

## Statistical Analysis Plan I6T-MC-AMAE

Relative Bioavailability of LY3074828 Solution Formulation in Pre-Filled Syringes Compared to Lyophilized Formulation After Single Subcutaneous Administration

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# STATISTICAL ANALYSIS PLAN

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## **Relative Bioavailability of LY3074828 Solution Formulation in Pre-Filled Syringes Compared to Lyophilized Formulation After Single Subcutaneous Administration**

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## 2. ABBREVIATIONS

Abbreviations pertain to the Statistical Analysis Plan (SAP) only (not the tables, figures and listings [TFLs]).

ADA	Anti-drug antibodies
AE	Adverse event
ALP	Alkaline phosphatase
ALT	Alanine aminotransferase
AUC	Area under the concentration versus time curve
AUC(0-t <sub>last</sub> )	Area under the concentration versus time curve from time zero to time t, where t is the last time point with a measurable concentration
AUC(0-∞)	Area under the concentration versus time curve from zero to infinity
%AUC(t <sub>last</sub> -∞)	Percentage of AUC(0-∞) extrapolated
BQL	Below the quantifiable lower limit of the assay
C <sub>last</sub>	Last quantifiable drug concentration
C <sub>max</sub>	Maximum observed drug concentration
CI	Confidence interval
CL/F	Apparent total body clearance of drug calculated after extra-vascular administration
CRF	Case Report Form
CRU	Clinical Research Unit
CSR	Clinical Study Report
CV	Coefficient of variation
DN-AUC(0-t <sub>last</sub> )	Dose normalized area under the concentration versus time curve from time zero to time t, where t is the last time point with a measurable concentration
DN-AUC(0-∞)	Dose normalized area under the concentration versus time curve from zero to infinity
DN-C <sub>max</sub>	Dose normalized maximum observed drug concentration
EC	Early Clinical
ECG	Electrocardiogram
e.g.	For example (Latin: <i>exempli gratia</i> )
ICH	International Conference on Harmonisation

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LLOQ	Lower limit of quantitation
MedDRA	Medical Dictionary for Regulatory Activities
MRE	Magnetic resonance elastography
PFS	Pre-filled syringe
PK	Pharmacokinetic
QTcB	QT interval corrected using Bazett's formula
QTcF	QT interval corrected using Fridericia's formula
SAP	Statistical Analysis Plan
SC	Subcutaneous
SD	Standard deviation
TFLs	Tables, Figures, and Listings
$t_{1/2}$	Half-life associated with the terminal rate constant ( $\lambda_z$ ) in non-compartmental analysis
TBL	Total bilirubin
$t_{\max}$	Time of maximum observed drug concentration
ULN	Upper limit of normal
VAS	Visual analog scale
$V_z/F$	Apparent volume of distribution during the terminal phase after extra-vascular administration
$V_{ss}/F$	Apparent volume of distribution at steady state after extra-vascular administration
WHO	World Health Organization

### 3. INTRODUCTION

This SAP has been developed after review of the Clinical Study Protocol (final version dated 05 April 2017).

This SAP describes the planned analysis of the safety, tolerability and pharmacokinetic (PK) data from this study. A detailed description of the planned TFLs to be presented in the clinical study report (CSR) is provided in the accompanying TFL shell document.

The intent of this document is to provide guidance for the statistical and PK analyses of data. In general, the analyses are based on information from the protocol, unless they have been modified by agreement between Eli Lilly and Company and Covance Early Clinical (EC) Biometrics. A limited amount of information concerning this study (e.g., objectives, study design) is given to help the reader's interpretation. This SAP must be signed off prior to first subject administration for this study. When the SAP and TFL shells are agreed upon and finalized, they will serve as the template for this study's CSR.

This SAP supersedes the statistical considerations identified in the protocol; where considerations are substantially different, they will be so identified. If additional analyses are required to supplement the planned analyses described in this SAP, they may be performed and will be identified in the CSR. Any substantial deviations from this SAP will be agreed upon between Eli Lilly and Company and Covance EC Biometrics and identified in the CSR. Any minor deviations from the TFLs may not be documented in the CSR.

This SAP is written with consideration of the recommendations outlined in the International Conference on Harmonisation (ICH) E9 Guideline entitled Guidance for Industry: Statistical Principles for Clinical Trials<sup>1</sup> and the ICH E3 Guideline entitled Guidance for Industry: Structure and Content of Clinical Study Reports<sup>2</sup>.

### 4. STUDY OBJECTIVES

#### 4.1 Primary Objectives

- To evaluate the relative bioavailability of LY3074828 solution formulation in pre-filled syringes (PFSs) and lyophilized formulation.

#### 4.2 Secondary Objectives

- To evaluate the relative bioavailability of CCI and CCI LY3074828 solution formulations, and CCI LY3074828 solution formulation in PFSs and CCI LY3074828 lyophilized formulation.
- To assess the tolerability of LY3074828 in healthy subjects.

#### 4.3 Exploratory Objective

- To assess local tolerability and leakage of a LY3074828 lyophilized formulation and solution formulations supplied in PFSs at injection-sites.

## 5. STUDY DESIGN

Study AMAE is a single-center, randomized, parallel-treatment, open-label, Phase 1 single-dose study evaluating LY3074828 healthy subjects.

**Screening Period ( $\leq 28$  days):** Subjects should be evaluated for study eligibility  $\leq 28$  days prior to enrollment.

**Residential Period (2 days):** Fifty-four subjects who fulfill the eligibility criteria will be randomized to 1 of 3 treatment arms, with 18 subjects randomized to each arm:

- Reference: CCI LY3074828 lyophilized formulation, as three subcutaneous (SC) injections
- Test 1: CCI LY3074828 solution formulation in two PFSs, as SC injections
- Test 2: CCI LY3074828 solution formulation in four PFSs, as SC injections

Subjects will report to the clinical research unit (CRU) on Day -1 and will remain at the CRU until the scheduled procedures have been completed on Day 2, as defined in the Schedule of Activities (Section 2 of the protocol). After randomization, study drug will be administered by SC injection in the morning of Day 1 after an overnight fast. Subjects within the same enrollment group may be dosed across several days if required by the site for logistical or other purposes.

**Outpatient Follow-up Period (12 weeks):** The follow-up period will include outpatient visits for a total of 12 weeks following dose administration on Day 1 to assess tolerability and PK of LY3074828.

## 6. TREATMENTS

The following is a list of the study treatment abbreviations that will be used in the TFLs.

Study Treatment Name	Abbreviation	Treatment order in TFL
CCI LY3074828 lyophilized formulation	Reference	1
CCI LY3074828 PFS solution formulation	Test 1	2
CCI LY3074828 PFS solution formulation	Test 2	3

## 7. SAMPLE SIZE JUSTIFICATION

Approximately 54 subjects (18 per treatment arm) may be enrolled to allow evaluable data from 16 subjects from each treatment arm to be obtained. The estimated total variability (coefficient of variation [CV]) in the area under the concentration time curve (AUC) from zero to infinity (AUC[0- $\infty$ ]), AUC from time zero to time t, where t is the last time point with a measurable



concentration,  $AUC[0-t_{last}]$ , and maximum observed drug concentration ( $C_{max}$ ) was 49%, 49%, and 23%, respectively, in Study AMAA following a single SC dose of CCI LY3074828. The CV of 49% was used for precision estimates and is assumed for all treatment arms. A sample size of 48 subjects will provide a precision, in log scale, of approximately 0.32 for the geometric means ratio in  $AUC(0-\infty)$ ,  $AUC(0-t_{last})$ , and  $C_{max}$  of lyophilized to solution formulation in log scale. That is, there is a 90% probability that the half-length of the 90% confidence interval (CI) of the geometric means ratio in log scale is not larger than 0.32. Subjects who are randomized but not administered treatment, or subjects (maximum of 6) that are administered treatment but do not have PK and anti-drug antibodies (ADA) samples collected up to and including Day 57, may be replaced to ensure that approximately 16 subjects from each treatment arm may complete the study.

## 8. DEFINITION OF ANALYSIS POPULATIONS

The “Safety” population will consist of all subjects who received study drug, and have at least one postdose safety assessment.

The “Pharmacokinetic” population will consist of all subjects who received study drug and have evaluable PK data.

All protocol deviations that occur during the study will be considered for their severity/impact and will be taken into consideration when subjects are assigned to analysis populations.

## 9. STATISTICAL METHODOLOGY

### 9.1 General

Data listings will be provided for all data that is databased. Summary statistics and statistical analysis will only be presented for data where detailed in this SAP. For continuous data, summary statistics will include the arithmetic mean, arithmetic standard deviation (SD), median, min, max and N; for log-normal data (e.g. the PK parameters: AUCs and  $C_{max}$ ) the geometric mean and geometric CV% will also be presented. For categorical data, frequency count and percentages will be presented. Data listings will be provided for all subjects up to the point of withdrawal, with any subjects excluded from the relevant population highlighted. Summary statistics and statistical analyses will generally only be performed for subjects included in the relevant analysis population. For the calculation of summary statistics and statistical analysis, unrounded data will be used.

Mean change from baseline is the mean of all individual subjects’ change from baseline values. Each individual change from baseline will be calculated by subtracting the individual subject’s baseline value from the value at the timepoint. The individual subject’s change from baseline values will be used to calculate the mean change from baseline using a SAS procedure such as Proc Univariate.

Data analysis will be performed using SAS® Version 9.3 or greater.



## 9.2 Demographics and Subject Disposition

Subject disposition will be listed. The demographic variables age, sex, race, ethnicity, body weight, height and body mass index will be summarized and listed. All other demographic variables will be listed.

## 9.3 Pharmacokinetic Assessment

### 9.3.1 Pharmacokinetic Analysis

The PK parameter estimates will be determined using non-compartmental procedures in validated software program (Phoenix WinNonlin Version 6.4.1 or later).

Plasma concentrations of LY3074828 will be used to determine the following PK parameters, when possible:

Parameter	Units	Definition
AUC(0-t <sub>last</sub> )	day*µg/mL	area under the concentration versus time curve from time zero to time t, where t is the last time point with a measurable concentration
DN-AUC(0-t <sub>last</sub> )	NA	dose normalized area under the concentration versus time curve from time zero to time t, where t is the last time point with a measurable concentration
AUC(0-∞)	day*µg/mL	area under the concentration versus time curve from zero to infinity
DN-AUC(0-∞)	NA	dose normalized area under the concentration versus time curve from zero to infinity
%AUC(t <sub>last</sub> -∞)	%	percentage of AUC(0-∞) extrapolated
C <sub>max</sub>	µg/mL	maximum observed drug concentration
DN-C <sub>max</sub>	NA	dose normalized maximum observed drug concentration
t <sub>max</sub>	day	time of maximum observed drug concentration
t <sub>1/2</sub>	day	half-life associated with the terminal rate constant ( $\lambda_z$ ) in non-compartmental analysis
CL/F	L/day	apparent total body clearance of drug calculated after extra-vascular administration
V <sub>Z</sub> /F	L	apparent volume of distribution during the terminal phase after extra-vascular administration
V <sub>ss</sub> /F	L	apparent volume of distribution at steady state after extra-vascular administration

Additional PK parameters may be calculated, as appropriate. The software and version used for the final analyses will be specified in the CSR. Any exceptions or special handling of data will be clearly documented within the final study report.

Formatting of tables, figures and abbreviations will follow the Eli Lilly Global PK/PD/TS Tool: NON-COMPARTMENTAL PHARMACOKINETIC STYLE GUIDE. The version of the tool effective at the time of PK analysis will be followed.

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## General PK Parameter Rules

- Actual sampling times will be used in the final analyses of individual PK parameters, except for non-bolus pre-dose sampling times which will be set to zero. For non-bolus, multiple dose profiles, the pre-dose time will be set to zero unless a time deviation falls outside of the protocol blood collection time window which is considered to impact PK parameter derivation.
- $C_{\max}$  and  $t_{\max}$  will be reported from observed values. If  $C_{\max}$  occurs at more than one time point,  $t_{\max}$  will be assigned to the first occurrence of  $C_{\max}$ .
- AUC parameters will be calculated using a combination of the linear and logarithmic trapezoidal methods (linear-log trapezoidal rule). The linear trapezoidal method will be applied up to  $t_{\max}$  and then the logarithmic trapezoidal method will be used after  $t_{\max}$ . The minimum requirement for the calculation of AUC will be the inclusion of at least three consecutive plasma concentrations above the lower limit of quantitation (LLOQ), with at least one of these concentrations following  $C_{\max}$ . AUC(0- $\infty$ ) values where the percentage of the total area extrapolated is more than 20% will be flagged. Any AUC(0- $\infty$ ) value excluded from summary statistics will be noted in the footnote of the summary table.
- Half-life ( $t_{1/2}$ ) will be calculated, when appropriate, based on the apparent terminal log-linear portion of the concentration-time curve. The start of the terminal elimination phase for each subject will be defined by visual inspection and generally will be the first point at which there is no systematic deviation from the log-linear decline in plasma concentrations. Half-life will only be calculated when a reliable estimate for this parameter can be obtained comprising of at least 3 data points. If  $t_{1/2}$  is estimated over a time window of less than 2 half-lives, the values will be flagged in the data listings. Any  $t_{1/2}$  value excluded from summary statistics will be documented in the footnote of the summary table.
- A uniform weighting scheme will be used in the regression analysis of the terminal log-linear portion of the concentration-time curve.
- The parameters based on the observed last quantifiable drug concentration ( $C_{\text{last}}$ ) will be reported.

## Individual PK Parameter Rules

- Only quantifiable concentrations will be used to calculate PK parameters with the exception of special handling of certain concentrations reported below the lower limit of quantitation (BQL). Plasma concentrations reported as BQL will be set to a value of zero when all of the following conditions are met:
  - The compound is non-endogenous.
  - The samples are from the initial dose period for a subject.

- The time points occur before the first quantifiable concentration.
- All other BQL concentrations that do not meet the above criteria will be set to missing.
- Also, where two or more consecutive concentrations are BQL towards the end of a profile, the profile will be deemed to have terminated and therefore any further quantifiable concentrations will be set to missing for the calculation of the PK parameters unless it is considered to be a true characteristic of the profile of the drug.

#### **Individual Concentration vs. Time Profiles**

- Individual concentrations will be plotted utilizing actual sampling times.
- The terminal point selections will be indicated on a semi-logarithmic plot.

#### **Average Concentration vs. Time Profiles**

- The average concentration profiles will be graphed using scheduled (nominal) sampling times.
- The average concentration profiles will be graphed using arithmetic average concentrations.
- The pre-dose average concentration for single-dose data from non-endogenous compounds will be set to zero. Otherwise, only quantifiable concentrations will be used to calculate average concentrations.
- Concentrations at a sampling time exceeding the sampling time window specified in the protocol, or  $\pm 10\%$ , will be excluded from the average concentration profiles.
- Concentrations excluded from the mean calculation will be documented in the final study report.
- A concentration average will be plotted for a given sampling time only if 2/3 of the individual data at the time point have quantifiable measurements that are within the sampling time window specified in the protocol or  $\pm 10\%$ . An average concentration estimated with less than 2/3 but more than 3 data points may be displayed on the mean concentration plot if determined to be appropriate and will be documented within the final study report.

#### **Treatment of Outliers during Pharmacokinetic Analysis**

Application of this procedure to all PK analyses is not a requirement. Rather, this procedure provides justification for exclusion of data when scientifically appropriate. This procedure describes the methodology for identifying an individual value as an outlier for potential exclusion, but does not require that the value be excluded from analysis. The following methodology will not be used to exclude complete profiles from analysis.

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#### Data within an Individual Profile

A value within an individual profile may be excluded from analysis if any of the following criteria are met:

- For PK profiles during single dosing of non-endogenous compounds, the concentration in a pre-dose sample is quantifiable.
- For any questionable datum that does not satisfy the above criteria, the profile will be evaluated and results reported with and without the suspected datum.

#### Data between Individual Profiles

1. If  $n < 6$ , then the dataset is too small to conduct a reliable range test. Data will be analyzed with and without the atypical value, and both sets of results will be reported.
2. If  $n \geq 6$ , then an objective outlier test will be used to compare the atypical value to other values included in that calculation:
  - a. Transform all values in the calculation to the logarithmic domain.
  - b. Find the most extreme value from the arithmetic mean of the log transformed values and exclude that value from the dataset.
  - c. Calculate the lower and upper bounds of the range defined by the arithmetic mean  $\pm 3 \times \text{SD}$  of the remaining log-transformed values.
  - d. If the extreme value is within the range of arithmetic mean  $\pm 3 \times \text{SD}$ , then it is not an outlier and will be retained in the dataset.
  - e. If the extreme value is outside the range of arithmetic mean  $\pm 3 \times \text{SD}$ , then it is an outlier and will be excluded from analysis.

If the remaining dataset contains another atypical datum suspected to be an outlier and  $n \geq 6$  following the exclusion, then repeat step 2 above. This evaluation may be repeated as many times as necessary, excluding only one suspected outlier in each iteration, until all data remaining in the dataset fall within the range of arithmetic mean  $\pm 3 \times \text{SD}$  of the log-transformed values.

#### Reporting of Excluded Values

Individual values excluded as outliers will be documented in the final report. Approval of the final report will connote approval of the exclusion.

### **9.3.2 Pharmacokinetic Statistical Methodology**

Log-transformed DN-AUC(0- $\infty$ ), DN-AUC(0- $t_{\text{last}}$ ), and DN- $C_{\text{max}}$  will be evaluated in a linear fixed-effects model with a fixed effect for formulation. If leakage occurs frequently, whether injection-site leakage occurred (yes/no) may also be included as a covariate in the model. Furthermore, if leakage is found to be significant, the amount of leakage will also be added to the

model. The formulation differences will be back transformed to present the ratios of geometric least squares means and the corresponding 90% CI.

A single linear model with contrasts will be used for all of the following comparisons:

- Primary objective: CCI LY3074828 PFS solution formulation versus CCI LY3074828 lyophilized formulation
- Secondary Objective: CCI LY3074828 PFS solution formulation versus CCI LY3074828 PFS solution formulation
- Secondary Objective: CCI LY3074828 PFS solution formulation versus CCI LY3074828 lyophilized formulation

Example SAS code:

```
proc mixed data=xxx;  
  by parameter;  
  class formulation ISLoccur;  
  model log_pk = formulation ISLoccur ISLamount / residual;  
  lsmeans formulation / alpha=0.1 cl pdiff;  
  ods output lsmeans=lsmeans;  
  ods output diffs=diffs;  
run;
```

The tmax will be analyzed using a Wilcoxon rank sum test for all of the above comparisons. Estimates of the median difference, 90% CIs, and p-values from the Wilcoxon rank sum test will be calculated.

Additional PK analyses may be conducted if deemed appropriate.

## 9.4 Safety and Tolerability Assessments

### 9.4.1 Adverse events

Where changes in severity are recorded in the Case Report Form (CRF), each separate severity of the adverse event (AE) will be reported in the listings, only the most severe will be used in the summary tables. A pre-existing condition is defined as an AE that starts before the subject has provided written informed consent and is ongoing at consent. A non-treatment emergent AE is defined as an AE which starts after informed consent but prior to dosing. A treatment-emergent AE is defined as an AE which occurs postdose or which is present prior to dosing and becomes more severe postdose.

All AEs will be listed. Treatment-emergent AEs will be summarized by treatment, severity and relationship to the study drug. The frequency (the number of AEs, the number of subjects experiencing an AE and the percentage of subjects experiencing an AE) of treatment-emergent AEs will be summarized by treatment, Medical Dictionary for Regulatory Activities (MedDRA) version 20.0 system organ class and preferred term. The summary and frequency AE tables will be presented for all causalities and those considered related to the study drug. Any serious AEs will be tabulated.

#### 9.4.2 Concomitant medication

Concomitant medication will be coded using the World Health Organization (WHO) drug dictionary (Version December 2016). Concomitant medication will be listed.

#### 9.4.3 Clinical laboratory parameters

All clinical chemistry and hematology data will be summarized by parameter and treatment, and listed. Urinalysis data will be listed. Additionally clinical chemistry, hematology and urinalysis data outside the reference ranges will be listed.

Values for any clinical chemistry, hematology and urinalysis values outside the reference ranges will be flagged on the individual subject data listings.

#### 9.4.4 Vital signs

Vital signs data will be summarized by treatment together with changes from baseline, where baseline is defined as Day 1 predose. Figures of mean vital signs and mean changes from baseline profiles will be presented by treatment. Furthermore, values for individual subjects will be listed.

#### 9.4.5 Electrocardiogram (ECG)

ECGs will be performed for safety monitoring purposes only and will not be presented.

#### 9.4.6 Injection Site Assessment

CCI [REDACTED]

CCI [REDACTED]

CCI [REDACTED]

[REDACTED]

[REDACTED]



CCI

CCI

#### 9.4.8 Injection Site Leakage

For the lyophilized formulation, injection-site assessments of leakage will be performed for the 2 injections in the lower quadrants of the abdomen (1.0 mL and 1.5 mL injections). For both dose levels of solution formulation in PFSSs, injection-site assessments of leakage will be performed for the first injection, which will be administered into a lower quadrant of the abdomen.

Injection site leakage data will be listed. Any bleeding from injection site will also be documented and listed.

#### 9.4.9 Immunogenicity

Immunogenicity data will be listed and frequency tables will be presented. The frequency of treatment-emergent ADAs will also be calculated. Treatment-emergent ADAs are those that are induced or boosted by exposure to study drug, with a 4-fold increase in titer compared to baseline if ADAs were detected at baseline or a titer 2-fold greater than the minimum required dilution (1:10) if no ADAs were detected at baseline.

To show the association of treatment-emergent ADAs with AEs, the frequency of treatment-emergent ADAs will be presented by MedDRA preferred term. Relationship between the presence of antibodies and the PK parameters of LY3074828 may be assessed graphically.

#### 9.4.10 Hepatic Monitoring

If a subject experiences elevated alanine aminotransferase (ALT)  $\geq 3 \times$  upper limit of normal (ULN), alkaline phosphatase (ALP)  $\geq 2 \times$  ULN, or elevated total bilirubin (TBL)  $\geq 2 \times$  ULN, liver tests will be performed to confirm the abnormality.

The subjects' liver disease history and associated person liver disease history data will be listed. Any concomitant medication of acetaminophen/paracetamol will be listed. Results from a magnetic resonance elastography (MRE) scan and biopsy assessment will be listed, if performed.

Hepatic risk factor assessment data will be listed. Liver related signs and symptoms data will be summarized by treatment and listed.

All hepatic chemistry, hematology, coagulation, and serology data will be summarized by parameter and treatment, and listed. Values outside the reference ranges will be flagged on the individual subject data listings.

#### **9.4.11 Other assessments**

All other safety assessments not detailed in this section will be listed but not summarized or statistically analyzed.

#### **9.4.12 Safety and Tolerability Statistical Methodology**

No inferential statistical analyses are planned.

### **10. INTERIM ANALYSES**

No interim statistical analyses are planned.

### **11. CHANGES FROM THE PROTOCOL SPECIFIED STATISTICAL ANALYSES**

There were no changes from the protocol specified statistical analyses.

### **12. REFERENCES**

1. International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use, ICH Harmonized Tripartite Guideline, Statistical Principles for Clinical Trials (E9), 5 February 1998.
2. International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use, ICH Harmonized Tripartite Guideline, Structure and Content of Clinical Study Reports (E3), 30 November 1995.

### **13. DATA PRESENTATION**

#### **13.1 Derived Parameters**

Individual derived parameters (e.g. PK parameters) and appropriate summary statistics will be reported to three significant figures. Observed concentration data, e.g.  $C_{\max}$ , should be reported as received. Observed time data, e.g.  $t_{\max}$ , should be reported as received. N and percentage values should be reported as whole numbers. Median values should be treated as an observed parameter and reported to the same number of decimal places as minimum and maximum values.

#### **13.2 Missing Data**

Missing data will not be displayed in listings.

### **13.3                    Insufficient Data for Presentation**

Some of the TFLs may not have sufficient numbers of subjects or data for presentation. If this occurs, the blank TFL shell will be presented with a message printed in the centre of the table, such as, “No serious adverse events occurred for this study.”

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