

Clinical Trial Protocol

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EudraCT No.	2018-003495-13	
BI Trial No.	1407-0014	
BI Investigational Medicinal Product	BI 730357	
Title	Relative bioavailability of a single oral dose of BI 730357 when administered alone or in combination with multiple oral doses of itraconazole in healthy male subjects (an open-label, one-way crossover study)	
Lay Title	A study in healthy men to test how itraconazole influences the amount of BI 730357 in the blood	
Clinical Phase	I	
Clinical Trial Leader	Phone: Fax:	
Principal Investigator	Phone: Fax:	
Status	Final Protocol (Revised Protocol (based on global amendment 2))	
Version and Date	Version: 3.0	Date: 20 February 2019
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CLINICAL TRIAL PROTOCOL SYNOPSIS

Company name	Boehringer Ingelheim
Protocol date	30 October 2018
Revision date	20 February 2019
BI trial number	1407-0014
Title of trial	Relative bioavailability of a single oral dose of BI 730357 when administered alone or in combination with multiple oral doses of itraconazole in healthy male subjects (an open-label, one-way crossover study)
Principal Investigator:	
Trial site	
Clinical phase	I
Trial rationale	Based on <i>in vitro</i> data, CYP3A is involved in metabolism of BI 730357. It is therefore necessary to explore the relative bioavailability of BI 730357 in plasma when given alone versus when given together with a strong CYP3A inhibitor.
Trial objective	To investigate the relative bioavailability of BI 730357 in plasma when given as oral single dose together with multiple oral doses of itraconazole (Test, T) as compared to when given alone as oral single dose (Reference, R).
Trial design	Open-label, one-way crossover design
Trial endpoints	Primary endpoints: AUC _{0-tz} and C _{max} of BI 730357 in plasma Secondary endpoints: AUC _{0-∞} of BI 730357 in plasma
Number of subjects	
total entered	14
each treatment	14
Diagnosis	Not applicable
Main criteria for inclusion	Healthy male subjects, age of 18 to 50 years (inclusive), body mass index (BMI) of 18.5 to 29.9 kg/m ² (inclusive)
Test product 1	BI 730357 as tablet formulation (tablet strength: 50 mg)
dose	Single doses of 50 mg in treatments T and R
mode of admin.	Oral with 240 mL of water after an overnight fast of at least 10 h

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Test product 2	Itraconazole oral solution (Sempera® Liquid 10 mg/mL)
dose	200 mg once daily for 12 days in treatment T
mode of admin.	Oral with 240 mL of water after an overnight fast of at least 9 h
Duration of treatment	<p><u>Treatment R (BI 730357 alone):</u> Single dose of 50 mg BI 730357 (Day 1)</p> <p><u>Treatment T (itraconazole + BI 730357):</u> 12 days of itraconazole treatment (200 mg itraconazole once daily) combined with a single dose of 50 mg BI 730357 (Day 1) on the fourth day of the itraconazole treatment (1 h after the itraconazole administration)</p> <p><u>Wash-out period</u> Administrations of BI 730357 will be separated by a wash-out phase of at least 10 days</p>
Statistical methods	Relative bioavailability will be estimated by the ratios of the geometric means (test/reference) for the primary and secondary endpoints. Additionally, their two-sided 90% confidence intervals (CIs) will be provided. This method corresponds to the two one-sided t-tests procedure, each at a 5% significance level. Since the main focus is on estimation and not testing, a formal hypothesis test and associated acceptance range is not specified. The statistical model will be an analysis of variance (ANOVA) on the logarithmic scale including effects for 'subjects' and 'treatment'. CIs will be calculated based on the residual error from the ANOVA. Descriptive statistics will be calculated for all endpoints.

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FLOW CHART

Period	Visit	Day	Planned time (relative to BI 73 0357 administration) [h:min]	Approximate clock time of actual day [h:min]	Event and comment	Safety laboratory ⁹	PK _{blood} (BI 730357)	12-lead ECG	Vital signs (BP, PR)	Questioning for AEs and concomitant therapy ⁶
SCR	1	-21 to -1			Screening (SCR) ¹	A				
Period 1 / Treatment R (BI 730357 alone) ⁷			2	-3 to -1	-75:00 ⁸	06:00	Ambulatory visit	B ⁸		
			1	-3:00	06:00	Admission to trial site	x ^{3,5}	x ³		
			0:00	09:00	BI 730357 administration					
			0:30	09:30		x				
			1:00	10:00		x				
			1:30	10:30		x				
			2:00	11:00	240 mL fluid intake	x				
			2:30	11:30		x				
			3:00	12:00		x				
			3:30	12:30		x				
			4:00	13:00	240 mL fluid intake, thereafter lunch ¹⁰	x				
			5:00	14:00		x				
			6:00	15:00		x				
			7:00	16:00	Snack (voluntary)		x			
			8:00	17:00						
			10:00	19:00	Dinner	x				
			12:00	21:00		x				
			2	24:00	09:00	Breakfast (voluntary) ¹⁰ , discharge from trial site	B	x		
			34:00	19:00	Ambulatory visit	x				
			3	47:00	08:00	Ambulatory visit	x			
			4	71:00	08:00	Ambulatory visit	x			
			6	119:00	08:00	Ambulatory visit	B	x		
			8	167:00	08:00	Ambulatory visit	x	x		

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FLOW CHART (cont'd)

Period	Visit	Day	Planned time (relative to BI 73 0357 administration) [h:min]	Approximate clock time of actual day [h:min]	Event and comment	Safety laboratory ⁹	PK _{blood} (BI 730357 +	12-lead ECG	Vital signs (BP, PR)	Questioning for AEs and concomitant therapy ⁶
Period 2 / Treatment T (BI 730357 + itraconazole) ⁷	3	-3	-73:00	08:00	Ambulatory visit, itraconazole administration	B ^{2,5}			x ²	
		-2	-49:00	08:00	Ambulatory visit, itraconazole administration				x ²	
		-1	-25:00	08:00	Ambulatory visit, itraconazole administration				x ²	
		1	-3:00	06:00	Admission to trial site		x ²		x ²	x ²
			-1:00	08:00	Itraconazole administration					
			0:00	09:00	BI 730357 administration					
			0:30	09:30			x			
			1:00	10:00			x			
			1:30	10:30			x		x	x
			2:00	11:00	240 mL fluid intake		x			
			2:30	11:30			x			
			3:00	12:00			x			
			3:30	12:30			x			
			4:00	13:00	240 mL fluid intake, thereafter lunch ¹⁰		x		x	x
			5:00	14:00			x			
			6:00	15:00			x			
			7:00	16:00	Snack (voluntary)					
			8:00	17:00			x			
			10:00	19:00	Dinner					
			12:00	21:00			x			x
		2	23:00	08:00	Itraconazole administration					x
			24:00	09:00	Breakfast (voluntary) ¹⁰ , discharge from trial site	B ²	x	x	x	x
			34:00	19:00	Ambulatory visit		x			x
			3	47:00	08:00	Ambulatory visit, itraconazole administration	x ¹¹			x ²
			4	71:00	08:00	Ambulatory visit, itraconazole administration	C ²	x ¹¹		x ²
			5	95:00	08:00	Ambulatory visit, itraconazole administration				x ²
			6	119:00	08:00	Ambulatory visit, itraconazole administration	B ²	x ¹¹		x ²
			7	143:00	08:00	Ambulatory visit, itraconazole administration				x ²
			8	167:00	08:00	Ambulatory visit, itraconazole administration	C ²	x ¹¹		x ²
			9	191:00	08:00	Ambulatory visit, itraconazole administration				x ²
			10	215:00	08:00	Ambulatory visit		x		x
			12	263:00	08:00	Ambulatory visit		x		x
FU	4	18 to 25			End of trial (EoTrial) examination ⁴	D		x	x	x

1. Subject must be informed and written informed consent obtained prior to starting any screening procedures. Screening procedures include physical examination, check of vital signs, ECG, safety laboratory (including drug screening), demographics (including determination of body height and weight, smoking status and alcohol history), relevant medical history, concomitant therapy and review of inclusion/exclusion criteria. Pharmacogenetic samples will be collected if needed.
2. The time is approximate; the procedure is to be performed and completed within 2h prior to itraconazole administration.
3. The time is approximate; the procedure is to be performed and completed within 3h prior to BI 730357 administration.
4. At the end of trial visit the EoTrial examination includes physical examination, vital signs, ECG, safety laboratory, recording of AEs and concomitant therapies.

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5. Period 1: Urine drug screening and alcohol breath test only; Period 2: Including urine drug screening and alcohol breath test.
6. AEs and concomitant therapies will be recorded throughout the trial, but will be specifically asked for at the times indicated in the [Flow Chart](#) above.
7. Treatments R and T will be separated by a wash-out period of at least 10 days between administrations of BI 730357
8. Safety laboratory to be taken and to be medically evaluated within 75 hours prior to first dosing of BI 730357; this safety laboratory assessment can be omitted if the screening examination is performed on Days -3, -2 or -1
9. Letter A, B, C and D define different sets of safety laboratory examinations (see Section [5.2.3](#))
10. If several actions are indicated at the same time, the intake of meals will be the last action.
11. Blood collection takes place exactly at the indicated times.

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ABBREVIATIONS

ADME	Absorption, distribution, metabolism, and excretion
AE	Adverse event
AESI	Adverse events of special interest
ANOVA	Analysis of variance
AUC _{0-∞}	Area under the concentration-time curve of the analyte in plasma over the time interval from 0 extrapolated to infinity
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
BCRP	Breast cancer resistance protein
BI	Boehringer Ingelheim
BMI	Body mass index (weight divided by height squared)
BP	Blood pressure
CA	Competent authority
CI	Confidence interval
CPLG	Innovation and Quality in Pharmaceutical Development's Clinical Pharmacology Leadership Group
C _{max}	Maximum measured concentration of the analyte in plasma
CNS	Central nervous system
CRF	Case Report Form, paper or electronic (sometimes referred to as 'eCRF')
CT Leader	Clinical Trial Leader
CT Manager	Clinical Trial Manager
CTP	Clinical Trial Protocol
CTR	Clinical Trial Report
CV	Arithmetic coefficient of variation
CYP	Cytochrome P450
DDI	Drug-drug interaction
DILI	Drug induced liver injury
DNA	Deoxyribonucleic acid
ECG	Electrocardiogram
eCRF	Electronic case report form
eDC	Electronic data capture
EDTA	Ethylenediaminetetraacetic acid

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EEG	Electroencephalogram
EMA	European Medicines Agency
EMG	Electromyogram
EoTrial	End of trial
EudraCT	European Clinical Trials Database
F	Absolute bioavailability factor
FDA	Food and Drug Administration (US)
FU	Follow-up
f_u	Fraction unbound
GCP	Good Clinical Practice
gCV	Geometric coefficient of variation
GLP	Good Laboratory Practice
gMean	Geometric mean
hERG	Human-ether-à-go-go related gene
hLXR α	Human liver X receptor alpha
HPC	Human Pharmacology Centre
hPXR	Human pregnane X receptor
IB	Investigator's Brochure
IC ₅₀	50% inhibitory concentration
ICF	Informed consent form
ICH	International Council on Harmonisation
IEC	Independent Ethics Committee
IL	Interleukin
IPD	Important protocol deviation
IQRM	Integrated quality and risk management
IRB	Institutional Review Board
ISF	Investigator site file
LC-MS/MS	Liquid chromatography with tandem mass spectrometry
MATE1	Multidrug and toxin extruder 1
MATE2-K	Multidrug and toxin extruder 2-K
MDA	Methylenedioxymethamphetamine
MDMA	Methylenedioxymethamphetamine
MedDRA	Medical Dictionary for Regulatory Activities
mRNA	Messenger ribonucleic acid
NOAEL	No observed adverse event level
P-gp	P-glycoprotein

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PK	Pharmacokinetic(s)
PKS	Pharmacokinetic set
PMDA	Pharmaceuticals and Medical Devices Agency (Japan)
PR	Pulse rate
PUVA	Psoralen ultraviolet A
QT	Time between start of the Q-wave and the end of the T-wave in an electrocardiogram
QTc	QT interval corrected for heart rate using the method of Fridericia (QTcF) or Bazett (QTcB)
R	Reference treatment
REP	Residual effect period
ROR α	Retinoic acid-related orphan receptor α (protein)
ROR β	Retinoic acid-related orphan receptor β (protein)
ROR γ	Retinoic acid-related orphan receptor γ (full length protein)
ROR γ t	Retinoic acid-related orphan receptor γ t (splice variant of ROR γ protein)
SAE	Serious adverse event
SCR	Screening
SmPC	Summary of Product Characteristics
SOP	Standard operating procedure
SRD	Single-rising dose
ss	(at) steady state
T	Test product or treatment
TS	Treated set
TSAP	Trial statistical analysis plan
ULN	Upper limit of normal
WOCBP	Woman of childbearing potential
XTC	Ecstasy

1. INTRODUCTION

BI 730357 is an antagonist at the retinoic acid-related orphan receptor γ t (ROR γ t). It is being developed as an oral therapy for the treatment of patients with psoriasis as well as other Th17-mediated diseases. ROR γ antagonism is a novel mechanism of action.

This trial will be performed to investigate the relative bioavailability of BI 730357 in plasma when given alone in comparison to when given together with the CYP3A and P-glycoprotein inhibitor itraconazole.

1.1 MEDICAL BACKGROUND

Retinoic acid-related orphan receptor γ t (ROR γ t) is a nuclear hormone receptor/transcription factor expressed in Th17 cells and in distinct subsets of lymphoid cells, including natural killer cells, innate lymphoid cells, and γ δ T-cells. Upon cell activation, in response to multiple activation signals including cytokines and T cell receptor engagement, ROR γ t regulates the transcription of interleukin (IL)-17A, IL-17F, and IL-22 genes, and of IL-23 receptor gene. Emerging clinical science indicates a pivotal role for the Th17 axis in the pathogenesis of psoriasis, and other immunologically-mediated diseases. By blocking ROR γ t-mediated transcription of critical pro-inflammatory cytokines, and IL-23R, and consequently their downstream signalling, ROR γ t antagonism could prove efficacious in the treatment of Th17-mediated diseases [[c09228382](#)].

1.2 DRUG PROFILE

1.2.1 BI 730357

1.2.1.1 Nonclinical data

1.2.1.1.1 Efficacy and selectivity

BI 730357 was profiled in cellular assays comprising primary human cells central to the pathogenesis underlying psoriasis, psoriatic arthritis and ankylosing spondylitis. BI 730357 provided consistent potency across all stimuli, cell types, and species tested, including in whole blood conditions. The compound showed equivalent *in vitro* potency in human, mouse, and rat. BI 730357 provided substantial inhibition of disease-relevant biomarker and histology reads in mechanistic preclinical *in vivo* mouse models of inflammation.

BI 730357 showed good off-target selectivity in that it exhibited no activity on ROR β and only low-level inverse-agonism against ROR α , low-level antagonism against hLXR α and low-level agonism activity against hPXR. No other off-target activities were detected.

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1.2.1.1.2 Safety pharmacology

General and safety pharmacology studies have been conducted with BI 730357 to address the core battery of CNS, cardiovascular, respiratory, and renal functions, and the results demonstrated an acceptable profile for clinical trials in healthy volunteers.

1.2.1.1.3 Toxicology

The toxicological profile of BI 730357 has been assessed in genetic toxicity, phototoxicity and repeated dose toxicity studies in rats and dogs [c09228382]:

The results of the *in vitro* and *in vivo* genetic toxicology studies (in bacterial and mammalian systems) showed that BI 730357 were free of any genotoxic potential.

1.2.1.1.4 Non-clinical pharmacokinetics

The disposition of BI 730357 is characterized in rat, dog, and minipig by low clearance and moderate volume of distribution. Moderate-to-high oral bioavailability was observed across species, which suggests that following oral administration, the bioavailability of BI 730357 in humans is likely to be moderate to high.

For a more detailed description of the BI 730357 non-clinical profile please refer to the current Investigator's Brochure (IB) [c09228382].

1.2.1.2 Clinical data

So far, BI 730357 has clinically been tested by Boehringer Ingelheim in a completed first-in-human trial and an on-going multiple-rising dose study [c09228382].

- In the first-in-human trial BI 730357 was administered in doses ranging from 2 mg through 800 mg as oral solution (2 and 8 mg) and film-coated tablets (25 to 800 mg) to a total of 66 healthy male volunteers.
- An ongoing multiple-rising-dose trial is evaluating administration of BI 730357 over 14 to 28 days with daily doses of 25 to 400 mg administered as film-coated tablets to healthy male volunteers.

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1.2.1.2.1 Clinical pharmacokinetics and metabolism

1.2.1.2.2 Clinical safety

For a more detailed description of the BI 730357 profile, please refer to the current Investigator's Brochure (IB) [c09228382].

1.2.2 Itraconazole

Absorption of itraconazole solution is fast with maximum plasma concentration being reached within 2.5 h after oral administration in fasting condition. Bioavailability of itraconazole liquid is increased by 30% when given under fasting condition compared to administration together with food [R18-2644]. Mean peak plasma concentrations were 547.7 ng/mL after a single dose of 200 mg itraconazole solution (fasting) and 1965 ng/mL after 15 days of daily treatment with 200 mg itraconazole (solution, fasting). Kinetics of itraconazole is non-linear. The half-life of itraconazole after multiple doses of 200 mg once daily with solution formulation was about 40 h [R17-3742].

In the liver, itraconazole is metabolised extensively to more than 30 metabolites [R17-3743]. Its main metabolite, OH-itraconazole, accounts for about twice the amount of plasma itraconazole at trough. It has been shown *in vitro* that CYP3A4 is mainly responsible for the formation of this metabolite [R18-2644]. FDA classifies itraconazole as strong index inhibitor of CYP3A and as inhibitor of P-glycoprotein (P-gp) [R18-0241]. However, not only itraconazole contributes to the *in vivo* inhibition of CYP3A observed after itraconazole administration but also three of its metabolites (OH-itraconazole, keto-itraconazole and N-desalkyl-itraconazole) [R10-1102].

For a more detailed description of itraconazole, please refer to the German Summary of Product Characteristics (SmPC) for Sempera® Liquid 10 mg/ml [R18-2644] and the UK SmPC for Sporanox® 10 mg/ml Oral Solution [R18-2643].

1.2.3 Residual Effect Period

The Residual Effect Period (REP, i.e., the period after the last dose with measurable drug levels and/or pharmacodynamic effects still likely to be present) of BI 730357 is 7 days for the mono-therapy (Treatment R). When given together with itraconazole (Treatment T), it is expected that plasma exposure of BI 730357 could be increased (albeit within the range explored in the clinical trial 1407-0001), and the time of relevant plasma exposure could be prolonged, which in turn could result in a prolonged period in which adverse effects could potentially occur.

For the use of itraconazole in Treatment T, the REP is defined as 9 days after last administration of itraconazole on Day 9 in Period 2. Therefore, the follow-up period will start earliest on Day 18 following BI 730357 dosing in Period 2, as this is expected to cover the period in which any potential adverse effects could reasonably occur.

1.3 RATIONALE FOR PERFORMING THE TRIAL

Based on in vitro data, CYP3A is responsible for approximately 90% of the metabolism of BI 730357. Therefore, the DDI victim potential of BI 730357 with regards to CYP3A inhibition is considered high if metabolism is the *main clearance pathway*. Inhibition of CYP3A4 may result in an increased drug exposure which might impact the safety of the patients.

This clinical trial will be performed in order to assess whether and to which extent the kinetics of BI 730357 is affected by the co-administration of a drug that inhibits CYP3A4. The probe drug to test the *in-vivo* inhibition of CYP3A4 is itraconazole.

Itraconazole is chosen for this trial as perpetrator drug, as this drug is recommended as strong inhibitor of CYP3A by EMA [[P15-06991](#)], as strong index inhibitor of CYP3A by FDA [[R18-0241](#)], and as strong inhibitor of CYP3A by PMDA [[P15-06298](#)]. Moreover, safety and tolerability of itraconazole were acceptable in previous drug-drug interaction trials ([c02336088](#), [c03355329](#), [c08928447](#)).

1.4 BENEFIT - RISK ASSESSMENT

Participation in this clinical trial is without any (therapeutic) benefit for healthy subjects. Their participation, however, is of major importance for the development of BI 730357. Subjects are exposed to risks of study procedures and risks related to the exposure to the trial medication.

1.4.1 Expected benefit to the target population

ROR γ t sits at a key focal point, integrating multiple signals, including T cell receptor engagement and cytokines, and driving the expression of multiple genes (IL-17A, IL-17F, IL-22, and IL-23R). Via sitting at this focal node integrating multiple signals and effecting multiple outputs, BI 730357 has the potential to have a broader effect in Th17-mediated diseases than individual cytokine blockades alone (e.g., IL-23 or IL-17), thereby filling an unmet medical need for the introduction of new, efficacious oral treatment options in the treatment of psoriasis and other Th17-mediated diseases.

1.4.2 Procedure-related risks

The use of an indwelling venous catheter or venepuncture for e.g. blood sampling may result in mild bruising, and in rare cases, in transient inflammation of the wall of the vein, or nerve injury, potentially resulting in paraesthesia, reduced sensibility, and/or pain for an indefinite period.

ECG electrodes may cause local and typically transient skin reactions.

The total volume of blood withdrawn per subject during the entire study will not exceed the volume of a normal blood donation (500 mL). No health-related risk to healthy subjects is expected from withdrawal of this volume of blood.

1.4.3 Drug-related risks and safety measures

1.4.3.1 BI 730357

As the nature of the target and the mechanism of action of BI 730357 are well understood from pre-clinical studies, comparable compounds have been tested by other companies before (although not a lot of published data are available), and the animal models are believed to be predictive for the effects in humans, BI 730357 is not seen as a high-risk compound.

As with other immune-targeted therapies, impaired host defense is a theoretical target-related toxicity, potentially resulting in increased risk of infection and/or malignancy. Th17 cells play an important role in defense against extracellular bacteria and fungi at mucosal surfaces [[R16-3166](#), [R16-3149](#)]. IL-17 antagonists are associated with increased infections [[R13-2643](#)]. Homozygous, but not heterozygous ROR γ knockout mice have a high incidence of T-cell lymphoma, thought to originate in the thymus [[R16-2630](#)]. While the translatability of the knockout phenotype to pharmacological ROR γ antagonism and to humans is unknown, this raises the hypothetical concern for clinical T-cell lymphoma risk. The exact cause of T-cell lymphomas in ROR γ knockout mice is not fully understood, but changes in homeostasis in the thymus, such as thymocyte apoptosis and proliferation, are thought to play a role. AEs and SAEs consistent with malignancy, and specifically those representing lymphoma, are to be carefully monitored and evaluated throughout the BI 730357 clinical development program. Based on the data obtained with BI 730357 so far, and based on the fact that in the current study single doses will be used, the increased risk of infection and/or malignancy is considered to be extremely small.

As with all drugs, the potential for hypersensitivity and allergic reactions has to be taken into consideration when BI 730357 is administered.

1.4.3.2 Itraconazole

In this trial itraconazole will be used in a standard dose of 200 mg once daily for 12 days. Multiple dosing of 200 mg itraconazole up to 15 days was of acceptable tolerability in healthy subjects [[c02336088](#), [c03355329](#), [c08928447](#), [R17-3742](#)].

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In order to address the risk of hepatotoxicity, only subjects with normal liver enzyme values will be included into the study (see Section [3.3.3](#), criterion 23). Safety laboratory parameters will be monitored closely. An individual subject will be removed from the trial if the subject shows an elevation of AST and/or ALT \geq 3-fold ULN combined with an elevation of total bilirubin \geq 2-fold ULN (measured in the same blood sample, see Section [3.3.4.1](#)). Further, most of the reported cases of serious hepatotoxicity during itraconazole treatment occurred in patients that suffered from concomitant liver diseases, had other significant diseases, or took concomitant hepatotoxic drugs. Subjects with liver diseases or a medical history of drug-induced liver failure are excluded from trial participation (Section 3.3.3, criteria 5 and 24).

Itraconazole has shown a dose-related increase in maternal toxicity, embryotoxicity and teratogenicity in nonclinical studies at high doses, and therefore itraconazole must not be used during pregnancy. Women of childbearing potential have to use a highly effective method of contraception until the menstrual period after the last itraconazole dose [[R18-2644](#), [R18-2643](#)]. For risk mitigation, only male subjects will be included into this clinical trial.

Considering these safety measures and taking into account the reported acceptable tolerability of itraconazole, the planned administration of itraconazole does not represent an undue risk to healthy male volunteers.

1.4.3.3 Potential drug-drug interaction between itraconazole and BI 730357

It is likely that concomitant administration of BI 730357 with itraconazole may cause an increase of plasma concentrations and $t_{1/2}$ of BI 730357. The effect of itraconazole in increasing C_{max} and AUC of other drugs can be as high as 3.4-fold and 11-fold, respectively, as seen with oral midazolam, a sensitive CYP3A4 substrate, when co-administered with oral itraconazole 200 mg/d [[R01-0516](#), R18-2644]. Therefore, a low dose of 50 mg BI 730357 has been selected for this trial.

the ratios of gMean plasma exposure parameters at 800 mg and at 50 mg were approximately 14 (C_{max}) and 13 (AUC_{0-24}). These ratios are assessed to be sufficient as safety margins for the current trial, even in case of substantial increases of BI 730357 plasma concentrations by itraconazole as it has been described for midazolam (see above).

1.4.3.4 Drug-induced liver injury

Although rare, a potential for drug-induced liver injury (DILI) is under constant surveillance by sponsors and regulators. Therefore, this trial requires timely detection, evaluation, and follow-up of laboratory alterations in selected liver laboratory parameters to ensure subjects' safety; see also section [5.2.6.1.4](#), adverse events of special interest.

1.4.4 Overall assessment of benefit-risk ratio

BI 730357 is a novel ROR γ t antagonist that has been adequately characterised in pre-clinical studies. The non-clinical safety package supports clinical trials in males and females with administration of BI 730357 for up to 39 weeks.

Preliminary data of the SRD part of trial 1407-0001 indicate good safety and tolerability of single oral doses of BI 730357 at all dose levels, i.e. up to 800 mg (see IB [[c09228382](#)]).

Due to the low dose of BI 730357 selected for this trial, BI 730357 plasma exposures, even in case of a substantial effect of itraconazole, are expected to be well within plasma exposure values that were observed in the SRD part of trial 1407-0001 and that were associated with good safety and tolerability.

The trial design is optimized to collect as much relevant information as possible on the pharmacokinetics of BI 730357 without exposing participating volunteers to undue risk. The potential for side effects has been assessed to be minimal and thus acceptable. However, there is always the potential for subjects receiving medication to experience adverse events (AEs), and rarely also serious adverse events (SAEs). Risks for subjects will be minimized and addressed by eligibility criteria, safety laboratory examinations, ECG and vital sign measurements, in-house observation periods and AE questioning.

Itraconazole is a recommended inhibitor of CYP3A in clinical trials and has been used successfully previously in clinical trials in healthy volunteers. The drug has a potential for hepatotoxicity, which is however accounted for by stringent exclusion criteria, liver enzyme measurement as part of safety laboratory examinations and stopping criteria for the individual subject.

If the investigator should have any clinical concern, the safety of subjects will be of upmost importance. The Investigator has the discretion to remove subjects from the trial should there be any safety concerns, or if the subjects' wellbeing is at jeopardy.

BI 730357 has the potential to have a broader effect in Th17-mediated diseases than individual cytokine blockades alone (e.g., IL-23 or IL-17), thereby filling an unmet medical need for the introduction of new, efficacious oral treatment options in the treatment of psoriasis and other Th17-mediated diseases.

This trial is required for the development of BI 730357. It is designed to assess the *in vivo* victim potential of BI 730357 for CYP3A inhibition. The resulting data are planned to inform concomitant medication restrictions in planned patient trials.

Considering the medical need for an effective and safe treatment of psoriasis, the benefit of this trial is assessed to outweigh the potential risks.

2. TRIAL OBJECTIVES AND ENDPOINTS

2.1 MAIN OBJECTIVES, PRIMARY AND SECONDARY ENDPOINTS

2.1.1 Main objectives

The main objective of this trial is to investigate the relative bioavailability of BI 730357 in plasma when given as oral single dose together with multiple oral doses of itraconazole (Test, T) as compared to when given alone as oral single dose (Reference, R).

2.1.2 Primary endpoints

The following pharmacokinetic parameters will be determined for BI 730357:

- 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)
- C_{max} (maximum measured concentration of the analyte in plasma)

2.1.3 Secondary endpoint

The following pharmacokinetic parameter will be determined for BI 730357:

- $AUC_{0-\infty}$ (area under the concentration-time curve of the analyte in plasma over the time interval from 0 extrapolated to infinity)

2.2.2.2 Safety and tolerability

Safety and tolerability of BI 730357 and itraconazole 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)

3. DESCRIPTION OF DESIGN AND TRIAL POPULATION

3.1 OVERALL TRIAL DESIGN AND PLAN

The study will be performed as an open-label, two-treatment, two-period, one-way crossover trial in healthy male subjects in order to compare the test treatment (T) to the reference treatment (R). The treatments will be one oral single dose of 50 mg BI 730357 as tablet formulation (tablet strength: 50 mg) together with multiple oral doses of 200 mg itraconazole as oral solution formulation (concentration: 10 mg/mL) (T) and one oral single dose of 50 mg BI 730357 as tablet formulation (tablet strength: 50 mg) given alone (R). In both treatments, BI 730357 is administered to subjects in the fasting state. In the first treatment period (Period 1, Visit 2), all subjects are planned to undergo treatment R, and in the second treatment period (Period 2, Visit 3), all subjects are planned to undergo treatment T. For details, refer to Section [4.1](#).

There will be a washout interval of at least 10 days between the administrations of BI 730357.

An overview of all relevant trial activities is provided in the [Flow Chart](#). For visit schedule and details of trial procedures at selected visits, refer to Sections [6.1](#) and [6.2](#), respectively.

3.2 DISCUSSION OF TRIAL DESIGN, INCLUDING THE CHOICE OF CONTROL GROUP

For relative bioavailability trials, the crossover design is preferred because of its efficiency: since each subject serves as his own control, the comparison between treatments is based on an intra-subject comparison, thus removing inter-subject variability from the comparison between treatments [\[R94-1529\]](#).

Because of the long half-life of itraconazole (about 40 hours) and its metabolites, a one-way crossover design was selected, with administration of itraconazole in the second study period only. This design is not expected to lead to systematic errors in the estimation of the treatment effects since nonspecific time-effects are unlikely due to the short trial duration. For itraconazole studies, this design is recommended by the Innovation and Quality in Pharmaceutical Development's Clinical Pharmacology Leadership Group (CPLG) [\[R17-3744\]](#).

For this pharmacokinetic drug-drug interaction trial, open-label treatment is acceptable, because the primary and secondary endpoints of this trial are pharmacokinetic endpoints derived from measurement of plasma concentrations of BI 730357. These endpoints are not expected to be affected by knowledge of treatment.

3.3 SELECTION OF TRIAL POPULATION

It is planned that 14 healthy male subjects will enter the study. They will be recruited from the volunteers' pool of the trial site. Because of the reproduction toxicity itraconazole has shown in nonclinical studies, only male subjects will be included in this study.

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A log of all subjects enrolled into the trial (i.e. who have signed informed consent) will be maintained in the Investigator Site File (ISF) irrespective of whether they have been treated with investigational drug or not.

3.3.1 Main diagnosis for trial entry

The study will be performed in healthy subjects.

3.3.2 Inclusion criteria

Subjects will only be included in the trial if they meet the following criteria:

1. Healthy male subjects according to the assessment of the investigator, as based on a complete medical history including a physical examination, vital signs (BP, PR), 12-lead ECG, and clinical laboratory tests
2. Age of 18 to 50 years (inclusive)
3. BMI of 18.5 to 29.9 kg/m² (inclusive)
4. Signed and dated written informed consent prior to admission to the study, in accordance with GCP and local legislation

3.3.3 Exclusion criteria

Subjects will not be allowed to participate, if any of the following general criteria apply:

1. Any finding in the medical examination (including BP, PR or ECG) deviating from normal and assessed as clinically relevant by the investigator
2. Repeated measurement of systolic blood pressure outside the range of 90 to 140 mmHg, diastolic blood pressure outside the range of 50 to 90 mmHg, or pulse rate outside the range of 45 to 90 bpm
3. Any laboratory value outside the reference range that the investigator considers to be of clinical relevance
4. Any evidence of a concomitant disease assessed as clinically relevant by the investigator
5. Gastrointestinal, hepatic, renal, respiratory, cardiovascular, metabolic, immunological or hormonal disorders
6. Cholecystectomy or other surgery of the gastrointestinal tract that could interfere with the pharmacokinetics of the trial medication (except appendectomy or simple hernia repair)
7. Diseases of the central nervous system (including but not limited to any kind of seizures or stroke), and other relevant neurological or psychiatric disorders
8. History of relevant orthostatic hypotension, fainting spells, or blackouts
9. Chronic or relevant acute infections
10. History of relevant allergy or hypersensitivity (including allergy to the trial medication or its excipients)

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11. Use of drugs within 30 days of planned administration of trial medication that might reasonably influence the results of the trial (including drugs that cause QT/QTc interval prolongation)
12. Intake of an investigational drug in another clinical trial within 60 days of planned administration of investigational drug in the current trial, or concurrent participation in another clinical trial in which investigational drug is administered
13. Smoker (more than 10 cigarettes or 3 cigars or 3 pipes per day)
14. Inability to refrain from smoking on specified trial days
15. Alcohol abuse (consumption of more than 30 g per day)
16. Drug abuse or positive drug screening
17. Blood donation of more than 100 mL within 30 days of planned administration of trial medication or intended blood donation during the trial
18. Intention to perform excessive physical activities within one week prior to the administration of trial medication or during the trial
19. Inability to comply with the dietary regimen of the trial site
20. A marked baseline prolongation of QT/QTc interval (such as QTc intervals that are repeatedly greater than 450 ms) or any other relevant ECG finding at screening
21. A history of additional risk factors for *Torsade de Pointes* (such as heart failure, hypokalaemia, or family history of Long QT Syndrome)
22. Subject is assessed as unsuitable for inclusion by the investigator, for instance, because the subject is not considered able to understand and comply with study requirements, or has a condition that would not allow safe participation in the study

In addition, the following trial-specific exclusion criteria apply:

23. Liver enzyme (ALT, AST, GGT) values above upper limit of normal at the screening examination
24. History of drug-induced liver injury
25. History of heart failure, or any evidence of ventricular dysfunction in the history
26. History of hereditary fructose intolerance
27. Male subjects with WOCBP partner who are unwilling to use male contraception (condom or sexual abstinence) from time point of first administration of trial medication until 30 days after the last administration of trial medication
28. Haemoglobin or Red Blood Cell Count below the lower limit of normal at the screening examination
29. White Blood Cell Count or Neutrophil Count outside the normal range at the screening examination

For study restrictions, refer to Section [4.2.2](#).

3.3.4 Withdrawal of subjects from treatment or assessments

Subjects may discontinue trial treatment or withdraw consent to trial participation as a whole ('withdrawal of consent') with very different implications; please see sections [3.3.4.1](#) and [3.3.4.2](#) below.

If a subject is removed from or withdraws from the trial prior to the first administration of trial medication, the data of this subject will not be entered in the case report form (CRF) and will not be reported in the clinical trial report (CTR). If a subject is removed from or withdraws from the trial after the first administration of trial medication, this will be documented and the reason for discontinuation must be recorded in the CRF; in addition, the data will be included in the CRF and will be reported in the CTR. At the time of discontinuation, a complete end of trial examination will be performed, if possible, and the information will be recorded in the CRF. If the discontinuation occurs before the end of the REP (see Section [1.2.3](#)), the discontinued subject should if possible be questioned for AEs and concomitant therapies at or after the end of the REP in order to ensure collection of AEs and concomitant therapies throughout the REP, if not contrary to any consent withdrawal of the subject.

3.3.4.1 Discontinuation of trial treatment

An individual subject will discontinue trial treatment if:

1. The subject wants to discontinue trial treatment, without the need to justify the decision
2. The subject has repeatedly shown to be non-compliant with important trial procedures and, in the opinion of both, the investigator and sponsor representative, is not willing or able to adhere to the trial requirements in the future.
3. The subject needs to take concomitant medication that interferes with the investigational medicinal product or other trial treatment
4. The subject can no longer receive trial treatment for medical reasons (such as surgery, adverse events [AEs], or diseases)
5. The subject has an elevation of AST and/or ALT ≥ 3 -fold ULN and an elevation of total bilirubin ≥ 2 -fold ULN (measured in the same blood sample) and/or needs to be followed up according to the DILI checklist provided in the ISF

In addition to these criteria, the investigator may discontinue subjects at any time based on his or her clinical judgment.

Even if the trial treatment is discontinued, the subject remains in the trial and, given his/her agreement, will undergo the procedures for early treatment discontinuation and follow up as outlined in the [Flow Chart](#) and section [6.2.3](#).

3.3.4.2 Withdrawal of consent to trial participation

Subjects may withdraw their consent to trial participation at any time without the need to justify the decision. If a subject wants to withdraw consent, the investigator should be involved in the discussion with the subject and explain the difference between trial treatment

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discontinuation and withdrawal of consent to trial participation, as well as explain the options for continued follow up after trial treatment discontinuation, please see section [3.3.4.1](#) above

3.3.4.3 Discontinuation of the trial by the sponsor

Boehringer Ingelheim reserves the right to discontinue the trial at any time for any of the following reasons:

1. Failure to meet expected enrolment goals overall or at a particular trial site
2. New toxicological findings, serious adverse events, or any safety information invalidating the earlier positive benefit-risk-assessment. More specifically, the trial will be terminated if more than 50% of the subjects have drug-related and clinically relevant adverse events of moderate or severe intensity, or if at least 1 drug-related serious adverse event is reported
3. Violation of GCP or the CTP impairing the appropriate conduct of the trial
4. The sponsor decides to discontinue the further development of the investigational product

3.3.5 Replacement of subjects

In case more than 2 subjects do not complete the trial, the Clinical Trial Leader together with the Trial Pharmacokineticist and the Trial Statistician are to decide, if and how many subjects will be replaced. A replacement subject will be assigned a unique trial subject number, and will be assigned to the same treatment as the subject █ replaces.

4. TREATMENTS

4.1 INVESTIGATIONAL TREATMENTS

The investigational product BI 730357 as tablet formulation has been manufactured by BI Pharma GmbH & Co. KG. Itraconazole oral solution will be obtained from a public pharmacy.

4.1.1 Identity of the Investigational Medicinal Products

The characteristics of the two test products are given below:

Test product 1

Substance:	BI 730357
Pharmaceutical formulation:	Tablet
Source:	BI Pharma GmbH & Co. KG, Germany
Unit strength:	50 mg
Posology:	1 – 0 – 0
Route of administration:	Oral
Duration of use:	1 day (in treatments R and T)

Test product 2

Name:	Sempera® Liquid 10 mg/ml
Substance:	Itraconazole
Pharmaceutical formulation:	Oral solution
Source:	Public pharmacy (obtained by the clinical site)
Holder of marketing authorization:	JANSSEN-CILAG GmbH, Neuss, Germany
Unit strength:	10 mg/mL
Posology:	20 mL – 0 – 0
Route of administration:	Oral
Duration of use:	12 days (in treatment T, only)

4.1.2 Selection of doses in the trial

Perpetrator (itraconazole)

The dose of itraconazole selected for this trial reflects standard clinical doses, is considered sufficient to yield significant CYP3A inhibition and has been used successfully and safely in previous drug-drug interaction trials ([c02336088](#), [c03355329](#), [c08928447](#)).

Victim (BI 730357)

Based on *in vitro* data, CYP3A is responsible for approximately 90% of the metabolism of BI 730357. If metabolic clearance is the main pathway of BI 730357 elimination, concomitant administration of BI 730357 with the strong CYP3A inhibitor itraconazole may result in substantial increases of BI 730357 plasma concentrations.

For the current trial, a dose of 50 mg BI 730357 is selected, in order to ensure that BI 730357 plasma concentrations, even in case of a substantial increase when given with itraconazole, are within the range of concentrations that were explored in the SRD part of trial 1407-0001 and that were associated with good safety and tolerability.

In the SRD part of trial 1407-0001, single oral doses of 2 to 800 mg BI 730357 were administered as oral solution or tablet formulation under fasting or fed conditions, and available data indicate that, at all doses tested, BI 730357 administration was safe and well tolerated.

I.e., the ratios of gMean plasma exposure parameters at 800 mg and at 50 mg were approximately 14 (C_{max}) and 13 (AUC_{0-24}). These ratios are assessed to be sufficient as safety margins for the current trial, to cover for increases of BI 730357 plasma exposures when given together with itraconazole (see also section [1.4.3.3](#)).

4.1.3 Method of assigning subjects to treatment groups

There is only one treatment sequence investigated in this trial, and each subject will be allocated to the same treatment sequence (R-T). The subjects will be allocated to a study subject number by drawing lots prior to first administration of trial medication in the morning of Day 1 of Visit 2. The randomization list of study subject numbers and assigned treatment sequence will be provided to the trial site in advance. Note that the randomization list is just needed for logistical reasons in this non-randomized, open-label trial. Hence, no bias is introduced when providing the randomization list in advance to the site. Reference and test treatments will be administered in the sequence specified in the [Flow Chart](#).

Once a subject number has been assigned, it cannot be reassigned to any other subject.

All subjects may be treated in one cohort, i.e. all subjects may receive treatment on the same calendar day. In case this is not feasible (e.g., due to logistical or recruitment reasons), the group may be split into several cohorts as required. Treatment of all subjects on the same calendar day is acceptable (for safety margin to exposure reached in previous SRD trial 1407.1 refer to Section 1.4.3.3; for discussion of study-associated risks and safety measures see Section [1.4.3](#)).

The randomisation procedure is described in Section [7.6](#).

4.1.4 Drug assignment and administration of doses for each subject

This trial is a one-way crossover study. All subjects will receive the 2 treatments in fixed order. The treatments to be evaluated are outlined in Table [4.1.4: 1](#) below.

Table 4.1.4: 1 Dosage and treatment schedule

Treatment period	Treatment	Substance	Formulation	Unit strength	Dosage	Total dose
1	R (Reference)	BI 730357	Tablet	50 mg	1 tablet on Day 1	50 mg
2	T (Test)	BI 730357 Itraconazole	Tablet Oral solution	50 mg 10 mg/mL	1 tablet on Day 1 20 mL (200 mg) on Days -3 to Day 9	50 mg 2400 mg

Administration of trial medication will be performed after subjects have fasted overnight; fasting is to start no later than 10 h before the scheduled dosing of BI 730357 and no later than 9 h before dosing of itraconazole.

The investigator (or authorised designee) will administer the trial medication as an oral dose together with about 240 mL of water to subjects who are in a standing position. For drug administration, the so-called four-eye principle (two-person rule) should be applied. For this, one authorised employee of the trial site should witness the administration of trial medication, and – if applicable – its preparation (e.g. reconstitution), if correct dosage cannot be ensured otherwise.

For restrictions with regard to diet, see Section [4.2.2.2](#).

Subjects will be kept under close medical surveillance until 24 h after drug administration of BI 730357. During the first 4 h after drug administration of BI 730357, subjects are not allowed to lie down (i.e. no declination of the upper body of more than 45 degrees from upright posture), except for medical reasons or for recording of 12-lead ECG and vital signs measurements.

The treatments will be separated by a wash-out phase of at least 10 days between administrations of BI 730357.

4.1.5 Blinding and procedures for unblinding

This Phase I trial will be handled in an open fashion throughout (that is, during the conduct, including data cleaning and preparation of the analysis). This is considered acceptable because the potential for bias seems to be low and does not outweigh practical considerations.

Emergency envelopes will not be provided, because the dose of trial medication is known to investigators and subjects.

4.1.6 Packaging, labelling, and re-supply

BI 730357 tablets

BI 730357 tablets will be provided by BI. They will be packaged and labelled in accordance with local law and the principles of Good Manufacturing Practice. For details of packing and the description of the label, refer to the ISF.

The telephone number of the sponsor and the name, address and telephone number of the trial site are provided in the subject information form. The EudraCT number is indicated on the title page of this protocol as well as on the subject information and informed consent forms.

No re-supply is planned.

Itraconazole oral solution

Itraconazole oral solution will be obtained by the clinical trial site from a public pharmacy. The drug will be dispensed out of the original, unmodified packages.

4.1.7 Storage conditions

Drug supplies will be kept in their original packaging and in a secure limited access storage area in accordance with the recommended (labelled) storage conditions. If necessary, a temperature log must be maintained to make certain that the drug supplies are stored at the correct temperature. If the storage conditions are found to be outside the specified range, the Clinical Trial Manager (as provided in the list of contacts) is to be contacted immediately.

4.1.8 Drug accountability

The investigator or designee will receive the investigational drugs delivered from the sponsor following requirements are fulfilled:

- Approval of the clinical trial protocol by the IRB / ethics committee
- Approval/notification of the regulatory authority, e.g. competent authority
- Availability of the *curriculum vitae* of the Principal Investigator
- Availability of a signed and dated clinical trial protocol

Only authorised personnel documented in the form 'Trial Staff List' may dispense medication to trial subjects. The trial medication must be administered in the manner specified in the CTP.

The investigator or designee must maintain records of the product's delivery to the trial site, the inventory at the site, the use by each subject, and the disposal of unused products. These records will include dates, quantities, batch / serial numbers, expiry ('use-by') dates, and the unique code numbers assigned to the investigational medicinal product and trial subjects. The investigator or designee will maintain records that document adequately that the subjects were provided the doses specified by the CTP and reconcile all investigational medicinal products received from the sponsor. At the time of disposal of remaining trial medication, the investigator or designee must verify that no remaining supplies are in the investigator's possession.

All unused medication will be disposed of locally by the trial site upon written authorisation of the Clinical Trial Leader. Receipt, usage and disposal of trial medication must be documented on the appropriate forms. Account must be given for any discrepancies.

4.2 OTHER TREATMENTS, EMERGENCY PROCEDURES, RESTRICTIONS

4.2.1 Other treatments and emergency procedures

There are no special emergency procedures to be followed. No additional treatment is planned. However, if adverse events require treatment, the investigator can authorise symptomatic therapy. In those cases, subjects will be treated as necessary and, if required, kept under supervision at the trial site or transferred to a hospital until all results of medical evaluations are acceptable.

4.2.2 Restrictions

4.2.2.1 Restrictions regarding concomitant treatment

In principle, no concomitant therapy is allowed. All concomitant or rescue therapies will be recorded (including time of intake on study days) on the appropriate pages of the CRF.

Known inhibitors/inducers of CYP3A as well as drugs with a known hepatotoxicity profile should be avoided during the entire study.

4.2.2.2 Restrictions on diet and life style

Poppy-seeds containing foods should not be consumed starting 3 days before the first drug administration in each treatment period, in order to avoid false-positive results in the drug screen.

While admitted to the trial site, the subjects will be instructed not to consume any foods or drinks other than those provided by the staff. Standardised meals will be served at the times indicated in the [Flow Chart](#).

No food is allowed within 10 h before and 4 h after intake of BI 730357.

Subjects will be advised to not consume any food within 9 h before and 1 h after itraconazole administration.

From 1 h before intake of BI 730357 on Day 1 of Period 1 until lunch, and from 1 h before intake of itraconazole on Day 1 of period 2 until lunch, fluid intake is restricted to the water administered with the drug, and an additional 240 mL of water at 2 h and 4 h post-dose (mandatory for all subjects). From lunch until 24 h post-dose, total fluid intake is restricted to 3000 mL.

Grapefruits, Seville oranges (sour or bitter oranges) and their juices, and dietary supplements and products containing St. John's wort (*Hypericum perforatum*) are not permitted from 7 days before the first administration of trial medication in Period 1 until after the last PK sample of Period 2 is collected.

Alcoholic beverages are not permitted from 2 days before the first administration of trial medication in period 1 until after the last PK sample in period 2 is collected.

Methylxanthine-containing drinks or foods (such as coffee, tea, cola, energy drinks, or chocolate) are not allowed from 10 h before until 24 h after administration of BI 730357.

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Smoking is not allowed during in-house confinement while admitted to the trial site.

Excessive physical activity (such as competitive sport) should be avoided from 7 days before the first administration of trial medication until the end of trial examination.

Direct exposure to the sun or exposure to solarium radiation, treatment with ultraviolet light (e.g. PUVA), or medication with known phototoxicity potential (e.g. doxycycline) should be avoided from the first administration of trial medication until the EoTrial examination. The use of sunscreens is mandatory in that time.

4.3 TREATMENT COMPLIANCE

Compliance will be assured by administration of all trial medication in the study centre under supervision of the investigating physician or a designee. The measured plasma concentrations of trial medication will provide additional confirmation of compliance.

Subjects who are non-compliant (for instance, who do not appear for scheduled visits or violate trial restrictions) may be removed from the trial and the CRF will be completed accordingly (for further procedures, please see Section [3.3.4.1](#)).

5. ASSESSMENTS

5.1 ASSESSMENT OF EFFICACY

Not applicable.

5.2 ASSESSMENT OF SAFETY

5.2.1 Physical examination

At screening, the medical examination will include demographics, height and body weight, smoking and alcohol history, relevant medical history and concomitant therapy, review of inclusion and exclusion criteria, review of vital signs (BP, PR), 12-lead ECG, laboratory tests, and a physical examination. At the end of trial examination, it will include review of vital signs, 12-lead ECG, laboratory tests, and a physical examination.

5.2.2 Vital signs

Systolic and diastolic blood pressures (BP) as well as pulse rate (PR) will be measured by a blood pressure monitor (Dinamap Pro 100, GE Medical Systems, Freiburg, Germany) at the times indicated in the [Flow Chart](#), after subjects have rested for at least 5 min in a supine position. All recordings should be made using the same type of blood pressure recording instrument on the same arm, if possible.

5.2.3 Safety laboratory parameters

For the assessment of laboratory parameters, blood and urine samples will be collected by the trial site at the times indicated in the [Flow Chart](#) after the subjects have fasted for at least 10 h. For retests, at the discretion of the investigator or designee, overnight fasting is not required.

The parameters that will be determined are listed in Tables [5.2.3: 1](#) and [5.2.3: 2](#). Reference ranges will be provided in the ISF, Section [10](#).

Manual differential white blood cell count or urine sediment examinations will only be performed if there is an abnormality in the automatic blood cell count or in the urinalysis, respectively.

Table 5.2.3: 1

Routine laboratory tests

Functional lab group	BI test name [comment/abbreviation]	A ¹	B ¹	C ¹	D ¹
Haematology	Haematocrit Haemoglobin Red Blood Cell Count/Erythrocytes White Blood Cells/Leucocytes Platelet Count/Thrombocytes (quant)	X X X X X	X X X X X	-- -- -- -- --	X X X X X
Automatic WBC differential, relative	Neutrophils/Leukocytes; Eosinophils/Leukocytes; Basophils/Leukocytes; Monocytes/Leukocytes; Lymphocytes/Leukocytes	X	X	--	X
Automatic WBC differential, absolute	Neutrophil, absol.; Eosinophils, absol.; Basophils, absol.; Monocytes, absol.; Lymphocytes, absol.	X	X	--	X
Manual differential WBC (if automatic differential WBC is abnormal)	Neut. Poly (segs); Neut. Poly (segs), absol.; Neutrophils Bands; Neutrophils Bands, absol.; Eosinophils/Leukocytes; Eosinophils, absol.; Basophils/ Leukocytes; Basophils, absol.; Monocytes/ Leukocytes; Monocytes, absol.; Lymphocytes/Leukocytes; Lymphocytes, absol.				
Coagulation	Activated Partial Thromboplastin Time Prothrombin time Prothrombin time - INR (International Normalization Ratio)	X X X	X X X	-- -- --	X X X
Enzymes	AST [Aspartate transaminase] /GOT, SGOT ALT [Alanine transaminase] /GPT, SGPT Alkaline Phosphatase Gamma-Glutamyl Transferase Glutamate Dehydrogenase (GLDH) Creatine Kinase [CK] Creatine Kinase Isoenzyme MB [only if CK is elevated] Lipase	X X X X X X X	X X X X X -- --	X X X X X -- --	X X X X X X X
Hormones	Thyroid Stimulating Hormone	X	--	--	--
Substrates	Glucose (Plasma) Creatinine Bilirubin, Total Bilirubin, Direct Protein, Total C-Reactive Protein (Quant) Cholesterol, total Triglyceride	X X X X X X X	X X X X X X X	-- -- -- -- -- -- --	X X X X X X X
Electrolytes	Sodium Potassium	X X	X X	-- --	X X
Urinalysis (Stix) ²	Urine Nitrite (qual) Urine Protein (qual) Urine Glucose (qual) Urine Ketone (qual) Urobilinogen (qual) Urine Bilirubin (qual) Urine RBC/Erythrocytes (qual) Urine WBC/Leucocytes (qual) Urine pH	X X X X X X X X X	-- -- -- -- -- -- -- -- --	-- -- -- -- -- -- -- -- --	X X X X X X X X X
Urine sediment ²	Only positive findings will be reported (for instance, the presence of sediment bacteria, casts in sediment, squamous epithelial cells, erythrocytes, leukocytes)				

1 A, B, C and D are different sets of laboratory values. The [Flow Chart](#) details at which time point which set is to be investigated.

2 Microscopic examination if erythrocytes, leukocytes, nitrite or protein are abnormal in urine

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The tests listed in Table 5.2.3: 2 are exclusionary laboratory tests that may be repeated as required. The results will not be entered in the CRF/database and will not be reported in the CTR. Except for drug screening, it is planned to perform these tests during screening only. Drug screening will be performed at screening and prior to first dosing in each treatment period.

Table 5.2.3: 2 Exclusionary laboratory tests

Functional lab group	Test name
Drug screening (urine)	Amphetamine/MDA Barbiturates Benzodiazepine Cannabis Cocaine Methadone Methamphetamines/MDMA/XTC Opiates Phencyclidine Tricyclic antidepressants
Infectious serology (blood)	Hepatitis B surface antigen (qualitative) Hepatitis B core antibody (qualitative) Hepatitis C antibodies (qualitative) HIV-1 and HIV-2 antibody (qualitative) Interferon- γ release assay to tuberculosis (qualitative), e.g. QuantiFERON [®] -TB Gold Test

To encourage compliance with alcoholic restrictions, a breath alcohol test (e.g. Alcotest[®] 7410, Dräger AG, Lübeck, Germany) will be performed prior to drug administration on Day 1 of treatment period 1 and on Day -3 of treatment period 2, and may be repeated at any time during the study at the discretion of an investigator or designee. The results will not be included in the CTR.

The laboratory tests listed in Tables [5.2.3: 1](#) and [5.2.3: 2](#) will be performed at MVZ Labor Ravensburg GbR, Elisabethenstraße 11, 88212 Ravensburg, Germany, with the exception of drug screening tests. These tests will be performed at the trial site using AccuSign[®] DOA 10 test, or comparable test systems.

Laboratory data will be transmitted electronically from the laboratory to the trial site.

5.2.4 Electrocardiogram

Twelve-lead ECGs (I, II, III, aVR, aVL, aVF, V1 - V6) will be recorded using a computerised electrocardiograph (CardioSoft EKG System, GE Medical Systems, Freiburg, Germany) at the times provided in the [Flow Chart](#).

To achieve a stable heart rate at rest and to assure high quality recordings, the site personnel will be instructed to assure a relaxed and quiet environment, so that all subjects are at complete rest.

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All ECGs will be recorded for a 10 sec duration after subjects have rested for at least 5 min in a supine position. ECG assessment will always precede all other study procedures scheduled for the same time to avoid compromising ECG quality.

All ECGs will be stored electronically on the Muse CV Cardiology System (GE Medical Systems, Freiburg, Germany). Electrode placement will be performed according to the method of Wilson, Goldberger and Einthoven modified by Mason and Likar (hips and shoulders instead of ankles and wrists).

All locally printed ECGs will be evaluated by the investigator or a designee. Abnormal findings will be reported as AEs (during the trial) or baseline conditions (at screening) if assessed to be clinically relevant by the investigator. Any ECG abnormalities will be carefully monitored and, if necessary, the subject will be removed from the trial and will receive the appropriate medical treatment.

ECGs may be repeated for quality reasons (for instance, due to alternating current artefacts, muscle movements, or electrode dislocation) and the repeated ECG will be used for analysis. Additional (unscheduled) ECGs may be collected by the investigator for safety reasons.

5.2.5 Other safety parameters

Not applicable.

5.2.6 Assessment of adverse events

5.2.6.1 Definitions of adverse events

5.2.6.1.1 Adverse event

An adverse event (AE) is defined as any untoward medical occurrence in a patient or clinical investigation subject administered a medicinal product and which does not necessarily have to have a causal relationship with this treatment.

An AE can therefore be any unfavourable and unintended sign (including an abnormal laboratory finding), symptom, or disease temporally associated with the use of a medicinal product, whether or not considered related to the medicinal product.

The following should also be recorded as an AE in the CRF and BI SAE form (if applicable):

- Worsening of the underlying disease or of other pre-existing conditions
- Changes in vital signs, ECG, physical examination, and laboratory test results, if they are judged clinically relevant by the investigator

If such abnormalities already pre-exist prior to trial inclusion, they will be considered as baseline conditions and should be collected in the eCRF only.

5.2.6.1.2 Serious adverse event

A serious adverse event (SAE) is defined as any AE which fulfils at least one of the following criteria:

- Results in death

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- Is life-threatening, which refers to an event in which the patient 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 more severe
- Requires inpatient hospitalisation
- Requires prolongation of existing hospitalisation
- Results in persistent or significant disability or incapacity
- Is a congenital anomaly/birth defect
- Is deemed serious for any other reason if it is an important medical event when based upon appropriate medical judgment which may jeopardise the patient and may require medical or surgical intervention to prevent one of the other outcomes listed in the above definitions. Examples of such events are intensive treatment in an emergency room or at home for allergic bronchospasm, blood dyscrasias or convulsions that do not result in hospitalisation or development of dependency or abuse

5.2.6.1.3 AEs considered ‘Always Serious’

Cancers of new histology and exacerbations of existing cancer must be classified as a serious event regardless of the time since discontinuation of the trial medication and must be reported as described in [5.2.6.2](#), subsections ‘AE Collection’ and ‘AE reporting to sponsor and timelines’.

In accordance with the European Medicines Agency initiative on Important Medical Events, Boehringer Ingelheim has set up a list of further AEs, which, by their nature, can always be considered to be ‘serious’ even though they may not have met the criteria of an SAE as defined above.

The latest list of ‘Always Serious AEs’ can be found in the eDC system, an electronic data capture system which allows the entry of trial data at the trial site. These events should always be reported as SAEs as described above.

5.2.6.1.4 Adverse events of special interest

The term adverse events of special interest (AESI) relates to any specific AE that has been identified at the project level as being of particular concern for prospective safety monitoring and safety assessment within this trial, e.g. the potential for AEs based on knowledge from other compounds in the same class. AESIs need to be reported to the sponsor’s Pharmacovigilance Department within the same timeframe that applies to SAEs, please see section [5.2.6.2.2](#).

The following are considered as AESIs:

- Hepatic injury

A hepatic injury is defined by the following alterations of hepatic laboratory parameters:

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- o An elevation of AST (aspartate transaminase) and/or ALT (alanine transaminase) ≥ 3 -fold ULN combined with an elevation of total bilirubin ≥ 2 -fold ULN measured in the same blood sample, or
- o Aminotransferase (ALT, and/or AST) elevations ≥ 10 fold ULN

These lab findings constitute a hepatic injury alert and the subjects showing these lab abnormalities need to be followed up according to the 'DILI checklist' provided in the ISF. In case of clinical symptoms of hepatic injury (icterus, unexplained encephalopathy, unexplained coagulopathy, right upper quadrant abdominal pain, etc.) without lab results (ALT, AST, total bilirubin) available, the Investigator should make sure that these parameters are analysed, if necessary in an unscheduled blood test. Should the results meet the criteria of hepatic injury alert, the procedures described in the DILI checklist should be followed.

- Severe infections (grading according to Rheumatology Common Toxicity Criteria (RCTC) developed by OMERACT [[R13-3515](#)])
- Opportunistic and mycobacterium tuberculosis infections
These include pneumocystis jirovecii, BK virus disease including polyomavirus-associated nephropathy, cytomegalovirus, posttransplant lymphoproliferative disorder (Epstein-Barr virus), progressive multifocal leukoencephalopathy, bartonellosis (disseminated only), blastomycosis, toxoplasmosis, coccidioidomycosis, histoplasmosis, aspergillosis (invasive only), candidiasis (invasive or pharyngeal), cryptococcosis, other invasive fungi (mucormycosis (zygomycosis, rhizopus, mucor, lichtheimia), scedosporium/pseudallescheria boydii, fusarium), legionellosis, listeria monocytogenes (invasive only), tuberculosis, nocardiosis, non-tuberculous mycobacterium, salmonellosis (invasive only), hepatitis B virus reactivation, herpes simplex (invasive only), herpes zoster, strongyloides (hyperinfection syndrome and disseminated forms only), paracoccidioides, penicillium marneffei, sporothrix schenckii, cryptosporidium species (chronic only), microsporidiosis, leishmaniasis (visceral only), trypanosoma cruzi Infection (Chagas' disease) (disseminated only), campylobacteriosis (invasive only), shigellosis (invasive only), vibriosis (invasive due to vibrio vulnificus), hepatitis C virus progression.

5.2.6.1.5 Intensity (severity) of AEs

The intensity (severity) of the AE should be judged based on the following:

Mild: Awareness of sign(s) or symptom(s) that is/are easily tolerated
Moderate: Sufficient discomfort to cause interference with usual activity
Severe: Incapacitating or causing inability to work or to perform usual activities

5.2.6.1.6 Causal relationship of AEs

Medical judgment should be used to determine the relationship, considering all relevant factors, including pattern of reaction, temporal relationship, de-challenge or re-challenge, confounding factors such as concomitant medication, concomitant diseases and relevant history.

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Arguments that may suggest that there is a reasonable possibility of a causal relationship could be:

- The event is consistent with the known pharmacology of the drug
- The event is known to be caused by or attributed to the drug class
- A plausible time to onset of the event relative to the time of drug exposure
- Evidence that the event is reproducible when the drug is re-introduced
- No medically sound alternative aetiologies that could explain the event (e.g. pre-existing or concomitant diseases, or co-medications)
- The event is typically drug-related and infrequent in the general population not exposed to drugs (e.g. Stevens-Johnson syndrome)
- An indication of dose-response (i.e. greater effect size if the dose is increased, smaller effect size if dose is reduced)

Arguments that may suggest that there is no reasonable possibility of a causal relationship could be:

- No plausible time to onset of the event relative to the time of drug exposure is evident (e.g. pre-treatment cases, diagnosis of cancer or chronic disease within days / weeks of drug administration; an allergic reaction weeks after discontinuation of the drug concerned)
- Continuation of the event despite the withdrawal of the medication, taking into account the pharmacological properties of the compound (e.g. after 5 half-lives). Of note, this criterion may not be applicable to events whose time course is prolonged despite removing the original trigger
- Additional arguments amongst those stated before, like alternative explanation (e.g. situations where other drugs or underlying diseases appear to provide a more likely explanation for the observed event than the drug concerned)
- Disappearance of the event even though the trial drug treatment continues or remains unchanged

5.2.6.2 Adverse event collection and reporting

5.2.6.2.1 AE collection

Upon enrolment into a trial, the subject's baseline condition is assessed (for instance, by documentation of medical history/concomitant diagnoses), and relevant changes from baseline are noted subsequently.

Subjects will be required to report spontaneously any AEs as well as the time of onset, end time, and intensity of these events. In addition, each subject will be regularly assessed by the medical staff throughout the clinical trial and whenever the investigator deems necessary. As a minimum, subjects will be questioned for AEs (and concomitant therapies) at the time points indicated in the [Flow Chart](#). Assessment will be made using non-specific questions such as 'How do you feel?'. Specific questions will be asked wherever necessary in order to more precisely describe an AE.

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A carefully written record of all AEs shall be kept by the investigator in charge of the trial. Records of AEs shall include data on the time of onset, end time, intensity of the event, and any treatment or action required for the event and its outcome.

The following must be collected and documented on the appropriate CRF(s) by the investigator:

- From signing the informed consent onwards until an individual subject's end of trial:
 - All AEs (serious and non-serious) and all AESIs
 - The only exception to this rule are AEs (serious and non-serious) and AESIs in Phase I trials in healthy volunteers, when subjects discontinue from the trial due to screening failures prior to administration of any trial medication. In these cases, the subjects' data must be collected at trial site but will not be entered in the CRF or trial database and will not be reported in the CTR.
- After the individual subject's end of trial:
 - The investigator does not need to actively monitor the subject for AEs but should only report any occurrence of cancer and related SAEs and related AESIs of which the investigator may become aware of by any means of communication, e.g. phone call. Those AEs should, however, not be reported in the CRF.

5.2.6.2.2 AE reporting to the sponsor and timelines

The Investigator must report SAEs, AESIs, and non-serious AEs which are relevant for the reported SAE or AESI, on the BI SAE form via fax immediately (within 24 hours) to the sponsor's unique entry point (country specific contact details will be provided in the ISF). The same timeline applies if follow-up information becomes available. In specific occasions the Investigator could inform the sponsor upfront via telephone. This does not replace the requirement to complete and fax the BI SAE form.

With receipt of any further information to these events, a follow-up SAE form has to be provided. For follow-up information, the same rules and timeline apply as for initial information.

5.2.6.2.3 Information required

All (S)AEs, including those persisting after the individual subject's end of trial, must be followed up until they have resolved, have been sufficiently assessed as 'chronic' or 'stable', or no further information can be obtained.

5.3 DRUG CONCENTRATION MEASUREMENTS AND PHARMACOKINETICS

5.3.1 Assessment of pharmacokinetics

For the assessment of pharmacokinetics, blood samples will be collected at the time points indicated in the [Flow Chart](#). The actual sampling times will be recorded and used for determination of pharmacokinetic parameters.

5.3.2 Methods of sample collection

5.3.2.1 Blood sampling for pharmacokinetic analysis

BI 730357

For quantification of BI 730357 in plasma, 2.7 mL of blood will be drawn from an antecubital or forearm vein into an K₂-EDTA (dipotassium ethylenediaminetetra-acetic acid)-anticoagulant blood drawing tube at the times indicated in the [Flow Chart](#). Blood will be withdrawn by means of either an indwelling venous catheter or by venipuncture with a metal needle.

The EDTA-anticoagulated blood samples will be centrifuged for approximately 10 min at approximately 2000 g to 4000 g and at 4 to 8 °C. Two plasma aliquots will be obtained and stored in polypropylene tubes. The first aliquot should contain at least 0.5 mL of plasma. The process from blood collection until transfer of plasma aliquots into the freezer should be completed within 90 min, with interim storage of blood samples and aliquots at room temperature avoiding exposure to direct sunlight. The time each aliquot was placed in the freezer will be documented. Until transfer on dry ice to the analytical laboratory, the aliquots will be stored upright at approximately -20°C or below at the trial site. The second aliquot will be transferred to the analytical laboratory after the bioanalyst has acknowledged safe arrival of the first aliquot. At the analytical laboratory, the plasma samples will be stored at approximately -20 °C or below until analysis.

At a minimum, the sample tube labels should list BI trial number, subject number, visit, planned sampling time, and the analyte (e.g. 'BI 730357').

Further use

After completion of the quantification of BI 730357, in plasma, the left-over and/or back-up aliquot may be used for further methodological investigations, e.g. for stability testing (including, if applicable, re-analysis of parent compound). However, only data related to the analyte will be generated by these additional investigations. The study samples will be discarded after completion of the additional investigations but not later than 5 years after the CTR is archived.

The results of any further investigations are not planned to be part of the CTR but can be included into the CTR if necessary.

5.3.3 Analytical determinations

5.3.3.1 Analytical determination of analyte plasma concentration

Concentrations of BI 730357, in plasma will be determined by validated LC-MS/MS (liquid chromatography tandem mass spectrometry) assays. All details of the analytical methods will be available prior to the start of sample analysis.

5.4 ASSESSMENT OF BIOMARKER(S)

Not applicable.

5.5 BIOBANKING

Not applicable.

5.6 OTHER ASSESSMENTS

5.6.1 Pharmacogenomic evaluation

Pharmacogenomic investigations explore the role of genetic variation in determining an individual's response to drugs. For this purpose, a sample of at most 10 mL of blood will be obtained at the screening examination from each subject whose genotype has not been previously determined. Separate informed consent for genotyping will be obtained from each volunteer prior to sampling.

DNA will be extracted from the blood sample in order to sequence genes coding for proteins that are involved in the absorption, distribution, metabolism, and excretion (ADME) of drugs.

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The gene sequences to be determined include known and likely functional variations of key ADME genes and incorporate more than 90% of ADME-related genetic markers identified by the PharmaADME group (weblink.pharmaadme.org). It is not intended to include the pharmacogenomic data in the CTR. However, the data may be part of the CTR, if necessary.

5.7 APPROPRIATENESS OF MEASUREMENTS

All measurements performed during this trial are standard measurements and will be performed in order to monitor subjects' safety and to determine pharmacokinetic parameters in an appropriate way. The scheduled measurements will allow monitoring of changes in vital signs, standard laboratory values, and ECG parameters that might occur as a result of administration of trial medication. The safety assessments are standard, are accepted for evaluation of safety and tolerability of an orally administered drug, and are widely used in clinical trials. The pharmacokinetic parameters and measurements outlined in Sections [2.1.2](#), [2.1.3](#), [2.2.2.1](#), and [5.3](#) are generally used assessments of drug exposure.

6. INVESTIGATIONAL PLAN

6.1 VISIT SCHEDULE

Exact times of measurements outside the permitted time windows will be documented. The acceptable time windows for screening and the end of trial examination are provided in the [Flow Chart](#).

Study measurements and assessments scheduled to occur 'before' trial medication administration are to be performed and completed within a 3h-period prior to BI 730357 administration in Visit 2, and within a 2h-period prior to the next itraconazole administration in Visit 3, if not indicated otherwise in the [Flow Chart](#).

Following administration of trial drugs in Visits 2 and 3, the acceptable deviation from the scheduled time for vital signs, ECG, and laboratory tests will be \pm 30 min on Day 1, \pm 45 min on Day 2, and \pm 60 min from Day 3 onwards.

If scheduled in the [Flow Chart](#) at the same time as a meal, blood sampling, vital signs, and 12-lead ECG recordings have to be done first. Furthermore, if several measurements including venepuncture are scheduled for the same time, venepuncture should be the last of the measurements due to its inconvenience to the subject and possible influence on physiological parameters.

For planned blood sampling times, refer to the [Flow Chart](#). While these nominal times should be adhered to as closely as possible, the actual sampling times will be recorded and used for the determination of pharmacokinetic parameters.

Starting from 119 hours after BI 730357 administration (and beyond), a time window of \pm 60 min will be allowed for PK blood sampling times.

If a subject misses an appointment, it will be rescheduled if possible. The relevance of measurements outside the permitted time windows will be assessed no later than at the Report Planning Meeting.

6.2 DETAILS OF TRIAL PROCEDURES AT SELECTED VISITS

6.2.1 Screening period

After having been informed about the trial, all subjects will provide written informed consent in accordance with GCP and local legislation prior to enrolment in the study.

For information regarding laboratory tests (including drug and virus screening), ECG, vital signs, and physical examination, refer to Sections [5.2.3](#) to [5.2.5](#).

Genotyping will be performed in those volunteers whose genotypes have not been previously determined (for details, see Section [5.3](#)).

6.2.2 Treatment periods

Each subject is expected to participate in 2 treatment periods. At least 10 days will separate administrations of BI 730357 in the first and second treatment period.

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On Day 1 of each treatment period, study participants will be admitted to the trial site and kept under close medical surveillance for at least 24 h following administration of BI 730357. The subjects will then be allowed to leave the trial site after formal assessment and confirmation of their fitness. On all other study days, subjects will be treated in an ambulatory fashion.

For details on time points and procedures for collection of plasma samples for PK analysis, refer to [Flow Chart](#) and Section [5.3.2](#).

The safety measurements performed during the treatment period are specified in Section [5.3](#) of this protocol and in the [Flow Chart](#). For details on times of all other trial procedures, refer to the [Flow Chart](#). AEs and concomitant therapy will be assessed continuously from screening until the end of trial examination.

6.2.3 Follow-up period and trial completion

For AE assessment, laboratory tests, recording of ECG and vital signs, and physical examination during the follow-up period, see Sections [5.2.2](#) to [5.2.5](#).

Subjects who discontinue treatment before the end of the planned treatment period should undergo the EoTrial Visit.

All abnormal values (including laboratory parameters) that are assessed as clinically relevant by the investigator will be monitored using the appropriate tests until a return to a medically acceptable level is achieved. (S)AEs persisting after a subject's EoTrial Visit must be followed until they have resolved, have been sufficiently characterised, or no further information can be obtained.

7. STATISTICAL METHODS AND DETERMINATION OF SAMPLE SIZE

7.1 STATISTICAL DESIGN – MODEL

The main objective of this trial is to investigate the relative bioavailability of BI 730357 in plasma when given as oral single dose together with multiple oral doses of itraconazole (Test, T) as compared to when given alone as oral single dose (Reference, R) on the basis of the primary and secondary pharmacokinetic endpoints, as listed in Section [2.1.2](#) and [2.1.3](#). The trial is designed to allow intra-subject comparisons and will be evaluated statistically by use of a linear model for logarithmically transformed PK endpoints.

A further objective is to evaluate and compare further pharmacokinetic parameters between the treatments, see Section [2.2.1](#). These further pharmacokinetic parameters will be assessed by descriptive statistics.

The assessment of safety and tolerability is a further objective of this trial, and will be evaluated by descriptive statistics for the parameters specified in Section [2.2.2.2](#).

7.2 NULL AND ALTERNATIVE HYPOTHESES

The relative bioavailability of BI 730357 in plasma after test versus reference treatment will be estimated by the ratios of the geometric means (test/reference), and their corresponding 2-sided 90% confidence intervals (CIs) will be provided. This method corresponds to the two one-sided t-tests procedure, each at the 5% significance level. Since the main focus is on estimation and not testing, a formal hypothesis test and associated acceptance range is not specified.

7.3 PLANNED ANALYSES

Analysis sets

Statistical analyses will be based on the following analysis sets:

- Treated set (TS): The treated set includes all subjects who were entered 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 or secondary 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 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.

Adherence to the protocol will be assessed by the trial team. Important protocol deviation (IPD) categories will be suggested in the IQRM plan, IPDs will be identified no later than in the Report Planning Meeting, and the IPD categories will be updated as needed.

Pharmacokinetics

The pharmacokinetic parameters listed in Section [2.1](#) for drug BI 730357 will be calculated by means of non-compartmental analysis. Noncompartmental pharmacokinetic parameters will be calculated based on actual sampling times using a validated pharmacokinetic software (Phoenix® WinNonlin® 6.3). Descriptive statistics will be used to evaluate plasma concentration data and PK parameters. The derivation of PK parameters is described in BI internal SOP ([001-MCS-36-472_RD-01](#)). Further details on analysis will be described in the TSAP.

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 of BI 730357 is $>5\% C_{max}$ value of that subject in the respective treatment period
- 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.

Only concentration values within the validated concentration range and actual sampling times will be used for the calculation of pharmacokinetic parameters. Concentrations used in the pharmacokinetic calculations will be in the same format provided in the bioanalytical report, (that is, to the same number of decimal places provided in the bioanalytical report).

7.3.1 Primary endpoint analyses

Primary analyses

The primary endpoints (refer to Section [2.1.2](#)) will be calculated according to the BI Standard Operating Procedure (SOP) 'Standards and processes for analyses performed within Clinical Pharmacokinetics/ Pharmacodynamics' ([001-MCS-36-472](#)).

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The statistical model used for the analysis of the primary endpoints will be an analysis of variance (ANOVA) model on the logarithmic scale. That is, the PK endpoints will be log-transformed (natural logarithm) prior to fitting the ANOVA model. This model will include effects accounting for the following sources of variation: subjects and treatment. The effect 'subject' will be considered as random, whereas 'treatment' will be considered as fixed. The model is described by the following equation:

$$y_{km} = \mu + s_m + \tau_k + e_{km}, \text{ where}$$

y_{km} = logarithm of response measured on subject m receiving treatment k ,

μ = the overall mean,

s_m = the effect associated with the mth subject, m = 1, 2, ..., n

τ_k = the kth treatment effect, k = 1, 2,

e_{km} = the random error associated with the mth subject who received treatment k.

where $s_m \sim N(0, \sigma_B^2)$ i.i.d., $e_{km} \sim N(0, \sigma_W^2)$ i.i.d. and s_m, e_{km} are independent random variables.

Point estimates for the ratios of the geometric means (test/reference) for the primary endpoints (see Section 2.1) and their two-sided 90% confidence intervals (CIs) will be provided.

For each endpoint, the difference between the expected means for log(T)-log(R) will be estimated by the difference in the corresponding adjusted means (Least Squares Means). Additionally their two-sided 90% confidence intervals will be calculated based on the residual error from the ANOVA and quantiles from the t-distribution. These quantities will then be back-transformed to the original scale to provide the point estimate and 90% CIs for each endpoint.

Further exploratory analyses

The same statistical model as stated above will be repeated for the primary endpoints but with 'subject' considered as fixed effects.

In addition to the model based approach all parameters will be calculated and analysed descriptively.

7.3.2 Secondary endpoint analyses

The secondary endpoints (refer to Section 2.1.3) will be calculated according to the BI SOP 'Standards and processes for analyses performed within Clinical Pharmacokinetics/ Pharmacodynamics' ([001-MCS-36-472](#)) and will be assessed statistically using the same methods as described for the primary endpoints.

7.3.4 Safety analyses

Safety will be analysed based on the assessments described in Section [2.2.2.2](#). All treated subjects (TS, refer to Section [7.3](#)) will be included in the safety analysis. Safety analyses will be descriptive in nature and based on BI standards. No hypothesis testing is planned.

For all analyses, the treatment actually administered (= treatment at onset) to the subject will be used (any deviations from the randomised treatment will be discussed in the minutes of the Report Planning Meeting).

Treatments will be compared in a descriptive way. Tabulations of frequencies/proportions will be used to evaluate categorical (qualitative) data, and tabulations of descriptive statistics will be used to analyse continuous (quantitative) data.

Measurements (such as ECG, vital signs, or laboratory parameters) or AEs will be assigned to treatments (see Section [4.1](#)) based on the actual treatment at the planned time of the measurement or on the recorded time of AE onset (concept of treatment emergent AEs). Therefore, measurements planned or AEs recorded prior to first intake of trial medication will be assigned to the screening period, those between first trial medication intake and end of REP (see Section [1.2.3](#)) will be assigned to the treatment period. Events occurring after the REP but prior to next intake or end of trial termination date will be assigned to 'follow-up'. In case of two or more treatments, the follow-up will be summarized according to the previous treatment. These assignments including the corresponding time intervals will be defined in detail in the TSAP. 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.

Additionally, further treatment intervals (analysing treatments) may be defined in the TSAP in order to provide summary statistics for time intervals, such as combined treatments, on-treatment totals, or periods without treatment effects (such as screening and follow-up intervals).

Adverse events will be coded using the Medical Dictionary for Regulatory Activities (MedDRA). Frequency, severity, and causal relationship of AEs will be tabulated by treatment, system organ class, and preferred term. SAEs, AESIs (see Section [5.2.6.1](#)), and other significant AEs (according to ICH E3) will be listed separately.

Previous and concomitant therapies will be presented per treatment group without consideration of time intervals and treatment periods.

Laboratory data will be compared to their reference ranges. Values outside the reference range as well as values defined as possibly clinically significant will be highlighted in the listings.

Relevant ECG findings will be reported as AEs.

7.4 INTERIM ANALYSES

No interim analysis is planned.

7.5 HANDLING OF MISSING DATA

7.5.1 Safety

It is not planned to impute missing values for safety parameters.

7.5.2 Pharmacokinetics

Handling of missing PK data will be performed according to the relevant Corporate Procedure ([001-MCS-36-472](#)).

PK parameters that cannot be reasonably calculated based on the available drug concentration-time data will not be imputed.

7.6 RANDOMISATION

In this trial subjects receive both treatments in the same order, thus no randomisation for the treatment assignment is performed (see also Section [4.1.3](#)). The sponsor will arrange for the packaging and labelling of BI 730357 trial medication. The randomisation list is just needed for logistical reasons in this trial. The randomisation list will be generated using a validated system that uses a pseudo-random number generator and a supplied seed number so that the resulting allocation is both reproducible and non-predictable.

The randomisation list will contain additional blocks to allow for subject replacement (refer to Section [3.3.5](#)).

7.7 DETERMINATION OF SAMPLE SIZE

It is planned to enter a total of 14 subjects in the trial, accounting for up to 2 non PK evaluable subjects. The planned sample size is not based on a power calculation but is considered sufficient to achieve the aims of this exploratory trial. With this sample size, the following precision in estimating the ratio of geometric means (test/reference) can be expected with 95% probability. Precision is defined as the ratio of upper CI limit to the relative BA estimate. Note that the precision is independent of the actual ratio of geometric means.

The intra-individual coefficient of variation (gCV) is estimated from inter-individual gCV from pharmacokinetic data of the SRD part of a previous trial (Study 1407-0001) using the result of 50 mg dose. The observed inter-individual gCV was 41.9% for C_{max} and 51.5% for AUC_{0-tz}. Assuming a within-subject correlation of 0.6 for C_{max} and 0.8 for AUC_{0-tz}, the estimated intra-individual gCV will roughly be 26% for C_{max} and 22% for AUC_{0-tz}.

Assuming a gCV of 22% for BI 730357 and given a sample size of 12 subjects with evaluable data for primary analysis, the precision of the two-sided 90% confidence interval of the bioavailability ratio will be approximately 1.238, for a greater gCV of 26%, the precision would still be approximately 1.285. Table [7.7: 1](#) provides an overview of the achievable

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precision for estimating the ratio of geometric means (test/reference). For illustrative purposes, the expected 90% confidence intervals with 95% tolerance probability are displayed for different values of the ratios T/R of geometric means.

Table 7.7: 1 Precision that can be expected with 95% tolerance probability and illustrative two-sided 90% confidence intervals around the ratios of geometric means (T/R) for different gCVs in a one-way crossover trial (N=12)

gCV [%]	Precision upper CL / relative BA estimate	Ratio [%] [*]	Lower CL [%]	Upper CL [%]
22	1.238	50	40.40	61.88
22	1.238	100	80.80	123.76
22	1.238	150	121.20	185.64
22	1.238	200	161.60	247.52
26	1.285	50	38.91	64.25
26	1.285	100	77.82	128.50
26	1.285	150	116.73	192.75
26	1.285	200	155.64	257.01

^{*}Ratio of geometric means (test/reference) for a PK endpoint is defined by $\exp(\mu_T)/\exp(\mu_R)$.

The expected 90% confidence interval limits in the table were derived by

$$CI\ limit_{upper,lower} = \exp(\ln(\theta) \pm \omega),$$

with θ being the ratio (T/R) on original scale and ω the distance from the estimate θ to either confidence interval limit on the log-scale, which was obtained from the achievable precision on the original scale.

The calculation was performed as described by Julius [R11-5230] using R Version 3.0.3.

8. INFORMED CONSENT, TRIAL RECORDS, DATA PROTECTION, PUBLICATION POLICY, AND ADMINISTRATIVE STRUCTURE

The trial will be carried out in compliance with the protocol, the ethical principles laid down in the Declaration of Helsinki, in accordance with the ICH Harmonized Guideline for Good Clinical Practice (GCP), relevant BI Standard Operating Procedures (SOPs), the EU regulation 536/2014, and other relevant regulations. Investigators and site staff must adhere to these principles.

Standard medical care (prophylactic, diagnostic, and therapeutic procedures) remains the responsibility of the subject's treating physician.

The investigator will inform the sponsor immediately of any urgent safety measures taken to protect the trial subjects against any immediate hazard, as well as of any serious breaches of the protocol or of ICH GCP.

The Boehringer Ingelheim transparency and publication policy can be found on the following web page: trials.boehringer-ingelheim.com. As a general rule, no trial results should be published prior to archiving of the CTR.

The terms and conditions of the insurance coverage are made available to the investigator and the subjects, and are stored in the ISF.

8.1 TRIAL APPROVAL, SUBJECT INFORMATION, INFORMED CONSENT

This trial will be initiated only after all required legal documentation has been reviewed and approved by the respective Institutional Review Board (IRB / Independent Ethics Committee (IEC and competent authority (CA) according to national and international regulations. The same applies for the implementation of changes introduced by amendments.

Prior to a subject's participation in the trial, written informed consent must be obtained from each subject (or the subject's legally accepted representative) according to ICH-GCP and to the regulatory and legal requirements of the participating country. Each signature must be personally dated by each signatory and the informed consent and any additional subject-information form retained by the investigator as part of the trial records. A signed copy of the informed consent and any additional subject information must be given to each subject or the subject's legally accepted representative.

The subject must be given sufficient time to consider participation in the trial. The investigator or delegate obtains written consent of the subject's own free will with the informed consent form after confirming that the subject understands the contents. The investigator or delegate must sign (or place a seal on) and date the informed consent form. If a trial collaborator has given a supplementary explanation, the trial collaborator also signs (or places a seal on) and dates the informed consent.

Re-consenting may become necessary when new relevant information becomes available and should be conducted according to the sponsor's instructions.

The consent and re-consenting process should be properly documented in the source documentation.

8.2 DATA QUALITY ASSURANCE

A risk-based approach is used for trial quality management. It is initiated by the assessment of critical data and processes for trial subject protection and reliability of the results as well as identification and assessment of associated risks. An Integrated Quality and Risk Management Plan documents the rationale and strategies for risk management during trial conduct including monitoring approaches, vendor management and other processes focusing on areas of greatest risk.

Continuous risk review and assessment may lead to adjustments in trial conduct, trial design or monitoring approaches.

A quality assurance audit/inspection of this trial may be conducted by the sponsor, sponsor's designees, or by IRB / IEC or by regulatory authorities. The quality assurance auditor will have access to all medical records, the investigator's trial-related files and correspondence, and the informed consent documentation of this clinical trial..

8.3 RECORDS

CRFs for individual subjects will be provided by the sponsor. For drug accountability, refer to Section [4.1.8](#).

ClinBaseTM

In the Human Pharmacology Centre (HPC) – Boehringer Ingelheim's Phase I unit – the validated ClinBaseTM system is used for processing information and controlling data collected in clinical studies. In addition to its function as a procedure control system, ClinBaseTM serves as data base. Instead of being entered into CRFs, selected data are directly entered into the system.

8.3.1 Source documents

In accordance with regulatory requirements, the investigator should prepare and maintain adequate and accurate source documents and trial records for each trial subject that include all observations and other data pertinent to the investigation. Source data as well as reported data should follow the 'ALCOA principles' and be attributable, legible, contemporaneous, original, and accurate. Changes to the data should be traceable (audit trail).

Data reported on the CRF must be consistent with the source data or the discrepancies must be explained.

Before providing any copy of subjects' source documents to the sponsor, the investigator must ensure that all subject identifiers (e.g., subject's name, initials, address, phone number, and social security number) have properly been removed or redacted to ensure subject confidentiality.

If the subject is not compliant with the protocol, any corrective action (e.g. re-training) must be documented in the subject file.

For the CRF, data must be derived from source documents, for example:

- Subject identification: sex, year of birth (in accordance with local laws and regulations)

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- Subject participation in the trial (substance, trial number, subject number, date subject was informed)
- Dates of subject's visits, including dispensing of trial medication
- Medical history (including trial indication and concomitant diseases, if applicable)
- Medication history
- AEs and outcome events (onset date [mandatory], and end date [if available])
- SAEs (onset date [mandatory], and end date [if available])
- Concomitant therapy (start date, changes)
- Originals or copies of laboratory results and other imaging or testing results, with proper documented medical evaluation (in validated electronic format, if available)
- ECG results (original or copies of printouts)
- Completion of subject's participation in the trial (end date; in case of premature discontinuation, document the reason for it, if known)
- Prior to allocation of a subject to a treatment into a clinical trial, there must be documented evidence in the source data (e.g. medical records) that the trial participant meets all inclusion criteria and does not meet any exclusion criteria. The absence of records (either medical records, verbal documented feedback of the subject or testing conducted specific for a protocol) to support inclusion/exclusion criteria does not make the subject eligible for the clinical trial.

Data directly entered into ClinBaseTM (that is, without prior written or electronic record) are considered to be source data. The place where data are entered first will be defined in a trial specific Source Data Agreement. The data in ClinBaseTM are available for inspection at any time.

8.3.2 Direct access to source data and documents

The investigator /institution will allow site trial-related monitoring, audits, IRB/IEC review and regulatory inspections. Direct access must be provided to the CRF and all source documents/data, including progress notes, copies of laboratory and medical test results, which must be available at all times for review by the Clinical Research Associate, auditor and regulatory inspector (e.g. FDA). They may review all CRFs and informed consents. The accuracy of the data will be verified by direct comparison with the source documents described in section [8.3.1](#). The sponsor will also monitor compliance with the protocol and GCP.

8.3.3 Storage period of records

Trial site:

The trial site(s) must retain the source and essential documents (including ISF) according to the local requirements valid at the time of the end of the trial.

Sponsor:

The sponsor must retain the essential documents according to the sponsor's SOPs.

8.4 EXPEDITED REPORTING OF ADVERSE EVENTS

BI is responsible to fulfil their legal and regulatory reporting obligation in accordance with regulatory requirements.

8.5 STATEMENT OF CONFIDENTIALITY AND SUBJECT PRIVACY

Individual subject data obtained as a result of this trial is considered confidential and disclosure to third parties is prohibited with the exceptions noted in section [8.7](#).

Data protection and data security measures are implemented for the collection, storage and processing of patient data in accordance with the principles 6 and 12 of the WHO GCP handbook.

Personalised treatment data may be given to the subject's personal physician or to other appropriate medical personnel responsible for the subject's welfare. Data generated at the site as a result of the trial need to be available for inspection on request by the participating physicians, the sponsor's representatives, by the IRB / IEC and the regulatory authorities.

8.5.1 Collection, storage and future use of biological samples and corresponding data

Measures are in place to comply with the applicable rules for the collection, biobanking and future use of biological samples and clinical data, in particular

- Sample and data usage has to be in accordance with the separate biobanking informed consent
- The BI-internal facilities storing biological samples from clinical trial participants as well as the external banking facility are qualified for the storage of biological samples collected in clinical trials.
- An appropriate sample and data management system, incl. audit trail for clinical data and samples to identify and destroy such samples according to ICF is in place
- A fit for the purpose documentation (biomarker proposal, analysis plan and report) ensures compliant usage
- A fit for purpose approach will be used for assay/equipment validation depending on the intended use of the biomarker data

Samples and/or data may be transferred to third parties and other countries as specified in the biobanking ICF

8.6 TRIAL MILESTONES

The **start of the trial** is defined as the date of the enrolment of the first subject in the trial.

The **end of the trial** is defined as the 'date of the last visit of the last subject in whole trial' ('Last Subject Completed') or 'end date of the last open AE' or 'date of the last follow-up test' or 'date of an AE has been decided as sufficiently followed-up', whichever is latest.

Early termination of the trial is defined as the premature termination of the trial for any reason before the end of the trial as specified in this protocol.

Temporary halt of the trial is defined as any unplanned interruption of the trial by the sponsor with the intention to resume it.

Suspension of the trial is defined as an interruption of the trial based on a Health Authority request.

The ethics committee/competent authority in each participating EU member state will be notified about the trial milestones according to the laws of each member state.

A final report of the clinical trial data will be written only after all subjects have completed the trial in all countries (EU or non-EU), so that all data can be incorporated and considered in the report.

The sponsor will submit to the EU database a summary of the final trial results within one year from the end of a clinical trial as a whole, regardless of the country of the last patient (EU or non-EU).

8.7 ADMINISTRATIVE STRUCTURE OF THE TRIAL

The trial is sponsored by Boehringer Ingelheim (BI).

The trial will be conducted at the Human Pharmacology Centre (HPC) of BI Pharma GmbH & Co. KG, Biberach, Germany, under the supervision of the Principal Investigator. Relevant documentation on the participating (Principal) Investigators (e.g. their curricula vitae) will be filed in the ISF.

BI has appointed a Clinical Trial Leader (CT Leader), responsible for coordinating all required trial activities, in order to

- Manage the trial in accordance with applicable regulations and internal SOPs
- Direct the clinical trial team in the preparation, conduct, and reporting of the trial
- ensure appropriate training and information of Clinical Trial Manager (CT Manager), Clinical Research Associates, and investigators of participating trial sites

The trial medication will be provided by the Clinical Trial Supplies Unit, BI Pharma GmbH & Co. KG, Biberach, Germany (BI 730357) or will be obtained by the clinical trial site from a public pharmacy (itraconazole).

Safety laboratory tests will be performed by the local laboratory of the trial site

Analyses of BI 730357 and itraconazole concentrations in plasma will be performed under the responsibility of the Department of Drug Metabolism and Pharmacokinetics, BI Pharma GmbH & Co. KG, Biberach, Germany at suitable contract research organisations.

On-site monitoring will be performed by BI or a contract research organisation appointed by BI.

Data management and statistical evaluation will be done by BI or a contract research organization appointed by BI according to BI SOPs.

Tasks and functions assigned in order to organise, manage, and evaluate the trial are defined according to BI SOPs. A list of responsible persons and relevant local information can be found in the ISF.

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10. APPENDICES

Not applicable.

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11. DESCRIPTION OF GLOBAL AMENDMENT(S)

11.1 GLOBAL AMENDMENT 1

Date of amendment	11 December 2018
EudraCT number	2018-003495-13
EU number	
BI Trial number	1407-0014
BI Investigational Medicinal Product(s)	BI 730357
Title of protocol	Relative bioavailability of a single oral dose of BI 730357 when administered alone or in combination with multiple oral doses of itraconazole in healthy male subjects (an open-label, one-way crossover study)
To be implemented only after approval of the IRB / IEC / Competent Authorities	<input checked="" type="checkbox"/>
To be implemented immediately in order to eliminate hazard – IRB / IEC / Competent Authority to be notified of change with request for approval	<input type="checkbox"/>
Can be implemented without IRB / IEC / Competent Authority approval as changes involve logistical or administrative aspects only	<input type="checkbox"/>
Section to be changed	<ol style="list-style-type: none">1. Section 3.3.3, exclusion criteria 28 and 292. Section 5.2.3 (Table 5.2.3:2)
Description of change	<ol style="list-style-type: none">1. Haematological parameters added2. Interferon-γ release assay to tuberculosis added
Rationale for change	<ol style="list-style-type: none">1. Requested by Ethics Committee to exclude anaemia and infections2. To exclude subjects with tuberculosis infection

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11.2 GLOBAL AMENDMENT 2

Date of amendment	20 February 2019
EudraCT number	2018-003495-13
EU number	
BI Trial number	1407-0014
BI Investigational Medicinal Product	BI 730357
Title of protocol	Relative bioavailability of a single oral dose of BI 730357 when administered alone or in combination with multiple oral doses of itraconazole in healthy male subjects (an open-label, one-way crossover study)
To be implemented only after approval of the IRB / IEC / Competent Authorities	<input type="checkbox"/>
To be implemented immediately in order to eliminate hazard – IRB / IEC / Competent Authority to be notified of change with request for approval	<input type="checkbox"/>
Can be implemented without IRB / IEC / Competent Authority approval as changes involve logistical or administrative aspects only	<input checked="" type="checkbox"/>
Section to be changed	Section 5.2.6.1.4 and 9.1
Description of change	Addition of adverse events of special interest (one paragraph for severe infections including published reference and one paragraph for opportunistic and mycobacterium tuberculosis infections)
Rationale for change	As with other immune-targeted therapies, impaired host defence is a theoretical target-related toxicity, potentially resulting in increased risk of infection and/or malignancy. Therefore, as stated in the current version of the Investigator's Brochure, AEs and SAEs consistent with infection and malignancy are to be evaluated throughout the BI 730357 clinical development program.



APPROVAL / SIGNATURE PAGE

Document Number: c24616632

Technical Version Number: 3.0

Document Name: clinical-trial-protocol-revision-2

Title: Relative bioavailability of a single oral dose of BI 730357 when administered alone or in combination with multiple oral doses of itraconazole in healthy male subjects (an open-label, one-way crossover study)

Signatures (obtained electronically)

Meaning of Signature	Signed by	Date Signed
Author-Trial Statistician		20 Feb 2019 15:13 CET
Author-Trial Clinical Pharmacokineticist		20 Feb 2019 16:00 CET
Author-Clinical Trial Leader		20 Feb 2019 16:19 CET
Approval-Therapeutic Area		20 Feb 2019 16:20 CET
Verification-Paper Signature Completion		21 Feb 2019 07:00 CET
Approval-Team Member Medicine		21 Feb 2019 13:36 CET

(Continued) Signatures (obtained electronically)

Meaning of Signature	Signed by	Date Signed