



## CLINICAL STUDY PROTOCOL

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**Study Title:** A Phase 2, Randomized, Double-Blind, Placebo Controlled Study Evaluating the Safety, Tolerability, and Efficacy of GS-9674 in Subjects with Primary Sclerosing Cholangitis Without Cirrhosis

**Sponsor:** Gilead Sciences, Inc.  
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**IND Number:** 131031

**EudraCT Number:** 2016-002442-23

**Clinical Trials.gov Identifier:** Not Available

**Indication:** Primary Sclerosing Cholangitis (PSC)

**Protocol ID:** GS-US-428-4025

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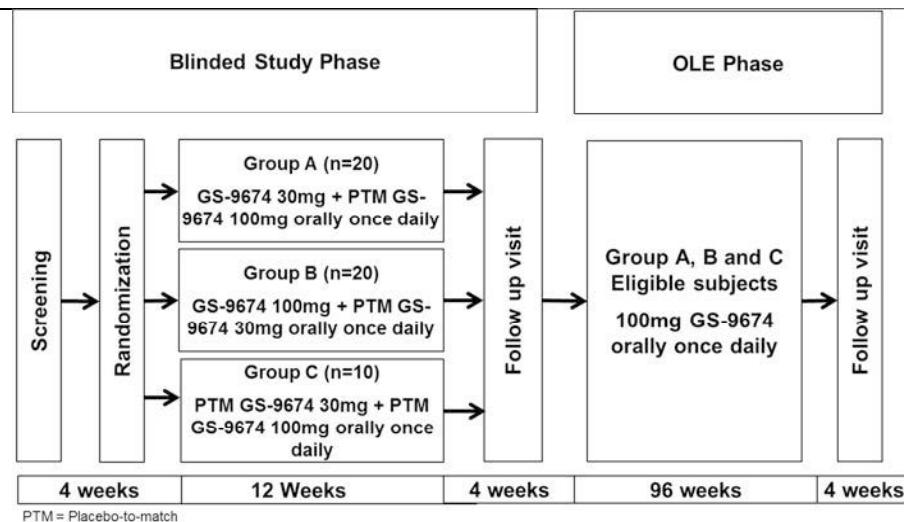
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## PROTOCOL SYNOPSIS

**Gilead Sciences, Inc.**  
**333 Lakeside Drive**  
**Foster City, CA 94404, U.S.A.**

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<b>Study Title:</b>	A Phase 2, Randomized, Double-Blind, Placebo Controlled Study Evaluating the Safety, Tolerability, and Efficacy of GS-9674 in Subjects with Primary Sclerosing Cholangitis Without Cirrhosis
<b>IND Number:</b>	131031
<b>EudraCT Number:</b>	2016-002442-23
<b>Clinical Trials.gov Identifier:</b>	Not Available
<b>Study Centers Planned:</b>	Approximately 30 centers in North America and Europe
<b>Objectives:</b>	<p>The primary objective of this study is to evaluate the safety and tolerability of GS-9674 in subjects with primary sclerosing cholangitis (PSC)</p> <p>The exploratory objectives of this study are listed in Section 2.</p>
<b>Study Design:</b>	<p>This is a Phase 2 randomized, double-blind, placebo controlled study evaluating the safety, tolerability, and efficacy of GS-9674 in subjects with PSC without cirrhosis.</p> <p>The study will consist of 2 phases, a Blinded Study Phase and an Open Label Extension (OLE) Phase.</p> <p><u>Blinded Study Phase:</u> Includes a 4-week screening period, 12 weeks of blinded treatment, and a Blinded Study Phase follow-up visit, 4 weeks after completion of blinded treatment.</p> <p>Subjects completing the Blinded Study Phase without permanently discontinuing study drug will be eligible to participate in the OLE Phase of the study.</p> <p><u>OLE Phase:</u> Includes a 96-week OLE and an OLE Phase follow-up visit 4 weeks after completion of open label treatment.</p> <p>Participation in the Blinded Study Phase can last up to 20 weeks and the OLE Phase can last up to 100 weeks, thus total study duration can be up 120 weeks.</p> <p>Subjects meeting the study's entry criteria will be randomly assigned in a 2:2:1 ratio to 1 of 3 treatment groups during the Blinded Study Phase as shown in the figure below:</p>



Randomization will be stratified by the presence or absence of ursodeoxycholic acid (UDCA) use.

Number of Subjects Planned:

Approximately 50 Subjects

Target Population:

Males and non-pregnant, females between 18-70 years of age with PSC without cirrhosis

Duration of Treatment:

Total study duration of up to 120 weeks with up to 20 Weeks for the Blinded Study Phase and up to 100 weeks for the OLE Phase.

Diagnosis and Main Eligibility Criteria:

Key inclusion and exclusion criteria are as follows:

#### **Inclusion Criteria**

- Diagnosis of PSC based on cholangiogram (magnetic resonance cholangiopancreatography [MRCP], endoscopic retrograde cholangiopancreatography [ERCP], or percutaneous transhepatic cholangiogram [PTC]) within the previous 12 months;
- Serum ALP  $>1.67 \times$  ULN;
- For subjects on ursodeoxycholic acid (UDCA), the dose of UDCA must have been stable for at least 6 months prior to screening through the end of treatment. For subjects not on UDCA, no UDCA use for at least before screening through the end of treatment;
- For subjects being administered biologic treatments (eg, anti-tumor necrosis factor [TNF] or anti-integrin monoclonal antibodies), immunosuppressants or systemic corticosteroids, the dose must have been stable at least 3 months prior to

screening and anticipated to remain stable throughout the trial;

- Screening FibroSURE/FibroTest® <0.75.

#### **Exclusion Criteria**

- ALT > 10xULN;
- Total bilirubin > 2x ULN;
- INR >1.2 unless on anticoagulant therapy;
- Serum albumin < 3.0 g/dL;
- Cirrhosis of the liver as defined by any of the following:
  - a) Historical liver biopsy demonstrating stage 4 fibrosis according to the Ludwig classification (or equivalent);
  - b) History of decompensated liver disease, including ascites, hepatic encephalopathy or variceal bleeding;
  - c) Liver stiffness >14.4 kPa by FibroScan®
- Small-duct PSC (histologic evidence of PSC with normal bile ducts on cholangiography);
- Other causes of liver disease including secondary sclerosing cholangitis and viral, metabolic, alcoholic, and other autoimmune conditions;
- Ascending cholangitis within 60 days of screening;
- Presence of a percutaneous drain or bile duct stent;
- Use of fibrates or obeticholic acid within 3 months prior to screening and through the end of treatment;
- Current, active inflammatory bowel disease (IBD) defined as a partial Mayo score of > 2.

Please refer to section [4.2](#) and [4.3](#) of the protocol for detailed inclusion and exclusion criteria.

Study Procedures/  
Frequency:

#### **Blinded Study Phase**

After signing the informed consent form, subjects will complete a screening visit which will include the following assessments: complete medical history, complete physical examination (PE), vital signs, cirrhosis assessments, laboratory assessments (blood chemistry, hematology, coagulation panel, and biomarkers), calculation of partial Mayo score for subjects with IBD, serum pregnancy test (for females of childbearing potential), urine drug test and review of adverse events (AEs) related to screening procedures and concomitant medications (CMs).

After the screening period, visits will occur at Baseline/Day 1 and at Weeks 1, 2, 4, 8, and 12. At minimum, vital signs, symptom-driven PE, safety laboratory tests (blood chemistry, hematology, and coagulation panel), calculation of partial Mayo score for subjects with IBD and review of adverse events and concomitant medications will be done at every visit.

## PPD

Eligible subjects will be randomized to one of three treatment groups of the Blinded Study Phase. Prior to initial dosing, required Baseline/Day 1 assessments will be performed and will include, symptom-driven PE, vital signs, laboratory assessments, pregnancy tests (for females of child-bearing potential), urine, blood, and stool collection for biomarker assessments, pruritus assessments and Quality of Life (QoL) questionnaires, standard 12-lead ECG, FibroScan®, review of AEs and CMs.

## PPD

While on study, subjects will undergo the following procedures and laboratory assessments:

- Symptom-directed PE and vital signs at Baseline/Day 1 and at Weeks 1, 2, 4, 8 and 12
- Height at Baseline/Day 1 and weight at all visits
- FibroScan® (if available) at Baseline/Day 1 and Week 12
- 12-lead ECG at Baseline/Day 1 and Week 12
- C-peptide, insulin and hemoglobin A1c (HbA1c) at Baseline/Day 1 and Week 12
- PK and PD sampling at Baseline/Day 1 (PD only) and at Weeks 1, 2, 4, 8 and 12
- Blood for Biomarker assessments at Baseline/Day 1 and at Weeks 1, 4, and 12
- Urine Biomarker collection at Baseline/Day 1 and at Weeks 1, 4, and 12

- Urine pregnancy testing (females of childbearing potential only) at Baseline/Day 1 and Weeks 1, 4, 8 and 12
- Stool collection at Baseline/Day 1 and Week 12
- Hematology, blood chemistry, coagulation panel (PT, PTT, INR) and fasting lipid profile at Baseline/Day 1 and Weeks 1, 2, 4, 8, and 12
- QoL Questionnaires: PBC-40, SF-36, and PSC Patient-Reported Outcome (PRO) at Baseline/Day 1 and Week 12
- Pruritus Assessments: Pruritus Visual Analog Scale (VAS) and 5D-Itch questionnaire at Baseline/Day 1 and at Weeks 1, 2, 4, 8, and 12
- Partial Mayo score calculation at Baseline/Day 1 and at Weeks 1, 2, 4, 8, and 12 for subjects with IBD

At the Blinded Study Phase follow up visit, subjects will have a symptom-driven PE, vital signs, laboratory assessments, urine pregnancy tests (for females of childbearing potential), urine, stool and blood collection for biomarker assessments, QoL and pruritus questionnaires (PBC-40, SF-36, PSC-PRO, Pruritus VAS and 5D-Itch), weight, review of AEs, and review of CMs and serum will be drawn for hematology, blood chemistry, and a coagulation panel.

Subjects will be unblinded to their Blinded Study Phase treatment assignment after the primary analysis has been completed, approximately 6 weeks after all subjects have completed the Blinded Study Phase.

During the Blinded Study Phase early termination (ET) visit, subjects who prematurely discontinue participation will complete Week 12 assessments and will also complete the Blinded Study follow-up visit 4 weeks after their last dose if possible.

#### **Open-Label Extension (OLE) Phase**

Subjects who do not permanently discontinue study drug and complete the Blinded Study Phase follow-up visit will be eligible to enter into the OLE Phase of the study for 96 weeks. Subjects will begin open-label treatment with GS-9674 (100 mg po once daily). The dose of GS-9674 may be reduced from 100 mg to 30mg (or subsequently increased back to 100 mg) at the PI's discretion with the approval of the Medical Monitor (MM), if required due to tolerability. In the OLE Phase, subjects will have in-clinic study assessments at OLE Baseline/Day 1, OLE Week 4, OLE Week 12, and every 12 weeks thereafter for symptom-driven PE, vital signs, laboratory assessments, urine pregnancy tests (for females of

childbearing potential), urine, stool and blood collection for biomarker assessments, calculation of partial Mayo score (subjects with IBD), QoL and pruritus questionnaires (PBC-40, SF-36, PSC PRO, Pruritus VAS and 5D-Itch), weight, and review of AEs and CMs.

Subjects in the OLE Phase will the complete treatment Week 96 visit and then return for their final visit, the OLE follow up visit 4 weeks following the last dose of study drug. Subjects who prematurely discontinue participation in the OLE Phase will complete the Week 96 assessments and will also complete the follow-up visit 4 weeks after their last dose if possible.

At the OLE follow up visit, subjects will have a symptom-driven PE, measurement of vital signs, review of AEs, CMs, pruritus and assessment and serum will be drawn for hematology, blood chemistry, lipids, and a coagulation panel. A urine pregnancy test will be performed for females of childbearing potential only.

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**Test Product:** GS-9674 is supplied as 30 mg and 100 mg strength (as free form equivalent) tablets. The tablets contain GS-9674-02 CCI [REDACTED]

GS-9674 30 mg tablets are round, plain-faced, film-coated orange tablets and GS-9674 100 mg tablets are capsule-shaped, plain-faced, film-coated orange tablets.

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**Reference Product:** Placebo-to-match (PTM) GS-9674 tablets are identical in size, shape, color and appearance to their corresponding strengths of active GS-9674 tablets. PTM GS-9674 tablets contain the following ingredients: CCI [REDACTED]

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**Dose and Mode of Administration:**

- **Treatment Group A:** GS-9674 30 mg (1 x 30 mg tablet) + PTM GS-9674 100 mg (1 x PTM 100 mg tablet) administered orally once daily with food.
- **Treatment Group B:** GS-9674 100 mg (1 x 100 mg tablet) + PTM GS-9674 30 mg (1 x PTM 30 mg tablet) administered orally once daily with food.

**Treatment Group C:** PTM GS-9674 30 mg (1 x PTM 30 mg tablet) + PTM GS-9674 100 mg (1 x PTM 100 mg tablet) administered orally once daily with food.

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## Criteria for Evaluation:

Safety:	<p>The primary endpoint is the safety of GS-9674 in subjects with PSC without cirrhosis.</p> <p>Safety will be assessed during the study through the reporting of AEs, and by clinical laboratory tests and vital sign assessments at various time points during the study. Concomitant medication usage will also be assessed throughout the study.</p> <p>An independent, external Data Monitoring Committee (DMC) that consists of two hepatologists and a PhD statistician will convene once 20 subjects have been randomized and every 3 to 4 months thereafter to monitor the study for safety events in Blinded Study Phase and every 6 month in the OLE Phase. The DMC will meet on an ad hoc basis if there are at least 3 similar Grade <math>\geq 3</math> serious, treatment related Common Terminology Criteria for Adverse Events (CTCAE) observed in the study. In the event of two similar treatment-related Grade 4 CTCAE events or one treatment-related Grade 5 CTCAE, the DMC will review the data and advise the sponsor regarding stopping or continuing the study.</p>
Efficacy:	<p>Efficacy will be assessed through a number of exploratory endpoints. These exploratory endpoints are described in Section 8.1.3.</p>
Pharmacokinetic and Pharmacodynamic:	<p>A single predose PK and PD blood sample will be collected at each on-treatment visit for all subjects. Plasma concentrations of GS-9674, GS-716070 (metabolite of GS-9674), and other metabolites as appropriate, will be determined for PK analyses as applicable. Plasma or serum concentrations of FGF19, C4, and bile acids will be determined as applicable for PD analyses.</p>

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## Statistical Methods:

Safety Analysis: All safety data collected will be listed and be summarized, as appropriate, by treatment group.

Efficacy Analysis: The biological and histological activity of study drugs will be evaluated using histologic endpoints and biomarker variables.

PPD

PPD

Exploratory  
Analysis:

PPD

Sample Size:

Due to the exploratory nature of this study, no formal power calculations were used to determine sample size. The number of subjects was chosen based on clinical experience with other similar proof of concept studies.

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This study will be conducted in accordance with the guidelines of Good Clinical Practice (GCP) including archiving of essential documents.

## **GLOSSARY OF ABBREVIATIONS AND DEFINITION OF TERMS**

° C	degrees Celsius
° F	degrees Fahrenheit
AE	adverse event
ALT	alanine aminotransferase
ALP	alkaline phosphatase
AMA	anti-mitochondrial antibodies
Apo B	apolipoprotein B
aPTT	activated partial thromboplastine time
AST	aspartate aminotransferase
ATP	Adenosine triphosphate
AUC	area under the plasma/serum/peripheral blood mononuclear cell concentration versus time curve
β-hCG	beta human chorionic gonadotropin
BAP	Biomarker Analysis Plan
BCRP	breast cancer resistance protein
BUN	blood urea nitrogen
BW	body weight
C4	7-alpha-hydroxy-4-cholesten-3-one
CFR	code of federal regulations
CrCL	creatinine clearance
C <sub>last</sub>	last observed quantifiable plasma/serum concentration of the drug
C <sub>max</sub>	maximum observed plasma/serum concentration of drug
CMs	concomitant medications
CNS	central nervous system
CRO	contract (or clinical) research organization
CTCAE	Common Terminology Criteria for Adverse Events
CSR	clinical study report
CYP3A	cytochrome P4503A
CV	cardiovascular
DILI	drug induced liver injury
DMC	Data Monitoring Committee
DNA	deoxyribonucleic acid
DSPH	Drug Safety and Public Health
EC50	Concentration of drug that gives half-maximum response
ECG	electrocardiogram
ET	early terminated
eCRF	electronic case report form
EDC	electronic data capture

e.g.	example
ELF™ Test	enhanced liver fibrosis test
ERCP	endoscopic retrograde cholangiopancreatography
EU	European Union
FAS	Full analysis set
FDA	(United States) Food and Drug Administration
FSH	Follicle-stimulating hormone
FGF	Fibroblast growth factor
FXR	Farnesoid X Receptor
GCP	good clinical practice
GCSF	granulocyte colony stimulating factor
GGT	gamma glutamyl transferase
GSI	Gilead Sciences, Inc.
HbA1c	Hemoglobin A1c
HBsAg	Hepatitis B surface antigen
HBV	Hepatitis B virus
Hct	Hematocrit
HDPE	High-density polyethylene
HCV	Hepatitis c virus
Hg	Hemoglobin
HIV	Human immunodeficiency virus
HLT	high-level term
HLGT	high-level group term
HMG-CoA	3-hydroxy-3-methylglutaryl-coenzyme A
HOMA-IR	homeostatic assessment of insulin resistance
IB	investigator's brochure
IBD	inflammatory bowel disease
ICF	Informed Consent Form
ICH	International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use
IEC	independent ethics committee
IMP	Investigational Medicinal Product
IND	Investigational New Drug (Application)
INR	international normalized ratio
IRB	institutional review board
IUD	intrauterine device
IWRS	interactive web response system
kg	Kilogram
LDH	lactate dehydrogenase
LLT	lower-level term

MedDRA	Medical Dictionary for Regulatory Activities
$\mu\text{g}$	Microgram
mg	Milligram
min	Minute
mL	Milliliter
mm	Millimeter
mm Hg	millimeters of mercury
MM	Medical Monitor
NAFLD	non-alcoholic fatty liver disease
NASH	non-alcoholic steatohepatitis
NTCP	sodium-taurocholate cotransporting polypeptide
NMR	nuclear magnetic resonance spectroscopy
NOAEL	no observed adverse event level
OATP	Organic anion-transporting polypeptide
OLE	Open Label Extension
PBC	Primary Biliary Cholangitis
PBMCs	peripheral blood mononuclear cell(s)
PD	Pharmacodynamic
PK	Pharmacokinetic
P-gp	P-glycoprotein
PO	taken by mouth
PRO	Patient –Reported Outcome
PSC	Primary Sclerosing Cholangitis
PT	preferred term
PTC	percutaneous transhepatic cholangiogram
PT	prothrombin time
PTT	Partial prothrombin time
QoL	Quality of Life
RBC	red blood cell count
RNA	ribonucleic acid
RXR	Retinoid X receptor
SADR	serious adverse drug reaction
SAE	serious adverse event
SAP	statistical analysis plan
SF-36	Short Form (36) Health Survey
SOC	System Organ Class
SOP	standard operating procedure
SUSAR	Suspected Unexpected Serious Adverse Reaction
$t_{1/2}$	Time required for the terminal elimination half-life of the drug
TEAEs	Treatment emergent adverse events

TGR5	bile acid receptor
TPO	thrombopoietin
TR-FRET	Time-resolved fluorescence resonance energy transfer
$T_{\text{last}}$	last measured concentration
$T_{\text{max}}$	time (observed time point) of $C_{\text{max}}$
TNF	tumor necrosis factor
UDCA	ursodeoxycholic acid
UGT	uridine diphosphate glucuronosyltransferase
ULN	upper limit of the normal range
US	United States
Vss	Volume of distribution at steady state
VAS	visual analog scale
WBC	white blood cell count

## 1. INTRODUCTION

### 1.1. Background

Primary Sclerosing Cholangitis (PSC) is a chronic biliary disease of unknown etiology characterized by a fibrosing cholangitis that leads to inflammation, cholestasis and cirrhosis. The overall incidence of PSC is 0.77 per 100,000 person-years, with a median age at diagnosis of 41 years and 2-to-1 male to female predominance {[Molodecky et al 2011](#)}. PSC is highly associated with inflammatory bowel disease (IBD), typically ulcerative colitis (UC) with up to 90% of PSC patients having associated IBD and conversely, PSC develops in approximately 8% of all IBD patients {[Saich et al 2008](#)}. There are approximately 30,000-45,000 patients with PSC in the United States, making it an orphan disease. PSC affects less than 1.6 in 10,000 people in the European Union (EU), equivalent to a total of fewer than 82,000 people.

PSC is a progressive disease that leads to cirrhosis of the liver. The clinical presentation of PSC is variable, and ranges from asymptomatic disease with mild elevations in alkaline phosphatase (ALP) and transaminases to more rapidly progressive, symptomatic disease in 15-30% of all patients. In addition to complications related to cirrhosis and portal hypertension, patients with PSC are prone to repeated episodes of bacterial cholangitis, pruritus, and are at high risk for cholangiocarcinoma. Specifically, the lifetime risk of cholangiocarcinoma in patients with PSC is 10-15%, a rate 160-fold that of the general population {[Saich et al 2008](#)}. Mortality from PSC is estimated to be 35% over 10 years from diagnosis {[Kornfeld et al 1997](#)}.

There are no approved therapies for PSC. Medical therapy with ursodeoxycholic acid (UDCA) may improve liver biochemistry, but has no impact on symptoms or clinical outcomes {[Triantos et al 2011](#)}. Immunosuppressive therapy has also been ineffective {[Lindor et al 2015](#)}. Episodes of ascending cholangitis are managed supportively with antibiotics in conjunction with therapeutic drainage if necessary. Liver transplantation is the only therapeutic option currently available to patients with PSC. Outcomes of transplantation are generally favorable (five-year survival ~85%), but the disease recurs post-transplant in up to 25% of patients {[Graziadei et al 1999](#)}.

The etiology of PSC is unknown. As noted above, there is a strong association with IBD and genome-wide association studies (GWAS) indicate moderate genetic associations with PSC. The strongest associations are in the HLA complex on chromosome 6p21 with weaker associations at loci known to be associated with IBD, chromosome 3p21, 2q35 and the GPC5/GPC6 region on chromosome 13q31 {[Karlsen et al 2010](#)}. Several hypotheses as to the underlying cause of the disease have been proposed including aberrant homing of T cells to the bile ducts, autoimmunity, bile acid toxicity, and gut bacterial translocation leading to fibrosing cholangitis, and subsequent cholestasis and hepatotoxicity.

## 1.2. **GS-9674**

### 1.2.1. **General Information**

GS-9674 is a potent agonist of Farnesoid X Receptor (FXR) whose activity in intestinal epithelial cells results in the release of fibroblast growth factor 19 (FGF19). FGF19 is an endocrine peptide which drives a signaling cascade to decrease hepatic lipogenesis, gluconeogenesis, triglyceride accumulation, and bile acid synthesis.

Please refer to the Investigator's Brochure (IB) for additional information on GS-9674 including:

- In Vitro FXR agonism
- Nonclinical Pharmacokinetics and In Vitro Metabolism
- Nonclinical Pharmacology and Toxicology

### 1.2.2. **Nonclinical Toxicology**

The nonclinical toxicity profile of GS-9674 has been assessed in mice and cynomolgus monkeys administered GS-9674 orally for 4 weeks in both species and for 13 weeks in monkeys and 26 weeks (in-life phase only) in mice. GS-9674-related effects included non-adverse findings in the liver for both species that are likely related to the pharmacology of the compound. In both mice and cynomolgus monkeys, mild increases in alkaline phosphatase (ALP) activity, liver weight, and hepatocellular hypertrophy were observed after 4 weeks of dosing. Minimal oval cell hyperplasia was also observed in the liver of cynomolgus monkeys after 4 weeks of dosing. The increases in ALP activity and liver weights persisted but did not progress with longer term dosing in monkeys (13 weeks) but the histopathological changes were no longer evident. In mice, the ALP activity and liver weights were still present and were modestly more pronounced with longer term dosing (26 weeks). In mice, the above findings were observed at  $\geq 100$  mg/kg/day after 4 weeks of dosing and at all doses ( $\geq 20$  mg/kg/day) after 26 weeks of dosing. In monkeys, the above findings were observed at doses of 300 mg/kg/day after both 4 and 13 weeks of dosing. Decreases in cholesterol ( $\geq 60$  mg/kg/day) and triglycerides ( $\geq 100$  mg/kg/day) as well as increased albumin ( $\geq 60$  mg/kg/day) observed in mice after 4 and/or 26 weeks of dosing as well as the decrease in serum bile acids (300 mg/kg/day) in monkey after 13 weeks of dosing are also likely to be related to the pharmacology of GS-9674. Other minimal to mild, non-adverse findings observed after 13 or 26 weeks of dosing in monkeys or mice, respectively, that were considered GS-9674-related included decreased red blood cell parameters (mouse;  $\geq 20$  mg/kg/day), increased platelets (mouse; 600/300 mg/kg/day), shortened activated partial thromboplastin time (monkey; 300 mg/kg/day), and increased phosphorus (mouse; 600/300 mg/kg/day). Findings present in monkeys after 13 weeks of dosing were reversible after a 4 week nondosing recovery period. In the 26 week mouse study, there were no adverse findings based on the in-life data at 60 mg/kg/day and the no-observed-adverse effect level (NOAEL) in monkeys after 13 weeks of dosing was 300 mg/kg/day.

Preliminary steady-state PK data from Cohort 5 (administration of GS-9674 100 mg with food) in the ongoing Phase 1 study of GS-9674 (GS-US-402-1851: Section 1.2.5.1) indicate adequate safety margins based on GS-9674 exposures at the nonclinical NOAEL doses in mouse and cynomolgus monkey (Table 1-1).

**Table 1-1. Exposure Margins for GS-9674 Based on Observed GS-9674 Exposure After Administration of 100 mg GS-9674 QD Under Fed Conditions at Steady-State in Cohort 5 Compared to Exposures Observed at NOAEL Doses in Mouse and Cynomolgus Monkey**

Species	NOAEL		Exposure Margin <sup>a</sup>
	Dose mg/kg/day	AUC <sub>tau</sub> μg*hr/mL	
Mouse	60 <sup>b</sup>	110	22
Cynomolgus Monkey	300	110	22

<sup>a</sup> Calculated using observed human AUC<sub>tau</sub> of 5.02 μg\*hr/mL at 100 mg QD dose administered fed from cohort 5 in Study GS-US-402-1851.

### 1.2.3. Nonclinical Pharmacology

GS-9674 is a potent and selective agonist of FXR. This conclusion is supported by the following data: 1) modeling demonstrated an interaction of GS-9674 with the binding domain of FXR/Retinoid X receptor (RXR) consistent with agonist activity, 2) GS-9674 induced an agonist response in a time-resolved fluorescence resonance energy transfer (TR-FRET) biochemical assay with an EC<sub>50</sub> of 16 nM, which was comparable to that of other known FXR agonists, and 3) GS-9674 did not activate the structurally similar bile acid receptor TGR5, did not activate other nuclear hormone receptors, and did not bind to a panel of other off-target receptors and enzymes.

The cellular potency of GS-9674 to activate FXR-mediated transcription was characterized using a firefly luciferase reporter gene engineered under the control of a FXR/RXR response element (PC-402-2012). GS-9674 caused complete FXR activation with an EC<sub>50</sub> value of 43 nM, which was more potent than chenodeoxycholic acid (EC<sub>50</sub> of 1770 nM).

Oral dose-ranging experiments in male cynomolgus monkeys demonstrated maximal increases in plasma FGF19 at a dose of 5 mg/kg (PC-402-2016). In addition, the oral administration of GS-9674 (30 mg/kg) to cynomolgus monkeys directly activated intestinal FXR, as measured by the expression of FXR-target genes in the ileum (15-fold increase in FGF19 mRNA, and a 2-fold increase in organic solute transporter (OSTα and OSTβ mRNA) (PC-402-2005).

The effects of GS-9674 on FGF19 levels were compared in cynomolgus monkeys following both oral and intravenous (IV) administration (PC-402-2016). Despite greater exposures following IV administration, only the oral administration of GS-9674 increased circulating FGF19 levels. These data suggest that intestinal FXR agonism by GS-9674 causes FGF19 production, whereas low systemic free drug concentrations limit effects following IV administration of GS-9674.

GS-9674 was evaluated in a choline-deficient high fat diet/NaNO<sub>2</sub> rat model of liver fibrosis (PC-402-2015). This in vivo model utilized “2 hits” to mimic the metabolic and oxidative stress components of NASH disease in humans {[Nakamoto et al 2009](#)}, {[Murakami et al 2013](#)}. Treatment with GS-9674 dose-dependently reduced both biochemical and histological measures of liver fibrosis in this model.

Safety pharmacology studies have been conducted to examine the potential effects of GS-9674 on the cardiovascular (CV), respiratory, and central nervous system (CNS) systems. There were no GS-9674-related effects on the CNS or respiratory system in mice administered up to 600 mg/kg. In addition, there was no significant human ether-a-go-go-related gene inhibition at concentrations up to 100  $\mu$ M or GS-9674-related effects on the CV system in monkeys administered up to 300 mg/kg.

Overall, the results from these pharmacology studies demonstrate that GS-9674 is a potent and selective agonist of intestinal FXR with the potential to benefit patients with PSC by inducing FGF19 production and reducing bile acid levels.

#### 1.2.4. Nonclinical Pharmacokinetics

GS-9674 has shown low oral bioavailability in nonclinical species (approximately 10% and 20% when dosed as **CCl<sub>4</sub>**). Low, pH-dependent solubility and efflux transport have been identified as factors likely limiting GS-9674 absorption.

The low systemic clearance (CL) of GS-9674 in rats, dogs and monkeys was considerably lower than the predicted hepatic clearance based on in vitro studies with hepatocytes. This discrepancy is most likely a result of protein-restricted clearance in vivo due to the very high plasma protein binding (> 99.6%) across species. The volume of distribution (V<sub>ss</sub>) of GS-9674 was consistent with extracellular fluid (ranging from 0.16-0.21 L/kg) in rats, dogs, and monkeys.

After oral dosing to albino and pigmented mice, [<sup>14</sup>C] GS-9674-derived radioactivity was distributed to most of the tissues, with the highest maximum concentrations of radioactivity determined in organs of absorption and excretion. Generally similar distribution patterns and tissue concentrations of [<sup>14</sup>C]GS-9674-derived radioactivity were observed in albino and pigmented mice with no observed binding to melanin. In both strains, no quantifiable radioactivity was detected in brain, suggesting [<sup>14</sup>C] GS-9674-derived radioactivity did not cross the blood-brain barrier. Fecal elimination was a predominant route of elimination of [<sup>14</sup>C] GS-9674-derived radioactivity in both mice (85.7% and 5.45% recovered in feces and urine, respectively) and monkeys (78.2% and 69.7% recovered in feces in intact and bile duct cannulated animals) likely representing drug not absorbed from the gastrointestinal tract. Approximately 6% of the administered radioactivity was excreted in bile and urine in monkeys. Radiolabeled material was primarily excreted within the first 48 hours.

GS-9674 undergoes oxidative metabolism in human hepatocytes. Comparison of metabolism in hepatocytes from mice, rats, dogs, monkeys, and humans did not identify any metabolites unique to humans, supporting the selection of mice and monkeys for the assessment of the toxicology of

GS-9674. Of the recombinant human CYP isozymes tested, CYP2C8, CYP3A4, and CYP2C19 were shown to metabolize GS-9674. Potent inhibitors of these CYPs therefore may affect metabolism of GS-9674. GS-9674 had little inhibitory effect on the activities of CYP1A2, CYP2B6, CYP2C19 or CYP2D6 ( $IC_{50} > 25 \mu M$ ). For CYP2C8, CYP2C9, and CYP3A,  $IC_{50}$  values of 2.4 to 13.6  $\mu M$  were obtained but GS-9674 was not a mechanism-based inhibitor of these enzymes. GS-9674 showed moderate inhibition of human UGT1A1, sodium-taurocholate cotransporting polypeptide (NTCP), and bile salt export pump ( $IC_{50} 2.8-7.7 \mu M$ ). GS-9674 inhibited human OATP1B1, OATP1B3, and OATP2B1 with  $IC_{50}$  values of 0.68, 0.41, and 0.21  $\mu M$ , respectively. GS-9674 therefore has the potential to affect hepatic/intestinal uptake of OATP substrates or metabolism of CYP2C8, CYP2C9, or CYP3A4 substrates when its concentrations are sufficiently high. However, low solubility, high protein binding (> 99.98%) and low systemic levels reduce the potential for GS-9674 to cause drug-drug interactions via inhibition of metabolic enzymes and transporters.

GS-9674 was a substrate for efflux transporters P-glycoprotein and breast cancer resistance protein, as well as the uptake transporters OATP1B1, 1B3, and 2B1, and NTCP. Inhibitors or genetic polymorphisms affecting the activity of these transporters may affect GS-9674 intestinal absorption and hepatic uptake. This was illustrated in an in vivo study in monkeys where pretreatment with cyclosporin A, a known inhibitor of efflux transporters, increased the bioavailability of GS-9674 approximately 5-fold.

GS-9674 is highly selective for FXR over other nuclear hormone receptors in cell-based reporter assays, including those associated with potential for induction of human drug metabolizing enzymes and transporters (eg, pregnane X receptor, constitutive androstane receptor). Thus the liability of GS-9674 to cause drug-drug interactions through proteins regulated by these nuclear receptors is low.

### **1.2.5. Clinical Trials of GS-9674**

Ongoing clinical experience with GS-9674 includes a Phase 1 clinical study (GS-US-402-1851). A brief PK summary of results from this ongoing study is presented below.

#### **1.2.5.1. GS-US-402-1851**

Study GS-US-402-1851 is an ongoing Phase 1, randomized, placebo-controlled, single- and multiple-dose study with 4 prespecified, staggered dose-escalation cohorts and 4 randomized, placebo-controlled, single- and multiple-dose cohorts with adaptive dose selection and dose frequency.

Preliminary data based on an interim safety analysis as of 22 June 2016 are provided in the following sections. A total of 105 subjects have been randomized into 7 cohorts. One subject withdrew consent after randomization but prior to dosing and was not replaced. Therefore, safety data described below includes 104 dosed subjects.

Subjects received single and multiple doses of GS-9674 at a dose of 10 mg QD (Cohort 1), 30 mg QD (Cohort 2), 100 mg QD (Cohort 3), or 300 mg QD (Cohort 4) administered in a

fasting state, or GS-9674 100 mg QD administered in a fed state (Cohort 5), GS-9674 50 mg BID (Cohort 6), or 15 mg BID (Cohort 7). A summary of treatment-emergent adverse events (AEs) is provided in [Table 1-2](#). Overall, the rate of any AEs was similar between subjects treated with GS-9674 or placebo. All AEs were Grade 1 or 2 in severity; AEs occurring in greater than two GS-9674 treated subjects were back pain (n = 5), diarrhea (n=3), and headache (n = 6).

**Table 1-2. Preliminary Safety Summary of Subjects Following Single- and Multiple-Dose Administration of GS-9674 Under Fasting or Fed Conditions in Healthy Volunteers (GS-US-402-1851)**

	Cohort 1: 10 mg QD Fasted (N = 12)	Cohort 2: 30 mg QD Fasted (N = 12)	Cohort 3: 100 mg QD Fasted (N = 12)	Cohort 4: 300 mg QD Fasted (N = 12)	Cohort 5: 100 mg QD Fed (N = 12)	Cohort 6: 50 mg BID (N = 11 <sup>a</sup> )	Cohort 7: 15 mg BID (N = 12)	Pooled Placebo (N = 21)
Treatment-Emergent Adverse Event	4 (33%)	3 (25%)	4 (33%)	3 (25%)	5 (42%)	3 (27%)	4 (33%)	5 (24%)
Treatment-Emergent Adverse Event Related to Study Drug	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (8%)	0 (0%)	1 (8%)	0 (0%)
Grade 3 or 4 Treatment-Emergent Adverse Event	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Grade 2,3, or 4 Treatment-Emergent Adverse Event	0 (0%)	1 (8%)	1 (8%)	0 (0%)	1 (8%)	0 (0%)	0 (0%)	0 (0%)

a 1 subject withdrew consent after randomization prior to dosing and was not replaced.

Grade 2 or 3 elevations in serum alanine aminotransferase (ALT) were seen in five (6%) GS-9674 treated subjects and one (5%) placebo treated subject. Of these, two GS-9674 treated subjects were noted to have grade 2 or 3 elevations of ALT during active treatment; one each in Cohort 6 (GS-9674 50 mg BID) and Cohort 7 (GS-9674 15 mg BID). The remaining subjects with elevated ALT were identified at the follow-up visit 4 days after completing study drug. In two of these subjects, elevated ALT was associated with very high serum creatine kinase levels, consistent with elevation due to strenuous exercise. All ALT elevations returned to baseline and were not associated with changes in bilirubin or coagulation parameters. There were no clinically important treatment- or dose-related trends in vital signs, ECG, or physical examination findings in this study.

Preliminary PK parameters for GS-9674 after single- and multiple-dose administration of 10, 30, 100 or 300 mg under fasting conditions and 100 mg under fed conditions in healthy volunteers are presented in [Table 1-3](#). GS-9674 was rapidly absorbed with a median  $T_{max}$  occurring between 1.25 and 3.25 hours under fasting conditions. Across the dose levels tested, plasma concentrations declined in a bi-phasic manner with a median  $t_{1/2}$  of 5.56 to 12.8 hours. The lower observed median  $t_{1/2}$  of 5 to 6 hours in the 10 mg and 30 mg cohorts, respectively, may be a result of plasma concentrations falling below the limit of quantitation during the distributional phase of the profile. In general, GS-9674 AUC and  $C_{max}$  increased less than dose proportionally above 10 mg upon single and multiple dosing. As expected based on the short GS-9674  $t_{1/2}$  and once daily dosing, minimal to no accumulation was observed for GS-9674 AUC,  $C_{max}$  or  $C_{24}$  from single to multiple dose administration. Administration of GS-9674 with food resulted in prolonged absorption of GS-9674 with an approximately 60% reduction in mean  $C_{max}$  and approximately 35% reduction in mean AUC. Plasma concentrations of GS-716070 (a metabolite of GS-9674 with ~40-fold less potency than GS-9674 against FXR) were analyzed in Cohort 5 (GS-9674 100 mg administered fed). The  $t_{1/2}$  of GS-716070 was similar to that of GS-9647 with AUC and  $C_{max}$  ~60% and 35%, respectively of that observed for GS-9674. Similar to GS-9674, GS-716070 did not accumulate upon multiple dosing.

**Table 1-3. Preliminary Plasma Pharmacokinetic Parameters of GS-9674 Following Single- and Multiple-Dose Administration of GS-9674 Under Fasting or Fed Conditions in Healthy Volunteers (GS-US-402-1851)**

	Parameter Mean (%CV)	Cohort 1: 10 mg Fasted (N = 12)	Cohort 2: 30 mg Fasted (N = 12)	Cohort 3: 100 mg Fasted (N = 12)	Cohort 4: 300 mg Fasted (N = 12)	Cohort 5: 100 mg Fed (N = 12)
Single Dose	AUC <sub>inf</sub> (ng*h/ml)	1260 (30.3)	2480 (37.2)	7740 (93.9)	12,500 (33.9)	5020 (40.4)
	C <sub>max</sub> (ng/ml)	304 (41.6)	580 (48.9)	2590 (118)	3060 (66.2)	928 (58.3)
	C <sub>24</sub> (ng/ml)	2.61 (49.9) <sup>b</sup>	6.04 (35.7)	23.5 (40.0)	76.0 (67.4)	26.8 (42.3)
	T <sub>max</sub> (h) <sup>a</sup>	3.00 (2.38, 4.00)	3.00 (2.38, 3.63)	1.75 (1.38, 2.63)	1.25 (1.00, 3.13)	3.75 (2.88, 4.25)
	T <sub>1/2</sub> (h) <sup>a</sup>	5.56 (5.46, 6.41)	8.10 (5.74, 9.58)	11.2 (8.30, 11.9)	12.4 (11.4, 13.9)	10.9 (8.87, 11.6)
Multiple Dose	AUC <sub>tau</sub> (ng*h/ml)	1280 (35.8)	2890 (23.5)	6720 (59.2)	8490 (48.8)	4180 (46.8)
	C <sub>max</sub> (ng/ml)	322 (42.4)	718 (32.8)	2230 (75.9)	2330 (81.5)	819 (53.4)
	C <sub>tau</sub> (ng/ml)	2.75 (55.5)	7.90 (50.3)	36.3 (42.5)	70.1 (56.3)	22.6 (37.4)
	T <sub>max</sub> (h) <sup>a</sup>	2.50 (1.50, 3.50)	3.00 (1.88, 3.13)	1.50 (1.00, 2.63)	3.25 (1.00, 5.00)	3.50 (3.00, 4.25)
	T <sub>1/2</sub> (h) <sup>a</sup>	6.75 (5.64, 8.45)	5.95 (5.54, 6.55)	8.99 (6.84, 11.49)	12.8 (10.0, 14.7)	13.1 (10.3, 15.0)

Pharmacokinetic parameters are presented as Mean (%CV), and shown to 3 significant digits

a T<sub>max</sub> and T<sub>1/2</sub> are presented as median (Q1, Q3)

b N=11

Preliminary changes in FGF19 and C4 levels as measured by the primary PD parameters (AUC<sub>2-8</sub>, C<sub>max</sub>, and C<sub>min</sub>) were determined to be the most sensitive measures of changes in FGF19 and C4 after multiple dose administration of placebo, 10, 30, 100 or 300 mg GS-9674 under fasting conditions and 100 mg under fed conditions in healthy volunteers are presented in [Table 1-4](#). In general, similar changes in PD parameters were observed after single or multiple dose administration (single dose data not shown). GS-9674 doses  $\geq$  30 mg significantly increased FGF19 AUC<sub>2-8</sub> and C<sub>max</sub> and reduced C4 AUC<sub>2-8</sub> and C<sub>max</sub>. Administration of 100 mg GS-9674 with food resulted in prolonged elevation of FGF19 plasma concentrations compared to administration of GS-9674 100 mg under fasting conditions. Across the dose range of 10 to 300 mg GS-9674 administered fasted, GS-9674 exposure was weakly correlated with changes in FGF19 and moderately correlated with changes in C4 (Spearman correlation r = 0.45, p=0.002). Additionally, FGF19 and C4 AUC<sub>2-8</sub> changes were inversely correlated (r = -0.335, p=0.02).

**Table 1-4. Preliminary Pharmacodynamic Parameters (FGF19 and C4) Following Multiple-Dose Administration of Placebo, or GS-9674 Under Fasting or Fed Conditions in Healthy Volunteers (GS-US-402-1851)**

PD Parameter Ratio Compared to Day -1 GeoMean (%CV)			Placebo		GS-9674				
			Fasted (N=12)	Fed (N=3)	10 mg Fasted (N=12)	30 mg Fasted (N=12)	100 mg Fasted (N=12)	100 mg Fed (N=12)	300 mg Fasted (N=12)
FGF19	Day 20	AUC <sub>2-8</sub>	1.35 (53.9)	0.77 (32.7)	3.07 (71.9)*	3.99 (42.0)*	3.61 (26.9)*	2.30 (40.1)*	3.94 (62.0)*
		C <sub>max</sub>	1.21 (48.0)	0.73 (45.2)	2.05 (94.6)*	2.39 (45.9)*	2.32 (44.9)*	2.24 (31.1)*	3.08 (57.0)*
C4	Day 20	AUC <sub>2-8</sub>	1.24 (93.8)	0.98 (41.9)	0.67 (86.8)*	0.39 (57.1)*	0.50 (101)*	0.69 (71.3)	0.33 (97.8)*
		C <sub>min</sub>	1.29 (78.7)	1.08 (42.6)	0.78 (59.3)	0.37 (59.6)*	0.71 (72.6)*	0.45 (80.5)*	0.44 (76.3)*

Pharmacodynamic parameters are presented as geometric mean ratio (arithmetic %CV), and shown to 3 significant digits  
\* p<0.05 compared to placebo

### 1.3. Rationale for this Study

PSC is a disorder of unknown etiology characterized by inflammation and fibrosis of the intrahepatic and extrahepatic bile ducts that result in the impairment of bile flow (cholestasis). Accumulation of excess bile acids causes hepatocellular cytotoxicity that leads to progressive liver fibrosis and cirrhosis. In pre-clinical and clinical studies, FXR agonism has been shown to reduce bile acid levels via FGF19-mediated suppression of cholesterol-7-alpha-hydroxylase (CYP7A1), the rate-limiting enzyme in bile acid biosynthesis {[Inagaki et al 2005](#)}, {[Pellicciari et al 2002](#)}, {[Mudaliar et al 2013](#)}. In addition, in a murine model of fibrosis caused by administration of a methionine choline deficient diet and sodium nitrite injections, GS-9674 has demonstrated an anti-fibrotic effect. Thus, GS-9674 is postulated to be beneficial in subjects with PSC.

This study will evaluate the safety, tolerability, and efficacy of 30 mg and 100 mg GS-9674 administered with food for 12 weeks in subjects with PSC. The doses were selected based on short-term safety, PD and PK results from Study GS-US-402-1851 in healthy subjects.

Across the range of GS-9674 doses evaluated (10 to 300 mg QD), doses  $\geq$  30 mg provide comparable intestinal FXR agonism assessed by increases in plasma FGF19 exposure. Food, by slowing oral absorption of GS-9674, results in prolonged elevation of plasma FGF19 concentrations. Exposure-response relationships show that changes in C4 exposure are negatively correlated with changes in FGF19 exposure as well as GS-9674 exposure. Based on these results, GS-9674 doses of 30 and 100 mg with food are selected for further study as they are expected to 1) provide enteral FXR agonism, reductions in bile acid pools, and liver biochemical improvements in subjects with PSC; and 2) inform regarding the impact of increasing systemic GS-9674 exposure on safety and efficacy.

In the Phase 1 study, GS-US-402-1851, GS-9674 was tested at doses up to 300 mg once daily for up to 14 days and was well-tolerated. Taken together, these data support the evaluation of GS-9674 30 and 100 mg in subjects with PSC.

Inclusion criteria for this study were developed in order to identify subjects with PSC who have persistently abnormal blood markers of liver biochemistry but without cirrhosis. These subjects are at an increased risk of PSC-related complications including the need for liver transplantation and death. Subjects with clinical and histologic evidence of cirrhosis will be excluded from this study due to the uncertain PK and PD properties of GS-9674 in the setting of subjects with cirrhosis. Targeting interventions in the proposed study population will provide evidence for the safety and efficacy of GS-9674 in subjects at risk for progressive hepatic fibrosis and cirrhosis.

### **1.3.1. Risk/Benefit Assessment for the Study**

Potential risks of a participant's study involvement include unknown AEs, general risks associated with frequent clinic visits and laboratory blood draws, and the associated pain and discomfort of phlebotomy. Strategies to mitigate these risks include close monitoring of lab values as well as AEs.

It should be noted that there are no currently approved therapies specifically for the treatment of PSC. The only therapeutic option available to PSC subjects with advanced liver disease is liver transplantation.

Subjects with PSC randomized to the placebo control arm in the study may benefit from frequent medical monitoring and close assessment of their PSC and associated pathologies during the duration of placebo treatment. Subjects randomized to GS-9674 and those who receive GS-9674 as part of the OLE phase, may benefit from an improvement in their underlying PSC which may manifest as improvements in liver biochemistry, measures of fibrosis, or improvements in quality of life. Importantly, this study will provide further data to inform the clinical development of the investigational medicinal product GS-9674 for use in an area of unmet medical need.

Overall, the nonclinical and limited preliminary clinical data show a positive benefit/risk ratio in support of the study in subjects with PSC. The study will be conducted in accordance with GCP and all applicable rules and regulations. Appropriate safety monitoring will be conducted throughout the study to further characterize the safety profile of GS-9674 in subjects without cirrhosis due to PSC.

### **1.4. Compliance**

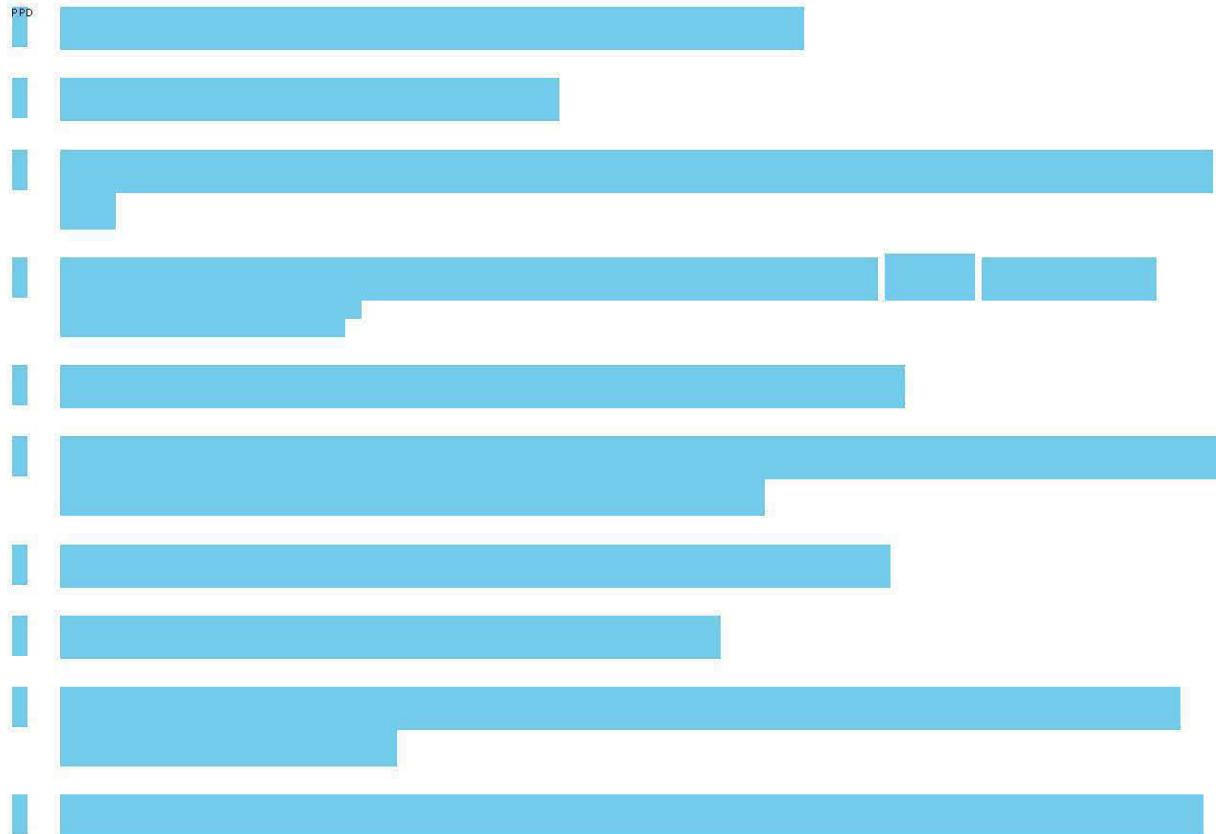
This study will be conducted in compliance with this protocol, Good Clinical Practice (GCP), and all applicable regulatory requirements.

## 2. OBJECTIVES

The **primary objective** of this study is as follows:

- To evaluate the safety and tolerability of GS-9674 in subjects with PSC

The **exploratory objectives** of this study are as follows:



### 3. STUDY DESIGN

#### 3.1. Study Design

This is a Phase 2 randomized, double-blind, placebo-controlled study evaluating the safety, tolerability, and efficacy of GS-9674 in subjects with PSC without cirrhosis.

The study will consist of 2 phases, a Blinded Study Phase and an OLE Phase.

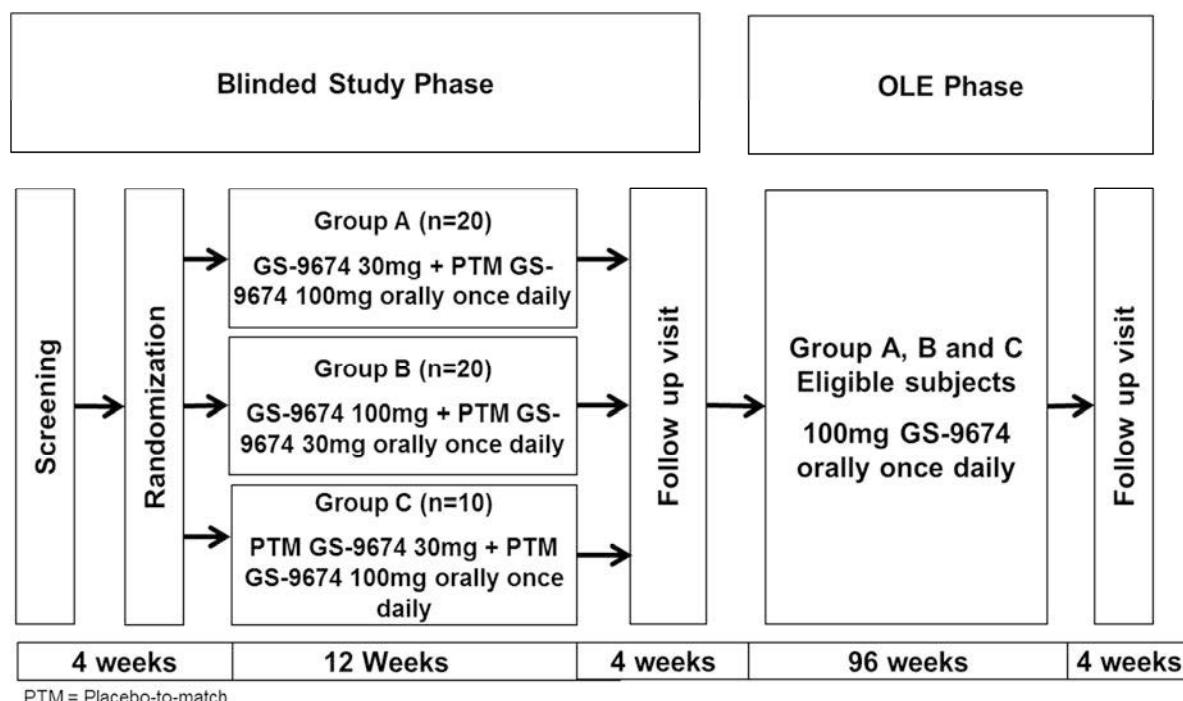
Blinded Study Phase: Includes a 4-week screening period, 12-weeks of blinded treatment, and a Blinded Study Phase Follow up visit 4 weeks after completion of blinded treatment.

Subjects completing the Blinded Study Phase without permanently discontinuing study drug will be eligible to participate in the OLE Phase of the study.

OLE Phase: Includes a 96-week OLE and an OLE Phase follow-up visit 4 weeks after completion of open label treatment.

The overall study design is presented graphically in [Figure 3-1](#).

**Figure 3-1. Overall Study Design**



### **3.2. Treatment Plan and Regimen**

Subjects meeting the study's entry criteria will be randomly assigned in a 2:2:1 ratio to 1 of 3 different treatment groups during the Blinded Study Phase as shown in [Figure 3-1](#).

Randomization will be stratified by the presence or absence of UDCA use.

Study drug(s) will be administered for a total of 12 weeks from the Baseline/Day 1 visit during the Blinded Study Phase and 96 weeks during the OLE Phase. Subjects will begin open-label treatment with GS-9674 (100 mg po daily). The dose of GS-9674 may be reduced from 100 mg to 30 mg (or subsequently increased back to 100 mg) at the PI's discretion with the approval of the MM, as required.

Subjects will be unblinded to their Blinded Study Phase treatment assignment after the primary analysis has been completed, approximately 6 weeks after all subjects have completed the Blinded Study Phase.

Dosage and administration of the study drug(s) and reference product are described in Section [5.3](#).

### **3.3. Biomarker Testing**

#### **3.3.1. Biomarker Samples to Address the Study Objectives:**

Biological specimens will be collected in this study as per the study procedures table ([Appendix 2](#)) and will be used to evaluate the association of exploratory systemic biomarkers with study drug response, including efficacy and/or adverse events and to increase knowledge and understanding of the biology of PSC or related diseases such as Primary Biliary Cholangitis (PBC) and/or the validation of a companion diagnostic for PSC. Because biomarker science is a rapidly evolving area of investigation, and adverse events in particular are difficult to predict, it is not possible to specify prospectively all tests that will be done on the specimens provided. The testing outlined is based upon the current state of scientific knowledge. It may be modified during or after the end of the study to remove tests no longer indicated and/or to add new tests based upon the growing state of art knowledge. Samples will be destroyed no later than 15 years after the end of the study.

Biomarker testing can include biomarkers that monitor auto-antibodies characteristic of PSC, and markers of bone metabolism. In addition biomarkers such as biochemicals, biological macromolecules, naturally occurring metabolites, and biomarkers of FXR activity (e.g. FGF19, C4 and bile acids) can also be determined.

### **3.3.2. Biomarker Samples for Optional Future Research**

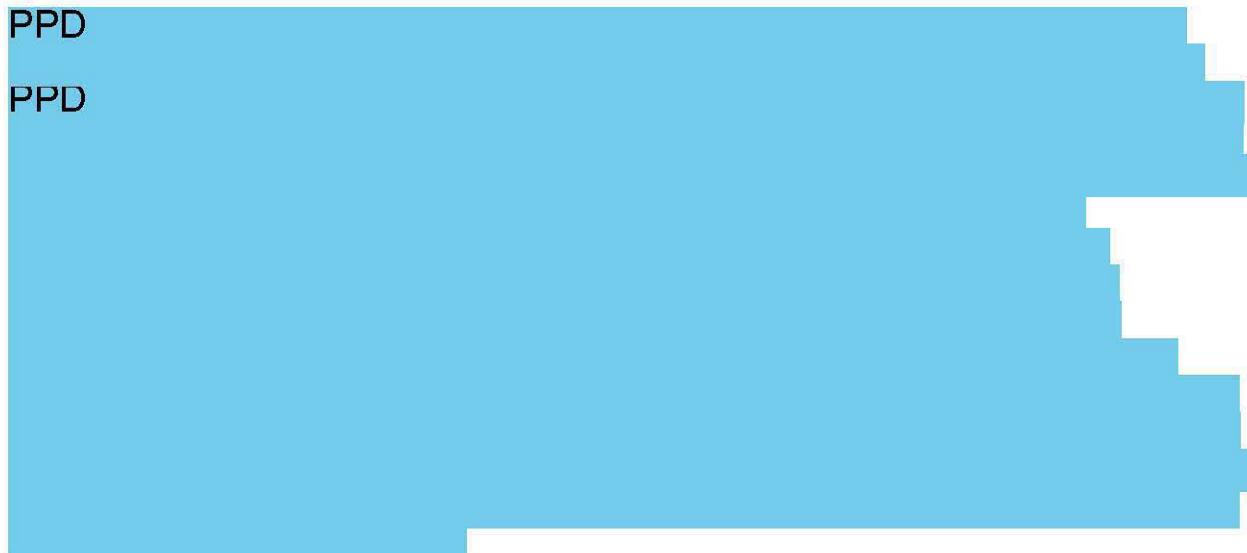
PPD



### **3.3.3. Biomarker Samples for Optional Genomic Research**

PPD

PPD



## 4. SUBJECT POPULATION

### 4.1. Number of Subjects and Subject Selection

This study will enroll approximately 50 adults, between 18 -70 years old with non-cirrhotic PSC.

### 4.2. Inclusion Criteria

Subjects must meet all of the following inclusion criteria to be eligible for participation in this study.

- 1) Males and females between 18-70 years of age; inclusive based on the date of the screening visit;
- 2) Willing and able to give informed consent prior to any study specific procedures being performed;
- 3) Diagnosis of PSC based on cholangiogram (magnetic resonance cholangiopancreatography [MRCP], endoscopic retrograde cholangiopancreatography [ERCP], or percutaneous transhepatic cholangiogram [PTC]) within the previous 12 months;
- 4) Serum ALP  $>1.67 \times$  ULN;
- 5) For subjects on UDCA, the dose of UDCA must have been stable for at least 6 months before screening through the end of the treatment. For subjects not on UDCA, no UDCA use for at least 6 month before screening through the end of the treatment;
- 6) For subjects being administered biologic treatments (eg, anti-tumor necrosis factor (TNF) or anti-integrin monoclonal antibodies), immunosuppressants or systemic corticosteroids, the dose must have been stable for at least 3 months prior to screening and anticipated to remain stable throughout the trial;
- 7) Screening FibroSURE/FibroTest<sup>®</sup>  $<0.75$ ;
- 8) Platelet count  $\geq 100,000/\text{mm}^3$ ;
- 9) Creatinine Clearance (CrCL) as calculated by the Cockcroft-Gault equation  $\geq 60 \text{ ml/min}$ ;
- 10) Females of childbearing potential (as defined in [Appendix 4](#)) must have a negative serum pregnancy test at the Screening visit and a negative urine pregnancy test on the Baseline/Day 1 visit prior to the first dose of study drug;
- 11) All female subjects of childbearing potential who engage in heterosexual intercourse must agree to use a highly effective method of contraception from the screening visit throughout the study period and for 30 days following the last dose of study drug(s) (see definition in [Appendix 4](#));

- 12) Male subjects with female partners of childbearing potential must use condoms during treatment and for 90 days after the last dose of study drug(s) (see [Appendix 4](#) for details);
- 13) Male subjects must agree to avoid sperm donation from Baseline/Day 1 visit throughout the study period and for 90 days after the last dose of study drug(s) (see [Appendix 4](#) for details);
- 14) Female subjects must refrain from egg donation and in-vitro fertilization during treatment and until at least 30 days after the last dose of study drug(s) (see [Appendix 4](#) for details);
- 15) Willing and able to comply with scheduled visits, drug administration plan, laboratory tests, liver biopsies, other study procedures, and study restrictions;
- 16) Must be able to read and complete QoL questionnaires independently.

#### **4.3. Exclusion Criteria**

Subjects who meet *any* of the following exclusion criteria are not to be enrolled in this study.

- 1) Pregnant or lactating females; lactating females must agree to discontinue nursing before the study drug (s) is administered;
- 2) ALT > 10x ULN;
- 3) Total bilirubin > 2x ULN;
- 4) INR > 1.2 unless on anticoagulant therapy;
- 5) Serum albumin < 3.0 g/dL;
- 6) Cirrhosis of the liver as defined by any of the following:
  - a) Historical liver biopsy demonstrating stage 4 fibrosis according to the Ludwig classification (or equivalent)
  - b) History of decompensated liver disease, including ascites, hepatic encephalopathy or variceal bleeding
  - c) Liver stiffness >14.4 kPa by FibroScan;
- 7) Small-duct PSC (histologic evidence of PSC with normal bile ducts on cholangiography);
- 8) Other causes of liver disease including secondary sclerosing cholangitis and viral, metabolic, alcoholic, and other autoimmune conditions.
- 9) Positive anti-mitochondrial antibody;

- 10) History of liver transplantation;
- 11) History of hepatocellular carcinoma or cholangiocarcinoma. If a dominant stricture is found, cholangiocarcinoma must be excluded prior to randomization;
- 12) Ascending cholangitis within 60 days of screening;
- 13) Presence of a percutaneous drain or bile duct stent;
- 14) Chronic hepatitis B (HBsAg positive);
- 15) Chronic hepatitis C (HCV antibody and RNA positive);
- 16) HIV Ab positive;
- 17) Current active inflammatory bowel disease (IBD) defined as a partial Mayo score of >2;
- 18) Known hypercoagulable condition or history of venous or arterial thromboembolic disease;
- 19) Alcohol consumption greater than 21 oz/week for males or 14 oz/week for females  
(1oz/30mL of alcohol is present in 1 12oz/360mL beer, 1 4oz/120mL glass of wine, and a 1 oz/30 mL measure of 40% proof alcohol);
- 20) History of intestinal resection or malabsorptive condition that may limit the absorption of GS-9674. Prior cholecystectomy and appendectomy are permitted;
- 21) Use of fibrates or obeticholic acid within 3 months prior to screening through the end of treatment;
- 22) Positive urine screen for amphetamines, cocaine or opiates (i.e. heroin, morphine) at screening. Subjects on stable methadone or buprenorphine maintenance treatment for at least 6 months prior to screening may be included in the study. Subjects with a positive urine drug screen due to prescription opioid-based medication are eligible if the prescription and diagnosis are reviewed and approved by the investigator;
- 23) Unstable cardiovascular disease as defined by any of the following:
  - a) Unstable angina within 6 months prior to screening
  - b) Myocardial infarction, coronary artery bypass graft surgery or coronary angioplasty within 6 months prior to screening
  - c) Transient ischemic attack or cerebrovascular accident within 6 months prior to screening
  - d) Obstructive valvular heart disease or hypertrophic cardiomyopathy
  - e) Congestive heart failure;

- 24) Use of any prohibited concomitant medications 28 days prior to Baseline/Day 1 through the treatment period as described in Section 5.5 of protocol;
- 25) History of a malignancy within 5 years of screening with the following exceptions:
  - a) Adequately treated carcinoma in situ of the cervix
  - b) Adequately treated basal or squamous cell cancer or other localized non-melanoma skin cancer;
- 26) Any laboratory abnormality or condition that, in the investigator's opinion, could adversely affect the safety of the subject or impair the assessment of study results;
- 27) Participation in another investigational study of a drug or device within 1 month prior or within 5 half-lives of the prior investigational agent (whichever is longer) prior to screening;
- 28) Concurrent participation in another therapeutic clinical study;
- 29) Known hypersensitivity to GS-9674, the metabolites, or formulation excipient;
- 30) Presence of any condition that could, in the opinion of the investigator, compromise the subject's ability to participate in the study, such as history of substance abuse or a psychiatric (including any subjects with a psychiatric hospital admission or emergency room visit in the 2 years prior to screening) or medical condition;
- 31) Unavailable for follow-up assessment or concern for subject's compliance with the protocol procedures.

## 5. INVESTIGATIONAL MEDICINAL PRODUCTS

### 5.1. Randomization, Blinding and Treatment Codes

An Interactive Web Response System (IWRS) will be used for centralized randomization and treatment assignment. Randomization will be stratified by the presence or absence of UDCA use.

Investigative site personnel will obtain the subject's identification number and study drug assignment from the IWRS. Subjects and all personnel directly involved in the conduct of the study will be blinded to treatment assignment.

Study drug(s) will be dispensed by the study pharmacist, or designee, in a blinded fashion to the subjects.

#### 5.1.1. Procedures for Breaking Treatment Codes

In the event of a medical emergency where breaking the blind is required to provide medical care to the subject, the investigator may obtain treatment assignment directly from the IWRS system for that subject (refer to the Study Reference Binder for IWRS unblinding instructions). Gilead recommends but does not require that the investigator contact the Gilead medical monitor before breaking the blind. Treatment assignment should remain blinded unless that knowledge is necessary to determine subject emergency medical care. The rationale for unblinding must be clearly explained in source documentation and on the case report form/ electronic case report form (eCRF), along with the date on which the treatment assignment was obtained. The investigator is requested to contact the Gilead medical monitor promptly in case of any treatment unblinding.

Blinding of study treatment is critical to the integrity of this clinical trial and therefore, if a subject's treatment assignment is disclosed to the investigator, the subject will have study treatment discontinued. All subjects will be followed until study completion unless consent to do so is specifically withdrawn by the subject.

Gilead Drug Safety and Public Health (DSPH) may independently unblind cases for expedited reporting of suspected unexpected serious adverse reactions (SUSARs).

### 5.2. Description and Handling of GS-9674 and PTM GS-9674

#### 5.2.1. Formulation

GS-9674 is supplied as 30 mg and 100 mg strength (as free form equivalent) tablets. The tablets contain GS-9674-02 **CCI**

GS-9674 tablets, 30 mg tablets are round, plain-faced, film-coated orange tablets and GS-9674 tablets, 100 mg tablets are capsule-shaped, plain-faced, film-coated orange tablets.

Placebo-to-match (PTM) GS-9674 tablets are identical in size, shape, color and appearance to their corresponding strengths of active GS-9674 tablets. PTM GS-9674 tablets contain the following ingredients: **CCI**  
[REDACTED]

### **5.2.2. Packaging and Labeling**

GS-9674 tablets and PTM GS-9674 tablets are packaged in white, high-density polyethylene (HDPE) bottles. Each bottle contains 30 tablets, silica gel desiccant, and polyester packing material. Each bottle is enclosed with a white, continuous thread, child-resistant screw cap with an induction-sealed, aluminum-faced liner.

Study drug(s) to be distributed to centers in the US and other participating countries shall be labeled to meet applicable requirements of the United States Food and Drug Administration (FDA), EU Guideline to Good Manufacturing Practice - Annex 13 (Investigational Medicinal Products), and/or other local regulations.

### **5.2.3. Storage and Handling**

Study drug GS-9674 and PTM GS-9674 tablets and PTM GS-9674 tablets should be stored at controlled room temperature of 25°C (77°F); excursions are permitted between 15°C and 30°C (59°F and 86°F). Storage conditions are specified on the label.

Until dispensed to the subjects, all bottles of study drugs should be stored in a securely locked area, accessible only to authorized site personnel. To ensure the stability and proper identification, study drug(s) should not be stored in a container other than the container in which they were supplied. Consideration should be given to handling, preparation, and disposal through measures that minimize drug contact with the body. Appropriate precautions should be followed to avoid direct eye contact or exposure when handling.

## **5.3. Dosage and Administration of GS-9674/PTM GS-9674**

GS-9674 and PTM GS-9674 tablets will be provided by Gilead Sciences. In order to maintain the blind, each subject will be supplied with 2 bottles of tablets during the blinded phase of the trial. One bottle will contain GS-9674 30 mg or PTM GS-9674 30 mg, the second bottle will contain GS-9674 100 mg or PTM GS-9674 100 mg. Dosing for each treatment group will be as follows:

- **Treatment Group A:** GS-9674 30 mg (1 x 30 mg tablet) + PTM GS-9674 100 mg (1 x PTM 100 mg tablet) administered orally once daily with food
- **Treatment Group B:** GS-9674 100 mg (1 x 100 mg tablet) + PTM GS-9674 30 mg (1 x PTM 30 mg tablet) administered orally once daily with food
- **Treatment Group C:** PTM GS-9674 30 mg (1 x PTM 30 mg tablet) + PTM GS-9674 100 mg (1 x PTM 100 mg tablet) administered orally once daily with food

During the OLE Phase of the study subjects will be provided with 100 mg bottles of GS-9674 only, unless reassigned to 30 mg dose due to tolerability. The dose of GS-9674 may be reduced from 100 mg to 30 mg (or subsequently increased back to 100 mg) at the PI's discretion with the approval of the MM, as required.

The study drug dose should be taken at approximately the same time each day with food.

A dose will be considered missed if the subject cannot take the dose within 12 hours of their regular dosing time. If a subject misses a dose, the subject should take their next dose at the regular dosing time.

#### **5.4. Prior and Concomitant Medications**

Concomitant use of certain medications or herbal/natural supplements with study drug may result in PK and/or PD interactions resulting in increases or decreases in exposure of study drug(s) or these medications.

Concomitant medications taken within 28 days of screening through the follow-up visit need to be recorded in the source documents and electronic Case Report Forms (eCRFs).

Subjects with co-morbid diseases requiring medication(s) must be taking the medication without a change in dose within 28 days of Baseline/Day 1.

#### **5.5. Prohibited Medications**

The following medications are prohibited from 28 days prior to Baseline/Day 1 up to and including the day of the last dose of study drug:

- Hematologic stimulating agents (e.g. erythropoiesis-stimulating agents (ESAs); granulocyte colony stimulating factor (GCSF); thrombopoietin (TPO) mimetics)
- Investigational agents or devices for any indication
- Concomitant use of certain medications or herbal/natural supplements (sensitive substrates, inhibitors or inducers of drug transporters P-gp, BCRP, or OATP, or the drug metabolizing enzyme CYP3A or inhibitors or inducers of CYP2C8) with study drug(s) may result in PK interactions resulting in increases or decreases in exposure of study drug(s) or concomitant medications. Examples of representative medications which are prohibited from 28 days prior to Baseline/Day 1 through the treatment period are listed below in [Table 5-1](#)

**Table 5-1. List of Prohibited Medications**

Drug Class	Agents Disallowed
Antibiotics	Azithromycin, Clarithromycin, Erythromycin
Acid Reducing Agents	Proton-Pump Inhibitors, H2-Receptor Antagonists, Antacids <sup>a</sup>
Alpha 1-Adrenoceptor Antagonists	Alfuzosin
Anticonvulsants <sup>b</sup>	Carbamazepine, Clonazepam, Ethosuximide, Oxcarbazepine, Phenobarbital, Phenytoin,
Antidiabetics	Glyburide, Repaglinide
Antidepressants	Trazodone
Antifungals	Itraconazole, Ketoconazole, Voriconazole
Antigout	Colchicine
Antimycobacterials <sup>b</sup>	Rifamycins, Isoniazid
Cardiac Medications	Amiodarone, Amlodipine, Bepridil, Digoxin, Diltiazem, Disopyramide, Dronedarone, Felodipine, Nicardipine, Nifedipine, Olmesartan, Ranolazine, Systemic Lidocaine, Telmisartan, Valsartan, Verapamil, Quinidine
Corticosteroids	Dexamethasone, Fluticasone
Endothelin Receptor Antagonists	Bosentan
Ergot Derivatives	Dihydroergotamine, Ergonovine, Ergotamine, Methylergonovine
GI Motility Agents	Cisapride
Herbal/Natural Supplements <sup>b</sup>	St. John's Wort, Echinacea, Milk thistle (i.e. silymarin), Chinese herb sho-saiko-to (or Xiao-Shai-Hu-Tang)
HMG-CoA Reductase Inhibitors <sup>c</sup>	Atorvastatin, Fluvastatin, Lovastatin, Pitavastatin, Pravastatin, Rosuvastatin, Simvastatin
Inhaled Beta Agonists	Salmeterol
Phosphodiesterase Type 5 (PDE5) inhibitors	Sildenafil, Tadalafil, Vardenafil
Sedatives/Hypnotics	Buspirone, Clorazepate, Diazepam, Estazolam, Flurazepam, Midazolam, Triazolam, Zolpidem
Selective Serotonin Reuptake Inhibitors	Fluvoxamine
Other	Gemfibrozil, Modafinil, Sulfasalazine, Methotrexate

a Antacids that directly neutralize stomach pH (i.e. Tums, Maalox) are permitted but may not be taken within 4 hours (before or after) study drug administration

b May result in a decrease in the concentrations of study drug

c Use with study drug may result in an increase in the concentration of the HMG-CoA Reductase Inhibitors. The 28 day washout period does not apply to HMG-CoA Reductase inhibitors, which can be taken up to the day before Baseline/Day 1

Medications for disease conditions **excluded** from the protocol (eg, HIV-1, HBV, or HCV infection, active cancer, transplantation) are not listed under this prohibited medication section and are disallowed in the study.

## **5.6.            Accountability for GS-9674/ PTM GS-9674**

The investigator or designee (eg, pharmacist) is responsible for ensuring adequate accountability of all used and unused study drug bottles. This includes acknowledgement of receipt of each shipment of study drug (quantity and condition), subject dispensing records, and returned or destroyed study product. All used and unused study drug bottles dispensed to subjects must be returned to the site.

Study drug accountability records will be provided to each study site to:

- Record the date received and quantity of study drug bottles
- Record the date, subject number, subject initials, and the study drug bottle number dispensed
- Record the date, quantity of used and unused study drug returned, along with the initials of the person recording the information.

### **5.6.1            Investigational Medicinal Product Return or Disposal**

Refer to Section [9.1.7](#) for instructions regarding study drug return or disposal.

## **6. STUDY PROCEDURES**

The study procedures to be conducted for each subject randomized in the study are presented in tabular form in [Appendix 2](#) and described in the text that follows. Additional information is provided in Study Reference Binder.

The investigator must document any deviation from protocol procedures and notify the sponsor or contract research organization (CRO).

### **6.1. Subject Randomization and Treatment Assignment**

It is the responsibility of the investigator to ensure that subjects are eligible to participate in the study prior to randomization and throughout the study.

Documentation of the personally signed and dated informed consent of each subject, using the study-specific ICF, is required before initiating the screening process.

After written informed consent has been obtained and eligibility to participate established, investigative site personnel will obtain the subject's identification number and study drug assignment from the interactive web response system (IWRS).

### **6.2. Pretreatment Assessments-Screening Visit**

Subjects will be screened within 4 weeks before randomization to determine eligibility for participation in the study. The screening period may be extended under special circumstances with the explicit approval of the Medical Monitor.

Screening labs may be repeated once within the screening period, prior to administration of study drug to rule out laboratory error, if any. This will be done at the discretion of the investigator.

The following will be performed and documented at Screening:

- Obtain written informed consent before initiation of any screening procedures
- Review and record whether the subject meets inclusion and exclusion criteria
- Obtain screening number from IWRS
- Obtain medical history
- Calculate partial Mayo Score for subjects with IBD
- Complete physical examination
- Record vital signs, body weight and height

- Obtain blood samples for
  - Chemistry
  - Hematology
  - Coagulation Panel
  - Biomarkers
  - HIV-1/2, HBV and HCV Serology
  - Serum pregnancy test (female subjects of child bearing potential only)
  - Serum FSH (only for some female subjects - see [Appendix 4](#))
- Cirrhosis assessment: FibroSURE/FibroTest®
- Urine drug screen for amphetamines, cocaine and opiates (ie, heroin, morphine)
- Record any SAEs and all AEs related to protocol mandated procedures occurring after signing of the consent form.
- Record all concomitant medications (CMs) that the subject has taken within 28 days prior to screening

Subjects meeting all of the inclusion criteria and none of the exclusion criteria will return to the clinic within 4 weeks after screening for randomization into the study.

From the time of obtaining informed consent through the first administration of investigational medicinal product, record all serious adverse events (SAEs), as well as any AEs related to protocol-mandated procedures on the adverse events case report form (eCRF). All other untoward medical occurrences observed during the screening period, including exacerbation or changes in medical history are to be captured on the medical history eCRF. See Section [7](#) Adverse Events and Toxicity Management for additional details.

### **6.3.                   Blinded Study Phase: Baseline/Day 1 Randomization and Assessments**

Subjects returning to the clinic for randomization at Baseline/Day 1 will be instructed to fast (no food or drink, except water), starting from midnight or earlier, as appropriate, on the evening prior to the Baseline/Day 1 visit to ensure an approximate 8-hour fast prior to the blood sample collection under fasting condition the next morning.

After review of inclusion and exclusion criteria to confirm continued eligibility, subjects will be randomized to study drug assignment and receive their Subject Identification Number via the

IWRS prior to their first dose of study drug. Randomization will be stratified by the presence or absence of UDCA use.

The following will be performed and documented at the Baseline/Day 1 visit prior to dosing:

- QoL Questionnaires (PBC-40, SF-36 and PSC PRO)
- Pruritus assessments (Pruritus VAS and 5D-Itch)

Note: It is recommended that QoL questionnaires be completed prior to any study procedures being performed and prior to the subject seeing a health care provider. Refer to the Study Reference Binder for guidance on QoL questionnaire administration.

- Calculate partial Mayo Score for subjects with IBD
- Symptom-driven physical examination
- Record vital signs, weight and height
- Obtain Blood samples for:
  - Chemistry
  - Hematology
  - Coagulation Panel
  - Lipid Profile
  - C-peptide, insulin and hemoglobin A1c (HbA1c)
  - Biomarkers
  - Single PD Sampling

## PPD

- Conduct standard 12-Lead ECG
- Perform FibroScan® (if available)
- Collect urine samples for:
  - Urine pregnancy test for females of child bearing potential only
  - Biomarkers

- Collect stool sample
- Dispense study drug, and provide subject with instruction on appropriate dosing and administration
- Record all CMs that the subject has taken since the previous visit
- Record any SAEs and all AEs occurring since the Screening visit

Once all visit procedures have been completed, subjects will take their Baseline/Day 1 dose of study drug with food while at the investigative site

Subjects will return to the investigative site at Week 1 ( $\pm 3$  days).

#### **6.4. Treatment Assessments (Blinded Study Phase)**

##### **6.4.1. Weeks 1, 2, 4 and 8 ( $\pm 3$ days)**

Subjects will be instructed to fast (no food or drink, except water), starting from midnight (00:00) or earlier, as appropriate, on the evening prior to ensure an approximate 8-hour fast prior to the fasted blood sample collection the next morning.

Subjects should also be instructed to HOLD their dose of study drug on the day of their visit until all visit procedures have been completed. The study drug dose should be taken with food after the visit.

The following treatment procedures/assessments are to be completed at the end of Weeks 1, 2, 4, and 8 for all subjects (see [Appendix 2](#)).

- Pruritus assessments (Pruritus VAS and 5D-Itch)
- Calculate partial Mayo Score for subjects with IBD
- Symptom-driven physical examination
- Record vital signs and body weight
- Obtain blood samples for:
  - Chemistry
  - Hematology
  - Coagulation Panel
  - Lipid Profile at Weeks 1, 4 and 8 only

- Biomarkers at Weeks 1 and 4 only
- Single PK and PD sampling

## PPD

- Obtain urine Samples for:
  - Urine pregnancy testing (female of childbearing potential only) at Weeks 1, 4 and 8 only
  - Biomarkers at Weeks 1 and 4 only
- Dispense the study drug as directed by IWRS (if applicable)
  - Review study drug compliance and drug administration instructions with subject
  - Reconcile study drug administration using pill counts at Weeks 4 and 8 only
- Record all CMs that the subject has taken since the previous visit
- Record any SAEs and all AEs occurring since the previous visit

### 6.4.2. Week 12 ( $\pm$ 3 days)

Subjects will be instructed to fast (no food or drink, except water), starting from midnight (00:00) or earlier, as appropriate, on the evening prior to the Week 12 visits to ensure an approximate 8-hour fast prior to the fasted blood sample collection the next morning.

The following treatment procedures/assessments are to be completed at this visit.

- QoL Questionnaires (PBC-40, SF-36 and PSC PRO)
- Pruritus assessments (Pruritus VAS and 5D-Itch)
- Calculate partial Mayo Score for subjects with IBD
- Symptom-driven physical examination
- Record vital signs and body weight
- Obtain blood samples for:
  - Chemistry

- Hematology
- Coagulation Panel
- Lipid Profile
- C-peptide, insulin and hemoglobin A1c
- Biomarkers
- Single PK and PD sampling
- Obtain Urine samples for:
  - Urine pregnancy testing (female of childbearing potential only)
  - Biomarker assessments
- Collect stool sample
- Conduct standard 12-Lead ECG
- Perform FibroScan® (if available)
- Review study drug compliance
  - Reconcile study drug administration using pill counts
  - All study drugs should be returned at this visit
- Record all CMs that the subject has taken since the previous visit
- Record any SAEs and all AEs occurring since the previous visit

Once all visit procedures have been completed, subjects will self-administer their last dose of study drug while at the investigative site.

If a subject discontinues treatment early for any reason they should complete the 12 week treatment visit assessment/ Early Termination Visit (ET) assessments then the follow up visit (4 weeks following the last dose of the study drug) should be completed (see [Appendix 2](#)).

## **6.5.           Blinded Study Phase follow-up Visit ( $\pm 5$ days)**

Subjects will return for a Blinded Study Phase follow-up visit after completing their 12 weeks of treatment. The ET subjects should also complete the follow-up visit after completing the ET visit.

The Blinded Study Phase follow-up visit will be completed 4 week post last dose of study drug.

The following will be performed and documented at this visit (see [Appendix 2](#)).

- QoL Questionnaires (PBC-40, SF-36 and PSC PRO)
- Pruritus assessments (Pruritus VAS and 5D-Itch)
- Calculate partial Mayo Score for subjects with IBD
- Symptom-driven physical examination
- Record vital signs and body weight
- Obtain blood samples for:
  - Chemistry
  - Hematology
  - Coagulation Panel
  - Lipid Profile
  - Biomarkers
- Obtain Urine samples for:
  - Urine pregnancy testing (females of childbearing potential only)
  - Biomarkers
- Record all CMs that the subject has taken since the previous visit
- Record any SAEs and all AEs occurring since the previous visit

Subjects will be unblinded to their Blinded Study Phase treatment assignment after the primary analysis has been completed, approximately 6 weeks after all subjects have completed the Blinded Study Phase or early terminated.

Subjects must have their OLE Baseline/Day 1 visit within 30 days of completing the Blinded Study Phase follow-up.

If OLE Baseline/Day 1 and Blinded Study Phase follow-up visit is on the same day subjects should only complete OLE Baseline /Day 1 assessments.

#### **6.6. Open Label Extension (OLE) Phase ( $\pm$ 5 days)**

Subjects will be instructed to fast (no food or drink, except water), starting from midnight (00:00) or earlier, as appropriate, on the evening prior to their visits to ensure an approximate 8-hour fast prior to the fasted blood sample collection the next morning.

Subjects should also be instructed to HOLD their dose of study drug on the day of the Baseline/Day 1 visit until all visit procedures have been completed. The study drug dose should be taken with food after the visit.

The following treatment procedures/assessments are to be completed at the OLE Baseline/Day 1 Visit, followed by OLE Weeks 4, 12, 24, 36, 48, 60, 72, 84 and 96 weeks (see [Appendix 2](#)).

- QoL Questionnaires (PBC-40, SF-36 and PSC PRO)
- Pruritus assessments (Pruritus VAS and 5D-Itch)
- Calculate partial Mayo Score for subjects with IBD
- Symptom-driven physical examination
- Record vital signs and body weight
- Obtain blood samples for:
  - Chemistry
  - Hematology
  - Coagulation Panel
  - Lipid Profile
  - Biomarkers
- Obtain Urine samples for:
  - Urine pregnancy testing (females of childbearing potential only)
  - Biomarkers at OLE Baseline/Day 1, Weeks 24, 48, 72 and 96 only

- Collect stool sample at OLE Baseline/Day 1, Week 48 and Week 96 only
- Dispense the study drug as directed by IWRS
  - Review study drug compliance and drug administration instructions with subject
  - Reconcile study drug administration using pill counts
  - Study drug should be returned at Week 96 visit
- Record all CMs that the subject has taken since the previous visit
- Record any SAEs and all AEs occurring since the previous visit

## **6.7.           Unscheduled Visits**

Additional unscheduled assessments may be performed at the discretion of the investigator.

Subjects returning to the clinic for an unscheduled visit will be instructed to fast (no food or drink, except water), starting from midnight (00:00) or earlier, as appropriate, on the evening prior to the visit to ensure an approximate 8-hour fast prior to the blood sample collection under fasting condition the next morning.

Subjects should also be instructed to HOLD their dose of study drug on the day of an unscheduled visit until all visit procedures have been completed. The study drug dose should be taken with food after the visit.

At a minimum, the following will be performed and documented.

- Calculate partial Mayo Score for subjects with IBD
- Symptom-driven physical examination
- Obtain blood samples for:
  - Chemistry
  - Hematology
  - Single PK and PD should be collected for any unscheduled visit during Blinded Study Phase (Weeks 1 to 12 visits).
- Record body weight
- Record all CMs that the subject has taken since the previous visit
- Record any SAEs and all AEs occurring since the previous visit

## **6.8. OLE follow-up Visit ( $\pm 5$ days)**

Subjects will return for OLE follow-up visit after completing their OLE Week 96 visit. Subjects should also complete the follow-up visit after completing the ET visit for the OLE Phase.

The OLE follow-up visit will be completed 4 week post last dose of study drug.

The following will be performed and documented at this visit (see [Appendix 2](#)).

- Pruritus assessments (Pruritus VAS and 5D-Itch)
- Calculate partial Mayo Score for subjects with IBD
- Symptom-driven physical examination
- Record vital signs and body weight
- Obtain blood samples for:
  - Chemistry
  - Hematology
  - Coagulation Panel
  - Lipid Profile
- Urine pregnancy test for female subjects of child bearing potential only
- Record all CMs that the subject has taken since the previous visit
- Record any SAEs and all AEs occurring since the previous visit

## **6.9. Assessments for Premature Discontinuation from Study**

Subjects prematurely discontinuing from the study either during the Blinded Study Phase or during the OLE Phase (for example, as a result of an AE), should have an Early Termination (ET) visit completed followed by a follow-up visit 4 weeks after the last dose of the study medication. The study assessments to be performed at the ET visit are the same as those performed at the Week 12 visit (refer to [Section 6.4.2](#)) for ET subjects in the Blinded Study Phase and Week 96 visit for ET subjects in the OLE Phase (refer to [Section 6.6](#)). The study assessments to be performed at the follow-up visits are listed in [Section 6.5](#) and [6.8](#) respectively. The subject will then be withdrawn from the study.

If these visits are not possible or acceptable to the subject or investigator, the subject may be withdrawn from the study.

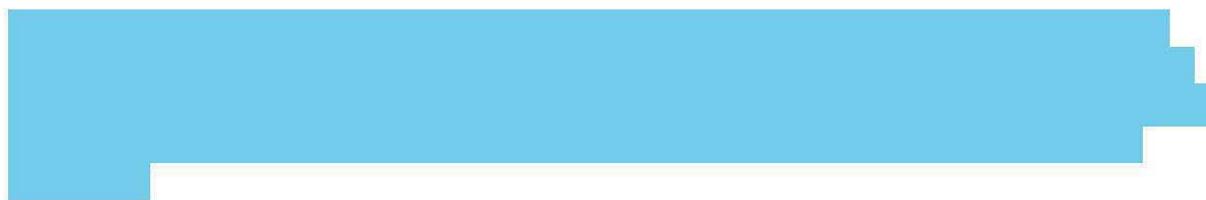
## **6.10. Criteria for Discontinuation of Study Treatment**

Study medication may be discontinued in the following instances:

- Intercurrent illness that would, in the judgment of the investigator, affect assessments of clinical status to a significant degree. Following resolution of intercurrent illness, the subject may resume study dosing at the discretion of the investigator.
- Unacceptable toxicity, or toxicity that, in the judgment of the investigator, compromises the ability to continue study-specific procedures or is considered to not be in the subject's best interest
- Subject request to discontinue for any reason
- Subject noncompliance
- Pregnancy during the study; refer to [Appendix 4](#).
- Sponsor discretion
- Discontinuation of the study at the request of Gilead, a regulatory agency or an institutional review board or independent ethics committee (IRB/IEC)

## **6.11. PK and PD Substudy Visits**

PPD



## **6.12. Procedures and Specifications**

### **6.12.1. Clinical Laboratory Analytes**

Chemistry:

Alanine aminotransferase (ALT), aspartate aminotransferase (AST), albumin, alkaline phosphatase (ALP), bicarbonate, blood urea nitrogen (BUN), calcium, chloride, creatinine, glucose, lactate dehydrogenase (LDH), magnesium, phosphorus, potassium, sodium, total and

direct bilirubin, total protein, uric acid, gamma-glutamyl transferase (GGT). Also includes C-Peptide, insulin and hemoglobin A1c (HbA1c) for the Baseline/Day1 and Week 12 visits.

Creatinine clearance is calculated by the Cockcroft-Gault equation {[Cockcroft et al 1976](#)} using actual body weight (BW). The calculation will be performed by the central laboratory.

Hematology:

Hematocrit (Hct), hemoglobin (Hb), platelet count, red blood cell count (RBC), white blood cell count (WBC) with differential (absolute and percentage) including lymphocytes, monocytes, neutrophils, eosinophils, and basophils and, reticulocyte count and mean corpuscular volume (MCV).

Coagulation Panel:

Prothrombin time (PT), partial thromboplastin time (PTT), and international normalized ratio (INR)

Pregnancy Tests:

Serum  $\beta$ -hCG or urine  $\beta$ -hCG (if positive, requires immediate confirmation with Serum  $\beta$ -hCG)

Additional Tests:

Lipid Profile, HIV-1, HBV & HCV Serology, urine drug screen (for amphetamines, cocaine, opiates), and genomic sample collection

Biomarker tests

Including but not limited to biomarkers of:

Circulating lipids - ApoB and NMR lipoprofile

Inflammation - hsCRP, TNF- $\alpha$

Bone formation – bone specific ALP and PTH

Liver fibrosis – ELF Test and FibroSURE/FibroTest<sup>®</sup>

FXR pathway activity - FGF19, C4 and bile acids

Urine samples:

Collected and stored for future biomarker testing (protein, albumin, retinol binding protein,  $\beta$ 2-microglobulin and creatinine)

## Pharmacokinetic (PK) and Pharmacodynamic (PD) Assessments

### *Single PK and PD Sampling*

Single PK and PD plasma samples will be collected and archived for 1) PK analysis of GS-9674, GS-716070 (metabolite of GS-9674), and other metabolites as applicable, 2) to measure the concentration of the PD biomarkers FGF19 and C4.

## PPD

### **6.12.2. Medical History**

Medical history including details regarding illnesses and allergies, date(s) of onset, and whether condition(s) is currently ongoing, and medication history, including nicotine and alcohol use, will be collected on all subjects during screening.

### **6.12.3. Physical Examination**

A complete physical examination should include source documentation of general appearance, and the following body systems: head, neck, and thyroid; eyes, ears, nose, throat, mouth, and tongue; chest (excluding breasts); respiratory; cardiovascular; lymph nodes; abdomen; skin, hair, nails; musculoskeletal and neurological.

The focus of a symptom-driven physical examination will be determined by the investigator based on subject complaint. For example if a subject complains of a cough a respiratory exam should be performed. If consistent with pneumonia (e.g. rales or crackles are identified) then an AE would be documented.

Height and body weight will be collected at specified time points.

### **6.12.4. Quality of Life (QoL) Measures and Pruritus Assessments**

It is recommended that these questionnaires be completed prior to the clinical and laboratory assessments. The subject should read the questionnaires by himself/herself and record the answers by himself/herself.

#### **6.12.4.1. Short Form-36 (SF-36) Health Survey**

The SF-36 Health Survey asks 36 questions to measure functional health and well-being from the subject's point of view and consists of eight health domains (physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional, and mental health). These health domain scales contribute to the physical health and mental health summary measures.

#### 6.12.4.2. Partial Mayo Score

The partial Mayo score is a survey for the assessment of IBD that considers stool frequency, rectal bleeding, and a physician's global assessment of disease severity.

#### 6.12.4.3. PSC Patient-Reported Outcome (PRO) Measure

The PSC PRO addresses the severity of common, everyday symptoms of PSC (e.g. pruritus, fatigue, right upper quadrant abdominal discomfort) and their functional impact (e.g. on physical function, activities of daily living, work productivity, etc.).

#### 6.12.4.4. Primary Biliary Cirrhosis-40 (PBC-40) Questionnaire

The PBC-40 is a health-related QoL questionnaire that includes 40 questions regarding PBC-related symptoms including itch, fatigue, cognition, and social and emotional assessments symptoms that are also relevant to the PSC population.

#### 6.12.4.5. Pruritus Visual Analog Scale (VAS) measure

The Pruritus VAS is a tool that uses a numeric scale for measuring the intensity of pruritus.

#### 6.12.4.6. 5D-Itch Questionnaire

The 5D- Itch questionnaire is a validated survey for the assessment of the severity of pruritus in patients with chronic pruritus due to dermatological and non-dermatological disorders.

### 6.12.5. **Electrocardiogram**

Standard 12-lead electrocardiogram (ECG) assessments will be performed. The Investigator will review the ECGs for any clinically significant abnormalities to ensure subject safety. Abnormal ECG findings that are considered clinically significant by the Investigator and meet the definition of an AE should be reported and recorded in the AE eCRF page.

### 6.12.6. **FibroScan®**

Liver stiffness will be assessed by FibroScan®. It is required that each subject's FibroScan® assessments be done with the same type of probe at each study visit. If FibroScan® is not available at a site the test may be omitted.

Please refer to the Study Reference Binder for instructions on FibroScan® measurements.

### 6.13. **End of Study**

End of study is defined as when the last patient last visit (LPLV) for the OLE follow-up visit occurs 4 weeks after completing OLE treatment or the OLE ET follow-up visit, whichever occurs later.

### **6.13.1. Sample Storage**

Residual biological samples from all visits will be frozen and stored. These stored samples may be used by Gilead or our research partners to help answer questions about the study drug, PSC and its associated conditions, or clinical laboratory testing to provide additional safety data. No human genetic testing will be performed without express consent of the study subjects. At the conclusion of this study, these samples may be retained in storage for Gilead for a period of up to 15 years.

## 7. ADVERSE EVENTS AND TOXICITY MANAGEMENT

### 7.1. Definitions of Adverse Events, Adverse Reactions, and Serious Adverse Events

#### 7.1.1. Adverse Events

An adverse event (AE) is any untoward medical occurrence in a clinical study subject administered a medicinal product, which does not necessarily have a causal relationship with the treatment. An AE can therefore be any unfavorable and/or unintended sign, symptom, or disease temporally associated with the use of a medicinal product, whether or not considered related to the medicinal product. AEs may also include pre- or post-treatment complications that occur as a result of protocol specified procedures, overdose, drug abuse/misuse reports, or occupational exposure. Preexisting events that increase in severity or change in nature during or as a consequence of participation in the clinical study will also be considered AEs.

An AE does not include the following:

- Medical or surgical procedures such as surgery, endoscopy, tooth extraction, and transfusion. The condition that led to the procedure may be an adverse event and must be reported
- Pre-existing diseases, conditions, or laboratory abnormalities present or detected before the Screening visit that do not worsen
- Situations where an untoward medical occurrence has not occurred (eg., hospitalization for elective surgery, social and/or convenience admissions)
- Overdose without clinical sequelae (see Section [7.6.1](#))
- Any medical condition or clinically significant laboratory abnormality with an onset date before the consent form is signed and not related to a protocol-associated procedure is not an AE. It is considered to be pre-existing and should be documented on the medical history CRF.

#### 7.1.2. Serious Adverse Events

A **serious adverse event** (SAE) is defined as an event that, at any dose, results in the following:

- Death
- Life-threatening (Note: The term “life-threatening” in the definition of “serious” refers to an event in which the subject was at risk of death at the time of the event; it does not refer to an event that hypothetically might have caused death if it were more severe.)
- In-patient hospitalization or prolongation of existing hospitalization

- Persistent or significant disability/incapacity
- A congenital anomaly/birth defect
- A medically important event or reaction: such events may not be immediately life-threatening or result in death or hospitalization but may jeopardize the subject or may require intervention to prevent one of the other outcomes constituting SAEs. Medical and scientific judgment must be exercised to determine whether such an event is a reportable under expedited reporting rules. Examples of medically important events include intensive treatment in an emergency room or at home for allergic bronchospasm; blood dyscrasias or convulsions that do not result in hospitalization; and development of drug dependency or drug abuse. For the avoidance of doubt, infections resulting from contaminated medicinal product will be considered a medically important event and subject to expedited reporting requirements.

#### **7.1.3. Clinical Laboratory Abnormalities and Other Abnormal Assessments as Adverse Events or Serious Adverse Events**

Laboratory abnormalities without clinical significance are not recorded as AEs or SAEs. However, laboratory abnormalities (eg, clinical chemistry, hematology, and urinalysis) that require medical or surgical intervention or lead to study drug interruption, modification, or discontinuation must be recorded as an AE, as well as an SAE, if applicable. In addition, laboratory or other abnormal assessments (eg, electrocardiogram, x-rays, vital signs) that are associated with signs and/or symptoms must be recorded as an AE or SAE if they meet the definition of an AE or SAE as described in Sections 7.1.1 and 7.1.2. If the laboratory abnormality is part of a syndrome, record the syndrome or diagnosis (eg, anemia), not the laboratory result (ie, decreased hemoglobin).

For specific information on handling of clinical laboratory abnormalities in this study, please refer to (Section 7.5).

#### **7.2. Assessment of Adverse Events and Serious Adverse Events**

The investigator or qualified subinvestigator is responsible for assessing AEs and SAEs for causality and severity, and for final review and confirmation of accuracy of event information and assessments.

##### **7.2.1. Assessment of Causality for Study Drugs and Procedures**

The investigator or qualified subinvestigator is responsible for assessing the relationship to GS-9674 therapy using clinical judgment and the following considerations:

- **No:** Evidence exists that the adverse event has an etiology other than the GS-9674. For SAEs, an alternative causality must be provided (eg, pre-existing condition, underlying disease, intercurrent illness, or concomitant medication).

- **Yes:** There is reasonable possibility that the event may have been caused by the investigational medicinal product.

It should be emphasized that ineffective treatment should not be considered as causally related in the context of adverse event reporting.

The relationship to study procedures (eg, invasive procedures such as venipuncture or biopsy) should be assessed using the following considerations:

- **No:** Evidence exists that the adverse event has an etiology other than the study procedure.
- **Yes:** The adverse event occurred as a result of protocol procedures (eg., venipuncture)

### **7.2.2. Assessment of Severity**

The severity grading of AEs will be assessed as Grade 1, 2, 3, 4 or 5 according to the Common Terminology Criteria for Adverse Events (CTCAE) Version 4.03, which can be found at [http://evs.nci.nih.gov/ftp1/CTCAE/CTCAE\\_4.03\\_2010-06-14\\_QuickReference\\_8.5x11.pdf](http://evs.nci.nih.gov/ftp1/CTCAE/CTCAE_4.03_2010-06-14_QuickReference_8.5x11.pdf) ([Appendix 3](#)).

For AEs associated with laboratory abnormalities, the event should be graded on the basis of the clinical severity in the context of the underlying conditions; this may or may not be in agreement with the grading of the laboratory abnormality.

The distinction between the seriousness and the severity of an adverse event should be noted. Severe is a measure of intensity; thus, a severe reaction is not necessarily a serious reaction. For example, a headache may be severe in intensity, but would not be classified as serious unless it met one of the criteria for serious events listed above.

### **7.3. Investigator Requirements and Instructions for Reporting Adverse Events and Serious Adverse Events to Gilead**

Requirements for collection prior to study drug initiation:

After informed consent, but prior to initiation of study medication, the following types of events should be reported on the case report form (eCRF): all SAEs and adverse events related to protocol-mandated procedures.

#### **Adverse Events**

Following initiation of study medication, collect all AEs, regardless of cause or relationship, until 30 days after last administration of GS-9674; AEs must be reported to the eCRF database as instructed.

All AEs should be followed up until resolution or until the adverse event is stable, if possible. Gilead Sciences may request that certain AEs be followed beyond the protocol defined follow up period.

## **Serious Adverse Events**

All SAEs, regardless of cause or relationship, that occurs after the subject first consents to participate in the study (ie, signing the informed consent) and throughout the duration of the study, including the protocol-required post treatment follow-up period, must be reported to the eCRF database and Gilead Drug Safety and Public Health (DSPH) as instructed. This also includes any SAEs resulting from protocol-associated procedures performed after informed consent is signed.

Any SAEs and deaths that occur after the post treatment follow-up visit and within 30 days of the last dose of study drug, regardless of causality, should also be reported.

Investigators are not obligated to actively seek SAEs after the protocol defined follow up period; however, if the investigator learns of any SAEs that occur after study participation has concluded and the event is deemed relevant to the use of IMP, he/she should promptly document and report the event to Gilead DSPH.

- All AEs and SAEs will be recorded in the eCRF database within the timelines outlined in the eCRF completion guideline.

### Electronic Serious Adverse Event (eSAE) Reporting Process

- Site personnel record all SAE data in the eCRF database and from there transmit the SAE information to Gilead DSPH within 24 hours of the investigator's knowledge of the event. Detailed instructions can be found in the eCRF completion guidelines.
- If for any reason it is not possible to record the SAE information electronically, ie, the eCRF database is not functioning, record the SAE on the paper serious adverse event reporting form and submit within 24 hours to:

Gilead DSPH	Email: Safety_FC@gilead.com
	Fax: +1 650-522-5477

- As soon as it is possible to do so, any SAE reported via paper must be transcribed into the eCRF Database according to instructions in the eCRF completion guidelines.
- If an SAE has been reported via a paper form because the eCRF database has been locked, no further action is necessary.
- For fatal or life-threatening events, copies of hospital case reports, autopsy reports, and other documents are also to be submitted by e-mail or fax when requested and applicable. Transmission of such documents should occur without personal subject identification, maintaining the traceability of a document to the subject identifiers.
- Additional information may be requested to ensure the timely completion of accurate safety reports.

- Any medications necessary for treatment of the SAE must be recorded onto the concomitant medication section of the subject's eCRF and the event description section of the SAE form.

#### **7.4. Gilead Reporting Requirements**

Depending on relevant local legislation or regulations, including the applicable US FDA Code of Federal Regulations, the EU Clinical Trials Directive (2001/20/EC) and relevant updates, and other country-specific legislation or regulations, Gilead may be required to expedite to worldwide regulatory agencies reports of SAEs, serious adverse drug reactions (SADRs), or suspected unexpected serious adverse reactions (SUSARs). In accordance with the EU Clinical Trials Directive (2001/20/EC), Gilead or a specified designee will notify worldwide regulatory agencies and the relevant IEC in concerned Member States of applicable SUSARs as outlined in current regulations.

Assessment of expectedness for SAEs will be determined by Gilead using reference safety information specified in the investigator's brochure or relevant local label as applicable.

All investigators will receive a safety letter notifying them of relevant SUSAR reports associated with any study drug. The investigator should notify the IRB or IEC of SUSAR reports as soon as is practical, where this is required by local regulatory agencies, and in accordance with the local institutional policy.

To minimize the possibility of exposing study subjects to unusual risk, the safety information from this study will also be reviewed periodically by an independent Data Monitoring Committee (DMC). The DMC may have access to partially blinded or unblinded data and will make recommendations regarding the study according to the DMC charter. See Section [8.12](#) for additional details regarding the DMC.

#### **7.5. Toxicity Management**

##### **7.5.1. PSC Specific Study Stopping Rule:**

Any subject without a history of IBD, who develops new onset IBD while participating in the study, must be discontinued from the study. Any subject with a history of IBD who experiences at least a 3-point increase in the partial Mayo score while in the study must be discontinued from the study.

##### **7.5.2. Observation for Drug Induced Liver Injury (DILI):**

Although subjects randomized in this study will have baseline liver disease, their hepatic function should not be significantly impaired. However, at baseline, some may have liver biochemistry levels above the upper limit of normal (ULN).

For subjects with ALT and AST below ULN at study start, close observation for DILI (as described below) should be considered in subjects with any of the following criteria (all labs confirmed by repeat testing):

- ALT or AST  $> 3 \times$  ULN
- Total bilirubin  $> 2 \times$  ULN
- Alkaline phosphatase  $> 3 \times$  ULN
- INR  $> 1.5 \times$  ULN (except for subjects on anticoagulant therapy)
- Clinical signs or symptoms that are, in the opinion of the investigator, consistent with hepatitis (such as right upper quadrant discomfort, fever, nausea, vomiting, jaundice, rash, or eosinophilia  $> 5\%$ )

For subjects with ALT or AST between 1 and  $5 \times$  ULN at study start, close observation for DILI (as described below) should be considered in subjects with any of the following criteria (all labs confirmed by repeat testing):

- ALT or AST  $> 2 \times$  baseline at any time
- Total bilirubin  $> 2 \times$  ULN
- Alkaline phosphatase  $> 3 \times$  ULN
- INR  $> 1.5 \times$  ULN (except for subjects on anticoagulant therapy)
- Clinical signs or symptoms that are, in the opinion of the investigator, consistent with hepatitis (such as right upper quadrant discomfort, fever, nausea, vomiting, jaundice, rash, or eosinophilia  $> 5\%$ ).

Close observation includes:

- Repeating liver biochemistries (ALT, AST, ALP, total bilirubin, INR) within 48 hours
- Obtaining a more detailed history of symptoms and prior or concurrent disease
- Obtaining a history of concomitant drug use (including nonprescription medications and herbal and dietary supplement preparations), alcohol use, recreational drug use, and special diets
- Obtaining a history of exposure to environmental chemical agents
- Ruling out other causes of liver disease as needed (obtain viral hepatitis panel, imaging for evaluation of biliary tract disease, etc. if required in the opinion of the primary investigator)
- Continue to monitor liver biochemistries twice weekly. Frequency can decrease to once a week or less if abnormalities stabilize or study drug has been discontinued and subject is asymptomatic

During a period of close observation, study drug can be continued, if desired, at the discretion of the Gilead Medical Monitor and the principal investigator during the DILI evaluation.

However, for all subjects, study drug should be withheld if any of the following criteria are met:

- ALT or AST > 3 x ULN AND either Total bilirubin > 2 x ULN or INR > 1.5 (in subjects not on anticoagulation)
- ALT or AST > 3 x ULN AND the appearance of fatigue, nausea, vomiting, right upper quadrant pain or tenderness, fever, rash, and/or eosinophilia (>5%)
- ALT or AST > 8 x ULN
- ALT or AST > 5 x ULN for more than 2 weeks  
AND
- No other cause for the combination of laboratory abnormalities is immediately apparent (e.g. prolonged INR with warfarin use) important potential causes or contributors to abnormal AST/ALT or total bilirubin values include, but are not limited to:
  - Obstructive gall bladder or bile duct disease
  - Viral or alcoholic hepatitis (e.g. hepatitis A/B/C/D/E, Epstein-Barr virus, cytomegalovirus, herpes simplex virus, varicella)
  - Autoimmune hepatitis
  - Concomitant administration of other hepatotoxins, including excessive doses of acetaminophen, drugs that inhibit bilirubin glucuronidation (e.g. indinavir, atazanavir, irinotecan), or herbal or dietary supplements
  - Hypoxic or ischemic hepatopathy or congestive hepatopathy in association with significant right-sided heart failure
  - Wilson disease
  - Nonalcoholic fatty liver disease (NAFLD)
  - Progression of malignancy involving the liver (note that metastatic disease to the liver, by itself, should not be used as an explanation for significant AST/ALT elevations)

Treatment-emergent toxicities will be noted by the Investigator and brought to the attention of the Medical Monitor. Whether or not considered treatment-related, all subjects experiencing AEs must be monitored periodically until symptoms subside, any abnormal laboratory values have resolved or returned to baseline levels or they are considered irreversible, or until there is a satisfactory explanation for the changes observed.

- Other than in the case of the liver enzymes noted above, Grade 3 or 4 clinically significant laboratory AEs should be confirmed by repeat testing as soon as practical to do so, and preferably within 3 calendar days of receipt of the original test results.
- For AEs associated with laboratory abnormalities, the event should be graded on the basis of the clinical severity in the context of the underlying conditions; this may or may not be in agreement with the grading of the laboratory abnormality.
- Any questions regarding toxicity management should be directed to the Medical Monitor.

## **7.6.           Special Situations Reports**

### **7.6.1.       Definitions of Special Situations**

Special situation reports include all reports of medication error, abuse, misuse, overdose, reports of AEs associated with product complaints, occupational exposure with an AE, pregnancy reports regardless of an associated AE, and AE in an infant following exposure from breastfeeding.

Medication error is any unintentional error in the prescribing, dispensing, or administration of a medicinal product while in the control of the health care provider, subject, or consumer.

Abuse is defined as persistent or sporadic intentional excessive use of a medicinal product by a subject.

Misuse is defined as any intentional and inappropriate use of a medicinal product that is not in accordance with the protocol instructions or the local prescribing information.

An overdose is defined as an accidental or intentional administration of a quantity of a medicinal product given per administration or cumulatively which is above the maximum recommended dose as per protocol or in the product labeling (as it applies to the daily dose of the subject in question). In cases of a discrepancy in drug accountability, overdose will be established only when it is clear that the subject has taken the excess dose(s). Overdose cannot be established when the subject cannot account for the discrepancy except in cases in which the investigator has reason to suspect that the subject has taken the additional dose(s).

Product complaint is defined as complaints arising from potential deviations in the manufacture, packaging, or distribution of the medicinal product.

Occupational exposure with an AE: exposure to a medicinal product as a result of one's professional or non-professional occupation.

## **7.6.2. Instructions for Reporting Special Situations**

### **7.6.2.1. Instructions for Reporting Pregnancies**

The investigator should report pregnancies in female study subjects that are identified after initiation of study medication and throughout the study, including the post study drug follow-up period, to Gilead DSPH using the pregnancy report form within 24 hours of becoming aware of the pregnancy.

Refer to Section [7.3](#) and the eCRF completion guidelines for full instructions on the mechanism of pregnancy reporting.

The pregnancy itself is not considered an AE nor is an induced elective abortion to terminate a pregnancy without medical reasons.

Any premature termination of pregnancy (eg, a spontaneous abortion, an induced therapeutic abortion due to complications or other medical reasons) must be reported within 24 hours as an SAE. The underlying medical reason for this procedure should be recorded as the AE term.

A spontaneous abortion is always considered to be an SAE and will be reported as described in Sections [7.1.1](#) and [7.1.2](#). Furthermore, any SAE occurring as an adverse pregnancy outcome post study must be reported to Gilead DSPH.

The subject should receive appropriate monitoring and care until the conclusion of the pregnancy. The outcome should be reported to Gilead DSPH using the pregnancy outcome report form. If the end of the pregnancy occurs after the study has been completed, the outcome should be reported directly to Gilead DSPH. Gilead DSPH contact information is as follows: Email: Safety\_FC@gilead.com and Fax: +1 (650) 522-5477.

Pregnancies of female partners of male study subjects exposed to Gilead or other study drugs must also be reported and relevant information should be submitted to Gilead DSPH using the pregnancy and pregnancy outcome forms within 24 hours. Monitoring of the subject should continue until the conclusion of the pregnancy. If the end of the pregnancy occurs after the study has been completed, the outcome should be reported directly to Gilead DSPH, fax number +1 650 522-5477 or email Safety\_FC@gilead.com.

Refer to [Appendix 4](#) for Pregnancy Precautions, Definition for Female of Childbearing Potential, and Contraceptive Requirements.

### **7.6.2.2. Reporting Other Special Situations**

All other special situation reports must be reported on the special situations report form and forwarded to Gilead DSPH within 24 hours of the investigator becoming aware of the situation. These reports must consist of situations that involve study drug and/or Gilead concomitant medications, but do not apply to non-Gilead concomitant medications.

Special situations involving non-Gilead concomitant medications does not need to be reported on the special situations report form; however, for special situations that result in AEs due to a non-Gilead concomitant medication, the AE should be reported on the AE form.

Any inappropriate use of concomitant medications prohibited by this protocol should not be reported as “misuse,” but may be more appropriately documented as a protocol deviation.

Refer to Section [7.3](#) and the eCRF completion guidelines for full instructions on the mechanism of special situations reporting.

All clinical sequelae in relation to these special situation reports will be reported as AEs or SAEs at the same time using the AE eCRF and/or the SAE report form. Details of the symptoms and signs, clinical management, and outcome will be reported, when available.

## 8. STATISTICAL CONSIDERATIONS

Details will be provided in the Statistical Analysis Plan (SAP).

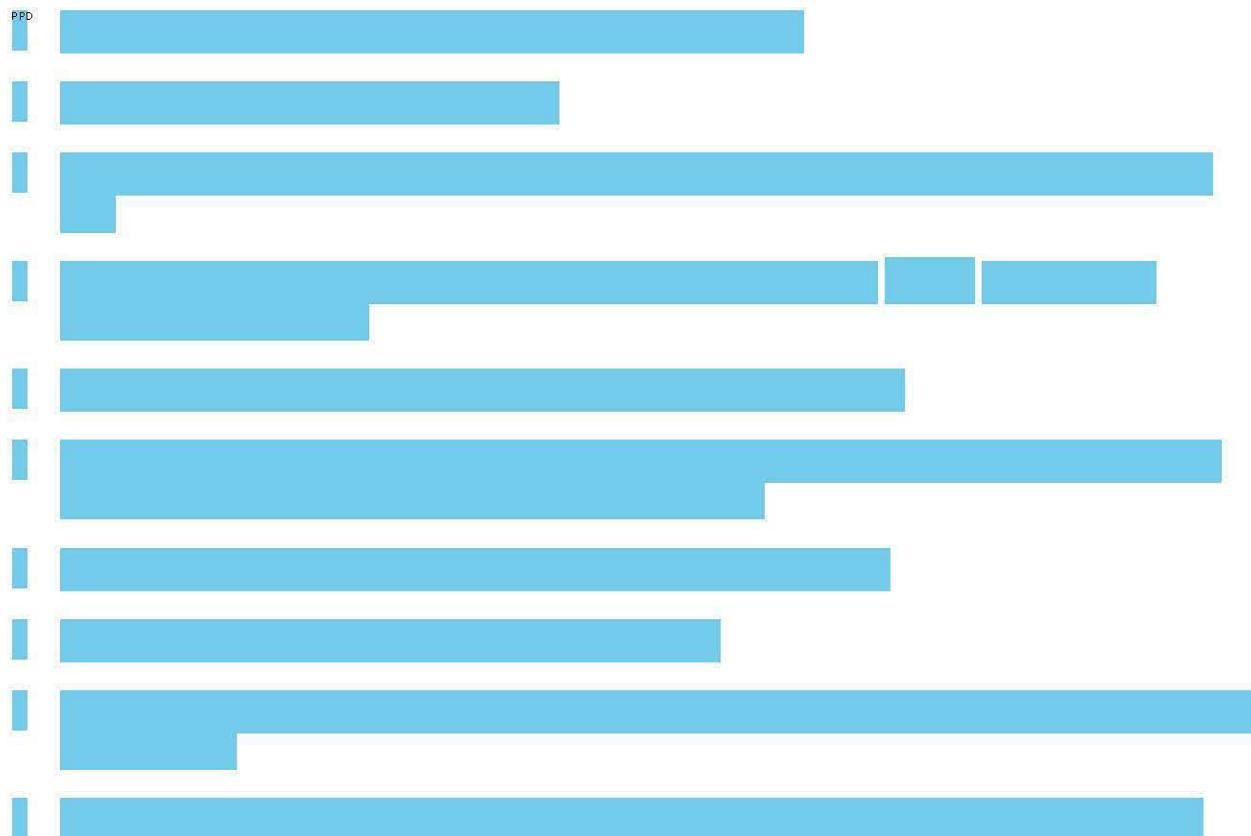
### 8.1. Analysis Objectives and Endpoints

#### 8.1.1. Analysis Objectives

The primary objective of this study is:

- To evaluate the safety and tolerability of GS-9674 in subjects with PSC

The exploratory objectives of this study are:



#### 8.1.2. Primary Endpoint

The primary endpoint is the safety of GS-9674 in subjects with PSC without cirrhosis. The safety and tolerability of GS-9674 will be evaluated by examining the incidence of treatment-emergent adverse events, including serious adverse events, clinical laboratory tests, and vital signs assessments at various time points during the study.

### **8.1.3. Exploratory Endpoints**



## **8.2. Analysis Conventions**

### **8.2.1. Analysis Sets**

#### **8.2.1.1. Efficacy**

The primary analysis set for efficacy analysis will be the Full Analysis Set (FAS) which includes all subjects who were randomized into the study and received at least one dose of study drug.

Subjects who receive study drug other than that to which they were assigned will be analyzed according to the treatment group to which they were randomized.

#### 8.2.1.2. Safety

The primary analysis set for safety analyses will include all subjects who received at least one dose of study drug. Treatment-emergent data will be analyzed and defined as data collected from the first dose of study drug through the date of last dose of study drug plus 30 days. Subjects who received study drug other than that to which they were assigned will be analyzed according to the study drug received.

#### 8.2.1.3. Pharmacokinetics

There are two pharmacokinetic analysis sets: 1) the PK analysis set which includes concentration data from the single samples drawn at each visit **PPD**

The PK analysis set will include all randomized subjects who took at least one dose of study drug and for whom concentration data of analytes GS-9674 (and its metabolites as applicable) are available. The PK analysis set will be used for analyses of population PK.

**PPD**

#### 8.2.1.4. Pharmacodynamics

There are two pharmacodynamics analysis sets: 1) The PD analysis set which includes concentration data from the single samples drawn at each visit **PPD**

The PD analysis set will include all randomized subjects who took at least one dose of study drug and for whom concentration data of FGF19, C4, and bile acids are available. The PD analysis set may be used for descriptive and/or population based PD analyses as applicable.

**PPD**

#### 8.2.1.5. Biomarkers

The Biomarker Analysis Set will include data from subjects in the Safety Analysis Set who have the necessary baseline and on-study measurements to provide interpretable results for the specific parameters of interest.

#### 8.2.2. Analysis by Study Phase

Result of statistical analysis for the randomized phase will be presented by treatment groups. Safety data from the OLE Phase will be summarized for overall subjects who roll-over into the OLE Phase for safety review, supporting regulatory document update or publication purposes.

An administrative interim analysis will be performed after first 30 subjects finish 12 weeks of treatment.

#### 8.3. Data Handling Conventions

Missing data can have an impact on the interpretation of the trial data. In general, values for missing data will not be imputed.

Where appropriate, safety data for subjects that did not complete the study will be included in summary statistics. For example, if a subject received study medication, the subject will be included in a summary of adverse events according to the treatment received; otherwise, if the subject is not dosed then they will be excluded from the summary. If safety laboratory results for a subject are missing for any reason at a time point, the subject will be excluded from the calculation of summary statistics for that time point. If the subject is missing a pre-dose value, then the subject will be excluded from the calculation of summary statistics for the pre-dose value and the change from pre-dose values.

Values for missing safety laboratory data and vital signs will not be imputed; however, a missing baseline result will be replaced with a screening result, if available. If no pre-treatment laboratory value is available, the baseline value will be assumed to be normal (ie, no grade [Grade 0]) for the summary of graded laboratory abnormalities.

#### 8.4. Demographic Data and Baseline Characteristics

Demographic and baseline measurements will be summarized using standard descriptive methods (n, mean, SD, median, Q1, Q3, minimum, and maximum) by treatment group and overall. Demographic summaries will include sex, race/ethnicity, and age.

Baseline characteristics summary will include body weight, height, body mass index, and other disease characteristics.

#### 8.5. Efficacy Analysis

The biological activity of GS-9674 will be evaluated using biomarker variables. **PPD**

## PPD

### 8.6. Exploratory Analyses

## PPD

### 8.7. Safety Analysis

All safety data collected on or after the date that GS-9674 was first dispensed up to the date of last dose of GS-9674 plus 30 days will be summarized by treatment group. Data for the pretreatment and follow-up periods will be included in data listings.

#### 8.7.1. Extent of Exposure

Data for a subject's extent of exposure to GS-9674 will be generated from the study drug administration eCRF. Exposure data will be summarized by treatment group.

#### 8.7.2. Adverse Events

Clinical and laboratory adverse events will be coded using the Medical Dictionary for Regulatory Activities (MedDRA). System Organ Class (SOC), High-Level Group Term (HLGT), High-Level Term (HLT), Preferred Term (PT), and Lower-Level Term (LLT) will be attached to the clinical database. Adverse event severity will be graded using the CTCAE Version 4.03.

Events will be summarized on the basis of the date of onset for the event. Treatment-emergent adverse events (TEAEs) are defined as 1 or both of the following:

- Any AEs with an onset date on or after the study drug start date and no later than 30 days after permanent discontinuation of study drug
- Any AEs leading to premature discontinuation of study drug

Summaries (number and percentage of subjects) of TEAEs by SOC and PT will be provided. Treatment-emergent AEs will also be summarized by relationship to study drug and severity. In addition, TEAEs leading to premature discontinuation of study drug and study will be summarized and listed.

All AEs collected during the course of the study will be presented in data listings with a field for treatment-emergent event (yes/no).

### **8.7.3.        Laboratory Evaluations**

Selected laboratory data will be summarized (n, mean, SD, Median, Q1, Q3, minimum, and maximum) by treatment group and study visit along with the corresponding change from baseline values.

Graded laboratory abnormalities will be defined using the grading scheme in the CTCAE Version 4.03 ([Appendix 3](#)). Grading of laboratory abnormalities for analysis purposes will be performed by the central laboratory.

Incidence of treatment-emergent laboratory abnormalities, defined as values that increase at least 1 toxicity grade from baseline at any time post baseline up to and including the date of last dose of study drug plus 30 days will be summarized by treatment group. If baseline data are missing, then any graded abnormality (ie, at least a Grade 1) will be considered treatment emergent.

### **8.7.4.        Other Safety Evaluations**

Vital sign measurements and 12-lead ECG data will be summarized by treatment group and listed by subject.

## **8.8.            Pharmacokinetic Analysis**

Plasma concentrations and pharmacokinetic parameters (eg, AUC<sub>tau</sub>, C<sub>max</sub> and C<sub>tau</sub>) will be listed and summarized as appropriate for GS-9674 (and its metabolites as applicable) using descriptive statistics.

Details of the analysis plan will be provided in the pharmacokinetic reporting and analysis plan.

## **8.9.            Pharmacodynamics Analysis**

Primary PD parameters (AUC<sub>partial</sub>, C<sub>max</sub>, C<sub>min</sub> as applicable) of FGF19 and C4 will be listed and summarized as appropriate for GS-9674 using descriptive statistics.

Details of the analysis plan will be provided in the pharmacodynamics reporting and analysis plan.

## **8.10.          Biomarker Analysis**

Descriptive statistics of biomarker expression and change from baseline will be provided at each sampling time by treatment. Point estimates and 95% confidence intervals may be calculated.

PPD

PPD

## **8.11. Sample Size**

Due to the exploratory nature of this study, no formal power calculations were used to determine sample size. The number of subjects was chosen based on clinical experience with other similar proof of concept studies.

## **8.12. Data Monitoring Committee**

An independent, external data monitoring committee (DMC) that consists of two hepatologists and a PhD statistician will review the progress of the study and perform reviews of safety data. The DMC will convene once 20 subjects have been randomized and will meet every 3 to 4 months thereafter to monitor the study for safety events in Blinded Study Phase and every 6 month in the OLE Phase. The DMC will meet on an ad hoc basis if there are at least 3 similar Grade  $\geq 3$  serious, treatment related Common Terminology Criteria for Adverse Events (CTCAE) observed in the trial. In the event of two similar treatment-related Grade 4 CTCAE events or one treatment-related Grade 5 CTCAE, the DMC will review the data and advise the sponsor regarding stopping or continuing the trial. The DMC will provide recommendation to Gilead whether the nature, frequency, and severity of adverse effects associated with study treatment warrant the early termination of the study in the best interests of the participants, whether the study should continue as planned, or the study should continue with modifications. The DMC may also provide recommendations as needed regarding study design.

The DMC's specific activities will be defined by a mutually agreed charter, which will define the DMC's membership, conduct and meeting schedule.

While the DMC will be asked to advise Gilead regarding future conduct of the study, including possible early study termination, Gilead retains final decision-making authority on all aspects of the study.

## **9. RESPONSIBILITIES**

### **9.1. Investigator Responsibilities**

#### **9.1.1. Good Clinical Practice**

The investigator will ensure that this study is conducted in accordance with the principles of the Declaration of Helsinki, International Conference on Harmonisation (ICH) guidelines, or with the laws and regulations of the country in which the research is conducted, whichever affords the greater protection to the study subject. These standards are consistent with the European Union Clinical Trials Directive 2001/20/EC and Good Clinical Practice Directive 2005/28/EC.

The investigator will ensure adherence to the basic principles of Good Clinical Practice, as outlined in 21 CFR 312, subpart D, "Responsibilities of Sponsors and Investigators," 21 CFR, part 50, 1998, and 21 CFR, part 56, 1998.

The investigator and all applicable subinvestigators will comply with 21 CFR, Part 54, 1998, providing documentation of their financial interest or arrangements with Gilead, or proprietary interests in the investigational drug under study. This documentation must be provided prior to the investigator's (and any subinvestigator's) participation in the study. The investigator and subinvestigator agree to notify Gilead of any change in reportable interests during the study and for 1 year following completion of the study. Study completion is defined as the date when the last subject completes the protocol-defined activities.

#### **9.1.2. Institutional Review Board (IRB)/Independent Ethics Committee (IEC) Review and Approval**

The investigator (or sponsor as appropriate according to local regulations) will submit this protocol, informed consent form, and any accompanying material to be provided to the subject (such as advertisements, subject information sheets, or descriptions of the study used to obtain informed consent) to an IRB/IEC/EC. The investigator will not begin any study subject activities until approval from the IRB/IEC/EC has been documented and provided as a letter to the investigator.

Before implementation, the investigator will submit to and receive documented approval from the IRB/IEC/EC any modifications made to the protocol or any accompanying material to be provided to the subject after initial IRB/IEC/EC approval, with the exception of those necessary to reduce immediate risk to study subjects.

#### **9.1.3. Informed Consent**

The investigator is responsible for obtaining written informed consent from each individual participating in this study after adequate explanation of the aims, methods, objectives, and potential hazards of the study and before undertaking any study-related procedures. The investigator must use the most current IRB/IEC/EC -approved consent form for documenting

written informed consent. Each informed consent (or assent as applicable) will be appropriately signed and dated by the subject or the subject's legally authorized representative and the person conducting the consent discussion, and also by an impartial witness if required by IRB/IEC/EC local requirements.

#### **9.1.4. Confidentiality**

The investigator must assure that subjects' anonymity will be strictly maintained and that their identities are protected from unauthorized parties. Only subject initials, date of birth, another unique identifier (as allowed by local law) and an identification code will be recorded on any form or biological sample submitted to the Sponsor, IRB/IEC/EC, or laboratory. Laboratory specimens must be labeled in such a way as to protect subject identity while allowing the results to be recorded to the proper subject. NOTE: The investigator must keep a screening log showing codes, names, and addresses for all subjects screened and for all subjects randomized in the trial. Subject data will be processed in accordance with all applicable regulations.

The investigator agrees that all information received from Gilead, including but not limited to the investigator brochure, this protocol, eCRF, the study drug, and any other study information, remain the sole and exclusive property of Gilead during the conduct of the study and thereafter. This information is not to be disclosed to any third party (except employees or agents directly involved in the conduct of the study or as required by law) without prior written consent from Gilead. The investigator further agrees to take all reasonable precautions to prevent the disclosure by any employee or agent of the study site to any third party or otherwise into the public domain.

#### **9.1.5. Study Files and Retention of Records**

The investigator must maintain adequate and accurate records to enable the conduct of the study to be fully documented and the study data to be subsequently verified. These documents should be classified into at least the following two categories: (1) investigator's study file, and (2) subject clinical source documents.

The investigator's study file will contain the protocol/amendments, CRF and query forms IRB/IEC and governmental approval with correspondence, informed consent, drug records, staff curriculum vitae and authorization forms, and other appropriate documents and correspondence.

The required source data should include sequential notes containing at least the following information for each subject:

- Subject identification (name, date of birth, gender);
- Documentation that subject meets eligibility criteria, ie, history, physical examination, and confirmation of diagnosis (to support inclusion and exclusion criteria);
- Documentation of the reason(s) a consented subject is not randomized;

- Participation in study (including study number);
- Study discussed and date of informed consent;
- Dates of all visits;
- Documentation that protocol specific procedures were performed;
- Results of efficacy parameters, as required by the protocol;
- Start and end date (including dose regimen) of study drug, including dates of dispensing and return;
- Record of all adverse events and other safety parameters (start and end date, and including causality and severity);
- Concomitant medication (including start and end date, dose if relevant; dose changes);
- Date of study completion and reason for early discontinuation, if it occurs.

All clinical study documents must be retained by the investigator until at least 2 years or according to local laws, whichever is longer, after the last approval of a marketing application in an ICH region (ie, United States, Europe, or Japan) and until there are no pending or planned marketing applications in an ICH region; or, if no application is filed or if the application is not approved for such indication, until 2 years after the investigation is discontinued and regulatory authorities have been notified. Investigators may be required to retain documents longer if specified by regulatory requirements, by local regulations, or by an agreement with Gilead. The investigator must notify Gilead before destroying any clinical study records.

Should the investigator wish to assign the study records to another party or move them to another location, Gilead must be notified in advance.

If the investigator cannot provide for this archiving requirement at the study site for any or all of the documents, special arrangements must be made between the investigator and Gilead to store these records securely away from the site so that they can be returned sealed to the investigator in case of an inspection. When source documents are required for the continued care of the subject, appropriate copies should be made for storage away from the site.

#### **9.1.6. Case Report Forms**

For each subject consented, an electronic case report form (eCRF) will be completed by an authorized study staff member whose training for this function is documented according to study procedures. eCRF should be completed on the day of the subject visit to enable the sponsor to perform central monitoring of safety data. The Eligibility Criteria eCRF should be completed only after all data related to eligibility have been received. Subsequent to data entry, a study monitor will perform source data verification within the EDC system. Original entries as well as

any changes to data fields will be stored in the audit trail of the system. Prior to database lock (or any interim time points as described in the clinical data management plan), the investigator will use his/her log in credentials to confirm that the forms have been reviewed, and that the entries accurately reflect the information in the source documents. The eCRF capture the data required per the protocol schedule of events and procedures. System-generated or manual queries will be issued to the investigative site staff as data discrepancies are identified by the monitor or internal Gilead staff, who routinely review the data for completeness, correctness, and consistency. The site coordinator is responsible for responding to the queries in a timely manner, within the system, either by confirming the data as correct or updating the original entry, and providing the reason for the update (e.g. data entry error). At the conclusion of the trial, Gilead will provide the site with a read-only archive copy of the data entered by that site. This archive must be stored in accordance with the records retention requirements outlined in Section 9.1.5.

#### **9.1.7.           Investigational Medicinal Product Accountability and Return**

Where possible, study drug should be destroyed at the site. If the site does not have acceptable procedures in place for drug destruction, arrangements will be made between the site and Gilead Sciences (or Gilead Sciences' representative) for return of unused study drug supplies. The study monitor will provide instructions for return.

The study monitor will evaluate each study center's study drug disposal procedures and provide appropriate instruction for destruction of unused study drug supplies. If the site has an appropriate standard operating procedure (SOP) for drug destruction as determined by Gilead QA, the site may destroy used (empty or partially empty) and unused study drug supplies in accordance with that site's approved SOP. A copy of the site's approved SOP will be obtained for central files.

If study drug is destroyed on site, the investigator must maintain accurate records for all study drug destroyed. Records must show the identification and quantity of each unit destroyed, the method of destruction, and the person who disposed of the study drug. Upon study completion, copies of the study drug accountability records must be filed at the site. Another copy will be returned to Gilead. Refer to the pharmacy binder for study drug disposal/return instructions.

The study monitor will review study drug supplies and associated records at periodic intervals.

#### **9.1.8.           Inspections**

The investigator will make available all source documents and other records for this trial to Gilead's appointed study monitors to the IRB/IEC/EC, or to regulatory authority or health authority inspectors.

#### **9.1.9.           Protocol Compliance**

The investigator is responsible for ensuring the study is conducted in accordance with the procedures and evaluations described in this protocol.

## **9.2. Sponsor Responsibilities**

### **9.2.1. Protocol Modifications**

Protocol modifications, except those intended to reduce immediate risk to study subjects, may be made only by Gilead. The investigator must submit all protocol modifications to the IRB/IEC in accordance with local requirements and receive documented IRB/IEC/EC approval before modifications can be implemented.

### **9.2.2. Study Report and Publications**

A clinical study report (CSR) will be prepared and provided to the regulatory agencies. Gilead will ensure that the report meets the standards set out in the ICH Guideline for Structure and Content of Clinical Study Reports (ICH E3). Note that an abbreviated report may be prepared in certain cases.

Investigators in this study may communicate, orally present, or publish in scientific journals or other scholarly media only after the following conditions have been met: the results of the study in their entirety have been publicly disclosed by or with the consent of Gilead in an abstract, manuscript, or presentation form or the study has been completed at all study sites for at least 2 years.

The investigator will submit to Gilead any proposed publication or presentation along with the respective scientific journal or presentation forum at least 30 days before submission of the publication or presentation.

No such communication, presentation, or publication will include Gilead's confidential information (see Section 9.1.4).

The investigator will comply with Gilead's request to delete references to its confidential information (other than the study results) in any paper or presentation and agrees to withhold publication or presentation for an additional 60 days in order to obtain patent protection if deemed necessary.

## **9.3. Joint Investigator/Sponsor Responsibilities**

### **9.3.1. Payment Reporting**

Investigators and their study staff may be asked to provide services performed under this protocol, e.g. attendance at Investigator's Meetings. If required under the applicable statutory and regulatory requirements, Gilead will capture and disclose to Federal and State agencies any expenses paid or reimbursed for such services, including any clinical trial payments, meal, travel expenses or reimbursements, consulting fees, and any other transfer of value.

### **9.3.2. Access to Information for Monitoring**

In accordance with regulations and guidelines, the study monitor must have direct access to the investigator's source documentation in order to verify the accuracy of the data recorded in the eCRF.

The monitor is responsible for routine review of the eCRF at regular intervals throughout the study to verify adherence to the protocol and the completeness, consistency, and accuracy of the data being entered on them. The monitor should have access to any subject records needed to verify the entries on the eCRF. The investigator agrees to cooperate with the monitor to ensure that any problems detected through any type of monitoring (central, on site) are resolved.

### **9.3.3. Access to Information for Auditing or Inspections**

Representatives of regulatory authorities or of Gilead may conduct inspections or audits of the clinical study. If the investigator is notified of an inspection by a regulatory authority the investigator agrees to notify the Gilead medical monitor immediately. The investigator agrees to provide to representatives of a regulatory agency or Gilead access to records, facilities, and personnel for the effective conduct of any inspection or audit.

### **9.3.4. Study Discontinuation**

Both the sponsor and the investigator reserve the right to terminate the study at any time. Should this be necessary, both parties will arrange discontinuation procedures and notify the appropriate regulatory authorities, IRBs/ IECs/ECs. In terminating the study, Gilead and the investigator will assure that adequate consideration is given to the protection of the subjects' interests.

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## 11. APPENDICES

- Appendix 1. Investigator Signature Page
- Appendix 2. Study Procedures Table for GS-US-428-4025
- Appendix 3. GSI Grading Scale for Severity of Adverse Events and Laboratory Abnormalities
- Appendix 4. Pregnancy Precautions, Definition for Female of Childbearing Potential, and Contraceptive Requirements

**Appendix 1.      Investigator Signature Page**

**GILEAD SCIENCES, INC.  
333 LAKESIDE DRIVE  
FOSTER CITY, CA 94404,  
U.S.A.**

**STUDY ACKNOWLEDGEMENT**

A Phase 2, Randomized, Double-Blind, Placebo Controlled Study Evaluating the Safety, Tolerability, and Efficacy of GS-9674 in Subjects with Primary Sclerosing Cholangitis Without Cirrhosis

GS-US-428-4025, Original, 29-June-2016

This protocol has been approved by Gilead Sciences, Inc. The following signature documents this approval.

*Stephen Djedjos*

C. Stephen Djedjos (Printed)  
Medical Monitor

**PPD**

Signature

29-June-2016

Date

**INVESTIGATOR STATEMENT**

I have read the protocol, including all appendices, and I agree that it contains all necessary details for me and my staff to conduct this study as described. I will conduct this study as outlined herein and will make a reasonable effort to complete the study within the time designated.

I will provide all study personnel under my supervision copies of the protocol and access to all information provided by Gilead Sciences, Inc. I will discuss this material with them to ensure that they are fully informed about the drugs and the study.

Principal Investigator Name (Printed)

Signature

Date

Site Number

**Appendix 2. Study Procedures Table for GS-US-428-4025**

	Screening <sup>a</sup>	Blinded Study Phase Treatment Weeks ( $\pm 3$ days)							OLE Weeks ( $\pm 5$ days)	
		Baseline (Day 1)	Week 1	Week 2	Week 4	Week 8	Week 12 /ET <sup>b</sup>	Blinded Study Phase follow-up visit <sup>c</sup> ( $\pm 5$ days)	OLE Baseline/Day 1, Weeks 4, 12, 24, 36, 48, 60, 72, 84, 96/ET <sup>b</sup>	OLE follow-up <sup>d</sup>
Subject Fasting <sup>e</sup>		X	X	X	X	X	X		X	
Written Informed Consent <sup>f</sup>	X									
Review Inclusion/Exclusion Criteria	X	X								
Medical History	X									
Partial Mayo Score	X	X	X	X	X	X	X	X	X	X
Pruritus VAS &5D-Itch <sup>g</sup>		X	X	X	X	X	X	X	X	X
QoL SF-36, PSC-PRO & PBC-40 <sup>g</sup>		X					X	X	X	
Symptom-directed PE <sup>h</sup>	X	X	X	X	X	X	X	X	X	X
Vital Signs <sup>i</sup>	X	X	X	X	X	X	X	X	X	X
Height and weight <sup>j</sup>	X	X	X	X	X	X	X	X	X	X
Chemistry <sup>k</sup>	X	X	X	X	X	X	X	X	X	X
Hematology <sup>l</sup>	X	X	X	X	X	X	X	X	X	X

		Blinded Study Phase Treatment Weeks ( $\pm 3$ days)							OLE Weeks ( $\pm 5$ days)	
		Screening <sup>a</sup>	Baseline (Day 1)	Week 1	Week 2	Week 4	Week 8	Week 12 /ET <sup>b</sup>	Blinded Study Phase follow-up visit <sup>c</sup> ( $\pm 5$ days)	OLE Baseline/Day 1, Weeks 4, 12, 24, 36, 48, 60, 72, 84, 96/ET <sup>b</sup>
Coagulation Panel <sup>m</sup>	X	X	X	X	X	X	X	X	X	X
Cirrhosis Assessments	X									
Lipid Profile		X	X		X	X	X	X	X	X
C-Peptide, Hemoglobin A1C and Insulin		X						X		
Blood for Biomarkers <sup>n</sup>	X	X	X		X		X	X	X	
Single PK and PD Sampling		X <sup>o</sup>	X	X	X	X	X			
HIV-1, HBV and HCV Serology	X									
Pregnancy Test <sup>p</sup>	X	X	X		X	X	X	X	X	X
Serum FSH <sup>q</sup>	X									
<b>PPD</b>										
12- lead ECGs		X					X			
Fibroscan <sup>s</sup>		X					X			

		Blinded Study Phase Treatment Weeks ( $\pm 3$ days)							OLE Weeks ( $\pm 5$ days)	
		Screening <sup>a</sup>	Baseline (Day 1)	Week 1	Week 2	Week 4	Week 8	Week 12 /ET <sup>b</sup>	Blinded Study Phase follow-up visit <sup>c</sup> ( $\pm 5$ days)	OLE Baseline/Day 1, Weeks 4, 12, 24, 36, 48, 60, 72, 84, 96/ET <sup>b</sup>
Urine drug screening <sup>f</sup>	X									
Urine collection (Biomarkers) <sup>u</sup>		X	X		X		X	X	X <sup>x</sup>	
Stool collection (Biomarkers) <sup>v</sup>		X					X	X	X <sup>y</sup>	
<b>PPD</b>										
Dispense GS-9674/ PTM GS-9674 <sup>x</sup>		X			X	X			X	
Concomitant Medications	X	X	X	X	X	X	X	X	X	X
Adverse Events	X	X	X	X	X	X	X	X	X	X
Take GS-9674/ PTM GS-9674 Tablets <sup>y</sup>		X – Daily (Baseline/ Day 1 to Week 12)							X-Daily (OLE Baseline/ Day 1 to Week 96)	

a The visit window may be extended under special circumstances with explicit approval of the Medical Monitor. Subjects who fail to meet eligibility criteria due to an abnormal laboratory result may undergo re-testing of the abnormal analyte during the screening window. This will be done at the discretion of the investigator and also with prior approval of the Medical Monitor.

b Blinded Study Phase subjects discontinuing the study at any time for any reason (Early Termination – ET) should complete the procedures listed for the Week 12/ Visit AND the follow-up visit. OLE Phase subjects discontinuing the study at any time for any reason (Early Termination – ET) should complete the procedures listed for the Week 96/ Visit AND the follow-up visit if possible.

- c After completing 12 weeks of treatment in the Blinded Study Phase, subjects will return for the follow-up visit 4 weeks post the last dose of the study drug and at that time they can begin their OLE Phase. Follow-up visit for Blinded Study Phase and Baseline/Day 1 OLE visit can occur on the same day if convenient. If OLE Baseline/Day 1 and Blinded study follow-Up visit is on the same day subjects should only complete OLE Baseline/Day 1 assessments.
- d Follow-up visit should be completed during the Blinded Study Phase as well as the OLE Phase.
- e Subjects must be in a fasted state for at least 8 hours prior to blood collection.
- f Obtain written informed consent before initiation of any screening procedure.
- g QoL questionnaires and Pruritus assessments should be completed prior to any study procedures being performed and prior to the subject seeing a health care provider. Refer to the Study Reference Binder for guidance on QoL questionnaire administration.
- h Complete PE at screening and symptom-directed PE for other visits. The focus of a symptom-driven physical examination will be determined by the investigator based on subject complaint.
- i Vital signs include blood pressure, heart rate, respiration rate, and body temperature.
- j Height should be collected at Screening and Baseline/Day 1 only. Weight should be collected at all visits. Refer to the Study Reference Binder for specific instructions on how weight should be measured.
- k Blood chemistry will include: alanine aminotransferase (ALT), aspartate aminotransferase (AST), albumin, alkaline phosphatase, bicarbonate, blood urea nitrogen (BUN), calcium, chloride, creatinine, glucose, lactate dehydrogenase (LDH), magnesium, phosphorus, potassium, sodium, total and direct bilirubin, total protein, uric acid, gamma-glutamyl transferase (GGT). Also includes C-Peptide, insulin and hemoglobin A1C (HbA1c) for the Baseline/Day 1, and Week 12 visits.
- l Hematology will include: complete blood cell count with differential (red blood cells, white blood cells, platelets, and hematocrit).
- m Coagulation Panel includes: PT, PTT, and INR.
- n Biomarker analyses include, but are not limited to, the tests listed in Section 6.12.1. Some of the blood collected for biomarkers may be stored for future testing.
- o PD sampling only at Baseline/Day 1.
- p Females of childbearing potential only (see [Appendix 4](#)). Serum pregnancy tests at Screening. Urine pregnancy test at all other visits, except Week 2 and 8.
- q Only required for some female subjects – see [Appendix 4](#).
- PPD**  
s Subject should be in fasted state for FibroScan® collection. Refer to the study reference binder for further details. If FibroScan® is not available at a site the test may be omitted.
- t Drug screen for amphetamines, cocaine, and opiates (ie, heroin, morphine).
- u Urine Biomarker sample collection at OLE Baseline/Day 1, Weeks 24, 48, 72 and 96 only.
- v Stool sample collection only at OLE Baseline/Day 1, Week 48 and Week 96 visit.
- PPD**  
x Study drug will be assigned via the IWRS system every 4 weeks from Baseline/Day 1 through Week 8 in Blind Study Phase and OLE Baseline/Day 1 and every 12 weeks thereafter in the OLE Phase.
- y Subjects to self-administer the study drug at the investigative site at the conclusion of the Baseline/Day 1 and Week 12 visit.

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**Appendix 3.            GSI Grading Scale for Severity of Adverse Events and Laboratory Abnormalities**

[http://evs.nci.nih.gov/ftp1/CTCAE/CTCAE\\_4.03\\_2010-06-14\\_QuickReference\\_8.5x11.pdf](http://evs.nci.nih.gov/ftp1/CTCAE/CTCAE_4.03_2010-06-14_QuickReference_8.5x11.pdf)

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**Appendix 4.      Pregnancy Precautions, Definition for Female of Childbearing Potential, and Contraceptive Requirements**

**1. Definitions**

**a. Definition of Childbearing Potential**

For the purposes of this study, a female born subject is considered of childbearing potential following the initiation of puberty (Tanner stage 2) until becoming post-menopausal, unless permanently sterile or with medically documented ovarian failure.

Women are considered to be in a postmenopausal state when they are  $\geq 54$  years of age with cessation of previously occurring menses for  $\geq 12$  months without an alternative cause. In addition, women of any age with amenorrhea of  $\geq 12$  months may also be considered postmenopausal if their follicle stimulating hormone (FSH) level is in the postmenopausal range and they are not using hormonal contraception or hormonal replacement therapy.

Permanent sterilization includes hysterectomy, bilateral oophorectomy, or bilateral salpingectomy in a female subject of any age.

**b. Definition of Male Fertility**

For the purposes of this study, a male born subject is considered of fertile after the initiation of puberty unless permanently sterile by bilateral orchidectomy or medical documentation.

**2. Contraception Requirements for Female Subjects**

**a. Study Drug Effects on Pregnancy and Hormonal Contraception**

GS-9674 has not yet been studied in pregnant women. There are no preclinical data available to determine whether GS-9674 is teratogenic or fetotoxic in early human pregnancy. There are insufficient data to exclude the possibility of a clinically relevant interaction between GS-9674 and hormonal contraceptives that result in reduced contraception efficacy.

Please refer to the latest version of the investigator's brochure for additional information.

**b. Contraception Requirements for Female Subjects of Childbearing Potential**

The inclusion of female subjects of childbearing potential requires the use of highly effective contraceptive measures. They must also not rely on hormone-containing contraceptives as a form of birth control during the study. They must have a negative serum pregnancy test at Screening and a negative urine pregnancy test on the Baseline/Day 1 visit prior to randomization. At minimum, a pregnancy test will be performed at the end of relevant system exposure. In the event of a delayed menstrual period (over one month between menstruations), a pregnancy test must be performed to rule out pregnancy. This is even true for women of childbearing potential with infrequent or irregular periods. Female subjects must agree to one of the following from Screening until 30 days following the last dose of the study drug GS-9674.

- Complete abstinence from intercourse of reproductive potential. Abstinence is an acceptable method of contraception only when it is in line with the subject's preferred and usual lifestyle.

Or

- Consistent and correct use of 1 of the following methods of birth control listed below.
  - Intrauterine device (IUD) with a failure rate of <1% per year
  - Tubal sterilization
  - Essure micro-insert system (provided confirmation of success 3 months after procedure)
  - Vasectomy in the male partner (provided that the partner is the sole sexual partner and had confirmation of surgical success 3 months after procedure)

Female subjects must also refrain from egg donation and in vitro fertilization during treatment and until at least 30 days after the last dose of the study drug GS-9674.

### **3. Contraception Requirements for Male Subjects**

It is theoretically possible that a relevant systemic concentration may be achieved in a female partner from exposure of the male subject's seminal fluid. Therefore, male subjects with female partners of childbearing potential must use condoms during treatment and for 90 days after last dose of GS-9674. Additional contraception recommendations should also be considered if the female partner is not pregnant.

Male subjects must agree to avoid sperm donation from baseline throughout the study period and for 90 days after last dose of GS-9674.

### **4. Unacceptable Birth Control Methods**

Birth control methods that are unacceptable include periodic abstinence (e.g., calendar, ovulation, symptothermal, post-ovulation methods), withdrawal (coitus interruptus), spermicides only, and lactational amenorrhea method (LAM). Female condom and male condom should not be used together.

## **5. Procedures to be Followed in the Event of Pregnancy**

Subjects will be instructed to notify the investigator if they become pregnant at any time during the study, or if they become pregnant within 30 days (90 days of partner of male subject) of last study drug dose. Subjects who become pregnant or who suspect that they are pregnant during the study must report the information to the investigator and discontinue study drug immediately. Subjects whose partner has become pregnant or suspects she is pregnant during the study must report the information to the investigator. Instructions for reporting pregnancy, partner pregnancy, and pregnancy outcome are outlined in Section [7.6.2.1](#).