

**Official Title:** A Prospective, Randomized, Double-masked, Active Comparator-controlled, Multi-center, Two-arm, Phase 3 Study to Evaluate the Efficacy and Safety of Intravitreal KSI-301 Compared with Intravitreal Aflibercept in Participants with Neovascular (Wet) Age-related Macular Degeneration (wAMD)

**NCT Number:** NCT04964089

**Document Date:** Protocol Version 2.0, 16 March 2022

## CLINICAL STUDY PROTOCOL

<b>Protocol Title:</b>	A Prospective, Randomized, Double-masked, Active Comparator-controlled, Multi-center, Two-arm, Phase 3 Study to Evaluate the Efficacy and Safety of Intravitreal KSI-301 Compared with Intravitreal Aflibercept in Participants with Neovascular (Wet) Age-related Macular Degeneration (wAMD)
<b>Protocol Number:</b>	KS301P107
<b>Version Date:</b>	16 March 2022
<b>Amendment Number:</b>	2.0
<b>Supersedes:</b>	Version 1.1 (Dated: 13 May 2021)
<b>Test Product:</b>	KSI-301
<b>Brief Title:</b>	A Study to Evaluate the Efficacy and Safety of KSI-301 Compared to Aflibercept in Participants with Neovascular (Wet) Age-related Macular Degeneration (wAMD)
<b>Study Phase:</b>	3
<b>Study Acronym/Name:</b>	DAYLIGHT
<b>Sponsor:</b>	Kodiak Sciences Inc. 2631 Hanover Street Palo Alto, CA 94304 USA
<b>Sponsor Contact &amp; Medical Monitor:</b>	[REDACTED] [REDACTED] Kodiak Sciences Inc.
<b>IND Number:</b>	136167
<b>EudraCT Number:</b>	2021-000225-27

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## FOR MEDICAL EMERGENCIES CONTACT:



## **PROTOCOL APPROVAL – SPONSOR SIGNATORY**

**Study Title:** A Prospective, Randomized, Double-masked, Active Comparator-controlled, Multi-center, Two-arm, Phase 3 Study to Evaluate the Efficacy and Safety of Intravitreal KSI-301 Compared with Intravitreal Aflibercept in Participants with Neovascular (Wet) Age-related Macular Degeneration (wAMD) (DAYLIGHT)

**Protocol Number:** KS301P107

**Version Date:** 16 March 2022

Protocol accepted and approved by:

[REDACTED]

[REDACTED]

Kodiak Sciences Inc.  
2631 Hanover Street  
Palo Alto, CA 94304

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Signature

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Date

## PROTOCOL APPROVAL – PRINCIPAL INVESTIGATOR SIGNATORY

**Study Title:** A Prospective, Randomized, Double-masked, Active Comparator-controlled, Multi-center, Two-arm, Phase 3 Study to Evaluate the Efficacy and Safety of Intravitreal KSI-301 Compared with Intravitreal Aflibercept in Participants with Neovascular (Wet) Age-related Macular Degeneration (wAMD) (DAYLIGHT)

**Protocol Number:** KS301P107

**Version Date:** 16 March 2022

I have read the protocol described above. I agree to conduct the study as described in the protocol. I also agree to conduct this study in compliance with Good Clinical Practice (GCP) and all applicable national and local laws and regulations, as well as with the requirements of the appropriate Institutional Review Board or independent Ethics Committee (IRB/IEC) and any other institutional requirements. These are stated in “Guidance for Good Clinical Practice” International Council for Harmonisation (ICH) guideline E6(R1) of Technical Requirements for Registration of Pharmaceuticals for Human Use, the Declaration of Helsinki, and any other applicable regulatory requirements. No changes will be made to the study protocol without prior written approval of the Sponsor and the IRB/IEC.

**Principal Investigator:**

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Print Name of Investigator

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Signature

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Date

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## LIST OF ABBREVIATIONS

Abbreviation	Definition
ADA	Anti-drug antibody
AE	Adverse event
AESI	Adverse event of special interest
ALT	Alanine aminotransferase
AMD	Age-related macular degeneration
ANCOVA	Analysis of covariance
AR	Adverse reaction
AST	Aspartate aminotransferase
ATE	Arterial thromboembolic events
AUC	Area under the curve (total exposure)
BCVA	Best corrected visual acuity
BP	Blood pressure
BUN	Blood urea nitrogen
CFR	Code of federal regulations
C <sub>max</sub>	Maximum concentration observed
CNV	Choroidal neovascularization
COVID-19	Coronavirus-19
CRO	Contract research organization
CSR	Clinical study report
CST	Central subfield thickness
DME	Diabetic macular edema
DR	Diabetic retinopathy
DVD	Digital Video Disc
EC	Ethics committee
ECG	Electrocardiograph
eCRF	Electronic case report form
EDC	Electronic data capture
ET	Early termination
ETDRS	Early treatment diabetic retinopathy study
EU	European Union
FA	Fundus fluorescein angiography
FAS	Full-analysis set
FDA	Food and Drug Administration
FP	Fundus photography
GCP	Good clinical practice
GGT	Gamma-glutamyl-transferase

Abbreviation	Definition
GLP	Good laboratory practice
IB	Investigator's Brochure
ICF	Informed consent form
ICH	International conference on harmonization
ICMJE	International committee of medical journal editors
IDMC	Independent Data Monitoring Committee
IMP	Investigational medicinal product
IND	Investigational new drug (application)
IOP	Intraocular pressure
IP	Investigational product
IRB	Institutional review board
IEC	Independent or institutional ethics committee
IRC	Intraretinal cysts
IRF	Intraretinal fluid
ITT	Intent to treat
IRT	Interactive Response Technology
IUD	Intrauterine device
IUS	Intrauterine hormone-releasing system
IVT	Intravitreal
LPLO	Last participant, last observation
ME	Macular edema
MedDRA	The medical dictionary for regulatory activities
NAB	Neutralizing antibody
NOAEL	No observed adverse effect level
OCT	Optical coherence tomography
OU	Both eyes
PI	Principal Investigator
PK	Pharmacokinetic
Q8W	Every eight weeks
RPE	Retinal pigment epithelium
RVO	Retinal vein occlusion
SAE	Serious adverse event
SAP	Statistical analysis plan
SAR	Serious adverse reaction
SAR-CoV-2	Severe acute respiratory syndrome coronavirus 2
SD-OCT	Spectral domain optical coherence tomography

Abbreviation	Definition
SDV	Source data verification
SE	Study Eye
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum glutamic pyruvic transaminase
SoA	Schedule of activities
SRF	Subretinal fluid
SUN	Standardization of uveitis nomenclature
SUSAR	Suspected unexpected serious adverse reactions
TEAEs	Treatment emergent adverse events
ULN	Upper limits of normal
VA	Visual acuity
VEGF	Vascular endothelial growth factor
wAMD	Wet (neovascular) age-related macular degeneration
WBC	White blood cell
WHODrug	World health organization drug dictionary
WOCBP	Women of childbearing potential

**1.0 PROTOCOL SUMMARY****1.1 Synopsis**

<b>Protocol Number:</b> KS301P107	<b>Version:</b> 2.0	<b>For National Authority Use Only</b>	
<b>IND Number:</b> 136167	<b>EudraCT Number:</b> 2021-000225-27		
<b>Sponsor:</b> Kodiak Sciences Inc. 2631 Hanover Street Palo Alto, CA 94304 (USA)			
<b>Investigational Product:</b> KSI-301			
<b>Title of Study:</b> A Prospective, Randomized, Double-masked, Active Comparator-controlled, Multi-center, Two-arm, Phase 3 Study to Evaluate the Efficacy and Safety of Intravitreal KSI-301 Compared with Intravitreal Aflibercept in Participants with Neovascular (Wet) Age-related Macular Degeneration (wAMD) (DAYLIGHT)			
<b>Brief Title:</b> A Study to Evaluate the Efficacy and Safety of KSI-301 Compared to Aflibercept in Participants with Neovascular (Wet) Age-related Macular Degeneration (wAMD)			
<b>Brief Study Rationale:</b> KSI-301 is a novel, potent, long-acting biopharmaceutical that inhibits vascular endothelial growth factor (VEGF). KSI-301 has enhanced retinal bioavailability, a greater inhibitory potency, and an extended ocular half-life, which may result in improved efficacy and/or a less frequent treatment regimen. Intensive treatment with aflibercept has been shown to provide better visual acuity results in a subset of patients with persistent fluid in the retina. Given the enhanced properties of KSI-301, this study has been designed to evaluate an intensive treatment regimen of KSI-301 5 mg compared to aflibercept 2 mg in participants with wAMD.			
<b>Development Phase:</b> 3	<b>Countries/Regions:</b> NA (North America) and EMEA (Europe, Middle-East, Africa)		
<b>Study Period:</b> Approximately 2 years			

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<b>Investigational Product:</b> KSI-301			

**Title of Study:**

A Prospective, Randomized, Double-masked, Active Comparator-controlled, Multi-center, Two-arm, Phase 3 Study to Evaluate the Efficacy and Safety of Intravitreal KSI-301 Compared with Intravitreal Aflibercept in Participants with Neovascular (Wet) Age-related Macular Degeneration (wAMD) (DAYLIGHT)

**Objectives and Key Endpoints:**

Objectives	Key Endpoints
<b>Primary</b>	
To demonstrate that KSI-301 5 mg is non-inferior to aflibercept 2 mg, with respect to the change in best corrected visual acuity (BCVA) from Day 1 to the average of Weeks 40, 44, and 48.	<ul style="list-style-type: none"> <li>Mean change in BCVA from baseline (Day 1) to the average of Weeks 40, 44, and 48, in Early Treatment Diabetic Retinopathy Study (ETDRS) Letters.</li> </ul>
<b>Secondary</b>	
To evaluate the efficacy of KSI-301 5 mg compared to aflibercept 2 mg over the study duration by assessing visual parameters.	<ul style="list-style-type: none"> <li>Mean change in BCVA (ETDRS Letters) from baseline (Day 1) by visit over time.</li> <li>Proportion of participants who gain <math>\geq 5</math>, <math>\geq 10</math> and <math>\geq 15</math> ETDRS letters from baseline (Day 1) by visit over time.</li> <li>Proportion of participants who lose <math>\geq 5</math>, <math>\geq 10</math> and <math>\geq 15</math> ETDRS letters from baseline (Day 1) by visit over time.</li> </ul>
To evaluate the efficacy of KSI-301 5 mg compared to aflibercept 2 mg over the study duration by assessing anatomical parameters.	<ul style="list-style-type: none"> <li>Mean change in optical coherence tomography (OCT) central subfield thickness (CST) and other morphological parameters from baseline (Day 1) to the average of Weeks 40, 44, and 48 and over time.</li> </ul>
To evaluate the safety and tolerability of KSI-301 5 mg compared to aflibercept 2 mg.	<ul style="list-style-type: none"> <li>Incidence of ocular and systemic adverse events up to Week 52.</li> </ul>
To assess the systemic pharmacokinetics (exposure) and immunogenicity of KSI-301.	<ul style="list-style-type: none"> <li>Systemic pharmacokinetic profile over time.</li> <li>Systemic anti-drug antibody status over time.</li> </ul>

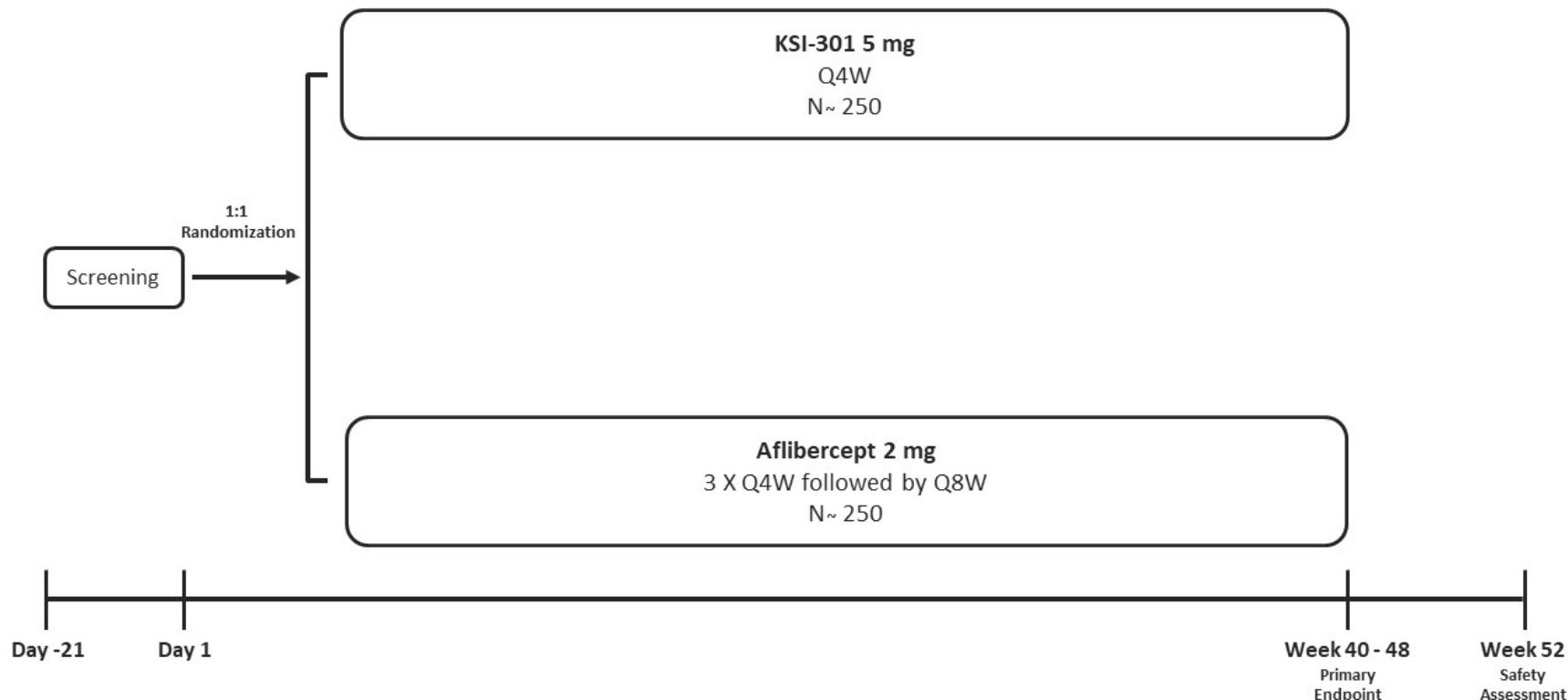
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<b>Investigational Product:</b> KSI-301		
<b>Title of Study:</b> A Prospective, Randomized, Double-masked, Active Comparator-controlled, Multi-center, Two-arm, Phase 3 Study to Evaluate the Efficacy and Safety of Intravitreal KSI-301 Compared with Intravitreal Aflibercept in Participants with Neovascular (Wet) Age-related Macular Degeneration (wAMD) (DAYLIGHT)		
<b>Design/Methodology/Masking:</b> This is a prospective, randomized, double-masked, two-arm, multi-center Phase 3 study to demonstrate that KSI-301 5 mg is non-inferior to aflibercept 2 mg, with respect to mean change in BCVA from Day 1 to the average of Weeks 40, 44, and 48, in participants with treatment-naïve wAMD. One eye per participant will be enrolled in the study. Participants will be randomized 1:1 into one of two treatment groups: KSI-301 or aflibercept. Randomization will be stratified by [REDACTED]  [REDACTED] Treatment group randomization at Day 1 and treatment or sham assignment for the duration of the study will be provided by the interactive response technology (IRT) system. For masking purposes, sham injections will be administered at every monthly visit if an active treatment is not administered. To preserve masking, two investigators are required for this study. The masked Investigator will be responsible for the examinations and safety assessments, including causality assessments for adverse events. The unmasked Investigator (and unmasked assistants, if any) will perform the intravitreal injections (active treatments and sham) and post-treatment assessments. This study is divided into a 21-day screening period, a 44-week treatment period, a 4-week follow-up period for safety and efficacy assessments at Week 48, and a final follow-up for safety assessments at Week 52 [REDACTED]		
<b>Number of Participants Planned:</b> Approximately 500	<b>Gender:</b> Male or female	<b>Age:</b> Adults $\geq$ 50 years of age
<b>Diagnosis and Main Criteria for Eligibility:</b> Eligible participants will have active, treatment-naïve choroidal neovascularization (CNV) secondary to wAMD, including subfoveal, juxtafoveal, and extrafoveal lesions or retinal angiomatic proliferations (RAP) lesions with a CNV component that affect the central subfield as evidenced by FA or OCT in the Study Eye at Screening. The CNV area in the Study Eye must be at least 50% of total lesion size at Screening. Participants will also have a BCVA ETDRS score between 83 and 25 letters, inclusive, in the Study Eye and a decrease in vision in the Study Eye that has been determined by the Investigator to be primarily the result of wAMD.		
<b>Total Participant Duration:</b> 55 weeks	<b>Duration of Treatment:</b> 44 weeks	
<b>Study Intervention (Investigational Medicinal Product), Dose, and Route of Administration:</b> <u>Treatment Group A:</u> Day 1 to Week 36: KSI-301 5 mg once every 4 weeks via intravitreal injection.		

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<b>Title of Study:</b> A Prospective, Randomized, Double-masked, Active Comparator-controlled, Multi-center, Two-arm, Phase 3 Study to Evaluate the Efficacy and Safety of Intravitreal KSI-301 Compared with Intravitreal Aflibercept in Participants with Neovascular (Wet) Age-related Macular Degeneration (wAMD) (DAYLIGHT)			
<b>Study Intervention (Active Control/Investigational Medicinal Product), Dose, and Route of Administration:</b> <u>Treatment Group B:</u> <ul style="list-style-type: none"> <li>Day 1 to Week 12: aflibercept 2 mg once every 4 weeks for 3 monthly doses via intravitreal injection, followed by a sham injection at week 12; and</li> <li>Week 16 to Week 44: aflibercept 2 mg once every 8 weeks via intravitreal injection. Sham injections will be administered at each monthly visit if an active treatment is not administered.</li> </ul>			
<b>Efficacy Evaluation:</b> Unless stated otherwise, all efficacy analyses will be performed on the intent to treat (ITT) population. The primary endpoint is mean change in ETDRS BCVA from Day 1 to the average of Weeks 40, 44, and 48. The primary assessment of efficacy will be based on a pairwise comparison in mean change in BCVA between treatment group A (KSI-301 5 mg) and treatment group B (aflibercept 2 mg). Other efficacy outcomes will be evaluated using ophthalmic assessments (including tonometry), fundus photography, spectral domain (SD)-OCT, and fluorescein angiography (FA). Secondary endpoints for efficacy will be assessed at Week 48. Planned time points for all efficacy assessments are provided in the Schedule of Activities (SoA) ( <a href="#">Section 1.3</a> ).			
<b>Safety Evaluation:</b> After informed consent has been obtained but prior to initiation of study intervention, only serious adverse events (SAEs) caused by a protocol-mandated intervention should be reported. After initiation of study intervention (Day 1), all AE and SAE information will be collected until the final safety follow-up visit at Week 52 or the ET visit, if applicable, as specified in <a href="#">Section 1.3</a> . The safety analysis will use outcomes of all participants who were exposed to study treatment, regardless of adherence to the protocol or treatment outcome. All reported adverse events (ocular and otherwise) in the safety population will be listed by MedDRA term, frequency, severity, association to the study therapy, and treatment group. By-treatment incidence rates will also be calculated for the treatment groups. For certain adverse events, per-injection rates will also be described.			
<b>Pharmacokinetic/Biomarker Evaluation:</b> Plasma concentrations of study intervention (KSI-301) will be measured, as specified in the SoA ( <a href="#">Section 1.3</a> ). Blood samples will also be analyzed for anti-drug antibodies (ADAs). For exploratory purposes, <span style="background-color: black; color: black;">[REDACTED]</span>			

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<b>Statistical Methods:</b> The study hypothesis is that treatment with KSI-301 5 mg will provide a non-inferior mean change in BCVA to aflibercept 2 mg in participants with wAMD. Using ETDRS BCVA data collected up to Week 48, the treatment groups will be compared using a non-inferiority analysis, with a margin [REDACTED]. Confidence intervals (CI) will be 100(1-2 $\alpha$ ) or 95% CI. The sample size of approximately 500 (250 per group) participants was calculated using the following assumptions: <ul style="list-style-type: none"> <li>Overall type I error rate of 0.025. Testing at the 0.025 level for non-inferiority corresponds to setting 95% CIs.</li> <li>Statistical power of <math>\geq 90\%</math>.</li> <li>Standard deviation of the distribution of change in visual acuity from baseline of [REDACTED] letters.</li> <li>The maximum, clinically acceptable true difference for KSI-301 to be considered non-inferior, or the “non-inferiority margin”, [REDACTED].</li> <li>The statistical test used to compare the two treatment groups at Week 48 is an independent t-test on the mean change in visual acuity from baseline.</li> <li>Lost to follow-up/dropout rate of approximately [REDACTED].</li> </ul> Analysis of study data will be performed when all participants have either completed the Week 48 visit or have discontinued from the study, all data have been entered into the database, cleaned and verified as appropriate, and the database has been locked.			
<b>Data Monitoring:</b> An Independent Data Monitoring Committee (IDMC) will monitor the study conduct and participant safety on an ongoing basis.			
<b>Date of Protocol/Amendment:</b>	16 March 2022		

## 1.2 Schema

Figure 1: Protocol KS301P107: Schema



Abbreviations: Q4W = once every four (4) weeks; Q8W = once every eight (8) weeks.

## 1.3 Schedule of Activities (SoA)

Visit	Screening	Day 1	Week 2	Week 4	Week 8	Week 12	Week 16	Week 20	Week 24	Week 28	Week 32	Week 36	Week 40	Week 44	Week 48/ET	Week 52 <sup>13</sup>
<b>Visit Windows (days)</b>	<b>D-21 to D-1</b>		+/-3	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7
Informed consent		X														
Demographics		X														
Medical & Ocular History		X														
Inclusion/Exclusion Criteria		X	X													
Concomitant Medication Review <sup>1</sup>		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
AE/SAE Review <sup>2</sup>			X	X	X	X	X	X	X	X	X	X	X	X	X	X
<b>General Assessments</b>																
Vital signs <sup>3</sup>		X	X													X
Laboratory <sup>4</sup>		X														X
Plasma ADA samples <sup>5</sup>			X		X					X						X
Plasma PK/biomarker samples <sup>5</sup>			X	X	X					X						X
Pregnancy test <sup>6</sup> (WOCBP only)		X	X		X	X	X	X	X	X	X	X	X	X	X	X
<b>Ophthalmic Assessments<sup>7</sup></b>																
BCVA ETDRS (4 meters) <sup>8</sup>		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
			X					X								
Ophthalmic exam (Slit-lamp, IOP <sup>9</sup> , dilated indirect ophthalmoscopy)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
SD-OCT <sup>10</sup>		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Color Fundus photos <sup>10</sup>		X														X

Visit	Screening	Day 1	Week 2	Week 4	Week 8	Week 12	Week 16	Week 20	Week 24	Week 28	Week 32	Week 36	Week 40	Week 44	Week 48/ET	Week 52 <sup>13</sup>
Visit Windows (days)	D-21 to D-1		+/-3	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7	+/-7
Fluorescein angiogram <sup>10</sup>	X														X	
Randomized study treatment (KSI-301, afibercept or sham) per IRT designation <sup>11</sup>		X		X	X	X	X	X	X	X	X	X	X	X		
Post-injection Assessments (vision check, IOP <sup>9</sup> ) <sup>12</sup>		X		X	X	X	X	X	X	X	X	X	X	X		

Abbreviations: ADA = anti-drug antibody; AE = adverse event; BCVA = best corrected visual acuity; ET = early termination; ETDRS = early treatment diabetic retinopathy study; IRT = interactive response technology; PK = pharmacokinetics; SAE = serious adverse event; SD-OCT = spectral domain optical coherence tomography; WOCBP = women of childbearing potential.

- <sup>1</sup> Record any concomitant medication used by the participant within 30 days prior to Day 1. Procedural medications administered (e.g., dilating drops, fluorescein) will not be recorded.
- <sup>2</sup> After informed consent has been obtained but prior to initiation of study intervention, only serious adverse events caused by a protocol-mandated intervention should be reported. After initiation of study intervention (Day 1), all AEs will be reported until the final study visit or the ET visit if applicable. See Section 8.3.1.
- <sup>3</sup> Height and weight are taken at screening only.
- <sup>4</sup> Clinical laboratory test as described in Appendix 2 and Table 4.
- <sup>5</sup> Blood draws for ADA, plasma PK, and biomarker samples are to be taken pre-injection.
- <sup>6</sup> Urine pregnancy test will be performed locally for women of childbearing potential, prior to fluorescein angiogram and study treatment (if applicable). If urine pregnancy test is positive, it must be confirmed with a serum pregnancy test. Local urine testing will be standard for the protocol unless serum testing is required by local regulation or IRB/IEC.
- <sup>7</sup> Ophthalmic assessments will be performed in both eyes at Screening and Week 48, and in the Study Eye only at all other timepoints.
- <sup>8</sup> Perform BCVA before any other ophthalmic assessments and prior to dilation.
- <sup>9</sup> Method used to measure IOP must remain consistent throughout study.
- <sup>10</sup> It is mandatory that the same model of device is used for the entire duration of the study.
- <sup>11</sup> Participants who discontinue study treatment should NOT be considered withdrawn from the study. Additional details are provided in Section 7.1.
- <sup>12</sup> Post injection assessments include vision check for counting fingers and tonometry. The post-injection assessments should be performed by unmasked assessors.
- <sup>13</sup> [REDACTED]

## 2.0 INTRODUCTION

KSI-301 is a novel, potent, long-acting biopharmaceutical that inhibits vascular endothelial growth factor (VEGF). It is being developed to treat neovascular (wet) age-related macular degeneration (wAMD), as well as macular edema (ME) secondary to retinal vein occlusion (RVO), diabetic macular edema (DME), and diabetic retinopathy (DR). KSI-301 offers the potential for participants to experience a longer interval between consecutive intravitreal injections compared to existing anti-VEGF therapies. Thus, KSI-301 may have the potential to improve real-world outcomes of anti-VEGF therapy, which in patients with wAMD, is currently limited by both the high treatment burden and insufficient durability of effect.

### 2.1 Study Rationale

Although substantial visual acuity benefits have been demonstrated with the approved intravitreal VEGF inhibitors (e.g., aflibercept and ranibizumab) in the first-line treatment of wAMD, some patients have an insufficient response to treatment, with continued loss of visual acuity and/or persistent retinal fluid ([Brown 2006](#); [Heier 2012](#); [Rosenfeld 2006](#)).

Pharmacokinetic modeling suggests that more frequent dosing with anti-VEGF therapy could be beneficial for such patients ([Stewart 2012](#)), and intensive treatment with aflibercept has shown to provide better visual acuity results in a subset of patients with persistent fluid in the retina ([Jaffe 2016](#)). With enhanced retinal bioavailability, a greater inhibitory potency, and an extended ocular half-life ([Section 2.2.3](#)), KSI-301 may lead to improved treatment outcomes. The ongoing Phase 2b/3 Study of KSI-301 versus aflibercept in participants with wAMD, Study KSI-CL-102, evaluates dosing regimens of KSI-301 at intervals of every 12 weeks or longer. Thus, this study, Study KS301P107, has been designed to evaluate an intensive treatment regimen of KSI-301 5 mg (Q4W) compared to aflibercept 2 mg (Q8W after 3 monthly loading doses) in participants with wAMD.

### 2.2 Background

#### 2.2.1 Neovascular (Wet) Age-related Macular Degeneration

Age-related macular degeneration (AMD) is a progressive disease that affects the macula, which is the central portion of the retina and is the region of the eye responsible for sharp, central vision and color perception. AMD affects people 50 years of age and older and the likelihood of AMD progression and associated vision loss increases with age. Population-based studies have shown that AMD accounts for 8.7% of all blindness worldwide and is the most common cause of blindness in developed countries. ([Wong 2014](#))

Neovascular (wet) AMD (wAMD) is an advanced form of AMD that is characterized by choroidal neovascularization and fluid leakage within and under the retina. In the United States and the European Union (EU), wAMD is the leading cause of severe vision loss in people over the age of 50. In the United States, the prevalence of wAMD is approximately 1.25 million, with an annual incidence of approximately 148,000 new cases ([Wong 2014](#)). Like AMD, the

likelihood of disease progression of wAMD increases with age, and both the prevalence and incidence of wAMD are projected to accelerate worldwide.

Approximately 50% of patients presenting with wAMD in one eye will develop wAMD in the fellow eye within five years, leading to a substantial number of patients requiring treatment in both eyes (Chew 2014). In many eyes with wAMD, the disease can progress quickly, with rapid loss of central vision needed for activities such as reading and driving. Untreated or undertreated wAMD can result in subretinal scarring with irreversible photoreceptor damage and loss, and ultimately permanent vision impairment or blindness.

## 2.2.2 Vascular Endothelial Growth Factor

VEGF stimulates vascular endothelial cell growth and induces vascular permeability. These biologic activities give it a central role in angiogenesis, both in normal and pathologic conditions. VEGF plays a critical role in the pathophysiology of choroidal and retinal neovascular diseases such as wAMD; DR, including DME; and ME due to RVO (Rubio 2016). Inhibition of pathologic VEGF activity is both an “anti-angiogenic” and “anti-permeability” approach to treat choroidal and retinal neovascular diseases and has been shown to be effective in preserving and improving visual acuity (Campochiaro 2015b; Cheung 2010).

Among the VEGF isoforms, VEGF-A is the most strongly linked to angiogenesis and vascular leakage (Campochiaro 2015a). Intravitreal VEGF-A inhibitors such as aflibercept and ranibizumab have been approved by regulatory authorities worldwide for use in these retinal vascular diseases. Phase 3 clinical trials of ranibizumab demonstrated that monthly injections of ranibizumab for DME and wAMD resulted in substantial visual acuity gains (Brown 2006; Nguyen 2012; Rosenfeld 2006). Similarly, the Phase 3 clinical trials of aflibercept in patients with wAMD demonstrated that every 8-week (Q8W) dosing of aflibercept (after 3 once-monthly loading doses) was non-inferior to monthly ranibizumab (Heier 2012).

The anti-VEGF therapy is well-established for the treatment of wAMD (Schmidt-Erfurth 2014). However, some patients have an insufficient response to treatment, with continued loss of BCVA and/or persistent retinal fluid using the approved posologies (Brown 2006; Heier 2012; Rosenfeld 2006). Pharmacokinetic modeling suggests that more frequent dosing with anti-VEGF therapy could be beneficial for such patients (Stewart 2012), and intensive treatment with aflibercept has shown to provide better visual acuity results in a subset of patients with persistent fluid in the retina (Jaffe 2016).

## 2.2.3 Description of KSI-301

KSI-301 is an antibody biopolymer conjugate (ABC) developed using the Sponsor’s proprietary ABC Platform™ technology. The antibody portion of KSI-301 binds to VEGF-A with high affinity and inhibits the ability of VEGF-A to bind and activate its cognate receptors (VEGFR1 and VEGFR2), thereby acting as an anti-angiogenic and anti-permeability agent. The inert biopolymer portion is an ultra-hydrophilic phosphorylcholine polymer that significantly

increases the overall molecular size of KSI-301, which in turn extends its ocular half-life by a factor [REDACTED] and ocular concentrations at three months by a factor of [REDACTED] compared to aflibercept. Due to the biophysical and biological properties of the ABC Platform on which it is built, KSI-301 is designed to have improved ocular durability, bioavailability, biocompatibility, and stability, and rapid systemic clearance. These properties make KSI-301 an ideal candidate for the management of retinal vascular diseases.

A detailed description of the chemistry, pharmacology, efficacy, and safety of KSI-301 is provided in the Investigator's Brochure (IB).

### **2.3 Benefit/Risk Assessment**

Detailed information about the known and expected benefits and risks and reasonably expected adverse events of KSI-301 may be found in the IB. A brief overview of known potential benefits and risks is provided in the subsections that follow.

#### **2.3.1 Known Potential Benefits**

KSI-301, an intravitreal VEGF inhibitor developed to treat wAMD, benefits from a well-documented mechanism of action in retinal vascular disease ([Homayouni 2009](#)). The efficacy and safety of commercially available intravitreal VEGF inhibitors in wAMD is also well-documented and established ([Schmidt-Erfurth 2014](#)). Based on its molecular design and structure, *in vitro* and *in vivo* nonclinical testing, and clinical data to date, it is expected that the efficacy and safety of KSI-301 should be at least comparable to standard of care.

The use of anti-VEGF therapy is a well-established treatment for wAMD ([Schmidt-Erfurth 2014](#)). However, some patients have an insufficient response to treatment, with continued loss of BCVA and/or persistent retinal fluid using the approved posologies ([Brown 2006](#); [Heier 2012](#); [Rosenfeld 2006](#)). Pharmacokinetic modeling suggests that more frequent dosing with anti-VEGF therapy could be beneficial for such patients ([Stewart 2012](#)), and intensive treatment with aflibercept has been shown to provide better visual acuity results in a subset of patients with persistent fluid in the retina ([Jaffe 2016](#)). Thus, an intensive treatment regimen of KSI-301 may provide clinically relevant benefits over existing therapies for patients with wAMD.

#### **2.3.2 Known Potential Risks**

Potential risks of treatment with KSI-301 were identified based on therapeutic protein class effects, VEGF-inhibition class effects, the intravitreal route of administration, nonclinical findings, and Phase 1/1b clinical experience. In consideration of the Coronavirus disease (COVID-19) pandemic caused by the virus SARS-CoV-2 and the impact it may have on clinical trials, COVID-19 related risks to participants are also carefully considered. A summary of known potential risks associated with KSI-301 is provided in [Table 1](#). Risks associated with COVID-19 are discussed below in [Section 2.3.2.1](#).

**Table 1: Protocol KS301P107: Risk Assessment**

Potential Risk of Clinical Significance	Summary of Data/Rationale for Risk	Mitigation Strategy
<b>Study Intervention [KSI-301]</b>		
Immunogenicity	<p>As with all therapeutic proteins, there is a potential for an immune response in participants treated with KSI-301. Clinical experience with commercially available intravitreal VEGF inhibitors has shown that SAEs related to inflammatory reactions can occur. Additional details are provided in IB Section 5.4.2.1.</p>	<p>Participants will be monitored following the injection and instructed to report any symptoms suggestive of an immune response without delay to facilitate early diagnosis and treatment (<a href="#">Section 8.1.4</a>).</p> <p>Participants with known hypersensitivity to intravitreal agents such as aflibercept or any ingredient of KSI-301 are excluded from this study (<a href="#">Section 5.2.2</a>).</p>
Arterial thromboembolic events (ATEs)	<p>ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause). There is a potential risk of ATEs following intravitreal use of VEGF inhibitors. Additional details are provided in IB Section 5.4.2.2.</p>	<p>Participants with recent history (6 months) of myocardial infarction, stroke, transient ischemic attack, acute congestive heart failure or any acute coronary event are excluded from this study (<a href="#">Section 5.2.2</a>).</p>
Intraocular inflammation	<p>Intraocular inflammation has been reported following treatment with intravitreal anti-VEGF medicines, including KSI-301. Additional details are provided in IB Section 5.4.2.3.</p>	<p>Participants will be monitored following the injection and instructed to report any symptoms suggestive of intraocular inflammation without delay to facilitate early diagnosis and treatment (<a href="#">Section 8.1.4</a>). Participants with active or suspected ocular infection or inflammation in either eye (e.g., blepharitis, infectious conjunctivitis, keratitis, scleritis, endophthalmitis) are excluded from this study (<a href="#">Section 5.2.1</a>). Participants with active intraocular inflammation will have study treatment interrupted (<a href="#">Section 7.1.1</a>).</p>
Hypersensitivity	<p>Hypersensitivity reactions may manifest as rash, pruritus, urticaria, severe anaphylactic/anaphylactoid reactions, or severe intraocular inflammation. Additional details are provided in IB Section 5.4.2.4.</p>	<p>Participants with known hypersensitivity to intravitreal agents such as aflibercept or any ingredient of KSI-301 are excluded from this study (<a href="#">Section 5.2.2</a>).</p>

**Table 1: Protocol KS301P107: Risk Assessment (Cont'd)**

Potential Risk of Clinical Significance	Summary of Data/Rationale for Risk	Mitigation Strategy
<b>Study Procedures</b>		
Risks associated with the method of administration	<p>These risks include endophthalmitis, increases in intraocular pressure, retinal detachment, retinal tear, traumatic cataract, and intraocular hemorrhage. Additional details are provided in IB Section 5.4.2.5.</p>	<p>Proper and aseptic injection technique when administering intravitreal injections will be used (<a href="#">Section 8.1.3</a>). Participants will be monitored following the injection and instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay to facilitate early diagnosis and treatment (<a href="#">Section 8.1.4</a>). Intraocular pressure and the perfusion of the optic nerve head will also be monitored and managed (<a href="#">Section 8.1.4</a>). Participants with active ocular infection or inflammation in either eye (e.g., blepharitis, infectious conjunctivitis, keratitis, scleritis, endophthalmitis) are excluded from this study (<a href="#">Section 5.2.1</a>).</p>
Exposure to SARS-CoV-2 virus	<a href="#">Section 2.3.2.1</a>	<a href="#">Section 2.3.2.1</a>

Abbreviations: ATEs = Arterial thromboembolic events; IB = Investigator's Brochure; SAE = serious adverse event; VEGF = vascular endothelial growth factor.

### 2.3.2.1 Risks Associated with Exposure to the Virus SARS-CoV-2

In consideration of the Coronavirus disease (COVID-19) pandemic caused by the virus SARS-CoV-2 and the impact it may have on clinical trials, COVID-19 related risks to participants are carefully considered and will be documented on an ongoing basis. Because wAMD is an acute onset, rapidly progressing disease, early diagnosis and treatment with intravitreal anti-VEGF therapy is associated with better functional outcomes, including prevention of irreversible vision loss ([Schmidt-Erfurth 2014](#)). Moreover, intravitreal anti-VEGF treatment is recognized as an essential health care service during the pandemic by ophthalmology physician societies worldwide. This trial affords all participants the opportunity to receive anti-VEGF therapy for their wAMD. Measures that prioritize trial participant safety and data integrity have been developed in consideration of local guidelines.

In order to minimize any added risk of exposure associated with trial participation beyond that associated with standard of care treatment, the Schedule of Activities (SoA) ([Section 1.3](#)) has been optimized to allow for an adequate follow-up and assessment of the safety and efficacy of KSI-301 without unnecessarily increasing participant exposure beyond that which may already exist from their attendance at clinic visits for anti-VEGF treatment of their wAMD.

As the pandemic situation develops, the Sponsor will reassess risks, which will be documented as part of the Sponsor's trial master file. In the event that escalation of the pandemic during this trial and local circumstances lead to a local change in risk assessment, additional measures may be implemented. In this case, an Investigator-driven risk assessment will be conducted and documented in the Investigator's site master file and communicated to the Sponsor.

### 2.3.3 Overall Benefit/Risk Conclusion

The potential benefits of treatment for wAMD with KSI-301 have been considered against both the risks associated with KSI-301 treatment and the COVID-19 pandemic. Participants in this study will be carefully monitored with special attention to known and potential risks and managed as appropriate. Exclusion criteria restrict enrollment of participants at higher risk, and routine monitoring and follow-up evaluations will be conducted for early detection of any AEs, as noted in [Section 8.3](#). Reassessment of the risks will continue as the COVID-19 situation develops and any changes to this approach will be documented accordingly.

Because wAMD is an acute onset, rapidly progressing disease, early diagnosis and treatment with intravitreal anti-VEGF therapy is associated with better functional outcomes, including prevention of irreversible vision loss ([Schmidt-Erfurth 2014](#)). Moreover, intravitreal anti-VEGF treatment is recognized as an essential health care service during the pandemic by physician groups worldwide. Therefore, based upon the well-known, clinically demonstrated mechanism of action ([Homayouni 2009](#)); favorable nonclinical and Phase 1a/1b safety, tolerability and bioactivity data; and a study design that includes extensive monitoring and COVID-19 risk mitigation, the Sponsor considers that the potential risks of study participation are outweighed by the value of the information to be gained and further study is warranted.

## 3.0 OBJECTIVES AND ENDPOINTS

Objectives	Endpoints
<b>Primary</b>	
To demonstrate that KSI-301 5 mg is non-inferior to aflibercept 2 mg, with respect to the change in best corrected visual acuity (BCVA) from Day 1 to the average of Weeks 40, 44, and 48.	<ul style="list-style-type: none"> <li>Mean change in BCVA from baseline (Day 1) to the average of Weeks 40, 44, and 48, in Early Treatment Diabetic Retinopathy Study (ETDRS) Letters.</li> </ul>
<b>Secondary</b>	
To evaluate the efficacy of KSI-301 5 mg compared to aflibercept 2 mg over the study duration by assessing visual parameters.	<ul style="list-style-type: none"> <li>Mean change in BCVA (ETDRS Letters) from baseline (Day 1) by visit over time.</li> <li>Proportion of participants who gain <math>\geq 5</math>, <math>\geq 10</math> and <math>\geq 15</math> letters from baseline (Day 1) by visit over time.</li> <li>Proportion of participants who lose <math>\geq 5</math>, <math>\geq 10</math> and <math>\geq 15</math> letters from baseline (Day 1) by visit over time.</li> <li>Proportion of participants with BCVA Snellen equivalent of 20/40 or better from baseline (Day 1) over time.</li> <li>Proportion of participants with BCVA Snellen equivalent of 20/200 or worse from baseline (Day 1) over time.</li> </ul>
To evaluate the efficacy of KSI-301 5 mg compared to aflibercept 2 mg over the study duration by assessing anatomical parameters.	<ul style="list-style-type: none"> <li>Mean change in optical coherence tomography (OCT) central subfield thickness (CST) and other morphological parameters from baseline (Day 1) to the average of Weeks 40, 44, and 48, and over time.</li> </ul>
To evaluate the safety and tolerability of KSI-301 5 mg compared to aflibercept 2 mg.	<ul style="list-style-type: none"> <li>Incidence of ocular and systemic adverse events up to Week 52.</li> </ul>
To assess the systemic pharmacokinetics (exposure) and immunogenicity of KSI-301.	<ul style="list-style-type: none"> <li>Systemic pharmacokinetic profile over time.</li> <li>Systemic anti-drug antibody status over time.</li> </ul>

## 4.0 STUDY DESIGN

### 4.1 Overall Design

This is a Phase 3, prospective, randomized, double-masked, two-arm, multi-center study evaluating the efficacy and safety of repeated intravitreal dosing of KSI-301 5 mg in participants with treatment-naïve wAMD.

The overall duration of the study is approximately 52 weeks after the last participant is randomized to the study. Participant duration is defined as the date a signed written informed consent is provided through the last safety follow-up visit at Week 52. Thus, participant duration is approximately 55 weeks and includes a screening period of up to 21 days (Days -21 to -1), a treatment period of approximately 44 weeks (Day 1 to Week 44), a 4-week follow-up period for safety and efficacy assessments at Week 48, and a final follow-up for safety assessments at Week 52 [REDACTED]

The primary endpoint is defined as the mean change in ETDRS BCVA from baseline (Day 1) to the average of Weeks 40, 44, and 48.

A single eye per participant will be designated as the Study Eye. If both eyes are eligible to become the Study Eye, the eye with worse BCVA at Screening will be selected as the Study Eye. If both eyes are eligible and have the same BCVA, the decision of which eye to select as the Study Eye will be made by the Investigator.

Participants will be randomly assigned (1:1) into one of two treatment groups:

- KSI-301 5 mg, or
- Aflibercept 2 mg.

Randomization will be stratified by [REDACTED]

[REDACTED] Additional details of the randomization methods are described in the statistical analysis plan (SAP).

#### 4.1.1 Screening Period

Participants will provide written informed consent to participate in the study before completing any protocol-specified procedures or evaluations not considered to be part of the participant's standard care. After providing informed consent, participants will be evaluated for eligibility criteria during the screening period within 21 days before administration of study intervention(s).

Participants who do not meet eligibility criteria within the 21-day screening period will not be eligible for randomization and will be considered as screen-failed. However, a participant may be re-screened up to one additional time at the discretion of the Investigator and in consultation with the Sponsor ([Section 5.4](#)). Instructions for participants who meet all eligibility criteria at the

Screening visit but do not meet the BCVA and/or SD-OCT CST eligibility criteria when they return for the planned Day 1 visit are provided in [Section 5.5](#).

When re-screening tests and procedures have been completed and results are available indicating the participant is eligible for study participation, the participant may be enrolled. When re-screening a participant, a new screening/enrollment number will be generated by the IRT system to ensure that there is an audit trail for the screen-failed participant.

#### 4.1.2 Treatment Period

Participants in this study will be treated until Week 44 and will have an additional efficacy and/or safety follow-up at Weeks 48 and 52, unless the Investigator decides to discontinue treatment, the Sponsor decides to terminate the study, or until any of the reasons for withdrawal/discontinuation provided in [Section 7.2](#) are met.

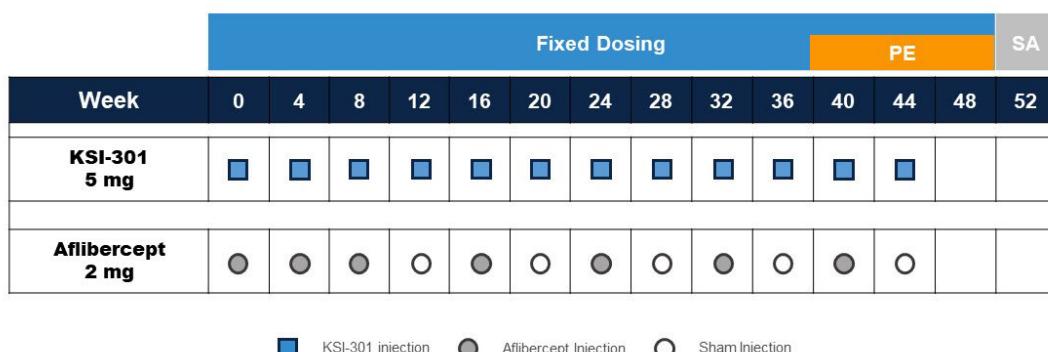
#### 4.1.3 Administration of Study Intervention

All participants will be treated starting on Day 1 through Week 36 according to their respective treatment group, as shown in [Figure 2](#).

Participants randomized to the KSI-301 treatment group will receive KSI-301 5 mg [REDACTED] once every four (4) weeks from Day 1 to Week 44.

Participants randomized to the aflibercept treatment group will initially receive three (3) monthly doses of aflibercept 2 mg (50  $\mu$ L) at Day 1, Week 4, and Week 8, followed by aflibercept 2 mg (50  $\mu$ L) once every 8 weeks (Q8W) until Week 44. Participants randomized to the aflibercept treatment group will receive a sham injection at each visit that aflibercept is not administered (i.e., at Weeks 12, 20, 28, and 36).

**Figure 2:** **Protocol KS301P107: Masked Dosing Regimens by Week**



Abbreviations: PE = primary endpoint; Q4W = once every four (4) weeks; Q8W = once every eight (8) weeks; SA = safety assessment.

## 4.2 Scientific Rationale for Study Design

This is a randomized, active comparator-controlled, double-masked, multi-center, Phase 3 study to evaluate the efficacy and safety of intravitreal KSI-301 compared with intravitreal aflibercept in participants with wAMD. A randomized, double-masked design minimizes bias and is well-established for demonstrating the safety and efficacy of an investigational treatment. The rationales for other key design features are provided below.

### 4.2.1 Choice of Population

KSI-301 is being evaluated as a first-line anti-VEGF medicinal product for the management of wAMD. Thus, participants must *not* have had prior use of an approved or investigational treatment (e.g., anti-VEGF) for wAMD in the Study Eye.

Enrollment of participants who are treatment-naïve for wAMD helps to minimize biases inherent in the inclusion of participants who have failed prior lines of therapy. Treatment-naïve participants with best corrected visual acuity (BCVA) of 83 to 25 letters will be enrolled because they are expected to be broadly representative of the general population of patients treated with first-line anti-VEGF with diagnosis of wAMD.

### 4.2.2 Choice of Active Comparator Control

An active comparator was selected for this trial because an effective treatment currently exists, rendering placebo (sham injection) control unethical.

The use of VEGF-inhibition therapy is a well-established treatment for wAMD ([Schmidt-Erfurth 2014](#)). Three highly potent anti-VEGF biologics are currently approved by both the United States (US) Food and Drug Administration (FDA) and the European Medicines Agency (EMA) for the treatment of wAMD: ranibizumab (Lucentis<sup>®</sup>), brolucizumab (Beovu<sup>®</sup>), and aflibercept (Eylea<sup>®</sup>). Aflibercept is chosen as the active comparator for this trial because the majority of patients with wAMD treated in routine clinical practice with an approved anti-VEGF receive aflibercept.

### 4.2.3 Choice of Primary Endpoint and Analysis

The primary endpoint, mean change in BCVA, was selected based on health authority feedback and precedent for Phase 3 studies in wAMD.

A non-inferiority primary analysis was selected because aflibercept results in significant clinical benefit for most patients, when administered according to the approved posology. KSI-301 efficacy outcomes are expected to be comparable (non-inferior) to aflibercept, but with the potential for improved outcomes in some patients. Consequently, the *a priori* assumption is that it is unlikely that KSI-301 (or any novel anti-VEGF) would demonstrate clinically meaningful superiority in vision outcomes to an approved anti-VEGF agent in a well-conducted, head-to-head trial, for the overall population.

A non-inferiority margin of [REDACTED] was selected based on health authority feedback. Five letters represent one line on the ETDRS visual acuity chart and is considered by many physicians to be a clinically meaningful change. Therefore, [REDACTED] as an upper threshold excludes the potential for clinically meaningful treatment effect differences between KSI-301 and aflibercept.

#### **4.2.4      Choice of Duration of Treatment and Follow-up**

The duration of treatment in this study will be the same for both groups (i.e., KSI-301 and aflibercept) (i.e., 44 weeks).

The primary endpoint will be assessed using ETDRS data collected up to Week 48. This time point and associated duration of treatment was selected on the basis of health authority feedback and precedent for other ongoing Phase 3 trials in wAMD.

The choice of a safety follow-up interval of 8 weeks after the last dose is based on the expected duration of effect for KSI-301 and aflibercept.

#### **4.3      Justification for Dose**

##### **4.3.1      KSI-301 Dose Rationale**

The durability and pharmacological effect of intravitreal anti-VEGF therapy is proportional to the concentration, potency, and half-life of the drug. A KSI-301 5 mg dose has approximately [REDACTED] times the equivalent molar dose of anti-VEGF binding capacity, at the time of injection, relative to 2 mg aflibercept. Preclinical modeling suggests that KSI-301 5 mg results in [REDACTED] fold the equivalent ocular concentration of aflibercept 2 mg three months after dosing.

Both KSI-301 2.5 mg and KSI-301 5 mg that are being evaluated in the ongoing Phase 1b portion of Study KSI-CL-101 have not resulted in any dose limiting ocular or systemic toxicities and, as expected, have no clear dose-efficacy response relationship. Because the 5 mg dose of KSI-301 may have incrementally improved pharmacological effects compared to the 2.5 mg dose, the 5 mg dose has been selected for this study.

The [REDACTED] injection volume used to deliver a 5 mg dose has been well-tolerated in previous KSI-301 studies (additional information can be found in the IB) as well as in other studies for of [REDACTED]

The overall development objective of KSI-301 in the treatment of wAMD is to reduce the number of required intravitreal injections, and with it the treatment burden for patients, clinicians, and health systems. However, establishing the safety and efficacy of an intensive treatment approach with KSI-301 is of importance for and of potential benefit to patients who experience a limited or insufficient response to extended interval treatment.

#### **4.3.2 Aflibercept Dose Rationale**

In the US, the recommended dose for aflibercept in wAMD is 2 mg (0.05 mL) administered by intravitreal injection every 4 weeks (approximately every 28 days, monthly) for the first 12 weeks (3 months), followed by 2 mg (0.05 mL) via intravitreal injection once every 8 weeks (2 months).

In the EU, the recommended dose for aflibercept is 2 mg per month for three consecutive doses. The treatment interval is then extended to two months. The treatment interval may then be maintained at two months or further extended using a treat-and-extend dosing regimen, where injection intervals are increased in 2- or 4-weekly increments to maintain stable visual and/or anatomic outcomes.

In the absence of a recommended posology that is consistent between regions, the Sponsor considers that a once every two-month (Q8W) interval after three initial loading doses provides the maximum possible treatment effect and best enables a head-to-head comparison with KSI-301 without undue risk.

#### **4.3.3 Sham Injection Rationale**

Sham injections are used to preserve study masking and minimize bias. Participants in the aflibercept treatment group will receive sham injections at each monthly visit when an active treatment is not administered.

### **4.4 End of Treatment**

Participants may withdraw from the study at any time and for any reason without prejudice to their future medical care by the Investigator or at the study site. Every effort should be made to keep participants in the study. The reasons for end-of-treatment/early termination are provided in [Section 7.0](#).

### **4.5 End of Study Definition**

The end of the study is defined as the last follow-up visit of the last participant enrolled (i.e., the last enrolled participant's final visit) or a Sponsor decision to terminate the study, whichever comes first.

A participant is considered to have completed the study if he/she has completed all phases of the study, including the Week 52 safety follow-up assessment.

### **4.6 Treatment After End of Study**

All participants will return to standard of care treatment, at the discretion of their Treating Physician, after completion of their final follow-up visit or once they discontinue from the study prematurely. The Sponsor will not provide continued access to study treatment following the end of the study or the end of each participant's study treatment period.

## 5.0 STUDY POPULATION

Participants will be randomized to a specified treatment group only if they meet all the inclusion criteria and none of the exclusion criteria.

Deviations from the inclusion and exclusion criteria are not allowed because they can potentially jeopardize the scientific integrity of the study, regulatory acceptability, or participant safety. Therefore, adherence to the criteria as specified in the protocol is essential. Prospective approval of protocol deviations to recruitment and enrollment criteria, also known as protocol waivers or exemptions, are not permitted.

Inclusion/exclusion criteria ([Sections 5.1](#) and [5.2](#)) will be assessed at Screening and on Day 1 to determine a participant's eligibility for the study. Instructions for participants who meet all eligibility criteria at the Screening visit but do not meet the BCVA and/or SD-OCT CST eligibility criteria when they return for the planned Day 1 visit are provided in [Section 5.5](#).

### 5.1 Inclusion Criteria

Participants are eligible to be included in the study only if all the criteria in [Sections 5.1.1](#) and [5.1.2](#) apply.

#### 5.1.1 Ocular Inclusion Criteria

Where applicable inclusion criteria will be confirmed or assessed by the independent, masked image Reading Center.

1. Active, treatment-naïve choroidal neovascularization (CNV) secondary to AMD, including subfoveal, juxtafoveal, and extrafoveal lesions, or retinal angiomatic proliferations (RAP) lesions with a CNV component that affects the central subfield, as evidenced by FA or OCT in the Study Eye at Screening.
2. The CNV area in the Study Eye must be at least 50% of total lesion size at Screening.
3. The lesion area in the Study Eye must be  $<30\text{ mm}^2$  (12-disc areas) and can include any CNV lesion subtype.
4. Intra- and/or subretinal fluid and/or subretinal hyperreflective material (SHRM) affecting the central subfield of the Study Eye on OCT at Screening.
5. BCVA ETDRS score between 83 and 25 letters, inclusive, in the Study Eye at screening and reconfirmed at Day 1.
6. Decrease in vision in the Study Eye determined by the Investigator to be primarily the result of wAMD.

In cases where both eyes are eligible, the eye with the worse BCVA at the Screening Visit will be selected as the Study Eye. If both eyes are eligible and have the same BCVA, the decision of which eye to select as the Study Eye will be made by the Investigator. Only one eye per participant can participate in the study.

### 5.1.2 General Inclusion Criteria

7. Capable of giving signed informed consent as described in [Appendix 1](#), which includes compliance with the protocols and restrictions listed in the informed consent form (ICF) and in this protocol.
8. Male or female  $\geq 50$  years of age.
9. For women of childbearing potential: agreement to remain as abstinent (refrain from heterosexual intercourse) or use contraceptive methods that result in a failure rate of  $<1\%$  per year during the treatment period [REDACTED]. Women of childbearing potential must have a negative urine pregnancy test result within 28 days prior to Day 1. If the urine pregnancy test is positive, it must be confirmed with a serum pregnancy test.
  - a. A woman is considered of childbearing potential if she is postmenarcheal, has not reached a postmenopausal state ( $\geq 12$  months of amenorrhea with no identified cause other than menopause), and has not undergone surgical sterilization (removal of ovaries and/or uterus). The definition of childbearing potential may be adapted for alignment with local guidelines or requirements.
  - b. Examples of contraceptive methods with a failure rate of  $<1\%$  per year include bilateral tubal ligation, male sterilization, established, proper use of hormonal contraceptives that inhibit ovulation, hormone-releasing intrauterine devices and copper intrauterine devices.
  - c. Contraception methods that do not result in a failure rate of  $<1\%$  per year such as cap, diaphragm, or sponge with spermicide, or male or female condom with or without spermicide, are not acceptable.
  - d. The reliability of sexual abstinence should be evaluated in relation to the duration of the clinical trial and the preferred and usual lifestyle of the participant. Periodic abstinence (e.g., calendar, ovulation, symptothermal, or postovulation methods) and withdrawal are not acceptable methods of contraception.
10. For men: agreement to remain abstinent or use contraceptive measures and agreement to refrain from donating sperm, as defined below:
  - a. With female partners of childbearing potential, men must remain abstinent or use a condom plus an additional contraceptive method that together result in a failure rate of  $<1\%$  per year during the treatment period [REDACTED] [REDACTED] after the last dose of study drug. Men must refrain from donating sperm during this same time period.
11. Ability and willingness to undertake all the scheduled visits and assessments.

## 5.2 Exclusion Criteria

Participants are excluded from the study if any of the criteria in [Sections 5.2.1](#) and [5.2.2](#) apply.

### 5.2.1 Ocular Exclusion Criteria

Where applicable exclusion criteria will be confirmed or assessed by the independent, masked image Reading Center.

1. BCVA of hand motion or worse in the non-Study Eye or non-physical presence of a non-Study Eye (i.e., monocular).
2. Active or suspected ocular or periocular infection or inflammation in either eye at Screening or on Day 1.
3. CNV secondary to other causes in the Study Eye, including pathologic myopia, angiod streaks, prior trauma, ocular histoplasmosis, or others.
4. Any history of macular pathology unrelated to AMD but affecting vision or contributing to subretinal or intraretinal fluid, such as central serous chorioretinopathy.
5. Fibrosis or atrophy of >50% of the lesion size and/or involving the foveal center of the Study Eye at Screening.
6. Subretinal blood affecting the foveal center of the Study Eye and/or more than 50% of the lesion size at Screening.
7. Retinal pigment epithelium tear or rip in the Study Eye at Screening or on Day 1.
8. Any approved or investigational treatment for neovascular AMD (other than oral vitamin supplements) in the Study Eye at any time.
9. Prior macular laser (e.g., thermal laser or photodynamic therapy laser) in the Study Eye.
10. Any history or evidence of a concurrent ocular condition present in the Study Eye, that in the opinion of the Investigator could require either medical or surgical intervention or affect macular edema or alter visual acuity during the study (e.g., vitreomacular traction, epiretinal membrane).
11. History of cataract surgery and/or minimally invasive glaucoma surgery (MIGS) in the Study Eye within 2 months of screening.
12. History of Yttrium-Aluminum Garnet (YAG) laser capsulotomy in the Study Eye within 2 months of screening.
13. Uncontrolled glaucoma (defined as intraocular pressure  $\geq$  25 mmHg despite treatment with antiglaucoma medication) in the Study Eye.
14. History of glaucoma-filtering surgery (trabeculectomy or tube shunt) in the Study Eye.
15. History of retinal detachment or treatment or surgery for retinal detachment in the Study Eye.
16. History of uveitis in either eye.
17. Significant media opacities, including cataract, in the Study Eye that might interfere with visual acuity, assessment of safety, OCT or fundus photography.

18. Cataract in the Study Eye that in the judgment of the Investigator is expected to require surgical extraction within 12 months of screening.
19. Aphakia in the Study Eye.
20. Prior vitrectomy in the Study Eye.
21. Prior intraocular or periocular steroids in the Study Eye.
22. Current vitreous hemorrhage or history of vitreous hemorrhage in the Study Eye within 3 months of Screening.
23. History of corneal transplant in the Study Eye.

### **5.2.2 General Exclusion Criteria**

24. Women who are pregnant or lactating or intending to become pregnant during the study
25. Recent history (within the 6 months prior to screening) of myocardial infarction, stroke, transient ischemic attack, acute congestive heart failure or any acute coronary event.
26. History of a medical condition that, in the judgment of the Investigator, would preclude scheduled study visits, completion of the study, or a safe administration of investigational product.
27. History of hypersensitivity to any component of KSI-301, aflibercept, ophthalmic dye (fluorescein), dilating drops, or any of the anesthetic or antimicrobial preparations used during the study, as assessed by the Investigator.
28. Participation in an investigational study within 30 days prior to the screening visit that involved treatment with any investigational drug (excluding vitamins and minerals) or device, except for non-therapeutic ophthalmic imaging devices.
29. Active cancer within the 12 months prior to Screening except for appropriately treated carcinoma in situ of the cervix, non-melanoma skin cancer, and prostate cancer with a Gleason score of <6 and stable prostate-specific antigen for >12 months.
30. Treatment with systemic anti-VEGF therapeutics within 90 days prior to Screening.
31. Uncontrolled blood pressure defined as a systolic value  $\geq 180$  mmHg or diastolic value  $\geq 100$  mmHg while at rest at Screening or on Day 1.
  - If a participant's initial blood pressure measurement exceeds these values, up to two additional readings may be taken later the same day or on a different day during the screening period. If a participant's blood pressure is controlled by antihypertensive medications, the participant must be on a stable medication regimen continuously for 21 days prior to Day 1.

### **5.3 Lifestyle Considerations**

No specific lifestyle restrictions are required.

## 5.4 Screen Failures

Screen failures are defined as participants who consent to participate in the clinical study but are not subsequently randomly assigned to study intervention. A minimal set of screen failure information is required to ensure transparent reporting of screen failure participants to meet the Consolidated Standards of Reporting Trials (CONSORT) publishing requirements and to respond to queries from regulatory authorities. Minimal information includes demography, screen failure details, eligibility criteria, and any serious adverse events (SAE) caused by a protocol-mandated intervention that occur during the screening period.

Participants who do not meet eligibility criteria within the 21-day screening period will not be eligible for randomization and will be considered ‘screen-failed’. However, a participant may be re-screened up to one additional time at the discretion of the Investigator and in consultation with the Sponsor. When re-screening, the participant must be re-consented if more than 30 days have elapsed since the date of the last informed consent. In the event of re-screening, screening procedures need not be repeated if they fall within the 21-day screening window. If the re-screening occurs outside the 21-day window, all assessments performed at the initial screening visit should be repeated during the re-screening visit except fluorescein angiogram (FA). If the re-screening visit is more than 8 weeks after the original screening visit, FA should be repeated. For a re-screening visit occurring fewer than 8 weeks after the original screening visit, although a new FA will not be required, the previously acquired FA will need to be re-submitted to the Reading Center labeled with the new participant number, along with the new screening images from the other modalities. This will ensure that all images from the participant are properly labeled, kept within the same directory and that eligible transmission numbers and audit trails are maintained.

When re-screening tests and procedures have been completed and results are available indicating the participant is eligible for study participation, the participant may be enrolled. When re-screening a participant, a new screening/enrollment number will be generated by IRT system to ensure there is an audit trail for the screen-failed participant.

## 5.5 Criteria for Temporarily Delaying Enrollment

Inclusion/Exclusion criteria will be assessed at Screening and on Day 1 to determine a participant’s eligibility for the study.

If a participant meets all eligibility criteria ([Sections 5.1](#) and [5.2](#)) at the Screening visit but does not meet the BCVA eligibility criterion due to expected variability and fluctuation in the BCVA value when they return for the planned Day 1 visit, the Sponsor will allow the participant to return one additional time to reassess the BCVA, provided the assessment still occurs within the 21-day screening window. This repeat measurement for Day 1 visit (Repeat Day 1) is not considered a rescreen. Women of childbearing potential who return for a Repeat Day 1 Visit must have a negative pregnancy test during the Repeat Day 1 Visit (i.e., the pregnancy test must

be performed and documented as negative on the same day as randomization/first injection). Day 1 and Repeat Day 1 Visit data shall be used in the eCRF and IRT as follows:

- eCRF: In the event that a participant has a Repeat Day 1 Visit, data from assessments conducted at the planned randomization (Day 1) visit shall be clearly documented in the participant's source data. If the participant meets the eligibility criteria at the Repeat Day 1 visit, all data for assessments performed at that visit are entered into the eCRF under Day 1 and the original non-qualifying data will be entered as Unscheduled Visit assessments.
- IRT: In the event that a participant has a Repeat Day 1 Visit and is eligible for this study, the BCVA and SD-OCT values from the Repeat Day 1 visit must be used for participant randomization into the IRT system. If the participant *does not* meet eligibility at the Repeat Day 1 visit, the participant must be recorded as a screen failure ([Section 5.4](#)) in the IRT system at that time.

## 6.0 STUDY INTERVENTION(S) AND CONCOMITANT THERAPY

Study intervention is defined as any investigational intervention(s), marketed product(s), placebo, or medical device(s) intended to be administered to a study participant according to the study protocol.

### 6.1 Study Intervention(s) Administered

Study interventions are summarized in [Table 2](#). For full information regarding the administration of study intervention and the contents of the kit, refer to the Pharmacy Manual. For additional information regarding the administration of aflibercept, refer to the approved prescribing information for aflibercept in your country, such as the Summary of Product Characteristics (SmPC) or U.S. Prescribing Information (USPI). The full instructions for administration of sham are described in the Pharmacy Manual.

**Table 2: Protocol KS301P107: Study Interventions**

Group Name	A	B	A or B
<b>Intervention Name</b>	KSI-301 5 mg	Aflibercept 2 mg	Sham
<b>Type</b>	Biological medicinal product	Biological medicinal product	Sham
<b>Dose Formulation</b>	Sterile liquid for intravitreal injection in single-use vials	Sterile liquid for intravitreal injection in single-use vials or prefilled syringes	Empty vial
<b>Unit Dose Strength(s)</b>	█ mg/mL (based on antibody mass)	40 mg/mL	N/A
<b>Dosage Level(s)</b>	5 mg █	2 mg (50 µL)	N/A
<b>Route of Administration</b>	Intravitreal injection	Intravitreal injection	Sham injection
<b>Use</b>	Experimental	Active control	Sham (to maintain study masking)
<b>IMP and NIMP</b>	IMP	IMP	NIMP
<b>Sourcing</b>	Provided centrally by the Sponsor	Provided centrally by the Sponsor	Provided centrally by the Sponsor
<b>Storage</b>	In the original packaging, as provided, until the time of use. Store at 2-8°C before use.	In the original packaging, as provided, until the time of use. Store at 2-8°C before use.	In the original packaging, as provided, until the time of use. Store at 2-8°C before use.
<b>Packaging and Labeling</b>	KSI-301 will be provided in vials that will be labeled as required per country requirement.	Aflibercept will be provided in vials or prefilled syringes that will be labeled as required per country requirement.	Sham will be provided in vials that will be labeled as required per country requirement.
<b>Reconstitution and Handling</b>	KSI-301 is an aqueous solution that is provided in vials and filled into syringes by unmasked site personnel without reconstitution or dilution.	Aflibercept is an aqueous solution that is provided in vials and filled into syringes by unmasked site personnel without reconstitution or dilution or provided in prefilled syringes.	Sham is provided as empty glass vials, which will remain empty throughout the sham treatment procedure. A sham injection mimics an intravitreal injection. It involves pressing the blunt end of an empty syringe, without a needle, against an anesthetized eye.
<b>Current/Former Name(s) or Alias(es)</b>	N/A	Eylea	N/A

## 6.2 Preparation/Handling/Storage/Accountability

### 6.2.1 Preparation, Handling, and Storage

Study interventions (KSI-301 and aflibercept) are aqueous solutions provided in vials (or prefilled syringes for aflibercept) and filled into syringes by unmasked site personnel without reconstitution or dilution.

Study drug kits must be stored in a secure refrigerator at a controlled temperature of 2°C to 8°C. All study drug vials or prefilled syringes (for aflibercept) should be stored in the original packaging, as provided, until the time of use.

Please refer to Pharmacy Manual for additional instructions.

## **6.2.2 Study Intervention Accountability and Reconciliation**

Study intervention packaging will be overseen by the Sponsor or their designee and bear a label with the identification required by local law, the protocol number, drug identification, and dosage. The packaging and labeling of the study medication will be in accordance with local regulations.

The investigational site will acknowledge receipt of the study intervention, to confirm the shipment condition and content. Any damaged shipments will be replaced. Upon arrival of the study intervention at the site, site personnel will complete the following:

- Check the shipment for damage.
- Verify proper identity, quantity, integrity of seals and temperature conditions.
- Report any deviations or product complaints to the Sponsor or their designee upon discovery. Any study intervention under investigation for integrity or temperature excursion should be quarantined in the IRT, and not used until the final assessment by the Sponsor or its designee.

The Investigator or designee must confirm appropriate temperature conditions have been maintained during transit for all study treatment received and any discrepancies are reported and resolved before use of the study treatment.

Only participants enrolled in the study may receive study intervention and only authorized site staff may supply or administer study intervention. All study intervention must be stored in a secure, environmentally controlled, and monitored (manual or automated) area in accordance with the labeled storage conditions with access limited to the Investigator and authorized site staff.

The Investigator, institution, or the head of the medical institution (where applicable) is responsible for study intervention accountability, reconciliation, and record maintenance (i.e., receipt, reconciliation, and final disposition records).

Further guidance and information for the final disposition of unused study interventions are provided in the Pharmacy Manual.

The pharmacist responsible for dispensing study treatment, or the designated site personnel, will select the correct study intervention as assigned through the IRT. Instructions for the preparation of KSI-301, aflibercept, or sham for administration, mandatory materials to be used, and pretreatment and post-treatment procedures are detailed in the Pharmacy Manual.

For more detailed information on the formulation, preparation, and handling of KSI-301, aflibercept, and sham, see the Pharmacy Manual.

### 6.3 Measures to Minimize Bias: Randomization and Masking

#### 6.3.1 Randomization

All participants will be centrally assigned to a randomized study intervention using an IRT system. Before the study is initiated, login information and directions for the IRT will be provided to each site.

Study intervention will be dispensed at the study visits as summarized in the SoA ([Section 1.3](#)).

#### 6.3.2 Masking and Unmasking

This is a double-masked study. There must be a minimum of two investigators per site to fulfill the masking requirements of this study, as follows:

- **Masked Evaluating Physician(s):** At least one Investigator will be designated as the evaluating physician who will be *masked* to participants' treatment assignments and will evaluate all ocular assessments (other than the immediate post-injection assessments done by unmasked personnel, as described below).
- **Unmasked Treating Physician(s):** At least one other Investigator will be designated as the treating (injecting) physician who will be *unmasked* to participants' treatment assignments and will administer study intervention (KSI-301, aflibercept, or sham). This physician or an unmasked assistant will also conduct the immediate post-injection assessments, including tonometry, in the Study Eye ([Section 8.1.4](#)). The unmasked treating physician and unmasked staff must not divulge treatment assignment to anyone.

As shown in [Section 6.1](#), there are three study interventions: (1) KSI-301 (the investigational medicinal product); (2) aflibercept (the active comparator); and (3) sham (for which an injection procedure is simulated but not actually performed). All three study interventions are provided in unmasked vials or prefilled syringes within masked cartons (also referred to as kits), as follows:

- **Masked Cartons:** All study interventions are provided in cartons that are identical in appearance and weight, making them indistinguishable from each other.  
Each carton is labeled with an identical carton label that includes a unique kit number. The IRT system will direct site personnel which specific carton to pull from inventory and use for a specific participant at a given visit based on the unique kit number printed on the carton label and that participant's treatment at that given visit.

- **Unmasked Vials or Prefilled Syringes Within the Masked Cartons:** Owing to differences among vials, syringes, dose-preparation procedures, and treatment procedures that cannot be masked, the treating (injecting) physician is unmasked to study treatment as are any assistants to the treating (injecting) physician. Only unmasked site staff are allowed to open the masked cartons.

Participants, study site personnel (except for the treating physician(s), assistant(s), and pharmacist if any), the designated evaluating physician(s), central Reading Center personnel, and the Sponsor and its agents will be masked to treatment assignment.

The visual acuity (VA) examiner (performing the refraction, BCVA examination) will be masked to the participant treatment assignment. The BCVA examiner will have no access to the VA scores of a participant's previous visits and may have access only to a participant's refraction data from previous visits.

A participant's treatment assignment will not be unmasked until the end of the study or unless medical treatment of the participant depends on knowing the study treatment the participant received. Emergency code break is available to the Investigator online in the IRT. If unmasking is necessary for participant management (for example, in the case of a serious adverse event for which participant management might be affected by knowledge of the treatment assignment), the Investigator will be able to break the treatment code by accessing the IRT system. Treatment codes must not be broken except in emergency situations. If the Investigator wishes to know a participant's treatment assignment for any other, non-emergency reasons, he or she should consult with the Medical Monitor. The Investigator should document and provide an explanation for any non-emergency unmasking (for example, accidental unmasking).

For regulatory reporting purposes and if required by local health authorities, the Sponsor or its agents (e.g., contract research organization (CRO) pharmacovigilance personnel) will break the treatment code for all serious, unexpected suspected adverse reactions (SUSARs) that are considered by the Investigator or Sponsor to be related to study intervention. The participant may continue to receive treatment, and the Investigator, participant, and Sponsor or CRO personnel, except for the pharmacovigilance personnel who must have access to participant treatment assignments to fulfill their roles, will remain masked to treatment assignments.

Additional information regarding masking and unmasking will be outlined in the Masking Manual.

#### 6.4 Study Intervention Compliance

Only participants enrolled in the study may receive study treatment and only ophthalmologists who have experience administering intravitreal injections may administer study treatment.

The unmasked Investigator is responsible for administering the correct dose of KSI-301 or aflibercept and for the sham administration, according to the study protocol. The date and time of

each dose administered in the clinic will be recorded in the source documents and electronic case report form (eCRF). To avoid medication dispensing errors, the study intervention, study participant and Study Eye identification will be confirmed at the time of dosing by a member of the unmasked study site team.

## 6.5 Dose Modification

Participants can only receive the specified dose for the intervention group, as follows:

- A. KSI-301: 5 mg [REDACTED]
- B. Aflibercept: 2 mg (50  $\mu$ L).

Alterations of the dosage are not allowed.

## 6.6 Continued Access to Study Intervention after the End of the Study

After participants complete their final follow-up visit or discontinue from the study prematurely, they will return to standard of care treatment at the discretion of their Treating Physician. The Sponsor will not provide continued access to study treatment following the end of the study or the end of each participant's study treatment period.

## 6.7 Treatment of Overdose

For this study, any dose of KSI-301 greater than 5 mg or aflibercept greater than 2 mg at a single study visit will be considered an overdose.

The Sponsor does not recommend any specific treatment for an overdose.

In the event of an accidental overdose, the Investigator/treating physician should:

- Contact the Medical Monitor immediately.
- Evaluate the participant to determine, in consultation with the Medical Monitor, whether additional steps should be taken.
- Closely monitor the participant for any AE/SAE.
- Document the quantity of the excess dose.

In addition to overdosing, an increased injection volume may cause an increase in intraocular pressure. In case of overdose, intraocular pressure should be monitored and if deemed necessary by the Treating Physician, adequate treatment should be initiated, including performing pressure lowering procedures (i.e., anterior chamber paracentesis).

## 6.8 Concomitant Therapy

Use of all concomitant medications will be recorded in the participant's eCRF, except for medications required for carrying out procedures in the SoA ([Section 1.3](#)) (e.g., dilating drops,

anesthetics, antiseptic, fluorescein, etc.) related to this study. Concomitant medications will include all prescription drugs, herbal products, vitamins, minerals, and over the counter (OTC) medications as used by the participant within 30 days prior to Day 1 through Week 52. Any changes in concomitant medications also will be recorded in the participant's eCRF.

Any concomitant medication deemed necessary for the welfare of the participant during the study may be given at the discretion of the Investigator. However, it is the responsibility of the Investigator to ensure that all relevant details regarding the medication are recorded in the eCRF. Participants who use oral contraceptives, hormone-replacement therapy, or other maintenance therapy should continue their use.

In case the fellow eye (non-Study Eye) requires anti-VEGF treatment during the conduct of the study, the participant may be treated at the discretion of the Investigator and according to the standard of care in the respective country. The treatment of the fellow eye (non-Study Eye) may be implemented at any time once the Day 1 injection has been administered. Anti-VEGF treatment for the fellow eye, including the date of each administration, must be documented as a concomitant medication on the appropriate eCRF. If the fellow eye requires treatment during the same visit as the Study Eye, the Study Eye should be treated first, and the fellow eye should be treated by the unmasked physician to preserve masking.

The Medical Monitor should be contacted if there are any questions regarding concomitant or prior therapy.

### **6.8.1 Prohibited Therapy**

At the discretion of the Investigator, participants may start or continue to receive all medications and standard treatments administered for other conditions, **except for the following:**

- Investigational therapies in the non-Study Eye,
- Intravitreal anti-VEGF drugs in the Study Eye other than study-assigned afibercept or KSI-301 until all assessments are completed at Week 48,
- Systemic anti-VEGF therapy,
- Concurrent use of intravitreal or periocular steroids or steroid implants in the Study Eye,
- Concurrent use of macular photocoagulation or photodynamic therapy with verteporfin in the Study Eye, and
- Investigational treatment with any drug (other than vitamins and minerals) or device.

Participants whose medical care requires use of a prohibited therapy must have study treatment interrupted or be discontinued from the study in order to receive that therapy. After discussion with the Sponsor, participants whose study treatment has been interrupted but no longer need a prohibited therapy may resume study treatment.

### 6.8.2      **Supportive Care for Adverse Events**

Supportive care for the known potential risks associated with anti-VEGF treatment and KSI-301 (summarized in [Table 1](#)) should be as per the standard of care in the respective country. No specific prophylactic therapies are recommended.

**7.0 DISCONTINUATION OF STUDY INTERVENTION AND PARTICIPANT DISCONTINUATION/WITHDRAWAL****7.1 Discontinuation of Study Intervention**

Participants may withdraw from the study at any time and for any reason without prejudice to their future medical care by the Investigator or at the study site. Every effort should be made to keep participants in the study.

If study intervention is discontinued, an end-of-treatment visit should occur 28 +/- 7 days after study treatment is discontinued or before a new treatment regimen begins. Participants who discontinue study drug should NOT be considered withdrawn from the study. Unless they withdraw consent or there is additional risk to the participant, participants who have discontinued study treatment should be encouraged to stay in the study and undergo as many scheduled visits as possible, with emphasis on the Weeks 40, 44, and 48 (primary endpoint) visits.

The reasons for study treatment discontinuation and/or withdrawal from the study (study discontinuation) will be recorded on the appropriate eCRF.

A participant may be withdrawn from the study for any of the following reasons:

1. The participant is noncompliant with the protocol.
2. The participant has a serious or intolerable adverse event(s) (AE[s]) that in the Investigator's opinion requires withdrawal from the study.
3. The participant has symptoms or an intercurrent illness not consistent with the protocol requirements or that justify withdrawal.
4. The participant is lost to follow-up.
5. Any medical condition that the Investigator or Sponsor determines may jeopardize the participants' safety if they remain in the study.
6. The participant withdraws consent, or the Investigator or Sponsor decides to discontinue the participant's participation in the study.
7. Pregnancy.

The Investigator will also withdraw a participant if the Sponsor terminates the study. Upon occurrence of a serious or intolerable AE, the Investigator will confer with the Sponsor. If a participant is discontinued because of an AE, the event will be followed until it is resolved, or no additional improvement is expected by the Investigator (based on a follow-up period of not less than 3 months). Any participant may withdraw his or her consent at any time.

**7.1.1 Treatment Interruption and/or Discontinuation due to Adverse Events or Concomitant Procedures**

Study treatment interruption and/or participant discontinuation from the study treatment due to certain adverse events or concomitant procedures in the Study Eye will be determined using the

criteria provided in [Table 3](#). If any of these are met, treatment will be interrupted (or discontinued if applicable) and notification will be sent to the Medical Monitor. Treatment may be resumed after resolution of the adverse event and upon agreement with both the Investigator and Medical Monitor. The reason for study treatment interruption or discontinuation should be recorded on the appropriate eCRF and, if applicable, on the adverse event eCRF.

**Table 3: Protocol KS301P107: Treatment Interruption Criteria**

Event (MedDRA Preferred Term)	Study Treatment Interruption Criteria
Vision loss	Interrupt study treatment for <i>treatment-related</i> decrease of $\geq 30$ letters in BCVA in the Study Eye compared with the most recent prior visit.
Intraocular inflammation	Interrupt study treatment if any active intraocular inflammation is present in the Study Eye.
Intraocular surgery	<p>Interrupt study treatment for intraocular surgery in the Study Eye, for example cataract surgery.</p> <p>Treatment may resume no earlier than 10 days after uncomplicated cataract surgery, provided there is no evidence of postoperative intraocular inflammation. For complicated cataract surgery or following other intraocular surgery, study treatment may be resumed as determined by the Investigator following discussion with the Medical Monitor.</p>
Elevated intraocular pressure	Interrupt study treatment if the pre-injection IOP is $>30$ mmHg in the Study Eye.
Retinal tear or break	<p>Interrupt study treatment if a retinal tear or break is present in the Study Eye.</p> <p>Treatment may be resumed no earlier than 10 days after successful laser retinopexy, as determined by the Investigator.</p>
Retinal detachment or macular hole	<p>Interrupt study treatment if rhegmatogenous retinal detachment or Stage 3 or Stage 4 macular hole occurs in the Study Eye.</p> <p>Treatment may be resumed no earlier than 14 days after successful treatment, as determined by the Investigator, following discussion with the Medical Monitor.</p>
Active infection	<p>Interrupt study treatment if infectious cellulitis, conjunctivitis, keratitis, scleritis, or endophthalmitis occurs in or around either eye.</p> <p>Infections should be treated as per the local standard of care.</p>

## 7.2 Participant Discontinuation/Withdrawal from the Study

Participants should be strongly encouraged to stay in the study and undergo as many scheduled visits as possible, with emphasis on the Weeks 40, 44, and 48 visits. However, participants are free to withdraw from the study or study treatment at any time upon request. Participant

participation in the study may be stopped at any time at the discretion of the Investigator or at the request of the Sponsor.

Participants who discontinue study treatment or active participation in the study will no longer receive study intervention. When a participant discontinues from study treatment or active participation in the study, the reason(s) for study treatment discontinuation or withdrawal shall be recorded by the Investigator or designee on the relevant page of the eCRF. Whenever possible, all participants who discontinue study treatment or withdraw from the study prematurely will undergo an Early Termination visit. Participants who fail to return for final assessments must be contacted by the site by phone and in writing to obtain follow-up.

If a participant exits early from the study between visits, the Investigator or designee must attempt to contact the participant and advise the participant to return for a final visit to complete the exit procedures. If the participant is unable or unwilling to return for the Early Termination visit, the ‘date of exit’ will be the date that the participant was last seen at the site or contacted by other communication.

If the participant withdraws consent for disclosure of future information, the Sponsor may retain and continue to use any data collected before such a withdrawal of consent.

If a participant withdraws from the study, he/she may request destruction of any samples taken and not tested, and the Investigator must document this in the site study records.

### 7.3 Lost to Follow-up

A participant will be considered lost to follow-up if he or she repeatedly fails to return for scheduled visits and is unable to be contacted by the study site.

The following actions must be taken if a participant fails to return to the clinic for a required study visit:

- The site must attempt to contact the participant and reschedule the missed visit as soon as possible and counsel the participant on the importance of maintaining the assigned visit schedule and ascertain whether the participant wishes to and/or should continue in the study.
- Before a participant is deemed lost to follow-up, the Investigator or designee must make every effort to regain contact with the participant (where possible, three telephone calls and, if necessary, a certified letter to the participant’s last known mailing address or local equivalent methods) and discuss the situation with the Sponsor. These contact attempts should be documented in the participant’s medical record.
- Should the participant continue to be unreachable, he/she will be considered to have withdrawn from the study.

Discontinuation of specific sites or of the study as a whole are handled as part of [Appendix 1](#).

## 8.0 STUDY ASSESSMENTS AND PROCEDURES

- Before undertaking any study procedures, all potential participants will sign an ICF. Participants will have the opportunity to have any questions answered before signing the ICF. The Investigator or designee must address all questions raised by the participant. The Investigator or designee will also sign the ICF.
- Study procedures and their timing are summarized in the SoA ([Section 1.3](#)). Assessments performed in the event of an unscheduled safety visit ([Appendix 5](#)) are at the discretion of the Investigator. Adherence to the study design requirements, including those specified in the SoA, is essential and required for study conduct. All screening evaluations must be completed and reviewed to confirm that potential participants meet all eligibility criteria. The Investigator will maintain a screening log to record details of all participants screened and to confirm eligibility or record reasons for screening failure, as applicable.
- Protocol waivers or exemptions are not allowed.
- Immediate safety concerns should be discussed with the Sponsor immediately upon occurrence or awareness to determine if the participant should continue or discontinue study intervention.

### 8.1 Efficacy Assessments

Planned time points for all efficacy assessments are provided in the SoA ([Section 1.3](#)).

#### 8.1.1 Medical History and Demographic Data

Medical history (general and ophthalmic) includes clinically significant diseases, surgeries and reproductive status. All medications (e.g., prescription drugs, OTC drugs, herbal or homeopathic remedies, nutritional supplements) used by the participant regularly or within 30 days preceding Day 1 will be recorded. A full ocular history including prior ocular treatments will be noted. Demographic data will include age, sex, ethnic origin (also referred to as self-reported race and ethnicity in some regions of the world), and smoking status.

#### 8.1.2 Ophthalmic Exams

Unless otherwise noted, ophthalmic assessments are captured for the Study Eye only.

Slit-lamp examination will include the following:

- Inspection of the eyelids,
- Inspection of the cornea,
- Examination of the anterior chamber,
- Examination of the pupil,
- Examination of the iris,
- Inspection of the lens,

- Inspection of the vitreous body, and
- Inspection of the retina and optic disc.

Dilated indirect ophthalmoscopy will include examination of the peripheral retina.

Tonometry shall be conducted as part of the ophthalmic exam. The method of IOP measurement (such as Goldmann tonometry or Tonopen) must remain the same throughout the study for each participant. Pre-injection tonometry should be performed prior to pupil dilation.

Participants will be instructed to report any signs or symptoms of intraocular inflammation (uveitis) or endophthalmitis such as pain, photophobia, redness, or reduced vision.

### **8.1.3 Injection Procedure**

The unmasked injecting Investigator must be qualified and trained in administering intravitreal injections and follow standard injection procedures in adherence to specific institutional or local policies associated with intravitreal injections. Aseptic technique must be observed by clinic staff involved in the assembly of the injection tray, study intervention preparation, anesthetic preparation, and study treatment administration. To minimize the risk of infection, the periocular skin, eyelid and conjunctiva of the Study Eye must be disinfected, as outlined in the Syringe Preparation and Injection Procedure Guidelines found in the Pharmacy Manual.

The unmasked injecting Investigator will choose one of the acceptable methods of ocular anesthesia on a per participant basis. Subconjunctival anesthesia is recommended (but not required) to maximize participant comfort. In order to maintain masking, the selected method of anesthesia for an individual participant must remain constant for the duration of the trial and at all visits irrespective of the study treatment assigned during the study visit (KSI-301, aflibercept or sham).

Please refer to the Pharmacy Manual for additional instructions on IMP preparation and administration.

### **8.1.4 Post-injection Assessments in the Study Eye**

Within 5 minutes after the injection, check vision for count fingers or hand motion.

- Tonometry (between 30 and 50 minutes after injection):

If the IOP is  $>30$  mmHg or has increased by  $\geq 10$  mmHg from pre-injection, the IOP will be measured again at 60–80 minutes post-injection. If there are no safety concerns, the participant will be permitted to leave the clinic. If the IOP value is of concern to the Investigator, the participant will remain in the clinic and will be managed in accordance with the Investigator's clinical judgment. The latest post-injection IOP measured (prior to any intervention for increased IOP, if applicable) will be recorded on the post-treatment IOP eCRF.

The method of post-injection IOP measurement (such as Goldmann tonometry or Tonopen) must be the same as the pre-injection method and remain the same throughout the study for each participant.

**8.1.5 Best Corrected Visual Acuity (BCVA) [REDACTED]****8.1.5.1 BCVA**

BCVA will be measured utilizing the ETDRS method by certified, masked personnel at the study sites. The measurement should be performed following refraction, and prior to any examination requiring contact with the eye and prior to dilating the eyes. A BCVA Testing Procedure Manual and training materials will be provided to all sites by the third-party VA Examiner certification vendor.



A BCVA [REDACTED] Testing Procedure Manual and training materials will be provided to all sites by the third-party VA Examiner certification vendor.

**8.1.6 Fundus Photography (FP)**

Fundus photography will be performed at the study sites by certified, masked personnel. It is mandatory that the same model of device is used for the entire duration of the study.

Additional specifications and instructions regarding acceptable equipment and imaging techniques will be provided by the Reading Center.

**8.1.7 Spectral Domain Optical Coherence Tomography (SD-OCT)**

SD-OCT will be performed at the study sites by certified, masked personnel on a qualified instrument. It is mandatory that the same model of device is used for the entire duration of the study.

Additional specifications and instructions regarding acceptable equipment and imaging techniques will be provided by the Reading Center.

**8.1.8 Fluorescein Angiography (FA)**

FA will be performed at all the study sites by certified, masked personnel. It is mandatory that the same model of device is used for the entire duration of the study.

Additional specifications and instructions regarding acceptable equipment imaging and imaging techniques will be provided by the Reading Center.

## 8.2 Safety Assessments

Planned time points for all safety assessments are provided in the SoA ([Section 1.3](#)).

### 8.2.1 Vital Signs

The following vital signs will be assessed with the participant in a seated position after resting for 5 minutes: blood pressure (BP), pulse rate, and body temperature. Height and weight will be recorded at the screening visit only.

### 8.2.2 Clinical Safety Laboratory Assessments

See [Appendix 2](#) for the list of clinical laboratory tests to be performed and refer to the SoA ([Section 1.3](#)) for the timing and frequency.

The Investigator or designee must review the laboratory report, document this review, and record any clinically significant changes occurring during the study as an AE. The laboratory reports must be filed with the source documents.

Abnormal laboratory findings associated with the underlying disease are not considered clinically significant unless judged by the Investigator to be more severe than expected for the participant's condition.

All laboratory tests with values considered clinically significantly abnormal during participation in the study or within 30 days after the last dose of study intervention should be repeated until the values return to normal or baseline or are no longer considered clinically significant by the Investigator or Medical Monitor.

- If clinically significant values do not return to normal/baseline within a period of time judged reasonable by the Investigator, the etiology should be identified, and the Sponsor notified.
- All protocol-required laboratory tests, as defined in [Appendix 2](#), must be conducted in accordance with the SoA ([Section 1.3](#)).
- If laboratory values from non-protocol-specified laboratory tests performed at the institution's local laboratory require a change in participant management or are considered clinically significant by the Investigator (e.g., SAE or AE or dose modification), then the results must be recorded.

### 8.2.3 Pregnancy Testing

Participant samples for pregnancy testing will be taken at the Screening and Day 1 visits and then monthly in women of childbearing potential only as specified in the SoA ([Section 1.3](#)).

Prior to enrollment in the study, female participants of childbearing potential and male participants must be advised of the importance of avoiding pregnancy or partner pregnancy, respectively, during the trial and the potential risks associated with an unintentional pregnancy. Contraceptive and barrier guidance and collection of pregnancy information is described in [Appendix 6](#).

### **8.3 Adverse Events, Serious Adverse Events, and Other Safety Reporting**

The definitions of AEs and SAEs are provided in [Appendix 3](#).

AEs will be reported by the participant (or, when appropriate, by a caregiver or surrogate).

The Investigator and any qualified designees are responsible for detecting, documenting, and recording events that meet the definition of an AE or SAE and remain responsible for following up AEs that are serious, considered related to the study intervention or study procedures, or that caused the participant to discontinue the study (see [Section 7](#)).

The method of recording, evaluating, and assessing causality of AEs and SAEs and the procedures for completing and transmitting SAE reports are provided in [Appendix 3](#).

#### **8.3.1 Time Period and Frequency for Collecting AE and SAE Information**

After informed consent has been obtained but prior to initiation of study intervention, only SAEs caused by a protocol-mandated assessment should be reported. After initiation of study intervention (Day 1), all AE and SAE information will be collected until the final safety follow-up visit at Week 52 or the ET visit, if applicable.

All SAEs will be recorded and reported to the Sponsor or designee immediately and under no circumstance should this exceed 24 hours, as indicated in [Appendix 3](#). The Investigator will submit any updated SAE data to the Sponsor within 24 hours of it being available.

Investigators are not obligated to actively seek information on AEs or SAEs after conclusion of the study participation. However, if the Investigator learns of any SAE, including a death, at any time after a participant has been discharged from the study, and he/she considers the event to be reasonably related to the study intervention or study participation, the Investigator must promptly notify the Sponsor.

#### **8.3.2 Method of Detecting AEs and SAEs**

Care will be taken not to introduce bias when detecting AEs and/or SAEs. At every study visit, open-ended and nonleading verbal questioning of the participant is the preferred method to inquire about AE occurrences. The participant will also be asked if they have been hospitalized, had any accidents, used any new medications, or changed concomitant medication regimens (both prescription and OTC medications).

In addition to participant observations, AEs identified from any study data (e.g., laboratory values, ophthalmic examination findings) or identified from review of other documents that are relevant to participant safety will be documented on the AE page in the eCRF.

The method of recording, evaluating, and assessing causality of AE and SAE and the procedures for completing and transmitting SAE reports are provided in [Appendix 3](#).

### **8.3.3 Follow-up of AEs and SAEs**

After the initial AE/SAE report, the Investigator is required to proactively follow each participant at subsequent visits/contacts. All SAEs and AEs of special interest (as defined in [Section 8.3.6](#)), will be followed until resolution, stabilization, the event is otherwise explained, or the participant is lost to follow-up (as defined in [Section 7.3](#)). Further information on follow-up procedures is provided in [Appendix 3](#).

### **8.3.4 Regulatory Reporting Requirements for SAEs**

Prompt notification by the Investigator to the Sponsor of an SAE is essential so that legal obligations and ethical responsibilities toward the safety of participants and the safety of a study intervention under clinical investigation are met. The Sponsor has a legal responsibility to notify both the local regulatory authority and other regulatory agencies about the safety of a study intervention under clinical investigation. The Sponsor will comply with country-specific regulatory requirements relating to safety reporting to the regulatory authority, Institutional Review Boards (IRB)/Independent Ethics Committees (IEC), and investigators.

An Investigator who receives an Investigator safety report describing an SAE or other specific safety information (e.g., summary or listing of SAEs) from the Sponsor will review and then file it along with the IB and will notify the IRB/IEC, if appropriate according to local requirements.

Investigator safety reports must be prepared for SUSARs according to local regulatory requirements and Sponsor policy and forwarded to investigators as necessary.

### **8.3.5 Pregnancy**

During the study, female and male participants are to be instructed to contact the Investigator immediately if they suspect they might be pregnant or if their partner becomes pregnant, respectively, and details will be collected. Additional urine or serum pregnancy testing may be performed during the study at the discretion of the Investigator, or in accordance with local requirements or regulations.

Pregnancy is not regarded as an AE unless there is a suspicion that an investigational product may have interfered with the effectiveness of a contraceptive medication. Any pregnancy that occurs during study participation must be reported using the same procedures as an SAE on a Sponsor prepared form. To ensure participant safety, each pregnancy must be reported to the Sponsor or its designee immediately (within 24 hours) after learning of its occurrence. The

pregnancy must be followed up to determine outcome (including spontaneous miscarriage, elective termination, normal birth, or congenital abnormality) and status of mother and child, even if the participant was discontinued from the study. Pregnancy complications and elective terminations for medical reasons must be reported as an AE or SAE. Spontaneous miscarriages must be reported as an SAE.

Any SAE occurring in association with a pregnancy, brought to the Investigator's attention after the participant has completed the study, and considered by the Investigator as possibly related to the study treatment, must be promptly reported to the Sponsor.

Pregnancy is considered a criterion for discontinuation from the study, please refer to [Section 7.1](#) for additional information. Contraceptive and barrier guidance and collection of pregnancy information is described in [Appendix 6](#).

### **8.3.6 Adverse Events of Special Interest**

An adverse event of special interest (AESI) is one of scientific and medical concern specific to the Sponsor's product or program where ongoing monitoring and rapid communication by the Investigator to the Sponsor may be appropriate. These AEs may be serious or non-serious. Applicable AEs may require additional investigation in order to characterize and understand, and depending upon the nature of the event, rapid communication by the Sponsor to other parties may also be required.

These AESIs must be reported by the Investigator using the same mechanism (Electronic data capture (EDC) or fax) and time frame (i.e., within 24 hours after learning of the event) as described previously for SAEs. The AESIs include the following:

- AEs resulting from medication error, including overdose, incorrect dose, incorrect drug, incorrect administration, or incorrect kit.
- AEs with sight-threatening potential, meeting one or more of the following criteria:
  - Causes a decrease  $\geq 30$  letter in BCVA compared with the last visual acuity assessment;
  - It is associated with severe intraocular inflammation (i.e., endophthalmitis, Grade 4 aqueous flare/aqueous cells, Grade 4 vitreous haze/vitreous cells; see [Appendix 4](#) for grading scales); or
  - Requires surgical intervention to prevent permanent loss of sight.
- Cases of potential liver injury ([Appendix 7](#)).

As with all AEs occurring in a study participant, a decision will be made by the Investigator concerning additional exposure to study treatment and further participation in the study.

#### 8.4 Pharmacokinetics

To understand the pharmacokinetic (PK) profile of the study intervention following intravitreal injection (i.e., systemic exposure), plasma concentration of KSI-301 will be measured. For exploratory purposes, [REDACTED]

[REDACTED] Plasma samples of comparator may also be analyzed for systemic PK and systemic biomarkers.

Blood samples of approximately 4 mL will be collected from participants for measurement of plasma concentrations of KSI-301, as specified in the SoA ([Section 1.3](#)).

Instructions for the collection and handling of biological samples will be included in the Central Laboratory Manual. The actual date and time when each sample is collected will be recorded.

#### 8.5 Genetics and/or Pharmacogenomics

Genetics and/or pharmacogenomics are not evaluated in this study.

#### 8.6 Biomarkers

Blood samples that were collected from participants for systemic PK analysis ([Section 8.4](#)) may also be analyzed for measurement of plasma biomarkers, as specified in the SoA ([Section 1.3](#)).

Instructions for the collection and handling of biological samples will be provided by the Central Laboratory Manual. The actual date and time when each sample is collected will be recorded.

#### 8.7 Immunogenicity Assessments

Blood samples of approximately 4 mL will be collected for detection and confirmation of anti-drug antibodies (ADAs), as well as assays to further characterize the anti-drug antibodies as specified in the SoA ([Section 1.3](#)). Additionally, plasma samples should also be collected and evaluated at the final visit from participants who discontinued study intervention or were withdrawn from the study as per the SoA.

The detection and characterization of ADAs to KSI-301 will be performed using a validated assay method. Plasma samples will be screened for antibodies binding to KSI-301 and the titer of confirmed positive samples will be reported. Specificity analyses may be performed to further characterize the immunogenicity of KSI-301. Anti-KSI-301 antibodies may be further characterized and/or evaluated for their ability to neutralize the activity of the study intervention(s) (neutralizing antibodies or NABs). All samples collected for detection of antibodies to study intervention will also be evaluated for KSI-301 plasma concentration to enable interpretation of the antibody data.

Samples may be stored for a maximum of 5 years (or according to local regulations) following the last participant's last visit for the study at a facility selected by the Sponsor to enable further analysis of immune responses to KSI-301.

## **8.8     Health Economics or Medical Resource Utilization and Health Economics**

These parameters are not evaluated in this study.

## 9.0 STATISTICAL CONSIDERATIONS

### 9.1 Study Hypothesis

Intensive treatment with KSI-301 5 mg will provide a non-inferior mean change in BCVA compared to aflibercept 2 mg in participants with visual impairment due to wAMD.

### 9.2 Sample Size Determination

The sample size for the comparison of the change in BCVA between treatment group A (KSI-301 5 mg once every 4 weeks) and treatment group B (aflibercept 2 mg once every 8 weeks after 3 initial monthly injections) from Day 1 to the average of Weeks 40, 44, and 48 is based on a non-inferiority approach. The following assumptions were made in order to calculate the sample size:

- Overall type I error rate of 0.025. Testing at the 0.025 level for non-inferiority corresponds to setting 95% CIs;
- Statistical power of  $\geq 90\%$ ;
- Standard deviation of the distribution of change in visual acuity from baseline of [REDACTED] letters;
- The maximum, clinically acceptable true difference for KSI-301 to be considered non-inferior, or the “non-inferiority margin,” [REDACTED];
- The statistical test used to compare the two treatment groups using ETDRS BCVA data collected up to Week 48 is an independent t-test on the mean change in visual acuity from baseline (Day 1); and
- Lost to follow-up/dropout rate of approximately [REDACTED].

The sample size calculated using the above assumptions is approximately 500 participants (250 per treatment group).  
[REDACTED]

**Note:** “enrolled” means a participant's agreement to participate in a clinical study following completion of the informed consent process, screening, and the Day 1 visit. Potential participants who are screened for the purpose of determining eligibility for the study, but who do not participate in the study, are not considered enrolled, unless otherwise specified by the protocol.

### 9.3 Analysis Sets

For the purpose of analysis, the following analysis sets are defined:

Population	Description
Randomized/intent to treat (ITT) set	The ITT set will be comprised of all participants who were randomized into one of the study groups. For analyses based on this population, participants will be grouped according to the study intervention assigned at randomization.
Evaluable/per protocol (PP) set	The PP set will comprise all ITT participants who fulfill all inclusion/exclusion criteria and have no significant protocol deviations that are expected to have a significant impact on the assessment of efficacy, including lack of compliance with study treatment, missing data, and having taken any prohibited medication. All analyses using the PP set will group participants according to the study intervention they actually received.
Safety set	The safety set will comprise all participants randomly assigned to study intervention and who receive at least one dose of study intervention. Participants will be analyzed according to the intervention they actually received.
Pharmacokinetic/biomarker/ADA-evaluable set	The PK/biomarker evaluable data set will comprise all participants in the ITT set with at least one post-Day 1 evaluable sample. The ADA-evaluable data set will consist of all participants in the ITT set with at least one evaluable sample.

### 9.4 Statistical Analyses

The study SAP will fully specify the statistical methodology and reporting for all aspects of the planned analyses. The SAP will be finalized prior to database lock and executed thereafter, and it will include a more technical and detailed description of the statistical analyses described in this section. This section is a summary of the planned statistical analyses of the most important endpoints including primary and key secondary endpoints.

Additional unplanned analyses may be required after all planned analyses have been completed, and additional analyses of key efficacy metrics may be performed between the primary and final analyses to support marketing applications for various jurisdictions. Any unplanned analyses will be clearly identified in the clinical study report.

#### 9.4.1 General Considerations

At baseline (Day 1), participants will be randomized 1:1 into one of two treatment groups:

- A. KSI-301 5 mg [REDACTED]: once every four (4) weeks from Day 1 to Week 44; or
- B. Aflibercept 2 mg (50  $\mu$ L): three (3) monthly doses at Day 1, Week 4, and Week 8, followed by once every 8 weeks (Q8W) until Week 44. Participants randomized to the

aflibercept treatment group will receive a sham injection at each visit that aflibercept is not administered (i.e., at Weeks 12, 20, 28, 36, and 44).

This study consists of one efficacy and safety assessment period ([Section 1.2](#)), as follows:

- Day 1 to Week 52, which consists of the treatment period (Day 1 through Week 44), 4-week efficacy and safety period (to Week 48), and a final 4-week safety assessment at Week 52 (8 weeks after the last dose).

Using ETDRS BCVA data collected up to Week 48, the treatment groups will be compared using a non-inferiority analysis, with a margin [REDACTED]. Confidence intervals will be  $100(1-2 \alpha)$  or 95% CI. If the null hypothesis of inferiority is rejected, testing for superiority will be performed. That is, if the lower confidence limit for the difference in mean BCVA lies within  $(-4.5, \infty)$ , the null hypothesis of inferiority will be rejected, and non-inferiority will be established. Furthermore, if the lower confidence limit lies within  $(0, \infty)$ , superiority will be established.

Analysis of data will be performed when all participants have either completed the Week 52 visit or have discontinued from the study, all data have been entered into the database, cleaned and verified as appropriate, and the database has been locked.

Details of all preplanned analyses, including imputation approaches for the handling of missing data, subgroup analyses (for example, across key demographic and ocular baseline characteristics), and sensitivity analyses, will be included in the SAP. The results of all analyses detailed in the SAP will appear in the final clinical study report.

#### 9.4.2 Primary Endpoint(s)

The primary endpoint is defined as the mean change in ETDRS BCVA from baseline (Day 1) to Weeks 40, 44, and 48. The primary assessment of efficacy will be based on a pairwise comparison in mean change in BCVA between treatment group A (KSI-301 5 mg) and treatment group B (aflibercept 2 mg).

Unless stated otherwise, all analyses described will be performed on the ITT Population.

Analysis of the primary endpoint data will be performed when the following occur:

- all participants have either completed the Week 48 visit or have discontinued from the study prior to the Week 48 visit, whichever comes later;
- all data up to and including the Week 48 visit have been entered into the database, and have been cleaned, and verified as appropriate; and
- the database for the primary analysis locked.

If there are no imbalances on important prognostic factors at baseline, a simple independent t-test and corresponding CIs will be used for evaluation of treatment differences. If there are

imbalances in key prognostic factors at baseline (e.g., BCVA) generalized linear models or other statistical models (such as mixed effects models) will be used to estimate the difference in mean change in BCVA between treatment groups and CIs derived from the corresponding standard error of the estimate. These models will also include indicator variables for stratification variables. An alpha level of 0.025 will be used for hypothesis testing and CIs will be 100(1-2 $\alpha$ ) or 95% CI. If the null hypothesis of inferiority is rejected, testing for superiority will be performed.

Full details on the statistical testing procedures along with supplementary and sensitivity analyses will be provided in the SAP.

#### **9.4.3 Secondary Endpoint(s)**

Key secondary endpoints will be assessed at Week 48 (for efficacy) or Week 52 (for safety):

- Mean change in BCVA (ETDRS Letters) from baseline (Day 1) by visit over time.
- Proportion of participants who gain  $\geq 5$ ,  $\geq 10$  and  $\geq 15$  ETDRS letters from baseline (Day 1) by visit over time.
- Proportion of participants who lose  $\geq 5$ ,  $\geq 10$  and  $\geq 15$  ETDRS letters from baseline (Day 1) by visit over time.
- Proportion of participants with BCVA Snellen equivalent of 20/40 or better from baseline (Day 1) over time.
- Proportion of participants with BCVA Snellen equivalent of 20/200 or worse from baseline (Day 1) over time.
- Mean change in OCT CST from baseline (Day 1) to Week 48 and over time.
- Incidence of ocular and systemic AEs up to Week 52.
- Systemic anti-drug antibody status over time (in the ADA-evaluable population).
- Systemic pharmacokinetic profile (i.e., systemic exposure) over time (in the PK-evaluable population).

Unless stated otherwise, all analyses described will be performed on the ITT Population.

For continuous key secondary efficacy endpoints, the between-group changes from baseline in BCVA at each time point will be computed and compared using t-tests, generalized linear models, mixed effects models, or other approaches as documented in the SAP. In addition, comparisons between groups determined by fixed effects of interest will be performed by analysis of covariance (ANCOVA) in which the dependent variable is the continuous variable of interest at the specified time point, the covariate is the baseline value of the variable of interest. Treatment group as well as stratification variables will be entered as fixed effects. Results of the t-test will be reported as 95% CIs for within group mean change from baseline. Results of

ANCOVA will be reported as 95% CIs for the difference in adjusted means for the grouping determined by the fixed effects of interest.

For categorical variables, the number and percentage of responders will be presented by treatment group for each time period and will be evaluated among treatment groups using chi-square tests of proportions supplemented with logistic regression models.

Additional endpoints and full details on statistical considerations will be provided in the SAP.

#### **9.4.4 Tertiary/Exploratory Endpoint(s)**

Exploratory endpoints will be described in the SAP.

#### **9.4.5 Safety Analysis**

The safety analysis (using the safety set described in [Section 9.3](#)) will use outcomes of all participants who were exposed to study treatment regardless of adherence to the protocol or treatment outcome. Safety analyses will be conducted concurrently with efficacy analyses.

In addition to analyses of ocular safety events, all reported AEs will be listed by MedDRA term, frequency, severity, association to the study therapy, and treatment group. By-treatment incidence rates will also be calculated for the treatment groups. For certain AEs, per-injection rates will also be described.

#### **9.4.6 Pharmacokinetic and Biomarker Analysis**

PK analyses will be outlined in the PK Analysis Plan; potential exploratory biomarker analyses will be outlined in a Biomarker Analysis Plan.

### **9.5 Interim Analysis**

There is no interim analysis planned for this study.

**10.0 APPENDICES WITH SUPPORTING DOCUMENTATION AND OPERATIONAL CONSIDERATIONS**

[Appendix 1:](#) Regulatory, Ethical, and Study Oversight Considerations

[Appendix 2:](#) Clinical Laboratory Tests

[Appendix 3:](#) AEs and SAEs: Definitions and Procedures for Recording, Evaluating, Follow-up, and Reporting

[Appendix 4:](#) Grading Scale for Assessment of Anterior Chamber Flare or Cells, Vitreous Cells or Haze

[Appendix 5:](#) Unscheduled Safety Assessment Visits

[Appendix 6:](#) Contraceptive and Barrier Guidance

[Appendix 7:](#) Liver Safety

[Appendix 8:](#) Protocol Amendment History

## 10.1 Appendix 1: Regulatory, Ethical, and Study Oversight Considerations

### 10.1.1 Regulatory and Ethical Considerations

This study will be conducted in accordance with the protocol and with the following:

- Consensus ethical principles derived from international guidelines including the Declaration of Helsinki and Council for International Organizations of Medical Sciences (CIOMS) International Ethical Guidelines
- Applicable ICH Good Clinical Practice (GCP) Guidelines
- Applicable laws and regulations

The protocol, protocol amendments, ICF, Investigator's Brochure, and other relevant documents (e.g., advertisements) must be submitted to an IRB/IEC by the Investigator and reviewed and approved by the IRB/IEC before the study is initiated.

Any amendments to the protocol will require IRB/IEC approval before implementation of changes made to the study design, except for changes necessary to eliminate an immediate hazard to study participants.

The Investigator will be responsible for the following:

- Providing written summaries of the status of the study to the IRB/IEC annually or more frequently in accordance with the requirements, policies, and procedures established by the IRB/IEC;
- Notifying the IRB/IEC of SAEs or other significant safety findings as required by IRB/IEC procedures; and
- Providing oversight of the conduct of the study at the site and adherence to requirements of 21 CFR, ICH guidelines, the IRB/IEC, European regulation 536/2014 for clinical studies, and all other applicable local regulations.

### 10.1.2 Financial Disclosure and Financial Obligations

Investigators are required to provide financial disclosure information to allow the Sponsor to submit the complete and accurate certification or disclosure statements to the appropriate regulatory authorities. In addition, Investigators must provide to the Sponsor a commitment to promptly update this information if any relevant changes occur during the investigation and for 1 year following the completion of the study.

Neither the Sponsor nor their CRO partner is financially responsible for additional testing or treatment of any medical condition that may be detected during the screening process. In addition, in the absence of specific arrangements, neither the Sponsor nor their CRO are financially responsible for further treatment of the participant's disease.

### 10.1.3 Informed Consent Process

The Investigator or his/her representative will explain the nature of the study to the participant and answer all questions regarding the study.

Participants must be informed that their participation is voluntary. Participants will be required to sign a statement of informed consent that meets the requirements of 21 CFR 50, local regulations, ICH guidelines, Health Insurance Portability and Accountability Act (HIPAA) requirements, where applicable, and the IRB/IEC or study center.

The medical record must include a statement that written informed consent was obtained before the participant was enrolled in the study and the date the written consent was obtained. The authorized person obtaining the informed consent must also sign the ICF.

If required by the IRB/EC, participants must be re-consented to the most current version of the ICF(s) during their participation in the study.

A copy of the ICF(s) must be provided to the participant.

Participants who are re-screened are required to sign a new ICF if it has been more than 30 days from the initial consent date.

The ICF will contain a separate section that addresses the use of remaining samples for optional exploratory research. The Investigator or authorized designee will explain to each participant the objectives of the exploratory research. Participants will be told that they are free to refuse to participate and may withdraw their consent at any time and for any reason during the storage period. A separate signature will be required to document a participant's agreement to allow any remaining specimens to be used for exploratory research. Participants who decline to participate in this optional research will not provide this separate signature.

### 10.1.4 Data Protection

Participants will be assigned a unique identifier by the Sponsor. Any participant records or datasets that are transferred to the Sponsor will contain the identifier only; participant names or any information which would make the participant identifiable will not be transferred.

The participant must be informed that his/her personal study-related data will be used by the Sponsor in accordance with local data protection law. The level of disclosure must also be explained to the participant who will be required to give consent for their data to be used as described in the informed consent.

Participant medical information obtained by this study is confidential, and disclosure to third parties other than those noted below is prohibited. All laboratory specimens, evaluation forms, reports, and other records will be identified in a manner designed to maintain participant confidentiality. All records will be kept in a secure storage area with limited access. Upon the

participant's permission, medical information may be given to his or her personal physician or other appropriate medical personnel responsible for his or her welfare.

The participant must be informed that his/her medical records may be examined by Clinical Quality Assurance auditors or other authorized personnel appointed by the Sponsor, by appropriate IRB/IEC members, and by inspectors from regulatory authorities.

All information provided by the Sponsor, verbally and in writing, is confidential. The Investigator agrees not to disclose any such information without prior written permission of the Sponsor. This document may be disclosed to study personnel under the Investigator's supervision and to the IRB under the condition that they also agree to maintain its confidentiality. Any supplemental information (e.g., protocol amendment) that may be added to this document is confidential and must also be handled accordingly. The information obtained from the Sponsor may be disclosed to obtain informed consent from participants who wish to participate in the study.

Study documents provided by the Sponsor (protocols, IB, etc.) will be stored appropriately to ensure their confidentiality.

The Investigator and all employees and co-workers involved with this study may not disclose or use for any purpose other than performance of the study any data, record, or other unpublished, confidential information disclosed to those individuals for the purpose of the study. Prior written agreement from the Sponsor or its designee must be obtained for the disclosure of any said confidential information to other parties.

### **10.1.5 Committees Structure**

#### **10.1.5.1 Independent Data Monitoring Committee**

An Independent Data Monitoring Committee (IDMC) will monitor the study conduct and safety on an ongoing basis. Members of the IDMC will be external to the Sponsor and will follow a charter that outlines the IDMC membership and responsibilities, the timing of IDMC meetings, the content of the analysis report for the IDMC meetings, and the communication with the Sponsor. The IDMC can recommend changes to the conduct of the study based on the evaluated data and may recommend stopping the study early for safety reasons. Nominal Type I error penalties for IDMC reviews will be outlined in the SAP.

### **10.1.6 Data Quality Assurance**

All participant data relating to the study will be recorded on printed or eCRF unless transmitted to the Sponsor or designee electronically (e.g., laboratory data). The Investigator is responsible for verifying that data entries are accurate and correct by physically or electronically signing the eCRF.

The Investigator must permit study-related monitoring, audits, IRB/IEC review, and regulatory agency inspections and provide direct access to source data documents.

Monitoring details describing strategy (e.g., risk-based initiatives in operations and quality such as Risk Management and Mitigation Strategies and Analytical Risk-Based Monitoring), methods, responsibilities and requirements, including handling of noncompliance issues and monitoring techniques (central, remote, or on-site monitoring) are provided in the Monitoring Plan.

The Sponsor or designee is responsible for the data management of this study including quality checking of the data.

The Sponsor assumes accountability for actions delegated to other individuals (e.g., CROs).

Records and documents, including signed ICFs, pertaining to the conduct of this study must be retained by the Investigator for 10 years after study completion unless local regulations or institutional policies require a longer retention period. No records may be destroyed during the retention period without the written approval of the Sponsor. No records may be transferred to another location or party without written notification to the Sponsor.

#### **10.1.7     Source Documents**

Source documents provide evidence for the existence of the participant and substantiate the integrity of the data collected. Source documents are filed at the Investigator's site.

Data reported on the eCRF or entered in the eCRF that are transcribed from source documents must be consistent with the source documents or the discrepancies must be explained. The Investigator may need to request previous medical records or transfer records, depending on the study. Also, current medical records must be available.

The Investigator must maintain accurate documentation (source data) that supports the information entered in the eCRF.

Study monitors will perform ongoing source data verification to confirm that data entered into the eCRF by authorized site personnel are accurate, complete, and verifiable from source documents; that the safety and rights of participants are being protected; and that the study is being conducted in accordance with the currently approved protocol and any other study agreements, ICH GCP, and all applicable regulatory requirements.

#### **10.1.8     Study and Site Start and Closure**

##### **First Act of Recruitment**

The study start date is the date on which the clinical study will be open for recruitment of participants.

## Study/Site Termination

The Sponsor or designee reserves the right to close the study site or terminate the study at any time for any reason at the sole discretion of the Sponsor. Study sites will be closed upon study completion. A study site is considered closed when all required documents and study supplies have been collected and a study site closure visit has been performed.

The Investigator may initiate study site closure at any time, provided there is reasonable cause and sufficient notice is given in advance of the intended termination.

Reasons for the early closure of a study site by the Sponsor or Investigator may include but are not limited to:

For study termination:

- Discontinuation of further study intervention development

For site termination:

- Failure of the Investigator to comply with the protocol, the requirements of the IRB/IEC or local health authorities, the Sponsor's procedures, or GCP guidelines
- Inadequate or no recruitment (evaluated after a reasonable amount of time) of participants by the Investigator

If the study is prematurely terminated or suspended, the Sponsor shall promptly inform the investigators, the IECs/IRBs, the regulatory authorities, and any CRO(s) used in the study of the reason for termination or suspension, as specified by the applicable regulatory requirements. The Investigator shall promptly inform the participant and should assure appropriate participant therapy and/or follow-up.

### 10.1.9 Publication Policy

The results of this study may be published or presented at scientific meetings. If this is foreseen, the Investigator agrees to submit all manuscripts or abstracts to the Sponsor before submission. This allows the Sponsor to protect proprietary information and to provide comments.

The Sponsor will comply with the requirements for publication of study results. In accordance with standard editorial and ethical practice, the Sponsor will generally support publication of multi-center studies only in their entirety and not as individual site data. In this case, a coordinating Investigator will be designated by mutual agreement.

Authorship will be determined by mutual agreement and in line with International Committee of Medical Journal Editors authorship requirements.

## 10.2 Appendix 2: Clinical Laboratory Tests

The tests detailed in [Table 4](#) will be performed by the central laboratory.

Local laboratory results are only required in the event that the central laboratory results are not available in time for either study intervention administration and/or response evaluation. If a local sample is required, it is important that the sample for central analysis is obtained at the same time.

Protocol-specific requirements for inclusion or exclusion of participants are detailed in [Section 5](#) of the protocol.

Additional tests may be performed at any time during the study as determined necessary by the Investigator or as required by local regulations.

Investigators must document their review of each laboratory safety report.

**Table 4: Protocol KS301P107: Required Safety Laboratory Tests**

Laboratory Tests	Parameters							
<b>Hematology</b>	Platelet Count	RBC Indices: MCV MCH %Reticulocytes	White blood cell (WBC) count with Differential: Neutrophils Lymphocytes Monocytes Eosinophils Basophils					
	Red blood cell (RBC) Count							
	Hemoglobin							
	Hematocrit							
<b>Clinical Chemistry</b>	Blood urea nitrogen (BUN)	Potassium	Aspartate Aminotransferase (AST)/Serum Glutamic Oxaloacetic Transaminase (SGOT)	Total and direct bilirubin				
	Creatinine	Sodium	Alanine Aminotransferase (ALT)/Serum Glutamic Pyruvic Transaminase (SGPT)	Total Protein				
	Glucose	Calcium	Alkaline phosphatase					
<b>Pregnancy testing</b>	Highly sensitive [serum or urine] human chorionic gonadotropin (hCG) pregnancy test (as needed for women of childbearing potential) <sup>1</sup>							
<b>Other Screening Tests</b>	Follicle stimulating hormone (to verify non-childbearing potential as required in <a href="#">Section 10.6.1</a> ) and estradiol (only if determined to be additionally required by the Investigator to verify non-childbearing potential).							
<b>NOTES:</b>								
1. Local urine testing will be standard for the protocol unless serum testing is required by local regulation or IRB/IEC.								

### 10.3 Appendix 3: AEs and SAEs: Definitions and Procedures for Recording, Evaluating, Follow-up, and Reporting

#### 10.3.1 Definition of AE

##### **AE Definition**

An AE is any untoward medical occurrence in a clinical study participant, temporally associated with the use of study intervention, whether or not considered related to the study intervention.

NOTE: An AE can therefore be any unfavorable and unintended sign (including an abnormal laboratory finding), symptom, or disease (new or exacerbated) temporally associated with the use of study intervention.

##### **Events Meeting the AE Definition**

Any abnormal laboratory test results (hematology, clinical chemistry, or urinalysis) or other safety assessments (e.g., ECG, radiological scans, vital signs measurements), including those that worsen from baseline, considered clinically significant in the medical and scientific judgment of the Investigator (i.e., not related to progression of underlying disease).

Exacerbation of a chronic or intermittent pre-existing condition including either an increase in frequency and/or intensity of the condition.

New conditions detected or diagnosed after study intervention administration even though it may have been present before the start of the study.

Signs, symptoms, or the clinical sequelae of a suspected intervention- intervention interaction.

Signs, symptoms, or the clinical sequelae of a suspected overdose of either study intervention or a concomitant medication. Overdose per se will not be reported as an AE/SAE unless it is an intentional overdose taken with possible suicidal/self-harming intent. Such overdoses should be reported regardless of sequelae.

“Lack of efficacy” or “failure of expected pharmacological action” per se will not be reported as an AE or SAE. Such instances will be captured in the efficacy assessments. However, the signs, symptoms, and/or clinical sequelae resulting from lack of efficacy will be reported as AE or SAE if they fulfill the definition of an AE or SAE.

##### **Events NOT Meeting the AE Definition**

Any clinically significant abnormal laboratory findings or other abnormal safety assessments which are associated with the underlying disease, unless judged by the Investigator to be more severe than expected for the participant’s condition.

The disease/disorder being studied or expected progression, signs, or symptoms of the disease/disorder being studied, unless more severe than expected for the participant’s condition.

Medical or surgical procedure (e.g., endoscopy, appendectomy): the condition that leads to the procedure is the AE.

Situations in which an untoward medical occurrence did not occur (social and/or convenience admission to a hospital).

Anticipated day-to-day fluctuations of pre-existing disease(s) or condition(s) present or detected at the start of the study that do not worsen.

### 10.3.2 Definition of SAE

**An SAE is defined as any serious adverse event that, at any dose:**

**a. Results in death**

**b. Is life-threatening**

The term 'life-threatening' in the definition of 'serious' refers to an event in which the participant was at risk of death at the time of the event. It does not refer to an event which hypothetically might have caused death if it were more severe.

**c. Requires inpatient hospitalization or prolongation of existing hospitalization**

In general, hospitalization signifies that the participant has been admitted (usually involving at least an overnight stay) at the hospital or emergency ward for observation and/or treatment that would not have been appropriate in the physician's office or outpatient setting. Complications that occur during hospitalization are AEs. If a complication prolongs hospitalization or fulfills any other serious criteria, the event is serious. When in doubt as to whether "hospitalization" occurred or was necessary, the AE should be considered serious.

Hospitalization for elective treatment of a pre-existing condition that did not worsen from baseline is not considered an AE.

**d. Results in persistent or significant disability/incapacity**

The term disability means a substantial disruption of a person's ability to conduct normal life functions.

This definition is not intended to include experiences of relatively minor medical significance such as uncomplicated headache, nausea, vomiting, diarrhea, influenza, and accidental trauma (e.g., sprained ankle) which may interfere with or prevent everyday life functions but do not constitute a substantial disruption.

**e. Is a congenital anomaly/birth defect**

**f. Other situations:**

Medical or scientific judgment should be exercised by the Investigator in deciding whether SAE reporting is appropriate in other situations such as significant medical events that may jeopardize the participant or may require medical or surgical intervention to prevent one of the other outcomes listed in the above definition. These events should usually be considered serious.

- Examples of such events include invasive or malignant cancers, intensive treatment for allergic bronchospasm, blood dyscrasias, convulsions.

### 10.3.3 The Recording and Follow-Up of AE and/or SAE

#### AE and SAE Recording

When an AE/SAE occurs, it is the responsibility of the Investigator to review all documentation (e.g., hospital progress notes, laboratory reports, and diagnostics reports) related to the event.

The Investigator or designee will then record all relevant AE/SAE information.

It is not acceptable for the Investigator to send photocopies of the participant's medical records to the Sponsor in lieu of completion of the AE/SAE required form.

There may be instances when copies of medical records for certain cases are requested by the Sponsor. In this case, all participant identifiers, with the exception of the participant number, will be redacted on the copies of the medical records before submission to the Sponsor.

The Investigator will attempt to establish a diagnosis of the event based on signs, symptoms, and/or other clinical information. Whenever possible, the diagnosis (not the individual signs/symptoms) will be documented as the AE/SAE.

The Medical Monitor or other Sponsor representative may contact the Investigator or investigational site personnel to request additional information regarding the event or to confirm information.

For the purposes of reporting events of infection and inflammation of the eye, the following terms and definitions should be used:

- Iritis: the presence of inflammatory cells in the anterior chamber
- The presence of aqueous flare alone will not constitute iritis but should be documented as an anterior chamber flare for AE reporting purposes
- Iridocyclitis: the presence of inflammatory cells in both the aqueous and vitreous
- Vitritis: the presence of active inflammation in the vitreous, demonstrated by the presence of inflammatory cells (trace or greater)
- Endophthalmitis: diffuse intraocular inflammation predominantly involving the vitreous cavity but also involving the anterior chamber, implying a suspected underlying infectious cause

Active inflammation in the vitreous should be clinically differentiated from cellular debris from prior episodes of inflammation, hemorrhage, or other causes.

Note: Trace benign, aqueous pigmented cells visible on slit-lamp examination that are caused by dilation and are not red blood cells or white blood cells or the result of any ocular disorder should not be recorded as an AE.

For the purposes of reporting events of elevated intraocular pressure, the following terms and definitions should be used:

- An AE of high IOP after the injection should be recorded as "Increased or Elevated IOP".
- Ocular Hypertension is a syndrome characterized by chronic elevated IOP with no optic nerve damage. Ocular hypertension should not be used to refer to a transient increase in IOP following the injection.
- Glaucoma is a condition with nerve damage, which may or may not have a concomitant high IOP.

#### Assessment of Intensity

The Investigator will make an assessment of intensity for each AE and SAE reported during the study and assign it to one of the following categories:

- Mild: An event that is easily tolerated by the participant, causing minimal discomfort and not interfering with everyday activities.
- Moderate: An event that causes sufficient discomfort to interfere with normal everyday activities.
- Severe: An event that prevents normal everyday activities. An AE that is assessed as severe should not be confused with an SAE. Severe is a category utilized for rating the intensity of an event; and both AEs and SAEs can be assessed as severe.

An event is defined as 'serious' when it meets at least one of the predefined outcomes as described in the definition of an SAE, NOT when it is rated as severe.

**Assessment of Causality**

The Investigator is obligated to assess the relationship between study intervention and each occurrence of each AE/SAE.

A “reasonable possibility” of a relationship conveys that there are facts, evidence, and/or arguments to suggest a causal relationship, rather than a relationship cannot be ruled out.

The Investigator will use clinical judgment to determine the relationship.

Alternative causes, such as underlying disease(s), concomitant therapy, and other risk factors, as well as the temporal relationship of the event to study intervention administration will be considered and investigated.

The Investigator will also consult the Investigator’s Brochure (IB) and/or Product Information, for marketed products, in his/her assessment.

For each AE/SAE, the Investigator must document in the medical notes that he/she has reviewed the AE/SAE and has provided an assessment of causality.

There may be situations in which an SAE has occurred, and the Investigator has minimal information to include in the initial report to the Sponsor. However, it is very important that the Investigator always make an assessment of causality for every event before the initial transmission of the SAE data to the Sponsor.

The Investigator may change his/her opinion of causality in light of follow-up information and send an SAE follow-up report with the updated causality assessment.

The causality assessment is one of the criteria used when determining regulatory reporting requirements.

The relationship to the intravitreal injection procedure or to study intervention will be assessed using the following definitions:

- Not Related - There is not a reasonable possibility that the AE is related to the injection procedure or to the study intervention.
- Related - There is a reasonable possibility that the AE is related to the injection procedure or to the study intervention.

**Follow-up of AEs and SAEs**

- The Investigator is obligated to perform or arrange for the conduct of supplemental measurements and/or evaluations as medically indicated or as requested by the Sponsor to elucidate the nature and/or causality of the AE or SAE as fully as possible. This may include additional laboratory tests or investigations, histopathological examinations, or consultation with other health care professionals.
- If a participant dies during participation in the study or during a recognized follow-up period, the Investigator will provide the Sponsor with a copy of any post-mortem findings including histopathology if applicable.
- New or updated information will be recorded in the originally submitted documents.
- The Investigator will submit any updated SAE data to the Sponsor within 24 hours of receipt of the information.

### 10.3.4 Reporting of SAEs

#### SAE Reporting to the Sponsor via an Electronic Data Collection Tool

- The primary mechanism for reporting an SAE to the Sponsor will be the electronic data collection tool.
- If the electronic system is unavailable, then the site will use the paper SAE data collection tool (see next section) to report the event within 24 hours.
- The site will enter the SAE data into the electronic system as soon as it becomes available.
- After the study is completed at a given site, the electronic data collection tool will be taken off-line to prevent the entry of new data or changes to existing data.
- If a site receives a report of a new SAE from a study participant or receives updated data on a previously reported SAE after the electronic data collection tool has been taken off-line, then the site can report this information on a paper SAE form (see next section) or to the Sponsor/medical monitor/SAE coordinator by telephone.



#### SAE Reporting to the Sponsor via Paper Data Collection Tool

- Facsimile transmission of the SAE paper data collection tool is the preferred method to transmit this information to the Sponsor/Medical Monitor or the SAE coordinator.
- In rare circumstances and in the absence of facsimile equipment, notification by telephone is acceptable with a copy of the SAE data collection tool sent by overnight mail or courier service.
- Initial notification via telephone does not replace the need for the Investigator to complete and sign the SAE data collection tool within the designated reporting time frames.



## 10.4 Appendix 4: Grading Scale for Assessment of Anterior Chamber Flare or Cells, Vitreous Cells or Haze.

### 10.4.1 Grading Scales for Anterior Chamber Cells or Flare

#### The SUN Working Group Grading Scale for Anterior Chamber Cells

Grade	Cells in Field <sup>1</sup>
0	<1
0.5+	1-5
1+	6-15
2+	16-25
3+	26-50
4+	>50

Abbreviations: SUN = Standardization of uveitis nomenclature.

<sup>14</sup> Field size is a 1 mm by 1 mm slit beam.

Source: ([Jabs 2005](#))

#### The SUN Working Group Grading Scale for Anterior Chamber Flare

Grade	Cells in Field <sup>1</sup>
0	None
1+	Faint
2+	Moderate (iris and lens details clear)
3+	Marked (iris and lens details hazy)
4+	Intense (fibrin or plastic aqueous)

Abbreviations: SUN = Standardization of uveitis nomenclature.

<sup>15</sup> Field size is a 1 mm by 1 mm slit beam.

Source: ([Jabs 2005](#))

**10.4.2 Grading Scale for Vitreous Cells**

Grade	Description
0	No Cells
½+	1-10
1 +	11-20
2 +	21- 30
3 +	31 - 100
4+	Greater than 100

Source: ([Foster 2013](#))**10.4.3 Grading Scale for Vitreous Haze**

Score	Description	Clinical Findings
0	Nil	None
1	Minimal	Posterior pole clearly visible
2	Mild	Posterior pole details slightly hazy
3	Moderate	Posterior pole details very hazy
4	Marked	Posterior pole details barely visible
5	Severe	Fundal details not visible

Source: ([Nussenblatt 1985](#))

## 10.5 Appendix 5: Unscheduled Safety Assessment Visits

Assessments performed at unscheduled safety visits are at the discretion of the Investigator. The following safety assessments are recommended:

- Vital signs (blood pressure, respiration rate, pulse, temperature);
- Hematology, serum chemistry panel, and coagulation panel;
- Best corrected visual acuity (BCVA);
- Slit-lamp examination (both eyes);
- Tonometry (both eyes);
- Indirect ophthalmoscopy (both eyes);
- Adverse events;
- Concurrent ocular procedures; and
- Concomitant medications.

The causality of adverse events is to be evaluated by a masked physician.

## 10.6 Appendix 6: Contraceptive and Barrier Guidance

### 10.6.1 Definitions

#### Women of Childbearing Potential (WOCBP)

A woman is considered fertile following menarche and until becoming postmenopausal unless permanently sterile (see below).

If fertility is unclear (e.g., amenorrhea in adolescents or athletes) and a menstrual cycle cannot be confirmed before first dose of study intervention, additional evaluation should be considered.

Women in the following categories are not considered WOCBP:

- Premenarchal
- Premenopausal female with one of the following:
  - Documented hysterectomy
  - Documented bilateral salpingectomy
  - Documented bilateral oophorectomy

For individuals with permanent infertility due to an alternate medical cause other than the above, (e.g., Müllerian agenesis, androgen insensitivity), Investigator discretion should be applied to determining study entry.

Note: Documentation can come from the site personnel's: review of the participant's medical records, medical examination, or medical history interview.

#### Postmenopausal Female

A postmenopausal state is defined as no menses for 12 months without an alternative medical cause.

A high follicle stimulating hormone (FSH) level in the postmenopausal range may be used to confirm a postmenopausal state in women not using hormonal contraception or hormone replacement therapy (HRT). However, in the absence of 12 months of amenorrhea, confirmation with more than one FSH measurement is required. The Screening Visit FSH will be processed using the chemistry tube and the Day 1 FSH will need to be collected separately and sent to the central lab for analysis. A pregnancy test is required until both FSH measurements have been collected and results have been received that verify the post-menopausal state of the female participant.

Females on HRT and whose menopausal status is in doubt will be required to use one of the non-estrogen hormonal highly effective contraception methods if they wish to continue their HRT

during the study. Otherwise, they must discontinue HRT to allow confirmation of postmenopausal status before study enrollment.

### 10.6.2 Contraception Guidance

Participants who use oral contraceptives, HRT, or other maintenance therapy should continue their use.

- For women of childbearing potential: agreement to remain as abstinent (refrain from heterosexual intercourse) or use contraceptive methods that result in a failure rate of <1% per year during the treatment period and [REDACTED]  
[REDACTED]
  - Examples of contraceptive methods with a failure rate of <1% per year include bilateral tubal ligation, male sterilization, established, proper use of hormonal contraceptives that inhibit ovulation, hormone-releasing intrauterine devices and copper intrauterine devices.
  - Contraception methods that do not result in a failure rate of <1% per year such as cap, diaphragm, or sponge with spermicide, or male or female condom with or without spermicide, are not acceptable.
  - The reliability of sexual abstinence should be evaluated in relation to the duration of the clinical trial and the preferred and usual lifestyle of the participant. Periodic abstinence (e.g., calendar, ovulation, symptothermal, or postovulation methods) and withdrawal are not acceptable methods of contraception.
- For men: agreement to remain abstinent or use contraceptive measures and agreement to refrain from donating sperm, as defined below:
  - With female partners of childbearing potential, men must remain abstinent or use a condom plus an additional contraceptive method that together result in a failure rate of <1% per year during the treatment period [REDACTED]  
[REDACTED] the last dose of study intervention. Men must refrain from donating sperm during this same time period.

### 10.6.3 Collection of Pregnancy Information

#### Female participants who become pregnant

- The Investigator will collect pregnancy information on any female participant who becomes pregnant while participating in this study. The initial information will be recorded on the appropriate form and submitted to the Sponsor within 24 hours of learning of a participant's pregnancy.

- The participant will be followed to determine the outcome of the pregnancy. The Investigator will collect follow-up information on the participant and the neonate, and the information will be forwarded to the Sponsor. Generally, follow-up will not be required for longer than 6 to 8 weeks beyond the estimated delivery date. Any termination of pregnancy will be reported, regardless of fetal status (presence or absence of anomalies) or indication for the procedure.
- While pregnancy itself is not considered to be an AE or SAE, any pregnancy complication or elective termination of a pregnancy for medical reasons will be reported as an AE or SAE.
- A spontaneous abortion (occurring at <22 weeks gestational age) or stillbirth (occurring at >22 weeks gestational age) is always considered to be an SAE and will be reported as such.
- Any post-study pregnancy related SAE considered reasonably related to the study intervention by the Investigator will be reported to the Sponsor, as described in [Section 8.3.4](#). While the Investigator is not obligated to actively seek this information in former study participants, he or she may learn of an SAE through spontaneous reporting.
- Any female participant who becomes pregnant while participating in the study will discontinue study intervention or be withdrawn from the study.

### **Male participants with partners who become pregnant**

- The Investigator will attempt to collect pregnancy information on any male participant's female partner who becomes pregnant while the male participant is in this study. This applies only to male participants who receive any study intervention.
- After obtaining the necessary signed informed consent from the pregnant female partner directly, the Investigator will record pregnancy information on the appropriate form and submit it to the Sponsor within 24 hours of learning of the partner's pregnancy. The female partner will also be followed to determine the outcome of the pregnancy. Information on the status of the mother and child will be forwarded to the Sponsor. Generally, the follow-up will be no longer than 6 to 8 weeks following the estimated delivery date. Any termination of the pregnancy will be reported regardless of fetal status (presence or absence of anomalies) or indication for the procedure.

## 10.7 Appendix 7: Liver Safety

Investigators must report to the Sponsor immediately (within 24 hours) the following laboratory findings as an AE indicative of severe liver injury (as defined by Hy's Law):

- Treatment-emergent ALT or AST more than 3 times the Upper Limits of Normal (ULN) in combination with an elevated total bilirubin (more than 2 times the ULN)
- Treatment-emergent ALT or AST more than 3 times the ULN in combination with clinical jaundice

The most appropriate diagnosis or (if the diagnosis cannot be established) the abnormal laboratory values should be recorded in the eCRF.

## 10.8 Appendix 8: Protocol Amendment History

The amendment history for Protocol KS301P107 is provided in [Table 5](#).

**Table 5: Protocol KS301P107: Amendment History**

Version	Version Date	Description
2.0	16 March 2022	<p>Changes from Version 1.1 include the following:</p> <ul style="list-style-type: none"><li>• [REDACTED]</li><li>• [REDACTED]</li><li>• Minor editorial and administrative revisions.</li></ul>
1.1	13 May 2021	<p>Changes from Version 1.0 include the following:</p> <ul style="list-style-type: none"><li>• Minor editorial and administrative revisions.</li></ul>
1.0	07 April 2021	<p>Original protocol; used for pre-submission review with a US Central IRB. This version was not submitted to any health authorities, nor was it implemented.</p>

## 11.0 REFERENCES

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