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TITLE: Winship 3185-16 A Phase II trial of pembrolizumab (MK-3475) in metastatic cutaneous squamous cell carcinoma

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1.0 TRIAL SUMMARY

Abbreviated Title	Pembrolizumab in cSCC
Trial Phase	II
Clinical Indication	cSCC, metastatic and unresectable
Trial Type	Interventional therapeutic
Type of control	None
Route of administration	IV
Trial Blinding	None
Treatment Groups	
Number of trial subjects	29
Estimated enrollment period	12 months
Estimated duration of trial	
Duration of Participation	

2.0 TRIAL DESIGN

2.1 Trial Design

This is a phase II trial of pembrolizumab in metastatic and unresectable cSCC. We hypothesize that pembrolizumab will increase active anti-tumor effect in patients with metastatic cSCC with an estimated RECIST response rate from 20% to 40%. The Type I error rate is set at 10% and power of this study will be at least 80%. The study will be conducted with Simon's optimal two stage design. In the first stage, 12 patients will be enrolled. If 2 or less of the 12 patients achieve response, the study will close to further accrual and pembrolizumab is deemed to be ineffective. If RECIST response is seen in 3 or more of the 12 patients, then the trial continues with the second stage in which additional 13 patients will be enrolled for a total of 25 patients. At the end of complete enrollment, we require 8 or more out of the total of 25 subjects to achieve response for the pembrolizumab to be deemed to have sufficiently improved clinical activity and justify further clinical development. Otherwise if 7 or less out of the 25 patients achieve response, the trial will conclude that pembrolizumab cannot increase active anti-tumor effect in patients with metastatic cSCC with an estimated RECIST response rate to 40%.

3.0 OBJECTIVE(S) & HYPOTHESIS(ES)

3.1 Primary Objective(s) & Hypothesis(es)

Objective: To establish the response rate of pembrolizumab in metastatic cutaneous squamous cell carcinoma.

Hypothesis: We hypothesize that pembrolizumab will have active anti-tumor effect in patients with metastatic, unresectable cSCC with an estimated RECIST response rate of 40%

3.2 Secondary Objective(s) & Hypothesis(es)

Objective: To determine the 6-month progression-free survival and 1 year overall survival of metastatic cSCC treated with pembrolizumab

Hypothesis: We hypothesize that treatment with pembrolizumab will improve 6-month PFS and 1-year OS over historic controls.

3.3 Exploratory Objective

Objective: To evaluate biomarkers of response in both tumor specimens and PBMCs in patients treated with cSCC. The biomarkers will determine PD-L1 staining on tumor specimens and its correlation with response. The expression of co-stimulator and co-inhibitory molecules on and functionality of T cell populations in peripheral blood, tumor, normal skin of patients with advanced cSCC before and after treatment with systemic pembrolizumab.

Hypothesis: We hypothesize that PD-L1 positive tumors will have a higher response rate than PDL1 negative tumors.

4.0 BACKGROUND & RATIONALE

4.1 Background

Refer to the Investigator's Brochure (IB)/approved labeling for detailed background information on MK-3475.

4.1.1 Pharmaceutical and Therapeutic Background

The importance of intact immune surveillance in controlling outgrowth of neoplastic transformation has been known for decades. Accumulating evidence shows a correlation between tumor-infiltrating lymphocytes (TILs) in cancer tissue and favorable prognosis in various malignancies. In particular, the presence of CD8+ T-cells and the ratio of CD8+ effector T-cells / FoxP3+ regulatory T-cells seems to correlate with improved prognosis and long-term survival in many solid tumors.

The PD-1 receptor-ligand interaction is a major pathway hijacked by tumors to suppress immune control. The normal function of PD-1, expressed on the cell surface of activated T-cells under healthy conditions, is to down-modulate unwanted or excessive immune responses, including autoimmune reactions. PD-1 (encoded by the gene Pdcd1) is an Ig superfamily member related to CD28 and CTLA-4 which has been shown to negatively regulate antigen receptor signaling upon engagement of its ligands (PD-L1 and/or PD-L2). The structure of

murine PD-1 has been resolved. PD-1 and family members are type I transmembrane glycoproteins containing an Ig Variable-type (V-type) domain responsible for ligand binding and a cytoplasmic tail which is responsible for the binding of signaling molecules. The cytoplasmic tail of PD-1 contains 2 tyrosine-based signaling motifs, an immunoreceptor tyrosine-based inhibition motif (ITIM) and an immunoreceptor tyrosine-based switch motif (ITSM). Following T-cell stimulation, PD-1 recruits the tyrosine phosphatases SHP-1 and SHP-2 to the ITSM motif within its cytoplasmic tail, leading to the dephosphorylation of effector molecules such as CD3 ζ , PKC θ and ZAP70 which are involved in the CD3 T-cell signaling cascade. The mechanism by which PD-1 down modulates T-cell responses is similar to, but distinct from that of CTLA-4 as both molecules regulate an overlapping set of signaling proteins. PD-1 was shown to be expressed on activated lymphocytes including peripheral CD4+ and CD8+ T-cells, B-cells, Tregs and Natural Killer cells. Expression has also been shown during thymic development on CD4-CD8- (double negative) T-cells as well as subsets of macrophages and dendritic cells. The ligands for PD-1 (PD-L1 and PD-L2) are constitutively expressed or can be induced in a variety of cell types, including non-hematopoietic tissues as well as in various tumors. Both ligands are type I transmembrane receptors containing both IgV- and IgC-like domains in the extracellular region and contain short cytoplasmic regions with no known signaling motifs. Binding of either PD-1 ligand to PD-1 inhibits T-cell activation triggered through the T-cell receptor. PD-L1 is expressed at low levels on various non-hematopoietic tissues, most notably on vascular endothelium, whereas PD-L2 protein is only detectably expressed on antigen-presenting cells found in lymphoid tissue or chronic inflammatory environments. PD-L2 is thought to control immune T-cell activation in lymphoid organs, whereas PD-L1 serves to dampen unwarranted T-cell function in peripheral tissues. Although healthy organs express little (if any) PD-L1, a variety of cancers were demonstrated to express abundant levels of this T-cell inhibitor. PD-1 has been suggested to regulate tumor-specific T-cell expansion in subjects with melanoma (MEL). This suggests that the PD-1/PD-L1 pathway plays a critical role in tumor immune evasion and should be considered as an attractive target for therapeutic intervention.

Pembrolizumab is a potent and highly selective humanized monoclonal antibody (mAb) of the IgG4/kappa isotype designed to directly block the interaction between PD-1 and its ligands, PD-L1 and PD-L2. KeytrudaTM (pembrolizumab) has recently been approved in the United States for the treatment of patients with unresectable or metastatic melanoma and disease progression following ipilimumab and, if BRAF V600 mutation positive, a BRAF inhibitor.

4.1.2 Preclinical and Clinical Trial Data

Refer to the Investigator's Brochure for Preclinical and Clinical data.

4.2 Rationale

4.2.1 Rationale for the Trial and Selected Subject Population

Cutaneous squamous cell of the skin (cSCC) is the second most common skin cancer in the US with over 700,000 new cases each year. Approximately 2000 individuals die from non-melanoma skin cancers in the US each year. This is likely an underestimation given that most are not reported because of their high incidence and typically excellent prognosis. Most are curable with surgery and/or radiation. However, especially in the elderly and immunosuppressed populations, squamous cell carcinomas can become aggressive. Approximately 5% of tumors will become metastatic, with a higher rate of metastases in tumors from the head and neck.

Tumors that are 2 cm or larger, greater than 4 mm in depth, or poorly differentiated have a poor prognosis. There are no known systemic treatments to improve overall survival in patients with metastatic disease that cannot be treated with surgery or radiation. Platinum based chemotherapy and EGFR inhibitors have been used, all with a poor overall response rate of between 10-20% and none have shown to improve clinical outcomes such as survival or progression free survival. Most data in this population is generated by case series and show median progression-free survival to be less than 6 months and median overall survival to be approximately 10 months (Jarkowski et al A, K Clin Oncol 2014).

Squamous cell carcinoma of the skin is a tumor related to immunosuppression. Chronic immunosuppression of T cells in solid organ transplant patients as well as bone marrow transplant patients is linked to an increased incidence of aggressive squamous cell carcinomas. In addition HIV and CLL patients also have an increased risk of cSCC development. Studies have shown that PD-1 and PD-L1 signals are in part responsible for the development and progression of squamous cell carcinomas

Belai et al (Carcinogenesis 2014) demonstrated that systemic inhibition of PD-1 resulted in a decreased number and delayed incidence rate of cSCCs in a murine model of SCC. This study also demonstrated that PD-1-PD-L1 interaction contributes to SCC development as seen in increasing numbers of SCC in mice. Increased CD8+ and CD4+ T cells were seen in tumor tissue after anti-PD1 treatment and were associated with decrease tumor incidence in the murine model.

cSCC in the advanced setting currently have no therapeutic options that improve outcome or are associated with long-term survival. Pre-clinical data demonstrates the importance of the PD-1 pathway in cSCC development and this is highlighted by the patient population that is mostly affected by this disease (patients with T cell suppression). Because of this, PD-1 blockade holds promise to improve outcomes in this clinical setting. Therefore, this trial is to evaluate the response rate of metastatic cSCC to pembrolizumab along with correlative studies to establish the role of the PD-1 pathway in this disease.

4.2.2 Rationale for Dose Selection/Regimen/Modification

An open-label Phase I trial (Protocol 001) is being conducted to evaluate the safety and clinical activity of single agent MK-3475. The dose escalation portion of this trial evaluated three dose levels, 1 mg/kg, 3 mg/kg, and 10 mg/kg, administered every 2 weeks (Q2W) in subjects with advanced solid tumors. All three dose levels were well tolerated and no dose-limiting toxicities were observed. This first in human study of MK-3475 showed evidence of target engagement and objective evidence of tumor size reduction at all dose levels (1 mg/kg, 3 mg/kg and 10 mg/kg Q2W). No MTD has been identified to date. 10.0 mg/kg Q2W, the highest dose tested in PN001, will be the dose and schedule utilized in Cohorts A, B, C and D of this protocol to test for initial tumor activity. Recent data from other clinical studies within the MK-3475 program has shown that a lower dose of MK-3475 and a less frequent schedule may be sufficient for target engagement and clinical activity.

PK data analysis of MK-3475 administered Q2W and Q3W showed slow systemic clearance, limited volume of distribution, and a long half-life (refer to IB). Pharmacodynamic data (IL-2 release assay) suggested that peripheral target engagement is durable (>21 days). This early PK and pharmacodynamic data provides scientific rationale for testing a Q2W and Q3W dosing schedule.

A population pharmacokinetic analysis has been performed using serum concentration time data from 476 patients. Within the resulting population PK model, clearance and volume parameters of MK-3475 were found to be dependent on body weight. The relationship between clearance and body weight, with an allometric exponent of 0.59, is within the range observed for other antibodies and would support both body weight normalized dosing or a fixed dose across all body weights. MK-3475 has been found to have a wide therapeutic range based on the melanoma indication. The differences in exposure for a 200 mg fixed dose regimen relative to a 2 mg/kg Q3W body weight based regimen are anticipated to remain well within the established exposure margins of 0.5 – 5.0 for MK-3475 in the melanoma indication. The exposure margins are based on the notion of similar efficacy and safety in melanoma at 10 mg/kg Q3W vs. the proposed dose regimen of 2 mg/kg Q3W (i.e. 5-fold higher dose and exposure). The population PK evaluation revealed that there was no significant impact of tumor burden on exposure. In addition, exposure was similar between the NSCLC and melanoma indications. Therefore, there are no anticipated changes in exposure between different indication settings.

The rationale for further exploration of 2 mg/kg and comparable doses of pembrolizumab in solid tumors is based on: 1) similar efficacy and safety of pembrolizumab when dosed at either 2 mg/kg or 10 mg/kg Q3W in melanoma patients, 2) the flat exposure-response relationships of pembrolizumab for both efficacy and safety in the dose ranges of 2 mg/kg Q3W to 10 mg/kg Q3W, 3) the lack of effect of tumor burden or indication on distribution behavior of pembrolizumab (as assessed by the population PK model) and 4) the assumption that the dynamics of pembrolizumab target engagement will not vary meaningfully with tumor type.

The choice of the 200 mg Q3W as an appropriate dose for the switch to fixed dosing is based on simulations performed using the population PK model of pembrolizumab showing that the fixed dose of 200 mg every 3 weeks will provide exposures that 1) are optimally consistent with those obtained with the 2 mg/kg dose every 3 weeks, 2) will maintain individual patient exposures in the exposure range established in melanoma as associated with maximal efficacy response and 3) will maintain individual patients exposure in the exposure range established in melanoma that are well tolerated and safe.

A fixed dose regimen will simplify the dosing regimen to be more convenient for physicians and to reduce potential for dosing errors. A fixed dosing scheme will also reduce complexity in the logistical chain at treatment facilities and reduce wastage.

4.2.3 Rationale for Endpoints

4.2.3.1 Efficacy Endpoints

The efficacy endpoints were established to evaluate the effectiveness of pembrolizumab in cutaneous squamous cell carcinoma. This will be the first in class use of PD-1 antibodies in this disease site and therefore no previous response rate has been established.

4.2.3.2 Biomarker Research

Biomarker of PDL-1 has been evaluated in both lung and melanoma and has been a marker associated with higher response rates. Therefore our biomarker studies outlined above will

further elucidate this marker is cSCC and establish whether it should be used to guide treatment options.

5.0 METHODOLOGY

5.1 Entry Criteria

5.1.1 Diagnosis/Condition for Entry into the Trial

All subjects must have cutaneous squamous cell carcinoma that is not curable by surgery or radiation. Both locally advanced and metastatic squamous cell carcinoma will be included.

5.1.2 Subject Inclusion Criteria

In order to be eligible for participation in this trial, the subject must:

1. Be willing and able to provide written informed consent/assent for the trial.
2. Be ≥ 18 years of age on day of signing informed consent.
3. Have measurable disease based on RECIST 1.1.
4. Be willing to provide tissue from a newly obtained core or excisional biopsy of a tumor lesion. *Newly-obtained is defined as a specimen obtained up to 6 weeks (42 days) prior to initiation of treatment on Day 1. Subjects for whom newly-obtained samples cannot be provided (e.g. inaccessible or subject safety concern) may submit an archived specimen only upon agreement from the Sponsor.*
5. Be willing to undergo normal skin biopsy prior to initiation of treatment and after treatment.
6. Have a performance status of 0 or 1 on the ECOG Performance Scale.
7. Demonstrate adequate organ function as defined in Table 1, all screening labs should be performed within 10 days of treatment initiation.

Table 1 Adequate Organ Function Laboratory Values

System	Laboratory Value
Hematological	
Absolute neutrophil count (ANC)	$\geq 1,500 / \text{mcL}$
Platelets	$\geq 100,000 / \text{mcL}$
Hemoglobin	$\geq 9 \text{ g/dL}$ or $\geq 5.6 \text{ mmol/L}$ without transfusion or EPO dependency (within 7 days of assessment)
Renal	
Serum creatinine OR Measured or calculated	$\leq 1.5 \times$ upper limit of normal (ULN) OR

creatinine clearance (GFR can also be used in place of creatinine or CrCl)	≥60 mL/min for subject with creatinine levels > 1.5 X institutional ULN
Hepatic	
Serum total bilirubin	≤ 1.5 X ULN OR Direct bilirubin ≤ ULN for subjects with total bilirubin levels > 1.5 ULN
AST (SGOT) and ALT (SGPT)	≤ 2.5 X ULN OR ≤ 5 X ULN for subjects with liver metastases
Albumin	≥2.5 mg/dL
Coagulation	
International Normalized Ratio (INR) or Prothrombin Time (PT)	≤1.5 X ULN unless subject is receiving anticoagulant therapy as long as PT or PTT is within therapeutic range of intended use of anticoagulants
Activated Partial Thromboplastin Time (aPTT)	≤1.5 X ULN unless subject is receiving anticoagulant therapy as long as PT or PTT is within therapeutic range of intended use of anticoagulants

^aCreatinine clearance should be calculated per institutional standard.

8. Female subject of childbearing potential should have a negative urine or serum pregnancy within 72 hours prior to receiving the first dose of study medication. If the urine test is positive or cannot be confirmed as negative, a serum pregnancy test will be required.
9. Female subjects of childbearing potential should be willing to use 2 methods of birth control or be surgically sterile, or abstain from heterosexual activity for the course of the study through 120 days after the last dose of study medication (Reference Section 5.7.2). Subjects of childbearing potential are those who have not been surgically sterilized or have not been free from menses for > 1 year.
10. Male subjects should agree to use an adequate method of contraception starting with the first dose of study therapy through 120 days after the last dose of study therapy.

5.1.3 Subject Exclusion Criteria

The subject must be excluded from participating in the trial if the subject:

1. Is currently participating and receiving study therapy or has participated in a study of an investigational agent and received study therapy or used an investigational device within 4 weeks of the first dose of treatment.
2. Has a diagnosis of immunodeficiency or is receiving systemic steroid therapy or any other form of immunosuppressive therapy within 7 days prior to the first dose of trial treatment. Patients with HIV adequately controlled on antiretrovirals (undetectable viral load) and patients with CLL not requiring systemic treatment will be included. In

addition, steroids for physiologic replacement will be allowed (must be equal to or less than 10mg of Prednisone/day).

3. Has a known history of active TB (Bacillus Tuberculosis)
4. Hypersensitivity to pembrolizumab or any of its excipients.
5. Has had a prior anti-cancer monoclonal antibody (mAb) within 4 weeks prior to study Day 1 or who has not recovered (i.e., ≤ Grade 1 or at baseline) from adverse events due to agents administered more than 4 weeks earlier.
6. Has had prior chemotherapy, targeted small molecule therapy, or radiation therapy within 2 weeks prior to study Day 1 or who has not recovered (i.e., ≤ Grade 1 or at baseline) from adverse events due to a previously administered agent.
 - Note: Subjects with ≤ Grade 2 neuropathy are an exception to this criterion and may qualify for the study.
 - Note: If subject received major surgery, they must have recovered adequately from the toxicity and/or complications from the intervention prior to starting therapy.
7. Has a known additional malignancy that is progressing or requires active treatment. Exceptions include basal cell carcinoma of the skin that has undergone potentially curative therapy or in situ cervical cancer. Asymptomatic CLL, not requiring intervention will be included as long as patients meet routine laboratory parameters of the study as outlined above. In addition, patients who have undergone curative bone marrow transplant and currently not requiring immunosuppression, will be allowed on study.
8. Has known active central nervous system (CNS) metastases and/or carcinomatous meningitis. Subjects with previously treated brain metastases may participate provided they are stable (without evidence of progression by imaging for at least four weeks prior to the first dose of trial treatment and any neurologic symptoms have returned to baseline), have no evidence of new or enlarging brain metastases, and are not using steroids for at least 7 days prior to trial treatment. This exception does not include carcinomatous meningitis which is excluded regardless of clinical stability.
9. Has active autoimmune disease that has required systemic treatment in the past 2 years (i.e. with use of disease modifying agents, corticosteroids or immunosuppressive drugs). Replacement therapy (eg., thyroxine, insulin, or physiologic corticosteroid replacement therapy for adrenal or pituitary insufficiency, etc.) is not considered a form of systemic treatment.
10. Has a history of (non-infectious) pneumonitis that required steroids or current pneumonitis
11. Has an active infection requiring systemic therapy. Exception HIV on antiretrovirals with negative viral load.

12. Has a history or current evidence of any condition, therapy, or laboratory abnormality that might confound the results of the trial, interfere with the subject's participation for the full duration of the trial, or is not in the best interest of the subject to participate, in the opinion of the treating investigator.
13. Has known psychiatric or substance abuse disorders that would interfere with cooperation with the requirements of the trial.
14. Is pregnant or breastfeeding, or expecting to conceive or father children within the projected duration of the trial, starting with the pre-screening or screening visit through 120 days after the last dose of trial treatment.
15. Has received prior therapy with an anti-PD-1, anti-PD-L1, or anti-PD-L2 agent.
16. Has known active Hepatitis B (e.g., HBsAg reactive) or Hepatitis C (e.g., HCV RNA [qualitative] is detected).
17. Has received a live vaccine within 30 days of planned start of study therapy.
18. cSCC that is curable via radiation or surgery. Palliative radiation is allowed as long as measurable disease outside radiation field is present for study.

Note: Seasonal influenza vaccines for injection are generally inactivated flu vaccines and are allowed; however intranasal influenza vaccines (e.g., Flu-Mist®) are live attenuated vaccines, and are not allowed.

5.2 Trial Treatments

The treatment to be used in this trial is outlined below in Table 2

Table 2 Trial Treatment

Drug	Dose/Potency	Dose Frequency	Route of Administration	Regimen/Treatment Period	Use
Pembrolizumab	200 mg	Q3W	IV infusion	Day 1 of each 3 week cycle	Experimental

Trial treatment should begin on the day of randomization or as close as possible to the date on which treatment is allocated/assigned.

5.2.1 Dose Selection/Modification

5.2.1.1 Dose Selection

The rationale for selection of doses to be used in this trial is provided in Section 4.0 – Background and Rationale.

Details on preparation and administration of pembrolizumab (MK-3475) are provided in the Pharmacy Manual.

5.2.1.2 Dose Modification

Adverse events (both non-serious and serious) associated with pembrolizumab exposure may represent an immunologic etiology. These adverse events may occur shortly after the first dose or several months after the last dose of treatment. Pembrolizumab must be withheld for drug-related toxicities and severe or life-threatening AEs as per Table 3 below. See Section 5.6.1 for supportive care guidelines, including use of corticosteroids.

Table 3

Dose Modification Guidelines for Drug-Related Adverse Events

Toxicity	Hold Treatment For Grade	Timing for Restarting Treatment	Discontinue Subject
Diarrhea/Colitis	2-3	Toxicity resolves to Grade 0-1.	Toxicity does not resolve within 12 weeks of last dose or inability to reduce corticosteroid to 10 mg or less of prednisone or equivalent per day within 12 weeks.
	4	Permanently discontinue	Permanently discontinue
AST, ALT, or Increased Bilirubin	2	Toxicity resolves to Grade 0-1	Toxicity does not resolve within 12 weeks of last dose.
	3-4	Permanently discontinue (see exception below) ¹	Permanently discontinue
Type 1 diabetes mellitus (if new onset) or Hyperglycemia	T1DM or 3-4	Hold pembrolizumab for new onset Type 1 diabetes mellitus or Grade 3-4 hyperglycemia associated with evidence of beta cell failure.	Resume pembrolizumab when patients are clinically and metabolically stable.
Hypophysitis	2-3	Toxicity resolves to Grade 0-1	Toxicity does not resolve within 12 weeks of last dose or inability to reduce corticosteroid to 10 mg or less of prednisone or equivalent per day within 12 weeks.
	4	Permanently discontinue	Permanently discontinue
Hyperthyroidism	3	Toxicity resolves to Grade 0-1	Toxicity does not resolve within 12 weeks of last dose or inability to reduce corticosteroid to 10 mg or less of prednisone or equivalent per day within 12 weeks.
	4	Permanently discontinue	Permanently discontinue
Hypothyroidism	2-4	Therapy with pembrolizumab can be continued while	Therapy with pembrolizumab can be continued while treatment for the thyroid disorder is

Toxicity	Hold Treatment For Grade	Timing for Restarting Treatment	Discontinue Subject
		treatment for the thyroid disorder is instituted	instituted.
Infusion Reaction	3-4	Permanently discontinue	Permanently discontinue
Pneumonitis	2	Toxicity resolves to Grade 0-1	Toxicity does not resolve within 12 weeks of last dose or inability to reduce corticosteroid to 10 mg or less of prednisone or equivalent per day within 12 weeks.
	3-4	Permanently discontinue	Permanently discontinue
Renal Failure or Nephritis	2	Toxicity resolves to Grade 0-1	Toxicity does not resolve within 12 weeks of last dose or inability to reduce corticosteroid to 10 mg or less of prednisone or equivalent per day within 12 weeks.
	3-4	Permanently discontinue	Permanently discontinue
All Other Drug-Related Toxicity ²	3 or Severe	Toxicity resolves to Grade 0-1	Toxicity does not resolve within 12 weeks of last dose or inability to reduce corticosteroid to 10 mg or less of prednisone or equivalent per day within 12 weeks.
	4	Permanently discontinue	Permanently discontinue

Note: Permanently discontinue for any severe or Grade 3 drug-related AE that recurs or any life-threatening event.

¹ For patients with liver metastasis who begin treatment with Grade 2 AST or ALT, if AST or ALT increases by greater than or equal to 50% relative to baseline and lasts for at least 1 week then patients should be discontinued.

² Patients with intolerable or persistent Grade 2 drug-related AE may hold study medication at physician discretion. Permanently discontinue study drug for persistent Grade 2 adverse reactions for which treatment with study drug has been held, that do not recover to Grade 0-1 within 12 weeks of the last dose.

Dosing interruptions are permitted in the case of medical / surgical events or logistical reasons not related to study therapy (e.g., elective surgery, unrelated medical events, patient vacation, and/or holidays). Subjects should be placed back on study therapy within 3 weeks of the scheduled interruption, unless otherwise discussed with the Sponsor. The reason for interruption should be documented in the patient's study record.

5.2.2 Timing of Dose Administration

Trial treatment should be administered on Day 1 of each cycle after all procedures/assessments have been completed as detailed on the Trial Flow Chart (Section 6.0). Trial treatment may be administered up to 3 business days before or after the scheduled Day 1 of each cycle due to administrative reasons.

All trial treatments will be administered on an outpatient basis.

Pembrolizumab 200 mg will be administered as a 30 minute IV infusion every 3 weeks. Sites should make every effort to target infusion timing to be as close to 30 minutes as possible. However, given the variability of infusion pumps from site to site, a window of -5 minutes and +10 minutes is permitted (i.e., infusion time is 30 minutes: -5 min/+10 min).

The Pharmacy Manual contains specific instructions for the preparation of the pembrolizumab infusion fluid and administration of infusion solution.

5.2.3 Trial Blinding/Masking

This is an open-label trial; therefore, the Sponsor, investigator and subject will know the treatment administered.

5.3 Randomization or Treatment Allocation

This is a nonrandomized trial.

5.4 Stratification

Patients will be stratified by locally advanced versus metastatic disease.

5.5 Concomitant Medications/Vaccinations (allowed & prohibited)

Medications or vaccinations specifically prohibited in the exclusion criteria are not allowed during the ongoing trial. If there is a clinical indication for one of these or other medications or vaccinations specifically prohibited during the trial, discontinuation from trial therapy or vaccination may be required. The sponsor-investigator should discuss any questions regarding this with the Merck Clinical team. The final decision on any supportive therapy or vaccination rests with the investigator and/or the subject's primary physician.

5.5.1 Acceptable Concomitant Medications

All treatments that the investigator considers necessary for a subject's welfare may be administered at the discretion of the investigator in keeping with the community standards of medical care. All concomitant medication will be recorded on the case report form (CRF) including all prescription, over-the-counter (OTC), herbal supplements, and IV medications and fluids. If changes occur during the trial period, documentation of drug dosage, frequency, route, and date may also be included on the CRF.

All concomitant medications received within 28 days before the first dose of trial treatment and 30 days after the last dose of trial treatment should be recorded. Concomitant medications administered after 30 days after the last dose of trial treatment should be recorded for SAEs and ECIs as defined in Section 7.2.

5.5.2 Prohibited Concomitant Medications

Subjects are prohibited from receiving the following therapies during the Screening and Treatment Phase (including retreatment for post-complete response relapse) of this trial:

- Antineoplastic systemic chemotherapy or biological therapy

- Immunotherapy not specified in this protocol
- Chemotherapy not specified in this protocol
- Investigational agents other than pembrolizumab
- Radiation therapy
 - Note: Radiation therapy to a symptomatic solitary lesion or to the brain may be allowed at the investigator's discretion if approved by the principal investigator.
- Live vaccines within 30 days prior to the first dose of trial treatment and while participating in the trial. Examples of live vaccines include, but are not limited to, the following: measles, mumps, rubella, varicella/zoster, yellow fever, rabies, BCG, and typhoid vaccine.
- Systemic glucocorticoids for any purpose other than to modulate symptoms from an event of clinical interest of suspected immunologic etiology. The use of physiologic doses of corticosteroids may be approved after consultation with the Sponsor.

Subjects who, in the assessment by the investigator, require the use of any of the aforementioned treatments for clinical management should be removed from the trial. Subjects may receive other medications that the investigator deems to be medically necessary.

The Exclusion Criteria describes other medications which are prohibited in this trial.

There are no prohibited therapies during the Post-Treatment Follow-up Phase.

5.6 Rescue Medications & Supportive Care

5.6.1 Supportive Care Guidelines

Subjects should receive appropriate supportive care measures as deemed necessary by the treating investigator. Suggested supportive care measures for the management of adverse events with potential immunologic etiology are outlined below and in greater detail in the ECI guidance document. Where appropriate, these guidelines include the use of oral or intravenous treatment with corticosteroids as well as additional anti-inflammatory agents if symptoms do not improve with administration of corticosteroids. Note that several courses of steroid tapering may be necessary as symptoms may worsen when the steroid dose is decreased. For each disorder, attempts should be made to rule out other causes such as metastatic disease or bacterial or viral infection, which might require additional supportive care. The treatment guidelines are intended to be applied when the investigator determines the events to be related to pembrolizumab.

Note: if after the evaluation the event is determined not to be related, the investigator is instructed to follow the ECI reporting guidance but does not need to follow the treatment guidance (as outlined in the ECI guidance document). Refer to Section 5.2.1 for dose modification.

It may be necessary to perform conditional procedures such as bronchoscopy, endoscopy, or skin photography as part of evaluation of the event. Suggested conditional procedures, as appropriate, can be found in the ECI guidance document.

- **Pneumonitis:**

- For **Grade 2 events**, treat with systemic corticosteroids. When symptoms improve to Grade 1 or less, steroid taper should be started and continued over no less than 4 weeks.
- For **Grade 3-4 events**, immediately treat with intravenous steroids. Administer additional anti-inflammatory measures, as needed.
- Add prophylactic antibiotics for opportunistic infections in the case of prolonged steroid administration.

- **Diarrhea/Colitis:**

Subjects should be carefully monitored for signs and symptoms of enterocolitis (such as diarrhea, abdominal pain, blood or mucus in stool, with or without fever) and of bowel perforation (such as peritoneal signs and ileus).

- All subjects who experience diarrhea/colitis should be advised to drink liberal quantities of clear fluids. If sufficient oral fluid intake is not feasible, fluid and electrolytes should be substituted via IV infusion. For Grade 2 or higher diarrhea, consider GI consultation and endoscopy to confirm or rule out colitis.
- For **Grade 2 diarrhea/colitis** that persists greater than 3 days, administer oral corticosteroids.
- For **Grade 3 or 4 diarrhea/colitis** that persists > 1 week, treat with intravenous steroids followed by high dose oral steroids.
- When symptoms improve to Grade 1 or less, steroid taper should be started and continued over no less than 4 weeks.

- **Type 1 diabetes mellitus (if new onset, including diabetic ketoacidosis [DKA]) or ≥ Grade 3 Hyperglycemia, if associated with ketosis (ketonuria) or metabolic acidosis (DKA)**

- For **T1DM or Grade 3-4 Hyperglycemia**
 - Insulin replacement therapy is recommended for Type I diabetes mellitus and for Grade 3-4 hyperglycemia associated with metabolic acidosis or ketonuria.
 - Evaluate patients with serum glucose and a metabolic panel, urine ketones, glycosylated hemoglobin, and C-peptide.

- **Hypophysitis:**

- For **Grade 2 events**, treat with corticosteroids. When symptoms improve to Grade 1 or less, steroid taper should be started and continued over no less than 4 weeks. Replacement of appropriate hormones may be required as the steroid dose is tapered.
- For **Grade 3-4 events**, treat with an initial dose of IV corticosteroids followed by oral corticosteroids. When symptoms improve to Grade 1 or less, steroid taper should be started and continued over no less than 4 weeks. Replacement of appropriate hormones may be required as the steroid dose is tapered.

- **Hyperthyroidism or Hypothyroidism:**
Thyroid disorders can occur at any time during treatment. Monitor patients for changes in thyroid function (at the start of treatment, periodically during treatment, and as indicated based on clinical evaluation) and for clinical signs and symptoms of thyroid disorders.
 - **Grade 2** hyperthyroidism events (and **Grade 2-4** hypothyroidism):
 - In hyperthyroidism, non-selective beta-blockers (e.g. propranolol) are suggested as initial therapy.
 - In hypothyroidism, thyroid hormone replacement therapy, with levothyroxine or liothyronine, is indicated per standard of care.
 - **Grade 3-4** hyperthyroidism
 - Treat with an initial dose of IV corticosteroid followed by oral corticosteroids. When symptoms improve to Grade 1 or less, steroid taper should be started and continued over no less than 4 weeks. Replacement of appropriate hormones may be required as the steroid dose is tapered.
- **Hepatic:**
 - For **Grade 2** events, monitor liver function tests more frequently until returned to baseline values (consider weekly).
 - Treat with IV or oral corticosteroids
 - For **Grade 3-4** events, treat with intravenous corticosteroids for 24 to 48 hours.
 - When symptoms improve to Grade 1 or less, a steroid taper should be started and continued over no less than 4 weeks.
- **Renal Failure or Nephritis:**
 - For **Grade 2** events, treat with corticosteroids.
 - For **Grade 3-4** events, treat with systemic corticosteroids.
 - When symptoms improve to Grade 1 or less, steroid taper should be started and continued over no less than 4 weeks.
- **Management of Infusion Reactions:** Signs and symptoms usually develop during or shortly after drug infusion and generally resolve completely within 24 hours of completion of infusion.

Table 4 below shows treatment guidelines for subjects who experience an infusion reaction associated with administration of pembrolizumab (MK-3475).

Table 4 Infusion Reaction Treatment Guidelines

NCI CTCAE Grade	Treatment	Premedication at subsequent dosing
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NCI CTCAE Grade	Treatment	Premedication at subsequent dosing
<u>Grade 1</u> Mild reaction; infusion interruption not indicated; intervention not indicated	Increase monitoring of vital signs as medically indicated until the subject is deemed medically stable in the opinion of the investigator.	None
<u>Grade 2</u> Requires infusion interruption but responds promptly to symptomatic treatment (e.g., antihistamines, NSAIDS, narcotics, IV fluids); prophylactic medications indicated for < =24 hrs	<p>Stop Infusion and monitor symptoms.</p> <p>Additional appropriate medical therapy may include but is not limited to:</p> <ul style="list-style-type: none"> IV fluids Antihistamines NSAIDS Acetaminophen Narcotics <p>Increase monitoring of vital signs as medically indicated until the subject is deemed medically stable in the opinion of the investigator.</p> <p>If symptoms resolve within one hour of stopping drug infusion, the infusion may be restarted at 50% of the original infusion rate (e.g., from 100 mL/hr to 50 mL/hr). Otherwise dosing will be held until symptoms resolve and the subject should be premedicated for the next scheduled dose.</p> <p>Subjects who develop Grade 2 toxicity despite adequate premedication should be permanently discontinued from further trial treatment administration.</p>	<p>Subject may be premedicated 1.5h (\pm 30 minutes) prior to infusion of pembrolizumab (MK-3475) with:</p> <p>Diphenhydramine 50 mg po (or equivalent dose of antihistamine).</p> <p>Acetaminophen 500-1000 mg po (or equivalent dose of antipyretic).</p>
<u>Grades 3 or 4</u> Grade 3: Prolonged (i.e., not rapidly responsive to symptomatic medication and/or brief interruption of infusion); recurrence of symptoms following initial improvement; hospitalization indicated	<p>Stop Infusion.</p> <p>Additional appropriate medical therapy may include but is not limited to:</p> <ul style="list-style-type: none"> IV fluids Antihistamines NSAIDS Acetaminophen Narcotics Oxygen Pressors 	No subsequent dosing

NCI CTCAE Grade	Treatment	Premedication at subsequent dosing
for other clinical sequelae (e.g., renal impairment, pulmonary infiltrates) Grade 4: Life-threatening; pressor or ventilatory support indicated	Corticosteroids Epinephrine Increase monitoring of vital signs as medically indicated until the subject is deemed medically stable in the opinion of the investigator. Hospitalization may be indicated. Subject is permanently discontinued from further trial treatment administration.	
Appropriate resuscitation equipment should be available in the room and a physician readily available during the period of drug administration.		

5.7 Diet/Activity/Other Considerations

5.7.1 Diet

Subjects should maintain a normal diet unless modifications are required to manage an AE such as diarrhea, nausea or vomiting.

5.7.2 Contraception

Pembrolizumab may have adverse effects on a fetus in utero. Furthermore, it is not known if pembrolizumab has transient adverse effects on the composition of sperm. Non-pregnant, non-breast-feeding women may be enrolled if they are willing to use 2 methods of birth control or are considered highly unlikely to conceive. Highly unlikely to conceive is defined as 1) surgically sterilized, or 2) postmenopausal (a woman who is ≥ 45 years of age and has not had menses for greater than 1 year will be considered postmenopausal), or 3) not heterosexually active for the duration of the study. The two birth control methods can be either two barrier methods or a barrier method plus a hormonal method to prevent pregnancy. Subjects should start using birth control from study Visit 1 throughout the study period up to 120 days after the last dose of study therapy.

The following are considered adequate barrier methods of contraception: diaphragm, condom (by the partner), copper intrauterine device, sponge, or spermicide. Appropriate hormonal contraceptives will include any registered and marketed contraceptive agent that contains an estrogen and/or a progestational agent (including oral, subcutaneous, intrauterine, or intramuscular agents).

Subjects should be informed that taking the study medication may involve unknown risks to the fetus (unborn baby) if pregnancy were to occur during the study. In order to participate in the study they must adhere to the contraception requirement (described above) for the duration of

the study and during the follow-up period defined in section 7.2.2-Reporting of Pregnancy and Lactation to the Sponsor and to Merck. If there is any question that a subject will not reliably comply with the requirements for contraception, that subject should not be entered into the study.

5.7.3 Use in Pregnancy

If a subject inadvertently becomes pregnant while on treatment with pembrolizumab, the subject will immediately be removed from the study. The site will contact the subject at least monthly and document the subject's status until the pregnancy has been completed or terminated. The outcome of the pregnancy will be reported to the Sponsor and to Merck without delay and within 24 hours to the Sponsor and within 2 working days to Merck if the outcome is a serious adverse experience (e.g., death, abortion, congenital anomaly, or other disabling or life-threatening complication to the mother or newborn).

The study investigator will make every effort to obtain permission to follow the outcome of the pregnancy and report the condition of the fetus or newborn to the Sponsor. If a male subject impregnates his female partner the study personnel at the site must be informed immediately and the pregnancy reported to the Sponsor and to Merck and followed as described above and in Section 7.2.2.

5.7.4 Use in Nursing Women

It is unknown whether pembrolizumab is excreted in human milk. Since many drugs are excreted in human milk, and because of the potential for serious adverse reactions in the nursing infant, subjects who are breast-feeding are not eligible for enrollment.

5.8 Subject Withdrawal/Discontinuation Criteria

Subjects may withdraw consent at any time for any reason or be dropped from the trial at the discretion of the investigator should any untoward effect occur. In addition, a subject may be withdrawn by the investigator or the Sponsor if enrollment into the trial is inappropriate, the trial plan is violated, or for administrative and/or other safety reasons. Specific details regarding discontinuation or withdrawal are provided in Section 7.1.4 – Other Procedures.

A subject must be discontinued from the trial for any of the following reasons:

- The subject or legal representative (such as a parent or legal guardian) withdraws consent.
- Confirmed radiographic disease progression
Note: For unconfirmed radiographic disease progression, please see Section 5.2.2
Note: A subject may be granted an exception to continue on treatment with confirmed radiographic progression if clinically stable or clinically improved.
- Unacceptable adverse experiences as described in Section 5.2.1.2
- Intercurrent illness that prevents further administration of treatment
- Investigator's decision to withdraw the subject
- The subject has a confirmed positive serum pregnancy test
- Noncompliance with trial treatment or procedure requirements
- The subject is lost to follow-up

- Completed 24 months of uninterrupted treatment with pembrolizumab or 35 administrations of study medication, whichever is later.
Note: 24 months of study medication is calculated from the date of first dose. Subjects who stop pembrolizumab after 24 months may be eligible for up to one year of additional study treatment if they progress after stopping study treatment provided they meet the requirements.
- Administrative reasons

The End of Treatment and Follow-up visit procedures are listed in Section 6 (Protocol Flow Chart) and Section 7.1.5 (Visit Requirements). After the end of treatment, each subject will be followed for 30 days for adverse event monitoring (serious adverse events will be collected for 90 days after the end of treatment as described in Section 7.2.3.1). Subjects who discontinue for reasons other than progressive disease will have post-treatment follow-up for disease status until disease progression, initiating a non-study cancer treatment, withdrawing consent or becoming lost to follow-up. After documented disease progression each subject will be followed by telephone for overall survival until death, withdrawal of consent, or the end of the study, whichever occurs first.

5.8.1 Discontinuation of Study Therapy after CR

Discontinuation of treatment may be considered for subjects who have attained a confirmed CR that have been treated for at least 24 weeks with pembrolizumab and had at least two treatments with pembrolizumab beyond the date when the initial CR was declared. Subjects who then experience radiographic disease progression may be eligible for up to one year of additional treatment with pembrolizumab via the Second Course Phase at the discretion of the investigator if no cancer treatment was administered since the last dose of pembrolizumab, the subject meets the safety parameters listed in the Inclusion/Exclusion criteria, and the trial is open. Subjects will resume therapy at the same dose and schedule at the time of initial discontinuation. Additional details are provided in Section 7.1.5.5.

5.9 Subject Replacement Strategy

Subjects that do not complete one cycle of treatment will be replaced.

5.10 Clinical Criteria for Early Trial Termination

Early trial termination will be the result of the criteria specified below:

1. Quality or quantity of data recording is inaccurate or incomplete
2. Poor adherence to protocol and regulatory requirements
3. Incidence or severity of adverse drug reaction in this or other studies indicates a potential health hazard to subjects
4. Plans to modify or discontinue the development of the study drug

In the event of Merck decision to no longer supply study drug, ample notification will be provided so that appropriate adjustments to subject treatment can be made.

6.0 TRIAL FLOW CHART

6.1 Study Flow Chart

Trial Period	Screening Phase		Treatment Cycles								End of Treatment	Post-Treatment		
	Pre-screening (Visit 1)	Main Study Screening (Visit 2)	1	2	3	4	To be repeated beyond 8 cycles					Safety Follow-up	Survival Follow-Up	
Treatment Cycle(q3week)/Title:							5	6	7	8				
Scheduling Window (Business Days):		-28 to -1		± 3	± 3	± 3	± 3	± 3	± 3	± 3	At time of D/C	30 days post D/C	Every 12 weeks	
Administrative Procedures														
Informed Consent	x													
Inclusion/Exclusion Criteria	x													
Demographics & Medical History		x												
Prior & Concomitant Medication Review		x	x	x	x	x	x	x	x	x	x			
Drug Administration			x	x	x	x	x	x	x	x				
Post Study Anti-Cancer Therapy											x	x	x	
Survival Status											x	x	x	
Clinical Procedures/Assessments														
Review Adverse Events			x	x	x	x	x	x	x	x	x	x	x	x
Full Physical Examination		x	x	x	x	x	x	x	x	x	x	x	x	x
Vital Signs & Weight		x	x	x	x	x	x	x	x	x	x	x	x	
ECOG Performance Status		x	x	x	x	x	x	x	x	x	x	x	x	
Laboratory Procedures/Assessments: Analysis Performed by LOCAL Laboratory														

Trial Period	Screening Phase		Treatment Cycles								End of Treatment	Post-Treatment	
	Pre-screening (Visit 1)	Main Study Screening (Visit 2)	1	2	3	4	To be repeated beyond 8 cycles					Safety Follow-up	Survival Follow-Up
Treatment Cycle(q3week)/Title:							5	6	7	8			
Scheduling Window (Business Days):		-28 to -1		± 3	± 3	± 3	± 3	± 3	± 3	± 3	At time of D/C	30 days post D/C	Every 12 weeks
Pregnancy Test – Urine or Serum		X	X	X	X	X	X	X	X	X	X		
PT/INR & aPTT		X	X	X	X	X	X	X	X	X	X	X	
CBC with Differential		X											
Comprehensive Serum Chemistry Panel		X	X	X	X	X	X	X	X	X	X	X	
Urinalysis		X	X	X	X	X	X	X	X	X	X	X	
T3, FT4, TSH, ACTH, Cortisol		X	X	X	X	X	X	X	X	X	X		
Efficacy Measurements													
Tumor Imaging*			X					X				X	
Tumor Biopsies/Archival Tissue Collection/Correlative Studies Blood													
Archival or Newly Obtained Tissue Collection**		X					X				X		
Correlative Studies Blood Collection***		X	X	X	X	X	X						
Normal Skin biopsy**		X					X				X		

*Tumor Imaging and Assessments will be performed after every 4 cycles. Tumor Imaging at D/C will have a +/-5 business day window.

**Tumor tissue and Normal Skin biopsy will be performed only at screening, after 4th cycle, and at progression. The normal skin biopsy and newly obtained tumor tissue biopsy are optional at time of treatment discontinuation.

***Blood for correlative will be drawn just prior to each cycle until cycle 5, then at progression

7.0 TRIAL PROCEDURES

7.1 Trial Procedures

The Trial Flow Chart - Section 6.0 summarizes the trial procedures to be performed at each visit. Individual trial procedures are described in detail below. It may be necessary to perform these procedures at unscheduled time points if deemed clinically necessary by the investigator.

Furthermore, additional evaluations/testing may be deemed necessary by the Sponsor and/or Merck for reasons related to subject safety. In some cases, such evaluation/testing may be potentially sensitive in nature (e.g., HIV, Hepatitis C, etc.), and thus local regulations may require that additional informed consent be obtained from the subject. In these cases, such evaluations/testing will be performed in accordance with those regulations.

7.1.1 Administrative Procedures

7.1.1.1 Informed Consent

The Investigator must obtain documented consent from each potential subject prior to participating in a clinical trial.

7.1.1.1.1 General Informed Consent

Consent must be documented by the subject's dated signature or by the subject's legally acceptable representative's dated signature on a consent form along with the dated signature of the person conducting the consent discussion.

A copy of the signed and dated consent form should be given to the subject before participation in the trial.

The initial informed consent form, any subsequent revised written informed consent form and any written information provided to the subject must receive the IRB/ERC's approval/favorable opinion in advance of use. The subject or his/her legally acceptable representative should be informed in a timely manner if new information becomes available that may be relevant to the subject's willingness to continue participation in the trial. The communication of this information will be provided and documented via a revised consent form or addendum to the original consent form that captures the subject's dated signature or by the subject's legally acceptable representative's dated signature.

Specifics about a trial and the trial population will be added to the consent form template at the protocol level.

The informed consent will adhere to IRB/ERC requirements, applicable laws and regulations and Sponsor requirements.

7.1.1.2 Inclusion/Exclusion Criteria

All inclusion and exclusion criteria will be reviewed by the investigator or qualified designee to ensure that the subject qualifies for the trial.

7.1.1.3 Medical History

A medical history will be obtained by the investigator or qualified designee. Medical history will include all active conditions, and any condition diagnosed within the prior 10 years that are considered to be clinically significant by the Investigator. Details regarding the disease for which the subject has enrolled in this study will be recorded separately and not listed as medical history.

7.1.1.4 Prior and Concomitant Medications Review

7.1.1.4.1 Prior Medications

The investigator or qualified designee will review prior medication use, including any protocol-specified washout requirement, and record prior medication taken by the subject within 28 days before starting the trial. Treatment for the disease for which the subject has enrolled in this study will be recorded separately and not listed as a prior medication.

7.1.1.4.2 Concomitant Medications

The investigator or qualified designee will record medication, if any, taken by the subject during the trial. All medications related to reportable SAEs and ECIs should be recorded as defined in Section 7.2.

7.1.1.5 Disease Details and Treatments

7.1.1.5.1 Disease Details

The investigator or qualified designee will obtain prior and current details regarding disease status.

7.1.1.5.2 Prior Treatment Details

The investigator or qualified designee will review all prior cancer treatments including systemic treatments, radiation and surgeries.

7.1.1.5.3 Subsequent Anti-Cancer Therapy Status

The investigator or qualified designee will review all new anti-neoplastic therapy initiated after the last dose of trial treatment. If a subject initiates a new anti-cancer therapy within 30 days after the last dose of trial treatment, the 30 day Safety Follow-up visit must occur before the first dose of the new therapy. Once new anti-cancer therapy has been initiated the subject will move into survival follow-up.

7.1.1.6 Assignment of Screening Number

Screening numbers will be assigned at time of consent. Numbers will be in order of consent.

7.1.2 Clinical Procedures/Assessments

7.1.2.1 Adverse Event (AE) Monitoring

The investigator or qualified designee will assess each subject to evaluate for potential new or worsening AEs as specified in the Trial Flow Chart and more frequently if clinically indicated. Adverse experiences will be graded and recorded throughout the study and during the follow-up period according to NCI CTCAE Version 4.0 (see Section 11.2). Toxicities will be characterized in terms regarding seriousness, causality, toxicity grading, and action taken with regard to trial treatment.

For subjects receiving treatment with pembrolizumab all AEs of unknown etiology associated with pembrolizumab exposure should be evaluated to determine if it is possibly an event of clinical interest (ECI) of a potentially immunologic etiology (termed immune-related adverse events, or irAEs).

Please refer to section 7.2 for detailed information regarding the assessment and recording of AEs.

7.1.2.2 Full Physical Exam

The investigator or qualified designee will perform a complete physical exam during the screening period. Clinically significant abnormal findings should be recorded as medical history. A full physical exam should be performed during screening.

7.1.2.3 Directed Physical Exam

For cycles that do not require a full physical exam per the Trial Flow Chart, the investigator or qualified designee will perform a directed physical exam as clinically indicated prior to trial treatment administration.

7.1.2.4 Vital Signs

The investigator or qualified designee will take vital signs at screening, prior to the administration of each dose of trial treatment and at treatment discontinuation as specified in the Trial Flow Chart (Section 6.0). Vital signs should include temperature, pulse, respiratory rate, weight and blood pressure. Height will be measured at screening only.

7.1.2.5 Eastern Cooperative Oncology Group (ECOG) Performance Scale

The investigator or qualified designee will assess ECOG status (see Section 11.1) at screening, prior to the administration of each dose of trial treatment and discontinuation of trial treatment as specified in the Trial Flow Chart.

7.1.2.6 Tumor Imaging and Assessment of Disease

Patients must have measurable disease by RECIST 1.1 criteria. Photographs may be used to follow disease. CT or MRI will be used to measure and follow response per RECIST v1.1 criteria.

7.1.2.7 Tumor Tissue Collection and Correlative Studies Blood Sampling

Tumor tissue will be collected at time point designated in the trial flow chart. At baseline archival specimen or fresh may be obtained to the equivalent of 15 unstained slides.

Fresh skin biopsy will consist of 6mm punches to non-cancerous skin site per institution protocol.

Blood specimens will be obtained at the time of routine lab draw and will consist of 20cc of additional blood drawn into 4 Cytotec tubes sent to the biorepository of cryopreservation for future analysis.

Blood and tissue specimen will be stored in the laboratories of Mandy Ford, PhD and Brian Pollack MD, PhD. They will be stored for five years after end of the study enrollment. Specimens will be destroyed if a patient chooses to withdraw consent.

The following studies will be conducted on blood and tissue specimens:

- 1) The frequencies of T cell subsets will be analyzed by flow cytometry using stains for CD3, CD8, CD4, CD25, HLA-DR, CD57, CCR7, CD45RA and FoxP3. T cell activation/differentiation will be determined based on CD45RA status, and central and effector memory cells will be further subdivided into CCR7⁺ and CCR7⁻ subsets, respectively (14). Special attention will be paid to the frequency of CD8⁺ effector (HLA-DR⁺ CCR7- CD45RA-) and CD4⁺CD25⁺FoxP3⁺ regulatory T cells (15). This overall T cell subset analysis will be carried prior, during, and after treatment with pembrolizumab.
- 2) Expression of the T cell inhibitory molecules PD-1, TIM-3, 2B4, CD160, Ptger4, Lag-3 and CTLA-4 on CD8⁺ T cells will be evaluated using fluorophore-labeled monoclonal antibodies to the inhibitory molecules and detected by flow cytometry. We hypothesize that reduced expression of other T cell coinhibitory molecules following pembrolizumab administration will be a biomarker positively associated with responsiveness to treatment and other major prognostic indicators for survival.
- 3) T cell functionality before and after pembrolizumab will be assessed by flow cytometry-based intracellular cytokine staining using fluorophore-labeled antibodies to IFN- γ , IL-2, IL-17 and TNF. We hypothesize that increased expression of these T cell cytokines following pembrolizumab administration will be a biomarker positively associated with responsiveness to treatment and other major prognostic indicators for survival.
- 4) To interrogate the impact of pembrolizumab on cutaneous immune homeostasis and immune cell trafficking, biopsies from normal skin and locally recurrent and/or metatatic cSCCs will be taken and evaluated using standard histopathology and immunohistochemistry. To identify cytotoxic T cells (CTLs), regulatory T cells (Tregs), dendritic cells (DCs) and tumor associated macrophages (TAM), biopsy sections will be stained with antibodies recognizing CD8 or FoxP3, for CTLs and Tregs respectively, CD68 for TAMs, and CD1a for tumor infiltrating DCs. We will couple the aforementioned IHC

staining with whole slide scanning and automated image analysis as we have done before to quantify IHC signals (Pollack, B et al Clinical Cancer Research, 2011).

7.1.3 Laboratory Procedures/Assessments

Details regarding specific laboratory procedures/assessments to be performed in this trial are provided below Laboratory Safety Evaluations (Hematology, Chemistry and Urinalysis)

Laboratory tests for hematology, chemistry, urinalysis, and others are specified in Table 5.

Table 5 Laboratory Tests

Hematology	Chemistry	Urinalysis	Other
Hematocrit	Albumin	Blood	Serum β -human chorionic gonadotropin†
Hemoglobin	Alkaline phosphatase	Glucose	(β -hCG)†
Platelet count	Alanine aminotransferase (ALT)	Protein	PT (INR)
WBC (total and differential)	Aspartate aminotransferase (AST)	Specific gravity	aPTT
Red Blood Cell Count	Lactate dehydrogenase (LDH)	Microscopic exam (<i>If abnormal</i>)	Total triiodothyronine (T3)
Absolute Neutrophil Count	Carbon Dioxide ‡ (CO_2 or bicarbonate)	results are noted	Free tyroxine (T4)
Absolute Lymphocyte Count	Uric Acid	Urine pregnancy test †	Thyroid stimulating hormone (TSH)
	Calcium		PK
	Chloride		
	Glucose		Blood for correlative studies
	Phosphorus		
	Potassium		
	Sodium		
	Magnesium		
	Total Bilirubin		
	Direct Bilirubin (<i>If total bilirubin is elevated above the upper limit of normal</i>)		
	Total protein		
	Blood Urea Nitrogen		

Hematology	Chemistry	Urinalysis	Other
† Perform on women of childbearing potential only. If urine pregnancy results cannot be confirmed as negative, a serum pregnancy test will be required.			
‡ If considered standard of care in your region.			

Laboratory tests for screening or entry into the Second Course Phase should be performed within 10 days prior to the first dose of treatment. After Cycle 1, pre-dose laboratory procedures can be conducted up to 72 hours prior to dosing. Results must be reviewed by the investigator or qualified designee and found to be acceptable prior to each dose of trial treatment.

7.1.3.1 Pharmacokinetic/Pharmacodynamic Evaluations

7.1.3.1.1 Blood Collection for Serum Pembrolizumab

Sample collection, storage and shipment instructions for serum samples will be provided in the Laboratory Manual.

The timepoints for PK blood sampling are described in Section 6 – Trial Flow Chart.

7.1.3.1.2 Blood Collection for Anti-Pembrolizumab Antibodies

Sample collection, storage and shipment instructions for blood samples will be provided in the Laboratory Manual.

7.1.4 Other Procedures

7.1.4.1 Withdrawal/Discontinuation

When a subject discontinues/withdraws prior to trial completion, all applicable activities scheduled for the final trial visit should be performed at the time of discontinuation. Any adverse events which are present at the time of discontinuation/withdrawal should be followed in accordance with the safety requirements outlined in Section 7.2 - Assessing and Recording Adverse Events. Subjects who a) attain a CR or b) complete 24 months of treatment with pembrolizumab may discontinue treatment with the option of restarting treatment if they meet the criteria specified in Section 7.1.5.5. After discontinuing treatment following assessment of CR, these subjects should return to the site for a Safety Follow-up Visit (described in Section 7.1.5.3.1) and then proceed to the Follow-Up Period of the study (described in Section 7.1.5.4).

7.1.5 Visit Requirements

Visit requirements are outlined in Section 6.0 - Trial Flow Chart. Specific procedure-related details are provided above in Section 7.1 - Trial Procedures.

7.1.5.1 Safety Follow-up Visits

The mandatory Safety Follow-Up Visit should be conducted approximately 30 days after the last dose of trial treatment or before the initiation of a new anti-cancer treatment, whichever comes first. All AEs that occur prior to the Safety Follow-Up Visit should be recorded. Subjects with an AE of Grade > 1 will be followed until the resolution of the AE to Grade 0-1 or until the beginning of a new anti-neoplastic therapy, whichever occurs first. SAEs that occur within 90 days of the end of treatment or before initiation of a new anti-cancer treatment should also be followed and recorded. Subjects who are eligible for retreatment

with pembrolizumab (as described in Section 7.1.5.5) may have up to two safety follow-up visits, one after the Treatment Period and one after the Second Course Phase.

7.1.5.2 Follow-up Visits

Subjects who discontinue trial treatment for a reason other than disease progression will move into the Follow-Up Phase and should be assessed every 6 weeks (42 ± 7 days) by radiologic imaging to monitor disease status. After 1 year, the imaging time point will occur every 9 weeks (± 7 days). Every effort should be made to collect information regarding disease status until the start of new anti-neoplastic therapy, disease progression, death, end of the study or if the subject begins retreatment with pembrolizumab as detailed in Section 7.1.5.5. Information regarding post-study anti-neoplastic treatment will be collected if new treatment is initiated.

Subjects who are eligible to receive retreatment with pembrolizumab according to the criteria in Section 7.1.5.5 will move from the follow-up phase to the Second Course Phase when they experience disease progression. Details are provided in Section 6.2 – Trial Flow Chart for Retreatment.

7.1.5.2.1 Survival Follow-up

Once a subject experiences confirmed disease progression or starts a new anti-cancer therapy, the subject moves into the survival follow-up phase and should be contacted by telephone every 12 weeks to assess for survival status until death, withdrawal of consent, or the end of the study, whichever occurs first.

7.1.5.3 Second Course Phase (Retreatment Period)

Subjects who stop pembrolizumab with SD or better may be eligible for up to one year of additional pembrolizumab therapy if they progress after stopping study treatment. This retreatment is termed the Second Course Phase of this study and is only available if the study remains open and the subject meets the following conditions:

- **Either**
 - Stopped initial treatment with pembrolizumab after attaining an investigator-determined confirmed CR according to RECIST 1.1, and
 - Was treated for at least 24 weeks with pembrolizumab before discontinuing therapy
 - Received at least two treatments with pembrolizumab beyond the date when the initial CR was declared

OR

- Had SD, PR or CR and stopped pembrolizumab treatment after 24 months of study therapy for reasons other than disease progression or intolerance

AND

- Experienced an investigator-determined confirmed radiographic disease progression after stopping their initial treatment with pembrolizumab
- Did not receive any anti-cancer treatment since the last dose of pembrolizumab
- Has a performance status of 0 or 1 on the ECOG Performance Scale
- Demonstrates adequate organ function as detailed in Section 5.1.2
- Female subject of childbearing potential should have a negative serum or urine pregnancy test within 72 hours prior to receiving retreatment with study medication.
- Female subject of childbearing potential should be willing to use 2 methods of birth control or be surgically sterile, or abstain from heterosexual activity for the course of the study through 120 days after the last dose of study medication (Reference Section 5.7.2). Subjects of child bearing potential are those who have not been surgically sterilized or have been free from menses for > 1 year.
- Male subject should agree to use an adequate method of contraception starting with the first dose of study therapy through 120 days after the last dose of study therapy.
- Does not have a history or current evidence of any condition, therapy, or laboratory abnormality that might interfere with the subject's participation for the full duration of the trial or is not in the best interest of the subject to participate, in the opinion of the treating investigator.

Subjects who restart treatment will be retreated at the same dose and dose interval as when they last received pembrolizumab. Treatment will be administered for up to one additional year.

Visit requirements are outlined in Section 6.0 – Trial Flow Chart.

7.2 Assessing and Recording Adverse Events

An adverse event is defined as any untoward medical occurrence in a patient or clinical investigation subject administered a pharmaceutical product and which does not necessarily have to have a causal relationship with this treatment. An adverse event can therefore be any unfavorable and unintended sign (including an abnormal laboratory finding, for example), symptom, or disease temporally associated with the use of a medicinal product or protocol-specified procedure, whether or not considered related to the medicinal product or protocol-specified procedure. Any worsening (i.e., any clinically significant adverse change in frequency and/or intensity) of a preexisting condition that is temporally associated with the use of the investigational product, is also an adverse event.

Changes resulting from normal growth and development that do not vary significantly in frequency or severity from expected levels are not to be considered adverse events.

Examples of this may include, but are not limited to, teething, typical crying in infants and children and onset of menses or menopause occurring at a physiologically appropriate time.

Merck product includes any pharmaceutical product, biological product, device, diagnostic agent or protocol-specified procedure, whether investigational (including placebo or active comparator medication) or marketed, manufactured by, licensed by, provided by or distributed by Merck for human use.

Adverse events may occur during the course of the use of Merck product in clinical trials or within the follow-up period specified by the protocol, or prescribed in clinical practice, from overdose (whether accidental or intentional), from abuse and from withdrawal.

Adverse events may also occur in screened subjects during any pre-allocation baseline period as a result of a protocol-specified intervention, including washout or discontinuation of usual therapy, diet, placebo treatment or a procedure.

Progression of the cancer under study is not considered an adverse event unless it is considered to be drug related by the investigator.

All adverse events will be recorded from the time the consent form is signed through 30 days following cessation of treatment and at each examination on the Adverse Event case report forms/worksheets. The reporting timeframe for adverse events meeting any serious criteria is described in section 7.2.3.1.

7.2.1 Definition of an Overdose for This Protocol and Reporting of Overdose to the Sponsor and to Merck

For purposes of this trial, an overdose of pembrolizumab will be defined as any dose of 1,000 mg or greater (≥ 5 times the indicated dose). No specific information is available on the treatment of overdose of pembrolizumab. Appropriate supportive treatment should be provided if clinically indicated. In the event of overdose, the subject should be observed closely for signs of toxicity. Appropriate supportive treatment should be provided if clinically indicated.

If an adverse event(s) is associated with (“results from”) the overdose of a Merck product, the adverse event(s) is reported as a serious adverse event, even if no other seriousness criteria are met.

If a dose of Merck’s product meeting the protocol definition of overdose is taken without any associated clinical symptoms or abnormal laboratory results, the overdose is reported as a non-serious Event of Clinical Interest (ECI), using the terminology “accidental or intentional overdose without adverse effect.”

All reports of overdose with and without an adverse event must be reported within 24 hours to the Sponsor and within 2 working days hours to Merck Global Safety. (Attn: Worldwide Product Safety; FAX 215 993-1220)

7.2.2 Reporting of Pregnancy and Lactation to the Sponsor and to Merck

Although pregnancy and lactation are not considered adverse events, it is the responsibility of investigators or their designees to report any pregnancy or lactation in a subject (spontaneously reported to them), including the pregnancy of a male subject's female partner that occurs during the trial or within 120 days of completing the trial completing the trial, or 30 days following cessation of treatment if the subject initiates new anticancer therapy, whichever is earlier. All subjects and female partners of male subjects who become pregnant must be followed to the completion/termination of the pregnancy. Pregnancy outcomes of spontaneous abortion, missed abortion, benign hydatidiform mole, blighted ovum, fetal death, intrauterine death, miscarriage and stillbirth must be reported as serious events (Important Medical Events). If the pregnancy continues to term, the outcome (health of infant) must also be reported.

Such events must be reported within 24 hours to the Sponsor and within 2 working days to Merck Global Safety. (Attn: Worldwide Product Safety; FAX 215 993-1220)

7.2.3 Immediate Reporting of Adverse Events to the Sponsor and to Merck

7.2.3.1 Serious Adverse Events

A serious adverse event is any adverse event occurring at any dose or during any use of investigational product that:

- Results in death;
- Is life threatening;
- Results in persistent or significant disability/incapacity;
- Results in or prolongs an existing inpatient hospitalization;
- Is a congenital anomaly/birth defect;
- Is a new cancer (that is not a condition of the study);
- Is associated with an overdose;
- Is another important medical event

Refer to Table 6 for additional details regarding each of the above criteria.

Any serious adverse event, or follow up to a serious adverse event, including death due to any cause other than progression of the cancer under study that occurs to any subject from the time the consent is signed through 90 days following cessation of treatment, or the initiation of new anti-cancer therapy, whichever is earlier, whether or not related to Merck product, must be reported within 24 hours to the Sponsor and within 2 working days to Merck Global Safety.

Non-serious Events of Clinical Interest will be forwarded to Merck Global Safety and will be handled in the same manner as SAEs.

Additionally, any serious adverse event, considered by an investigator who is a qualified physician to be related to Merck product that is brought to the attention of the investigator at any time outside of the time period specified in the previous paragraph also must be reported immediately to the Sponsor and to Merck.

SAE reports and any other relevant safety information are to be forwarded to the Merck Global Safety facsimile number: +1-215-993-1220

A copy of all 15 Day Reports and Annual Progress Reports is submitted as required by FDA, European Union (EU), Pharmaceutical and Medical Devices agency (PMDA) or other local regulators. Investigators will cross reference this submission according to local regulations to the Merck Investigational Compound Number (IND, CSA, etc.) at the time of submission. Additionally investigators will submit a copy of these reports to Merck & Co., Inc. (Attn: Worldwide Product Safety; FAX 215 993-1220) at the time of submission to FDA.

All subjects with serious adverse events must be followed up for outcome.

7.2.3.2 Events of Clinical Interest

Selected non-serious and serious adverse events are also known as Events of Clinical Interest (ECI) and must be recorded as such on the Adverse Event case report forms/worksheets and reported within 24 hours to the Sponsor and within 2 working days to Merck Global Safety. (Attn: Worldwide Product Safety; FAX 215 993-1220)Events of clinical interest for this trial include:

1. An overdose of Merck product, as defined in Section 7.2.1 - Definition of an Overdose for This Protocol and Reporting of Overdose to the Sponsor, that is not associated with clinical symptoms or abnormal laboratory results.
2. an elevated AST or ALT lab value that is greater than or equal to 3X the upper limit of normal and an elevated total bilirubin lab value that is greater than or equal to 2X the upper limit of normal and, at the same time, an alkaline phosphatase lab value that is less than 2X the upper limit of normal, as determined by way of protocol-specified laboratory testing or unscheduled laboratory testing.*

***Note:** These criteria are based upon available regulatory guidance documents. The purpose of the criteria is to specify a threshold of abnormal hepatic tests that may require an additional evaluation for an underlying etiology. The trial site guidance for assessment and follow up of these criteria can be found in the Investigator Trial File Binder (or equivalent).

7.2.4 Evaluating Adverse Events

An investigator who is a qualified physician will evaluate all adverse events according to the NCI Common Terminology for Adverse Events (CTCAE), version 4.0. Any adverse event which changes CTCAE grade over the course of a given episode will have each change of grade recorded on the adverse event case report forms/worksheets.

All adverse events regardless of CTCAE grade must also be evaluated for seriousness.

Table 6 Evaluating Adverse Events

An investigator who is a qualified physician, will evaluate all adverse events as to:

V4.0 CTCAE Grading	Grade 1	Mild; asymptomatic or mild symptoms; clinical or diagnostic observations only; intervention not indicated.
	Grade 2	Moderate; minimal, local or noninvasive intervention indicated; limiting age-appropriate instrumental ADL.
	Grade 3	Severe or medically significant but not immediately life-threatening; hospitalization or prolongation or hospitalization indicated; disabling; limiting self-care ADL.
	Grade 4	Life threatening consequences; urgent intervention indicated.
	Grade 5	Death related to AE
Seriousness	<p>A serious adverse event is any adverse event occurring at any dose or during any use of investigational product that:</p> <p>†Results in death; or</p> <p>†Is life threatening; or places the subject, in the view of the investigator, at immediate risk of death from the event as it occurred (Note: This does not include an adverse event that, had it occurred in a more severe form, might have caused death.); or</p> <p>†Results in a persistent or significant disability/incapacity (substantial disruption of one's ability to conduct normal life functions); or</p> <p>†Results in or prolongs an existing inpatient hospitalization (hospitalization is defined as an inpatient admission, regardless of length of stay, even if the hospitalization is a precautionary measure for continued observation. (Note: Hospitalization [including hospitalization for an elective procedure] for a preexisting condition which has not worsened does not constitute a serious adverse event.); or</p> <p>†Is a congenital anomaly/birth defect (in offspring of subject taking the product regardless of time to diagnosis); or</p> <p>Is a new cancer; (that is not a condition of the study) or</p> <p>Is an overdose (whether accidental or intentional). Any adverse event associated with an overdose is considered a serious adverse event. An overdose that is not associated with an adverse event is considered a non-serious event of clinical interest and must be reported within 24 hours.</p> <p>Other important medical events that may not result in death, not be life threatening, or not require hospitalization may be considered a serious adverse event when, based upon appropriate medical judgment, the event may jeopardize the subject and may require medical or surgical intervention to prevent one of the outcomes listed previously (designated above by a †).</p>	

Duration	Record the start and stop dates of the adverse event. If less than 1 day, indicate the appropriate length of time and units						
Action taken	Did the adverse event cause the investigational product to be discontinued?						
Relationship to test drug	<p>Did the investigational product cause the adverse event? The determination of the likelihood that the Merck product caused the adverse event will be provided by an investigator who is a qualified physician. The investigator's signed/dated initials on the source document or worksheet that supports the causality noted on the AE form, ensures that a medically qualified assessment of causality was done. This initialed document must be retained for the required regulatory time frame. The criteria below are intended as reference guidelines to assist the investigator in assessing the likelihood of a relationship between the test drug and the adverse event based upon the available information.</p> <p>The following components are to be used to assess the relationship between the Merck product and the AE; the greater the correlation with the components and their respective elements (in number and/or intensity), the more likely the Merck product caused the adverse event (AE):</p> <table border="1"> <tr> <td>Exposure</td><td>Is there evidence that the subject was actually exposed to the Merck product such as: reliable history, acceptable compliance assessment (pill count, diary, etc.), expected pharmacologic effect, or measurement of drug/metabolite in bodily specimen?</td></tr> <tr> <td>Time Course</td><td>Did the AE follow in a reasonable temporal sequence from administration of the Merck product? Is the time of onset of the AE compatible with a drug-induced effect (applies to trials with investigational medicinal product)?</td></tr> <tr> <td>Likely Cause</td><td>Is the AE not reasonably explained by another etiology such as underlying disease, other drug(s)/vaccine(s), or other host or environmental factors</td></tr> </table>	Exposure	Is there evidence that the subject was actually exposed to the Merck product such as: reliable history, acceptable compliance assessment (pill count, diary, etc.), expected pharmacologic effect, or measurement of drug/metabolite in bodily specimen?	Time Course	Did the AE follow in a reasonable temporal sequence from administration of the Merck product? Is the time of onset of the AE compatible with a drug-induced effect (applies to trials with investigational medicinal product)?	Likely Cause	Is the AE not reasonably explained by another etiology such as underlying disease, other drug(s)/vaccine(s), or other host or environmental factors
Exposure	Is there evidence that the subject was actually exposed to the Merck product such as: reliable history, acceptable compliance assessment (pill count, diary, etc.), expected pharmacologic effect, or measurement of drug/metabolite in bodily specimen?						
Time Course	Did the AE follow in a reasonable temporal sequence from administration of the Merck product? Is the time of onset of the AE compatible with a drug-induced effect (applies to trials with investigational medicinal product)?						
Likely Cause	Is the AE not reasonably explained by another etiology such as underlying disease, other drug(s)/vaccine(s), or other host or environmental factors						

Relationship to Merck product (continued)	The following components are to be used to assess the relationship between the test drug and the AE: (continued)
	<p>Dechallenge Was the investigational product discontinued or dose/exposure/frequency reduced? If yes, did the AE resolve or improve? If yes, this is a positive dechallenge. If no, this is a negative dechallenge.</p> <p>(Note: This criterion is not applicable if: (1) the AE resulted in death or permanent disability; (2) the AE resolved/improved despite continuation of the Merck product; or (3) the trial is a single-dose drug trial); or (4) Merck product(s) is/are only used one time.)</p>

Rechallenge	<p>Was the subject re-exposed to the Merck product in this study? If yes, did the AE recur or worsen? If yes, this is a positive rechallenge. If no, this is a negative rechallenge. (Note: This criterion is not applicable if: (1) the initial AE resulted in death or permanent disability, or (2) the trial is a single-dose drug trial); or (3) Merck product(s) is/are used only one time).</p> <p>NOTE: IF A RECHALLENGE IS PLANNED FOR AN ADVERSE EVENT WHICH WAS SERIOUS AND WHICH MAY HAVE BEEN CAUSED BY THE MERCK PRODUCT, OR IF REEXPOSURE TO THE MERCK PRODUCT POSES ADDITIONAL POTENTIAL SIGNIFICANT RISK TO THE SUBJECT, THEN THE RECHALLENGE MUST BE APPROVED IN ADVANCE BY THE U.S. CLINICAL MONITOR AS PER DOSE MODIFICATION GUIDELINES IN THE PROTOCOL.</p>
Consistency with Trial Treatment Profile	<p>Is the clinical/pathological presentation of the AE consistent with previous knowledge regarding the Merck product or drug class pharmacology or toxicology?</p>
<p>The assessment of relationship will be reported on the case report forms /worksheets by an investigator who is a qualified physician according to his/her best clinical judgment, including consideration of the above elements.</p>	
Record one of the following	<p>Use the following scale of criteria as guidance (not all criteria must be present to be indicative of a Merck product relationship).</p>
Yes, there is a reasonable possibility of Merck product relationship.	<p>There is evidence of exposure to the Merck product. The temporal sequence of the AE onset relative to the administration of the Merck product is reasonable. The AE is more likely explained by the Merck product than by another cause.</p>
No, there is not a reasonable possibility Merck product relationship	<p>Subject did not receive the Merck product OR temporal sequence of the AE onset relative to administration of the Merck product is not reasonable OR there is another obvious cause of the AE. (Also entered for a subject with overdose without an associated AE.)</p>

7.2.5 Sponsor Responsibility for Reporting Adverse Events

Written IND safety reports will be submitted to the FDA by the IND sponsor, for serious, unexpected suspected adverse reactions within 15 calendar days of learning of its occurrence. If the event is fatal or is deemed to be life threatening, the report will be made within 7 calendar days. The IND sponsor will also make an assessment of whether the event constitutes an unanticipated problem posing risks to subjects or others (UP). This assessment will be provided to the Emory University IRB, which, in turn will make a final determination. If the Emory IRB determines an event is a UP it will notify the appropriate regulatory agencies and institutional officials.

8.0 STATISTICAL ANALYSIS PLAN

8.1 Statistical Analysis Plan

The study will be conducted with optimal two stage design (Simon R Control Clin Trials 1989 10(1)1-10).

The Type I error rate is set at 10% and power of this study will be at least 80%. The study will be conducted with Simon's optimal two stage design. In the first stage, 12 patients will be enrolled. If 2 or less of the 12 patients achieve response, the study will close to further accrual and pembrolizumab is deemed to be ineffective. If RECIST response is seen in 3 or more of the 12 patients, then the trial continues with the second stage in which additional 13 patients will be enrolled for a total of 25 patients. At the end of complete enrollment, we require 8 or more out of the total of 25 subjects to achieve response for the pembrolizumab to be deemed to have sufficiently improved clinical activity and justify further clinical development. Otherwise if 7 or less out of the 25 patients achieve response, the trial will conclude that pembrolizumab cannot increase active anti-tumor effect in patients with metastatic cSCC with an estimated RECIST response rate to 40%.

The response rate of pembrolizumab in metastatic cutaneous squamous cell carcinoma will be estimated as percentage and 95% confidence interval (CI) will be constructed assuming a binomial distribution. The 6-month progression-free survival and 1 year overall survival of metastatic cSCC treated with pembrolizumab will be estimated with Kaplan Meier method and compared between different groups using Logrank test. Cox proportional model will be further employed to assess the treatment effect on survival with and without adjusting for other factors. Similar survival analysis will be conducted for the 6-month progression-free survival and 1 year overall survival of metastatic cSCC treated with pembrolizumab.

8.2 Exploratory Objective

OBJECTIVE: To evaluate biomarkers of response in both tumor specimens and PBMCs in patients treated with cSCC. The biomarkers will determine PD-L1 staining on tumor specimens and its correlation with response. The expression of co-stimulator and co-inhibitory molecules on and functionality of T cell populations in peripheral blood, tumor, normal skin of patients with advanced cSCC before and after treatment with systemic pembrolizumab.

Hypothesis: We hypothesize that PD-L1 positive tumors will have a higher response rate than PDL1 negative tumors.

9.0 LABELING, PACKAGING, STORAGE AND RETURN OF CLINICAL SUPPLIES

9.1 Investigational Product

The investigator shall take responsibility for and shall take all steps to maintain appropriate records and ensure appropriate supply, storage, handling, distribution and usage of investigational product in accordance with the protocol and any applicable laws and regulations.

Clinical Supplies will be provided by Merck as summarized in Table 7.

Table 7 Product Descriptions

Product Name & Potency	Dosage Form
Pembrolizumab 50 mg	Lyophilized Powder for Injection
Pembrolizumab 100 mg/ 4mL	Solution for Injection

9.2 Packaging and Labeling Information

Clinical supplies will be affixed with a clinical label in accordance with regulatory requirements.

9.3 Clinical Supplies Disclosure

This trial is open-label; therefore, the subject, the trial site personnel, the Sponsor and/or designee are not blinded to treatment. Drug identity (name, strength) is included in the label text; random code/disclosure envelopes or lists are not provided.

9.4 Storage and Handling Requirements

Clinical supplies must be stored in a secure, limited-access location under the storage conditions specified on the label.

Receipt and dispensing of trial medication must be recorded by an authorized person at the trial site.

Clinical supplies may not be used for any purpose other than that stated in the protocol.

9.5 Returns and Reconciliation

The investigator is responsible for keeping accurate records of the clinical supplies received from Merck or designee, the amount dispensed to and returned by the subjects and the amount remaining at the conclusion of the trial.

Upon completion or termination of the study, all unused and/or partially used investigational product will be destroyed at the site per institutional policy. It is the Investigator's responsibility to arrange for disposal of all empty containers, provided that procedures for proper disposal have been established according to applicable federal, state, local and institutional guidelines and procedures, and provided that appropriate records of disposal are kept.

10.0 ADMINISTRATIVE AND REGULATORY DETAILS

The Data and Safety Monitoring Committee (DSMC) of the Winship Cancer Institute will provide oversight for the conduct of this study. The DSMC functions independently within Winship Cancer Institute to conduct internal monitoring functions to ensure that research being conducted by Winship Cancer Institute Investigators produces high-quality scientific data in a manner consistent with good clinical practice (GCP) and appropriate regulations that govern clinical research. Depending on the risk level of the protocol, the DSMC review may occur every 6 months or annually. For studies deemed High Risk, initial study monitoring will occur within 6 months from the date of the first subject accrued, with 2 of the first 5 subjects being reviewed. For studies deemed Moderate Risk, initial study monitoring will occur within 1 year from the date of the first subject accrued, with 2 of the first 5 subjects being reviewed. Subsequent monitoring will occur in routine intervals per the Winship Data and Safety Monitoring Plan (DSMP).

The DSMC will review pertinent aspects of the study to assess subject safety, compliance with the protocol, data collection, and risk-benefit ratio. Specifically, the Winship Cancer Institute Internal Monitors assigned to the DSMC may verify informed consent, eligibility, data entry, accuracy and availability of source documents, AEs/SAEs, and essential regulatory documents. Following the monitoring review, monitors will provide a preliminary report of monitoring findings to the PI and other pertinent individuals involved in the conduct of the study. The PI is required to address and respond to all the deficiencies noted in the preliminary report. Prior to the completion of the final summary report, monitors will discuss the preliminary report responses with the PI and other team members (when appropriate). A final monitoring summary report will then be prepared by the monitor. Final DSMC review will include the final monitoring summary report with corresponding PI response, submitted CAPA (when applicable), PI Summary statement, and available aggregate toxicity and safety data.

The DSMC will render a recommendation and rating based on the overall trial conduct. The PI is responsible for ensuring that instances of egregious data insufficiencies are reported to the IRB. Continuing Review submissions will include the DSMC recommendation letter. Should any revisions be made to the protocol-specific monitoring plan after initial DSMC approval, the PI will be responsible for notifying the DSMC of such changes. The Committee reserves the right to conduct additional audits if necessary.

Trial expansion

The Melanoma Working Group will review the status of every patient enrolled to the study in the weekly meetings. The Melanoma working group will make recommendations whether sufficient data is available to move forward or stop study after Stage I of the design is completed. The PI or designee will obtain approval from the DSMC for enrollment in part II of the study. The PI will provide an update on all relevant safety data of patients entered to a dose level to the DSMC when dose escalation is planned.

Monitoring plan

Dr. Kudchadkar and the investigators on the melanoma working group, the clinical research coordinator and the regulatory affairs coordinator will meet on a regular basis to review and discuss study data to ensure subject safety. The research coordinators will maintain one spread sheet which will summarize all the patient data for patients actively being treated on the trial as well as a roadmap detailing pending tests/treatments for each individual patient. During the Winship 3185-16

team meeting the group will review the eligibility criteria for each new patient. Adverse events (AE/SAE) will be maintained using the standard CTO AE log. Investigators will review the toxicities, grade and attribute each toxicity. During the team meeting the group will review all the toxicity (AE/SAE) logs, case report form completion and roadmap for each patient on the trial. Spot checks will be performed to ensure completion of CRF. All CRF will be maintained electronically in OnCore®. Documentation of the discussions during these meetings are completed, filed and forwarded to the Winship Cancer Institute ("WCI") Data Safety Monitoring Committee (DSMC) at WCI.

Prior to study activation, the study team will undergo a training session lead by the study P.I. After completion of training, the regulatory staff will obtain signatures for all study team members on a training log. The material used for training (i.e. power point slides) and the training logs will be maintained by the regulatory staff. In case new team members join the trial during the study conduct, individual training will be performed at that time. The P.I. and the study investigators will discuss any required modifications to this study at the team meetings. No modifications to this study are implemented until they are submitted for review and approved by the Emory University IRB. After changes are approved by the IRB, the PI will conduct training focused on the new changes. The comments from the WCI DSMC are forwarded to the IRB at the time of the annual renewal of this study or sooner if warranted and requested by the WCI DSMC.

The Sponsor-Investigator will ensure that monitoring is competed and all reporting requirements are met.

APPENDICES

10.1 ECOG Performance Status

Grade	Description
0	Normal activity. Fully active, able to carry on all pre-disease performance without restriction.
1	Symptoms, but ambulatory. Restricted in physically strenuous activity, but ambulatory and able to carry out work of a light or sedentary nature (e.g., light housework, office work).
2	In bed <50% of the time. Ambulatory and capable of all self-care, but unable to carry out any work activities. Up and about more than 50% of waking hours.
3	In bed >50% of the time. Capable of only limited self-care, confined to bed or chair more than 50% of waking hours.
4	100% bedridden. Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.
5	Dead.

* As published in Am. J. Clin. Oncol.: *Oken, M.M., Creech, R.H., Tormey, D.C., Horton, J., Davis, T.E., McFadden, E.T., Carbone, P.P.: Toxicity And Response Criteria Of The Eastern Cooperative Oncology Group. Am J Clin Oncol 5:649-655, 1982.* The Eastern Cooperative Oncology Group, Robert Comis M.D., Group Chair.

10.2 Common Terminology Criteria for Adverse Events V4.0 (CTCAE)

The descriptions and grading scales found in the revised NCI Common Terminology Criteria for Adverse Events (CTCAE) version 4.0 will be utilized for adverse event reporting. (<http://ctep.cancer.gov/reporting/ctc.html>)

10.3 Response Evaluation Criteria in Solid Tumors (RECIST) 1.1 Criteria for Evaluating Response in Solid Tumors

RECIST version 1.1* will be used in this study for assessment of tumor response. While either CT or MRI may be utilized, as per RECIST 1.1, CT is the preferred imaging technique in this study.

* As published in the European Journal of Cancer:

E.A. Eisenhauer, P. Therasse, J. Bogaerts, L.H. Schwartz, D. Sargent, R. Ford, J. Dancey, S. Arbuck, S. Gwyther, M. Mooney, L. Rubinstein, L. Shankar, L. Dodd, R. Kaplan, D. Lacombe, J. Verweij. New response evaluation criteria in solid tumors: Revised RECIST guideline (version 1.1). *Eur J Cancer*. 2009 Jan;45(2):228-47.

In addition, volumetric analysis will be explored by central review for response assessment.

11.0 REFERENCES

Jarkowski A 3rd, Hare R, Loud P, Skitzki JJ, Kane JM 3rd, May KS, Zeitouni NC, Nestico J, Vona KL, Groman A, Khushalani NI. Systemic Therapy in Advanced Cutaneous Squamous Cell Carcinoma (CSCC): The Roswell Park Experience and a Review of the Literature. *Am J Clin Oncol*. 2014 May 29.

Belai EB¹, de Oliveira CE, Gasparoto TH, Ramos RN, Torres SA, Garlet GP, Cavassani KA, Silva JS, Campanelli AP. Carcinogenesis. 2014 Feb;35(2):424-31.

Pollack BP, Sapkota B, and Cartee TV. Epidermal growth factor receptor inhibition augments the expression of MHC class I and II genes. *Clin Cancer Res*. 2011 Jul 1: 17(13): 4400-13.

Simon R. Optimal two-stage designs for phase II clinical trials. *Control Clin Trials*. 1989 Mar;10(1):1-10.

Oken MM, Creech RH, Tormey DC, Horth J, Davis TE, McFadden ET, and Carbone PP. Toxicity and response criteria of the Eastern Cooperative Oncology Group. *Am J Clin Oncol*. 1982 Dec;5(6):649-55.

Eisenhauer E\$A, Therasee P, Bogaerts J, Schwartz LH, Sarent D, Ford R, Dancey J, Arbuck S, Gwyther S, Mooney M, Rubinstein L, Shankar L, Dodd L, Kaplan R, Lacombe D, and Verweij J. New response evaluation criteria in solid tumors: revised RECIST guideline (version 1.1). *Eur J Cancer*. 2009 Jan;45(2):228-47.