Official Title: A Phase 1/2, Open-Label, Multicenter Study of INCB000928 Administered as a Monotherapy in Participants With Anemia Due to Myelodysplastic Syndromes or Multiple Myeloma

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Statistical Analysis Plan

INCB 00928-105

A Phase 1/2, Open-Label, Multicenter Study of INCB000928 Administered as a Monotherapy in Participants With Anemia Due to Myelodysplastic Syndromes or Multiple Myeloma

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Sponsor:	**Incyte Corporation** **1801 Augustine Cut-Off** **Wilmington, DE 19803** **United States**
Protocol Version:	**Protocol Amendment 5 dated 06 DEC 2023**
CRF Approval Date:	**19 JAN 2024**
SAP Version:	**Amendment 1**
SAP Author:	[redacted], **Biostatistics**
Date of Plan:	**29 AUG 2024**

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

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LIST OF ABBREVIATIONS

Abbreviation	Term
AE	adverse event
AUC_{0-t}	area under the steady-state plasma or serum concentration-time curve over 1 dose interval
BOIN	Bayesian optimal interval design
CI	confidence interval
C_{max}	maximum concentration
CR	complete response
CRF	case report form
CTCAE	Common Terminology Criteria for Adverse Events
CYP	cytochrome P450
DLT	dose-limiting toxicity
ECG	electrocardiogram
ECOG	Eastern Cooperative Oncology Group
eCRF	electronic case report form
ERFE	erythroferrone
FAS	full analysis set
Hgb	hemoglobin
IPSS-R	Revised International Prognostic Scoring System
IWG	International Working Group
LFS	leukemia-free survival
MDS	myelodysplastic syndromes
MedDRA	Medical Dictionary for Regulatory Activities
MM	multiple myeloma
MPN	myeloproliferative neoplasm
MTD	maximum tolerated dose
PD	pharmacodynamics
PFS	progression-free survival
PK	pharmacokinetics
PR	partial response
pRBC	packed red blood cell
PT	preferred term
RBC	red blood cell
RDE	recommended dose for expansion
SAE	serious adverse event
SAP	Statistical Analysis Plan

Abbreviation	Term
SOC	system organ class
TD	transfusion-dependent
TEAE	treatment-emergent adverse event
TI	transfusion-independent
T_{max}	time to maximum observed concentration
ULN	upper limit of normal
WHO	World Health Organization

1. INTRODUCTION

This is a Phase 1/2, open-label, multicenter, dose-finding study intended to evaluate the safety and tolerability, PK, PD, and preliminary efficacy of INCB000928 administered as a monotherapy in participants with MDS or MM who are transfusion-dependent or present with symptomatic anemia. 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.

The purpose of this SAP is to provide details of the statistical analyses that have been outlined in the INCB 00928-105 Protocol. In the dose-escalation stage, a BOIN design will be used to determine the MTD. In each dose-escalation cohort, data from both participants with MDS and participants with MM will be evaluated together. In the expansion stage, an additional 15 evaluable participants will be enrolled in each of the disease groups and at each of the identified RDE(s) in the dose-escalation stage to further evaluate the safety, efficacy, PK, and PD.

PK analysis will be conducted by the Incyte pharmacokineticist, and the details of the analysis methodology and results will be reported separately.

The details of the analysis methodology of biomarkers and PD and results will be reported separately.

2. STUDY INFORMATION, OBJECTIVES, AND ENDPOINTS

2.1. Protocol and Case Report Form Version

This SAP is based on INCB 00928-105 Protocol Amendment 5 dated 06 DEC 2023 and CRFs approved 19 JAN 2024. Unless superseded by an amendment, this SAP will be effective for all subsequent Protocol amendments and eCRF versions.

2.2. Study Objectives and Endpoints

Table 1 presents the objectives and endpoints.

Table 1: Objectives and Endpoints

Objectives	Endpoints
Primary	
To determine the safety and tolerability of INCB000928 monotherapy in participants with MDS or MM.	• Frequency and severity of AEs and SAEs, including changes in vital signs, ECGs, physical examinations, and clinical blood and urine laboratory parameters. • Identification of the DLTs, MTD, and RDE(s).
Secondary	
To determine the efficacy of INCB000928 in participants with MDS or MM.	**For both MDS and MM disease groups:** • For transfusion-independent participants at baseline: – The proportion of participants with anemia response, defined as an Hgb increase of at least 1.5 g/dL relative to baseline for any 8-week period (with each assessment meeting this requirement) during the first 24 weeks of treatment. – Duration of anemia response, defined as the interval from the first onset of anemia response to the earliest date of loss of anemia response that persists for at least 4 weeks or death from any cause. • For transfusion-dependent participants at baseline: – The proportion of participants with RBC-TI, defined as the absence of any RBC transfusion for at least 8 consecutive weeks during the first 24 weeks of treatment. – Duration of RBC-TI period for participants achieving RBC-TI for at least 8 consecutive weeks during the first 24 weeks of treatment. • Rate of RBC transfusion through Weeks 12 and 24, defined as the average number of RBC units per participant-month during the treatment period. • The largest increase from baseline in the mean Hgb values over any rolling 8-week treatment period during the first 24 weeks of treatment.

Table 1: Objectives and Endpoints (Continued)

Objectives	Endpoints
To determine the efficacy of INCB000928 in participants with MDS or MM (continued).	**For MDS participants only:** • Overall response rate, defined as the proportion of participants with CR or PR as per Cheson et al (2006) definitions for MDS and as per Savona et al (2015) definitions for MDS/MPN overlap syndromes, as applicable. • PFS, defined as the interval from the first dose of study drug until the first documented progression or death as per Cheson et al (2006) definitions for MDS and as per Savona et al (2015) definitions for MDS/MPN overlap syndromes. • LFS, defined as the interval from the first dose of study drug until the first documented leukemia transformation or death from any cause. **For MM participants only:** • Overall response rate, defined as the proportion of participants with stringent CR, CR, very good PR, and PR as per Kumar et al (2016). • PFS, defined as the interval from the first dose of study drug until the first documented progression or death as per Kumar et al (2016).
To evaluate the PK of INCB000928 in participants with MDS or MM.	PK parameters: C_{max}, t_{max}, and AUC_{0-t}.
To evaluate the effect of INCB000928 on the iron homeostasis and the erythropoiesis parameters in participants with MDS or MM.	• Blood levels of hepcidin. • Iron homeostasis parameters. • Erythropoiesis parameters.
Exploratory	
[redacted]	

3. STUDY DESIGN

This Phase 1/2, open-label, multicenter, dose-finding study is intended to evaluate the safety and tolerability, PK, PD, and preliminary efficacy of INCB000928 administered as a monotherapy in participants with MDS or MM who are transfusion-dependent or present with symptomatic anemia.

The study has 2 disease groups:

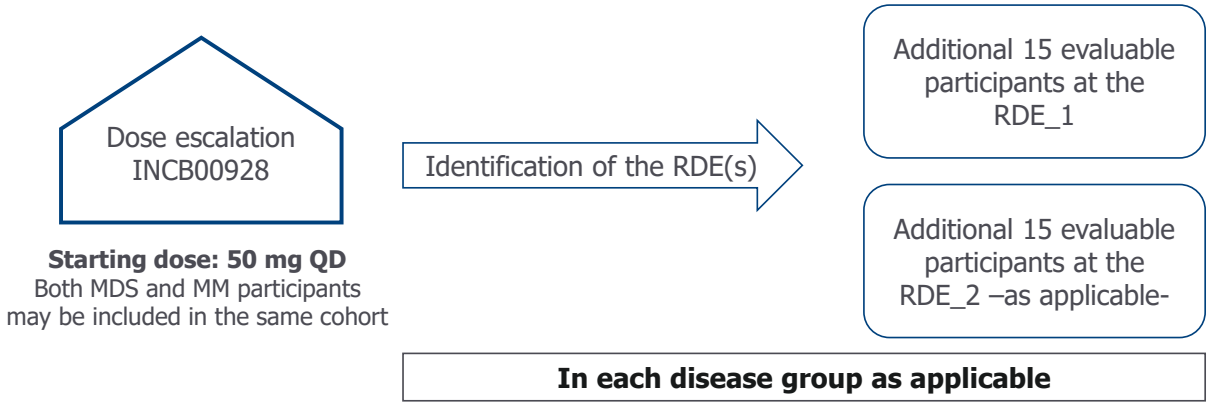
- Participants with MDS or MDS/MPN overlap syndromes, collectively referred to as MDS participants.
- Participants with relapsed/refractory MM.

In the dose-escalation stage, a BOIN design (Liu and Yuan 2015) will be used to determine the MTD. In each dose-escalation cohort, data from both participants with MDS and participants with MM will be evaluated together. One or more RDE(s) may be defined in each treatment group as applicable.

In the expansion stage, the RDE(s) identified in the dose-escalation stages will be taken forward and administered to an additional 15 evaluable participants in each of the disease groups and at each of the identified RDE(s), and further evaluation of the safety, efficacy, PK, and PD of the RDE(s) will be performed in a parallel and independent fashion in each disease group. In the event that more than 1 RDE is explored in a disease group, the participants in this disease group will be randomly allocated to one of the RDEs.

Figure 1 presents a schematic representation of the study design.

Figure 1: Study Design Schema



MDS disease group: MDS participants who are transfusion-dependent or present with symptomatic anemia
MM disease group: Relapsed/refractory MM participants who are transfusion-dependent or present with symptomatic anemia

3.1. Randomization

For the dose-escalation stage, randomization is not applicable. In the expansion stage, in the event that more than 1 RDE is explored in a disease group, the participants in that treatment group will be randomly allocated in a 1:1 ratio to one of the RDE(s).

3.2. Control of Type I Error

All statistical analyses are exploratory in nature. Unless otherwise specified, all CIs provided will be at the 95% confidence level.

3.3. Sample Size Considerations

3.3.1. Dose Escalation and De-Escalation Algorithm

In the dose-escalation stages, a BOIN design (Liu and Yuan 2015) will be used to determine the MTD; participants with MDS and participants with MM will be evaluated together.

The cohort size will be 3. In each disease group, up to approximately 24 evaluable participants may be treated in the dose-escalation stages, and the dose-escalation procedure may be stopped if the number of evaluable participants treated at any dose level is > 9. The value of 0.6×0.28 is the highest DLT rate that is deemed subtherapeutic. The lowest DLT rate deemed overly toxic is 1.4×0.28, meaning that if the participants have a DLT(s) rate of $\leq 0.6 \times 0.28$, dose escalation is required; if the participants have a DLT(s) rate of $\geq 1.4 \times 0.28$, dose de-escalation is required. An equal prior probability of hypothesis being true is assigned to each of the hypotheses. The value of 0.95 is selected for the cutoff to eliminate an overly toxic dose for safety.

Table 2 will be used to guide dose escalation/de-escalation decisions.

Table 2: Decision Boundaries

Number of participants treated at current dose	1	2	3	4	5	6	7	8	9
Escalate if number of participants with DLT(s) is ≤	0	0	0	0	1	1	1	1	1
De-escalate if number of participants with DLT(s) is ≥	1	1	2	2	2	3	3	3	4
Unacceptable toxicity if number of participants with DLT(s) is ≥	NA	NA	3	3	4	4	4	5	5

NA = not applicable.

If the number of participants with DLT(s) specified in the last row is reached, that dose level and above dose levels will be eliminated. If the number of participants with DLT(s) is between the escalation and de-escalation boundaries specified in the second and third rows in Table 2, another 3 evaluable participants will be enrolled in the current dose level cohort.

The exact number of participants treated in each dose-escalation stage will depend upon the number of participants required per dose level and upon the number of dose levels studied.

One or more RDE(s) may be defined in each treatment group, as applicable. The definition of the RDE(s) are as follows:

- Defined RDE doses are pharmacodynamically active,
- RDE doses will not exceed the MTD defined in each treatment group.

At the end of the dose-escalation stage of the study, the estimated MTD is the dose at which the observed DLT rate is closest to the target DLT rate of 28% using an isotonic method that takes the assumption of a monotonic dose-toxicity relationship into account.

Assuming the true DLT is 28% and the number of dose levels to be tested is 5, Table 3 provides the operating characteristics of BOIN design with a maximum sample size of 24 and an early stopping rule of 9 participants at each dose level for the 6 scenarios in Table 4.

Table 3: Operating Characteristics of BOIN Design

	Scenarios					
	1	**2**	**3**	**4**	**5**	**6**
Average number of participants treated at the MTD	—	7	6	6	5	4
Total number of participants treated	12	13	16	19	21	21
Correct selection (%)	13.2	55.4	43.4	41.6	36.7	39.5
Risk of overdosing (%)	67	34.1	28.4	27.1	24.2	0
Risk of underdosing (%)	0	10.5	28.2	31.3	39.1	60.5

Table 4: Six Scenarios for the Simulation of BOIN Design

	DLTs for 5 Dose Levels				
Scenarios	**Dose 1**	**Dose 2**	**Dose 3**	**Dose 4**	**Dose 5**
1	0.40	0.45	0.50	0.55	0.65
2	**0.28**	0.35	0.45	0.55	0.65
3	0.15	**0.28**	0.35	0.45	0.55
4	0.05	0.15	**0.28**	0.35	0.45
5	0.05	0.10	0.15	**0.28**	0.35
6	0.05	0.10	0.15	0.20	**0.28**

3.3.2. Expansion Stages

The RDE(s) identified in the dose-escalation stages will be taken forward and administered to an additional 15 evaluable participants in each of the disease groups and at each of the identified RDE(s), and further evaluation of the safety, efficacy, PK, and PD of the RDE(s) will be performed in a parallel and independent fashion in each disease group. In the event that more than o1 RDE is explored in a disease group, the participants in this disease group will be randomly allocated to one of the RDEs.

Fifteen participants per cohort will provide a > 75% chance of identifying a toxicity with a true event rate of 9%. Table 5 provides the probability of identifying ≥ 1 AE on different event rates.

Table 5: Probability of Identifying ≥ 1 Adverse Event for Different True Event Rates

True Event Rate	Probability of Identifying ≥ 1 AE
5%	54%
9%	76%
15%	91%

3.4. Schedule of Assessments

Refer to Protocol Amendment 5 dated 06 DEC 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 INCB000928 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

Day # = (visit/reporting date – 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

Day # = (visit/reporting date – 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 INCB000928, unless otherwise defined below.

When scheduled assessments and unscheduled assessments occur on the same day and the 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.

Recording of Hgb values and RBC transfusions is mandatory within 8 weeks prior to Cycle 1 Day 1 (Day -56 to Day 1). The baseline Hgb value is defined as the average of all eligible Hgb

assessments. The Hgb values within the window from the date of RBC transfusion +1 day to the date of RBC transfusion +14 days will be excluded. The Hgb values eligible for baseline evaluation will be calculated based on information entered on Transfusion History eCRF and Local Labs – HGB eCRF. For baseline evaluations, when a Hgb assessment triggers a transfusion, it will be collected in both the Transfusion History eCRF and Local Labs – HGB eCRF, and only the Hgb value collected on the Local Labs – HGB eCRF will be included for baseline calculation. The transfusion records for baseline will be based on the information entered on Transfusion History eCRF and PRBC/Platelet Transfusions eCRF.

Baseline ECG will be determined as the average of all nonmissing values for each ECG parameter before the first administration of INCB000928. If there are multiple records for each test at the same visit, those records will be averaged for analysis.

4.1.4. Handling of Missing and Incomplete Dates

In general, values for missing dates will not be imputed unless methods for handling missing dates 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 partial dates for analyses requiring dates.

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

- 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 of the year will be used.
- If the diagnosis date is completely missing, then 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, a missing or partial date of the last dose will be handled 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.

For relevant efficacy endpoints, a partial date of the death date will be handled as follows in the calculation:

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

4.1.5. Cycle Length and Duration

Cycle 1 Day 1 is the day that the first dose of INCB000928 is administered. The scheduled cycle length is 28 days. The actual Day 1 of subsequent cycles will correspond with the first day of administration of INCB000928 in that cycle; thus, treatment cycles may become out of sync with the originally planned schedule, and the cycle length may be different from 28 days. The date of the Day 1 of subsequent cycles recorded on the eCRF will be used as the Day 1 of the subsequent cycles.

4.2. Variable Definitions

The following variables will only be calculated if not reported on the eCRF.

4.2.1. Body Mass Index

Body mass index will be calculated as follows:

Body mass index (kg/m^2) = [weight (kg)] / [height (m)]^2.

4.2.2. Prior and Concomitant Medication

Prior medication is defined as any nonstudy medication started before the first dose of INCB000928.

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

- Before the date of first administration of INCB000928 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 INCB000928 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 INCB000928. In the listing, it will be indicated whether a medication is only prior, only concomitant, 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® 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.

5.2. Treatment Groups

This is a Phase 1/2, open-label, multicenter, dose-finding study to evaluate the safety and tolerability, PK, PD, and preliminary efficacy of INCB000928 administered as a monotherapy in participants with MDS or MM who are transfusion-dependent or present with symptomatic anemia. Data will be summarized by disease type and dose level based on the dose regimen initially assigned. The participants in the dose-expansion stage will be combined with the participants on that dose level in the dose-escalation stage. In the event that several dose regimens tested are deemed substantially below the MTD, these doses may be combined for summary purposes.

5.3. Analysis Populations

5.3.1. All-Screened Population

The all-screened population will include all participants who signed the informed consent form.

5.3.2. Full Analysis Set

The FAS includes all participants who received at least 1 dose of INCB000928. The FAS will be used for the summary of demographics, baseline characteristics, participant disposition, and analyses of all safety and efficacy data.

5.3.3. DLT Evaluable Population

The DLT evaluable population will include all participants in the FAS population who meet the following criteria:

- Observed for at least the first treatment cycle (ie, 28 days)
- Receive at least 75% of doses of study treatment at the level assigned to that cohort (ie, 21 days of treatment) or have a DLT during the first study treatment cycle
- Have not received any strong or potent CYP3A4/5 inhibitor or inducer during the first study drug treatment cycle (DLT assessment period)
- Participants who do meet all of the eligibility requirements of the study may be replaced.
- Is not part of a backfill cohort.

6. BASELINE, EXPOSURE, AND DISPOSITION

Appendix A provides a list of data displays. Sample data displays are included in a separate document.

6.1. Demographics, Baseline Characteristics, and Disease History

6.1.1. Demographics and Baseline Characteristics

The following demographics and baseline characteristics will be summarized for the FAS: age, sex, race, ethnicity, weight, height, and body mass index.

6.1.2. Baseline Disease Characteristics

The following baseline disease characteristics will be summarized for the FAS by disease type and dose level: ECOG performance status and TD or TI status at baseline.

6.1.2.1. Myelodysplastic Syndromes History

The time since diagnosis, MDS type at diagnosis, extramedullary disease present or not, IPSS-R score at initial diagnosis, current IPSS-R score, current percentage of bone marrow blasts, and current MDS type will be summarized for all MDS participants in the FAS by dose level.

Time since diagnosis will be calculated as follows:

Time since diagnosis (years) = (Day 1 date – date of diagnosis + 1) / 365.25.

6.1.2.2. Myelodysplastic Syndromes/Myeloproliferative Neoplasms History

The time since diagnosis, MDS/MPN type at diagnosis, and extramedullary disease present or not will be summarized for all MDS/MPN participants in the FAS by dose level.

6.1.3. Prior Therapy

The number of prior systemic anticancer therapy regimens will be summarized for all participants in the FAS by disease type and dose level. The component drugs of prior systemic therapy regimens will be coded using the WHO Drug Dictionary. The number and percentage of participants who received each drug will be summarized by WHO drug class and WHO drug PT. The regimen name, dose, unit, frequency, route, start and stop dates, and reason for discontinuation will be listed.

The number of participants who received prior antianemic treatment will be summarized for all participants in the FAS by disease type and dose level. The component drugs of prior systemic therapy regimens will be coded using the WHO Drug Dictionary. The number and percentage of participants who received each drug will be summarized by WHO drug class and WHO drug PT. The regimen name, dose, unit, frequency, route, start and stop dates, and reason for discontinuation will be listed.

The number of participants who received prior radiation will be summarized for the FAS by disease type and dose level. The radiotherapy type, body site, start and stop dates, total dose, reason for regimen, best response, number or fractions received, and total dose will be listed.

The number of participants who had prior surgery or surgical procedure for the malignancies under study will be summarized for the FAS by disease type and dose level. The date and description of the surgery/procedure will be listed.

The number of participants who had RBC/platelet transfusion in the 12 weeks prior to start of screening will be summarized for the FAS by disease type and dose level. The transfusion date, blood component, reason for RBC/platelet transfusion, quantity, and units will be listed.

6.1.4. Medical History

For participants in the FAS, medical history will be summarized by disease type and dose level. This summation will include the number and percentage of participants with significant medical history for each body system/organ class as documented on the eCRF.

6.2. Disposition of Participant

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 by disease type and dose level. The number of participants enrolled by country and/or site will also be provided by disease type and dose level.

6.3. Protocol Deviations

Protocol deviations recorded in the iCORE system will be summarized and listed.

6.4. Exposure

For participants in the FAS, exposure to INCB000928 will be summarized descriptively by disease type and dose level as the following:

- **Duration of treatment with INCB000928 (days)**: date of last dose of study drug – date of first dose of study drug + 1.
- **Average daily dose of INCB000928 (mg/day)**: total actual INCB000928 dose taken (mg) / duration of treatment with INCB000928 (days).

  Total actual dose taken will be calculated based on the information entered on the Dosing eCRF.
- **INCB000928 dose modifications**: number of participants who had INCB000928 dose reduction, escalation, and interruption.

6.5. Study Drug Compliance

For participants in the safety population, overall compliance (%) for INCB000928 will be calculated for all participants as follows:

compliance (%) = 100 × [total dose actually taken] / [total prescribed dose].

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

The total actual dose taken will be calculated based on information entered on the Dosing eCRF.

6.6. Prior and Concomitant Medication

Prior medications and concomitant medications will be coded using the WHO Drug Dictionary. The 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 data displays. Sample data displays are included in a separate document.

7.1. General Considerations

Unless otherwise stated, FAS will be used in all efficacy analyses. Summary tables may be replaced with listings when appropriate.

7.2. Analysis of the Secondary Efficacy Endpoints

7.2.1. Proportion of Participants With Anemia Response

Hgb values and RBC transfusions at baseline will be recorded for a minimum of 8 weeks before Cycle 1 Day 1. Baseline Hgb value will be determined according to Section 4.1.3.

The proportion of participants with anemia response will be estimated as described below for the FAS. Summary tables may be replaced with listings when there are not sufficient data.

7.2.1.1. Proportion of Participants With RBC-TI for Participants Who Are Transfusion-Dependent at Baseline

Transfusion-dependent at baseline is defined as a participant having received at least 4 units of RBC transfusions during the 28 days immediately preceding Cycle 1 Day 1 or received at least 4 units of RBC transfusions in the 8 weeks immediately preceding Cycle 1 Day 1, for an Hgb level of < 8.5 g/dL, in the absence of bleeding or treatment-induced anemia. In addition, the most recent transfusion episode must have occurred in the 28 days before Cycle 1 Day 1.

For participants who are TD at baseline, RBC-TI will be defined as achieving RBC transfusion independence ≥ 8 consecutive weeks (absence of any RBC transfusion over any 56-day period). At least 2 separate Hgb assessments with 28 ± 6 days between each measurement are required during this 56-day window. The RBC-TI response rate will be estimated with its 95% CI for each disease type and dose level for participants in the FAS who have been on treatment for at least 56 days or discontinued from treatment before 8 weeks. The CI will be calculated by the exact binomial distribution.

For each 8-week period that the participant was on study, whether the participant received RBC transfusion will be recorded. If a participant completes the safety follow-up or starts a new anticancer treatment or antianemic treatment before the end of an 8-week window, then whether the participant received RBC transfusion will be missing. The participant will not be considered RBC-TI during this 8-week period.

Additional 8-week windows (eg, Days 2-57, Days 3-58) will be derived for participants remaining on study for more than 8 weeks during the first 24 weeks of treatment.

7.2.1.2. Proportion of Participants with Anemia Response for Participants Who Are Transfusion-Independent at Baseline

Transfusion-independent at baseline is defined as participants who are not TD at baseline.

For participants who are TI at baseline, anemia response will be defined as an Hgb increase ≥ 1.5 g/dL relative to baseline for any ≥ 8-week period (56 days with each assessment meeting this requirement) during the first 24 weeks of treatment. Any postbaseline Hgb assessment(s) within the window from the date received RBC transfusion +1 day to the date received RBC transfusion + 14 days are not eligible to determine the anemia response and will be excluded. At least 2 separate Hgb assessments with 28 ± 6 days between each measurement are required during this 56-day window. The proportion of participants with anemia response will be estimated along with its 95% CI for each disease type and dose level for participants in the FAS population who have been on treatment for at least 56 days or discontinued from treatment before 8 weeks. The CI will be calculated by the exact binomial distribution. A valid baseline Hgb value is required for participants to be included in the calculation of anemia response rate.

For each 8-week period that the participant was on study, the Hgb value will be recorded according to the Schedule of Activities in the Protocol. If a participant completes the safety follow-up or starts a new anticancer treatment or antianemic treatment before the end of an 8-week window, the participant will not be considered as a responder during this 8-week period.

Additional 8-week windows (eg, Days 2-57, Days 3-58) will be derived for participants remaining on study for more than 8 weeks during the first 24 weeks of treatment.

7.2.2. Duration of Anemia Response

The duration of anemia response will be estimated as described below for participants in the FAS.

7.2.2.1. Duration of Anemia Response for Participants Who Are Transfusion-Dependent at Baseline

For participants who are TD at baseline, duration of RBC-TI period will be defined as the interval from the day of first onset of RBC-TI period to the day of first available RBC transfusion after the first RBC-TI period or death from any cause. If loss of RBC-TI or death is not observed prior to the date of analysis, the duration will be censored at the last assessment of Hgb prior to the new anticancer therapy or new antianemic therapy, whichever is earlier.

The endpoint will be derived for TD participants at baseline in the FAS who achieved RBC-TI for at least 8 weeks.

7.2.2.2. Duration of Anemia Response for Participants Who Are Transfusion-Independent at Baseline

For participants who are TI at baseline, duration of anemia response will be defined as the interval from the first onset of anemia response during the first 24 weeks of treatment to the

earliest date of loss of anemia response that persists for at least 4 weeks or death from any cause. The loss of anemia response for participants who are TI at baseline is defined as an Hgb increase relative to baseline < 1.5 g/dL, and the Hgb increase < 1.5 g/dL is confirmed by a second measurement at least 4 weeks later with no measurement in between with Hgb ≥ 1.5 g/dL relative to baseline. If loss of anemia response or death is not observed prior to the date of analysis, the duration will be censored at the last assessment of Hgb prior to a new anticancer treatment or antianeimic treatment, whichever is earlier.

The endpoint will be derived for TI participants at baseline in the FAS who had anemia response.

7.2.3 Largest Increase From Baseline in Mean Hemoglobin Values

The largest increase from baseline in the mean Hgb values over any rolling 8-week treatment period during the first 24 weeks of treatment will be summarized by disease type and by dose level descriptively for each participant in the FAS remaining on study for more than 8 weeks during the first 24 weeks of treatment and with at least 1 valid Hgb assessment. Any postbaseline Hgb assessment(s) within the window from the date of RBC transfusion +1 day to the date of RBC transfusion +14 days will be considered invalid and will be excluded.

The Hgb baseline value will be defined according to the algorithm provided in Section 4.1.3. The 8-week treatment period will be defined according to the algorithm provided in Section 7.2.1.

Missing values will not be imputed.

7.2.4 Rate of Packed Red Blood Cell Transfusion Through Weeks 12 and 24

Rate of pRBC transfusion through Weeks 12 and 24, defined as the average number of pRBC units per participant-month during the treatment period, will be summarized by disease type and by dose level descriptively. The pRBC transfusion(s) up to the last available transfusion record prior to a new anticancer treatment will be included in the analysis.

The average number of pRBC units though Weeks 12 and 24 will be calculated as follows:

> Rate of pRBC units through Weeks 12 and 24 = Total pRBC units received through Weeks 12 and 24 / (days the participant is on treatment during Weeks 12 and 24 / 30.4375)

The endpoint will be derived for participants in the FAS who have been on treatment for at least 78 days.

7.2.5 Endpoints for Participants With Myelodysplastic Syndromes

7.2.5.1 Overall Response for Myelodysplastic Syndromes and Myelodysplastic Syndromes/Myeloproliferative Neoplasms

The IWG criteria for myelodysplasia provide criteria for response to treatment in MDS. Overall response assessment for MDS participants will be assessed according to the IWG criteria for MDS (Cheson et al 2006). The overall response assessment for MDS/MPN will be assessed according to Savona et al (2015). The overall response assessment will be performed every sixth cycle starting with Cycle 3.

The number of participants with responses (including CR and PR), marrow CR, stable disease, and progressive disease according to Cheson et al (2006) for MDS participants will be

summarized. The number of participants with anemia response, platelet response, and neutrophil response and the number of participants whose disease progresses or relapses after hematologic response will also be summarized.

The number of participants with responses including CR, PR, marrow CR, and no response according to Savona et al (2015) for MDS/MPN will be summarized. The number of participants with anemia response, platelet response, neutrophil response, and spleen response will also be summarized.

Overall response rate, defined as the proportion of participants with CR or PR, will be calculated with its 95% CI.

Missing values will not be imputed. An MDS or MDS/MPN participant will be included in the overall response rate analysis if the participant has a baseline measurement and

- has ≥ 1 post-baseline response assessment OR
- has been on treatment for at least 171 days OR
- discontinues treatment

7.2.5.2 Progression-Free Survival

Progression-free survival is defined as the interval from the first dose of study treatment until the first documented progression or death according to Cheson et al (2006) for participants with MDS. Partial death dates will be handled using the rules described in Section 4.1.4. Censoring for PFS will follow the algorithm outlined in Table 6.

Table 6: Evaluation and Censoring of Progression-Free Survival

Situation	Outcome	Date of Progression or Censoring
No valid postbaseline response assessments	Censored	Date of Day 1
Progression documented between scheduled response assessments	Progressed	Date of first overall response of PD
No progression	Censored	Date of last valid response assessment
Treatment discontinuation for undocumented progression	Censored	Date of last valid response assessment
Treatment discontinuation for toxicity or other reason	Censored	Date of last valid response assessment
New anticancer treatment started	Censored	Date of last valid response assessment 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 2 or more missed assessments	Censored	Date of last valid response assessment

The number of MDS participants with documented progression or death will be summarized.

7.2.5.3 Leukemia-Free Survival

Leukemia-free survival is defined as the interval from the first dose of study treatment until the first documented leukemia transformation or death from any cause. If the participant does not have leukemia transformation or death before the time of analysis, the participant will be censored at the time of analysis or end of treatment, whichever is earlier. The number of participants with leukemia transformation or death will be summarized.

8. SAFETY AND TOLERABILITY

Appendix A provides a list of data displays. Sample data displays are included in a separate document.

8.1. General Considerations

The safety endpoints, including frequency and severity of AEs and SAEs as well as mean change and percentage change in vital signs, ECGs, and laboratory parameters, will be summarized by disease type and dose level in the FAS.

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.

8.2. Adverse Events

8.2.1. 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 until 30 days after the last dose of study drug. 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 National Cancer Institute CTCAE v5. 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 to be treatment-related AEs. If the investigator does not specify the relationship of the AE to study drug, the AE will be considered to be treatment-related. The incidence of AEs and treatment-related AEs will be tabulated. In addition, serious TEAEs will also be tabulated.

8.2.2. Dose-Limiting Toxicities

Dose-limiting toxicities among the DLT evaluable population will be summarized by disease type. The DLT incidence rate along with a 90% CI based on exact binomial distribution will be provided for each dose level using the DLT evaluable population for events that occurred within the DLT observation period. The participants with DLTs and the type of DLT will be listed.

8.2.3. Adverse Event Summaries

An overall summary of AEs by disease type and dose level will include the following:

- Number (%) of participants who had any TEAEs
- Number (%) of participants who had any DLTs
- Number (%) of participants who had any serious TEAEs
- Number (%) of participants who had any Grade 3 or higher TEAEs
- Number (%) of participants who had any TEAEs related to INCB000928
- Number (%) of participants who had TEAE leading to INCB000928 dose modification
  - Number (%) of participants who temporarily interrupted INCB000928 because of TEAEs
  - Number (%) of participants who permanently discontinued INCB000928 because of TEAEs
  - Number (%) of participants who had INCB000928 dose reductions because of TEAEs
- Number (%) of participants who had any fatal TEAEs

The following summaries will be produced by MedDRA term (if 10 or fewer participants appear in a table, a listing may be appropriate):

- Summary of TEAEs by MedDRA SOC and PT
- Summary of TEAEs by MedDRA PT in decreasing order of frequency
- Summary of Grade 3 or higher TEAEs by MedDRA SOC and PT
- Summary of Grade 3 or higher TEAEs by MedDRA PT in decreasing order of frequency
- Summary of serious TEAEs by MedDRA SOC and PT
- Summary of serious TEAEs by MedDRA PT in decreasing order of frequency
- Summary of INCB000928 treatment-related TEAEs by MedDRA SOC and PT
- Summary of INCB000928 treatment-related TEAEs by MedDRA PT in decreasing order of frequency
- Summary of Grade 3 or higher INCB000928 treatment-related TEAEs by MedDRA SOC and PT
- Summary of INCB000928 treatment-related serious TEAEs by MedDRA SOC and PT
- Summary of TEAEs with a fatal outcome by MedDRA SOC and PT

- Summary of TEAEs leading to INCB000928 dose reduction by MedDRA SOC and PT
- Summary of TEAEs leading to INCB000928 dose interruption by MedDRA SOC and PT
- Summary of TEAEs leading to discontinuation of INCB000928 by MedDRA SOC and PT

8.3. Clinical Laboratory Tests

8.3.1. 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, 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.

8.3.2. 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 nonmissing laboratory values for a participant's particular test within a visit window, the convention described in Table 7 will be used to determine the record used for by-visit tabulations and summaries.

Table 7: Identification of Records for Postbaseline By-Visit Summaries

Priority	Laboratory Visit	Proximity to Visit Window	Tiebreaker
1	Scheduled	In-window	Use smallest laboratory sequence number
2	Unscheduled	In-window	
3	Scheduled	Out-of-window	

Numeric laboratory values will be summarized descriptively in SI units, and non-numeric test values will be tabulated when necessary.

For test results that will be summarized with available normal ranges, the number and percentage of participants with laboratory values being low (but never high), normal, high (but never low), and both low and high will be calculated for each test. This shift summary will be produced for each test for the safety population. The denominator for the percentage calculation will use the number of participants in the baseline category (ie, low, high, normal, missing) as the denominator for the percentage in each of the categories during the study.

Severity grades will be assigned to laboratory test values based on the numerical component of CTCAE v5. 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 severity.

In cases where differentials of hematology parameters are obtained without corresponding absolute count data, efforts will be made to investigate if the conversion to an absolute value will lead to additional abnormalities. This will be discussed with the clinical team regarding appropriate documentation and action.

8.3.3. Hy's Law Events

Participants with elevated alanine aminotransferase or aspartate aminotransferase > 3 × ULN range and alkaline phosphatase < 2 × ULN range accompanied by total bilirubin > 2 × ULN range at the same visit will be listed by disease type and dose level. The elevations must be at the same time or within a specified timeframe.

8.4. Vital Signs

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

Normal ranges for vital sign values are defined in Table 8. For participants exhibiting vital sign abnormalities, the abnormal values will be listed along with their assigned treatment group. Alert vital signs are defined as an absolute value outside the defined normal range and percentage change > 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 8: 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	≥ 35.5°C
Respiratory rate	≤ 24 breaths/min	≥ 8 breaths/min

8.5. Electrocardiograms

Twelve-lead ECGs including PR, RR, heart rate, QT, QRS, QTcB, and QTcF intervals will be obtained for each participant during the study. Change and percentage change from baseline will be summarized for each ECG parameter at each scheduled visit and timepoint. Baseline will be defined according to the algorithm provided in Section 4.1.3. If there are multiple postbaseline records for each test at the same visit and/or timepoint, those records will be averaged for analysis.

Normal ranges for ECG values are defined in Table 9. 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 group. 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 millisecond, > 500 millisecond, or change from baseline > 30 millisecond, will be summarized.

Table 9: Normal Ranges for Electrocardiogram Intervals

Parameter	High Threshold	Low Threshold
PR	≤ 220 ms	≥ 75 ms
RR	≤ 1330 ms	≥ 600 ms
QT	≤ 500 ms	≥ 300 ms
QRS	≤ 120 ms	≥ 50 ms
QTcB, QTcF	≤ 450 ms	≥ 295 ms
Heart rate	≤ 100 bpm	≥ 45 bpm

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

Twelve-lead ECGs will be obtained for each participant during the study. Electrocardiogram abnormalities, both at baseline and postbaseline visits, will be tabulated by treatment group. Incidences of abnormalities and a description of the abnormality will be listed with study visit and assigned treatment group.

9. INTERIM ANALYSES

No formal interim analyses are planned. Safety data will be monitored continuously in order to determine dosing in subsequent cohorts, per the algorithm in the Protocol (Section 4.1.1). Regular review meetings of the Data Monitoring Committee will be held at the end of the dose-escalation stage and then every 6 months until the end of the study.

10. CHANGES AND MODIFICATIONS TO THE ANALYSIS PLAN

All versions of the SAP are listed in Table 10.

Table 10: Statistical Analysis Plan Versions

SAP Version	Date
Original	08 JAN 2021
Amendment 1	29 AUG 2024

10.1. Changes to Protocol-Defined Analyses

Not applicable.

10.2. Changes to the Statistical Analysis Plan

10.2.1. Amendment 1

Protocol Amendment 3 included updates to allow participants from both disease groups to be evaluated together in the dose-escalation stage of the study. Protocol Amendment 4 included updates to allow 1 or more RDE(s) in each disease group and to add the expansion of each RDE into the dose-expansion stages. Sections 1 and 3 have been modified to address these changes.

Protocol Amendment 4 clarified that the Hgb and RBC transfusions are mandatory within 8 weeks prior to Cycle 1 Day 1 and provided clarification of baseline Hgb derivation. Sections 4 and 7 have been modified to reflect these changes.

In addition, Section 7 has been updated to clarify that Hgb assessed within a 14-day washout window of a RBC transfusion will be excluded from efficacy analysis.

Protocol Amendment 4 updates included the addition of triplicate ECGs to evaluate the effects of INCB000928 on cardiac parameters. Sections 4 and 8 have been modified to address this change.

Protocol Amendment 5 included updates to reduce the investigational sampling for participants on the study following the Sponsor's strategic decision to stop further recruitment. Section 7 has been modified to address this change. In addition, due to the recruitment termination, Sections 6 and 7 and Appendix A were updated to remove the endpoints and analysis related to MM.

Appendix A was updated to remove planned tables, figures, and listings that are not needed due to the early study recruitment termination.

Other minor updates included the following:

- Section 5 has been updated to clarify that the all-screened population will include all participants who signed the informed consent form.
- Section 5 has been updated to indicate participants in a backfill cohort will not be included in the DLT evaluable population.
- Section 6 has been updated to clarify that the total dose actually taken for drug compliance will be the sum of doses prescribed by investigator accounting for dose modifications on the Dosing eCRF.

- Section 8.3.3 has been updated to clarify that the Hy's Law events will be listed and the elevations must be at the same time or within a specified timeframe.
- Section 8.5 was updated to include heart rate in order to align with Appendix A planned tables.

11. REFERENCES

Cheson BD, Greenberg PL, Bennett JM, et al. Clinical application and proposal for modification of the International Working Group (IWG) response criteria in myelodysplasia. Blood 2006;108:419-425.

Kumar S, Paiva B, Anderson KC, et al. International Myeloma Working Group consensus criteria for response and minimal residual disease assessment in multiple myeloma. Lancet Oncol 2016;17:e328-e346.

Liu S, Yuan Y. Bayesian optimal interval designs for phase I clinical trials. J R Stat Soc C 2015;64:507-523.

Savona MR, Malcovati L, Komrokji R, et al. An international consortium proposal of uniform response criteria for myelodysplastic/myeloproliferative neoplasms (MDS/MPN) in adults. Blood 2015;125:1857-1865.

APPENDIX A. PLANNED TABLES, FIGURES, AND LISTINGS

This appendix provides a list of the planned tables, figures, and listings for the Clinical Study Report. Shells are provided in a separate document for tables that are not in the Standard Safety Tables v1.9.

The lists of tables, figures, and listings 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
Baseline and Demographic Characteristics			
1.1 Disposition			
1.1.1	Analysis Populations	FAS	X
1.1.2	Summary of Participant Disposition	FAS	X
1.1.3	Summary of Number of Participants Enrolled by Country and Site	FAS	X
1.1.4	Summary of Protocol Deviations	FAS	X
1.2 Demography and Baseline Characteristics			
1.2.1	Summary of Demographics and Baseline Characteristics	FAS	X
1.3 Baseline Disease Characteristics			
1.3.1.1	Summary of Myelodysplastic Syndromes History	MDS Only FAS	
1.3.1.2	Summary of Myelodysplastic Syndrome/Myeloproliferative Neoplasm History	MDS/MPN FAS	
1.4 Prior Medication and Concomitant Medication			
1.4.1	Summary of Prior Medications	FAS	X
1.4.2	Summary of Concomitant Medications	FAS	X
1.4.3	Summary of Prior Systemic Cancer Therapy by WHO Drug Class and Preferred Term	FAS	X
1.4.4	Summary of Prior Antianemic Treatment by WHO Drug Class and Preferred Term	FAS	X
1.5 General Medical History			
1.5.1	Summary of General Medical History	FAS	X
Efficacy			
2.2 Secondary Efficacy			
2.2.1.1	Summary of Anemia Response Through Week 24	FAS	
2.2.2.1	Summary of the Largest Increase From Baseline in Mean Hemoglobin Values Over Any Rolling 8-Week Treatment Period During the First 24 Weeks of Treatment	FAS	
2.2.2.2	Rate of Packed Red Blood Cell Transfusion Through Weeks 12 and 24	FAS	
2.2.3.1	Overall Response Rate for Participants With Myelodysplastic Syndromes	MDS Only FAS	
2.2.3.2	Summary of Progression-Free Survival for Participants With Myelodysplastic Syndromes	MDS Only FAS	
2.2.3.3	Summary of Leukemia-Free Survival for Participants With Myelodysplastic Syndromes and Myelodysplastic Syndromes/Myeloproliferative Neoplasms	FAS	

Table No.	Title	Population	Standard
2.2.4.1	Overall Response Rate for Participants With Myelodysplastic Syndromes/Myeloproliferative Neoplasms	MDS/MPN FAS	
Safety			
3.1 Dose Exposure			
3.1.1	Summary of Exposure and Duration of Exposure to INCB000928	FAS	X
3.1.3	Summary of Study Drug Compliance	FAS	X
3.2 Adverse Events			
3.2.1	Overall Summary of Treatment-Emergent Adverse Events	FAS	X
3.2.2	Summary of Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	FAS	X
3.2.3	Summary of Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	FAS	X
3.2.6	Summary of Grade 3 or Higher Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	FAS	X
3.2.7	Summary of Grade 3 or Higher Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	FAS	X
3.2.8	Summary of Serious Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	FAS	X
3.2.9	Summary of Serious Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	FAS	X
3.2.10	Summary of INCB000928 Treatment-Related Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	FAS	X
3.2.11	Summary of INCB000928 Treatment-Related Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	FAS	X
3.2.14	Summary of Grade 3 or Higher INCB000928 Treatment-Related Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	FAS	X
3.2.15	Summary of INCB000928 Treatment-Related Serious Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	FAS	X
3.2.16	Summary of Treatment-Emergent Adverse Events With a Fatal Outcome by MedDRA System Organ Class and Preferred Term	FAS	X
3.2.18	Summary of Treatment-Emergent Adverse Events Leading to INCB000928 Dose Reduction by MedDRA System Organ Class and Preferred Term	FAS	X
3.2.19	Summary of Treatment-Emergent Adverse Events Leading to INCB000928 Dose Interruption by MedDRA System Organ Class and Preferred Term	FAS	X
3.2.20	Summary of Treatment-Emergent Adverse Events Leading to Discontinuation of INCB000928 by MedDRA System Organ Class and Preferred Term	FAS	X
3.2.24	Summary of Dose-Limiting Toxicities	DLT Evaluable	
3.2.25	Summary of Tolerability	FAS	
3.3 Laboratory			
3.3.1.1	Summary of Laboratory Values - Hematology	FAS	X
3.3.1.2	Summary of Laboratory Values - Chemistry	FAS	X
3.3.1.3	Summary of Laboratory Values - Coagulation	FAS	X

Table No.	Title	Population	Standard
3.3.3.1	Shift Summary of Hematology Laboratory Values in CTCAE Grade - to the Worst Abnormal Value	FAS	X
3.3.3.2	Shift Summary of Chemistry Laboratory Values in CTCAE Grade - to the Worst Abnormal Value	FAS	X
3.3.3.3	Shift Summary of Coagulation Laboratory Values in CTCAE Grade - to the Worst Abnormal Value	FAS	X
3.3.4	Summary of Ferritin Values up to Cycle 7 Day 1	FAS	X
3.4 Vital Signs			
3.4.1	Summary of Systolic Blood Pressure	FAS	X
3.4.2	Summary of Diastolic Blood Pressure	FAS	X
3.4.3	Summary of Pulse	FAS	X
3.4.4	Summary of Respiratory Rate	FAS	X
3.4.5	Summary of Body Temperature	FAS	X
3.4.6	Summary of Weight	FAS	X
3.5 ECG			
3.5.1	Summary of PR Interval (ms) From 12-Lead ECG	FAS	X
3.5.2	Summary of QRS Interval (ms) From 12-Lead ECG	FAS	X
3.5.3	Summary of QT Interval (ms) From 12-Lead ECG	FAS	X
3.5.4	Summary of QTcB Interval (ms) From 12-Lead ECG	FAS	X
3.5.5	Summary of QTcF Interval (ms) From 12-Lead ECG	FAS	X
3.5.6	Summary of RR Interval (ms) From 12-Lead ECG	FAS	X
3.5.7	Summary of Heart Rate (bpm) From 12-Lead ECG	FAS	X
3.5.8	Summary of Outliers of QT, QTcB, and QTcF Interval Values (ms) From 12-Lead ECG	FAS	X
3.5.9	Summary of Clinically Significant ECG Abnormality	FAS	X

Figures

Figure No.	Title
4.6 Laboratory Data	
4.6.1	Line Graph of Selected Laboratory Values (Hemoglobin, Iron Metabolism, Erythropoiesis) by Study Visit

Listings

Listing No.	Title
2.1 Discontinued Participants (Participant Disposition)	
2.1.1	Participant Enrollment and Disposition Status
2.1.3	Participant Inclusion and Exclusion Criteria Violations
2.2 Protocol Deviations	
2.2.1	Protocol Deviations
2.3 Data Excluded From PK, Efficacy, and/or Safety Analyses	
2.3.1	Analysis Population

Listing No.	Title
2.4 Demographic and Baseline Characteristics (Including Prior and Concomitant Medications)	
2.4.1	Demographic and Baseline Characteristics
2.4.2.1	Myelodysplastic Syndromes History
2.4.2.2	Myelodysplastic Syndromes/Myeloproliferative Neoplasms History
2.4.3	Medical History
2.4.4	Prior and Concomitant Medication
2.4.5	Prior Radiation Treatment
2.4.6	Prior Systemic Therapy
2.4.7	Prior Antianemic Treatment
2.4.8	Prior Surgery or Surgical Procedure
2.5 Drug Compliance	
2.5.1	Study Drug Compliance
2.5.2	Study Drug Administration
2.6 Efficacy (and/or PK Data)	
2.6.1	Deaths
2.6.2	RBC/Platelet Transfusion
2.6.3	Response Assessment for Participants With Myelodysplastic Syndromes
2.6.4	Response Assessment for Participants With Myelodysplastic Syndromes/Myeloproliferative Neoplasms
2.6.5	Derived Time to Anemia Response for Participants With Myelodysplastic Syndromes
2.6.6	Leukemia Transformation
2.6.7	ECOG Status
2.7 Adverse Events	
2.7.1	Adverse Events
2.7.2	Serious Adverse Events
2.7.3	Grade 3 and Higher Adverse Events
2.7.4	Fatal Adverse Events
2.7.7	Adverse Events Leading to Interruption, Reduction, or Discontinuation of INCB000928
2.7.9	Treatment-Related Adverse Events
2.7.10	Dose-Limiting Toxicities
2.8.1 Laboratory Data	
2.8.1.1	Clinical Laboratory Values - Hematology
2.8.1.1.1	Abnormal Clinical Laboratory Values - Hematology
2.8.1.2	Clinical Laboratory Values - Chemistry
2.8.1.2.1	Abnormal Clinical Laboratory Values - Chemistry
2.8.1.4	Clinical Laboratory Values - Coagulation
2.8.1.4.1	Abnormal Laboratory Values - Coagulation
2.8.1.5	Hy's Law Events
2.8.1.6	Ferritin Values up to Cycle 7 Day 1
2.8.2 Vital Signs	
2.8.2.1	Vital Signs
2.8.2.2	Abnormal Vital Sign Values
2.8.2.3	Alert Vital Sign Values

Listing No.	Title
2.8.3 ECG	
2.8.3.1	12-Lead ECG Values
2.8.3.2	Abnormal 12-Lead ECG Values
2.8.3.3	Alert 12-Lead ECG Values
2.11 Physical Examination	
2.11.1	Physical Examinations