Supplementary Table 1. Main characteristics of the studies in patients with dyslipidemia or hypertriglyceridemia with or without a high risk of CV disease

Study	Study design	Patient population	Study drug (no. of patients)	Comparator or control (no. of patients)	Treatment duration (and/or safety follow-up)	Outcomes with fenofibrate alone/in combination
Min et al. (2012) [20]	Retrospective case-control	Hypertriglyceridemia with high risk for CV disease	Fenofibrate (200 mg) (n=140)	General measures (a low-calorie and a low-fat diet and aerobic exercise) (n=140)	2 months	CRP levels were decreased in patients with high CRP and /or low HDL-C levels and without severe overweight
Lee et al. (2012) [23]	Randomized, open-label, multi-center study	Mixed hyperlipidemia with CV risk factors	Fenofibrate (160 mg/day) plus rosuvastatin (10 mg/day) (n=90)	Rosuvastatin (10 mg/day) (n=90)	Diet and lifestyle changes, 6 weeks Treatment, 24 weeks Safety, 4 weeks	Incidences of muscle or liver enzyme elevation; AEs were comparable with rosuvastatin alone
Zhao et al. (2016) [24]	Prospective, multi-center, single-arm, open-label, phase 4 study	Dyslipidemia and high CV risk	Fenofibrate (200 mg daily) add-on to statin (n=506)	-	Treatment, 8 weeks Safety: additional 30 days after the final dose of fenofibrate	Significant decrease in TG and increase in HDL-C No cases of myositis or rhabdomyolysis
Park et al. (2021) [25]	Prospective, multi-center, randomized, double-blind, phase 4 study	Patients with dyslipidemia, with controlled LDL-C and elevated TG	Choline fenofibrate (178.8 mg/day) plus statin (n=64)	Atorvastatin (10 or 20 mg) or rosuvastatin (10 mg) plus placebo (n=63)	8 weeks	Significantly reduced TG and increased HDL-C levels with no additional SAEs No clinical problems in the combination group due to increased serum creatinine levels (by ~0.14 mg/dL) No differences in the liver function tests and serum creatine kinase levels and no cases of yopathy or rhabdomyolysis
Ihm et al. (2020) [10]	Multi-center, randomized, double-blind, parallel-group, therapeutic-confirmatory clinical trial	Mixed dyslipidemia and high CV disease risk	Pitavastatin (2 mg) plus fenofibrate (160 mg) plus a pitavastatin-matched placebo (n=174)	Pitavastatin (2 mg) plus a pitavastatin/ fenofibrate-matched placebo (n=173)	Treatment, 8 weeks Extension study, 16 weeks	Greater reduction in non-HDL-C levels from baseline to week 8 More efficacious in reducing levels of inflammatory markers such as fibrinogen and hsCRP and had a significant effect on remnant C
Woo et al. (2018) [26]	Retrospective observational	Patients with ≥1 CV risk factors, LDL-C lower than the target levels (as defined by NCEP ATP III guidelines), and TG ≥150 mg/dL	Fenofibrate (135–160 mg) for the first time (n=1,113)	-	Median follow-up, 4 months	The percentage reduction of TG was more in women, patients without DM, non-smokers, those with pre-treatment TG ≥500 mg/dL or median, with atherogenic dyslipidemia, or without statin use

(*Continued to the next page*)

Supplementary Table 1. Continued.

Study	Study design	Patient population	Study drug (no. of patients)	Comparator or control (no. of patients)	Treatment duration (and/or safety follow-up)	Outcomes with fenofibrate alone/in combination
Koh et al. (2012) [27]	Randomized, single-blind, placebo-controlled, parallel study	Hypertriglyceridemia	Fenofibrate (160 mg/day) (n=48)	Omega-3 FA (2 mg/day) (n=50) or placebo (n=49)	2 months	Significantly decreased non-HDL-C and TG/HDL-C, and increased HDL-C and ApoAI compared with placebo and omega-3 FA A significant decrease in fasting insulin and increased plasma adiponectin and insulin sensitivity than omega-3 FA
Koh et al. (2016) [28]	Randomized, single-blind, placebo-controlled, parallel study	Hypertriglyceridemia	Fenofibrate (160 mg/day) plus omega-3 FA (2 mg/day) (n=49)	Fenofibrate alone (160 mg/day) (n=49) or placebo (n=48)	2 months	TGs and TG/HDL-C ratio were significantly decreased with combination therapy Similar clinical benefits of combination and fenofibrate alone were noted for ApoB, non-HDL-C, FMD, CRP, and fibrinogen
Oikawa et al.(2017) [29]	Three-arm parallel-group, open-label andomized trial (EFECTL study)	Combined hyperlipidemia	Fenofibrate (200 mg/day capsule or 160 mg/day tablet) plus, ezetimibe (10 mg/day) (n=107)	Fenofibrate alone (200 mg/day capsule or 160 mg/day tablet) (n=52) or ezetimibe alone (10 mg/day) (n=51)	52 weeks	Significantly greater improvements in LDL-C and TG levels with combination therapy Safety profile was similar between combination and fenofibrate monotherapy
Wang et al. (2018) [30]	Randomized, controlled, clinical trial	Elderly patients with mixed dyslipidemia (age ≥60 years)	Micronized fenofibrate (200 mg/day) (n=31) or micronized fenofibrate (200 mg/day) plus policosanol (20 mg/day) (n=33)	Policosanol (20 mg/day) (n=34)	Dietary baseline period: 2 weeks Treatment: 24 weeks	Combination therapy showed significantly greater reductions in TC, non-HDL-C, and LDL-C compared with fenofibrate monotherapy Arterial stiffness (brachial-ankle pulse wave velocity and QoL) was also significantly improved with good tolerability

CV, cardiovascular; CRP, C-reactive protein; HDL-C, high-density lipoprotein cholesterol; AE, adverse event; TG, triglyceride; LDL-C, low-density lipoprotein cholesterol; SAE, serious adverse event; hsCRP, high-sensitivity C-reactive protein; NCEP ATP III, National Cholesterol Education Program Adult Treatment Panel III; DM, diabetes mellitus; FA, fatty acid; ApoB, apolipoprotein B; FMD, flow-mediated dilation; QoL, quality of life.