Statistical Analysis Plan J2G-MC-JZJZ Version 1.0

An Open-label, Randomized Study to Evaluate the Bioequivalence of Selpercatinib Formulations

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STATISTICAL ANALYSIS PLAN

An Open-Label, Randomized Study to Evaluate the Bioequivalence of Selpercatinib Formulations

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1. TABLE OF CONTENTS

2. ABBREVIATIONS

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

AE	Adverse event
AUC	Area under the concentration versus time curve
AUC(0-∞)	Area under the concentration versus time curve from time zero to infinity
AUC(0-t_{last})	Area under the concentration versus time curve from time zero to time t, where t is the last time point with a measurable concentration
BE	Bioequivalence
BQL	Below the quantifiable lower limit of the assay
CI	Confidence interval
CL/F	Apparent total body clearance of drug calculated after extra-vascular administration
C_{last}	Last quantifiable drug concentration
C_{max}	Maximum observed drug concentration
CRF	Case Report Form
CRU	Clinical Research Unit
CSR	Clinical Study Report
CV	Coefficient of variation
ECG	Electrocardiogram
GMR	Geometric mean ratio
ICH	International Conference on Harmonisation
MedDRA	Medical Dictionary for Regulatory Activities
NG	Nasal gastric
PD	Pharmacodynamic
PK	Pharmacokinetic
SAE	Serious adverse event
SAP	Statistical Analysis Plan
SD	Standard deviation
$t_{1/2}$	Half-life associated with the terminal rate constant (λ_z) in non-compartmental analysis
TEAE	Treatment-emergent adverse event

TFLs	Tables, Figures, and Listings
t_{max}	Time of maximum observed drug concentration
V_{ss}/F	Apparent volume of distribution at steady state after extravascular administration
V_z/F	Apparent volume of distribution during the terminal phase after extra-vascular administration
WHO	World Health Organization

3. INTRODUCTION

This SAP has been developed after review of the Clinical Study Protocol (final version dated 19 July 2021), Protocol Amendment (a) (final version dated 04 August 2021), Protocol Amendment (b) (final version dated 13 August 2021), and Protocol Amendment (c) (final version dated 14 October 2021).

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

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

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

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

4. STUDY OBJECTIVES AND ENDPOINTS

Objectives	Endpoints
Primary	
• To evaluate the bioequivalence (BE) of a single 160-mg dose of selpercatinib as the tablet formulation (test) compared to the commercial capsule formulation (reference)	• Maximum observed drug concentration (C_{max}), area under the concentration versus time curve from time zero to infinity (AUC[0-∞]), and area under the concentration versus time curve from time zero to time t, where t is the last time point with a measurable concentration (AUC[0-t_{last}]) of selpercatinib
Secondary	
• To describe the safety and tolerability of a single 160-mg oral dose of selpercatinib	• Summary of the number of treatment-emergent adverse events

as the tablet formulation (test) compared to the commercial capsule formulation (reference)	(TEAEs) and serious adverse events (SAEs)
Exploratory	
• To determine whether the PK of selpercatinib are altered by initial pH	• C_{max}, AUC(0-∞), and time of maximum observed drug concentration (t_{max}) of selpercatinib

5. STUDY DESIGN

5.1 Overall Design

Study J2G-MC-JZJZ will be a Phase 1 open-label, randomized, two-period, two-formulation, two-sequence, two-stage adaptive crossover study in adult heathy male and female participants. The new 160 mg tablet will be compared to 2 × 80 mg commercially available capsules (160 mg is the highest approved dose). Figure 1 below illustrates the study randomization and crossover schema.

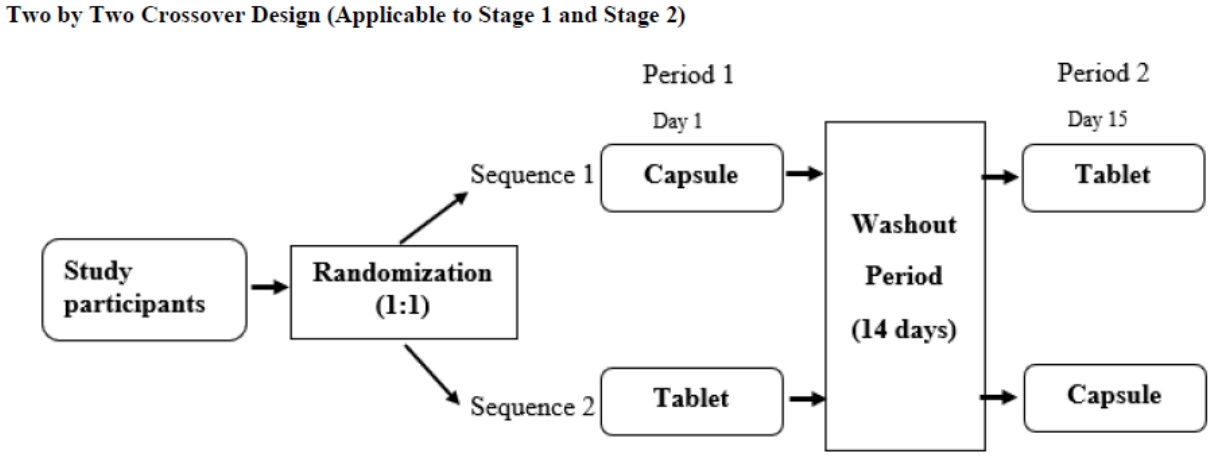

Figure 1: J2G-MC-JZJZ Study Schema

Exploratory analysis of pH measurements (done via nasal gastric [NG] tube insertion and aspiration of gastric secretions and testing via pH meter) will be included in Stage 1 to understand the pH dynamics, including the potential of pH effect on absorption. The pH will not be measured in Stage 2 of the study.

Safety assessments, including adverse events (AEs), concomitant medications, medical assessments, clinical laboratory tests, vital signs, and electrocardiograms (ECGs), and blood sampling for PK, will also be performed.

5.1.1 Screening

All participants will be screened within 28 days prior to enrolment.

5.1.2 Treatment and Assessment Period

Stage 1:

Participants will be admitted to the clinical research unit (CRU) on Day -1. On the morning of Day 1, participants will be randomized to receive a single oral dose of 160-mg selpercatinib as the capsule or tablet formulation, and will be dosed according to the randomization sequence following an overnight fast of at least 10 hours. On Day 1, participants will have an NG tube placed in the stomach prior to dosing to assess gastric pH. Participants will remain resident at the CRU until discharge on Day 7.

Participants will attend outpatient visits for the collection of PK blood samples and assessment of vital signs on Days 9 and 11.

Participants will be re-admitted to the CRU on Day 14 and in the morning of Day 15 will receive their second single oral dose of 160-mg selpercatinib as the capsule or tablet formulation, according to the randomization schedule, following an overnight fast of at least 10 hours. On Day 15, participants will have an NG tube placed in the stomach prior to dosing to assess gastric pH. Participants will remain resident at the CRU until discharge on Day 21.

Participants will attend outpatient visits for the collection of PK blood samples and assessment of vital signs on Days 23, 25, and 28.

There will be a washout of at least 14 days between doses of selpercatinib.

Stage 2:

Participants will be admitted to the CRU on Day -1. On the morning of Day 1, participants will be randomized to receive a single oral dose of 160-mg selpercatinib as the capsule or tablet formulation, and will be dosed according to the randomization sequence following an overnight fast of at least 10 hours. Participants will remain resident at the CRU until discharge on Day 7.

Participants will attend outpatient visits for the collection of PK blood samples and assessment of vital signs on Days 9 and 11.

Participants will be re-admitted to the CRU on Day 14 and in the morning of Day 15 will receive their second single oral dose of 160-mg selpercatinib as the capsule or tablet formulation, according to the randomization schedule, following an overnight fast of at least 10 hours. Participants will remain resident at the CRU until discharge on Day 21.

Participants will attend outpatient visits for the collection of PK blood samples and assessment of vital signs on Days 23, 25, and 28.

There will be a washout of at least 14 days between doses of selpercatinib.

6. TREATMENTS

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

Study Treatment Name	Abbreviation	Treatment order in TFL
160 mg selpercatinib (2 x 80 mg capsules)	Capsule	1
160 mg selpercatinib (1 x 160 mg tablet)	Tablet	2

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

Sequence	Study Treatment Sequence Name	Abbreviation	Treatment order in TFL
1	160 mg selpercatinib (2 x 80 mg capsules) / 160 mg selpercatinib (1 x 160 mg tablet)	Capsule / Tablet	1
2	160 mg selpercatinib (1 x 160 mg tablet) / 160 mg selpercatinib (2 x 80 mg capsules)	Tablet / Capsule	2

7. SAMPLE SIZE JUSTIFICATION

The incidence of those participants with a different PK profile (2 of 19 participants in Study LOXO-RET-18015) has meant that Lilly is planning to enrol up to approximately 60 participants in Stage 1. This is to ensure that at least 50 participants will complete Stage 1 and a sufficient variation of gastric pH will be incorporated in Stage 1.

If the true intraparticipant coefficient of variation (CV) is 30% for C_{max} and 20% for the area under the concentration versus time curve (AUC), the first 50 participants in Stage 1 will give approximately 90% power to meet BE criteria at a 1-sided α level of 0.05, under an assumption of a geometric mean ratio (GMR) of 1.05.

The table below shows the required sample size for Stage 2 to provide the power for C_{max} of 90% based on different intraparticipant CV for C_{max} from Stage 1, assuming the true tablet-to-capsule GMR is 1.05 under scenario when the power is less than 90% and BE is not met at Stage 1. The actual sample size for Stage 2 will be determined based on the observed intraparticipant CV at Stage 1.

In Stage 1, dropouts will not be replaced.

In Stage 2, dropouts will not be replaced, but over-enrollment of up to 20% of the determined sample size will be permitted to ensure a sufficient number of participants.

Sample Size for Stage 2 Based on Intraparticipant CV for C_{max} in Stage 1

Intraparticipant CV for C_{max} in Stage 1	Required Sample Size for Stage 2
40%	50
50%	100
60%	156
70%	216

Note: The total sample size will be at least 50 for Stage 1 plus the required sample size for Stage 2.

8. DEFINITION OF ANALYSIS POPULATIONS

The "Safety" population will consist of all enrolled participants who received at least one dose of selpercatinib, whether or not they completed all protocol requirements, and have at least one postdose safety assessment.

The "Pharmacokinetic" population will consist of all participants who received at least one dose of selpercatinib and have evaluable PK data. Participants may be excluded from the PK summary statistics and statistical analysis if a participant has an AE of vomiting that occurs at or before 2 times median time of maximum observed drug concentration (t_{max}).

The "Pharmacodynamic" population will consist of all participants who received at least one does of selpercatinib and have evaluable PD data. Participants may be excluded from the PD summary statistics and statistical analysis if a participant has an AE of vomiting that occurs at or before 2 times median t_{max}.

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

9. STATISTICAL METHODOLOGY

9.1 General

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

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

Data analysis will be performed using SAS® Version 9.4 or greater.

9.2 Demographics and Participant Disposition

Participant disposition will be summarized and listed. The demographic variables age, sex, race, ethnicity, country of enrolment, site ID, body weight, height and body mass index will be summarized and listed. All other demographic variables will be listed only.

9.3 Pharmacokinetic Assessment

9.3.1 Pharmacokinetic Analysis

Noncompartmental methods applied with a validated software program (Phoenix WinNonlin Version 8.1 or later) to the plasma concentrations of selpercatinib will be used to determine the following PK parameters, when possible:

Parameter	Units	Definition
AUC(0-t_{last})	ng.h/mL	area under the concentration versus time curve from time zero to time t, where t is the last time point with a measurable concentration
AUC(0-∞)	ng.h/mL	area under the concentration versus time curve from time zero to infinity
C_{max}	ng/mL	maximum observed drug concentration
t_{max}	h	time of maximum observed drug concentration
$t_{1/2}$	h	half-life associated with the terminal rate constant (λ_z) in non-compartmental analysis
CL/F	L/h	apparent total body clearance of drug calculated after extra-vascular administration
V_Z/F	L	apparent volume of distribution during the terminal phase after extra-vascular administration
V_{SS}/F	L	apparent volume of distribution at steady state after extra-vascular administration

Additional PK parameters may be calculated, as appropriate.

The software and version used for the final analyses will be specified in the CSR. Any exceptions or special handling of data will be clearly documented within the CSR.

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

General PK Parameter Rules

- Actual sampling times will be used in the final analyses of individual PK parameters, except for non-bolus pre-dose sampling times which will be set to zero.

- C_{max} and t_{max} will be reported from observed values. If C_{max} occurs at more than one time point, t_{max} will be assigned to the first occurrence of C_{max}.

- AUC parameters will be calculated using a combination of the linear and logarithmic trapezoidal methods (linear-log trapezoidal rule). The linear trapezoidal method will be applied up to t_{max} and then the logarithmic trapezoidal method will be used after t_{max}. The minimum requirement for the calculation of AUC will be the inclusion of at least three

consecutive plasma concentrations above the lower limit of quantification, with at least one of these concentrations following C_{max}.

- The $t_{1/2}$ will be calculated, when appropriate, based on the apparent terminal log-linear portion of the concentration-time curve. The start of the terminal elimination phase for each participant will be defined by visual inspection and generally will be the first point at which there is no systematic deviation from the log-linear decline in plasma concentrations. Half-life will only be calculated when a reliable estimate for this parameter can be obtained comprising of at least 3 data points. If $t_{1/2}$ is estimated over a time window of less than 2 half-lives, the values will be flagged in the data listings. Any $t_{1/2}$ value excluded from summary statistics will be documented in the footnote of the summary table.

- A uniform weighting scheme will be used in the regression analysis of the terminal log-linear portion of the concentration-time curve.

- The parameters based on last predicted observed drug concentration (C_{last}) will be reported (except in bioequivalence and bioavailability studies, where only the observed parameters will be reported).

Individual PK Parameter Rules

- Only quantifiable concentrations will be used to calculate PK Parameters with the exception of special handling of certain concentrations reported below the lower limit of quantitation (BQL). Plasma concentrations reported as BQL will be set to a value of zero when all of the following conditions are met:

    - The compound is non-endogenous.

    - The samples are from the initial dose period for a participant or from a subsequent dose period following a suitable wash-out period.

    - The time points occur before the first quantifiable concentration.

- All other BQL concentrations that do not meet the above criteria will be set to missing.

- Also, where two or more consecutive concentrations are BQL towards the end of a profile, the profile will be deemed to have terminated and therefore any further quantifiable concentrations will be set to missing for the calculation of the PK parameters unless it is considered to be a true characteristic of the profile of the drug.

Individual Concentration vs. Time Profiles

- Individual concentrations will be plotted utilizing actual sampling times.

- The terminal point selections will be indicated on a semi-logarithmic plot.

Average Concentration vs. Time Profiles

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

Treatment of Outliers during PK Analysis

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

Data within an Individual Profile

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

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

Data between Individual Profiles

1. If n<6, then the dataset is too small to conduct a reliable range test. Data will be analyzed with and without the atypical value, and both sets of results will be reported.

2. If n≥6, then an objective outlier test will be used to compare the atypical value to other values included in that calculation:

    a. Transform all values in the calculation to the logarithmic domain.

    b. Find the most extreme value from the arithmetic mean of the log transformed values and exclude that value from the dataset.

    c. Calculate the lower and upper bounds of the range defined by the arithmetic mean ±3*SD of the remaining log-transformed values.

    d. If the extreme value is within the range of arithmetic mean ±3*SD, then it is not an outlier and will be retained in the dataset.

    e. If the extreme value is outside the range of arithmetic mean ±3*SD, then it is an outlier and will be excluded from analysis.

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

Reporting of Excluded Values

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

9.3.2 Pharmacokinetic Statistical Methodology

PK parameters will be evaluated to estimate BE of the selpercatinib tablet and capsule formulations.

For the primary analysis, log-transformed C_{max}, AUC(0-t_{last}), and AUC(0-∞) parameters will be evaluated in a linear mixed effect model with fixed effects for treatment formulation, period, sequence, and a random effect for participant. The differences between the tablet (test) and capsule (reference) formulations will be back-transformed to present the ratios of geometric least squares means and the corresponding CIs. Intra-participant CV will be derived and bioequivalence will be met if the CI for the ratio falls within 80%-125%.

CCI

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CCI

For secondary analysis, the t_{max} will be analyzed using a Wilcoxon signed rank test. Estimates of the median difference based on the individual paired differences, CIs, and p-values from the Wilcoxon signed rank test will be calculated.

9.4 Pharmacodynamic Assessment

9.4.1 Pharmacodynamic Statistical Methodology

The gastric pH data (Stage 1 only) will be summarized by treatment formulation (capsule or tablet), along with changes from baseline (Day 1 or 15 predose, as applicable). A scatter plot of predose gastric pH data versus PK parameters by day will be produced, with a regression line fitted. This data will also be listed.

9.5 Safety and Tolerability Assessments

9.5.1 Adverse events

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

All AEs will be listed. TEAEs will be summarized by treatment, severity and relationship to the study drug. The frequency (the number of AEs, the number of participants experiencing an AE and the percentage of participants experiencing an AE) of TEAEs will be summarized by treatment, Medical Dictionary for Regulatory Activities (MedDRA) version 24.0 system organ class and preferred term. The summary and frequency AE tables will be presented for all causalities and those considered related to the study drug by the investigator. Any SAEs will be listed.

Discontinuations due to AEs will be listed.

9.5.2 Concomitant medication

Concomitant medication will be coded using the WHO drug dictionary (Version March 2021). Concomitant medication will be listed.

9.5.3 Clinical laboratory parameters

All clinical chemistry and hematology data will be summarized by parameter and treatment sequence, and listed. Urinalysis data will be listed. Additionally, clinical chemistry, hematology

and urinalysis data outside the reference ranges will be listed and flagged on individual participant data listings.

9.5.4 Vital signs

Vital signs data will be summarized by treatment sequence together with changes from baseline, where baseline is defined as the Day 1 or Day 15 predose assessment, as appropriate. Figures of mean vital signs and mean changes from baseline profiles will be presented by treatment sequence.

Values for individual participants will be listed.

9.5.5 Electrocardiograms

ECGs will be performed for safety monitoring purposes only and will not be presented. Any clinically significant findings from ECGs will be reported as an AE.

9.5.6 Hepatic Monitoring

If a participant experiences elevated laboratory parameters, as detailed in Section 8.2.7.1 of the protocol, additional tests will be performed to confirm the abnormality. Additional safety data may be collected if required, as defined in the protocol. Where applicable, the following will be presented.

The participants' liver disease history and associated person liver disease history data will be listed. Use of acetaminophen during the study, which has a potential for hepatotoxicity, will be listed. Results from any hepatic monitoring procedures, such as a magnetic resonance elastography scan, and biopsy assessments will be listed, if performed.

Hepatic risk factor assessment data will be listed. Liver related signs and symptoms data will be summarized by treatment and listed. Alcohol and recreational drug use data will also be listed.

All hepatic chemistry, hematology, coagulation, and serology data will be listed. Values outside the reference ranges will be flagged on the individual participant data listings.

9.5.7 Other assessments

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

9.5.8 Safety and Tolerability Statistical Methodology

No inferential statistical analyses are planned.

10. INTERIM ANALYSES

At completion of Stage 1, an interim analysis will be conducted to test BE and estimate the power before continuing to Stage 2.

In order to meet the BE criterion at a specific α level, the 2-sided confidence interval (CI) for the tablet-to-capsule (tablet formulation / capsule formulation) GMR for AUC and C_{max} at the (1-2α) level should fall within 80%-125%. The sequential design approach of Potvin's Method C will be used to preserve the overall type I error rate at the 1-sided significance level of 0.05.

The BE testing and alpha spending scheme is described in Figure 2. At an interim analysis, the power will be evaluated using the intraparticipant CV from Stage 1 using α level of 0.05 assuming the true tablet-to-capsule GMR is 1.05. If Stage 1 has at least 90% power, BE will be tested at Stage 1 at an α level of 0.05. The study will be stopped whether BE is met or not met. The evaluation of the power at Stage 1 will be based on C_{max}, which has higher variability. If the power is less than 90%, BE will be tested at an α level of 0.0294 as originally proposed by Pocock (Pocock 1977). If the BE criterion is met, the study will be stopped. If the BE criterion is not met, the sample size for Stage 2 will be calculated based on the intraparticipant CV at Stage 1 and an α level of 0.0294 assuming the true tablet-to-capsule GMR is 1.05, and Stage 2 will be initiated. At Stage 2, BE will be evaluated using data from both stages at an α level of 0.0294.

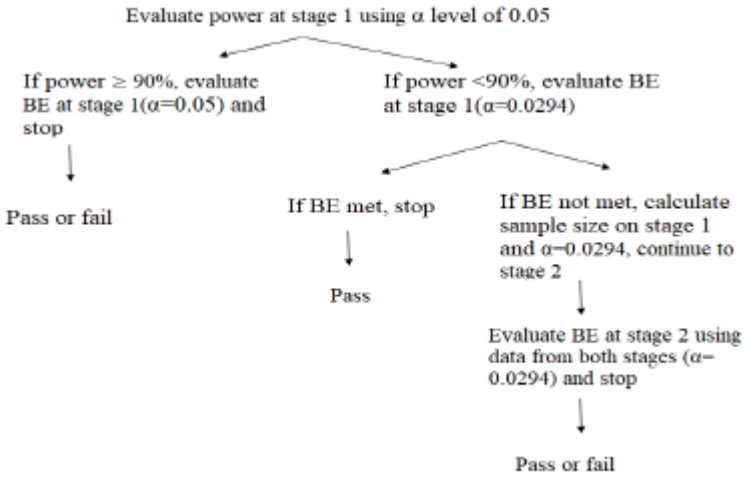

Figure 2: Adaptive sequential design method C (Potvin, 2007).

11. CHANGES FROM THE PROTOCOL SPECIFIED STATISTICAL ANALYSES

There were no changes from the protocol specified statistical analyses.

12. REFERENCES

1. International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use, ICH Harmonized Tripartite Guideline, Statistical Principles for Clinical Trials (E9), 5 February 1998.

2. International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use, ICH Harmonized Tripartite Guideline, Structure and Content of Clinical Study Reports (E3), 30 November 1995.

3. Pocock SJ. Group sequential methods in the design and analysis of clinical trials. Biometrika 1977; 64:191–199.

4. Potvin D, DiLiberti CE, Hauck WW, Parr AF, Schuirmann DF, Smith RA. Sequential design approaches for bioequivalence studies with crossover designs. Pharmaceut. Statist. 2007, https://doi.org/10.1002/pst.294.

13. DATA PRESENTATION

13.1 Derived Parameters

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

13.2 Missing Data

Missing data will not be displayed in listings.

13.3 Insufficient Data for Presentation

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

14. APPENDICES

Appendix 1: Document History

Status and Version	Date of Change	Summary/Reason for Changes
Final Version 1.0	NA	NA; the first version.

NA = not applicable

Leo Document ID = 9400c0a9-dd87-4116-8be6-ade9fb1f71cf

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