Boston Scientific
Advancing science for life™

FARAPOINT™
Pulsed Field Ablation Catheter

Part of the FARAPULSE™ PFA Platform

The global leader in PFA clinical research

Purpose-built, evidence-backed

Designed for workflow versatility and predictable point-by-point ablation, the FARAPOINT™ Pulsed Field Ablation Catheter creates focal and linear lesions with consistent depth

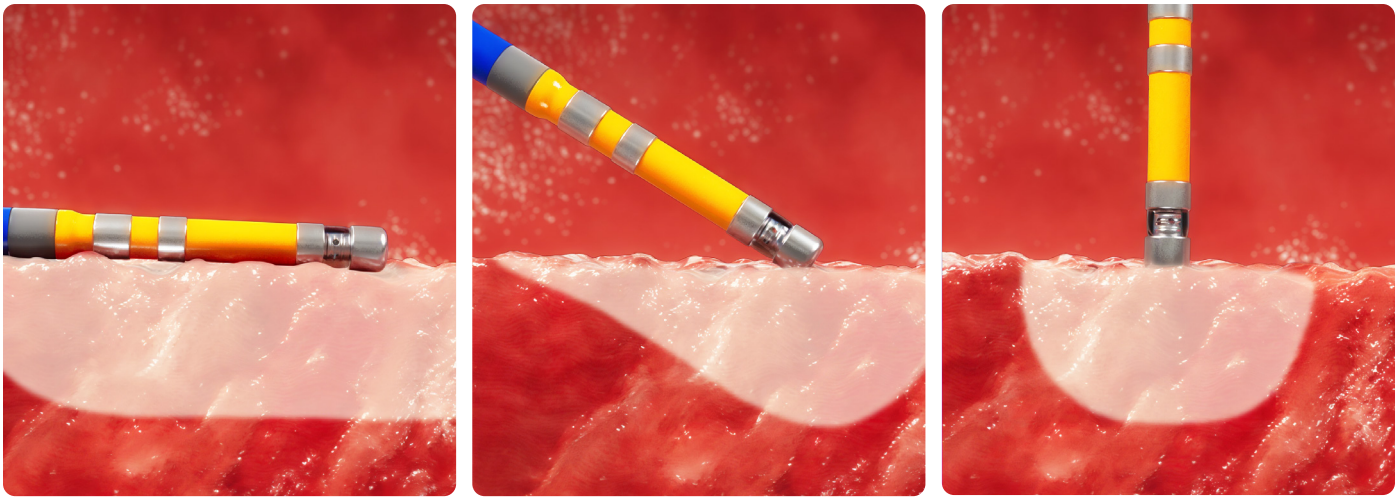


Illustration based on Boston Scientific preclinical study showing depth up to 8 mm with 4 apps

FARAPOINT clinical studies

Completed

ADVANTAGE AF Phase II
Adjunctive CTI ablation in PersAF

PersAFOne II
First-in-human

PersAFOne III
CTI ablation with prophylactic nitroglycerin

Initiated/Planned

DISRUPT
Real-world registry

REMATCH
Redo AF

OPTIMIZE
EGF-guided mapping and ablation

FOCUS-PFA
Evaluation for PVC and VT

ASCEND VT
Evaluation for ischemic VT

Scan the code to view the FARAPOINT clinical compendium

Proven effectiveness and demonstrated safety

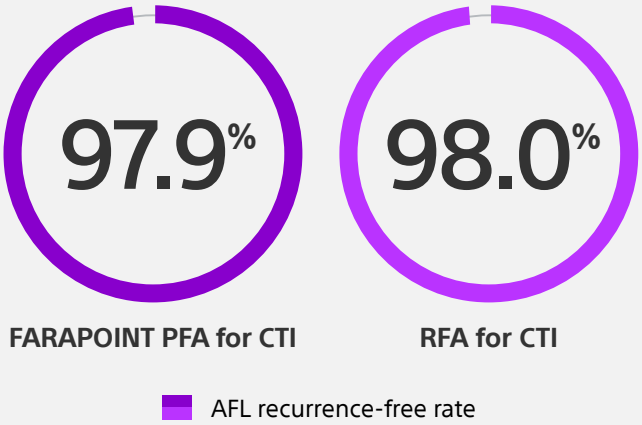
FARAPOINT provided an effective and safe alternative for adjunctive CTI ablation

ADVANTAGE CTI subanalysis

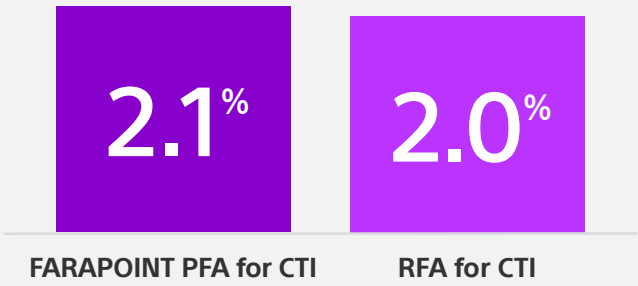
Compared Phase II patients treated with FARAPOINT PFA (n=141/255 or 55.0%) to Phase I patients treated with RFA (n=50, 50/260 or 19.0%) for CTI

Similar AFL recurrence-free rate to RFA[1]

The freedom from typical AFL recurrence at 1 year was similar for both FARAPOINT PFA and RFA



No difference in CTI ablation safety rates between FARAPOINT PFA and RFA[1]



Primary safety event rate at 90 days*

*Rate of predefined safety events: myocardial infarction, stroke, transient ischemic attack, thromboembolism, pulmonary edema, unresolved phrenic nerve palsy/paresis, serious vascular access complications, heart block, GI disorders occurring within 7 days of the index procedure; cardiac tamponade/perforation or pericarditis, or other PFA system/procedure related cardiovascular or pulmonary adverse event within 30 days of the index procedure, and pulmonary vein stenosis or atrio-esophageal fistula occurring prior to the 1-year follow-up. Mortality (within 7 days of procedure in Phase I and within 30 days of procedure in Phase II) was also included in the primary safety endpoint.

No coronary spasm[2]

With the use of a prophylactic nitroglycerin (NTG) protocol, the FARAPOINT cohort in ADVANTAGE Phase II** had no reports of clinically manifested coronary artery spasm, as evidenced by no instances of ST segment changes or ventricular fibrillation.

Nitro protocol history

PersAFOne III used FARAPOINT for CTI and tested two prophylactic NTG protocols. Trial results demonstrated that one of the prophylactic NTG protocols effectively prevented severe spasm.[3]

KEY PRECLINICAL FINDING

What about long-term coronary artery safety?

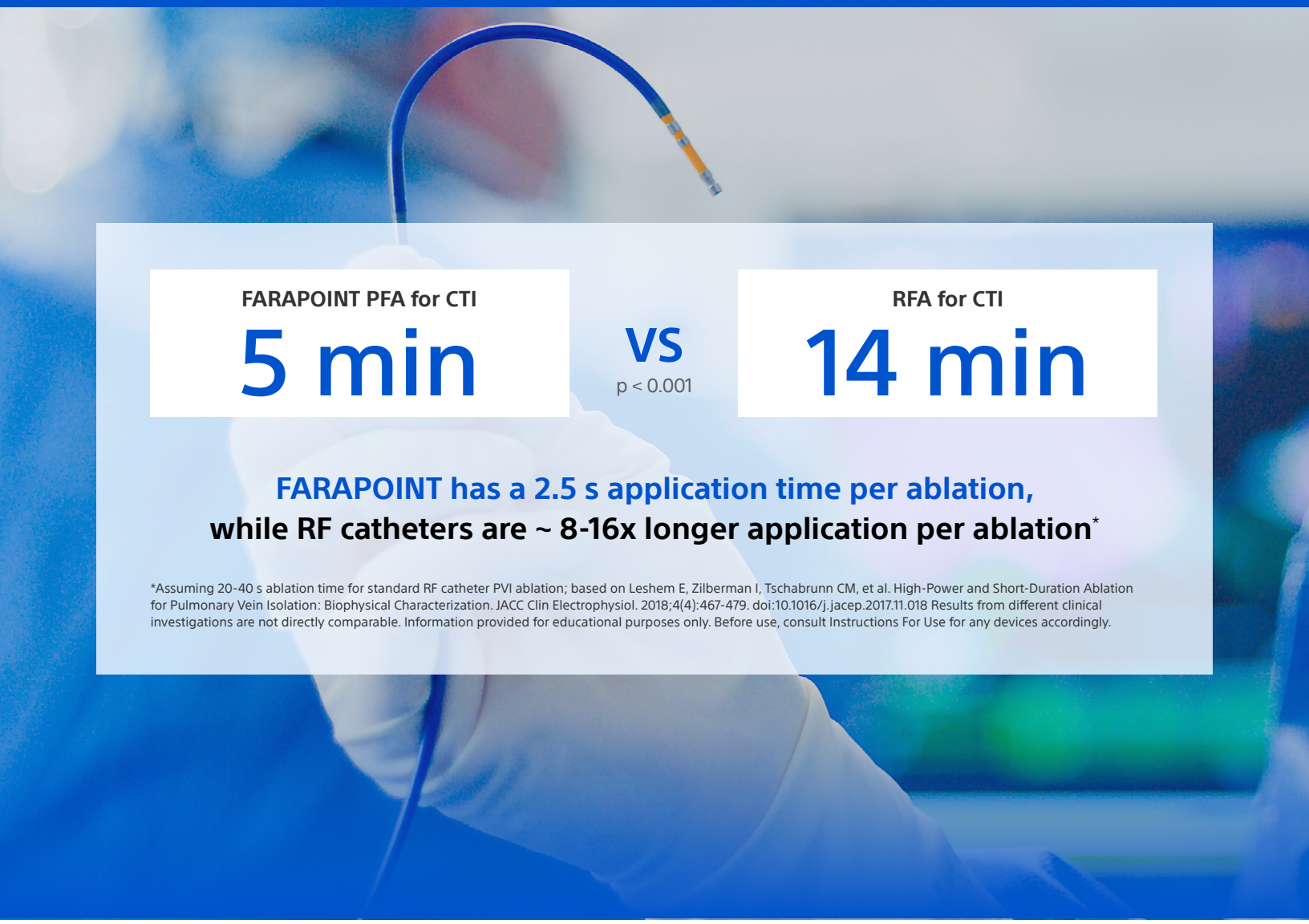
In an animal study, chronic coronary artery injury*** was mild and similar between FARAPOINT PFA and RFA.[4]

**In the ADVANTAGE Phase II study, 255 persAF patients were treated with FARAWAVE for PVI and PWA, and 55% of them were additionally treated for AFL using FARAPOINT PFA for CTI. At 1 year, overall effectiveness was 73.4% and CTI effectiveness was 96.4% at 1 year. The safety rate at 90 days was 2.4%.

***Characterized by neointimal hyperplasia

Efficient and consistent workflow

FARAPOINT PFA for CTI ablation demonstrated greater efficiency compared to RFA with a significantly shorter ablation time[6]



FARAPOINT PFA for CTI

5 min

VS

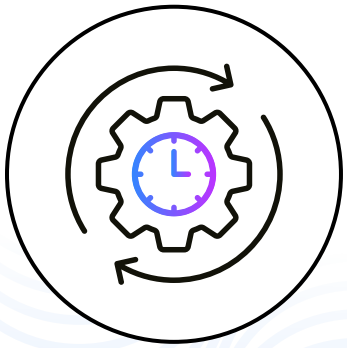
$p < 0.001$

RFA for CTI

14 min

FARAPOINT has a 2.5 s application time per ablation,
while RF catheters are ~ 8-16x longer application per ablation*

*Assuming 20-40 s ablation time for standard RF catheter PVI ablation; based on Leshem E, Zilberman I, Tschabrunn CM, et al. High-Power and Short-Duration Ablation for Pulmonary Vein Isolation: Biophysical Characterization. JACC Clin Electrophysiol. 2018;4(4):467-479. doi:10.1016/j.jacep.2017.11.018 Results from different clinical investigations are not directly comparable. Information provided for educational purposes only. Before use, consult Instructions For Use for any devices accordingly.



FARAPOINT PFA for CTI led to more predictable procedures[1]

FARAPOINT patients had significantly lower variance in the number of applications than those treated with RFA (F=8.0, p=0.001)

Preclinical spotlight: FARAPOINT depth

KEY FINDING #1

In preclinical studies, FARAPOINT PFA delivered sufficient lesion depths with variable voltage in multiple applications — up to 8 mm with 4 apps

Voltage (kV)	# Apps/ Site	7-day lesion depth (mm) (from preclinical data)*
1.4	1	2.4 (2.0 to 2.7)
	2	3.5 (2.9 to 4.0)
1.7	1	3.3 (2.9 to 3.7)
	2	3.9 (3.2 to 4.5)
2.0	1	3.6 (3.3 to 3.9)
	2	4.5 (4.0 to 5.0)

***2.0kV at 4 apps found mean lesion depth of**

7.0 ± 1.6 mm

2-5 day preclinical lesion study
(Indicates 95% confidence intervals)

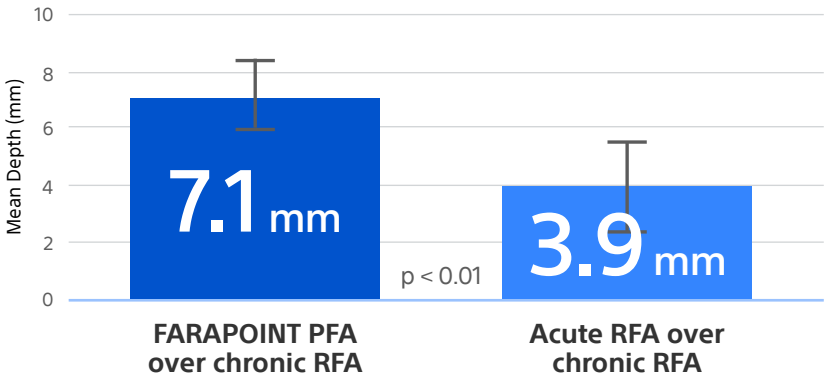
Source: Boston Scientific preclinical study

KEY FINDING #2

When reablating on top of chronic scar tissue, FARAPOINT PFA created deeper lesions than RFA**[5]

In a preclinical study[5], swine underwent redo ablation ~5 weeks after initial RFA lesions were applied using either FARAPOINT PFA (2.0 kV, 4 applications/site) or RFA

Lesion depths in scarred tissue



Acute RFA over chronic RFA
3.9 ± 1.6 mm lesions

PFA over chronic RFA:
7.1 ± 1.3 mm lesions

**Chronic RF lesion depth estimated to be 3 to 4 mm

KEY TERMS:
Scar tissue: Fibrotic, non-conductive myocardium from prior ablation, surgery, or chronic disease, typically seen as low-voltage zones (<0.5 mV) with heterogeneous conduction on electroanatomic mapping

Infarct tissue: Myocardium damaged by ischemic necrosis from coronary occlusion, comprising dense scar, border zones, and viable but diseased myocardium (also typically seen as low-voltage zones on electroanatomical mapping)

1. Reddy VY, Gerstenfeld EP, Schmidt B, et al. Focal pulsed field ablation vs standard radiofrequency ablation for typical atrial flutter: a sub-study across Phase 1 & 2 of the pivotal ADVANTAGE AF trial. *Heart Rhythm*. 2025;22(4)[suppl]:S454. doi.org/10.1016/j.hrthm.2025.03.1167
2. Reddy VY, Gerstenfeld EP, Schmidt B, et al. Pulsed field ablation of persistent atrial fibrillation with continuous ECG monitoring follow-up: ADVANTAGE AF-Phase 2. *Circulation*. Published online April 24, 2025. doi:10.1161/CIRCULATIONAHA.125.074485
3. Malyshev Y, Neuzil P, Petru J, et al. Nitroglycerin to ameliorate coronary artery spasm during focal pulsed-field ablation for atrial fibrillation. *JACC Clin Electrophysiol*. 2024;10(5):885-896. doi:10.1016/j.jacep.2023.12.015
4. Gerstenfeld, E. P. (2025). Comparison of monopolar and bipolar pulsed field vs radiofrequency ablation on coronary artery injury in a swine model. *JACC: Clinical Electrophysiology.* Advance online publication. https://doi.org/10.1016/j.jacep.2025.10.017
5. Younis, A., Buck, E., Santangeli, P., et al. (2024, February). Efficacy of pulsed field vs radiofrequency for the reablation of chronic radiofrequency ablation substrate: Redo pulsed field ablation. *JACC: Clinical Electrophysiology.* https://www.jacc.org/doi/10.1016/j.jacep.2023.09.015
6. Reddy, V. (2025, November). Pulsed field ablation of cavotricuspid isthmus ablation in persistent atrial fibrillation with continuous ECG monitoring: A sub-analysis of ADVANTAGE AF Phase 2. Presented at the Asia Pacific Heart Rhythm Society (APHRS) Annual Meeting

FARAPULSE™ Pulsed Field Ablation System indications, safety, and warnings

https://www.bostonscientific.com/en-US/products/catheters--ablation/farapulse/farapulse-indications.html

OPAL HDx™ Mapping System indications, safety, and warnings

https://www.bostonscientific.com/en-US/products/capital-equipment--mapping-and-navigation/opal-hdx-brief-summary.html

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