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**Statistical Analysis Plan**

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**An Open-label, Single-arm, Phase 2 Study to Evaluate the Efficacy and Safety of Trastuzumab Deruxtecan (T-DXd) for Patients with HER2-mutant Metastatic NSCLC who have Disease Progression on or after at Least One-line of Treatment (DESTINY-Lung05)**

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## LIST OF ABBREVIATIONS

Abbreviation or special term	Explanation
ADA	Anti-drug antibodies
AE	Adverse event
AESI	Adverse event of special interest
ALP	Alkaline phosphatase
ALT	Alanine aminotransferase
AST	Aspartate aminotransferase
ATC	Anatomical Therapeutic Chemical
BLQ	Below the limit of quantification
BoR	Best objective response
BP	Blood pressure
CHF	Congestive heart failure
CI	Confidence interval
CNS-PFS	Central nervous system progression-free survival
COVID-19	Coronavirus 2019-nCoV, also referred to as severe acute respiratory syndrome coronavirus 2
CR	Complete response
CrCl	Creatinine clearance
CRO	Contract research organisation
CSP	Clinical study protocol
CSR	Clinical study report
CT	Computed tomography
CTCAE	Common Terminology Criteria for Adverse Events
CV	Coefficient of variation
DBL	Database lock
DCO	Data cut-off
DCR	Disease control rate
DLCO	Diffusing capacity of the lungs for carbon monoxide
DoR	Duration of response
d.p.	Decimal place
ECG	Electrocardiogram
ECHO	Echocardiogram
ECOG	Eastern Cooperative Oncology Group

Abbreviation or special term	Explanation
eCRF	Electronic case report form
EOT	End of treatment
FAS	Full analysis set
FEV1	Forced expiratory volume in 1 second
FEV6	Forced expiratory volume in 6 seconds
FiO <sub>2</sub>	Fraction of inspired oxygen
HER2	Human epidermal growth factor receptor 2
HRCT	High resolution CT scan
ICF	Informed consent form
ICR	Independent central review
ILD	Interstitial lung disease
ITT	Intent-to-treat
IV	Intravenous
LD	Longest diameter
LLOQ	Lower limit of quantification
LV	Left ventricular
LVEF	Left ventricular ejection fraction
MedDRA	Medical Dictionary for Regulatory Activities
MI	Myocardial infarction
MRI	Magnetic resonance imaging
MUGA	Multigated acquisition scan
NA	Not applicable
nAb	Neutralising ADAs
NC	Not calculable
NCI	National Cancer Institute
NE	Not evaluable
NED	No evidence of disease
NQ	Not quantifiable
NTL	Non-target lesion
NYHA	New York Heart Association
OAE	Other significant adverse events
ORR	Objective response rate
OS	Overall survival
PD	Progressive disease

Abbreviation or special term	Explanation
PEF	Peak expiratory flow
PFS	Progression-free survival
PK	Pharmacokinetics
PR	Partial response
PS	Performance status
PT	Preferred term
QTc	Corrected QT interval
QTcF	QT interval corrected by Fridericia's formula
RDI	Relative dose intensity
RECIST 1.1	Response Evaluation Criteria in Solid Tumours, Version 1.1
RES	Response evaluable set
SAE	Serious adverse events
SAF	Safety analysis set
SAP	Statistical analysis plan
SD	Stable disease
SoA	Schedule of Activities
SOC	System organ class
SpO <sub>2</sub>	Pulse oximetry
T-DXd	Trastuzumab deruxtecan
TEAE	Treatment emergent adverse events
TL	Target lesion
TLC	Total lung capacity
TTR	Time to response
ULN	Upper limit of normal
WHO-DD	World Health Organisation Drug Dictionary

## AMENDMENT HISTORY

Section Number Change refer to:	Version/Date	Brief description of change	Chang from CSP	Rationale
N/A	V1.0 (07 October 2022)	N/A – version 1.0	N/A	N/A
Section 2.1	V2.0 (22 September 2023)	Updated description on the analyses based on ITT and RES	Yes	To improve previous content
Section 2.2	V2.0 (22 September 2023)	Added exclusion criteria 15 to IPD categories	NA	To improve previous content
Section 3.1.1	V2.0 (22 September 2023)	Updated rules for TL visit responses determination subsequent to CR	NA	To improve previous content
Section 3.2.2.6	V2.0 (22 September 2023)	Added source for last known alive date	NA	To improve previous content
Section 3.2.2.7	V2.0 (22 September 2023)	Added the censoring rule for 2 or more consecutive missing visits for CNS-PFS and clarified evaluable requirement for participants with baseline CNS metastasis.	NA	To improve previous content
Section 3.3.1	V2.0 (22 September 2023)	Added definition for patient-year exposure.	No	To improve previous content.
Section 3.3.10.1	V2.0 (22 September 2023)	Added time window derivation for EOT and post-treatment 40 day safety follow-up visit.	No	To improve previous content
Section 3.3.10.2	V2.0 (22 September 2023)	Added additional consideration for imputing partial missing prior anticancer therapy start date	No	To improve previous content.
Section 3.7.1	V2.0 (22 September 2023)	Updated definition for concomitant therapy	No	To align with AstraZeneca oncology TA template.



Section Number Change refer to:	Version/Date	Brief description of change	Chang from CSP	Rationale
Section 4.2.1	V2.0 (22 September 2023)	<ol style="list-style-type: none"> <li>1) Added analysis for concordance of confirmed ORR.</li> <li>2) Added summary tables for onset of confirmed response in relation to study treatment and subsequent anticancer therapy.</li> <li>3) Added forest plot for ORR subgroup analysis.</li> <li>4) Removed unnecessary subgroups</li> </ol>	No	To improve previous content.
Section 4.2.5	V2.0 (22 September 2023)	Added summaries of subsequent cancer therapy in relation to progression.	No	To improve previous content.
Section 4.2.11	V2.0 (22 September 2023)	Updated scope of ADA listing to include only ADA positive records	No	To improve previous content.
Section 4.2.12.1	V2.0 (22 September 2023)	<ol style="list-style-type: none"> <li>1) Added summaries for adverse events by selected group term or preferred term.</li> <li>2) Updated analysis for all death.</li> <li>3) Renamed adverse event of special interest PT term from “left ventricular ejection fraction decrease” to “left ventricular dysfunction”.</li> <li>4) Added details to the treatment-emergent adverse event definition.</li> <li>5) Updated summaries for death to reflect death within and outside treatment-emergent period</li> </ol>	No	To improve previous content.
Section 4.2.12.3	V2.0 (22 September 2023)	Added listing for vital signs	No	To improve previous content.

<b>Section Number Change refer to:</b>	<b>Version/Date</b>	<b>Brief description of change</b>	<b>Chang from CSP</b>	<b>Rationale</b>
Section 4.2.12.5	V2.0 (22 September 2023)	Re-categorised laboratory parameters presented in CTCAE grade shift outputs	No	To improve previous content.
Section 4.2.12.8	V2.0 (22 September 2023)	Added analyses for left ventricular ejection fraction (LVEF).	No	To improve previous content.
Section 4.2.13	V2.0 (22 September 2023)	1) Additional details to baseline disease characteristics. 2) Removed analysis for discrepancies between local and central tissue testing.	No	To improve previous content.
Section 4.2.15	V2.0 (22 September 2023)	Exploratory safety summary added for COVID-19.	No	To improve previous content.
Section 4.2.16	V2.0 (22 September 2023)	Added PFS and OS to the analysis scope of first DCO	Yes	PFS is expected to be mature and present both PFS and OS information to provide comprehensive evaluation for efficacy
Section 6	V2.0 (22 September 2023)	Added descriptions for changes of analysis from protocol	Yes	To improve previous content.

# 1 STUDY DETAILS

This statistical analysis plan (SAP) contains a more detailed description of the analyses in the clinical study protocol (CSP). This current SAP is based on the version 2.0 of the CSP.

## 1.1 Study objectives

The objectives for this study and the corresponding endpoints are shown in [Table 1](#).

**Table 1 Study objectives and corresponding endpoints**

Objectives	Endpoints
<b>Primary</b>	
To evaluate confirmed ORR by ICR of T-DXd in participants with HER2-mutant NSCLC.	Confirmed ORR, defined as the proportion of participants with confirmed CR or PR, as assessed by ICR based on RECIST 1.1.
<b>Secondary</b>	
To evaluate confirmed ORR by investigator assessment.	Confirmed ORR, by investigator assessment based on RECIST 1.1.
To evaluate DoR, DCR, BOR, PFS, and OS.	<ul style="list-style-type: none"> <li>• DoR, defined as time from the initial confirmed response (CR or PR) until documented tumour progression or death from any cause. DoR will be assessed by ICR and by the investigator based on RECIST 1.1.</li> <li>• DCR, defined as the proportion of participants who achieved confirmed CR, PR, or SD during study intervention. DCR will be assessed by ICR and by the investigator based on RECIST 1.1.</li> <li>• BOR, is a participant's best confirmed response during their participation in the study, but prior to starting any subsequent anticancer therapy, up until RECIST 1.1-defined progression or the last evaluable assessment in the absence of RECIST 1.1-defined progression. BOR will be assessed by ICR and by the investigator based on RECIST 1.1.</li> <li>• PFS, defined as the time from date of enrolment until first objective radiographic tumour progression or death from any cause. PFS will be assessed by ICR and by the investigator based on RECIST 1.1.</li> <li>• OS, defined as the time from date of enrolment until death from any cause.</li> </ul>
To evaluate CNS-PFS.	CNS-PFS, defined as the time from date of enrolment until CNS tumour progression per RECIST 1.1 as

Objectives	Endpoints
	assessed by ICR or death due to any cause in the absence of CNS progression.
To evaluate the PK and immunogenicity of T-DXd.	<ul style="list-style-type: none"> <li>• Serum concentrations of intact T-DXd, total anti-HER2 antibody, and DXd, and evaluation of appropriate PK parameters. T-DXd PK data will also be analysed via a PopPK approach if data allows.</li> <li>• Presence of ADAs against T-DXd in serum. Neutralising ADAs will also be assessed.</li> </ul>
Safety	
To evaluate the safety and tolerability of T-DXd.	Occurrence of TEAEs, SAEs and AESIs, physical examination findings, ECOG PS, vital sign measurements, standard clinical laboratory parameters, ECG parameters, ECHO/MUGA findings, and ophthalmologic findings.
Tertiary/Exploratory	
CCI [REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]

ADA = anti-drug antibody; AESI = adverse event of special interest; BOR = best observed response; CNS-PFS = central nervous system progression-free survival; CR = complete response; DCR = disease control rate; DoR = duration of response; DXd = MAAA-1181a; ECG = electrocardiogram; ECHO = echocardiogram; ECOG PS = Eastern Cooperative Oncology Group performance status; HER2 = human epidermal growth factor receptor 2; ICR = independent central review; MUGA = multiple gated acquisition; NSCLC = non-small cell lung cancer; ORR = objective response rate; OS = overall survival; PFS = progression-free survival; PK = pharmacokinetic(s); PopPK = population pharmacokinetic(s); PR = partial response; RECIST 1.1 = Response Evaluation Criteria in Solid Tumours, Version 1.1; SAE = serious adverse event; SD = stable disease; T-DXd = trastuzumab deruxtecan; TEAE = treatment emergent adverse event; CCI [REDACTED]

## 1.2 Study design

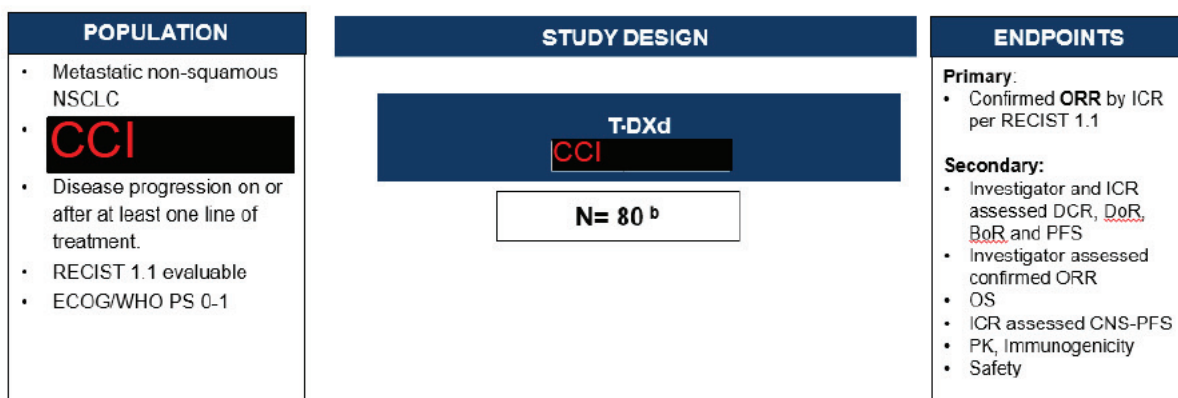
This is a Phase 2, open label, single-arm multicentre study in China assessing the efficacy and safety of T-DXd in participants with metastatic non-squamous non-small cell lung cancer (NSCLC) whose tumours have a HER2 exon 19 or 20 mutation, with disease progression on or after at least one-line of treatment.



After signing the informed consent form (ICF), participants will begin screening procedures. Following completion of all screening procedures and documentation of all baseline assessments, eligible participants are enrolled in the study. Enrolled participants will receive T-DXd at CCI [REDACTED]. Participants will continue to receive T-DXd until PD per RECIST 1.1 as assessed by the investigator, unless unacceptable toxicity, withdrawal of consent, or other criterion for withdrawal is met (with the exception of CNS-only progression).

An overview of the study design is shown in Figure 1.

**Figure 1 Overview of study design**



[REDACTED]

[REDACTED]

BOR = best observed response; CNS = central nervous system; DCR = disease control rate; DoR = duration of response; ECOG PS = Eastern Cooperative Oncology Group performance status; HER2 = human epidermal growth factor receptor 2; ICR = independent central review; N = number of patients; NSCLC = non-small cell lung cancer; ORR = objective response rate; OS = overall survival; PFS = progression-free survival; PK = pharmacokinetic(s); CCI [REDACTED] RECIST 1.1 = Response Evaluation Criteria in Solid Tumours, Version 1.1; T-DXd = trastuzumab deruxtecan; WHO = World Health Organisation.

### 1.3 Number of subjects

Approximately 80 participants in China with metastatic non-squamous NSCLC whose tumours have a HER2 exon 19 or 20 mutation, with disease progression on or after at least

one-line of treatment will be enrolled to study intervention. This is to ensure that approximately 66 participants enrolled in the study have study qualifying activating HER2 exon 19 or 20 mutation assessed by central laboratory as these participants will form the basis of the primary analysis population.



## 2 ANALYSIS SETS

### 2.1 Definition of Analysis Sets

Analysis populations for this study are defined in [Table 2](#). A summary of the analysis populations used for each outcome variable is provided in [ADA](#), anti-drug antibody; [HER2](#), Human epidermal growth factor receptor 2; [ICF](#), informed consent form; [ICR](#), independent central review; [PK](#), pharmacokinetic(s); [T-DXd](#), trastuzumab deruxtecan.

Table 3.

**Table 2 Populations for Analysis**

Population/Analysis Set	Description
Intent-to-treat (ITT) Analysis Set	All participants who signed an ICF and were enrolled in the study. Note: “enrolled” refers to participants confirmed as eligible and with treatment assigned in the IRT. Participants who sign an ICF, but are not enrolled, are considered “screen failures”.
Full analysis set (FAS)	All enrolled participants with HER2 exon 19 or 20 mutation assessed by central laboratory.
Safety analysis set (SAF)	All enrolled participants who have received at least 1 dose of study intervention.
Response evaluable set (RES)	All enrolled participants with HER2 exon 19 or 20 mutation assessed by central laboratory who received at least 1 dose of study intervention and had measurable disease at baseline by ICR.
PK analysis set	All enrolled participants who have received at least 1 dose of study intervention and had at least 1 post-dose measurable serum concentration of T-DXd.
T-DXd ADA evaluable set	All participants in the Safety Analysis Set with a non-missing baseline T-DXd ADA result and at least one non-missing post-baseline T-DXd ADA result.

[ADA](#), anti-drug antibody; [HER2](#), Human epidermal growth factor receptor 2; [ICF](#), informed consent form; [ICR](#), independent central review; [PK](#), pharmacokinetic(s); [T-DXd](#), trastuzumab deruxtecan.

**Table 3 Summary of Outcome Variables and Analysis Populations**

Outcome variable	Population(s)
<b>Primary Efficacy Variable</b>	
• Confirmed ORR by ICR per RECIST 1.1	Primary analysis: FAS Supplementary analyses: ITT Analysis Set, RES (only if differ from FAS)
<b>Secondary Efficacy Variables</b>	
• Confirmed ORR by investigator assessment per RECIST 1.1 • DoR, DCR, BOR, and PFS, by ICR and by investigator assessment per RECIST 1.1 • OS • CNS-PFS	FAS <sup>a</sup> Supplementary analyses: ITT Analysis Set <sup>a</sup> (only for ORR, DoR, PFS and OS, only if differ from FAS)
<b>Baseline and Other Variables</b>	
• Demography, baseline, and disease characteristics • Important deviations • Medical/surgical history • Previous and subsequent anticancer therapy • Concomitant medications/procedures	Primary analysis: FAS Supplementary analyses: ITT Analysis Set (only for demography, disease characteristics and important deviations, only if differ from FAS)
<b>Pharmacokinetics</b>	
• PK data	PK analysis set
<b>Immunogenicity</b>	
• ADAs	T-DXd ADA evaluable set
<b>Safety</b>	
• Exposure to study intervention • Safety data	SAF

<sup>a</sup> DoR analysis will be based on the subset of participants in the corresponding analysis population who achieved confirmed response.

ADA, anti-drug antibody; AE, adverse event; CNS-PFS, progression-free survival in central nervous system; DoR, duration of response; ECG, electrocardiogram; FAS, full analysis set; ICR, independent central review; ITT, Intent-to-treat; ORR, objective response rate; ORR, objective response rate; OS, overall survival; PFS, progression-free survival; PK, pharmacokinetic(s); RECIST 1.1, Response Evaluation Criteria in Solid Tumours, Version 1.1; SAF, safety analysis set; T-DXd, trastuzumab deruxtecan.

## 2.2 Protocol deviations

The following general categories will be considered important protocol deviations (IPDs) and will be programmatically identified from the electronic Case Report Form (eCRF) data or detected via site monitoring. These will be listed and discussed in the clinical study report (CSR) as appropriate (see protocol deviation plan for more details):

- Patients who deviate from key inclusion criteria per the CSP (Deviation code 1): 1, 3, 4, 5, 7, 8, 9, 10, 12.
- Patients who deviate from key exclusion criteria per the CSP (Deviation code 2): 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14,15, 16, 17, 18, 21.
- Discontinuation criteria for study treatment met but patient not withdrawn from study treatment (Deviation code 3).

- Investigational product deviation (Deviation code 5)
  - Patient enrolled but who received their study treatment at an incorrect dose or received an alternative study treatment to that which was intended for them.
  - Patient enrolled but who received a dose less than 19 days after the previous one, or more than 126 days after the previous one.
  - Patient enrolled but who did not receive study treatment.
- Received prohibited concomitant medications (including other anti-cancer agents) (Deviation code 6). Please refer to the CSP section 6.5.1 for those medications that are detailed as being ‘excluded’ from permitted use during the study. This will be used as a guiding principle for the physician review of all medications prior to database lock (DBL).
- Study procedure deviations (Deviation code 7)
  - Baseline RECIST scan > 28 days before enrolment.
  - No baseline RECIST 1.1 assessment on or before date of enrolment.
  - Failure to perform mandatory ILD test (HRCT) in case of potential ILD, as per CSP
  - Failure to perform mandatory safety assessment(s) in  $\geq 2$  consecutive visits.

The important protocol deviations will be listed and summarised. The third category of Deviation code 5 would lead to exclusion from the safety analysis set and the RES. None of the other deviations will lead to patients being excluded from the analysis sets described in Section 2.1 (with the exception of the PK analysis set, if the deviation is considered to impact upon PK). A per-protocol analysis excluding patients with specific important protocol deviations is not planned. However, a ‘deviation bias’ sensitivity analysis may be performed on the objective response rate endpoint, excluding patients with deviations that may affect the efficacy evaluation if the deviations happen in > 10% of patients.

Any other deviations from monitoring notes or reports will be reported in an appendix to the CSR.

## **3 PRIMARY AND SECONDARY VARIABLES**

### **3.1 Derivation of RECIST Visit Responses**

For all patients, the RECIST tumour response data will be used to determine each patient’s visit response according to RECIST version 1.1. It will also be used to determine if and when a patient has progressed in accordance with RECIST and their best objective response to study treatment.



Baseline radiological tumour assessments are to be performed no more than 28 days before enrolment and ideally as close as possible to and prior to the start of study treatment. Tumour assessments are then performed every 6 weeks ( $\pm 1$  week) from the date of enrolment for 48 weeks, and then every 9 weeks ( $\pm 1$  week) thereafter, starting at Week 57 until RECIST 1.1-defined radiological PD per investigator assessment (plus one additional follow-up scan [4 weeks later], if clinically feasible). In the case of CNS-only progression, participants continuing to receive study intervention should follow the on-treatment data collection schedule, including RECIST 1.1 tumour assessments, until a second progression (CNS or body; plus one additional follow-up scan [4 weeks later], if clinically feasible).

If an unscheduled assessment is performed, and the patient has not progressed, every attempt should be made to perform the subsequent assessments at their scheduled visits. This schedule is to be followed in order to minimise any unintentional bias caused by some patients being assessed at a different frequency than other patients.

From the investigator's review of the imaging scans, the RECIST tumour response data will be used to determine each patient's visit response according to RECIST version 1.1. At each visit, patients will be programmatically assigned a RECIST 1.1 visit response of complete response (CR), partial response (PR), stable disease (SD) or progressive disease (PD), using the information from target lesions (TLs), non-target lesions (NTLs) and new lesions and depending on the status of their disease compared with baseline and previous assessments. If a patient has had a tumour assessment that cannot be evaluated then the patient will be assigned a visit response of not evaluable (NE), unless there is evidence of progression in which case the response will be assigned as PD.

Please refer to Sections [3.1.1](#), [3.1.2](#) and [3.1.3](#) for the definitions of CR, PR, SD and PD.

RECIST outcomes (i.e., ORR, DoR, DCR, BoR, PFS and TTR) will be calculated programmatically for the site investigator data (see Section [3.2](#)) from the overall visit responses.

### **3.1.1 Target lesions (TLs) – site investigator data**

Measurable disease is defined as having at least one measurable lesion, not previously irradiated, which is  $\geq 10$  mm in the longest diameter (LD), (except lymph nodes which must have short axis  $\geq 15$  mm) with computed tomography (CT) or magnetic resonance imaging (MRI) and which is suitable for accurate repeated measurements. A patient can have a maximum of five measurable lesions recorded at baseline with a maximum of two lesions per organ (representative of all lesions involved and suitable for accurate repeated measurement) and these are referred to as TLs. Note that lymph nodes also constitute an organ. If more than one baseline scan is recorded, then measurements from the one that is closest and prior to the

first dose of study treatment will be used to define the baseline sum of TLs. It may be the case that, on occasion, the largest lesion does not lend itself to reproducible measurement. In which circumstance the next largest lesion, which can be measured reproducibly, should be selected.

All other lesions (or sites of disease) not recorded as TL should be identified as NTLs at baseline. Measurements are not required for these lesions, but their status should be followed at subsequent visits.

Note: For patients who do not have measurable disease at entry (i.e. no TLs) but have non-measurable disease, evaluation of overall visit responses will be based on the overall NTL assessment and the absence/presence of new lesions (see Section 3.1.3 for further details). If a patient does not have measurable disease at baseline then the TL visit response will be not applicable (NA).

**Table 4 TL Visit Responses (RECIST 1.1)**

Visit Responses	Description
Complete response (CR)	Disappearance of all TLs since baseline. Any pathological lymph nodes selected as TLs must have a reduction in short axis to <10mm.
Partial response (PR)	At least a 30% decrease in the sum of diameters of TLs, taking as reference the baseline sum of diameters as long as criteria for PD are not met.
Stable disease (SD)	Neither sufficient decrease in sum of diameters to qualify for PR nor sufficient increase to qualify for PD.
Progressive disease (PD)	A $\geq 20\%$ increase in the sum of diameters of TLs and an absolute increase of $\geq 5\text{mm}$ , taking as reference the smallest sum of diameters since treatment started including the baseline sum of diameters.
Not evaluable (NE)	Only relevant if any of the TLs at follow-up were not assessed or not evaluable (e.g., missing anatomy) or had a lesion intervention at this visit. Note: If the sum of diameters meets the progressive disease criteria, progressive disease overrides not evaluable as a TL response.
Not applicable (NA)	Only relevant if no TLs are recorded at baseline.

### Rounding of TL data

For calculation of PD and PR for TLs, percentage changes from baseline and previous minimum should be rounded to one decimal place (d.p.) before assigning a TL response. For example, 19.95% should be rounded to 20.0% but 19.94% should be rounded to 19.9%.

## Missing TL data

If all TL measurements are missing, then the TL visit response will be NE.

If the sum of **available** TLs is sufficiently increased to result in a 20% increase, and an absolute increase of  $\geq 5$ mm from nadir even assuming the non-recorded TLs have disappeared, the TL visit response will be PD. Note: the nadir can only be taken from assessments where all the TLs had a LD recorded.

If there is at least one TL measurement missing and a **TL** visit response of PD cannot be assigned, the **TL** visit response will be not evaluable (NE).

## Lymph nodes

For lymph nodes, if the size reduces to  $< 10$ mm then these are considered non-pathological. However, a size will still be given, and this size should still be used to determine the TL visit response as normal. In the special case where all lymph nodes are  $< 10$ mm and all other TLs are 0mm then although the sum may be  $> 0$ mm the calculation of TL response should be over-written as a CR.

## TL visit responses subsequent to CR

Only CR, PD or NE can follow a CR. If a CR has occurred, then the following rules at the subsequent visits must be applied:

- Step 1: If all lesions meet the CR criteria (i.e. 0mm or  $< 10$ mm for lymph nodes) then response will be set to CR irrespective of whether the criteria for PD of TL is also met i.e. if a lymph node short axis diameter increases by 20% and/or the absolute increase is  $\geq 5$  mm from nadir but remains  $< 10$ mm.
- Step 2: If some lesion measurements are missing but all other lesions meet the CR criteria (i.e. 0mm or  $< 10$ mm for lymph nodes) then response will be set to NE irrespective of whether the criteria for PD of TL is also met, i.e. if a lymph node short axis diameter increases by 20% but remains  $< 10$ mm.
- Step 3: If not all lesions are missing and those that are non-missing do not meet the CR criteria for lesions other than lymph nodes (i.e. reappearance of previously disappeared lesion) or at least one lymph node with short axis diameter which is  $\geq 10$ mm resulting in an increase in short axis diameter of  $\geq 20\%$  or and an absolute increase of  $\geq 5$ mm, then response will be set to PD.
- Step 4: If all lesions are missing the response will be set to NE.

### **TL too big to measure**

If a TL becomes too big to measure this will be indicated in the database and a size ('x') above which it cannot be accurately measured should be recorded. If using a value of x in the calculation of TL response would not give an overall visit response of PD, then this will be flagged and reviewed by the study team. A visit response of PD is expected to remain in the vast majority of cases.

### **TL too small to measure**

If a TL becomes too small to measure then this will be indicated as such on the case report form and a value of 5mm will be entered into the database and used in TL calculations. However, a smaller value may be used if the radiologist has not indicated 'too small to measure' on the case report form and has entered a smaller value that can be reliably measured. If a TL response of PD results (at a subsequent visit) then this will be reviewed by the study team.

### **TL completely disappeared**

If a lesion has completely disappeared, the diameter should be recorded as 0 mm. If a lesion appears in the same location on a subsequent scan, it will be recorded as an NL.

### **Irradiated lesions/lesion intervention**

Previously irradiated lesions (i.e. lesion irradiated prior to entry into the study) should be recorded as NTLs and should not form part of the TL assessment, unless they show objective progression, meet the other requirements for measurable lesion, and is the only lesion available.

Any TL (including lymph nodes), which has had intervention during the study (for example, irradiation / palliative surgery / embolisation), should be handled in the following way. Once a lesion has had intervention then it should be treated as having intervention for the remainder of the study noting that an intervention will most likely shrink the size of tumours:

- Step 1: the diameters of the TLs (including the lesions that have had intervention) will be summed and the calculation will be performed in the usual manner. If the visit response is PD, this will remain as a valid response category.
- Step 2: If there was no evidence of progression after step 1, treat the lesion diameter (for those lesions with intervention) as missing and if  $\leq 1/3$  of the TLs have missing measurements then scale up as described in the 'Scaling' section below. If the scaling

results in a visit response of PD then the patient would be assigned a TL response of PD.

- Step 3: If, after both steps, PD has not been assigned, then, if appropriate (i.e. if  $\leq 1/3$  of the TLs have missing measurements), the scaled sum of diameters calculated in step 2 should be used, and PR or SD then assigned as the visit response. Patients with intervention are evaluable for CR as long as all non-intervened lesions are 0 (or  $< 10\text{mm}$  for lymph nodes) and the lesions that have been subject to intervention have a value of 0 (or  $< 10\text{mm}$  for lymph nodes) recorded. If scaling up is not appropriate due to too few non-missing measurements then the visit response will be set as NE.

At subsequent visits, the above steps will be repeated to determine the TL and overall visit response. When calculating the previous minimum, lesions with intervention should be treated as missing and scaled up (as per step 2 above).

### **Scaling (applicable only for irradiated lesions/lesion intervention)**

If  $> 1/3$  of TL measurements are missing (because of intervention) then the TL response will be NE, unless the sum of diameters of non-missing TL would result in PD (i.e. if using a value of 0 for missing lesions, the sum of diameters has still increased by 20% or more compared to nadir and the sum of TLs has increased by  $\geq 5\text{mm}$  from nadir).

If  $\leq 1/3$  of the TL measurements are missing (because of intervention) then the results will be scaled up (based on the sizes at the nadir visit to give an estimated sum of diameters) and this will be used in calculations; this is equivalent to comparing the visit sum of diameters of the non-missing lesions to the nadir sum of diameters excluding the lesions with missing measurements.

### **Example of scaling**

Lesion 5 is missing at the follow-up visit; the nadir TL sum including lesions 1-5 was 74mm.

The sum of lesions 1-4 at the follow-up is 68mm. The sum of the corresponding lesions at the nadir visit is 62mm.

Scale up as follows to give an estimated TL sum of 81mm:

$$68 \times 74 / 62 = 81\text{mm}$$

CR will not be allowed as a TL response for visits where there is missing data. Only PR, SD or PD (or NE) could be assigned as the TL visit response in these cases. However, for visits

with  $\leq 1/3$  lesion assessments not recorded, the scaled up sum of TLs diameters will be included when defining the nadir value for the assessment of progression.

### **Lesions that split in two or more parts**

If a TL splits in two or more parts, then the LDs of the split lesions should be summed and reported as the LD for the lesion that split.

### **Lesions that merge**

If two or more TLs merge, then the LD of the merged lesion should be recorded for one of the TL sizes and the other TL size should be recorded as 0cm. If the merged TLs are non-nodal lesions, record the long axis diameter of the merged lesion. If pathologic lymph nodes coalesce and are no longer individually separable within a conglomerate mass, the vector of the longest diameter of the coalesced mass should be used to determine the perpendicular vector for the maximal short axis diameter.

### **Change in method of assessment of TLs**

CT and MRI are the only methods of assessment that can be used in this trial. If a change in method of assessment occurs between CT and MRI, this will be considered acceptable and no adjustment within the programming is needed.

If a change in method involves clinical examination (e.g. CT changes to clinical examination or vice versa), any affected lesions should be treated as missing.

### **3.1.2 Non-target lesions (NTLs) and new lesions – site investigator data**

At each visit, the investigator will record an overall assessment of the NTL response. This section provides the definitions of the criteria that will be used to determine and record overall response for NTL at the investigational site at each visit.

NTL response will be derived based on the investigator's overall assessment of NTLs as follows:

**Table 5 NTL Visit Responses**

<b>Visit Responses</b>	<b>Description</b>
Complete response (CR)	Disappearance of all NTLs present at baseline with all lymph nodes non-pathological in size (<10 mm short axis).
Non-CR/Non-PD	Persistence of one or more NTLs with no evidence of progression.
Progressive disease (PD)	Unequivocal progression of existing NTLs. Unequivocal progression may be due to an important progression in one lesion

	only or in several lesions. In all cases, the progression MUST be clinically significant for the physician to consider changing (or stopping) therapy.
Not evaluable (NE)	Only relevant when one or some of the NTLs were not assessed and, in the investigator's opinion, they are not able to provide an evaluable overall NTL assessment at this visit.  Note: For patients without TLs at baseline, this is relevant if any of the NTLs were not assessed at this visit and the progression criteria have not been met.
Not applicable (NA)	Only relevant if there are no NTLs at baseline.

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To achieve 'unequivocal progression' on the basis of NTLs, there must be an overall level of substantial worsening in non-target disease such that, even in the presence of SD or PR in TLs, the overall tumour burden has increased sufficiently to merit a determination of disease progression. A modest 'increase' in the size of one or more NTLs is usually not sufficient to qualify for unequivocal progression status.

Details of any new lesions will also be recorded with the date of assessment. The presence of one or more new lesions is assessed as progression.

A lesion identified at a follow up assessment in an anatomical location that was not scanned at baseline is considered a new lesion and will indicate disease progression.

The finding of a new lesion should be unequivocal: i.e. not attributable to differences in scanning technique, change in imaging modality or findings thought to represent something other than tumour.

New lesions will be identified via a Yes/No tick box. The absence and presence of new lesions at each visit should be listed alongside the TL and NTL visit responses.

A new lesion indicates progression so the overall visit response will be PD irrespective of the TL and NTL response.

If the question 'Any new lesions since baseline' has not been answered with Yes or No and the new lesion details are blank this is not evidence that no new lesions are present, but should not overtly affect the derivation.

Symptomatic progression is not a descriptor for progression of NTLs: it is a reason for stopping study therapy and will not be included in any assessment of NTLs.



Patients with ‘symptomatic progression’ requiring discontinuation of treatment without objective evidence of disease progression at that time should continue to undergo tumour assessments where possible until objective disease progression is observed.

### 3.1.3 Overall visit response – site investigator data

Table 6 defines how the previously defined TL and NTL visit responses will be combined with new lesion information to give an overall visit response.

**Table 6 Overall visit responses**

TARGET	NON-TARGET	NEW LESIONS	OVERALL VISIT RESPONSE
CR	CR or NA	No (or NE)	<b>CR</b>
CR	Non-CR/Non-PD or NE	No (or NE)	<b>PR</b>
PR	Non-PD or NE or NA	No (or NE)	<b>PR</b>
SD	Non-PD or NE or NA	No (or NE)	<b>SD</b>
PD	Any	Any	<b>PD</b>
Any	PD	Any	<b>PD</b>
Any	Any	Yes	<b>PD</b>
NE	Non-PD or NE or NA	No (or NE)	<b>NE</b>
NA	CR	No (or NE)	<b>CR</b>
NA	Non-CR/Non-PD	No (or NE)	<b>SD</b>
NA	NE	No (or NE)	<b>NE</b>

CR Complete response; NA Not applicable; NE Not evaluable; PD Progressive disease; PR Partial response; SD Stable disease.

### 3.1.4 Independent review

A planned independent central review (ICR) of all radiological imaging data will be carried out using RECIST version 1.1. All radiological scans for all patients (including those at unscheduled visits, or outside visit windows) will be collected on an ongoing basis and sent to an AstraZeneca appointed Contract Research Organisation (CRO) for central analysis. The imaging scans will be reviewed by two independent radiologists using RECIST 1.1 and will be adjudicated, if required (i.e. two reviewers’ review the scans and adjudication is performed by a separate reviewer in case of a disagreement). For each patient, the ICR defines the overall visit response (i.e. the response obtained overall at each visit by assessing TLs, NTLs and new lesions) data and no programmatic derivation of visit response will be necessary. (For patients with TLs at baseline: CR, PR, SD, PD, NE; for patients with NTLs only: CR, SD, PD, NE; for patients with no disease identified at baseline: PD, no evidence of disease [NED], NE). If a patient has had a tumour assessment that cannot be evaluated then the patient will be assigned



a visit response of NE (unless there is evidence of progression in which case the response will be assigned as PD). RECIST assessments/scans contributing towards a particular visit may be performed on different dates and for the central review the date of progression for each reviewer will be provided based on the earliest of the scan dates of the component that triggered the progression.

If adjudication is performed, the reviewer that the adjudicator agreed with will be selected as a single reviewer (note in the case of more than one review period, the latest adjudicator decision will be used). In the absence of adjudication, the records for all visits for a single reviewer will be used. The reviewer selected in the absence of adjudication will be the reviewer who read the baseline scan first. The records from the single selected reviewer will be used to report all ICR RECIST information including dates of progression, visit response, censoring and changes in target lesion dimensions. Endpoints (of ORR, PFS, DoR, best percentage change in tumour size and DCR) will be derived programmatically from this information.

Results of this independent review will not be communicated to investigators and the management of patients will be based solely upon the results of the RECIST 1.1 assessment conducted by the investigator.

An ICR of all patients will be performed prior to DBL, which will cover all of the scans up to the data cut-offs (DCOs).

Further details of the ICR will be documented in the Independent Review Charter (IRC).

## **3.2 Efficacy Variables**

### **3.2.1 Primary variable: Confirmed Objective response rate (ORR) by ICR**

The primary variable of the study is confirmed ORR by ICR according to RECIST1.1. Confirmed ORR (per RECIST 1.1 by ICR) is defined as the number (percentage) of patients with a confirmed response of CR or PR as assessed by ICR based on RECIST 1.1.

A confirmed response of CR/PR means that a response of CR/PR is recorded at 1 visit and confirmed by repeat imaging not less than 4 weeks after the visit when the response was first observed with no evidence of progression between the initial and CR/PR confirmation visit.

Data obtained up until progression, or last evaluable assessment in the absence of progression, will be included in the assessment of ORR. Patients who discontinue treatment without progression, receive a subsequent anti-cancer therapy (note that for this analysis radiotherapy is not considered a subsequent anti-cancer therapy) and then respond will not be included as

responders in the ORR (i.e. both visits contributing to a response must be prior to subsequent therapy for the patient to be considered as a responder).

In the case where a patient has two non-consecutive visit responses of PR, then, as long as the time between the 2 visits of PR is greater than 4 weeks and there is no PD between the PR visits, the patient will be defined as a responder. Similarly, if a patient has visit responses of CR, NE, CR, then, as long as the time between the 2 visits of CR is greater than 4 weeks, then a best response of CR will be assigned.

### **3.2.2 Secondary Variables**

#### **3.2.2.1 Confirmed ORR by Investigator Assessment**

The secondary efficacy endpoint of confirmed ORR is defined as the proportion of participants who have a confirmed CR or PR, as determined by the investigator at local site per RECIST 1.1.

Investigator assessed ORR will be estimated using the same methods as those specified for ORR by ICR (see Section 3.2.1).

#### **3.2.2.2 Duration of Response (DoR)**

DoR according to RECIST 1.1 by ICR and investigator assessment will be derived programmatically.

For patients who achieved a confirmed CR or PR per RECIST 1.1, DoR is defined as the time from the date of first documented response (which is subsequently confirmed) until date of documented progression or death in the absence of disease progression (i.e., date of PFS event or censoring – date of first response + 1). The end of response should coincide with the date of progression or death from any cause used for the PFS endpoint. The time of the initial response will be defined as the latest of the dates contributing towards the first visit that was CR or PR that was subsequently confirmed.

If a patient does not progress following a response, then their DoR will use the PFS censoring time. DoR will not be defined for those patients who do not have documented response.

#### **3.2.2.3 Disease Control Rate (DCR)**

DCR according to RECIST 1.1 by ICR and investigator assessment will be derived programmatically.

DCR is defined as the percentage of patients who have a confirmed CR/PR, or SD for at least 5 weeks (i.e., 6 weeks – 1 week to allow for an early assessment within the assessment window) after the date of enrolment (without subsequent anti-cancer therapy, where

radiotherapy is not considered as a subsequent anti-cancer therapy) per RECIST 1.1. DCR could be calculated as the percentage of patients with BoR of CR, PR or SD. See Section 3.2.2.4 for the BoR definition.

#### **3.2.2.4 Best Observed Response (BoR)**

BoR is calculated based on the overall visit responses from each RECIST assessment described in Section 3.1.3. It is the best response a patient has had following date of enrolment, but prior to starting any subsequent anti-cancer therapy (radiotherapy is not considered as a subsequent anti-cancer therapy), and up to and including RECIST progression or the last evaluable assessment in the absence of RECIST progression. Categorisation of BoR will be based on RECIST using the following response categories: confirmed CR, confirmed PR, SD, NED, PD and NE. Unconfirmed CR/PR will be included in SD. A BoR of NED applies only to those patients entering the study with no measurable disease at baseline.

CR or PR must be confirmed. For determination of a best response of SD, the earliest of the dates contributing towards a particular overall visit assessment will be used. SD should be recorded at least 6 weeks minus 1 week, i.e. at least 35 days (to allow for an early assessment within the assessment window), after date of enrolment. For CR/PR, the initial overall visit assessment that showed a response will use the latest of the dates contributing towards a particular overall visit assessment.

BoR will be determined programmatically based on RECIST from the overall visit response using all ICR data up until the first progression event and prior to starting any subsequent anti-cancer therapy (radiotherapy is not considered as a subsequent anti-cancer therapy). It will also be determined programmatically based on RECIST using all site investigator data up until the first progression event and prior to starting any subsequent anti-cancer therapy. The denominators for each case will be consistent with those used in the ORR analysis.

For patients whose progression event is death, BoR will be calculated based upon all evaluable RECIST assessments prior to death.

For patients who die with no evaluable RECIST assessments, if the death occurs  $\leq 91$  days (i.e.,  $2 \times 6$  weeks + 1 week to allow for a late assessment within the assessment window) after date of enrolment, then BoR will be assigned to the progression (PD) category. For patients who die with no evaluable RECIST assessments, if the death occurs  $> 91$  days after date of enrolment then BoR will be assigned to the NE category.

### 3.2.2.5 Progression free survival (PFS)

PFS according to RECIST 1.1 by ICR and investigator assessment will be derived programmatically.

PFS is defined as the time from date of enrolment until the date of objective disease progression or death (by any cause in the absence of progression) regardless of whether the patient withdraws from therapy or receives another anti-cancer therapy prior to progression (i.e. date of PFS event or censoring – date of enrolment + 1). Patients who have not progressed or died at the time of analysis will be censored at the time of the latest date of assessment from their last evaluable RECIST assessment. However, if the patient progresses or dies immediately after two or more consecutive missed visits, the patient will be censored at the time of the latest evaluable RECIST 1.1 assessment prior to the two missed visits (Note: NE visit is not considered as missed visit).

Given the scheduled visit assessment scheme (i.e. every 6 weeks from the enrolment for 48 weeks and then every 9 weeks thereafter until RECIST 1.1-defined radiological PD) the definition of two missed visits will change over time, as described in [Table 7](#).

**Table 7 PFS: Definition of 2 Missed Visits**

Timing of Previous RECIST Assessment	Definition of 2 Missed Visits
≤ study day 35	13 weeks since date of enrolment (i.e., $2 \times 6 \text{ weeks} + 1 \text{ week for a late assessment} = 13 \text{ weeks}$ )
> study day 35 and before study day 288 (i.e., week 41)	14 weeks since the previous RECIST assessment (i.e., $2 \times 6 \text{ weeks} + 1 \text{ week for an early assessment} + 1 \text{ week for a late assessment} = 14 \text{ weeks}$ )
From study day 288 and before study day 330 (i.e., week 42 to week 47)	17 weeks since the previous RECIST assessment (i.e., $6 \text{ weeks} + 9 \text{ weeks} + 1 \text{ week for an early assessment} + 1 \text{ week for a late assessment} = 17 \text{ weeks}$ )
From study day 330 onwards (i.e., week 48)	20 weeks since the previous RECIST assessment (i.e., $2 \times 9 \text{ weeks} + 1 \text{ week for an early assessment} + 1 \text{ week for a late assessment} = 20 \text{ weeks}$ )

Study day is calculated as (date of assessment – date of enrolment + 1)

If the patient has no evaluable visits or does not have baseline data they will be censored at Day 1 (date of enrolment) unless they die within two visits of baseline (12 weeks plus 1 week allowing for a late assessment within the visit window).

The PFS time will always be derived based on scan/assessment dates not visit dates.

RECIST assessments/scans contributing towards a particular visit may be performed on different dates. The following rules will be applied:

- For ICR assessments, the date of progression will be determined based on the **earliest** of the scan dates of the component that triggered the progression for the adjudicated reviewer selecting PD or of the reviewer who read baseline first if there is no adjudication for ICR data.
- For investigational assessments, the date of progression will be determined based on the **earliest** of the dates of the component that triggered the progression.
- For both ICR and investigational assessments, when censoring a patient for PFS the patient will be censored at the **latest** of the dates contributing to a particular overall visit assessment.

Note: for TLs only the latest scan date is recorded out of all scans performed at that assessment for the TLs and similarly for NTLs only the latest scan date is recorded out of all scans performed at that assessment for the NTLs.

#### 3.2.2.6 Overall survival (OS)

Overall survival (OS) is defined as the time from the date of enrolment until death due to any cause regardless of whether the patient withdraws from study treatment or receives another anti-cancer therapy (i.e. date of death or censoring – date of enrolment + 1). Any patient not known to have died at the time of analysis will be censored based on the last recorded date on which the patient was known to be alive.

Note: Survival calls will be made in the week following the date of each DCO for analysis, and if patients are confirmed to be alive or if the death date is post the DCO date these patients will be censored at the date of DCO. The status of ongoing, withdrawn (from the study) and “lost to follow-up” patients at the time of the final OS analysis should be obtained by the site personnel by checking the patient’s notes, hospital records, contacting the patient’s general practitioner and checking publicly-available death registries. In the event that the patient has actively withdrawn consent to the processing of their personal data, the vital status of the patient can be obtained by site personnel from publicly available resources where it is possible to do so under applicable local laws.

Note: For any OS analysis performed prior to the final OS analysis, in the absence of survival calls being made, it may be necessary to use all relevant CRF fields to determine the last recorded date on which the patient was known to be alive for those patients still on treatment (since the SURVIVE module is only completed for patients off treatment if a survival sweep

is not performed). The last date for each individual patient is defined as the latest among the following dates recorded on the CRFs:

- Adverse event (AE) start and stop dates
- Admission and discharge dates of hospitalisation
- Study treatment date
- End of treatment date
- Laboratory test dates
- Date of vital signs
- Disease assessment dates on RECIST CRF
- Start and stop dates of alternative anticancer treatment
- Date last known alive on survival status CRF
- Decision date in Patient Follow Up Checklist CRF
- End of study date

### **3.2.2.7 CNS-PFS**

CNS-PFS according to RECIST 1.1 by ICR will be derived programmatically.

CNS-PFS is defined as the time from the date of enrolment until the date of documented disease progression in the CNS as assessed by ICR using RECIST 1.1 or death by any cause in the absence of CNS progression. If CNS progression occurs, the date of CNS progression will be recorded as the date of the earliest RECIST 1.1 assessment where CNS progression was identified.

If a participant has disease progression in CNS or dies immediately after 2 or more consecutive missed visits (i.e., RECIST 1.1 visits for the intent of assessing the primary endpoint, PFS), the subject will be censored at the time of the latest evaluable RECIST 1.1 assessment prior to the 2 missed visits. Participants who have neither CNS progression nor death before the time of analysis will be censored at the latest date of their last evaluable RECIST 1.1 assessment, or at Day 1 (date of enrolment) if the patient has no evaluable visits. For participants with CNS metastasis at baseline, a brain scan must be conducted for an assessment to be considered as evaluable.

The analysis will include all enrolled participants in the FAS, regardless of whether the participant withdraws from study intervention or receives another anticancer therapy.

### 3.2.3 Exploratory Variables

#### 3.2.3.1 CCI

[REDACTED]

[REDACTED]

[REDACTED]

#### 3.2.3.2 CCI

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

### 3.3 Safety Variables

#### 3.3.1 Exposure and dose interruptions

##### Total (or intended) exposure of study treatment

The total (or intended) exposure (i.e. duration of treatment) of a patient to study treatment is calculated using the start and stop dates of the treatment and the intended dosing interval. The

total (or intended) exposure is calculated as the number of days from date A to date B (i.e. B-A+1) where

- A is the date of first dose of study treatment
- B is the earliest of:
  - The date of death,
  - The date of DCO, and
  - The date when the last non-zero dose of study drug was received (i.e. > 0mg of T-DXd) + 20 (the scheduled number of days between doses minus one).

### **Actual exposure of study treatment**

- Actual exposure = intended exposure – total duration of dose delays, where intended exposure will be calculated as above.

Since patients will receive T-DXd via IV infusion CCI (±2 days), the total duration of dose delays (for deriving actual exposure) will be calculated as follows:

- Total duration of dose delays = sum for all dosing dates of positive values of [date of the dose – date of the previous dose – (21+2) days].

Dose reductions are permitted and the actual exposure calculation makes no adjustment for any dose reductions that may have occurred.

### **Number of treatment cycles received**

Exposure will also be measured by the number of cycles received. A cycle corresponds to a period of 21 days. If a cycle is prolonged due to toxicity, this should still be counted as one cycle. A cycle will be counted if treatment is started even if the full dose is not delivered.

### **Patient-year exposure**

Patient-year exposure is defined as the sum of total actual exposure of study treatment (in years) over all patients.

### **Safety follow-up**

- Safety follow-up = min ((last dose date + 47), date of withdrawal of consent, date of death, date of DCO) – first dose date + 1.



### 3.3.2 Dose intensity

Relative dose intensity (RDI) is the percentage of the actual dose delivered relative to the intended dose through to the last day of dosing. RDI will be defined as follows:

- $RDI = 100\% * d/D$ , where d is the actual cumulative dose delivered up to the actual last day of dosing and D is the intended cumulative dose up to the actual last day of dosing. D is the total dose that would be delivered if there were no modification to dose or schedule. When accounting for the calculation of intended cumulative dose 2 days should be added to the date of last dose to reflect the protocol allowed window for dosing.

When deriving actual dose administered the volume before and after infusion will also be considered:

Actual dose = actual dose per administration (initial or reduced dose level) \* proportion of actual dose administered, where the proportion of the actual dose administered will be calculated as (volume before infusion - volume after infusion)/volume before infusion.

For T-DXd, RDI calculations use doses measured in dose units of mg.

For the calculation of the intended dose the +/- 10% weight adjustment will be applied, by which the latest weight measurement (before dosing) will be considered in the calculation if it differs by at least 10% from the previous weight used in the calculation. The weight at screening (baseline) will be used to initially calculate the dose.

When accounting for the calculation of intended cumulative dose, 2 days should be added to the date of last dose to reflect the protocol allowed window for dosing.

### 3.3.3 Adverse events

AEs and serious adverse events (SAEs) will be collected throughout the study, from date of informed consent throughout the treatment period and the safety follow-up period (until 40 (+7) days after the last dose of study treatment). In the case of unresolved ILD/pneumonitis or events which are considered to be due to a late onset toxicity to study treatment, collection continues during Long-term Follow-up as specified in [Section 8.3.1 of the CSP](#). Events will be defined as treatment emergent if they onset, or worsen in severity or seriousness, during the treatment period or safety follow-up as defined in the CSP. The Medical Dictionary for Regulatory Activities (MedDRA) (using the latest or current MedDRA version) will be used to code the AEs. AEs will be graded according to the National Cancer Institute Common Terminology Criteria for AEs (NCI CTCAE) (using CTCAE version 5).

### **Other significant adverse events (OAE)**

During the evaluation of the AE data, an AstraZeneca medically qualified expert will review the list of AEs that were not reported as SAEs and ‘Discontinuation of Investigational Product due to Adverse Events’ (DAEs). Based on the expert’s judgement, significant adverse events of particular clinical importance may, after consultation with the Global Patient Safety Physician, be considered other significant adverse events (OAEs) and reported as such in the CSR. A similar review of laboratory/vital signs/ECG data will be performed for identification of OAEs.

Examples of these are marked haematological and other laboratory abnormalities, and certain events that lead to intervention (other than those already classified as serious) or significant additional treatment.

### **AEs of special interest**

Some clinical concepts (including some selected individual preferred terms and higher-level terms) have been considered “AEs of special interest” (AESI) to the T-DXd program. AESIs represent pre-specified risks that are considered to be of importance to a clinical development program.

Based on the available pre-clinical and clinical data, review of the cumulative literature, reported toxicities for the same class of agents, and biological plausibility, ILD/pneumonitis and left ventricular (LV) Dysfunction are considered to be AESIs.

Other categories may be added as necessary or existing terms may be merged. An AstraZeneca medically qualified expert after consultation with the Global Patient Safety Physician has reviewed the AEs of interest and identified which higher-level terms and which MedDRA preferred terms contribute to each AESI. Further reviews may take place prior to DBL to ensure any further terms not already included are captured within the categories.

### **3.3.4 Physical examinations**

Physical examinations will be performed as described in Section 8.2.1 of the CSP.

Abnormalities recorded prior to the first dose of study treatment will be recorded as part of the patient’s baseline signs. Abnormalities first recorded after first dose of study treatment will be recorded as AEs unless they fulfil any of the SAE criteria, are the reason for study treatment discontinuation, or are considered to be clinically relevant as judged by the investigator.

### 3.3.5 Vital signs

The following vital signs will be measured as described in Section 8.2.2 of the CSP: Systolic and diastolic blood pressure (BP), pulse rate, temperature and respiratory rate. Body weight will also be recorded along with vital signs.

For the derivation of baseline and post-baseline visit values, the definitions and rules described in Section 3.3.10.1 for visit windows, and how to handle multiple records will be used.

### 3.3.6 Electrocardiograms

Resting 12-lead electrocardiograms (ECGs) will be recorded at screening, before Cycle 1 infusion (within 3 days before administration), and then every 4 cycles, at end of treatment (EOT) and at safety follow up visit as described in Section 8.2.3 of the CSP. ECGs will be obtained in triplicate at screening and C1D1, and subsequent ECGs will be performed in triplicate only if an abnormality is noted, otherwise single ECGs will be performed.

The following ECG variables will be collected: heart rate, RR interval, PR interval, QT interval, QT interval corrected for heart rate using Fridericia's correction (QTcF interval), QRS duration, and an overall evaluation.

The overall evaluation of an ECG will either be "normal", "abnormal" or "borderline", with abnormalities categorised as either "clinically significant" or "not clinically significant". Any clinically significant abnormalities detected require triplicate ECG results. At each time point at which triplicate ECGs are required, 3 individual ECG tracings should be obtained in succession, no more than 2 minutes apart. The full set of triplicates should be completed within 5 minutes. Where triplicate ECG results are taken, a single mean value for numeric parameters will be used, and the worst case of the three results will be used for the overall evaluation.

For the derivation of visit windows where baseline and post-baseline visits have triplicate ECGs, the date/time equal to the earliest date/time of the 3 results will be used.

Where QTcF is not collected, it will be calculated programmatically using the reported ECG values (RR and QT) as follows (where RR are in seconds, QT and QTcF are in milliseconds):

$$QTcF = \frac{QT}{\sqrt[3]{RR}}$$

Alternatively, RR (or QT) can be programmatically derived if not collected but QTcF and QT (or RR, respectively) is collected. RR can be calculated as follows:

$$RR = \left( \frac{QT}{QT_{cF}} \right)^3$$

The following relationship between RR and heart rate (with RR expressed in seconds and heart rate in bpm) will be used to derive programmatically the missing parameter in case only one of these variables is available:

$$RR = \frac{60}{\text{Heart rate}}$$

### 3.3.7 Elevated troponin levels

Troponin will be collected at screening, when a patient reports signs or symptoms suggesting CHF, MI or other causes of myocyte necrosis, and at end of treatment (EOT). Further details regarding repeat testing are described in Section 8.2.4 of the CSP.

### 3.3.8 Laboratory measurements

Blood and urine samples for the determination of clinical chemistry, haematology, coagulation and urinalysis will be collected as described in Section 8.2.4 of the CSP.

For the derivation of baseline and post-baseline visit values, the rules described in Sections 4.1 and 3.3.10.1 of this document considering baseline, visit windows and how to handle multiple records will be used.

Change from baseline in haematology and clinical chemistry variables will be calculated for each post-dose visit. NCI CTCAE (version 5.0) grades will be defined at each visit according to the CTCAE grade criteria using project ranges, after conversion of lab result to corresponding project-wide preferred units. The following parameters have CTCAE grades defined for both high and low values: potassium, sodium, magnesium, glucose and corrected calcium so high and low CTCAE grades will be calculated.

Corrected calcium will be programmatically derived during the creation of the reporting database using the following formula:

$$\text{Corrected calcium (mmol/L)} = \text{Total calcium (mmol/L)} + ([40 - \text{albumin (g/L)}] \times 0.02)$$

Calculated creatinine clearance (CrCl) will be programmatically derived in the reporting database using the Cockcroft-Gault formula:

$$\text{Creatinine clearance (mL/min)} = ([140 - \text{age at first dose}] \times \text{weight (kg)} [\times 0.85 \text{ if patient is female}]) / (72 \times \text{serum creatinine (mg/dL)})$$

Absolute values will be compared to the project reference range and classified as low (below range), normal (within range or on limits of range), and high (above range).

The maximum or minimum value (depending on the direction of an adverse effect) will be defined for each laboratory parameter as the maximum (or minimum) post-dose value at any time.

Local reference ranges will be used for the primary interpretation of laboratory data at the local laboratory. Project reference ranges will be used for reporting purposes.

The denominator used in laboratory abnormality summaries will include only evaluable patients (i.e., those who had sufficient data to have the possibility of an abnormality). For example:

- If a CTCAE criterion involves a change from baseline, evaluable patients would have both a pre-dose and at least 1 post-dose value recorded.
- If a CTCAE criterion does not consider changes from baseline, to be evaluable the patient need only have 1 post-dose value recorded.

### **3.3.9 Other safety assessments**

#### **3.3.9.1 Echocardiograms/multigated acquisition scans**

Echocardiograms (ECHO)/multigated acquisition (MUGA) scans will be performed as described in Section 8.2.5.1 of the CSP. These will be used to assess the left ventricular ejection fraction (LVEF). The LVEF and method details will also be reported. Change from baseline of LVEF will be calculated.

#### **3.3.9.2 Pulmonary assessments**

Pulse oximetry (SpO<sub>2</sub>) will be measured as described in Section 8.2.5.2 of the CSP.

#### **3.3.9.3 ECOG performance status**

ECOG performance status (PS) will be assessed as described in Section 8.2.5.4 of the CSP as the following:

0. Fully active; able to carry out all usual activities without restrictions.
1. Restricted in strenuous activity, but ambulatory and able to carry out light work or work of a sedentary nature (e.g., light housework or office work).
2. Ambulatory and capable of self-care, but unable to carry out any activities; up and about more than 50% of waking hours.

3. Capable of only limited self-care; confined to bed or chair more than 50% of waking hours.
4. Completely disabled; unable to carry out any self-care and totally confined to bed or chair.
5. Dead.

Any significant change from baseline or screening will be reported as an AE.

#### **3.3.9.4 Ophthalmologic assessments**

Ophthalmologic assessments including visual acuity testing, slit lamp examination and fundoscopy will be performed at screening, EOT, and as clinically indicated.

#### **3.3.9.5 ILD/Pneumonitis investigation**

If ILD is suspected, additional assessments are performed as described in the CSP, including pulmonary function test and high resolution CT scan (HRCT).

For the pulmonary function test, the following parameters will be measured: diffusing capacity of the lungs for carbon monoxide (DLCO) (if feasible), SpO<sub>2</sub>, FiO<sub>2</sub>, whether the patient has received oxygen treatment, oxygen treatment start and stop dates and method provided, forced expiratory volume in 1 second (FEV1), forced vital capacity (FVC), FEV1% predicted, FVC % predicted, peak expiratory flow (PEF), forced expiratory volume in 6 seconds (FEV6), total lung capacity (TLC), FEV1/FVC ratio.

An overview of the HRCT radiological findings will be collected at screening for all patients and if ILD/pneumonitis is suspected.

#### **3.3.10 General considerations for safety assessments**

##### **3.3.10.1 Time windows**

Time windows will be defined for any presentations that summarise values by visit. The following conventions will apply:

- The time windows will be exhaustive so that data recorded at any time point has the potential to be summarised. Inclusion within the time window will be based on the actual date and not the intended date of the visit.
- All unscheduled visit data have the potential to be included in the summaries.
- The window for the visits following baseline will be constructed in such a way that the upper limit of the interval falls half way between the two visits (the lower limit of the first post-baseline visit will be Day 2). If an even number of days exists between two consecutive visits then the upper limit will be taken as the earlier of the two middle days. For example, the visit windows for vital signs data are:

- Cycle 1 Day 1, visit window 1
  - Cycle 1 Day 8, visit window 2 - 11
  - Cycle 1 Day 15, visit window 12 - 18
  - Cycle 2 Day 1, visit window 19 - 32
  - Cycle 3 Day 1, visit window 33 - 53
  - Cycle 4 Day 1, visit window 54 – 74.
- For end of treatment (EOT) visit, the above rules do not apply and only the specific visit will be counted.
- For post-treatment 40 day safety follow-up, all visits after EOT up to last dose + 47 days will be included.
- Note, for safety data that are collected during the study both pre-infusion and post-infusion (e.g. vital signs), visit summaries following the first dose will present the pre-infusion and post-infusion timepoints separately. The pre-infusion timepoint will not be presented at Cycle 1 as any pre-infusion data at Cycle 1 are included in the derivation of baseline.
- For summaries showing the maximum or minimum values, the maximum/minimum value recorded on treatment will be used (regardless of where it falls in an interval).
- Listings should display all values contributing to a time point for a patient.
- For visit based summaries, if there is more than one value per patient within a time window then the closest value to the scheduled visit date will be summarised, or the earlier, in the event the values are equidistant from the nominal visit date. If there are two values recorded on the same day and the parameter is CTCAE gradable then the record with the highest toxicity grade should be used. Alternatively, if there are two records recorded on the same day and the toxicity grade is the same (or is not calculated for the parameter), then the average of the two records should be used. The listings will highlight the value for the patient that contributed to the summary table, wherever feasible. Note: in summaries of extreme values all post baseline values collected are used including those collected at unscheduled visits regardless of whether or not the value is closest to the scheduled visit date.
- For summaries at a patient level, all values will be included, regardless of whether they appear in a corresponding visit based summary, when deriving a patient level statistic such as a maximum.

### 3.3.10.2 Missing data

Missing safety data will generally not be imputed. However, safety assessment values of the form of “< x” (i.e. below the lower limit of quantification [LLOQ]) or “> x” (i.e. above the upper limit of quantification) will be imputed as “x” in the calculation of summary statistics but will be displayed as “< x” or “> x” in the listings. Additionally, adverse events that have missing causality (after data querying) will be assumed to be related to study drug.



Furthermore, for missing diagnostic dates, if day and/or month are missing use 01 and/or Jan. If year is missing, put the complete date to missing.

### **AE and Medication Start/Stop Dates**

The original incomplete or missing dates will be presented in the listing.

- Adverse events: all AEs will be considered as treatment-emergent unless the opposite can be clearly stated. Imputation will be done only in the context of identifying treatment-emergent AEs.
- Concomitant medications: all medications will be considered as concomitant unless the opposite can be clearly stated. Imputation will be done only in the context of identifying concomitant medications.

For missing AE and medications start dates, the following will be applied:

- a. Missing day - Impute the 1<sup>st</sup> of the month unless month is the same as month of the first dose of study drug then impute first dose date
- b. Missing day and month - Impute 1<sup>st</sup> January unless year is the same as first dose date then impute first dose date
- c. Completely missing - Impute first dose date unless the end date suggests it could have started prior to this in which case impute the 1<sup>st</sup> January of the same year as the end date.

When imputing a start date, ensure that the new imputed date is sensible (i.e. is prior to the end date of the AE or medication).

For missing AE and medication end dates, the following will be applied:

- a. Missing day - Impute the last day of the month unless month is the same as month of last dose of study treatment then impute last dose date
- b. Missing day and month – Impute 31<sup>st</sup> December unless year is the same as last dose then impute last dose date.
- c. Completely missing:
  - AE: since there is no ongoing flag recorded in CRF, then assume that AE is still present (i.e., do not impute a date).
  - Medication: if the ongoing flag is missing then assume that medication is still being taken (i.e., do not impute a date). If the medication has stopped and start date of medication is prior to first dose date then impute the first dose date, if the medication started on or after first dose date then impute a date that is after the last dose date.



When imputing a stop date, ensure that the new imputed date is sensible (i.e., is after the start date of the AE or medication). When imputing a stop date for prior anticancer therapy, ensure the new imputed date is before informed consent date.

Patients with a partial date of birth (i.e. for those countries where year of birth only is given) will have the 1<sup>st</sup> of the month imputed if the day is missing, and 1<sup>st</sup> Jan imputed if the day and month is missing.

Flags will be retained in the database indicating where any programmatic imputation has been applied, and in such cases, any durations would not be calculated.

### **Date of Death**

If a patient is known to have died where only a partial death date is available then the date of death will be imputed as the latest of the last date known to be alive +1 from the database and the death date using the available information provided:

- a. For missing day only – using the 1<sup>st</sup> of the month.
- b. For missing day and month – using the 1<sup>st</sup> of January.

If there is evidence of death but the date is entirely missing, it will be treated as missing (i.e., the patient will be censored at the last known alive date).

## **3.4 Pharmacokinetic Variables**

PK concentration data will be collected as per the CSP to assess the PK of T-DXd, total anti-HER2 antibody, and DXd.

Individual concentrations below the Lower Limit of Quantification (LLOQ) of the bioanalytical assay will be reported as NQ (Not Quantifiable) in the listings with the LLOQ defined in the footnotes of the relevant TFLs. Individual plasma concentrations that are Not Reportable will be reported as NR and those that are missing will be reported as NS (No Sample) in the listings. Plasma concentrations that are NQ, NR or NS will be handled as follows for the provision of descriptive statistics:

- If, at a given time point, 50% or less of the serum concentrations are not quantifiable (NQ), the geometric mean, coefficient of variation (CV)%, geometric CV%, mean and SD will be calculated treating the NQ as the LLOQ.
- If more than 50%, but not all, of the concentrations are NQ, the geometric mean, CV%, geometric CV%, and SD will be reported as data not calculable (NC). The maximum value will be reported from the individual data, and the minimum and median will be set to NQ.

- If all the concentrations are NQ, the geometric mean, mean, minimum, median and maximum will be reported as NQ and the CV%, geometric CV% and SD as NC. The number of values below LLOQ ( $n < \text{LLOQ}$ ) will be reported for each time point together with the total number of collected values ( $n$ ).

Three observations  $> \text{LLOQ}$  are required as a minimum for a plasma concentration or PK parameter (e.g.  $C_{\text{max}}$ ,  $C_{\text{min}}$ ,  $C_{\text{last}}$ ) to be summarised. Two observations  $> \text{LLOQ}$  are presented as minimum and maximum with the other summary statistics as NC.

### 3.5 Immunogenicity Variables

Blood samples for determination of ADAs against T-DXd and neutralising ADAs (nAb) in serum will be collected per the Schedule of Activities (SoA) in the CSP. ADA results from each sample will be reported as either positive or negative. If the sample is positive, the ADA titre will be reported as well. In addition, the presence of neutralising ADA may be tested for all ADA-positive samples using a ligand-binding assay. The nAb results will be reported as positive or negative.

The number of patients in the ADA analysis set who fulfil the following criteria will be determined. The percentage of patients in each of the categories listed below will be calculated, using the number of patients in the ADA evaluable set as the denominator.

- ADA positive at any visit; the percentage of ADA-positive patients in the ADA analysis set is known as ADA prevalence. A patient is defined as being ADA positive if a positive ADA result is available at any time, including baseline and all post-baseline measurements; otherwise ADA negative.
- ADA positive post-baseline and positive at baseline.
- ADA not detected post-baseline and positive at baseline.
- Treatment-induced ADA, defined as ADA positive post-baseline and not detected at baseline.
- Treatment-boosted ADA, defined as a baseline positive ADA titre that was boosted to a 2-fold or higher level (greater than the analytical variance of the assay) following drug administration.
- Treatment-emergent ADA, defined as either treatment-induced or treatment-boosted ADA; the percentage of patients fulfilling this criterion in the ADA analysis set is known as ADA incidence.
- Treatment-emergent ADA persistently positive, defined as treatment-emergent ADA+ patients having at least 2 post-baseline ADA positive measurements with at least 16

weeks (112 days) between the first and last positive measurement, or an ADA positive result at the last available assessment.

- Treatment-emergent ADA transiently positive, defined as treatment-emergent ADA+ patients having at least one post-baseline ADA positive measurement and not fulfilling the conditions for persistently positive.
- nAb positive at any visit (baseline or post-baseline).

### 3.6 Biomarker Variables

Samples for the determination of biomarkers will be taken from all enrolled patients according to the schedule described in Section 8.6 of the CSP.

Tumour tissue samples will be tested by a central laboratory for study-qualifying activating HER2 exon 19 and 20 mutations to define eligibility to be enrolled for the study or retrospective central confirmation for participants who enrolled by study qualified local test, and evaluate their association with the observed clinical responses to T -DXd.

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### 3.7 Other variables

#### 3.7.1 Prior and concomitant medications and procedures

Information on any treatment within the four weeks prior to initiation of study drug and all concomitant treatments given up to 47 days after discontinuation of study treatment, or objective disease progression (whichever is later), with reasons for the treatment, will be recorded in the eCRF. Thereafter, only subsequent regimens of anti-cancer therapy will be recorded in the eCRF.

All therapies (drug and non-drug), including herbal preparations, whether prescribed or over the-counter, that are used during the study will be recorded on the eCRF. Details include generic and/or brand names of the medications, World Health Organisation Drug Dictionary (WHO-DD) encoding (latest or current version), reason for use, route, dose, dosing frequency, and start and end dates.

Procedures performed during the study will be recorded on the eCRF and details include the procedure name, WHO-DD encoding (latest or current version), reason for the procedure, and start and end dates.

For the purpose of inclusion in prior and/or concomitant medication or therapy summaries, missing start and stop dates for medications and procedures will be handled using the rules described in Section 3.3.10.2.

Prior medications, concomitant and post-treatment medications are defined based on imputed start and stop dates as follows:

- Prior therapies are defined as those taken prior to study treatment with a stop date prior to the first dose of study treatment.
- Concomitant therapies are those that are ongoing at first IP dose date or started after first dose of IP either prior to or on the date of last IP dose.
- Post-treatment therapies are those with a start date after the last dose date of study treatment.

Missing coding terms should be listed and summarised as "Not coded". Disallowed concomitant medications will be determined via clinical review.

## 4 ANALYSIS METHODS

### 4.1 General principles

Efficacy data will be summarised and analysed using the FAS for the primary analyses of primary variable, both the RES and ITT Analysis Set for supplementary analyses of primary variable, the FAS for all secondary efficacy variables analyses, and the ITT Analysis Set for supplementary analysis of secondary efficacy variables (only for ORR, DoR, PFS and OS), as specified in Table 3. Supplementary analyses based on the RES and ITT Analysis Set will only be conducted if they differ from the FAS.

Safety and treatment exposure data will be summarised based upon the SAF. Study population and demography data will be summarised based upon the FAS and ITT Analysis Set as specified in Table 3.

PK data will be analysed using the PK analysis set. ADAs will be summarised using the T-DXd ADA evaluable set. Study day will be relative to the date of first dose of study treatment, unless a patient discontinued prior to receiving treatment, in which case study day will be relative to date of enrolment.

The below mentioned general principles will be followed throughout the study:

- Descriptive statistics will be used for all variables, as appropriate. Continuous variables will be summarised by the number of observations, mean, standard deviation,

median, upper and lower quartiles, minimum, and maximum. For log-transformed data it is more appropriate to present geometric mean, CV, median, minimum and maximum. Categorical variables will be summarised by frequency counts and percentages for each category.

- Unless otherwise stated, percentages will be calculated out of the population total.
- For continuous data, the mean and median will be rounded to 1 additional decimal place compared to the original data. The standard deviation will be rounded to 2 additional decimal places compared to the original data. Minimum and maximum will be displayed with the same accuracy as the original data.
- For categorical data, percentages will be rounded to 1 decimal place. Note, percentages of 100.0 will be presented as 100 with no decimal.
- The analyses will be descriptive, and no inferential analysis will be performed based on statistical tests.
- SAS® version 9.4 or higher will be used for all analyses.

The last observation before the first dose of study treatment will be considered the baseline measurement. For assessments on the day of first dose where time is not captured, a nominal pre-dose indicator, if available, will serve as sufficient evidence that the assessment occurred prior to first dose.

Assessments on the day of the first dose where neither time nor a nominal pre-dose indicator are captured will be considered prior to the first dose if such procedures are required by the CSP to be conducted before the first dose.

If two visits are equally eligible to assess status at baseline (e.g., screening and baseline assessments both on the same date with no time recorded), the average will be used as the baseline value. In the scenario where there are two assessments recorded on the same day, one with time recorded and the other without time recorded, the one with the time recorded would be selected as baseline.

Where safety data are summarised over time, time on study will be calculated in relation to date of first dose of study treatment.

In all summaries change from baseline variables will be calculated as the post-treatment value minus the value at baseline. The percentage change from baseline will be calculated as (post-baseline value - baseline value) / baseline value x 100.

When calculating time to an event or duration, the default unit will be days unless otherwise specified. If an analysis requires days be converted to weeks, the time to event or duration will

be divided by 7. If an analysis requires days be converted to months, the time to event or duration will be divided by (365.25/12).

## **4.2 Analysis methods**

### **4.2.1 Objective response rate**

The confirmed ORR will be based on all scans regardless of whether they were scheduled or not. The confirmed ORR as assessed by ICR (based on the FAS) will be estimated and presented as the number (%) of patients along with the corresponding exact 95% Clopper-Pearson CI. A summary will be produced that presents the number and percentage of patients with a confirmed tumour response (CR/PR).

As supplementary analyses to the primary endpoint, summaries presenting the confirmed ORR as assessed by ICR based on the RES and ITT Analysis Set will also be produced.

For the secondary endpoint of ORR by investigator assessment, will be analysed in the FAS and ITT Analysis Set using the same methods as described in the primary analysis for the primary endpoint.

The concordance of confirmed ORR between ICR and investigator will be evaluated in the FAS. Summary tables showing the onset of confirmed response in relation to study treatment and subsequent anticancer therapy will also be presented for the ICR and investigator assessments in the FAS.

### **Subgroup analysis**

Subgroup analyses will be conducted for the primary endpoint. ORRs and 95% CIs as for the primary endpoint for each level of each subgroup will be summarised and presented on a forest plot, along with the result of the overall primary analysis in the FAS:

- Lines of prior systemic therapy (1 versus 2 versus  $\geq 3$ )
- Age at enrolment ( $< 65$  versus  $\geq 65$  years)
- Sex (male versus female)
- Smoking status at baseline (current or former versus never)
- ECOG Performance status (0 versus 1)
- HER2 mutation type by central lab (exon 19 versus exon 20)
- Prior treatment with platinum therapy (yes versus no)
- Prior treatment with immunotherapy (yes versus no)
- Prior treatment with platinum therapy and immunotherapy in combination (yes versus no)

- Presence of CNS metastasis at baseline (yes versus no)

#### **4.2.2 Duration of response**

Kaplan-Meier plots of DoR will be presented. Median DoR will also be summarised calculated from the KM curve, and its corresponding 95% CI, calculated using the Brookmeyer-Crowley method with log-log transformation (Brookmeyer & Crowley, 1982; Klein & Moeschberger, 1997). Only patients who have a confirmed complete response or confirmed partial response will be included in this summary table. Swimmer plots that clearly show the profile of each patient who responds may also be produced.

Duration of response summaries will be presented for both the ICR and investigator assessments for the FAS and ITT Analysis Set.

#### **4.2.3 Disease control rate**

The DCR will be estimated and presented with the corresponding exact 95% Clopper-Pearson CI at each DCO, for both ICR and investigator assessments.

The number and percentage of patients meeting the definition of disease control will be presented for both the ICR and the investigator assessments.

These summaries for DCR will be presented for the FAS.

#### **4.2.4 Best objective response**

BoR will be summarised by number (%) for each category (confirmed CR, confirmed PR, SD, NED, PD and NE). The number (%) of patients with a single visit response (i.e., an unconfirmed response) will be presented. In addition, an exploratory summary of BoR including unconfirmed responses (unconfirmed CR or unconfirmed PR) as a response will be presented. No formal statistical analyses are planned for BoR.

The BoR summaries will be presented for the ICR and investigator assessments for the FAS.

#### **4.2.5 Progression free survival**

The treatment status at progression of patients at the time of analysis will be summarised. This will include the number (%) of patients who were on treatment at the time of progression, the number (%) of patients who discontinued study treatment prior to progression, the number (%) of patients who have not progressed and were on treatment or discontinued treatment. This will also provide a distribution of the number of days prior to progression for the patients who have discontinued treatment.



Summaries of the number and percentage of patients experiencing a PFS event, the type of event (RECIST 1.1 or death) and the number and percentage of censored patients and detailed reason for censoring will be provided along with median PFS and its corresponding 95% CI, calculated using the Brookmeyer-Crowley method with log-log transformation (Brookmeyer & Crowley, 1982; Klein & Moeschberger, 1997).

The percentage of patients alive and progression-free at 3-monthly intervals from enrolment date (Kaplan-Meier estimates) will be presented along with 95% CI.

The duration of follow-up for censored patients will be presented (median, minimum and maximum) using time from date of enrolment to date of censoring. In addition, the number of days from last RECIST assessment (i.e., censoring date) to DCO will be summarised for censored patients.

The PFS summaries and Kaplan-Meier plots will be presented for the ICR and investigator assessments for the FAS. The PFS summaries will also be provided for the ITT Analysis Set.

Summaries of subsequent cancer therapy in relation to progression for ICR and investigator assessments will be presented for FAS and ITT Analysis Set.

ICR and investigator assessments based on RECIST 1.1 at each timepoint will be listed for all enrolled patients. In addition, a summary of new lesions (i.e., sites of new lesions) will be produced.

#### **4.2.6 Overall survival**

Kaplan-Meier plots will be presented for OS for the FAS and ITT Analysis Set. Summaries of the number and percentage of patients who have died, those still in survival follow-up, those lost to follow-up and those who have withdrawn consent will be provided along with the median OS and corresponding 95% confidence interval (if calculable), calculated using the Brookmeyer-Crowley method with log-log transformation (Brookmeyer & Crowley, 1982; Klein & Moeschberger, 1997).

The percentage of patients alive at 3-monthly intervals (Kaplan-Meier estimates) will be presented along with 95% CI.

In addition, median duration of follow-up and range of follow-up (minimum, maximum) will be summarised where duration of follow-up is defined as time from enrolment to the date of death (i.e. overall survival) or to the date of censoring (date last known to be alive) for all patients and censored patients.



#### **4.2.7 CNS-PFS**

CNS-PFS will be presented for ICR assessments for the FAS. A Kaplan-Meier plot of CNS-PFS will be presented. Summaries of the number and percentage of participants experiencing a CNS-PFS event and the type of event (RECIST 1.1 CNS-PD or death) will be provided along with appropriate descriptive statistics (based on Kaplan-Meier estimates). No sensitivity analysis of CNS-PFS will be presented.

#### **4.2.8 TTR**

The TTR will be summarised (i.e., number of patients [%] based upon the number of responders) by the scheduled assessment timepoint that the response was first observed. Additionally, descriptive summary statistics (i.e., minimum, maximum, median, Q1 and Q3) will also be presented. These summaries will be repeated for both the ICR and investigator assessments, for the FAS.

#### **4.2.9 Tumour size change**

The absolute values, change in TL tumour size from baseline and percentage change in TL tumour size from baseline will be summarised using descriptive statistics and presented at each timepoint.

The best change in TL tumour size from baseline (where best change in TL size is the maximum reduction from baseline or the minimum increase from baseline in the absence of a reduction) will also be summarised. The number and percentage of patients whose best percentage change data is imputed will also be presented.

Tumour size may also be presented graphically using waterfall plots, to present each patient's best percentage change in TL tumour size as a separate bar, with the bars ordered from the largest increase to the largest decrease. A reference line at the 30% change in TL tumour size level will be added to the plots, which corresponds with the definition of 'partial response'. All progressions will be marked with a '●' or designated with patterns or colours for ORR categories. The scale in these plots will be fixed to be from -100 to 100 to avoid presenting extreme values. Values that are capped as a result of this restriction to the scale are marked with '#'. Values are ordered in descending order.

Additionally, a 'spider' plot will be produced. This depicts each patient's percentage change in TL tumour size as a line over time and progression due to non-target and/or new lesions will be indicated.

These summaries will be repeated for both the ICR and investigator assessments, for the FAS.

#### **4.2.10 PK**

PK concentration data will be listed by patient and dosing day/time and will be tabulated using summary statistics for all patients in the PK analysis set.

Serum concentrations of T-DXd, total anti-HER2 antibody, and DXd will be summarised by nominal sample time using standard summary statistics for PK concentrations (geometric mean, geometric coefficient of variation, arithmetic mean, standard deviation, median, minimum, maximum and n). All serum concentrations will be listed.

If the data are suitable, the relationship between PK exposure and efficacy/safety parameters may be investigated graphically or using an appropriate data modelling approach. The results of such an analysis, if conducted, will be reported in a separate report. The PK, pharmacodynamics, demographic, safety, and efficacy data collected in this study may also be combined with similar data from other studies and explored using population PK and/or PK-PD (pharmacokinetic-pharmacodynamic) methods.

#### **4.2.11 Immunogenicity**

A summary of the number and percentage of patients who developed detectable ADA to T-DXd by ADA categories (see Section 3.5 for categories) will be presented based on the T-DXd ADA evaluable set.

Immunogenicity results of all ADA positive patients in the SAF will be listed regardless of ADA evaluable status. ADA titre and neutralising antibody data will be listed for samples confirmed positive for the presence of T-DXd antibodies. AEs in ADA positive patients by ADA positive category will be listed.

The effect of ADA on PK, pharmacodynamics, efficacy, and safety will be evaluated, if the data allow.

#### **4.2.12 Safety**

Safety and tolerability data from all cycles of treatment will be combined. The SAF will be used for reporting of safety data. Safety summaries will be descriptive only. No formal statistical analyses will be performed on the safety variables.

##### **4.2.12.1 Adverse events**

All treatment emergent AEs (TEAEs) with an onset date or that worsen in severity or seriousness on or after date of first dose and up to and including 47 days following the date of last dose of treatment or until the initiation of the first subsequent anti-cancer therapy (excluding radiotherapy), whichever occurs first are included in the summaries. This will more accurately depict AEs attributable to study treatment only, as some AEs up to 40 (+7)

days following discontinuation of the study treatment are likely to be attributable to subsequent therapy. Any other AEs will be flagged in the data listings but not included in the summaries. Any AE occurring before the first dose of study treatment which does not worsen during treatment, will be referred to as 'pre-treatment'.

All AEs, both in terms of current MedDRA preferred term and CTCAE grade, will be summarised descriptively by count (n) and percentage (%).

Summary information (the number and percent of patients reporting at least one event) by system organ class (SOC) and/or preferred term (PT) will be tabulated for:

- All AEs (\*)
- Most common AEs (frequency of >5%)
- All AEs possibly related to study treatment (\*)
- AEs by maximum reported CTCAE grade
- AEs with CTCAE grade 3 or higher (\*)
- AEs with CTCAE grade 3 or higher possibly related to study treatment (\*)
- Most common AEs (frequency of >5%) with CTCAE grade 3 or higher
- AEs with outcome of death
- AEs with outcome of death possibly related to study treatment
- All SAEs (\*)
- All SAEs possibly related to study treatment (\*)
- AEs leading to dose modification of study treatment (including interruption and/or reduction)
- AEs leading to discontinuation of study treatment (\*)
- AEs leading to discontinuation of study treatment, possibly related to study treatment (\*)
- AEs leading to dose interruption of study treatment (\*)
- AEs leading to dose interruption of study treatment, possibly related to study treatment (\*)
- AEs leading to dose reduction of study treatment (\*)
- AEs leading to dose reduction of study treatment, possibly related to study treatment (\*)

Summary information (the number and percent of patients reporting at least one event) by selected group term or PT will also be tabulated for selected categories marked as (\*).

An overview of AEs will be presented, including the number and percentage of patients in each of the categories above, as well as the number of individual occurrences in those categories. The MedDRA dictionary (latest or current version) will be used for coding.

For the truncated AE tables of most common AEs, all events that occur in at least 5% of patients overall in the SAF will be summarised by preferred term, by decreasing frequency. This cut-off may be modified after review of the data. When applying a cut-off (e.g., 5%), the raw percentage should be compared to the cut-off, no rounding should be applied first (i.e., an AE with frequency 4.9% will not appear if the cut-off is 5%).

An additional AE summary will be presented for pre-treatment AEs and AEs which started more than 47 days after last dose of study treatment or after the start of subsequent anti-cancer therapy.

All reported AEs will be listed along with the date of onset (including study day), date of resolution (if AE is resolved), investigator's assessment of CTCAE grade and relationship to study drug. If an AE has changes in CTCAE grade, the maximum value will be presented.

Frequencies and percentages of patients reporting each PT will be presented (i.e. multiple events per patient will not be accounted for apart from on the episode level summaries which may be produced).

### **Adverse events of special interest**

ILD/pneumonitis and LV Dysfunction are considered to be AESIs (see Section 3.3.3 for details). AESI categories will be summarised separately unless otherwise specified.

Potential ILD/pneumonitis (AESI-defined ILD cases identified based on MedDRA preferred terms) will be adjudicated by the ILD Adjudication Committee as follows:

- Adjudicated as ILD/pneumonitis
  - Adjudicated as drug-related ILD/pneumonitis
  - Adjudicated as not drug-related pneumonitis
- Adjudicated as not ILD/pneumonitis
- Unable to adjudicate due to insufficient information

A summary of all potential ILD events that were submitted to the ILD adjudication committee for adjudication will be provided and categorised as above. Maximum CTCAE grade per adjudication committee will also be summarised for the events adjudicated as ILD (drug related/not drug-related). For events unable to be adjudicated due to insufficient information, the maximum CTCAE grade per investigator assessment will be summarised.

Summaries of ILD/pneumonitis events will be primarily based on adjudicated drug-related ILD events from the ILD adjudication committee. For adjudicated ILD events, summaries of causality and CTCAE grading are as determined by the ILD Adjudication Committee.

For LV dysfunction, categories will be based on preferred terms provided by the patient safety team prior to database lock. All preferred terms provided by the patient safety team will be listed and the listing will identify those present in the study.

The number (%) of patients who have at least one AESI, at least one AESI causally related to study treatment, at least one AESI of grade 3 or higher, at least one serious AESI, at least one AESI with outcome of death, at least one AESI leading to discontinuation of study treatment, at least one AESI leading to drug interruption and at least one AESI leading to dose reduction will be presented. An overall AESI summary will be presented, including the number and percentage of patients in each of these categories.

A summary table of AESIs will be produced for each AESI category, sub-category (if applicable) and preferred term by maximum CTCAE grade.

Key patient information for each AESI occurrence will be listed.

Duration of the first treatment-emergent AESI will be summarised using Kaplan-Meier approach and estimates of the lower and upper quartiles and median will be calculated. For ongoing AESIs in the database, stop date is censored at the earliest of following:

- Death date.
- Start of subsequent cancer therapy.
- Last dose of study treatment + 47 days.

If all of the above dates are missing, the stop date will be censored at the patient's last alive date, derived as per Section 3.2.2.6. When summarising duration of the first treatment-emergent AESI for adjudicated ILD/pneumonitis events, only adjudicated drug-related events will be considered.

## Deaths

A by-period summary of all deaths will be provided with the number and percentage of patients categorised as:

- Total number of deaths (regardless of date of death)
- Death related to disease under investigation only as determined by the investigator
- AE with outcome of death only.
  - AE onset  $\leq$  47 days following last dose of study treatment and prior to start of subsequent therapy
  - AE onset date  $>$  47 days following last dose of study treatment or after start of subsequent therapy

- Death related to disease under investigation, as determined by the investigator, and AE with outcome of death
  - Primary cause of death due to AE
    - AE onset  $\leq$  47 days following last dose of study treatment and prior to start of subsequent therapy
    - AE onset date  $>$  47 days following last dose of study treatment or after start of subsequent therapy
- Other deaths

Listing for SAE, all death and key subject listings for AEs leading to discontinuation of study treatment and death will be presented.

#### **4.2.12.2 Exposure**

Exposure will be listed and summarised for the SAF. The following summaries will be produced:

- Total exposure
- Actual exposure
- Summary statistics (mean, standard deviation, median, quartiles, minimum and maximum) of relative dose intensity (RDI)
- Summary of dose interruptions, reductions and cycle delays
- Number of treatment cycles.

For patients on study treatment at the time of each analysis, the DCO date will be used to calculate exposure.

Details of administration of study treatment will be listed for patients in the SAF.

#### **4.2.12.3 Vital signs**

Summaries of vital signs data will include all data obtained until 47 days after the last dose of study treatment or until the initiation of the first subsequent anti-cancer therapy (radiotherapy is not considered a subsequent anti-cancer therapy) following discontinuation of study treatment (whichever occurs first). Absolute values and change from baseline for diastolic and systolic BP, pulse rate, respiratory rate, temperature and body weight will be summarised at each visit. Summary will include both before infusion and end of infusion values on Day 1 of each cycle, except for Cycle 1 Day 1, which will have the end of infusion value only. The denominator in vital signs data should only include those patients with recorded data.

Listing for vital signs will be presented.

#### 4.2.12.4 ECGs

ECG data obtained up until 47 days following the last dose of study treatment or until the initiation of the first subsequent anti-cancer therapy (radiotherapy is not considered a subsequent anti-cancer therapy) following discontinuation of study treatment (whichever occurs first) will be included in the summaries.

Absolute values and change from baseline for ECG heart rate, PR interval, QRS interval, QT interval, RR interval and QTcF will be presented.

ECG evaluations will be summarised using a shift table of baseline to worst evaluation during the study.

#### 4.2.12.5 Laboratory measurements

Laboratory data obtained up until 47 days following the last dose of study treatment or until the initiation of the first subsequent anti-cancer therapy (radiotherapy is not considered a subsequent anti-cancer therapy) following discontinuation of study treatment (whichever occurs first) will be included in the summary tables.

All laboratory data will be listed. Flags will be applied to values falling outside reference ranges.

Absolute values and change from baseline for all continuous haematology, clinical chemistry and urinalysis laboratory parameters will be summarised by visit.

Scatter plots (shift plots) of baseline to maximum/minimum value (as appropriate) on treatment may be produced for certain parameters if warranted after data review.

Boxplots of absolute values by week, and boxplots of change from baseline by week, may be presented for certain parameters if warranted after data review.

Shift tables for laboratory values by worst CTCAE grade will be produced and for specific parameters separate shift tables indicating hyper- and hypo-directionality of change will be produced. The laboratory parameters for which CTCAE grade shift outputs will be produced are:

- Haematology: Haemoglobin, platelet count, leukocytes (absolute count), differential leukocytes count (neutrophils, lymphocytes)
- Clinical chemistry: serum creatinine, total bilirubin, albumin, alkaline phosphatase (ALP), alanine aminotransferase (ALT), aspartate aminotransferase (AST), corrected calcium (Ca) (hypo- and hyper-), potassium (K) (hypo- and hyper-), sodium (Na) (hypo- and hyper-), magnesium (hypo- and hyper-) and glucose (hypo)



- Coagulation: activated partial thromboplastin time (aPTT).

As coagulation tests will be performed as clinically indicated during the treatment period, the coagulation parameters will be included in summary tables if a sufficient number of assessments are recorded. Only listings will be provided in case of insufficient data.

For the parameters with no CTCAE grading that are listed in the CSP, shift tables from baseline to worst value on treatment will be provided. Additional summaries will include a shift table for categorical urinalysis parameters comparing baseline value to maximum value.

The denominator used in laboratory summaries of CTCAE grades will only include evaluable patients. If a CTCAE criterion involved a change from baseline, evaluable patients are those who have both a pre-dose and at least 1 post-dose value recorded. If a CTCAE criterion does not consider changes from baseline. Evaluable patients are those who have at least 1 post-dose value recorded.

### **Liver Enzyme Elevations and Hy's Law**

The following summaries will include the number (%) of patients who have:

- Elevated ALT, AST, Total bilirubin and ALP during the study
  - ALT  $\geq 3x$  –  $<5x$ ,  $\geq 5x$  –  $<8x$ ,  $\geq 8x$  –  $<10x$ ,  $\geq 10x$  –  $<20x$ , and  $\geq 20x$  upper limit of normal (ULN) during the study.
  - AST  $\geq 3x$  –  $<5x$ ,  $\geq 5x$  –  $<8x$ ,  $\geq 8x$  –  $<10x$ ,  $\geq 10x$  –  $<20x$ , and  $\geq 20x$  ULN during the study.
  - Total bilirubin  $\geq 1.5x$  –  $<2x$ ,  $\geq 2x$  –  $<3x$ ,  $\geq 3x$  –  $<5x$ ,  $\geq 5x$  ULN during the study.
  - ALT or AST  $\geq 3x$  –  $<5x$ ,  $\geq 5x$  –  $<8x$ ,  $\geq 8x$  –  $<10x$ ,  $\geq 10x$  –  $<20x$ , and  $\geq 20x$  ULN during the study.
  - ALP  $\geq 1.5x$  –  $<2x$ ,  $\geq 2x$  ULN during the study.
  - Potential Hy's Law: ALT or AST  $\geq 3x$  ULN and total bilirubin  $\geq 2x$  ULN during the study, irrespective of an increase in ALP: the onset date of ALT or AST elevation should be prior to or on the date of total bilirubin elevation.

Narratives may be provided in the CSR for patients who have ALT  $\geq 3x$  ULN plus total bilirubin  $\geq 2x$  ULN or AST  $\geq 3x$  ULN plus total bilirubin  $\geq 2x$  ULN at any visit.

Liver biochemistry test results over time for patients with elevated ALT (i.e.,  $\geq 3x$  ULN) or AST (i.e.,  $\geq 3x$  ULN), and elevated total bilirubin (i.e.,  $\geq 2x$  ULN) (at any time during treatment) will be plotted. Individual patient data where ALT or AST plus total bilirubin are elevated at any time will be listed also.



Plots of maximum post-baseline ALT and AST vs. maximum post-baseline total bilirubin, expressed as multiples of ULN, will also be produced with reference lines at  $3 \times \text{ULN}$  for ALT and AST, and  $2 \times \text{ULN}$  for Total bilirubin. In each plot, total bilirubin will be in the vertical axis.

#### **4.2.12.6 WHO/ECOG performance status**

All WHO/ECOG performance status data will be listed. A shift table will be presented, from baseline to worst evaluation during treatment.

#### **4.2.12.7 Pulmonary assessments**

SpO<sub>2</sub> will be summarised for each visit.

#### **4.2.12.8 Other safety assessments**

ECHO/MUGA scan results and ophthalmologic findings will be listed.

LVEF will be summarised for worst post-baseline grade, lowest post-baseline measurement and maximum decrease from baseline.

LVEF will also be summarised at baseline and over time in terms of absolute values and changes from baseline at each scheduled assessment.

A shift table by worst CTCAE grade for LVEF decrease will be presented.

Summaries of data collected for suspected ILD/pneumonitis investigation may be presented in patient narratives.

#### **4.2.13 Demographics and baseline characteristics**

The following will be summarised and/or listed for all patients in the FAS, and the ITT for categories marked as (\*):

- Patient disposition (including screening failures and reason for screening failure)
- Important protocol deviations (\*)
- Inclusion in analysis sets
- Demographics (age, age group [ $<40$ ,  $\geq 40 - < 65$ ,  $\geq 65 - < 75$  and  $\geq 75$  years], sex, race and ethnicity) (\*)
- Patient characteristics at baseline (height, weight, BMI group) (\*)
  - BMI will be calculated as:  $\text{weight (kg)}/\text{height (m)}^2$ .
  - BMI group: underweight  $<18.5$ ; Normal  $18.5 - <25.0$ ; overweight  $25.0 - <30.0$ ; obese  $\geq 30.0$
- Patient recruitment by centre

- Previous disease-related treatment modalities
- Previous chemotherapy and radiotherapy prior to this study
- Disease characteristics at baseline (ECOG performance status, primary tumour location, histology type, tumour grade, AJCC stage, time from diagnosis to start of study treatment, overall disease classification, histological subtype, presence of liver metastasis, presence of CNS metastasis and other gene abnormality status) (\*)
- Disease characteristics at time of diagnosis (primary tumour location, histology type, tumour grade, AJCC stage)
- Extent of disease at baseline
- TNM classification at baseline
- TNM classification at time of diagnosis
- Disease related medical history (past and current)
- Relevant surgical history
- Nicotine use, categorised (never, current, former)
- Pulmonary function test at baseline
- Pulmonary medical history

### **Baseline Biomarker Status**

Summaries and analyses for exploratory biomarkers (other than what is specified below) will be documented in a separate analysis plan and will be reported outside the CSR in a separate report.

The baseline biomarker status will be summarised for the ITT Analysis Set. The number (%) of patients who are HER2-mutant confirmed by central tissue testing, HER2-mutant not confirmed by central tissue testing and overall will be summarised, and presented separately for each mutation type (exon 19, exon 20).

Baseline HER2 activating mutation data and HER2 expression data will be listed, including information on patients with other potential HER2 mutations not included in the protocol pre-specified list of HER2 activating mutations.

#### **4.2.14 Concomitant and other treatments**

Medications received prior to, concomitantly or post-treatment will be coded using the AstraZeneca Drug Dictionary Anatomical Therapeutic Chemical (ATC) Classification codes. Medications will be summarised for the FAS by ATC classification and Generic Drug Name.

The following summaries will be produced:

- Summary of prior medications

- Summary of allowed concomitant medications
- Summary of disallowed concomitant medications
- Summary of post study treatment cancer therapies

All concomitant, prior and post study treatment discontinuation medication and therapy data will be listed.

#### **4.2.15 COVID-19**

Summaries of data relating to patients diagnosed with coronavirus 2019-nCoV (COVID-19), and the impact of COVID-19 on study conduct (in particular missed visits, delayed or discontinued study treatment, and other protocol deviations) may be generated, including:

- Disposition (discontinued study treatment due to COVID-19 and withdrew study due to COVID-19)
- Deviations (overall deviations plus if due to COVID-19 and not due to COVID-19)
- Summary of COVID-19 disruption (visit impact, drug impacted)
- Summary of treatment impacted due to COVID-19 (dose delay, dose reduction, and treatment discontinuation)
- Safety data analysis separately for patients affected by COVID-19 (i.e., deaths or adverse events summary attributed to COVID-19 pandemic).
- Listing for patients affected by the COVID-19 pandemic
- Listing for patients with reported issues in the Clinical Trial Management System due to the COVID-19 pandemic.

Additional summaries and sensitivity analyses may be conducted to investigate the impact of COVID-19 on study endpoints. In these sensitivity analyses, any patient who had a death with primary or secondary cause as COVID-19 infection will be censored at their COVID-19 infection death date. COVID-19 deaths will be identified by primary/secondary cause of death.

#### **4.2.16 Data Cut-offs**

At the first DCO, approximately 6 months after the last patient's first dose, ORR, DoR, DCR, PFS, OS, tumour size change, safety, immunogenicity, and PK data will be summarised for the populations planned in the respective sections. At the final DCO, approximately CO months after the last patient's first dose, all endpoints will be summarised, including updated summaries for those endpoints summarised at the first DCO.

## **5 INTERIM ANALYSES**

There are no planned interim analyses for this study.

## **6 CHANGES OF ANALYSIS FROM PROTOCOL**

Analyses based on ITT and RES will only be conducted if they differ from FAS.

An additional analysis of best overall response will be conducted, including unconfirmed response (PR and CR) as a response.

PFS is expected to mature at first DCO, thus PFS and OS will be analysed at the first DCO.

## **7 REFERENCES**

Brookmeyer, R., & Crowley, J. A. (1982). Confidence Interval for the Median Survival Time. *Biometrics*, 38:29-41.

Klein, J., & Moeschberger, M. (1997). *Survival Analysis: Techniques for Censored and Truncated Data*. New York: Springer-Verlag.

## **8 APPENDIX**

Not applicable.

## SIGNATURE PAGE

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