STATISTICAL ANALYSIS PLAN

Protocol Number:	URO-901-3006
Protocol Title:	A Phase 3 Open-Label Extension Study to Evaluate the Long-Term Safety and Efficacy of Vibegron in Men with Overactive Bladder (OAB) Symptoms on Pharmacological Therapy for Benign Prostatic Hyperplasia (BPH)
Protocol Version and Date:	Version 1.0; 22-MAY-2019
Investigational Product:	Vibegron (URO-901, RVT-901, MK-4618, KRP-114V)
Indication	OAB symptoms for men with BPH
Development Phase:	Phase 3
US IND Number:	106410
EudraCT Number:	2018-003136-72
Sponsor:	Urovant Sciences, GmbH Gotthardstrasse 3 CH-6300 Zug Switzerland Telephone +41 (42) 2155999
SAP Version **Effective Date**	v1.0 31-Jul-2023
SAP Author	[redacted], MS Sr. Principal Biostatistician/Director, Urovant Sciences, Inc.

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SIGNATURE PAGE

This document has been prepared and/or reviewed by:

[redacted], MS
Sr. Principal Biostatistician Director1
Urovant Sciences, Inc

DocuSigned by:
[redacted]
Signer Name: [redacted]
Signing Reason: I am the author of this document
Signing Time: 31-Jul-2023 | 13:12 PDT
B33C8EF459EF4B3097837C5822732C5E

31-Jul-2023 | 13:12 PDT
Date (dd-MMM-yyyy)

[redacted] MD
SVP Clinical Development
Urovant Sciences, Inc

DocuSigned by:
[redacted]
Signer Name: [redacted]
Signing Reason: I approve this document
Signing Time: 31-Jul-2023 | 13:39 PDT
ED06CA2798A14397A229C2908626A2F4

31-Jul-2023 | 13:39 PDT
Date (dd-MMM-yyyy)

[redacted] PhD, MS
Sr. Director Clinical Development
Urovant Sciences, Inc

DocuSigned by:
[redacted]
Signer Name: [redacted]
Signing Reason: I approve this document
Signing Time: 31-Jul-2023 | 13:13 PDT
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Date (dd-MMM-yyyy)

[redacted] BS
Director Clinical Operations
Urovant Sciences, Inc

DocuSigned by:
[redacted]
Signer Name: [redacted]
Signing Reason: I approve this document
Signing Time: 31-Jul-2023 | 16:31 PDT
9884B0C84C344F9EB35FE1AE1B204171

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Date (dd-MMM-yyyy)

[redacted], PharmD
Associate Director, Drug Safety and Pharmacovigilance
Urovant Sciences, Inc

DocuSigned by:
[redacted]
Signer Name: [redacted]
Signing Reason: I approve this document
Signing Time: 01-Aug-2023 | 08:05 PDT
6037CD32E9D045329CAA7CCA01F51D15

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Date (dd-MMM-yyyy)

This document has been approved by

[redacted] MS
Sr. Director Biostatistics
Urovant Sciences, Inc

DocuSigned by:
[redacted]
Signer Name: [redacted]
Signing Reason: I approve this document
Signing Time: 01-Aug-2023 | 05:28 PDT
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LIST OF ABBREVIATIONS

Abbreviation	Term
5-ARI	5α-reductase inhibitor
ADaM	analysis data model
AE	adverse event
AESI	adverse events of special interest
BMI	body mass index
BP	blood pressure
BPH	benign prostatic hyperplasia
CFB	change from baseline
CI	confidence interval
CRF	case report form
DBP	diastolic blood pressure
DSMB	data safety monitoring board
eCRF	electronic case report form
FAS	full analysis set
FAS-EXT	full analysis set extension
FAS-EXT-I	full analysis set extension for incontinence
[redacted]	
IPSS	International Prostate Symptom Score
IWRS	interactive web response system
LS	least squares
MAR	missing at random
MedDRA	Medical Dictionary for Regulatory Activities
MMRM	mixed model for repeated measures
OAB	overactive bladder
[redacted]	[redacted]
PGI	patient global impression
PPS	per-protocol set
PT	preferred term
PRO	patient reported outcome
PVR	post-void residual
QoL	quality of life
REML	restricted (or residual) maximum likelihood
SAE	serious adverse event
SAF-EXT	safety set extension
SAP	statistical analysis plan
SBP	systolic blood pressure
SD	standard deviation
SDTM	study data tabulation model

Abbreviation	Term
SE	standard error
SOC	system organ class
TEAE	treatment emergent adverse event
TLF	table, listing, figure
UUI	urge urinary incontinence
VAS	visual analog scale
VV	volume voided
WHO	World Health Organization
β3-AR	beta-3 adrenergic receptor

SAP VERSION HISTORY

Version	*Date*	*Description of Changes*
1.0	**<< Date >>**	***Original Document***

1. INTRODUCTION

This Statistical Analysis Plan (SAP) provides a description of the statistical methodology to be implemented for the analyses of data from Study URO-901-3006 Protocol Version 1.0. Any deviations from this analysis plan will be substantiated by statistical rationale and will be documented in the final clinical study report.

1.1. Study Objectives and Endpoints

Assessments in Study URO-901-3006 are referenced to the initial Baseline (Visit 3) from Study URO-901-3005. Change from baseline (CFB) study endpoints for safety parameters for study URO-901-3006 are relative to the most recent assessment prior to starting vibegron. CFB study endpoints for efficacy in Study URO-901-3006 are relative to Study URO-901-3005 baseline. At the Week 52 visit, CFB comprises 52 weeks of vibegron exposure for subjects randomized to vibegron in Study URO-901-3005 and 28 weeks of vibegron exposure for subjects randomized to placebo.

With respect to study endpoints, "per day" refers to a "Diary Day", which is defined as the time between when the subject gets up for the day each morning and the time the subject gets up for the day the next morning as recorded in the subject bladder diary (approximately a 24-hour period).

1.1.1. Primary Objective

Primary Objective	Endpoints
To demonstrate the long-term safety of vibegron 75 mg in men with BPH with symptoms of OAB	• Adverse Events (AEs) • Clinical laboratory assessments • Vital sign assessments • Post-void residual (PVR) urine volume • International Prostate Symptom Score (IPSS) Total Score

1.1.2. Secondary Efficacy Objectives

Secondary Efficacy Objectives	Endpoints
To demonstrate the long-term efficacy of vibegron 75 mg in men with BPH with symptoms of OAB	• CFB to Week 52 in the average number of micturition episodes per day • CFB to Week 52 in the average number of urgency episodes (urgency: need to urinate immediately) per day • CFB to Week 52 in the average number of nocturia episodes per night • CFB to Week 52 in the average number of urge urinary incontinence episodes per day in subjects with incontinence at Study URO-901-3005 baseline • CFB to Week 52 in the IPSS Storage score (1-week recall) • CFB to Week 52 in the average volume voided per micturition

1.1.3. Exploratory Efficacy Objectives

Exploratory Efficacy Objectives	Endpoints
[redacted]	

1.1.4. Exploratory Quality of Life (QoL) Objectives

Exploratory QoL Objectives	Endpoints
[redacted]	

1.2. Study Design

1.2.1. Overall Study Design

This is an international Phase 3, open-label 28-week extension study to evaluate the safety and efficacy of vibegron 75 mg in men with symptoms of OAB on stable doses of pharmacological therapy for BPH. This study is an extension for subjects who have completed the Phase 3, double-blind, randomized, 24-week Study URO-901-3005.

Approximately 300 men with symptoms of OAB on stable doses of pharmacological therapy for BPH who completed 24 weeks in Study URO-901-3005 and continue to qualify for this study may be permitted to enroll in this extension study, from approximately 60 study sites.

During this extension study, subjects who had been randomized in Study URO-901-3005 to receive vibegron 75 mg will continue their same treatment once daily for an additional 28 weeks, and subjects who had been randomized in Study URO-901-3005 to the placebo group will receive study treatment of vibegron 75 mg once daily for 28 weeks during the extension. Thus, through participation in both the URO-901-3005 and URO-901-3006 (extension) studies, subjects originally randomized to vibegron will receive 52 weeks total of vibegron treatment, and subjects originally randomized to placebo will receive 28 weeks total of vibegron treatment.

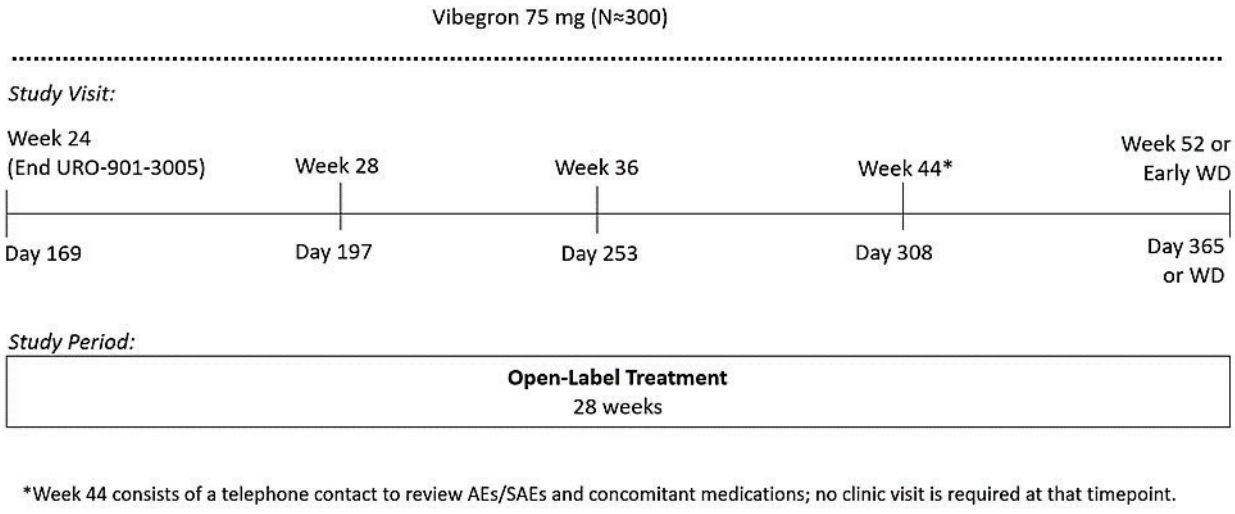
Study visits will be named to reflect continuation from Study URO-901-3005, with the first study visit of this extension study occurring at Week 24. Following enrollment in this extension study, subjects will return to the clinic for visits at Week 28, Week 36, and Week 52 (all relative to Day 1 of Study URO-901-3005). A telephone contact will occur at Week 44 to review AEs/serious AEs (SAEs) and concomitant medications.

This study consists of a 28-week open-label Treatment Period. Unscheduled Visit(s) may be arranged as needed.

A Data Safety Monitoring Board (DSMB) will be retained to assess, on an ongoing basis, all safety aspects of this study. This will be an external independent DSMB that monitors the safety for both Study URO-901-3005 and Study URO-901-3006. The detailed activities including meeting plans will be described and documented in the DSMB Charter. A separate statistical analysis plan will be prepared for the DSMB.

The study schema is shown in Figure 1.

Figure 1: Study Schema



*Week 44 consists of a telephone contact to review AEs/SAEs and concomitant medications; no clinic visit is required at that timepoint.

1.2.2. Randomization and Blinding

No additional randomization will be applied for this study, and all subjects will receive open-label treatment with vibegron 75 mg QD during the study treatment period.

1.2.3. Statistical Hypotheses

There are no formal statistical hypotheses for this trial.

1.2.4. Sample Size Justification

Approximately 300 subjects rolling over from Study URO-901-3005, in addition to other long-term safety data with vibegron, is sufficient to characterize the long-term safety profile of vibegron 75 mg once daily in men with symptoms of OAB on stable doses of pharmacological therapy for BPH. With the assumption of approximately 33% dropout, 100 subjects will be expected to complete the study for the duration of 1-year on vibegron.

2. PLANNED ANALYSES

2.1. Interim Analysis

No interim analysis is planned for this study.

An Independent DSMB will be utilized in the study to ensure objective medical and/or statistical review of safety issues in order to protect the ethical and safety interests of subjects and to protect the scientific validity of the study. An external statistician will provide the required summaries to the DSMB. Further details of the DSMB review are described in the charter and separate DSMB SAP.

2.2. Final Analysis

Analysis of data in study URO-901-3006 includes baseline assessments and post-vibegron-exposure safety and efficacy data collected in study URO-901-3005 and depends on double-blind randomized treatment assignments from URO-901-3005. No treatment assignments from URO-901-3005 will be unblinded within study URO-901-3006 until after study URO-901-3005 has been formally unblinded.

eClinical Solutions, LLC will perform the production and quality control of all tables, figures and listings on behalf of Urovant Sciences, Inc.

Statistical programming will start after data have been collected and are available in the database. Blinded dry-runs using dummy treatment codes for study URO-901-3005 will be performed prior to database lock to ensure programming displays and algorithms are developed as planned.

The planned final analysis will be performed once the clinical database lock has taken place on both URO-901-3005 and URO-901-3006 and treatment codes for URO-901-3005 have been unblinded.

3. ANALYSIS POPULATION

3.1. Analysis Sets

3.1.1. All Subjects Extension

The All Subjects Extension consists of all subjects who signed the informed consent form (ICF) for URO-901-3006 and have screening data entered into the database. This population is used primarily for subject accounting purposes and will generally not be used for summary or analysis.

3.1.2. Safety Analysis Set Extension

The Safety Analysis Set Extension (SAF-Ext) will serve as the primary population for the analysis of safety data in this trial.

The SAF-Ext consists of all randomized subjects in Study URO-901-3005 who

a) have completed the 24-week treatment period in the Study URO-901-3005, and

b) enrolled into the extension Study URO-901-3006 and received at least one dose of vibegron in this study.

Safety endpoints will be descriptively summarized for the entire Safety Analysis Set Extension. No imputation will be performed for missing safety data. Baseline will be established as the last observation prior to the first dose of vibegron. All safety data collected on or after the first exposure to vibegron within the combined experience of the patient on URO-901-3005 and

URO-901-3006 will be included in the safety analysis for URO-901-3006, and all analyses by visit will index visits from the first dose of vibegron on either study; subjects who received placebo in study URO-901-3005 will only contribute safety data up to Week 28.

3.1.3. Full Analysis Set Extension

The Full Analysis Set Extension (FAS-Ext) population will serve as the primary population for the analysis of efficacy data in this trial. Since the endpoints related to incontinence only apply to subjects who meet the definition of incontinence at trial entry, it is necessary to have a separate FAS definition with an additional criterion to define the primary analysis population for incontinence endpoints. Model-based estimates will be additionally restricted to only include subjects who were randomized to vibegron in the parent study.

The following FAS populations are defined in the study:

- **Full Analysis Set Extension (FAS-Ext):** All OAB subjects who took at least one dose of vibegron in the extension study and have at least one evaluable change from URO-901-3005 baseline micturition measurement in this study.
- **Full Analysis Set Extension for Incontinence (FAS-Ext-I):** All OAB subjects who took at least one dose of vibegron in the extension study, were included in the FAS-I population in the URO-901-3005 study, and have at least one evaluable change from baseline (i.e., Study URO-901-3005 baseline) urge urinary incontinence measurement in this study.

Subjects will be included in one of two vibegron treatment groups based on the original randomization from the parent study (URO-901-3005): 28 weeks Vibegron 75 mg, 52 weeks Vibegron 75 mg. Efficacy endpoints will be descriptively summarized by treatment group.

3.1.4. Per-Protocol Populations

The Per-Protocol Extension (PP-Ext) population and Per-Protocol Extension population for Incontinence (PPS-Ext-I) exclude patients from the FAS-Ext and FAS-Ext-I respectively due to important deviations from either protocol that may substantially affect the results of the efficacy endpoints (i.e., Major PDs associated with efficacy). Subjects assigned placebo in URO-901-3005 will only consider protocol deviations from URO-901-3006 and inclusion/exclusion protocol deviations from study URO-901-3005. The final determination of protocol violations, and thereby the composition of the Per-Protocol populations will be made prior to database lock and will be documented. A supportive analysis using the Per Protocol populations will be performed for the 6 secondary efficacy endpoints as defined in Section 1.1.2 (i.e., CFB in micturition, urgency, nocturia, and urge urinary incontinence episodes; IPSS Storage score; and volume voided per micturition).

Efficacy endpoints will be descriptively summarized by treatment group (i.e. 28 weeks Vibegron 75 mg, 52 weeks Vibegron 75 mg).

3.2. Violations and Deviation

Major protocol deviations are considered to have major impact on subject safety, efficacy or the validity of the study data.

Exclusion from per-protocol analysis is noted for each protocol deviation in the Protocol Deviation specifications. Patients with major protocol deviations that may impact efficacy results will be excluded from the PPS-Ext and PPS-Ext-I. Efficacy protocol deviations may include, but are not limited to the following:

- Subjects who do not meet the inclusion criteria
- Subjects who meet any of the exclusion criteria
- Concomitant use of prohibited medications
- Other (e.g., IP compliance<70%)

Subjects excluded from the per protocol analysis in URO-901-3005 will also be excluded from per protocol analysis in URO-901-3006, with the exception of on-study protocol deviations in the placebo arm as noted in section 3.1.4.

The final list of major protocol deviations will be finalized and documented before database lock. All major protocol deviations related to efficacy will be discussed and finalized prior to database lock. Only major protocol deviations will be summarized and listed in the Clinical Study Report (CSR).

4. GENERAL STATISTICAL CONSIDERATIONS

4.1. General Principles for Data Analysis

4.1.1. Multicenter Study

In the parent study the stratified permuted block randomization is not done within centers. The analyses will be conducted by pooling data from all study centers and will not include study center as a covariate in the statistical modeling.

4.2. General Data Handling Conventions

4.2.1. Study Treatment Description

Treatment groups based on the randomized treatment in the parent study will be displayed as shown in the following table:

Table 1: Study Treatment Description

Data Displays for Reporting		
Description	Sections Included	Order in TLF
52 weeks Vibegron 75mg	Demographic and baseline data, Efficacy, Safety	1

28 weeks Vibegron 75mg	Demographic and baseline data, Efficacy (descriptive tables only), Safety	2
Overall Vibegron 75 mg	Demographic and baseline data, Safety	3

4.2.2. Reporting Conventions

General rules

In general, all collected safety data and any derived efficacy and PRO data will be presented in subject data listings for all enrolled subjects. This includes all data collected on the parent study, URO-901-3005, relevant to the definition of baseline and all data collected on URO-901-3005 after the first dose of vibegron, excluding assessments not repeated during 3006 (orthostatic vital signs, ECGs, urodynamics, and prostate volume measurement). Listings will be ordered by treatment group, subject number, and assessment week or event date. The treatment group presented in listings will be based on the actual treatment assignment in study URO-901-3005 (placebo as 28 Weeks Vibegron 75mg, vibegron 75mg as 52 weeks Vibegron 75mg), unless otherwise noted.

Summary tables will be provided for all subjects who sign informed consent for study URO-901-3006. Unless otherwise specified; all demographic and baseline data and safety data will be presented by treatment group and overall. Unless otherwise specified; all efficacy data will be presented by treatment group. In general, continuous variables will be summarized to indicate the population sample size (N), number of subjects with available data (n), arithmetic mean, SD, median, minimum, Q1, Q3 and maximum values. Categorical variables will be summarized by the population size (N), number of subjects with available data (n), number of subjects in each category, and the percentage of subjects in each category. Unless otherwise noted, the denominator to determine the percentage of subjects in each category will be based on the number of subjects with available data (n) in the analysis set of interest. Select ordinal data may be summarized using both descriptive statistics and counts and percentages of subjects in each category, as appropriate.

The data analyses will be conducted using the SAS® System (SAS Institute Inc., Cary, NC) version 9.4 or above. The eClinical Solutions standard operating procedures will be followed for the validation of all SAS programs and outputs.

Formats

Numeric data will be reported at the precision collected on the eCRF. The reported precision from non eCRF sources may be adjusted to a clinically interpretable number of decimal places.

Unscheduled Visits

Unscheduled visits will be assigned to a study visit using the all-inclusive windows defined in Section 4.2.4. However, data summaries for non-diary data will only report visits that are planned assessment time points for each parameter, according to the Time and Events table. All

visits for bladder diary data will be fully derived as described in section 4.2.4.2. Assessments at unscheduled visits will be included for "any time On-treatment" endpoints and in data listings.

4.2.3. Premature Withdrawal and Missing Data

All data collected in the study database after the subject's cessation of study treatment should be included in summary and analysis as defined by analysis rules. Data of subjects who are not treated with vibegron on either Study URO-901-3005 or URO-901-3006 will only be listed.

If any missing data are present in diary data for any reasons, no explicit missing data imputation will be performed for the analysis of change from baseline since a mixed model for repeated measures (MMRM) will be applied to change from baseline analysis.

Missing items from the subject reported outcomes (PROs) will not be imputed. Some scores may still be calculated from the non-missing questions; handling rules are detailed for each individual PRO within the appropriate subsection of 4.3.2.

In general, missing safety data will not be imputed and only observed values will be analyzed.

If the relationship of an AE record ("Relationship to investigational product" on AE CRF) is missing this AE will be considered "Probably Related" to the study treatment. If the AE intensity is missing every effort should be made to acquire the information from the investigator. "Severe" will be assigned to a missing intensity for reporting purposes.

Dates of AEs and medications reported under the URO-901-3005 protocol (including all start dates of events and medications initially reported in URO-901-3005 and end dates of events and medications that were not ongoing at the time of URO-901-3006 entry) will follow the date imputation rules from the URO-901-3005 SAP; dates will not be re-imputed.

The general imputation rules of partial missing date and time for both AE and medication is detailed below:

<u>Dates missing the day of the year will adhere to the following conventions:</u>

- The missing day of onset date will be set to:
  - The day of first active treatment with vibegron in URO-901-3006, if the onset YYYY-MM is the same as YYYY-MM of the first active treatment
  - First day of the month that the event occurred otherwise.

- The missing day of end date will be set to:
  - The death date, if the end date YYYY-MM is the same as the YYYY-MM of the death date
  - The end of study participation, if the end date YYYY-MM is the same as the YYYY-MM of the end of study participation date
  - The last day of the month of the occurrence otherwise.

<u>Dates missing both the day and month of the year will adhere to the following conventions:</u>

- Missing onset date will be set to:
  - January 1 of the year of the onset, if the onset YYYY is after the YYYY of the first active treatment
  - The date of the first active treatment in URO-901-3006, if the onset YYYY is the same as the YYYY of the first active treatment

- The missing end date will be set to:
  - The death date, if the end date YYYY is the same as the YYYY of the death date
  - The end of study participation, if the end date YYYY is the same as the YYYY of the end of study participation date
  - December 31 of the year of occurrence otherwise.

4.2.4. Assessment Windows

4.2.4.1. Study Reporting Periods

Based on study design and variables under consideration, study time periods are defined as below.

Table 2: Definition of Study Reporting Periods

Analysis description	Analyzing Study Period	Start Date	End Date
General	Pre Treatment (Day -49 – Day 1/Week 24)	Date of informed consent	Prior to the date of first dose of vibegron on either study URO-901-3005 or URO-901-3006
	Treatment (Day 1/Week 24 – Week 52)	Date of first dose of vibegron on either study URO-901-3005 or URO-901-3006	Date of last dose of vibegron on URO-901-3006 + 5 or EOS, whichever is earlier
Adverse events	Prior (Summarized as Medical History)	Start date ≥ date of informed consent on URO-901-3005 and < date of first dose of vibegron in either study.	No restriction
	Treatment Emergent (TEAE)	Start date (AE begins or worsens in severity) ≥ date of first dose of vibegron* and ≤ date of last dose of vibegron + 5 days or EOS visit, whichever is earlier.	No restriction

Analysis description	Analyzing Study Period	Start Date	End Date
Prior or Concomitant Medication/ Procedure	Prior medication/ procedure	Start date < date of first vibegron dose	End date < date of first vibegron dose OR medication not marked as 'ongoing' on study URO-901-3005 and subject received placebo on study URO-901-3005
	Concomitant medication/ procedure	Start date ≥ date of first dose of vibegron and ≤ date of last vibegron dose + 5 days or EOS visit, whichever is earlier.	
		Start date < date of first vibegron dose, but ongoing during vibegron treatment period	End date ≥ date of first vibegron dose OR medication marked as 'ongoing' on study URO-901-3005.
First and last dose of vibegron refer to the first and last dose across both study URO-901-3005 and URO-901-3006, for subjects who were treated with at least one dose of vibegron in study URO-901-3006. EOS: End of study is defined as the date when the subject has completed one of the following: completes Week 52 Safety Follow-up, discontinued from the study, or is lost to follow-up. *AEs with a start date equal to the date of first dose of vibegron will be considered treatment-emergent unless the relatedness to study drug is marked 'Not applicable'. Overlapping period: Medication start date <= period start date < medication end date, medication start date < period end date <=medication end date, or period start date <= medication start or end date < period end date, then the medication is considered overlapping with the period.			

4.2.4.2. Analysis Visit Windows

Analysis visit windows for both diary and non-diary efficacy data are shown in Table 3. All observations will be given an analysis visit, assigned based on relative study day from the first blinded treatment in study URO-901-3005. If multiple repeats of the same assessment are observed within an analysis window, unless the measure was intended to be averaged over replicates, the record closest to the nominal time (earlier in case of a tie) will be used for by-visit summaries. If fewer than three of the diary days are within the analysis window, only the data within the window will be used to calculate visit-level averages.

Table 3: Efficacy Analysis Visit Window Slotting

Analysis window label	Non-diary data			Diary data		
	Nominal visit	Nominal day	Visit Window	Nominal visit[a]	Nominal day	Window
Baseline	Visit 3	1	NA[b]	Run-in	-1	[-7[c], -1]
Week 1	Visit 4	8	[2, 11]			
Week 2	Visit 5	15	[12, 22]	Visit 4	15	[7,18]
Week 4	Visit 6	29	[23, 42]	Visit 5	29	[19, 39]
Week 8	Visit 7	57	[43, 70]	Visit 6	57	[47, 67]
Week 12	Visit 8	85	[71, 98]	Visit 7	85	[68, 102]
Week 16	Visit 9	113	[99, 126]	Visit 8	113	[103, 123]
Week 20	Visit 10	141	[127, 154]	Visit 9	141	[131, 151]
Week 24	Visit 11	169	[155, 182[b]]	Visit 10	169	[159, 179]
Week 28	Visit 12	197	[183[d], 224]	Visit 11	197	[187, 207]
Week 36	Visit 13	253	[225, 308]	Visit 12	253	[243, 263]
Week 52	Visit 14	365	> Day 309	Visit 13	365	[345, 385]

a Nominal visit for diary data is the visit where the diary was dispensed.
b Must have occurred prior to the first dose administered in study URO-901-3006.
c If randomization was delayed for any reason, diaries completed within 7 days prior to the baseline visit will still be considered within the analysis window.
d Must have occurred on or after the first dose administered in study URO-901-3006.

For all non-diary safety data including safety laboratory, vital signs, and PVR volume to be summarized by visit, data records will be slotted to one of the protocol-specified visits using the following algorithm:

1. Determine relative study day and last dose day:

   Relative study day will be derived as described in Section 4.3.3.

   Note that the date of first double-blind dose on URO-901-3005 is Day 1 and the day before the date of double-blind first dose is Day -1. There is no Study Day 0.

2. For non-early withdrawal records, if a nominal visit number for a scheduled visit was assigned, then it will be used to summarize the record after checking to make sure that visit numbers match with therapy phases:

   - Check that all records entered as a pre-treatment visit for study URO-901-3005 occur on or before the day of the first dose of double-blind treatment (i.e. day ≤1). Any record with day > 1 should be re-slotted to an on-treatment visit using the relative day window below.
   - Check that all records slotted to an on-treatment visit for study URO-901-3005 and all records for study URO-901-3006 are on or after the day of the first dose of double-blind treatment. If they are not, the visit should be moved to pre-treatment.

3. Any early withdrawal record (regardless of the visit number assigned), any unscheduled visit record at any time, any repeat visit record, or any record for which the visit number was missing or the visit number was not for a scheduled visit, should be slotted or re-slotted to a visit using the window below.

Table 4: Analysis Visit Window Slotting

Analysis window label	URO-901-3005 Randomized Arm					
	Vibegron			Placebo		
	Nominal visit	Nominal day	Visit Window	Nominal visit	Nominal day	Visit Window
Baseline	Visit 3	1	NA[a]	Visit 3	1	[1,182[b]]
Week 1	Visit 4	8	[2, 11]	NA	NA	NA
Week 2	Visit 5	15	[12, 22]	NA	NA	NA
Week 4	Visit 6	29	[23, 42]	Visit 12	197	[183[c],224]
Week 8	Visit 7	57	[43, 70]	NA	NA	NA
Week 12	Visit 8	85	[71, 98]	Visit 13	253	[225,308]
Week 16	Visit 9	113	[99, 126]	NA	NA	NA
Week 20	Visit 10	141	[127, 154]	NA	NA	NA
Week 24	Visit 11	169	[155, 182[a]]	NA	NA	NA
Week 28	Visit 12	197	[183[b], 224]	Visit 14	365	> Day 309
Week 36	Visit 13	253	[225, 308]	NA	NA	NA
Week 52	Visit 14	365	> Day 309	NA	NA	NA

a Must have occurred prior to the first dose administered in study URO-901-3005.
b Must have occurred prior to the date of first dose administered in study URO-901-3006.
c Must have occurred on or after the date of first dose administered in study URO-901-3006.

Note: The cut-off days to define the window for slotting through Week 20 are aligned with study URO-901-3005.

For parameters which were **not** scheduled to be collected at all visits, the all-inclusive visit intervals defined for all visits (i.e., the window defined above) will still be used to slot records. If a value is slotted to a visit unscheduled for a parameter, it will not be summarized (and not be included in the efficacy datasets) but will be included in data listings.

4. If after all records have been slotted or re-slotted, there are multiple valid records within a visit, use the record following the rules below:

   - If there are multiple values for an endpoint in one window, the visit closest to the nominal day will be selected for by-visit displays. If the visits are equidistant from the nominal day, then the earlier visit will be selected. All values will be stored in analysis datasets.

4.3. Data Definitions and Deviations

4.3.1. Bladder Diary Endpoints

The bladder diary records what time subjects woke up for the day, what time they went to bed, and asks the subjects to record every time they had a urination event. For each event, subjects recorded the time, if they had a need to urinate immediately, if they urinated in the toilet, if they had accidental urine leakage, and if they had leakage what the main reason was for the leakage (urge or other) for 3 days and volume voided per micturition (over one 24-hour period) prior to each study visit. If fewer than three days were collected within the diary window, the average of the days within window will be used. If more than three days were collected within the diary window, the average of the three closest days to the nominal timepoint will be used.

The following efficacy parameters will be derived based on the Diary data for baseline, Weeks 2, 4, 8, 12, 16, 20, 24, 28, 36, and 52.

4.3.1.1. Secondary Efficacy Endpoints (Bladder Diary)

Although these endpoints are automatically derived in eCRF Day 3 Bladder Diary page, the final statistical analysis will use the value derived by the biometrics team based on the algorithm described below.

CFB in average daily number of micturition episodes to Week 52

The number of micturition episodes will be defined as the number of times a subject has voided in the toilet as indicated on the Bladder Diary. Average number of micturition episodes per day at each study visit will be calculated as the total number of micturition records within the diary analysis visit windows described in Table 3 divided by non-missing diary days (diary days with at least one void reported).

CFB in average daily number of urgency episodes to Week 52

The number of urgency episodes will be defined as the number of times a patient has checked that he had “need to urinate immediately” micturition in the toilet or “urge” accident leakage as indicated on the Bladder Diary. Average daily number of urgency episodes at each study visit will be calculated as the total number of urgency episodes within the diary analysis visit windows divided by non-missing diary days.

CFB in average nightly number of nocturia episodes to Week 52

Average nightly number of nocturia episodes will be calculated in the same manner as average daily number of micturition episodes but only include episodes occurring during sleep (all episodes occurring after the time reported that a subject went to bed on the same diary day and prior to the time a subject reported getting up for the day on the subsequent diary day). If no subsequent time of awakening was filled out, all records after the time a subject went to bed on the day will be used.

CFB in average daily number of urge urinary incontinence (UUI) episodes to Week 52 for subjects with UI at study URO-901-3005 baseline

The number of UUI episodes will be defined as the number of times a subject has checked that they had "urge" as the main reason for accident leakage regardless of whether “other” is checked in addition to “urge”. Average UUI episodes per day at each study visit will be calculated in the same manner as described above for the micturition endpoint. The UUI endpoint will be analyzed in the FAS-Ext-I and PPS-Ext-I population.

CFB in average volume voided per micturition to Week 52

The total volume voided will be the sum of all urinary volumes collected regardless of whether patients checked “Urinated in Toilet” or not. Average volume voided per micturition at each study visit will be calculated as the total volume voided divided by the total number of micturition episodes during non-missing diary days.

4.3.1.2. Exploratory Efficacy Endpoints (Bladder Diary)

4.3.2. Patient Reported Questionnaire Endpoints

4.3.2.1. International Prostate Symptom Score

The International Prostate Symptom Score (IPSS) is based on the responses to 7 questions concerning urinary symptoms and 1 question concerning quality of life. Each question concerning urinary symptoms allows the subject to choose 1 out of 6 answers indicating increasing severity of the particular symptom. The responses are assigned points from 0 to 5. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

The questions refer to the following urinary symptoms:

Questions	Symptom
1	Incomplete emptying
2	Frequency
3	Intermittency
4	Urgency
5	Weak Stream
6	Straining
7	Nocturia

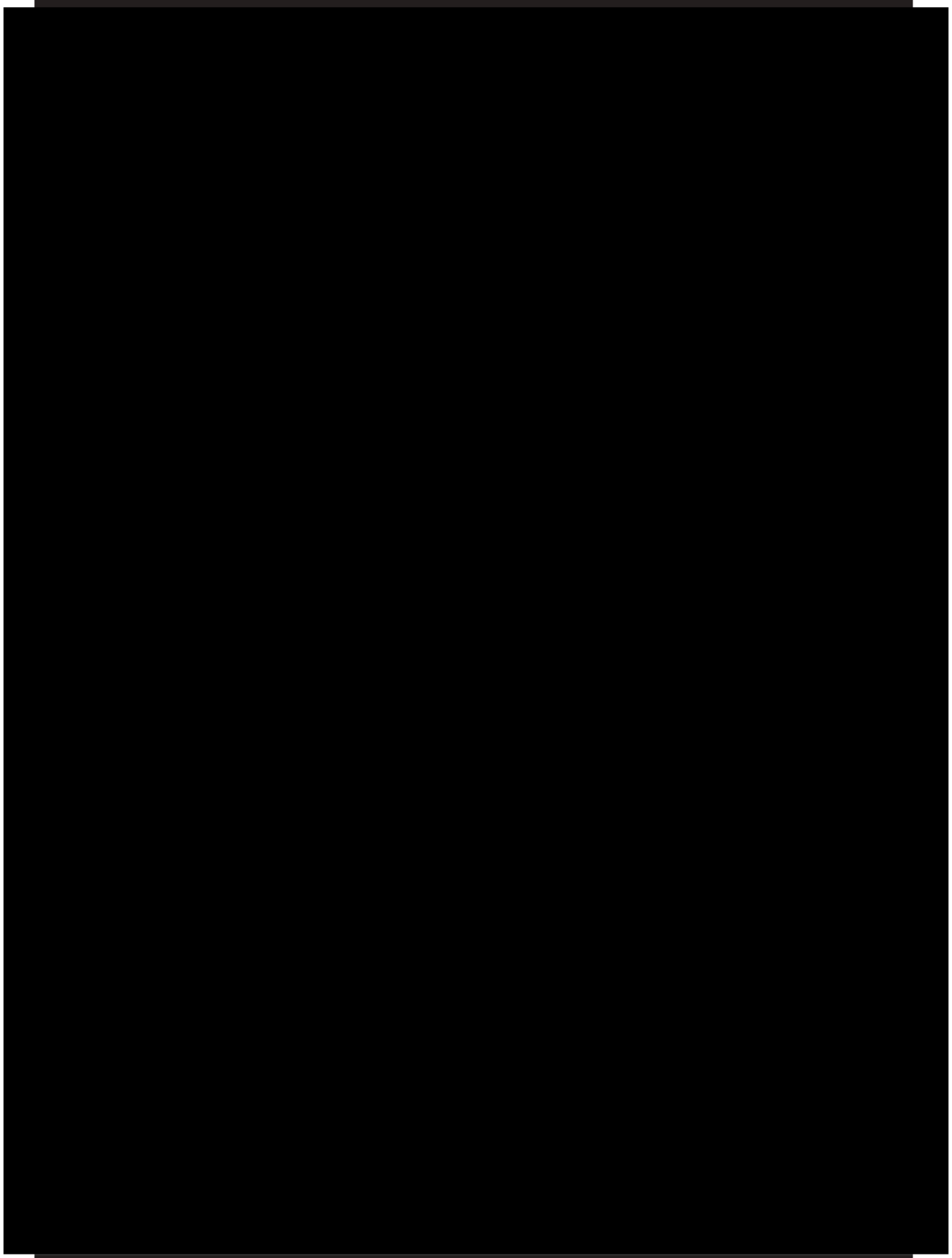
Question 8 refers to the subject's perceived quality of life (QoL). The answers to the single question to assess the quality of life this question range from 0: "delighted" to 6: "terrible".

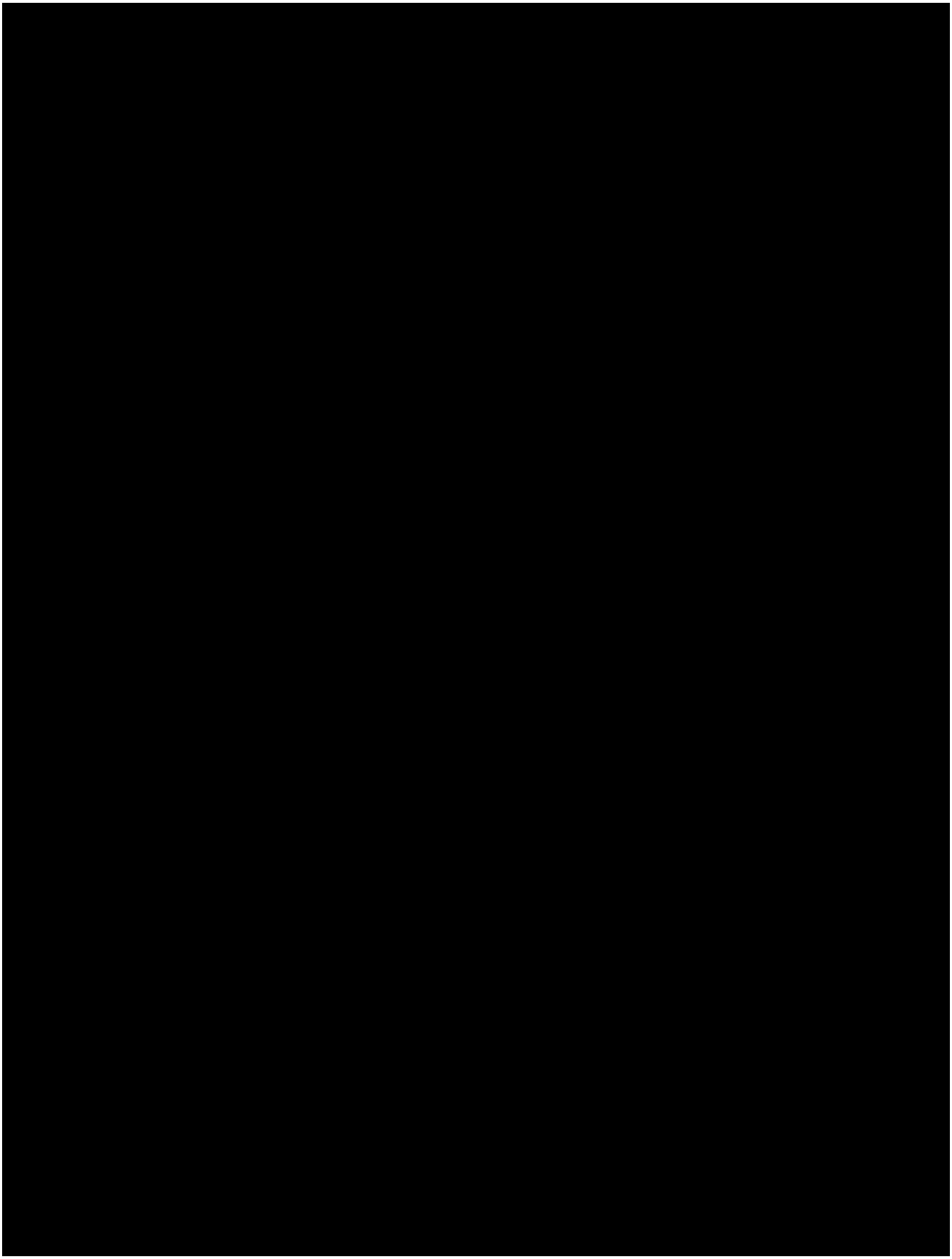
The IPSS questions reference storage symptoms (frequency, urgency and nocturia scores) and voiding symptoms (incomplete empty, intermittency, weak stream and straining) [1]. The following parameters will be derived:

CFB in IPSS storage score to Week 52 (secondary efficacy)

The IPSS storage score will be derived as the sum of the IPSS storage questions (sum of frequency, urgency and nocturia scores) for each visit. If any of these questions are not answered, the IPSS storage score will not be calculated.

[redacted]





Function Domain	Questions	Direction of Domain Scores
[redacted]		

4.3.3. Study Day and Duration

Study day is relative to the start date of the double-blind treatment on the parent study URO-901-3005. This is used to describe the relative time of an event or assessment that happened during the study. The first day of the study is defined as the day a patient first receives either vibegron or placebo in the double-blind treatment period. This is expected to be the same day as the randomization as Day 1. There is no study Day 0 defined in the study.

- For event or assessment that occurred on or after the first dose of double-blind treatment date:
  Study day = Date of event or examination – date of first study treatment + 1
- For event or assessment that occurred prior to the first dose of double-blind treatment date:
  Study day = Date of event or examination – date of first study treatment

Treatment day will be defined in the same manner relative to the date of first dose of vibegron.

Similarly, a duration between any two dates (such as AE duration) expressed in days will be calculated using the following conventions:

- Duration = Later date – earlier date + 1

4.3.4. Baseline and Change from Baseline

In general, the last recorded value on or prior to the date of randomization in the parent study URO-901-3005 will serve as the baseline measurement for efficacy endpoints while the last recorded value prior to first double-blind dose of study treatment will serve as the baseline measurement for safety endpoints. The mean of multiple values will be used as baseline for the following situations:

- If multiple measurements are scheduled on the same baseline day (i.e., blood pressure)
- If multiple measurements are collected on the same baseline day without the time or "repeat" status to differentiate the records

For efficacy endpoints derived from the Bladder Diary, the baseline will be the average value over the diary days in the baseline analysis visit window on study URO-901-3005.

Change from baseline will be calculated as the post-baseline value minus the baseline value. Percentage change from baseline will be calculated as the change from baseline divided by the baseline value, multiplied by 100. If either the baseline or post-baseline value is missing, then change from baseline and percentage change from baseline will be set to missing.

5. Demographics, Other Baseline Characteristics, Procedures And Medication

5.1. Subject Disposition and Withdrawals

Subject disposition will be summarized by treatment group and overall for the consented and treated subjects. The summary table will present the frequency and percentage of subjects in each of the analysis sets, treatment on URO-901-3006, and those who discontinued the study prematurely along with the primary reasons for discontinuation.

For the summary of the treated subjects, the following additional categories will be presented as well; discontinued treatment with study drug (and reason), completed study, and withdrawn from study (and reason).

The frequency and percentage of subjects with at least one major Protocol Deviation (PD), major PD by classification and reasons/category for PD will be summarized by planned overall treatment duration and overall for the FAS-Ext. Inclusion in each of the analysis sets (SAF-Ext, FAS-Ext, FAS-Ext-I, PPS-Ext, PPS-Ext-I), and any reasons for exclusion will be summarized by planned overall treatment duration for the Treated Set.

Eligibility criteria, screening failures (including date and primary reason for failure), and informed consent (protocol version, informed consent version date and date signed) will be listed for all patients screened.

A summary of treated subjects by country and investigator will be provided. Randomization details will also be listed, including the date of randomization, randomization number and randomization strata.

5.2. Demographic and Baseline Characteristics

All demographic and baseline characteristic data will be summarized by planned overall treatment duration and overall using descriptive statistics for all subjects for each of the following analysis sets: SAF-Ext, FAS-Ext, FAS-Ext-I, PPS-Ext and PPS-Ext-I.

The summary table will include Ethnicity and Race, Region (US and non-US), Prior Anticholinergic Use (Yes/No), Prior Beta-3 agonist Use (Yes/No), Diabetes Mellitus (Yes/No), Baseline Hypertension (Yes/No), Pre-existing Hypertension (Yes/No), Age category 1 (<55, ≥55 to <65, ≥65 to <75, ≥75 years), Age category 2 (<65, ≥65 years), Age category 3 (<65, ≥65 to <85 years, ≥85 years), baseline average micturition episodes per day (≤ 12 vs > 12), Alpha blocker use with or without 5-ARI (with vs without), Urinary Incontinence (yes or no), total IPSS score, alpha blocker (tamsulosin, doxazosin, alfuzosin, other), and 5-ARI (finasteride, dutasteride, other).

Prior Anticholinergic Use and Prior Beta-3 agonist Use will be calculated from all prior medications documented on the Prior and Concomitant Medications electronic case report form (eCRF).

Baseline Hypertension will be defined as baseline systolic blood pressure (SBP) ≥140 mmHg or baseline diastolic blood pressure (DBP) ≥90 mmHg, regardless of medical history.

Pre-existing hypertension will be defined as having a medical history of hypertension or Baseline hypertension (baseline SBP ≥140 mmHg or baseline DBP ≥90 mmHg). The following list of preferred terms will be used to search for medical history of hypertension:

- Accelerated hypertension
- Diastolic hypertension
- Essential hypertension
- Hypertension
- Hypertensive crisis
- Hypertensive emergency
- Hypertensive heart disease
- Malignant hypertension
- Malignant hypertensive heart disease
- Secondary hypertension
- Supine hypertension
- Systolic hypertension

Age (years), height (cm), weight (kg), BMI captured at Screening on study URO-901-3005, and baseline IPSS total score will be summarized as a continuous variable.

Unless otherwise stated, percentages will be calculated out of the number of patients in the given analysis set.

All demographic data will be listed.

5.3. Other Baseline Characteristics

The data from the 3-day bladder diary during run-in period on study URO-901-3005 (reviewed at Visit 3 Baseline visit) prior to first dose of double-blind medication will be used as baseline for each subject. This includes average daily number of micturition episodes, average daily number of urgency episodes, average number of nocturia episodes per night, average daily number of urge urinary incontinence episodes, and average volume voided per micturition. In addition, the baseline IPSS storage score will be presented. These will be summarized by treatment group and overall using descriptive statistics for continuous data for all subjects in FAS-Ext, FAS-Ext-I, PPS-Ext and PPS-Ext-I analysis sets.

5.4. Medical History and Concomitant Disease

Descriptions of medical history findings will be coded using Medical Dictionary for Regulatory Activities (MedDRA) version 23.0 or higher.

Medical history will include all events entered on the medical history form in URO-901-3005 as well as any AEs with the end date prior to the first date of active treatment on either URO-901-3005 or URO-901-3006.

A disease or illness reported as medical history without a start date will be included in medical history without a date assigned. Medical history will be sorted by descending overall frequency, by system organ class (SOC) and preferred term (PT) in the summary table. Medical history data listings will be sorted by treatment, subject number, start date, SOC and PT. The SAF-Ext will be the analysis set for medical history data.

5.5. Prior and Concomitant Procedures

Prior and concomitant procedures will be coded using Medical Dictionary for Regulatory Activities (MedDRA) version 23.0 or higher.

Prior procedures are defined as procedures with a start date prior to the first dose of vibegron on study URO-901-3005 or URO-901-3006. Concomitant procedures will be defined as procedures started on or after the first dose of vibegron but prior to the last dose + 5 days, or started prior to the first dose of vibegron and were ongoing during the study. Post procedures are defined as any procedure initiated after last dose of vibegron + 5 days (See Table 2). Partial procedure start dates will be imputed as detailed in 4.2.3.

All procedures will be listed for the SAF-Ext population, sorted by treatment, subject number, start date, SOC and PT, with indicators of prior and concomitant status.

5.6. Prior and Concomitant Medication

Prior and concomitant medications will be coded using the World Health Organization (WHO) Drug B3-Sept Format, 2020 version or later. Except for Prior OAB medication, the number and percentage of subjects taking prior medications and concomitant medications will be summarized overall by ATC (Anatomical Therapeutic Chemical) Levels 2 and 4 for all subjects in the SAF-Ext. Prior OAB medications will be summarized by ATC Levels 2, 4 and Preferred Term in the SAF-Ext. Prior medications, OAB medication and concomitant medications will be listed for all subjects in the SAF-Ext.

5.6.1. Prior Medication

Prior medications are defined as those medications taken prior to the first dose of vibegron on study URO-901-3005 or URO-901-3006. The prior non-OAB and prior OAB medications will be summarized separately.

The following criterion will be used for selecting prior OAB medication:

Table 7. OAB Medication Selection

Class	Variable Selected	Selection
Anticholinergics	Preferred Term	darifenacin, fesoterodine, festoterodine fumarate hyoscyamine, oxybutynin, oxybutynin hydrochloride, propantheline, solifenacin, solifenacin succinate, tolterodine, tolterodine l-tartrate, trospium, trospium chloride
Beta-3 adrenergic agonists	Preferred Term	mirabegron, vibegron

Combination medications will be identified if the preferred term contains a term from the selection.

5.6.2. Concomitant Medication

Concomitant medications are defined as medications that were started on or after the first dose of vibegron on study URO-901-3005 or URO-901-3006 but prior to the last dose of vibegron + 5 days or started prior to the first dose of vibegron and were ongoing or ended after the first dose of vibegron. Partial medication start dates will be imputed as detailed in 4.2.3.

Non-OAB and OAB concomitant medications will be summarized separately.

6. EFFICACY ANALYSIS

Subjects were asked to fill out a Bladder Diary for 3 consecutive days prior to the Run-in visit, Baseline visit, Weeks 2, 4, 8, 12, 16, 20, 24, 28, 36, and 52.

In general, the FAS-Ext will be used for all analyses of non-incontinence efficacy endpoints. The FAS-Ext-I will be used for all incontinence efficacy endpoints; these are the endpoints related to UUI episodes and total incontinence episodes.

6.1. Secondary Efficacy Analysis

The secondary efficacy analysis will be done on the FAS-Ext or FAS-Ext-I population, repeated in a supportive analysis on the PP-Ext or PP-Ext-I population, respectively. Descriptive

summaries for observed and CFB for each efficacy endpoint will be provided by visit and treatment group.

For the assessment of change from baseline to Week 52 for endpoints with repeated-measures over time, a mixed model for repeated measures (MMRM) analysis incorporating on-treatment values at all time points for the subjects in the 52-week treatment group will be used. The model takes into account correlation within the same subject over time by using all available data on the subjects within the same covariate set. With the assumption of missing at random (MAR), this approach will provide unbiased estimates of treatment effects.

The MMRM model will include terms for visit, baseline value, alpha blocker use with or without 5-ARI (with vs. without), baseline urinary incontinence (yes vs. no) [for the FAS-Ext and PP-Ext analyses only], region (US vs. non-US), and any other parameter-specific covariates noted in sections 6.1.1 and 6.1.2. The Kenward-Roger adjustment will be used with restricted (or residual) maximum likelihood (REML) to make statistical inference. An unstructured covariance matrix will be used to model the correlation among repeated measurements. If the unstructured covariance model fails to converge with the default Newton-Raphson algorithm, the Fisher scoring algorithm will be used to provide initial values of the covariance parameters. In the rare event that none of the above methods yield convergence, the following structures will be investigated: heterogeneous Toeplitz, Toeplitz, heterogeneous First-Order Autoregressive [AR (1)], heterogeneous compound symmetry (HCS), and compound symmetry (CS). The covariance structure converging to the best fit, as determined by Akaike's information criterion (AIC), will be used.

Estimates of least square means (LSMEANS), standard errors, and 95% confidence intervals will be presented at each time point. The estimated LSMEANS (Standard Error (SE)) of CFB over time from the model will be plotted.

An example of the SAS code for the base procedure is given below:

```
proc mixed data = datain method = reml;
    class AVISITN USUBJID ARI UI REGION;
    model CHG = AVISITN ARI UI REGION BASE
                / ddfm=KR solution chisq;
    repeated AVISITN / subject=USUBJID type=UN r rcorr;
    lsmeans AVISITN / cl alpha=0.05;
run;
```

Where AVISITN is the visit number, USUBJID is the unique subject identifier, ARI indicates if the subject used alpha blocker with or without 5-ARI at baseline (with or without), UI indicates baseline urinary incontinence (yes or no), REGION indicates if the subject is in the United States or in the non-US countries and BASE indicates baseline value. The default Newton-Raphson algorithm is employed for type = UN.

The normality assumptions for the primary analysis model will be assessed by inspection of the residuals from the model and normal probability plots. If assumptions of normality are not met, additional supportive analysis of the data will be performed in order to assess the robustness of the conclusions drawn from the model.

6.1.1. Bladder Diary Endpoints

Refer to parameter derivations from Bladder Diary data in Section 4.3.1. Scheduled post-treatment visits for bladder diary endpoints include Weeks 2, 4, 8, 12, 16, 24, 28, 36, and 52.

CFB to Week 52 in average daily number of micturition episodes

This analysis will be done on the FAS-Ext set and repeated on the PP-Ext set, with no additional covariates.

CFB to Week 52 in average daily number of urgency episodes

This analysis will be done on the FAS-Ext set and repeated on the PP-Ext set, with an additional categorical covariate of average number of micturition episodes per day (≤ 12 vs. > 12).

CFB to Week 52 in the average nightly number of nocturia episodes

This analysis will be done on the FAS-Ext set and repeated on the PP-Ext set, with no additional covariates.

CFB to Week 52 in the average daily number of UUI episodes for subjects with baseline incontinence in study URO-901-3005

This analysis will be done on the FAS-Ext-I set and repeated on the PP-Ext-I set, with no additional covariates.

CFB to Week 52 in the average volume voided per micturition

This analysis will be done on the FAS-Ext and PP-Ext sets, with no additional covariates.

6.1.2. IPSS Endpoint

Refer to endpoint definitions in section 4.3.2.1. Scheduled visits for the IPSS include Weeks 4, 8, 12, 24, 36, and 52.

CFB to Week 52 in the IPSS storage score (1-week recall)

This analysis will be done on the FAS-Ext set and repeated on the PP-Ext set, with no additional covariates.

6.2. Exploratory Endpoints

[redacted]

[redacted]

6.2.2. Other Quality of Life Endpoints

The FAS-Ext will be the analysis population for the PRO data unless stated otherwise.

6.2.2.1. CFB in [redacted] Scores

[redacted]

6.2.2.3. Patient Global Impression Scores

The questionnaire is assessed at baseline, Weeks 4, 12, 24, and 52 for the 52-week treatment group, and baseline and Week 28 (Week 52 relative to the start of URO-901-3005) for the 28-week treatment group. The Patient Global Impression (PGI) questions are designed to assess a

subject's overall impression of OAB in 5 categories: [redacted]

Each of the responses to the PGI questions will be assigned a numerical value starting from 1. A higher score represents a worse outcome in each category.

Table 8: PGI Scoring

PGI Category	Score
[redacted]	1 = None 2 = Mild 3 = Moderate 4 = Severe
[redacted]	1 = Complete control 2 = A lot of control 3 = Some control 4 = Only a little control 5 = No control
[redacted]	1 = Never 2 = Rarely 3 = Sometimes 4 = Often 5 = Very often
[redacted]	1 = Much better 2 = Moderately better 3 = A little better 4 = No change 5 = A little worse 6 = Moderately worse 7 = Much worse

The questions [redacted] PGI-Control, PGI-Frequency and PGI-Leakage are ordinal assessments going from lower impact of disease to highest impact of disease with score with scores ranging from 1 to 4 for [redacted] and 1 of 5 for [redacted] These questions will be summarized descriptively as numerical variables of score and change from baseline by treatment group and visit. Additionally, these questions will be analyzed as categorical variables with count and percent for each category by treatment group and visit.

The [redacted] question is asked relative to baseline. The score will only be summarized as a categorical variable with count and percent for each category by treatment group and visit.

The FAS-Ext will be the analysis set for all categories except for [redacted] The FAS-Ext-I will be the analysis set for the [redacted] analysis.

[redacted]

7. SAFETY ANALYSIS

The SAF-Ext will be used for all safety analyses. Safety will be assessed based on extent of exposure and compliance, AE reports, clinical laboratory data, physical examinations, vital signs, post-void residual volume, and total IPSS score.

No inferential statistical testing is planned on the safety data, all data will be summarized and listed only.

7.1. Extent of Exposure

The duration of exposure with vibegron over studies URO-901-3005 and URO-901-3006 will be expressed as the time in days from the first dose of vibegron as recorded on the Study Drug Administration CRF page through to last treatment day (inclusive) as recorded on the End of Treatment CRF page, excluding any days where it is recorded that an interruption has occurred on the AE CRF page. If no last treatment date is recorded, it will be imputed as the minimum of the date of the last visit on study 3006 and the date when last dispensed study treatment was scheduled to be exhausted (last dispensation date + number of doses dispensed).

Interruptions to dosing can be due to delays in resupply (measured by gaps in the study drug log) or interruptions due to AE. Interruptions due to AE that overlap partially or completely will be listed separately but not double-counted for summing interruption days.

Gaps in the study drug log will be determined by comparing the dispensation date of a record to the previous dispensation date (where up to four bottles may have been dispensed). The gap is measured from the study day of previous dispensation + number of pills dispensed + number of days of AE interruption within the period.

Interruption in days = date interruption started – date interruption stopped + 1

This is given by the following formula:

Duration (days) = date of last vibegron dose – date of first vibegron dose – interruption days + 1

Duration of exposure will be summarized by treatment group and overall for the SAF-Ext set using summary statistics for continuous variables. A listing will present the treatment start and end date together with date(s) of interruption and the overall duration of exposure.

7.2. Treatment Compliance

Study treatment compliance (%) will be calculated as the actual number of vibegron doses taken divided by the expected number of vibegron doses, multiplied by 100 and summarized by treatment duration.

These numbers will be calculated as the sum of the number of tablets indicated as taken by the subject on each dispensation record. Where no treatment bottle is returned, and thus the actual number of doses taken is unknown, it will be assumed that the subject took medication as directed until another bottle was dispensed, their supply was exhausted, or end of treatment was noted. This is calculated as (minimum of [next dispensation date – dispensation date + 1], [doses dispensed] and [EOT date – dispensation date + 1]).. Imputed values will be clearly noted in the listing.

The expected number of vibegron doses is the same as the calculated duration of exposure detailed in section 7.1.

Treatment Compliance will be summarized for the SAF-Ext and FAS-Ext population. Additionally, the number and percentage of subjects within each planned treatment duration with compliance in the following categories will be provided: <80%, 80 – 120%, and >120%. All data will be listed.

7.3. Adverse Events

AEs will be coded using MedDRA version 23.0 or higher.

All reported AEs (whether treatment emergent or not) on both study URO-901-3005 and URO-901-3006 will be included in by-subject AE listings on the Safety Set Extension. Sorting will be by country, site, subject, date of event, SOC, PT and then verbatim description. An additional overall AE listing will be presented for subjects that were enrolled but not dosed with vibegron on URO-901-3006.

An AE will be considered treatment emergent (TEAE) if it begins or worsens in severity after the first dose of vibegron on study URO-901-3005 or URO-901-3006 through 5 days after the last dose of vibegron. Partial AE start dates will be imputed as detailed in Section 4.2.3.

Summary tables will be based on TEAEs. The incidence of TEAEs will be presented using counts and percentages of subjects with TEAEs and tabulated by SOC and PT. SOC will be sorted in descending frequency and PT within SOC will be sorted by descending frequency based on the incidence across subjects overall. If a subject has multiple occurrences (start and stop) of an event associated with a specific SOC or PT within a SOC, a subject will only be counted once in the incidence count for the SOC or PT within SOC respectively.

An overall summary table of AEs will be presented detailing the number and percentage of subjects, and number of events for the following categories:

- At least one TEAE;

- At least one Treatment-Related TEAE;
- At least one Grade ≥ 3 TEAE (Mild = Grade 1, Moderate = Grade 2, Severe of Medically Significant = Grade 3, Life-Threatening = Grade 4, Death = Grade 5)
- At least one Grade ≥ 3 Treatment-Related TEAE;
- At least one Serious TEAE;
- At least one Serious Treatment-Related TEAE;
- At least one TEAE leading to Discontinuation from Study Medication;
- At least one TEAE of Special Interest;
- At least one Treatment-Related TEAE of Special Interest

Where not otherwise noted, all the following summaries are presented by PT:

- All TEAEs (by SOC and PT);
- Treatment-Related TEAEs (i.e., possibly or probably related);
- TEAEs occurring in 2% or more of the population;
- All TEAEs by SOC, PT, and maximum severity (where the maximum intensity per patient will be counted at each level of summarization);
- TEAES with Grade ≥ 3;
- Treatment-Related TEAES with Grade ≥ 3;
- Serious TEAEs;
- Treatment-Related Serious TEAEs;
- Fatal TEAEs;
- TEAEs leading to Discontinuation from Study Treatment;
- TEAE of Special Interest (by protocol-defined AESI category);
- Treatment-Related TEAE of Special Interest (by protocol-defined AESI category);
- Non-fatal TEAEs;
- Hypertension TEAEs by Pre-existing Hypertension (Yes vs No) and Baseline Hypertension (Yes vs. No). Hypertension TEAEs will be selected as any TEAE with a preferred term of Hypertension.

In addition, a summary of all TEAEs by PT occurring in at least 2% of subjects will be created and ordered by descending overall frequency.

Adverse events of special interest for this study include:

- Adverse events consistent with urinary retention
- Adverse events suggestive of cystitis or urinary tract infection (UTI)
- Potential major cardiac and cerebrovascular events, including death (or any event with fatal outcome), myocardial infarction, cerebrovascular accident, hospitalization for unstable angina or chest pain, hospitalization for heart failure requiring hospitalization, and coronary revascularization/angioplasty/stent
- Adverse events consistent with hypertension (see protocol section 8.4.6)
- Adverse events consistent with orthostatic hypotension as confirmed by orthostatic vital signs
- Elevated serum aspartate aminotransferase (AST) or alanine aminotransferase (ALT) lab value requiring that study drug be temporarily withheld or permanently discontinued
- Neoplasms

Treatment listings will include the planned treatment duration, start and stop dates/times of the AE, study day (relative to start of double-blind treatment on URO-901-3005) and treatment day (relative to the day of first dose of vibegron). A treatment related AE is defined as an AE for which the investigator classifies the AE as being “Probably Related” or “Possibly Related” to study treatment on the Adverse Event CRF. Missing relationship and severity (intensity) will be imputed per Section 4.2.3.

The following additional listings will be provided:

- Listing of Deaths
- Listing of Serious TEAEs
- Listing of Treatment-Emergent AESIs
- Listing of TEAEs Leading to Withdrawal or Interruption of Study Treatment
- Listing of all AEs with a flag for TEAEs and onset (Prior = prior to first dose of vibegron or Treatment = on or after first dose of vibegron.)
- Listing of all medical history including pre-treatment adverse events with coded preferred terms in the hypertension AE search list:
  - Accelerated hypertension
  - Diastolic hypertension
  - Essential hypertension
  - Hypertension

- Hypertensive crisis
- Hypertensive emergency
- Hypertensive heart disease
- Malignant hypertension
- Malignant hypertensive heart disease
- Secondary hypertension
- Supine hypertension
- Systolic hypertension.

7.4. Laboratory Evaluations

All continuous laboratory parameters will be summarized descriptively by absolute value at each visit together with the corresponding changes from baseline. All parameters will be summarized in SI units.

The number and percentage of subjects with laboratory measurements outside of the central laboratory normal range will also be summarized by visit. Shift tables from baseline to maximum post-baseline value, to minimum post-baseline value, last post-baseline value, and at each post-baseline visit will be provided for hematology and chemistry parameters to display low, normal, high, and missing values by treatment group in a 3-by-3 contingency table. Denominators for percentages will be the number of subjects with non-missing data at the specific assessment and baseline.

ALT/AST and Total Bilirubin will be displayed as eDISH plots. Maximum post-baseline total bilirubin will be presented (<2 and ≥2 x ULN) and plotted against maximum post-baseline ALT (<3, ≥3 - <5, ≥5-<10, and ≥10 x ULN), expressed as multiples of ULN. This will be repeated to show maximum post-baseline total bilirubin against maximum post-baseline AST.

Data for subjects with ALT or AST ≥3 x ULN, and bilirubin ≥2 x ULN will be presented, which will include all visits for this subset of subjects. A line plot of liver biochemistry test results (including ALP, ALT, AST, total bilirubin, and GGT) over time will also be presented for this subset of patients.

A sample for the urinalysis and urine culture will be sent to the central laboratory only if the urine dipstick performed at the site tests positive for the presence of leukocytes, nitrites, or blood cells. Central urinalysis data will be provided only in the listing.

Any data outside the central laboratory normal reference ranges will be explicitly noted on the listings that are produced.

7.5. Vital Sign Assessments

Vital sign data including blood pressure, pulse rate, respiration rate, body temperature and weight will be collected at all study visits except for the Week 1, Week 16, and 44 telephone visits. Height will be measured at Screening only. Blood pressure will be measured in triplicate at each visit. The average of triplicates will be used for summary. For subjects in URO-901-3005 Study Part 1 at any visits with orthostatic blood pressure measurements: blood pressure (in triplicate) and pulse rate taken pre-dose in sitting position are equivalent to all other pre-dose vital sign values and will be used. Orthostatic and standing blood pressure measurements collected during Part 1 of URO-901-3005 will not be included in any summaries on URO-901-3006.

For all parameters, absolute values and change from baseline will be presented for scheduled visits using descriptive statistics for continuous variables. In addition, the maximum post-baseline change from baseline value and change from baseline to the end of treatment will be summarized for each of the vital signs.

To further investigate changes in SBP/DBP/pulse rate from baseline, the following tables will be prepared:

- Counts and percent of subjects in each group with at least a 5/10/15 CFB at 2 consecutive post-baseline visits and at Week 52 will be produced for all subjects, by pre-existing hypertension category (Yes/No) and by pre-existing hypertension category (Yes/No).
- Maximum post-baseline CFB (including 95% CI of Mean)

The line plot of mean (SE) of change from baseline in blood pressure and pulse rate over time will be prepared. A by-subject listing, sorted by subject identifier, will be presented including all vital sign results (scheduled or unscheduled).

7.6. Physical Examination

Brief physical examination data will be collected at Screening, Baseline, Week 12, 24, and 52. A listing of all physical exam results for subjects with at least one abnormal result will be produced.

7.7. Post-Void Residual (PVR) Urine Volume

PVR urine volume data will be summarized at Baseline and every visit. The summary will comprise a continuous summary at each visit, including change from baseline, and a categorical summary of PVR at the following categories: <100 mL, ≥ 100 and < 200 mL, ≥ 200 and < 350 mL, and ≥ 350 mL. All PVR data will be listed.

7.8. IPSS Total Score

IPSS total score at Screening, Day 1, Weeks 4, 8, 12, 24, 36, and 52 for the 52-week treatment group and baseline, Week 12 and Week 28 for the 28-week treatment group will be summarized by treatment group and visit, including change from baseline.

8. COVID-19 CONSIDERATIONS

This study was conducted during the COVID-19 global pandemic. During the time period of the pandemic, it is anticipated that changes in study visit schedules, missed visits, or patient discontinuations may lead to missing information (e.g., for protocol-specified procedures). In accordance with FDA guidance on statistical considerations for clinical trials during the COVID-19 public health emergency [3], it is important to capture specific information in the case report form that explains the basis of the missing data, including the relationship to COVID-19 for missing protocol-specified information (e.g., from missed study visits or study discontinuations due to COVID-19).

The proportion of subjects with COVID-19 impact on visits will be summarized by treatment group overall and by visit. The reasons (e.g. subject acquired COVID-19, subject unable to travel due to COVID-19, investigative site closure due to COVID-19, etc.) will also be summarized. In addition, subjects who discontinued treatment due to COVID-19 will be summarized with the COVID-19 reason for discontinuation. A listing of subjects who had COVID-19 information collected will be generated which will document the date of contact, the reason for the telephone follow-up, the visit that was missed, and if any doses were missed due to IP availability.

9. CHANGE FROM ANALYSIS PLANNED IN PROTOCOL

9.1. Secondary Efficacy

CFB in average IPSS Storage score has been changed to CFB in IPSS Storage score.

9.2. Exploratory Endpoints

CFB at all URO-901-3005 or URO-901-3006 protocol-specified timepoints apart from [redacted] have been added for all secondary efficacy endpoints.

9.3. COVID-19 Considerations

The COVID-19 global pandemic began during the conduct of the study. The recommended impact analysis was therefore added to the SAP, as the operational change of increased visit windows had been communicated via study memo with no protocol amendment.

9.4. Physical Examination

Physical examination was removed from primary objectives; any clinically significant finding is reported by the investigator as an adverse event and is summarized with adverse events. Physical examination results will be only listed.

10. REFERENCES

[1] Jiang YH, Lin VC, Liao CH, Kuo HC. International Prostatic Symptom Score-voiding/storage subscore ratio in association with total prostatic volume and maximum flow rate is diagnostic of bladder outlet-related lower urinary tract dysfunction in men with lower urinary tract symptoms. PLoS One. 2013;8(3):e59176.

[2] [redacted] crosswalk value set https://euroqol.org/eq-5d-instruments/[redacted] about/valuation-standard-value-sets/crosswalk-index-value-calculator/

[3] Statistical Considerations for Clinical Trials During the COVID-19 Public Health Emergency https://www.fda.gov/regulatory-information/search-fda-guidance-documents/statistical-considerations-clinical-trials-during-covid-19-public-health-emergency-guidance-industry

11. APPENDIX

11.1. Table of Contents for Data Display Specifications

11.1.1. Output Tables

Table 9: List of Output Tables

Title		Population	Programming notes
Study Population			
14.1.1.1	Subject Disposition	Screened	Include two sections: screened, treated
14.1.1.2	Enrollment by Country and Investigator	SAF-Ext	
14.1.2.1	Major Protocol Deviations	FAS-Ext	
14.1.2.2	Reasons for Exclusion from Analysis Sets	SAF-Ext	
14.1.3.1	Subject Demographic and Baseline Characteristics	SAF-Ext	
14.1.3.2	Subject Demographic and Baseline Characteristics	FAS-Ext	
14.1.3.3	Subject Demographic and Baseline Characteristics	FAS-Ext-I	
14.1.3.4	Subject Demographic and Baseline Characteristics	PPS-Ext	
14.1.3.5	Subject Demographic and Baseline Characteristics	PPS-Ext-I	
14.1.3.8	Other Baseline Characteristics	FAS-Ext	
14.1.3.9	Other Baseline Characteristics	FAS-Ext-I	
14.1.3.10	Other Baseline Characteristics	PPS-Ext	

Title		Population	Programming notes
14.1.3.11	Other Baseline Characteristics	PPS-Ext-I	
14.1.4	Medical History	SAF-Ext	
14.1.5.1	Prior Non-Overactive-Bladder (OAB) Medication	SAF-Ext	
14.1.5.2	Prior Overactive Bladder (OAB) Medication	SAF-Ext	
14.1.6.1	Non-OAB Concomitant Medication	SAF-Ext	
14.1.6.2	OAB Concomitant Medication	SAF-Ext	
14.1.7.1	COVID-19 Impact	SAF-Ext	
Efficacy Endpoints			
Secondary Efficacy Endpoints			
14.2.1.1	Average Daily Number of Micturition Episodes	FAS-Ext	Descriptive statistics, include CFB
14.2.1.2	Change from Baseline in Daily Average Number of Micturition Episodes (MMRM)	FAS-Ext	Include all intervals, but present Week 52 first
14.2.1.3	Change from Baseline in Daily Average Number of Micturition Episodes (MMRM)	PPS-Ext	Include all intervals, but present Week 52 first
14.2.2.1	Average Daily Number of Urgency Episodes	FAS-Ext	Descriptive statistics, include CFB
14.2.2.2	Change from Baseline in Average Daily Number of Urgency Episodes (MMRM)	FAS-Ext	Include all intervals, but present Week 52 first
14.2.2.3	Change from Baseline in Average Daily Number of Urgency Episodes (MMRM)	PPS-Ext	Include all intervals, but present Week 52 first
14.2.3.1	Average Number of Nocturia Episodes per Day	FAS-Ext	Descriptive statistics, include CFB

Title		Population	Programming notes
14.2.3.2	Change from Baseline in Average Number of Nocturia Episodes per Day (MMRM)	FAS-Ext	Include all intervals, but present Week 52 first
14.2.3.3	Change from Baseline in Average Number of Nocturia Episodes per Day (MMRM)	PPS-Ext	Include all intervals, but present Week 52 first
14.2.4.1	Average Daily Number of Urge Urinary incontinence Episodes	FAS-Ext-I	Descriptive statistics, include CFB
14.2.4.2	Change from Baseline in Average Daily Number of Urge Urinary incontinence Episodes (MMRM)	FAS-Ext-I	Include all intervals, but present Week 52 first
14.2.4.3	Change from Baseline in Average Daily Number of Urge Urinary incontinence Episodes (MMRM)	PPS-Ext-I	Include all intervals, but present Week 52 first
14.2.5.1	International Prostate Symptom Score (IPSS) Storage Score	FAS-Ext	Descriptive statistics, include CFB
14.2.5.2	Change from Baseline in International Prostate Symptom Score (IPSS) Storage Score (MMRM)	FAS-Ext	Include all intervals, but present Week 52 first
14.2.5.3	Change from Baseline in International Prostate Symptom Score (IPSS) Storage Score (MMRM)	PPS-Ext	Include all intervals, but present Week 52 first
14.2.6.1	Average Volume Voided per Micturition	FAS-Ext	Descriptive statistics, include CFB
14.2.6.2	Change from Baseline in Average Volume Voided per Micturition (MMRM)	FAS-Ext	Include all intervals, but present Week 52 first
14.2.6.3	Change from Baseline in Average Volume Voided per Micturition (MMRM)	PPS-Ext	Include all intervals, but present Week 52 first
Other Efficacy and PROs Endpoints			

Title		Population	Programming notes
14.2.7.1	International Prostate Symptom Score (IPSS) Quality of Life Score	FAS-Ext	Descriptive statistics, include CFB
14.2.7.2	International Prostate Symptom Score (IPSS) Voiding Score	FAS-Ext	Descriptive statistics, include CFB
14.2.8.1	Urgency Episodes per Day 50% Responder Analysis	FAS-Ext	Descriptive statistics
14.2.9.1	Change from Baseline in Average Number of Total Incontinence Episodes per Day	FAS-Ext-I	Descriptive statistics, include CFB
14.2.9.2	Urge Urinary Incontinence Episodes per Day 75% Responder Analysis	FAS-Ext-I	Descriptive statistics
14.2.10.1	[redacted]	FAS-Ext	[redacted]
14.2.11.1	[redacted]	FAS-Ext	
14.2.11.2	[redacted] Crosswalk Index Value	FAS-Ext	
14.2.11.3	[redacted] VAS Value	FAS-Ext	
14.2.12.1	Overall Symptom Severity Bladder Symptoms Based on [redacted]	FAS-Ext	

Title		Population	Programming notes
14.2.12.2	Overall Symptom Control over Bladder Symptoms Based on [redacted]	FAS-Ext	Repeat 14.2.12.1
14.2.12.3	Overall Symptom Frequency Based on [redacted]	FAS-Ext	Repeat 14.2.12.1
14.2.12.4	Overall Urgency-Related Leakage over Bladder Symptoms Based on [redacted]	FAS-Ext-I	Repeat 14.2.12.1
14.2.12.5	Overall Change of Bladder Symptoms Based on [redacted]	FAS-Ext-I	Categorical summary
14.2.12.1	[redacted] Domain Scores and Overall Satisfaction Score	FAS-Ext	Include CFB
Safety Endpoints			
14.3.1.1.1	Treatment Exposure	SAF-Ext	
14.3.1.1.1	Treatment Exposure	FAS-Ext	
14.3.1.2	Treatment Compliance	SAF-Ext	
14.3.1.3	Treatment Compliance	FAS-Ext	
Adverse Events			
14.3.2.1	Overall Summary of Treatment Emergent Adverse Events	SAF-Ext	
14.3.2.2	Treatment Emergent Adverse Events by System Organ Class and Preferred Term	SAF-Ext	Descending frequency of SOC and PT
14.3.2.3	Treatment-Related Treatment Emergent Adverse Events by Preferred Term	SAF-Ext	Descending frequency of preferred term

Title		Population	Programming notes
14.3.2.4	Treatment-Emergent Adverse Events by Preferred Term and Maximum Intensity	SAF-Ext	Descending frequency of preferred term
14.3.2.5	Treatment Emergent Adverse Events with Grade ≥ 3 by Preferred Term	SAF-Ext	Descending frequency of preferred term
14.3.2.6	Treatment-Related Emergent Adverse Events with Grade ≥ 3 by Preferred Term	SAF-Ext	Descending frequency of preferred term
14.3.2.7	Treatment-Emergent Adverse Events occurring in ≥ 2% subjects by Preferred Term	SAF-Ext	Descending frequency of preferred term
14.3.2.8	Serious Treatment Emergent Adverse Events by Preferred Term	SAF-Ext	Descending frequency of preferred term
14.3.2.9	Treatment-Related Serious Treatment Emergent Adverse Events by Preferred Term	SAF-Ext	Descending frequency of preferred term
14.3.2.10	Treatment Emergent Adverse Events Leading to Discontinuation from Study Treatment by Preferred Term	SAF-Ext	Descending frequency of preferred term
14.3.2.11	Fatal TEAEs by Preferred Term	SAF-Ext	Descending frequency of preferred term
14.3.2.12	Treatment Emergent Adverse Events of Special Interest by Preferred Term	SAF-Ext	Descending frequency of preferred term
14.3.2.13	Treatment-Related Treatment Emergent Adverse Events of Special Interest by Preferred Term	SAF-Ext	Descending frequency of preferred term
14.3.2.14	Non-Fatal Treatment-Emergent Adverse Events by Preferred Term	SAF-Ext	Descending frequency of preferred term
14.3.2.15	Hypertension Treatment Emergent Adverse Events by Preferred Term, and Pre-Existing Hypertension	SAF-Ext	Descending frequency of preferred term
14.3.2.16	Hypertension Treatment Emergent Adverse Events by Preferred Term, and Baseline Hypertension	SAF-Ext	Descending frequency of preferred term
14.3.2.17	Listing of Deaths	SAF-Ext	

Title		Population	Programming notes
14.3.2.18	Listing of Treatment Emergent Serious Adverse Events	SAF-Ext	
14.3.2.19	Listing of Treatment Emergent Adverse Events Leading to Withdrawal or Interruption of Study Treatment	SAF-Ext	
14.3.2.20	Listing of TEAEs of Special Interest	SAF-Ext	
Safety Labs			
14.3.3.1	Hematology Laboratory Parameters	SAF-Ext	Include observed and CFB
14.3.3.2	Clinical Chemistry Laboratory Parameters	SAF-Ext	Include observed and CFB
14.3.3.3	Urinalysis Laboratory Parameters	SAF-Ext	Include observed and CFB
14.3.3.4	Summary of Other Laboratory Parameters	SAF-Ext	
14.3.3.5	Abnormal Classification of Hematology Laboratory Parameters	SAF-Ext	
14.3.3.6	Abnormal Classification of Clinical Chemistry Laboratory Parameters	SAF-Ext	
14.3.3.7	Abnormal Classification of Urinalysis Laboratory Parameters	SAF-Ext	
14.3.3.8	Abnormal Classification Summary of Other Laboratory Parameters	SAF-Ext	
14.3.3.9	Shift Table of L/N/H Classification for Hematology Laboratory Parameters	SAF-Ext	
14.3.3.10	Shift Table of L/N/H Classification for Chemistry Laboratory Parameters	SAF-Ext	
14.3.3.11	Maximum Post-baseline ALT and AST vs. Maximum Post-baseline Bilirubin	SAF-Ext	

Title		Population	Programming notes
14.3.3.12	Listing of Subjects who Potentially Met Hy's Law	SAF-Ext	
14.3.3.13	Summary of Liver Function Laboratory Findings	SAF-Ext	
Vital Signs			
14.3.4.1	Vital Sign Parameters	SAF-Ext	Include all observed and CFB
14.3.4.2	Vital Sign Parameter Change from Baseline Shifts at 3 Consecutive Visits	SAF-Ext	SBP, DBP and PR
14.3.4.3	Vital Sign Parameter Change from Baseline Shifts at Week 52	SAF-Ext	SBP, DBP and PR
14.3.4.4	Vital Sign Parameter Maximum Post-Baseline Change from Baseline	SAF-Ext	SBP, DBP and PR
Other			
14.3.5.1	Post-Void Residual Volume	SAF-Ext	
14.3.6.1	Total IPSS score	SAF-Ext	
14.3.7.1	Physical Examination Shift from Baseline	SAF-Ext	

11.1.2. Output Figures

Table 10: List of Output Figures

Title		Population	Programming notes
Efficacy Endpoints			
14.2.1.1	Plot of LS Means (SE) of Change from Baseline in Average Daily Number of Micturition Episodes (MMRM)	FAS-Ext	Including all visits
14.2.2.1	Plot of LS Means (SE) of Change from Baseline in Average Daily Number of Urgency Episodes (MMRM)	FAS-Ext	Including all visits

Title		Population	Programming notes
14.2.3.1	Plot of LS Means (SE) of Change from Baseline in Average Number of Nocturia Episodes per Day (MMRM)	FAS-Ext	Including all visits
14.2.4.1	Plot of LS Means (SE) of Change from Baseline in Average Number of Urge Urinary incontinence Episodes per Day (MMRM)	FAS-Ext-I	Including all visits
14.2.5.1	Plot of LS Means (SE) of Change from Baseline in International Prostate Symptom Score (IPSS) Storage Score (MMRM)	FAS-Ext	Including all visits
14.2.6.1	Plot of LS Means (SE) of Change from Baseline in Volume Voided per Micturition (MMRM)	FAS-Ext	Including all visits
Safety Endpoints			
14.3.3.1	Scatter Plot of Maximum ALT Post-Baseline versus Maximum Total Bilirubin Expressed as Multiples of ULN	SAF-Ext	
14.3.3.2	Scatter Plot of Maximum AST Post-Baseline versus Maximum Total Bilirubin Expressed as Multiples of ULN	SAF-Ext	
14.3.3.3	Line Plot of Liver Chemistry Test Results over Time for Subjects with Elevated ALT or AST, and Elevated Total Bilirubin at Any Time	SAF-Ext	Only produce for subjects who potentially met Hy's law
14.3.4.1	Line Plot of Mean (SE) in CFB of Systolic Blood Pressure	SAF-Ext	X-axis starts from baseline visit
14.3.4.2	Line Plot of Mean (SE) in CFB of Diastolic Blood Pressure	SAF-Ext	X-axis starts from baseline visit
14.3.4.3	Line Plot of Mean (SE) in CFB of Pulse Rate	SAF-Ext	X-axis starts from baseline visit
14.3.5.1	Line Plot of Mean (SE) Post-Void Residual Urine Volume	SAF-Ext	X-axis starts from baseline visit, separate lines for treatment groups

Title		Population	Programming notes
14.3.6.1	Line Plot of Mean (SE) IPSS Total Scores	SAF-Ext	X-axis starts from baseline visit, separate lines for treatment groups

11.1.3. Output Listings

Table 11: List of Output Listings

Title		Population	Programming notes
Disposition and Demographics			
16.2.1.1	Subject Disposition – Screen Failures	Screened	
16.2.1.2	Eligibility Criteria-Inclusion/Exclusion Criteria – Screen Failures	Screened	
16.2.1.3	Subject Disposition	SAF-Ext	
16.2.1.4	Protocol Deviation	FAS-Ext	
16.2.1.5	Exclusion from Analysis Sets	SAF-Ext	
16.2.1.6	Demographic and Baseline Characteristics	SAF-Ext	
16.2.1.7	Medical History	SAF-Ext	
16.2.1.8	Procedures	SAF-Ext	
16.2.1.9	Prior Non-OAB Medications	SAF-Ext	Separate from prior OAB medication listing.
16.2.1.10	Concomitant Medications	SAF-Ext	
16.2.1.11	Prior OAB Medication	SAF-Ext	
16.2.1.12	Treatment Administration	SAF-Ext	
16.2.1.13	Study Drug Accountability	SAF-Ext	
16.2.1.14	Study Drug Compliance	SAF-Ext	
16.2.1.15	COVID-19 Impact	SAF-Ext	
Efficacy			
16.2.2.1	Derived Average Bladder Diary Parameters	FAS-Ext	
16.2.2.2	Derived Responder Parameters from Bladder Diary	FAS-Ext	

Title		Population	Programming notes
16.2.2.3	Derived Parameters from International Prostate Symptom Score (IPSS) Data	FAS-Ext	
16.2.2.4	[redacted]	FAS-Ext	
16.2.2.5	[redacted]	FAS-Ext	
16.2.2.6	Global Impression Data	FAS-Ext	
16.2.2.7	[redacted]	FAS-Ext	

Safety			
16.2.3.1	All Adverse Events	SAF-Ext	
16.2.3.2	All Adverse Events Prior to Treatment	Screened	
16.2.3.3	All Adverse Events During Treatment	SAF-Ext	
16.2.3.4	Hematology Laboratory Parameters	SAF-Ext	
16.2.3.5	Clinical Chemistry Laboratory Parameters	SAF-Ext	
16.2.3.6	Urinalysis Laboratory Parameters	SAF-Ext	
16.2.3.7	Other Laboratory Parameters	SAF-Ext	
16.2.3.8	Vital Signs	SAF-Ext	
16.2.3.8	Physical Examination	SAF-Ext	
16.2.3.9	Post-Void Residual (PVR) Volume	SAF-Ext	