

**Official Title:** A Phase 2, Multicenter, Open-Label Study of Parsaclisib, a PI3K $\delta$  Inhibitor, in Japanese Participants With Relapsed or Refractory Follicular Lymphoma (CITADEL-213)

**NCT Number:** NCT04434937

**Document Date:** Statistical Analysis Plan Amendment 1: 26-January-2023

## Statistical Analysis Plan

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### INCB 50465-213

A Phase 2, Multicenter, Open-Label Study of Parsaclisib, a PI3K $\delta$  Inhibitor, in Japanese Participants With Relapsed or Refractory Follicular Lymphoma (CITADEL-213)

<b>Sponsor:</b>	<b>Incyte Biosciences Japan GK 1-1-2 Yurakucho Chiyoda-ku Tokyo 100-0006, Japan</b>
<b>Protocol Version:</b>	<b>Protocol Amendment 4 dated 24 JAN 2023</b>
<b>CRF Approval Date:</b>	<b>10 FEB 2021</b>
<b>SAP Version:</b>	<b>Amendment 1</b>
<b>SAP Author:</b>	<b>██████████, PhD ████████████████████, Biostatistics</b>
<b>Date of Plan:</b>	<b>26 JAN 2023</b>

This study is being conducted in compliance with Good Clinical Practice, including the archiving of essential documents.









<b>Abbreviation</b>	<b>Term</b>
ORR	objective response rate
OS	overall survival
PD	progressive disease
PFS	progression-free survival
PI3K	phosphoinositide 3-kinase
PJP	<i>Pneumocystis jirovecii</i> pneumonia
■	■
PR	partial response
PT	preferred term
PWB	physical well-being
QD	once daily
QTcB	QT interval corrected using Bazett's formula
QTcF	QT interval corrected using Fridericia's formula
R-CHOP	rituximab, cyclophosphamide, doxorubicin hydrochloride, vincristine, prednisone
SAP	Statistical Analysis Plan
SD	stable disease
SOC	system organ class
SWB	social/family well-being
TEAE	treatment-emergent adverse event
ULN	upper limit of normal
WHO	World Health Organization

## **1. INTRODUCTION**

This is a Phase 2, multicenter, open-label study designed to evaluate the efficacy and safety of piasclisib in Japanese participants with relapsed or refractory FL who have received at least 2 prior systemic therapies.

Section 2 of the Protocol provides a detailed description of the investigational product, target patient population, rationale for doses to be examined, and potential risks and benefits of treatment with piasclisib.

The purpose of this SAP is to provide details of the statistical analyses that have been outlined in the study INCB 50465-213 Protocol. The scope of this plan includes the interim and final analyses that are planned and will be executed by the Department of Biostatistics or designee,

## **2. STUDY INFORMATION, OBJECTIVES, AND ENDPOINTS**

### **2.1. Protocol and Case Report Form Version**

This SAP is based on INCB 50465-213 Protocol Amendment 4 dated 24 JAN 2023 and CRFs approved 10 FEB 2021. Unless superseded by an amendment, this SAP will be effective for all subsequent Protocol amendments and CRF versions.

### **2.2. Study Objectives and Endpoints**

Table 1 presents the objectives and endpoints.



**Table 1: Objectives and Endpoints**

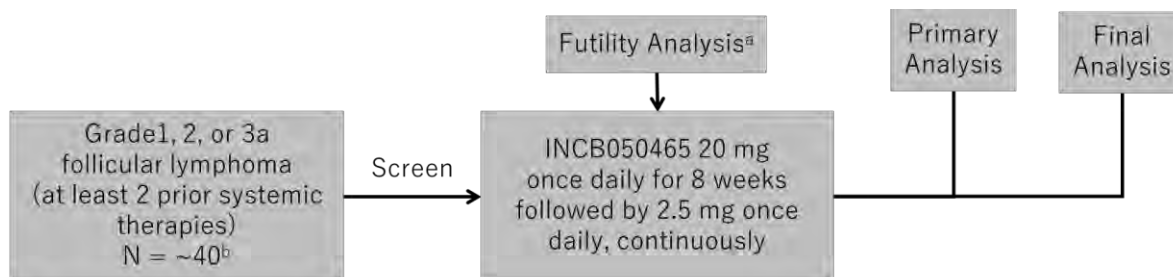
Objectives	Endpoints
<b>Primary</b>	
To assess the efficacy of pascalisib in terms of ORR in participants with relapsed or refractory FL.	ORR, defined as the percentage of participants with a CR or PR as defined by revised response criteria for lymphomas (Cheson et al 2014), as determined by an IRC.
<b>Secondary</b>	
To assess CRR.	CRR, defined as the percentage of participants with a CR as defined by revised response criteria for lymphomas (Cheson et al 2014), as determined by an IRC.
To assess DOR.	DOR, defined as the time from first documented evidence of CR or PR until disease progression or death from any cause among participants who achieve an objective response, as determined by radiographic disease assessment provided by an IRC.
To assess PFS.	PFS, defined as the time from the date of the first dose of study treatment until the earliest date of disease progression, as determined by radiographic disease assessment provided by an IRC, or death from any cause.
To assess OS.	OS, defined as the time from the date of the first dose of study treatment until death from any cause.
To assess best percentage change in target lesion size.	Best percentage change in target lesion size from baseline, where target lesion size is measured by the sum of the product of the diameters of all target lesion sizes.
To characterize the safety and tolerability of pascalisib.	Safety and tolerability assessed by monitoring the frequency and severity of AEs; includes performing physical examinations and collecting vital signs, 12-lead ECGs, and clinical laboratory data.

### 3. STUDY DESIGN

This is a Phase 2, multicenter, open-label study evaluating parsaclisib treatment based on the primary endpoint of ORR. Participants with relapsed or refractory FL (Grades 1, 2, or 3a) who have received at least 2 prior systemic therapies and who are ineligible HSCT will be screened for eligibility. A total of approximately 40 participants will be enrolled, including approximately 18 participants who have history of ASCT. Participants will receive parsaclisib 20 mg QD for 8 weeks followed by 2.5 mg QD. Participants may receive treatment until disease progression, death, HSCT (if become eligible), unacceptable toxicity, or consent withdrawal, whichever occurs first. Participants will be evaluated for ORR by an IRC and followed for CRR, DOR, PFS, OS, and safety. [Figure 1](#) presents the study design schema.

An interim futility analysis is planned when the first 20 participants have been treated and evaluated for response or have been followed for at least 9 weeks or have permanently discontinued study treatment because of disease progression, withdrawal of consent, or death. The study will be terminated for futility if  $\leq 7$  of the 20 participants have responded (ie, CR or PR) based on assessments provided by the IRC; otherwise the study will continue. A timely assessment of response will be performed to avoid the risk of overenrollment.

**Figure 1: Study Design**



<sup>a</sup>An interim futility analysis is planned when the first 20 participants have been evaluated for response, have been followed for at least 9 weeks, or have permanently discontinued study treatment because of disease progression, withdrawal of consent, or death.

<sup>b</sup>Approximately 18 participants with history of ASCT will be involved.

#### 3.1. Randomization

Not applicable.

#### 3.2. Control of Type I Error

No formal statistical tests will be performed. Two-sided 95% CIs will be reported for all analyses when appropriate.

No adjustment for alpha-spending is considered as there are no plans to stop the study early for overwhelming efficacy. An IDMC will be assembled to monitor safety data and study conduct. The IDMC will also be charged with evaluating interim futility results. See [Section 10](#) for details regarding interim analyses conducted in this study.

### 3.3. Sample Size Considerations

Approximately 40 participants will be enrolled. If the true ORR is 62%, then with 40 total participants, there is approximately 90% probability of observing the lower bound of the 95% CI of  $ORR \geq 35\%$ .

A historical examination of efficacy in the subgroup of patients with FL who received R-CHOP (or the equivalent) as their first therapy and experienced early relapse showed an ORR of 33% (Flinn et al 2019). And previous studies of PI3K inhibitor for relapse or refractory FL set ORR of 30% to 40% as target. Thus ORR of 35% is a clinically relevant target of patients with relapse or refractory FL (Flinn et al 2019, Dreyling et al 2017).

### 3.4. Schedule of Assessments

Refer to Protocol Amendment 4 dated 24 JAN 2023 for a full description of all study procedures and assessment schedules for this study.

## 4. DATA HANDLING DEFINITIONS AND CONVENTIONS

### 4.1. Scheduled Study Evaluations and Study Periods

#### 4.1.1. Day 1

Day 1 is the date that the first dose of study drug (parsaclisib) is administered to the participants.

#### 4.1.2. Study Day

If a visit/reporting date is on or after Day 1, then the study day at the visit/reporting date will be calculated as

$$\text{Day \#} = (\text{Visit/Reporting Date} - \text{Day 1 date} + 1).$$

If the visit/reporting date is before Day 1, then the study day at the visit/reporting date will be calculated as

$$\text{Day \#} = (\text{Visit/Reporting Date} - \text{Day 1 date}).$$

A study day of -1 indicates 1 day before Day 1.

#### 4.1.3. Baseline Value

Baseline is the last nonmissing measurement obtained before the first administration of parsaclisib, unless otherwise defined.

When scheduled assessments and unscheduled assessments occur on the same day and time of the assessment or time of first dose is not available, use the following convention to determine baseline:

- If both a scheduled and an unscheduled visit are available on the day of the first dose and the time is missing, use the scheduled assessment as baseline.
- If all scheduled assessments are missing on the day of the first dose and an unscheduled assessment is available, use the unscheduled assessment as baseline.

#### 4.1.4. Handling of Missing and Incomplete Data

In general, values for missing data will not be imputed unless methods for handling missing data are specified in this section or relevant sections. The original reported dates collected on the eCRF should be used in all relevant listings. The following rules will be used for handling missing or partial dates for analyses requiring dates.

When calculating time since initial diagnosis of cancer, partial diagnosis date will be handled in the calculation as follows:

- If only the day is missing, then the first day of the month will be used.
- If both the month and day are missing, then 01 JAN will be used.
- Otherwise, the time since diagnosis will not be calculated.

When the date of the last dose is used in deriving variables such as duration of treatment or TEAE flag, missing or partial date of last dose will be handled in the calculation as follows:

- If only the day is missing, then the earlier date of the last day of the month or the date that the participant discontinued treatment will be used.
- If both the month and day are missing, then the earlier date of 31 DEC of the year or the date that the participant discontinued treatment will be used.
- Otherwise, the date that the participant discontinued treatment will be used as the date of the last dose.

When calculating DOR, PFS, and OS, a partial date of death will be handled in the calculation as follows:

- If mmyyyy for the last known alive date = mmyyyy for the death date, then the day after the last known alive date will be used.
- If mmyyyy for the last known alive date < mmyyyy for the death date, then the first day of the death month will be used.
- Otherwise, the partial death date will not be handled.

When calculating time to onset or duration of a TEAE, a partial or missing AE onset/end date will be handled in the calculation as follows:

- If only the day is missing, then the first day of the month or Day 1, whichever is later, will be used as the onset date; the earlier date of the last day of the month or the date that the participant discontinued study or died will be used as the end date.
- If both the month and day are missing, then 01 JAN or Day 1, whichever is later, will be used as the onset date; the earlier date of 31 DEC or the date that the participant discontinued study or died will be used as the end date.
- Otherwise, Day 1 will be used as the onset date, and the missing end date will not be handled.

## 4.2. Variable Definitions

### 4.2.1. Body Mass Index

Body mass index will be calculated as follows:

$$\text{BMI (kg/m}^2\text{)} = [\text{weight (kg)}] / [\text{height (m)}]^2.$$

### 4.2.2. Prior and Concomitant Medication

Prior medication is defined as any nonstudy medication started before the first dose of pascalisib.

Concomitant medication is defined as any nonstudy medication that is started accordingly:

- Before the date of first administration of pascalisib and is ongoing throughout the study or ends on/after the date of first study drug administration.
- On/after the date of first administration of pascalisib and is ongoing or ends during the course of study.

A prior medication could also be classified as "both prior and concomitant medication" if the end date is on or after first dose of pascalisib. In the listing, it will be indicated whether a medication is prior-only, concomitant-only, or both prior and concomitant.

For the purposes of analysis, all medications will be considered concomitant medications unless the medications can unequivocally be defined as not concomitant.

## 5. STATISTICAL METHODOLOGY

### 5.1. General Methodology

Unless otherwise noted, SAS<sup>®</sup> software (SAS Institute Inc, Cary, NC; v9 or later) will be used for the generation of all tables, graphs, and statistical analyses. Descriptive summaries for continuous variables will include, but not be limited to, the number of observations, mean, standard deviation, median, minimum, and maximum. Descriptive summaries for categorical variables will include the number and percentage of participants in each category.

Interim analyses are planned for this study as defined in Section 10.

### 5.2. Treatment Groups

This is a Phase 2, multicenter, open-label study. For the purpose of analysis, the 2.5 mg QD dosing period is considered a maintenance dosing period. All data will be presented in summary tables by initially assigned treatment.

### 5.3. Analysis Populations

#### 5.3.1. All-Screened Population

The all-screened population includes all participants who signed the informed consent form. The all-screened population will be used for the summary of analysis populations.

### **5.3.2. Full Analysis Set**

The FAS includes all participants enrolled in the study who received at least 1 dose of pardaclisib.

The FAS will be used for the summary of demographics, baseline characteristics, participant disposition, and analyses of all efficacy data.

### **5.3.3. Safety Population**

The safety population includes all participants enrolled in the study who received at least 1 dose of pardaclisib.

All safety analyses will be conducted using the safety population.

## **6. BASELINE, EXPOSURE, AND DISPOSITION VARIABLES AND ANALYSES**

[Appendix A](#) provides a list of planned tables, figures, and listings. Sample data displays are included in a separate document.

### **6.1. Baseline and Demographics, Physical Characteristics, and Disease History**

#### **6.1.1. Demographics and Baseline Characteristics**

The following demographics will be summarized and listed for the FAS: age, sex, race, weight, height, BMI. Eastern Cooperative Oncology Group performance status at baseline will be summarized and listed for the FAS.

#### **6.1.2. Disease History**

Time since diagnosis, initial grade, initial cytogenetics, initial Ann Arbor staging, initial FLIPI risk category, initial presence of B-symptoms, current grade, current cytogenetics, current Ann Arbor staging, current FLIPI risk category, current presence of B-symptoms, bone marrow involvement at baseline (Yes vs No), bulky disease at baseline (longest diameter  $\geq 10$  cm vs  $< 10$  cm) at baseline by the IRC, and relapsed/refractory status to the most recent prior therapy will be summarized and listed for all participants in the FAS. Date of tumor marker tests and test results will be listed.

Time since diagnosis will be calculated as follows:

$$\text{Time since diagnosis (years)} = (\text{Day 1 date} - \text{date of diagnosis} + 1) / 365.25.$$

### 6.1.3. Prior Therapy

Number of prior systemic cancer therapy regimens will be summarized for all participants in the FAS. The component drugs of prior systemic therapy regimens will be coded using the WHO Drug Dictionary. Number and percentage of participants with each drug will be summarized by WHO drug class and WHO drug PT. Regimen name, component drugs, start and stop date, route of the medication, best response, reason for discontinuation, and date of relapse/progression will be listed.

Number of participants who received prior radiation will be summarized for the FAS. Radiotherapy type, anatomical location of the administration, start and stop date, reason for regimen, best response, and total dose will be listed.

Number of participants who had prior surgery or surgical procedure for the malignancy under study will be summarized for the FAS. Date and description of the surgery/procedure will be listed.

Number of participants who had prior hematopoietic stem cell transplant will be summarized for the FAS. Date of transplant, type of transplant, source of cells, line of therapy, best response, date of relapse/progression, and regimen and drug used with the transplant will be listed.

### 6.1.4. Medical History

Medical history will be coded to SOC and PT using MedDRA coding dictionary. For participants in the FAS, medical history will be summarized by SOC and PT and listed.

## 6.2. Disposition of Participants

The number and percentage of participants who were treated, who were ongoing with study treatment, who discontinued study treatment with a primary reason for discontinuation, who were still in the study, and who withdrew from the study with a primary reason for withdrawal will be summarized for the FAS.

The number of participants enrolled by site will also be provided for the FAS.

## 6.3. Protocol Deviations

Protocol deviations recorded on the eCRF will be summarized and listed for the FAS.

## 6.4. Exposure

For participants in the safety population, exposure to parsaclisib will be summarized descriptively as the following:

- **Duration of treatment (days):** Date of last dose – date of first dose + 1. Duration of treatment in months will be calculated based on the assumption that the average month has 30.4375 days. The number and percentage of participants in each duration category ( $\geq 6$  months,  $\geq 12$  months,  $\geq 18$  months,  $\geq 24$  months as applicable) will be summarized.
- **Duration of treatment during the initial QD dosing period (days):** Date of last dose during initial QD dosing period – date of first dose + 1.

- **Duration of treatment during the maintenance dosing period (days):** Date of last dose – date of first dose during the maintenance dosing period + 1.
- **Average reported daily dose during the initial QD dosing period (mg/day):** Total reported dose taken during initial QD dosing period (mg) / duration of treatment during the initial QD dosing period (days).
- **Average reported daily dose during the maintenance dosing period (mg/day):** Total reported dose taken during the maintenance dosing period (mg) / duration of treatment during the maintenance dosing period (days).
- **Dose modifications:** Number of participants who had dose reduction and interruption will be summarized. The number of dose reductions and the number of interruptions for each participant will be summarized.

## 6.5. Study Drug Compliance

For participants in the safety population, overall compliance (%) for parsaclisib will be calculated for all participants as

$$\text{compliance (\%)} = 100 \times [\text{total dose actually taken}] / [\text{total prescribed dose}].$$

The total prescribed dose is defined as the sum of the doses prescribed by the investigator accounting for dose modifications.

The total actual dose taken will be calculated based on information entered on the Drug Accountability CRF. If there are dispensed drugs that have not been returned yet, the actual dose taken starting from the dispense date of the unreturned drugs will be imputed by the dose taken as reported on the dosing CRF.

## 6.6. Prior and Concomitant Medication

Prior medications and concomitant medications will be coded using the WHO Drug Dictionary. Number and percentage of participants in the FAS for each prior and concomitant medication will be summarized by WHO drug class and WHO drug PT.



## 7. EFFICACY

[Appendix A](#) provides a list of planned tables, figures, and listings. Sample data displays are included in a separate document.

### 7.1. Efficacy Hypotheses

Not applicable.

### 7.2. Response Assessment

An objective assessment of disease status is required at baseline (screening) using the CT-based response criteria of the Lugano Classification ([Cheson et al 2014](#)). Disease status will be subsequently assessed by CT/MRI every 8 weeks through Week 24, then every 12 weeks through Week 96, and then every 24 weeks thereafter until disease progression.

Bone marrow examination is required as a baseline assessment at screening except for reasons provided in Section 8.2.2 of the Protocol. If disease is present in bone marrow at baseline, a bone marrow examination will be required to confirm CR or may be performed as clinically indicated. If the bone marrow does not have lymphoma involvement at baseline, a repeat marrow examination is not required to confirm indication of CR on imaging. All bone marrow examination should include a unilateral aspiration and biopsy, when feasible.

Sites will use the CT-based response criteria of the Lugano Classification ([Cheson et al 2014](#)) to assess response to treatment locally. At each postbaseline disease assessment, response will be collected in the eCRF as CR, PR, SD, PD, or NE.

All imaging will be submitted to the IRC. Imaging data and applicable clinical data will be reviewed and response will be assessed using the CT-based response criteria of the Lugano Classification ([Cheson et al 2014](#)) by independent reviewers as described in the Independent Review Charter. An overall timepoint response at each postbaseline disease assessment, the best overall response, the date of initial response (if applicable), and the date of progression along with the reason(s) of disease progression (if applicable) for each participant, considering radiographic data and clinical data, will be provided by the clinical reviewer. These data will be used in the analyses of related efficacy endpoints.

### 7.3. Analysis of the Primary Efficacy Parameter

The primary efficacy analysis will be conducted when the last patient in the FAS has been followed for 12 months from the first dose of treatment.

#### 7.3.1. Best Overall Response and Overall Response Rate

For responses determined by the IRC, the best overall response for each participant will be provided by the clinical reviewer. A participant is considered an objective responder if they have a best overall response of CR or PR.

The ORR is the proportion of objective responders. Participants who do not have sufficient baseline or on-study response assessment information to be adequately assessed for response status will be included in the denominators in the calculation of ORR.

Best overall response as determined by the IRC will be descriptively summarized. The ORR as determined by the IRC will be estimated with 95% CIs. Confidence intervals will be calculated based on the exact method for binomial distributions.

When applicable, sensitivity analysis of ORR as determined by the IRC may be provided excluding participants who do not have evaluable radiological images at baseline per the IRC.

### **7.3.2. Subgroup Analyses for Objective Response Rate**

Subgroups will be formed based on the following participant characteristics and baseline variables for those participants whose data are available:

- Age: < 65 years,  $\geq$  65 years
- Gender: male, female
- Current FL grade: 1, 2, 3a
- Current Ann Arbor Staging: I-II, III-IV
- Current FLIPI risk category: low (0 - 1), intermediate (2), high ( $\geq$  3)
- Number of prior systemic therapy regimens: 2,  $\geq$  3
- Bone marrow involvement at baseline: yes, no, unknown
- ECOG performance status:  $\leq$  1 versus 2
- Bulky disease at baseline: longest diameter  $\geq$  10 cm vs < 10 cm at baseline by IRC
- Relapsed/refractory status to the most recent prior therapy: relapsed, refractory, unknown
- Prior history of ASCT: yes, no

Subgroups may be further divided, combined, or eliminated based on emerging data. The ORR as determined by IRC and its 95% exact binomial CIs will be provided for participants for each subgroup. A forest plot will be created to summarize the variability in ORR as determined by the IRC for participants across subgroups.

## **7.4. Analysis of the Secondary Efficacy Parameters**

### **7.4.1. Complete Response Rate**

Complete response rate is the percentage of participants with a best overall response of CR as defined by revised response criteria for lymphomas ([Cheson et al 2014](#)). For responses determined by the IRC, the best overall response for each participant will be provided by the clinical reviewer. Participants who do not have sufficient baseline or on-study response assessment information to be adequately assessed for response status will be included in the denominators in the calculation of CRR.

The CRR as determined by the IRC will be estimated with 95% CIs. Confidence intervals will be calculated based on the exact method for binomial distributions.

#### **7.4.2. Duration of Response**

Duration of response is defined as the time from first documented evidence of CR or PR until disease progression or death due to any cause among participants who achieve an objective response (ie, CR or PR), as determined by revised response criteria for lymphomas (Cheson et al 2014). For responses assessed by the IRC, the date of initial response and date of disease progression will be provided by the clinical reviewer for participants who have achieved best response of CR or PR. Censoring of DOR will follow the same algorithm as the censoring of PFS (see Section 7.4.3).

The total number of responders per the IRC, the number of participants whose disease progressed per the IRC or who died, and the number of participants censored will be summarized. The Kaplan-Meier estimate of median DOR as determined by the IRC will be presented with its 95% CI, with the CIs calculated using the generalization of Brookmeyer and Crowley's method (1982) with log-log transformation (Klein and Moeschberger 1997).

#### **7.4.3. Progression-Free Survival**

Progression-free survival is defined as the time from the date of the first dose of the study drug to the first documented disease progression as determined by revised response criteria for lymphomas (Cheson et al 2014), or death due to any cause, whichever occurs first. For responses assessed by IRC, date of disease progression will be provided by the Clinical Reviewer. Censoring for PFS will follow the algorithm outlined in Table 2, which is based on FDA Guidance for Industry: Clinical Trial Endpoints for the Approval of Non-Small Cell Lung Cancer Drugs and Biologics (2015) and Guidance for Industry: Clinical Trial Endpoints for the Approval of Cancer Drugs and Biologics (2018).

The number of participants whose disease progressed per the IRC or who died, and the number of participants censored will be summarized. The Kaplan-Meier estimate of median PFS as determined by the IRC will be presented with its 95% CIs, with the CIs calculated using the generalization of Brookmeyer and Crowley's method (1982) with log-log transformation (Klein and Moeschberger 1997). Progression-free survival rates at 6, 12, 18, and 24 months will also be provided with 95% CIs calculated using Greenwood's formula to estimate the standard error.

**Table 2: Evaluation and Censoring of Progression-Free Survival**

<b>Situation</b>	<b>Outcome</b>	<b>Date of Progression or Censoring</b>
No baseline tumor assessments	Censored	Day 1
No valid postbaseline response assessments	Censored	Day 1
Progression documented between scheduled response assessments	Progressed	Date of first overall response of PD
No progression	Censored	Date of last valid radiologic assessment (not NE and not missing)
Study discontinuation for undocumented progression	Censored	Date of last valid radiologic assessment (not NE and not missing)
Study discontinuation for toxicity or other reason	Censored	Date of last valid radiologic assessment (not NE and not missing)
New anticancer treatment started	Censored	Date of last valid radiologic assessment (not NE and not missing) on/before starting a new anticancer treatment
Death before first progressive response assessment	Progressed	Date of death
Death between adequate response assessments	Progressed	Date of death
Death or progression after two or more missed assessments	Censored	Date of last valid radiologic assessment (not NE and not missing) before the missed assessments

NE = not evaluable.

#### 7.4.4. Overall Survival

Overall survival is defined as the time from the date of the first dose of study drug to death due to any cause. For participants who are still alive at the time of the analysis, OS will be censored on the date the participant is last known to be alive.

The number of participants who died and the number of participants censored will be summarized. The Kaplan-Meier estimate of median OS will be presented with its 95% CIs, with the CIs calculated using the generalization of Brookmeyer and Crowley's method (1982) with log-log transformation (Klein and Moeschberger 1997). Survival rates at 6, 12, 18, and 24 months will also be provided with 95% CIs calculated using Greenwood's formula to estimate the standard error.

#### 7.4.5. Best Percentage Change in Target Lesion Size

For participants in the FAS with measurable lesions at baseline, target lesion sizes will be measured by the sum of the product of diameters of all target lesions. The best percentage change from baseline, defined as the largest decrease in target lesion sizes on/before new anti-lymphoma therapy during the study, will be summarized. A waterfall plot of the best percentage change will be generated using data from the IRC. Note that for participants who

only have increases in target lesion sizes from baseline, the smallest increase will be considered as the best change from baseline. For the IRC, 2 radiologic reviewers will conduct separate reviews for each participant. An adjudication will be performed per the Independent Review Charter when Reviewers 1 and 2 disagree on the CT/MRI best overall response, or when best overall response is consistent, but the date of initial response and/or the date of progression differ between Reviewers 1 and 2. The adjudicator will select the read that he or she believes more accurately reflects the adjudication parameter(s) in question. This is considered the "accepted read," and data from this reviewer will be used for the analysis. When there is no adjudication needed, data from Reviewer 1 will be used for the analysis. An indicator will be provided to identify the read that is considered to be the accepted assessment in data from the IRC.

Best change in target lesion size as reported by the investigator will also be summarized as described above. Target lesions considered "too small to measure" will be assigned a default value of 5 mm × 5 mm for purposes of this analysis. Likewise, target lesions identified as "not present" at postbaseline assessments will be assigned 0 mm × 0 mm for this analysis. In the event that a target lesion is unaccounted for in a particular postbaseline timepoint (ie, the assessment is missing or NE), then the overall sum of target lesions will not be evaluable for that postbaseline timepoint.





### **7.5.2. Other Efficacy Analyses**

For investigator-reported responses, sites will use the CT-based response criteria of the Lugano Classification ([Cheson et al 2014](#)) to assess response to treatment locally. At each postbaseline disease assessment, responses will be collected in the eCRF as CR, PR, SD, PD, or NE. The best overall response is the best response recorded before and including the first PD, in the order of CR, PR, SD, PD, and NE. The best overall response will be determined from response assessments on or before the start date of new anticancer therapy. In the case of SD, assessment must meet the SD criteria at least once on or after Day 42. Participants who fail to meet this criterion will have best response of PD if the next available assessment after the initial assessment indicates PD or will have best response of NE if there are no additional assessments available. For investigator-reported response data, the date of PD for PFS and DOR will be the timepoint at which progression is first recorded. Analyses of best overall response, ORR, CRR, DOR, and PFS as reported by the investigator will be summarized as described in Sections [7.3](#) and [7.4](#).

For participants with bone marrow biopsy examination, date of bone marrow biopsy exam, exam adequacy, cellularity %, overall cellularity, bone marrow involvement of disease, immunohistochemistry testing, and bone marrow fibrosis score will be listed. For participants with bone marrow aspirate examination, date of bone marrow aspirate exam, exam adequacy, bone marrow aspirate results, bone marrow involvement of disease, cytogenetic analysis, and molecular analysis will be listed.



## 9. SAFETY AND TOLERABILITY

[Appendix A](#) provides a list of planned tables, figures, and listings. Sample data displays are included in a separate document.

### 9.1. General Considerations

Summary tables may be replaced with listings when appropriate. For instance, an AE frequency table may be replaced with a listing if it only contains a few unique PTs reported on relatively few participants.

### 9.2. Adverse Events

#### 9.2.1. Adverse Event Definitions

A TEAE is any AE either reported for the first time or worsening of a pre-existing event after the first dose of study drug and within 30 days of the last administration of study drug regardless of starting new anti-lymphoma therapy. Analysis of AEs (as discussed below) will be limited to TEAEs, but data listings will include all AEs regardless of their timing in relation to study drug administration. For purposes of analysis, all AEs will be considered TEAEs unless the AE can unequivocally be defined as not treatment-emergent.

Adverse events will be tabulated by MedDRA PT and SOC. Severity of AEs will be graded using the NCI CTCAE (v5.0; [NCI 2017](#)), Grades 1 through 5. The CTCAE reporting guidelines and grading details are available on the Cancer Therapy Evaluation Program website.

The subset of AEs considered by the investigator to be related to study drug will be considered treatment-related AEs. If the investigator does not specify the relationship of the AE to study drug, the AE will be considered treatment-related. The incidence of AEs and treatment-related AEs will be tabulated. In addition, serious TEAEs will also be tabulated.

#### 9.2.2. Adverse Events of Special Interest

The number of participants who experienced TEAEs of special interest listed below will be summarized by maximum severity.

- Colitis
- Diarrhea
- Exfoliative dermatitis
- Febrile neutropenia
- Rash
- Intestinal perforation
- Pneumonitis
- Pneumonia
- PJP infection
- CMV infection



- Herpes simplex
- Varicella zoster virus infection

The time to onset of a TEAE is defined as the interval between the date of first dose of study drug and the date of the first occurrence of a TEAE. Participants who have not experienced a TEAE at the time of analysis will be right-censored at the earlier of 30 days after the last dose date and date of last study visit through the end of safety follow-up. If participants have missing or partial last dose dates of study drug or onset date of a TEAE, the partial or missing dates will be handled using the rules explained in Section 4.1.4.

Summaries of time to onset of new or worsening Grade 3 or higher AEs will be provided using descriptive statistics and the life-table method for rash, colitis, diarrhea, febrile neutropenia, pneumonia, herpes simplex, and varicella zoster virus infection. In addition, summaries of time to onset of new or worsening AEs of any grade will be provided using descriptive statistics and the life-table method for colitis, diarrhea, exfoliative dermatitis, intestinal perforation, pneumonia, pneumonitis, PJP infection, CMV infection, herpes simplex, and varicella zoster virus infection. Kaplan-Meier plots of time to onset of new or worsening Grade 3 or higher AEs will be provided for rash, colitis, and diarrhea. In addition, Kaplan-Meier plots of time to onset of new or worsening AEs of any grade will be provided for colitis and diarrhea.

Descriptive statistics of time to onset of these TEAEs of special interest are based on all participants who have experienced a TEAE at the time of analysis. To summarize these TEAEs of special interest using the life-table method, the effective sample size is defined as the number of participants at the beginning of interval minus half the participants censored in the interval. The conditional proportion is calculated as the number of first events divided by the effective sample size in the interval.

The longest duration of a TEAE of any grade is defined as the longest interval between the date of occurrence of a TEAE and the date of resolution. The longest duration of a Grade 3 or higher TEAE is defined as the longest interval between the date of occurrence of a Grade 3 or higher TEAE and the date of improvement to Grade 2 or lower. If participants have missing or partial onset/end date of a TEAE, the partial or missing dates will be handled using the rules explained in Section 4.1.4. Participants who have missing end date of a TEAE at the time of analysis will be right-censored using the following algorithm:

- If the TEAE is serious, then the participant will be censored at the earlier date of data cutoff, study discontinuation, and death.
- If the TEAE is not serious,
  - If the participant is ongoing with study treatment, then the participant will be censored at the data cutoff date, OR
  - If the participant discontinued treatment, then the participant will be censored at date of safety follow-up visit, or 35 days after the end of treatment visit (or after the last dose if the end of treatment visit was not performed), whichever is later; the censored date will be truncated by the earlier date of data cutoff, study discontinuation, and death if beyond.

Longest duration of new or worsening Grade 3 or higher colitis, diarrhea, rash, and febrile neutropenia will be summarized. In addition, longest duration of new or worsening AEs of any grade will be summarized for colitis, diarrhea, and rash.

The total number of participants whose TEAE of any grade resolved or whose Grade 3 or higher TEAE improved to Grade 2 or lower and the number of participants censored will be summarized. The Kaplan-Meier estimate of median time to resolution/improvement and its 95% CIs will be provided, with the CIs calculated using the generalization of Brookmeyer and Crowley's method (1982) with log-log transformation (Klein and Moeschberger 1997). Resolution/improvement rates at selected timepoints will also be provided with 95% CIs calculated using Greenwood's formula to estimate the standard error.

TEAEs of special interest to be summarized may be adjusted based on emerging data.

### 9.2.3. Adverse Event Summaries

Overall summaries of TEAEs will be provided during the parsaclisib initial QD dosing period, maintenance dosing period, and overall period (ie, all TEAEs regardless of the timing of occurrence). These summaries will include the following:

- Number (%) of participants reporting any TEAEs
- Number (%) of participants reporting any Grade 3 or higher TEAEs
- Number (%) of participants reporting any serious TEAEs
- Number (%) of participants reporting any TEAEs related to parsaclisib
- Number (%) of participants reporting any Grade 3 or higher TEAEs related to parsaclisib
- Number (%) of participants reporting any serious TEAEs related to parsaclisib
- Number (%) of participants who had TEAE with fatal outcome
- Number (%) of participants with parsaclisib dose reductions because of TEAEs
- Number (%) of participants who temporarily interrupted parsaclisib because of TEAEs
- Number (%) of participants who permanently discontinued parsaclisib because of TEAEs

The following summaries will be produced for TEAEs during the overall period by MedDRA term (if 5 or fewer participants appear in a table, a listing may be appropriate):

- Summary of TEAEs by SOC and PT
- Summary of TEAEs by PT in decreasing order of frequency
- Summary of TEAEs by SOC, PT, and maximum severity
- Summary of TEAEs by PT and maximum severity in decreasing order of frequency
- Summary of Grade 3 or higher TEAEs by SOC and PT
- Summary of Grade 3 or higher TEAEs by PT in decreasing order of frequency

- Summary of serious TEAEs by SOC and PT
- Summary of serious TEAEs by PT in decreasing order of frequency
- Summary of parsaclisib treatment-related TEAEs by SOC and PT
- Summary of parsaclisib treatment-related TEAEs by PT in decreasing order of frequency
- Summary of parsaclisib treatment-related TEAEs by SOC, PT, and maximum severity
- Summary of Grade 3 or higher parsaclisib treatment-related TEAEs by SOC and PT
- Summary of parsaclisib treatment-related serious TEAEs by SOC and PT
- Summary of TEAEs with a fatal outcome by SOC and PT
- Summary of TEAEs leading to parsaclisib dose reduction by SOC and PT
- Summary of TEAEs leading to parsaclisib dose interruption by SOC and PT
- Summary of TEAEs leading to discontinuation of parsaclisib by SOC and PT
- Summary of selected TEAEs of special interest by maximum severity
- Summary of time to onset of selected TEAEs of special interest
- Summary of time to onset of selected TEAEs of special interest: life-table method
- Summary of longest duration of selected TEAEs of special interest

The following supporting summaries will be produced for TEAEs during the parsaclisib initial QD dosing period and the maintenance dosing period by MedDRA term.

- Summary of TEAEs by PT in decreasing order of frequency
- Summary of TEAEs by PT and maximum severity in decreasing order of frequency
- Summary of Grade 3 or higher TEAEs by PT in decreasing order of frequency
- Summary of serious TEAEs by PT in decreasing order of frequency
- Summary of TEAEs with a fatal outcome by SOC and PT
- Summary of TEAEs leading to discontinuation of parsaclisib by SOC and PT

## **9.3. Clinical Laboratory Tests**

### **9.3.1. Laboratory Value Definitions**

Laboratory values and change from baseline values will be summarized descriptively by visit. Baseline will be determined according to Section 4.1.3. If there are multiple values that meet the criteria for baseline, the value from the central laboratory has priority over the value from the local laboratory. Thereafter, additional rules may be provided after consultation with the medical monitor to delineate which value will be defined as baseline.

Laboratory test values will be assessed for severity based on the numerical component of CTCAE v5.0.

### **9.3.2. Laboratory Value Summaries**

All test results and associated normal ranges from central laboratories will be reported in SI units. Any laboratory test results and associated normal ranges from local laboratories will be converted to SI units.

When there are multiple laboratory nonmissing values for a participant's particular test at a scheduled visit, central laboratory values have higher priority over local laboratory values. If a tie still exists, the laboratory value with the smallest laboratory sequence number will be used in by-visit summaries.

Numeric laboratory values will be summarized descriptively in SI units, and non-numeric test values will be tabulated when necessary. In addition, line graphs will be provided for ALT, AST, hemoglobin, platelet counts, leukocytes, neutrophils, and lymphocytes.

Shift tables will be presented showing change in CTCAE grade from baseline to worst grade postbaseline. Separate summaries for abnormally high and abnormally low laboratory values will be provided when the laboratory parameter has both high and low grading criteria. The denominator for the percentage calculation will be the number of participants in the baseline category. The number of participants who experienced worsening of laboratory abnormalities will be summarized by maximum postbaseline severity.

### **9.3.3. Potential Hy's Law Events**

Participants with elevated ALT or AST  $> 3 \times$  ULN range and alkaline phosphatase  $< 2 \times$  ULN range accompanied by total bilirubin  $> 2 \times$  ULN range at the same visit will be listed.

### **9.3.4. Worsening Laboratory Events of Special Interest**

Laboratory events of special interest are listed below.

- ALT increased
- AST increased
- Absolute neutrophil count decreased

The time to onset of a worsening laboratory event is defined as the interval between the date of first dose of study drug and the date of the first occurrence of CTC grade worse than baseline for the laboratory event. Participants who have not experienced a worsening laboratory event at the time of analysis will be right-censored at the last postbaseline study visit with nonmissing CTC grade of the laboratory event.

Time to onset of worsening Grade 3 or 4 laboratory events of special interest will be summarized using descriptive statistics and the life-table method as described in Section 9.2.2, and the Kaplan-Meier plot of time to onset of worsening Grade 3 or 4 absolute neutrophil count decreased will be provided. Laboratory events of special interest to be summarized may be adjusted based on emerging data.

## 9.4. Vital Signs

Values at each scheduled visit, change, and percentage change from baseline for vital signs, including weight, systolic blood pressure, diastolic blood pressure, pulse, body temperature, and respiratory rate will be summarized descriptively.

Normal ranges for vital sign values are defined in [Table 4](#). The abnormal values for participants exhibiting vital sign abnormalities will be listed along with their assigned treatment regimen.

Alert vital signs are defined as an absolute value outside the defined normal range and percentage change greater than 25%. Note that the definition of alert vital signs does not apply for body temperature and weight. The abnormal values for participants exhibiting alert vital sign abnormalities will be listed.

**Table 4: Normal Ranges for Vital Sign Values**

Parameter	High Threshold	Low Threshold
Systolic blood pressure	≤ 155 mmHg	≥ 85 mmHg
Diastolic blood pressure	≤ 100 mmHg	≥ 40 mmHg
Pulse	≤ 100 bpm	≥ 45 bpm
Temperature	≤ 38°C	≥ 35°C
Respiratory rate	≤ 24 breaths/min	≥ 12 breaths/min

## 9.5. Electrocardiograms

Twelve-lead ECGs including PR, QRS, QT, QTcB, QTcF, and RR intervals will be obtained for each participant during the study. Values at each scheduled visit, change, and percentage change from baseline will be summarized for each ECG parameter. Baseline will be determined as the average of all nonmissing values before the first administration of pascalisib.

Normal ranges for ECG values are defined in [Table 5](#). Electrocardiogram values will also be considered abnormal if the absolute percentage change from baseline is more than 25% (30% for QRS interval). Participants exhibiting ECG abnormalities will be listed with study visit and assigned treatment regimen. Abnormal values for participants with alert ECG values, defined as both the absolute value and the percentage change from baseline being outside normal ranges, will be identified and listed. Outliers of QT, QTcB, and QTcF values, defined as absolute values > 450 milliseconds or change from baseline > 30 milliseconds, will be summarized.

**Table 5: Normal Ranges for Electrocardiogram Values**

Parameter	High Threshold	Low Threshold
PR	≤ 220 ms	≥ 75 ms
QRS	≤ 120 ms	≥ 50 ms
QT	≤ 500 ms	≥ 300 ms
QTcB, QTcF	≤ 450 ms	≥ 295 ms
RR	≤ 1330 ms	≥ 600 ms

QTcB = Bazett's correction; QTcF = Fridericia's correction.

## 10. INTERIM ANALYSES

An interim futility analysis is planned when the first 20 participants have been evaluated for response or have been followed for at least 9 weeks or have permanently discontinued study treatment because of disease progression, withdrawal of consent, or death. The study will be terminated for futility if  $\leq 7$  of the 20 participants have responded (ie, CR or PR) based on assessments provided by the IRC; otherwise the study will continue. The probability of stopping at interim for futility is 60.10% when the true response rate is 35% or 1.32% when the true response rate is 62%.

An IDMC will be charged with evaluating interim futility results. The IDMC will consist of clinicians and an independent statistician. The IDMC will make recommendations to the sponsor at the planned interim futility analysis. The process by which the IDMC will make recommendations and decisions will be documented in the IDMC charter. Additional operational details of the interim analyses, including tables, figures, and listings provided to the IDMC, will be provided in the IDMC Charter.

There is no efficacy interim analysis planned for the study as there are no plans to stop the study early for overwhelming efficacy.

## 11. CHANGES AND MODIFICATIONS TO THE ANALYSIS PLAN

All versions of the SAP are listed in [Table 6](#).

**Table 6: Statistical Analysis Plan Versions**

SAP Version	Date
Original	22 MAR 2021
Amendment 1	26 JAN 2023

### 11.1. Changes to Protocol-Defined Analyses

Not applicable.

### 11.2. Changes to the Statistical Analysis Plan

#### Amendment 1 (26 JAN 2023):

**Overall Rationale for the Amendment:** The minimum observation period required for evaluation of the primary endpoint (ORR) was updated based on the time to response data from a non-Japanese study. This modification led to the SAP Amendment 1 reflecting this change.

- Section 7.3 has been modified to include the timing of the primary analysis.

## 12. REFERENCES

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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* 2014;32:3059-3068.

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Flinn IW, Miller CB, Ardeshta KM, et al. DYNAMO: a Phase II study of duvelisib (IPI-145) in patients with refractory indolent non-Hodgkin lymphoma. *J Clin Oncol* 2019;37:912-922.

Klein JP, Moeschberger ML. *Survival analysis: techniques for censored and truncated data*, New York, NY: Springer-Verlag; 1997.

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## APPENDIX A. PLANNED TABLES, FIGURES, AND LISTINGS

This appendix provides a list of the planned tables, figures, and listings for the Clinical Study Report. Standard tables will follow the conventions in the Standard Safety Tables v1.10. Shells are provided for nonstandard tables in a separate document.

The lists of tables, figures, and listings and the shells are to be used as guidelines. Modifications of the lists that do not otherwise affect the nature of the analysis will not warrant an amendment to the SAP.

### Tables

Table No.	Title	Population	Standard
<b>Baseline and Demographic Characteristics</b>			
1.1.1	Analysis Populations	All-Screened	X
1.1.2	Summary of Participant Disposition	FAS	X
1.1.3	Summary of Number of Participants Enrolled by Site	FAS	X
1.1.4	Summary of Protocol Deviations	FAS	X
1.2.1	Summary of Demographics and Baseline Characteristics	FAS	X
1.3.1	Summary of Baseline Disease Characteristics	FAS	X
1.3.2	Summary of Prior Cancer Therapy	FAS	
1.3.3	Summary of Prior Systematic Cancer Therapy by WHO Drug Class and Preferred Term	FAS	
1.4.1	Summary of Prior Medications	FAS	X
1.4.2	Summary of Concomitant Medications	FAS	X
1.5.1	Summary of General Medical History	FAS	X
<b>Efficacy</b>			
2.1.1	Summary of Best Overall Response and Objective/Complete Response Rate as Determined by Independent Review Committee	FAS	
2.1.2	Summary of Best Overall Response and Objective/Complete Response Rate as Reported by Investigator	FAS	
2.1.3	Summary of Best Overall Response and Objective Response Rate as Determined by Independent Review Committee by Subgroup	FAS	
2.2.1	Summary of Duration of Response as Determined by Independent Review Committee	FAS	
2.2.2	Summary of Duration of Response as Reported by Investigator	FAS	
2.2.3	Summary of Progression-Free Survival as Determined by Independent Review Committee	FAS	
2.2.4	Summary of Progression-Free Survival as Reported by Investigator	FAS	
2.2.5	Summary of Overall Survival	FAS	
2.2.6	Summary of Best Change in Target Lesion Size as Determined by Independent Review Committee	FAS	
2.2.7	Summary of Best Change in Target Lesion Size as Reported by Investigator	FAS	

Table No.	Title	Population	Standard
<b>Safety</b>			
3.1.1	Summary of Exposure and Compliance	Safety	
3.1.2	Summary of Exposure and Average Daily Dose During Initial QD and Maintenance Dosing Periods	Safety	
3.2.1	Overall Summary of Treatment-Emergent Adverse Events	Safety	X
3.2.2	Summary of Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety	X
3.2.3	Summary of Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	Safety	X
3.2.4	Summary of Treatment-Emergent Adverse Events by MedDRA System Organ Class, Preferred Term, and Maximum Severity	Safety	X
3.2.6	Summary of Grade 3 or Higher Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety	X
3.2.7	Summary of Grade 3 or Higher Treatment-Emergent Adverse Events by Preferred Term in Decreasing Order of Frequency	Safety	X
3.2.8	Summary of Serious Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety	X
3.2.9	Summary of Serious Treatment-Emergent Adverse Events by Preferred Term in Decreasing Order of Frequency	Safety	X
3.2.10	Summary of Parsaclisib Treatment-Related Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety	X
3.2.11	Summary of Parsaclisib Treatment-Related Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	Safety	X
3.2.12	Summary of Parsaclisib Treatment-Related Treatment-Emergent Adverse Events by MedDRA System Organ Class, Preferred Term, and Maximum Severity	Safety	X
3.2.14	Summary of Grade 3 or Higher Parsaclisib Treatment-Related Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety	X
3.2.15	Summary of Parsaclisib Treatment-Related Serious Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety	X
3.2.16	Summary of Treatment-Emergent Adverse Events With a Fatal Outcome by MedDRA System Organ Class and Preferred Term	Safety	X
3.2.18	Summary of Treatment-Emergent Adverse Events Leading to Parsaclisib Dose Reduction by MedDRA System Organ Class and Preferred Term	Safety	X
3.2.19	Summary of Treatment-Emergent Adverse Events Leading to Parsaclisib Dose Interruption by MedDRA System Organ Class and Preferred Term	Safety	X
3.2.20	Summary of Treatment-Emergent Adverse Events Leading to Discontinuation of Parsaclisib by MedDRA System Organ Class and Preferred Term	Safety	X
3.2.25	Summary of Treatment-Emergent Adverse Events by MedDRA Preferred Term and Maximum Severity in Decreasing Order of Frequency	Safety	

Table No.	Title	Population	Standard
3.2.26	Summary of Selected Treatment-Emergent Adverse Events of Special Interest by Maximum Severity	Safety	
3.2.27	Summary of Time to Onset of Selected Treatment-Emergent Adverse Events of Special Interest	Safety	
3.2.28	Summary of Time to Onset of Selected Treatment-Emergent Adverse Events of Special Interest: Life-Table Method	Safety	
3.2.29	Summary of Longest Duration of Selected Treatment-Emergent Adverse Events of Special Interest	Safety	
3.3.1.1	Summary of Laboratory Values - Hematology	Safety	X
3.3.1.2	Summary of Laboratory Values - Chemistry	Safety	X
3.3.3.1	Shift Summary of Hematology Laboratory Values in CTC Grade - To the Worst Abnormal Value	Safety	X
3.3.3.2	Shift Summary of Chemistry Laboratory Values in CTC Grade - To the Worst Abnormal Value	Safety	X
3.3.3.4	Treatment-Emergent Worsening of Laboratory Abnormalities - Hematology	Safety	X
3.3.3.5	Treatment-Emergent Worsening of Laboratory Abnormalities - Chemistry	Safety	X
3.3.6	Time to Onset of Treatment-Emergent Worsening of Laboratory Events of Special Interest	Safety	
3.3.7	Time to Onset of Treatment-Emergent Worsening of Laboratory Events of Special Interest: Life-Table Method	Safety	
3.4.1	Summary of Systolic Blood Pressure	Safety	X
3.4.2	Summary of Diastolic Blood Pressure	Safety	X
3.4.3	Summary of Pulse	Safety	X
3.4.4	Summary of Respiratory Rate	Safety	X
3.4.5	Summary of Body Temperature	Safety	X
3.4.6	Summary of Weight	Safety	X
3.5.1	Summary of PR Interval (ms) From 12-Lead ECG	Safety	X
3.5.2	Summary of QRS Interval (ms) From 12-Lead ECG	Safety	X
3.5.3	Summary of QT Interval (ms) From 12-Lead ECG	Safety	X
3.5.4	Summary of QTcB Interval (ms) From 12-Lead ECG	Safety	X
3.5.5	Summary of QTcF Interval (ms) From 12-Lead ECG	Safety	X
3.5.6	Summary of RR Interval (ms) From 12-Lead ECG	Safety	X
3.5.8	Summary of Outliers of QT, QTcB, and QTcF Interval Values From 12-Lead ECG	Safety	X
3.5.9	Summary of Clinically Significant ECG Abnormality	Safety	X

## Figures

Figure No.	Title
4.1.1	Forest Plot of Objective Response Rate as Determined by Independent Review Committee
4.2.1	Kaplan-Meier Estimates of Duration of Response as Determined by Independent Review Committee
4.2.2	Kaplan-Meier Estimates of Duration of Response as Reported by Investigator
4.2.3	Kaplan-Meier Estimates of Progression-Free Survival as Determined by Independent Review Committee
4.2.4	Kaplan-Meier Estimates of Progression-Free Survival as Reported by Investigator
4.2.5	Kaplan-Meier Estimates of Overall Survival

Figure No.	Title
4.2.6	Waterfall Plot of Best Percent Change in Sum of Target Lesions as Determined by Independent Review Committee
4.2.7	Waterfall Plot of Best Percent Change in Sum of Target Lesions as Reported by Investigator
4.5.1	Kaplan-Meier Estimates of Time to Onset of Selected TEAEs of Special Interest
4.5.2	Kaplan-Meier Estimates of Longest Duration of Selected TEAEs of Special Interest
4.6.1	Line Graph of Mean Values Over Time for Selected Laboratory Values (ALT, AST, Hemoglobin, Platelet Counts, Leukocytes, Neutrophils, and Lymphocytes)
4.6.2	Kaplan-Meier Estimates of Time to Onset of Selected Worsening Laboratory Events of Special Interest

### Listings

Listing No.	Title
2.1.1	Participant Enrollment and Disposition Status
2.1.2	Participant Inclusion and Exclusion Criteria Violations
2.2	Protocol Deviations
2.3	Analysis Population
2.4.1	Demographic and Baseline Characteristics
2.4.2	Disease History
2.4.3	Prior Systemic Therapy
2.4.4	Prior Radiation Treatment
2.4.5	Prior Surgery or Surgical Procedure
2.4.6.1	Prior Stem Cell Transplant History
2.4.6.2	Prior Stem Cell Transplant Medication
2.4.7	Medical History
2.4.8	Prior and Concomitant Medication
2.4.9	Tumor Markers
2.5.1	Study Drug Compliance
2.5.2	Study Drug Administration
2.6.1	Best Overall Response, Duration of Response, and Progression-Free Survival per Independent Review Committee
2.6.2	Best Overall Response, Duration of Response, and Progression-Free Survival per Investigator
2.6.3	Overall Response Assessment by Visit per Independent Review Committee
2.6.4	Independent Review Committee Response Assessment: Target Lesions
2.6.5	Independent Review Committee Response Assessment: Nontarget Lesions
2.6.6	Independent Review Committee Response Assessment: New Lesions
2.6.7	Overall Response Assessment by Visit per Investigator
2.6.8	Investigator Response Assessment: Target Lesions
2.6.9	Investigator Response Assessment: Nontarget Lesions
2.6.10	Investigator Response Assessment: New Lesions
2.6.11	Deaths and Overall Survival
2.6.12	Bone Marrow Examination
2.7.1	Adverse Events
2.7.2	Serious Adverse Events
2.7.3	Grade 3 and Higher Adverse Events

<b>Listing No.</b>	<b>Title</b>
2.7.4	Fatal Adverse Events
2.7.5	Treatment-Related Adverse Events
2.7.6	Adverse Events Leading to Interruption, Reduction or Discontinuation of Parsaclisib
2.8.1	Clinical Laboratory Values - Hematology
2.8.2	Clinical Laboratory Values - Chemistry
2.8.3	Abnormal Clinical Laboratory Values - Hematology
2.8.4	Abnormal Clinical Laboratory Values - Chemistry
2.8.5	Potential Hy's Law Events
2.9.1	Vital Signs
2.9.2	Abnormal Vital Sign Values
2.9.3	Alert Vital Sign Values
2.10.1	12-Lead ECG Values
2.10.2	Abnormal 12-Lead ECG Values
2.10.3	Alert 12-Lead ECG Values