRHD) based on AUC. In rabbits and cynomolgus monkeys administered semaglutide during organogenesis, early pregnancy losses and structural abnormalities were observed at below the MRHD (rabbit) and greater than or equal to 2-fold the MRHD (monkey). These findings coincided with a marked maternal body weight loss in both animal species (see Data). The estimated background risk of major birth defects and miscarriage for the indicated population are unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively. Clinical Considerations: *Disease-associated maternal and/or embryo/fetal risk:* Appropriate weight gain based on pre-pregnancy weight is currently recommended for all pregnant patients, including those who already have overweight or obesity, because of the obligatory weight gain that occurs in maternal tissues during pregnancy. Data: *Animal Data:* In a combined fertility and embryofetal development study in rats, subcutaneous doses of 0.01, 0.03 and 0.09 mg/kg/day (0.04-, 0.1-, and 0.4-fold the MRHD) were administered to males for 4 weeks prior to and throughout mating and to females for 2 weeks prior to mating, and throughout organogenesis to Gestation Day 17. In parental animals, pharmacologically mediated reductions in body weight gain and food consumption were observed at all dose levels. In the offspring, reduced growth and fetuses with visceral (heart blood vessels) and skeletal (cranial bones, vertebra, ribs) abnormalities were observed at the human exposure. In an embryofetal development study in pregnant rabbits, subcutaneous doses of 0.0010, 0.0025 or 0.0075 mg/kg/day (0.01-, 0.1-, and 0.9-fold the MRHD) were administered throughout organogenesis from Gestation Day 6 to 19. Pharmacologically mediated reductions in maternal body weight gain and food consumption were observed at all dose levels. Early pregnancy losses and increased incidences of minor visceral (kidney, liver) and skeletal (sternebra) fetal abnormalities were observed at greater than or equal to 0.0025 mg/kg/day, at clinically relevant exposures. In an embryofetal development study in pregnant cynomolgus monkeys, subcutaneous doses of 0.015, 0.075, and 0.15 mg/kg twice weekly (0.4-, 2-, and 6-fold the MRHD) were administered throughout organogenesis, from Gestation Day 16 to 50. Pharmacologically mediated, marked initial maternal body weight loss and reductions in body weight gain and food consumption coincided with the occurrence of sporadic abnormalities (vertebra, sternebra, ribs) at greater than or equal to 0.075 mg/kg twice weekly (greater than or equal to 2 times human exposure). In a pre- and postnatal development study in pregnant cynomolgus monkeys, subcutaneous doses of 0.015, 0.075, and 0.15 mg/kg twice weekly (0.2-, 1-, and 3-fold the MRHD) were administered from Gestation Day 16 to 140. Pharmacologically mediated marked initial maternal body weight loss and reductions in body weight gain and food consumption coincided with an increase in early pregnancy losses and led to delivery of slightly smaller offspring at greater than or equal to 0.075 mg/kg twice weekly (greater than or equal to 1-time human exposure). **Lactation:** Risk Summary: There are no data on the presence of semaglutide or its metabolites in human milk, the effects on the breastfed infant, or the effects on milk production. Semaglutide was present in the milk of lactating rats. When a drug is present in animal milk, it is likely that the drug will be present in human milk *(see Data)*. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for WEGOVY® and any potential adverse effects on the breastfed infant from WEGOVY® or from the underlying maternal condition. Data: In lactating rats, semaglutide was detected in milk at levels 3 to 12-fold lower than in maternal plasma. **Females and Males of Reproductive Potential:** Because of the potential for fetal harm, discontinue WEGOVY® in patients at least 2 months before they plan to become pregnant to account for the long half-life of semaglutide *[see Use in Specific Populations]*. **Pediatric Use:** The safety and effectiveness of WEGOVY® as an adjunct to a reduced calorie diet and increased physical activity for weight reduction and long-term maintenance have been established in pediatric patients aged 12 years and older with obesity. Use of WEGOVY® for this indication is supported by a 68-week, double-blind, placebo-controlled clinical trial in 201 pediatric patients aged 12 years and older with a BMI corresponding to ≥95th percentile for age and sex and from studies in adult patients with obesity. Adverse reactions with WEGOVY® treatment in pediatric patients aged 12 years and older were generally similar to those reported in adults. Pediatric patients aged 12 years and older treated with WEGOVY® had greater incidences of cholelithiasis, cholecystitis, hypotension, rash, and urticaria compared to adults treated with WEGOVY® *[see Adverse Reactions]*. There are insufficient data in pediatric patients with type 2 diabetes treated with WEGOVY® for obesity to determine if there is an increased risk of hypoglycemia with WEGOVY® treatment similar to that reported in adults. Inform patients of the risk of hypoglycemia and educate them on the signs and symptoms of hypoglycemia. In pediatric patients aged 12 years and older with type 2 diabetes, monitor blood glucose prior to starting WEGOVY® and during WEGOVY® treatment. When initiating WEGOVY® in pediatric patients aged 12 years and older with type 2 diabetes, consider reducing the dose of concomitantly administered insulin secretagogue (such as sulfonylureas) or insulin to reduce the risk of hypoglycemia *[see Warnings and Precautions]*. The safety and effectiveness of WEGOVY® have not been established in pediatric patients less than 12 years of age. **Geriatric Use:** In the WEGOVY® clinical trials for weight reduction and long-term maintenance, 233 (9%) WEGOVY®-treated patients were aged 65 to 75 years and 23 (1%) WEGOVY®-treated patients were aged 75 years and older. In a cardiovascular outcomes trial, 2656 (30%) WEGOVY®-treated patients were aged 65 to 75 years and 703 (8%) WEGOVY®-treated patients were aged 75 years and older. No overall difference in effectiveness was observed between patients aged 65 years and older and younger adult patients. In the cardiovascular outcomes trial, patients aged 75 years and older reported more fractures of the hip and pelvis on WEGOVY® than on placebo. Patients aged 75 years and older (WEGOVY®-treated and placebo-treated) reported more serious adverse reactions overall compared to younger adult patients *[see Adverse Reactions]*. **Renal Impairment:** No dose adjustment of WEGOVY® is recommended for patients with renal impairment. In a study in patients with renal impairment, including end-stage renal disease, no clinically relevant change in semaglutide pharmacokinetics was observed. **Hepatic Impairment:** No dose adjustment of WEGOVY® is recommended for patients with hepatic impairment. In a study in patients with different degrees of hepatic impairment, no clinically relevant change in semaglutide pharmacokinetics was observed.

OVERDOSAGE: Overdoses have been reported with other GLP-1 receptor agonists. Effects have included severe nausea, severe vomiting, and severe hypoglycemia. In the event of overdose, appropriate supportive treatment should be initiated according to the patient's clinical signs and symptoms. In the event of an overdose of WEGOVY®, consider contacting the Poison Help line (1-800-222-1222) or a medical toxicologist for additional overdosage management recommendations. A prolonged period of observation and treatment for these symptoms may be necessary, taking into account the long half-life of WEGOVY® of approximately 1 week.

More detailed information is available upon request.

Manufactured by: Novo Nordisk A/S, DK-2880 Bagsvaerd, Denmark

For additional information about WEGOVY® contact: Novo Nordisk Inc., 800 Scudders Mill Road, Plainsboro, NJ 08536, 1-833-934-6891

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A LUXURIOUS STAY AT THE TAMPA EDITION:

Where Elegance Meets Innovation

BY JEN HELMLE



Nestled in the vibrant heart of Tampa's Water Street district, the Tampa EDITION is an exceptional fusion of modern luxury and chic design. This hotel, part of the renowned EDITION Hotels collection, is a destination that radiates sophistication, delivering an experience that redefines hospitality. Offering an impeccable balance between understated elegance and cutting-edge amenities, the Tampa EDITION is not just a place to stay—it's a place to immerse yourself in the city's burgeoning cultural and culinary scene.

First Impressions: A Modern Urban Sanctuary

From the moment you step into the Tampa EDITION, you are greeted by an ambiance that perfectly blends the natural beauty of the Floridian coast with refined urban sophistication. The hotel's architecture, designed by the acclaimed Ian Schrager in collaboration with Marriott, is an homage to sleek modernism, with an emphasis on clean lines and organic materials. The lobby's interior design exudes calm and serenity with its neutral palette of soft beige, cream, and muted greys, punctuated by lush green plants and bespoke artworks. It's a place where you instantly feel the stress of everyday life melt away.

The hotel's 172 guest rooms and suites continue this theme of modern luxury, with bespoke furnishings, floor-to-ceiling windows, and a soothing decor that emphasizes natural light. Plush bedding, marble bathrooms with deep soaking tubs, and tech-forward features like smart lighting and entertainment systems are just a few of the touches that make a stay here feel indulgent and highly personalized. Many rooms provide stunning views of the surrounding Water Street development and Tampa Bay, enhancing the sense of connection between the indoors and the tropical outdoors.

Each room has been meticulously designed with comfort and style in mind. Warm, natural woods, textured fabrics, and large-scale photography reflect a sense of understated luxury. The attention to detail is impeccable, from the curated minibar selections featuring local craft beers and artisanal snacks to the ultra-soft robes and deluxe bath products provided in each suite.

Culinary Delights: Dining at the Tampa EDITION

The hotel's culinary offerings are nothing short of extraordinary. Lilac, the signature fine-dining restaurant helmed by Michelin-starred chef John Fraser, is a must-visit. Offering a contemporary Mediterranean menu with a focus on locally sourced ingredients, Lilac delivers dishes that are both innovative and comforting. The experience here is all about precision and creativity, with every dish a visual and gastronomic masterpiece. Whether it's the delicate branzino served with seasonal vegetables or the rich and aromatic lamb shoulder, each bite at Lilac is a reminder that you're dining at one of the finest establishments in Tampa.

The restaurant's wine list is equally impressive, with a strong focus on boutique wines from both local vineyards and notable international labels. The sommelier team is always on hand to guide you through the selection, ensuring perfect pairings with each course.

For something more casual but equally indulgent, Market at EDITION provides a vibrant yet relaxed dining atmosphere. With an Italian-inspired menu, this all-day café offers everything from light, refreshing salads to hearty pizzas and pastas, making it the perfect spot for a midday bite or a laid-back din-





ner. The open kitchen concept allows diners to watch as chefs skillfully prepare fresh dishes, adding an element of theater to the dining experience. The ingredients here are always seasonal and locally sourced, ensuring that each dish bursts with fresh, bold flavors.

For a unique culinary experience, the Jupiter Terrace is a fantastic option. Situated on the hotel's rooftop, this open-air dining venue offers a tropical, relaxed atmosphere with a refined edge. The Mediterranean-inspired menu at Azure at EDITION features fresh seafood, grilled meats, and vibrant salads, with dishes like charred octopus and seafood paella taking center stage. The setting is intimate yet lively, perfect for savoring signature cocktails while watching the sunset over Tampa Bay.

Bars and Nightlife: Where Style Meets Scene

No luxury hotel is complete without a selection of expertly curated bars, and the Tampa EDITION is no exception. Punch Room, an intimate lounge that oozes sophistication, is the perfect setting for an evening cocktail. With its dimly lit atmosphere, plush seating, and extensive list of craft cocktails, this is a favorite among guests seeking a more private, exclusive experience. The bar staff here are cocktail artisans, blending flavors with an attention to detail that elevates the drinking experience to an art form. Whether you prefer a classic Negroni or a contemporary twist on a traditional favorite, the mixologists at Punch Room have something to impress every palate.

If you're in the mood for a more social scene, the Lobby Bar offers a lively atmosphere with chic décor and an impressive drinks list. The sleek marble bar and gold accents create a polished backdrop for mingling with other guests, and the bartenders here specialize in crafting bold and imaginative cocktails using house-infused spirits and fresh ingredients. Whether you're stopping by for a pre-dinner aperitif or a late-night drink, the Lobby Bar is a social hub that perfectly captures the essence of the EDITION brand—stylish, contemporary, and buzzing with energy.

Amenities: Elevating Every Moment of Your Stay

The amenities at the Tampa EDITION reflect the hotel's commitment to luxury and wellness, ensuring that every guest leaves feeling refreshed and rejuvenated. The Rooftop Pool is a centerpiece of the hotel, with stunning views of the city and bay. It's a serene spot to soak up the Florida sunshine by day or enjoy the vibrant nightlife of the rooftop bar by night. The pool area is framed by lush greenery and comfortable loungers, creating an oasis of calm in the middle of the bustling city. Poolside service is attentive yet unobtrusive, with cocktails and light bites available from the adjacent Azure bar.

Fitness enthusiasts will appreciate the state-of-the-art gym, complete with the latest in cardio and strength training equipment. Whether you're a yoga devotee or prefer a high-intensity workout, the gym's well-equipped facilities will meet all your needs. The hotel's expert trainers are also available for personalized workout sessions or fitness consultations.

For those looking for a more rejuvenating experience, the hotel's spa offers a range of treatments designed to refresh and revitalize. The serene, minimalist setting creates an ideal environment for relaxation, with treatments ranging from personalized massages to holistic skincare services. Whether you opt for a restorative massage or a signature facial, the spa's skilled therapists use natural, high-quality products to ensure every treatment feels luxurious and deeply nourishing.

The hotel also boasts a dedicated event space, perfect for corporate events, weddings, and private parties. With its blend of sleek modern design and advanced technology, it ensures that any occasion hosted here will be memorable. The customizable spaces range from small, intimate rooms for private gatherings to expansive halls for grand celebrations, all featuring the same attention to detail and luxury that defines the Tampa EDITION experience.



Exploring the Surrounding Area: Water Street and Beyond

The Tampa EDITION is ideally situated in the Water Street district, one of the city's most exciting new developments. Guests can explore Sparkman Wharf, a lively area filled with pop-up restaurants, craft breweries, and entertainment options, all just a short stroll from the hotel. Whether you're looking to grab a casual bite, sample local beers, or enjoy live music by the waterfront, Sparkman Wharf offers something for everyone.

For those interested in the arts, the Tampa Museum of Art and the Straz Center for the Performing Arts are nearby, offering a rich array of exhibitions and performances throughout the year. The Florida Aquarium, just minutes away, is another fantastic option for families, providing an immersive experience into the marine life native to the Gulf of Mexico and beyond. Kids and adults alike will enjoy the aquarium's touch tanks, educational exhibits, and fascinating shark and stingray encounters.

If you're in the mood for outdoor adventure, the Riverwalk offers a scenic way to explore downtown Tampa. This pedestrian-friendly path runs along the Hillsborough River, connecting parks, restaurants, and cultural venues. Rent a bike, take a leisurely stroll, or hop on one of the electric scooters available throughout the area to take in the sights. Along the way, you'll find beautiful waterfront views, public art installations, and plenty of green spaces to stop and relax.

Guests of the EDITION will also find themselves within easy reach of Tampa's iconic Amalie Arena, home to the Tampa Bay Lightning hockey team and host to major concerts and events. Sports fans will love the convenience of being just a short walk from one of the city's premier entertainment venues, while culture enthusiasts can take in a Broadway show or catch a live performance at the Straz Center.

For shopping, the nearby Hyde Park Village offers a curated mix of high-end boutiques, trendy local stores, and popular dining spots. This open-air shopping district is perfect for an afternoon of retail therapy, followed by a leisurely lunch at one of the many stylish eateries.

Finally, Ybor City, once the cigar capital of the world, is a vibrant neighborhood in Tampa that boasts an exciting nightlife and delicious food. You can explore this historic district on a walking tour to learn more about the architecture and immigrant history, or indulge in a food tour that takes you to Latin and soul food restaurants. As the sun sets, the area transforms into a lively entertainment district where you can do a pub crawl, dance the night away, or catch some live music. To get there, you can hop on a free streetcar from downtown.

Final Verdict: A Must-Experience Hotel in Tampa

The Tampa EDITION stands out as a premier luxury destination that combines impeccable service, world-class dining, and stylish design with a focus on modern comfort. Its central location makes it an ideal base for exploring everything Tampa has to offer, while its amenities ensure that you may never want to leave the hotel.

Whether you're in town for business, leisure, or a romantic getaway, the Tampa EDITION offers a truly unforgettable experience—a perfect blend of Tampa's laid-back coastal charm and the cutting-edge sophistication that the EDITION brand is known for. Every aspect of your stay is thoughtfully designed to elevate your visit, making it a standout choice among luxury hotels in the region. From its culinary excellence to its world-class amenities and prime location, the Tampa EDITION is a must-experience for any traveler seeking the finest that Tampa has to offer.



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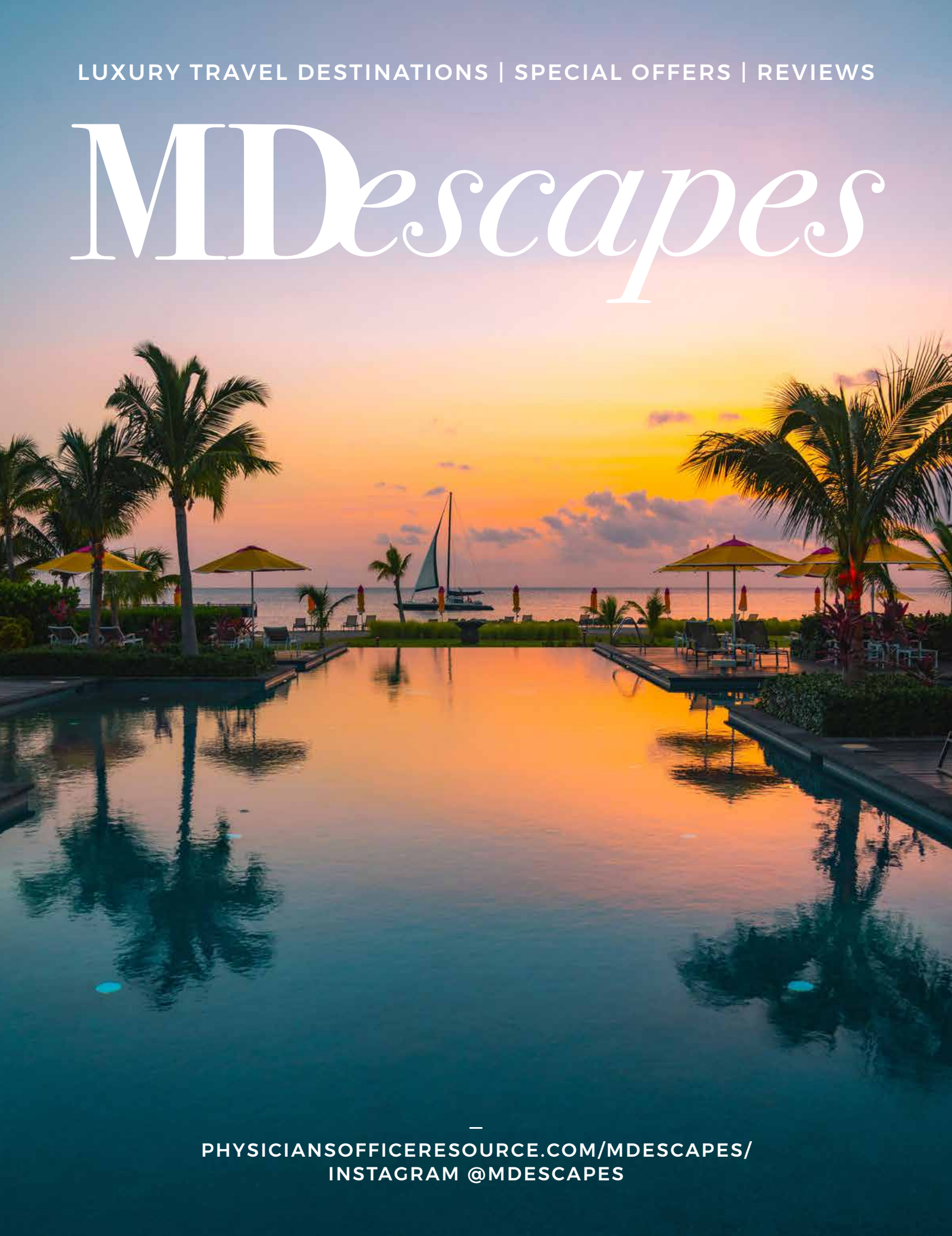
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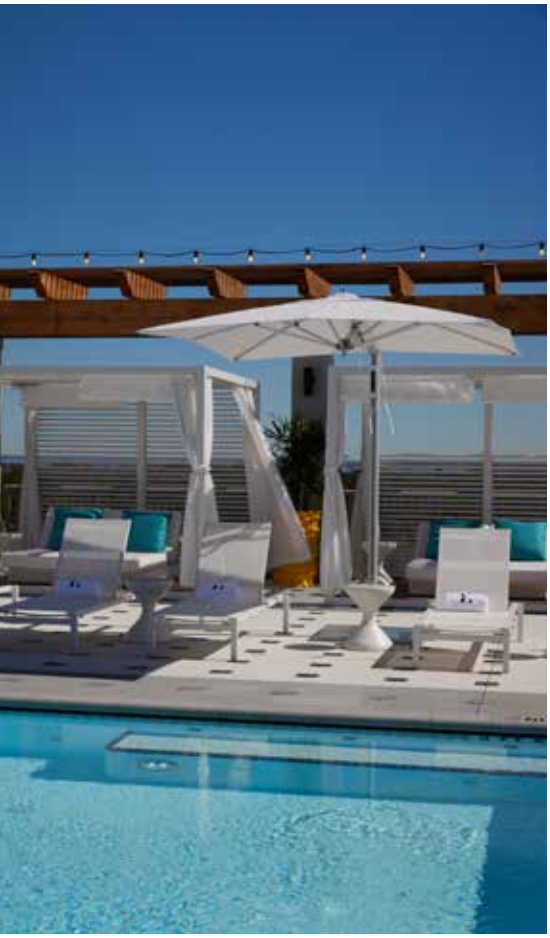
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