Protocol C4971003

A PHASE 1B/2 STUDY OF PF-07901801, A CD47 BLOCKING AGENT, WITH TAFASITAMAB AND LENALIDOMIDE FOR PARTICIPANTS WITH RELAPSED/REFRACTORY DIFFUSE LARGE B CELL LYMPHOMA NOT ELIGIBLE FOR STEM CELL TRANSPLANTATION

Statistical Analysis Plan
(SAP)

Version: 2.0

Date: 04 May 2023

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

TABLE OF CONTENTS

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

LIST OF TABLES

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

LIST OF FIGURES

APPENDICES

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

1. VERSION HISTORY

This SAP (Version 2) for study C4971003 is based on protocol amendment 1 dated 14 March 2023.

Table 1 Summary of Changes

Version/ Date	Associated Protocol Amendment	Rationale	Specific Changes
1	Original 18 August 2022	N/A	N/A
2	Amendment 1, 14 March 2023	The Phase 2 dosing of PF-07901801 was changed from body weight-based to a fixed dosing approach in Protocol Amendment 1. Updates are to reflect this change in the Protocol Amendment 1 and to reflect the most recent version of the study CRF.	Updated the study design and the corresponding analyses and summaries to reflect the Protocol Amendment 1 where the Phase 2 dosing of PF-07901801 was updated to fixed dosing approach; updated several analyses to reflect the data collected in the most recent version of the study CRF. Section 2 "INTRODUCTION" – updated to clarify the doses of PF-07901801 for Phase 2 are fixed doses; clarified the primary analysis of the study would include all data up to 12 months after the last patient in Phase 2 received the first dose of study treatment; clarified that additional analyses of the data would take place during the dose escalation portion. Section 2.3 "Study Design" – updated to reflect the study design in Protocol Amendment 1. Section 3.2.3 "Pharmacokinetic Endpoints" – removed post-dose concentrations of Tafasitamab and Lenalidomide to be consistent with the study protocol. Section 3.4 "Baseline Variables" – clarified the last measurement prior to or on the 'start date' would serve as the baseline measurement for efficacy analyses. Section 5.2.6 "Definition of start of new anti-cancer therapy", Section 6.6.1.4 "Prior Anti-cancer Therapies", Section 6.6.5 "Subsequent Anti-Cancer Therapies" - updated to reflect the exact CRF page names.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

			Section 5.2.10 "Adequate Baseline Disease Assessment" – refined the criteria for adequate baseline based on clinical input. Section 6 "Analyses and summaries" – removed the analyses with combined data from Phase 1b and Phase 2. Section 6.4.1 "Biomarker Analysis" – clarified that biomarker analysis would be detailed in a separate biomarker analysis plan. Section 6.6.1.1 "Demographic Characteristics" – updated age categories of interest. Section 6.6.1.3 "Disease Characteristics" – updated to reflect the most recent CRF. Section 6.6.2.1 "Disposition" – removed disposition for long-term follow up as this information is not collected in CRF. Section 6.6.3.1 "Exposure to PF-07901801" – updated to reflect the summary of exposure for PF-07901801 in Phase 2 where fixed dosing approach is used. Section 6.7.4 "Laboratory Data"- removed the derivation for WBC in percentage because the CRF does not collect WBC in percentage. Minor editorial and consistency changes throughout the document.

2. INTRODUCTION

This statistical analysis plan (SAP) provides the detailed methodology for summary and statistical analyses of the data collected in Study C4971003.

The purpose of this Phase 1b/2 study is to evaluate the safety, tolerability and potential clinical benefits of PF-07901801 in combination with standard doses of tafasitamab and lenalidomide in participants with R/R DLBCL not eligible for high dose chemotherapy followed by ASCT. Phase 1b will assess DLTs to select up to 2 fixed doses of PF-07901801 to be administered in combination with tafasitamab and lenalidomide in the randomized Phase 2 of the study. The Phase 2 of the study will determine the recommended Phase 3 dose of PF-07901801 to be administered in combination with tafasitamab and lenalidomide.

Statistical analyses will be performed using cleaned eCRF data as well as non-CRF data (ie, pharmacokinetics data, immunogenicity data, and biomarker data). The primary analysis of

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

the study will include all data up to a cut-off date corresponding to 12 months after the last patient in Phase 2 receives the first dose of study treatment. The final analysis of the data will be performed after last patient last visit (LPLV).

Additional analyses of the data will take place during the dose escalation portion and may be performed for publication or regulatory reporting purposes.

Throughout this document 'start date' refers to date of randomization for Phase 2 and first dose of study treatment for Phase 1b unless otherwise specified.

2.1. Modifications to the Analysis Plan Described in the Protocol

Not applicable.

2.2. Study Objectives, Endpoints, and Estimands

Phase 1b			
Type	**Objective**	**Endpoint**	**Estimand**
		Primary	
Safety	To assess DLTs, safety and tolerability of PF-07901801 in combination with tafasitamab and lenalidomide in adult participants with R/R DLBCL in order to select up to 2 doses of PF-07901801 for further evaluation in Phase 2 of the study.	DLTs during the DLT observation period (28 days following C1D1).	DLT rate estimated based on data from DLT-evaluable participants during the DLT observation period (28 days following C1D1).
		Secondary	
Safety	To evaluate the overall safety profile of the combination.	• AEs as characterized by type, frequency, severity (as graded by NCI CTCAE v5.0), timing, seriousness, and relationship to study treatment. • Laboratory abnormalities as characterized by type, frequency, severity (as graded by NCI CTCAE v5.0), and timing.	NA
Efficacy	To evaluate the anti-tumor activity of PF-07901801 in combination with tafasitamab and lenalidomide.	OR, DoR, CR, DoCR, and PFS per Lugano Response Classification Criteria 2014 as assessed by the investigator.	NA

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

PK	To evaluate the PK of PF-07901801.	Pre- and post-dose concentration of PF-07901801.	NA
PK	To evaluate the PK of tafasitamab and lenalidomide.	Pre-dose concentrations of tafasitamab and lenalidomide.	NA
Immunogenicity	To evaluate immunogenicity of PF-07901801 and tafasitamab.	ADAs and NAbs against PF-07901801 and tafasitamab.	NA
Tertiary/Exploratory			
Biomarker	To understand the relationship between the therapeutic intervention(s) being studied and the biology of the participant's disease.	CCI [redacted] obtained at baseline, on treatment and/or at end of study.	NA

Phase 2			
Type	**Objective**	**Endpoint**	**Estimand**
Primary			
Efficacy	To assess the clinical anti-tumor activity of PF-07901801 in combination with tafasitamab and lenalidomide.	OR per Lugano Response Classification Criteria 2014 as assessed by the investigator.	The treatment effect of PF-07901801 in combination with tafasitamab and lenalidomide on OR per the Lugano 2014 response criteria as determined by investigator assessment from the 'start date' until the first documentation of PD, death, or start of new anticancer therapy. Participants who do not have a post-baseline disease assessment due to early PD, who receive anticancer therapies other than the study treatment prior to achieving an objective response, or who die, experience PD, or stop disease assessments for any reason prior to achieving an objective response will be counted as non-responders.
Secondary			
Efficacy	To assess additional efficacy outcomes of PF-07901801 in	DoR, CR, DoCR and PFS by investigator per Lugano	NA

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

	combination with tafasitamab and lenalidomide.	Response Classification Criteria 2014.	
Efficacy/ Safety/ PK	Select the RP3D for PF-07901801 in combination with tafasitamab and lenalidomide.	All endpoints in this study.	NA
Safety	To further evaluate the overall safety profile and tolerability of PF-07901801 in combination with tafasitamab and lenalidomide.	• AEs as characterized by type, frequency, severity (as graded by NCI CTCAE v5.0), timing, seriousness, and relationship to study treatment. • Laboratory abnormalities as characterized by type, frequency, severity (as graded by NCI CTCAE v5.0), and timing.	NA
PK	To evaluate the PK of PF-07901801.	Pre- and post-dose concentrations of PF-07901801.	NA
PK	To evaluate the PK of tafasitamab and lenalidomide.	Pre-dose concentrations of tafasitamab and lenalidomide.	NA
Immuno genicity	To evaluate immunogenicity of PF-07901801 and tafasitamab.	ADAs and NAbs against PF-07901801 and tafasitamab.	NA
Tertiary/Exploratory			
Biomark er	To understand the relationship between the therapeutic intervention(s) being studied and the biology of the participant's disease.	CCI [redacted] obtained at baseline, on treatment and/or at end of study.	NA

2.2.1. Primary Estimand(s)

Phase 1b Primary Estimand

Primary Estimand: DLT rate estimated based on data from DLT-evaluable participants during the DLT observation period (28 days following C1D1). The estimand has the following attributes:

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- Population: DLT-evaluable participants with R/R DLBCL, as defined by the inclusion and exclusion criteria to reflect the targeted population of the treatment, who receive at least 1 dose of the study treatment in the Phase 1b of the study and either experience DLT(s) during the DLT observation period or complete the DLT observation period without DLT. Participants without DLTs who receive less than 80% of the planned dose of PF-07901801 or less than 75% of the planned dose of any component of the tafasitamab and lenalidomide regimen in the DLT observation period are not evaluable for DLTs.

- Variable: Occurrence of DLTs during the DLT observation period.

- Intercurrent event: The data from participants who are not DLT-evaluable will be excluded. Participants without DLTs who stopped treatment before receiving at least 80% of the planned dose of PF-07901801 and at least 75% of the planned dose of any component of the tafasitamab and lenalidomide regimen will be excluded.

- Population-level summary measure: DLT rate defined as the number of DLT-evaluable participants with DLTs in the DLT observation period divided by the number of DLT-evaluable participants.

Phase 2 Primary Estimand

Primary Estimand: The treatment effect of PF-07901801 in combination with tafasitamab and lenalidomide on OR per the Lugano 2014 response criteria[1] as determined by investigator assessment. The estimand has the following attributes:

- Population: R/R DLBCL participants, as defined by the inclusion and exclusion criteria to reflect the targeted population of the treatment, who received at least 1 dose of study treatment.

- Variable: Objective response defined as CR or PR per Lugano 2014 response criteria as determined by investigator, from the 'start date' until the first documentation of PD, death, or start of new anticancer therapy.

- Intercurrent events: All data collected after an intercurrent event of subsequent anticancer therapy will be excluded. All response assessments regardless of gaps in disease assessments will be considered. Participants who do not have a post-baseline disease assessment due to early PD, who receive anticancer therapies other than the study treatment prior to achieving an objective response, or who die, experience PD, or stop disease assessments for any reason prior to achieving an objective response will be counted as non-responders.

- Population-level summary measure: ORR defined as the proportion of participants in the analysis population with an objective response, and 2-sided 95% CI for ORR using the Wilson method. Results will be displayed by treatment group.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

2.3. Study Design

C4971003 is a multicenter, international, Phase 1b/2 study of different doses of PF-07901801 in combination with tafasitamab and lenalidomide in participants with R/R DLBCL who have completed at least 1 line of systemic treatment (at least 1 containing an anti-CD20 therapy), and who are not candidates for high dose therapy/ASCT. See Figure 1 for design schema.

The Phase 1b will be conducted in approximately 20 participants. The objectives of the Phase 1b are to evaluate the safety and tolerability, PK, PD of PF-07901801 in combination with standard doses of tafasitamab and lenalidomide, and to select doses for Phase 2.

The planned 3 dose levels of PF-07901801 to be assessed in Phase 1b are:

- Cohort 1 (DL1): 4 mg/kg, C1 to C3 QW then ≥ C4 Q2W
- Cohort 2 (DL2): 10 mg/kg, C1 to C3 QW then ≥ C4 Q2W
- Cohort 3 (DL3): 18 mg/kg, C1 to C3 QW then ≥ C4 Q2W

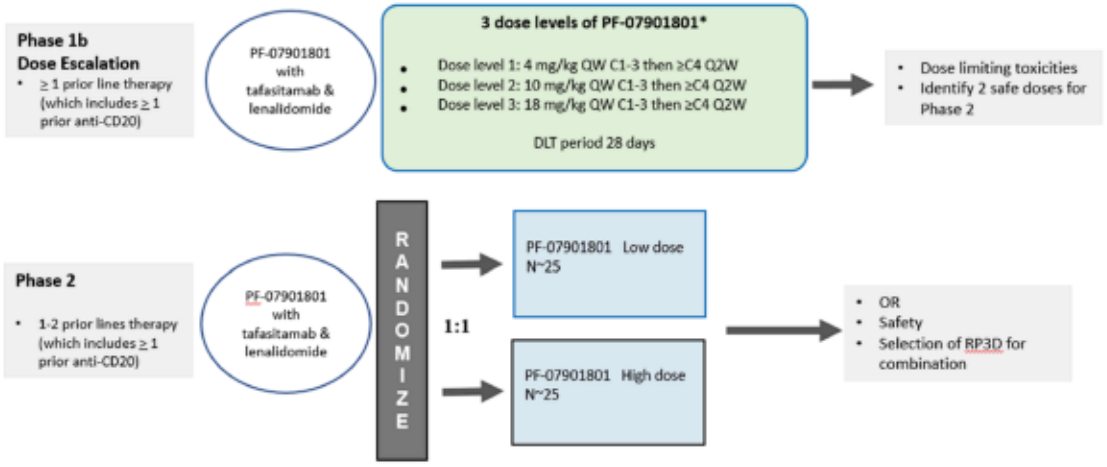
An escalation/de-escalation approach guided by mTPI-2[2] will be used in Phase 1b to identify the safe doses ofPF-07901801 when administered in combination with tafasitamab and lenalidomide.

At the sponsor's discretion proceeding to Phase 2 will be determined upon completion of Phase 1b. The totality of data including efficacy, safety, PK, PD, biomarker, and other considerations will be used to determine the fixed doses of PF-07901801 that are recommended for further development in Phase 2.

In the Phase 2 part of the study, approximately 50 participants will be randomized 1:1 into 2 selected fixed doses of PF-07901801 in combination with standard doses of tafasitamab and lenalidomide to assess the efficacy and further characterize the safety and tolerability of the combination therapy. If only 1 dose of PF-07901801 is recommended, approximately 25 participants may be treated at this dose in combination with tafasitamab and lenalidomide.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

Figure 1 Study Design



*A minimum of 2 to 4 participants is required at each dose level.
Approximately 6 to 9 participants will be treated at the MTD or highest safe tested dose level before proceeding to Phase 2.

3. ENDPOINTS AND BASELINE VARIABLES: DEFINITIONS AND CONVENTIONS

3.1. Primary Endpoints

Phase 1b

The primary endpoint of the Phase 1b of the study is the DLTs during the DLT observation period (28 days following C1D1).

Severity of AEs will be graded according to NCI CTCAE v5.0. For the purpose of the Phase 1b, any of the following AEs occurring during the DLT observation period which are considered by the investigator at least possibly related to any or all of the combination study treatments will be classified as DLTs:

Hematologic:

- G4 thrombocytopenia (<25,000/μL) lasting ≥72 hours or a platelet count ≤10,000/μL at any time, unexplained by underlying disease.
- ≥G3 thrombocytopenia associated with ≥G2 bleeding, unexplained by underlying disease.
- G4 anemia, unexplained by underlying disease.
    - Prophylactic use of erythropoietin or blood products are not allowed during the DLT period in Phase 1b.
- G4 neutropenia lasting ≥7 days, unexplained by underlying disease.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- G3 febrile (≥38.3°C) neutropenia lasting ≥7 days, unexplained by underlying disease.
- G4 febrile neutropenia unexplained by underlying disease.

Non-hematologic:

- Any treatment-related ≥G3 non-hematologic toxicity (see below for specifications applying to special circumstances) with the following exceptions:
    - G3 nausea, vomiting and diarrhea that improve to G2 or better within 72 hours after supportive care;
    - Transient G3 fatigue lasting ≤7 days;
    - G3 AEs that recover to baseline or G1 within 3 days;
    - Transient asymptomatic ≥G3 laboratory abnormalities considered not clinically significant following agreement between investigators and the sponsor's medical monitor and starting to recover within 72 hours of their onset with standard supportive care;
    - Hypersensitivity that can be controlled with medical treatment and resolves to asymptomatic (≤G1) within 72 hours.
- Other ≥G2 PF-07901801-related non-hematologic toxicities that, in the opinion of the investigator, require a dose reduction or discontinuation of PF-07901801 may be considered a DLT.

Phase 2

The primary endpoint in the Phase 2 part of the study is OR per Lugano Response Classification Criteria 2014 as assessed by the investigator.

OR is defined as a best overall response (BOR) of complete response (CR) or partial response (PR) according to Lugano Response Classification Criteria 2014. BOR will be assessed programmatically based on reported overall responses from the 'start date' until the first documentation of progressive disease (PD), death or start of new anti-cancer therapy, whichever occurs first.

3.2. Secondary Endpoints

3.2.1. Efficacy Endpoints

3.2.1.1. Complete Response

CR is defined as a BOR of CR per Lugano Response Classification Criteria 2014 as assessed by the investigator, from the 'start date' until the first documentation of PD, death or start of new anti-cancer therapy. CR rate is defined as the proportion of participants with a CR.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

3.2.1.2. Duration of Response

Duration of response (DoR) is defined, for participants with an objective response per Lugano Response Classification Criteria 2014, as the time from the first documentation of OR until PD, or death due to any cause, whichever occurs first.

3.2.1.3. Duration of Complete Response

Duration of complete response (DoCR) is defined, for participants with a CR per Lugano Response Classification Criteria 2014, as the time from the first documentation of a CR until PD, or death due to any cause, whichever occurs first.

3.2.1.4. Progression-free Survival

Progression-free survival (PFS) is defined as the time from the 'start date' until PD per Lugano Response Classification Criteria 2014, or death due to any cause, whichever occurs first.

3.2.2. Safety Endpoints

3.2.2.1. Adverse Events

Adverse Events (AEs) as graded by the NCI CTCAE v5.0 and coded using MedDRA.

3.2.2.2. Laboratory Parameters

Laboratory abnormalities as graded by the NCI CTCAE v5.0. For laboratory tests without NCI CTCAE grade definitions, results will be categorized as normal, abnormal, or not done.

3.2.3. Pharmacokinetic Endpoints

- Pre- and post-dose concentrations of PF-07901801.
- Pre-dose concentrations of Tafasitamab.
- Pre-dose concentrations of Lenalidomide.

3.2.4. Immunogenicity Endpoints

Incidence and titers of ADAs and NAbs against PF-07901801 and tafasitamab.

3.3. Exploratory Endpoints

CCI [redacted]

3.4. Baseline Variables

In this study, 'study drug' refers to PF-07901801 or tafasitamab or lenalidomide, and 'study treatment' refers to PF-07901801 plus tafasitamab plus lenalidomide.

Start and end dates of study treatment:

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

The date of first dose of study treatment is the earliest date of the first non-zero dose date for the study drugs in the combination.

The date of last dose of study treatment is the latest date of the last non-zero dose date for the study drugs in the combination.

Definition of baseline:

Definition of baseline for efficacy analyses

The last measurement prior to or on the 'start date' will serve as the baseline measurement for efficacy analyses. For Phase 2 patients, if such a value is missing, the last measurement prior to the first dose of study treatment will be used as the baseline measurement except for analyses of tumor data where the baseline assessment would be considered as missing.

Definition of baseline for safety analyses

The last available assessment prior to the start of study treatment is defined as 'baseline' value or 'baseline' assessment for safety analyses. If an assessment is planned to be performed prior to the first dose of study treatment in the protocol and the assessment is performed on the same day as the first dose of study treatment, it will be assumed that it was performed prior to study treatment administration, if assessment time point is not collected or is missing. If assessment time points are collected, the observed time point will be used to determine pre-dose on study day 1 for baseline calculation. Unscheduled assessments will be used in the determination of baseline. However, if time is missing, an unscheduled assessment on study day 1 will be considered to have been obtained after study treatment administration.

Patients who start treatment and discontinue from the treatment/study on the same day may have two different sets of data collected on study day 1 (one during study and one in the End of Treatment (EOT) visit. Data reported at the EOT visit are not eligible for baseline selection.

If a scheduled pre-dose measurement actually occurred post-dose, then the corresponding measurement will be treated and analyzed similar to an unscheduled post-dose measurement.

3.5. Safety Endpoints

3.5.1. Adverse Events

Treatment-Emergent Adverse Events

Treatment-emergent adverse events (TEAEs) are those events with onset dates occurring during the on-treatment period, or if the worsening of an event is during the on-treatment period .

On-treatment period is defined as the time from the first dose of study treatment through minimum (28 days + last dose of study treatment, start day of new anti-cancer drug therapy – 1 day). The start day of new anti-cancer drug therapy after the first dose of study treatment is derived as outlined in Section 5.2.5.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

4. ANALYSIS SETS (POPULATIONS FOR ANALYSIS)

For purposes of analysis, the following analysis sets are defined.

Population	Description	Applicable Analysis (for additional information refer to section 6)
DLT Evaluable Set	All enrolled participants who receive at least 1 dose of the study treatment in the Phase 1b of the study and either experience DLT(s) or complete the DLT observation period without DLT. Participants without DLTs who receive less than 80% of the planned dose of PF-07901801 or less than 75% of the planned dose of any component of the tafasitamab and lenalidomide regimen in the DLT observation period are not evaluable for DLTs. The DLT observation period is 28 days following C1D1.	Primary endpoint, main analysis (section 6.1.1.1)
Safety Analysis Set	All enrolled participants who received at least 1 dose of study treatment.	Primary endpoint, main analysis (Section 6.1.2.1) Secondary endpoints (Section 6.2)
PK Analysis Set	The PK analysis set will include all participants in the safety analysis set who have at least 1 post-dose concentration measurement.	Secondary endpoints (Section 6.3.1)
Immunogenicity Analysis Set	All participants in the safety analysis set who have at least 1 sample tested for ADA.	Secondary endpoints (Section 6.3.2)
Biomarker Analysis Set	All participants in the safety analysis set who have at least 1 baseline biomarker assessment. Analysis sets will be defined separately for biomarkers based on CCI [redacted]	Exploratory endpoints (Section 6.4.1)

"Enrolled" means a participant's, or their legally authorized representative's, agreement to participate in a clinical study following completion of the informed consent process and assignment to study treatment.

5. GENERAL METHODOLOGY AND CONVENTIONS

5.1. Hypotheses and Decision Rules

5.1.1. Hypotheses and sample size determination

Phase 1b

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

For Phase 1b of this combination, due to the dynamic nature of the Bayesian allocation procedure, the exact sample size of the "Up-and-Down" matrix design using the mTPI-2 approach cannot be determined in advance. It is expected that up to 20 patients will need to be enrolled in Phase 1b using the mTPI-2 approach.

Phase 2

Up to 2 fixed doses will be selected for further evaluation in Phase 2 of the study. Approximately 25 participants will be treated for each selected dose. With 25 participants per arm, ORR can be estimated with a maximum standard error of 10%. Table 2 provides the 95% CIs for ORR based on Wilson method (with continuity correction) for different observed responses.

Table 2 Sample Size and 95% CI for ORR based on Wilson Method (with Continuity Correction)

N=25	Number of responses	Observed ORR	95% CI for ORR
	1	0.04	0.002, 0.223
	2	0.08	0.014, 0.275
	3	0.12	0.032, 0.323
	4	0.16	0.053, 0.369
	5	0.2	0.076, 0.413
	6	0.24	0.102, 0.455
	7	0.28	0.129, 0.496
	8	0.32	0.157, 0.536
	9	0.36	0.187, 0.574
	10	0.4	0.218, 0.611
	11	0.44	0.250, 0.647
	12	0.48	0.283, 0.682
	13	0.52	0.318, 0.717
	14	0.56	0.353, 0.750
	15	0.6	0.389, 0.782
	16	0.64	0.426, 0.813
	18	0.72	0.504, 0.871
	20	0.8	0.587, 0.924
	22	0.88	0.677, 0.968

5.1.2. Decision Rules

Phase 1b

The mTPI-2 design (with target pT=0.3, e1=0.05, e2=0.05) will be utilized to estimate the MTD of PF-07901801, in combination with standard doses of tafasitamab and lenalidomide. Other evidence such as safety data beyond DLT window, clinical activity, PK, PD and biomarker data will also be evaluated in determining the recommended doses for further development in the Phase 2.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

The mTPI-2 design uses a Bayesian statistics framework and a beta binomial hierarchical model to compute the unit probability mass (UPM; the ratio of the probability mass of the interval to the length of the interval) of dosing intervals. The dose interval that has the largest UPM is selected as the winning model. The dose de-escalation/escalation recommendation for the mTPI-2 design with target pT=0.3, e1=0.05, e2=0.05 is as follows:

- If intervals {(0.15, 0.25), (0.05, 0.15), (0, 0.05)} exhibit the largest UPM: escalate to next higher dose;
- If interval (0.25, 0.35) exhibits the largest UPM: stay at current dose;
- If intervals {(0.35, 0.45), (0.45, 0.55), (0.55, 0.65), (065, 0.75), (0.75, 0.85), (0.85, 0.95), (0.95, 1)} exhibit the largest UPM: de-escalate to next lower dose.

The detailed decision rules for mTPI-2 design with target pT=0.3, e1=0.05, e2=0.05 are listed in Table 3.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

Table 3 mTPI-2 Decision Rules (pT=0.3, e1=0.05, e2=0.05)

Number of Patients with DLTs	Number of Patients														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
0	E	E	E	E	E	E	E	E	E	E	E	E	E	E	E
1	D	D	S	S	E	E	E	E	E	E	E	E	E	E	E
2		DU	D	D	D	S	S	S	E	E	E	E	E	E	E
3			DU	DU	D	D	D	D	S	S	S	S	E	E	E
4				DU	DU	DU	D	D	D	D	D	S	S	S	S
5					DU	DU	DU	DU	DU	D	D	D	D	D	S
6						DU	DU	DU	DU	DU	DU	D	D	D	D
7							DU	DU	DU	DU	DU	DU	DU	D	D
8								DU	DU	DU	DU	DU	DU	DU	DU
9									DU	DU	DU	DU	DU	DU	DU
10										DU	DU	DU	DU	DU	DU
11											DU	DU	DU	DU	DU
12												DU	DU	DU	DU
13													DU	DU	DU
14														DU	DU
15															DU

E = Escalate to the next higher dose level
S = Stay at the current dose level
D = De-escalate to the next lower dose level
DU = The current dose level is unacceptably toxic and should be eliminated from further dose finding

Phase 2

There are no formal decision rules for Phase 2.

5.2. General Methods

Unless otherwise specified, all efficacy analyses and safety analyses will be performed using the Safety Analysis Set. All analyses will be performed by phase and by treatment group (i.e. dose level) as follows:

- Phase 1b
    - Dose level 1
    - Dose level 2
    - Dose level 3

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- Phase 2
    - Selected fixed dose level 1
    - Selected fixed dose level 2

5.2.1. Data Handling After the Cutoff Date

Data after the cutoff date may not undergo the cleaning process and will not be displayed in any listings or used for summary statistics, statistical analyses or imputations.

5.2.2. Pooling of Centers

In order to provide overall estimates of treatment effects, data will be pooled across centers. The 'center' factor will not be considered in statistical models or for subgroup analyses due to the high number of participating centers in contrast to the anticipated small number of participants enrolled at each center.

5.2.3. Analyses to Assess the Impact of COVID-19 Pandemic

Data summaries and analyses may be performed to assess the impact of COVID-19 on the trial population and study data. Details of these summaries and analyses are included in the respective sections.

5.2.4. Definition of Study Day

Start day of study treatment is the day of the first dose of study treatment.

The study day for assessments occurring on or after the start of study treatment (e.g.. adverse event onset, disease measurement) will be calculated as:

Study day = Date of the assessment/event – start of study treatment + 1.

The study day for assessments occurring prior to the first dose of study treatment (e.g., baseline characteristics, medical history) will be negative and calculated as:

Study day= Date of the assessment/event – start of study treatment.

The study day will be displayed in all relevant data listings.

5.2.5. Definition of start of new anti-cancer drug therapy

Start date of new anti-cancer drug therapy is used to determine the end of the on-treatment period (see Section 5.2.7).

The start date of new anti-cancer drug therapy is the earliest start date of anti-cancer drug therapy recorded in the 'Follow-up Cancer Therapy' eCRF pages that is after the first dose of study treatment. When start date of anti-cancer drug therapy is missing or partially missing, the imputation rules described in Section 5.3.3.4 should be applied using only data from the 'Follow-up Cancer Therapy' eCRF pages.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

5.2.6. Definition of start of new anti-cancer therapy

Start date of new anti-cancer therapy (drug, radiation, surgery) is used for censoring in efficacy analyses.

The start date of new anti-cancer therapy is the earliest date after the first dose of study treatment amongst the following:

- Start date of anti-cancer drug therapy recorded in the 'Follow-up Cancer Therapy' eCRF pages
- Start date of radiation therapy recorded in 'Radiation' eCRF page with 'Treatment Setting' = 'Curative'
- Surgery date recorded in 'Cancer Surgery' eCRF page when 'Surgery Outcome' = 'Resected' or 'Partially Resected'.

When start date of anti-cancer therapy is missing or partially missing, the imputation rules described in Section 5.3.3.4 should be applied using 'Follow-up Cancer Therapy', 'Radiation', and 'Cancer Surgery' eCRF pages.

5.2.7. Definition of on-treatment period

Safety endpoints will be summarized based on the on-treatment period unless otherwise specified.

On-treatment period is defined as the time from the first dose of study treatment through minimum (28 days + last dose of study treatment, start day of new anti-cancer drug therapy – 1 day).

Safety data collected outside the on-treatment period as described above will be listed and flagged in listings but not summarized.

5.2.8. Standard derivations and reporting conventions

The following conversion factors will be used to convert days into weeks, months or years: 1 week = 7 days, 1 month = 30.4375 days, 1 year = 365.25 days.

Demographics and physical measurements:

- Age [years]: (year of given informed consent - year of birth)
- Body mass index (BMI) (kg/m^2) = weight (kg)/[height (m)]^2

For reporting conventions, mean and median should generally be displayed one more decimal place than the raw data and standard deviation should be displayed to two more decimal places than the raw data. Percentages will be reported to one decimal place. The

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

rounding will be performed to closest integer / first decimal using the common mid-point between the two consecutive values. E.g., 5.1 to 5.4 will be rounded to an integer of 5, and 5.5 to 5.9 will be rounded to an integer of 6.

5.2.9. Unscheduled Visits

Generally, data collected at unscheduled visits will be included and analyzed for both safety and efficacy analyses in the same fashion as the data collected at scheduled visits except where otherwise noted in the sections that follow. Descriptive statistics (mean, SD, median, minimum, maximum, quartiles) by nominal visit or time point for safety endpoints such as laboratory measurements, ECGs and vital signs will include only data from scheduled visits.

5.2.10. Adequate Baseline Disease Assessment

Adequate baseline is defined using the following criteria:

- All baseline assessments must be within 42 days prior to and including the 'start date'.
- Baseline lesions must be assessed with an acceptable method of tumor assessment as specified in the protocol and must include PET/CT, or PET and CT, or possibly PET /MRI or PET and MRI in some circumstances.
- At least 1 target, PET-avid lesion must be identified.
- All lesions (target and non-target) must have non-missing assessments. For target lesions, non-missing measurements and the longest diameter should meet the criteria for being measurable; for non-target lesions, non-missing lesions status at baseline.

5.2.11. Adequate Post-baseline Disease Assessment

An adequate post-baseline assessment is defined as an assessment where a response of CR, PR, SD, or PD can be determined. Time points where the response is not evaluable (NE) or no assessment was performed will not be used for determining the censoring date for time-to-event endpoints including PFS, DoR, and DoCR.

5.2.12. Analyses for Continuous and Qualitative Variables

Continuous variables will be summarized using descriptive statistics ie, number of nonmissing values and number of missing values [ie, n (missing)], mean, median, standard deviation, minimum, maximum and first and third quartile (Q1 and Q3).

Qualitative variables will be summarized by frequency counts and percentages. Unless otherwise specified, the calculation of proportions will include the missing category. Therefore, counts of missing observations will be included in the denominator and presented as a separate category.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

In case the analysis refers only to certain visits, percentages will be based on the number of participants still present in the study at that visit, unless otherwise specified.

5.2.13. Analyses for Time-to-Event Endpoints

Kaplan-Meier estimates (product-limit estimates) will be presented together with a summary of associated statistics including the median time with 2-sided 95% CIs. Probabilities of an event at particular timepoints will be estimated with corresponding 2-sided 95% CIs. The CI for the median will be calculated according to Brookmeyer and Crowley, 1982[3] and the CIs for the survival function estimates at particular timepoints will be derived using the log(-log) method[4].

5.3. Methods to Manage Missing Data

Unless otherwise specified, all data will be evaluated as observed, and no imputation method for missing values will be used.

In all patient data listings imputed values will be presented. In all listings imputed information will be flagged.

Missing statistics, e.g. when they cannot be calculated, should be presented as 'ND' or 'NA'. For example, if N=1, the measure of variability (SD) cannot be computed and should be presented as 'ND' or 'NA'.

5.3.1. Missing Pharmacokinetic Data

5.3.1.1. Pharmacokinetic Concentrations

Concentrations below the limit of quantification

For all calculations, tables and figures, all concentrations assayed as below the level of quantification (BLQ) will be set to zero. The BLQ values will be excluded from calculations of geometric means and their CIs. A statement similar to 'All values reported as BLQ have been replaced with zero' should be included as a footnote to the appropriate tables and figures.

Deviations, missing concentrations and anomalous values

In summary tables and median profiles, concentrations will be set to missing if one of the following cases is true:

1. A concentration has been reported as ND (i.e., not done) or NS (i.e., no sample);
2. A deviation in sampling time is of sufficient concern or a concentration has been flagged as anomalous by the clinical pharmacologist.

At the discretion of the clinical pharmacologist, summary statistics may not be presented at a particular time point if more than 50% of the data are missing. For analysis of pharmacokinetic concentrations, no values will be imputed for missing data.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

5.3.1.2. Pharmacokinetic Parameters

If a PK parameter cannot be derived from a patient's concentration data, the parameter will be coded as NC (i.e., not calculated). NC values will not be generated beyond the day that a patient discontinues.

In summary tables, statistics will be calculated by setting NC values to missing. Statistics will not be presented for a particular treatment if more than 50% of the data are NC. For statistical analyses (i.e., analysis of variance), PK parameters coded as NC will also be set to missing.

If an individual patient has a known biased estimate of a PK parameter (due for example to a deviation from the assigned dose level), this will be footnoted in summary tables and will not be included in the calculation of summary statistics or statistical analyses.

5.3.2. Handling of Incomplete or Missing Dates

5.3.2.1. Disease History

Incomplete dates for disease history (e.g., initial diagnosis date, date of documented, locally advanced, metastatic disease diagnosis, date of response or progression on prior treatment) will be imputed as follows:

- If the day is missing, it will be imputed to the 15th day of the month.
- If both day and month are missing and the year is prior to the year of the first study treatment, the month and day will be imputed as July 1st.
- If both day and month are missing and the year is same as the year of the first study treatment, the month and day will be imputed as January 1st.
- If the date is completely missing, no imputation will be performed.

5.3.2.2. Adverse Events

Incomplete AE-related dates will be imputed as follows:

- If the AE onset date is missing completely, then the onset date will be replaced by the start of study treatment.
- If only the day part of the AE onset date is missing, but the month and year are equal to the start of study treatment, then the AE onset date will be replaced by the start of study treatment. For example, if the AE onset date is --/JAN/2015, and study treatment start date is 15/JAN/2015, then the imputed AE onset date will be 15/JAN/2015.
- If both the day and month of the AE onset date are missing but the onset year is equal to the start of study treatment, then the onset date will be replaced by the start of

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

study treatment. For example, if AE onset date is --/---/2014, and study treatment start date is 19/NOV/2014, then the imputed AE onset date will be 19/NOV/2014.

- In all other cases the missing onset day or missing onset month will be replaced by 1.
- Incomplete stop date will be replaced by the last day of the month (if day is missing only), if not resulting in a date later than the date of patient's death. In the latter case the date of death will be used to impute the incomplete stop date.
- In all other cases the incomplete stop date will not be imputed. If stop date of AE is after date of cut-off outcome of AE is ongoing at cut-off.

5.3.2.3. Prior and concomitant medications

Incomplete prior/concomitant medication dates will be imputed as follows:

- If the medication date is missing completely, then the medication date will be replaced by the start of study treatment.
- If the day of medication date is missing, but the month and year are equal to the start of study treatment, then the medication date will be replaced by the start of study treatment. For example, if the medication start date is --/JAN/2015, and study treatment start date is 15/JAN/2015, then the imputed medication start date will be 15/JAN/2015.
- If both the day and month of medication start date are missing but the start year is equal to the start of study treatment, then the medication date will be replaced by the start of study treatment. For example, if the medication start date is --/---/2014, and study treatment start date is 19/NOV/2014, then the imputed medication start date will be 19/NOV/2014.
- In all other cases the missing medication day or missing medication month will be replaced by 1.
- Incomplete stop date will be replaced by the last day of the month (if day is missing only), if not resulting in a date later than the date of patient's death. In the latter case the date of death will be used to impute the incomplete stop date.
- In all other cases the incomplete medication stop date will not be imputed.

5.3.2.4. Exposure

No imputation will be done for first dose date. Date of last dose of study drug if unknown or partially unknown will be imputed as follows:

- If the last date of study drug is completely missing and there is no End of Treatment eCRF page and no death date, the patient should be considered to be ongoing and use the cut-off date for the analysis as the last dosing date

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- If the last date of study drug is completely or partially missing and there is EITHER an End of Treatment eCRF page OR a death date available (within the cut-off date), then imputed last dose date is:

  = 31DECYYYY, if only Year is available and Year < Year of min (EOT date, death date)

  = Last day of the month, if both Year and Month are available and Year = Year of min (EOT date, death date) and Month < the month of min (EOT date, death date)

  = min (EOT date, death date), for all other cases.

5.3.3. Imputation Rules for Date of Last Contact and Efficacy Assessments

5.3.3.1. Date of Last Contact

The date of last contact will be derived for patients not known to have died at the analysis cut-off using the latest complete date among the following:

- All patient assessment dates (blood draws (laboratory, PK), vital signs, performance status, ECG, disease assessments)
- Start and end dates of anti-cancer therapies administered after study treatment discontinuation
- AE start and end dates
- Last date of contact collected on the 'Survival Follow-up' eCRF (do not use date of survival follow-up assessment unless status is 'alive')
- Study drug start and end dates
- Randomization date
- Withdrawal of consent date
- Date of discontinuation on disposition eCRF pages (do not use if reason for discontinuation is lost to follow-up).

Only dates associated with actual examinations of the patient will be used in the derivation. Dates associated with a technical operation unrelated to patient status such as the date a blood sample was processed will not be used. Assessment dates after the cut-off date will not be applied to derive the last contact date.

5.3.3.2. Date of Death

Missing or partial death dates will be imputed based on the last contact date:

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- If the date is missing, it will be imputed as the day after the date of last contact
- If the day or both day and month is missing, death will be imputed to the maximum of the full (non-imputed) day after the date of last contact and the following:
    - Missing day: 1st day of the month and year of death;
    - Missing day and month: January 1st of the year of death.

5.3.3.3. Tumor Assessments

All investigation dates (e.g., PET/CT scan, CT scan) must be completed with day, month and year.

If there are multiple scan dates associated with an evaluation, i.e., radiological assessments occur over a series of days rather than the same day, the choice of date of assessment could impact the date of progression and/or date of response. If there are multiple scan dates associated with an evaluation, the earliest of the scan dates associated with the evaluation will be used as the date of assessment.

If one or more investigation dates for an evaluation are incomplete but other investigation dates are available, the incomplete date(s) are not considered for calculation of the assessment date and assessment date is calculated as the earliest of all investigation dates.

If all measurement dates for an evaluation have no day recorded, the 1st of the month is used. If the month is not completed, for any of the investigations for an evaluation, the missing month will be imputed with the planned month for the assessment between the previous and the following assessment. If both a previous and following assessments are not available, this assessment will not be used for any calculations.

5.3.3.4. Date of Start of New Anticancer Therapy

Incomplete dates for start date of new anti-cancer therapy (drug therapy, radiation, surgery) will be imputed as follows and will be used for determining censoring dates for efficacy analyses and in the derivation of the end of on-treatment period. PD date below refers to PD date by investigator assessment.

- The end date of new anti-cancer therapy will be included in the imputations for start date of new anti-cancer therapy. If the end date of new anti-cancer therapy is
    - completely missing then it will be ignored in the imputations below
    - partially missing with only year (YYYY) available then the imputations below will consider 31DECYYYY as the end date of the new anti-cancer therapy

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- partially missing with only month and year available then the imputations below will consider the last day of the month for MMMYYYY as the end date of the new anti-cancer therapy

- For patients who have not discontinued study treatment at the analysis cut-off date, last dose of study treatment is set to the analysis cut-off date in the imputations below.

- If the start date of new anti-cancer therapy is completely or partially missing then the imputed start date of new anti-cancer therapy is derived as follows:

  - Start date of new anti-cancer therapy is completely missing

    Imputed start date = min [max(PD date + 1, last dose of study treatment + 1), end date of new anti-cancer therapy]

  - Only year (YYYY) for start of anti-cancer therapy is available

    IF YYYY < Year of min [max(PD date + 1, last dose of study treatment + 1), end date of new anti-cancer therapy] THEN imputed start date = 31DECYYYY;

    ELSE IF YYYY = Year of min [max(PD date + 1, last dose of study treatment + 1), end date of new anti-cancer therapy]

    THEN imputed start date = min [max(PD date + 1, last dose of study treatment + 1), end date of new anti-cancer therapy]

    ELSE IF YYYY > Year of min [max(PD date + 1, last dose of study treatment + 1), end date of new anti-cancer therapy]

    THEN imputed start date = 01JANYYYY

- Both Year (YYYY) and Month (MMM) for start of anti-cancer therapy are available

  - IF YYYY = Year of min [max(PD date + 1, last dose of study treatment + 1), end date of new anti-cancer therapy], AND

    MMM < Month of min [max(PD date + 1 day, last dose of study treatment + 1 day), end date of new anti-cancer therapy]

    THEN imputed start date = DAY (Last day of MMM) MMM YYYY;

  - ELSE IF YYYY = Year of min [max(PD date + 1, last dose of study treatment + 1), end date of new anti-cancer therapy], AND

    MMM = Month of min [max(PD date + 1 day, last dose of study treatment + 1 day), end date of new anti-cancer therapy]

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

THEN imputed start date = min [max(PD date + 1 day, last dose of study treatment + 1 day), end date of new anti-cancer therapy]);

- ELSE IF YYYY = Year of min [max(PD date + 1, last dose of study treatment + 1), end date of new anti-cancer therapy], AND

  MMM > Month of min [max(PD date + 1 day, last dose of study treatment + 1 day), end date of new anti-cancer therapy]

  THEN imputed start date = 01 MMM YYYY;

- ELSE IF YYYY < Year of min [max(PD date + 1, last dose of study treatment + 1), end date of new anti-cancer therapy]

  THEN imputed start date = DAY (Last day of MMM) MMM YYYY;

- ELSE IF YYYY > Year of min [max(PD date + 1, last dose of study treatment + 1), end date of new anti-cancer therapy]

  THEN imputed start date = 01 MMM YYYY.

6. ANALYSES AND SUMMARIES

Refer to Section 4 for definitions of analysis sets and Section 5.2 for general methodology.

All summaries will be by treatment group using the data from Phase 1b and Phase 2 separately.

6.1. Primary Endpoints

6.1.1. DLT for Phase 1b

6.1.1.1. Main Analysis

- Estimand strategy: All DLT data from DLT-evaluable participants during the DLT observation period (28 days following C1D1) will be included in the analysis.
- Analysis set: DLT Evaluable Set.
- Intercurrent events and missing data: The data from participants who are not DLT-evaluable will be excluded. Participants without DLTs who stopped treatment before receiving at least 80% of the planned dose of PF-07901801 and at least 75% of the planned dose of any component of the tafasitamab and lenalidomide regimen will be excluded. No imputations for missing data will be performed.
- Analysis methodology: DLTs will be listed and summarized by treatment group. DLT rate will be calculated for each treatment group as the number of DLT-evaluable

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

participants with DLTs in the DLT observation period divided by the number of DLT-evaluable participants.

6.1.2. OR as assessed by the Investigator per Lugano 2014 response criteria for Phase 2

6.1.2.1. Main Analysis

- Estimand strategy: All OR data from Phase 2 will be included in the analysis.
- Analysis set: Safety Analysis Set.
- Intercurrent events and missing data: All data collected after an intercurrent event of subsequent anticancer therapy will be excluded. Participants who do not have a post-baseline disease assessment due to early PD, who receive anticancer therapies other than the study treatment prior to achieving an objective response, or who die, experience PD, or stop disease assessments for any reason prior to achieving an objective response will be counted as non-responders. Missing data will be imputed following Section 5.3.
- Analysis methodology: Assessment of response will be made as per investigator using Lugano 2014 response criteria. The analyses will be by treatment group.

  Best overall response (BOR) will be assessed based on reported overall responses at different evaluation time points from the 'start date' until documented disease progression, according to the following rules. Only tumor assessments performed before the start of any further anti-cancer therapies will be considered in the assessment of BOR.

  CR = at least 1 determination of CR before first documentation of progression

  PR = at least 1 determination of PR before first documentation of progression (and not qualifying for a CR)

  SD = at least 1 SD assessment $\geq$ 6 weeks after the 'start date' and before first documentation of progression (and not qualifying for CR or PR).

  PD = at least 1 PD assessment (and not qualifying for CR, PR or SD).

  Not Evaluable (NE): all other cases.

  Objective response (OR) is defined as BOR of CR or PR according to Lugano 2014 response criteria.

  Patients who do not have an on-treatment tumor assessment due to early progression, who receive anti-tumor therapies other than the study treatments prior to reaching a CR or PR, or who die, progress, or drop out for any reason prior to reaching a CR or PR will be counted as non-responders in the assessment of OR. Each patient will have an objective response status (0: no OR; 1: OR). OR rate (ORR) is the proportion of patients with OR in the analysis set.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

ORR by treatment group will be calculated along with the 2-sided 95% CI using the Wilson method (with continuity correction).

In addition, the frequency (number and percentage) of patients with a BOR of CR, PR, SD, PD and NE will be tabulated. Patients with BOR of NE will be summarized by reason for having NE status. The following reasons will be used:

- No adequate baseline assessment
- No post-baseline assessments due to death
- No post-baseline assessments due to other reasons
- All post-baseline assessments have overall response NE
- New anti-cancer therapy started before first post-baseline assessment
- SD of insufficient duration (< 6 weeks after 'start date')

6.2. Secondary Endpoints

Refer to Section 6.7 for safety endpoints.

The following analyses will be based on the Safety Analysis Set.

In addition to what is described below, the objective response (OR) will also be analyzed similar to that described in Section 6.1.2.1 for Phase 1b in the Safety Analysis Set.

6.2.1. Complete Response

CR is defined as a BOR of CR per Lugano Response Classification Criteria 2014 as assessed by the investigator, from the 'start date' until the first documentation of PD, death or start of new anti-cancer therapy. CR rate (CRR) is defined as the proportion of participants with a CR.

Point estimate of CRR will be calculated along with corresponding 2-sided 95% CI using the Wilson method (with continuity correction).

6.2.2. Duration of Response

Duration of response (DoR) is defined, for participants with an OR per Lugano Response Classification Criteria 2014, as the time from the first documentation of objective response (CR or PR) to the date of first documentation of PD or death due to any cause.

If a patient has not had an event (PD or death), DoR is censored at the date of last adequate tumor assessment. The censoring rules for DoR are as described in Table 4.

DoR (months) = [date of event or censoring– first date of OR +1]/30.4375

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

Table 4 Outcome and Event Dates for DoR Analyses

Scenario	Date of event/censoring	Outcome
PD or death - After at most one missing or inadequate post-baseline tumor assessment, OR - ≤ 22 weeks after 'start date'	Date of PD or death	Event
PD or death - After 2 or more missing or inadequate post-baseline tumor assessments	Date of last adequate tumor assessment [a] documenting no PD before new anti-cancer therapy is given or missed tumor assessments	Censored
No PD and no death	Date of last adequate tumor assessment [a] documenting no PD before new anti-cancer therapy is given or missed tumor assessments	Censored
Treatment discontinuation due to 'Disease progression' without documented progression	Not applicable	Information is ignored. Outcome is derived based on documented progression only.
New anti-cancer therapy given	Date of last adequate tumor assessment [a] documenting no PD before new anti-cancer therapy is given or missed tumor assessments	Censored

[a] If there are no adequate post-baseline assessments prior to PD or death, then the time without adequate assessment should be measured from the 'start date'; if the criteria were met the censoring will be on the 'start date'.

Kaplan-Meier estimates (product-limit estimates) will be presented by treatment group together with a summary of associated statistics including the median DoR time with 2-sided 95% CIs. In particular, the DoR rate at 3, 6, 9 and 12 months (and in subsequent 6-month increments as appropriate) will be estimated with corresponding 2-sided 95% CIs. The CIs for the median will be calculated according to Brookmeyer and Crowley (1982)[3] and the CIs for the survival function estimates at the time points defined above will be derived using the log-log transformation according to Kalbfleisch and Prentice (2002)[4] (conftype=loglog default option in SAS Proc LIFETEST) with back transformation to a CI on the untransformed scale. The estimate of the standard error will be computed using Greenwood's formula.

Depending on the number of ORs, DoR may be displayed graphically and analyzed using Kaplan-Meier methodology. If the number of patients with OR is small, the Kaplan-Meier method may not provide reliable estimates. In this case, only descriptive statistics or listings will be provided.

Frequency (number and percentage) of patients with each event type (PD or death) and censoring reasons will be presented by treatment group. Reasons for censoring will be summarized according to the categories in Table 5 following the hierarchy shown.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

Table 5 DoR Censoring Reasons and Hierarchy

Hierarchy	Condition	Censoring Reason
1	Start of new anti-cancer therapy	Start of new anti-cancer therapy
2	Event after 2 or more missing or inadequate post-baseline tumor assessments/ 'start date'	Event after 2 or more missing assessments [a]
3	No event and [withdrawal of consent date ≥ 'start date' OR Follow Up Discontinuation Reason = 'withdrawal by subject']	Withdrawal of consent
4	No event and lost to follow-up in any disposition page	Lost to follow-up
5	No event and [EOS present OR disposition page for any epoch after screening says patient will not continue into any subsequent phase of the study] and no adequate post-baseline tumor assessment	No adequate post-baseline tumor assessment
6	No event and none of the conditions in the prior hierarchy are met	Ongoing without an event

[a] 2 or more missing or inadequate post-baseline tumor assessments.

6.2.3. Duration of Complete Response

Duration of complete response (DoCR) is defined, for participants with a CR per Lugano Response Classification Criteria 2014, as the time from the first documentation of a CR until PD, or death due to any cause, whichever occurs first.

DoCR (months) = [date of event or censoring– first date of CR +1]/30.4375

DoCR will be analyzed in the same way as that is for DoR as described in Section 6.2.2.

6.2.4. Progression-free Survival

Progression-free survival (PFS) is defined as the time from the 'start date' until PD per Lugano Response Classification Criteria 2014, or death due to any cause, whichever occurs first.

PFS data will be censored on the date of the last adequate tumor assessment for patients who do not have an event (PD or death), for patients who start a new anti-cancer therapy prior to an event or for patients with an event after two or more missing tumor assessments. Patients who do not have an adequate baseline tumor assessment or who do not have an adequate post-baseline tumor assessment will be censored on the 'start date' unless death occurred on or before the time of the second planned tumor assessment (i.e. ≤ 22 weeks after 'start date') in which case the death will be considered an event.

The censoring and event date options to be considered for the PFS analysis are presented in Table 6.

PFS (months) = [date of event or censoring– 'start date' +1]/30.4375

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

Table 6 Outcome and event dates for PFS analyses

Scenario	Date of event/censoring	Outcome
No adequate baseline assessment	'Start date' [a]	Censored [a]
PD or death - After at most one missing or inadequate post-baseline tumor assessment, OR - ≤ 22 weeks after 'start date'	Date of PD or death	Event
PD or death - After 2 or more missing or inadequate post-baseline tumor assessments	Date of last adequate tumor assessment [b] documenting no PD before new anti-cancer therapy is given or missed tumor assessments	Censored
No PD and no death	Date of last adequate tumor assessment [b] documenting no PD before new anti-cancer therapy is given or missed tumor assessments	Censored
Treatment discontinuation due to 'Disease progression' without documented progression	Not applicable	Information is ignored. Outcome is derived based on documented progression only.
New anti-cancer therapy given	Date of last adequate tumor assessment [b] documenting no PD before new anti-cancer therapy is given or missed tumor assessments	Censored

[a] However if the patient dies ≤22 weeks after 'start date' the death is an event with date on death date

[b] If there are no adequate post-baseline assessments prior to PD or death, then the time without adequate assessment should be measured from the 'start date'; if the criteria were met the censoring will be on the 'start date'.

Kaplan-Meier estimates (product-limit estimates) will be presented and displayed graphically as appropriate, by treatment group, together with a summary of associated statistics including the median PFS time with two-sided 95% CIs. In particular, the PFS rate at 3, 6, 9, 12, 18 and 24 months (and in subsequent 12-month increments as appropriate) will be estimated with corresponding 2-sided 95% CIs. The CIs for the median will be calculated according to Brookmeyer and Crowley (1982) and the CIs for the survival function estimates at the time points defined above will be derived using the log-log transformation according to Kalbfleisch and Prentice (2002) (conftype=loglog default option in SAS Proc LIFETEST) with back transformation to a CI on the untransformed scale. The estimate of the standard error will be computed using Greenwood's formula.

Frequency (number and percentage) of patients with each event type (PD or death) and censoring reasons will be presented by treatment group.

Reasons for censoring will be summarized according to the categories in Table 7 following the hierarchy shown.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

Table 7 PFS Censoring Reasons and Hierarchy

Hierarchy	Condition	Censoring Reason
1	No adequate baseline assessment	No adequate baseline assessment
2	Start of new anti-cancer therapy	Start of new anti-cancer therapy
3	Event after 2 or more missing or inadequate post-baseline tumor assessments/ 'start date'	Event after 2 or more missing assessments [a]
4	No event and [withdrawal of consent date ≥ 'start date' OR Follow Up Discontinuation Reason = 'withdrawal by subject']	Withdrawal of consent
5	No event and lost to follow-up in any disposition page	Lost to follow-up
6	No event and [EOS present OR disposition page for any epoch after screening says patient will not continue into any subsequent phase of the study] and no adequate post-baseline tumor assessment	No adequate post-baseline tumor assessment
7	No event and none of the conditions in the prior hierarchy are met	Ongoing without an event

[a] 2 or more missing or inadequate post-baseline tumor assessments.

The PFS time or censoring time and the reasons for censoring will also be presented in a patient listing.

6.3. Other Secondary Endpoints

6.3.1. Pharmacokinetic/Pharmacodynamics

The following pharmacokinetic analyses will be based on the PK analyses set by treatment group using the data from Phase 1b and Phase 2.

6.3.1.1. Pharmacokinetic Concentrations

Pharmacokinetic blood samples for determination of PF-07901801, tafasitamab and lenalidomide concentrations will be collected in accordance with the regimen specified in the schedule of events. The concentrations as reported by the bioanalytical lab will be used without rounding for all analyses.

For concentration data, all values below the limit of quantification (BLQ) will be set to 0 for summary statistics and graphs. Individual concentrations of PF-07901801, tafasitamab and lenalidomide will be summarized by dose levels (or treatment groups) at each time point using descriptive statistics. Individual concentration plots and median data by dose levels (or treatment groups) graphs will be produced. All graphs will be presented using both linear and semi-logarithmic scales.

The below precision will be used for descriptive and statistical summary of PF-07901801, tafasitamab and lenalidomide concentrations:

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- Geometric Means, Medians and their %CV and Confidence Intervals (CIs) – 1 more significant figure than the data
- Standard Deviation – 1 more significant figure than means
- CV% – whole numbers
- Minimum, Maximum – same significant figures as the data
- Ratios, CIs (log transformed data) – 2 decimal places

All PF-07901801, tafasitamab and lenalidomide concentrations will be presented in a by-patient listing. Additionally, time elapsed since dosing and deviation from scheduled time point will be presented.

6.3.1.2. Pharmacokinetic Parameters

The PK data from this study may be used to develop a population PK model and may also be pooled with other studies for population PK model analysis. The correlations between PF-07901801, tafasitamab and lenalidomide exposure parameters and pharmacodynamic biomarker, efficacy and/or safety outcomes may be explored if data allows. The results of these modeling analyses will be reported separately from the clinical study report.

The potential drug-drug interactions between PF-07901801, tafasitamab, and/or lenalidomide will also be evaluated if data allows.

6.3.2. Immunogenicity

The following analyses of immunogenicity data will be based on the Immunogenicity analysis set by treatment group using the data from Phase 1b and Phase 2.

Final individual subject results from the ADA and NAb assay (as appropriate) will be presented in the listings and the incidence summarized by descriptive statistics in tabular form by dose levels (or treatment groups).

Summary tables that show the number and percentage of subjects that fall into the following categories will also be produced by dose levels (or treatment groups):

Treatment-induced ADA	Baseline ADA titer is missing or negative and subject has ≥ 1 post-treatment positive ADA titer.
Treatment-boosted ADA	Baseline ADA titer is positive, and subject has a ≥ 4-fold dilution increase in ADA titer from baseline in ≥ 1 post-treatment sample. If ADA titer is log10 transformed, a 4-fold dilution increase is equivalent to 0.602 unit increase in titer (log10) from baseline. If ADA titer is log2 transformed, a 4-fold dilution increase is equivalent to 2 unit increase in titer (log2) from baseline.
ADA-positive subject	A subject with ≥ 1 treatment-induced or treatment-boosted ADA response.
ADA-negative subject	An ADA evaluable subject without treatment-induced or treatment-boosted ADA response. Subject either has (1) all ADA-negative results

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

	throughout the study or (2) is ADA positive at baseline but did not become treatment-boosted post-dose.
ADA incidence	The percent of ADA-positive subjects in a treatment group/cohort or study.
Treatment-induced NAb	Baseline NAb titer is missing or negative or ADA-negative and subject has ≥ 1 post-treatment positive NAb titer.
Treatment-boosted NAb	Baseline NAb titer is positive and subject has a ≥ 4-fold dilution increase in NAb titer from baseline in ≥ 1 post-treatment sample. If NAb titer is log10 transformed, a 4-fold dilution increase is equivalent to 0.602 unit increase in titer (log10) from baseline. If NAb titer is log2 transformed, a 4-fold dilution increase is equivalent to 2 unit increase in titer (log2) from baseline.
NAb-positive subject	An ADA-positive subject with ≥ 1 treatment-induced or treatment-boosted NAb response. For ADA-positive (treatment-boosted) subjects, subject is NAb positive only if the subject has ≥1 treatment-induced or treatment-boosted NAb response at the visit where the subject has a treatment-boosted ADA response. For visits where the subject did not show a boosted ADA response, the subject is classified as NAb-negative for the visit even if the subject has post-treatment positive NAb titer for that visit.
NAb-negative subject	NAb evaluable participant who is either (1) an ADA-negative subject or (2) an ADA-positive subject without treatment-induced or treatment-boosted NAb response (i.e. subject has all NAb-negative results throughout the study or subject is NAb positive at baseline but did not become treatment-boosted post-dose). Note: in the event a subject is ADA-positive at baseline but did not show a boosted response post-treatment, subject is classified as ADA-negative and NAb-negative at the subject level even if the subject has post-treatment positive NAb titer. As such all ADA-negative subjects are NAb-negative regardless of NAb titer data.
NAb incidence	The percent of NAb-positive subjects in a treatment group/cohort or study.
Transient ADA	An ADA-positive subject with (1) a treatment-induced or treatment-boosted ADA sample detected only at 1 sampling time (excluding the last time point) post-treatment, or (2) treatment-induced or treatment-boosted ADA samples detected at ≥ 2 time points where the first and last positive samples (irrespective of any negative samples in between) are separated by < 16 weeks, and the subject's last sample is ADA negative.
Persistent ADA	An ADA-positive subject with first and last positive ADA samples (treatment-induced or treatment-boosted) detected over a period of ≥ 16 weeks post-treatment, irrespective of any negative samples in between.
Indeterminate ADA	An ADA-positive subject who is not persistent or transient.
Transient NAb	A NAb-positive subject with (1) a treatment-induced or treatment-boosted NAb sample detected only at 1 sampling time (excluding the last

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

	time point) post-treatment, or (2) treatment-induced or treatment-boosted NAb samples detected at ≥ 2 time points where the first and last positive samples (irrespective of any negative samples in between) are separated by < 16 weeks, and the subject's last sample is NAb negative or ADA negative
Persistent NAb	A NAb-positive subject with first and last positive NAb samples (treatment-induced or treatment-boosted) detected over a period of ≥ 16 weeks post-treatment, irrespective of any negative samples in between.
Indeterminate NAb	A NAb-positive subject who is not persistent or transient.

Titers will be reported as median, range and interquartile range if applicable.

Descriptive summaries (mean, standard deviation, median, and range) of time to ADA response will be presented by dose levels (or treatment groups) if applicable.

6.4. Exploratory Endpoints

6.4.1. Biomarker Analysis

CCI [redacted]

Exploratory biomarker endpoints will not be reported in CSR. Results of exploratory endpoint analyses will be disseminated to the scientific community to the extent possible through presentation at scientific meetings and/or publication in peer-reviewed scientific journals.

6.5. Subset Analyses

All the subset analyses will be exploratory; no adjustment for multiplicity will be performed. Analyses will only be performed if there is sufficient sample size. As a general rule, subset analysis will only be performed if there are ≥10 participants overall within the defined subset. Deviations from these analyses will be described in the clinical study report.

ORR and DoR (if meaningful) will be summarized in the following subsets within each treatment group using the data from Phase 2.

- Prior anti-cancer therapy (CAR-T vs others)
- Lines of prior therapies (1 vs ≥2)
- IPI score (≤ 3 vs > 3)
- Response to most recently administered prior anti-cancer therapy (CR/PR vs SD/PD)
- Classification based on molecular profiling (GCB, ABC, unclassified)

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

6.6. Baseline and Other Summaries and Analyses

6.6.1. Baseline Summaries

The following analyses will be based on the Safety Analysis Set overall and separately by treatment group.

6.6.1.1. Demographic Characteristics

The following demographic and baseline characteristics will be summarized:

- Gender (Male, Female)
- Age (years): summary statistics
- Age categories (<70, ≥ 70)
- Race (White, Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, Other, Unknown)
- Ethnicity (Hispanic, Not Hispanic, Not reported)
- Geographical Region (North America, Europe, Asia, Rest of the World)
- Physical measurements
    - Height (cm)
    - Weight (kg)
    - Body Mass Index (BMI) (kg/m^2)
- ECOG Performance Status

Site codes will be used for the determination of the patient's geographic region.

The listing of demographics and baseline characteristics will include the following information: patient identifier, treatment group, age, sex, race, ethnicity, height (cm), weight (kg), BMI (kg/m^2) and ECOG.

6.6.1.2. Medical History

Medical history will be coded using the most current available version of Medical Dictionary for Regulatory Activities (MedDRA) and will be summarized from the 'Medical History' eCRF page. Medical history will be summarized as the numbers and percentages of patients by MedDRA preferred term (PT) as event category and MedDRA primary system organ class (SOC) as summary category. Each patient will be counted only once within each PT or SOC.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

Medical history will be displayed in terms of frequency tables: ordered by primary SOC and PT in alphabetical order.

6.6.1.3. Disease Characteristics

The following baseline disease characteristics will be summarized using information collected on the 'Primary Diagnosis' and Tumor Assessment eCRF pages, as well as molecular biomarker pages:

- Current histopathological classification
- Classification based on molecular profiling (GBC, ABC, unclassified)
- Stage - initial diagnosis
- Stage - Current
- IPI score
- Time since initial histopathological diagnosis to 'start date' (months), defined as ('start date' – date of initial histopathological diagnosis)/30.4375
- Time since most recent recurrence/metastatic (months), defined as ('start date' – date of most recent recurrence/metastatic)/30.4375
- Involved tumor sites at baseline
- Response to first line of prior anti-cancer therapy
- Response to the most recently administered prior anti-cancer therapy
- Bulky disease (defined as any target lesion with the longest diameter ≥7.5cm)

Listing of disease history will be provided with all relevant data (as collected on the 'Primary Diagnosis' and Tumor Assessment eCRF pages) and derived variables as above.

6.6.1.4. Prior Anti-cancer Therapies

The prior anti-cancer therapies are collected under the 'Prior Cancer Therapy', 'Radiation' and 'Cancer Surgery' eCRF pages.

The number and percentage of patients in each of the following anti-cancer therapy categories will be tabulated:

- Patients with at least one type of prior anti-cancer therapy
- Patients with at least one prior anti-cancer drug therapy
- Patients with at least one prior anti-cancer radiotherapy (curative/palliative)

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- Patients with at least one prior anti-cancer surgery
- Patients with at least one prior transplant
- Patients with prior CAR-T

Prior anti-cancer drug therapy will be summarized as follows based on the number and percentage of patients with the following:

- At least one prior anti-cancer drug therapy
- Number of prior anti-cancer drug therapy regimens: missing / 1 / 2 / 3 / 4/ ≥5

The prior anti-cancer drug therapies will also be summarized based on the number and percentage of patients by the drug class and preferred term. A patient will be counted only once within a given drug class and within a given drug name, even if he/she received the same medication at different times. The summary will be sorted on decreasing frequency of drug class and decreasing frequency of drug name in a given drug class. In case of equal frequency regarding drug class (respectively drug name), alphabetical order will be used.

Prior anti-cancer therapies will be included in the listings that follow with a flag to identify prior therapies. These will include the patient identification number, and all the relevant collected data-fields on the corresponding eCRF pages.

- Listing of anti-cancer drug therapies
- Listing of anti-cancer radiotherapy (curative/palliative)
- Listing of transplant
- Listing of anti-cancer surgeries

6.6.2. Study Conduct and Participant Disposition

The following analyses will be performed based on the Safety Analysis Set overall and separately by treatment group for Phase 1b and Phase 2 separately.

6.6.2.1. Disposition

The percentages below will be calculated based on the number of patients in the Safety Analysis Set.

- Total number of patients screened overall
- Number of patients enrolled/randomized into the study

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- Number of patients who discontinued from the study prior to treatment with study drug overall and by the main reason for discontinuation
- Number and percentage of patients in each of the analysis sets defined in Section 4
- Number and percentage of patients with study drug ongoing (separately for each study drug when administered in combination)
- Number and percentage of patients who discontinued study drug overall and by the main reason for discontinuation of study drug (separately for each study drug when administered in combination)
- Number and percentage of patients who entered follow-up
- Number and percentage of patients who discontinued follow-up overall and by the main reason for discontinuation

In addition the following will be summarized:

- Number and percentage of treated patients overall, by region (Europe, EEA (required by EudraCT), North America, Latin America, Middle East, Asia, Australasia, Africa), by country within region
- Number and percentage of treated patients by center

Dispositions related to COVID-19 may be presented in a separate listing if there is significant impact of COVID-19.

6.6.2.2. Protocol Deviations

Potentially important protocol deviations will be compiled prior to database lock. Potentially important protocol deviations will be summarized by category (n[%]) for the Safety Analysis Set.

In addition, protocol deviations related to COVID-19 may be presented in a separate listing if there is significant impact of COVID-19.

6.6.3. Study Treatment Exposure and Compliance

The following analyses will be based on the safety analysis set by treatment group.

Cycle definitions for study drugs that are administered in combination apply to all the study drugs in the combination. Ie, cycle is patient-dependent, rather than study-drug-dependent when study drugs are administered in combination.

For Cycle X, actual cycle start date for each patient is

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- the earliest start date of dosing in the Cycle X day 1 visit eCRF exposure page, if the patient received study treatment on that visit (ie, any study drug with dose>0 at that visit)

- the first day of assessments in the Cycle X day 1 visit, if the patient did not receive study treatment on that visit (ie, all study drugs had dose=0 at that visit). Use start date in the exposure page if available; if start date is not available then use date of collection of vital signs on Cycle X day 1 visit.

Actual cycle end date for each patient is,

- for all cycles X except the last cycle, actual cycle end date = actual cycle (X+1) start date – 1 day;

- for the last cycle, actual cycle end date = actual cycle start date + 28 (in days) – 1 day

Cycle duration (weeks) = (actual cycle end date – actual cycle start date + 1)/7

When summarizing exposure for each study drug, only cycles from first dose of study treatment until the last cycle with non-zero dose of at least one of the study drugs should be included.

Exposure will be summarized as dose received (duration of exposure, cumulative dose, actual dose intensity) and as dose received relative to intended dose (relative dose intensity [RDI]).

The information that will be summarized depends on how the study drug is dosed (eg, infusion cyclical, oral daily, oral cyclical).

The formulae below should be applied to each study drug separately even when study drugs are administered in combination.

6.6.3.1. Exposure to PF-07901801

Phase 1b:

The dose level for PF-07901801 is calculated as actual dose administered/weight (mg/kg). The last available weight of the patient on or prior to the day of dosing will be used.

PF-07901801 will be administered weekly (QW) during Cycle 1, 2, and 3, then bi-weekly (Q2W). Each cycle is 28 days (4 weeks).

Cohort	Dose (mg/kg)
1 (DL1)	4 mg/kg QW for C1 to C3 then Q2W
2 (DL2)	10 mg/kg QW for C1 to C3 then Q2W
3 (DL3)	18 mg/kg QW for C1 to C3 then Q2W

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

Intended duration of treatment with PF-07901801 (weeks) =

(end date–date of first dose of study drug +1) (days) / 7(days/week),

where end date = start date of last cycle with non-zero dose of study drug + 28 – 1

Duration of exposure to PF-07901801 (weeks) =

(last dose date - first dose date + d) (days) / 7 (days/week),

where d is the number of days based on the maximum number of cycles of PF-07901801 started and defined as following.

- For patients who started 3 cycles or less: d=7 days,
- For patients who started Cycle ≥4: d = 14 days.

Cumulative dose (mg/kg) is the sum of the actual doses of PF-07901801 received.

Intended cumulative dose (mg/kg) is based on the maximum number of cycles of PF-07901801started and defined as following

- For patients who started no more than 3 cycles:
  - Intended cumulative dose (mg/kg)= DL(mg/kg/dose)*4 (doses/cycle)*Number of Cycles started.
- For patients who started maximum Cycle i, where i ≥ 4:
  - Intended cumulative dose (mg/kg) = DL(mg/kg*dose)*4 (doses/cycle)*3 (cycles) + DL(mg/kg)*2(doses/cycle)*(i-3)(cycles) = DL(mg/kg*dose) (2i+6) (doses)

Actual Dose Intensity (DI)

- Overall actual DI (mg/kg/4-week cycle) = [overall cumulative dose (mg/kg)] / [intended duration of treatment with PF-07901801 (weeks)/4].

Relative Dose Intensity (RDI)

- Intended DI (mg/kg/4-week cycle) = [intended cumulative dose (mg/kg)] / [intended duration of treatment with PF-07901801 (weeks)/4]
- Overall RDI (%) = 100 × [overall actual DI] / [intended DI]

Phase 2:

Up to 2 fixed doses of PF-07901801 will be explored in Phase 2.

The dose level for PF-07901801 is calculated as actual dose administered (mg).

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

PF-07901801 will be administered weekly (QW) during Cycle 1, 2, and 3, then bi-weekly (Q2W). Each cycle is 28 days (4 weeks).

Intended duration of treatment with PF-07901801 and duration of exposure of PF-07901801 are calculated in the same way as that for Phase 1b.

Cumulative dose (mg) is the sum of the actual doses of PF-07901801 received.

Intended cumulative dose (mg) is based on the maximum number of cycles of PF-07901801started and defined as following

- For patients who started no more than 3 cycles:
    - Intended cumulative dose (mg)= DL(mg/dose)*4 (doses/cycle)*Number of Cycles started.
- For patients who started maximum Cycle i, where $i \geq 4$:
    - Intended cumulative dose (mg) = DL(mg/dose)*4 (doses/cycle)*3 (cycles) + DL(mg/dose)*2(doses/cycle)*(i-3)(cycles)

Actual Dose Intensity (DI)

- Overall actual DI (mg/4-week cycle) = [overall cumulative dose (mg)] / [intended duration of treatment with PF-07901801 (weeks)/4].

Relative Dose Intensity (RDI)

- Intended DI (mg/4-week cycle) = [intended cumulative dose (mg)] / [intended duration of treatment with PF-07901801 (weeks)/4]
- Overall RDI (%) = 100 × [overall actual DI] / [intended DI]

6.6.3.2. Exposure to Tafasitamab

The dose level for tafasitamab is calculated as actual dose administered/weight (mg/kg). The last available weight of the patient on or prior to the day of dosing will be used.

Tafasitamab will be administered at 12 mg/kg IV according to the following schedule: each cycle has 28 days.

- C1: Days 1, 4, 8, 15 and 22.
- C2 and C3 (QW): Days 1, 8, 15 and 22.
- ≥C4 (Q2W): Days 1 and 15.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

Intended duration of treatment with tafasitamab (weeks) =

(end date–date of first dose of study drug +1)/7,

where end date = start date of last cycle with non-zero dose of study drug + 28 – 1

Duration of exposure to tafasitamab (weeks) =

(last dose date - first dose date + d) (days) / 7 (days/week),

where d is the number of days based on the maximum number of cycles of tafasitamab started and defined as following.

- For patients who started only Cycle 1:
  - d=3, if only Day 1 dose received;
  - d=4, if the last day the dose received is Day 4;
  - d=7, if the last day the dose received is Day 15 or Day 22.
- For patients who started Cycle 2 or 3: d = 7 days;
- For patients who started Cycle ≥4: d = 14 days.

Cumulative dose (mg/kg) is the sum of the actual doses of tafasitamab received.

Intended cumulative dose (mg/kg) is based on the maximum number of cycles of tafasitamab started and defined as following

- For patients who started Cycle 1 only:
  - Planned cumulative dose (mg/kg) = 5*12 mg/kg=60 mg/kg
- For patients who started no more than Cycle 2:
  - Planned cumulative dose (mg/kg) = 5*12 mg/kg + 4*12 mg/kg=108 mg/kg
- For patients who started no more than Cycle 3:
  - Planned cumulative dose (mg/kg) = 5*12 mg/kg + 4*12 mg/kg + 4*12 mg/kg =156 mg/kg
- For patients who started no more than Cycle i, where i ≥ 4:
  - Planned cumulative dose (mg/kg) = 156 mg/kg + (i-3)*2*12 mg/kg =156 mg/kg + (i-3)*24 mg/kg = (i*24 + 84) mg/kg

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

Actual Dose Intensity (DI)

- Overall actual DI (mg/kg/4-week cycle) = [overall cumulative dose (mg/kg)] / [intended duration of treatment with tafasitamab (weeks)/4].

Relative Dose Intensity (RDI)

- Intended DI (mg/kg/4-week cycle) = [intended cumulative dose (mg/kg)] / [intended duration of treatment with tafasitamab (weeks)/4]
- Overall RDI (%) = 100% × [overall actual DI] / [intended DI]

6.6.3.3. Exposure to Lenalidomide

The dose level is calculated as actual dose administered (mg/day).

Lenalidomide will be administered 25 mg PO daily on Days 1 through 21 of each 28-day cycle for up to 12 cycles.

Intended duration of treatment lenalidomide (weeks) =

(end date–date of first dose of study drug +1)/7,

where end date = start date of last cycle with non-zero dose of study drug + 28 – 1.

Duration of exposure to lenalidomide (weeks) =

(last dose date of lenalidomide – first dose date of lenalidomide + 7)/7

Cumulative dose (mg) is the sum of the actual doses of lenalidomide received in the study.

Actual Dose Intensity (DI)

- Overall actual DI (mg/4-week cycle) = Cumulative dose (mg) / Duration of exposure to lenalidomide (weeks) / 4 (weeks/cycle)

Intended Dose Intensity (DI)

- Overall intended DI (mg/4-week cycle) = 25 (mg/day) × 21 (days/4-week cycle) =525 (mg/4-week cycle).

Relative Dose Intensity (RDI)

- RDI (%) = [Overall actual DI (mg/4-week cycle) / Overall intended DI (mg/4-week cycle)] × 100% =[Overall actual DI (mg/4-week cycle) / 525 (mg/4-week cycle)] × 100%

6.6.3.4. Dose reductions

Applicable to PF-07901801 and tafasitamab. Dose reduction is defined as actual non-zero dose < 90% of the planned dose.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

Applicable to lenalidomide. Dose reduction is defined as a change to a non-zero dose level lower than that planned in the protocol.

The number and percentage of patients with at least one dose reduction as well as a breakdown of the number of dose reductions (1, 2, 3, ≥4) will be summarized.

6.6.3.5. Dose interruptions

Applicable to lenalidomide.

An interruption is defined a 0 mg dose administered on one or more days for lenalidomide on Days 1 through 21 of each 28-day cycle. What follows defines how dose interruptions will be counted in the case of multiple dose interruptions.

- If an interruption occurs consecutively for at least two days, then it will be counted only once (example: If the actual dose on days 1-3 is 25 mg and actual dose on days 4-5 is 0 mg and dose interruption on days 4-5 is due to AE, then the total number of dose interruptions is 1).

- If an interruption occurs for more than one day but the days are not consecutive, ie there is at least one dosing day in between, then each dose interruption will be counted as a different occurrence (example: If the actual dose on days 1, 3 and 5, is 25 mg and actual dose on days 2 and 4 is 0 mg the total number of dose interruptions is 2).

A dose interruption is not considered a dose reduction.

The number and percentage of patients with dose interruptions and the corresponding reasons will be summarized.

6.6.3.6. Dose Delays

Applicable to PF-07901801 and tafasitamab.

Dose Delay is the difference between the actual time between two consecutive non-zero doses and the planned time between the same two consecutive non-zero doses.

Dose Delay for Dose x (days) = Date of Dose x – Date of Dose (x-1) – Planned days between two consecutive doses.

Dose delays will be grouped into the following categories:

- No delay
- 1-2 days delay
- 3-6 days delay
- 7 or more days delay

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

For example, for PF-07901801, administered on a 2-week schedule, if one patient receives avelumab on Day 1, then the next PF-07901801 administration date will be on Day 15; however, if the patient receives PF-07901801 at Day 16 or 17, this is considered as 1-2 days delay.

No delay and 1-2 days delay will also be summarized together.

The number and percentage of patients with delayed study drug administration and maximum length of delay, ie, the worst case of delay if patients have multiple dose delays will be summarized.

6.6.3.7. Infusion rate reductions

Applicable to PF-07901801.

The number and percentage of patients with at least one infusion rate reduction of ≥50% compared to the first infusion rate reported in the eCRF as well as the frequency of patients with 1, 2, 3 or ≥4 infusion rate reductions of ≥50% will be summarized.

6.6.3.8. Infusion interruptions

Applicable to PF-07901801

An infusion interruption is defined as an infusion that is stopped and re-started on the same day (ie, for a visit more than one infusion start time and infusion end time are recorded).

The number and percentage of patients with at least one infusion interruption as well as the frequency of patients with 1, 2, 3, or ≥4 infusion interruptions will be summarized.

6.6.4. Concomitant Medications and Nondrug Treatments

The following analyses will be based on the Safety Analysis Set.

Concomitant medications are medications, other than study medications, which started prior to first dose date of study treatment and continued on on-treatment period as well as those started during the on-treatment period. Prior medications are medications, other than study medications and pre-medications for study drug, which are started before the first dose of study treatment.

Prior and concomitant medications will be summarized from the 'Concomitant Medications' eCRF page. Pre-medications for study drug will also be summarized separately.

Summary of prior and concomitant medications will include the number and percentage of patients by Anatomical Therapeutic Chemical (ATC) Classification level 2 and preferred term. A patient will be counted only once within a given drug class and within a given drug name, even if he/she received the same medication at different times. If any prior or concomitant medication is classified into multiple ATC classes, the medication will be summarized separately under each of these ATC classes. The summary tables will be sorted on decreasing frequency of drug class and decreasing frequency of drug name in a given drug

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

class. In case of equal frequency regarding drug class (respectively drug name), alphabetical order will be used. In case any specific medication does not have ATC classification level 2 coded term, it will be summarized under 'Unavailable ATC classification' category.

A listing of concomitant medications will be created with the relevant information collected on the 'Concomitant Medications' eCRF page.

A listing of concurrent procedures will be created with the relevant information collected on the 'Non-drug Treatments' eCRF page.

6.6.5. Subsequent Anti-Cancer Therapies

The following analyses will be based on the Safety Analysis Set by treatment group for Phase 1b and Phase 2 seperately.

Anti-cancer treatment will be provided in a data listing with data retrieved from 'Follow-up Cancer Therapy', 'Radiation', and 'Cancer Surgery' eCRF pages.

Number and percentage of patients with any anti-cancer therapy after discontinuation will be tabulated overall and by type of therapy based on the data collected from the 'Follow-up Cancer Therapy', 'Radiation' and 'Cancer Surgery' eCRF pages.

6.7. Safety Summaries and Analyses

Summaries of AEs and other safety parameters will be based on the Safety Analysis Set.

6.7.1. Adverse Events

Treatment-emergent adverse events (TEAEs) are those events with onset dates occurring during the on-treatment period for the first time, or if the worsening of an event is during the on-treatment period as defined in Section 5.2.7.

All analyses described below will be based on TEAEs if not otherwise specified. The AE listings will include all AEs (whether treatment-emergent or not). AEs outside the on-treatment period will be flagged in the listings. Summaries of TEAEs due to COVID-19 may be produced if appropriate.

- Related Adverse Events: adverse events with relationship to study treatment (as recorded on the AE eCRF page, Relationship with study treatment = Related) reported by the investigator and those of unknown relationship (i.e., no answer to the question 'Relationship with study treatment'). Related AEs are those related to any study drug (ie, at least one of the study drugs).

- Serious Adverse Events (SAE): serious adverse events (as recorded on the AE eCRF page, Serious Adverse Event = Yes).

- Adverse Events Leading to Dose Reduction: adverse events leading to dose reduction of study treatment (as recorded on the AE eCRF page, Action taken with study treatment = Dose reduced).

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- Adverse Events Leading to Interruption of Study Treatment: adverse events leading to interruption of study treatment (as recorded on the AE eCRF page, Action taken with study treatment = Drug interrupted.

- Adverse Events Leading to Permanent Treatment Discontinuation: adverse events leading to permanent discontinuation of study treatment (as recorded on the AE eCRF page, Action taken with study treatment =Drug withdrawn).

- Adverse Events Leading to Death: adverse event leading to death (as recorded on the AE eCRF page, Outcome = Fatal, as well as AEs of Grade 5).

Unless otherwise specified, AEs will be summarized by number and percentage of patients with the AE in the category of interest as described above, by treatment group, primary SOC and PT.

Each patient will be counted only once within each SOC or PT. If a patient experiences more than one AE within a SOC or PT for the same summary period, only the AE with the strongest relationship or the worst severity, as appropriate, will be included in the summaries of relationship and severity.

6.7.1.1. All Adverse Events

Adverse events will be summarized by worst severity (according to NCI CTCAE version 5.0) per patient, using the latest version of MedDRA preferred term (PT) as event category and MedDRA primary system organ class (SOC) body term as Body System category.

In case a patient has events with missing and non-missing grades, the maximum of the nonmissing grades will be displayed. No imputation of missing grades will be performed.

The following tables will be created:

- The overall summary of AEs table will include the frequency (number and percentage) of patients with each of the following by treatment group:
    - TEAEs
    - TEAEs, Grade $\geq$ 3
    - Related TEAEs
    - Related TEAEs, Grade $\geq$ 3
    - TEAEs leading to dose reduction of PF-07901801
    - TEAEs leading to dose reduction of lenalidomide
    - TEAEs leading to interruption of PF-07901801

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- TEAEs leading to interruption of tafasitamab
- TEAEs leading to interrupton of lenalidomide
- TEAEs leading to discontinuation of PF-07901801
- TEAEs leading to discontinuation of tafasitamab
- TEAEs leading to discontinuation of lenalidomide
- TEAEs leading to discontinuation of all study drugs
- Related TEAEs leading to discontinuation of PF-07901801
- Related TEAEs leading to discontinuation of tafasitamab
- Related TEAEs leading to discontinuation of lenalidomide
- Related TEAEs leading to discontinuation of all study drugs
- Serious TEAEs
- Related Serious TEAEs
- TEAEs leading to death
- Related TEAEs leading to death

- TEAEs by SOC and PT and worst grade
- TEAEs related to PF-07901801 by SOC and PT and worst grade
- TEAEs related to tafasitamab by SOC and PT and worst grade
- TEAEs related to lenalidomide by SOC and PT and worst grade
- TEAEs leading to death by SOC and PT
- Related TEAEs leading to death by SOC and PT

6.7.1.2. Adverse events leading to dose reduction of study drug

AEs leading to dose reduction will be defined as AEs identified in the AE eCRF page with an action taken with study treatment of 'dose reduced'.

The frequency (number and percentage) of patients with each of the following will be presented for TEAEs leading to dose reduction of each study drug by treatment group:

- TEAEs leading to dose reduction of PF-07901801 by SOC and PT

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- TEAEs leading to dose reduction of Tafasitamab by SOC and PT
- TEAEs leading to dose reduction of Lenalidomide by SOC and PT

The listing of all AEs leading to dose reduction will also be provided with the relevant information.

6.7.1.3. Adverse events leading to interruption of study drug

AEs leading to interruption will be defined as AEs identified in the AE eCRF page with an action taken with study treatment of 'drug interrupted'.

The frequency (number and percentage) of patients with each of the following will be presented for TEAEs leading to interruption of each study drug by treatment group:

- TEAEs leading to interruption of PF-07901801 by SOC and PT
- TEAEs leading to interruption of Tafasitamab by SOC and PT
- TEAEs leading to interruption of Lenalidomide by SOC and PT

The listing of all AEs leading to interruption of study treatment will also be provided with the relevant information.

6.7.1.4. Adverse events leading to discontinuation of study drug

The frequency (number and percentage) of patients with each of the following will be presented for TEAEs leading to permanent discontinuation of each study drug and study treatment, by treatment group:

- TEAEs leading to discontinuation of PF-07901801 by SOC and PT
- Related TEAEs leading to discontinuation of PF-07901801 by SOC and PT
- TEAEs leading to discontinuation of Tafasitamab by SOC and PT
- Related TEAEs leading to discontinuation of Tafasitamab by SOC and PT
- TEAEs leading to discontinuation of Lenalidomide by SOC and PT
- Related TEAEs leading to discontinuation of Lenalidomide by SOC and PT
- TEAEs leading to discontinuation of all study drugs by SOC and PT
- Related TEAEs leading to discontinuation of all study drugs by SOC and PT

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

The listing of all AEs leading to treatment discontinuation will also be provided with the relevant information.

6.7.2. Deaths

The frequency (number and percentage) of patients in the Safety Analysis Set who died at any time and who died within 28 days after last dose of study treatment as well as the primary reason for death, will be tabulated based on information from the 'Death Details' and 'Survival Follow-Up' eCRFs, by treatment group.

In addition, date and cause of death will be provided in individual patient data listing together with selected dosing information (study treatment received, date of first / last administration, dose) and will include the following information:

- AEs with fatal outcome (list preferred terms of AEs with outcome=Fatal, as well as AEs of Grade 5),
- Flag for death within 28 days of last dose of study treatment

Deaths due to COVID-19 may be presented in a separate listing if there is significant impact of COVID-19.

6.7.3. Serious Adverse Events

The frequency (number and percentage) of patients with each of the following will be presented for treatment-emergent SAEs by treatment group:

- SAEs by SOC and PT
- Related SAEs by SOC and PT

The listings of all SAEs will also be provided with the relevant information with a flag for SAEs with onset outside of the on-treatment period.

6.7.4. Laboratory Data

6.7.4.1. Hemotology and Chemistry Parameters

Laboratory results will be classified according to the NCI CTCAE criteria version 5.0. Nonnumerical qualifiers (with the exception of fasting flags) will not be taken into consideration in the derivation of CTCAE criteria (e.g., hypokalemia Grade 1 and Grade 2 are only distinguished by a non-numerical qualifier and therefore Grade 2 will not be derived). Additional laboratory results that are not part of NCI CTCAE will be presented according to the categories: below normal limit, within normal limits and above normal limit (according to the laboratory normal ranges).

Quantitative data will be summarized using simple descriptive statistics (mean, SD, median, Q1, Q3, minimum, and maximum) of actual values and changes from baseline for each

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

nominal visit over time (unscheduled measurements would therefore not be included in these summaries as described in Section 5.2.9). End of Treatment visit laboratory results will be summarized separately. The changes computed will be the differences from baseline. Qualitative data based on reference ranges will be described according to the categories (i.e., Low, Normal, High).

Abnormalities classified according to NCI CTCAE toxicity grading version 5.0 will be described using the worst grade. For those parameters which are graded with two toxicities such as potassium (hypokalemia/hyperkalemia), the toxicities will be summarized separately. Low direction toxicity (e.g., hypokalemia) grades at baseline and post baseline will be set to 0 when the variables are derived for summarizing high direction toxicity (e.g., hyperkalemia), and vice versa.

For WBC differential counts (total neutrophil, lymphocyte, monocyte, eosinophil, and basophil counts), the absolute value will be used.

For calcium, CTCAE grading is based on Corrected Calcium and Ionized Calcium (CALCIO). Corrected Calcium is calculated from Albumin and Calcium as follows:

Corrected calcium (mmol/L) = measured total Calcium (mmol/L) + 0.02 (40 - serum albumin [g/L]).

Liver function tests: Alanine aminotransferase (ALT), aspartate aminotransferase (AST), and total bilirubin (TBILI) are used to assess possible drug induced liver toxicity. The ratios of test result over upper limit of normal (ULN) will be calculated and classified for these three parameters during the on-treatment period.

Summary of liver function tests will include the following categories. The number and percentage of patients with each of the following during the on-treatment period will be summarized by treatment group:

- ALT $\geq 3\times$ULN, ALT $\geq 5\times$ULN, ALT $\geq 10\times$ULN, ALT $\geq 20\times$ULN
- AST $\geq 3\times$ULN, AST $\geq 5\times$ULN, AST $\geq 10\times$ULN, AST $\geq 20\times$ULN
- (ALT or AST) $\geq 3\times$ULN, (ALT or AST) $\geq 5\times$ULN, (ALT or AST) $\geq 10\times$ULN, (ALT or AST) $\geq 20\times$ULN
- TBILI $\geq 2\times$ULN
- Concurrent ALT $\geq 3\times$ULN and TBILI $\geq 2\times$ULN
- Concurrent AST $\geq 3\times$ULN and TBILI $\geq 2\times$ULN
- Concurrent (ALT or AST) $\geq 3\times$ULN and TBILI $\geq 2\times$ULN

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- Concurrent (ALT or AST) ≥ 3×ULN and TBILI ≥ 2×ULN and ALP > 2×ULN

- Concurrent (ALT or AST) ≥ 3×ULN and TBILI ≥ 2×ULN and (ALP ≤ 2×ULN or missing)

Concurrent measurements are those occurring on the same date.

Categories will be cumulative, i.e., a patient with an elevation of AST ≥10×ULN will also appear in the categories ≥5×ULN and ≥3×ULN. Liver function elevation and possible Hy's Law cases will be summarized using frequency counts and percentages.

An evaluation of Drug-Induced Serious Hepatotoxicity (eDISH) plot will also be created, with different symbols for different treatment groups, by graphically displaying

- peak serum ALT(/ULN) vs peak total bilirubin (/ULN) including reference lines at ALT=3×ULN and total bilirubin =2×ULN.

- peak serum AST(/ULN) vs peak total bilirubin (/ULN) including reference lines at AST=3×ULN and total bilirubin =2×ULN.

In addition, a listing of all TBILI, ALT, AST and ALP values for patients with a postbaseline TBILI ≥ 2×ULN, ALT≥ 3×ULN or AST ≥ 3×ULN will be provided.

Parameters with NCI-CTC grades available:

The laboratory toxicities will be tabulated using descriptive statistics (number of patients and percentages) during the on-treatment period. The denominator to calculate percentages for each laboratory parameter is the number of patients evaluable for CTCAE grading (i.e. those patients for whom a Grade 0, 1, 2, 3 or 4 can be derived).

- The summary of laboratory parameters by CTCAE grade table will include number and percentage of patients with Grade 1, 2, 3, 4, Grade 3/4 and any grade (Grades 1-4), laboratory abnormalities during the on-treatment period.

- The shift table will summarize baseline CTCAE grade versus the worst on-treatment CTCAE grade. The highest CTCAE grade during the on-treatment period is considered as the worst grade (Grade 0, 1, 2, 3, or 4) for the summary.

The above analyses apply to hematology and chemistry evaluations which can be graded per CTCAE, i.e.:

- Hematology:
  Hemoglobin (HB), Leukocytes (white blood cell decreased), Lymphocytes (lymphocyte count increased/decreased), Neutrophils / Absolute Neutrophils Count (ANC) (neutrophil count decreased), Platelet Count (PLT) (platelet count decreased).

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- Serum Chemistry:
  Albumin (hypoalbuminemia), Alkaline Phosphatase (alkaline phosphatase increased), Alanine Aminotransferase (ALT) (ALT increased), Aspartate Aminotransferase (AST) (AST increased), Total Bilirubin (blood bilirubin increased, Creatinine (creatinine increased), Potassium (hypokalemia/ hyperkalemia), Sodium (hyponatremia/ hypernatremia), Magnesium (hypomagnesemia / hypermagnesemia), Calcium (hypocalcemia/ hypercalcemia), Glucose (hypoglycemia / hyperglycemia), Phosphates (hypophosphatemia).

Parameters with NCI-CTC grades not available:

Hematology and chemistry evaluations which cannot be graded per CTCAE criteria will be summarized as frequency (number and percentage) of patients with:

- shifts from baseline normal to at least one result above normal during on-treatment period
- shifts from baseline normal to at least one result below normal during on-treatment period

In this study, these apply to the following parameters:

- Hematology: Absolute Monocytes, Absolute Eosinophils, Absolute Basophils, and Reticulocytes
- Serum Chemistry: Chloride, Total Urea, Uric Acid, Lactate Dehydrogenase (LDH), Immunoglobulin

6.7.4.2. Other Laboratory Parameters

All other parameters collected on the eCRF will be listed in dedicated listings presenting all corresponding collected information on the eCRF.

- Coagulation: partial thromboplastin time (PTT) and prothrombin time (INR)
- Urinalysis: all urinalysis parameters
- Pregnancy test

The listings of laboratory results will be provided for all laboratory parameters. The listings will be sorted by parameters and assessment dates or visits for each patient. Laboratory values that are outside the normal range will also be flagged in the data listings, along with corresponding normal ranges. A listing of CTCAE grading will also be generated for those laboratory tests.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

In addition, listings of abnormal values will be provided for hematology, chemistry, urinalysis, coagulation parameters. If there is at least one abnormal assessment for any parameter, all the data for that laboratory parameter will be included into the listing.

For all tests not mentioned above but present in the clinical data, a listing of patients with at least one result for the relevant test will be provided.

6.7.5. Vital Signs

Weight for the purposes of dose calculation will be recorded at screening and within 3 days pre-dose Day 1 of each cycle. Height will be measured at screening only.

Vital sign summaries will include all vital sign assessments from the on-treatment period. All vital sign assessments will be listed, and those collected outside the on-treatment period will be flagged in the listing.

All vital sign parameters will be summarized using descriptive statistics (mean, SD, median, Q1, Q3, minimum, and maximum) of actual values and changes from baseline for each visit over time. End of Treatment visit will be summarized separately. The changes computed will be the differences from baseline.

6.7.6. Electrocardiograms

ECG summaries will include all ECG assessments from the on-treatment period. All ECG assessment will be listed, and those collected outside the on-treatment period will be flagged in the listing.

QTcF will be summarized based on values collected on the eCRF. In case QTcF is missing, it will be derived based on RR and QT using the following formula:

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

where RR represents the RR interval of the ECG, in seconds, and can be estimated as 60/Heart Rate.

If there are replicate measurements on the same nominal visit, the average of the replicate measurements will be reported and it should be determined after the derivation of the individual parameter at each time point.

ECG Summaries

The following analyses will be performed for each applicable ECG parameters (RR, PR, QT, QTcF and QRS) by treatment group, during the on-treatment period, for pre-PF-07901801 ECG records. The denominator to calculate percentages for each category is the number of patients evaluable for the category.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

- For each of the ECG parameters (HR, QT, QTcF, QRS, PR intervals), descriptive statistics at baseline, at each post-baseline time point and changes from baseline at each post-baseline time point
- Frequency (number and percentage) of patients with notable ECG values according to the following cateogries:
    - QT/QTcF increase from baseline > 30 ms, > 60 ms
    - QT/QTc > 450 ms, > 480 ms, > 500 ms
    - HR ≤ 50 bpm and decrease from baseline ≥ 20 bpm
    - HR ≥ 120 bpm and increase from baseline ≥ 20 bpm
    - PR ≥ 220 ms and increase from baseline ≥ 20 ms
    - QRS ≥ 120 ms

For each of the ECG parameters, changes from pre-infusion to the end of infusion for PF-07901801 and changes from end of infusion for PF-07901801 to end of infusion for tafasitamab will also be summarized for the first 3 cycles.

Patients with notable ECG interval values and qualitative ECG abnormalities will be listed for each patient and time point and the corresponding notable values and abnormality findings will be included in the listings.

Unscheduled ECG measurements will not be used in computing the descriptive statistics for change from baseline at each post-baseline time point. However, they will be used in the analysis of notable ECG changes and the shit table analysis of notable QT parameters.

6.7.7. B-Symptoms

Assessment of the presence or absence of B-symptoms will be performed at Screening and on Day 1 for all cycles, as well as the EOT.

B-symptoms are defined as the presence of: (a) unintentional weight loss of more than 10% within the previous 6 months, and/or (b) persistent or recurrent fevers of ≥ 38° C without other evidence of infection, and/or (c) drenching night sweats without evidence of infection.

Frequency (number and percentage) of patients with presence and absence of B-symptoms will be summarized by treatment group for baseline and each post-baseline visit during the on-treatment period. EOT visit will be summarized separately.

7. INTERIM ANALYSES

There is no formal interim analysis planned for this study.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

7.1. Introduction

Not applicable.

7.2. Interim Analyses and Summaries

Not applicable.

8. REFERENCES

[1] Cheson BD, Fisher RI, Barrington SF, et al. Recommendations for initial evaluation, staging, and response assessment of Hodgkin and non-Hodgkin lymphoma: the Lugano classification. J Clin Oncol. 32(27): 3059-68, 2014.

[2] Guo W, et al. A Bayesian interval dose-finding design addressingOckham's razor: mTPI-2. Contemporary Clinical Trials. 58: 23-33, 2017.

[3] Brookmeyer R, Crowley JJ. A confidence interval for the median survival time. Biometrics. 38: 29-41, 1982.

[4] Kalbfleisch JD, Prentice, RL. Statistical Analysis of Failure Time Data, 2nd Edition. Hoboken, Wiley Interscience.

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

APPENDICES

Appendix 1. List of Abbreviations

Abbreviation	Term
ADA	Anti-drug antibody
AE	Adverse event
ALP	Alkaline phosphatase
ALT	Alanine aminotransferase
AST	Aspartate aminotransferase
ASCT	Autologous stem cell transplantation
ATC	Anatomic Therapeutic Chemical
AUC	Area under the curve
BLQ	Below the limit of quantitation
BMI	Body mass index
BOR	Best overall response
BP	Blood pressure
CI	Confidence interval
CK	Creatine kinase
C_{max}	Maximum observed concentration
COVID-19	Coronavirus disease 2019
CR	Complete response
CRF	Case report form
CSR	Clinical study report
CT	Computed tomography
CTCAE	Common Terminology Criteria for Adverse Events
DI	Dose intensity
DL	Dose level
DLBCL	Diffuse large B cell lymphoma
DLT	Dose limiting toxicity
DoCR	Duration of complete response
DoR	Duration of response
ECG	Electrocardiogram
ECOG	Eastern Cooperative Oncology Group
eCRF	Electronic case report form
eDISH	Evaluation of drug-induced serious hepatotoxicity
EOS	End of study
EOT	End of treatment
FDA	Food and Drug Administration (United States)
LLN	Lower limit of normal
LPLV	Last patient last visit
MedDRA	Medical Dictionary for Regulatory Activities
MRI	Magnetic resonance imaging
MTD	Maximum tolerated dose
mTPI	Modified toxicity probability interval
N/A	Not applicable

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)

Abbreviation	Term
Nab	Neutralizing antibody
NCI	National Cancer Institute
ND	Not done
NE	Not evaluable
OR	Objective response
ORR	Objective response rate
OS	Overall survival
RP2D	Recommended Phase 2 dose
RP3D	Recommended Phase 3 dose
PD	Pharmacodynamic(s)
PD	Progressive disease
PET	Positron emission tomography
PFS	Progression-free survival
PK	Pharmacokinetic(s)
PR	Partial response
pT	Target probability
PT	Preferred term
QT	Time from the beginning of the QRS complex to the end of the T wave
QTc	Corrected QT
QTcF	Corrected QT (Fridericia method)
QD	Once daily
Q2W	Once every two weeks
QW	Once weekly
RDI	Relative dose intensity
R/R	Relapsed/refractory
SAE	Serious adverse event
SAP	Statistical analysis plan
SD	Standard deviation
SD	Stable disease
SOC	System organ class
TBILI	Total bilirubin
TEAE	Treatment-emergent adverse events
T_{max}	Time for C_{max}
ULN	Upper limit of normal
UPM	Unit probability mass
WBC	White blood cell
WHO	World Health Organization

090177e19d6a1ac0\Approved\Approved On: 09-May-2023 20:57 (GMT)