Statistical Analysis Plan

Title: Statistical Analysis Plan for Protocol SL03-OHD-104: An Open-Label Phase 1A/1B Dose Escalation and Expansion Cohort Study of SL-172154 (SIRPα-Fc-CD40L) in Combination with Azacitidine or With Azacitidine and Venetoclax for the Treatment of Subjects with Higher Risk Myelodysplastic Syndrome (MDS) or Acute Myeloid Leukemia (AML)

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LIST OF ABBREVIATIONS

ADA	Anti-drug antibodies
AE	Adverse event
ALT	Alanine aminotransferase
AML	Acute myeloid leukemia
APTT	Activated partial thromboplastin time
ARC	Agonist redirected checkpoint
AST	Aspartate aminotransferase
AUC	Area under the serum concentration time curve
$AUC_{0\text{-last}}$	Area under the serum concentration time curve, time 0 to the last quantifiable concentration
$AUC_{0\text{-inf}}$	Area under the serum concentration time curve from time 0 extrapolated to infinity
$AUC_{0\text{-t}}$	Area under the serum concentration time curve, time 0 to time = t
$\%AUC_{ext}$	Percentage of AUC0-inf due to extrapolation from Tlast to infinity
AUCtau	The area under the serum concentration time curve, over the dosing interval
CBC	Complete blood count
C1D1	Cycle 1, day 1
CL	Clearance
cm	Centimeters
Cmax	Maximum observed concentration
Cmin	Minimum observed concentration
CR	Complete remission
CRi	Complete remission with incomplete hematologic recovery
CR_{MRD-}	Complete remission without minimal residual disease
CrCl	Creatinine clearance
CRF	Case report form
CRS	Cytokine release syndrome
CTCAE	Common terminology criteria for adverse event
DAT	Direct antiglobulin test
DC	Dendritic cells
DLT(s)	Dose-limiting toxicity(ies)
DOR	Duration of response
ECG	Electrocardiogram
ECHO	Echocardiogram
ECOG	Eastern Cooperative Oncology Group
eCRF	Electronic Case Report Form
EFS	Event free survival
EOI	End of infusion
FDA	Food and Drug Administration
FSH	Follicle stimulating hormone
GCP	Good Clinical Practice
Hgb	Hemoglobin
hr (time)	Hour(s)
HR	Heart rate
ICF	Informed consent
ICH	International Conference of Harmonisation
INR	International normalized ratio
IP	Investigational product
irAE	Immune-related adverse event
IRB	Institutional Review Board
IRR(s)	Infusion-related reaction(s)

IV (i.v.)	Intravenous
Kg	Kilogram
LLN	Lower limit of normal
LVEF	Left ventricular ejection fraction
MAD	Maximum administered dose
MDS	Myelodysplastic syndrome
mg	Milligrams
mg/dL	Milligrams per deciliter
mg/kg	Milligrams per kilogram
Min	Minutes
mL	milliliter
MLFS	Morphologic leukemia-free state
mm	millimeter
MRD	Minimal residual disease
MTD	Maximum tolerated dose
mTPI-2	Modified toxicity probability interval 2
NCI	National Cancer Institute
ng	Nanogram
NK	Natural killer
ORR	Objective response rate
PBMC	Peripheral blood mononuclear cells
PD	Progressive Disease
PFS	Progression free survival
PK	Pharmacokinetic
PK/PD	Pharmacokinetic/pharmacodynamic
PR	Partial remission
PT	Prothrombin time
QTc	Corrected QT interval
RBC	Red blood cell
RP2D	Recommended phase 2 dose
RR	Respiratory rate
SAE	Serious Adverse Event
SAP	Statistical analysis plan
SD	Stable disease
SL-172154	SIRPα-Fc-CD40L agonist redirected checkpoint
T4	Thyroxine 4
t½	terminal elimination half-life
T_{last}	Time of last observed quantifiable concentration
TLS	Tumor lysis syndrome
T_{max}	Time of maximum observed concentration
TME	Tumor microenvironment
TNF-α	Tumor necrosis factor alpha
TSH	Thyroid stimulating hormone
µg	Microgram
ULN	Upper limit of normal
Vz	Volume of distribution
WBC	White blood cell
Wk	Week
λz	Terminal elimination rate constant
~	Approximately

1. INTRODUCTION

This statistical analysis plan outlines the planned analyses for Protocol SL03-OHD-104: An Open-Label Phase 1A/1B Dose Escalation and Expansion Cohort Study of SL-172154 (SIRPα-Fc-CD40L) in Combination with Azacitidine or with Azacitidine and Venetoclax for the Treatment of Subjects with Higher Risk Myelodysplastic Syndrome (MDS) or Acute Myeloid Leukemia (AML):

Protocol Version	Approval date
Version v0.0	24September2021
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The purpose of this amendment is to update the analysis plan to provide select data outputs for study report due to earlier termination of the study. All decisions regarding the data analysis, as defined in this document, have been made prior to Database Freeze of the study data. Any deviations from these guidelines will be documented in the clinical study report.

2. STUDY OBJECTIVES AND OUTCOME MEASURES

Primary Objectives	Outcome Measures
To evaluate the safety and tolerability of SL-172154 administered alone or with azacitidine OR azacitidine + venetoclax in subjects with higher-risk MDS or AML	• Incidence and severity of adverse events (AE) per National Cancer Institute Common Terminology Criteria for Adverse Events (NCI-CTCAE), version 5.0 • Change from baseline in safety laboratory values per NCI-CTCAE, version 5.0 • AEs leading to treatment discontinuation, AEs leading to dose reduction of SL-172154 • Maximum tolerated dose (MTD) of SL-172154 in monotherapy and each combination regimen based on the rate of DLTs, or the Maximum Administered Dose (MAD; the highest dose administered).
To select the recommended Phase 2 dose (RP2D) for SL-172154 administered with azacitidine OR azacitidine + venetoclax in subjects with higher-risk MDS or AML	• Number and occurrence of DLTs as defined in the protocol • Available pharmacokinetic (PK) parameters • Available pharmacodynamic (PD) effects • Safety • Anti-tumor activity

Part D: • To evaluate safety and anti-tumor activity of SL-172154 at 1.0 mg/kg and 3.0 mg/kg administered with azacitidine vs azacitidine monotherapy in higher-risk MDS subjects • To evaluate safety and anti-tumor activity of SL-172154 at 1.0 mg/kg vs 3.0 mg/kg administered with azacitidine in higher-risk MDS subjects	• Safety endpoints as listed above • Complete remission (CR) based on Investigator assessed disease response according to International Working Group (IWG) 2006 criteria
Part E: • To evaluate safety of SL-172154 at 3.0 mg/kg administered with azacitidine vs Investigator's Choice therapy in subjects with TP53m-AML • To evaluate overall survival of SL-172154 at 3.0 mg/kg administered with azacitidine vs Investigator's Choice therapy in subjects with TP53m-AML	• Safety endpoints as listed above • Overall survival (OS)
Secondary Objectives	**Outcome Measures**
To assess preliminary evidence of anti-tumor activity of SL-172154 administered alone or with azacitidine OR azacitidine + venetoclax in subjects with higher-risk MDS or AML Part D: To assess preliminary evidence of anti-tumor activity of SL-172154 administered with azacitidine compared to azacitidine monotherapy in subjects with higher-risk MDS Part E: To assess preliminary evidence of anti-tumor activity of 3.0 mg/kg SL--172154 administered with azacitidine vs Investigator's Choice therapy in subjects with TP53m-AML	• Investigator assessed disease response according to International Working Group (IWG) 2006 criteria (MDS) [Cheson, 2006] or European Leukemia Net (ELN) 2017 criteria (AML) [Döhner, 2017] ○ Complete remission (CR) ○ Objective response rate (ORR) defined as CR, partial remission (PR), marrow CR, or hematologic improvement (HI) for MDS, or CR, CR with incomplete hematologic improvement (CRi), PR, or MLFS for AML ○ Composite CR rate (CR and CRi) for AML ○ CR/CR with partial hematological recovery (CRh) for AML • Time to response • Duration of response (DOR) • Progression free survival (PFS) • Event free survival (EFS) • Overall Survival (OS) • Minimal residual disease (MRD)-negative response rate • Proportion of subjects with MDS with hematologic improvement

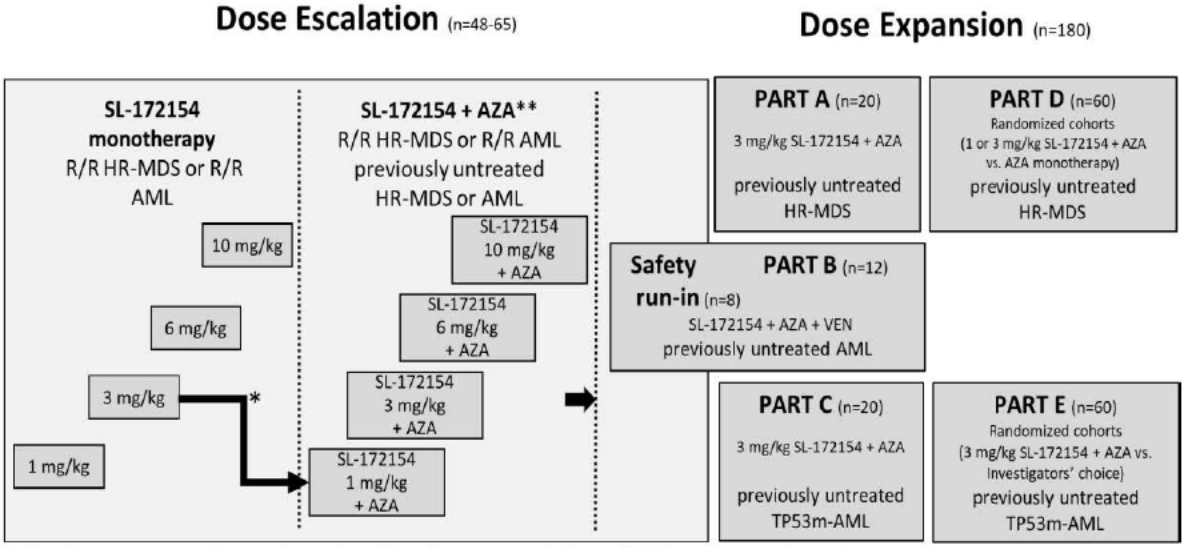
To evaluate immunogenicity to SL-172154 during and after treatment of SL-172154 administered alone or with azacitidine OR azacitidine + venetoclax in subjects with higher-risk MDS or AML	• Number/proportion of subjects with positive or negative anti-drug antibody (ADA) titer • ADA duration • Transient vs. persistent ADA
To assess the pharmacokinetic profile of SL-172154 when administered alone or with azacitidine OR azacitidine + venetoclax in subjects with higher-risk MDS or AML	• Maximum observed concentration (Cmax), time at which the maximum concentration is observed (Tmax), and minimum observed concentration (Cmin) following single and multiple doses of SL-172154 • Area under the serum concentration-time curve (AUC) • Terminal elimination half-life (t½), Clearance (CL) and Volume of Distribution (Vz), as data permit
Exploratory Objectives	**Outcome Measures**
To assess the rate and duration of RBC and platelet transfusion independence in subjects with higher-risk MDS or AML receiving SL-172154 alone or with azacitidine OR azacitidine + venetoclax Part D: To assess the rate and duration of RBC and platelet transfusion independence in subjects with higher-risk MDS administered SL-172154 with azacitidine compared to azacitidine monotherapy Part E: To assess the rate and duration of RBC and platelet transfusion independence in subjects with TP53m-AML administered SL-172154 with azacitidine vs Investigator's Choice therapy	• Proportion of subjects who have a 56-day or longer period with no RBC transfusions • Duration of RBC transfusion independence • Proportion of subjects who have a 56-day or longer period with no platelet transfusions • Duration of platelet transfusion independence
To assess MRD in subjects with higher-risk MDS or AML receiving SL-172154 alone or with azacitidine OR azacitidine + venetoclax Part D: To assess MRD in subjects with higher-risk MDS administered SL-172154 with azacitidine compared to azacitidine monotherapy	• MRD assessed in bone marrow aspirate by next-generation sequencing (NGS) and/or flow cytometry

Part E: To assess MRD in subjects with TP53m-AML administered SL-172154 with azacitidine vs Investigator's Choice therapy	
To assess pharmacodynamic biomarkers in peripheral blood and bone marrow aspirate prior to, on-treatment and following treatment with SL-172154 administered alone or with azacitidine OR azacitidine + venetoclax in subjects with higher-risk MDS or AML	Pharmacodynamic biomarkers in peripheral blood and bone marrow aspirate may include: • Changes in T cells subsets, B cells, macrophages and DCs • Evidence of SL-172154 localization (CD47 or CD40 receptor occupancy) on hematopoietic cells and/or leukemic cells in the bone marrow and peripheral blood

3. STUDY DESIGN

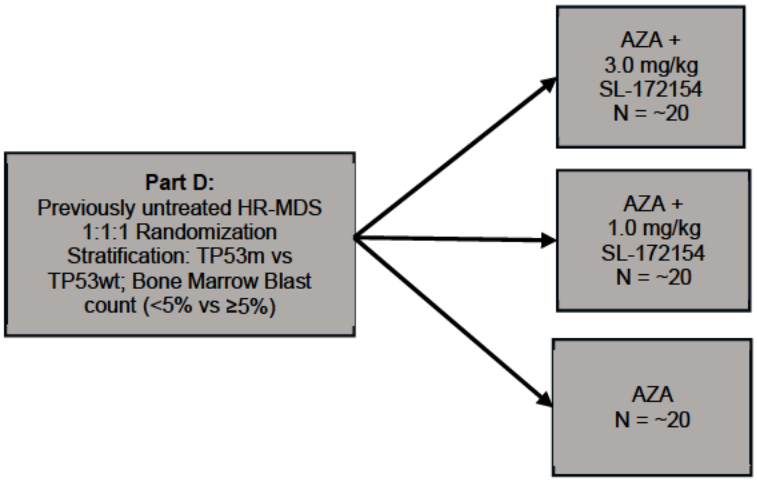
SL03-OHD-104 is an open label, multicenter, Phase 1A/1B trial in subjects with higher risk (i.e., intermediate, high or very high risk by IPSS-R) MDS or AML as depicted in the study schema 1-3. Dose expansion Parts B and Part E were not implemented and therefore, no corresponding analyses will be provided in the study report.

STUDY SCHEMA 1



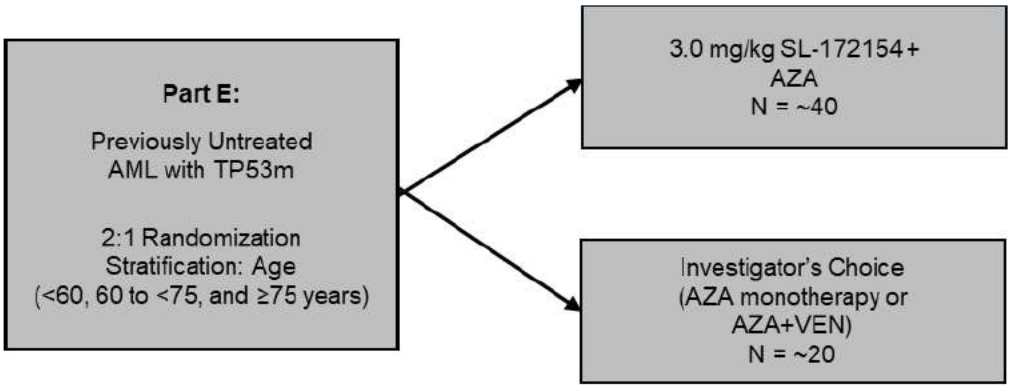
*When the SL-172154 monotherapy cohort is cleared for safety in Dose Level 2 (3.0 mg/kg), the combination dose escalation cohort (1.0 mg/kg of SL-172154 with azacitidine) will open and can enroll subjects in parallel.
**To escalate the dose of SL-172154 in combination with azacitidine, the monotherapy dose level for SL-172154 should have been cleared for safety.
AZA: VEN: HR-MDS: higher-risk MDS, defined as MDS with intermediate, high or very high-risk category by Revised International Prognostic Scoring System. TP53m includes disease with tumor protein (TP) 53 gene mutation/deletion

STUDY SCHEMA 2



Abbreviations: HR-MDS = higher-risk myelodysplastic syndrome; AZA = azacitidine; TP53m includes disease with tumor protein (TP) 53 gene mutation/deletion; TP53wt=Wild-type tumor protein (TP) 53.

STUDY SCHEMA 3



Abbreviations: AZA = azacitidine; TP53m-AML = AML with tumor protein (TP) 53 gene mutation or deletion; VEN = venetoclax

3.1 Study Design

The study is designed to evaluate the safety, PK, pharmacodynamic effects, and preliminary anti-tumor activity of SL-172154 monotherapy and SL-1712154 administered with either azacitidine or azacitidine and venetoclax. Throughout the treatment period (monotherapy as well as combination regimens) for all subjects, an ongoing review of available safety data will be undertaken by a Safety Monitoring Committee (SMC). Subjects will receive SL-172154 as monotherapy or administered with azacitidine with or without venetoclax until documented disease progression, unacceptable toxicity or intolerance, withdrawal of consent, or the subject meets other criteria for discontinuation (whichever occurs first). SL-172154 will be administered

once weekly during Cycles 1 and 2 and biweekly during Cycle 3 and thereafter, in 28-day cycles. For all subjects in all cohorts, prophylactic premedication for IRR with dexamethasone, an antipyretic and antihistamines should be administered at least 30 minutes prior to each SL-172154 administration.

The study will initially enroll subjects with relapsed or refractory disease (MDS or AML) to SL-172154 monotherapy dose escalation cohort. In the initial monotherapy cohort, SL-172154 (1.0 mg/kg, IV) will be administered once weekly and assessed for dose limiting toxicity (DLT). Subjects will be enrolled into sequential cohorts of approximately 5 subjects and evaluated for DLT during the 28-day DLT evaluation. The planned dose escalation of SL-172154 is outlined in Table 1. Treatment will be administered in 28-day cycles until at least one of the study treatment discontinuation criteria is met.

Upon completing the DLT evaluation period of the 3.0 mg/kg SL-172154 cohort in monotherapy dose escalation and the decision to escalate to the next dose level is confirmed, enrollment may begin in parallel to the dose escalation cohort investigating SL-172154 administered with azacitidine using a starting dose of 1.0 mg/kg SL-172154. Subjects with relapsed/refractory AML or higher-risk MDS will be enrolled in this dose escalation cohort; previously untreated subjects with AML and known adverse cytogenetics (e.g., ELN adverse risk group) as well as previously untreated subjects with MDS with at least one TP53 gene deletion/mutation may also be considered for enrollment in this cohort. Subjects will be enrolled into sequential cohorts of approximately 5 subjects in SL-172154 and azacitidine (Table 2) and evaluated for DLT during the 28-day DLT evaluation period. Azacitidine (IV or SQ) will be administered at the standard dose and schedule. Dose escalation of SL-172154 administered with azacitidine will continue until a dose of SL-172154 is identified for the combination.

Once the selected dose of SL-172154 administered with azacitidine is identified in dose escalation, enrollment to a safety run-in cohort (n=8) of SL-172154 administered with azacitidine and venetoclax will commence using the same SL-172154 dose. Treatment-naïve subjects with AML will be enrolled.

The following cohorts will utilize the modified Toxicity Probability Interval (mTPI-2) design [Guo, 2017] with target DLT rate of 20% for the maximum tolerated dose (MTD): (1) SL-172154 monotherapy dose escalation, (2) SL-172154 and azacitidine dose escalation cohort, and (3) SL-172154, azacitidine and venetoclax safety run-in cohort. The dose escalation decision rules based on the mTPI-2 model are outlined in Section 3.2.1. In selecting the dose of SL-172154 for the combination regimen(s) to be evaluated in the expansion cohorts, the totality of the data from the dose escalation phase including the safety of the combination and pharmacodynamic activity will be taken into account.

Upon identification of a selected dose for the SL-172154 and AZA combination regimen, a dose expansion cohort will enroll additional subjects to further evaluate the safety and efficacy of the combination regimen. In the dose expansion part of the study, approximately 20 treatment naïve subjects with higher-risk MDS will be enrolled to receive SL-172154 at the selected dose with AZA (Part A) and will include subjects with wild-type TP53 and TP53 gene mutation/deletion. In addition, approximately 20 treatment naïve AML subjects with a known TP53 gene

mutation/deletion will be enrolled to receive SL-172154 at the selected dose with AZA (Part C). Safety and efficacy of SL-1721514 in combination with AZA will be further evaluated and compared to standard therapy in treatment-naïve high-risk MDS and TP53m AML subjects (Part D and Part E). In Part D, approximately 60 treatment-naïve subjects with higher-risk MDS will be randomized to three arms (approximately 20 subjects per arm). The three arms consist of two experimental arms at two dose levels of SL-172154 (1.0 mg/kg and 3.0 mg/kg) in combination with AZA, and one control arm for AZA monotherapy. In Part E, approximately 60 subjects with previously untreated TP53m-AML will be randomized 2:1 into two arms: 40 subjects to 3.0 mg/kg SL-172154 + AZA and 20 subjects to Investigator's Choice therapy.

Once the SL-172154 dose in combination with azacitidine and venetoclax is confirmed during the safety run-in, approximately 12 additional treatment naïve subjects with AML will be enrolled to dose expansion (Part B) to have approximately 20 subjects receive SL-172154 with azacitidine and venetoclax.

3.1.1 SL-172154 Monotherapy dose escalation

Subjects with AML or higher-risk MDS being treated in the relapsed/refractory setting will be enrolled in this cohort. Subjects will be enrolled in cohorts of approximately 5 subjects into sequential dose levels of SL-172154 and assessed for DLT during the first cycle (28 days) of treatment. The planned doses and duration of infusion of SL-172154 is outlined in Table 1. Premedication as prophylaxis for IRR with antipyretic and antihistamines should be administered at least 30 minutes prior to each SL-172154 administration. At each dose level, a minimum 3-day stagger between dosing the first and second subject is required. Doses explored in SL03-OHD-104 will not exceed the highest dose cleared for safety in SL03-OHD-101. Treatment will be administered in 28-day cycles until at least one of the study treatment discontinuation criteria is met.

Table 1 SL-172154 Dosing

Dose Level (DL)	IV Dose of SL-172154 (mg/kg) [a,b]	Duration of Infusion
DL -1[c]	0.3	30 minutes (+/- 10 minutes)
DL 1 (starting dose)	1.0	60 minutes (+/- 10 minutes)
DL 2	3.0	180 minutes (+/- 15 minutes)
DL 3	6.0	180 minutes (+/- 15 minutes)
DL 4	10	180 minutes (+/- 15 minutes)

a. SL-172154 will be administered once weekly on days 1, 8, 15, and 22 of each 28-day cycle.
b. The actual body weight in kilograms (kg) will be used for dose calculation in all subjects who body weight is ≤100 kg. For subjects with body weight >100 kg, the dose to be administered should be the same as that calculated for a subject weighing 100 kg.
c. Dose level -1 at 0.3 mg/kg will be evaluated if 1.0 mg/kg is not safe per mTPI-2.

3.1.2 Dose Escalation in Combination Treatment

SL-172154 administered with azacitidine (dose escalation)

Upon completing the DLT evaluation period of the SL-172154 3.0 mg/kg cohort in monotherapy dose escalation, enrollment may begin in the dose escalation cohorts investigating SL-172154 administered with azacitidine. The starting dose of SL-172154 will be 1.0 mg/kg and will be administered once weekly by IV infusion on Days 2, 9, 16 and 23 in 28-day cycles. The planned doses and duration of infusion of SL-172154 is outlined in Table 1. The planned dose escalation of SL-172154 is outlined in Table 2. Premedication as prophylaxis for IRR with antipyretic and antihistamines should be administered at least 30 minutes prior to each SL-172154 administration. Doses explored in SL03-OHD-104 will not exceed the highest dose cleared for safety in SL03-OHD-101. Subjects will be enrolled in cohorts of approximately 5 subjects into sequential dose levels of SL-172154 administered with azacitidine (75mg/m^2, IV or SQ on Days 1-7 or alternative 5-2-2 schedule) and evaluated for dose limiting toxicity (DLT) during the 28-day DLT evaluation period starting from the first dose of azacitidine. Treatment will be administered in 28-day cycles until at least one of the study treatment discontinuation criteria is met.

The safety as well as available PK, PD and efficacy data from these subjects will inform the selected dose of SL-172154 to be further evaluated in Dose Expansion when administered in combination with azacitidine to either treatment-naïve subjects with higher-risk MDS (Part A) or treatment-naïve AML subjects with at least one known TP53 gene deletion or mutation (Part C).

Table 2 SL-172154 Administered with Azacitadine

Dose Level (DL)	SL-172154 Dose[a,b] [D2, 9, 16, 23 in each 28d cycle]	Combination Regimen
DL -1a[c]	0.3 mg/kg	Azacitidine (75mg/m^2) SC or IV on days 1-7 or use 5-2-2 schedule in each 28-day cycle. On days when both are administered, azacitidine administration should be completed at least 30 minutes prior to the start of the SL-172154 infusion.
DL 1a	1.0 mg/kg	
DL 2a	3.0 mg/kg	
DL 3a	6.0 mg/kg	
DL 4a	10 mg/kg	

a. SL-172154 will be administered once weekly on days 2, 9, 16, and 23 of each 28-day cycle; administer 30 min +/- 10 min for doses ≤ 1mg/kg or 60 min +/- 15 min for doses ≥ 3mg/kg.
b. The actual body weight in kilograms (kg) will be used for dose calculation in all subjects who body weight is ≤100 kg. For subjects with body weight >100 kg, the dose to be administered should be the same as that calculated for a subject weighing 100 kg.
c. Dose level -1a at 0.3 mg/kg will be evaluated if 1.0 mg/kg is not safe per mTPI-2.

SL-172154 administered with azacitidine and venetoclax (safety run-in)

Once the selected dose of SL-172154 administered with azacitidine is identified in dose escalation, enrollment to a safety run-in cohort of SL-172154 administered with azacitidine and venetoclax

will commence using the same SL-172154 dose. Treatment-naïve subjects with AML will be enrolled.

SL-172154 will be administered once weekly by IV infusion on Days 2, 9, 16 and 23 in 28-day cycles. Premedication as prophylaxis for IRR with antipyretic and antihistamines should be administered at least 30 minutes prior to each SL-172154 administration. Azacitidine (75mg/m^2, IV or SQ on Days 1-7 or alternative 5-2-2 schedule) and venetoclax (target dose of 400mg, oral, once daily) will be administered at their standard dose and schedule in 28-day cycles. A ramp up schedule for venetoclax will be used with 100mg (day 1), 200mg (day 2), 400mg (day 3), and 400mg once daily thereafter. All subjects will undergo bone marrow evaluation at Cycle 1 Day 22 (±2 days) and at Cycle 2 Day 22 (±4 days) to evaluate bone marrow blasts SL-172154 dosing should continue until the bone marrow results become available.

- If bone marrow blasts are <5 %, venetoclax will be withheld until absolute neutrophil count (ANC) ≥ 0.5 x 109/L (preferably ≥ 1.0 x 109/L) and platelet count ≥ 50 × 109/L for 14 days. When counts have recovered to ANC ≥ 0.5 x 109/L (preferably ≥ 1.0 x 109/L) and platelet count ≥ 50 × 109/L, the next cycle of treatment can begin. Venetoclax and AZA will resume on the same day after the interruption. Interruption beyond 14 days from the most recent dose of venetoclax is allowed if medically necessary. Consider repeating bone marrow before starting the next cycle if counts recovery is significantly delayed.

- If bone marrow blasts are ≥5% (persistent AML), continue venetoclax without interruption.

A minimum 7-day delay between dosing the first and second subject is required for the Safety Run-in. Subjects will be enrolled in cohorts of approximately 5 subjects to receive the selected dose level of SL-172154 administered with azacitidine and venetoclax and evaluated for DLT during the 28-day DLT evaluation period starting from the first dose of azacitidine and venetoclax. Approximately eight subjects, in total, will be enrolled at a given dose in the safety run-in cohort evaluating SL-172154 administered with azacitidine and venetoclax prior to moving into the expansion cohort with this combination regimen. Treatment will continue until at least one of the study treatment discontinuation criteria is met.

The safety as well as the available PK, PD and efficacy data from these subjects will inform the dose of SL-172154 selected to be further evaluated in Dose Expansion (Part B) when administered in combination with azacitidine and venetoclax to treatment-naïve subjects with AML.

Table 3 SL-172154 Administered with Azacitidine and Venetoclax

Dose Level (DL)	SL-172154[a,b] [D2, 9, 16, 23 in each 28d cycle]	Combination Regimen
DL -1b[c]	1 dose level lower that was evaluated in the SL-172154 + azacitidine Dose Escalation portion of the study	Azacitidine (75 mg/m^2) SC or IV on days 1-7 or 5-2-2 schedule in each 28-day cycle. On days when both are administered, azacitidine administration should be completed at least 30 minutes prior to the start of the SL-172154 infusion. Venetoclax (target dose 400 mg) PO QD in each 28-day cycle.
DL 1b	Dose selected in combination with azacitidine in Dose Escalation	

a. SL-172154 will be administered once weekly on days 2, 9, 16, and 23 of each 28-day cycle; administer 30 min +/- 10 min for doses ≤ 1mg/kg or 60 min +/- 15 min for doses ≥ 3mg/kg.
b. The actual body weight in kilograms (kg) will be used for dose calculation in all subjects who body weight is ≤100 kg. For subjects with body weight >100 kg, the dose to be administered should be the same as that calculated for a subject weighing 100 kg.
c. Dose level -1 at 0.3 mg/kg will be evaluated if 1.0 mg/kg is not safe per mTPI-2.

3.1.3 Dose Expansion Cohorts

Part A: SL-172154 Administered with Azacitidine in Subjects with Higher-risk MDS

Treatment-naïve subjects with higher-risk (intermediate, high, or very high per IPSS-R) MDS will be enrolled to receive SL-172154 and azacitidine at a dose and schedule identified in the dose escalation part of the study to further evaluate the safety, pharmacodynamic effects, and efficacy of this regimen. Prophylactic premedication for IRR with dexamethasone, antipyretic and antihistamines should be administered at least 30 minutes prior to each SL-172154 administration. The goal is to enroll approximately 20 subjects with MDS at the potential RP2D for this combination regimen, including both dose escalation and expansion. Treatment will be administered in 28-day cycles until at least one of the study treatment discontinuation criteria is met.

Part B: SL-172154 Administered with Azacitidine and Venetoclax in Subjects with AML

Once the SL-172154 dose in combination with azacitidine and venetoclax is confirmed during the safety run-in, approximately 12 additional subjects will be enrolled in the expansion cohort with this triplet combination regimen. Treatment-naïve subjects with AML will be enrolled to receive SL-172154, azacitidine, and venetoclax at a dose and schedule identified in the safety run-in part of the study to further evaluate the safety, pharmacodynamic effects, and efficacy of this regimen. Prophylactic premedication for IRR with dexamethasone, antipyretic and antihistamines should be administered prior to each SL-172154 administration. The goal is to enroll approximately 20 subjects with AML at the potential RP2D for the combination regimen, including both safety run-in and expansion. Treatment will be administered in 28-day cycles until at least one of the study treatment discontinuation criteria is met.

Part C: SL-172154 Administered with Azacitidine in AML Subjects with TP53 gene mutation/deletion

Treatment-naïve subjects with AML who have at least one TP53 mutation or deletion will be enrolled to receive SL-172154 and azacitidine at a dose and schedule identified in the dose escalation part of the study to further evaluate the safety, pharmacodynamic effects, and efficacy of this regimen. Prophylactic premedication for IRR with dexamethasone, antipyretic and antihistamines should be administered at least 30 minutes prior to each SL-172154 administration. The goal is to enroll approximately 10 treatment naïve subjects with TP53 mutant AML at the potential RP2D for the combination regimen in. Treatment will be administered in 28-day cycles until at least one of the study treatment discontinuation criteria is met.

Part D (Randomized Cohorts): SL-172154 with Azacitidine vs Azacitidine monotherapy in HR-MDS Subjects

Approximately 60 previously untreated subjects with higher-risk (intermediate, high, or very high per IPSS-R) MDS will be randomized to three arms (approximately 20 subjects per arm): 3.0 mg/kg of SL-172154 in combination with azacitidine, 1.0 mg/kg of SL-172154 in combination with azacitidine, or azacitidine monotherapy. Subjects will be stratified based on TP53 mutation status (TP53m vs TP53wt) and baseline bone marrow blast count (<5% vs ≥5%). Prophylactic premedication for IRR with dexamethasone, antipyretic and antihistamines should be administered at least 30 minutes prior to each SL-172154 administration. Treatment will be administered in 28-day cycles until at least one of the study treatment discontinuation criteria is met.

Part E (Randomized Cohorts): SL-172154 with Azacitidine vs Investigator's Choice Therapy in TP53m-AML Subjects

Approximately 60 previously untreated subjects with TP53m-AML will be randomized 2:1 into two arms: 40 subjects on 3.0 mg/kg of SL-172154 + azacitidine and 20 subjects on Investigator's Choice therapy. Investigator must select the intended Investigator's Choice therapy regimen prior to randomization. Subjects will be stratified based on age (<60, 60 to <75, and ≥75 years). Prophylactic premedication for IRR with dexamethasone, antipyretic and antihistamines should be administered at least 30 minutes prior to each SL-172154 administration. Treatment will be administered in 28-day cycles until the study treatment discontinuation criteria is met.

All subjects for Part E will undergo bone marrow evaluation at Cycle 1 Day 22 (Window: ±2 days) and at Cycle 2 Day 22 (Window: ±4 days) to evaluate bone marrow blasts. For the subjects who receive venetoclax and AZA in the control arm, the following actions are recommended. Venetoclax dose should continue until the bone marrow results become available.

- If bone marrow blasts are <5 %, venetoclax will be withheld until ANC ≥ 0.5 x 10^9/L (preferably ≥ 1.0 x 10^9/L) and platelet count ≥ 50 × 10^9/L for 14 days. When counts have recovered to ANC ≥ 0.5 x 10^9/L (preferably ≥ 1.0 x 10^9/L) and platelet count ≥ 50 × 10^9/L, the next cycle of treatment can begin. Venetoclax and AZA will resume on the same day after the interruption. Interruption beyond 14 days from the most recent dose of venetoclax is allowed if medically necessary. Consider repeating bone marrow before starting the next cycle if counts recovery is significantly delayed.

• If bone marrow blasts are ≥5% (persistent AML), continue venetoclax without an interruption.

3.1.4 Selection of Recommended Phase 2 Dose

Selection of the recommended Phase 2 dose (RP2D) for SL-172154 in combination with azacitidine or in combination with azacitidine and venetoclax will be based upon the totality of the safety, tolerability, PK, PD, and efficacy data in subjects treated with the respective regimen in dose escalation and dose expansion cohorts. The RP2D is a dose of SL-172154 that can be safely administered with standard of care doses of azacitidine or azacitidine with venetoclax. In addition, preliminary efficacy of the combination regimens will be assessed to determine if the regimen warrants further evaluation in a Phase 2 study.

3.1.5 Evaluation of a Less Frequent Dosing Schedule

If safety and pharmacodynamic data support exploration of a less intensive dosing schedule, then subsequent cohort enrollment on an alternative less frequent schedule may be instituted in lieu of the weekly schedule for SL-172154 dosing. For example, SL-172154 may be administered once every two weeks in every cycle or once every 21 or 28 days. The starting dose on this less intensive schedule would be instituted at the current dose level of the selected schedule that is safe as defined by the mTPI-2 method [Guo, 2017] or a lower dose level based on emerging safety data. Any such evaluation of alternative dosing schedule(s) will be done by protocol amendment.

3.2 Statistical Design

3.2.1 Dose Escalation

The monotherapy and combination dose escalation will utilize a mTPI-2 design [Guo, 2017] with a target DLT rate of 20% for the maximum tolerated dose. For the SL-172154, azacitidine and venetoclax safety run-in, the number of DLTs will be evaluated based on the same mTPI-2 design.

The mTPI-2 design employs a simple Beta-Binomial Bayesian model with decision rules based on the unit probability mass from the posterior probability of DLT rate. With the target DLT rate of 20%, the posterior probability of DLT rate unit interval (0, 1) is divided into subintervals with equal length of 0.1 that correspond to different dose escalation decisions: subinterval of (0.15, 0.25) is to stay at the current dose, subintervals below 0.15 is to escalate to next higher dose, and subintervals above 0.25 is to de-escalate to the next lower dose. Subjects will be enrolled in cohorts of approximately 5 subjects during the dose escalation. After each cohort of approximately 5 subjects, the posterior unit probability for subintervals will be calculated based on a noninformative prior distribution for the DLT rate (Beta (1,1)) and the total number of subjects with DLTs and DLT evaluable subjects for the current dose. A dose escalation/stay/de-escalation decision that corresponds to the subinterval with the highest unit probability mass will be selected. A minimum of 3 DLT evaluable subjects will be enrolled to a dose level and evaluated for DLT before a dose escalation/stay/de-escalation decision can be made unless unacceptable toxicity is observed prior to the enrollment of 3 subjects e.g., two subjects experience DLT before the third subject enrolls. A dose level will be considered unsafe, with unacceptable toxicity and no

additional subjects enrolled at that dose level and above, if it has an estimated 95% or more probability of exceeding the target DLT rate of 20%. The maximum number of subjects evaluated for DLT for each dose level will be 15 subjects (about 3 cohorts of 5 subjects) if the dose escalation decision is to stay at the current dose from the first 2 cohorts. Based on the above design, the dose escalation decision rules for each dose level are:

- Dose escalate if the observed DLT rate <14%;
- Stay at the current dose if the observed DLT rate between 14%-24%;
- Dose de-escalate if the observed DLT rate ≥25%

See Table 4 for dose escalation decision rules based on the total number of subjects evaluable for DLT and the number of subjects with DLT observed. The operating characteristics of the mTPI-2 design based on 10,000 simulations are in Table 5.

Table 4 Dose Escalation Decision Rules for Each Dose Level based on mTPI-2

Number of subjects with DLTs	Number of DLT-Evaluable Subjects												
	3	4	5	6	7	8	9	10	11	12	13	14	15
0	E	E	E	E	E	E	E	E	E	E	E	E	E
1	D	D	S	S	S	E	E	E	E	E	E	E	E
2	DU	D	D	D	D	D	S	S	S	S	S	S	E
3	DU	DU	DU	DU	D	D	D	D	D	D	S	S	S
4	.	DU	DU	DU	DU	DU	DU	D	D	D	D	D	D
5	.	.	DU	DU	DU	DU	DU	DU	DU	DU	DU	D	D
6	.	.	.	DU	DU	DU	DU	DU	DU	DU	DU	DU	DU
7	.	.	.	.	DU	DU	DU	DU	DU	DU	DU	DU	DU
8	.	.	.	.	.	DU	DU	DU	DU	DU	DU	DU	DU
E = escalate to the next higher dose level					S = stay at the current dose level								
D = de-escalate to the next lower dose level					DU = de-escalate to the next lower dose level and current dose level will never be used again due to unacceptable toxicity								

Note: For each dose level, a minimum of 3 evaluable subjects will be enrolled and evaluated before a dose escalation/stay/de-escalation decision can be made unless unacceptable toxicity is observed prior to the enrollment of 3 subjects e.g., 2 subjects experience DLT before the third subject enrolls.

Table 5 Operating Characteristics of mTPI-2 Design Based on 10000 Simulations

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Number of Patients	% Early Stopping
Scenario1							
True DLT rate	0.2	0.35	0.43	0.48	0.54		
Selection %	76.32	12.23	0.96	0.13	0		10.36
# Pts treated	14	5.57	0.65	0.04	0	20.3	
Scenario2							
True DLT rate	0.07	0.2	0.35	0.46	0.57		
Selection %	23.78	59.72	15.07	1.07	0.03		0.33
# Pts treated	10.34	12.19	4.38	0.44	0.01	27.4	
Scenario3							
True DLT rate	0.01	0.04	0.08	0.2	0.35		
Selection %	0.08	2.48	31.41	53.52	12.51		0
# Pts treated	5.36	6.56	8.55	7.34	2.01	29.8	
Scenario4							
True DLT rate	0.05	0.1	0.2	0.4	0.55		
Selection %	4.2	29.52	56.36	9.54	0.26		0.12
# Pts treated	7.18	9.95	8.94	2.6	0.13	28.8	

3.2.1 Dose Expansion

For each Part A, B and C expansion cohort, the goal is to enroll approximately 20 subjects treated at the potential RP2D in either dose expansion or dose escalation. The sample size of 20 is primarily chosen to obtain a preliminary assessment of the antitumor activity with a certain degree of precision. Table 6provides the 90% confidence interval (CI) based on exact probability method for a range of possible responses out of 20 subjects.

Table 6 Response Rate and 90% CI out of 20 Subjects

# Responses / 20 Subjects	Response rate	90% CI
2	10%	1.8%, 28.3%
4	20%	7.1%, 40.1%
6	30%	14.0%, 50.8%
8	40%	21.7%, 60.6%
10	50%	30.2%, 69.8%
12	60%	39.4%, 78.3%
14	70%	49.2%, 86.0%
16	80%	59.9%, 92.9%
18	90%	71.7%, 98.2%

Expansion Part A, B and C cohorts will allow further characterization of the safety profile of SL-172154 in combination with azacitidine or azacitidine and venetoclax, with particular emphasis on

toxicities leading to discontinuation of SL-172154 and the combination agents, serious adverse events (SAEs) and Grade ≥3 AEs. The Safety Monitoring Committee will meet monthly, provided that subjects have been enrolled and data are available, to review and discuss safety data and communicate results of ongoing analyses throughout the conduct of dose expansion. Continuous toxicity monitoring based on the Pocock-type stopping boundary [Ivanova, 2005] will be used for the rate of AEs leading to treatment discontinuation within the expansion cohorts for the SL-172154 and azacitidine combination regimen (Part A or C) or SL-172154, azacitidine and venetoclax combination regimen (Part B). The discontinuation rate owing to AEs with azacitidine and venetoclax or azacitidine was 24% and 20% respectively [DiNardo, 2020a], thus a 20% rate of subjects with AEs leading to treatment discontinuation was selected for the combination regimen. Accrual will be temporarily stopped if an excessive number of subjects who experience AEs leading to SL-172154 and the combination agent(s) discontinuation; that is, if the number of subjects who experience AEs leading to SL-172154 and the combination agent discontinuation is equal to or more than b_n out of n subjects as described in the table below. The sequential stopping boundaries are selected to have at least 70% probability to stop when the true rate of subjects with AEs leading to treatment discontinuation is 30%.

Number of Patients, n	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Boundary, b_n	-	2	2	2	3	3	3	4	4	4	4	5	5	5	5	6	6	6	6	6

For the Part D dose expansion cohort, 60 previously untreated subjects with higher-risk (intermediate, high, or very high per IPSS-R) MDS will be randomized 1:1:1 to three arms: 3.0 mg/kg of SL-172154 in combination with azacitidine (n=20), 1.0 mg/kg of SL-172154 in combination with azacitidine (n=20), or azacitidine monotherapy (n=20). Subjects will be stratified based on TP53 mutation status and baseline bone marrow blast (<5% vs ≥5%) to have similar distribution for these 2 stratification factors across treatment arms. The sample size calculation was performed using nQuery version 9.3.1. A sample size of 20 in each arm provides 71% power to detect difference in CR rate between SL-172154 in combination with azacitidine (either 3.0 mg/kg or 1.0 mg/kg) and azacitidine monotherapy based on the following assumptions:

- CR is 22% for azacitidine monotherapy
- CR rate is 55% for SL-172154 in combination with azacitidine (either SL-172154 3.0 mg/kg or 1.0 mg/kg)
- One-sided type one error is 0.1

For the Part E dose expansion cohort, 60 subjects with previously untreated TP53m-AML will be randomized 2:1 to 3.0 mg/kg of SL-172154 in combination with azacitidine (n=40) vs Investigator's Choice therapy (n=20). The sample size calculation was based on the following assumptions:

- One-sided type one error is 0.05
- Median OS is 7.4 months for Investigator's Choice therapy
- Median OS is 14.8 months for SL-172154 3.0 mg/kg in combination with azacitidine
- Hazard ratio of 0.5

- Enrollment time is 12 months and maximum follow-up time is 30 months

With the above assumptions, a total of 45 death events will provide 70% power to detect statistically significant difference in OS between treatment arms at one-sided alpha level of 0.05. Subjects will be stratified by age group (<60, 60 to <75, and ≥75 years) to have similar distribution of ages between treatment arms. The sample size calculation was performed using nQuery version 9.3.1.

3.3 Sample Size

The planned sample size is approximately 220-237 subjects, depending on the number of dose levels evaluated in dose escalation for each of the regimens. Twenty to 26 subjects will be enrolled in a SL-172154 monotherapy dose escalation cohort. For the SL-172154 and azacitidine combination regimen, approximately 20 to 26 subjects will be enrolled in dose escalation cohorts, approximately 20 subjects will be enrolled in the expansion cohort (Part A) and approximately 10 subjects will be enrolled in the AML TP53 expansion cohort (Part C); for the SL-172154, azacitidine and venetoclax combination regimen, approximately 8-13 subjects will be enrolled in the safety run-in cohort and approximately 12 additional subjects will be enrolled in the expansion cohort (Part B). For Part D, approximately 60 subjects will be enrolled with approximately 20 subjects in each arm. For Part E, approximately 60 subjects will be enrolled with approximately 40 subjects in the SL-172154 3.0 mg/kg + azacitidine arm and approximately 20 subjects in the Investigator's Choice therapy arm (2:1 randomization).

NOTE: The planned sample sizes may be revised if more subjects (i.e., subjects available for dosing beyond the number required in a cohort) are enrolled than anticipated. The actual number of subjects to be enrolled for dose escalation will depend upon the number of dose levels evaluated and the number of DLTs observed for each dose level and related dose escalation/stay/de-escalation decisions. The Sponsor, in consultation with the SMC, may also elect to add subjects to the monotherapy cohort or combination dose escalation cohort if additional data is needed to select the dose level for the dose expansion cohorts.

3.4 Duration of Study Treatment

Subjects will receive the assigned study treatment (e.g., SL-172154 monotherapy or SL-172154 and azacitidine administered with or without venetoclax) until any of the following events occur during the study:

- Documented disease progression
- A subject suffers an AE that, in the judgement of the investigator, sponsor, or medical monitor, presents an unacceptable risk to the subject
- General or specific changes in the subject's condition (e.g., a significant intercurrent illness or complication) that, in the judgement of the investigator, are unacceptable for further administration of study treatment
- Subject decision to withdraw from further treatment on the study
- Subject becomes eligible for and consents to transplant

- Occurrence of pregnancy
- Significant noncompliance with protocol requirements
- The sponsor or legal representative of the sponsor requests the subject to withdraw
- Death
- Termination of the study by the Sponsor

If SL-172154 is permanently discontinued for any reason, the subject should complete the Post Treatment visit (PTV) and continue in the survival follow-up portion of the study. At the Investigator's discretion, the subject may continue to receive approved agents, either azacitidine alone or in combination with venetoclax during the survival follow-up period; in such instances, this therapy will be considered subsequent anticancer therapy in term of data collection on the appropriate electronic case report form (eCRF).

A subject meeting the response criteria of relapsed or progressive disease, or determination of clinical progression is considered a sufficient reason to discontinue study drug treatment. However, if the determination of progression is equivocal, the investigator may continue study drug treatment until it is considered to be no longer beneficial to the subject. The decision to discontinue a subject from the study treatment remains the responsibility of the investigator and should not be delayed or refused by the Sponsor. In the event of study treatment discontinuation, subjects should be strongly encouraged to complete all scheduled assessments at the End of Treatment visit and the Survival Follow-up contacts.

3.5 Duration of Follow-up

Subjects who are withdrawn from study treatment for unacceptable AE(s) should be followed until the event(s) are resolved, the patient is lost to follow-up, the AE is otherwise explained, or further recovery is not deemed to be feasible. Data on these events should be collected on the AE eCRF.

Subjects who permanently discontinue IP for reasons other than progression will continue with disease assessments until progression or the start of another anti-cancer therapy.

Subjects who discontinue IP for any reason other than withdrawal of consent will be followed for survival and will be contacted approximately every 3 months until death or the end of the study, whichever occurs first. During survival follow-up, relevant information regarding subsequent anticancer therapy(ies) for AML or MDS will be collected and entered in the EDC. In addition, for subjects that proceed to hematopoietic cell transplantation (HCT), HCT-relevant information will be collected and entered in the EDC.

3.6 End of Study

The end of study is defined as the point of final data capture (e.g., the point at which all required data has been collected to answer the research questions in the protocol) or date the study is closed by the Sponsor, whichever occurs first.

After the end of study, subjects who are still on study treatment will receive standard of care treatment as determined by their health care provider after completion of the study.

3.7 Study Assessments and Procedures

The detailed study assessments and procedures are described in section 6 of the protocol.

4. ANALYSIS POPULATIONS

The populations defined for analysis will include the following:

- Screened population: all subjects who have signed the main study informed consent.
- Screen failures: all subjects who have signed the main study informed consent but have not received any dose of study treatment.
- All Treated Population: all subjects who have received at least one dose of study treatment. Safety data will be evaluated based on this population.
- DLT Evaluable Population: all treated subjects in the monotherapy or combination dose escalation/safety run-in cohorts who receive at least 2 of 4 scheduled doses of SL-172154 and at least 50% of the scheduled doses of the combination agent (azacitidine or venetoclax) and complete the safety follow-up through the DLT evaluation period or experience any DLT during the DLT evaluation period. DLT evaluable subjects will be used to guide dose escalation and to determine the MTD or maximum administer dose (MAD).
- Response Evaluable Population: subjects in All Treated Population who have baseline disease assessment and at least one post-baseline disease assessment or have progressed or died before the first post-baseline disease assessment. The baseline and post-baseline disease assessments must have adequate specimen for assessment.
- Pharmacokinetic (PK) population: subjects in the All Treated Population for who at least one PK sample is obtained and analyzed for SL-172154 concentration.
- Intent-to-treat (ITT) population for Part D and E cohort of dose expansion: all randomized subjects regardless of whether treatment was administered. This population will be based on the treatment to which the subject was randomized. Any subject who receives a treatment randomization number will be considered to have been randomized.
- Immunogenicity Population is defined as subjects in the All-Treated Population who had at least one ADA sample obtained and analyzed. The Immunogenicity Population was used for the ADA analysis.

5. GENERAL ANALYSIS CONSIDERATIONS

All decisions regarding the data analysis, as defined in this document, have been made prior to Database Freeze of the study data. Any deviations from these guidelines will be documented in the clinical study report. As the study was terminated earlier, a subset of planned tables, listings and figures as specified in Section 12 will be provided for study report.

5.1 Data Analysis during Dose Escalation

During the dose escalation, the number of subjects with DLTs will be summarized by dose level for monotherapy and each combination regimen. The summary of DLTs will be based on the DLT evaluable population. Select AE summary tables and listings may be provided during dose escalation to support dose escalation decisions.

5.2 Reporting Conventions

The statistical analyses will be reported using summary tables, figures, and data listings. The International Conference on Harmonization (ICH) numbering convention will be used for tables, listings, and figures.

Separate summary tables for monotherapy and combination regimens will be provided by dose level and all subjects receiving the same regimen. Subjects at the same dose level from dose escalation and expansion cohorts will also be pooled together for select summary tables. Summary tables by treatment arm will be provided for each randomized cohort (Expansion Part D and E).

Data from all participating sites will be pooled prior to the data analysis. It is anticipated that subject accrual will spread thinly across sites and summaries of data by site would be unlikely to be informative and will therefore, not be provided.

Continuous variables will be summarized with means, standard deviations, medians, minimums, and maximums. The precision of the original measurements will be maintained in the summaries and listings, when possible. Generally, means, medians and standard deviations will be presented with an increasing level of precision. Means and medians will be presented to one more decimal place than the raw data, and the standard deviations will be presented to two more decimal places than the raw data.

Categorical variables will be summarized by counts and percentages of subjects in the corresponding categories. Percentages are routinely based on the total number of the specified population if not otherwise mentioned. For frequency counts, categories whose counts are zero will be displayed for the sake of completeness. For example, if none of the subjects discontinue due to “lost to follow-up,” this reason will be included in the table with a count of 0. Categories with zero counts will not have zero percentages displayed.

All confidence intervals (CIs) will be constructed at the 95% confidence level.

When rounding is required, rounding will be done to the nearest round-off unit. For example, if the round-off unit is the ones place (i.e., integers), values ≥ XX.5 will be rounded up to XX+1 while values < XX.5 will be rounded down to XX.

Individual subject data will be presented by treatment regimen (monotherapy and combination), cohort (dose escalation, dose expansion) and dose level in the data listings. Data from all

assessments, whether scheduled or unscheduled, will be included in the listings. Listings will present the data in their original format (without any imputation).

Summaries by planned time will include data from scheduled assessments and all data will be reported according to the nominal visit date for which it was recorded (i.e., no visit windows will be applied). Unscheduled data, when summarized, will be included only in calculation of the maximum or minimum value over time such as the worst-case post-baseline. If multiple assessments are reported on the same date for the same scheduled planned time, then the worst-case result will be analyzed.

All analyses and tabulations will be performed using SAS® v9.4 or above.

5.3 Data Handling

5.3.1 Premature Withdrawal and Missing Data

Subjects who prematurely withdraw from the study will be included in analyses up to the time of withdrawal, regardless of the duration of treatment and survival follow-up.

Missing data occurs when any requested data is not provided, leading to blank fields on the collection instrument. These data will be indicated using a “blank” in subject data listings. Answers such as “Not applicable”, “Not Done’, “Unknown”, “Not evaluable”, etc. are not considered to be missing data and should be displayed as such.

The length of study treatment for each subject will depend on the safety, tolerability, and efficacy of the treatment, so the duration on treatment will vary across subjects. Subjects with shorter duration on treatment due to the natural history of their disease or medical necessities of treatment of their disease will not be considered to have missing data.

In the event the study is prematurely discontinued, a review will be carried out by the study team to assess which statistical analyses are still considered appropriate.

5.3.2 Baseline and Change from Baseline

Unless otherwise specified, the baseline value is defined as the last value obtained on or before the date and time of the first dose of study treatment on Cycle 1 Day (C1D1). Post-baseline values are defined as value obtained after the first dose of study treatment. Change from baseline is calculated as: (post-baseline value - baseline value). The percent change from baseline is calculated as: (change from baseline/baseline value) *100. If either baseline or post-baseline value is missing, the change from baseline and percent change from baseline is set to be missing as well.

5.3.3 Study Day

The reference date for safety data analyses is the date of the first dose of study treatment.

- **Study Day –** Study Day 1 is defined as the date of the first dose of study treatment; the day before the first dose is defined as Study Day -1. For a given event date, Study Day is calculated relative to the date of first dose of study treatment.

  Study Day = [Event Date – First Dose Date] (in days) + 1 day,
  where the event date is on or after the first dose date.

  Study Day = [Event Date – First Dose Date] (in days),
  where the event date is before the first dose date.

The reference date for efficacy data analyses is the date of the first dose of study treatment for dose escalation and expansion Part A, B and C. For expansion randomized cohort Part D and E, the reference date for efficacy data analysis is the date of the randomization.

5.3.4 Study Day and Duration

Duration is calculated as the number of time units between one date and another later date plus one day.

- **Duration (Days) –** A duration in days is calculated as the number of days between one date (Date1) and another later date (Date2) plus 1 day.

  Duration (days) = [Date2 – Date1] (in days) + 1 day.

- **Duration (Months) –** A duration in months is calculated as the duration in days divided by 365.25/12, rounded to one decimal place.
- **Duration (Years) –** A duration in years is calculated as the duration in days divided by 365.25, rounded to one decimal place.

5.3.5 Imputation of Partial Date

In general, imputed partial dates will not be used to derive study day. Partial dates may be imputed for exploratory analysis. The imputed partial data will be flagged in the dataset to indicate the level of imputation. Imputed dates will not be displayed in the data listings. Values derived using imputed dates will be flagged in the data listing. The following rules will be used to impute partial date:

Dataset	Variable	Rule
Cancer history	Date of initial diagnosis	Impute to derive time since initial diagnosis. If both month and day are missing, impute to January 1st. If the day is missing, impute to first day of the month. Time since initial diagnosis based on imputed date will be flagged in the data listing. Imputed dates for partial date with missing day will be included in the summary analysis of time since initial diagnosis.

6. STUDY POPULATION

Summary tables will be provided for dose escalation and expansion (Part A, B and C), respectively. Summary tables by treatment arm will be provided for each randomized cohort (Expansion Part D and E). Subjects at the same dose level from dose escalation and expansion cohorts will also be pooled together for select summary tables. Unless specified otherwise, the summary tables will be provided for the following groups:

- SL-172154 monotherapy
  - By dose level and all subjects
- SL-172154 in combination with azacitidine in dose escalation and expansion Part A and C
  - Dose escalation, by dose level and all subjects
  - Expansion Part A: HR-MDS
  - Expansion Part C: TP53m AML
  - All subjects receiving 3.0 mg/kg SL-172154 in combination with Azacitidine from dose escalation and expansion Part A and C
  - All subjects receiving SL-172154 in combination with Azacitidine from dose escalation and expansion Part A and C, regardless of dose level
- SL-172154 in combination with azacitidine/venetoclax
  - By cohort (safety run-in, expansion) and all subjects
- Part D randomized cohort for HR-MDS by treatment arm
  - 1.0 mg/kg SL-172154 + azacitidine
  - 3.0 mg/kg SL-172154 + azacitidine
  - Azacitidine monotherapy
- Part E randomized cohort for TP53m AML by treatment arm
  - 3.0 mg/kg SL-172154 + Azacitidine
  - Azacitidine +/- venetoclax, including azacitidine with or without venetoclax
  - Azacitidine + venetocclax
  - Azacitidine monotherapy

6.1 Subject Disposition

Summaries of study population and subject disposition will include the number of subjects in each analysis population, the number of subjects by study completion status, and the primary reason for study completion/discontinuation. The summary will be provided by dose level for SL-172154 monotherapy, SL-172154 in combination with azacitidine and SL-172154 in combination with azacitidine and venetoclax in all screened subjects from dose escalation and expansion Part A, B and C. For randomized Part D and E, summary will be provided by treatment arm for screened subjects. In addition, summary will be provided by treatment regimen for all screened subjects in dose escalation and expansion part A, B and C. Study population and subject disposition information will be presented in a data listing for all treated subjects.

Summary of study treatment status will include the number of subjects by treatment status and the primary reason for treatment discontinuation for SL-172154, azacitidine and venetoclax, respectively. Summary of study treatment status will be based on All Treated Population for dose escalation and expansion Part A, B and C and Intent to Treated Population for randomized cohort

in Part D and E. Subject treatment discontinuation information for SL-172154, azacitidine and venetoclax will be presented in a data listing.

Informed consent and protocol amendment reconsent will be listed for all treated subjects in dose escalation and expansion Part A, B and C and all subjects in Intent to Treated Population for randomized cohort Part D and E.

6.2 Protocol Deviations

Protocol deviations will be summarized for all subjects in each treatment regimen in All Treated Population in dose escalation and expansion Part A, B and C. For randomized cohort in Part D and E, protocol deviations in ITT population will be summarized by treatment arm. The number of subjects for each protocol deviation type and subtype will be summarized for all protocol deviations and major protocol deviations, respectively. Protocol deviations will be tracked by the study team throughout the conduct of the study in accordance with the Protocol Deviation Specification and Data Management Plan. A listing with deviation details will be provided for all protocol deviations.

6.3 Demographic

Demographic variables including age, sex, ethnicity, race, weight, height, and body surface area (m^2) at screening will be summarized. Body surface area will be calculated as the following:

Body surface area (m^2)=SQRT[(height (cm) x weight (kg)/3600]

Descriptive statistics will be presented for age, weight, height, and body surface area. Frequency counts and percentages will be presented for age groups (<18 years, 18 to <65 years, 65 to <75 years and ≥75 years), sex, ethnicity, race, and country (USA, Canada and UK).

Demographic data will be summarized by dose level/regimen for All Treated population in dose escalation and expansion Part A, B and C and by treatment arm for ITT population for Part D and E. Demographics data will be presented in a data listing for All Treated, ITT population (expansion Part D and E) and Screen Failure population, respectively.

6.4 Study Cancer History

Study cancer history will be summarized and listed separately for AML and MDS subjects.

6.4.1 AML

For AML subjects, study cancer history information includes disease status at baseline (previously untreated, relapsed-refractory), AML category (de novo, secondary, other), further categories for secondary AML, 2016 WHO classification, date of the initial diagnosis of AML, time since the initial diagnosis, TP53 mutation status, complex karyotype at baseline and bone marrow blast count category at screening (<30%, 30% to <50%, and ≥50%).

Summary of AML history will be provided by dose level and all subjects for each treatment regimen in dose escalation and expansion Part B and C based on All Treated population and by treatment arm in expansion Part E based on ITT population. For SL-172154 in combination with azacitidine/venetoclax in expansion Part B, the number of reasons for ineligibility to receive intensive therapy (1, 2 or more) will be included in the summary. A separate summary will be provided for all TP53m AML subjects receiving SL-172154 in combination with azacitidine in Part C and Part E.

The AML cancer history information including presence of TP53 mutation or deletion and disease status at baseline will be presented in a data listing.

6.4.1 MDS

For MDS subjects, study cancer history information includes MDS category (de novo, treatment related MDS), 2016 WHO classification, IPSS-R risk category, date of the initial diagnosis of MDS, time since initial diagnosis, bone marrow blast count category at baseline (<5%, 5% to <10%, and 10% to <20%), TP53 mutation status, and complex karyotype at baseline.

Summary will be provided by dose level and all subjects for each treatment regimen in dose escalation and expansion Part A based on All Treated population and by treatment arm in expansion Part D based on ITT population.

The MDS cancer history will be presented in a data listing for MDS subjects. For AML subjects with MDS history, the MDS cancer history will be presented in a separate data listing.

6.5 General Medical and Surgical History

General medical history and surgical history along with start/end date and ongoing status at study entry will be presented in a data listing for AML and MDS subjects separately.

6.6 Prior Anti-Cancer Treatment

Prior anti-cancer treatment for AML and MDS will be summarized and listed separately for AML and MDS subjects. Prior cancer systemic treatment for cancers other than AML and MDS will be listed. Prior study cancer systemic treatment drugs will be coded using the World Health Organization (WHO) Drug Dictionary (WHODrug-Global-B3, Version September 2021).

6.6.1 AML

Prior systemic treatment for AML including the line of therapy number, drug name, start/end date, duration, intent, best response, and date of progression will be presented in a data listing.

Prior HCT for AML including date, intent, type of HCT, stem cell source, donor type and preparative regimen type for allogeneic HCT will be presented in a data listing.

Number of subjects with prior systemic treatment for AML, best response for the front line therapy, time to relapse/progression for the last prior line of systemic treatment, and number of lines for

prior systemic therapy will be summarized by dose level for each treatment regimen in dose escalation based on All Treated population. Prior HCT performed for salvage intent will be counted as one line of prior systemic therapy, however prior HCT performed as consolidation will not be counted as one line of prior systemic therapy.

For prior HCT, number of subjects with prior HCT, any allogeneic HCT, and any autologous HCT and number of HCTs will be summarized by dose level for each treatment regimen in dose escalation based on All Treated population.

Prior anti-cancer surgical treatment for AML including procedure and date of procedure will be presented in a data listing.

Prior radiotherapy for AML including the start/end date and intent of radiotherapy will be presented in a data listing. Radiotherapy used as preparative regimen for HCT (e.g. total-body irradiation) will be included in this listing.

6.6.2 MDS

Prior study cancer systemic treatment for MDS including the line of therapy number, drug name, start/end date, duration, best response, and date of progression will be presented in a data listing.

Prior HCT for MDS including date, intent, type of HCT, stem cell source, donor type and preparative regimen type for allogeneic HCT will be presented in a data listing.

Number of subjects with prior systemic treatment, best response to the front line therapy, and time to relapse/progression for the last prior line of systemic treatment, and number of lines for prior systemic therapy will be summarized by dose level for SL-172154 monotherapy dose escalation cohorts based on All Treated population. Prior HCT performed as salvage intent will be counted as one line of prior systemic therapy.

For prior HCT, number of subjects with prior HCT, any allogeneic HCT, and any autologous HCT and number of HCTs will be summarized by dose level for SL-172154 monotherapy dose escalation cohorts based on All Treated population.

Prior anti-cancer surgical treatment and radiotherapy for MDS will be presented in a data listing. Radiotherapy used as preparative regimen for HCT (e.g. total-body irradiation) will be included in this listing.

6.7 Concomitant Medications and Premedications

Concomitant medications including premedications for IRR prophylaxis prior to SL-172154 administration, premedications for nausea and vomiting with azacitidine administration, and premedications for tumor lysis syndrome with venetoclax administration will be mapped to Anatomical Therapeutic Chemical (ATC) class and Generic Drug Names using the WHO Drug Dictionary (WHODrug-Global-B3, Version September 2021).

Concomitant medications will include medications taken on or after the date of the first dose of study drug. Any medications that are started prior to the date of the first dose but continued beyond the date of first dose will be counted as concomitant medications. Concomitant medications and along with dose, route, start/end date, and indication for each medication will be presented in a data listing. A separate listing will be provided for all premedications for SL-172154 administration.

6.8 Concomitant Procedures

Concomitant procedures include cancer-related or treatment-related procedures or palliative radiotherapy that is administered while on study therapy. Concomitant procedures along with start/end date and indication for the procedure will be presented in a data listing.

6.9 Post Treatment Anti-Cancer Treatment

Post treatment anti-cancer systemic treatment for AML and MDS will be listed separately for AML and MDS subjects. Post treatment anti-cancer drugs will be coded using the WHO Drug Dictionary (WHODrug-Global-B3, Version September 2021). Post treatment HCT and HCT-relevant information (e.g., type of transplant, GVHD and transplant-related complications) will be listed separately for AML and MDS subjects.

7. EFFICACY ANALYSES

The primary efficacy analysis will be based on All Treated population for dose escalation and expansion Part A, B and C and Intent to Treat population for randomized cohort in expansion Part D and E. The secondary efficacy analysis will be based on Response Evaluable population for select efficacy endpoints.. Efficacy data will be summarized separately for AML and MDS subjects.

7.1 AML Efficacy Analyses

The efficacy endpoints based on investigator assessment per ELN 2017 criteria for AML (Döhner, 2017) include CR, composite CR (CR+CRi), CR+CRh, ORR, MRD negative CR, MRD negative response (CR/CRi/MLFS), cytogenetic CR, time to response, duration of response, and EFS. Other efficacy endpoints include rate and duration of transfusion independence and overall survival.

Unless specified otherwise, AML efficacy summary tables will be presented for each treatment regimen as the following:

- SL-172154 monotherapy (all are relapsed/refractory)
  - By dose level and all subjects
- SL-172154 in combination with azacitidine
  - Relapsed/refractory in dose escalation, by dose level and all subjects across dose levels
  - Previously untreated with TP53 mutation/deletion in dose expansion Part C
- SL-172154 in combination with azacitidine/venetoclax
  - By cohort (safety run-in, expansion) and all subjects

- Randomized cohort in dose expansion Part E by treatment arm
  - SL-172154+azacitidine
  - Azacitidine +/- Venetoclax

Disease evaluations will include bone marrow examinations, hematologic parameters (e.g., hemoglobin, ANC, platelet counts, blast counts), and physical examination of extramedullary disease of AML. In addition, MRD based on local and central assessment will be evaluated on subjects enrolled in the Expansion cohorts. All laboratory efficacy assessments must be performed until relapse/disease progression, discontinuation of study treatment for a subsequent HCT, or withdrawal of consent. If a subject discontinues study treatment for reasons other than relapse/progression, disease assessment should continue until disease relapse/progression or the initiation of a subsequent AML anti-cancer therapy.

7.1.1 Response Assessment

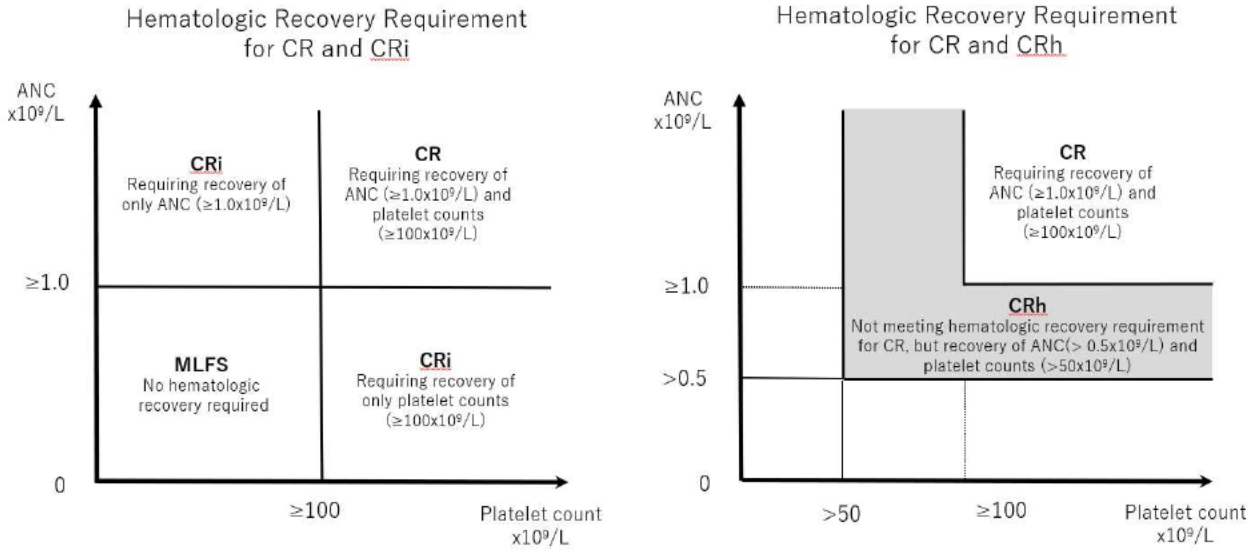
For AML subjects, response will be evaluated based on investigator assessment per 2017 ELN response criteria in AML [Dohner, 2017]. Response is based on the most recent bone marrow results and recent hematology values. For subjects who require a delay in study treatment for peripheral blood count recovery after a bone marrow evaluation, hematology values for up to 2 weeks from the bone marrow evaluation or pre-dose labs from Day 1 of the next cycle can be used to determine the response. For subjects with cytogenetic abnormalities at the baseline bone marrow test, cytogenetic CR should be reported per 2003 IWG AML response criteria [Cheson, 2003] when the result is available.

Category	**ELN Response Criteria**
CR without minimal residual disease (CR_{MRD-})	If studied pretreatment, CR with negativity for a genetic marker by RT-qPCR or NGS, or CR with negativity by MFC
Complete Remission (CR)	• Bone marrow blasts <5% • Absence of circulating blasts and blasts with Auer rods • Absence of extramedullary disease • ANC ≥1.0 x 10^9/L • Platelet count ≥100 x 10^9/L
CR with incomplete hematologic recovery (CRi)	All CR criteria except for residual neutropenia (<1.0 x 10^9/L) **or** thrombocytopenia (<100 x 10^9/L)
Morphologic leukemia-free state (MLFS)	• Bone marrow blasts <5% • Absence of circulating blasts and blasts with Auer rods • Absence of extramedullary disease • No hematologic recovery required
Partial remission (PR)	• All hematologic criteria of CR • Decrease of bone marrow blast percentage to 5% to 25%, AND • Decrease of pretreatment bone marrow blast percentage by at least 50%

Stable disease	• Absence of CR_{MRD-}, CR, CRi, PR, MLFS, AND • PD criteria not met
Hematologic relapse after CR_{MRD-} /CR/CRi	Relapse may be reported as follows: • Hematologic relapse (after CR_{MRD-}, CR, CRi): o Bone marrow blasts ≥5% or reappearance of blasts in the blood, o or development of extramedullary disease.
Molecular relapse (after CR_{MRD-})	If studied pretreatment, reoccurrence of MRD as assessed by RT-qPCR, NGS, or by MFC.
Progressive Disease (PD)	Evidence for an increase in bone marrow blast percentage and/or increase of absolute blast counts in the blood: • >50% increase in marrow blasts over baseline (minimum 15% point increase is required in cases with <30% blasts at baseline); or persistent marrow blast percentage of >70% over at least 3 months; without at least a 100% improvement in ANC to an absolute level (>0.5 x 10^9/L and/or platelet count to >50 x 10^9/L nontransfused) **OR** • >50% increase in peripheral blasts (WBC x %blasts) to >25 x 10^9/L (in absence of differentiation syndrome) **OR** • New extramedullary disease

Additionally, CRh (complete remission with partial hematologic recovery) will be evaluated separately from the ELN response criteria. CRh is defined as all CR criteria except for partial hematological recovery of peripheral blood counts (e.g., platelets >50 x 10^9/L and ANC >0.5 x 10^9/L) as described in Figure 1. CRh will be derived programmatically based on investigator disease assessment.

Figure 1 Hematologic Recovery Requirements for CR, CRh, and CRi



Bone marrow assessment will be listed. Bone marrow blast percent change from baseline is calculated as: (post-baseline value - baseline value) *100/baseline value. Baseline blast value is defined as the last blast value obtained on or before the first dose of study treatment on C1D1 and for which the specimen is adequate for bone marrow assessment. Only bone marrow blast from assessment with the specimen being adequate for assessment will be included in the calculation of percent change from baseline. Maximum bone marrow blast percent reduction from baseline (best percent change) is defined as the maxim reduction or minimum increase if all post baseline values are higher than baseline among all post baseline bone marrow blast before the initiation of post treatment therapy for AML. For SL-172154 in combination with azacitidine +/- venetoclax, if a subject discontinues SL-172154 but continue azacitidine +/- venetoclax, treatment of azacitidine +/- venetoclax after SL-172154 discontinuation will not be considered as post treatment therapy.

Bone marrow blast character result such as "<x%", ">y%" and range result as "x%-y%" will be imputed as specified in the table below. The imputed value will not be included in the data listing but will be used for the bone marrow blast percent change calculation. The percent change based on imputed value will be flagged in the data listing along with "<" or ">" as appropriate.

Bone marrow blast character results post baseline	Imputed value
<x%	(x-0.1)%
x%-y%	[(x+y)/2]%
>y%	(Y+0.1)%

7.1.2 Response Derivation

The date of relapse and disease progression is the first time at which relapse or progression can be declared. For example, if both bone marrow and hematology values indicate disease progression, then the PD date will be the earlier date of bone marrow and hematology assessments. The date of bone marrow sampling will be assigned as the date for CR/CRi/CRh/MLFS/PR/SD. Subjects with unknown or missing best response will be assumed to be non-responders and will be included in the denominator when calculating response rate. If a subject has 2 or more consecutive missed or non-evaluable disease assessments followed by an assessment showing no relapse or progressive disease, then the assumption will be the that the subject did not progress during the missed or non-evaluable assessments.

The best response per ELN 2017 criteria is defined as the best response (CR>CRi>MLFS >PR>SD>PD) among all post-baseline time point assessments until relapse or disease progression or start of any post treatment therapy including HCT for AML, whichever is earlier. For subjects who have not met the criteria for relapse or PD, the best response is defined as the best overall response among all post-baseline timepoint assessments prior to the start of post treatment therapy. For SL-172154 in combination with azacitidine +/- venetoclax, if a subject discontinues SL-172154 but continue azacitidine +/- venetoclax, treatment of azacitidine +/- venetoclax after SL-172154 discontinuation will not be considered as post treatment therapy. Specifically, the best response will be derived programmatically as the following based on investigator assessments:

- CR > CRi > MLFS > PR>SD > PD > NE
- PD is considered the best overall response when PD is documented and a best overall response of CR, CRi, MLFS, PR, or SD could not be established before documentation of PD.
- NE is considered the best overall response when PD has not been documented and a best response of CR, CRi, MLFS, PR, or SD could not be established.

7.1.3 CR Rate

The CR rate is the proportion of subjects who achieve a CR per ELN 2017 criteria at any time point during the study prior to the initiation of any post study treatment therapy for AML. Subjects who do not have any post-baseline disease assessment will be considered as non-responders in the calculation of the CR rate for All Treated or Intent to Treat population.

The CR rate will be estimated with a 95% CI using the exact probability method. For randomized cohort in expansion Part E, the CR rate and 95% CI in each treatment arm will be calculated; CR rates will be compared between treatment arms using Fisher's exact test along with 95% CI for the difference in CR rate. If data warrant, the CR rate will be compared using Cochran-Mantel-Haenszel test stratified by age groups.

7.1.4 Composite CR Rate

The composite CR rate is the proportion of subjects who achieve a CR and CRi per ELN 2017 criteria at any time point during the study prior to the initiation of any post study treatment therapy. Subjects who do not have any post-baseline disease assessment will be considered as non-responders in the calculation of composite CR rate for All Treated or Intent to Treat population.

The composite CR rate will be estimated with a 95% CI using the exact probability method. For randomized cohort in expansion Part E, the composite CR rate and 95% CI in each treatment arm will be calculated; CR rates will be compared between treatment arms using Fisher's exact test along with 95% CI for the difference in composite CR rate. If data warrant, the composite CR rate will be compared using Cochran-Mantel-Haenszel test stratified by age groups.

7.1.5 CR+CRh Rate

The CR+CRh rate is the proportion of subjects who achieve a CR or CRh at any time point during the study prior to the initiation of any post study treatment therapy. CRh is defined as all CR criteria except for partial hematological recovery of peripheral blood counts (platelets > 50 x 10^9/L and ANC > 0.5 x 10^9/L). Subjects who do not have any post-baseline disease assessment will be considered as non-responders in the calculation of CR+CRh rate for All Treated or Intent to Treat population.

The CR+CRh rate will be estimated with a 95% CI using the exact probability method. For randomized cohort in expansion Part E, the CR/CRh rate and 95% CI in each treatment arm will be calculated; CR/CRh rates will be compared between treatment arms using Fisher's exact test

along with 95% CI for the difference in CR rate. If data warrant, the CR/CRh rate will be compared using Cochran-Mantel-Haenszel test stratified by age groups.

7.1.6 Objective Response Rate

The ORR is defined as the proportion of subjects who reach objective response prior to the initiation of any post study treatment therapy. The objective response for AML is defined as CR, CRi, MLFS, or PR based on ELN 2017 criteria for AML. Subjects who do not have any post-baseline disease assessment will be considered as non-responders in the calculation of ORR for All Treated or Intent to Treat population.

The ORR will be estimated with a 95% CI using the exact probability method. The number and percent of subjects with the best response of CR, CRi, CRh, MLFS, PR, SD, and PD will be summarized. Subjects with the best response of CRi will be further categorized as CRi with residual neutropenia (ANC $<1.0x10^9$/L) or residual thrombocytopenia (platelet $<100x10^9$/L). For randomized cohort in expansion Part E, ORR and 95% CI in each treatment arm will be calculated; ORR will be compared between treatment arms using Fisher's exact test along with 95% CI for the difference in CR rate. If data warrant OR will be compared using Cochran-Mantel-Haenszel test stratified by age groups.

Individual subject response data will be presented in a data listing. Individual subject duration on SL-172154 will be plotted using horizontal bars with information on dose level, treatment status, response at each disease assessment, and subsequent HCT. Subjects who discounted study treatment due to termination of the study will be labelled as "ongoing at study termination".

7.1.7 Cytogenetic CR

Among subjects with cytogenetic abnormalities at the baseline bone marrow test, cytogenetic CR rate is defined as the proportion of subjects who achieve reversion to a normal karyotype at time of CR per ELN2017 criteria. Cytogenetic abnormalities at baseline and status at post-baseline will be based on investigator assessment with cytogenetic analysis being conducted per local standard practice. Subjects with cytogenetic CR per investigator assessment will be specified in the response listing.

For randomized cohort in expansion Part E, the cytogenetic CR rate and 95% CI in each treatment arm will be calculated; cytogenetic CR rates will be compared between treatment arms using Fisher's exact test along with 95% CI for the difference in cytogenetic CR rate.

7.1.8 Response and CR rate without minimal residual disease

Minimal residual disease based on investigator assessment

Minimal residual disease status, if performed at investigator site for subjects who achieve CR will be reported as CR without minimal residual disease (CR_{MRD-}). The MRD status performed at investigator sites for subjects with CR along with assessment method will be presented in a data listing.

Minimal residual disease based on central assessment

Minimal residual disease status will be assessed centrally for subjects with CR/CRi/MLFS and will be reported as MRD-negative or MRD-positive. MRD-negative based on multiparameter flow cytometry (MFC) is defined as the best MRD value with difference from normal multiparameter flow cytometry less than or equal to 0.02%, MRD-negative based on targeted next generation sequence (NGS) is defined as the best MRD value with a variant allele frequency (VAF) less than or equal to 3%. Response without minimal residual disease rate is defined as the proportion of subjects who achieve CR/CRi/MLFS and MRD negativity prior to initiation of any post treatment therapy for AML. CR without minimal residual disease (CR_{MRD-}) rate is defined as the proportion of subjects who achieve MRD negativity and CR prior to initiation of any post treatment therapy for AML. Subjects who have no MRD assessment will be considered as non-responder for the calculation of the rate of response without minimal residual disease and CR without minimal residual disease. Response without minimal residual disease and CR without minimal residual disease will be calculated for minimal residual disease assessment based on NGS and MFC respectively. The rate of response without minimal residual disease and CR without minimal residual disease will be estimated along with a 95% CI using the exact probability method. Individual subject MRD negative or positive result along with assessment method will be presented in a data listing for central assessment.

For randomized cohort in expansion Part E, the rate of response without minimal residual disease and CR without minimal residual disease will be estimated along with 95% CI in each treatment; CR rates will be compared between treatment arms using Fisher's exact test along with 95% CI for the difference.

7.1.9 Time to Response

Time to objective response is defined as the time from the first dose of study treatment or the date of randomization for randomized cohort in expansion Part E to the date of the first objective response per ELN 2017 criteria and will be evaluated only among subjects who have achieved object response (CR, CRi, MLFS and PR).

Time to CR is defined as the time from the first dose of study treatment or the date of randomization for randomized cohort in expansion Part E to the date of CR per ELN 2017 criteria and will be evaluated only among subjects who have achieved CR.

Time to composite CR is defined as the time from the first dose of study treatment or the date of randomization for randomized cohort in expansion Part E to the earlier date of CR or CRi per ELN 2017 criteria and will be evaluated only among subjects who have achieved CR or CRi.

Time to CR/CRh is defined as the time from the first dose of study treatment or the date of randomization for randomized cohort in expansion Part E to the earlier date of CR or CRh and will be evaluated only among subjects who have achieved CR or CRh.

Time to objective response, time to CR, time to composite CR and time to CR+CRh will be summarized descriptively and graphically using Kaplan-Meier methods. The Kaplan-Meier

estimate for the median time to response along with 95% confidence intervals and the first and third quartiles will be determined. Brookmeyer-Crowley method will be used for the confidence interval calculation. Individual subject time to response will be presented in a data listing.

7.1.10 Duration of Response

Duration of response includes duration of CR, duration of composite CR, duration of CR/CRh and duration of OR.

Duration of CR

Duration of CR (DoCR) will be evaluated for subjects who achieve the response of CR during study treatment period. For the primary analysis, the duration of CR is defined as the following:

- For subjects who receive consolidation HCT, DoCR is the time from the date of the first CR during the study treatment period to the date of the first disease status of non-CR (not in complete remission as disease status) during the follow up period or death due to any cause, whichever is earlier. If disease status is only CR during the follow up period, then DoCR will be censored at the date of last disease status of CR. If disease status after HCT is not available, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection). Any post treatment therapy will be assumed either as preparation for HCT or maintenance therapy.
- For subjects who do not receive consolidation HCT, DoCR is the time from the date of the first CR during the study treatment period to the earliest evidence of hematologic relapse from CR or death due to any cause prior to initiation of post treatment therapy for AML, whichever occurs first. If the specified event does not occur, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection) prior to initiation of post treatment therapy for AML.

Sensitivity analysis will define duration of CR as the time from the date of the first CR during study treatment period to the earliest evidence of hematologic relapse from CR, progressive disease or death due to any cause prior to initiation of any post treatment therapy for AML, whichever occurs first. If the specified event does not occur, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection) prior to any post treatment for AML.

Duration of Composite CR

Duration of composite CR will be evaluated for subjects who achieve the response of composite CR during study treatment period. For the primary analysis, the duration of composite CR is defined as the following:

- For subjects who receive consolidation HCT, it is the time from the date of the first CR or CRi during the study treatment period to the date of the first disease status of non-CR (not in complete remission as disease status) during the follow up period or death due to any cause, whichever is earlier. If disease status is only CR during the follow up period, then it will be censored at the date of last disease status of CR. If disease status after HCT is not

available, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection). Any post treatment therapy will be assumed either as preparation for HCT or maintenance therapy.

- For subjects who do not receive consolidation HCT, it is the time from the date of the first CR or CRi during the study treatment period to the earliest evidence of hematologic relapse from CR/CRi or death due to any cause prior to initiation of post treatment therapy for AML, whichever occurs first. If the specified event does not occur, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection) prior to initiation of post treatment therapy for AML.

For the sensitivity analysis, the duration of composite CR is defined as the time from the date of the first CR or CRi during study treatment period to the earliest evidence of hematologic relapse, progressive disease or death due to any cause prior to initiation of any post treatment therapy for AML, whichever occurs first. If the specified event does not occur, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection) prior to any post treatment for AML.

Duration of CR/CRh

Duration of CR/CRh will be evaluated for subjects who achieve the response of CR or CRh during study treatment period. For the primary analysis, the duration of CR/CRh is defined as the following:

- For subjects who receive consolidation HCT, it is the time from the date of the first CR or CRh during the study treatment period to the date of the first disease status of non-CR (not in complete remission as disease status) during the follow up period or death due to any cause, whichever is earlier. If disease status is only CR during the follow up period, then it will be censored at the date of last disease status of CR. If disease status after HCT is not available, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection). Any post treatment therapy will be assumed either as preparation for HCT or maintenance therapy.
- For subjects who do not receive consolidation HCT, it is the time from the date of the first CR or CRh during the study treatment period to the earliest evidence of hematologic relapse from CR/CRh or death due to any cause prior to initiation of post treatment therapy for AML, whichever occurs first. If the specified event does not occur, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection) prior to initiation of post treatment therapy for AML.

For the sensitivity analysis, the duration of CR/CRh is defined as the time from the date of the first CR or CRh during study treatment period to the earliest evidence of hematologic relapse from CR or CRh, progressive disease or death due to any cause prior to initiation of any post treatment therapy for AML, whichever occurs first. If the specified event does not occur, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection) prior to any post treatment for AML.

Duration of Objective Response

Duration of objective response will be evaluated for subjects who achieve objective response CR, CRi, MLFS and PR) during study treatment period. For the primary analysis, the duration of objective response is defined as the following:

- For subjects who receive consolidation HCT, it is the time from the first objective response (CR, CRi, MLFS and PR) to the first disease status of non-CR (not in complete remission as disease status) during the follow up period, progressive disease, or death due to any cause, whichever occurs first. If disease status is only CR during the follow up period, then it will be censored at the date of last disease status of CR. If disease status after HCT is not available, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection). Any post treatment therapy will be assumed either as preparation for HCT or maintenance therapy.
- For subjects who do not receive consolidation HCT, it is the time from the date of the first objective response during the study treatment period to the earliest evidence of hematologic relapse from CR/CRi, progressive disease or death due to any cause prior to initiation of post treatment therapy for AML, whichever occurs first. If the specified event does not occur, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection) prior to initiation of post treatment therapy for AML.

For the sensitivity analysis, duration of objective response is defined as the time from the date of the first objective response (CR, CRi, MLFS and PR) per ELN 2017 criteria to the earliest evidence of relapse from CR or CRi, progressive disease or death due to any cause prior to initiation of any post treatment therapy for AML, whichever occurs first. If the specified event does not occur, subjects will be censored at the date of last disease assessment prior to initiation of any post treatment therapy for AML (i.e., the last available date of bone marrow sample collection).

Duration of CR, CR/CRi, CR/CRh and objective response will be summarized descriptively (median and range with censored values flagging with plus sign) and graphically using Kaplan-Meier methods. The Kaplan-Meier estimate for the median along with 95% confidence intervals and the first and third quartiles will be determined. Brookmeyer-Crowley method will be used for the confidence interval calculation. Individual duration of response will be presented in a data listing.

7.1.11 Event Free Survival

The primary analysis of EFS will be based on the primary definition of EFS, sensitivity analysis will be conducted based on the secondary definition of EFS.

Primary EFS definition

EFS is defined as the time from the first dose of study treatment or the date of randomization for randomized cohort in expansion Part E to the date of hematologic relapse from CR or CRi per ELN2017 criteria, treatment failure, disease progression, or death from any cause prior to initiation of any non-HCT post treatment therapy for AML, whichever occurs first. Treatment failure is

defined as failure to achieve CR/CRi by the end of cycle 7 disease assessment. If the specified event does not occur, subjects will be censored. The detailed censoring rule is described in Table 29. Subjects without any disease assessments performed after the first dose of study treatment will be censored on study day 1.

Secondary EFS definition

The secondary EFS definition is same as the primary definition except event time will be the first day of study treatment or the date of randomization for randomized cohort in expansion Part E for subjects with treatment failure.

The distribution of EFS will be estimated using Kaplan-Meier methodology. The median and quartiles of OS and their 95% CIs will be assessed using the Kaplan-Meier method and Brookmeyer and Crowley method, respectively. The EFS at 6, 12, and 18 months, and other times of interest will be estimated using the Kaplan-Meier method. EFS will be summarized and listed for All Treated population.

Table 7 Event/Censor and Corresponding Event/Censor Time for EFS

Scenario	Event/Censor	Event time/Censor date
Relapse from CR or CRi prior any non-HCT post treatment therapy for AML	Event	Date of hematologic relapse
Treatment failure (defined as failure to achieve CR/CRi by the end of cycle 7 disease assessment)	Event	For subjects who achieve MLFS, SD, PR up to the end of cycle 7 disease assessment and without PD, the even time is the date of the end of Cycle 7 disease assessment. For subjects who have PD before or on the end of cycle 7 disease assessment, the event is the date of documented PD. For sensitivity analysis, censored at the first day of study treatment or the date of randomization for randomized cohort in expansion Part E for subjects with treatment failure.
Death due to any cause and have not received non-HCT post-treatment therapy	Event	Death date
Any non-HCT post treatment therapy for AML in the absence of relapse from CR/CRi, disease progression or treatment failure	Censor	Date of the last disease assessment prior to initiation of non-HCT post treatment therapy for AML
CR after post treatment HCT for AML but before any non-HCT post treatment	Censor	Date of last CR after initiation of post treatment HCT
Non-CR after post treatment HCT for AML but before any non-HCT post treatment	Event	Date of first non-CR after initiation of post treatment HCT but before non-HCT post treatment
None of the above	Censor	Date of the last bone marrow disease assessment prior to initiation of non-HCT post treatment therapy for AML

7.1.12 Transfusion Independence

Transfusion history of RBC and platelet for the 4 weeks prior to the first dose of study treatment regardless of hemoglobin level will be used to determine transfusion independence/dependence at baseline. AML subjects will be grouped into the following subgroups based on transfusion status at baseline:

- **Transfusion status at baseline**
  - Dependent, subjects with >=1 RBC or platelet transfusions during the 4-week period prior to the first dose of study treatment.
  - Independent, subjects without any RBC or platelet transfusions during the 4-week period prior to the first dose of study treatment.
  - Not evaluable, subjects with unknow or missing information about RBC or platelet transfusion during the 4-week period prior to the first dose of study treatment.
- **RBC transfusion status at baseline**
  - Dependent, subjects with >=1 RBC transfusions during the 4-week period prior to the first dose of study treatment.
  - Independent, subjects without any RBC transfusion during the 4-week period prior to the first dose of study treatment.
  - Not evaluable, subjects with unknow or missing information about RBC transfusion during the 4-week period prior to the first dose of study treatment.
- **Platelet transfusion status**
  - Dependent, subjects with >=1 platelet transfusion during the 4-week period prior to the first dose of study treatment.
  - Independent, subjects without any platelet transfusion during the 4-week period prior to the first dose of study treatment.
  - Not evaluable, subjects with unknow or missing information about platelet transfusion during the 4-week period prior to the first dose of study treatment.

After the first dose of study treatment, transfusions will be collected during study treatment until 30 days after the last dose of study treatment or at the time of the post treatment visit, whichever occurs later.

RBC transfusion independence rate is defined as the proportion of subjects who have a 56-day or longer period (>=56 days) with no RBC transfusions between the first dose of study treatment and 1) on or before the last dose of study treatment plus 30 days or post treatment visit, whichever occurs later, 2) before the initiation of post-treatment therapy for AML, and 3) death, whichever occurs earliest among 1), 2) and 3). RBC transfusion independence rate will be provided for the first 24 weeks, 48 weeks, and throughout the study treatment, and will be summarized separately for subjects with RBC transfusion independent and dependent at baseline respectively.

Platelet transfusion independence rate is defined as the proportion of subjects who have a 56-day or longer period (>=56 days) with no platelet transfusions between the first dose of study treatment and 1) on or before the last dose of study treatment plus 30 days or post treatment visit, whichever occurs later, 2) before the initiation of post-treatment therapy for AML, and 3) death, whichever occurs earliest among 1), 2) and 3). Platelet transfusion independence rate will be provided for the

first 24 weeks, 48 weeks, and throughout the study treatment, and will be summarized separately for subjects with platelet transfusion independent and dependent at baseline respectively.

Transfusion independence rate is defined as the proportion of subjects who have a 56-day or longer period (>=56 days) with no RBC and platelet transfusions between the first dose of study treatment and 1) on or before the last dose of study treatment plus 30 days or post treatment visit, whichever occurs later, 2) before the initiation of post-treatment therapy for AML, and 3) death, whichever occurs earliest among 1), 2) and 3). The transfusion independence rate will be provided for the first 24 weeks, 48 weeks, and throughout study treatment, and will be summarized separately for subjects with transfusion independent and dependent at baseline respectively.

Individual subject transfusion will be presented in a data listing.

The duration of transfusion independence is defined as the longest time period a subject receives no transfusion for at least 56 days. The duration of transfusion independence is measured the start of the transfusion independence (Day 1 of the transfusion independence period) to the date of the first transfusion after transfusion independence period but prior to initiation of any new post study treatment therapy for AML. The descriptive statistics (median and range) will be provided for the duration of transfusion independence for RBC, platelet and any of RBC and platelet, respectively. If data warrant, duration of transfusion independence will be evaluated using Kaplan-Meier method.

Time to first transfusion independence is defined as duration from the date of the first dose or the date of randomization for randomized cohort in expansion Part E to the start of the first transfusion independence (Day 1 of the transfusion independence period). The descriptive statistics (median and range) will be provided for the time to the first transfusion independence for RBC, platelet and any of RBC and platelet, respectively. If data warrant, time to transfusion independence will be evaluated using Kaplan-Meier method.

7.1.13 Overall Survival

The OS is defined as time from the first day of study treatment or the date of randomization for randomized cohort in expansion Part E to the date of death from any cause. All events of death will be included, regardless of whether the event occurred while the subject was still on study treatment or after the subject discontinued study treatment.

For subjects who are alive at the data cut-off or lost to follow-up will be censored for OS at the last date of documented survival. The date of the last known alive will be determined by selecting the last available date of the following study procedures for a subject: adverse event start data, bone marrow collection, disease assessment, vital signs assessment, clinical laboratory collection, study drug administration, concomitant medicine, sample collection, transfusion, survival follow-up contact, post treatment anticancer therapy, and ECOG performance status.

The median and quartiles of OS and their 95% CIs will be assess using the Kaplan-Meier method and Brookmeyer and Crowley method, respectively. The proportion of subjects alive at 6, 12, 18 and 24 months, and other times of interest will be estimated using the Kaplan-Meier method. OS will be summarized and listed for All Treated population.

7.2 MDS Efficacy Analyses

The efficacy endpoints for MDS that are based on the investigator assessment per IWG MDS response criteria (Cheson 2006) include CR, CR and marrow CR with HI, objective response, hematologic improvement, cytogenetic CR, MRD-negative CR, MRD-negative response, time to response, duration of response, PFS, and EFS. Other efficacy endpoints include rate and duration of transfusion independence, time to transformation to AML, and overall survival.

Unless specified otherwise, MDS efficacy summary tables will be presented for each treatment regimen as the following:

- SL-172154 monotherapy (all are relapsed/refractory)
  - By dose level and all subjects
- SL-172154 in combination with azacitidine in dose escalation and expansion Part A
  - Dose escalation, by dose level and all subjects
  - Expansion Part A
  - All subjects receiving 3.0 mg/kg SL-172154 in combination with Azacitidine from dose escalation and expansion Part A and C
- Previously untreated in dose expansion Part A by status of TP53 mutation or deletion (multi-hit vs single-hit) based on central review
- Randomized Cohort in Expansion Part D by treatment arm

Disease evaluation will include bone marrow examinations, MRD status based on central assessment, and hematologic parameters (e.g., hemoglobin, ANC, platelet counts). Bone marrow aspirates must be performed at screening for all subjects. All laboratory efficacy assessment must be performed until disease progression or withdrawal of consent, even if the subject is discontinued from study treatment. If a subject discontinues study treatment for reasons other than relapse/progression, disease assessment should continue until disease relapse/progression or the initiation of a subsequent MDS anti-cancer therapy.

Bone marrow for disease assessments should be performed at the following timepoints:

- Screening (baseline)
- End of Cycle 1 (performed within 7 days prior to Cycle 2 Day 1)
- End of every 3 Cycles until Cycle 13 (e.g., End of Cycle 4, Cycle 7, Cycle 10, Cycle 13)
- End of every 6 Cycles beyond Cycle 13 (e.g., End of Cycle 19, Cycle 25, etc.)
- At time of relapse/progression: if clinically feasible
- A bone marrow assessment is strongly encouraged when a subject discontinues study treatment as (s)he becomes eligible for and is planned to proceed to HCT.
- In the event a subject experiences prolonged response or stable disease beyond Cycle 7, less frequent bone marrow assessment is permitted after consultation with the Sponsor Medical Monitor.

7.2.1 Response Assessment

Response for subjects with MDS will be evaluated based on the investigator assessment per IWG [Cheson, 2006]. Subject's response is based on the most recent bone marrow results and recent

hematology values. For subjects who required a delay in study treatment for peripheral blood count recovery after a bone marrow evaluation, hematology values for up to 2 weeks from the bone marrow evaluation or pre-dose labs from Day 1 of the next cycle can be used to determine the IWG response. Response assessment for hematologic improvement will be performed at each cycle beginning in Cycle 2 regardless of whether a bone marrow test is performed. Additionally, for subjects with cytogenetic abnormalities at the baseline bone marrow test, cytogenetic CR should be reported per 2003 IWG AML response criteria [Cheson, 2003] when the result is available.

Category	IWG Response criteria (response must last at least 4 weeks)
Complete Remission (CR)	Requires all of the following maintained for a minimum of four weeks. When reporting the CR achievement date, report the first date when CR was achieved (not the four week date in which CR was maintained). Bone marrow evaluation: <= 5% myeloblasts with normal maturation of all cell lines Peripheral blood evaluation: • Hemoglobin ≥ 10 g/dL untransfused without erythropoietic support • ANC ≥ 1000/mm3 without myeloid growth factor support • Platelets ≥ 100,000/mm3 without thrombopoietic support • 0% blasts in blood
Marrow CR	• Bone marrow: ≤ 5% myeloblasts and decrease by ≥ 50% over pretreatment • Peripheral blood: if hematologic improvement (HI) responses, they will be noted in addition to marrow CR
PR	All CR criteria if abnormal before treatment except: • Bone marrow blasts decreased by ≥ 50% over pretreatment but still > 5% • Cellularity and morphology not relevant
SD	Failure to achieve at least PR, but no evidence of progression for > 8 weeks
Relapse after CR, marrow CR or PR	At least one of the following: • Return to pretreatment bone marrow blast percentage • Decrement of >=50% from maximum response levels in granulocytes • Decrement of >=50% from maximum response levels in platelets • Reduction in Hgb by >=1.5 g/dl • Transfusion dependence
Cytogenetic CR	• Disappearance of the chromosomal abnormality without appearance of new ones in subjects who achieve CR.
Disease Progression by Bone Marrow	For Subjects with: • Less than 5% blasts: ≥ 50% increase in blasts to > 5% blasts • 5% - 10% blasts: ≥ 50% increase to > 10% blasts • 10% - 20% blasts ≥ 50% increase to > 20% blasts And any of the following:

	• At least 50% decrement from maximum remission/response in granulocytes or platelets • Reduction in Hgb by ≥ 2 g/dL • Transfusion dependence

Minimal residual disease (MRD) status for subjects who achieve CR or marrow CR, will be reported at MRD-negative or MRD-positive. MRD-negative is defined as the best MRD value which is less than 10^{-3} residual blasts per leukocytes as measured in the bone marrow.

Bone marrow assessment will be listed. Bone marrow blast percent change from baseline is calculated as: (post-baseline value - baseline value) *100/baseline value. Baseline blast value is defined as the last blast value obtained on or before the first dose of study treatment on C1D1 and for which the specimen is adequate for bone marrow assessment. Only bone marrow blast from assessment with the specimen being adequate for assessment will be included in the calculation of percent change from baseline. Maximum bone marrow blast percent reduction from baseline (best percent change) is defined as the maxim reduction or minimum increase if all post baseline values are higher than baseline among all post baseline bone marrow blast for which the bone marrow specimens are adequate for bone marrow assessment.

Bone marrow blast character result such as "<x%", ">y%" and range result as "x%-y%" will be imputed as specified in the table below. The imputed value will not be included in the data listing but will be used for the bone marrow blast percent change calculation. The percent change based on imputed value will be flagged in the data listing along with "<" or ">" as appropriate.

Bone marrow blast character results post baseline	Imputed value
<x%	(x-0.1)%
x%-y%	[(x+y)/2]%
>y%	(Y+0.1)%

The hematologic improvement (HI) is defined to have at least one of HI in erythroid (HI-E), platelet (HI-P) or neutrophil (HI-N) that last at least 8 weeks based on the IWG 2006 MDS criteria.

Hematologic Improvement [a]	IWG 2006 Response Criteria (response must last at least 8 weeks)
HI-E Erythroid response (pretreatment, <11g/dL)	• Hgb increase by ≥1.5 g/dL • Relevant reduction of units of RBC transfusions by an absolute number of at least 4 RBC transfusions/8 wk compared with the pretreatment transfusion number in the previous 8 wk. Only RBC transfusions given for a Hgb of ≤9.0 g/dL pretreatment will count in the RBC transfusion response evaluation
HI-P Platelet response (pretreatment, <100 x 10^9/L)	• Absolute increase of ≥30 x 10^9/L for subjects starting with >20 x 10^9/L platelets at pretreatment • Increase from <20 x 10^9/L at pretreatment to >20 x 10^9/L and by at least 100%
HI-N Neutrophil response (pretreatment, <1.0 x 10^9/L)	• At least 100% increase and an absolute increase of >0.5 x 10^9/L
Progression or relapse after HI[b]	At least 1 of the following: • At least 50% decrement from maximum response levels in granulocytes or platelets • Reduction in hemoglobin by ≥ 1.5 g/dL • Transfusion dependence

a. Pretreatment counts should be the averages of at least 2 measurements (not influenced by transfusions) at least 1 week apart. If the Screening result is less than 7 days prior to Cycle 1 Day 1, an historical result reported ≥7 days prior to Cycle 1 Day 1 should be reported.

b. In the absence of another explanation, such as acute infection, repeated courses of chemotherapy, gastrointestinal bleeding, hemolysis, etc. It is recommended that the 2 kinds of erythroid and platelet responses be reported overall as well as by the individual response pattern.

7.2.2 Response Derivation

The date of relapse is the earliest time that relapse can be declared. For example, if both bone marrow and hematology values indicate relapse, then the relapse date will be the earlier date of bone marrow and hematology assessments. The date of disease progression is the later time at which progression can be declared from both bone marrow and hematology. For example, if bone marrow or hematology values both meet the criteria for disease progression, then the PD date will be the later date of bone marrow and hematology assessments; if bone marrow, hematology assessment and transfusion dependence all meet the criteria for disease progression, first select the earlier date between hematology assessment and transfusion dependence and then select the later date between this date and bone marrow date. The date of bone marrow samples collection will be assigned as CR/marrow CR/PR/SD date.

The best response per IWG 2006 criteria is defined as the best response (CR>marrow CR >PR>SD>PD) among all post-baseline time point assessments until relapse or disease progression or start of any post treatment therapy (including HCT) for MDS, whichever is earlier. For subjects who have not met the criteria for relapse or PD or have not started post-treatment therapy for MDS, the best response is defined as the best overall response among all post-baseline timepoint assessments.

Based on the investigator assessment at post-baseline assessments, the best overall response will be determined programmatically as the following and Table :

- CR > PR> marrow CR ~~> PR~~>SD > PD > NE
- CR = at least two determinations of CR with at least 4 weeks apart before relapse or progression.
- Marrow CR = at least two determinations of marrow CR or better with at least 4 weeks apart before relapse or progression (and not qualifying for CR).
- PR = at least two determinations of PR or better with at least 4 weeks apart before relapse or progression (and not qualifying for CR or marrow CR).
- PD is considered the best overall response when PD is documented and a best overall response of CR, marrow CR, PR or SD could not be established before documentation of PD.
- SD: no evidence of progression/relapse for >8 weeks
- Clinical deterioration will not be considered as documented disease progression in the determination of the best response.
- NE is considered the best overall response when PD has not been documented and a best response of CR, marrow CR, PR or SD could not be established.

Table 11. Best response when confirmation of CR/marrow CR/PR

Response First time point	**Response Subsequent time point**	**BEST response**
CR	CR	CR
CR	Marrow CR	Marrow CR
CR	PR	PR
Marrow CR	Marrow CR or CR	Marrow CR
Marrow CR	PR	PR
PR	PR/marrow CR/CR	PR
CR/marrow CR/PR	SD	SD provided no progression for >8 weeks
CR/marrow CR/PR	Relapse for CR/marrow CR/PR	PD or SD provided no progression for >8 weeks
SD	SD	SD provided no progression for >8 weeks
SD	PD	PD or SD provided no progression for >8 weeks
CR/marrow CR/PR	NE	SD provided no progression for >8 weeks
SD	NE	SD provided no progression for >8 weeks

7.2.3 CR Rate

The CR rate is the proportion of subjects who achieve a best response of CR that is confirmed at least 4 weeks later at any time point during the study prior to initiation of any post study treatment for MDS. Subjects who do not have any post-baseline disease assessment will be considered as non-responders in the calculation of CR rate. The CR rate will be estimated with a 95% CI using the exact probability method. The number and percentage of subjects with confirmed or unconfirmed CR will be summarized.

7.2.3 CR/Marrow CR with HI

The CR/marrow CR with HI rate is the proportion of subjects who achieve a best response of 1) CR that is confirmed at least 4 weeks later; or 2) marrow CR that is confirmed at least 4 weeks later and at least one of HI-E, HI-P or HI-N that confirmed 8 weeks later at any time point during the study prior to initiation of any post study treatment for MDS. Subjects who do not have any post-baseline disease assessment will be considered as non-responders in the calculation of CR/marrow CR with HI rate. The CR/marrow CR rate with HI will be estimated with a 95% CI using the exact probability method. The number and percentage of subjects with CR/marrow CR with HI will be summarized.

7.2.4 Objective Response Rate

The ORR is defined as the proportion of subjects who achieve an objective response as the best response prior to the initiation of any post study treatment therapy for MDS. The objective response includes CR, marrow CR, and PR that must be confirmed at least 4 weeks later, or at least one of HI-E, HI-P or HI-N that must be confirmed at least 8 weeks later.

The ORR rate will be estimated with a 95% CI using the exact probability method. The number and percent of subjects with the best response of CR, marrow CR, PR and HI by confirmation status, and SD, PD and not evaluable (NE) will be summarized.

Individual subject response data will be presented in a data listing. Individual subject duration on SL-172154 will be plotted using horizontal bars with information on dose level, treatment status, response at each disease assessment, and subsequent HCT. Subjects who discounted study treatment due to termination of the study will be labelled as “ongoing at study termination”.

7.2.5 Hematologic Improvement

Response for hematologic improvement will be assessed according to the IWG 2006 MDS criteria and are measured in subjects with pretreatment abnormal values: hemoglobin level less than 11g/dl, platelet count less than $100x10^9$/L, and absolute neutrophil count less than $1.0\ x10^9$/L. Pretreatment counts should be the averages of at least 2 measurements at least 1 week apart. If the Screening result is less than 7 days prior to Cycle 1 Day 1, an historical result reported ≥7 days prior to Cycle 1 Day 1 should be reported. The HI response will be not evaluable if only one pretreatment measurement is available, or affected by transfusion (i.e., transfusion is <5 days for

RBC and <7 days for platelet before pretreatment measurement), or the 2 pretreatment measurements are <7 day apart.

Response of HI-E (based on Hgb increase), HI-P and HI-N must be confirmed at least 8 weeks later before the start of any post treatment therapy (including HCT). Response of HI-E based on RBC transfusion changes is automatically confirmed as RBC transfusion are based on 8 weeks interval comparison with the previous 8 weeks. The number and percentage of subjects with confirmed and unconfirmed HI-E, HI-P or HI-N will be summarized among all subjects with abnormal pretreatment values. Response of HI-E, HI-P and HI-N along with the hematologic values will be listed.

7.2.6 Cytogenetic CR

Among subjects with cytogenetic abnormalities at the baseline bone marrow test, cytogenetic CR rate is defined as the proportion of subjects who achieve reversion to a normal karyotype at time of CR. Cytogenetic abnormalities at baseline and status at post-baseline will be based on investigator assessment. The cytogenetic CR will be summarized and presented in the response listing.

7.2.7 Response or CR without minimal residual disease

Minimal residual disease status for subjects who achieve CR or marrow CR will be evaluated at central lab and will be reported as MRD-negative or MRD-positive. MRD-negative based on multiparameter flow cytometry (MFC) is defined as the best MRD value with difference from normal multiparameter flow cytometry less than or equal to 0.02%, MRD-negative based on targeted next generation sequence (NGS) is defined as the best MRD value with a variant allele frequency (VAF) less than or equal to 3%.

Response without minimal residual disease (Response $_{MRD-}$) rate is defined as the proportion of subjects who achieve CR/marrow CR and MRD negativity prior to initiation of any post treatment therapy for MDS. CR without minimal residual disease (CR_{MRD-}) rate is defined as the proportion of subjects who achieve CR and MRD negativity prior to initiation of any post treatment therapy for MDS. Subjects who have no MRD assessment will be considered as non-responder for the calculation of the rate of response without minimal residual disease and CR_{MRD-}. Response without minimal residual disease and CR without minimal residual disease will be calculated for minimal residual disease assessment based on NGS and MFC respectively. Both the rate of CR_{MRD-} and Response $_{MRD-}$ will be estimated along with a 95% CI using the exact probability method. Individual subject MRD negative or positive result along with assessment method will be presented in a data listing

7.2.8 Time to Response

Time to CR is defined as the time from the first dose of study treatment to the date of the first CR that is confirmed 4 weeks later. Time to CR will be evaluated only for the subset of subjects with confirmed CR.

Time to objective response is defined as the time from the first dose of study treatment to the date of the first objective response (CR, marrow CR, PR or hematologic improvement) that is confirmed at least 4 weeks later for CR, marrow CR or PR and at least 8 weeks later for HI. Time to objective response will be evaluated only for the subset of subjects with confirmed objective response.

Time to CR and objective response will be summarized descriptively and graphically using Kaplan-Meier methods. The Kaplan-Meier estimate for the median along with 95% confidence intervals and the first and third quartiles will be determined. Brookmeyer-Crowley method will be used for the confidence interval calculation. Individual subject time to response will be presented in a data listing.

7.2.9 Duration of Response

Duration of CR (DoCR) will be evaluated for subjects who achieve the response of CR during study treatment period. For the primary analysis, the duration of CR is defined as the following:

- For subjects who receive consolidation HCT, DoCR is the time from the date of the first CR during the study treatment period to the date of the first disease status of non-CR (not in complete remission as disease status) during the follow up period or death due to any cause, whichever is earlier. If disease status is only CR during the follow up period, then DoCR will be censored at the date of last disease status of CR. If disease status after HCT is not available, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection). Any post treatment therapy will be assumed either as preparation for HCT or maintenance therapy.
- For subjects who do not receive consolidation HCT, DoCR is the time from the date of the first CR during the study treatment period to the earliest evidence of hematologic relapse from CR or death due to any cause prior to initiation of post treatment therapy for AML, whichever occurs first. If the specified event does not occur, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection) prior to initiation of post treatment therapy for AML.

For the sensitivity analysis, DoCR is defined as the time from the date of the first CR to the date of relapse, progressive disease or death from any cause prior to initiation of any post treatment therapy for MDS, whichever occurs earlier. If the specified event does not occur, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection) prior to initiation of any post treatment therapy for MDS.

Duration of objective response will be evaluated for subjects who achieve the objective response (CR, marrow CR, or PR that is confirmed at least 4 weeks later or hematologic improvement that is confirmed at least 8 weeks later) during study treatment period. For the primary analysis, the duration of objective is defined as the following:

- For subjects who receive consolidation HCT, it is the time from the date of the first objective response during the study treatment period to the date of the first disease status of non-CR (not in complete remission as disease status) during the follow up period or

death due to any cause, whichever is earlier. If disease status is only CR during the follow up period, then it will be censored at the date of last disease status of CR. If disease status after HCT is not available, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection). Any post treatment therapy will be assumed either as preparation for HCT or maintenance therapy.

- For subjects who do not receive consolidation HCT, it is the time from the date of the first CR during the study treatment period to the earliest evidence of hematologic relapse from CR or death due to any cause prior to initiation of post treatment therapy for AML, whichever occurs first. If the specified event does not occur, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection) prior to initiation of post treatment therapy for AML.

For the sensitivity analysis, the duration of objective response is defined as the time from the date of the first objective response to the date of relapse, progressive disease, or death due to any cause prior to initiation of any post treatment therapy for MDS, whichever occurs first. If the specified event does not occur, subjects will be censored at the date of last disease assessment (i.e., the last available date of bone marrow sample collection).

The duration of objective response and duration of CR will be summarized descriptively and graphically using Kaplan-Meier methods. The Kaplan-Meier estimate for the median along with 95% confidence intervals and the first and third quartiles will be determined. Brookmeyer-Crowley method will be used for the confidence interval calculation. Individual duration of response will be presented in a data listing.

7.2.10 Progression Free Survival

The PFS is defined as the time from the first dose of study treatment to the date of disease progression or relapse per IWG 2006 MDS criteria, or death from any cause, whichever occurs first. If the specified event does not occur, subjects will be censored. The detailed censoring rule is described in Table 14. Data for subjects without any disease assessments performed after the first dose of study treatment will be censored at the study day 1.

The distribution of PFS will be estimated using Kaplan-Meier methodology. The median and quartiles of PFS and their 95% CIs will be assess using the Kaplan-Meier method and Brookmeyer and Crowley method, respectively. The PFS rate at 6, 12, 18 and 24 months, and other times of interest will be estimated using the Kaplan-Meier method. PFS will be summarized and listed for All Treated population.

Table 14. Event/Censor and Corresponding Event/Censor Time for PFS

Scenario	Event/Censor	Event time/Censor date
Relapse from CR/marrow CR/PR or disease progression on or prior to the start of any post-treatment therapy	Event	Earlier date of relapse or disease progression
Death due to any cause without any post treatment therapy	Event	Death date
None of the above	Censor	Last bone marrow assessment prior to any post-treatment therapy. If the last response is HI, then date of the last hematologic assessment prior to any post-treatment therapy

7.2.11 Event Free Survival

The length of EFS is defined as the time from the first dose of study treatment to the date of transformation to AML or death from any cause, whichever occurs first. If the specified event does not occur, subjects will be censored. The detailed censoring rule is described in Table 15.

Table 15. Event/Censor and Corresponding Event/Censor Time for EFS

Scenario	Event/Censor	Event time/Censor date
Transformation to AML	Event	Date of transformation to AML
Death due to any cause without any post treatment therapy	Event	Death date
None of the above	Censor	Last bone marrow assessment prior to any post-treatment therapy. If the last response is HI, then date of the last hematologic assessment prior to any post-treatment therapy

The distribution of EFS will be estimated using Kaplan-Meier methodology. The median and quartiles of PFS and their 95% CIs will be assess using the Kaplan-Meier method and Brookmeyer and Crowley method, respectively. The EFS rate at 6, 12, 18 and 24 months, and other times of interest will be estimated using the Kaplan-Meier method. EFS will be summarized and listed for All Treated population.

7.2.12 Time to Transformation to AML

Time to transformation to AML is defined as the time from the first dose of study treatment to the date of documented AML diagnosis. Time to AML transformation will be summarized descriptively and graphically using Kaplan-Meier methods. The Kaplan-Meier estimate for the median along with 95% confidence intervals and the first and third quartiles will be determined. Brookmeyer-Crowley method will be used for the confidence interval calculation. Individual subject time to AML transformation will be presented in a data listing.

7.2.13 Transfusion Independence Rates

To determine transfusion burden at baseline for MDS subjects, transfusion history will be collected for the 8 weeks prior to initiating study treatment. Only RBC transfusion administered for a mean hemoglobin level below 9g/dL are to be considered for the determination of the transfusion dependence or independence at baseline; transfusion for intercurrent disease (e.g., bleeding, surgical procedure, etc.) should not be considered.

Transfusion history of RBC and platelet for the 8 weeks prior to the first dose of study treatment will be used to determine transfusion independence/dependence at baseline as the following:

- **Transfusion status at baseline**
  - Dependent, subjects with >=2 RBC or >=1 platelet transfusions during the 8-week period prior to the first dose of study treatment.

  - Independent, subjects with 0-1 RBC or no platelet transfusions during the 8-week period prior to the first dose of study treatment.
  - Not evaluable, subjects with unknow or missing information about RBC or platelet transfusion during the 8-week period prior to the first dose of study treatment.
- **RBC transfusion status at baseline**
  - Dependent, subjects with >=2 RBC transfusions during the 8-week period prior to the first dose of study treatment.
  - Independent, subjects with 0-1 RBC transfusion during the 8-week period prior to the first dose of study treatment.
  - Not evaluable, subjects with unknow or missing information about RBC transfusion during the 8-week period prior to the first dose of study treatment.
- **Platelet transfusion status**
  - Dependent, subjects with >=1 platelet transfusion during the 8-week period prior to the first dose of study treatment.
  - Independent, subjects without any platelet transfusion during the 8-week period prior to the first dose of study treatment.
  - Not evaluable, subjects with unknow or missing information about platelet transfusion during the 8-week period prior to the first dose of study treatment.

After the first dose of study treatment, transfusions will be collected during study treatment until 30 days after the last dose of study treatment or at the time of the post treatment visit, whichever occurs later.

RBC transfusion independence rate is defined as the proportion of subjects who have a 56-day or longer period with no RBC transfusions between the first dose of study treatment and 1) on or before the last dose of study treatment plus 30 days or post treatment visit, whichever occurs later, 2) before the initiation of post-treatment therapy for MDS/AML, and 3) death, whichever occurs earliest among 1), 2) and 3). RBC transfusion independence rate will be provided for the first 24 weeks, 48 weeks, and throughout the study treatment, and will be summarized separately for subjects with RBC transfusion independent and dependent at baseline respectively.

Platelet transfusion independence rate is defined as the proportion of subjects who have a 56-day or longer period with no platelet transfusions between the first dose of study treatment and a 1) on or before the last dose of study treatment plus 30 days or post treatment visit, whichever occurs later, 2) before the initiation of post-treatment therapy for MDS/AML, and 3) death, whichever occurs earliest among 1), 2) and 3). Platelet transfusion independence rate will be provided for the first 24 weeks, 48 weeks, and throughout the study treatment, and will be summarized separately for subjects with platelet transfusion independent and dependent at baseline respectively.

Transfusion independence rate is defined as the proportion of subjects who have a 56-day or longer period with no RBC and platelet transfusions between the first dose of study treatment and 1) on or before the last dose of study treatment plus 30 days or post treatment visit, whichever occurs later, 2) before the initiation of post-treatment therapy for MDS/AML, and 3) death, whichever occurs earliest among 1), 2) and 3). The transfusion independence rate will be provided

for the first 24 weeks, 48 weeks, and throughout the study treatment, and will be summarized separately for subjects with transfusion independent and dependent at baseline respectively.

Individual subject transfusions will be presented in a data listing.

The duration of transfusion independence is defined as the longest time period that a subject receives no transfusion for at least 56 days. The duration of transfusion independence is measured from the start of the first transfusion independence (Day 1 of transfusion independence) to the date of first transfusion after the transfusion independence period but prior to initiation of any new post study treatment therapy for MDS/AML. The descriptive statistics (median and range) will be provided for the duration of transfusion independence. If data warrant, duration of transfusion independence will be evaluated using Kaplan-Meier method.

Time to first transfusion independence is defined as duration from the date of the first dose to the start of the first transfusion independence (Day1 of transfusion independence). The descriptive statistics (median and range) will be provided for the time to the first RBC transfusion independence. If data warrant, time to transfusion independence will be evaluated using Kaplan-Meier method.

7.1.14 Overall Survival

The OS is defined as time from the first day of study treatment to the date of death from any cause. All events of death will be included, regardless of whether the event occurred while the subject was still on study treatment or after the subject discontinued study treatment.

For subjects who are alive at the data cut-off or lost to follow-up will be censored for OS at the last date of documented survival. The date of the last known alive will be determined by selecting the last available date of the following study procedures for a subject: adverse event start data, bone marrow collection, disease assessment, vital signs assessment, clinical laboratory collection, study drug administration, concomitant medicine, sample collection, transfusion, survival follow-up contact, post treatment anticancer therapy, and ECOG performance status.

The median and quartiles of OS and their 95% CIs will be assessed using the Kaplan-Meier method and Brookmeyer and Crowley method, respectively. The proportion of subjects alive at 6, 12, 18 and 24 months, and other times of interest will be estimated using the Kaplan-Meier method. OS will be summarized and listed for All Treated population.

8. SAFETY ANALYSES

Safety analyses will include Maximum Tolerated Dose (MTD) evaluation, AEs, laboratory test results (hematology, chemistry, liver, thyroid, and coagulation panels), death, vital signs/pulse oximetry/weight, and ECOG. Cardiac assessment (ECG and ECHO), and blood phenotype (ABO/Rh) with direct antiglobulin test (DAT) will be evaluated at screening only.

Unless specified otherwise, summary tables and data listings for safety analysis will be based on All Treated population (AML+MDS). Separate summary will be provided for each treatment

regimen: SL-172154 monotherapy, SL-172154 in combination with azacitidine, and SL-172154 in combination with azacitidine and venetoclax. For select safety data, summary also will be provided for AML and MDS subjects, respectively. Summary tables will be presented by all subjects receiving the same treatment regimen, by dose escalation and dose level, and by dose expansion, and. Subjects at the same dose level from dose escalation and expansion cohorts will be pooled together for summary tables. Specifically, summary tables will be presented as the following unless specified otherwise:

- SL-172154 monotherapy
  - By dose level and all subjects
- SL-172154 in combination with azacitidine
  - Dose escalation, by dose level
  - Dose expansion, by cohort (MDS, AML with TP53 mutation or deletion)
  - All subjects from escalation and expansion cohort receiving 3mg/kg
  - All subjects from dose escalation and expansion cohort Part A and C
- SL-172154 in combination with azacitidine/venetoclax, all subjects
- Randomized cohort in dose expansion Part D by treatment arm
  - 1.0 mg/kg SL-172154+azacitidine
  - 3.0 mg/kg SL-172154+azacitidine
  - Azacitidine
- Randomized cohort in dose expansion Part E by treatment arm
  - SL-172154+azacitidine
  - Azacitidine +/- Venetoclax

Separate summary tables will be provided by dose level and all subjects receiving the same regimen for monotherapy and combination regimens in dose escalation and expansion Part A, B and C). Subjects at the same dose level from dose escalation and expansion cohorts will also be pooled together for summary tables. Summary tables by treatment arm will be provided for each randomized cohort (Expansion Part D and E). Unless specified otherwise, the following summary tables will be provided:

- Summary table by dose level and all subjects receiving SL-172154 monotherapy
- Summary table for all subjects receiving SL-172154 in combination with Azacitidine in dose escalation and expansion Part A and C. Summary will be provided for the following subgroups:
  - In dose escalation, 1mg/kg, 3.0 mg/kg, 6.0 mg/kg and all subjects in dose escalation
  - Expansion Part A: HR-MDS
  - Expansion Part C: TP53m AML
  - All subjects receiving 3.0 mg/kg SL-172154 in combination with Azacitidine from dose escalation and expansion Part A and C
  - All subjects receiving SL-172154 in combination with Azacitidine from dose escalation and expansion Part A and C, regardless of dose level
- Summary table for all subjects receiving SL-172154 in combination with Azacitidine and venetoclax in expansion Part B
- Summary table by treatment arm for HR-MDS randomized cohort in Part D

- Summary table by treatment arm for TP53m AML randomized cohort in Part E
- Summary table for select data from SL-172154 in combination with Azacitidine with the following subgroups:
    - 1.0 mg/kg SL-172154 in combination with Azacitidine from dose escalation and expansion Part D
    - 3.0 mg/kg SL-172154 in combination with Azacitidine from dose escalation and expansion Part A, C, D and E
    - SL-172154 in combination with Azacitidine from dose escalation and expansion regardless of SL-172154 dose level

Unless specified otherwise, summary tables and data listings for this section will be based on All Treated population. Separate summary will be provided for each treatment regimen: SL-172154 monotherapy, SL-172154 in combination with azacitidine, and SL-172154 in combination with azacitidine and venetoclax. Summary tables will be presented by SL-172154 dose level, dose escalation, dose expansion, and all subjects receiving the same regimen. Subjects at the same SL-172154 dose level from dose escalation and expansion cohorts will also be pooled together for each specific treatment regimen. Select summary will also be provided by treatment regimen and all subjects in the study. Specifically, summary tables will be presented as the following unless specified otherwise:

- Study level summary
    - By treatment regimen and all subjects in the study
- SL-172154 monotherapy
    - By dose level and all subjects
- SL-172154 in combination with azacitidine
    - Dose escalation, by dose level
    - Dose expansion, by cohort (MDS, AML with TP53 mutation or deletion)
    - All subjects from escalation and expansion cohort receiving the same dose level
    - All subjects from dose escalation and expansion cohort
- SL-172154 in combination with azacitidine/venetoclax
    - By cohort (safety run-in, expansion) and all subjects
    - By dose level if there are >1 dose levels

8.1 Study Drug Exposure

Study drug exposure will be summarized and listed for SL-172154, azacitidine and venetoclax respectively.

8.1.1 SL-172154

The individual subject SL-172154 administration will be provided in a data listing by treatment regimen, cohort (escalation, safety run-in, and expansion), dose level, and date of first dose. The individual SL-172154 administration at each visit including date of administration, reason for not administered, assigned dose level, body weight at C1D1, total dose(mg) and volume to be

administered, actual dose received, rate of infusion, concentration, start/end time, infusion outcome, and infusion interruption related information (if any) will be included in the listing.

The actual body weight (kg) will be used for SL-172154 dose calculation in all subjects whose body weight is <=100 kg. For subjects with body weight >100 kg, weight of 100 kg will be used for dose calculation. The subject should be dosed according to their C1D1 weight throughout the study (mg/kg) unless there is >=10% change (increase or decrease) in their weight from the weight recorded at the C1D1 visit, in which case the expected dose will be re-calculated.

The actual dose received (mg) in each dosing day will be calculated as the following:

- Total dose in mg to be administered *(actual total volume received /total volume to be administered)

The SL-172154 exposure will be summarized by dose level and all subjects for each treatment regimen. Total number of doses received, duration on SL-172154, relative dose intensity, average dose, cumulative dose, and infusion outcome will be summarized. Average dose received is calculated as the cumulative dose (mg) that a subject received divided by the total number of doses received. Duration on SL-172154 treatment is defined as:

- If the last dose is within the first 2 cycles, the duration on SL-172154 is minimum of (date of death plus 1 day, data cutoff date plus 1 day, and date of last dose +7 days) minus date of first dose.
- If the last dose is in cycle 3 or later, the duration on SL-172154 is minimum of (date of death plus 1 day, data cutoff date plus 1 day, and date of last dose +14 days) minus date of first dose.
- If the last dose is in cycle 3 or later but on the weekly schedule (before initiation of biweekly scheduled in cycle 3 or later per protocol amendment), the duration on SL-172154 is minimum of (date of death plus 1 day, data cutoff date plus 1 day, and date of last dose +7 days) minus date of first dose.

Dose compliance is defined as the total mg of SL-172154 actually taken divided by the total mg of SL-172154 assigned, expressed as a percentage. For example, if a subject received the assigned total dose of 100 mg on cycle C1D1, C1D8, and C1D15, missed a dose on C2D1, received 80 mg on C2D15 (assigned dose is 100mg) and then discontinued from study treatment, then the dose compliance is calculated as (100+100+100+0+80)/(100*5)=76%.

In addition to mean, median, minimum, and maximum, duration on SL-172154 treatment will also be summarized in the following categories: 0-4 weeks, >4 to 8 weeks, >8 to 16 weeks, >16 to 28 weeks, >28 to 40 weeks, >40 to 52 weeks, >52 to 76 weeks, and >76 weeks.

8.1.2 Azacitidine

The individual subject azacitidine administration will be provided in a data listing by treatment regimen, cohort (escalation, safety run-in, and expansion), dose level, and date of first dose. The individual azacitidine administration at each visit including date of administration, reason for not

administered, dose level, route, body area (m^2), total dose(mg), time of subcutaneous administration, start/end time and outcome for infusion will be included in the listing.

The azacitidine exposure will be summarized by SL-172154 dose level and all subjects for each azacitidine combination regimen. Total number of doses, number of treatment cycles, duration on azacitidine treatment, and dose compliance will be summarized. Dose compliance is defined as the total mg of azactidine taken divided by the total mg of azacitidine assigned, expressed as a percentage. Number of azacitidine treatment cycle is defined as number of cycles with at least at dose of azacitidine. Duration on azacitidine treatment is defined as number of cycles times 28 day.

8.1.3 Venetoclax

The individual subject venetoclax administration will be provided in a data listing by cohort (safety run-in and expansion), dose level, and date of first dose. The individual venetoclax administration at each visit including action taken prior to dosing (full dose per protocol, dose reduced, etc.) with related reason, dose (mg), start and end date will be included in the listing. Total number of doses received, duration on venentoclax treatment and dose compliance will be summarized. Duration of venetoclax treatment is defined as time from the first dose of venetoclax to the last dose of venetoclax plus one day regardless of any drug interruption. Dose compliance is defined as the total mg of venetoclax taken divided by the total mg of venetoclax assigned, expressed as a percentage.

8.2 Maximum Tolerated Dose Evaluation

The SL-172154 MTD will be estimated for SL-172154 monotherapy and SL-172154 in combination with azacitidine based on the DLT Evaluable Population. The number and percentage of subjects with DLT will be presented by dose level for SL-172154 monotherapy and SL-172154 in combination with azacitidine. The MTD level will be indicated in the summary. The number and percentage of subjects with DLT will also be summarized for SL-172154 in combination with azacitidine and venetoclax. The DLTs will listed for each treatment regimen.

The MTD will be estimated using isotonic regression (based on the DLTs observed in the DLT evaluable subjects). A MAD will be reported if the DLT rate never reaches ≥15%. Otherwise, an MTD will be reported. Isotonic regression is a way to estimate the MTD under the assumption that toxicity increases with dose. When using isotonic regression, the first step is to identify the doses where the dose-toxicity monotonicity assumption is violated. The DLT estimate is then adjusted for the violators such that the final estimate of the DLT rate increases with the dose. The target DLT rate is then used to select the MTD. For example, suppose that when the dose escalation is completed, the observed DLT rates [# subjects who experienced DLT]/[# evaluable subjects] at 4 dose levels are (0/3, 1/8, 0/5, 1/5). In this example the observed DLT rate at Dose Level 2 (i.e., 1/8=12.5%) is higher than the observed DLT rate at Dose Level 3 (i.e., 0/5=0%). To adjust for this violation, the DLT estimates are replaced with their average, i.e., (1/8+0/5)/2=1/16, resulting in the isotonic regression DLT estimates (0/3, 1/16, 1/16, 1/5), which monotonically increases with the dose level. Based on this isotonic estimate and target DLT rate of 20% for MTD, Dose Level 4 will be selected as the MTD. If there are no violators of the dose-toxicity monotonicity assumption, isotonic regression directly uses the observed DLT rates as the final estimates for MTD selection.

In the case of dose levels with estimated DLT rate of equal distance (tied dose levels) from the target toxicity of 20%, the following approach will be used: among all tied dose levels the highest dose level with DLT rate ≤ 20% will be selected, unless all tied dose levels have estimated DLT rate > 20%, in which case the lowest dose level will be selected.

8.3 Adverse Events

The AE terms on the eCRFs will be mapped to the preferred terms and system organ classes using the Medical Dictionary for Regulatory Activities (MedDRA) in the most current version available at time of analysis. All AEs except for cytokine release syndrome (CRS) will be graded as per NCI CTCAE v5. CRS will be graded per the American Society for Transplantation and Cellular Therapy Consensus Grading Criteria for CRS (Lee, 2019).

All AEs start or worsen on or after the first dose of study treatment are defined as treatment-emergent adverse events (TEAEs). Only TEAEs will be included in AE summary tables. An overview summary of TEAEs will be produced, in which number and percentages of subjects with any TEAEs, DLT, serious TEAEs, fatal TEAEs, maximum Grade 3/4 TEAEs, drug related TEAEs, drug related serious TEAEs, drug related maximum Grade 3/4 TEAEs, infusion related reaction, and TEAEs leading to drug withdrawn, dose not given/delayed, dose reduced, and infusion or drug interrupted for each treatment regimen. Drug-related TEAEs will be summarized for SL-172154, azacitidine and venetoclax, respectively. Subjects with maximum Grade3/4 TEAEs are defined as subjects whose maximum grade of all TEAEs is Grade 3 or 4, subjects with fatal AEs will not be included. Subjects with maximum Grade3/4 drug related TEAEs are defined as subjects whose maximum grade of all drug TEAEs is Grade 3 or 4, subjects with fatal drug related AEs will not be included. Grade 5 TEAEs (fatal TEAEs) will be reported separately from Grade 3 and 4 TEAEs.The overview summary of TEAEs will be provided for each treatment regimen and for AML and MDS subjects respectively in each treatment regimen.

Drug-related AEs are defined as AEs being related or possibly related to study treatment. A worst-case scenario approach will be taken for handling of missing relationship to study treatment, i.e., AEs with the relationship to study treatment as missing will be counted as drug-related AEs. Drug-related AEs include AEs related to SL-172154, azacitidine and venetoclax, respectively.

The TEAE summary tables will use the following algorithms for counting subjects:

- **Preferred term rows:** each subject is counted once within each unique preferred term at the maximum grade. For example, if a subject has two headaches, the subject is counted only once under the preferred term “Headache”. Subjects experiencing the same AE preferred term several times with different grades will only be counted once with the maximum grade.
- **SOC rows:** each subject is counted only once at the maximum grade at each SOC level although they may have several different preferred term events within the same SOC.
- **Any event row**: each subject with at least one adverse event will be counted only once at the maximum grade no matter how many events they have.

All TEAEs and non-serious TEAEs will be summarized by MedDRA system organ class, preferred term and maximum toxicity grade for each treatment regimen. The system organ class and preferred terms will be ordered by descending order of the subject incidence of system organ classes and preferred terms within each system organ class based on all subjects for each treatment regimen.

The following summary tables will be presented by MedDRA preferred term, in which the preferred terms will be order by descending order of subject incidence of preferred terms based on all subjects for each treatment regimen:

- Summary of all TEAEs.
- Summary of drug-related TEAEs (SL-172154, azacitidine, venetoclax).
- Summary of Maximum Grade 3/4 TEAEs, this will include all TEAEs with maximum toxicity grade 3 or 4. Subjects with both Grade 5 and Grade 3/4 for the same AE preferred term will not be included in the number of subjects with maximum Grade 3/4 for the specific AE preferred term. However, if a subject experiences a Grade 5 TEAE but experiences a Grade 3/4 event for other AE preferred term, this subject will be included in the number of subjects for the specific Grade 3/4 AE preferred term.
- Summary of Maximum Grade 3/4 drug-related TEAEs (SL-172154, azacitidine, venetoclax).
- Summary of serious TEAEs
- Summary of drug-related serious TEAEs (SL-172154, azacitidine, venetoclax)
- Summary of regimen-related TEAEs
- Summary of TEAEs leading to drug withdrawn for each drug
- Summary of TEAEs leading to SL-172154 dose not given/delayed, dose reduced, and infusion interrupted.
- Summary of TEAEs leading to azacitidine dose not given/delayed and dose reduced
- Summary of TEAEs leading to venetoclax drug interrupted and dose reduced.

The following summary tables by MedDRA preferred term will be provided separately for AML and MDS subjects:

- Summary of all TEAEs
- Summary of SL-172154 related TEAEs
- Summary of maximum grade 3/4 TEAEs
- Summary of serious TEAEs

Listings of all AEs, DLTs, SAEs, fatal AEs, drug related AEs, AEs leading to dose modification, and AEs leading to drug withdrawn and dose modification (dose not given/delayed, dose reduced, and infusion or drug interrupted) will be presented in data listings. Infusion related reaction along

with signs/symptoms, premedication and concomitant medication for IRR will be listed. Cytokine release syndrome (CRS) along with signs/symptoms, premedication and concomitant medication for CRS will be listed. Pretreatment AE, defined as AEs that start prior to the first dose of the study treatment, will be flagged in relevant listings. Listing of all AEs for Screen Failures population will be presented in a data listing.

8.4 Death

All death records will be presented in a data listing. Subject incidence of deaths within and outside of 30 days of last dose and cause of death will be summarized.

8.5 Clinical Laboratory Evaluation

The clinical laboratory evaluation includes the following:

- Hematology: hemoglobin, hematocrit, platelet count, red blood cell count, white blood cell count with differential.
- Clinical chemistry: blood urea nitrogen or urea, creatinine, glucose, sodium, potassium, calcium, magnesium, phosphorus, total protein, albumin, lactate dehydrogenase, bicarbonate, or CO2.
- Liver panel: ALT, AST, total and direct bilirubin, and alkaline phosphatase.
- Thyroid: thyroid stimulating hormone, free thyroxine 4.
- Coagulation: prothrombin time, international normalized ratio, activated partial thromboplastin time, fibrinogen, and D-dimer.

The clinical laboratory grades will be reported using the CTCAE v5.0. All clinical laboratory data will be included in the listing. Separate listings will be provided for haematology, clinical chemistry, liver panel, thyroid, and coagulation tests. For each listing, baseline value will be specified for each subject.

Hematology, clinical chemistry, liver panel, and coagulation will be summarized for the worst case shift from baseline toxicity grade for each treatment regimen. Frequencies of baseline toxicity grade along with the maximum observed toxicity grade, as defined by the NCI CTCAE v5.0, will be presented for each laboratory parameter. The determination of the maximum grade post-baseline considers both planned and unscheduled assessments. Separate summaries indicating hyper- and hypo- directionality of change will be produced, where appropriate.

For those laboratory parameters that cannot be graded by the NCI CTCAE, the frequencies of the post-baseline laboratory value categorized as below normal range, within normal range and above normal range will be summarized. If a subject has a decrease to below normal range and an increase to above normal range, then the subject is counted in both the below normal range category and the above normal range category.

Selected laboratory parameters including but not limited to hemoglobin, platelet counts, and neutrophils counts will be plotted over time.

Subjects with elevated post-baseline ALT, AST or Total Bilirubin that fall into the following categories will be summarized for each treatment regimen.

Liver Function Parameters	Category
ALT	≥ 3 × ULN
AST	≥ 3 × ULN
Total bilirubin	≥ 2 × ULN
Potential Hy's law	(AST ≥ 3 × ULN or ALT ≥ 3 × ULN) and (Total Bilirubin ≥ 2 × ULN)[a]
ULN: upper limit of normal range. [a] Total Bilirubin ≥ 2 × ULN is defined as at least one case of post-dose TBL ≥ 2 x ULN occurred at the same day or after the first incidence date of ALT or AST ≥ 3 x ULN post treatment.	

8.6 Blood Phenotype and Direct Antiglobulin Test

Blood phenotype and DAT assessment date and result will be presented in a data listing.

8.7 Vital Signs and Pulse Oximetry

Vital signs (blood pressure, heart rate, respiration rate, temperature) and pulse oximetry will be presented in a data listing. Body weight along with percent change from baseline will be presented in a data listing.

8.8 Cardiac Assessments

Cardiac assessments by ECHO and 12-lead ECG will be presented in a data listing.

8.9 ECOG Performance Status

Eastern Cooperative Oncology Group (ECOG) performance status scores will be summarized for baseline, and worst-case shift from baseline in a table and presented in a data listing.

9. PHARMACOKINETIC ANALYSES

The merge of SL-172154 serum concentration with CRF data will be performed after database lock by Shattuck Labs to generate a dataset with actual PK sampling times, actual time relative to the start of infusion, and SL-172154 concentrations. Derivation of PK parameters will be performed by Certara using Phoenix WinNonlin (Version 8.4 or higher).

Unless specified otherwise, all PK data analysis will be based on PK population. Subjects who have infusion outcome as "Not Completed" on the PK sample collection day will be included in the summary of dose normalized PK parameter but will be excluded from other summary by dose level for the corresponding PK sample collection day. The PK concentration and PK parameters will be summarized as the following:

- SL-172154 monotherapy, by dose level
- SL-172154 in combination with azacitidine

- Dose escalation, by dose level
- Dose expansion, by cohort (HR-MDS, AML with TP53 mutation or deletion)
- All subjects from escalation and expansion cohort receiving 3mg/kg SL-172154+azacitidine

9.1 Data Handling

The nominal time relative to the start of infusion will be calculated as the planned time relative to the end of infusion plus the planned infusion duration as in table 9 below:

Table 9. Nominal time relative to start of infusion

Timepoint	Nominal Infusion Time (Hours)			
	0.5	1	2	3
Predose	Predose	Predose	Predose	Predose
EOI	0.5	1	2	3
0.5 hour post EOI	1	1.5	2.5	3.5
1 hour post EOI	1.5	2	3	4
1.5 hours post EOI	2	2.5	3.5	4.5
2 hours post EOI	2.5	3	4	5
4 hours post EOI	4.5	5	6	7
6 hours post EOI	6.5	7	8	9
EOI=end of infusion				

The actual time relative to the start of infusion will be calculated as the actual sampling time relative to the start of infusion (SOI) or the SOI of the first infusion period if there is (are) infusion interruption(s). Missing PK sampling time will be handled as the following when calculating the actual time relative to SOI:

- If a sampling time is missing and no infusion interruption, the actual time relative to SOI will be calculated as time from SOI to end of infusion (EOI) plus planned time relative EOI.
- If a sampling time is missing and there is interruption(s) during the infusion, the actual time relative to SOI will be calculated as time from the SOI of first infusion period to the EOI of the last infusion period plus planned infusion time relative to EOI.

Concentration values that are below the limit of quantification (BLQ) will be handled as the following:

- If a BLQ value occurs at the predose, the BLQ value will be assigned as zero concentration. If one or more BLQ values occur in a profile after infusion but before the first measurable concentration, the BLQ values will be assigned a value of zero concentration. For linear plots, zero concentration value(s) will be included in the plot. For log-linear plots, zero concentration value(s) will be assigned a missing value.
- If a BLQ value occurs after a measurable concentration in a profile and is followed by a measurable concentration, then the BLQ will be set as missing.

- If a BLQ value occurs after the last measurable concentration in a profile, then the BLQ values will be set as missing.
- If two or more BLQ values occur in succession after a measurable concentration, the profile will be deemed to have terminated at the first BLQ value (BLQ values will be set to missing) and any subsequent concentration will be set as missing.
- BLQ values that are set to be missing will be omitted from PK parameter generation, concentration summary, and the individual PK profile plots.
- For the time point that all concentrations are BLQ and all BLQ results are imputed to be zero, then the mean/median concentration will be reported as zero.

9.2 SL-172154 Concentration

SL-172154 concentration will be summarized for each nominal time point relative to the EOI. Standard summary statistics will be calculated (i.e., mean, standard deviation, median, minimum, maximum, coefficient of variation (CV%), geometric mean, geometric CV%).

SL-172154 concentration will be sorted by cohort, dose level, sample collection day and nominal time in the listing. All SL-172154 concentration values will be listed in the same precision as the source data.

The individual concentration-time (**actual time since SOI**) profiles by dose level will be provided. The mean profile with mean+/- SD at each **nominal time form EOI** will be provided by dose level. For SL-172154 monotherapy, the mean profile will be plotted for C1D1, C1D15 and C2D1. For SL-172154 in combination with azacitidine, the mean profile will be plotted for C1D2, C1D16 and C2D2; the dose level of 3.0 mg/kg will include subjects from dose escalation and expansion part A and C. Each of the figures will contain one plot on the untransformed scale (i.e. linear plot) and one plot on the log transformed scale (i.e. semi-log plot).

9.3 SL-172154 PK Parameters

The PK parameters will be derived from the concentration-time data using the actual collection time from SOI. The PK parameters will be calculated by standard non-compartmental analysis (NCA) as data permits. At least one post-dose concentration at planned time of end of infusion or 0.5hour post end of infusion is required for C_{max} calculation, and at least three consecutive post-dose concentrations are required for AUC parameter calculation.

Table 10 SL-172154 PK Parameters

C_{max}	Maximum observed concentration over a dosing interval
C_{last}	Last quantifiable concentration
T_{max}	Time of maximum observed concentration
$AUC_{0\text{-}last}$	The area under the serum concentration time curve, from time 0 to the last quantifiable concentration, calculated by a combination of linear and logarithmic trapezoidal methods (Linear up/log down method).

$AUC_{0\text{-}inf}$	Area under the serum concentration time curve from time 0 extrapolated to infinity, calculated as $AUC_{0\text{-}last}$ + C_{last}/terminal elimination rate constant (λ_z). Reliability of $AUC_{0\text{-}inf}$ values is contingent on the percent of the total area obtained by extrapolation: $AUC_{0\text{-}inf}$ values with <20% of the total area coming from C_{last}/λ_z are considered acceptable. Any exceptions to the above procedures will be clearly documented/justified in the report.
AUC_{tau}	The area under the serum concentration time curve over the dosing interval, calculated by a combination of linear and logarithmic trapezoidal methods (Linear up/log down method).
$\%AUC_{ext}$	Percentage of $AUC_{0\text{-}inf}$ due to extrapolation from T_{last} to infinity
$t_{½}$	Terminal elimination half-life, estimated using the equation [ln(2)/λ_z]
CL	Clearance; calculated as Dose/$AUC_{0\text{-}inf}$ after the first dose and Dose/AUC_{tau} for later time unless specified otherwise
Vz	Volume of distribution, calculated as Dose/(λ_z * $AUC_{0\text{-}inf}$) for first dose and Dose/(λ_z * AUC_{tau}) for later time unless specified otherwise
AR_{AUCtau}	Accumulation ratio of AUC_{tau} or $AUC_{0\text{-}xx}$ (over the dosing interval), C1D15/C1D1 and C2D1/C1D1 for monotherapy and C1D16/C1D2 and C2D2/C1D2 for combination
AR_{Cmax}	Accumulation ratio of C_{max} (C1D15/C1D1 and C2D1/C1D1 for monotherapy and C1D16/C1D2 and C2D2/C1D2 for combination).

The elimination rate constant (λ_z) will be determined if the log-linear terminal elimination phase is apparent and excludes C_{max}. The λ_z will only be considered reliable if the adjusted coefficient of determination (adj-R^2) is greater than or equal to 0.8. Parameters dependent on λ_z (i.e., $t_{1/2}$, $AUC_{0\text{-}inf}$, $AUC_{\%ext}$, CL, Vz) will not be presented if λ_z cannot be estimated.

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

- λ_z lower: Lower limit of time (h) included in the calculation of λ_z
- λ_z N: Number of data points used in the calculation of λ_z
- λ_z upper: Upper limit of time (h) included in the calculation of λ_z
- Adjusted-R^2: Regression coefficient for calculation of λ_z

All PK parameters will be sorted by dose level in the listing and summarized by dose level at each PK sample collection day for SL-172154 monotherapy and SL-172154 in combination with azacitidine, respectively. For each of the PK parameters, except T_{max}, the following summary statistics will be calculated: median, minimum, maximum, arithmetic mean, standard deviation, CV%, geometric mean, and geometric CV%. For T_{max}, median, minimum, and maximum will be calculated. All PK parameters will be reported with the same precision as the source concentration data except that T_{max} and $t_{1/2}$ will be reported with 2 decimal places and λ_z will be reported with at least 3 significant figures.

9.4 Assessment of Dose Proportionality

An assessment of dose proportionality will not be based strictly on statistical rule criteria but rather, several factors will be considered when assessing dose proportionality, such as results derived from graphical evaluation (box plots of dose-normalized PK parameters) and descriptive statistics of PK parameters by dose, as data permit.

Dose normalized PK parameters will be calculated by dividing total administered dose (mg) for AUC0-inf, AUC0-last, AUCtau, and Cmax. Dose proportionality will be evaluated graphically using box plots of dose normalized PK parameters (AUC0-inf, AUC0-last, AUCtau, and Cmax) by dose level for each collection day.

10.IMMUNOGENICITY

The ADA and Nab data analysis will be based on Immunogenicity population and summarized as the following:

- SL-172154 monotherapy, by dose level
- SL-172154 in combination with azacitidine
    - Dose escalation, by dose level
    - Dose expansion, by cohort (HR-MDS, AML with TP53 mutation or deletion)
    - All subjects from escalation and expansion cohort receiving 3mg/kg
    - All subjects from escalation and expansion cohort regardless of dose level

ADA data will be summarized among all subjects who are ADA negative or missing right before the first dose of SL-172154 in Immunogenicity population. Number of subjects with treatment induced ADA, sustained ADA, persistent ADA, CD40/CD40L neutralizing antibody (Nab), and onset and duration of treatment induced ADA will be summarized. Sustained ADA response was defined as treatment induced ADA in ≥2 consecutive samples without a subsequent negative sample or in the last sample. Persistent ADA response was defined as treatment induced ADA in ≥2 samples, with the first and last samples (irrespective of any negative in between) separated by ≥16 weeks, or only in 1 sample but the last sample, or only in 1 sample but less than 16 weeks before a negative last sample. ADA and Nab data will be listed for all subjects in Immunogenicity population. Subjects with a positive ADA will have their samples analyzed for Nab.

11. LITERATURE REFERENCES

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2. Brookmeyer, R. and Crowley, J. (1982). A confidence interval for the median survival time. Biometrics 38 29-41.
3. Cheson BD, Bennett JM, Kopecky KJ, et al. Revised recommendations of the International Working Group for Diagnosis, Standardization of Response Criteria, Treatment Outcomes, and Reporting Standards for Therapeutic Trials in Acute Myeloid Leukemia. J Clin Oncol 2003;21:4642-9.

4. 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;108:419-25.
5. Dohner H, Estey E, Grimwade D, et al. Diagnosis and management of AML in adults: 2017 ELN recommendations from an international expert panel. Blood 2017;129:424-47.
6. Guo W, Wang SJ, Yang S, Lynn H, Ji Y. A Bayesian interval dose-finding design addressing Ockham's razor: mTPI-2. Contemp Clin Trials 2017; 58:23-33.
7. Lee DW, Santomasso BD, Locke FL, et al. ASTCT Consensus Grading for Cytokine Release Syndrome and Neurologic Toxicity Associated with Immune Effector Cells. Biol Blood Marrow Transplant 2019;25:625-38.

12.APPENDIX: LIST OF TABLES, FIGURES AND LISTINGS

Tables, listings and figures for abbreviated clinical study report (aCSR) are specified.

12.1 List of Tables

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
14.1		**Demographics**		
	14.1.1.1	Study Populations and Subject Disposition by Treatment Regimen and All Subjects	Screened	Yes
	14.1.1.2	Study Populations and Subject Disposition for SL-172154 Monotherapy	All Treated	Yes
	14.1.1.3	Study Populations and Subject Disposition for SL-172154 in Combination with Azacitidine	All Treated	Yes
	14.1.1.4	Study Populations and Subject Disposition for Part D Randomized Cohort in HR-MDS	ITT	Yes
	14.1.2.1	Study Treatment Status for SL-172154 Monotherapy	All Treated	Yes
	14.1.2.2	SL-172154 Treatment Status for SL-172154 in Combination with Azacitidine	All Treated	Yes
	14.1.2.3	SL-172154 Treatment Status for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A and C)	All Treated	Yes
	14.1.2.4	Azacitidine Treatment Status for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A and C)	All Treated	Yes
	14.1.2.5	SL-172154 Treatment Status for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.1.2.6	Azacitidine Treatment Status for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.1.3.1	Protocol Deviations All Subjects	All Treated	Yes
	14.1.4.1	Demographic and Baseline Characteristics for All Subjects Receiving SL-172154 Monotherapy	All Treated	Yes

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.1.4.2	Demographic and Baseline Characteristics for All Subjects Receiving SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A and C	All Treated	Yes
	14.1.4.3	Demographic and Baseline Characteristics for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	14.1.4.4	Demographic and Baseline Characteristics for HR-MDS in Part D Randomized Cohort	ITT	Yes
	14.1.5.1	AML Cancer History for SL-172154 Monotherapy	All Treated	Yes
	14.1.5.2	AML Cancer History for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion	All Treated	Yes
	14.1.6.1	MDS Cancer History for SL-172154 Monotherapy	All Treated	Yes
	14.1.6.2	MDS Cancer History for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A	All Treated	Yes
	14.1.6.3	MDS Cancer History for Part D Randomized Cohort in HR-MDS	ITT	Yes
	14.1.7.1	Prior Systemic Anti-Cancer Therapy for AML Subjects Receiving SL-172154 Monotherapy	All Treated	Yes
	14.1.7.2	Prior Systemic Anti-Cancer Therapy for AML for Subjects Receiving SL-172154 in Combination with Azacitidine	All Treated	Yes
	14.1.8.1	Prior Hematopoietic Cell Transplantation for AML for Subjects Receiving SL-172154 Monotherapy	All Treated	Yes
	14.1.8.2	Prior Hematopoietic Cell Transplantation for AML for Subjects Receiving SL-172154 in Combination with Azacitidine	All Treated	Yes
	14.1.9.1	Prior Systemic Anti-Cancer Therapy for MDS for Subjects Receiving SL-172154 Monotherapy	All Treated	Yes
	14.1.10.1	Prior Hematopoietic Cell Transplantation for MDS for Subjects Receiving SL-172154 Monotherapy	All Treated	Yes
14.2		**Efficacy**		
	14.2.2.1	AML Best Response Per ELN2017 for SL-172154 Monotherapy	All Treated	Yes
	14.2.2.2	AML Best Response Per ELN2017 for SL-172154 in Combination with Azacitidine	All Treated	Yes
	14.2.3.1	Time to Response and Duration of Response for AML Subject Receiving SL-172154 Monotherapy	All Treated	No
	14.2.3.2	Time to Response and Duration of Response for AML Subjects Receiving SL-172154 in Combination with Azacitidine	All Treated	No

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.2.3.3	Time to Response and Duration of Response for Previously Untreated TP53m AML Subjects Receiving SL-172154 in Combination with Azacitidine in Expansion Part C	ALL Treated	Yes
	14.2.4.1	AML Event Free Survival for SL-172154 Monotherapy	All Treated	No
	14.2.4.2	AML Event Free Survival for SL-172154 in Combination with Azacitidine	All Treated	No
	14.2.5.1	Transfusion Independence for AML Subjects Receiving SL-172154 Monotherapy	All Treated	No
	14.2.5.2	Transfusion Independence for Previously Untreated TP53m AML Subjects Receiving SL-172154 in Combination with Azacitidine	All Treated	Yes
	14.2.5.3	Transfusion Independence for AML Subjects Receiving SL-172154 in Combination with Azacitidine	All Treated	No
	14.2.6.1	Overall Survival for AML Subjects Receiving SL-172154 Monotherapy	All Treated	No
	14.2.6.2	Overall Survival for AML Subjects Receiving SL-172154 in Combination with Azacitidine in Dose Escalation	All Treated	No
	14.2.6.3	Overall Survival for Previously Untreated TP53m AML Subjects Receiving SL-172154 in Combination with Azacitidine	All Treated	Yes
	14.2.7.1	MDS Best Unconfirmed Response Per IWG 2006 Criteria for SL-172154 Monotherapy	All Treated	yes
	14.2.7.2	MDS Best Unconfirmed Response Per IWG 2006 Criteria for SL-172154 in Combination with Azacitidine	All Treated	yes
	14.2.7.3	MDS Best Unconfirmed Response Per IWG2006 Criteria by TP53 Mutation Status Based on Local Assessment for Previously Untreated HR-MDS Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	14.2.7.4	MDS Best Unconfirmed Response Per IWG2006 Criteria by TP53 Mutation Status Based on Central Assessment for Previously Untreated HR-MDS Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	14.2.8.1	MDS Hematologic Improvement Per IWG 2006 Criteria for SL-172154 Monotherapy	All Treated	No
	14.2.8.2	MDS Hematologic Improvement Per IWG 2006 Criteria for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	No

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.2.8.3	MDS Hematologic Improvement Per IWG2006 Criteria for Previously Untreated HR-MDS Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	No
	14.2.9.1	Time to Response and Duration of Response for HR-MDS Subject Receiving SL-172154 Monotherapy	All Treated	No
	14.2.9.2	Time to Response and Duration of Response for Previously Untreated HR-MDS Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	14.2.9.3	Time to Response and Duration of Response for HR-MDS Subjects Receiving SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	No
	14.2.10.1	MDS Progression Free Survival for SL-172154 Monotherapy	All Treated	No
	14.2.10.2	MDS Progression Free Survival for SL-172154 in Combination with Azacitidine	All Treated	No
	14.2.11.1	MDS Event Free Survival for SL-172154 Monotherapy	All Treated	No
	14.2.11.2	MDS Event Free Survival for SL-172154 in Combination with Azacitidine	All Treated	No
	14.2.12.1	Time to Transformation to AML for SL-172154 Monotherapy	All Treated	No
	14.2.12.2	Time to Transformation to AML for Previously Untreated HR-MDS Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	14.2.13.1	Transfusion Independence for HR-MDS Subjects Receiving SL-172154 Monotherapy	All Treated	No
	14.2.13.2	Transfusion Independence for Previously Untreated HR-MDS Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	14.2.13.3	Transfusion Independence for HR-MDS Subjects Receiving SL-172154 in Combination with Azacitidine	All Treated	No
	14.2.14.1	Overall Survival for HR-MDS Subjects Receiving SL-172154 Monotherapy	All Treated	Yes
	14.2.14.2	Overall Survival for HR-MDS Subjects SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.2.14.3	Overall Survival for Previously Untreated HR-MDS Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
14.3		**Safety**		
14.3.1		**Study drug exposure/adverse event**		
	14.3.1.1.1	SL-172154 Exposure for All Subjects Receiving SL-172154 Monotherapy	All Treated	Yes
	14.3.1.1.2	SL-172154 Exposure for All Subjects Receiving SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	14.3.1.1.3	SL-172154 Exposure for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 **3mg/kg** in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.1.4	SL-172154 Exposure for Part D Randomized Cohort in HR-MDS	All treated	Yes
	14.3.1.2.1	Azacitidine Exposure for All Subjects Receiving SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.2.2	Azacitidine Exposure for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 **3mg/kg** in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.2.3	Azacitidine Exposure for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.3.1	Overall Summary of Treatment Emergent Adverse Events for All Subjects Receiving SL-172154 Monotherapy	All Treated	Yes
	14.3.1.3.2	Overall Summary of Treatment Emergent Adverse Events for All Subjects Receiving SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.3.3	Overall Summary of Treatment Emergent Adverse Events for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 **3mg/kg** in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.3.4	Overall Summary of Treatment Emergent Adverse Events for Randomized Part D in HR-MDS	All Treated	Yes
	14.3.1.4.1	Dose Limiting Toxicities for SL-172154 Monotherapy	DLT Evaluable	Yes

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.3.1.4.2	Dose Limiting Toxicities for SL-172154 in Combination with Azacitidine Dose Escalation	DLT Evaluable	Yes
	14.3.1.5.1	All Treatment Emergent Adverse Events by System Organ Class and Preferred Term for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.5.2	All Treatment Emergent Adverse Events by System Organ Class and Preferred Term for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion part A and C	All Treated	Yes
	14.3.1.5.3	All Treatment Emergent Adverse Events by System Organ Class and Preferred Term for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.5.4	All Treatment Emergent Adverse Events by System Organ Class and Preferred Term for Randomized Cohort Part D in HR-MDS	All Treated	Yes
	14.3.1.6.1	All Treatment Emergent Adverse Events by Preferred Term for All Subjects Receiving SL-172154 Monotherapy	All Treated	Yes
	14.3.1.6.2	All Treatment Emergent Adverse Events by Preferred Term for All Subjects Receiving SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.6.3	All Treatment Emergent Adverse Events by Preferred Term for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.6.4	All Treatment Emergent Adverse Events by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.7.1	Serious Treatment Emergent Adverse Events by Preferred Term for All Subjects Receiving SL-172154 Monotherapy	All Treated	Yes
	14.3.1.7.2	Serious Treatment Emergent Adverse Events by Preferred Term for All Subjects Receiving SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.7.3	Serious Treatment Emergent Adverse Events by Preferred Term for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 **3mg/**kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.7.4	Serious Treatment Emergent Adverse Events by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.8.1	Treatment Emergent Fatal Adverse Events by Preferred Term for SL-172154 Monotherapy	All Treated	Yes

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.3.1.8.2	Treatment Emergent Fatal Adverse Events by Preferred Term for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.8.3	Treatment Emergent Fata Adverse Events by Preferred Term for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 **3mg/kg** in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.8.4	Treatment Emergent Fatal Adverse Events by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	No
	14.3.1.9.1	Maximum Toxicity Grade 3/4 Treatment Emergent Adverse Events by Preferred Term for All Subjects Receiving SL-172154 Monotherapy	All Treated	Yes
	14.3.1.9.2	Maximum Toxicity Grade 3/4 l Treatment Emergent Adverse Events by Preferred Term for All Subjects Receiving SL-172154 in Combination with Azacitidine for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.9.3	Maximum Toxicity Grade 3/4 Treatment Emergent Adverse Events by Preferred Term for Previously Untreated HR-MDS and TP53 AML Subjects Receiving SL-172154 **3mg/kg** in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.9.4	Toxicity Grade 3/4 Treatment Emergent Adverse Events by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.10.1	SL-172154-Related Treatment Emergent Adverse Events by Preferred Term for All Subjects Receiving SL-172154 Monotherapy	All Treated	Yes
	14.3.1.10.2	SL-172154-Related Treatment Emergent Adverse Events by Preferred Term for All Subjects Receiving SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.10.3	SL-172154-Related Treatment Emergent Adverse Events by Preferred Term for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.10.4	SL-172154-Related Treatment Emergent Adverse Events by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.11.1	Azacitidine-Related Treatment Emergent Adverse Events by Preferred Term for All Subjects Receiving SL-172154 in Combination with Azacitidine	All Treated	Yes

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.3.1.11.2	Azacitidine -Related Treatment Emergent Adverse Events Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.12.1	SL-172154-Related **Serious** Treatment Emergent Adverse Events by Preferred Term for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.12.2	SL-172154-Related **Serious** Treatment Emergent Adverse Events by Preferred Term for SL-172154 in Combination with Azacitidine (Dose Escalation and	All Treated	Yes
	14.3.1.12.3	SL-172154-Related Serious Treatment Emergent Adverse Events by Preferred Term for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 **3mg/kg** in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.12.4	SL-172154-Related **Serious** Treatment Emergent Adverse Events by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.12.5	Azacitidine-Related **Serious** Treatment Emergent Adverse Events Preferred Term for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.12.6	Azacitidine-Related **Serious** Treatment Emergent Adverse Events by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.13.1	SL-172154-Related Maximum **Grade 3/4** Treatment Emergent Adverse Events by Preferred Term for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.13.2	SL-172154-Related Maximum **Grade 3/4** Treatment Emergent Adverse Events by Preferred Term for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.13.3	SL-172154-Related Maximum **Grade 3/4** Treatment Emergent Adverse Events by Preferred Term for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.13.4	SL-172154-Related Maximum **Grade 3/4** Treatment Emergent Adverse Events by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.14.1	Azacitidine-Related Maximum **Grade 3/4** Treatment Emergent Adverse Events Preferred Term for All Subjects Receiving SL-172154 in Combination with Azacitidine	All Treated	Yes

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.3.1.14.3	Azacitidine -Related Maximum **Grade 3/4** Treatment Emergent Adverse Events Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.15.1	Treatment Emergent Adverse Events Leading to SL-172154 Dose Not Given/Delayed by Preferred Term for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.15.2	Treatment Emergent Adverse Events Leading to SL-172154 Dose Not Given/Delayed by Preferred Term for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.15.3	Treatment Emergent Adverse Events Leading to SL-172154 Dose Not Given/Delayed by Preferred Term for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.15.4	Treatment Emergent Adverse Events Leading to SL-172154 Dose Not Given/Delayed by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.16.1	Treatment Emergent Adverse Events Leading to SL-172154 Infusion Interrupted by Preferred Term for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.16.2	Treatment Emergent Adverse Events Leading to SL-172154 Infusion Interrupted by Preferred Term for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.16.3	Treatment Emergent Adverse Events Leading to SL-172154 Infusion Interruption by Preferred Term for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.16.4	Treatment Emergent Adverse Events Leading to SL-172154 Infusion Interrupted by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.17.1	Treatment Emergent Adverse Events Leading to SL-172154 Dose Reduced by Preferred Term for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.17.2	Treatment Emergent Adverse Events Leading to SL-172154 Dose Reduced by Preferred Term for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.3.1.17.3	Treatment Emergent Adverse Events Leading to SL-172154 Dose Reduction by Preferred Term for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.17.4	Treatment Emergent Adverse Events Leading to SL-172154 Dose Reduced by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.18.1	Treatment Emergent Adverse Events Leading to SL-172154 Withdrawn by Preferred Term for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.18.2	Treatment Emergent Adverse Events Leading to SL-172154 Withdrawn by Preferred Term for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.18.3	Treatment Emergent Adverse Events Leading to SL-172154 Withdrawn by Preferred Term for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.18.4	Treatment Emergent Adverse Events Leading to SL-172154 Withdrawn by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.19.1	SL-172154 Related Infusion Related Reaction at Subject Level for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.19.2	SL-172154 Related Infusion Related Reaction at Subject Level for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.19.3	SL-172154 Related Infusion Related Reaction at Subject Level for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.19.4	SL-172154 Related Infusion Related Reaction at Subject Level for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.20.1	SL-172154 Related Infusion Related Reaction at Event Level for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.20.2	SL-172154 Related Infusion Related Reaction at Event Level for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.20.3	SL-172154 Related Infusion Related Reaction at Event Level for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.3.1.19.4	SL-172154 Related Infusion Related Reaction at Subject Level for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.21.1	Symptoms of SL-172154 Related Infusion Related Reaction at Event Level for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.21.2	Symptoms of SL-172154 Related Infusion Related Reaction at Event Level for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.21.3	Symptoms of SL-172154 Related Infusion Related Reaction at Event Level for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.21.4	Symptoms of SL-172154 Related Infusion Related Reaction at Subject Level for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.21.5	Symptoms of SL-172154 Related Infusion Related Reaction at Subject Level for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.21.6	Symptoms of SL-172154 Related Infusion Related Reaction at Subject Level for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.21.8	Symptoms of SL-172154 Related Infusion Related Reaction at Event Level for Part D Randomization Cohort in HR-MDS	All Treated	Yes
	14.3.1.21.9	Symptoms of SL-172154 Related Infusion Related Reaction at Event Level for Part D Randomization Cohort in HR-MDS	All Treated	Yes
	14.3.1.22.1	Deaths for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.22.2	Deaths for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.22.3	Deaths for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.22.4	Deaths for Part D Randomization Cohort in HR-MDS	All Treated	Yes
	14.3.1.23.1	All Treatment Emergent Adverse Events by System Organ Class, Preferred Term and Maximum Toxicity Grade for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.23.2	All Treatment Emergent Adverse Events by System Organ Class, Preferred Term and Maximum Toxicity Grade for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.3.1.23.3	All Treatment Emergent Adverse Events by System Organ Class, Preferred Term and Maximum Toxicity Grade for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.1.23.4	All Treatment Emergent Adverse Events by System Organ Class, Preferred Term and Maximum Toxicity Grade for Part D Randomization Cohort in HR-MDS	All Treated	Yes
	Non-serious treatment emergent AE (>=5% for total at preferred term level)			
	14.3.1.24.1	Non-Serious Treatment Emergent Adverse Events (>=5%) by System Organ Class and Preferred Term for SL-172154 Monotherapy	All Treated	Yes
	14.3.1.24.2	Non-Serious Treatment Emergent Adverse Events (>=5%) by System Organ Class and Preferred Term for SL-172154 in Combination with Azacitidine in Dose Escalation	All Treated	Yes
	14.3.1.24.3	Non-Serious Treatment Emergent Adverse Events (>=5%) by System Organ Class and Preferred Term for SL-172154 in Combination with Azacitidine in Dose Expansion Part A and C	All Treated	Yes
	14.3.1.24.4	Non-Serious Treatment Emergent Adverse Events (>=5%) by System Organ Class and Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.1.25.1	Toxicity Grade 3/4/5 Treatment Emergent Adverse Events (>=5%) by System Organ Class and Preferred Term for All Subjects Receiving SL-172154 Monotherapy	All Treated	No
	14.3.1.25.2	Toxicity Grade 3/4/5 Treatment Emergent Adverse Events by Preferred Term for All Subjects Receiving SL-172154 in Combination with Azacitidine	All Treated	No
	14.3.1.25.3	Toxicity Grade 3/4/5 Treatment Emergent Adverse Events by Preferred Term for Part D Randomized Cohort in HR-MDS	All Treated	No
14.3.5		**Laboratory**		
	14.3.5.1.1	Hematology – Maximum CTCAE Grade Shift from Baseline for All Subjects Receiving SL-172154 Monotherapy	All Treated	No
	14.3.5.1.2	Hematology – Maximum CTCAE Grade Shift from Baseline for All Subjects Receiving SL-172154 in combination with Azacitidine	All Treated	No
	14.3.5.2.1	Chemistry – Maximum CTCAE Grade Shift from Baseline for SL-172154 Monotherapy	All Treated	No
	14.3.5.2.2	Chemistry – Maximum CTCAE Grade Shift from Baseline for SL-172154 in combination with Azacitidine	All Treated	No

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.3.5.3.1	Liver Function Tests – Maximum CTCAE Grade Shift from Baseline for All Subjects Receiving SL-172154 Monotherapy	All Treated	Yes
	14.3.5.3.2	Liver Function Tests – Maximum CTCAE Grade Shift from Baseline for All Subjects Receiving SL-172154 in combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.5.3.3	Liver Function Tests – Maximum CTCAE Grade Shift from Baseline for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	14.3.5.4.1	Coagulation Tests – Maximum CTCAE Grade Shift from Baseline for SL-172154 Monotherapy	All Treated	No
	14.3.5.4.2	Coagulation Tests – Maximum CTCAE Grade Shift from Baseline for SL-172154 in combination with Azacitidine	All Treated	No
	14.3.5.5.1	Laboratory Results without CTCAE - Maximum Shift from Baseline with Respect to Normal Range for SL-172154 Monotherapy	All Treated	No
	14.3.5.5.2	Laboratory Results without CTCAE - Maximum Shift from Baseline with Respect to Normal Range for SL-172154 in combination with Azacitidine	All Treated	No
	14.3.5.6.1	Worst Case Post Baseline Liver Function Tests for SL-172154 Monotherapy	All Treated	Yes
	14.3.5.6.2	Worst Case Post Baseline Liver Function Tests for SL-172154 in combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.5.6.3	Worst Case Post Baseline Liver Function Tests for Previously Untreated HR-MDS and TP53m AML Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.5.6.4	Worst Case Post Baseline Liver Function Tests for Part D Randomized Cohort in HR-MDS	All Treated	Yes
14.3.6		**Other Safety Data**		
	14.3.6.1.1	ECOG Performance Status – Maximum Shift from Baseline for SL-172154 Monotherapy	All Treated	Yes
	14.3.6.1.2	ECOG Performance Status – Maximum Shift from Baseline for SL-172154 in combination with Azactidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	14.3.6.1.3	ECOG Performance Status – Maximum Shift from Baseline for Part D Randomized Cohort in HR-MDS	All Treated	Yes
14.3.7		PK		

ICH Heading	Table Number	Table Description	Analysis Population	aCSR
	14.3.7.1	SL-172154 Serum Concentration-Time Data for SL-172154 Monotherapy	PK	Yes
	14.3.7.2	SL-172154 Serum Concentration-Time Data for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	PK	Yes
	14.3.7.3	SL-172154 PK Parameters for SL-172154 Monotherapy	PK	Yes
	14.3.7.4	SL-172154 PK Parameters for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	PK	Yes
14.3.8		Immunogenicity		
	14.3.8.1	Treatment Induced Anti-Drug Antibody for SL-172154 Monotherapy	Immunogenicity	Yes
	14.3.8.2	Treatment Induced Anti-Drug Antibody for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	Immunogenicity	Yes

12.2 List of Figures

ICH Heading	Figure Number	Figure Description	Analysis Population	aCSR
14.2				
	14.2.1.1	Plot of Duration of SL-172154 Treatment by Response for Previously Untreated AML with TP53m (Dose Expansion Part C)	All Treated	Yes
	14.2.1.2	Plot of Duration on SL-172154 Treatment by Response for Previously Untreated HR-MDS Subjects Receiving SL-172154 3mg/kg with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	14.2.2.1	Plot of Maximum Percent Reduction in Bone Marrow Blast from Baseline for AML Subjects in SL-172154 Monotherapy	All Treated	Yes
	14.2.2.2	Plot of Maximum Percent Reduction in Bone Marrow Blast from Baseline for AML Subjects in SL-172154 in Combination with Azacitidine (Dose Escalation)	All Treated	yes
	14.2.2.3	Plot of Maximum Percent Reduction in Bone Marrow Blast from Baseline for Previously Untreated TP53m AML Receiving SL-172154 in Combination with Azacitidine (Expansion Part C)	All Treated	yes
	14.2.2.4	Plot of Maximum Percent Reduction in Bone Marrow Blast from Baseline for Previously Untreated HR-MDS Subjects Receiving SL-172154 3mg/kg with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	yes
	14.2.3.1	Kaplan-Meier Plot of Duration of CR for AML Subjects in SL-172154 in Combination with Azacitidine in Expansion Part C	All Treated	Yes
	14.2.3.2	Kaplan-Meier Plot of Duration of CR/CRi for AML Subjects in SL-172154 in Combination with Azacitidine in Expansion Part C	All Treated	Yes

	14.2.3.3	Kaplan-Meier Plot of Duration of CR/CRh for AML Subjects in SL-172154 in Combination with Azacitidine in Expansion Part C	All Treated	Yes
	14.2.3.4	Kaplan-Meier Plot of Duration for Objective Response (CR/CRi/MLFS/PR) for AML Subjects in SL-172154 in Combination with Azacitidine in Expansion Part C	All Treated	No
	14.2.3.5	Kaplan-Meier Plot of Duration of CR for Previously Untreated HR-MDS Subjects Receiving SL-172154 3mg/kg with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	14.2.3.6	Kaplan-Meier Plot of Duration of Objective Response (CR/marrow CR/ /PR/HI) for Previously Untreated MDS Subjects Receiving SL-172154 3mg/kg with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	No
	14.2.4.1	Kaplan-Meier Plot of Overall Survival for Previously Untreated TP53m AML Subjects in SL-172154 in Combination with Azacitidine	All Treated	Yes
	14.2.4.2	Kaplan-Meier Plot of Overall Survival for Previously Untreated HR-MDS Subjects Receiving SL-172154 3mg/kg with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	14.2.4.3	Kaplan-Meier Plot of Overall Survival for Previously Untreated HR-MDS Subjects with TP53 Mutation Based on Central Assessment Receiving SL-172154 3mg/kg with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
14.3				
	14.3.1.1	Box Plot of Hemoglobin Change from Baseline for Subjects Receiving SL-172154 Monotherapy	All Treated	No
	14.3.1.2	Box Plot of Hemoglobin Change from C1D2 Predose SL-172154 Infusion for Subjects Receiving SL-172154 in Combination with Azacitidine in Dose Escalation	All Treated	No
	14.3.1.3	Box Plot of Hemoglobin Change from C1D2 Predose for Previously Untreated HR-MDS Subjects Receiving SL-172154 3mg/kg in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	14.3.1.4	Box Plot of Hemoglobin Change from C1D2 Predose for TP53m AML Subjects Receiving SL-172154 in Combination with Azacitidine in Expansion Part C	All Treated	Yes
14.3.7	14.3.7.1	Plot of Individual SL-172154 Concentration-time Profiles by Dose Level for Monotherapy on C1D1, C1D15 and C2D1 (Linear and Semi-log)	PK	Yes
	14.3.7.2	Plot of Individual SL-172154 Concentration-time Profiles by Dose Level for SL-172154 in Combination with Azacitidine on C1D2, C1D16 and C2D2 (Linear and Semi-log) Note: include 4 groups: dose escalation 1 mg/kg and 3 mg/kg, dose expansion HR-MDS (Part A) and TP53m AML (part C)	PK	Yes
	14.3.7.3	Plot of Mean (+/-SD) SL-172154 Concentration-time Profile by Dose Level for Monotherapy on C1D1, C1D15 and C2D1 (Linear and Semi-log)	PK	Yes
	14.3.7.4	Plot of Mean (+/-SD) SL-172154 Concentration-time Profile by Dose Level for SL-172154 in Combination with Azacitidine on C1D2, C1D16 and C2D2 (Linear and Semi-log) Note: combine all subjects at 3 mg/kg from dose escalation and expansion as one group	PK	Yes

	14.3.7.5	Plot of Mean (+/-SD) Dose Normalized SL-172154 Concentration-time Profile by Dose Level for Monotherapy on C1D1, C1D15 and C2D1 (Linear and Semi-log)	PK	yes
	14.3.7.6	Plot of Mean (+/-SD) Dose Normalized SL-172154 Concentration-time Profile by Dose Level for SL-172154 in Combination with Azacitidine Dose Escalation on C1D2, C1D16 and C2D2 (Linear and Semi-log) Note: combine all subjects at 3 mg/kg from dose escalation and expansion as one group	PK	yes
	14.3.7.7	Box Plot of Dose Normalized C_{max} by Dose Level for SL-172154 Monotherapy	PK	yes
	14.3.7.8	Box Plot of Dose Normalized C_{max} by Dose Level for SL-172154 in Combination with Azacitidine Note: combine all subjects at 3 mg/kg from dose escalation and expansion as one group	PK	yes
	14.3.7.9	Box Plot of Dose Normalized $AUC_{0\text{-last}}$ versus Dose Level for SL-172154 Monotherapy on C1D1, C1D15 and C2D1	PK	Yes
	14.3.7.10	Box Plot of Dose Normalized $AUC_{0\text{-last}}$ versus Dose Level for SL-172154 in Combination with Azacitidine on C1D2, C1D16 and C2D2 Note: combine all subjects at 3 mg/kg from dose escalation and expansion as one group	PK	yes
	14.3.7.11	Box Plot of Dose Normalized $AUC_{0\text{-inf}}$ versus Dose Level for SL-172154 Monotherapy on C1D1, C1D15 and C2D1	PK	yes
	14.3.7.12	Box Plot of Dose Normalized $AUC_{0\text{-inf}}$ versus Dose Level for SL-172154 in Combination with Azacitidine on C1D2, C1D16 and C2D2 Note: combine all subjects at 3 mg/kg from dose escalation and expansion as one group	PK	yes
	14.3.7.13	Box Plot of Dose Normalized AUC_{tau} versus Dose Level for SL-172154 Monotherapy on C1D1, C1D15 and C2D1	PK	yes
	14.3.7.14	Box Plot of Dose Normalized AUC_{tau} versus Dose Level for SL-172154 in Combination with Azacitidine on C1D2, C1D16 and C2D2 Note: combine all subjects at 3 mg/kg from dose escalation and expansion as one group	PK	yes

12.3 List of Data Listings

ICH Heading	Listing Number	Listing Description	Analysis Population	aCSR
16.2		**SUBJECT DATA LISTINGS**		
16.2.1		**Discontinued subjects**		
	16.2.1.1.1	Study Population and Subject Disposition for SL-172154 Monotherapy	All Treated	Yes
	16.2.1.1.2	Study Population and Subject Disposition for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A and C	All Treated	Yes
	16.2.1.1.3	Study Population and Subject Disposition for Part D Randomized Cohort in HR-MDS	ITT	Yes

ICH Heading	Listing Number	Listing Description	Analysis Population	aCSR
	16.2.1.2.1	Study Treatment Discontinuation for SL-172154 Monotherapy	All Treated	Yes
	16.2.1.2.2	SL-172154 Treatment Discontinuation for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A and C	All Treated	Yes
	16.2.1.2.3	SL-172154 Treatment Discontinuation Part D Randomized Cohort in HR-MDS	All Treated	Yes
	16.2.1.2.4	Azacitidine Treatment Discontinuation for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A and C	All Treated	Yes
	16.2.1.2.5	Azacitidine Treatment Discontinuation Part D Randomized Cohort in HR-MDS	All Treated	Yes
	16.2.1.3.1	Inform Consent and Protocol Amendment Reconsent for SL-172154 Monotherapy	All Treated	Yes
	16.2.1.3.2	Inform Consent and Protocol Amendment Reconsent for SL-172154 in Combination with Azacitidine Dose Escalation and Expansion Part A and C	All Treated	Yes
	16.2.1.3.3	Inform Consent and Protocol Amendment Reconsent for Part D Randomized Cohort in HR-MDS	ITT	Yes
16.2.2		**Protocol deviations**		
	16.2.2.1.1	Protocol Deviations for SL-172154 Monotherapy	All Treated	Yes
	16.2.2.1.2	Protocol Deviations for SL-172154 in Combination with Azacitidine Dose Escalation and Expansion Part A and C	All Treated	Yes
	16.2.2.1.3	Protocol Deviations for Part D Randomized Cohort in HR-MDS	ITT	Yes
	16.2.2.2.1	Inclusion and Exclusion Criteria Deviation for SL-172154 Monotherapy	All Treated	Yes
	16.2.2.2.2	Inclusion and Exclusion Criteria Deviation for SL-172154 in Combination with Azacitidine Dose Escalation and Expansion Part A and C	All Treated	Yes
	16.2.2.2.3	Inclusion and Exclusion Criteria Deviation for Part D Randomized Cohort in HR-MDS	ITT	Yes
16.2.4		**Demographics**		
	16.2.4.1.1	Demographic and Baseline Characteristics for SL-172154 Monotherapy	All Treated	Yes
	16.2.4.1.2	Demographic and Baseline Characteristics for SL-172154 in Combination with Azacitidine Dose Escalation and Expansion Part A and C	All Treated	Yes
	16.2.4.1.3	Demographic and Baseline Characteristics for Part D Randomized Cohort in HR-MDS	ITT	Yes
	16.2.4.2.1	AML Cancer History for SL-172154 Monotherapy	All Treated	Yes

ICH Heading	Listing Number	Listing Description	Analysis Population	aCSR
	16.2.4.2.2	AML Cancer History for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part C	All Treated	Yes
	16.2.4.3.1	MDS Cancer History for SL-172154 Monotherapy	All Treated	Yes
	16.2.4.3.2	MDS Cancer History for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A	All Treated	Yes
	16.2.4.3.3	MDS Cancer History for Part D Randomized Cohort in HR-MDS	ITT	Yes
	16.2.4.4.1	Previous MDS Cancer History for AML Subjects - SL-172154 Monotherapy	All Treated	No
	16.2.4.4.2	Previous MDS Cancer History for AML Subjects - SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part C	All Treated	No
	16.2.4.5.1	AML Baseline Cytogenetic Results Based on Central Review - SL-172154 Monotherapy	All Treated	No
	16.2.4.5.2	AML Baseline Cytogenetic Results Based on Central Review - SL-172154 in Combination with Azacitidine	All Treated	No
	16.2.4.6.1	MDS Baseline Cytogenetic Results Based on Central Review - SL-172154 Monotherapy	All Treated	No
	16.2.4.6.2	MDS Baseline Cytogenetic Results Based on Central Review - SL-172154 in Combination with Azacitidine	All Treated	No
	16.2.4.7.1	General Medical and Surgical History for SL-172154 Monotherapy	All Treated	Yes
	16.2.4.7.2	General Medical and Surgical History for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A and C	All Treated	Yes
	16.2.4.7.3	General Medical and Surgical History for Part D Randomized Cohort in HR-MDS	ITT	Yes
	16.2.4.8.1	Prior Systemic Anticancer Treatment for AMLSL-172154 Monotherapy	All Treated	Yes
	16.2.4.8.2	Prior Systemic Anticancer Treatment for AML SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part C	All Treated	Yes
	16.2.4.9.1	Prior Systemic Anticancer Treatment for MDS - SL-172154 Monotherapy	All Treated	Yes
	16.2.4.9.2	Prior Systemic Anticancer Treatment for MDS - SL-172154 in Combination with Azacitidine Dose Escalation and Expansion Part A	All Treated	No
	16.2.4.9.3	Prior Systemic Anticancer Treatment for Previous MDS in AML Subjects -SL-172154 Monotherapy	All Treated	No
	16.2.4.9.4	Prior Systemic Anticancer Treatment for Previous MDS in AML Subjects -SL-172154 in Combination with Azacitidine	All Treated	No
	16.2.4.10.1	Prior Systemic Anticancer Treatment for Cancers other than MDS and AML-SL-172154 Monotherapy	All Treated	No

ICH Heading	Listing Number	Listing Description	Analysis Population	aCSR
	16.2.4.10.2	Prior Systemic Anticancer Treatment for Cancers other than MDS and AML - SL-172154 in Combination with Azacitidine	All Treated	No
	16.2.4.11.1	Prior Hematopoietic Cell Transplantation for AML- SL-172154 Monotherapy	All Treated	Yes
	16.2.4.11.2	Prior Hematopoietic Cell Transplantation for AML – SL-172154 in Combination with Azacitidine Dose Escalation and Expansion Part C	All Treated	Yes
	16.2.4.12.1	Prior Hematopoietic Cell Transplantation for MDS - SL-172154 Monotherapy	All Treated	Yes
	16.2.4.12.2	Prior Hematopoietic Cell Transplantation for MDS – SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A	All Treated	Yes
	16.2.4.12.3	Prior Hematopoietic Cell Transplantation for MDS – SL-172154 in Combination with Azacitidine in Part D Randomized Cohort in HR-MDS	ITT	Yes
	16.2.4.13.1	Prior Radiotherapy for SL-172154 Monotherapy	All Treated	No
	16.2.4.13.2	Prior Radiotherapy for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A and C	All Treated	No
	16.2.4.13.3	Prior Radiotherapy for Part D Randomized Cohort in HR-MDS	ITT	No
	16.2.4.14.1	Prior Surgical Treatment for SL-172154 Monotherapy	All Treated	No
	16.2.4.14.2	Prior Surgical Treatment for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A and C	All Treated	No
	16.2.4.14.3	Prior Surgical Treatment for Part D Randomized Cohort in HR-MDS	ITT	No
	16.2.4.15.1	Concomitant Medications for SL-172154 Monotherapy	All Treated	Yes
	16.2.4.15.2	Concomitant Medications for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A and C	All Treated	Yes
	16.2.4.15.3	Concomitant Medications for Part D Randomized Cohort in HR-MDS	ITT	Yes
	16.2.4.16.1	Premedications for SL-172154 Monotherapy	All Treated	Yes
	16.2.4.16.2	Premedications for SL-172154 in Combination with Azactidine in Dose Escalation and Expansion Part A and C	All Treated	Yes
	16.2.4.16.3	Premedications for Part D Randomized Cohort in HR-MDS	ITT	Yes
	16.2.4.17.1	Concomitant Procedures for SL-172154 Monotherapy	All Treated	No
	16.2.4.17.2	Concomitant Procedures for SL-172154 in Combination with Azactidine in Dose Escalation and Expansion Part A and C	All Treated	No
	16.2.4.17.3	Concomitant Procedures for Part D Randomized Cohort in HR-MDS	ITT	No

ICH Heading	Listing Number	Listing Description	Analysis Population	aCSR
	16.2.4.18.1	Post Treatment Anticancer Systemic Treatment for AML subjects - SL-172154 Monotherapy	All Treated	No
	16.2.4.18.2	Post Treatment Anticancer Systemic Treatment for AML subjects – SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part C	All Treated	Yes
	16.2.4.19.1	Post Treatment Anticancer Systemic Treatment for MDS subjects - SL-172154 Monotherapy	All Treated	No
	16.2.4.19.2	Post Treatment Anticancer Systemic Treatment for MDS subjects – SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A	All Treated	Yes
	16.2.4.19.3	Post Treatment Anticancer Systemic Treatment for MDS subjects – Part D Randomized Cohort in HR-MDS	ITT	No
	16.2.4.20.1	Post Treatment Hematopoietic Cell Transplantation for AML subjects -SL-172154 Monotherapy	All Treated	No
	16.2.4.20.2	Post Treatment Hematopoietic Cell Transplantation for AML subjects – SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part C	All Treated	Yes
	16.2.4.21.1	Post Treatment Hematopoietic Cell Transplantation for MDS subjects -SL-172154 Monotherapy	All Treated	No
	16.2.4.21.2	Post Treatment Hematopoietic Cell Transplantation for MDS subjects – SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A	All Treated	Yes
	16.2.4.21.3	Post Treatment Hematopoietic Cell Transplantation for MDS subjects – Part D Randomized Cohort in HR-MDS	ITT	No
16.2.5		**Study Drug Exposure**		
	16.2.5.1.1	SL-172154 Administration for SL-172154 Monotherapy	All Treated	Yes
	16.2.5.1.2	SL-172154 Administration for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.5.1.3	SL-172154 Administration for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	16.2.5.2.1	Azacitidine Administration for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.5.2.2	Azacitidine Administration for SL-172154 in Combination with Azacitidine (Part D Randomized Cohort)	All Treated	Yes
	16.2.5.3	SL-172154 Administration for Subjects with SL-172154 Overdose	All Treated	Yes
	16.2.5.4	PK		
	16.2.5.4.1	SL-172154 Serum Concentration-Time Data for SL-172154 Monotherapy	PK	Yes
	16.2.5.4.2	SL-172154 Serum Concentration-Time Data for SL-172154 in Combination with Azactidine in Dose Escalation and Expansion Part A and C	PK	Yes

ICH Heading	Listing Number	Listing Description	Analysis Population	aCSR
	16.2.5.4.3	SL-172154 PK Parameters for SL-172154 Monotherapy	PK	Yes
	16.2.5.4.4	SL-172154 PK Parameters for SL-172154 in Combination with Azactidine in Dose Escalation and Expansion Part A and C	PK	Yes
	16.2.5.5.1	Anti-Drug Antibodies for SL-172154 Monotherapy	Immunogenicity	Yes
	16.2.5.5.2	Anti-Drug Antibodies for SL-172154 in Combination with Azactidine in Dose Escalation and Expansion Part A and C	Immunogenicity	Yes
16.2.6		**Individual efficacy response data**		
	16.2.6.1.1	Bone Marrow Assessment for AML Subjects - SL-172154 Monotherapy	All Treated	Yes
	16.2.6.1.2	Bone Marrow Assessment for AML Subjects - SL-172154 in Combination with Azacitidine	All Treated	Yes
	16.2.6.2.1	AML Response Per ELN2017 for SL-172154 Monotherapy	All Treated	Yes
	16.2.6.2.2	AML Response Per ELN2017 for SL-172154 in Combination with Azacitidine	All Treated	Yes
	16.2.6.3.1	AML Response (CR/CRi/MLFS/PR) Details for SL-172154 Monotherapy	All Treated	Yes
	16.2.6.3.2	AML Response (CR/CRi/MLFS/PR) Details for SL-172154 in Combination with Azacitidine	All Treated	Yes
	16.2.6.4.1	Minimal Residual Disease status based on Central Assessment for AML Subjects - SL-172154 Monotherapy	All Treated	Yes
	16.2.6.4.2	Minimal Residual Disease status based on Central Assessment for AML Subjects - SL-172154 in Combination with Azacitidine	All Treated	Yes
	16.2.6.5.1	AML Time to Response and Duration of Response for SL-172154 Monotherapy	All Treated	Yes
	16.2.6.5.2	AML Time to Response and Duration of Response for SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part C	All Treated	Yes
	16.2.6.6.1	AML Event Free Survival for SL-172154 Monotherapy	All Treated	No
	16.2.6.6.2	AML Event Free Survival for SL-172154 in Combination with Azacitidine	All Treated	No
	16.2.6.7.1	Transfusions for AML subjects - SL-172154 Monotherapy	All Treated	Yes
	16.2.6.7.2	Transfusions for AML subjects - SL-172154 in Combination with Azacitidine	All Treated	Yes
	16.2.6.8.1	Overall Survival for AML subjects - SL-172154 Monotherapy	All Treated	Yes

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	16.2.6.8.2	Overall Survival for AML subjects - SL-172154 in Combination with Azacitidine	All Treated	Yes
	16.2.6.9.1	Bone Marrow Assessment for MDS Subjects - SL-172154	All Treated	Yes
	16.2.6.9.2	Bone Marrow Assessment for MDS Subjects - SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	16.2.6.9.3	Bone Marrow Assessment for MDS Subjects - SL-172154 in Combination with Azacitidine (Randomized Cohort Part D)	All Treated	Yes
	16.2.6.10.1	MDS Response Per IWG2006 Criteria for SL-172154 Monotherapy	All Treated	Yes
	16.2.6.10.2	MDS Response Per IWG2006 Criteria for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	16.2.6.10.3	MDS Response Per IWG2006 Criteria for SL-172154 in Combination with Azacitidine (Randomized Cohort Part D)	All Treated	Yes
	16.2.6.11.1	MDS Hematologic Improvement Per IWG 2006 Criteria for SL-172154 Monotherapy	All Treated	
	16.2.6.11.2	MDS Hematologic Improvement Per IWG 2006 Criteria for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	
	16.2.6.11.3	MDS Hematologic Improvement Per IWG 2006 Criteria for SL-172154 in Combination with Azacitidine (Randomized Cohort Part D)	All Treated	
	16.2.6.12.1	Minimal Residual Disease status based on Central Assessment for MDS Subjects – SL172154 Monotherapy	All Treated	No
	16.2.6.12.2	Minimal Residual Disease status based on Central Assessment for MDS Subjects - SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	No
	16.2.6.13.1	MDS Time to Response and Duration of Response – SL172154 Monotherapy	All Treated	No
	16.2.6.13.2	MDS Time to Response and Duration of Response - SL-172154 in Combination with Azacitidine in Dose Escalation and Expansion Part A	All Treated	Yes
	16.2.6.13.3	MDS Time to Response and Duration of Response - SL-172154 in Combination with Azacitidine (Randomized Cohort Part D)	All Treated	Yes
	16.2.6.14.1	MDS Progression Free Survival, Event Free Survival and Time to Transformation to AML – SL172154 Monotherapy	All Treated	No
	16.2.6.14.2	MDS Progression Free Survival, Event Free Survival and Time to Transformation to AML - SL-172154 in Combination with Azacitidine	All Treated	No
	16.2.6.15.1	Transfusions for MDS subjects – SL172154 Monotherapy	All Treated	Yes
	16.2.6.15.2	Transfusions for MDS subjects - SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A)	All Treated	Yes
	16.2.6.15.3	Transfusions for MDS subjects - SL-172154 in Combination with Azacitidine (Randomized Cohort Part D)	All Treated	Yes

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	16.2.6.16.1	Overall Survival for MDS subjects – SL172154 Monotherapy	All Treated	Yes
	16.2.6.16.2	Overall Survival for MDS subjects - SL-172154 in Combination with Azacitidine Dose Escalation and Expansion Part A	All Treated	Yes
	16.2.6.16.3	Overall Survival for MDS subjects - SL-172154 in Combination with Azacitidine (Randomized Cohort Part D)	All Treated	Yes
16.2.7		**Adverse Event Listings**		
	16.2.7.1.1	All Adverse Events for SL-172154 Monotherapy	All Treated	Yes
	16.2.7.1.2	All Adverse Events for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.1.3	All Adverse Events for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	16.2.7.2.1	SL-172154 Related Adverse Events for SL-172154 Monotherapy	All Treated	Yes
	16.2.7.2.2	SL-172154 Related Adverse Events for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.2.3	SL-172154 Related Adverse Events for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	16.2.7.2.4	Azacitidine Related Adverse Events for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.2.5	Azacitidine Related Adverse Events for Part D Randomized Cohort in HR-MDS	All Treated	Yes
	16.2.7.3.1	Fatal Adverse Events for SL-172154 Monotherapy	All Treated	Yes
	16.2.7.3.2	Fatal Adverse Events for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.3.3	Fatal Adverse Events for SL-172154 in Combination (Part D Randomized cohort)	All Treated	Yes
	16.2.7.4.1	Maximum Grade 3/4 Adverse Events for SL-172154 Monotherapy	All Treated	Yes
	16.2.7.4.2	Maximum Grade 3/4 Adverse Events for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.4.3	Maximum Grade 3/4 Adverse Events for SL-172154 in Combination with Azacitidine (Part D Randomized cohort)	All Treated	Yes
	16.2.7.5.1	Dose Limiting Toxicities for SL-172154 Monotherapy	DLT	Yes
	16.2.7.5.2	Dose Limiting Toxicities for SL-172154 in Combination with Azacitidine	DLT evaluable	Yes
	16.2.7.6.1	Serious Adverse Events for SL-172154 Monotherapy	All Treated	Yes
	16.2.7.6.2	Serious Adverse Events for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.6.3	Serious Adverse Events for SL-172154 in Combination (Part D Randomized cohort)	All Treated	Yes

ICH Heading	Listing Number	Listing Description	Analysis Population	aCSR
	16.2.7.7.1	Infusion Related Reaction Adverse Events for SL-172154 Monotherapy	All Treated	Yes
	16.2.7.7.2	Infusion Related Reaction Adverse Events for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.7.3	Infusion Related Reaction Adverse Events for SL-172154 in Combination with Azacitidine (Part D Randomized cohort)	All Treated	Yes
	16.2.7.8.1	Adverse Events Leading to SL-172154 Drug Withdrawn – SL172154 Monotherapy	All Treated	Yes
	16.2.7.8.2	Adverse Events Leading to SL-172154 Drug Withdrawn - - SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.8.3	Adverse Events Leading to SL-172154 Drug Withdrawn - SL-172154 in Combination with Azacitidine (Part D Randomized cohort)	All Treated	Yes
	16.2.7.9.1	Adverse Events Leading to SL-172154 Dose Modifications – SL172154 Monotherapy	All Treated	Yes
	16.2.7.9.2	Adverse Events Leading to SL-172154 Dose Modifications - SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.9.3	Adverse Events Leading to SL-172154 Dose Modifications - SL-172154 in Combination (Part D Randomized cohort)	All Treated	Yes
	16.2.7.10.1	Adverse Events Leading to Azacitidine Drug Withdrawn - SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.10.2	Adverse Events Leading to Azacitidine Drug Withdrawn - SL-172154 in Combination with Azacitidine (Part D Randomized cohort)	All Treated	Yes
	16.2.7.12	All Adverse Events for Screen Failure Population	Screen Failure	Yes
	16.2.7.13.1	Death – SL172154 Monotherapy	All Treated	Yes
	16.2.7.13.2	Death – - SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.13.3	Death - SL-172154 in Combination with Azacitidine (Part D Randomized cohort)	All Treated	Yes
	16.2.7.14.1	Infusion Related Reaction Sign and Symptoms for SL-172154 Monotherapy	All Treated	Yes
	16.2.7.14.2	Infusion Related Reaction Sign and Symptoms for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.14.3	Infusion Related Reaction Sign and Symptoms for SL-172154 in Combination with Azacitidine (Part D Randomized cohort)	All Treated	Yes
	16.2.7.15.1	Cytokine Release Syndrome Sign and Symptoms for SL-172154 Monotherapy	All Treated	Yes

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	16.2.7.15.2	Cytokine Release Syndrome Sign and Symptoms for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.7.15.3	Cytokine Release Syndrome Sign and Symptoms for SL-172154 in Combination with Azacitidine (Part D Randomized cohort)	All Treated	Yes
16.2.8		**Individual Laboratory Measurements**		
	16.2.8.1.1	Hematology for SL-172154 Monotherapy	All Treated	No
	16.2.8.1.2	Hematology for SL-172154 in Combination with Azacitidine	All Treated	No
	16.2.8.2.1	Clinical Chemistry for SL-172154 Monotherapy	All Treated	No
	16.2.8.2.2	Clinical Chemistry for SL-172154 in Combination with Azacitidine	All Treated	No
	16.2.8.3.1	Liver Function Tests for SL-172154 Monotherapy	All Treated	Yes
	16.2.8.3.2	Liver Function Tests for SL-172154 in Combination with Azacitidine (Dose Escalation and Expansion Part A/C)	All Treated	Yes
	16.2.8.3.3	Liver Function Tests for SL-172154 in Combination with Azacitidine (Part D Randomized cohort)	All Treated	Yes
	16.2.8.4.1	Thyroid Function Tests for SL-172154 Monotherapy	All Treated	No
	16.2.8.4.2	Thyroid Function Tests for SL-172154 in Combination with Azacitidine	All Treated	No
	16.2.8.5.1	Coagulation Tests for SL-172154 Monotherapy	All Treated	No
	16.2.8.5.2	Coagulation Tests for SL-172154 in Combination with Azacitidine	All Treated	No
	16.2.8.6.1	Blood phenotype and Direct Antiglobulin Test for SL-172154 Monotherapy	All Treated	No
	16.2.8.6.2	Blood phenotype and Direct Antiglobulin Test for SL-172154 in Combination with Azacitidine	All Treated	No
16.2.9		**Listing of other safety data**		
	16.2.9.1.1	Vital Signs and Pulse Oximetry for SL-172154 Monotherapy	All Treated	No
	16.2.9.1.2	Vital Signs and Pulse Oximetry for SL-172154 in Combination with Azacitidine	All Treated	No
	16.2.9.2.1	Cardiac Assessments (ECG/ECHO) for SL-172154 Monotherapy	All Treated	No
	16.2.9.2.2	Cardiac Assessments (ECG/ECHO) for SL-172154 in Combination with Azacitidine	All Treated	No
	16.2.9.3.1	ECOG Performance Status for SL-172154 Monotherapy	All Treated	No
	16.2.9.3.2	ECOG Performance Status for SL-172154 in Combination with Azacitidine	All Treated	No

ICH Heading	Listing Number	Listing Description	Analysis Population	aCSR
	16.2.9.4.1	Body Weight for SL-172154 Monotherapy	ALL Treated	No
	16.2.9.4.2	Body Weight for SL-172154 in Combination with Azacitidine	ALL Treated	No