STATISTICAL ANALYSIS PLAN

The FIRST (**F**irst-line ovarian cancer treatment with N**ir**aparib plu**s** **T**SR-042) Study:

A RANDOMIZED, DOUBLE-BLIND, PHASE 3 COMPARISON OF PLATINUM-BASED THERAPY WITH TSR-042 AND NIRAPARIB VERSUS STANDARD OF CARE PLATINUM-BASED THERAPY AS FIRST-LINE TREATMENT OF STAGE III OR IV NONMUCINOUS EPITHELIAL OVARIAN CANCER

Protocol 3000-03-005/ENGOT-OV44/GSK 213350 (FIRST)

Protocol Number:	3000-03-005/ENGOT-OV44/GSK 213350 (FIRST)
Protocol Version and Date:	Version 10.0: 24 October 2024 (Amendment 8) Version 9.0: 07 June 2024 (Amendment 7) Version 8.0: 01 February 2022 (Amendment 6) Version 7.0: 19 August 2020 (Amendment 5) Version 6.0: 14 January 2020 (Amendment 4) Version 5.0: 17 July 2019 (Amendment 3) Version 4.0: 01 November 2018 (Amendment 2) Version 3.0: 11 July 2018 (Amendment 1) Version 2.0: 07 May 2018 (Original) Version 1.0: 27 April 2018
Name of Test Drug:	Niraparib (GSK3985771); Dostarlimab (TSR-042)
Phase:	Phase 3
Methodology:	Double-Blind, Placebo-Controlled
Sponsor:	GSK
Sponsor Representatives:	PPD MD PPD
SAP Version and Date:	Version 6.0: 06 Nov 2024 (Amendment 5) Version 5.0: 13 AUG2024 (Amendment 4) Version 4.0: 28 JUN 2024 (Amendment 3) Version 3.0: 29 MAY 2024 (Amendment 2) Version 2.0: 18 OCT 2022 (Amendment 1) Version 1.0: 16 AUG 2022

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LIST OF ABBREVIATIONS AND DEFINITION OF TERMS

Abbreviation	Definition
CCI [redacted]	
ADP	Adenosine diphosphate
AE	Adverse event
AEMI	Adverse event of medical interest
AESI	Adverse event of special interest
ALP	Alkaline phosphatase
ALT	Alanine aminotransferase
AML	Acute myeloid leukemia
ANC	Absolute neutrophil count
aPTT	Activated partial thromboplastin time
AST	Aspartate aminotransferase
ATC	Anatomical Therapeutic Chemical
AUC	Area under curve
BICR	Blinded Independent Central Review
BMI	Body mass index
BOR	Best overall response
BRCA	Breast cancer susceptibility gene
BRCAmut	BRCA mutated
BRCAwt	BRCA wild-type
BUN	Blood urea nitrogen
CxDx	Cycle x/Day x
CA-125	Cancer antigen 125
CBC	Complete blood count
CC0	Complete cytoreduction score of zero
CDx	Companion diagnostic
CI	Confidence interval
COVID-19	Coronavirus disease 2019
CPMS	Clinical Pharmacology Modeling & Simulation

Abbreviation	Definition
CR	Complete response
CREAT	Creatinine
CSR	Clinical study report
CTCAE	Common Terminology Criteria for Adverse Events
CCI [redacted]	
DBP	Diastolic blood pressure
DCO	Data cut off
DCR	Disease control rate
DNA	Deoxyribonucleic acid
DOR	Duration of response
ECG	Electrocardiogram
ECOG	Eastern Cooperative Oncology Group
eCRF	Electronic case report form
EORTC-QLQ-C30	European Organization for Research and Treatment of Cancer Quality of Life Questionnaire C30
EORTC-QLQ-OV28	European Organization for Research and Treatment of Cancer Quality of Life Questionnaire Ovarian Cancer Module OV28
EQ-5D-5L	European Quality of Life scale, 5-Dimensions
E-R	Exposure-response
EOT	End of treatment
CCI [redacted]	
FH	Fleming-Harrington
FIGO	International Federation of Gynecology and Obstetrics
FUACT	Follow-up anticancer therapy
G-CSF	Granulocyte colony stimulating factor
CCI [redacted]	
GI	Gastrointestinal
GSK	Glaxo Smith Kline
GSKMQ	GSK MedDRA query
HLT	High level terms

Abbreviation	**Definition**
HR	Hazard ratio
HRD	Homologous recombination deficiency
HRd	Homologous recombination deficient
HRp	Homologous recombination proficient
HRQoL	Health-related quality of life
HRR	Homologous recombinant repair
HRRneg	HRR negative
HRRpos	HRR positive
HUI	Health Utility Index
ICF	Informed consent form
ID	Identifier
IDMC	Independent Data Monitoring Committee
IDS	Interval debulking surgery
IHC	ImmunoHistoChemistry
INR	International normalized ratio
IPCW	Inverse Probability of Censoring Weighting
irAE	Immune-related adverse event
IRB	Institutional review board
IRR	Infusion-related reaction
ITT	Intent-to-treat
IV	Intravenous
KM	Kaplan-Meier
LATA	Last adequate tumor assessment
LC/MS/MS	Liquid chromatography with tandem mass spectroscopy
MCT	Meaningful change threshold
MDS	Myelodysplastic syndrome
MedDRA	Medical Dictionary for Regulatory Activities
MH	Mantel Haenszel
MMRM	Mixed-effects model for repeated measures

Abbreviation	Definition
MPFS	Maintenance progression-free survival
MSAF	Maintenance safety analysis population
NA	Not applicable
NCI	National Cancer Institute
NACT	Neoadjuvant chemotherapy
ND	No disease
NE	Not evaluable
OPS	Output and programming specification
ORR	Objective response rate
OS	Overall survival
PARP	Poly(ADP-ribose) polymerase
PD	Progressive disease / disease progression
PD-L1	Programmed death-ligand 1
PD-1	Programmed cell death protein 1
PDMS	Protocol Deviation Management System
PDS	Primary debulking surgery
PFS	Progression-free survival
PK	Pharmacokinetic
PR	Partial response
PRO	Patient-Reported Outcome
PT	Preferred term
QoL	Quality of life
Q_1	First quartile
Q_3	Third quartile
RAPIDO DV	Reporting and analysis plan improving design and delivery of outputs data viewer
RDI	Relative dose intensity
RECIST	Response Evaluation Criteria in Solid Tumors
REML	Restricted maximum likelihood

Abbreviation	**Definition**
ResBio	Resolution Biosciences
RMST	Restricted mean survival time
RoW	Rest of world
RS	Raw score
RTSM	Randomization and Trial Supply Management
SAC	Statistical analysis complete
SAE	Serious adverse event
SAF	Safety analysis
SAP	Statistical analysis plan
SAS	Statistical Analysis System
SBP	Systolic blood pressure
SD	Stable disease
SDTM	Study Data Tabulation Model
SMQ	Standardized MedDRA queries
SoA	Schedule of assessments
SoC	Standard of care
SOC	System organ class
TAP	Tumor area positivity
TEAE	Treatment-emergent adverse event
TESAE	Treatment-emergent serious adverse event
TFST	Time to first subsequent therapy
TOEP	Toeplitz
TOEPH	Toeplitz with heterogeneity
TOI	Term of interest
TSH	Thyroid stimulating hormone
TSST	Time to second subsequent therapy
US	United States
VAS	Visual Analogue Score
WHO	World Health Organization

1. INFORMATION FROM THE STUDY PROTOCOL

1.1. Objectives

Primary Objective

The primary objective is to compare the progression free survival (PFS) of platinum-based combination therapy, dostarlimab, and niraparib treatment (Arm 3) to platinum-based combination therapy and niraparib treatment (Arm 2) in participants with Stage III or IV high grade nonmucinous epithelial ovarian cancer.

CCI [redacted]

Secondary Objectives

CCI [redacted]

- Overall survival (OS, CCI [redacted]
- Blinded Independent Central Review (BICR) determined PFS per RECIST v1.1 criteria
- Health-related quality of life (HRQoL)
- Time to first subsequent therapy (TFST)
- Time to second subsequent therapy (TSST)
- Time from randomization to the earliest date of assessment of progression after initiation of subsequent anticancer therapy following study treatment or death by any cause (PFS2)
- Objective response rate (ORR) per CCI [redacted]
- Duration of response (DOR) per CCI [redacted]
- Disease control rate (DCR) per CCI [redacted]
- Pharmacokinetics (PK) and immunogenicity of dostarlimab
- PK of niraparib

Secondary objectives for platinum-based combination therapy (Arm 1), platinum-based combination therapy and niraparib (Arm 2) and platinum-based combination therapy, dostarlimab, and niraparib (Arm 3) for all participants will evaluate:

- Safety and tolerability

Exploratory Objectives

CCI [redacted]

1.2. Study Design

1.2.1. Synopsis of Study Design

1.2.1.1. Design Features

This is a global, multicenter, randomized, double-blind, controlled Phase 3 study in participants with newly diagnosed, Stage III or IV high-grade nonmucinous epithelial ovarian, fallopian tube, or peritoneal cancer (collectively referred to as "ovarian cancer"). The currently recommended SoC for the first-line treatment of Stage III or IV ovarian cancer is a combination of paclitaxel-carboplatin, with or without concurrent and maintenance bevacizumab. The use and schedule of bevacizumab is optional and must be determined prior to randomization.

The study is open to participants with inoperable ovarian cancer, participants who have macroscopic residual disease at the end of the primary debulking surgery (PDS) and have recovered from PDS and participants for whom platinum-based combination neoadjuvant chemotherapy (NACT) is planned. Participants with Stage IIIC disease that has been completely resected (also known as complete cytoreduction score of 0 [CC0]) are eligible if the following criteria is present: aggregate ≥5 cm extra-pelvic disease assessed by the Investigator during PDS.

Treatment Arm 1 consists of SoC and intravenous (IV) dostarlimab placebo followed by oral niraparib placebo and IV dostarlimab placebo in the maintenance phase of treatment. Arm 2 consists of SoC and IV dostarlimab placebo followed by oral niraparib and IV dostarlimab placebo maintenance therapy. Arm 3 consists of SoC and IV dostarlimab followed by oral niraparib and IV dostarlimab maintenance therapy.

CCI [redacted]

CCI [redacted]

This study was designed to enable rapid adaptation to evolving treatment paradigms and provide Investigators with the current SoC for participants with advanced ovarian cancer. This ensures that study participants will have access to contemporaneous SoC with or without investigational treatment while maintaining the integrity of the study. Full details on adaptations to the study design are located in the protocol.

In total, CCI [redacted]

CCI [redacted]

[b] All participants previously randomized to placebo and not receiving bevacizumab will be unblinded and provided the option to receive niraparib maintenance if they have received chemotherapy or discontinued chemotherapy ≤12 weeks.

1.2.1.2. Study Periods

The study consists of the following periods:

Pre-Screening Period

During the Pre-Screening Period, participants may sign a pre-Screening informed consent form consenting to collection of the required tumor tissue sample CCI [redacted] CCI [redacted] CCI [redacted] CCI [redacted]. The Pre-Screening Period can take place within the 14 days prior to the Screening Period, defined as the date of signing the main informed consent, but does not have to encompass the full period. A participant can move to the Screening Period once deemed able.

Screening Period

During the Screening Period, participants will sign the main consent form and complete all assessments required to determine eligibility into the study. The Screening Period is within 28 days prior to Cycle 1 Day 1 (C1D1) of the Chemotherapy Run-In Period.

Chemotherapy Run-In Period (Cycle 1)

Prior to randomization, all participants will receive 1 cycle of paclitaxel-carboplatin during a Chemotherapy Run-In Period. Participants may also receive bevacizumab with paclitaxel-carboplatin as part of SoC per local practice. However, bevacizumab must not be administered less than 28 days before or 28 days following major surgery, and post-operative incisions must be fully healed. The determination to use bevacizumab must be made prior to randomization. Participants will be randomized following Cycle 1, prior to treatment in Cycle 2 during the Chemotherapy Treatment Period. Randomization may occur up to one week prior to Cycle 2 Day 1. Intraperitoneal chemotherapy and weekly paclitaxel will not be allowed.

Chemotherapy Treatment Period (Cycles 2 to 6)

Prior to chemotherapy administration of Cycle 2, all of the following criteria must be met:

- Absolute neutrophil count (ANC) ≥1500 cells/µL, or ≥1000 cells µL if granulocyte colony stimulating factor (G-CSF) is to be administered
- Platelet count ≥100 000 cells/µL

Hemoglobin ≥8 g/dL

Thereafter, retreatment criteria for remaining chemotherapy Cycles 3 to 6 should be in accordance with treatment guidelines per local practice.

Following randomization, participants who have inoperable disease or who have undergone PDS will receive Cycles 2 to 6 of paclitaxel-carboplatin, for a total of 6 cycles of chemotherapy inclusive of Cycle 1. Participants will also receive dostarlimab/placebo in combination with paclitaxel-carboplatin started with Cycle 2 of chemotherapy, for a total 5 cycles. Bevacizumab may continue per local practice.

Participants for whom NACT is planned will receive 3 to 4 cycles of paclitaxel-carboplatin prior to interval debulking surgery (IDS) (inclusive of Cycle 1) and 2 to 3 additional cycles of paclitaxel-carboplatin following surgery for a maximum of 6 cycles of chemotherapy that cannot be extended. Interval debulking surgery planned after 6 cycles of chemotherapy should be discussed with the Sponsor. These participants will also receive dostarlimab/placebo, which will be started with Cycle 2 of chemotherapy, for a total of 5 cycles. Chemotherapy and dostarlimab/placebo will resume upon recovery of surgery. Participants for whom NACT is planned may receive bevacizumab with paclitaxel/carboplatin per local practice; however, bevacizumab must not be administered less than 28 days before or 28 days following major surgery, and post-operative incisions must be fully healed. Intraperitoneal chemotherapy and weekly paclitaxel will not be allowed.

Maintenance Treatment Period

Participants who complete the Chemotherapy Treatment Period without progressive disease (PD) will start the Maintenance Treatment Period 3 weeks after Cycle 6 Day 1. Dostarlimab/placebo ± bevacizumab will also continue in the Maintenance Treatment Period in combination with oral maintenance treatment, per study schedule. However, the start of niraparib/placebo will be delayed at least 6 weeks after Cycle 6 Day 1 and up to 9 weeks after to allow for adequate recovery of hematologic toxicity.

Prior to starting the first dose of oral niraparib/placebo maintenance treatment, participants must have a complete blood count (CBC) that demonstrates adequate recovery from hematologic toxicity due to chemotherapy and blood pressure within the following limits:

- Absolute neutrophil count ≥1500 cells/μL
- Platelet count ≥100 000/μL
- Hemoglobin ≥9 g/dL
- Blood pressure <150/100 mmHg

Weekly CBC is to be performed for the first 4 weeks from the start of niraparib/placebo in the Maintenance Treatment Period as follows:

1. Week 1 (Day of first dose): Cycle X Maintenance Day 1 (-3 day window)
2. Week 2: Cycle X Day 8 (no window, 7 days from First Dose)
3. Week 3: Unscheduled Visit (no window, 14 days from First Dose)
4. Week 4: Cycle X+1 Maintenance Day 1 (-3 day window)

The recommended order of administration is provided below, unless local clinical practice or institutional policies differ:

During the Chemotherapy Treatment Period, CCI [redacted] CCI [redacted]

During the Maintenance Treatment Period, CCI [redacted] CCI [redacted]

Follow-up Period (not defined in protocol)

After treatment discontinuation, participants will be followed for safety, follow-up anticancer therapy, progression free survival, overall survival among other parameters as outlined in the study protocol, APPENDIX 1.

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1.2.3. Stopping Rules and Unblinding

There are no pre-specified stopping rules for the study.

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CCI An unblinded study team consisting of, at a minimum, a site Pharmacist, back-up Pharmacist, and Sponsor Monitor will keep confidential the treatment assignment of each participant and will dispense the study medication, retain, and monitor the drug accountability records for the trial.

Participants who require unblinding of treatment assignment will be permanently discontinued from study treatment but will continue to be followed unless the participant withdraws consent.

Following implementation of Amendment 4, Arm 1 participants receiving bevacizumab will remain blinded. Arm 1 participants not receiving bevacizumab will be unblinded centrally by the Sponsor and a communication will be sent to the investigative site unblinding the participants and indicating the treatment groups as outlined in the study protocol, APPENDIX 11.

Further details on unblinding are included in the study protocol Section 5.4.3 and the Study Blinding Plan Version 3.0.

1.2.4. Study Procedures

The schedule of assessments is outlined in the study protocol APPENDIX 1.

1.2.5. Study Treatments

For analysis purposes and variable derivations, the chemotherapy run-in cycle received prior to randomization is not considered part of study treatment. Any study protocol treatment received post-randomization, including SoC (carboplatin+paclitaxel±bevacizumab), study drug (niraparib and dostarlimab) and placebo, is considered study treatment. The first dose in the chemotherapy period from randomization onwards, is considered first dose of study treatment. Randomization is expected at C2D1.

Analyses will be presented by treatment arm per the following naming conventions:

Arm 1: carboplatin+paclitaxel±bevacizumab + IV dostarlimab placebo in the chemotherapy period followed by oral niraparib placebo + IV dostarlimab placebo ±bevacizumab in the maintenance treatment period

Arm 2: carboplatin+paclitaxel±bevacizumab + IV dostarlimab placebo in the chemotherapy period followed by oral niraparib + IV dostarlimab placebo ±bevacizumab in the maintenance treatment period

Arm 3: carboplatin+paclitaxel±bevacizumab + IV dostarlimab in the chemotherapy period followed by oral niraparib + IV dostarlimab ±bevacizumab in the maintenance treatment period.

1.2.6. Study Endpoints

1.2.6.1. Efficacy Endpoints

The primary efficacy endpoint is PFS CCI [redacted] defined as the time from the date of randomization to the date of first documented PD CCI [redacted], or death by any cause, whichever occurs first.

Secondary efficacy endpoints are:

- OS, defined as the time from randomization to the date of death by any cause.
- BICR CCI [redacted]
- TFST, defined as the time from randomization until the start date of the first subsequent anticancer therapy or death by any cause, whichever occurs first.

- TSST, defined as the time from randomization until the start date of the second subsequent anticancer therapy or death by any cause, whichever occurs first.
- PFS2, defined as the time from randomization until the date of first PD per Investigator's assessment after initiation of subsequent anticancer therapy or death by any cause, whichever occurs first.
- ORR [redacted]
- DOR [redacted]
- DCR [redacted]

[redacted]

1.2.6.2. HRQoL Endpoints

[redacted]

1.2.6.3. Biomarker Endpoints

[redacted]

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[redacted]

1.2.6.4. Immunogenicity Endpoints

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[redacted]

1.2.6.5. Pharmacokinetic Endpoints

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[redacted]

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2. PARTICIPANT POPULATION

2.1. Population Definitions

In general, analyses will focus on the following analysis populations:

- The Screened population consists of all participants who signed the Pre-screening or Screening Informed Consent Form (ICF).
- The Enrolled population consists of all screened participants who received at least one cycle of SoC chemotherapy prior to randomization.
- The Intent-to-Treat (ITT) population consists of all randomized participants. These participants will be analyzed "as randomized". Any deceased participants randomized in error with death prior to randomization will be excluded from the population.
- The Safety Analysis (SAF) population consists of all randomized participants who were treated with at least one dose of study treatment. These participants will be analyzed "as treated", according to the treatment they actually received. This will differ from the randomized treatment if another arm's planned treatment was administered for more than ≥50% of cycles.

- The Maintenance Safety Analysis (MSAF) population consists of all participants within the Safety Analysis population that have received at least one dose of maintenance study treatment. First dose of study treatment in the maintenance period is defined as the first dose after maintenance enrollment.
- The PK analysis population consists of all participants in Arm 2 and Arm 3 who have received at least 1 dose of dostarlimab and/or niraparib and have at least one measurable post dose PK result. These participants will be analyzed "as treated", according to the treatment they actually received.

CCI [redacted]

2.2. Protocol Deviations

A protocol deviation is any failure to comply with the study protocol as approved by the relevant regulatory authority, ethics committee and/or institutional review board (IRB), whether planned or unplanned.

Protocol deviations will be tracked by the study team throughout the conduct of the study and captured through Glaxo Smith Kline (GSK) Protocol Deviation Management System (PDMS) or as a TESARO PDs.

These protocol deviations will be reviewed as follows.

- Data will be reviewed prior to database lock to ensure all important protocol deviations are captured and categorized in the protocol deviations dataset. All protocol deviations will be identified and finalized prior to database lock.

Protocol deviations that have been identified as due to coronavirus disease 2019 (COVID-19) have a prefix "COVID-19", protocol deviations that have been identified due to the war in Ukraine contain "CONFLICT". They will be assessed for importance following the same criteria as any other protocol deviations.

A summary and listing of important protocol deviations will be provided.

3. GENERAL STATISTICAL METHODS

3.1. Sample Size Determination

CCI [redacted]

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[redacted]

3.2. General Methods

Unless otherwise specified, all summaries and reporting will follow GSK Core Data Standards.

The ITT population will be used for all participant disposition and efficacy analyses unless otherwise specified (e.g., screening status will be based on the screened population, treatment status will be based on the safety population). The SAF population will be used for all safety analyses unless otherwise specified (e.g., certain safety listings will be based on the Enrolled population, maintenance period analyses will be based on the MSAF population).

Tabulations will be produced for appropriate demographic, baseline, efficacy, and safety parameters.

Participant-level data will be available interactively via Reporting and Analysis Plan Improving Design and Delivery of Outputs Data Viewer (RAPIDO DV) at the time of statistical analysis complete (SAC).

For categorical variables, summary tabulations of the number and percentage of participants within each category of the parameter will be presented.

For continuous variables, unless otherwise specified, the number of participants, mean, standard deviation, median, first quartile (Q_1), third quartile (Q_3), minimum, and maximum values will be presented.

Summaries will include all data collected per the schedule of assessments (SoA), listings will include all data collected per SoA and any unscheduled assessments unless otherwise specified. confidence intervals (CIs) will use 95% confidence level unless otherwise specified.

In addition:

- P-values greater than or equal to 0.0001, in general, will be presented to 4 decimal places; p-values less than 0.0001 will be presented as "<0.0001"
- Weeks will be calculated as Number of days divided by 7
- Months will be calculated as Number of days divided by 30.4375
- Years will be calculated as Number of days divided by 365.25
- All tables, figures, and listings will include footers at the bottom of the page reflecting the path of the programs used to generate the tables, figures, and listings, and date and time of the generation of the output.

3.3. Computing Environment

All statistical analyses will be performed using Statistical Analysis System (SAS) statistical software v9.4 or later, unless otherwise noted. Medical history and AEs will be coded using the current MedDRA version. Laboratory parameter changes will be described using shift tables, relative to version 4.03 of the National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE). Prior and concomitant medications will be coded using the latest version of the World Health Organization (WHO) Anatomical Therapeutic Chemical (ATC) Classification.

3.4. Analysis Periods

Unless otherwise specified:

- Efficacy measures will begin at "date of randomization"
    - Analysis day for efficacy variables will use the date of randomization as reference date.
- Safety measures will begin at "date of first dose of study treatment" after randomization.
    - Analysis day for safety variables will use the date of first dose of study treatment as reference date.

The following study periods will be defined for the calculation of flags, concomitant medications and safety assessments.

Study Periods for Exposure/Laboratory/Vital Signs Calculations

- Study treatment start date is defined as the date of first dose of study treatment after randomization.
- Study treatment stop date is defined as the latest dose of all study treatment.
- Chemotherapy treatment period: study treatment start date ≤ date ≤ min(chemotherapy study treatment stop date + 90 days, maintenance study treatment start date-1 day)

  - For participants who do not start maintenance treatment, set maintenance study treatment start date to Infimum.
  - Chemotherapy study treatment stop date is defined as the latest date from chemotherapy dosing of SoC, dostarlimab/placebo and bevacizumab.
- Maintenance treatment period: maintenance study treatment start date ≤ date ≤study treatment stop date + 90 days
  - Maintenance study treatment start date is defined as the earliest date from the maintenance dosing of niraparib/placebo and dostarlimab/placebo and bevacizumab.
- Overall treatment period: study treatment start date ≤ date ≤ study treatment stop date + 90 days

Study Periods for Prior/Concomitant Medications

- Prior: stop date < study treatment start date (post-randomization)
- Concomitant: study treatment start date ≤ date ≤ min (study treatment stop date + 90 days, date of initiation of first subsequent anticancer therapy)

If start date < study treatment start date and stop date is on or after the treatment start date or missing, then the medication is considered to be concomitant.

If start date is missing and stop date is missing, on or after the treatment start date, then the medication is considered to be concomitant. Details on handling of partial dates can be found in Section 3.10.

Period of Occurrence for Treatment Emergent Adverse Events

As per protocol, AEs are required to be captured through 30 days after cessation of study treatment and SAEs are required to be captured through 90 days after the last dose of study treatment (or a minimum of 30 days post-treatment discontinuation if the participant starts alternative anticancer therapy), for the period of occurrence for treatment emergent AEs, 90 days will be used to cover both AEs and SAEs.

- Chemotherapy period: study treatment start date ≤ AE start date ≤ min(chemotherapy study treatment stop date + 90 days, maintenance study treatment start date-1, date of initiation of first subsequent anticancer therapy)
  - For participants who do not start maintenance treatment, set maintenance study treatment start date to Infimum
- Maintenance period: maintenance study treatment start date ≤ AE start date ≤ min(study treatment stop date + 90 days, date of initiation of first subsequent anticancer therapy)
- Overall period: study treatment start date ≤ AE start date ≤ min(study treatment stop date + 90 days, date of initiation of first subsequent anticancer therapy)

AEs with a missing start date and either a missing stop date, or a stop date on or after the initiation of study treatment are considered to be treatment emergent with start dates falling in the chemotherapy and overall treatment periods.

3.5. Baseline Definitions

Unless otherwise specified, baseline is defined as the most recent measurement prior to first dose of study treatment. If time is not collected, any measurements on the date of first dose of study treatment are assumed to be prior to first dose and used as the baseline. For HRQoL assessments, for participants who did not receive study treatment during the study, baseline will be defined as the latest, non-missing collected value, excluding end of treatment, safety follow-up, long term follow-up visit records and unscheduled visits after end of treatment.

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CCI

[redacted]

CCI

[redacted]

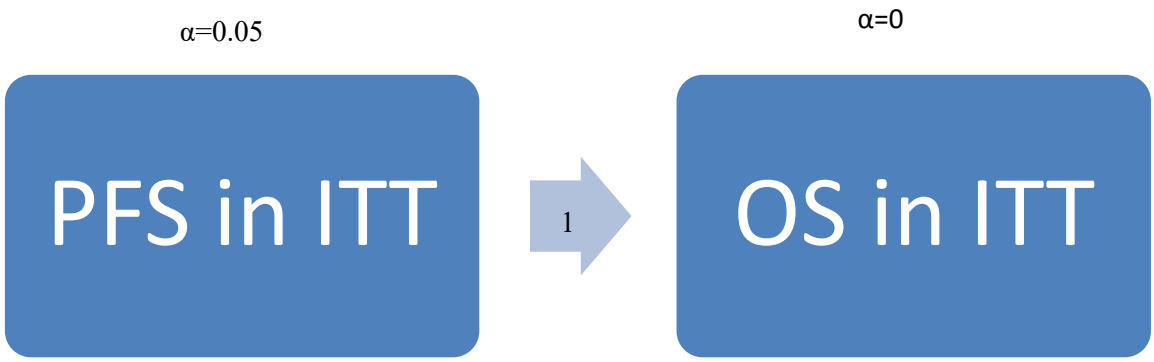
3.8. Multiplicity

3.8.1. Multiple Comparisons

To control the overall Type I error, a hierarchical testing procedure will be used. First, PFS in Arm 2 vs Arm 3 will be tested at 2-sided significance level of 0.05. If the test is statistically significant and favoring Arm 3, OS in Arm 2 vs Arm 3 will be tested at 2-sided significance level.

For the interim OS analysis that will be performed at the primary PFS analysis, the Haybittle-Peto stopping boundary will be used. This assigns a significance level of 0.0001 for the interim analysis and 0.05 for the final OS analysis (2-sided test). Figure 2 outlines the testing procedure. Starting with PFS, if a test is successful (meaning statistically significant and favoring Arm 3), 100% of the alpha will be carried over to the subsequent test. If at any point a test fails, inferential testing will stop as there will be no more alpha to test the remaining endpoints.

Figure 2 Testing Strategy



3.8.2. Interim Analyses

No interim analyses will be performed for PFS. An interim analysis of OS will be performed at the time of the primary PFS analysis, and a final OS analysis will be performed once survival data reach approximately 60% maturity in Arms 2 and 3.

3.9. Missing Data

Unless otherwise specified, there will be no substitutions made to accommodate missing data points. Methods for handling incomplete Patient-Reported Outcomes (PRO) instruments are performed according to their scoring manuals.

3.10. Handling of Partial Dates

Table 1 provides details on the handling of and imputation for partial dates.

Table 1 Handling of Partial Dates

Element	Reporting Detail
General	• Partial dates will be displayed as captured in participant listing displays. • However, where necessary, display macros may impute dates as temporary variables for sorting data in listings only. In addition, partial dates may be imputed for 'slotting' data to study phases or for specific analysis purposes as outlined below. • Imputed partial dates will not be used to derive study day, time to onset or duration (e.g., time to onset or duration of AEs), elapsed time variables (e.g., time since diagnosis). In addition, imputed dates are not used for deriving the last known alive date in OS analysis dataset. • Imputations will only be performed for: adverse event dates, COVID-19 test dates, concomitant medications, follow-up anticancer therapy and death dates as described in this table.

Adverse Events/COVID-19 test dates	• Partial dates for AE recorded in the CRF will be imputed using the following conventions:
	Missing start day
	• If study treatment start date is missing (i.e., participant did not start study treatment), then set start date = 1st of month.
	• Else if study treatment start date is not missing:
	  ○ If month and year of start date = month and year of study treatment start date, then
	  ▪ If stop date contains a full date and stop date is earlier than study

<table>
<tr><th>Element</th><th colspan="2">Reporting Detail</th></tr>
<tr><td></td><td></td><td>treatment start date, then set start date= 1st of month.
▪ Else set start date = study treatment start date.
o Else set start date = 1st of month.</td></tr>
<tr><td></td><td>Missing start day and month</td><td>• If study treatment start date is missing (i.e., participant did not start study treatment), then set start date = January 1.
• Else if study treatment start date is not missing:
o If year of start date = year of study treatment start date, then
▪ If non-missing AE stop date is unequivocally earlier than study treatment start date, then set start date = January 1.
▪ Else set start date = study treatment start date.
o Else set start date = January 1.</td></tr>
<tr><td></td><td>Missing end day</td><td>A ‘28/29/30/31’ will be used for the day (dependent on the month and year).</td></tr>
<tr><td></td><td>Missing end day and month</td><td>No Imputation</td></tr>
<tr><td></td><td>Completely missing start/end date</td><td>No imputation</td></tr>
<tr><td>Concomitant Medications</td><td colspan="2">• Partial dates for any concomitant medications recorded in the CRF will be imputed using the following convention:</td></tr>
<tr><td></td><td>Missing start day</td><td>• If study treatment start date is missing (i.e., participant did not start study treatment), then set start date = 1st of month.
• Else if study treatment start date is not missing:
o If month and year of start date = month and year of study treatment start date, then
▪ If stop date contains a full date and stop date is earlier than study treatment start date, then set start date= 1st of month.
▪ Else set start date = study treatment start date.
o Else set start date = 1st of month.</td></tr>
</table>

<table>
<tr><th>Element</th><th>Reporting Detail</th></tr>
<tr><td></td><td>
<table>
<tr><td>Missing start day and month</td><td>• If study treatment start date is missing (i.e., participant did not start study treatment), then set start date = January 1.
• Else if study treatment start date is not missing:
o If year of start date = year of study treatment start date, then
▪ If stop date contains a full date and stop date is earlier than study treatment start date, then set start date = January 1.
▪ Else set start date = study treatment start date.
o Else set start date = January 1.</td></tr>
<tr><td>Missing end day</td><td>A ‘28/29/30/31’ will be used for the day (dependent on the month and year).</td></tr>
<tr><td>Missing end day and month</td><td>A ‘31’ will be used for the day and ‘Dec’ will be used for the month.</td></tr>
<tr><td>Completely missing start/end date</td><td>No imputation</td></tr>
<tr><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Follow-up Anticancer Therapy for Efficacy Evaluation</td><td>• Completely missing start dates will remain missing, with no imputation applied;
• Partial start dates will be imputed using the following convention:
o If both month and day are missing, no imputation will be applied;
o If only day is missing:
o If the month of partial date is the same as the month of last dosing date, minimum of (last dosing date + 1, last day of the month) will be used for the day;
o If the month of partial date is the same as the month of last disease assessment and the last CCI disease assessment is PD, minimum of (last date of disease assessment + 1, last day of the month) will be used for the day;
o If both conditions above are met, the later date will be used for the day;</td></tr>
</table>

Element	Reporting Detail
	○ Otherwise, a '01' will be used for the day; • Completely or partially missing end dates will remain missing, with no imputation applied; Note: If end date is earlier than the imputed start date, then the start date will be considered as the therapy end date.
Death	• If a participant is known to have died where only a partial death date is available, then the date of death will be imputed as the latest of the last complete known to be alive date + 1 from the database and the death date using the available information provided: ○ For missing day only – use the 1st of the month ○ For missing day and month- use the 1st of January

3.11. Visit Windows

It is expected that all visits should occur according to the protocol schedule. By-visit summaries and analyses will be by nominal visit (all data will be tabulated per the evaluation visit as recorded on the eCRF even if the assessment is outside of the visit window for analysis). In data listings, the relative day of all dates will be presented.

For HRQoL endpoints, visit windows will be applied to HRQoL assessments after Safety Follow-up as shown in Table 2 when applicable. If multiple assessments are observed in a window, the visit closest to the scheduled assessment date will be used. If equally close, the earlier visit will be used. If multiple assessments are on the same date a worst-case approach will be used to select the worst HRQoL assessments per domain score.

HRQoL assessments should be collected at the EOT Visit, 30-day (±7 days) Safety Follow-up Visit, 90-day (±14 days) Long-Term Follow-up Visit, and every 180 days (±14 days) thereafter, which will continue until death or the end of study data collection.

Table 2 Windows (Inclusive) for HRQoL Assessments after EOT

Visit after EOT	Scheduled Day after EOT	Window (Days)
3 months	90	64 to 180
9 months	270	181 to 360
15 months	450	361 to 540
21 months	630	541 to 720
27 months	810	721 to 900
33 months	990	901 to 1080
39 months	1170	1081 to 1260
45 months	1350	1261 to 1440
51 months	1530	1441 to 1620

4. STUDY ANALYSES

Unless otherwise specified, the study population analyses will be based on the ITT analysis population (e.g., screening status will be based on the Screened population, treatment status will be based on the SAF population).

Study analyses will be conducted in all participants and PD-L1 positive participants (identified as a clinically plausible subgroup).

4.1. Participant Disposition

The following participant disposition summaries will be provided by treatment arm and overall (Arm 1, Arm 2, Arm 3, Overall), unless otherwise specified:

- Screening status, number and percentage of participants who were:
    - Screened (i.e., signed the pre-screening or screening ICF)
    - Screen failures (with reason for screen failure)
    - Enrolled (i.e., received the chemotherapy run-in cycle)
- Run-in status, number and percentage of participants who:
    - Received the chemotherapy run-in cycle and were subsequently randomized
    - Received the chemotherapy run-in cycle and were not randomized (with reason for run-in failure)

Subject status, number and percentage of participants who are:

- Ongoing (on **any** study treatment, in follow-up)

  - Withdrawn from study (with reason for study withdrawal as captured in the eCRF on the discontinuation of study page)
- Treatment status, number and percentage of participants who are:
  - Ongoing (on **any** study treatment)
  - Withdrawn from **all** study treatment (with reason for study treatment withdrawal as captured in the eCRF on the discontinuation of treatment page)
- Subject disposition at each treatment period, number and percentage of participants who:
  - Entered the treatment period
  - Completed the treatment period
  - Withdrawn from **all** treatment in the treatment period (with reasons for withdrawal)
  - Are ongoing in the treatment period (receiving **any** treatment in the treatment period)
- Study population, number and percentage of participants within each study population

Subject status will be presented on the screened population and summarized by each country and site identifier (ID). Treatment status and subject disposition at each treatment period will be presented on the SAF population.

The number and percentage of participants in the ITT population will be summarized by each country and site ID.

A listing of reasons for study withdrawal and subjects excluded from any population will also be provided.

4.2. Demographics, Baseline Characteristics, and Medical History

4.2.1. Demographic and Baseline Characteristics

Demographics, baseline characteristics, and medical history information will be summarized by treatment arm (Arm 1, Arm 2, Arm 3, Overall) for the ITT population.

Demographic and baseline data for each participant will be provided in a data listing.

The demographic tables will include the following information:

- Age at time of screening (years) as reported on the eCRF
- Age ranges (18 to <65, ≥65 to <75, ≥75 years and ≥65 to <85, ≥85 years)
- Race (White, Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, mixed, unknown, and not reported)
- Race group (White, Other)
- Ethnicity (Hispanic or Latino, Non-Hispanic or Latino, unknown, and not reported)
- Geographic region (United States [US]/Canada, Europe, rest of world [RoW])
- Baseline weight (kg)

- Baseline height (cm)
- Baseline body mass index (BMI) kg/m^2
- ECOG performance status at screening
- ECOG performance status at baseline
- PD-L1 status (positive or negative, not to be presented for PD-L1 positive output)
- Planned starting dose of niraparib/placebo [redacted] mg vs [redacted] mg)
- Bevacizumab use in chemotherapy run-in period (yes or no)
- Measurable disease at baseline (yes or no)
    - Based on Investigator [redacted] assessment obtained from the [redacted] evaluation eCRF form.
- HRD Myriad status (HRd, Homologous recombination proficient [HRp], unknown)
- BRCA Myriad Status (BRCAmut, BRCAwt, BRCAwt HRd, unknown)
    - In database: BRCAmut = positive for clinically significant mutation, BRCAwt = positive for wild- type BRCA, HRd = positive for HRD status. Unknown includes inconclusive, missing and failed test results.

The following disease characteristic information will be provided based on the eCRF:

- Primary tumor site (ovarian, primary peritoneal, or fallopian tube)
- Time from initial diagnosis to randomization (days)
- Cancer stage International Federation of Gynecology and Obstetrics (FIGO) at time of initial diagnosis
- Site of metastatic disease and number of metastatic sites (<3, >=3)
- Residual disease following PDS (yes vs no vs N/A)
- Surgical status at the time of screening (PDS, IDS, non-surgical (inoperable))
- Histological and cytological ovarian cancer pathology at diagnosis
    - Histological subtype (serous, endometrioid, carcinosarcoma, non-mucinous, other)
    - Tumor grade (grade 2, grade 3, not assessable)

The following stratification information will also be provided:

- Stratification variables according to the RTSM values as randomized:
    - Concurrent bevacizumab use (yes or no)
    - HRR mutation status (BRCAmut, BRCAwt HRRpos, BRCAwt HRRneg/not determined)
    - Disease burden as defined by Stage III cancer with residual disease <1 cm (i.e., yes or no)

- Stratification variables according to the actual values*:
    - Concurrent bevacizumab use (yes or no)
        - This information will be obtained from the bevacizumab study treatment eCRF form (bevacizumab use = yes for participants with any exposure to bevacizumab after randomization).
    - HRR mutation status (BRCAmut, BRCAwt HRRpos, BRCAwt HRRneg/not determined)
        - This information will be obtained from the ResBio results.

*Not relevant for disease burden for which the only data source is the RTSM

- A cross-tabulation of the RTSM stratification and the actual stratification for concurrent bevacizumab and HRR mutation status.

4.2.2. Medical Conditions

Medical conditions will be coded for the ITT population using the current MedDRA version, and the number and percentage of participants experiencing at least 1 such diagnosis by System Organ Class (SOC) and preferred term (PT) will be reported. Prior hematologic toxicity will be summarized for participants with any prior hematologic toxicity greater than or equal to CTCAE grade 3, graded using NCI CTCAE v4.03.

4.3. Efficacy Analyses

All efficacy analyses will be performed in the ITT analysis population (Arm 2, Arm 3) unless otherwise specified.

4.3.1. Primary Efficacy Endpoint

PFS CCI [redacted]
CCI [redacted]
CCI [redacted]. In other words, for each participant:

PFS (months) = (date of PD/death/censor – date of randomization +1)/30.4375

The PFS comparison between Arm 2 and Arm 3 will be performed using a stratified log-rank test with a 2-sided type I error rate of α=0.05. A stratified Cox proportional hazards model will be used to estimate the treatment effect by HR and its 95% CI. The strata as defined in Section 3.6 will be used.

The stratified log-rank test will be performed using SAS PROC LIFETEST. The HR with 2-sided 95% CI will be estimated using SAS PHREG procedure with ties=EXACT option in the model. In this analysis the baseline hazard function will be allowed to vary across strata; i.e., the MODEL statement will include treatment group variable as the only covariate and the STRATA statement will include the stratification factors.

Kaplan-Meier (KM) methodology will be used to estimate the distribution of PFS, including the quartiles (i.e., 25th percentile, median, 75th percentile) and associated 95% CIs using the Brookmeyer-Crowley method [Brookmeyer, 1982]. KM plots will be presented and will include the number of participants at risk over time by treatment group.

Summaries of the number and percentage of participants experiencing a PFS event vs those who were censored, and the reason for event (PD or death) or censoring (see possible reasons in censoring table) will also be provided.

The KM PFS rates at 6, 12, 24 and 36 months and their 95% CIs will be presented by treatment arm.

For the primary PFS analysis, the censoring rules described in Table 3 will apply. Adequate assessments are assessments that are not NE or missing.

In addition, a listing of efficacy data will be produced, presenting the primary PFS.

Table 3 Censoring Rules for Primary Analysis of PFS

Scenario	Event/Censor	Date of Event/Censor
No adequate baseline or post-baseline radiological tumor assessments[1] and no death	Censored	Date of randomization
No PD and no death	Censored	Date of last adequate radiological disease assessment
Start of subsequent anticancer therapy prior to PD/death[2]	Censored	Date of last adequate radiological disease assessment prior to start of subsequent anticancer therapy[2]
PD or death after ≤ 1 missed/inadequate radiological disease assessment	Event	Date of PD or death (whichever occurs first)
PD/death after ≥2 missed/inadequate consecutive radiological disease assessments (see section on extended time without a PFS assessment for calculation)	Censored	Date of last adequate radiological disease assessment prior to the consecutive missing assessments[3]

[1] Censoring for this scenario is done at randomization irrespective of receipt of new anticancer therapy.

[2] Any radiological disease assessments taking place on the same day as anticancer therapy, will be considered prior to the start of anticancer therapy.
[3] If no adequate radiological disease assessment prior to PD/death, censoring will occur at the date of randomization.
Note: Only anticancer therapy recorded on the follow-up anticancer therapy form is considered.

Extended time without a PFS assessment

Tumor assessments for all participants are required at Screening, C1D1 maintenance (+/-14 days), every 4 months (+/-7 days) for 24 months and every 6 months (+/-7 days) for 12 months and every 12 months thereafter. For IDS participants, an extra tumor assessment is required during the chemotherapy period and prior to IDS. If death or PD follow 2 missed consecutive visits, then PFS is censored at the time of the last adequate tumor assessment (LATA).

The definition of 2 missed/inadequate consecutive visits varies according to the scan schedule and is defined by matching the LATA prior to an event (PD/death) to a scheduled visit using the midpoint as described in Table 4. LATA before the midpoint is assigned to the scheduled visit prior to it. LATA after the midpoint is assigned to the scheduled visit after it.

Table 4 Tumor Assessment Windowing

Assessment Schedule **(excludes extra scan for IDS participants)**	**Scheduled visit -1-2 weeks (7-14 days)**	**Scheduled visit (from randomization)**	**Scheduled visit +1-2 weeks (7-14 days)**	**Midpoint (floor for non-integers)**
C1D1 maintenance	C1D1*-14 days	C1D1	C1D1+14 days	C1D1+2 months – 3 days
Every 4 months from C1D1 maintenance	C1D1+4 months-7 days	C1D1+4 months	C1D1+4 months+7 days	C1D1+6 months
	C1D1+8 months-7 days	C1D1+8 months	C1D1+8 months+7 days	C1D1+10 months
	C1D1+12 months-7 days	C1D1+12 months	C1D1+12 months+7 days	C1D1+14 months
	C1D1+16 months-7 days	C1D1+16 months	C1D1+16 months+7 days	C1D1+18 months

Assessment Schedule **(excludes extra scan for IDS participants)**	**Scheduled visit -1-2 weeks (7-14 days)**	**Scheduled visit (from randomization)**	**Scheduled visit +1-2 weeks (7-14 days)**	**Midpoint (floor for non-integers)**
	C1D1+20 months-7 days	C1D1+20 months	C1D1+20 months+7 days	C1D1+22 months
	C1D1+24 months-7 days	C1D1+24 months	C1D1+24 months+7 days	C1D1+27 months
Every 6 months from C1D1 maintenance +24 months until C1D1 maintenance + 36 months	C1D1+30 months-7 days	C1D1+30 months	C1D1+30 months+7 days	C1D1+33 months
	C1D1+36 months-7 days	C1D1+36 months	C1D1+36 months+7 days	C1D1+42 months
Every 12 months from C1D1 maintenance + 36 months	C1D1+48 months-7 days	C1D1+48 months	C1D1+48 months+7 days	C1D1+54 months
	C1D1+60 months-7 days	C1D1+60 months	C1D1+60 months+7 days	C1D1+66 months

*C1D1 = C1D1 maintenance (first maintenance dose date)

For cases where the LATA occurs on or after the maintenance treatment start date, an event occurring after LATA + T2 is considered to have occurred after 2 consecutive missed assessments, where T2 is defined as follows:

- If LATA prior to event is on or before C1D1 maintenance + 18 months, T2 = 4 months*2+21 days = 264 days

- If LATA prior to event is after C1D1 maintenance+18 months and on or before C1D1 maintenance +22 months, T2 = 4 months+6 months + 14 days= 318 days
- If LATA prior to event is after C1D1 maintenance +22 months, and on or before C1D1 maintenance +27 months, T2 = 6 months*2 +14 days= 379 days
- If LATA prior to event is after C1D1 maintenance +27 months, and on or before C1D1 maintenance +33 months, T2 = 6 months+12 months+14 days = 561 days
- If LATA prior to event is after C1D1 maintenance +33 months, T2 = 12 months*2 + 14 days = 744 days

For cases where the LATA occurs prior to the maintenance treatment start date or in the case where maintenance treatment start date is missing, the event occurring after LATA + 264 days is considered to have occurred after 2 consecutive missed assessments.

Duration of follow-up

PFS duration of follow-up will be estimated using the reverse Kaplan-Meier methodology, performed by reversing the censoring indicator used in the primary PFS analysis, i.e., "censored" becomes an "event" and vice versa. The distribution of duration of follow-up will be presented through quartiles (i.e. 25th percentile, median, 75th percentile), minimum and maximum.

4.3.1.1. Sensitivity Analyses

In addition to the primary PFS analysis, several sensitivity analyses will be performed. For each of the following sensitivity analyses, a PFS summary table will be produced with a stratified log-rank test (nominal p-value), HR and 95% CI with the same stratification factors as the primary analysis, unless indicated otherwise. The HRs and 95% CIs will be presented on a forest plot.

4.3.1.1.1. No censoring at follow-up therapy (SA1)

For the analysis, subsequent anticancer therapy will be ignored, i.e., PD or death after initiation will count as events. The censoring rules described in Table 5 will apply. Only CCI PDs that are recorded in the CCI evaluation eCRF form will be considered.

Table 5 PFS SA1 Censoring Rules

Scenario	Event/Censor	Date of Event/Censor
No adequate baseline or post-baseline radiological tumor assessments and no death	Censored	Date of randomization
No PD and no death	Censored	Date of last adequate radiological disease assessment
PD or death after ≤ 1 missed/inadequate radiological disease assessment	Event	Date of PD or death (whichever occurs first)
PD/death ≥ 2 missed/inadequate consecutive radiological disease assessments (see section on extended time without a PFS assessment for calculation)	Censored	Date of last adequate radiological disease assessment prior to the consecutive missing assessments

4.3.1.1.2. Initiation of follow-up therapy treated as an event (SA2)

For the analysis, initiation of first subsequent anticancer therapy will be considered as an event, the censoring rules described in Table 6 will apply. Only PDs recorded from CCI evaluation eCRF form will be considered. The PFS event date will be the earliest of the following event dates: PD per CCI, initiation of first subsequent anticancer therapy or death by any cause.

Table 6 PFS SA2 Censoring Rules

Scenario	Event/Censor	Date of Event/Censor
No baseline or post-baseline radiological tumor assessments, no death and no subsequent anticancer therapy	Censored	Date of randomization
No PD, no death, and no subsequent anticancer therapy	Censored	Date of last adequate radiological disease assessment
PD, death, or start of subsequent anticancer therapy[1] ≤ 1 missed/inadequate radiological assessment	Event	Date of PD, death or start of subsequent anticancer therapy (whichever occurs first)
PD/death/start of subsequent anticancer therapy ≥ 2 missed/inadequate consecutive radiological disease assessments (see section on extended time without a PFS assessment for calculation)	Censored	Date of last adequate radiological disease assessment prior to the consecutive missing assessments

[1] Any radiological disease assessments taking place on the same day as anticancer therapy, will be considered prior to the start of anticancer therapy.
Note: Only anticancer therapy recorded on the follow-up anticancer therapy form is considered.

4.3.1.1.3. Clinical disease progression treated as an event (SA3)

For this analysis, PD will include PD per CCI [redacted] by Investigator's assessment and disease progression per clinical criteria taken from the discontinuation of treatment eCRF page under reason for discontinuation = "disease progression per clinical criteria by Investigator".

The PFS event date will be the earliest of the following event dates: PD CCI [redacted] disease progression per clinical criteria or death by any cause.

The censoring rules used in the primary analysis will be applied.

4.3.1.1.4. Based on actual stratification levels (SA4)

The analysis will be conducted if there is >5% discordance between the RTSM and actual data for concurrent bevacizumab use or HRR mutation status. The censoring rules used in the primary analysis will be applied. The pooling strategy defined in Section 3.6 will be applied regardless of the resulting number of events per stratum in the actual strata.

The information for disease burden as defined by stage III cancer with residual disease <1cm (yes/no) can only be obtained from the RTSM and will be used in this analysis. For concurrent bevacizumab use, the actual values will be obtained from the bevacizumab study treatment eCRF form (bevacizumab use = yes for participants with any exposure to bevacizumab after randomization). For HRR mutation status, the actual values will be obtained from the ResBio results.

4.3.1.1.5. PD-L1 status as stratification factor (SA5)

PD-L1 status will be included within the strata for the stratified log-rank test and stratified Cox proportional hazards model (which will follow the pooling strategy defined in Section 3.6). The censoring rules used in the primary analysis will be applied.

4.3.1.1.6. Unstratified log-rank test (SA6)

An unstratified analysis will be conducted. The censoring rules used in the primary analysis will be applied.

4.3.1.1.7. Non-proportional hazards (SA7)

The proportional hazards assumption on which the previous analyses are based will be assessed by visual inspection of the KM curves and of a plot of log-log survival vs log time. If non-proportionality is indicated (possible due to e.g., dostarlimab exhibiting delayed effect), the time-dependency of the treatment effect will be further assessed by adding an interaction term of treatment by time in the Cox model. If the p-value for the interaction term is < 0.10, then the proportional hazards assumption is considered to not have been met and the methods outlined below will be applied to analyze the PFS data. These are applicable regardless of whether the hazards are proportional.

Restricted Mean Survival Time (RMST)
The treatment effect will be assessed through the RMST difference. The RMST [Royston, 2013] is a measure of average survival time within a specified time frame. It is estimated as the area under the survival curve for each treatment arm, from time 0 to a pre-defined time $\tau = \tau_0$, here defined as the minimum of the largest observed survival times between the treatment arms. The RMST can be interpreted as the expected survival time restricted to the common follow-up time $\tau = \tau_0$ among all participants. The estimated RMST for each treatment arm at time τ_0, the

difference in RMST and its 95% CI, together with the one-sided (nominal) p-value will be reported.

MaxCombo Test
The treatment effect will be assessed using the stratified MaxCombo test statistic and p-value. The stratified MaxCombo test statistic (Zmin) is the minimum of 4 correlated, stratified, Fleming-Harrington (FH) weighted log-rank test statistics. The FH statistics (G(0,0), G(1,0), G(0,1), G(1,1)) correspond to no event weighting (~log-rank test), early event weighting, late event weighting and middle event weighting. The p-value (nominal) for the MaxCombo test is obtained by integrating the 4-dimensional multivariate normal distribution with mean (0,0,0,0) and covariance matrix equal to V(G(0,0), G(1,0), G(0,1), G(1,1)) with respect to Zmin.

4.3.1.2. Subgroup Analyses

Subgroup analyses will be performed separately for the subgroups defined in Section 3.7. If there are <10 events for a particular subgroup level, then the subgroup level analysis will not be performed. Subgroup analyses controlling for or involving stratification factors will be based on the actual strata levels.

For each subgroup, HR and associated CI will be calculated from a stratified Cox proportional hazard model with treatment as the only covariate. When the subgroup is a stratification factor, the corresponding stratification factor will not be included in the stratified Cox proportional hazards model. The HRs and 95% CIs for each subgroup for both stratified (main) and unstratified (sensitivity) analyses will be presented on a forest plot including the HR and 95% CI for the overall group. If stratified analyses are not applicable for a subgroup level (per the pooling strategy defined in Section 3.6), then unstratified analyses will be conducted for all subgroup levels. Summaries of the number and percentage of participants experiencing a PFS event for each subgroup will be provided along with the median PFS by treatment group.

In addition, for the HRR ResBio test status and HRD Myriad test status subgroups KM descriptive statistics and plots may be presented for each subgroup level.

4.3.1.2.1. Supportive Subgroup Analyses

Shrinkage estimation
A supportive subgroup analysis using shrinkage estimation may be conducted to further assess the treatment effect across subgroups.

A Bayesian hierarchical model that assumes a universal treatment effect and accounts for both the within and between subgroup variability is used for the estimation. This is defined as:

1. Prior on between subgroup variance τ^2: τ ~ half-normal with parameter 1
2. Prior on treatment effect: $\mu \sim Normal(mean = 0, var = 14)$
3. Random subgroup treatment effect: $\mu_i \sim Normal(mean = \mu, var = \tau^2)$

4. Likelihood for data $y_i(logHR_i) \sim Normal(mean = \mu_i, var = \sigma_i^2)$ where $logHR_i$ and σ_i are the treatment effect and standard deviation estimated from the main frequentist model and i is the subgroup level indicator.

The median logHR and 95% credible intervals for each subgroup will be calculated from the resulting posterior distributions for μ_i and transformed to the HR scale to obtain the final estimates.

4.3.2. Secondary Efficacy Endpoints

4.3.2.1. OS

OS is defined as the time from the date of randomization to the date of death by any cause, i.e.:

OS (months) = (date of death/censor – date of randomization +1)/30.4375

Participants with no death will be censored at their last known alive date. The last known alive (LKA) date is calculated as the latest date available per participant within selected Study Data Tabulation Model (SDTM) data. The survival times for participants whose last known alive date or death date is after DCO will be censored at the date of DCO. Survival information captured while on study and retrieved post study discontinuation will be included in the calculation of OS.

Partial dates are to be excluded from the calculation of LKA date. Dates of data collection that may have been added to the database without a participant's presence, as well as dates related to medical disease history will be excluded. Further details can be found in the OPS.

OS will be analyzed using the same methodology as PFS, as described in Section 4.3.1. The KM OS rates at 6, 12, 24 and 36 months will be provided. In addition, OS will be presented in a listing of efficacy data.

Duration of follow-up
Time to OS follow-up will be estimated using reverse KM methodology, performed by reversing the censoring indicator, used in the OS analysis, i.e., "censored" becomes an "event" and vice versa. However, survival information retrieved post study discontinuation will be excluded. The distribution of time to OS follow-up will be presented through quartiles (i.e., 25th percentile, median, 75th percentile), minimum and maximum.

Subgroup/Sensitivity analyses
At the time of final OS analysis (approximately 60% maturity), the subgroup analyses detailed for PFS in Section 4.3.1.2 (including the supportive) will be repeated for OS. These analyses may also be conducted at the primary PFS analysis, if PFS statistical significance is met at that point.

A sensitivity analysis for non-proportional hazards will also be conducted if needed, per the criteria and methodology described in Section 4.3.1.1.7.

If there is imbalance in the first/second subsequent anticancer therapy types/regimens received between treatment arms, a sensitivity analysis using the Inverse Probability of Censoring Weighting (IPCW) or other appropriate methodology may be conducted. Details will be described in a separate document.

4.3.2.2. CCI [redacted] by BICR assessment

An analysis as described in Section 4.3.1 (primary only) but based on CCI [redacted] by BICR will be conducted. Reported p-values are nominal.

4.3.2.3. TFST

TFST is defined as the time from randomization until the start date of the first subsequent anticancer therapy or death by any cause, whichever occurs first, i.e.:

TFST (months) = (date of first subsequent anticancer therapy/death/censor–date of randomization+1)/30.4375

First subsequent anticancer therapy is defined as the earliest anticancer therapy on the follow-up anticancer therapy form.

TFST will be analyzed using the same methodology as described in Section 4.3.1 but following the event/censoring rules in Table 7. Reported p-values are nominal.

Table 7 TFST Censoring Rules

Scenario	Event/Censor	Date of Event/Censor
Death or initiation of first subsequent anticancer therapy	Event	Date of first dose of subsequent anticancer therapy or death (whichever occurs first)
No death, no initiation of first subsequent anticancer therapy	Censored	Last date known not to have received first subsequent anticancer therapy assumed to be the last known alive date if there is no evidence of initiation of first subsequent anticancer therapy up to that point

4.3.2.4. TSST

TSST is defined as the time from the date of randomization until the start date of the second subsequent anticancer therapy or death by any cause, whichever occurs first, i.e.:

TSST (months) = (date of second subsequent anticancer therapy/death/censor–date of randomization+1)/30.4375

Initiation of second subsequent anticancer therapy is defined as an anticancer therapy with a start date after the first subsequent anticancer therapy and a recorded PD on first subsequent anticancer therapy, as captured on the follow-up anticancer therapy eCRF form.

TSST will be analyzed using the same methodology as described in Section 4.3.1 but following the event/censoring rules in Table 8. Reported p-values are nominal.

Table 8 TSST Censoring Rules

Scenario	Event/Censor	Date of Event/Censor
Death or initiation of second subsequent anticancer therapy[1]	Event	Date of first dose of second subsequent anticancer therapy or death (whichever occurs first)
No death, no initiation of second subsequent anticancer therapy	Censored	Last date known not to have received second subsequent anticancer therapy assumed to be the last known alive date if there is no evidence of initiation of second subsequent anticancer therapy up to that point

[1]After a recorded PD on first subsequent anticancer therapy. Participants with multiple subsequent therapy start dates but without a PD on first subsequent anticancer therapy will be censored.

4.3.2.5. PFS2

PFS2 is defined as the time from the date of randomization until the date of PD per Investigator's assessment after starting follow-up anticancer therapy or death due to any cause, whichever occurs first, i.e.:

PFS2 (months) = (date of PD after initiating first subsequent anticancer therapy/death/censor–date of randomization+1)/30.4375

PFS2 will be analyzed using the same methodology as described in Section 4.3.1 but following the event/censoring rules in Table 9. Reported p-values are nominal. PD dates after initiation of first subsequent anticancer therapy will be obtained from the follow-up anticancer therapy eCRF form.

Table 9 PFS2 Censoring Rules

Scenario	Event/Censor	Date of Event/Censor
Death or PD after initiation of first subsequent anticancer therapy	Event	Date of PD after initiation of first subsequent therapy or death (whichever occurs first)
No initiation of first subsequent anticancer therapy, no PD after initiation of first subsequent anticancer therapy, no death	Censored	Last known alive date

4.3.2.6. ORR/DCR per RECIST v1.1 without confirmation by Investigator assessment

ORR per CCI [redacted] by Investigator assessment is defined as the proportion of participants with measurable disease at baseline achieving a BOR of CR or PR CCI [redacted] by Investigator assessment.

DCR per CCI [redacted] by Investigator assessment is defined as the proportion of participants with measurable disease at baseline achieving a BOR of CR, PR or SD per CCI [redacted] by Investigator assessment.

ORR and DCR without response (CR/PR) confirmation will be presented. ORR and DCR will be analyzed for participants with measurable disease at baseline. Analyses will also be presented by debulking surgery status at screening (IDS vs PDS vs non-surgical).

BOR is the best response recorded from the start of study treatment until PD per CCI [redacted] or initiation of subsequent anticancer therapy (as recorded on the follow-up anticancer therapy form), whichever occurs first. The number and percentage of participants achieving a BOR of each of the following CCI [redacted] categories will be summarized:

- CR
- PR
- SD
- PD
- Not Evaluable (NE)

- Not Applicable (NA)
    - For participants with no baseline/post-baseline assessments

Assessments of "No Disease (ND)" will be assigned as "CR" for the purposes of response evaluations. For SD to be assigned BOR, assessments must have met the SD criteria for a minimum interval of 12 weeks following randomization. If the minimum time for SD is not met, BOR will depend on the subsequent assessments. For example, if an assessment of PD follows the assessment of SD and SD does not meet the minimum time requirement, the best response will be PD. Alternatively, participants lost to follow-up after an SD assessment not meeting the minimum time criterion will be considered NE.

Participants included in the analysis with NE as BOR (including missing) will be assumed to be non-responders.

The point estimate and 95% exact CI for ORR and DCR will be summarized by treatment group using the Clopper-Pearson method. The stratified Mantel Haenzel (MH) method [Mantel, 1959] with Sato's variance estimator [Sato, 1989] will be used for a comparison of the ORR between the 2 treatment groups. The difference in ORR and its 2-sided 95% CI will be calculated using SAS PROC FREQ using the COMMONRISKDIFF(TEST=MH) option. The same approach will be used to compare DCR.

In addition, the overall response for each visit and the BOR will be included in the listing of efficacy data.

4.3.2.7. DOR CCI [redacted]

DOR is defined as the time from the first documented response (PR/CR) to the first documented disease progression per Investigator assessed CCI [redacted] or death by any cause in participants with measurable disease at baseline who responded to treatment, i.e.,

DOR (months) = (date of PD/death/censor–date of first documented response+1)/30.4375

The same censoring rules as those defined in Section 4.3.1 for PFS will be applied.

4.3.2.8. HRQoL

HRQoL assessments will be collected on the day of study treatment administration, prior to dosing and clinical procedures, during the chemotherapy treatment period at C1D1, Cycle 2/Day 1, and every 2 cycles thereafter (Cycle 4/Day 1, Cycle 6/Day 1) and during the Maintenance Treatment Period at Day 1 of every cycle (i.e., every 21 days ± 7 days) for the first 3 cycles, Day 1 of every 3 cycles (i.e., every 9 weeks ± 7 days) through 15 cycles, Cycle 17 and every 6 cycles thereafter until PD or end of study treatment. For participant who discontinue treatment, HRQoL assessments will be collected at the EOT Visit, 30 days (±7 days) Safety Follow-up Visit, 90-days (±14 days) Long-Term Follow-up Visit, and every 180 days (±14 days) thereafter, which continued until death or the end of study data collection. HRQoL assessments may occur remotely if the participant is no longer actively returning to the clinic.

4.3.2.8.1. Analysis population

All HRQoL analyses will be based on the ITT analysis population unless otherwise specified.

4.3.2.8.2. Description and Scoring of the EQ-5D-5L

EQ-5D was first developed to include three levels of severity in each of five dimensions (EQ-5D-3L) by EuroQol Group. This study used an updated version of the EQ-5D including five levels of severity in each of the existing five dimensions (EQ-5D-5L).

The five dimensions asking participant to rate their perceived health state today include: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Each item is reported on a Likert-type scale ranging from 1 to 5 with increasing levels of severity (no problems, slight problems, moderate problems, severe problems, and unable to/extreme problems). Table 10 details the response levels of the EQ-5D-5L descriptive system.

Table 10 Scores of EQ-5D-5L Descriptive System

Original Response Category	Score
No problems	1
Slight problems	2
Moderate problems	3
Severe problems	4
Unable to/Extreme problems	5

Note: Missing values is to be coded as 9. Ambiguous values (e.g., two boxes are ticked for a single dimension) should be treated as missing values.

A unique health state, the EQ-5D-5L profile, based on the five dimension is reported as a five-digit code with a possible total of 3,125 health states. For example, state 11111 indicates no problems on any of the five dimensions; versus, state 55555 indicates extreme problems on all five dimensions. Any missing items will be coded as "9" in creating participant profiles.

Generally, the EQ-5D-5L profile is converted into a weighted health state utility value, the EQ-5D HUI, by applying a country-specific valuation set to the profile that represents the comparative value of health states. The HUI values summarize how good or bad each health state is on a scale from 1 (full health) to <0 (worse health/dead). High HUI value indicates a good HRQoL, and low HUI indicates poor HRQoL. The EQ-5D index value is regarded as missing when responses are missing for one or more of the five dimensions. For the purposes of this analysis, the US Pickard value set will be used to calculate the HUI. [Pickard, 2019].

Using the weighted US scores in Table 11 [EuroQol, 2022], the following calculation is used for the HUI score:

$$\text{HUI Score} = 1 - (CS_1 + CS_2 + CS_3 + CS_4 + CS_5)$$

where CS1 to CS5 are the converted weighted US values for each of the 5 domains included in the HUI.

A VAS is collected separately and records the respondent's self-rated health on a vertical, visual analogue scale from 0 ('Worst imaginable health state') to 100 ('Best imaginable health state').

Table 11 US Weighted Scores of EQ-5D-5L Descriptive System

Dimension	Original Score	Weighted Score
CBI		

CCI

[redacted]

CBI

[redacted]

CCI

[redacted]

CCI

[redacted]

CCI

[redacted]

CBI

[redacted]

CCI

[redacted]

CCI

[redacted]

CCI

[redacted]

4.3.2.8.4. Statistical Methods for the PRO Analyses

General considerations

For continuous variables, summary statistics (the number of available observations, means, standard deviations, medians, minimums, maximums, first quartile Q_1, and third quartile Q_3) will be reported. For categorical variables, the frequency and percentage in each category will be displayed. Analyses will be summarized by treatment arm, unless otherwise specified. Statistical tests and 95% CIs will be 2-sided and have an associated alpha level of 0.05 unless otherwise specified. No adjustments for multiple testing or estimation will be used, so all p-values and 95% CIs will be considered nominal.

Only scheduled visits per protocol before EOT will be used in the by-visit analyses; unscheduled visit data collected after EOT will be included in the by-visit analysis after visit windowing in Section 3.11 has been applied. Only responses collected on the same visit and date will be used for deriving scale scores at each visit. If there are multiple assessments on the same visit a worst-case approach per domain will be used to select the worst questionnaire assessments for that domain.

HRQoL Compliance

Summary measures of the overall participant compliance rate, and the participant compliance rate over time will be derived for each HRQoL questionnaire. These will be based upon the following definitions:

- **Expected forms:** number of participants expected to complete a HRQoL form. Date of study discontinuation and/or date of death will be used to determine the last visit at which a participant is still expected under HRQoL follow-up.
- **Received forms**: number of participants with at least one PRO form received.
- **Evaluable forms**: number of forms with at least one non-missing scale or item, depending on the corresponding questionnaire's scoring instruction as defined in the SAP.
- **All questions completed:** number of participants with a post-baseline form fully completed (not completion rates for individual items).

- **Compliance rate by visit**: number of participants with an evaluable form at that visit, divided by the number of participants expected to complete the form at that visit, multiplied by 100.
- **Overall compliance rate**: number of participants with an evaluable baseline form and at least one evaluable post-baseline form, divided by the number of participants expected to complete the baseline form, multiplied by 100. The target for compliance for each HRQoL questionnaire is 90%.

The distribution of forms expected and the reasons for forms not expected will be reported at each visit. The following estimates will be provided to characterize the number of expected and not expected forms:

- PRO assessment forms expected
- PRO assessment forms not expected – due to death (while on study)
- PRO assessment forms not expected – due to study discontinuation (with reason other than death)
- PRO assessment forms not expected – time point not reached

Missing Data

PROs will be scored per their respective scoring manuals, with missing data handled as described in said manual. No other imputations will be performed. Analyses will include available observed data.

Absolute Scores and Changes from Baseline (descriptive)

For domains and scales, absolute scores and their changes from baseline will be summarized and plotted at each time point for:

- EQ-5D-5L: VAS and HUI scores
- EORTC-QLQ-C30: global health status/QoL scale, 5 functioning multi-scale scores (physical, role, cognitive, emotional and social), 3 multi-item symptom scales (fatigue, pain, and nausea and vomiting) and 6 single symptom scales (dyspnea, appetite loss, insomnia, constipation, diarrhea and financial difficulties).
- EORTC-QLQ-OV28 scale scores: 3 functional scales (body image, sexuality, and attitude to disease/treatment) and 5 symptom scales (abdominal/GI, peripheral neuropathy, hormonal/menopausal symptoms, other chemotherapy side effects, and hair loss).

Longitudinal Analysis for Change from Baseline

A mixed-effects model for repeated measures (MMRM) will be performed on change from baseline to compare treatment arms adjusting for correlations across multiple time points within a participant. MMRM will be presented for global health status/QoL, physical functioning, role functioning, fatigue, pain and appetite loss domains in EORTC-QLQ-C30 and the abdominal/gastrointestinal domain in EORTC-QLQ-OV28. The model will include treatment arm, scheduled visit, treatment arm-by-scheduled visit interaction, concurrent bevacizumab use (actual, yes or no), HRR mutation status (actual, BRCAmut or BRCAwt), surgical status (at the time of screening, PDS, planned IDS or inoperable) as explanatory variables, and baseline,

baseline-by-visit as covariates. Treatment, visit, treatment-by-visit interactions, planned IDS, bevacizumab use and HRR mutation status will be fixed effects in the model. All scheduled visits will be included apart from those with <25% data out of the total number of subjects within the population.

An unstructured covariance matrix will be used to model the between and within participant variance and the Kenward-Roger approximation will be used to estimate the degrees of freedom. Restricted maximum likelihood (REML) estimation will be used. If the fit of the unstructured covariance structure fails to converge, the following covariance structures *with participant as random effect in the model* will be used in order until convergence is reached: Toeplitz with heterogeneity (TOEPH) and Toeplitz (TOEP). If there are still issues with the fit of the model or the estimation of the treatment effects, no covariance structure will be specified, participant will be treated as a random effect.

Least square means by treatment arm and least square mean differences, together with their 95% CIs will be summarized and plotted over time. Overall, least square mean estimates and estimates of the treatment difference will be derived, representing the average treatment effect over visits, giving each visit equal weight.

Change from Baseline based on Minimal Clinically Important Threshold for the EORTC QLQ-C30 and the QLQ-OV28

The number and percentage of participants that have improved, remained stable or worsened with respect to a clinically meaningful change in EORTC QLQ-C30 and EORTC QLQ-OV28 will be reported by treatment arm and scheduled visit. [Osoba, 1998], estimated a change of 10 points as a meaningful change threshold (MCT) in QLQ-C30 scale scores. Therefore, for the QLQ-C30 scales, as well as the QLQ-OV28 functional symptom scales a 10-point change will be considered a clinically meaningful change as described in Table 14.

Table 14 Definition of Change from Baseline for EORTC QLQ-C30 and QLQ-OV28 Scales Based on Minimum Clinically Important Difference (MCID) Threshold

Definition	Description
For Global Health Status/QoL & function scales:	
• **Improved**	change from baseline ≥ 10 points
• **Stable**	-10 points < change from baseline < 10 points
• **Worsened**	change from baseline ≤ -10 points
For symptom scales	
• **Improved**	change from baseline ≤ -10 points
• **Stable**	-10 points < change from baseline < 10 points
• **Worsened**	change from baseline ≥ 10 points

4.3.3. PD-L1 Positive Participants

The following efficacy analyses, as described in the Sections above, will be conducted in the PD-L1 positive subgroup:

- PFS per CCI [redacted] by Investigator assessment
  - Forest plot of selected primary sensitivity analyses (SA1, SA4, SA7 RMST only)
  - Subgroup analyses (standard and shrinkage)
- PFS per CCI [redacted] by BICR assessment
- OS
- TFST
- TSST
- PFS2

4.3.4. Comparisons to Arm 1

Efficacy analyses (e.g., PFS, OS) comparing Arm 1 to Arm 2 and/or Arm3 may be conducted in appropriate populations (where data quality is not compromised by Arm 1 data collection limitations, e.g., BRCAwt participants who received bevacizumab). Stratified analyses will be controlled for applicable stratification factors depending on the populations analyzed.

4.4. Safety Analyses

The safety analyses will focus on the SAF population (Arm 1, Arm 2, Arm 3), maintenance period analyses will be based on the MSAF population, unless otherwise specified.

4.4.1. Treatment Exposure

Exposure data will be summarized by treatment arm and the Overall population, and study period as defined in Section 3.4.

All treatment exposure will be presented in a data listing, including any treatment deviations.

4.4.1.1. Niraparib/placebo Treatment Exposure

During the maintenance treatment period, starting at C2D1, niraparib/placebo is administered daily in 21-day cycles as CCI mg CCI for up to 3 years. Dose is based on the participant's actual body weight and platelet count. Participants with an actual body weight of ≥ 77 kg and platelet count ≥ 150,000 /µL will take CCI mg/day. Those with an actual body weight < 77 kg and/or a platelet count of < 150,000 /µL will take CCI mg/day.

The following parameters for niraparib/placebo treatment exposure will be summarized as continuous variables (only relevant to the maintenance period):

- **Duration of exposure (months),** defined as the [last dose date – first dose date + 1] / 30.4375. Last dose date equals last dose date for participants who have discontinued treatment but accounts for the last dispensation cycle for ongoing participants.
- **Number of cycles** is based on the last available exposure visit assigned and will be summarized as a continuous variable.
- **Cumulative dose (mg)** is the total number of CBI consumed multiplied by the dosage (mg). Total number of CCI consumed is the sum of the number of CCI dispensed minus the sum of the number of CCI returned by the participant during the study.
- **Dose intensity (mg/day)**, defined as sum of the daily doses consumed divided by duration of exposure (converted to days).
- **Relative dose intensity (RDI; %),** defined as dose intensity (mg/day) divided by intended dose intensity (mg/day) multiplied by 100, where intended dose intensity is the first intended starting dose CCI mg/day or CCI mg/day).

4.4.1.2. Dostarlimab/placebo Treatment Exposure

During the chemotherapy treatment period, dostarlimab/placebo is dosed at CCI mg on D1 of a 21-day cycle starting with C2, via a CCI [redacted]. Administration will continue throughout the chemotherapy treatment period to the maintenance treatment period.

During the maintenance treatment period, dostarlimab/placebo is dosed at CCI mg on D1 of a 42-day cycle (i.e. every 6 weeks) beginning with the C1 of the maintenance period, via a CCI CCI [redacted]

The following parameters for dostarlimab/placebo treatment exposure will be summarized as continuous variables:

- **Duration of exposure (months)** will be summarized as follows:
    - Chemotherapy period: (date of last dose of treatment in the chemotherapy period – date of first dose of treatment + 21)/30.4375
    - Maintenance period: (date of last dose of treatment in the maintenance period – date of first dose treatment in the maintenance period + 42)/30.4375
    - Overall period:
        - For participants who did not receive maintenance treatment: (date of last dose of treatment – date of first dose of treatment + 21)/30.4375
        - For participants who received maintenance treatment: (date of last dose of treatment – date of first dose of treatment + 42)/30.4375
- **Number of cycles** is based on the last available exposure visit assigned and will be summarized as a continuous variable.
- **Cumulative dose (mg)** is calculated as the sum of all doses actually infused.
- **Dose intensity (mg/wk)** is calculated as the cumulative dose divided by duration of exposure (converted to weeks).
- **RDI (%)** is calculated as dose intensity (mg/wk) divided by intended dose intensity (mg/wk) multiplied by 100, where intended dose intensity is CCI mg/wk during the chemotherapy treatment period, and CCI mg/wk during the maintenance period.

4.4.1.3. Chemotherapy/Bevacizumab Treatment Exposure

The chemotherapy/bevacizumab treatment exposure will be summarized as follows:

- **Duration of exposure (months),** defined as (date of last dose of any chemotherapy/bevacizumab treatment – date of first dose of any chemotherapy/bevacizumab treatment + 21)/30.4375, summarized as a continuous variable (for bevacizumab both chemotherapy and maintenance periods are relevant)
- **Number of cycles** will be summarized as a continuous variable
    - For paclitaxel and carboplatin number of cycles reached is based on the last available exposure visit assigned

  - For bevacizumab, docetaxel and cisplatin number of cycles is based on the number of exposure visits with valid dosage.

- **Cumulative dose (mg/m^2** for paclitaxel/docetaxel/cisplatin**, mg** for carboplatin, **mg/kg** for bevacizumab**)** is calculated as the sum of all doses actually infused.
- **Dose intensity (mg/m^2/wk** for paclitaxel/docetaxel/cisplatin**, mg/wk** for carboplatin**, mg/kg/wk** for bevacizumab**)** is calculated as the cumulative dose divided by duration of exposure (converted to weeks)
- **RDI (%)** is calculated as dose intensity divided by intended dose intensity multiplied by 100.
  - For paclitaxel, cisplatin, docetaxel intended dose intensity (mg/m2/wk) is calculated as (intended starting dose level/3)/body surface area. Body surface area is taken as collected in the study treatment eCRF pages at first dose of the study treatment. Intended starting dose level is taken as the first intended dose on or after randomization. Further details on intended dose level may be found in the study protocol.
  - For carboplatin, intended dose intensity (mg/wk) is calculated by converting the intended dose unit from area under curve (AUC) to mg using Calvert's formula [van Warmerdam, 1995] then dividing by 3:
    - Intended dose (mg) = Intended dose (AUC) * (GFR + 25), where GFR = 0.85 * (140 – age in years) * weight in kg / (72 * serum creatinine (mg/dL)) [Stevens, 2006]
    - Intended dose intensity (mg/week) = Intended dose (mg)/3
  - For bevacizumab, intended dose intensity is (7.5/3) mg/kg/wk or (15/3) mg/kg/wk (intended dose level as collected in the bevacizumab study treatment eCRF page at first dose of the study treatment)

Bevacizumab treatment exposure will be presented in a summary table for the chemotherapy, maintenance, and overall period. Carboplatin and paclitaxel treatment exposure will be presented in a summary table for the chemotherapy period. Cisplatin and docetaxel treatment exposure will be presented in a data listing.

4.4.1.4. Overall Treatment Exposure

The overall treatment exposure will be summarized for the overall period only as follows:

- **Duration of exposure (months)**, defined as maximum exposure, i.e., from the first dose of any study treatment to the max(last dose date + 1 cycle of any study treatment), summarized as a continuous variable.
- **Number of cycles** will be summarized as a continuous variable.

4.4.1.5. Dose/infusion Interruptions

Dose interruption refers to temporarily halting niraparib/placebo treatment to manage adverse events during oral study drug administration.

Infusion interruption refers to halting treatment (dostarlimab/placebo, carboplatin, paclitaxel or bevacizumab) to manage reactions occurring during IV administration.

For both dose (niraparib/placebo) and infusion (dostarlimab/placebo, carboplatin, paclitaxel, bevacizumab) interruptions the number and percentage of participants with an interruption will be summarized alongside the categories for interruptions (0, 1, 2 and 3 or more). In addition, the number and percentage of reason for interruption will be presented, participants may be present in multiple categories.

Infusion interruptions will be presented for the chemotherapy, maintenance and overall period.

Any infusion interruptions for cisplatin and docetaxel will be presented in a data listing.

4.4.1.6. Dose Reductions

The number and percentage of participants with a niraparib/placebo dose reduction will be summarized, alongside the categories (1, 2 and 3 or more) for reductions. In addition, the number and percentage of reason for reductions will be presented, participants may be present in multiple categories.

4.4.1.7. Infusion Delays

Infusion delay refers to delay in IV administration greater than 3 days (of dostarlimab/placebo, carboplatin, paclitaxel or bevacizumab). The number and percentage of participants with an infusion delay (dostarlimab/placebo, carboplatin, paclitaxel, bevacizumab), the number and percentage with 0, 1, 2 and 3 or more infusion delays, number and percentage of delays categorized by delay duration in days (<21, 21-42, >42) and reasons for infusion delay will be summarized.

Infusion delays will be presented for the chemotherapy, maintenance and overall period.

Any infusion delays for cisplatin and docetaxel will be presented in a data listing.

4.4.2. Adverse Events

4.4.2.1. Overview

All AEs will be coded using the current MedDRA version. The severity of toxicity will be graded according to NCI CTCAE v4.03. The relationship of each AE to study treatment component will be assessed by the Investigator. All AEs for which the relationship to study treatment is missing will be considered as related.

If the "seriousness" flag is missing from the AE eCRF page, but "reason for considering event as serious" is provided, the AE will be assumed to be serious.

AE summaries will be sorted by descending overall frequency, by SOC and PT unless otherwise specified. For by-maximum grade summaries, participants experiencing the same AE multiple times with different grades will only be counted once under the maximum recorded.

AE summaries will only consider TEAEs, unless clearly indicated otherwise. TEAEs are defined as AEs with start date on or after the initiation of study treatment and within 90 days after the last dose of study treatment or initiation of subsequent anticancer therapy, whichever occurs first. AEs with a missing start date and either a missing stop date, or a stop date on or after the initiation of study treatment are considered to be TEAEs with start dates falling in the overall and chemotherapy treatment periods. For analysis purposes, TEAEs will be further classified into periods of occurrence, per the flag definition in Section 3.4.

The data will be summarized by treatment arm (Arm 1, Arm 2, Arm 3, Overall), period of occurrence and for the overall treatment regimen, unless otherwise specified. For any summary tables presented by bevacizumab use (Overall, Received Bevacizumab, Did Not Receive Bevacizumab), the bevacizumab categories will be determined from exposure data with participants classed as having received bevacizumab if they have received at least one dose of bevacizumab on the study after randomization.

The following summary tables will be provided:

- Overview of TEAEs for the overall treatment regimen only
- Presented by bevacizumab use
- Including the number and percentages of participants with the following:
    - TEAEs
    - TEAEs grade ≥ 3
    - TEAEs related to any treatment
    - TEAEs related to dostarlimab/placebo
    - TEAEs related to niraparib/placebo
    - TEAEs related to any treatment grade ≥ 3
    - TEAEs related to dostarlimab/placebo grade ≥ 3
    - TEAEs related to niraparib/placebo grade ≥ 3
    - Treatment-emergent serious adverse events (TESAEs)
    - TESAEs related to any treatment
    - TESAEs related to dostarlimab/placebo
    - TESAEs related to niraparib/placebo
    - TEAEs leading to any infusion interruption
    - TEAEs leading to dostarlimab/placebo infusion interruption
    - TEAEs leading to niraparib/placebo dose interruption

  - TEAEs leading to any infusion delay
  - TEAEs leading to dostarlimab/placebo infusion delay
  - TEAEs leading to any treatment discontinuation
  - TEAEs leading to dostarlimab/placebo treatment discontinuation
  - TEAEs leading to niraparib/placebo treatment discontinuation
  - TEAEs leading to any treatment dose reduction
  - TEAEs leading to niraparib/placebo dose reduction
  - TEAEs leading to death
  - Treatment-related TEAEs leading to death
  - Treatment-emergent immune-related AEs
  - Treatment-emergent AESIs related to niraparib/placebo
- TEAEs by SOC, PT and maximum grade
  - Presented by bevacizumab use
- TEAEs related to any treatment by SOC, PT and maximum grade
  - Presented by bevacizumab use
  - Related to any treatment includes any drug that can be taken throughout the treatment period, including: carboplatin, paclitaxel, bevacizumab, docetaxel, cisplatin, dostarlimab/placebo and niraparib/placebo.
- TEAEs related to dostarlimab/placebo by SOC, PT, and maximum grade
- TEAEs related to niraparib/placebo by SOC, PT, and maximum grade (relevant to the maintenance treatment period only)
- TEAEs related to chemotherapy/bevacizumab by SOC, PT, and maximum grade in the chemotherapy period
  - Chemotherapy includes any of the following drugs: carboplatin, paclitaxel, docetaxel and cisplatin
- TEAEs leading to discontinuation of any treatment by SOC and PT
  - Presented by bevacizumab use
- TEAEs leading to dostarlimab/placebo discontinuation by SOC and PT
- TEAEs leading to niraparib/placebo discontinuation by SOC and PT (relevant to the maintenance treatment period only)
- Treatment related TEAEs leading to discontinuation of any treatment by SOC and PT
  - Presented by bevacizumab use
- Dostarlimab/placebo related TEAEs leading to dostarlimab/placebo discontinuation by SOC and PT

- Niraparib/placebo related TEAEs leading to niraparib/placebo discontinuation by SOC and PT (relevant to the maintenance treatment period only)
- TEAEs leading to any infusion interruption by SOC and PT
- TEAEs leading to dostarlimab/placebo infusion interruption by SOC and PT
- TEAEs leading to niraparib/placebo dose interruption by SOC and PT (relevant to the maintenance treatment period only)
- TEAEs leading to any treatment dose reduction by SOC and PT (relevant to the overall and chemotherapy period only)
- TEAEs leading to niraparib/placebo dose reduction by SOC and PT (relevant to the maintenance treatment period only)
- TEAEs leading to any infusion delay by SOC and PT
- TEAEs leading to dostarlimab/placebo infusion delay by SOC and PT
- Common (≥5% overall) TEAEs by PT in the overall treatment period
- Common (≥5% in either treatment arm) non-serious TEAEs by SOC and PT (number of participants and occurrences) in the overall treatment period
- Non-Serious TEAEs related to any treatment by PT in the overall treatment period
- TESAEs by SOC, PT, and maximum grade
    - Presented by bevacizumab use
- TESAEs by SOC, PT (number of participants and occurrences) in the overall treatment period
    - Presented by bevacizumab use
- TESAEs related to any treatment by SOC, PT and maximum grade
    - Presented by bevacizumab use
- TESAEs related to dostarlimab/placebo by SOC, PT and maximum grade
    - Presented by bevacizumab use
- TESAEs related to niraparib/placebo by SOC, PT and maximum grade (relevant to the maintenance treatment period only)
- Fatal and non-fatal TESAEs related to any treatment by PT in the overall treatment period
    - Presented by bevacizumab use
    - Related fatal AEs are recorded on the AE eCRF page as a serious AE due to death and recorded as an AE related to treatment.
- Fatal and non-fatal TESAEs related to dostarlimab/placebo by PT in the overall treatment period
- Fatal and non-fatal TESAEs related to niraparib/placebo by PT (relevant to the maintenance treatment period only)

- irTEAEs by group category, PT and maximum grade
- The following will be presented in the maintenance treatment period
    - TEAESIs by group category, PT and maximum grade
    - TEAEMIs by group category, PT and maximum grade
        - Presented by bevacizumab use
- Infusion-related reactions (IRRs) by PT and maximum grade
- Dostarlimab-related IRRs by PT and maximum grade
- All AESIs by group category, PT and maximum grade (SAF analysis population, includes all AEs, not just TEAEs)

In addition, an AE listing containing all AEs and a death subject profile on the enrolled population will be provided.

Additional adverse event summaries may be provided for the purposes of disclosure summaries and will be described in a separate document.

4.4.2.2. Adverse Events of Special Interest

Table 15 outlines the AESIs for the study, with the criteria of mapping MedDRA PTs for each AESI using Standardized MedDRA Queries (SMQs), High Level Terms (HLTs) and/or PTs. The associated SMQs will be obtained from the latest MedDRA dictionary, these will then be reviewed by the safety team before being used in the analysis.

Table 15 Adverse Events of Special Interest

Group Term	MedDRA Criteria for Selection of Preferred Terms
MDS/AML	Myelodysplastic syndrome (SMQ Narrow) Leukemias acute myeloid (HLT)
Second primary malignancies other than MDS/AML	• Hematological malignant tumor (SMQ Narrow) • Non-haematological malignant tumors (SMQ Narrow) Selected PTs not considered a second primary malignancy will be flagged and removed upon clinical/safety team review.

Abbreviations: AML = acute myelogenous leukemia; HLT = high level terms; MDS = myelodysplastic syndrome; MedDRA = Medical Dictionary for Regulatory Activities; PT = preferred term; SMQ = Standardized MedDRA Query.

4.4.2.3. Adverse Events of Medical Interest

The AEMIs will be summarized in a similar manner as the AESIs. Table 16 outlines the AEMIs with their associated SMQs and/or PTs. The associated SMQs will be obtained from the latest MedDRA dictionary, these will then be reviewed by the safety team before being used in analysis.

Table 16 Adverse Events of Medical Interest

Group Term	MedDRA Criteria for Selection of Preferred Terms
Thrombocytopenia events	Haematopoietic thrombocytopenia (SMQ Broad)
Anemia events	Haematopoietic erythropenia (SMQ Broad)
Leukopenia events	Haematopoietic leukopenia (SMQ Narrow)
Neutropenia events	Selected PTs considered in clinical/safety team review as related to neutropenia in the Haematopoietic leukopenia (SMQ Narrow)
Pancytopenia events	Haematopoietic cytopenias affecting more than one type of blood cell (SMQ Broad)
Hypertension events	Hypertension (SMQ Narrow)

Abbreviations: MedDRA = Medical Dictionary for Regulatory Activities; PT = preferred term; SMQ = Standardized MedDRA Query.

4.4.2.4. Immune-Related Adverse Events

The irAEs include any Grade≥2 TEAEs related to dostarlimab/placebo identified by a GSK MedDRA query (GSKMQ) using the GSK Terms of Interest (TOI) codes outlined in Table 17.

Table 17 irAE GSKMQ TOI Codes

TOI Code	TOI Category Name
322658	Hypersensitivity
322659	Immune-mediated cardiovascular
322660	Immune-mediated endocrinopathies
322661	Immune-mediated Gastrointestinal
322662	Immune-mediated hematologic
322663	Immune-mediated hepatic
322664	Immune-mediated musculoskeletal
322665	Immune-mediated nervous system
322666	Immune-mediated ocular
322667	Immune-mediated Others
322668	Immune-mediated pancreatitis
322669	Immune-mediated Pulmonary
322670	Immune-mediated renal
322671	Immune-mediated skin adverse reactions

4.4.2.5. IRRs

IRRs include AEs related to any infusion which occurred on the same or the day after infusion and are identified by a CMQ using the TOI code outlined in Table 18.

Table 18 IRR CMQ TOI Code

TOI Code	TOI Category Name
323695	Infusion-related reactions

4.4.3. Deaths

All deaths will be summarized. The summary will include status (death, alive at last contact, follow-up ended, follow-up ongoing), primary cause of death and number of deaths relative to the last dose of study treatment (>30 days or ≤ 30 days). Both deaths captured while on study and those retrieved post study withdrawal will be included in the output.

4.4.4. COVID-19

COVID-19 data will be summarized by treatment arm (Arm 1, Arm 2, Arm 3, Overall) unless otherwise specified within the overall study treatment period as defined in Section 3.4.

COVID-19 assessments will be presented for any participant with a suspected, probable, or confirmed COVID-19 case diagnosis from the COVID-19 eCRF. Data will be presented in a summary table providing the number of participants with a COVID-19 case diagnosis, the number of events, the worst case COVID-19 case diagnosis, whether a COVID-19 test was performed and the results from the test.

4.4.5. Laboratory Data

Laboratory data will be summarized by treatment arm (Arm 1, Arm 2, Arm 3, Overall) for chemotherapy and overall treatment periods, as defined in Section 3.4 unless otherwise specified. This will include the analyses of chemistry, hematology, coagulation and urinalysis and other screening laboratory tests. Hematology tests will also be presented for the maintenance period and by bevacizumab use. Descriptive statistics (mean, standard deviation, median, Q_1, Q_3, min and max) will be used to summarize change from baseline in observed value according to the largest increase, decrease, and at EOT.

Summaries of worst-case grade increase from baseline grade will be provided for all the laboratory tests that are gradable by CTCAE v4.03. These summaries will display the number and percentage of participants with a maximum post-baseline grade increasing from their baseline grade (e.g., Increase to Grade 1, Increase to Grade 2, Increase to Grade 3, Increase to Grade 4) and maximum grade increase subtotals (e.g., Increase to Grades 1 to 4, Increase to Grades 2 to 4, Increase to Grades 3 to 4). Missing baseline grade is assumed to be grade 0. For laboratory tests that are graded for both low and high values, summaries will be done separately and labelled by direction, e.g., sodium will be summarized as hyponatremia and hypernatremia separately.

Shifts from baseline CTCAE grade to the worst-case post-baseline CTCAE grade will also be provided for chemistry and hematology.

For laboratory tests that are not gradable by CTCAE v4.03, summaries of worst-case changes from baseline with respect to normal range will be generated as required as per collected data. Decreases to low, changes to normal or no changes from baseline, and increases to high will be summarized for the worst-case post-baseline. If a participant has a decrease to low and an increase to high during the same time interval, then the participant is counted in both the “To Low” categories and the “To High” categories. Missing baseline value is assumed to be normal.

The calculation of worst-case will use both scheduled and unscheduled visits.

A summary of hepatobiliary laboratory assessments will be provided, as alkaline phosphatase (ALP) is not collected, ALP criteria will not be included in the summary.

In addition, scatter plots will be produced for the following in the overall treatment period:

- Maximum post-baseline vs baseline for ALT
- Maximum total bilirubin post-baseline vs maximum ALT post-baseline.

A listing of all laboratory values on the safety population will be provided.

4.4.6. Vital Signs

Vital signs data will be summarized by treatment arm (Arm 1, Arm 2, Arm 3, Overall) for the chemotherapy, maintenance and overall treatment periods, as defined in Section 3.4 unless otherwise specified. Change from baseline for vital signs parameters (systolic and diastolic blood pressure, pulse rate, temperature and weight) will be summarized and analyzed according to the largest increase, decrease, and at the EOT, irrespective of scheduled or unscheduled visit.

A worst-case post-baseline blood pressure summary table of the number and percent of participants categorized as low or high according to the below criteria will be presented. If a participant has a decrease to low and an increase to high during the same time interval, then the participant is counted in both the "To Low" categories and the "To High" categories.

- Systolic blood pressure (SBP) (mmHg):
  - Low: <90 and decrease from baseline ≥20
  - High: >160 and increase from baseline ≥20
- Diastolic blood pressure (DBP) (mmHg):
  - Low: <50 and decrease from baseline ≥10
  - High: >100 and increase from baseline ≥10

The calculation of worst-case will use both scheduled and unscheduled visits.

A listing of all vital sign measurements on the safety population will be provided.

4.4.7. ECOG Performance Status

ECOG performance status data will be summarized by treatment arm (Arm 1, Arm 2, Arm 3, Overall) for the overall treatment period, as defined in Section 3.4 unless otherwise specified.

A summary of change from baseline for worst-case post baseline for ECOG performance status will be performed. The calculation of worst-case will use both scheduled and unscheduled visits. Change categories will be presented as improved (any decrease in ECOG performance grade), no change and deteriorated (any increase in ECOG performance grade).

4.4.8. Pregnancy

Participant level data of participants who became pregnant during the study may be explored in the RAPIDO DV.

4.4.9. Prior and Concomitant Medications and Surgical Procedures

All medications will be coded using the WHO Drug dictionary.

Medication start and stop dates will be compared to the date of first dose of study drug to allow medications to be classified as either prior or concomitant medications.

Prior, concomitant medications and surgical procedures will be summarized by treatment arm (Arm 1, Arm 2, Arm 3, Overall).

Prior medications are defined as medications other than study treatment with end date prior to the first dose of study treatment.

Concomitant medications are defined as medications other than study treatment with at least one dosing date on or after the date of first dose of study treatment, but not more than 90 days after the last dose of study treatment or initiation of subsequent anticancer therapy, whichever occurs first.

If start date is prior to study treatment start date and stop date is either missing or after initiation of study treatment then the medication is assumed to be "concomitant". If both start and stop dates are missing for a medication, it will be assumed to be "concomitant".

The following will be provided:

- Summary of Prior Medications by ingredient
- Summary of Concomitant Medications by ingredient

Concomitant surgical procedures are defined as all procedures reported on the concomitant procedure eCRF. These will be coded using the current MedDRA version, and the number and percentage of participants with at least one such procedure will be reported by indication and PT.

In addition, a listing of concomitant medications (including prior medications) will be produced.

4.4.10. Follow-Up Anticancer Therapies

The following data are collected in the eCRF for follow-up anticancer therapy (FUACT): name of drug (and/or class), start and stop date, PD date, and best response.

Lines of FUACT are determined for each participant based on the reported start date(s) therapies and the reported PD date(s) after the start of any FUACT.

If there are one or more PD dates, all the reported FUACT will be grouped into lines of therapies by comparing their reported start dates to the reported PD dates. FUACT starting prior to the first PD date and following the start of any FUACT are grouped as the "first-line" of FUACT. FUACT starting after the first PD date and prior to the second PD date are grouped as the "second line" of FUACT, and so forth. If no PD date is reported after initiating FUACT, all reported FUACT will be grouped as the "first-line" of FUACT.

Any radiological disease assessments taking place on the same day as anticancer therapy, will be considered to have occurred prior to the start of the line of FUACT.

For each line of FUACT, the start date of the line is the earliest start date of any reported FUACT in the line and the stop date of the line is the latest stop date of any FUACT in the line. Reported follow-up anticancer therapy will be summarized by the following for all participants and PD-L1 positive participants:

- Any follow-up anticancer therapy
    - Number and percentage of participants receiving any follow-up anticancer therapy
- Any follow-up radiotherapy (yes or no)
- Number of lines of follow-up anticancer therapies (1, 2 or ≥3 lines)
- Follow-up anticancer therapies
    - Number and percentage of participants reported by type and PT

The follow-up anticancer therapies will be summarized for first line of follow-up anticancer therapy and any line of follow-up anticancer therapy, according to a categorization list that will be provided in a separate document.

4.5. Pharmacokinetic Analysis

CCI

[redacted]

4.6. Immunogenicity Analysis

CCI

[redacted]

CCI

[redacted]

CCI [redacted]

4.7. Interim Analyses

Planned periodic safety analyses will be conducted by the Independent Data Monitoring Committee (IDMC) CCI [redacted]
CCI [redacted]

CCI [redacted]

4.8. Changes to Protocol Defined Analyses

There were no changes or deviations to the planned statistical analysis specified in FIRST Protocol V9.0 (Amendment 7).

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6. SAP AMENDMENT SUMMARY OF CHANGES

Version 6.0 (Amendment 5):

- Updates to address dry run comments including:
  - Removal of unknown PD-L1 category in PD-L1 subgroup analyses and identification of 1% cut-off as exploratory
  - Removal of NA category in residual disease following PDS according to the ovarian cancer history eCRF subgroup analyses
- Correction of SAP amendment summary of changes for completeness

Version 5.0 (Amendment 4):

- Updates consistent with protocol amendment 7.0 including:
  - Removal of PFS per CCI [redacted] in PD-L1 positive participants for the primary objective
  - Update to the hierarchical testing strategy to follow PFS per CCI [redacted] in all participants followed by OS in all participants.
  - Update to sample size determination and power, the number of events has changed from 278 PFS events in the PD-L1 positive population to 692 PFS events in Arms 2 and 3.
  - Update to the exploratory objective to include all Arm 1 vs Arm 2 participants.
  - Update to adjustments for covariates/stratification factors to use a pooling strategy focused on the ITT population
- Various updates to clarify which outputs will be produced on ITT and PD-L1 positive populations.
- Editorial, administrative and formatting revisions as needed throughout.

Version 4.0 (Amendment 3)

- Update to HRQoL Compliance to reflect latest guidance that target compliance for each instrument is 90%

Version 3.0 (Amendment 2):

- Multiple analysis clarified and re-reviewed by the team throughout the SAP
- Additional statements and/or sections added throughout the document, including:
  - Addition of PD-L1 TAP≥1% subgroup
  - Additional statement on ITT population to ensure participants with death prior to randomization are not included

  - Addition of mSAF population
  - Additional section on analysis periods, for additional clarity for different analyses such as lab, vital signs, concomitant medications
  - Addition of DOR
  - Section 3.6 added for adjustments for covariates/stratification factors
  - Section added for sensitivity analysis non-proportional hazards including the MaxCombo and RMST
  - Section added for supportive analysis, shrinkage estimation
  - Sections added for chemotherapy and bevacizumab treatment exposure, dose/infusion interruptions, dose reductions and infusion delays
  - Sections added for further detail on COVID-19 and pregnancy
  - Update to primary analysis PFS censoring rules, particularly around missed assessments, with further details added on tumor assessment windowing.
- Removal of statements and/or sections, including:
  - Maintenance progression free survival (mPFS)
  - Electrocardiograms (ECGs)
  - Removal of PD-L1 safety outputs, no current assumption the safety profile is to change between the ITT and PD-L1 populations
  - Removal of PP population
  - Removal of clinical PDs as an event in the primary analysis and inclusion in the sensitivity analysis to include clinical PDs

Version 2.0 (Amendment 1):

- Scope of safety analysis expanded to provide a more comprehensive summary (by treatment arm, population (PD-L1 vs Overall), bevacizumab use, and treatment period)
- Minor language updates and corrections for clarity
- Electrocardiogram (ECG) listing removed as this data is only collected at screening
- mPFS and DOR added as secondary endpoints, and PFS of Arm 1 vs Arm 2 *BRCA*wt participants who receive bevacizumab added as exploratory endpoint to align w/ protocol
- Statement about TAP cutoff for determination of PD-L1 status added
- Common AE cutoff changed from 10% to 5% to reflect current disclosure conventions
- Scope of PRO analysis expanded to reflect regulatory expectations