TRIAL STATISTICAL ANALYSIS PLAN

c36743424-01

BI Trial No.:	1407-0041
Title:	Bioequivalence of three different tablet formulations of 30 mg of apremilast (EU-sourced Otezla® vs. US-sourced Otezla® vs. Japan-sourced Otezla®) administered in healthy male and female subjects in the fasted state as well as (for EU-sourced Otezla® vs. US-sourced Otezla®) in the fed state (an open-label, randomised, single-dose, five-period, ten-sequence crossover study) (Revised Protocol including Amendments 1 and 2 [c30404410-03])
Investigational Product(s):	BI 730357
Responsible trial statistician(s):	[redacted] Phone: [redacted] Fax: [redacted]
Date of statistical analysis plan:	30 SEP 2021 SIGNED
Version:	final

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2. LIST OF ABBREVIATIONS

See Medicine Glossary:
http://glossary

Term	Definition / description
AESI	Adverse event of special interest
ANOVA	Analysis of variance
AUC_{0-tz}	Area under the concentration-time curve of the analyte in plasma over the time interval from 0 to the last quantifiable data point
$AUC_{0-\infty}$	Area under the concentration-time curve of the analyte in plasma over the time interval from 0 extrapolated to infinity
BMI	Body mass index
CI	Confidence interval
C_{max}	Maximum measured concentration of the analyte in plasma
CSD	Company Standard Displays
CV	Arithmetic coefficient of variation
F/U	Follow Up
gCV	Geometric coefficient of variation
gMean	Geometric mean
Max	Maximum
MedDRA	Medical Dictionary for Regulatory Activities
Min	Minimum
N	Number non-missing observations
P10	10^{th} percentile
P90	90^{th} percentile
PKS	PK parameter analysis set
Q1	1^{st} quartile
Q3	3^{rd} quartile
RAGe	Report Appendix Generator system
REP	Residual Effect Period
RPM	Report Planning Meeting
SD	Standard deviation
SOC	System organ class
TS	Treated set

Term	Definition / description
WHO-DD	World Health Organization Drug Dictionary

3. INTRODUCTION

As per ICH E9 (1) the purpose of this document is to provide a more technical and detailed elaboration of the principal features of the analysis described in the protocol, and to include detailed procedures for executing the statistical analysis of the primary and secondary variables and other data.

This Trial statistical analysis plan (TSAP) assumes familiarity with the Clinical Trial Protocol (CTP), including Protocol Amendments. In particular, the TSAP is based on the planned analysis specification as written in CTP Section 7 "Statistical Methods and Determination of Sample Size". Therefore, TSAP readers may consult the CTP for more background information on the study, e.g., on trial objectives, study design and population, treatments, definition of measurements and variables, planning of sample size, randomisation.

Study data (including data entered in the RAVE EDC system and external data provided by suppliers) will be stored in a Clinical Data Repository (CDR).

Pharmacokinetic (PK) parameters will be calculated using Phoenix WinNonlin™ software (version 6.3 or higher, [redacted]).

The statistical analyses will be performed within the validated working environment CARE, including SAS™ (current Version 9.4, by [redacted]), and a number of SAS™-based tools (e.g., macros for the analyses of AE data or laboratory data; Report Appendix Generator system (RAGe) for compilation/formatting of the CTR appendices).

4. CHANGES IN THE PLANNED ANALYSIS OF THE STUDY

The study was prematurely terminated with only 20 of the 40 planned subjects as the development program of BI 730357 had been terminated in all indications, for the treatment of adult patients with plaque psoriasis, axial spondyloarthritis, and psoriatic arthritis.

Consequently, an abbreviated clinical trial report is planned where data on trial subjects, safety, and PK concentrations will be reported. Only descriptive statistics of PK parameters will be provided; no statistical evaluation of PK parameters will be performed.

In addition, the following change compared to the protocol will be made:
In CTP section 7.3 the following was defined: *Important protocol deviation (IPD) categories will be suggested in the TSAP, IPVs will be identified no later than in the Report Planning Meeting, and the IPV categories will be updated as needed.* Due to SOP changes, the iPD categories are no longer suggested in TSAP, but included in an iPD specification file (3).

5. ENDPOINTS(S)

5.1 PRIMARY ENDPOINT(S)

Section 2.1.2 of the CTP:

The following pharmacokinetic parameters will be determined for apremilast:

- *AUC_{0-tz} (area under the concentration-time curve of the analyte in plasma over the time interval from 0 to the last quantifiable data point)*
- *$AUC_{0-\infty}$ (area under the concentration-time curve of the analyte in plasma over the time interval from 0 extrapolated to infinity)*
- *C_{max} (maximum measured concentration of the analyte in plasma)*

5.2 SECONDARY ENDPOINT(S)

5.2.1 Key secondary endpoint(s)

This section is not applicable as no key secondary endpoints have been defined in the CTP.

5.2.2 Secondary endpoint(s)

This section is not applicable as no secondary endpoints have been defined in the CTP.

[redacted]

Safety and tolerability endpoints

Section 2.2.2.2 of the CTP: *Safety and tolerability of apremilast will be assessed based on:*

- *Adverse Events (including clinically relevant findings from the physical examination)*
- *Safety laboratory tests*
- *12-lead ECG*
- *Vital signs (blood pressure, pulse rate)*

6. GENERAL ANALYSIS DEFINITIONS

6.1 TREATMENT(S)

For basic study information on investigational products and selection of doses, please see CTP Sections 3 and 4.

The study was to be performed as an open-label, five-period, ten-sequence crossover design. In total, it was planned to assign 40 healthy male and female subjects.

There will be a washout period of at least 5 days between the apremilast administrations.

For details of dosage and formulation see Table 6.1: 1 below:

Table 6.1: 1 Treatments and labels used in the analysis

Treatment		**Short label**
A	Otezla (EU source), 30 mg tablet, qd, fasted	T fasted
B	Otezla (US source), 30 mg tablet, qd, fasted	R1 fasted
C	Otezla (EU source), 30 mg tablet, qd, fed	T fed
D	Otezla (US source), 30 mg tablet, qd, fed	R1 fed
E	Otezla (Japan source), 30 mg tablet, qd, fasted	R2 fasted

The study was prematurely stopped after 20 subjects have been treated. Therefore, all analyses will be performed for these subjects only.

Section 1.2.2 of CTP: *The Residual Effect Period (REP) of apremilast is four days. This is the period after the last dose with measurable drug levels and/or pharmacodynamic effects is still likely to be present.*

The following study phases will be defined for the analysis of adverse events (AEs):

- **Screening**
  - Ranging from 0:00h on day of informed consent until administration time of apremilast in treatment period 1.
- **On treatment** (labelled "**Tfasted**", "**Tfed**", "**R1fasted**", "**R1fed**", "**R2fasted**")
  - **EU-sourced Otezla fasted** ("**Tfasted**"): Ranging from the time of administration of Otezla (EU source) in the fasted state until 4 days (96 h) thereafter OR until next administration of Otezla, whatever occurs first.
  - **EU-sourced Otezla fed** ("**Tfed**"): Ranging from the time of administration of Otezla (EU source) in the fed state until 4 days (96 h) thereafter OR until next administration of Otezla, whatever occurs first.
  - **US-sourced Otezla fasted** ("**R1fasted**"): Ranging from the time of administration of Otezla (US source) in the fasted state until 4 days (96 h) thereafter OR until next administration of Otezla, whatever occurs first.
  - **US-sourced Otezla fed** ("**R1fed**"): Ranging from the time of administration of Otezla (US source) in the fed state until 4 days (96 h) thereafter OR until next administration of Otezla, whatever occurs first.
  - **Japan-sourced Otezla fasted** ("**R2fasted**"): Ranging from the time of administration of Otezla (Japan source) in the fasted state until 4 days (96 h) thereafter OR until next administration of Otezla, whatever occurs first.
- **Follow-up** (labelled "**F/U Tfasted**", "**F/U Tfed**", "**F/U R1fasted**", "**F/U R1fed**", "**F/U R2fasted**")
  - **F/U Tfasted**: Ranging from the end of REP Tfasted until the next administration of Otezla OR until trial termination, whatever occurs first.
  - **F/U Tfed**: Ranging from the end of REP Tfed until the next administration of Otezla OR until trial termination, whatever occurs first.
  - **F/U R1fasted**: Ranging from the end of REP R1fasted until the next administration of Otezla OR until trial termination, whatever occurs first.
  - **F/U R1fed**: Ranging from the end of REP R1fed until the next administration of Otezla OR until trial termination, whatever occurs first.
  - **F/U R2fasted**: Ranging from the end of REP R2fasted until the next administration of Otezla OR until trial termination, whatever occurs first.

Section 7.3.4 of the CTP: *Note that AEs occurring after the last per protocol contact but entered before final database lock will be reported to Pharmacovigilance only and will not be captured in the trial database.*

The following AE displays will be provided in the report:

A) Section 15.3 and Appendix 16.1.13.1.8 (for ClinicalTrials.gov and EudraCT only) of the CTR displays:

In these displays, the on treatment phase will be analysed (labelled with the name of the study treatment (short label)). Screening and follow-up periods will not be included in this analysis.
The following totals will be provided in addition (Section 15.3 only):

- a total over all on treatment phases included in this analysis ("**Total**")

B) Section 15.4 of the CTR displays:

- Screening
- On treatment (labelled with the name of the study treatment (short label))
- Follow-up phases (labelled “F/U Tfasted”, “F/U Tfed”, “F/U R1fasted”, “F/U R1fed”, “F/U R2fasted”)

For detailed information on the handling of the treatments refer to Technical TSAP ADS plan and Analysis Data Reviewers guide.

6.2 IMPORTANT PROTOCOL DEVIATIONS

Data discrepancies and deviations from the CTP will be identified for all treated subjects.

Consistency check listings (for identification of deviations of time windows) and a list of protocol deviations (e.g. deviations in drug administration, in blood sampling times, etc.) will be provided to be discussed at the Report Planning Meeting (RPM). At this meeting, all manual deviations identified at the sites by the CRAs and deviations too complex to program will be reviewed by the trial team to decide which are considered important. For definition of important protocol deviations (iPD), and for the process of identification of these, refer to the Boehringer Ingelheim (BI) SOP "Identify and Manage Important Protocol Deviations (iPD)" (2).

Section 7.3 of the CTP: *Important protocol deviation (iPD) categories will be suggested in the TSAP,* IPVs *will be identified no later than in the Report Planning Meeting, and the IPV categories will be updated as needed.*

Due to SOP changes, the iPD categories are no longer suggested in TSAP, but included in an iPD specification file (3).

If any iPDs are identified, they are to be summarised into categories and will be captured in the iPD specification file and the decision log. The iPD specification file (e.g. the DV domain specifications) will be stored within the TMF in EDMS.

The iPDs will be summarized and listed in the CTR.

6.3 SUBJECT SETS ANALYSED

Section 7.3 of the CTP:

- *Treated set (TS): The treated set includes all subjects who were randomized and treated with at least one dose of study drug. The treated set will be used for safety analyses.*

- *Pharmacokinetic parameter analysis set (PKS): This set includes all subjects in the treated set (TS) who provide at least one PK endpoint that was defined as primary and was not excluded due to a protocol deviation relevant to the evaluation of PK or due to PK non-evaluability (as specified in the following subsection 'Pharmacokinetics'). Thus, a subject will be included in the PKS, even if he/she contributes only one PK parameter value for one period to the statistical assessment. Descriptive and model based analyses of PK parameters will be based on the PKS.*

[…]

Plasma concentration data and parameters of a subject will be included in the statistical pharmacokinetic (PK) analyses if they are not flagged for exclusion due to a protocol deviation relevant to the evaluation of PK (to be decided no later than in the Report Planning Meeting) or due to PK non-evaluability (as revealed during data analysis, based on the criteria specified below). Exclusion of a subject's data will be documented in the CTR.

Relevant protocol deviations may be

- *Incorrect trial medication taken, i.e. the subject received at least one dose of trial medication the subject was not assigned to*
- *Incorrect dose of trial medication taken*
- *Use of restricted medications*

Plasma concentrations and/or parameters of a subject will be considered as non-evaluable, if for example

- *The subject experienced emesis that occurred at or before two times median t_{max} of the respective treatment (Median t_{max} is to be determined excluding the subjects experiencing emesis),*
- *A predose concentration is >5% C_{max} value of that subject*
- *Missing samples/concentration data at important phases of PK disposition curve*

Plasma concentration data and parameters of a subject which is flagged for exclusion will be reported with its individual values but will not be included in the statistical analyses. Descriptive and inferential statistics of PK parameters will be based on the PKS.

The descriptive analysis of PK concentrations will be based on the ADS ADPC as described at the beginning of Section 7.

Table 6.3: 1 Subject sets analysed

	Subject set	
Class of endpoint	TS	PKS
Analyses of PK endpoints		X
Safety parameters	X	
Demographic/baseline parameters	X	
Important protocol deviations	X	
Disposition	X	
Exposure	X	

6.5 POOLING OF CENTRES

This section is not applicable, because the study was performed in only one centre.

6.6 HANDLING OF MISSING DATA AND OUTLIERS

Handling of missing data and outliers will be performed as described in the CTP, Section 7.5.

The only exceptions where imputation might be necessary for safety evaluation are AE dates. Missing or incomplete AE dates are imputed according to BI standards (see BI-KMED-BDS-HTG-0035) (4).

Missing data and outliers of PK data are handled according to BI standards (see BI-KMED-TMCP-MAN-0012 (5) and BI-KMED-TMCP-MAN-0014 (6).

6.7 BASELINE, TIME WINDOWS AND CALCULATED VISITS

The baseline value is defined as the last measurement before administration of Otezla in each treatment period.

Section 6.1 of the CTP: *Study measurements and assessments scheduled to occur 'before' trial medication administration on Day 1 are to be performed and completed within a 3 h-period prior to the trial drug administration.*

The acceptable deviation from the scheduled time for vital signs and laboratory tests will be ± 45 min.

Adherence to time windows will be checked via the consistency check listings at the RPM.

Unscheduled measurements of laboratory data and vital signs data will be assumed to be repeat measurements of the most recent scheduled measurement (e.g. for follow-up or confirmation of a particular value). Therefore, unscheduled measurements will be assigned to the planned time point of the previous scheduled measurement.

7. PLANNED ANALYSIS

Safety analysis (refer to Section 7.8) will be performed by [redacted] and will be presented in Sections 15.1 to 15.4 of the CTR and in Appendix 16.2 and 16.1.13.1.

Descriptive data analysis of PK endpoints and concentrations will be performed by the department of [redacted] at [redacted] and will be presented in Section 15.6 of the CTR.

The format of the listings and tables will follow the BI standards (see BI-KMED-BDS-HTG-0045 (7)) with the exception of those generated for PK-calculations following BI standards for PK/PD analysis (8).

The individual values of all subjects will be listed, sorted by treatment sequence, subject number and visit. The listings will be included in Appendix 16.2 of the CTR.

For end-of-text tables, the set of summary statistics for non-PK parameters is:

N	number non-missing observations
Mean	arithmetic mean
SD	standard deviation
Min	minimum
Median	median
Max	maximum

For analyte concentrations, the following descriptive statistics will additionally be calculated:

CV	arithmetic coefficient of variation
gMean	geometric mean
gCV	geometric coefficient of variation

For PK parameters, the following descriptive statistics will additionally be calculated:

CV	arithmetic coefficient of variation
gMean	geometric mean
gCV	geometric coefficient of variation
P10	10th percentile
Q1	1st quartile
Q3	3rd quartile
P90	90th percentile

The data format for descriptive statistics of concentrations will be identical to the data format of the respective concentrations. The descriptive statistics of PK parameters will be calculated using the individual values with the number of decimal places as provided by the evaluation program. Then the individual values as well as the descriptive statistics will be reported with three significant digits in the CTR.

Tabulations of frequencies for categorical data will include all possible categories and will display the number of observations in a category as well as the percentage (%) relative to the respective treatment group (unless otherwise specified, all subjects in the respective subject set whether they have non-missing values or not).

The precision for percentages should be one decimal point, unless the denominator is smaller than 100 (in all treatment columns), in which case percentages are given in integer numbers. The category missing will be displayed only if there are actually missing values.

Exclusion of PK parameters

The ADS "ADPP" (PK parameters) contains column variables APEXC and APEXCO indicating inclusion/exclusion (APEXC) of a PK parameter and an analysis flag comment (APEXCO). All analyses based on the PKS will include parameters if they are not flagged for exclusion, that is APEXC is equal to "Included".

Exclusion of PK concentrations

The ADS "ADPC" (PK concentrations per time-point or per time-interval) contains column variables ACEXC and ACEXCO indicating inclusion/exclusion (ACEXC) of a concentration and an analysis flag comment (ACEXCO). Exclusion of a concentration depends on the analysis flag comment ACEXCO. For example, if ACEXCO is set to 'ALL CALC', the value will be excluded for all types of analyses based on concentrations. If ACEXCO is set to 'DESC STATS' the value will be excluded from descriptive evaluations per planned time point/time interval. If ACEXCO contains the addition 'TIME VIOLATION' or 'TIME DEVIATION' the value can be used for further analyses based on actual times. If ACEXCO is set to 'HALF LIFE', the value will be excluded from half-life calculation (and, as a consequence, any calculation that relies on λ_z) only; the value is included for all other analyses.

Further details are given in *BI-KMED-TMCP-MAN-0014* "Noncompartmental Pharmacokinetic / Pharmacodynamic Analyses of Clinical Studies" (6) and *BI-KMED-TMCP-MAN-0010*: "Description of Analytical Transfer Files and PK/PD Data Files" (9).

7.1 DEMOGRAPHIC AND OTHER BASELINE CHARACTERISTICS

Only descriptive statistics are planned for this section of the report, based on the TS.
The data will be summarised by treatment sequence and in total.

7.2 CONCOMITANT DISEASES AND MEDICATION

Only descriptive statistics are planned for this section of the report, based on the TS.

Concomitant diseases will be coded using the coding system of the Medical Dictionary for Drug Regulatory Activities (MedDRA). Medications will be coded using the World Health Organization Drug Dictionary (WHO-DD). The coding version number will be displayed as a footnote in the respective output.

The diagnoses and medications will be listed. Subjects without any concomitant diagnoses or concomitant therapies should be marked with a "No" in the respective column.

The relevance of the concomitant therapies to the evaluation of PK will be decided no later than at the RPM.

7.3 TREATMENT COMPLIANCE

Only descriptive statistics are planned for this section of the report.

It is not intended to list the compliance separately. Any deviation from complete intake will be addressed in the RPM (see Section 6.2) and described in the CTR.

7.4 PRIMARY ENDPOINT(S)

The study was prematurely stopped after 20 subjects have been treated. Primary endpoints will be analysed descriptively only. The statistical evaluation of PK endpoints described in Section 7.3.1 of the CTP will not be performed.

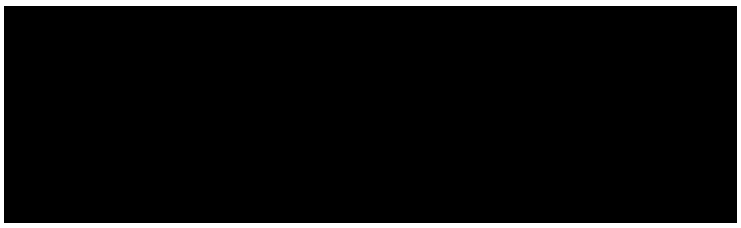
7.5 SECONDARY ENDPOINT(S)

7.5.1 Key secondary endpoint(s)

This section is not applicable, as no key secondary endpoint has been specified in the protocol.

7.5.2 (Other) Secondary endpoint(s)

This section is not applicable, as no secondary endpoint has been specified in the protocol



Safety and tolerability endpoints

Refer to Section 7.8 for a description of the analysis of safety and tolerability.

7.7 EXTENT OF EXPOSURE

Descriptive statistics are planned for this section of the report based on the TS. The date and time of drug administrations will be listed for each subject.

7.8 SAFETY ANALYSIS

All safety analyses will be performed on the TS.

The safety data for treated subjects who failed to complete the study (dropouts or withdrawals) will be reported as far as their data are available. All withdrawals will be documented and the reason for withdrawal recorded.

7.8.1 Adverse Events

AEs will be coded with the most recent version of MedDRA.

Unless otherwise specified, the analyses of AEs will be descriptive in nature. All analyses of AEs will be based on the number of subjects with AEs and NOT on the number of AEs. BI standards as presented in "Analysis and Presentation of Adverse Event Data from Clinical Trials – Display Template" [BI-KMED-BDS-HTG-0041] (10) and [BI-KMED-BDS-HTG-0066] (11) will be applied.

The analysis of AEs will be based on the concept of treatment emergent AEs. That means that all AEs will be assigned to 'screening', 'on-treatment' or 'follow-up' phases as defined in Section 6.1. AEs will be analysed based on actual treatments, as defined in Table 6.1: 1.

According to the CTP, adverse events of special interest (AESI) will be analysed:

Section 5.2.6.1.4 of the CTP: *For this trial, depression, mood changes, suicidal ideation, and suicidal behaviour/attempt are considered as AESIs.*

According to ICH E3 (12), in addition to deaths and serious adverse events, 'other significant' AEs need to be listed in the clinical trial report. These will be any non-serious adverse event that led to an action taken with study drug (e.g. discontinuation or dose reduced or interrupted).

An overall summary of AEs will be presented.

The frequency of subjects with AEs will be summarised by treatment, primary system organ class (SOC) and preferred term (PT). Separate tables will be provided for subjects with serious AEs, for subjects with drug-related AEs, for subjects with drug-related serious adverse events and for subjects with AESIs. In addition, the frequency of subjects with AEs will be summarised by treatment, worst intensity, SOC and PT.

The SOCs and PTs will be sorted by frequency (within SOC). The MedDRA version number will be displayed as a footnote in the respective output.

In addition, frequencies of subjects with non-serious AEs that had an incidence of > 5% for at least one treatment will be summarised by treatment, primary SOC and PT.

For disclosure of adverse events on EudraCT, additional information not included in a standard AE analysis will be performed. The following three entries will be created:

- Adverse Events per arm for disclosure on EudraCT
- Non-serious Adverse Events for disclosure on EudraCT
- Serious Adverse Events for disclosure on EudraCT

7.8.2 Laboratory data

The analyses of laboratory data will be descriptive in nature and will be based on BI standards [BI-KMED-BDS-HTG-0042] (13).

Laboratory data will be analysed qualitatively via comparison of laboratory data to their reference ranges. Values outside the reference range as well as values defined as possibly clinically significant will be flagged in the data listings.

Clinically relevant findings in laboratory data will be reported as baseline conditions (at screening) or as AEs (during the trial) if judged clinically relevant by the investigator, and will be analysed as such.
It is the investigator's responsibility to decide whether a lab value is clinically significantly abnormal or not (at the RPM at the latest).

Descriptive statistics of laboratory data including change from baseline will be calculated by planned time point based on the worst value of the subject at that planned time point (or assigned to that planned time point).

7.8.3 Vital signs

Descriptive statistics over time including change from baseline will be performed for vital signs (blood pressure and pulse rate). In the listing the difference from baseline will also be displayed.

For vital signs, descriptive statistics will be calculated by planned time point based on the last value of the subject at that planned time point (or assigned to that planned time point).

Clinically relevant findings in vital signs will be reported as AEs.

7.8.4 ECG

ECG recordings will be checked by the investigator for pathological results. Clinically relevant abnormal findings for ECG will be listed under 'Relevant Medical History / Baseline Conditions' (when they occurred during screening). No separate ECG listing will be provided.

7.8.5 Others

Physical examination

Physical examination findings will be reported as relevant medical history/baseline condition (i.e., a condition already existent before intake of study drug) or as AE (when on treatment) and will be summarised as such.
No separate listing or analysis of physical examination findings will be prepared.

8. TIMEPOINT OF RELEASE OF TREATMENT INFORMATION

The treatment information will be loaded into the trial database at trial initiation.

9. REFERENCES

1.	*CPMP/ICH/363/96:* "Statistical Principles for Clinical Trials", ICH Guideline Topic E9, Note For Guidance on Statistical Principles for Clinical Trials, current version.
2.	*001-MCS-40-413:* "Identify and Manage Important Protocol Deviations (iPD) ", current version, IDEA for CON.
3.	*BI-KMED-BDS-TMP-0059*: "iPD specification document (sdtm-dv-domain-specification)", template, current version, KMED.
4.	*BI-KMED-BDS-HTG-0035*: "Handling of Missing and Incomplete AE Dates", current version; KMED.
5.	*BI-KMED-TMCP-MAN-0012*: "Standards and processes for analyses performed within Clinical Pharmacokinetics/Pharmacodynamics", current version; KMED.
6.	*BI-KMED-TMCP-MAN-0014*: "Noncompartmental Pharmacokinetic / Pharmacodynamic Analyses of Clinical Studies", current version; KMED.
7.	*BI-KMED-BDS-HTG-0045*: "Standards for Reporting of Clinical Trials and Project Summaries", current version; KMED.
8.	*BI*-KMED-TMCP-OTH-0003: "Graphs and Tables for Clinical Pharmacokinetics and Pharmacodynamic Noncompartmental Analyses", current version, KMED.
9.	*BI-KMED-TMCP-MAN-0010*: "Description of Analytical Transfer Files and PK/PD Data Files", current version; KMED.
10.	*BI-KMED-BDS-HTG-0041*: "Analysis and Presentation of Adverse Event Data from Clinical Trials – Display Template", current version; KMED.
11.	BI-KMED-BDS-HTG-0066: "Analysis and Presentation of AE data from clinical trials", current version, KMED.
12.	*CPMP/ICH/137/95*: "Structure and Content of Clinical Study Reports", ICH Guideline Topic E3; Note For Guidance on Structure and Content of Clinical Study Reports, current version.
13.	*BI-KMED-BDS-HTG-0042*: "Handling, Display and Analysis of Laboratory Data", current version; KMED.

11. HISTORY TABLE

Table 11: 1 History table

Version	Date (DD-MMM-YY)	Author	Sections changed	Brief description of change
1	**30-SEP-21**	[redacted]	None	This is the final TSAP