

Integrated Analysis Plan

Study Number: MS200527_0131
Clinical Study Protocol Title: A Phase I, Open-Label Study of the Relative Bioavailability of Evobrutinib Tablet Manufacturing Batches in Healthy Participants
Study Phase: Phase I
Merck Compound: Evobrutinib (M2951)
Protocol Version: 08 September 2022/Version 1.0

Integrated Analysis Plan
Author:

Coordinating Author	
PPD [REDACTED], On behalf of Merck	PPD [REDACTED]
Function	Author(s) / Data Analyst(s)
PPD [REDACTED]	PPD [REDACTED]

Integrated Analysis Plan
Date and Version: 06 FEB 2023 / Version Final 1.0

Integrated Analysis Plan
Reviewers:

Function	Name
PPD [REDACTED], Merck	[REDACTED]
PPD [REDACTED], Merck	[REDACTED]
PPD [REDACTED], Merck	[REDACTED]
PPD [REDACTED], Merck Clinical Trial Lead, Merck	[REDACTED]
PPD [REDACTED], Merck	[REDACTED]
PPD [REDACTED], Merck	[REDACTED]

Confidential

This document is the property of Merck KGaA, Darmstadt, Germany, or one of its affiliated companies.
It is intended for restricted use only and may not - in full or part - be passed on, reproduced, published or used without
express permission of Merck KGaA, Darmstadt, Germany or its affiliate.
Copyright © [2023] by Merck Healthcare KGaA, Darmstadt, Germany or its affiliate. All rights reserved.

Approval Page

Integrated Analysis Plan: MS200527_0131

A Phase I, Open-Label Study of the Relative Bioavailability of Evobrutinib Tablet Manufacturing Batches in Healthy Participants

Approval of the IAP by all Merck Data Analysis Responsible has to be documented within EDMS via eSignature. With the approval, the Merck responsible for each of the analysis also takes responsibility that all reviewers' comments are addressed adequately.

By using eSignature, the signature will appear at the end of the document.

1 Table of Contents

Approval Page	2	
1	Table of Contents.....	3
2	List of Abbreviations and Definition of Terms	5
3	Modification History	6
4	Purpose of the Integrated Analysis Plan	6
5	Objectives and Endpoints	6
6	Overview of Planned Analyses	7
7	Changes to the Planned Analyses in the Clinical Study Protocol	7
8	Analysis Sets and Subgroups.....	7
8.1	Definition of Analysis Sets.....	7
8.2	Subgroup Definition and Parameterization	7
9	General Specifications for Data Analyses	8
9.1	Definition of Baseline and Change from Baseline	9
9.2	Study Day / Study Intervention Day.....	9
9.3	Definition of Duration and 'Time Since' Variables	9
9.4	Imputation of Missing Data	9
10	Study Participants	10
10.1	Disposition of Participants and Discontinuations.....	10
10.2	Protocol Deviations / Exclusion from Analysis Sets	11
10.2.1	Important Protocol Deviations.....	11
10.2.2	Reasons Leading to the Exclusion from an Analysis Set	11
11	Demographics and Other Baseline Characteristics.....	11
11.1	Demographics	12
11.2	Medical History	12
11.3	Other Baseline Characteristics.....	12
12	Previous or Concomitant Therapies/Procedures.....	12
13	Study Intervention: Compliance and Exposure	12
14	Efficacy Analyses	13
15	Safety Analyses	13
15.1	Adverse Events	13
15.1.1	All Adverse Events	13

15.1.2	Adverse Events Leading to Discontinuation of Study Intervention	14
15.2	Deaths, Other Serious Adverse Events, and Other Significant Adverse Events	15
15.2.1	Deaths	15
15.2.2	Serious Adverse Events	15
15.2.3	Other Significant Adverse Events	15
15.3	Clinical Laboratory Evaluation	15
15.4	Vital Signs	16
15.5	Other Safety or Tolerability Evaluations	16
16	Analyses of Other Endpoints/Estimands	17
16.1	Pharmacokinetics	17
16.1.1	Descriptive Statistics of PK Concentration Data	17
16.1.2	Descriptive Statistics of PK Parameter Data	17
16.1.3	Statistical Analysis of PK Parameter Data	18
16.1.4	General Specifications for PK Concentration and PK Parameter Data	18
16.1.5	Estimation of Pharmacokinetic Parameters	19
16.1.5.1	Estimation of Pharmacokinetic Parameters in Plasma	19
16.1.6	Presentation of PK Concentration and PK Parameter Data	21
16.1.6.1	Listings and Tables	21
16.1.6.2	Graphical Summaries and Individual plots (PK Analysis Set)	21
17	References	21
18	Appendices	22

2

List of Abbreviations and Definition of Terms

ADaM	Analysis Data Model
AE	Adverse Event
AESI	Adverse Events of Special Interest
ANOVA	Analysis of VARIANCE
BLQ	Below Lower Limit of Quantification
BMI	Body Mass Index
CDISC	Clinical Data Interchange Standards Consortium
CI	Confidence Interval
eCRF	electronic Case Report Form
CSR	Clinical Study Report
ECG	Electrocardiogram
GBS	Global Biostatistics
IAP	Integrated Analysis Plan
ICH	International Conference on Harmonization
LCI	Lower Limit of Confidence Interval
LLOQ	Lower Limit of Quantification
NCA	Noncompartmental Analysis
MCAR	Missing Completely at Random
MedDRA	Medical Dictionary for Regulatory Activities
PT	Preferred Term
PK	Pharmacokinetics
SAE	Serious Adverse Event
SD	Standard Deviation
SDTM	Study Data Tabulation Model
SOC	System Organ Class
TEAE	Treatment-Emergent Adverse Event
TLF	Tables, Listings, and Figures
UCI	Upper Limit of Confidence Interval

3 Modification History

Unique Identifier for Version	Date of IAP Version	Author	Changes from the Previous Version
Final 1.0	06-FEB-2023	PPD	Initial Version

4 Purpose of the Integrated Analysis Plan

The purpose of this IAP is to document technical and detailed specifications for the final analysis of data collected for protocol MS200527_0131. Results of the analyses described in this IAP will be included in the CSR. Additionally, the planned analyses identified in this IAP may be included in regulatory submissions or future manuscripts. Any post-hoc, or unplanned analyses performed to provide results for inclusion in the CSR but not identified in this prospective IAP will be clearly identified in the CSR.

The IAP is based upon Section 9 (Statistical considerations) of the study protocol and protocol amendments and is prepared in compliance with ICH E9. It describes analyses planned in the protocol and protocol amendments.

The wording used in this IAP is chosen to best match the respective wording in the study protocol template, the CSR template, CDISC requirements and special requirements for table layouts. Therefore, the following approach is used:

Generally, the term 'participant' will be used instead of 'subject' or 'patient'. However, in tables and listings the term 'subject' will be used to match CDISC requirements, except for in-text tables where 'participant' will be used to match the CSR and protocol templates. Similarly, the term 'study intervention' will be used in this document instead of 'treatment' to match protocol and CSR templates, however, tables and listings will use 'treatment' for brevity reasons. Exceptions from this rule are commonly used terms like "on-treatment", "treatment-emergent", "treatment policy", "subject-years", "by-subject", or names of eCRF pages like "Treatment Termination" page.

5 Objectives and Endpoints

Objectives	Endpoints
Primary	
To compare the single-dose PK of different manufacturing batches of evobrutinib TF2 formulation relative to a reference batch under fasted conditions in healthy participants	AUC _{0-∞} and C _{max}
Secondary	

Objectives	Endpoints
To assess the safety and tolerability of evobrutinib administered as a single oral dose of different manufacturing batches of TF2 formulation under fasted conditions in healthy participants	Nature, occurrence, and severity of treatment-emergent adverse events (TEAEs) Absolute values and changes in safety laboratory tests Single 12-lead ECGs evaluated by Investigator (morphology and time intervals). Listing of the ECG description if classified as "abnormal". Vital signs assessed from time of first dose to end of study participation
To further characterize the PK of different manufacturing batches of evobrutinib TF2 formulation	Additional PK parameters, e.g. $AUC_{0-\text{last}}$, t_{max} , $t_{1/2}$, CL/F, V_z/F , F_{rel}

6 Overview of Planned Analyses

The final, planned analyses identified in the CSP and in this IAP will be performed after the last participant has completed the last visit and after all data queries resolved as well as the database locked.

A data review meeting will be held prior to database lock for the final analysis. In addition, no database can be locked until this IAP has been approved.

7 Changes to the Planned Analyses in the Clinical Study Protocol

There are no changes to the planned analyses in the clinical study protocol.

8 Analysis Sets and Subgroups

8.1 Definition of Analysis Sets

Analysis Set	Description
Screening (SCR)	All participants, who provided informed consent, regardless of the participant's enrollment and study intervention status in the study.
Safety (SAF)	All participants, who were administered any dose of any study intervention. Analyses will consider participants as treated.
Pharmacokinetic (PK)	The PK Analysis Set is a subset of the Safety Analysis Set and will consist of all participants who receive at least one dose of active IMP and provide at least one measurable postdose concentration. A measurement below lower limit of quantification is considered a valid measurement. Participants will be analyzed according to the actual treatment they received in each period. All PK analyses will be based on the PK Analysis Set.

PK=pharmacokinetic; SAF=safety; SCR=Screening.

8.2 Subgroup Definition and Parameterization

Not applicable.

9**General Specifications for Data Analyses**

The results of this study will be reported using summary tables, figures, and data listings, as appropriate. All data will be summarized by study intervention and/or scheduled time point, as applicable.

Listings

In the individual participant data listing all individual data will be listed as measured. Repeated and unscheduled measurements will be included in the listings. All listings will be sorted by subject ID and nominal time point, if not stated otherwise.

Tables and Descriptive Statistics

All safety data will be summarized by study intervention, as appropriate. All PK data will be summarized by study intervention and nominal time point. All individual data will be listed as measured in the individual participant data listing. Repeated and unscheduled measurements included in the listings will not be used for statistical analyses or summaries, unless the repeated measurement was performed due to unreliable values/technical reasons, e.g., clotted samples.

Unless otherwise specified, continuous variables will be summarized using descriptive statistics, i.e., the number of participants with non-missing values (n), the number of participants with missing values (nmiss), mean, standard deviation, median, 25th percentile (Q1) and 75th percentile (Q3), minimum, and maximum. If there are no missing values, the number of participants with missing values should be indicated by a 0. Mean, Median, Q1, Q3, Min, Max will have the same precision as the SDTM data (decimal places). SD will be presented with one decimal place more than the mean.

Qualitative variables will be summarized by frequency counts and percentages. Unless otherwise stated the calculation of proportions will be based on the number of participants of the analysis set of interest that received the respective study intervention for safety and PK summaries and for all other evaluations the analysis set of interest [N]. Therefore, counts of missing observations will be included in the denominator and presented as a separate category.

The following labels will be used for the study interventions in tables, listings, and figures, if not stated otherwise:

Treatment A: A single oral administration of 45 mg evobrutinib (TF2 formulation) Batch A
= **CCI** (reference)

Treatment B: A single oral administration of 45 mg evobrutinib (TF2 formulation) Batch B
= **CCI** (lower dissolution bound)

Treatment C: A single oral administration of 45 mg evobrutinib (TF2 formulation) Batch C
= **CCI** (upper dissolution bound)

Treatment D: A single oral administration of 45 mg evobrutinib (TF2 formulation) Batch D
=CC1 (hammer-milled)

All statistical analyses will be performed using SAS® Software version 9.4 or higher.

9.1 Definition of Baseline and Change from Baseline

If not otherwise specified, 'baseline' refers to the last scheduled measurement before first administration of study intervention in each respective period.

However, if a participant is missing the baseline collection, the previous non-missing evaluation could become the baseline value (e.g. from Screening). If no baseline or previous to baseline evaluations exist, then the baseline value will be treated as missing.

Absolute changes from baseline are defined as

$$\text{absolute change} = \text{visit value} - \text{baseline value}$$

9.2 Study Day / Study Intervention Day

Study day 1 for this study is defined as the start date of study intervention, the day before is Day - 1 (no Day 0 is defined). Study day is defined relative to Day 1.

9.3 Definition of Duration and 'Time Since' Variables

The following definitions and calculations of duration, as applicable, will be applied:

- Duration of AE (in days hh:mm) = end date and time - start date and time of the AE, if missing time for either the beginning or end then = end date - start date + 1; in case of multiple records for the same AE, the duration will be calculated over all these records
- Days hh:mm from dosing = start date and time of the event - date and time dose administration (for TEAEs), if missing time for either the dosing or event then days hh:mm from dosing = event start date - date of dose administration + 1
- Relative (Rel.) Day in period of AE = start date of the event - date of admin in period + 1 (for AEs on or after the day of dosing within a period)
- Rel. Day in study of AE = start date of the event - date of first admin + 1 (for AEs on or after the day of dosing)
- Rel. Day in study of AE = start date of the event - date of first admin (for events before the day of dosing of the study only)

9.4 Imputation of Missing Data

In this Phase I PK study, missing observations will be assumed to be missing completely at random (MCAR). No action will be taken to handle missing data. A participant who withdraws prior to the

last planned observation in a study period will be included in the analyses up to the time of discontinuation.

10 Study Participants

The subsections in this section include specifications for reporting participant disposition and study intervention/study discontinuations. Additionally, procedures for reporting protocol deviations are provided.

10.1 Disposition of Participants and Discontinuations

The following will be presented in a summary table:

- Total number of participants screened (i.e., participants who gave informed consent)
- Number of screened participants who discontinued from the study prior to first dosing overall and grouped by the main reason for discontinuation:
 - Participant did not meet all eligibility criteria
 - Withdrew consent
 - Other (COVID-19-related and COVID-19-non-related)
- Number of treated participants
- Number and percentage of treated participants who completed study
- Number and percentage of treated participants who discontinued the study or study intervention, with the primary reason of discontinuation:
 - Adverse event
 - Lost to follow-up
 - Protocol non-compliance
 - Death
 - Withdrew consent
 - Other (COVID-19-related and COVID-19-non-related)

A listing of discontinued participants will be provided.

A listing of participants affected by COVID-19-will also be provided. The start of COVID-19 pandemic will be defined by 11th of March 2020 when the WHO declared COVID-19 as pandemic.

The number and percentage of participants will be presented by group of study intervention and total, where applicable. Percentages will be presented with respect to the number of treated participants, where applicable.

10.2 Protocol Deviations / Exclusion from Analysis Sets

10.2.1 Important Protocol Deviations

Listings of important protocol deviations will be provided including the date and relative day in relation to dosing in the relevant period. A distinction will be made between important protocol deviations due to COVID-19 versus not due to COVID-19. The respective important protocol deviations will be flagged accordingly.

Important protocol deviations or important events that might influence PK include, but may not be limited to the following:

- Adverse events, diarrhea etc. (these instances will be discussed on a case-by case basis)
- Vomiting after administration following oral dosing (these instances will be discussed in alignment with applicable regulatory guidelines on a case-by-case basis)
- Sample processing errors that may lead to inaccurate bioanalytical results
- Inaccurate dosing or dosing errors (e.g., dose administration delayed, dose change or missed doses)
- Predose or trough sample collected after the actual dosing
- Non-compliance with food and drink requirements (e.g., non-fasted, incomplete meal consumption, caffeine intake)
- Concomitant medication, vitamins, dietary or herbal supplements

Should one or more of these events be available at the Data Review Meeting, its implication for PK evaluation will be discussed and agreed amongst relevant study team members (e.g., Sponsor Clinical Pharmacology/Biostatistics/Clinical Pharmacokinetics & Pharmacodynamics team representative). Appropriate action will be taken such as flagging individual values to be excluded from analysis.

10.2.2 Reasons Leading to the Exclusion from an Analysis Set

All criteria/reasons leading to the exclusion of a participant from an analysis set will be listed based on the Safety Analysis Set.

If participants are excluded from the PK Analysis Set, the reasons for exclusion will be listed.

Reasons for excluding individual PK concentrations will also be listed separately and flagged in the main listing.

11 Demographics and Other Baseline Characteristics

Demographics and baseline characteristics will be presented for the SAF.

11.1 Demographics

Descriptive statistics will be presented for age, height, weight, and BMI. Frequency counts and percentages will be presented for sex, race, and ethnicity. The summary will be performed overall.

BMI (kg/m²) will be derived (i.e., not taken directly from the database) according to the following formula:

$$\text{BMI [kg/m}^2\text{]} = \frac{\text{weight [kg]}}{\text{height[cm}^2\text{]}} \times 10000$$

11.2 Medical History

Medical history will be coded using the Medical Dictionary for Regulatory Activities (MedDRA), most current version at time of data base lock, and listed. The medical history will be listed by participant including preferred term (PT) as event category and system organ class (SOC) body term as Body System category.

11.3 Other Baseline Characteristics

Other baseline measurements, such as virus screen, cotinine, alcohol and drugs of abuse screen, eGFR, and pregnancy test in women will be listed.

12 Previous or Concomitant Therapies/Procedures

Medications will be presented for the Safety Analysis Set.

Previous medications are defined as any medication discontinued prior to the administration of study intervention. Concomitant medications are defined as any medication taken during the course of the study, with a starting date greater than or equal to the administration of study intervention, or with a starting date prior to the administration of study intervention and ongoing at the time of the administration of study intervention.

The World Health Organization Drug dictionary (WHO-DD) most current version at time of database lock, will be used for coding of prior and concomitant medications and they will be described using PT as applicable.

Previous and concomitant medications will be listed. Concomitant procedures, if any, will also be listed. The following information will be displayed in a listing: generic or trade name (as reported in CRF), WHO drug name (including ATC coding and PT), dose/unit, route, frequency, reason for use, start/end date and time

13 Study Intervention: Compliance and Exposure

The dosing of each participant is monitored by the study nurse or investigator. A listing of date and time of each drug administration and each blood sampling, including time deviations as well

as measured plasma concentrations, will be provided sorted by participant. Information on meal intake will be listed by participant, if provided.

14 Efficacy Analyses

Not applicable.

15 Safety Analyses

This section includes specifications for summarizing safety endpoints that are common across clinical studies such as adverse events, laboratory tests, and vital signs.

All safety analyses will be performed for the Safety Analysis Set.

Safety analyses will be done according to the as-treated principle.

15.1 Adverse Events

All AEs recorded during the study will be coded with the MedDRA, latest version at time of database lock, and assigned to a SOC and a PT.

TEAEs are those events with onset dates on or after the first administration of study intervention on Day 1. Any AE occurring before the administration of study intervention on Day 1 and resolved before administration of study intervention or not worsening after administration of study intervention on Day 1 will be included in the AE listings but will not be included in the summary tables (unless otherwise stated). These will be referred to as “pre-treatment” AEs.

In case AE-related dates are partial, the available information will be used in a conservative approach to determine whether the AE is treatment-emergent.

All analyses described in Section 15.1 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.

Unless otherwise specified, TEAEs will be summarized by number and percentage of participants with the TEAE in the category of interest, as well as the number of events, in total by primary SOC and PT in alphabetical order for SOC and decreasing overall frequency for PT.

If an event was reported more than once due to change in intensity and change in relationship, the worst severity and the worst relationship to study intervention will be tabulated.

Each participant will be counted only once within each SOC or PT.

15.1.1 All Adverse Events

The number and percentage of participants experiencing at least one TEAE as well as the number of events will be summarized by study intervention and overall:

- The number and percentage of participants with any TEAE, any related TEAE, any serious TEAE, any related serious TEAE, any severe TEAE, any related severe TEAE, any AESI, any TEAE leading to death, any related TEAE leading to death, any TEAE leading to study discontinuation.
- The number and percentage of participants with at least one TEAE and the number of events by SOC and PT.
- The number and percentage of participants with TEAEs excluding SAEs and the number of events, with frequency $\geq 5\%$ in any study intervention arm by SOC and PT
- The number and percentage of participants with at least one TEAE and the number of events by severity, SOC, and PT
- The number and percentage of participants with at least one related TEAE and the number of events by SOC and PT
- The number and percentage of participants with at least one AESI recorded and the number of events by SOC and PT.

Unless otherwise stated, AEs will be displayed with SOC terms sorted alphabetically and PTs within each SOC term sorted in descending overall frequency.

For determining incidence counts, within each level of TEAE term, if a participant experiences more than one occurrence, the participant will only be counted once for that TEAE.

AEs related to any study intervention are those events with relationship missing, unknown or yes.

In case a participant had events with missing and non-missing severity, the maximum non-missing severity will be displayed.

15.1.2 Adverse Events Leading to Discontinuation of Study Intervention

TEAEs leading to permanent discontinuation of study treatment will be summarized by treatment and overall including number of participants, percentage, and number of events.

A listing of TEAEs leading to permanent discontinuation of a study treatment will additionally be provided.

15.2 Deaths, Other Serious Adverse Events, and Other Significant Adverse Events

15.2.1 Deaths

A listing of deaths, if any, will be provided.

15.2.2 Serious Adverse Events

A summary table of serious adverse events (SAEs), if any, by treatment and overall will be provided displaying the number and percentage of participants by treatment with at least one SAE and the number of SAEs overall and by SOC and PT. SOC terms and PTs within each SOC term will be sorted alphabetically.

Listing of SAEs, if any, will be provided.

15.2.3 Other Significant Adverse Events

The following AESI were defined:

- Infections (serious, severe, and opportunistic, \geq Grade 3)
- Seizures
- Elevated lipase, elevated amylase, pancreatitis
- Liver-related events

More information can be found in the CSP, Section 8.3.7.

AESIs will be flagged based on an external excel file which includes the precise descriptions of the AESIs (SMQs, PTs and laboratory constellations) and will be used to retrospectively identify AESIs in the AE listings. Summary table of the number and percentage of participants with at least one AESI by SOC and PT will also be provided.

15.3 Clinical Laboratory Evaluation

Listings and summary statistics at each assessment time will be presented using SI units. Normal ranges will be provided by the laboratory department, and out of range flags will be calculated based on the normal ranges. Laboratory data not transferred from the central laboratory in SI units will be converted to SI units before processing. Both original units and SI units will be provided in the SDTM domain.

Laboratory parameters will be listed by participant and time-point and flags for measurements outside the reference ranges, where applicable, and summarized indicating the study intervention at the respective time-point using descriptive statistics for absolute values.

Safety laboratory parameters are separated into:

- Hematology (including coagulation)
- Biochemistry

- Urinalysis
- Other tests

Tables will be produced for Hematology and Biochemistry laboratory parameters. Listings of abnormal test results (low and high) will also be provided.

15.4 Vital Signs

Vital signs data will be summarized by treatment and time point using descriptive statistics for baseline (see definition in Section 9), each evaluation during the study, and change from baseline to each evaluation. Listings of vital sign data will be provided.

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.

Tympanic temperature will be listed by participant and time-point.

15.5 Other Safety or Tolerability Evaluations

Safety ECG data will be summarized by study intervention and time point using descriptive statistics for baseline (see definition in Section 9), each evaluation during the study, and change from baseline to each evaluation. Listing of safety ECG data will be provided.

ECG summaries will include all ECG assessments from the on-treatment period. All ECG assessments will be listed.

The analysis of QT data is complicated by the fact that the QT interval is highly correlated with heart rate. Because of this correlation, formulas are routinely used to obtain a corrected value, denoted QTc, which is independent of heart rate. This QTc interval is intended to represent the QT interval at a standardized heart rate. Several correction formulas have been proposed in the literature. The QT interval will be corrected for heart rate by the Fridericia's formula, QTcF, is defined as

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

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

Investigator reported interpretation results will also be tabulated by study intervention and time point using the number and percentage of participants for each interpretation category (Normal, Abnormal Not Clinically Significant [NCS], Abnormal Clinically Significant [CS]). Abnormality reason will also be displayed.

16 Analyses of Other Endpoints/Estimands

16.1 Pharmacokinetics

PK evaluation will be performed by Nuvisan GmbH.

All statistical analyses and descriptive summaries of PK data will be performed on the PK Analysis Set.

16.1.1 Descriptive Statistics of PK Concentration Data

Concentrations of evobrutinib will be descriptively summarized by study intervention using number of observations (n), arithmetic Mean, SD, CV%, Min, Median, Max, geometric mean (GeoMean), the geometric coefficient of variation (GeoCV%) and the 95% confidence interval (CI) for the GeoMean (LCI 95% GM, UCI 95% GM). Descriptive statistics will only be calculated for $n > 2$ in which a measurement of BLQ represents a valid measurement and will be taken as zero for summary statistics of PK concentration data.

Any mean or median value that is below the lower limit of quantification will be shown as BLQ.

Descriptive statistics of PK concentration data will be calculated using values with the same precision as the source data and rounded for reporting purposes only. In export datasets, as well as in the SDTM PC domain, PK concentrations will be provided with full precision and will not be rounded.

The following conventions will be applied when reporting descriptive statistics of PK concentration data:

n	0 decimal place
Mean, Min, Median, Max:	3 significant digits
SD:	4 significant digits
CV%:	1 decimal place

16.1.2 Descriptive Statistics of PK Parameter Data

PK parameter data of evobrutinib on Day 1 will be descriptively summarized by study intervention and day using Mean, SD, CV%, Min, Median, Max, geometric mean (GeoMean), the geometric coefficient of variation (GeoCV%) and the 95% confidence interval (CI) for the GeoMean (LCI 95% GM, UCI 95% GM). For PK parameters related to time (e.g. t_{max} , t_{lag} , t_{last}), only n, Min, Median, and Max may be reported.

Descriptive statistics will only be calculated for a PK parameter when $n > 2$.

PK parameters read directly from the measurements (i.e., C_{max}) will be reported with the same precision as the source data. All other PK parameters will be reported to 3 significant figures. In export datasets, as well as in the SDTM PP domain, PK parameters will be provided with full precision and will not be rounded. Descriptive statistics of PK parameter data will be calculated using full precision values and rounded for reporting purposes only.

The following conventions will be applied when reporting descriptive statistics of PK parameter data:

n	0 decimal place
Mean, Min, Median, Max, GeoMean, 95% CI:	3 significant digits
SD:	4 significant digits
CV%, GeoCV%:	1 decimal place

16.1.3 Statistical Analysis of PK Parameter Data

Analysis of Primary Endpoints

A linear mixed model with BATCH, PERIOD, and SEQUENCE as fixed effects and SUBJECT within SEQUENCE as a random effect will be applied to log-transformed primary endpoints C_{max} and $AUC_{0-\infty}$ based on the PK analysis set. Differences between batches (treatment A will be used as 'reference') on the log scale for each comparison will be estimated for the parameters together with their 90% CIs. Point estimates and CIs will be back transformed to the original scale by exponentiation for presentation. Ratio of geometric LSMEAN with 90% CI and geometric LSMEAN with 95 % CI will be presented.

Analysis of Secondary Endpoints

Summary statistics of PK parameters will be provided by study intervention.

16.1.4 General Specifications for PK Concentration and PK Parameter Data

Predose samples that occur before the first drug administration will be assigned a time of 0 hours, as if the sample had been taken simultaneously with the study intervention administration.

Predose or trough samples which have been taken after the subsequent dosing will be reported as a protocol deviation. The resulting concentrations will be included in concentration listings but excluded from descriptive statistics of concentrations and from PK parameter estimation.

Values BLQ will be taken as zero for summary statistics of PK concentration data, PK parameter estimation (e.g., AUC) and for graphical presentations.

Missing concentrations (e.g., no sample, insufficient sample volume for analysis, no result or result not valid) will be reported generally as "N.R.". A participant who withdraws prior to the last planned observation will be included in the analyses up to the time of discontinuation if still included in the PK analysis set.

If samples are collected outside of the PK sampling time windows defined in the CSP in Section 8.4, these will be included in the PK parameter estimation (NCA) but will be excluded from the concentration summary and mean/median concentration plots.

PK concentrations which are erroneous due to a sampling processing or analytical error (as documented in the bioanalytical report) may be excluded from the PK analysis if agreed by the Sponsor. In this case the rationale for exclusion will be provided in the CSR. Any other PK concentrations that appear implausible to the Clinical Pharmacologist/Clinical PK/PD Scientist will not be excluded from the analysis. Any implausible data will be documented in the CSR.

If important protocol deviations occurred likely to affect the PK profile of participants as specified in Section 10.2.1, the impacted concentrations and PK parameters will be excluded from summary statistics and further statistical evaluation.

Any PK concentrations or PK parameters excluded from summary statistics will be included in participants listings and flagged; a reason for exclusion will be detailed in the CSR (e.g., a footnote or a table of exclusions). Any flags will be included in the study specific CDISC data sets.

PK concentrations and PK parameters excluded from summary statistics will not be included in mean/median figures. Mean plots will only contain values where $n > 2$.

16.1.5 Estimation of Pharmacokinetic Parameters

The computer program Phoenix® WinNonlin® version 7.0, or higher (Certara, L.P., Overlook Center, Suite101, Princeton, NJ 08540) will be used to derive PK parameters applying NCA.

The statistical software SAS® (Statistical Analysis System, SAS-Institute, Cary NC, USA, windows version 9.4 or higher) will be used to generate additional PK parameters and produce tables, listings, and figures.

16.1.5.1 Estimation of Pharmacokinetic Parameters in Plasma

PK parameters will be calculated using the actual elapsed time since dosing. If the actual sampling time is missing, calculations may be performed using the scheduled time. Details (e.g., number of samples, participants affected) will be described in the CSR. If actual dosing time is missing, scheduled time might be used for NCA after performance of adequate plausibility checks and agreement with the sponsor. Decision and rational should be included in the CSR. Otherwise, there will be no further imputation of missing data.

The following plasma PK parameters will be calculated, when appropriate, for evobrutinib on Day 1 for each period:

Symbol	Definition
$AUC_{0-\infty}$	The AUC from time zero (= dosing time) up to infinity with extrapolation of the terminal phase.
$AUC_{0-t_{last}}$	The AUC from time zero (= dosing time) to the time of the last quantifiable concentration (t_{last}).
C_{max}	Maximum observed concentration.
t_{max}	The time to reach the C_{max} in a dosing interval.
$t_{1/2}$	The terminal half-life.
t_{lag}	The time prior to the first concentration at or above LOQ.
CL/F	The apparent total body clearance following extravascular administration.
V_z/F	The apparent volume of distribution during the terminal phase following extravascular administration.
F_{rel}	Relative Bioavailability [%] of each Batch in relation to the Reference Batch (treatment A) will be calculated: $F_{rel} = 100 \times (AUC_{0-\infty} \text{ [Batch]} \times \text{Dose}_{\text{[Reference Batch]}}) / (AUC_{0-\infty} \text{ [Reference Batch]} \times \text{Dose}_{\text{[Batch]}})$
λ_z	Terminal first order (elimination) rate constant.

Additional PK parameters may be calculated where appropriate.

Units for PK parameter outputs will be based on concentration and dose units used in the study, unless otherwise specified. If concentration data units change within the study, PK parameters will be reported using consistent units throughout study outputs. In such cases, the Sponsor will specify relevant units for reporting before the final PK evaluation.

The parameters C_{max} and t_{max} will be obtained directly from the concentration-time profiles. If C_{max} occurs at more than one timepoint, t_{max} will be assigned to the first occurrence of C_{max} .

The following PK parameters will be calculated for diagnostic purposes and listed, but will not be summarized:

- First (λ_z low) and last (λ_z up) time point of the time interval of the log-linear regression to determine λ_z .
- Number of data points (N_z) included in the log-linear regression analysis to determine λ_z .
- Goodness of fit statistic (adjusted R^2) for calculation of λ_z .
- AUC from time t_{last} extrapolated to infinity given as percentage of $AUC_{0-\infty}$ ($AUC_{extra\%}$).
- Span ratio of interval over which $t_{1/2}$ was estimated/ $t_{1/2}$.

The regression analysis should contain data from at least 3 different time points in the terminal phase consistent with the assessment of a straight line on the log-transformed scale. Phoenix WinNonlin “best fit” methodology will be used as standard. If warranted, further adjustment may be made by the pharmacokineticist, after agreement with the Sponsor. The last quantifiable concentration $> LLOQ$ should always be included in the regression analysis, while the concentration at t_{max} and any concentrations BLQ which occur after the last quantifiable data point $> LLOQ$ should not be used.

If $AUC_{extra\%} > 20\%$ and/or the coefficient of correlation (R^2 adj) of λ_z is < 0.8 and/or the observation period over which the regression line is estimated (span ratio) is less than 2-fold the resulting $t_{1/2}$, the rate constants and all derived parameters (e.g. $t_{1/2}$, $AUC_{0-\infty}$, CL/F , etc.) will be

listed, flagged and included in the parameter outputs. Should more than 10% of subjects be flagged for AUC_{extra} and/or Rsq adj (for a particular analyte), a sensitivity analysis excluding flagged parameters may be performed after discussion with the Sponsor.

16.1.6 Presentation of PK Concentration and PK Parameter Data

16.1.6.1 Listings and Tables

The following PK tables will be produced (PK Analysis Set):

- Descriptive statistics of plasma concentrations by nominal time and study intervention
- Descriptive statistics of plasma PK parameters by study intervention

The following PK Listings will be produced (Safety Analysis Set):

- Individual plasma concentrations by nominal time, participant, and study intervention sorted in chronological order
- Individual plasma PK parameters by participant and study intervention
- PK sampling date, actual time, nominal time, deviation from time, percentage time deviation by participant, and study intervention sorted in chronological order
- Phoenix® WinNonlin® NCA Core Output

16.1.6.2 Graphical Summaries and Individual plots (PK Analysis Set)

The following graphical summaries and individual plots will be provided:

- Overlaid individual plasma concentration versus time plots on linear and semi-log scale, using actual times, by study intervention
- Overlaid individual plasma concentration versus time plots by participant on linear and semi-log scale using actual times. If any postdose concentration is BLQ the line representing LLOQ will be added to the semi-log plots
- Arithmetic mean concentration time plots; linear ($\pm SD$ for arithmetic mean) and semi-log; using scheduled (nominal) time points by study intervention; if any postdose concentration is BLQ the line representing LLOQ will be added to the semi-log plots
- Median concentration time plots; linear and semi-log; using scheduled (nominal) time points by study intervention; if any postdose concentration is BLQ the line representing LLOQ will be added to the semi-log plots
- Boxplots for primary PK parameters $AUC_{0-\infty}$ and C_{max} by study intervention
- Spaghetti plot of primary PK parameters by study intervention

17 References

Not applicable.

18 Appendices

Not applicable.