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☒ **Approval of SAP** ☐ **Approval of SAP Amendment**	SAP Version: 2.0, 29 Nov 2022

Name and Title of SAP Author (NIS):	PPD Ph.D.; PPD Sc.D. PPD MS; PPD MS

Approval indicates that the SAP provides analysis specifications consistent with the analysis outlined in the approved protocol and meets the standards and requirements used for programming of tables, listings, and figures.

SAP Approver (NIS) Name:	PPD
SAP Approver (NIS) Title:	PPD Pfizer
Signature:	DocuSigned by: PPD PPD
Date:	December 8, 2022

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SAP Approver (NIS) Name:	PPD
SAP Approver (NIS) Title:	PPD CorEvitas
Signature:	DocuSigned by: PPD
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CorEvitas Statistical Analysis Plan: Characteristics and 6-month Outcomes Among Real-world Rheumatoid Arthritis Patients Initiating Inflectra

Prepared for: PPD MD, RhMSUS

Pfizer

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1. Table of Contents

2. List of Abbreviations

ABA	Abatacept
ADA	Adalimumab
BMI	Body Mass Index
CABG	Coronary Artery Bypass Grafting
CDAI	Clinical Disease Activity Index
CDM	Clinical Data Management
CHF	Congestive Heart Failure
CI	Confidence Interval
CSP	Cyclosporine
CTZ	Certolizumab
CVD	Cardiovascular Disease
DAS	Disease Activity Score
DMARD	Disease-Modifying Antirheumatic Drug
csDMARD	Conventional Disease-Modifying Antirheumatic Drug
bDMARD	Biologic Disease-Modifying Antirheumatic Drug
tsDMARD	Targeted Synthetic Disease-Modifying Antirheumatic Drug
DVT	Deep Venous Thrombosis
ETA	Etanercept
EQ-5D	Euro-QoL 5-Dimensional
ERB	Ethical Review Board
GOL	Golimumab
GPP	Good Pharmacoepidemiology Practices
HAQ	Health Assessment Questionnaire
IBD	Inflammatory Bowel Disease
ICMJE	International Committee of Medical Journal Editors
IEC	Independent Ethics Committee

IFX	Infliximab
IQR	Interquartile Range
IRB	Institutional Review Board
MI	Myocardial Infarction
MTX	Methotrexate
OR	Odds Ratio
PCI	Percutaneous Coronary Intervention
PDE 4	Phosphodiesterase 4
PGA	Physician Global Assessment
PII	Personally Identifiable Information
PRO	Patient Reported Outcome
RA	Rheumatoid Arthritis
RTX	Rituximab
SD	Standard Deviation
SOPs	Standard Operating Procedures
SSZ	Sulfasalazine
TCZ	Tocilizumab
TIA	Transient Ischemic Attack
TNFi	Tumor Necrosis Factor inhibitors
Non-TNFi	Non-Tumor Necrosis Factor inhibitors
TOFA	Tofacitinib
VAS	Visual Analogue Scale
WPAI	Work Productivity and Activity Impairment

3. Research Methods

3.1. Background and Rationale

Rheumatoid arthritis (RA) is a chronic, immune-mediated, inflammatory disease affecting many joints, including those in the hands and feet. RA has a wide global presence and is estimated to affect 0.5 to 1% of the general population. Inflectra is one of four currently available biosimilars for infliximab, approved in April 2016 (https://www.fda.gov/drugs/biosimilars/biosimilar-product-information). There is a need to understand how biosimilars are used in the real world for rheumatoid arthritis patients (e.g., attitudes / hesitancy about biosimilars, sequencing, issues with payers). There are also questions about how Inflectra is being used in the real world (e.g., line of therapy, how many use originators first v. do not). This study will examine treatment patterns and effectiveness of real-world Inflectra initiators in The CorEvitas RA registry.

3.2. Objectives

3.2.1. *Primary Objective(s)*

Describe characteristics of Inflectra patients at initiation.

3.2.1.1. Hypotheses

There is no hypothesis for this descriptive analysis.

3.2.2. Secondary Objective(s)

Describe characteristics at initiation and describe 6-month outcomes of after initiating Inflectra, among patients who have 6 months follow-up information in The CorEvitas RA Registry.

3.2.2.1. Hypotheses

Six-month disease activity and patient reported outcome measures will differ from initiation values.

3.3. Research Design

This is a descriptive study of RA patients initiating Inflectra using data from The CorEvitas RA registry.

3.3.1. Data Source

The CorEvitas RA Registry is an ongoing longitudinal clinical registry that was established in 2001. Longitudinal follow-up data is collected from both patients and their treating rheumatologist during routine clinical encounters using CorEvitas RA Registry questionnaires. These questionnaires collect data on patient demographics, disease duration, medical history (including all prior and current treatments for RA), smoking status, alcohol use, cannabis use, disease activity, patient reported outcome measures, disease characteristics, comorbidities and adverse events, infections, hospitalizations, and other targeted safety outcomes. Blood collection, endoscopy and other diagnostic tests are not required for participation; however, relevant standard of care laboratory and imaging results are reported when available.

The registry currently (as of December 2021) includes 211 private and academic active clinical sites with over 910 physicians throughout 42 states in the U.S. This registry collects data from both the physicians and the patients at the time of a regular office visit. The registry has enrolled over 57,000 patients with RA. The collection of data from CorEvitas' RA Registry represents over 225,180 patient years of data. Structured clinical data is available in this Registry (e.g. disease activity scores, comorbidities, imaging results, patient-reported outcomes data, etc.) that is not available in claims databases.

To be eligible for enrollment into The CorEvitas RA Registry, a patient must satisfy all of the inclusion criteria and none of the exclusion criteria listed below.

Registry Inclusion Criteria

The patient must:

1. Be at least 18 years of age
2. Be able and willing to provide written consent for participation in the registry as well as Personally Identifiable Information (PII) that includes Full Name and Date of Birth at a minimum.
3. Have been diagnosed with RA by a rheumatologist.
4. Meet at least one of the following criteria:
    a. Currently receiving an Eligible Medication* that was started within 365 days of the Enrollment Visit.
        i. A temporary interruption of an Eligible Medication*
    b. Prescribed or receiving the first dose of an Eligible Medication* on the day of the Enrollment Visit.
    c. Diagnosed with RA within 365 days of the Enrollment Visit regardless of treatment regimen ("Early RA").

Registry Exclusion Criteria

The patient must not:

1. Have a diagnosis of Juvenile idiopathic arthritis (JIA), Psoriatic arthritis (PsA), Spondyloarthritis (SpA), Ankylosing spondylitis (AS), Systemic lupus erythematosus (SLE), or any other form of autoimmune inflammatory arthritis.
2. Be starting *only* a non-eligible medication, unless the patient was diagnosed with RA within 365 days of the Enrollment Visit. Non-

* Eligible Medications are biologics, biosimilars, and JAK-inhibitors FDA-approved for the treatment of RA. Prior use of an Eligible Medication does not exclude a patient from enrollment.

eligible medications include csDMARDs – for example methotrexate, sulfasalazine, leflunomide, etc. - and including prednisone.

3. Be participating in or planning to participate in a double-blind randomized clinical trial of an RA drug. Of note, concurrent participation in another observational registry or open-label Phase 3b/4 trial is not excluded.

Data Included in this Study

Data from The CorEvitas RA Registry as of 02/28/2022 will be used for this study, or most recent data cut. The study will include visits from 4/05/2016 (Approval date of Inflectra) to 02/28/2022 (or the most recent data cut at the time of SAP approval).

3.3.2. Study Population of Interest

This study will include two separate cohorts of patients who meet the criteria specified for the study objectives:

Cohort 1: All patients who initiated Inflectra at or after enrollment in CorEvitas' RA Registry through 4/30/2021 (or most recent data cut at the time of SAP approval).

- For this analysis patients must initiate Inflectra (defined as first ever use of Inflectra) at the registry enrollment visit or at a follow up visit from April 2016 onward.

Cohort 2: Among patients included in Cohort 1, those who have a 6-month follow-up visit (3-9 month window) after Inflectra initiation.

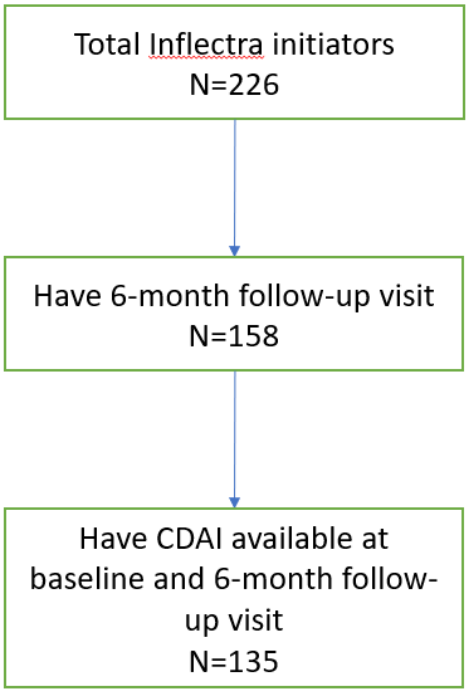
- For this analysis patients must additionally have 1) CDAI measured at baseline and 2) 6-month follow-up visit and CDAI measured at the 6-month follow-up visit.

Note: Additionally, the specified populations will be used to calculate each of the following outcomes variables (Table 4).

- Achievement of LDA (CDAI≤10).
    - Among patients with moderate or high disease activity (CDAI>10) at baseline.
- Rate of response at follow up visit-achievement of remission (CDAI≤2.8).
    - Among patients with LDA, moderate, or high disease activity (CDAI>2.8) at baseline.

Study Groups:

Preliminary feasibility counts: (As of 4/30/2021)



	Population for Cohort 1	**Population for Cohort 2**
	N=226	**N=135**
Prior use of Biologic/JAKi, n (%)		
Naive	46 (20.4)	27 (20.0)
1	96 (42.5)	59 (43.7)
2	51 (22.6)	27 (20.0)
3+	33 (14.6)	22 (16.3)
For Biologic/JAKi-experienced	**N=175**	**N=106**
Switched from, n (%)		
From Remicade	89 (50.9)	50 (47.2)
From other Remicade Biosimilar	8 (4.6)	7 (6.6)
From Other Biologic	71 (40.6)	45 (42.5)
From JAKi	7 (4.0)	4 (3.8)

3.3.3. Time Period Definitions

CorEvitas' RA Registry is an observational registry and therefore collects patient and physician data at patient clinical visits with the rheumatologist. Unlike clinical studies, visits are not timed at exact uniform time periods. Thus, time period definitions for the current study need to accommodate this unique feature of observational registries.

A "6-month" follow-up is defined as a clinical visit to the rheumatologist 3 to 9 months from the enrollment visit in accordance with the registry protocol.

3.3.4. Study Outcomes

3.3.4.1. Primary Outcome(s)

- The primary study outcome will be Achievement of LDA (CDAI ≤ 10).

We will estimate the rate of response at 6 months. Response is defined as the achievement of LDA (CDAI≤10) among patients with moderate or high disease activity (CDAI>10) at baseline. For patients who discontinue Inflectra prior to 6 months, outcomes will be imputed via last observation carried forward (LOCF), using only registry visits that occur before the discontinuation.

3.3.4.2. Secondary Outcome(s)

The secondary study outcomes will be the following:

- Achievement of remission (CDAI ≤ 2.8)
  Rate of response at follow up visit-achievement of remission (CDAI≤2.8) among patients with LDA, moderate, or high disease activity (CDAI>2.8) at baseline. For patients who discontinue Inflectra prior to 6 months, outcomes will be imputed via last observation carried forward (LOCF), using only registry visits that occur before the discontinuation.
- Δ CDAI
- Δ HAQ
- Δ patient pain
- Δ patient fatigue

- Achievement of mACR20/50/70

3.3.5. Variables

Demographic / Lifestyle characteristics

- Age
- Sex
- Race/ethnicity
- Education
- Work status
- Insurance type
- Smoking status
- Alcohol use
- Body mass index

Medication Use

- Prior medication use
    - Number of prior csDMARDs (not including at the time of the Inflectra initiation)
    - Concomitant therapy (none, MTX only, nonMTX csDMARD only, MTX & nonMTX csDMARD)
    - Number of prior biologics
    - Prednisone use (History, Current, dose in current users)
    - Last therapy prior to Inflectra

- Reason for Inflectra Initiation
    - Number of patients with at least 1 reason reported
    - Total number of reasons
    - % Safety, % Efficacy, % Cost/Insurance, % Other reasons

Clinical Characteristics and Assessments

- Disease duration
- Age of onset
- Composite disease activity measures (physician derived elements)
    - Clinical Disease Activity Index (CDAI)
    - Disease Activity Score (DAS28(ESR))
    - Physician global assessment
    - 28 joint count (TJC, SJC)
- Patient reported outcome measures (PROs)
    - Health Assessment Questionnaire (HAQ)
    - Pain VAS (0-100)
    - Patient global assessment VAS (0-100)
    - Fatigue VAS (0-100)
    - Stiffness VAS (0-100)

- EQ-5D-3L

History of comorbidities

- CVD (MI, stroke, acute coronary syndrome, coronary artery disease, CHF, revascularization procedure including percutaneous coronary intervention [PCI], coronary artery bypass grafting [CABG] or coronary artery stents, ventricular arrhythmia, cardiac arrest, unstable angina, peripheral ischemia, peripheral arterial disease, other CV, DVT, and TIA.)
- History of malignancy (lung cancer, breast cancer, lymphoma, skin cancer (melanoma and squamous), and other cancer)
- Hypertension
- Diabetes
- Depression
- Fibromyalgia

3.3.6. Analysis Plan

Tables 1-2: Descriptive statistics for the variables listed in Section 3.3.5 will be provided for all patients who initiated Inflectra (Cohort 1) and patients who initiated Inflectra with a 6-month follow-up visit (Cohort 2). All variables will be based on those collected at the visit at which Inflectra was initiated. If Inflectra was initiated between visits, we will use variables from the visit prior to the initiation, if the prior visit is within 4 months of the initiation. Categorical variables will be summarized using frequency counts and percentages. Continuous variables will be summarized by the number of observations, mean, and standard deviation; medians and interquartile ranges will be provided for variables with highly skewed distributions.

Table 3: Mean, standard deviation, median and interquartile range will be used to summarize duration on previous therapy prior to Inflectra. Frequencies and counts will be used to summarize the last therapy prior to Inflectra initiation: 1) Patients naïve to biologic/tsDMARDs prior to start of Inflectra, 2) Patients who switch from Remicade to Inflectra, 3) patients switch from another non-infliximab biologic/tsDMARD to Inflectra. These summaries will be provided for all patients who initiated Inflectra (Cohort 1) and patients who initiated Inflectra with a 6-month follow-up visit (Cohort 2).

Table 4: Analyses of outcomes at the 6-month follow-up after Inflectra initiation will be descriptive (using Cohort 2: patients who initiated Inflectra with a 6-month follow-up

visit). Primary and secondary outcomes will be described as mean absolute differences for continuous measures and as frequencies and proportions for dichotomous measures, with corresponding 95% confidence intervals (95% CI). Mean absolute difference will be defined as the value at the 6-month follow-up visit minus the value at baseline. For patients who discontinued Inflectra prior to follow-up window, outcomes will be imputed as via LOCF using registry visit information collected prior to reported discontinuation.

Table 5: Frequencies and counts will be used to summarize reasons for initiation of Inflectra for Cohort 2.

Stata Release 16 (StataCorp LLC, College Station TX), R Version 4.0.3 (The R Foundation for Statistical Computing, Vienna Austria), or SAS Version 9.4 (SAS Institute, Cary NC) will be used for analyses.

3.3.7. Missing Data

Missing data are expected for demographic characteristics (e.g., age, etc.); however, the number of patients with missing data is expected to be very small. For every variable, the number of patients with missing information can be reported, if requested.

3.3.8. Sample Size and Power Considerations

This is a descriptive, exploratory study; therefore, power calculations were not considered.

3.4. Strengths and Limitations

3.4.1. Strengths

CorEvitas^{SM} (formerly Corrona) was founded in 2000 without any ownership links to the pharmaceutical industry. CorEvitas has a clear track record of published scientific research using the Registry data to provide answers to clinically relevant questions in a real-world setting.

CorEvitas' RA Registry is a longitudinal prospective registry collecting data from both patients and providers on RA treatment and a wide range of both physician- and

patient-reported disease outcomes. This provides a unique resource of large sample size, and longitudinal follow-up on the real-world use of biologic drugs in the US. The registry enables examination of response patterns based on measures relevant to patient-physician encounters and a large set of patient histories and characteristics to use as predictors of response. The registry contains clinical data (e.g., disease activity scores, comorbidities, patient-reported outcomes data, etc.) that are not available in claims databases.

3.4.2. Limitations

CorEvitas' RA Registry used in this research includes a sample of adults with RA that are not necessarily representative of all adults with RA in the US and Canada. In particular, these are patients with RA with clinical visits with rheumatologists. In addition, history of medication use prior to enrollment is derived from what is reported by patients and their current rheumatologist within the registry. The "cause" of visits is not captured, although the assumption can likely be made that the rheumatology visit is "RA related." The registry captures physician-reported prescribing, and there are no measures of patient adherence.

Additional possible study limitations are variables with small cell counts (n<5) will be suppressed to protect patient confidentiality, and 6-month outcome analyses will be unadjusted.

3.5. Intentional Data Masking

Risk of Reidentification

Reidentification occurs when patient direct identifiers (name, address, etc.) are linked to the deidentified data. In CorEvitas' RA Registry, the risk of this sort of reidentification is thought to be extremely rare. However, increased computing power and improved mathematical algorithms have raised the risk of reidentification of subjects from publicly

available information especially for rare conditions or comorbidities [1] . Thus, CorEvitas may suppress cells and/or population subsets with less than 5 individuals.

3.6. Data Quality

Data quality is controlled, monitored, and managed according to the CorEvitas Master Registry Monitoring Plan (RMP). All study personnel must complete standardized protocol training prior to initiating data collection. Each Investigator is also required to designate one staff member as the primary Registry Coordinator responsible for addressing data clarifications requests from CorEvitas in a timely manner. All data collectors in the field have continuous access to a dedicated Registry Manager who answers questions and provides guidance on specific definitions and clinical situations.

Data quality review (i.e. monitoring) occurs at the site level as well as in aggregate to check for Case Report Form completeness, consistency, and compliance with all data collection requirements set forth in the registry protocol. Monitoring is performed in addition to the edit checks and event completion rules configured in the 21 CRF Part 11 compliant EDC system. The majority of monitoring is conducted using centralized (i.e. remote) methods in accordance with the Agency for Healthcare and Research Quality's (AHRQ) data collection and quality assurance recommendations. [2] These methods include but are not limited to routine remote monitoring visits and automated database quality control listings. Onsite audits of source data are also performed for a subset of registry sites as defined by the Master RMP.

Remote monitoring visits are conducted for the duration of the registry beginning when the first patient is enrolled. Qualified monitors within CorEvitas' Clinical Data Management (CDM) department are responsible for conducting remote monitoring visits. Registry Managers are responsible for site retraining and resolving any compliance issues identified during these visits. Sites also receive data clarification requests (i.e. queries) at regular intervals from designated CDM and Pharmacovigilance personnel. Queries are issued and tracked through the study's EDC system. Sites are required to respond to data queries within 5 to 7 business days of receipt.

3.7. Institutional Review Board (IRB)/Independent Ethics Committee (IEC)

Observational studies using the CorEvitas' RA Registry data are covered under the Ethical Review Board (ERB) submitted for the Registry data collection. Observational studies will be submitted to ERBs for approval or waivers sought whenever required by local law. Regulatory authorities will be notified and approval sought as required by local laws and regulations. Progress reports will be submitted to ERBs and regulatory authorities as required by local laws and regulations.

This study will be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki and that are consistent with Good Pharmacoepidemiology Practices (GPPs) [3] and applicable laws and regulations of the country or countries where the study is being conducted, as appropriate.

4. List of Figures and Tables

5. Tables

Table 1. Demographic and clinical characteristics at Inflectra initiation visit.

	All initiators (Cohort 1) N=	**Initiators with 6 months follow up (Cohort 2) N=**
Demographic/socioeconomic characteristics		
Age: Mean ± SD Median (IQR)		
Female: n (%)		
Race/Ethnicity: n (%)		
White		
Non-white		
Type of Insurance:		
None: n (%)		
Private: n (%)		
Medicare: n (%)		
Medicaid: n (%)		
Final education: n (%)		
Primary		
High school		
College/Univ.		
Unknown		
Work Status: n (%)		
Full Time		
Part Time		
Disabled		
Retired		
Other		
Lifestyle		
Smoking status: n (%)		
Never		
Previous		
Current		
Alcohol use: n (%)		
None/<1 drink per week		
1-3 drinks per week		
1-2 drinks per day		

	All initiators (Cohort 1) N=	Initiators with 6 months follow up (Cohort 2) N=
> 3 drinks per day		
History of comorbidities: n (%)		
Cardiovascular disease**		
Malignancy***		
Hypertension		
Diabetes		
Osteoporosis		
Fibromyalgia		
Depression		

** included: MI, stroke, TIA acute coronary syndrome, coronary artery disease, CHF, revascularization procedure including percutaneous coronary intervention [PCI], coronary artery bypass grafting [CABG] or coronary artery stents, ventricular arrhythmia, cardiac arrest, unstable angina, other CVs, carotid artery disease.

*** History of lung cancer, breast cancer, lymphoma, skin cancer (melanoma and squamous), and other cancer

Table 2. RA disease characteristics, disease activity measures and PROs at Inflectra initiation visit.

RA disease characteristics	**All initiators (Cohort 1)** **N=**	**Initiators with 6 months follow up (Cohort 2)** **N=**
Duration of RA: Mean ± SD Median (IQR)		
Age onset RA: Mean ± SD Median (IQR)		
Disease Activities		
CDAI: Mean ± SD Median (IQR)		
Category of disease activity: n (%)		
Remission (CDAI < 2.8)		
LDA (2.8 ≤ CDAI < 10)		
MDA (10 ≤ CDAI < 22)		
HDA (22 ≤ CDAI)		
Tender Joint Count (28): Mean ± SD Median (IQR)		
Swollen Joint Count (28): Mean ± SD Median (IQR)		
Physician Global Assessment (0-100): Mean ± SD Median (IQR)		
DAS28(ESR): Mean ± SD Median (IQR)		
Patient reported outcomes		
Patient Global Assessment VAS (0-100): Mean ± SD Median (IQR)		
Patient Pain Assessment VAS (0-100): Mean ± SD Median (IQR)		
Patient Fatigue Assessment VAS (0-100): Mean ± SD Median (IQR)		
Stiffness VAS (0-100): Mean ± SD		

RA disease characteristics	All initiators (Cohort 1) N=	Initiators with 6 months follow up (Cohort 2) N=
Median (IQR)		
HAQ (0-3): Mean ± SD Median (IQR)		
EQ-5D-3L categorical domains		
Walking, n (%)		
Self-care, n (%)		
Usual activities, n (%)		
Pain and discomfort, n (%)		
Anxiety and depression, n (%)		
Problems with sleeping, n (%)		
Treatment		
Concomitant therapies: n (%)		
None		
MTX only		
nonMTX csDMARD only		
MTX & nonMTX csDMARD		
History of csDMARD: n (%)		
None		
1		
2+		
History of biologics/tsDMARD: n (%)		
None		
1		
2+		
Prednisone		
History of prednisone use: n (%)		
Current prednisone use: n (%)		
Dose in users: Mean ± SD Median (IQR)		

Table 3. Previous therapy prior to Inflectra initiation

	All initiators (Cohort 1) **N=**	**Initiators with 6 months follow up (Cohort 2)** **N=**
Duration on previous therapy prior to Inflectra: Mean ± SD Median (IQR)		
Last therapy prior to Inflectra: n (%)		
Pts naïve to biologics/tsDMARD start Inflectra		
Pts switch from Remicade to Inflectra		
Pts switch from another non-infliximab biologic/tsDMARD to Inflectra		

Table 4. Outcome measures at 6 months after Inflectra initiation

Binary outcomes	**N=**
	n (%) 95% CI
Achievement of LDA (CDAI≤10)[a]	
Achievement of Remission (CDAI≤2.8)[b]	
Achievement of mACR20	
Achievement of mACR50	
Achievement of mACR70	
Continuous outcomes	Mean (SD) 95% CI
Δ CDAI:	
Δ Patient global assessment (0-100)	
Δ HAQ (0-3)	
Δ patient pain VAS (0-100)	
Δ patient fatigue VAS (0-100)	

[a] Calculated among those patients with moderate or high disease activity (CDAI>10) at baseline.
[b] Calculated among those patients with LDA, moderate or high disease activity (CDAI>2.8) at baseline.

Table 5. Reasons for initiation of Inflectra

# of initiations, n	
# of patients reporting at least one reason, n (%)	
Total # of reasons, n	
Safety: n (%)	
Efficacy: n (%)	
Cost/Insurance: n (%)	
Other reason: n (%)	

Notes:

- Safety: includes infection, lymphoma/malignancy, toxicity, serious and minor side effect.
- Efficacy: includes lack of efficacy, disease flare, active disease, primary loss of efficacy, and secondary loss of efficacy, inadequate initial response, failure to maintain initial response.
- Cost/Insurance includes lack of insurance
- Other reason: includes no longer needed, formulary restriction, patient preference, recent journal report, recent meeting report, withdrawn by FDA, physician preference, peer suggestion, fear of future side effect, patient doing well, and frequency of administration, temporary interruption, to improve compliance, to improve tolerability, route of administration.

6. References

[1] G. E. Simon, S. M. Shortreed, R. Y. Coley, R. B. Penfold, R. C. Rossom, B. E. Waitzfelder, K. Sanchez and F. L. Lynch, "Assessing and Minimizing Re-identification Risk in Research Data Derived from Health Care Records," *EGEMS (Wash DC),* p. 6, 2019.

[2] Agency for Healthcare Research and Quality (AHRQ), "Data Collection and Quality Assurance," in *Registries for Evaluating Patient Outcomes: A User's Guide*, 4 ed., vol. 1, September 2020.

[3] W. P. Battisti, E. Wager, L. Baltzer, D. Bridges, A. Cairns, C. I. Carswell, L. Citrome, J. A. Gurr, L. A. Mooney, B. J. Moore, T. Peña, C. H. Sanes-Miller, K. Veitch, K. L. Woolley and Y. E. Yarker, "Good Publication Practice for Communicating Company-Sponsored Medical Research: GPP3," *Ann Intern Med,* pp. 461-4, 2015.

Amendment / Version History

1- Prepared for PPD PharmD, Pfizer has changed to Prepared for PPD MD
2-The change realigned SAP language to the general practices that CorEvitas is currently implementing for handling discontinuations in the efficacy studies in the real-world settings.

In section 3.3.4.1 and 3.3.4.2 replace "Patients who discontinue Inflectra within 6 months and switch to another biologic or JAK will be considered "non-responders" with "For patients who discontinue Inflectra prior to 6 months, outcomes will be imputed via last observation carried forward (LOCF), using only registry visits that occur before the discontinuation."

In section 3.3.6, under Table 4 paragraph, replace "For patients who discontinued Inflectra prior to follow-up, dichotomous outcomes will be imputed as non-response. For continuous outcomes, if a patient discontinues Inflectra and does not switch to another drug, we use the value at the follow-up visit. If a patient discontinues and switches to another biologic/tsDMARD, we use the value at the switch visit, if available (otherwise set to missing)." with "For patients who discontinued Inflectra prior to follow-up window, outcomes will be imputed as via LOCF using registry visit information collected prior to reported discontinuation."