

Supplementary Methods

Quality control

Quality control assessment of ancestry-specific results files from each study was conducted prior to meta-analysis using the EasyQC software package.¹ All quality control steps were performed in replicate by two analysts to check for consistency. Alleles were harmonized according to the 1000G phase 1 version 3 reference panel and duplicated variants or variants that had inconsistencies with the reference were excluded. Variants with betas or standard errors > 5 or imputation quality < 0.3 were excluded from the analysis. The effective minor allele count was calculated for all variants as the product of the minor allele count and the imputation quality, and variants with values < 10 were excluded from each analysis. We used the meta-analysis software METAL to apply genomic control corrections to each of the study-specific analyses in order to correct for inflation due to cryptic relatedness and population substructure.² Variants present in fewer than three studies were excluded from the meta-analysis.

Conditional analysis

Genotypes from 8,481 European-ancestry individuals from the Framingham Heart Study were used as the reference panel. Variants with low imputation quality ($r^2 < 0.3$) or low frequency (MAF $< 0.1\%$) were excluded from the reference panel. A collinear parameter of 0.1 was applied, meaning that during the stepwise model selection procedure, variants correlated with any of the already selected variants at $r^2 > 0.1$ were not considered for inclusion into the model.

Proportion of variance explained

The proportion of variance in FVII activity explained by each lead variant was calculated using the formula $r^2 = \beta^2 / \text{var}(y) * 2 * f * (1-f)$, where f is the frequency and y is log-transformed FVII activity. The beta and frequency values were taken from summary statistics and the total variance in FVII activity was calculated as the sample-size weighted mean variance across cohorts. The variance explained was first

calculated for each lead variant separately, and then summed to obtain the variance explained by all loci. For loci predicted to harbor multiple independent variants, we used the joint beta to estimate the variance explained.

Functional validation

Human liver HuH7 cells, obtained from the Health Science Research Resources Bank (cell number JCRB0403; Osaka Japan), were cultured in DMEM Glutamax 4500 glucose medium supplemented with 10% Fetal Bovine Serum (ThermoFisher Scientific) and then plated in 6 well plates. Cells were silenced at 80% confluence using Lipofectamine RNAiMAX (ThermoFisher Scientific) with either s37271 or s47939 to target *REEP3*, or with s225897 or s48121 to target *JAZF1*. Details on these silencers can be found in the *Silencer Select* siRNA database from ThermoFisher Scientific (<https://www.thermofisher.com/order/genome-database/details/sirna/>). Glucose-free medium was added 5 h after the silencer transfection, as glucose deprivation may increase the production of FVII.³ Cells were collected 72 h after transfection and total RNA was extracted using a commercial kit (Omega-biotek). Results were compared to cells treated with a scramble siRNA (Ambion negative control #1). Relative gene expression of *REEP3*, *JAZF1*, and *F7* compared to a housekeeping gene was measured using qRT-PCR (Step One Plus Real Time PCR System, Applied Biosystems) in both groups (control and silenced cells) with TaqMan probes (ThermoFisher Scientific) and calculated using the $2^{-\Delta\Delta C_t}$ method.⁴ In experiments on *REEP3* the *RPLPO* housekeeping gene was used, whereas in experiments on *JAZF1* the *GAPDH* housekeeping gene was used.

To measure the amount of FVII protein released in the media, media were collected 72 h after transfection and FVII was measured using Mesoscale with the Human Factor VII MSD commercial kit (MESO SCALE DIAGNOSTICS, LLC). We repeated the experiment three times and pooled results were expressed as the significant difference between every silencer and the scramble control in a model that included the effect of experiment (FVII level \sim silencer + experiment). Analyses were performed in R.

As a positive control, we also silenced the *F7* gene itself and measured the effect on *F7* mRNA levels. We performed 2 experiments with 6 replicates each.

Mendelian randomization

Mendelian randomization based on summary statistics was performed in two steps. First, causal effect estimates are obtained separately for each of the lead genetic variant at significant loci as the ratio of the variant's association with disease to the variant's association with FVII activity, or $\beta_{\text{Variant-Disease}}/\beta_{\text{Variant-FVII}}$. The second step is to combine the causal effect estimates produced by each of the genetic variants. This is achieved using meta-analytic techniques, since each variant provides independent information on the causal effect.^{5,6} We used three meta-analytic techniques: 1) inverse-variance weighted meta-analysis (primary analysis), 2) MR-Egger,⁷ and 3) weighted median estimator.⁸ The 95% confidence intervals for causal estimates were calculated based on the estimates (beta/log-transformed OR) and standard error (SE): estimate \pm 1.96*SE. Additionally, we visually examined the causal effect estimates produced by each of the individual variants using scatter plots, funnel plots, and forest plots, and performed heterogeneity Q tests.^{9,10} When there was significant heterogeneity (P -value < 0.05) among the single variant causal effect estimates, we used scatter plots and funnel plots to identify the genetic variant with the largest outlying effect estimate. This outlier was when then removed and all analyses were repeated. In addition to the results of these three meta-analytic techniques, we also considered the causal effect estimate obtained from the lead variant at the *F7* locus, given that the lead variant at the *F7* locus is located in the gene that encodes the FVII protein, so it may be less likely to influence clinical outcomes through pathways that do not involve FVII.

There was a degree of sample overlap between our GWAS of FVII and the GWAS of IS, CAD, and VTE, which may bias the effect estimates away from the null.¹¹ Sample overlap between our genome-wide association study (GWAS) of FVII and the GWAS of ischemic stroke (IS), coronary artery disease (CAD), and venous thromboembolism (VTE) was evaluated on a study-by-study basis due to a lack of

access to the individual-level data used in each of these GWAS. Four studies overlapped between the MEGASTROKE GWAS of IS and our GWAS of FVII (ARIC, CHS, FHS, and RS),¹² five studies overlapped with the CARDIoGRAMplusC4D GWAS of CAD (ARIC, FHS, LURIC, PROCARDIS, and RS),¹³ and three studies overlapped with the INVENT GWAS of VTE (ARIC, CHS, and MEGA).¹⁴ While overlapping samples thus constitute a modest to large proportion of the samples in our GWAS of FVII, they only constitute a small proportion of the samples in the GWAS of these cardiovascular outcomes.

Study descriptions

The **Atherosclerosis Risk in Communities (ARIC)** study has been described in detail previously.¹⁵ Men and women aged 45-64 years at baseline were recruited from four communities: Forsyth County, North Carolina; Jackson, Mississippi; Minneapolis, Minnesota; and Washington County, Maryland. A total of 15,792 individuals, predominantly White and African American, participated in the baseline examination in 1987-1989, with three additional triennial follow-up examinations and a fifth exam in 2011-2013, and a sixth exam in 2016-2017. Activities of FVII was measured using clotting assays (% activity) in plasma samples obtained at the baseline examination.^{16,17}

The **Cardiovascular Health Study (CHS)** is a population-based cohort study of risk factors for coronary heart disease and stroke in adults ≥ 65 years conducted across four field centers [PMID: 1669507]. The original predominantly European ancestry cohort of 5,201 persons was recruited in 1989-1990 from random samples of the Medicare eligibility lists; subsequently, an additional predominantly African-American cohort of 687 persons was enrolled in 1992-1993 for a total sample of 5,888.

Blood samples were drawn from all participants at their baseline examination and DNA was subsequently extracted from available samples. Genotyping was performed at the General Clinical Research Center's Phenotyping/Genotyping Laboratory at Cedars-Sinai among CHS participants who consented to genetic testing and had DNA available using the Illumina 370CNV BeadChip system (for

European ancestry participants, in 2007) or the Illumina HumanOmni1-Quad_v1 BeadChip system (for African-American participants, in 2010).¹⁸

Coagulation Factor VII levels were measured on the Coag-A-Mate X2 (Organon-Teknika, Durham, NC). Factor VII activity was determined using factor VII-deficient plasma (Baxter-Dade) and Thromborel S (Behring Diagnostics, Marburg, Germany) human placenta-derived thromboplastin. The standard was an unassayed pooled normal plasma (George King Biomedical, Overland Park, KS) that was calibrated with the World Health Organization reference plasma.

CHS was approved by institutional review committees at each field center and individuals in the present analysis had available DNA and gave informed consent including consent to use of genetic information for the study of cardiovascular disease.

The **Coronary Artery Risk Development in Young Adults (CARDIA)** study is a prospective multicenter study with 5115 Caucasian and African American participants ages 18-30 years at baseline, recruited from four centers. The recruitment was done from the total community in Birmingham, AL, from selected census tracts in Chicago, IL and Minneapolis, MN; and from the Kaiser Permanente health plan membership in Oakland, CA. The details of the study design for the CARDIA study have been published before.¹⁹ Eight examinations have been completed since the baseline examination in 1985–1986, with follow-up examinations 2, 5, 7, 10, 15, 20, and 25 years after baseline. FVII coagulant activity was assayed at year 5 by a one-stage system with reagents from Pacific Hemostasis and George King Biomedical, Inc. The standard curve was prepared with a universal reference plasma from Curtin Matheson Scientific, and the results calculated as a percentage of the standard with a MLA-Electra 800.

The **Framingham Heart Study (FHS)** was started in 1948 with 5,209 randomly ascertained participants from Framingham, Massachusetts, US, who had undergone biannual examinations to investigate cardiovascular disease and its risk factors. In 1971, the Offspring cohort (comprising 5,124 children of the original cohort and the children's spouses) and in 2002, the Third Generation

(consisting of 4,095 children of the Offspring cohort) were recruited. FHS participants in this study are of European ancestry. The methods of recruitment and data collection for the Offspring and Third Generation cohorts have been described.²⁰

Factor VII antigen levels were determined by ELISA (Diagnostica Stago) in the Offspring cohort at exam 5 (1991-1995).²¹ Values were expressed as percentage of the standard. The intra-assay CV was 3.0%.

The **Genetic Analysis of Idiopathic Thrombophilia 2 (GAIT2)** project is a family based study where 935 subjects in 35 extended pedigrees were collected. To be included in the study, a family was required to have at least 10 living individuals in 3 or more generations. Families were selected through a proband with idiopathic thrombophilia, which was defined as recurrent thrombotic events (at least one of which was spontaneous), a single spontaneous thrombotic episode plus a first-degree relative also affected, or onset of thrombosis before age 45. Thrombosis in these probands was considered idiopathic when biological causes as antithrombin deficiency, protein S and C deficiencies, activated protein C resistance, plasminogen deficiency, heparin cofactor II deficiency, Factor V Leiden, dysfibrinogenemia, lupus anticoagulant and antiphospholipid antibodies, were excluded. Subjects were interviewed by a physician to determine their health and reproductive history, current medications, alcohol consumption, use of sex hormones (oral contraceptives or hormonal replacement therapy) and their smoking history. By the use of the short form of the International Physical Activity Questionnaire (IPAQ, available at www.ipaq.ki.se), physical activity was also determined. Specifically, they were also questioned about previous episodes of venous and arterial thrombosis, the age at which these events occurred, and the presence of potentially correlated disorders such as diabetes, lipid disease, asthma, allergic rhinitis, atopic dermatitis, and autoimmune disease. The residence of each subject was determined to assess the contribution of shared environmental influences (such as diet) common to members of a household. The study was performed according to the Declaration of Helsinki. All procedures of the study were reviewed by the Institutional

Review Board of the Hospital de la Santa Creu i Sant Pau, Barcelona, Spain. Adult subjects gave informed consent for themselves and for their minor children.

The **Ludwigshafen Risk and Cardiovascular Health (LURIC)** study is a monocentric hospital based prospective study including 3,316 individuals referred for coronary angiography recruited in the Ludwigshafen Cardiac Center, southwestern Germany from 1997 – 2000 . Clinical indications for angiography were chest pain or a positive non-invasive stress test suggestive of myocardial ischemia. To limit clinical heterogeneity, individuals suffering from acute illnesses other than acute coronary syndrome, chronic non-cardiac diseases and a history of malignancy within the five past years were excluded. All participants were of European ancestry and completed a detailed questionnaire which gathered information on medical history, clinical, and lifestyle factors. Study protocols were approved by the ethics committee of the "Landesärztekammer Rheinland-Pfalz" and the study was conducted in accordance with the "Declaration of Helsinki". Informed written consent was obtained from all participants.

Coronary heart disease at baseline was defined as the presence of a visible luminal narrowing (>50% stenosis) in at least one of 15 coronary segments according to the classification of the American Heart Association. Fasting blood samples were obtained by venipuncture in the early morning and stored for later analyses. For this study a subset of 3,061 samples were used that had been genotyped on an Affymetrix 6.0 array.

The **Multiple Environmental and Genetic Assessment of risk factors for venous thrombosis (MEGA)** study is a large population-based case-control study.²² Data collection and ascertainment of venous thrombotic events have been previously described in detail. In short, patients with a first deep vein thrombosis or pulmonary embolism were recruited at six anticoagulation clinics in the Netherlands between 1999 and 2004. The diagnosis of a deep vein thrombosis was based on compression ultrasonography, whereas a pulmonary embolism was confirmed by perfusion and ventilation scintigraphy, helical computed tomography or pulmonary angiography. Blood samples were taken at least

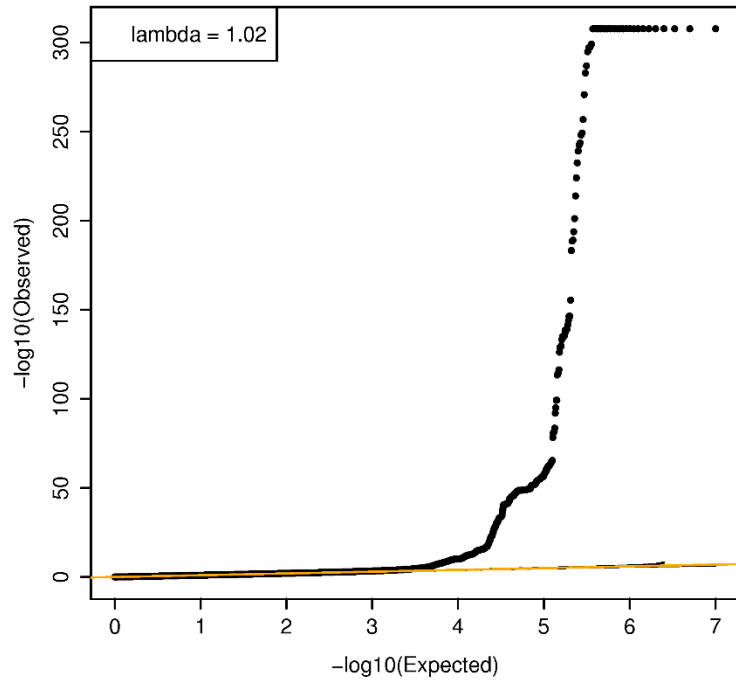
3 months after discontinuation of vitamin K antagonist treatment, unless patients were still receiving anticoagulant therapy one year after their venous thrombosis event. For the present analyses, patients who were still receiving anticoagulant treatment at the time of blood collection were excluded. Factor VII was measured with a mechanical clot detection method on an STA-R coagulation analyzer (Diagnostica Stago, Asnieres, France). For genome-wide genotyping with the Illumina Human660-Quad Beadchip, we sampled 1,499 patients with a first episode of VT. Patients with a cancer diagnosis were excluded.

The **Precocious Coronary Artery Disease Study (PROCARDIS)** consists of CAD cases and controls from four European countries (UK, Italy, Sweden and Germany). CAD (defined as myocardial infarction, acute coronary syndrome, unstable or stable angina, or need for coronary artery bypass surgery or percutaneous coronary intervention) was diagnosed before 66 years of age and 80% of cases had a sibling fulfilling the same criteria for CAD. Subjects with self-reported non-European ancestry were excluded. Among the “genetically-enriched” CAD cases, 70% had suffered myocardial infarction (MI). For this study, 1270 Swedish PROCARDIS were analyzed for FVII antigen levels in plasma using ELISA with pair antibodies from Affinity Biologicals.

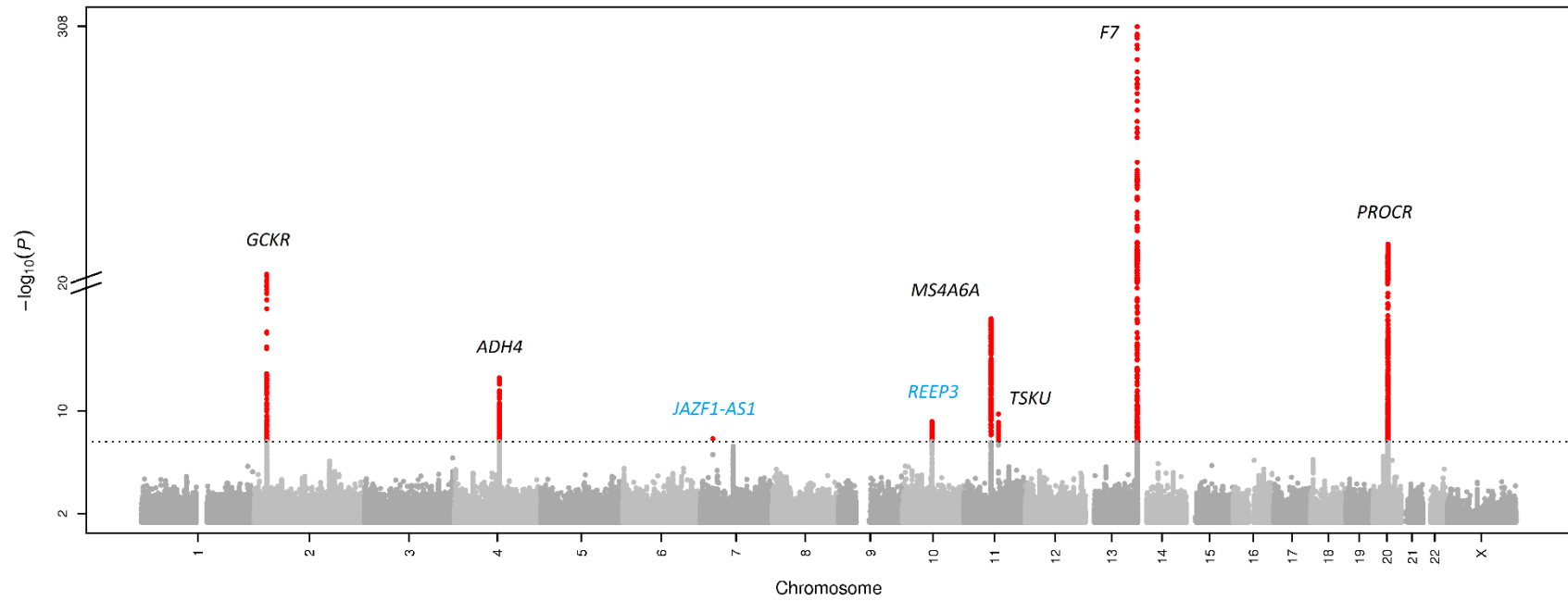
The **Rotterdam Study (RS)** is a prospective, population-based cohort study of determinants of several chronic diseases in older adults.²³ RS-I comprised 7,983 inhabitants of Ommoord, a district of Rotterdam in the Netherlands, who were 55 years or over. The baseline examination took place between 1990 and 1993.

Factor VII activity was measured with a one-stage clotting assay by using human thromboplastin (Tromborel S, Siemens) and factor VII-deficient plasma (Ortho Diagnostic System). The plasma concentrations were expressed as percentage activity by relating the clotting time to a calibration curve constructed of a standardized control plasma. As a control, the pooled plasma of 50 healthy middle-aged persons was used and three control samples were run with each batch of study samples. The intra-assay CV was 1.7%, the inter-assay CV was 3.7%, and reference range was 0.60-1.40 U/ml.

Supplementary Figure 1: QQ plot of the trans-ancestry meta-analysis of FVII activity.

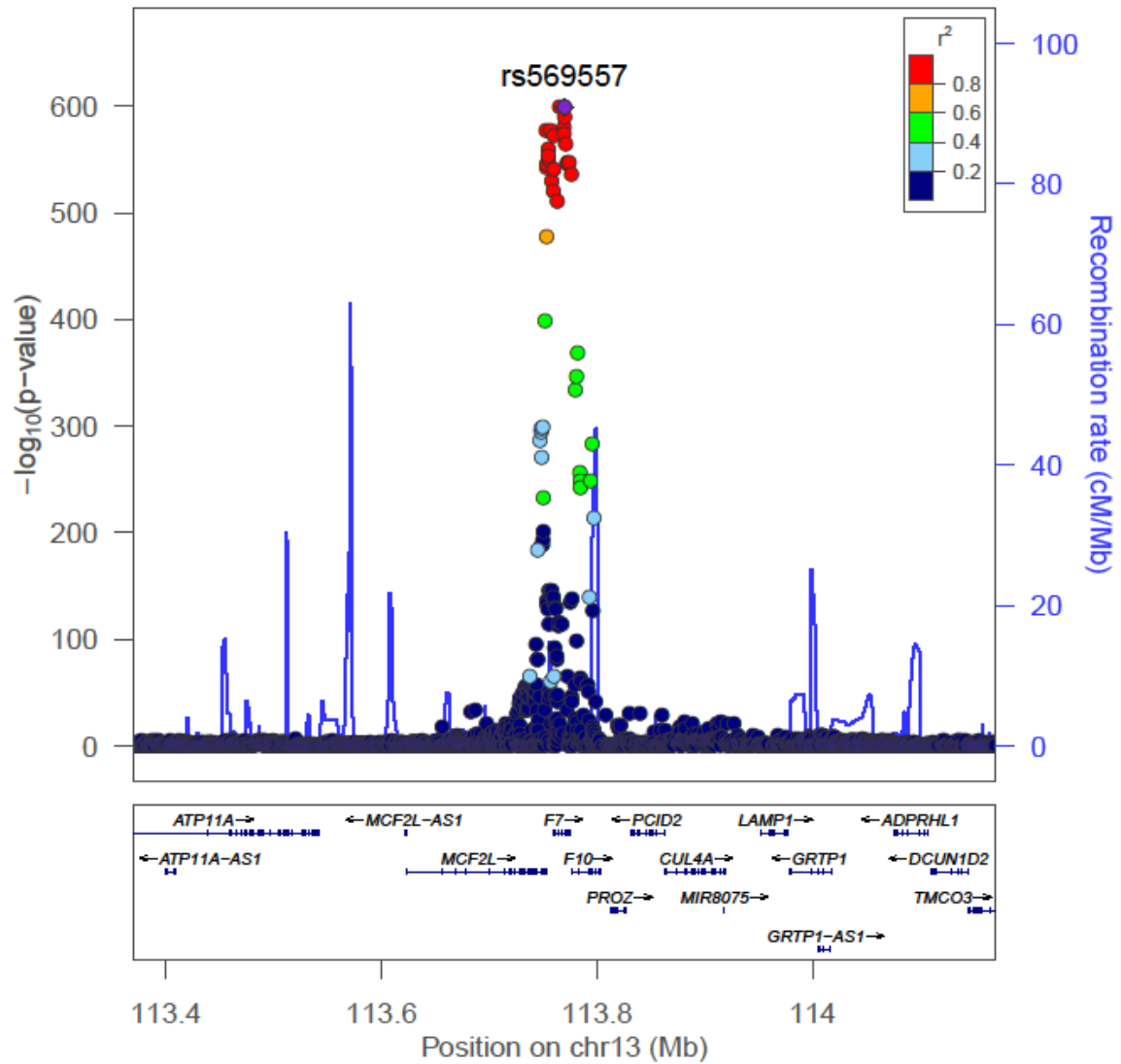


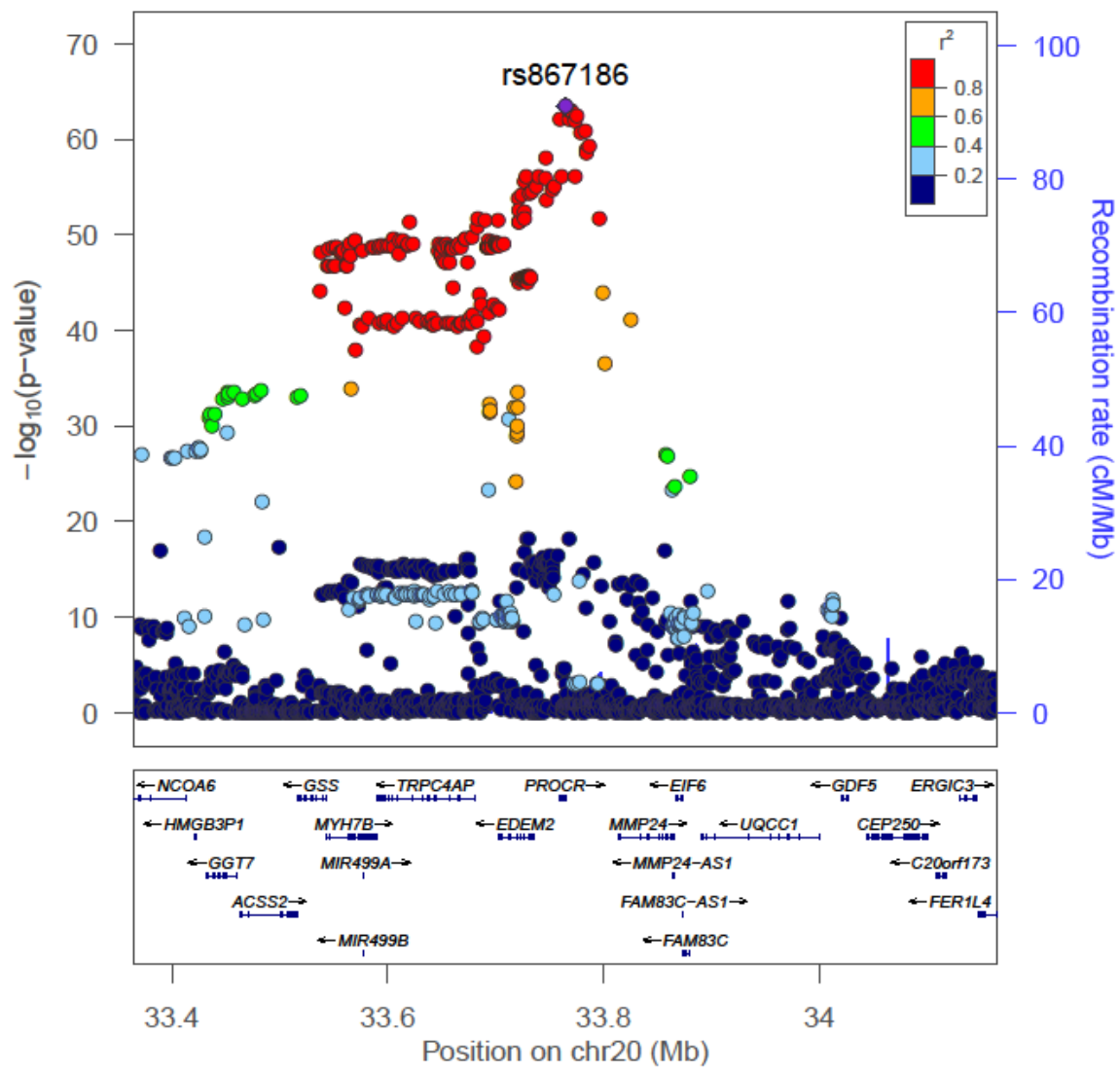
Supplementary Figure 2: Manhattan plot of the trans-ancestry meta-analysis of FVII activity.

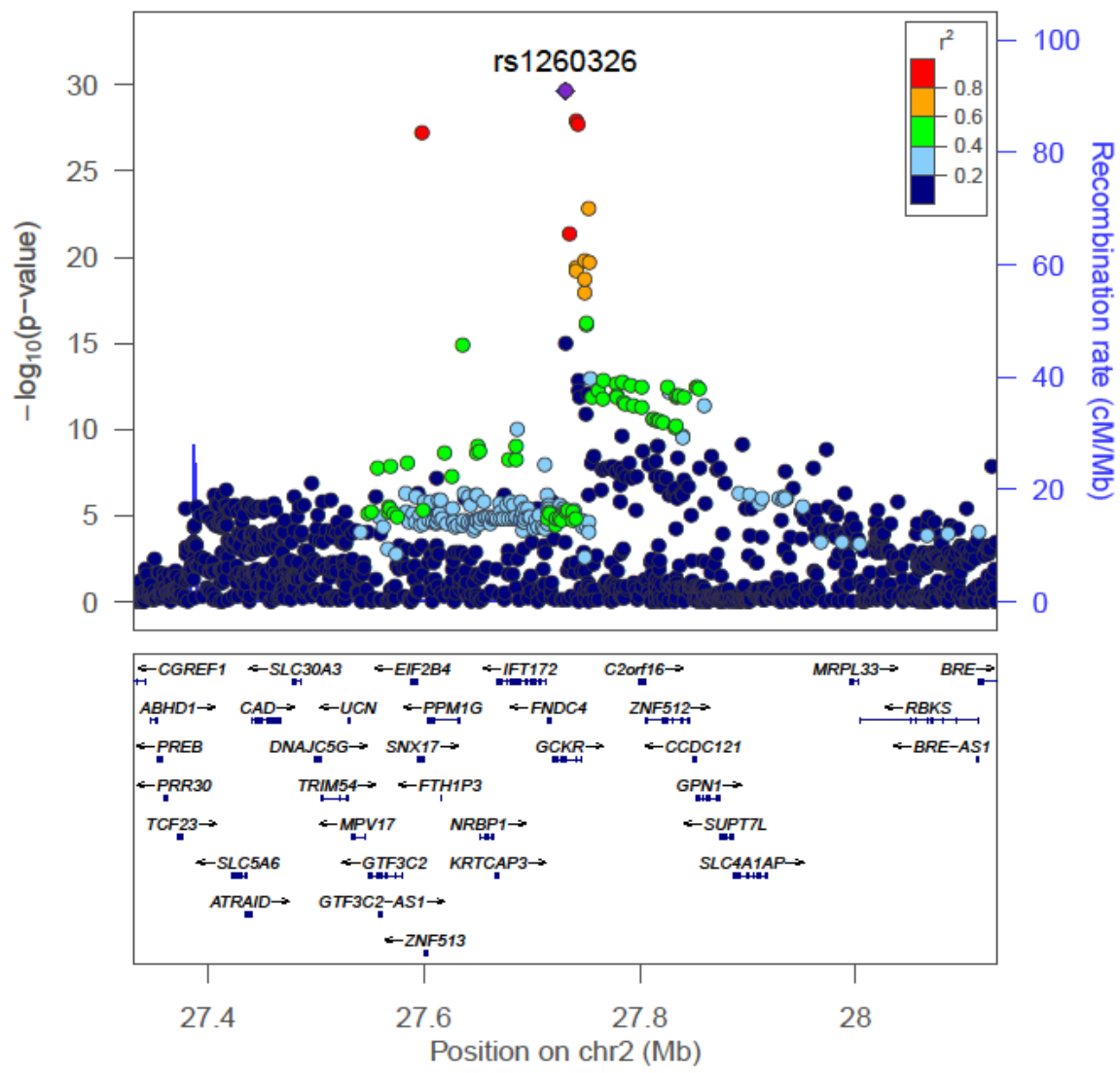


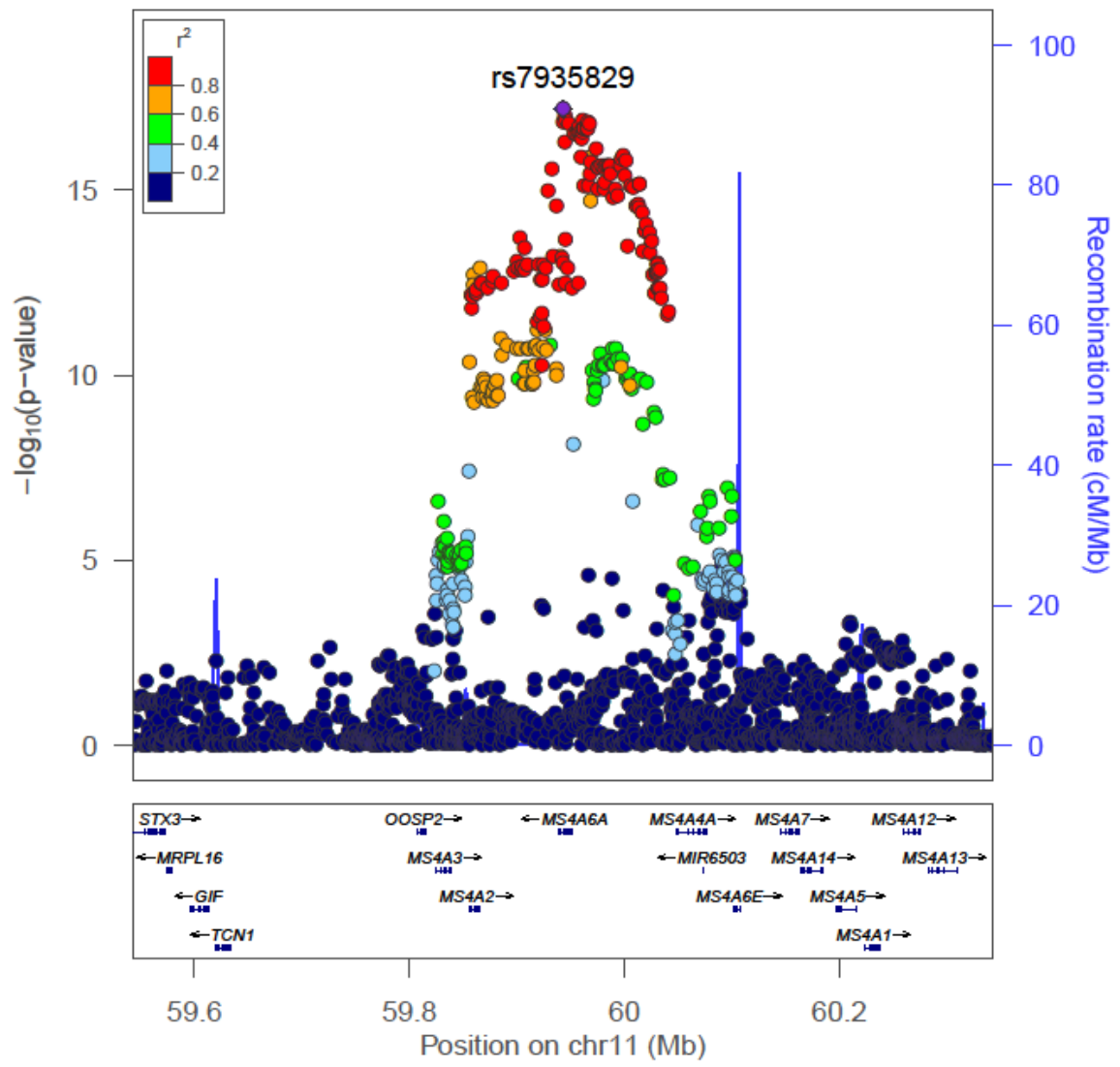
Genome-wide significant loci are annotated with the name of the closest gene. Gene names in blue indicate novel loci.

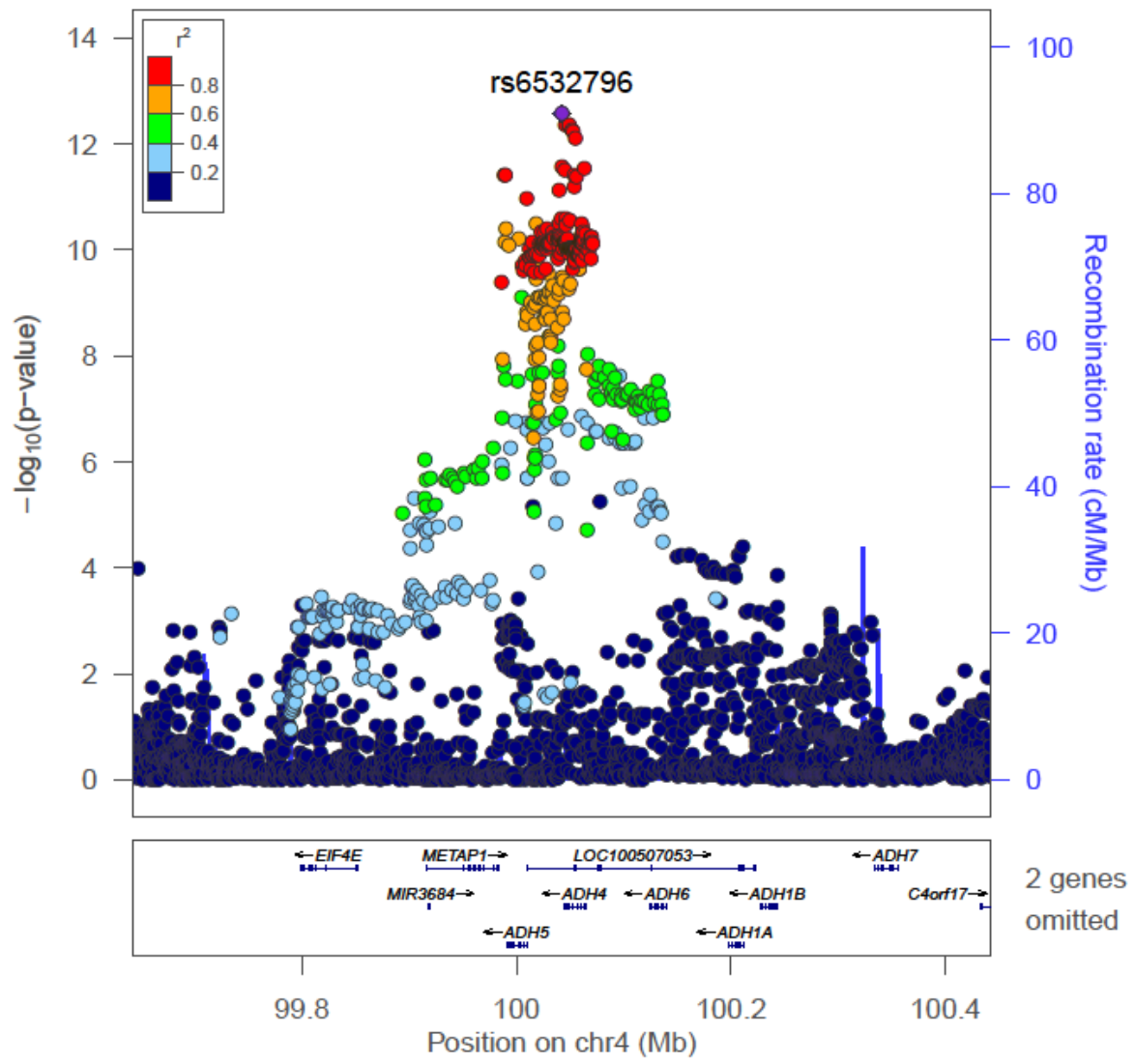
Supplementary Figure 3: Regional association plots of the known loci in the trans-ancestry meta-analysis of FVII activity. Linkage disequilibrium information based on European ancestry population.

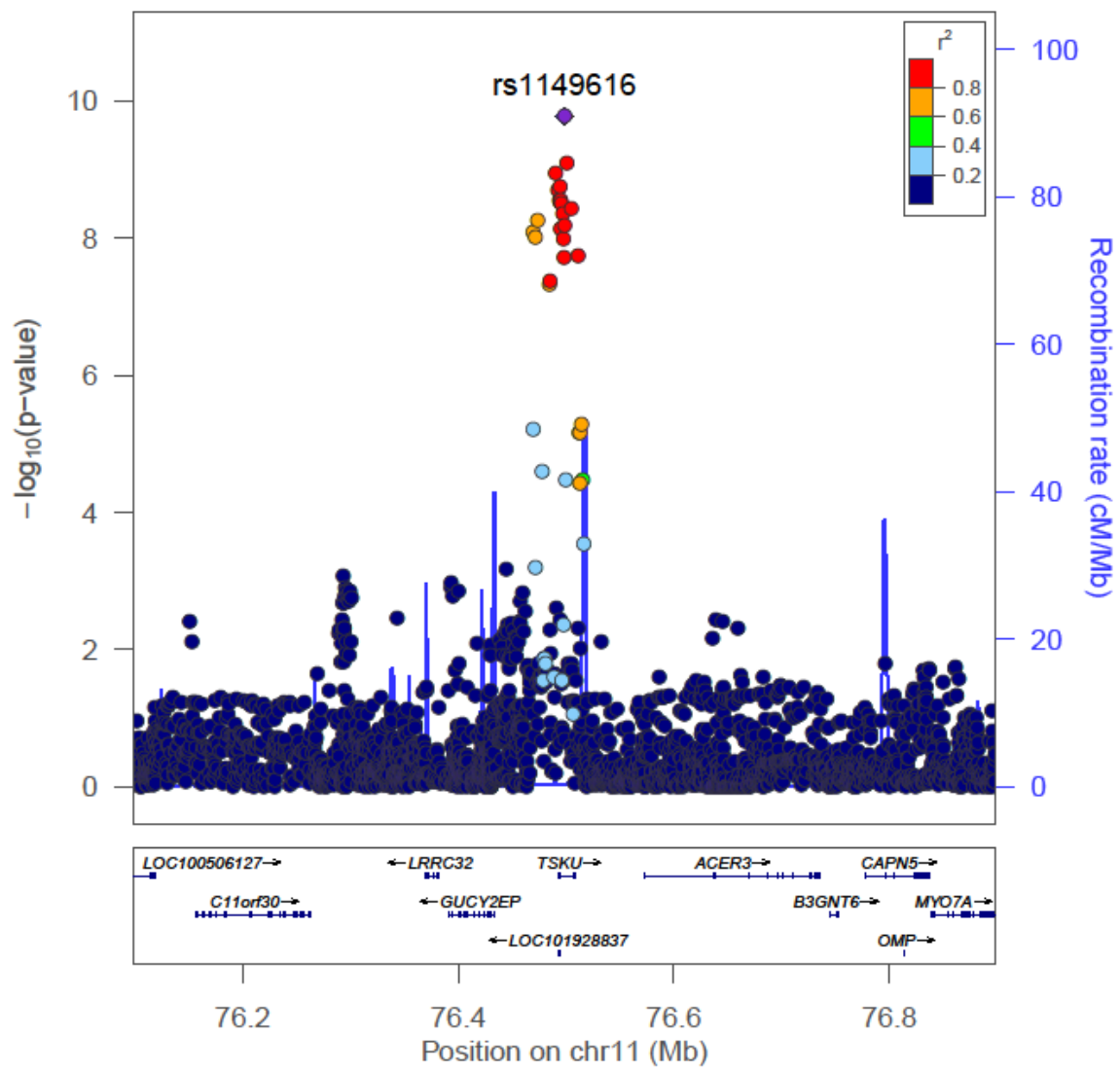




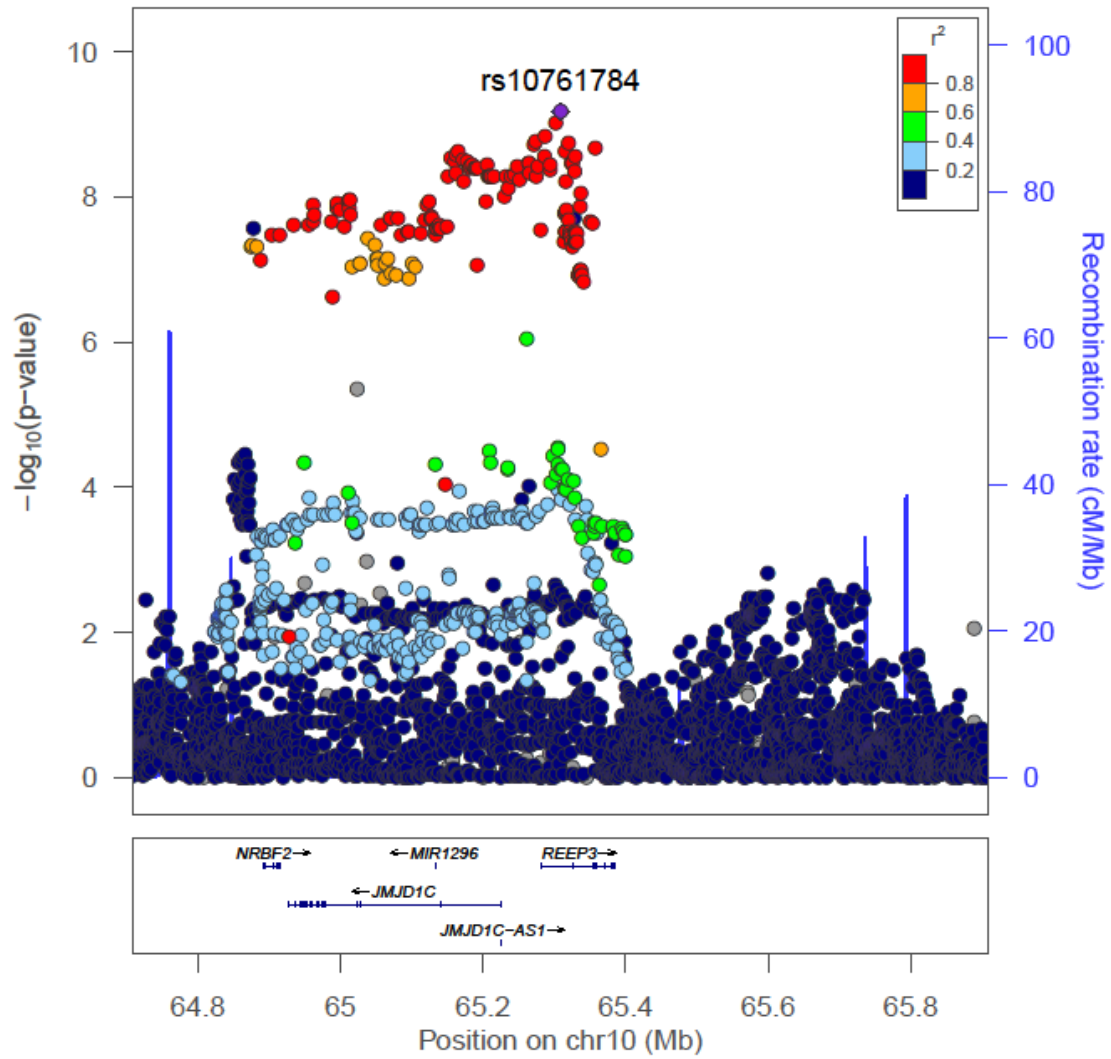


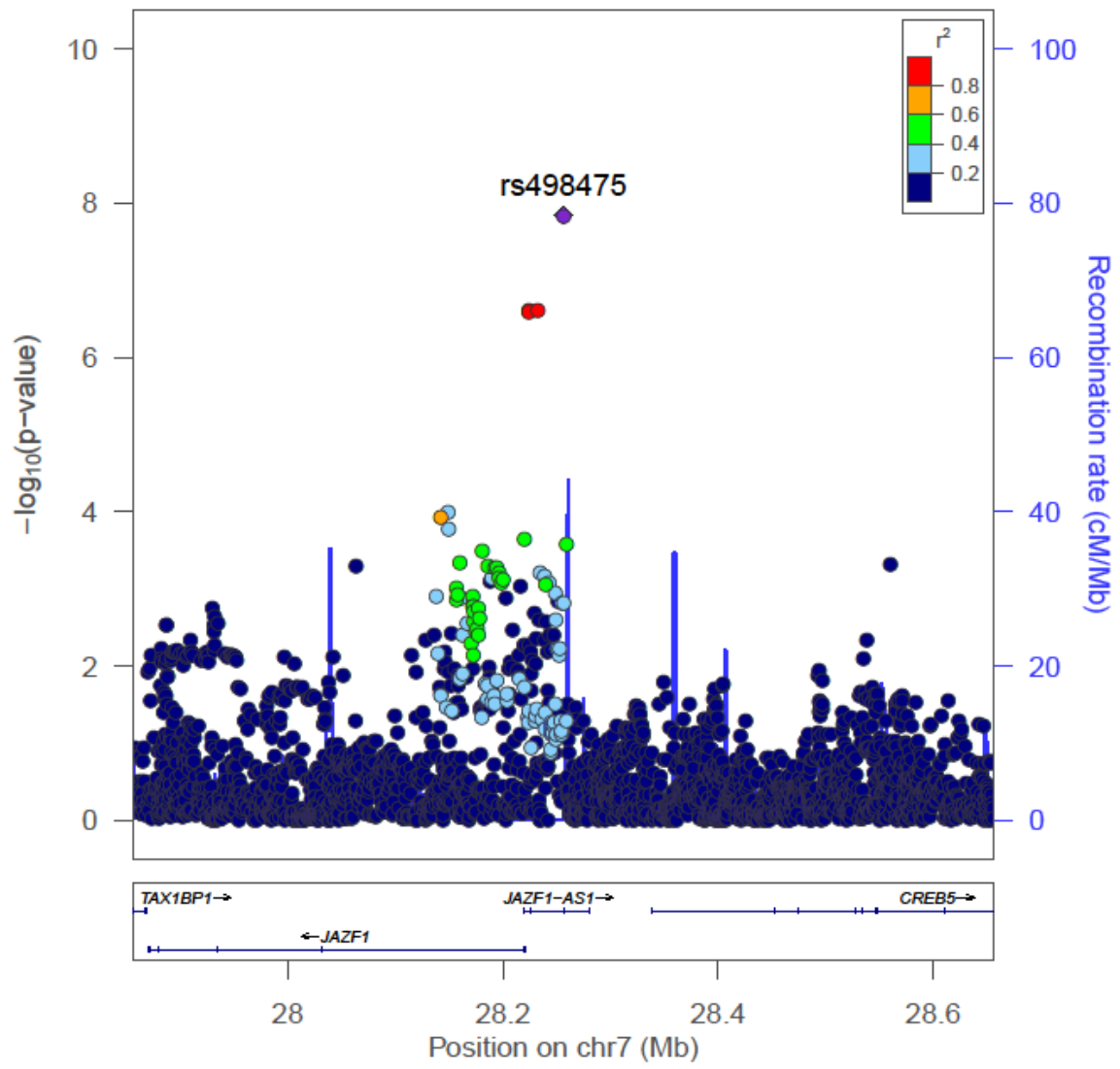




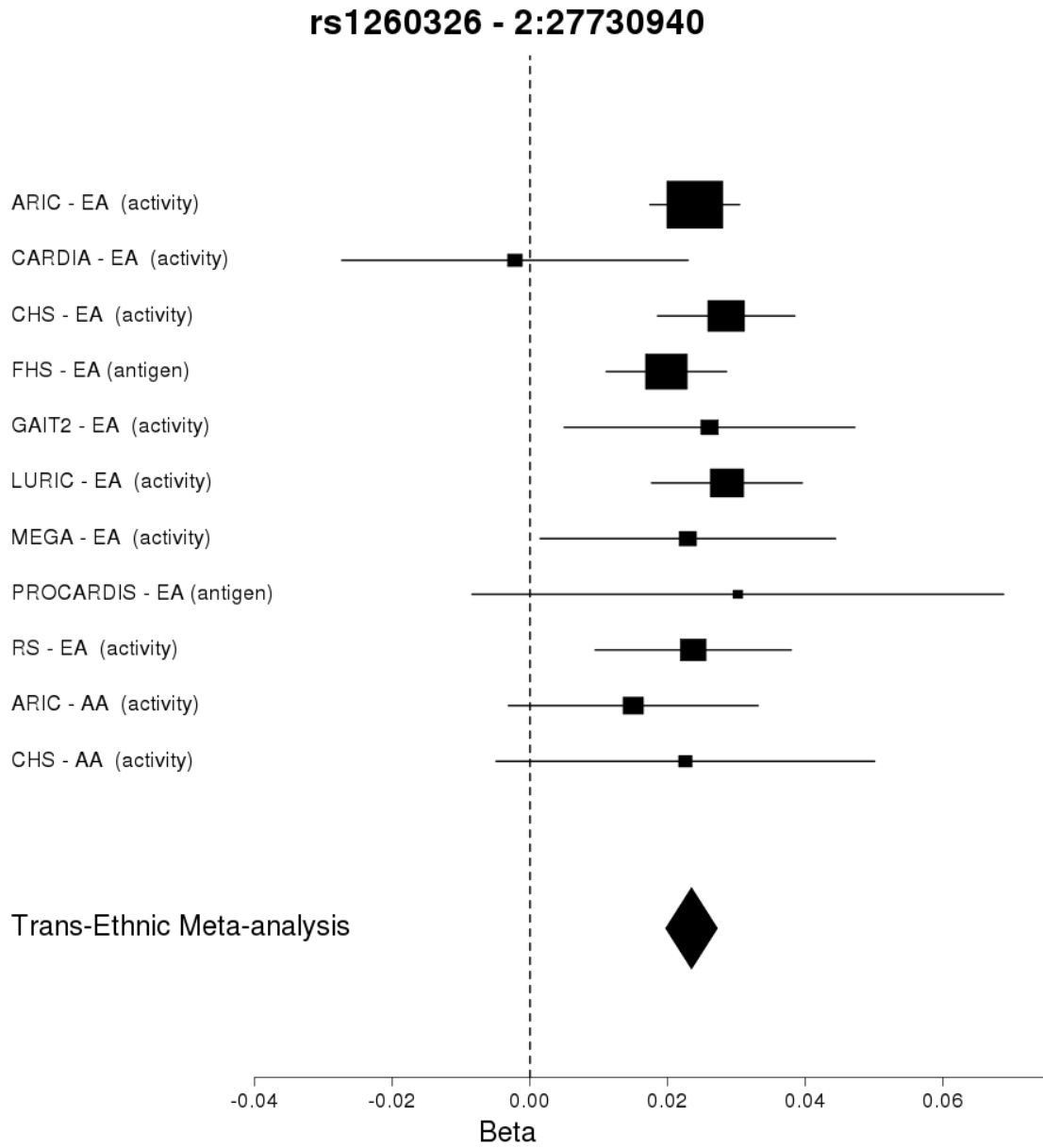


Supplementary Figure 4: Regional association plots of the novel *REEP3* and *JAZF1* loci in the trans-ancestry meta-analysis of FVII activity. Linkage disequilibrium information based on European ancestry population.

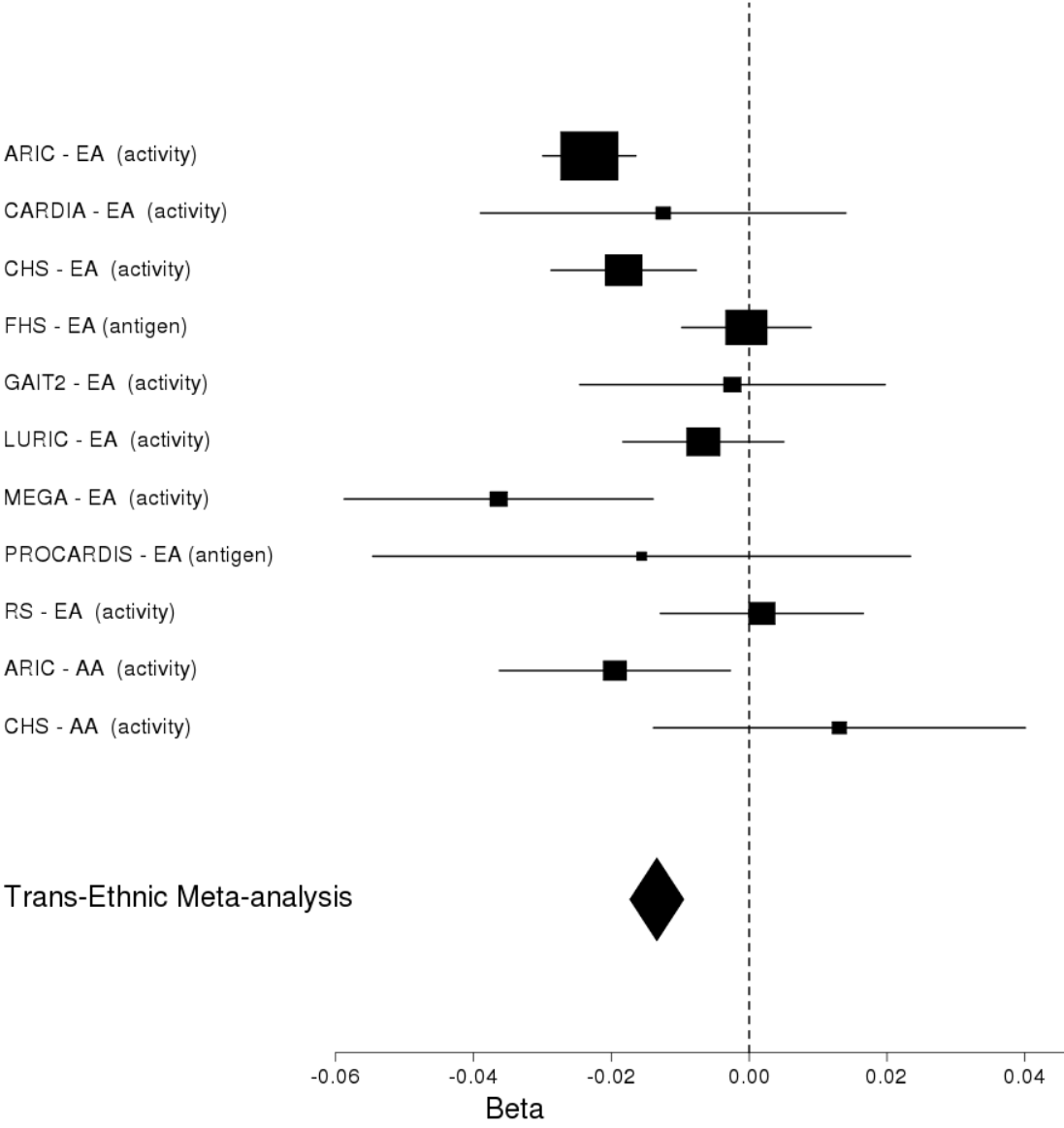




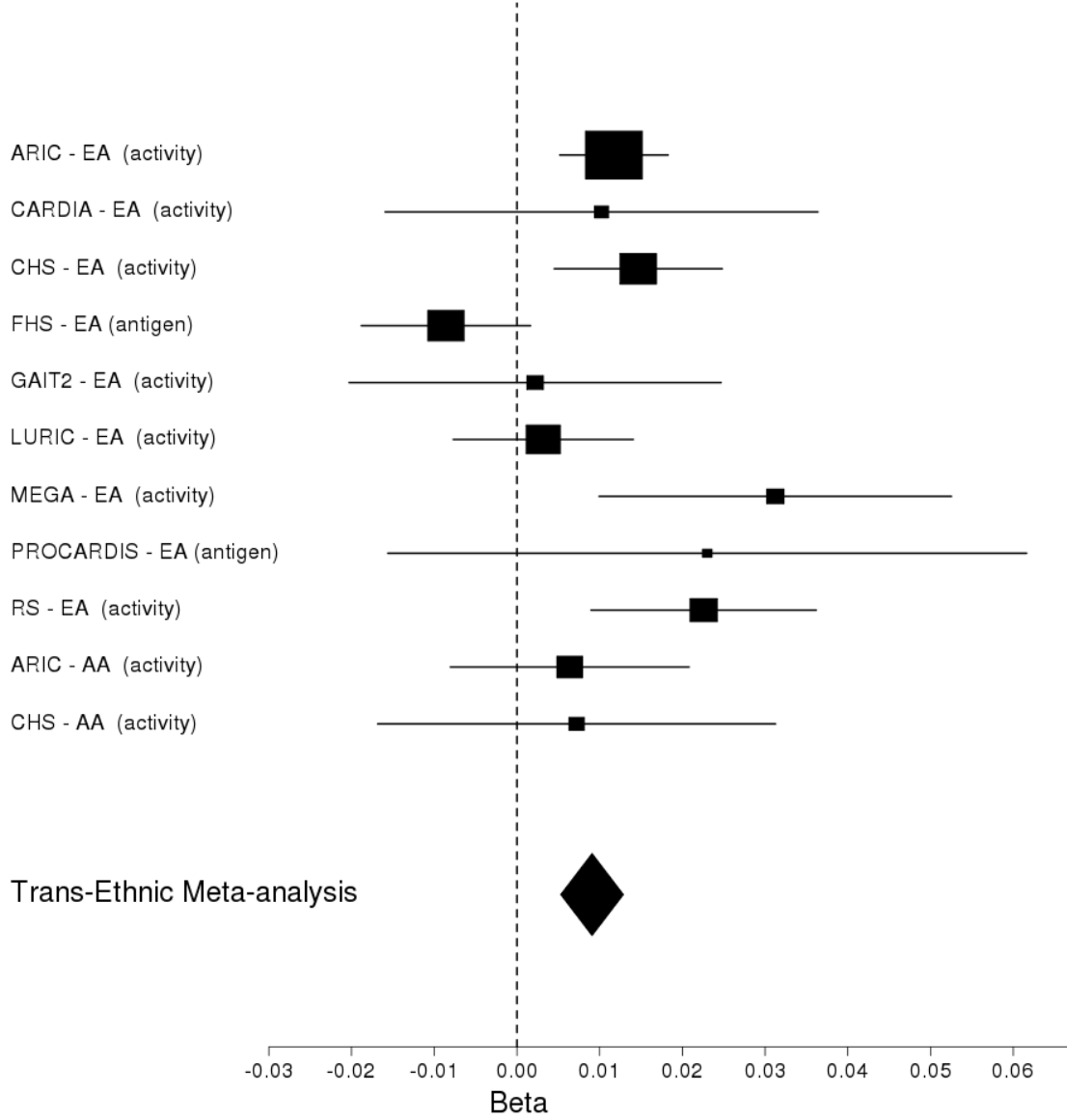
Supplementary Figure 5: Forest plots showing the study-specific associations of genetic variants with FVII activity. EA refers to European ancestry and AA refers to African American ancestry.



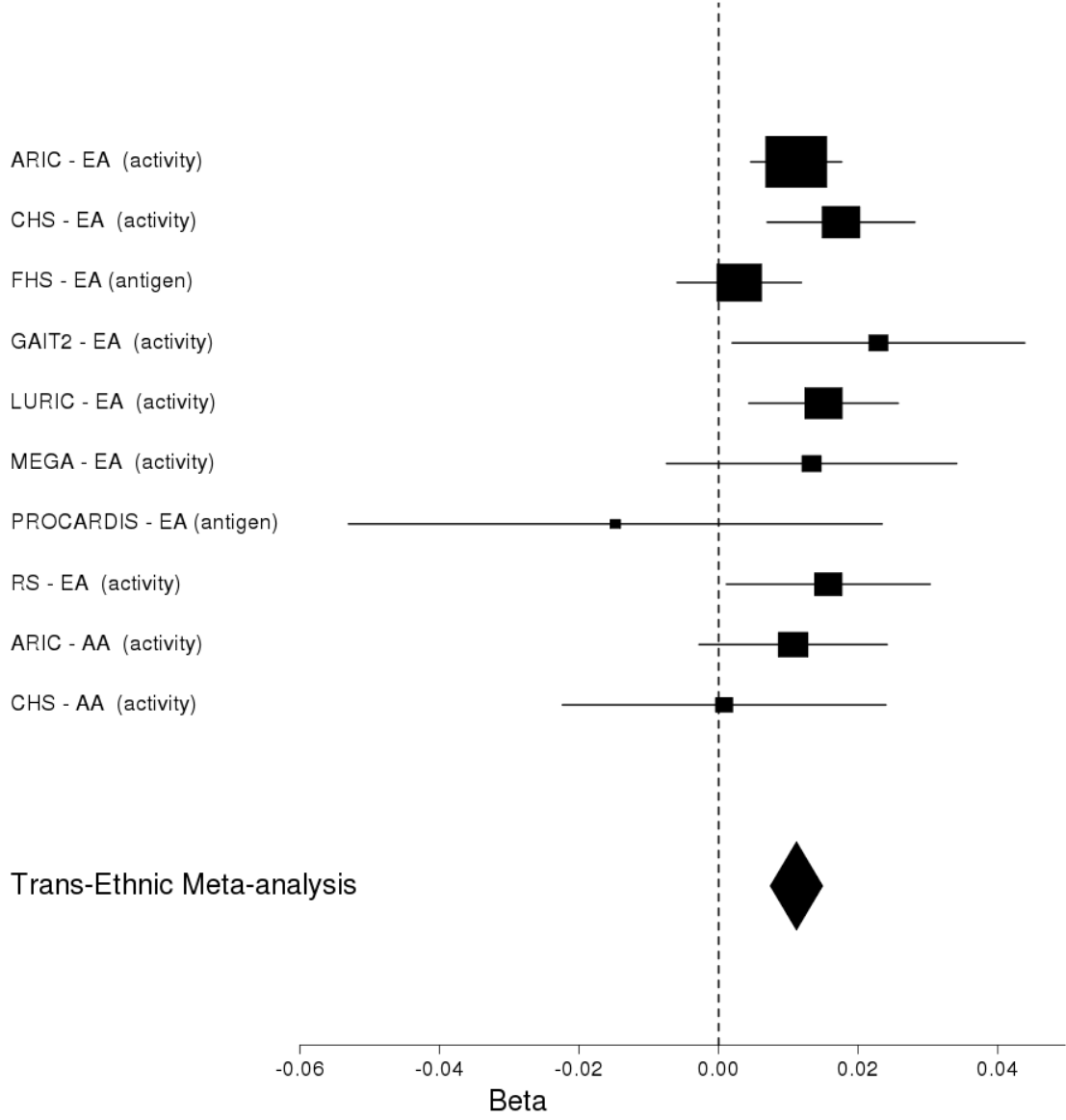
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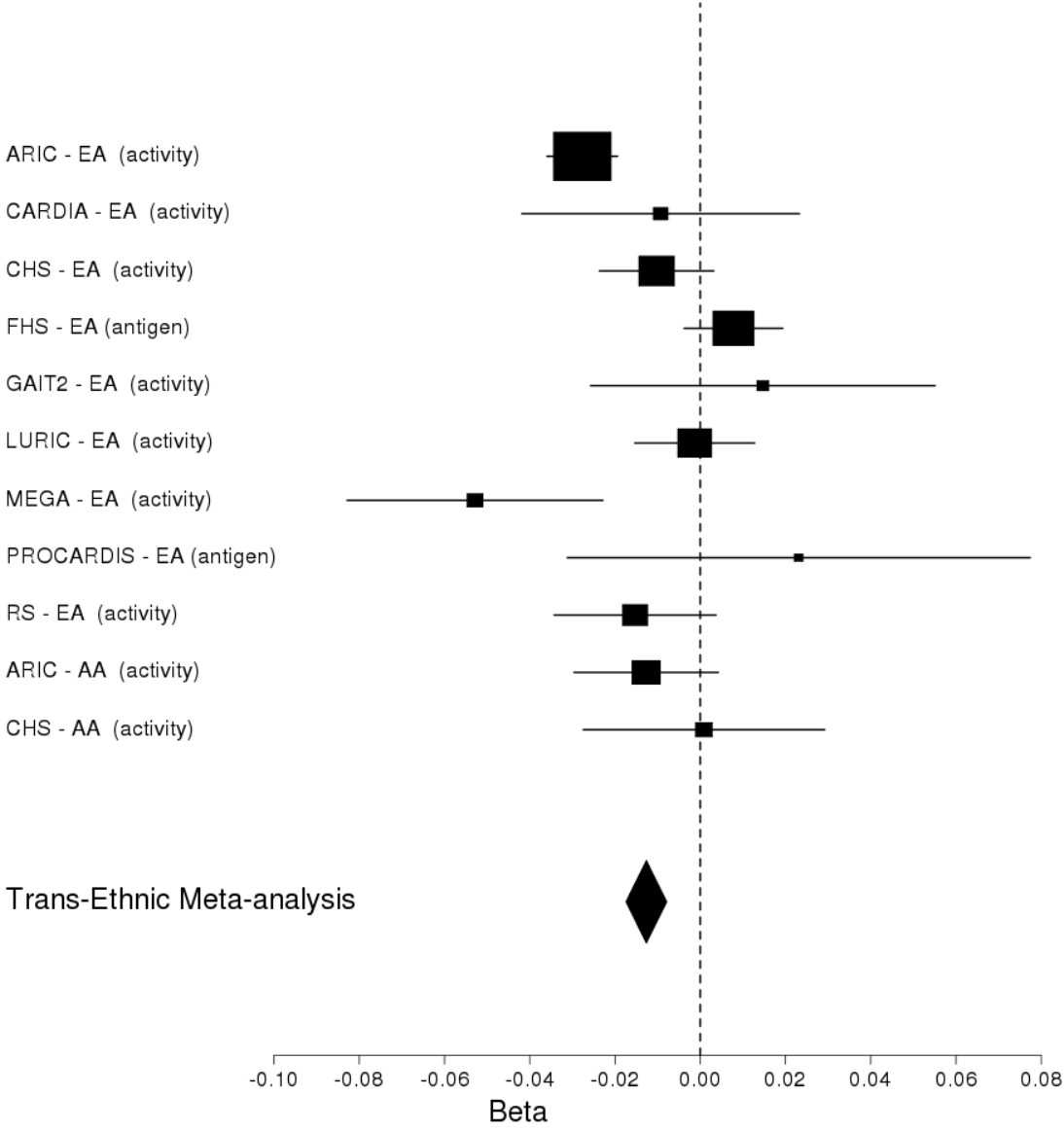
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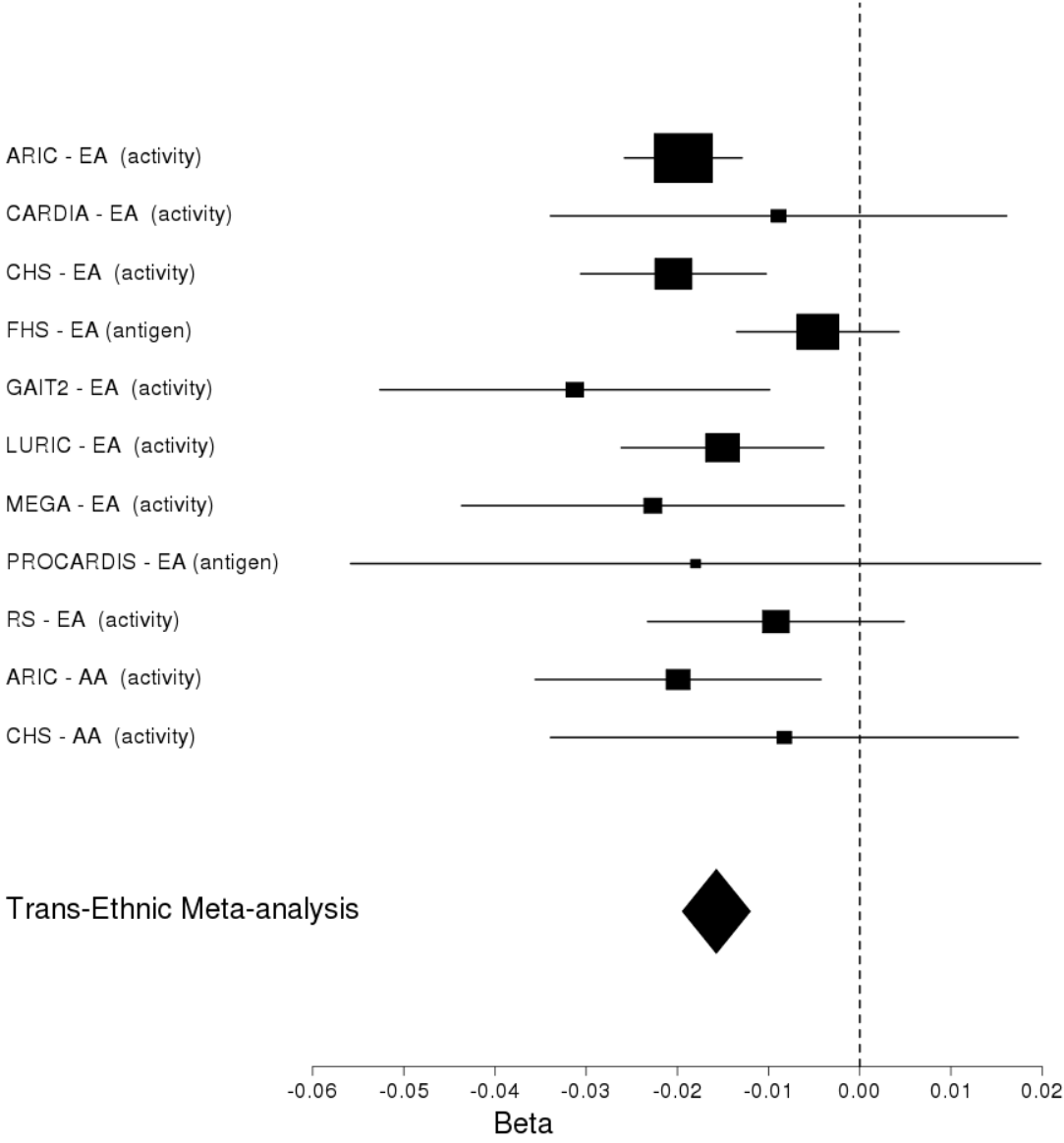
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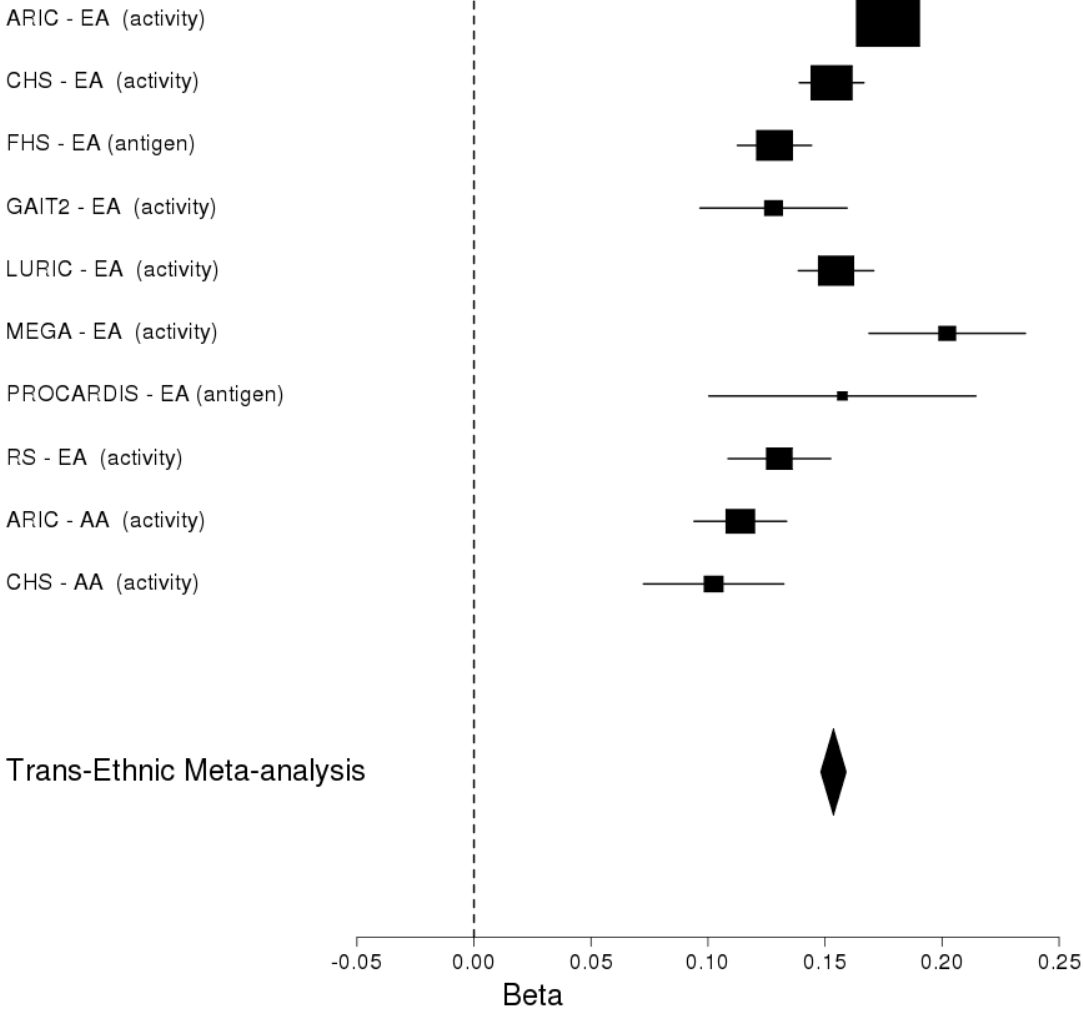
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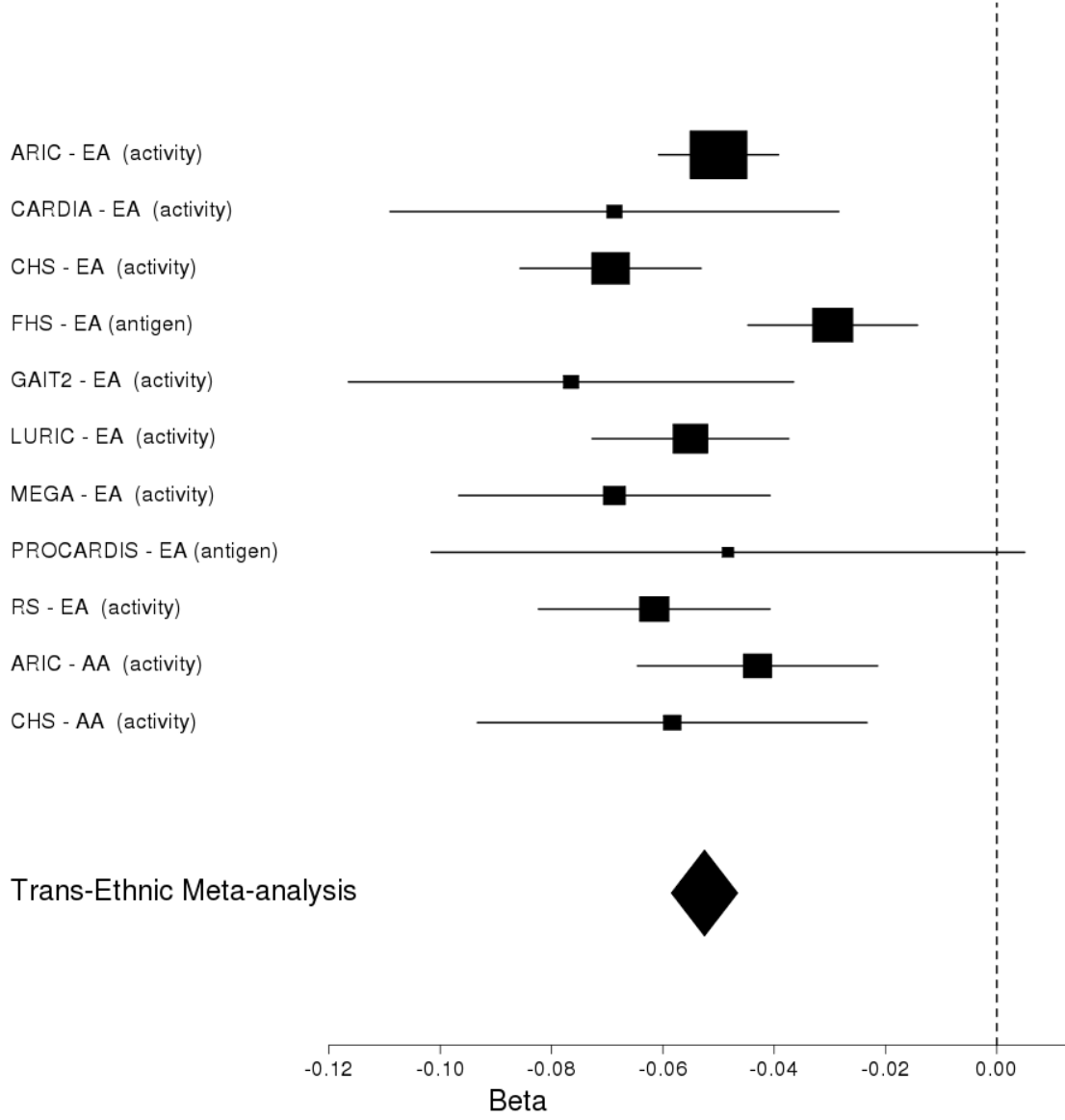
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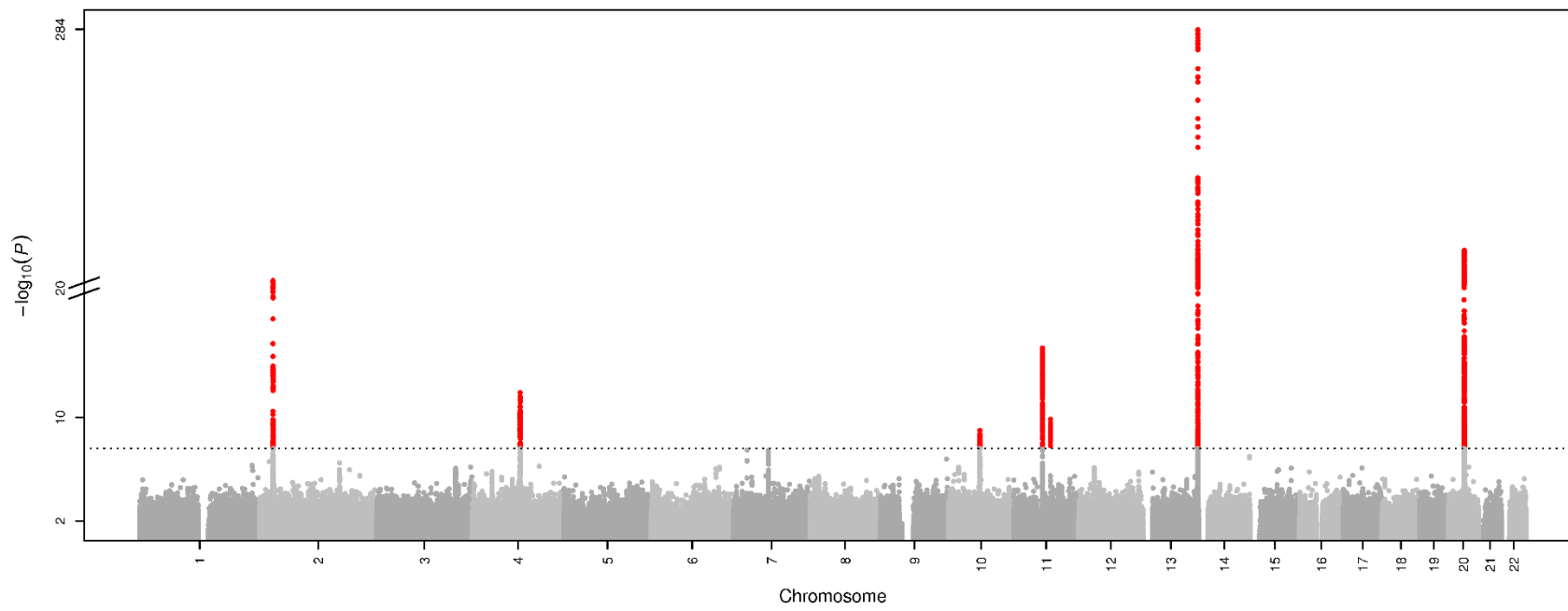
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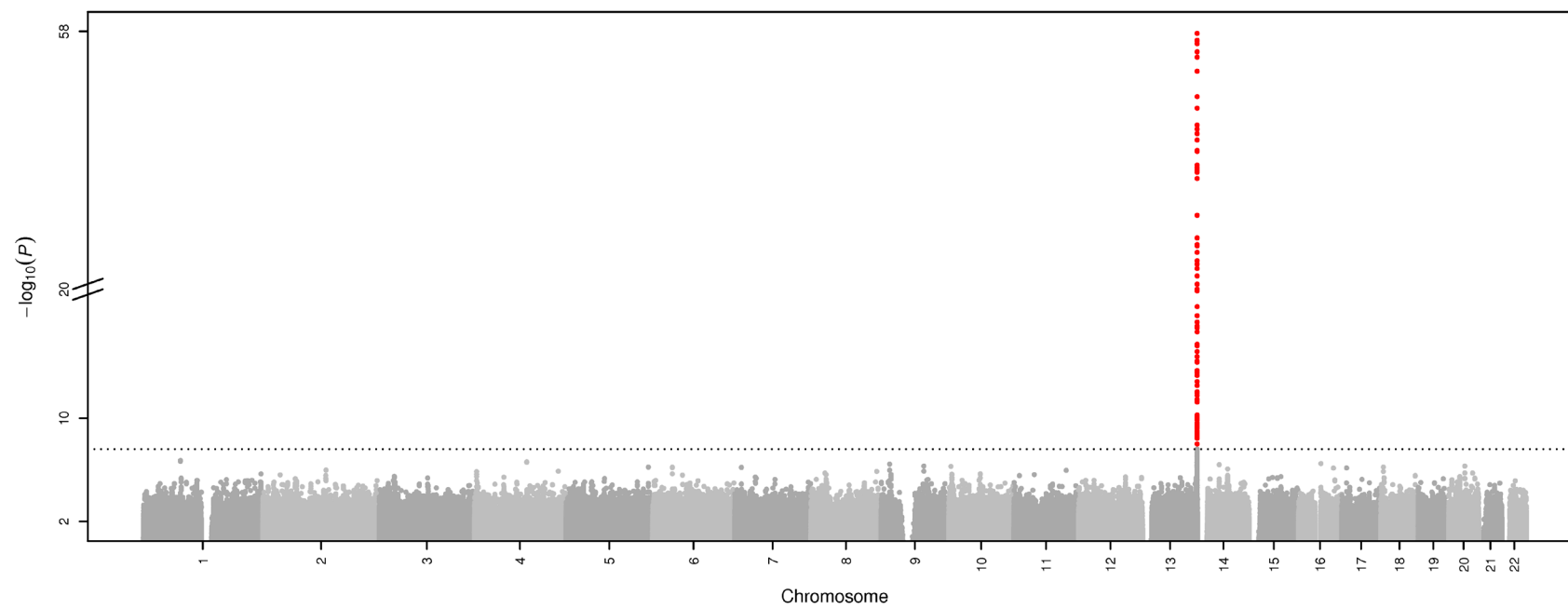
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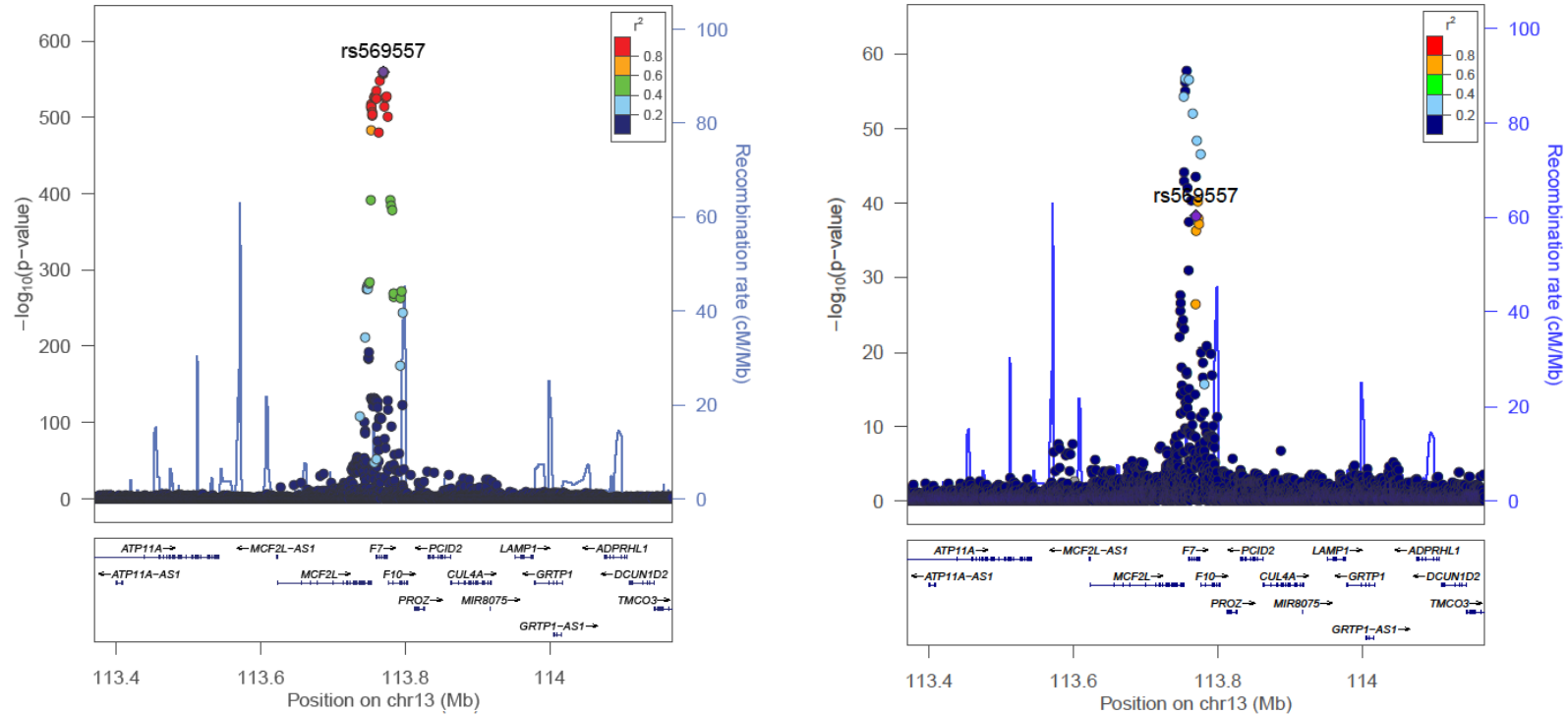
Supplementary Figure 6: Manhattan plot of the European-ancestry meta-analysis of FVII activity.

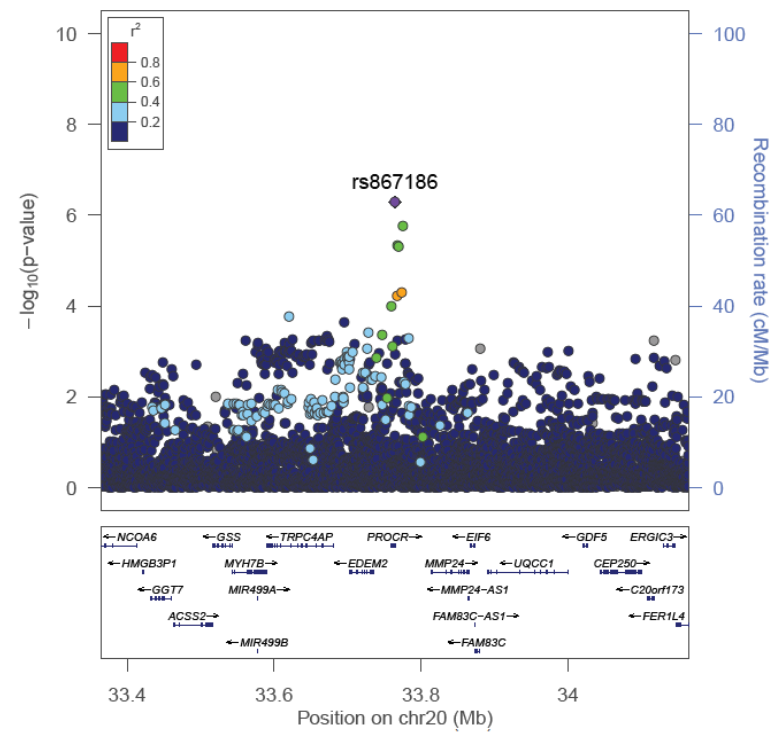
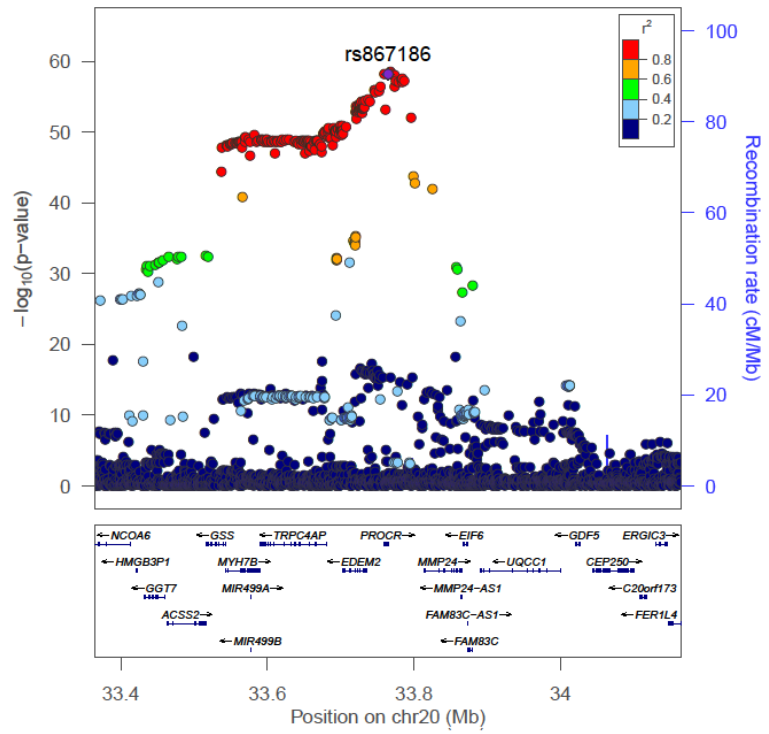


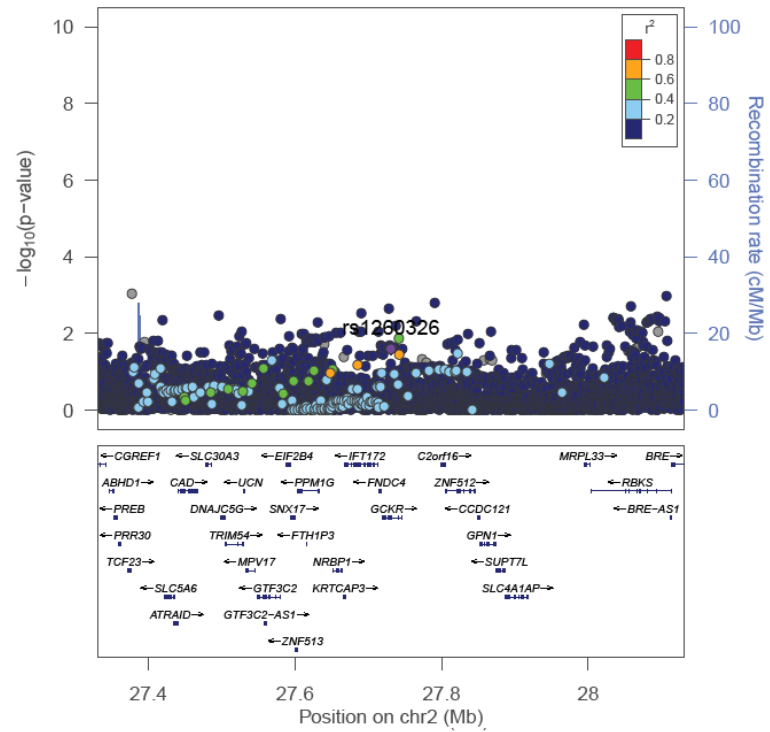
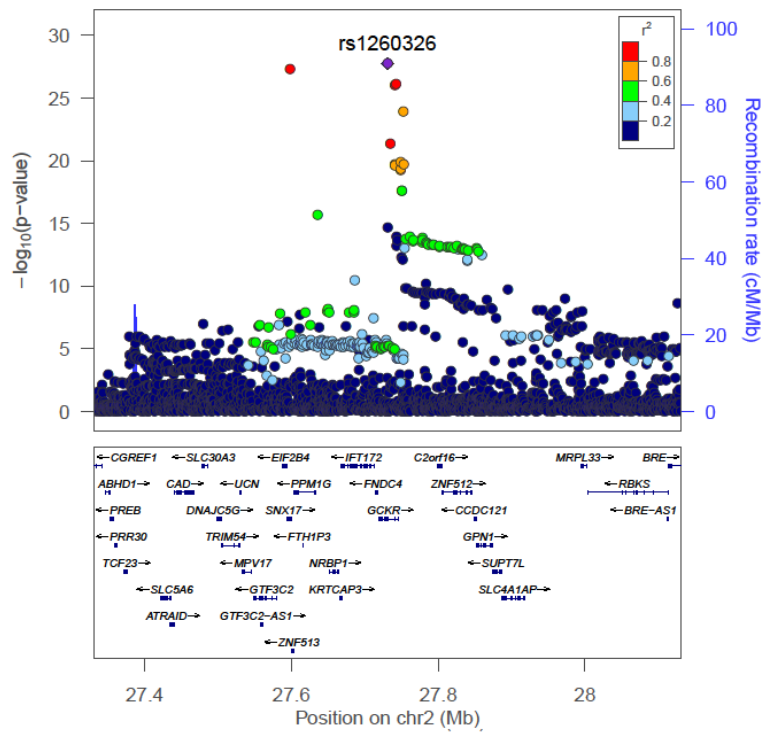
Supplementary Figure 7: Manhattan plot of the African-ancestry meta-analysis of FVII activity.

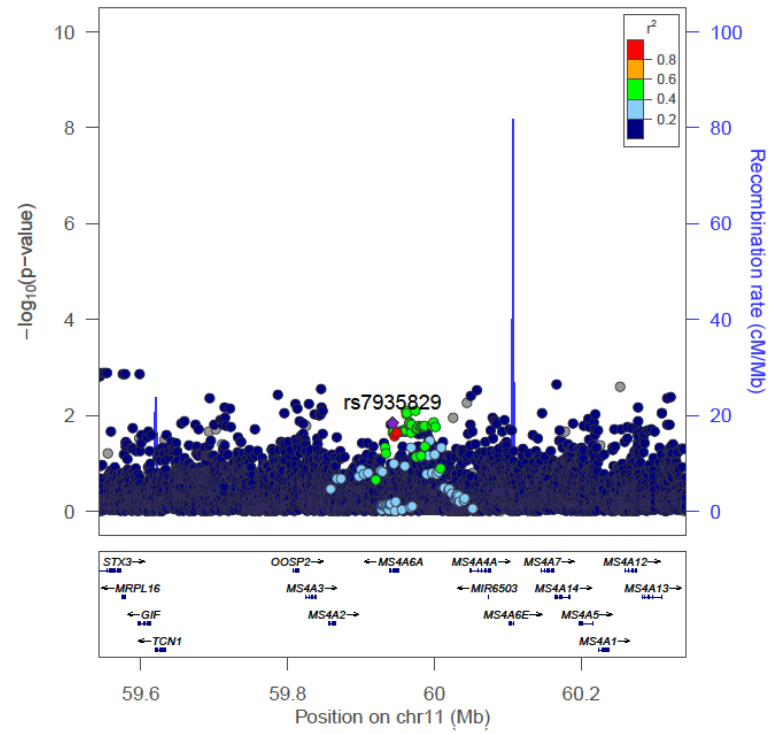
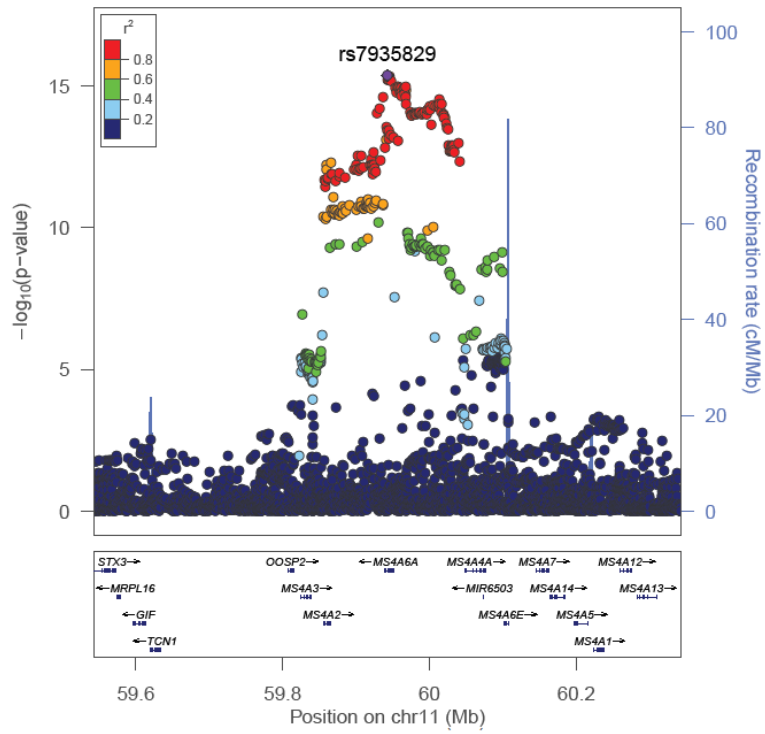


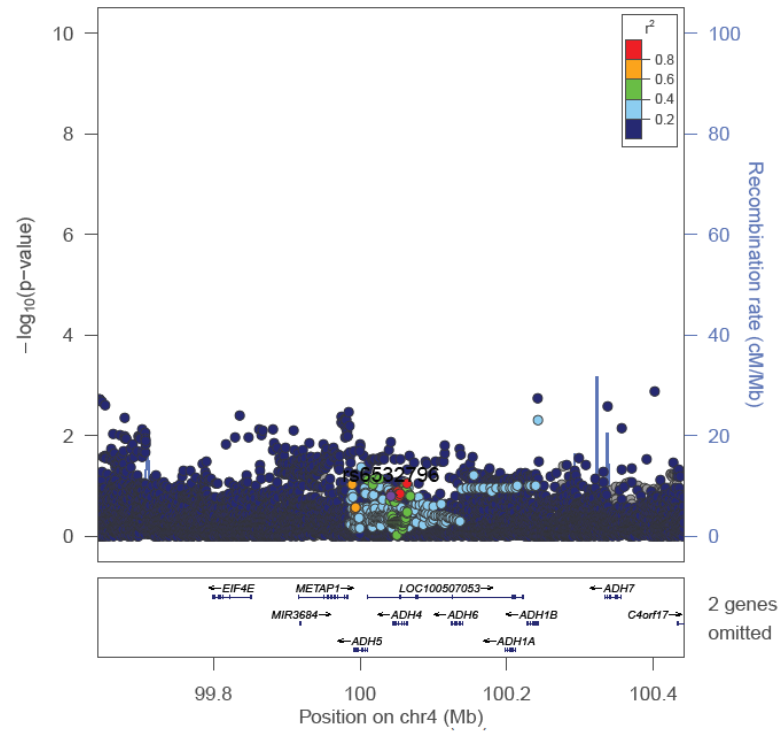
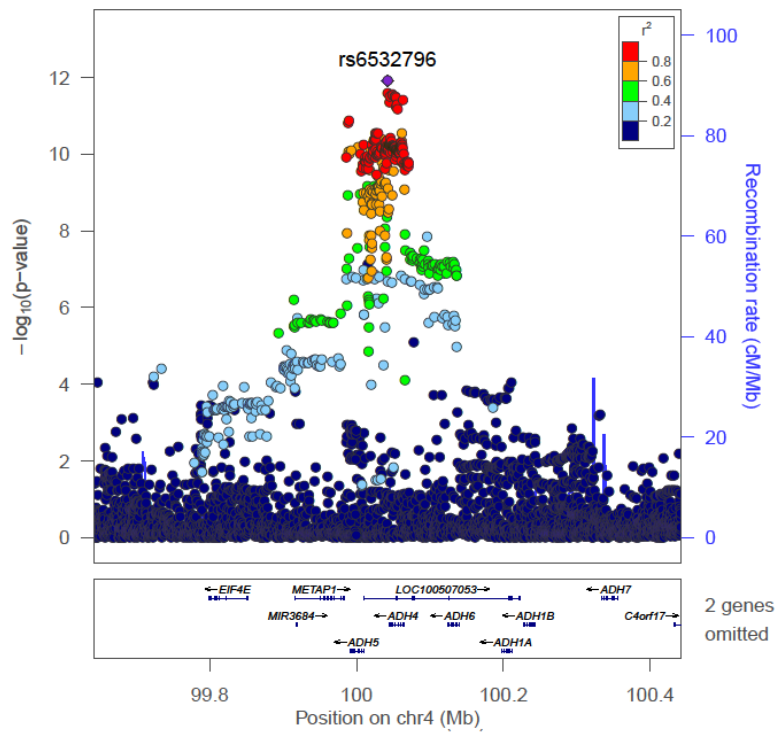
Supplementary Figure 8: Regional association plots of the ancestry-specific meta-analysis of FVII activity. European-specific results are shown on the left, with European-specific information on linkage disequilibrium, and African-specific results are shown on the right with African-specific information on linkage disequilibrium. Plots are shown for all index variants significant in the trans-ancestry meta-analysis of FVII activity.

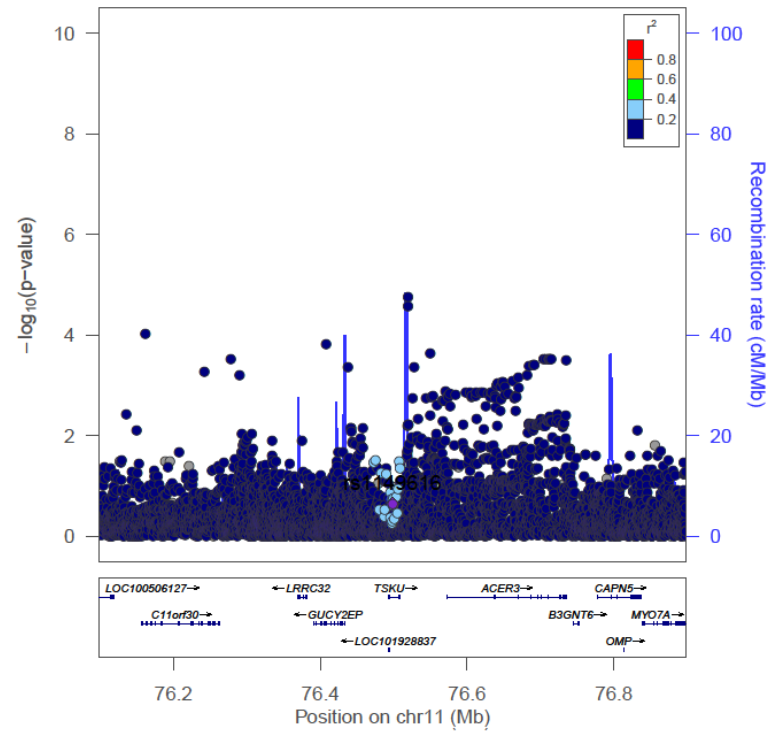
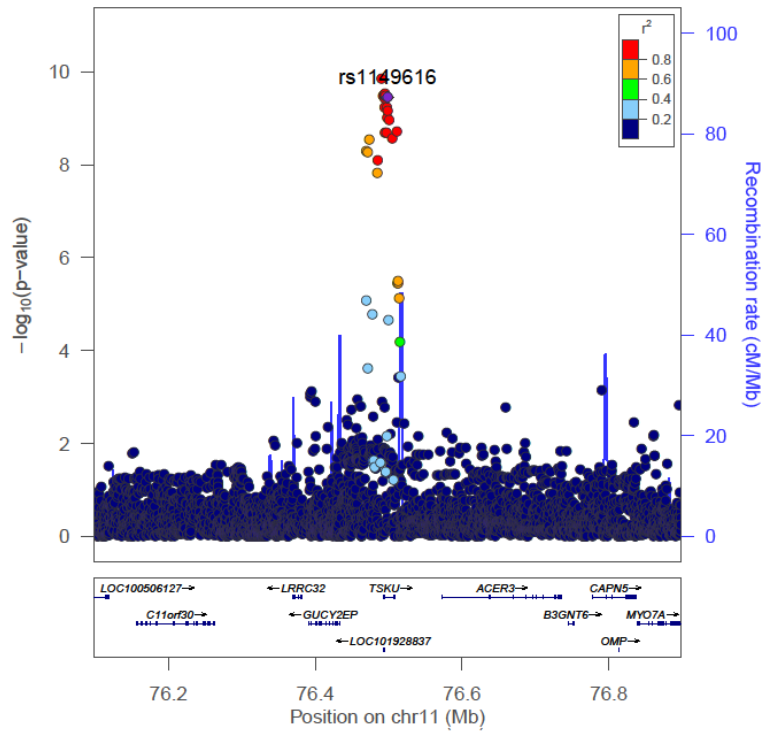


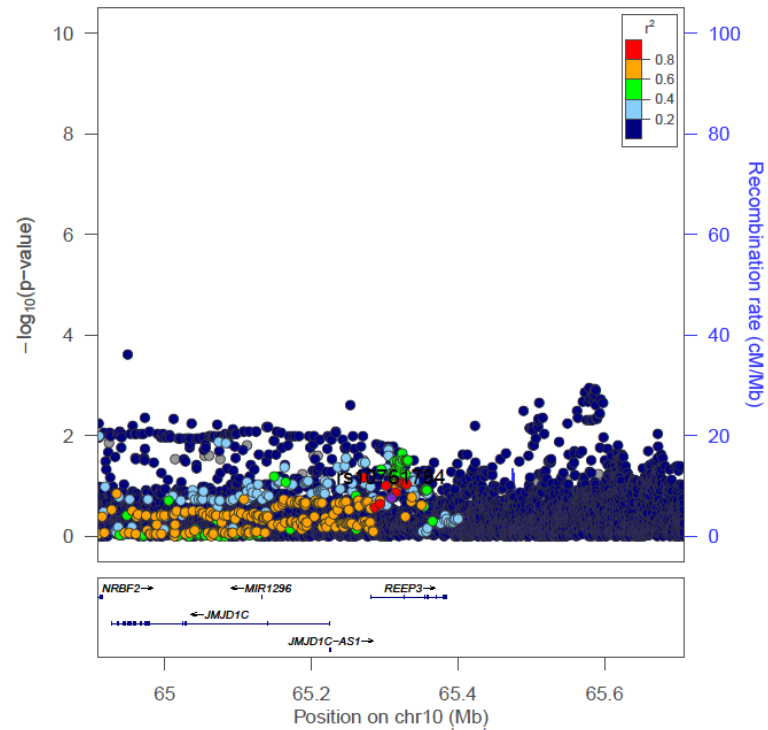
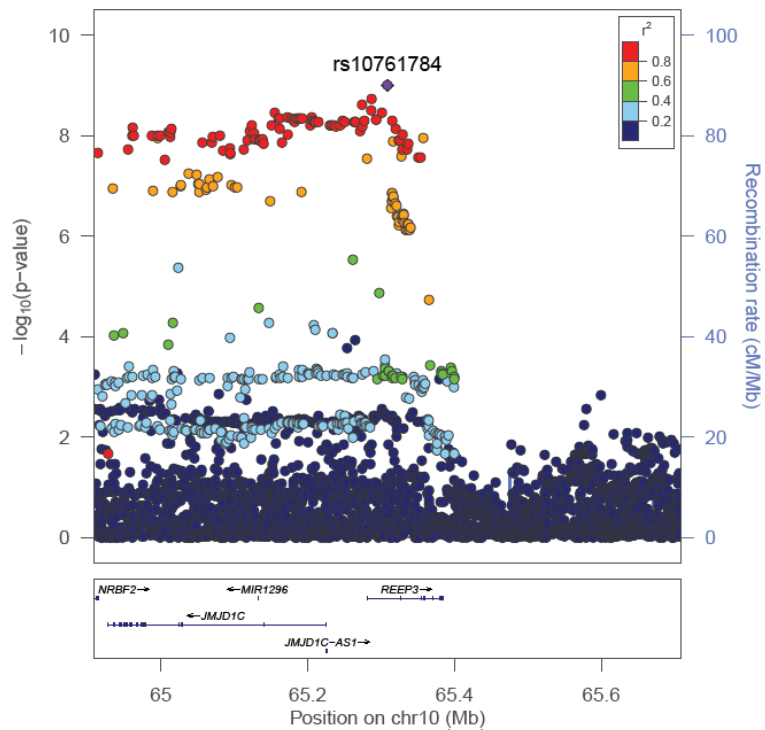


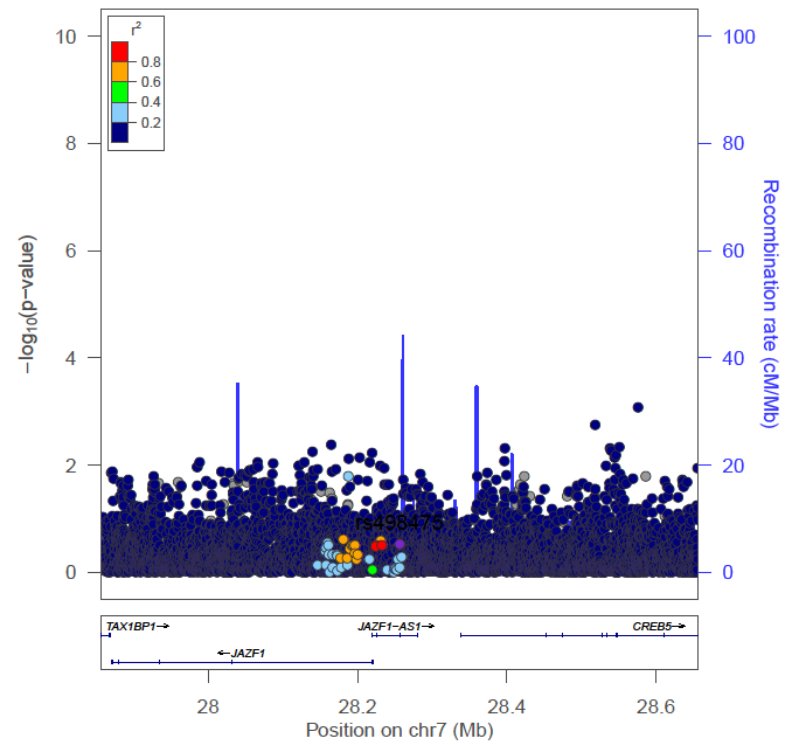
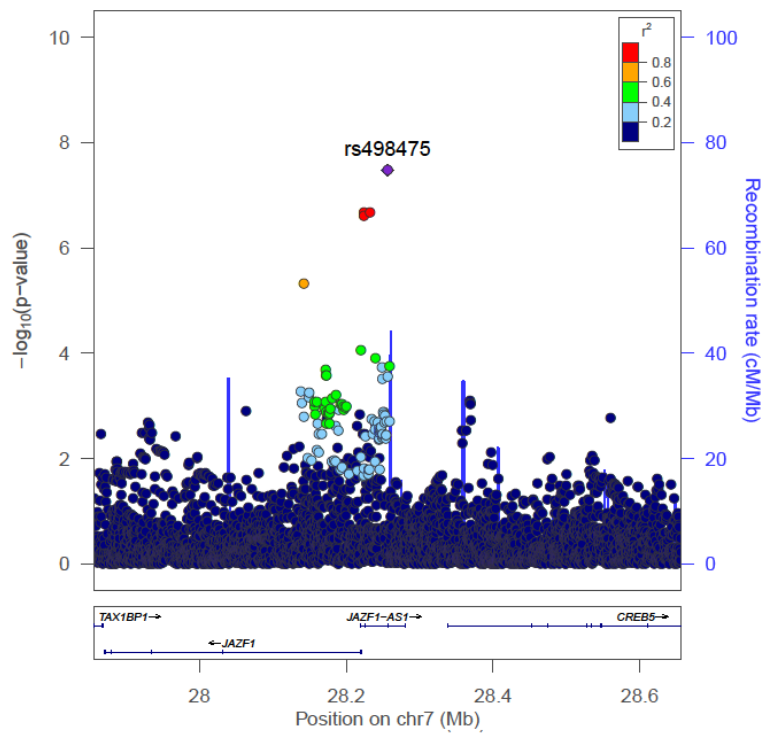




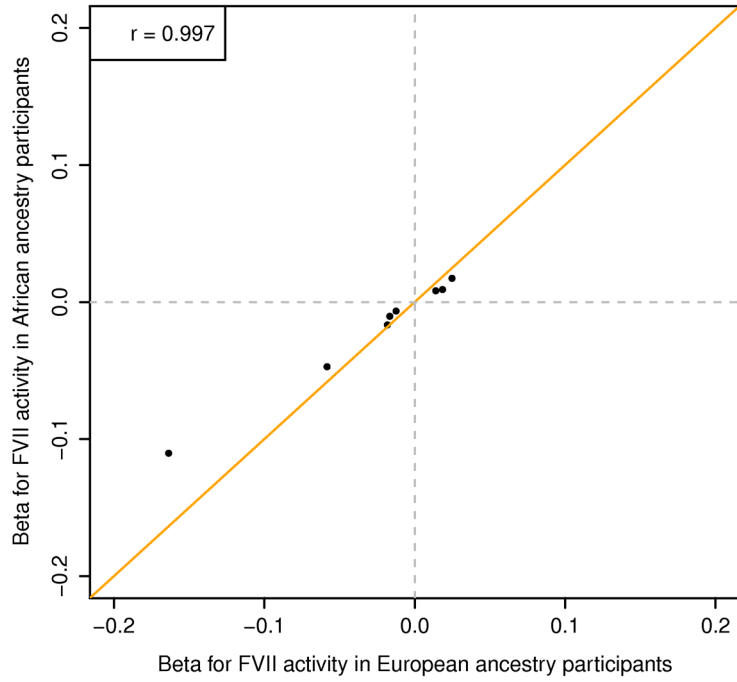




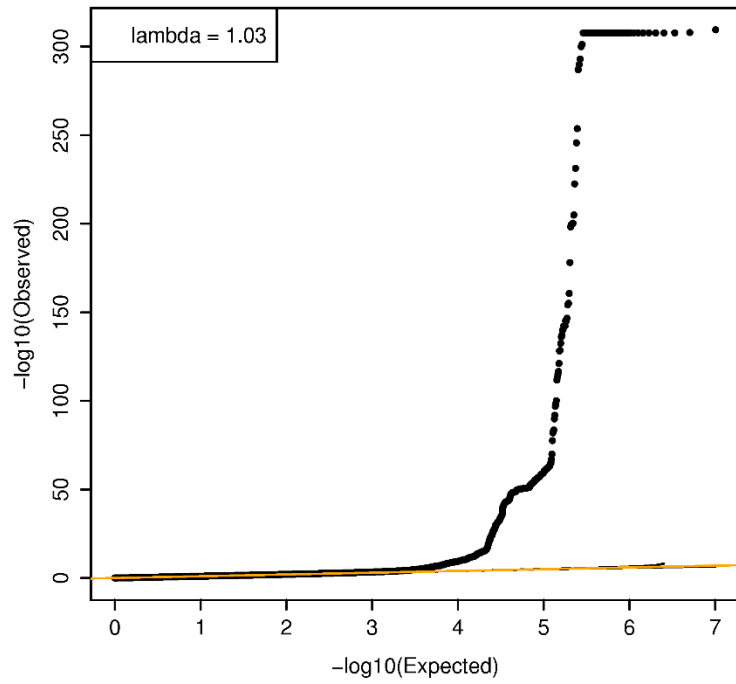




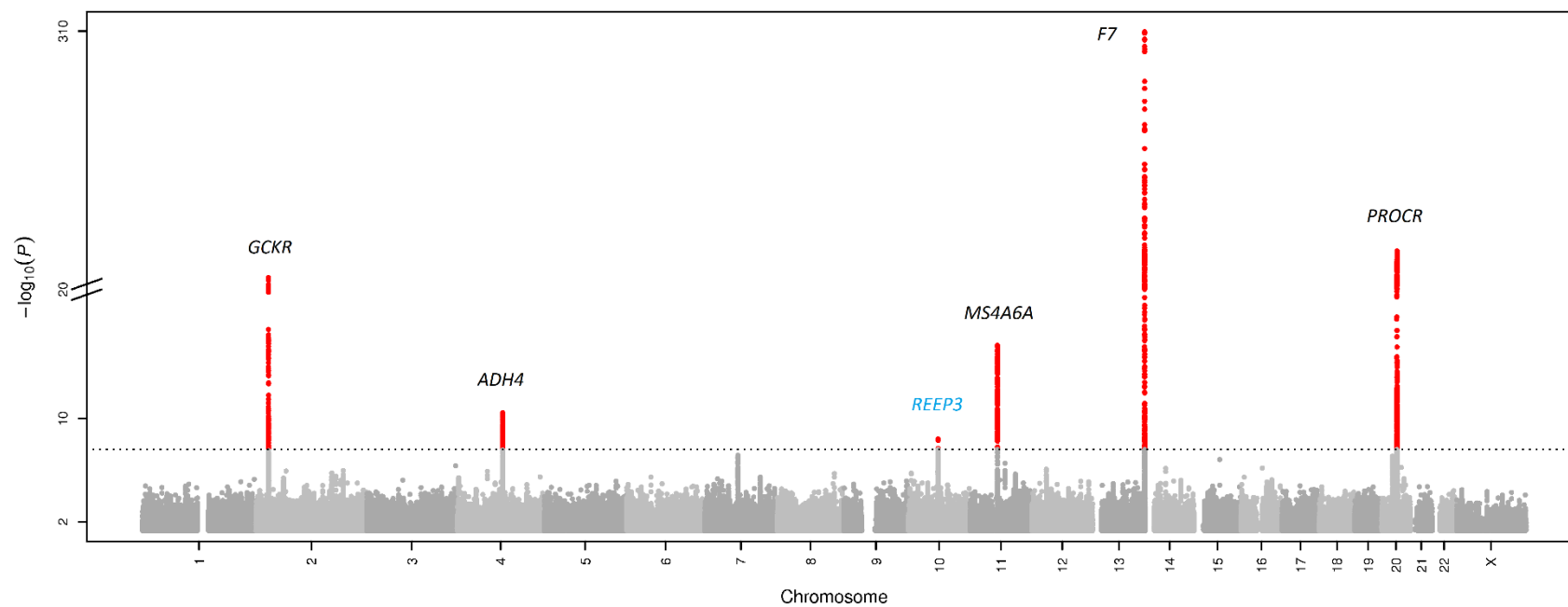
Supplementary Figure 9: Comparison of the betas for FVII activity between European-ancestry and African-ancestry participants.



Supplementary Figure 10: QQ plot of the trans-ancestry combined meta-analysis of FVII activity and antigen.

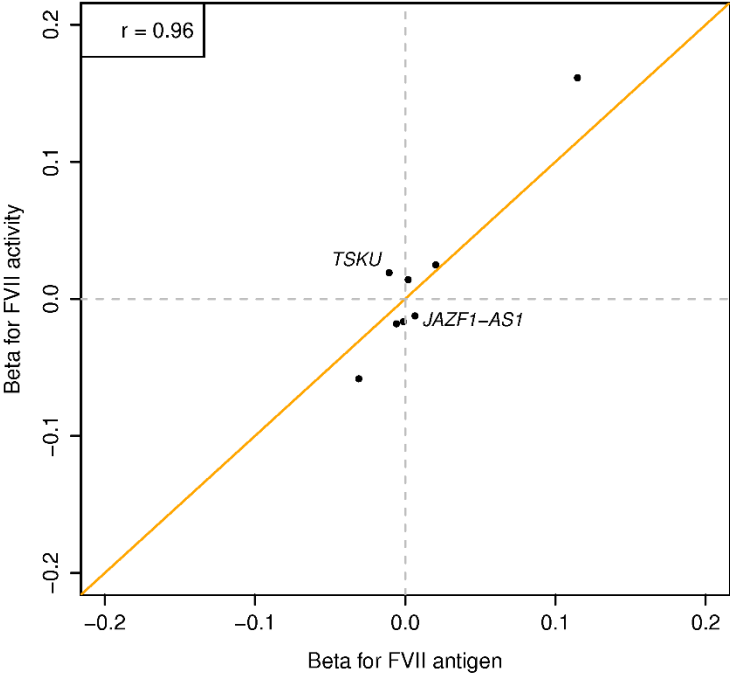


Supplementary Figure 11: Manhattan plot of the trans-ancestry combined meta-analysis of FVII activity and antigen.

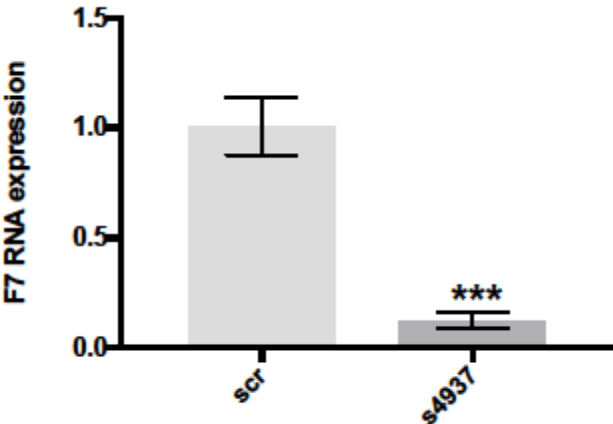


Genome-wide significant loci are annotated with the name of the closest gene. Gene names in blue indicate novel loci.

Supplementary Figure 12: Comparison of the betas for FVII activity and antigen in European-ancestry participants.



Supplementary Figure 13: Effect of silencing the *F7* gene on *F7* mRNA levels: a positive control.



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