Official Title: An Open-Label Phase 1/2 Study of Itacitinib (INCB039110) in Combination With Ibrutinib in Subjects With Relapsed or Refractory Diffuse Large B-Cell Lymphoma

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STATISTICAL ANALYSIS PLAN

INCB 39110-206

An Open-Label Phase 1/2 Study of INCB039110 in Combination With Ibrutinib in Subjects With Relapsed or Refractory Diffuse Large B-Cell Lymphoma

IND Number:	[redacted]
Sponsor:	**Incyte Corporation** **1801 Augustine Cut-Off** **Wilmington, DE 19803**
Protocol Version:	**Protocol Amendment 5 dated 18 JUN 2020**
CRF Approval Date:	**02 NOV 2016**
SAP Version:	**Amendment 2**
SAP Author:	[redacted] [redacted]**, Biostatistics**
Date of Plan:	**29 NOV 2022**

This study is being conducted in compliance with good clinical practice, including the archiving of essential documents.

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LIST OF ABBREVIATIONS

The following abbreviations and special terms are used in this statistical analysis plan.

Abbreviation	Definition
ABC	activated B-cell
AE	adverse event
ALT	alanine aminotransferase
ANC	absolute neutrophil count
aPTT	activated partial thromboplastin time
AST	aspartate aminotransferase
[redacted]	[redacted]
[redacted]	[redacted]
CI	confidence interval
[redacted]	[redacted]
CLL	chronic lymphocytic leukemia
[redacted]	[redacted]
[redacted]	[redacted]
CR	complete response
CRF	case report form
CRP	C-reactive protein
CSR	Clinical Study Report
CTCAE	Common Terminology Criteria for Adverse Events
DLBCL	diffuse large B-cell lymphoma
DLT	dose-limiting toxicity
DNA	deoxyribonucleic acid
DOR	duration of response
ECG	electrocardiogram
ECOG	Eastern Cooperative Oncology Group
eCRF	electronic case report form
FDA	Food and Drug Administration
GCB	germinal center B-Cell
HBc	hepatitis B core
HBsAg	hepatitis B surface antigen
HBV	hepatitis B virus
HCV	hepatitis C virus
IgG	immunoglobulin G
INR	international normalized ratio

Abbreviation	Definition
ITT	intent to treat
JAK	Janus kinase
LDH	lactate dehydrogenase
MedDRA	Medical Dictionary for Regulatory Activities
NCI	National Cancer Institute
NE	not evaluable
ORR	objective response rate
OS	overall survival
PD	progressive disease
PFS	progression-free survival
[redacted]	[redacted]
PP	per protocol
PR	partial response
PT	prothrombin time
PTT	partial thromboplastin time
QD	once daily
RNA	ribonucleic acid
SAE	serious adverse event
SAP	Statistical Analysis Plan
TEAE	treatment-emergent adverse event
[redacted]	[redacted]

1. INTRODUCTION

INCB 39110-206 is an open-label, single-group, Phase 1/2 study of INCB039110 in combination with ibrutinib in subjects with relapsed or refractory DLBCL. Phase 1 will evaluate the safety and tolerability of INCB039110 when combined with ibrutinib in subjects with DLBCL (ABC, GCB, or unclassifiable); Phase 2 will evaluate the efficacy of the combination in subjects with ABC or unclassifiable DLBCL at the dose determined in Phase 1. INCB039110 is a small molecule inhibitor of the JAK family of protein tyrosine kinases, with selectivity for JAK1. Members of the JAK family play an important role in signal transduction after cytokine and growth factor binding to their receptors; aberrant production of cytokines and growth factors has been associated with a number of cancers. Ibrutinib (IMBRUVICA®) is a first-in-class, potent, orally administered, covalently binding inhibitor of Bruton's tyrosine kinase. Ibrutinib has been approved in many regions, including the United States and Europe, for the treatment of patients with mantle cell lymphoma and CLL who have received at least 1 prior therapy, first-line treatment of patients with CLL with a deletion of the short arm of chromosome 17 (del17p) or a TP53 mutation, and patients with Waldenström's macroglobulinemia. Ibrutinib is currently under investigation in various indications as a single agent and in combinations.

A detailed description of the investigational product, target patient population, rationale for doses to be examined, and potential risks and benefits of treatment with INCB039110 and ibrutinib is provided in the Protocol, Section 1. The purpose of this SAP is to define the methodology for analyzing and summarizing the data collected during the conduct of Study INCB 39110-206.

2. STUDY INFORMATION, OBJECTIVES, AND ENDPOINTS

2.1. Protocol and Case Report Form Version

This SAP is based on INCB 39110-206 Protocol Amendment 5 dated 18 JUN 2020 and CRFs approved on 02 NOV 2016. Unless superseded by an amendment, this SAP will be effective for all subsequent Protocol Amendments and eCRF versions.

2.2. Study Objectives

2.2.1. Phase 1

2.2.1.1. Primary Objective

The primary objective of Phase 1 is to evaluate the safety and tolerability of INCB039110 in combination with ibrutinib in subjects with relapsed or refractory DLBCL.

2.2.1.2. Secondary Objective

The secondary objective of Phase 1 is to evaluate the efficacy of INCB039110 in combination with ibrutinib in terms of ORR.

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]

2.2.2. Phase 2

2.2.2.1. Primary Objective

The primary objective of Phase 2 is to evaluate the efficacy of INCB039110 in combination with ibrutinib in subjects with relapsed or refractory non-GCB DLBCL as demonstrated by ORR.

2.2.2.2. Secondary Objectives

The secondary objectives of Phase 2 are as follows:

- To evaluate efficacy in terms of DOR, durable response rate, PFS, and OS.
- To evaluate the safety and tolerability of the treatment combination.

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]

2.3. Study Endpoints

2.3.1. Phase 1

2.3.1.1. Primary Endpoint

Safety and tolerability will be assessed by evaluating the frequency, duration, and severity of AEs (including SAEs and DLTs), and changes in clinical and laboratory assessments.

2.3.1.2. Secondary Endpoints

Efficacy will be assessed by ORR, defined as the percentage of subjects achieving either a CR or PR.

[redacted]

- [redacted]
- [redacted]
- [redacted]

2.3.2. Phase 2

2.3.2.1. Primary Endpoint

Efficacy will be assessed by ORR, defined as the percentage of subjects achieving either a CR or PR.

2.3.2.2. Secondary Endpoints

- DOR, defined as the time from earliest date of disease response until earliest date of disease progression.
- Durable response rate, defined as the percentage of subjects achieving a CR or PR for > 16 weeks.
- PFS, defined as the time from enrollment until the earliest date of disease progression determined by objective radiographic disease assessments, or death due to any cause.
- OS, defined as the date of enrollment until death due to any cause.
- Safety and tolerability via assessment of the frequency, duration, and severity of AEs and SAEs, and changes in clinical and laboratory assessments.

[redacted]

- [redacted]
- [redacted]

3. STUDY DESIGN

3.1. Overall Study Design

This is an open-label, single-group, Phase 1/2 study of INCB039110 in combination with ibrutinib in subjects with relapsed or refractory DLBCL. Phase 1 will evaluate the safety and tolerability of INCB039110 when combined with ibrutinib in subjects with DLBCL (ABC, GCB, or unclassifiable) using a 6 + 3 design; Phase 2 will evaluate the efficacy of the combination in subjects with ABC or unclassifiable DLBCL at the dose determined in Phase 1 using a Simon 2-stage expansion design. Subjects may continue to receive study treatment until evidence of disease progression, unacceptable toxicity, or consent withdrawal.

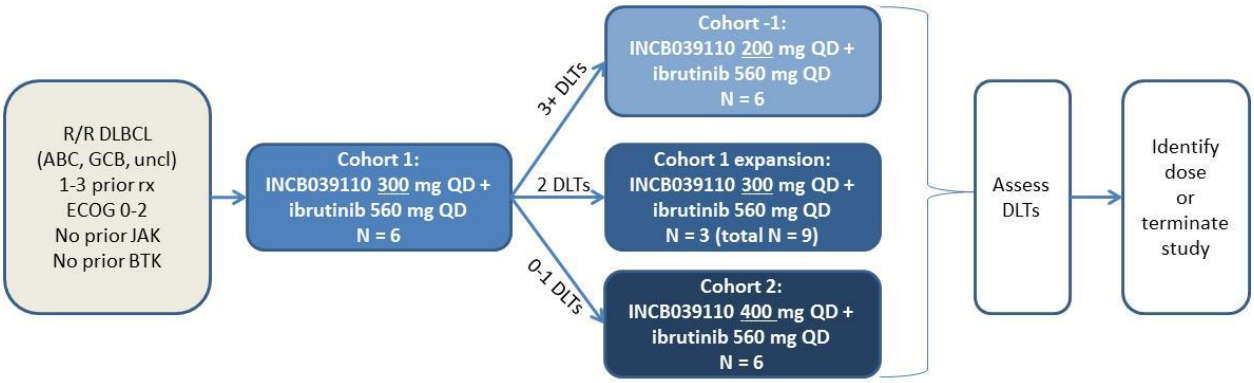
3.1.1. Phase 1

The starting dose of INCB039110 will be 300 mg QD. Depending on tolerability, the dose of INCB039110 in combination with ibrutinib (560 mg QD) could be increased to 400 mg QD (Cohort 2) or decreased to 200 mg QD (Cohort -1). The dose selected for study in Phase 2 will be the dose tolerated by at least two-thirds of subjects who did not require a dose reduction within the first 28 days of treatment. In order to be included in the tolerability review, a subject must have received the cohort-specific dose of INCB039110 and ibrutinib for at least 75% of the days during the 28-day DLT surveillance period or have experienced a DLT. Additional subjects may be enrolled to achieve a minimum cohort size of 6 should withdrawal or dose interruptions/reductions result in a subject being nonevaluable. Dose cohorts are outlined in Table 1, and the design is depicted in Figure 1.

Table 1: Phase 1 Dose Cohorts

Cohort	Number	Regimen	Subjects With DLT	Action
-1	6	INCB039110 200 mg QD + ibrutinib 560 mg QD	≤ 1	Begin expansion portion of the study
			2	Enroll 3 additional subjects (9 subjects total)
			≥ 3	Terminate study
1 (Starting dose)	6	INCB039110 300 mg QD + ibrutinib 560 mg QD	≤ 1	Escalate to Cohort 2
			2	Enroll 3 additional subjects (9 subjects total); if no new DLTs, escalate to Cohort 2
			≥ 3	Reduce to Cohort -1
2	6	INCB039110 400 mg QD + ibrutinib 560 mg QD	≤ 1	Begin Phase 2 study
			2	Enroll 3 additional subjects (9 subjects total); if no new DLTs, begin Phase 2 study
			≥ 3	Begin Phase 2 study using Cohort 1 dose

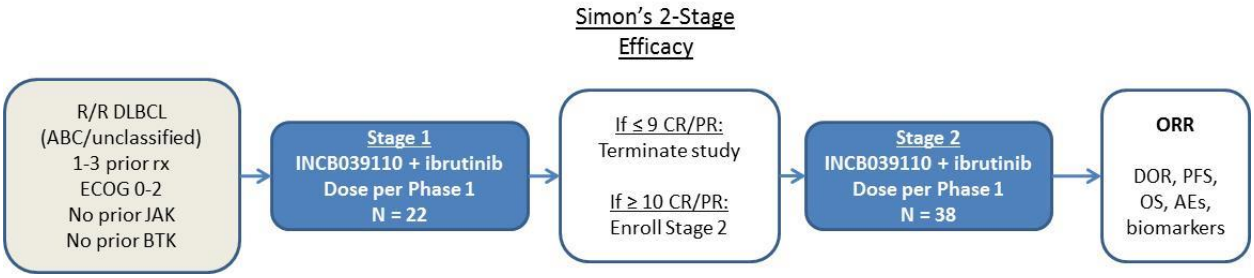
Figure 1: Phase 1 Design Schema



3.1.2. Phase 2

Subjects with ABC or unclassifiable DLBCL will receive the recommended Phase 2 dose of INCB039110 in combination with ibrutinib as determined in Phase 1. Phase 2 will use a Simon 2-stage design with a stopping rule to allow early termination of the study at the end of Stage 1 if there is lack of sufficient efficacy. During Stage 1, if 9 or fewer of the first 22 evaluable subjects achieve an objective response (defined as a CR or PR), then the study may be terminated. If 10 or more subjects achieve an objective response, then the study will continue and accrue 38 additional subjects to Stage 2. Subjects who were enrolled but did not receive treatment will be excluded from the efficacy analysis and replaced. A timely assessment of response will be made to avoid risk of overenrollment before accrual to Stage 2. At the end of Stage 2, ORR will be assessed for sufficient efficacy to warrant further study. The study will be considered successful if the total number of objective responders is 29 or more. The design is depicted in Figure 2.

Figure 2: Phase 2 Design Schema



3.1.3. Definition of Dose-Limiting Toxicities

A DLT will be defined as the occurrence of any toxicities in Table 2 occurring up to and including Study Day 28, except those with a clear alternative explanation (eg, disease progression) or transient (≤ 72 hours) abnormal laboratory values without associated clinically significant signs or symptoms based on investigator determination. All DLTs will be assessed by the investigator using CTCAE v4.03 criteria (NCI 2010). In order to be included in the tolerability review, subjects must have received the cohort-specific dose of INCB039110 and ibrutinib for at least 75% of the days during the 28-day surveillance period or have experienced a DLT. Additional subjects may be enrolled to achieve a minimum cohort size should withdrawal or dose interruptions/reductions result in subjects being nonevaluable.

Table 2: Criteria for Defining Dose-Limiting Toxicity

Toxicity
Nonhematologic
• Any ≥ Grade 3 nonhematologic toxicity, EXCEPT the following: – Transient (≤ 72 hours) abnormal laboratory values without associated clinically significant signs or symptoms. – Nausea, vomiting, and diarrhea adequately controlled with medical therapy within 48 hours. – Singular or nonfasting elevations in blood glucose (ie, blood glucose excursions will be considered toxicities if fasting blood glucose is elevated on 2 separate sequential occasions).
Hematologic
• Grade 3 thrombocytopenia with bleeding. • Grade 4 thrombocytopenia. • Febrile neutropenia (ANC < 1.0×10^9/L and fever > 101°F/38.5°C). • Grade 4 neutropenia that does not recover to ≤ Grade 2 in ≤ 3 days after interrupting study drug. • Grade 4 anemia unresponsive to treatment. **Note:** "INCB039110 is suspected to cause transient decreases in ANC as a result of margination; therefore, DLT rules require neutropenia to persist after holding INCB039110 for 2 to 3 days. If the clinical status of the subject allows, investigators are encouraged to wait 24 hours before starting growth factors, to determine if white blood cell margination is contributing to the degree of neutropenia."

3.2. Level of Significance

The level of significance for the primary endpoint in Phase 2 is 1-sided 10%, which is deemed acceptable for a proof-of-concept study.

3.3. Sample Size Considerations

3.3.1. Sample Size for Phase 1

For Phase 1, the decision to de-escalate the dose will be driven by the number of observed toxicities and can be calculated based on the binomial distribution. A 6 + 3 dose escalation design will be used in this study.

3.3.2. Sample Size for Phase 2

The study will lead to a decision between 2 prespecified hypotheses about the probability of an ORR, p. The null hypothesis H_0: p = 40% reflects a response rate that would be of no clinical benefit, and the alternative hypothesis H_A: p = 55% is a response rate that might lead to larger, confirmatory studies. Using a Simon 2-stage optimal design, a total of 60 subjects will be needed for 80% power at 1-sided alpha = 0.1 level. If there are ≤ 9 objective responders from the first 22 evaluable subjects, then this will support the null hypothesis, and the study will be terminated. Otherwise, 38 additional subjects will be enrolled (Stage 2).

3.4. Schedule of Assessments

All study assessments will be performed as indicated in the schedule of assessments in Table 8 of Protocol Amendment 5 (dated 18 JUN 2020); the order of assessments is suggested by the order of mention within the schedule. Laboratory assessments are shown in Table 9 of Protocol Amendment 5 (dated 18 JUN 2020).

4. DATA HANDLING DEFINITIONS AND CONVENTIONS

4.1. Scheduled Study Evaluations and Study Periods

4.1.1. Day 1

Day 1 is the date of first dose of INCB039110 or ibrutinib.

4.1.2. Study Day

The study day at a visit or reporting date will be calculated by the visit or reporting date minus the Day 1 date plus 1 (visit date – Day 1 date + 1). This study day will be subtracted by 1 if it is ≤ 0, so that a study day of 0 will never occur. A study day of -1 indicates 1 day before Day 1.

4.1.3. Scheduled Visits

Study evaluations in weeks or days from Day 1 are presented in the Schedule of Assessments.

4.1.4. Baseline Assessments

Baseline is defined as the last nonmissing measurement obtained before the first dose of INCB039110 or ibrutinib is administered.

4.1.5. Last Available Value

The last available value is the last nonmissing measurement obtained after starting INCB039110 or ibrutinib and within 90 days after the last dose of INCB039110 or ibrutinib.

4.2. Variable Definitions

4.2.1. Prior and Concomitant Medication

Prior medication is defined as any nonstudy drug started before the first dose of INCB039110 or ibrutinib.

Concomitant medication is defined as any nonstudy drug that is started accordingly:

- Before the date of first administration of INCB039110 or ibrutinib and is ongoing throughout the study or ends on/after the date of first study drug administration.
- On/after the date of first administration of INCB039110 or ibrutinib and is ongoing or ends during the course of study drug administration.

Note: A prior medication could also be classified as "both prior and concomitant medication" if the end date is on or after first dose of INCB039110 or ibrutinib. In the listing, it will be indicated whether a medication is prior-only, concomitant-only, or both prior and concomitant medication.

The start/stop dates recorded in the eCRF by the investigator and his or her research staff will be used to identify when a concomitant medication was taken during the study. Any missing start date must be queried for resolution. Unresolved missing start dates will be handled as follows:

- If the date is completely missing, then the medication will be considered both prior and concomitant.
- If only the day is missing, and the last day of the month is before the first dose date on Day 1, then the concomitant medication will be considered as starting before Day 1, and the incomplete date will be imputed as the last day of the month.
- If only the day is missing, and the first day of the month is after the first dose date on Day 1, then the concomitant medication will be considered as starting after Day 1, and the incomplete date will be imputed as the first day of the month.
- If only the day is missing, and the month is equal to the month of the first dose date on Day 1, then the incomplete date will be imputed as the first day of the month.
- If both the month and day are missing, and the last day of the year is before the first dose date on Day 1, then the concomitant medication will be considered as starting before Day 1, and the incomplete date will be imputed as if it is the last day of the year. Otherwise, the incomplete date will be imputed as if it is the first day of the year.

5. STATISTICAL METHODOLOGY

5.1. General Methodology

Unless otherwise noted, SAS® software (SAS Institute Inc, Cary, NC; version 9.1 or later) will be used for the generation of all tables, graphs, and statistical analyses. Descriptive summaries for continuous variables will include, but not be limited to, the number of observations, mean, standard deviation, median, minimum, and maximum. Descriptive summaries for categorical variables will include the number and percentage of subjects in each category.

For the Phase 1 portion of the study, the safety run-in population (defined in Section 5.3.3) will be used for all safety analyses. For the Phase 2 portion of the study, the safety evaluable population will be used for all safety analyses, and the ITT population will be used for all efficacy analyses. [redacted]

5.2. Treatment Groups

Subjects will be summarized overall and based on the dose regimen initially assigned:

- Ibrutinib 560 mg QD + INCB039110 200 mg QD
- Ibrutinib 560 mg QD + INCB039110 300 mg QD
- Ibrutinib 560 mg QD + INCB039110 400 mg QD

Table summaries, unless otherwise indicated, will be provided by treatment group. Note that 1 of the above 3 treatments will be recommended for Phase 2 of the study, and separate summaries will be provided for the Phase 1 and Phase 2 portions of the study.

5.3. Analysis Populations

5.3.1. Intent-to-Treat Population

The ITT population will include all subjects enrolled into the Phase 2 portion of the study. This population will be used for analyses of all efficacy data.

5.3.2. Per Protocol Population

The PP population for efficacy data will include subjects in the ITT population who are considered to be compliant with the Protocol and will be defined for supportive sensitivity analyses for the primary and secondary efficacy endpoints. This population will include subjects in the ITT population who received at least 80% of the assigned study drug regimen, met all inclusion/exclusion criteria, and had no significant Protocol violations as determined by sponsor. A subject who is discontinued because of disease progression is considered to be evaluable for the PP population.

5.3.3. Safety Population

The safety run-in population will include all subjects enrolled in the Phase 1 portion of the study who received at least 1 dose of study drug. The safety evaluable population will include all subjects enrolled in the Phase 2 portion who received at least 1 dose of study drug. Treatment

groups for this population will be determined according to the actual treatment that the subject receives on Day 1. All safety analyses in Phase 1 and 2 will be conducted using the safety run-in population and safety evaluable population, respectively.

[redacted]

6. BASELINE, EXPOSURE, AND DISPOSITION VARIABLES AND ANALYSES

A list of planned tables, figures, and listings is provided in Appendix B.

6.1. Baseline and Demographics, Physical Characteristics, and Disease History

The following demographic and baseline characteristics will be summarized for the safety run-in/safety evaluable populations: age, sex, race, ethnicity, weight, height, ECOG performance status, prior radiation (yes/no), prior surgery (yes/no), prior treatment regimens, number of prior treatment regimens, subtype of DLBCL, B symptoms, and bulky disease (≥ 10 cm).

6.2. Disposition of Subjects

The number and percentage of subjects who were enrolled and who were withdrawn from the study (with a primary reason for withdrawal) will be summarized for the ITT and safety run-in/safety evaluable populations.

6.3. Protocol Deviations

Protocol deviations captured on the Protocol Deviation Log will be presented in the subject data listings.

6.4. Exposure

For subjects in the ITT and safety run-in/safety evaluable populations, exposure to INCB039110 and ibrutinib will be summarized descriptively as follows:

- **Duration of treatment (days):** The duration of treatment will be number of study days between Day 1 and the last nonzero dose administration record of INCB039110 or ibrutinib taken by the subject.
- **Average daily dose of INCB039110 or ibrutinib (mg/day):** Average daily dose of study drug (mg/day) = [total actual study drug taken (mg)] / [duration of treatment with study drug (days)].

6.5. Study Drug Compliance

For subjects in the ITT and safety run-in/safety evaluable populations, overall compliance (%) for INCB039110 or ibrutinib will be calculated for all subjects as follows:

$$\text{overall compliance (\%)} = 100 \times (\text{total dose taken}) / (\text{intended dose})$$

The intended dose will be determined up to the earliest study day of permanent discontinuation of INCB039110 or ibrutinib (ie, AE discontinuation is the first AE with action taken being "drug withdrawn"), last study drug record in the database, or subject death. Intended dose is defined as the sum of the doses prescribed by the investigator accounting both for planned dose reductions as well as those reductions or increases mandated by the investigator.

6.6. Medical History

For subjects in the ITT and safety run-in/safety evaluable populations, medical history will be summarized by assigned treatment group. This summation will include the number and percentage of subjects with significant medical history for each body system/organ class and documented on the Medical History eCRF.

6.7. Prior and Concomitant Medication

For subjects in the safety run-in/safety population, prior medications and concomitant medications will be coded using the WHO Drug Dictionary and summarized by WHO drug class and WHO drug term. In the data listing, each medication will be recorded as prior, concomitant, or both prior and concomitant. Results will be summarized as number and percentage of subjects with prior and concomitant medications by preferred term and WHO drug class.

Prior medication information will also be used to identify anticancer medication received by subjects before enrollment into the study. Prior anticancer medication data will be summarized and presented by treatment group as well as listed.

7. EFFICACY

A list of planned tables, figures, and listings is provided in Appendix B.

7.1. General Considerations

Not applicable.

7.2. Efficacy Hypotheses

Objective response rate (primary endpoint): Administration of INCB039110 in combination with ibrutinib increases ORR in subjects with relapsed or refractory non-GCB DLBCL compared with historical rate.

7.3. Analysis of the Primary Efficacy Parameter

7.3.1. Primary Efficacy Analysis

The primary variable for the Phase 2 of the study is ORR, which is defined as the proportion of subjects with best response (CR or PR) by modified Lugano Classification (Cheson et al 2014) for DLBCL. The proportion of responders within each treatment group will be estimated with 90% CIs by treatment group. Confidence intervals will be calculated based on the method of Koyama and Chen (2008) that accounts for early termination rules of the Simon 2-stage design. Within each treatment group, 1- sample binomial test will be used to test the null hypothesis.

In general, best response is determined on the subject level using the highest overall response achieved postbaseline. In the case of SD, measurements must meet the SD criteria at least once after study entry at a minimum interval of 56 days. Subjects who fail to meet these criteria will have best response of PD if the next available Lugano Classification evaluation after the initial scan indicates PD or NE if no additional evaluations are available.

7.4. Analysis of the Secondary Efficacy Parameter

7.4.1. Duration of Response

For objective responders, the DOR is the time from the first overall response contributing to an objective response (CR or PR) to the earlier of the subject's death and first overall response of PD (by Lugano Classification for DLBCL) occurring after the first overall response contributing to the objective response. Median DOR and 90% CIs will be estimated using the Kaplan-Meier method. Subjects who are still responding at the time of database freeze or discontinuation will be right-censored at the time of last valid radiologic assessment. The DOR evaluation will be performed separately for each treatment group, and no statistical comparison will be made.

7.4.2. Durable Response Rate

For objective responders, the durable response rate is defined as the percentage of subjects achieving a CR or PR (as determined by Lugano Classification) for ≥ 16 weeks since the time from the first overall response contributing to an objective response (CR or PR). Confidence intervals will be calculated based on the Clopper-Pearson method for binomial distributions.

7.4.3. Progression-Free Survival

Progression-free survival is defined as the number of days from the date of first dose (which is not necessarily Day 1) to the earlier of death or disease progression. Date of death will be determined using the Death Report, the Survival Follow-Up, and the Subject Status eCRFs. Disease progression is measured by investigator assessment of objective radiographic disease assessments per Lugano Classification. Censoring for PFS will follow the algorithm outlined in Table 3, which is based on FDA guidance (FDA 2007). The analyses will be based on the ITT population, according to treatment assignment. Time-to-event data will be analyzed by the Kaplan-Meier method, treating subjects with no observed death or progression as censored at the last valid radiologic assessment visit. Median PFS and 90% CI will be estimated.

Table 3: Evaluation and Censoring of Progression-Free Survival

Situation	Outcome	Date of Progression or Censoring
No baseline tumor assessments	Censored	Date of enrollment
Progression documented between scheduled visits	Progressed	Earliest of: • Date of radiological assessment showing new lesion (if progression is based on new lesion); or • Date of last radiological assessment of measured lesions (if progression is based on increase in sum of measured lesions)
No progression	Censored	Date of last valid radiologic assessment (not NE and not missing)
Treatment discontinuation for undocumented progression	Censored	Date of last valid radiologic assessment (not NE and not missing)
Treatment discontinuation for toxicity or other reason	Censored	Date of last valid radiologic assessment (not NE and not missing)
New anticancer treatment started	Censored	Date of last valid radiologic assessment (not NE and not missing)
Death before first pharmacodynamic assessment	Progressed	Date of death
Death between adequate assessment visits	Progressed	Date of death
Death or progression after more than 1 missed assessment	Censored	Date of last valid radiologic assessment (not NE and not missing)

7.4.4. Overall Survival

Overall survival will be determined from the date of first dose until death. Survival data will be analyzed using Kaplan-Meier method, treating subjects with no observed death as censored at their last date known to be alive. Median survival and 90% CI will be estimated. Overall survival data will continue to be collected until 75% of subjects have died, have withdrawn consent, or are lost to follow-up.

7.4.5. Other Efficacy Analyses

7.4.5.1. Eastern Cooperative Oncology Group Performance Status

Subjects' ECOG performance status and changes in status at scheduled assessment times will be summarized.

7.4.5.2. Weight

Subjects' body weight and change from baseline in body weight at scheduled assessment times will be summarized.

[redacted]

8. SAFETY AND TOLERABILITY

A list of planned tables, figures, and listings is provided in Appendix B.

8.1. General Considerations

The analyses for this section will be provided mainly for the Phase 2 portion using the safety evaluable population. Data from the Phase 1 portion using the safety run-in population will be summarized separately where appropriate. Summary tables may be replaced with listings when appropriate. For instance, an AE frequency table may be replaced with a listing if it only contains a few unique preferred terms reported on relatively few subjects. Additional summaries for specific subgroups may be included on an ad hoc basis.

8.2. Adverse Events

8.2.1. Adverse Event Definitions

A TEAE is any AE either reported for the first time or worsening of a pre-existing event after first dose of study drug and until 30 days after the last dose of study drug. Analysis of AEs (as discussed below) will be limited to TEAEs, but data listings will include all AEs regardless of their timing to study drug administration.

Adverse events will be tabulated by the MedDRA preferred term and system organ class. Severity of AEs will be described and graded using the NCI CTCAE v4.03. The CTCAE reporting guidelines and grading details are available on the Cancer Therapy Evaluation Program website (NCI 2010).

A grading (severity) scale is provided for each AE term. If the toxicity is not included in the CTCAE v4.03 criteria, then it will be rated on a scale of 1 to 4 as follows: 1 = mild, 2 = moderate, 3 = severe, and 4 = life-threatening. All toxicities will be graded based on the worst level reached, not the level that they may have reached if they had not been treated. When the intensity of an AE changes over time for a reporting period (eg, between visits), each change in intensity will be collected as an AE until the event resolves. Only the worst grade will be reported in AE summaries. Also, the Grade 3 or higher AEs will be reported in the listing to display all higher intensity AEs.

The subset of AEs considered by the investigator to be related to INCB039110 or ibrutinib will be considered to be treatment-related AEs. If the investigator does not specify the relationship of the AE to study drug, then the AE will be considered to be treatment-related. The incidence of AEs and treatment-related AEs will be tabulated. Serious adverse events will also be tabulated.

Any missing onset date, causality, or severity must be queried for resolution. Unsolved missing values will be handled according to the following rules:

- An unsolved missing causality will be considered treatment-related.
- An unsolved missing severity will be identified as an unknown severity.

For purposes of analysis, all AEs will be considered TEAEs unless the AE can unequivocally be defined as not treatment-emergent. Therefore, an unsolved missing onset date will be considered treatment-emergent, with the following exceptions:

- If the stop/resolution date is before the first dose administration date on Day 1, then the AE will be considered as not being treatment-emergent.
- If both the month and day are missing, and the last day of the year is before the first dose administration date on Day 1, then the AE will not be considered treatment-emergent.
- If only the day is missing, and the last day of the month is before the first dose administration date on Day 1, then the AE will not be considered treatment-emergent.
- If only the day is missing, and the first day of the month is after the first dose administration date on Day 1, then the AE will be considered treatment-emergent.

8.2.2. Adverse Event Summaries

An overall summary of AEs by treatment group will include the following:

- Number (%) of subjects reporting any TEAEs
- Number (%) of subjects reporting any DLTs (would be Phase 1 only)
- Number (%) of subjects reporting any treatment-related TEAEs
- Number (%) of subjects reporting any serious TEAEs
- Number (%) of subjects reporting any Grade 3 or 4 TEAEs
- Number (%) of subjects with INCB039110 dose reductions because of TEAEs
- Number (%) of subjects who temporarily interrupted INCB039110 because of TEAEs
- Number (%) of subjects who permanently discontinued INCB039110 because of TEAEs
- Number (%) of subjects with ibrutinib dose reductions because of TEAEs
- Number (%) of subjects who temporarily interrupted ibrutinib because of TEAEs
- Number (%) of subjects who permanently discontinued ibrutinib because of TEAEs
- Number (%) of subjects with dose reductions of any study drug because of TEAEs
- Number (%) of subjects who temporarily interrupted any study drug because of TEAEs
- Number (%) of subjects who permanently discontinued any study drug because of TEAEs
- Number (%) of subjects who had a fatal TEAE
- Number (%) of subjects reporting any AEs related to reference therapy

The following summaries will be produced by MedDRA term (if ≤ 10 subjects appear in a table, then a listing may be appropriate):

- Number (%) of subjects reporting TEAEs by system organ class and preferred term
- Number (%) of subjects reporting TEAEs by preferred term in decreasing order of frequency
- Number (%) of subjects reporting TEAEs by system organ class, preferred term, and highest CTCAE grade
- Number (%) of subjects reporting any Grade 3 or 4 TEAEs by system organ class and preferred term
- Number (%) of subjects reporting any Grade 3 or 4 TEAEs by preferred term in decreasing order of frequency
- Number (%) of subjects reporting treatment-related TEAEs by system organ class and preferred term
- Number (%) of subjects reporting treatment-related TEAEs by preferred term in decreasing order of frequency
- Number (%) of subjects reporting treatment-related TEAEs by system organ class, preferred term, and highest CTCAE grade
- Number (%) of subjects reporting any Grade 3 or 4 treatment-related TEAEs by system organ class and preferred term
- Number (%) of subjects reporting any Grade 3 or 4 treatment-related TEAEs by preferred term in decreasing order of frequency
- Number (%) of subjects reporting TEAEs leading to death by system organ class and preferred term
- Number (%) of subjects reporting serious TEAEs by system organ class and preferred term
- Number (%) of subjects reporting serious TEAEs by preferred term in decreasing order of frequency
- Number (%) of subjects reporting treatment-related serious TEAEs by system organ class and preferred term
- Number (%) of subjects reporting TEAEs leading to dose reduction by system organ class and preferred term
- Number (%) of subjects reporting TEAEs leading to dose interruption by system organ class and preferred term
- Number (%) of subjects reporting TEAEs leading to discontinuation of medication by system organ class and preferred term
- Number (%) of subjects reporting TEAEs requiring concomitant medications by system organ class and preferred term

8.3. Clinical Laboratory Tests

8.3.1. Laboratory Value Definitions

Laboratory values and change from baseline values will be summarized descriptively by visit. The baseline value will be determined using the last nonmissing values collected before the first dose. For baseline laboratory candidates with the same date and time, additional rules may be provided after consultation with the medical monitor to delineate which value will be defined as baseline.

Laboratory test values outside the normal range will be assessed for severity based on CTCAE grade or similar criteria where clinical intervention is required for CTCAE grading. The incidence of abnormal laboratory values and shift tables relative to baseline will be tabulated.

8.3.2. Laboratory Value Summaries

Clinical laboratory tests, including hematology and serum chemistry (see Appendix A), will be performed for each subject during the study in accordance with Table 9 of Protocol Amendment 5 (dated 18 JUN 2020).

If specific safety issues arise, then additional unscheduled laboratory tests or analyses may be performed at the discretion of the investigator.

All test results and associated normal ranges from central laboratories will be reported in SI units. All tests with numeric values will have a unique unit per test. Any laboratory test results and associated normal ranges from local laboratories will be converted to SI units. For the limited number of cases where the associated normal ranges from a local laboratory cannot be obtained despite due diligence, a set of standard normal ranges based on documented reference ranges will be applied to facilitate reporting the test results.

When there are multiple nonmissing laboratory values for a subject's particular test within a visit window, the convention shown in Table 4 will be used to determine the record used for by-visit tabulations and summaries.

Table 4: Identification of Records for By-Visit Summaries

Priority	Laboratory Visit	Central or Local Laboratory	Proximity to Visit Window	Tiebreaker
1	Scheduled	Central	In-window	Use smallest laboratory sequence number
2	Scheduled	Local	In-window	
3	Unscheduled	Central	In-window	
4	Unscheduled	Local	In-window	
5	Scheduled	Central	Out-of-window	
6	Scheduled	Local	Out-of-window	

Laboratory parameters will be summarized. Shift tables based on worst postbaseline value recorded will use all postbaseline values. Other laboratory parameters collected will only be listed in an appendix to the CSR in their original units without SI conversions. A detailed listing of the serum chemistry, hematology, and urinalysis tests is provided in Appendix A.

Numeric laboratory values will be summarized descriptively, and non-numeric test values will be tabulated. In addition, line graph and box-and-whisker plots will be provided for prespecified laboratory parameters.

For test results that will be summarized with available normal ranges, the number and percentage of subjects with the laboratory values being low (but never high), normal, high (but never low), and both low and high will be calculated for each test.

This shift summary will be produced for each test for the safety run-in/safety evaluable population as well as the subset of subjects treated at the maximum tolerated dose. The denominator for the percentage calculation will use the number of subjects in the baseline category (ie, low, high, normal, missing) as the denominator for the percentage in each of the categories during the treatment period.

For all gradable laboratory parameters, the values will be classified into grade levels corresponding to CTCAE v4.03 criteria. For specific laboratory values requiring clinical intervention to grade, the classification according to the quantitative component will be provided.

The number and percentage of subjects with the laboratory values of Grade 1, 2, 3, or 4 will be calculated for each treatment according to the largest treatment-emergent worsening of laboratory grade. Separate summaries for abnormally high and abnormally low laboratory values will be provided when the laboratory in question has both high and low grading criteria. For instance, if a subject has a baseline fasting glucose of 210 mg/dL, maximum fasting glucose after starting treatment of 245 mg/dL, and minimum fasting glucose after starting treatment of 52 mg/dL, then the subject will be counted as follows:

- The subject will be counted as a Grade 2 "Glucose decreased" in summaries of hypoglycemia because the subject was not hypoglycemic at study entry but became hypoglycemic after treatment.
- The subject will not count as a "Glucose increased" in summaries of hyperglycemia because the subject met the numeric requirements for Grade 2 hyperglycemia at baseline (fasting glucose value > 160 to 250 mg/dL) and did not increase in grade after starting treatment.

In cases where differentials of hematology parameters are obtained without corresponding absolute count data, efforts will be made to investigate if the conversion to an absolute value will lead to additional abnormalities. This will be discussed with the clinical team regarding appropriate documentation and action.

8.4. Vital Signs

Vital signs, including systolic blood pressure, diastolic blood pressure, pulse, respiration rate, and body temperature, will be taken with subjects in the seated position during the study in accordance with Table 8 of Protocol Amendment 5 dated 18 JUN 2020. Change and percentage change from baseline will be calculated using the last nonmissing value before first dose of study drug (Day 1) as the baseline value.

Incidences of clinically notable vital sign abnormalities are defined in Table 5. The abnormal values for subjects exhibiting clinically notable vital sign abnormalities will be listed along with

their assigned treatment group. Alert vital signs are defined as an absolute value outside the defined range and percentage change > 25%.

Table 5: Criteria for Clinically Notable Vital Sign Abnormalities

Parameter	High Threshold	Low Threshold
Systolic blood pressure	> 155 mmHg	< 85 mmHg
Diastolic blood pressure	> 100 mmHg	< 40 mmHg
Pulse	> 100 bpm	< 45 bpm
Temperature	> 38°C	< 35.5°C
Respiratory rate	> 24/min	< 8/min

8.5. Electrocardiograms

Twelve-lead ECGs will be obtained for each subject during the study in accordance with Table 8 of Protocol Amendment 5 dated 18 JUN 2020. The baseline for each parameter is the average of all available values collected at screening, Day -1, and Day 1 predose. Electrocardiogram results will be reviewed for clinically notable abnormalities according to predefined criteria (see Table 6). Number and percentage of subjects with alert ECG values (outliers), defined as the absolute value outside the defined range (see Table 6) and percentage change > 25% (30% for QRS interval) will be summarized and listed if applicable. Electrocardiogram abnormalities, both at baseline and postbaseline visits, will be tabulated by treatment group. Incidences of abnormalities will be listed with study visit, assigned treatment group, and a description of the abnormality.

Table 6: Criteria for Clinically Notable Electrocardiogram Abnormalities

Parameter	High Threshold	Low Threshold
QTcF[a]	> 460 msec	< 295 msec
PR	> 220 msec	< 75 msec
QRS	> 120 msec	< 50 msec
QT	> 500 msec	< 300 msec
RR	> 1500 msec	< 600 msec

[a] QTcF (Fridericia correction).

9. INTERIM ANALYSES

No interim analysis is planned.

10. CHANGES AND MODIFICATIONS TO THE ANALYSIS PLAN

All versions of the SAP are listed in Table 7.

Table 7: Statistical Analysis Plan Versions

SAP Version	Date
Original	17 APR 2017
Amendment 1	10 OCT 2017
Amendment 2	29 NOV 2022

10.1. Changes to Protocol-Defined Analyses

Not applicable.

10.2. Changes to the Statistical Analysis Plan

10.2.1. Original to Amendment 1

Updates to the original SAP include the following:

- In Section 6.1, baseline disease staging was removed, prior systemic therapy other than radiation was changed to prior treatment regimens, and number of lines of previous anticancer therapies was changed to number of prior treatment regimens. In Appendix B, the summary table for prior medications for cancer was revised to prior therapies for cancer, and the listing for systemic cancer medication history was revised to prior treatment regimens.
- In Section 6.4 and Appendix B, references to study cycles were removed, and analyses summarized by cycles were updated to be summarized by day. Average daily dose (mg/day) of study drug was added.
- In Appendix B, summary tables including QTcB and RR interval values were removed or revised to exclude those values. Shift summary tables of laboratory values in CTC grade (both one and two directional) were removed. The standard summary table for clinically significant ECG abnormalities was removed. Shift summary tables and listings of laboratory hematology and chemistry values were added. Standard summary tables for ECOG status and 12-lead ECG QT interval values were added. Sample table shells were removed in accordance with new standard operating procedures. Formatting changes were applied as necessary, and table numbering was modified as a result of the changes listed above.
- Other minor, administrative changes have been incorporated throughout the SAP and are noted in the redline version of the amendment.

10.2.2. Amendment 1 to Amendment 2

Updates to Amendment 1 of the SAP include the following:

- In Section 4.2, age was removed from the variable definitions as the latest CRF design does not collect birth date.
- In Section 5.3.2, the definition of the PP population was revised to be consistent with Protocol Amendment 5.
- In Section 8.2.1, the definition of TEAE was updated.
- In Section 8.2.2 and Appendix B, the summary tables for TEAEs leading to study withdraw, nonserious TEAEs, and clinically notable vital signs were removed; a summary table for body weight was added.
- Other minor, administrative changes have been incorporated throughout the SAP and are noted in the redline version of the amendment.

11. REFERENCES

Cheson BD, Fisher RI, Barrington SF, et al. Recommendations for initial evaluation, staging, and response assessment of Hodgkin and non-Hodgkin lymphoma: the Lugano classification. J Clin Oncol 2014;32:3059-3068.

Food and Drug Administration (FDA). Guidance for Industry: Clinical Trial Endpoints for the Approval of Cancer Drugs and Biologics. 2007. http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/ucm071590.pdf. Accessed July 22, 2016.

Koyama T, Chen H. Proper inference from Simon's two-stage designs. Stat Med 2008;27:3145-3154.

National Cancer Institute (NCI). Common Terminology Criteria for Adverse Events version 4.0. 2010. http://ctep.cancer.gov/reporting/ctc.html. Accessed July 15, 2016.

APPENDIX A. CLINICAL LABORATORY TESTS

Serum Chemistries	Serology	Hematology	Coagulation
Albumin	HBsAg	Hemoglobin	PT
Alkaline phosphatase	Anti-HBsAg	Hematocrit	PTT
ALT	Anti-HBc IgG	Platelet count	aPTT
AST	HCV antibody	Red blood cell count	INR
Bicarbonate	HCV-RNA	White blood cell count	
Blood Urea Nitrogen	HBV-DNA	Differential cell count:	
Calcium		Basophils	
Chloride		Eosinophils	
Creatinine		Lymphocytes (absolute)	
Glucose		Monocytes	
LDH		Neutrophils (absolute)	
Phosphate			
Potassium			
Sodium			
Total bilirubin[a]			
Direct bilirubin[a]			
Indirect bilirubin			
Total serum protein			
Total cholesterol			
CRP			

[a] Only required if total bilirubin is elevated.

APPENDIX B. PLANNED TABLES, FIGURES, AND LISTINGS

This appendix provides a list of the planned tables, figures, and listings for the CSR. Standard tables will follow the conventions in the Standard Safety Tables Shells initial version. In-text tables are identical in structure and content as appendix tables, but follow a Rich Text Format.

Note: Data from the Phase 1 portion will be summarized separately where appropriate. Table and listing numbers that end in ".x" below will end in ".1" for Phase 1 and ".2" for Phase 2.

Tables

Table No.	Title	Population[a]	Standard	In-Text
Baseline and Demographic Characteristics				
1.1.1.x	Analysis Populations		X	X
1.1.2.x	Summary of Subject Disposition	Safety Run-in / ITT	X	X
1.1.4.x	Summary of Protocol Deviations	Safety Run-in / ITT	X	X
1.2.1.x	Summary of Demographics and Baseline Characteristics	Safety Run-in / ITT	X	X
1.3.1.x	Summary of Baseline Disease Characteristics	Safety Run-in / ITT		X
1.4.1.x	Summary of General Medical History	Safety Run-in / ITT		X
1.5.1.x	Summary of Prior Medications	Safety Run-in / ITT		X
1.5.2.x	Summary of Concomitant Medications	Safety Run-in / ITT		X
1.5.3.x	Summary of Prior Therapies for Cancer	Safety Run-in / ITT		X
Efficacy				
2.1.1.x	Summary of Best Response per Lugano Classification	Safety Run-in / ITT		X
2.1.2	Summary of Best Response per Lugano Classification (Phase 2)	PP		X
2.4.1	Summary of Duration of Response per Lugano Classification (Phase 2)	ITT		X
2.4.2	Summary of Durable Response Rate (Phase 2)	ITT		X
2.5.1	Kaplan-Meier Analysis of Progression-Free Survival per Lugano Classification (Phase 2)	ITT		X
2.6.1	Kaplan-Meier Analysis of Overall Survival (Phase 2)	ITT		X
2.8.1.x	Summary of ECOG Status	Safety Run-in / ITT	X	X
Safety				
3.1.1.x	Summary of Exposure and Duration of Exposure to INCB039110 and Ibrutinib	Safety Run-in / ITT	X	X
3.1.2.x	Summary of INCB039110 and Ibrutinib Compliance	Safety Run-in / ITT	X	X
3.2.1.x	Overall Summary of Treatment-Emergent Adverse Events	Safety Run-in / Safety Evaluable	X	X
3.2.2.x	Summary of Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.3.x	Summary of Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	Safety Run-in / Safety Evaluable	X	X
3.2.4.x	Summary of Treatment-Emergent Adverse Events by MedDRA System Organ Class, Preferred Term, and Maximum Severity	Safety Run-in / Safety Evaluable	X	X

Table No.	Title	Population[a]	Standard	In-Text
3.2.5.x	Summary of Grade 3 or Higher Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.6.x	Summary of Grade 3 or Higher Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	Safety Run-in / Safety Evaluable	X	X
3.2.7.x	Summary of INCB039110 Treatment-Related, Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.8.x	Summary of Ibrutinib Treatment-Related, Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.9.x	Summary of INCB039110 Treatment-Related, Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	Safety Run-in / Safety Evaluable	X	X
3.2.10.x	Summary of Ibrutinib Treatment-Related, Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	Safety Run-in / Safety Evaluable	X	X
3.2.11.x	Summary of INCB039110 Treatment-Related, Treatment-Emergent Adverse Events by MedDRA System Organ Class, Preferred Term, and Maximum Severity	Safety Run-in / Safety Evaluable	X	X
3.2.12.x	Summary of Ibrutinib Treatment-Related, Treatment-Emergent Adverse Events by MedDRA System Organ Class, Preferred Term, and Maximum Severity	Safety Run-in / Safety Evaluable	X	X
3.2.13.x	Summary of Grade 3 or Higher INCB039110 Treatment-Related, Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.14.x	Summary of Grade 3 or Higher Ibrutinib Treatment-Related, Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.15.x	Summary of Grade 3 or Higher INCB039110 Treatment-Related, Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	Safety Run-in / Safety Evaluable	X	X
3.2.16.x	Summary of Grade 3 or Higher Ibrutinib Treatment-Related, Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	Safety Run-in / Safety Evaluable	X	X
3.2.17.x	Summary of Treatment-Emergent Adverse Events With a Fatal Outcome by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.18.x	Summary of Serious Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.19.x	Summary of Serious Treatment-Emergent Adverse Events by MedDRA Preferred Term in Decreasing Order of Frequency	Safety Run-in / Safety Evaluable	X	X

Table No.	Title	Population[a]	Standard	In-Text
3.2.21.x	Summary of INCB039110 Treatment-Related, Treatment-Emergent Serious Adverse Events by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.22.x	Summary of Ibrutinib Treatment-Related, Treatment-Emergent Serious Adverse Events by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	
3.2.24.x	Summary of Treatment-Emergent Adverse Events Leading to Dose Reduction of INCB039110 by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.25.x	Summary of Treatment-Emergent Adverse Events Leading to Dose Reduction of Ibrutinib by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.26.x	Summary of Treatment-Emergent Adverse Events Leading to Dose Interruption of INCB039110 by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.27.x	Summary of Treatment-Emergent Adverse Events Leading to Dose Interruption of Ibrutinib by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.28.x	Summary of Treatment-Emergent Adverse Events Leading to Discontinuation of INCB039110 by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.29.x	Summary of Treatment-Emergent Adverse Events Leading to Discontinuation of Ibrutinib by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
3.2.30.x	Summary of Treatment-Emergent Adverse Events Requiring Concomitant Medications by MedDRA System Organ Class and Preferred Term	Safety Run-in / Safety Evaluable	X	X
Laboratory				
3.3.1.x	Summary of Laboratory Values – Hematology	Safety Run-in / Safety Evaluable	X	X
3.3.3.x	Summary of Laboratory Values – Chemistry	Safety Run-in / Safety Evaluable	X	X
3.3.5.x	Shift Summary of Laboratory Hematology Values in CTC Grade - To the Worst Abnormal Value	Safety Run-in / Safety Evaluable	X	X
3.3.6.x	Shift Summary of Laboratory Chemistry Values in CTC Grade - To the Worst Abnormal Value	Safety Run-in / Safety Evaluable	X	X
Vital Signs				
3.4.1.x	Summary of Systolic Blood Pressure	Safety Run-in / Safety Evaluable	X	X
3.4.2.x	Summary of Diastolic Blood Pressure	Safety Run-in / Safety Evaluable	X	X
3.4.3.x	Summary of Pulse	Safety Run-in / Safety Evaluable	X	X
3.4.4.x	Summary of Body Temperature	Safety Run-in / Safety Evaluable	X	X
3.4.5.x	Summary of Respiration Rate	Safety Run-in / Safety Evaluable	X	X
3.4.6.x	Summary of Body Weight	Safety Run-in / Safety Evaluable	X	X

Table No.	Title	Population[a]	Standard	In-Text
ECGs				
3.5.1.x	Summary of 12-Lead ECG: PR Interval Values	Safety Run-in / Safety Evaluable	X	X
3.5.2.x	Summary of 12-Lead ECG: QRS Interval Values	Safety Run-in / Safety Evaluable	X	X
3.5.3.x	Summary of 12-Lead ECG: QT Interval Values	Safety Run-in / Safety Evaluable	X	X
3.5.4.x	Summary of 12-Lead ECG: QTcF Interval Values	Safety Run-in / Safety Evaluable	X	X
3.5.5.x	Outliers of QT and QTcF Interval Values	Safety Run-in / Safety Evaluable	X	X
3.5.6.x	Summary of Clinically Significant ECG Abnormalities	Safety Run-in / Safety Evaluable	X	X

[a] For table numbers ending in " x" the populations will be the safety run-in population for all Phase 1 tables and the ITT or safety evaluable population for Phase 2 tables.

Figures

Figure No.	Title
4.6.1	Kaplan-Meier Plot of Progression-Free Survival (Phase 2)
4.7.1	Kaplan-Meier Plot of Overall Survival (Phase 2)
4.9.1.1.1	Line Graph of Mean and STD for Hemoglobin (G/L) by Visit (Phase 1)
4.9.1.1.2	Line Graph of Mean and STD for Neutrophils (GI/L) by Visit (Phase 1)
4.9.1.1.3	Line Graph of Mean and STD for Platelets (GI/L) by Visit (Phase 1)
4.9.1.1.4	Line Graph of Mean and STD for Leukocytes (GI/L) by Visit (Phase 1)
4.9.1.2.1	Line Graph of Mean and STD for Hemoglobin (G/L) by Visit (Phase 2)
4.9.1.2.2	Line Graph of Mean and STD for Neutrophils (GI/L) by Visit (Phase 2)
4.9.1.2.3	Line Graph of Mean and STD for Platelets (GI/L) by Visit (Phase 2)
4.9.1.2.4	Line Graph of Mean and STD for Leukocytes (GI/L) by Visit (Phase 2)

Listings

Listing No.	Title
2.1.1.x	Subject Enrollment and Disposition Status
2.2.1.x	Protocol Deviations
2.3.1.x	Analysis Populations
2.3.2.x	Subject Inclusion and Exclusion Criteria
2.4.1.x	Demographics and Baseline Characteristics
2.4.2.x	Medical History
2.4.3.x	Prior Treatment Regimens
2.4.4.x	Prior Surgery
2.4.5.x	Prior Radiotherapy
2.4.6.x	Flow Cytometry
2.4.7.x	Hematopoietic Stem Cell Transplant History
2.4.8.x	DLBCL History
2.4.9.x	Prior and Concomitant Drug Treatments
2.4.10.x	PRBC/Platelet Transfusions
2.4.11.x	Procedures and Non-Drug Therapy

Listing No.	Title
2.5.1.x	Study Drug Administration of INCB039110
2.5.2.x	Study Drug Administration of Ibrutinib
2.5.3.x	INCB039110 Compliance
2.5.4.x	Ibrutinib Compliance
2.6.1.x	Investigator Response
2.6.2	PFS Events and Assessments (Phase 2)
2.6.3	OS Events and Assessments (Phase 2)
2.6.4	Duration of Response and Durable Response (Phase 2)
2.6.5.x	Target Lesions
2.6.6.x	Non-Target Lesions
2.6.7.x	New Lesions
2.6.8.x	Bone Marrow Testing
2.6.9.x	ECOG Status
2.6.10.x	Deaths
2.7.1.x	Adverse Events
2.7.2.x	Dose-Limiting Toxicities
2.7.3.x	Serious Adverse Events
2.7.4.x	Grade 3 and Higher Adverse Events
2.7.5.1.x	Adverse Events Leading to Discontinuation of INCB039110
2.7.5.2.x	Adverse Events Leading to Discontinuation of Ibrutinib
2.7.6.x	Fatal Adverse Events
2.7.7.x	Deaths
2.7.8.x	Adverse Events of Special Interest
2.8.1.x	Clinical Laboratory Values - Hematology
2.8.2.x	Clinical Laboratory Values - Chemistry
2.8.3.x	Abnormal Clinical Laboratory Values - Hematology
2.8.4.x	Abnormal Clinical Laboratory Values - Chemistry
2.9.1.x	Vital Signs
2.9.2.x	Abnormal Vital Sign Values
2.9.3.x	Body Weight
2.10.1.x	12-Lead ECG Values
2.10.2.x	Abnormal 12-Lead ECG Values
2.10.3.x	Clinically Significant ECG Abnormality