# Statistical Analysis Plan (SAP)

**GCT1107-01**
**A Phase 1/2 Study of PRO1107 in Patients with Advanced Solid Tumors**

| | |
|---|---|
| **Compound:** | GEN1107; IgG1-PTK7-LD343 |
| **Trial Phase (if applicable):** | 1b/2 |
| **Document Date and Version:** | 24 April 2025, Version 1.0 (original) |

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# VERSION HISTORY

This Statistical Analysis Plan (SAP) for Trial GCT1107-01 is based on the protocol version 3.0 dated 13 Feb 2025.

| SAP Version | Approval Date | Change | Rationale |
|---|---|---|---|
| 1 | 24 April, 2025 | Not Applicable | Original version |

# Abbreviations

| | |
|---|---|
| acMMAE | antibody-conjugated monomethyl auristatin E |
| ADA | antidrug antibody |
| ADC | antibody-drug conjugate |
| AE | adverse event |
| ALC | absolute lymphocyte count |
| ALK | anaplastic lymphoma kinase |
| ALT | alanine aminotransferase |
| ANC | absolute neutrophil count |
| ASCO-CAP | American Society of Clinical Oncology-College of American Pathologists |
| AST | aspartate aminotransferase |
| ATS | all-treated patients |
| AUC | area under the curve |
| β-hCG | beta human chorionic gonadotropin |
| BCVA | best corrected visual acuity |
| BRAF | v-RAF murine sarcoma viral oncogene homolog B |
| BSA | body surface area |
| $C_{eoi}$ | concentration at the end of infusion |
| $C_{max}$ | maximum concentration |
| $C_{trough}$ | trough concentration |
| CBC | complete blood count |
| CFR | Code of Federal Regulations |
| CI | confidence interval |
| CKD-EPI | Chronic Kidney Disease Epidemiology Collaboration |
| CLIA | Clinical Laboratory Improvement Amendments |
| CMP | comprehensive metabolic panel |
| cCR | confirmed complete response |
| CR | complete response |
| cPR | confirmed partial response |
| CRF | case report form |
| CT | computed tomography |
| CYP3A | cytochrome P450 3A |
| DE | DLT-evaluable |
| DEC | Dose Escalation Committee |
| DILI | drug-induced liver injury |
| DLT | dose-limiting toxicity |
| dMMR | deficient in mismatch repair |
| DNA | deoxyribonucleic acid |

| | |
|---|---|
| DOR | duration of objective response |
| ECG | electrocardiogram |
| ECOG | Eastern Cooperative Oncology Group |
| eCRF | electronic case report form |
| EE | efficacy evaluable |
| EGFR | epidermal growth factor receptor |
| ELISA | enzyme-linked immunosorbent assay |
| EOT | end of treatment |
| ER | estrogen receptor |
| ESCC | esophageal squamous cell carcinoma |
| FDA | Food and Drug Administration |
| FFPE | formalin-fixed paraffin-embedded |
| FGFR | fibroblast growth factor receptor |
| FIH | first-in-human |
| FRα | folate receptor alpha |
| GCIG | Gynecological Cancer Intergroup |
| G-CSF | granulocyte colony-stimulating factor |
| GEJ | gastroesophageal junction |
| GLP | Good Laboratory Practice |
| GM-CSF | granulocyte, macrophage colony-stimulating factor |
| HBsAg | hepatitis B surface antigen |
| HBV | hepatitis B virus |
| HCV | hepatitis C virus |
| HER2 | human epidermal growth factor receptor 2 |
| Hgb | hemoglobin |
| HIV | human immunodeficiency virus |
| HNSTD | highest non-severely toxic dose |
| HRD | homologous recombination deficiency |
| IB | Investigator's Brochure |
| ICH | International Council for Harmonisation |
| IEC | independent ethics committee |
| IHC | immunohistochemistry |
| ILD | interstitial lung disease |
| IND | investigational new drug |
| IRB | institutional review board |
| IRR | infusion-related reaction |
| IV | intravenous |
| LC-MS/MS | liquid chromatography with tandem mass spectrometry |
| MedDRA | Medical Dictionary for Regulatory Activities |

| | |
|---|---|
| MMAE | monomethyl auristatin E |
| MRI | magnetic resonance imaging |
| MTD | maximum tolerated dose |
| NCI CTCAE | National Cancer Institute Common Terminology Criteria for Adverse Events |
| NGS | next generation sequencing |
| NSAIDs | non-steroid anti-inflammatory drugs |
| NSCLC | non-small cell lung cancer |
| NTD | non-tolerated dose |
| OCT | optical coherence tomography |
| ORR | objective response rate |
| OS | overall survival |
| PARP | poly-ADP ribose polymerase |
| PCR | polymerase chain reaction |
| PD | progressive disease |
| PD-1 | programmed cell death protein-1 |
| PD-L1 | programmed death-ligand 1 |
| PFS | progression-free survival |
| PK | pharmacokinetic(s) |
| PKE | PK-evaluable |
| pMMR | proficient in mismatch repair |
| PO | per oral (by mouth) |
| PR | partial response |
| PROC | platinum-resistant ovarian cancer |
| PTK7 | protein tyrosine K 7 |
| PT/PTT/INR | prothrombin time/partial thromboplastin time/international normalized ratio |
| RECIST | Response Evaluation Criteria in Solid Tumors |
| ROS1 | proto-oncogene tyrosine-protein kinase ROS |
| RP2D | recommended Phase 2 dose |
| SAE | serious adverse event |
| SAP | statistical analysis plan |
| SOE | schedule of events |
| SUSAR | suspected unexpected serious adverse reaction |
| t1/2 | half-life |
| TAb | total antibody |
| TEAE | treatment-emergent adverse event |
| $T_{max}$ | time to maximum concentration |
| TNBC | triple-negative breast cancer |
| ULN | upper limit of normal |
| uMMAE | unconjugated monomethyl auristatin E |

| | |
|---|---|
| UPC | urine protein/creatinine ratio |
| USP | United States Pharmacopeia |
| WFI | water for injection |

# 1 INTRODUCTION

## 1.1 Scope of the Statistical Analysis Plan

This SAP for GCT1107-01 is based on protocol version 3.0 dated 13 Feb 2025. It describes definitions of analysis sets, derived variables, and statistical methods for the planned analyses as specified in the protocol.

## 1.2 Objectives and Endpoints

**Table 1 Objectives and Endpoints**

| OBJECTIVES | ENDPOINTS |
|---|---|
| **Primary** | |
| • Evaluate the safety and tolerability of GEN1107<br>• Identify the maximum tolerated dose (MTD), if reached, and the recommended dose for expansion of GEN1107 | • Type, incidence, severity, and seriousness of adverse events (AEs) per the National Cancer Institute Common Terminology Criteria for Adverse Events (NCI CTCAE), Version 5.0, and per Appendix K, and relatedness of AEs<br>• Type, incidence, and severity of laboratory abnormalities<br>• Incidence of dose-limiting toxicities (DLTs) |
| • **Secondary** | |
| • Assess the antitumor activity of GEN1107<br>• Assess the PK of GEN1107<br>• Assess the immunogenic potential of GEN1107<br>• Evaluate preliminary antitumor activity based on CA-125 tumor marker levels in subjects with ovarian cancer | • ORR per RECIST, Version 1.1<br>• DCR<br>• PFS<br>• DOR<br>• PK parameters for GEN1107 related analytes<br>• Incidence of ADA<br>• CA-125 response per GCIG criteria for ovarian cancer |
| **Exploratory** | |
| • Evaluate efficacy of GEN1107<br>• Assess exploratory biomarkers in relation to antitumor activity, safety, pharmacodynamics, and resistance to GEN1107 | • OS<br>• Exploratory biomarkers of GEN1107-mediated and disease-related effects |
| Abbreviations: ADA=antidrug antibodies; AE=adverse event; DCR=disease control rate; DLT=dose-limiting toxicity; DOR=duration of objective response; MTD=maximum tolerated dose; NCI CTCAE=National Cancer Institute Common Terminology Criteria for Adverse Events; ORR=objective response rate; OS=overall survival; PFS=progression-free survival; PK=pharmacokinetics; RECIST=response evaluation criteria in solid tumors. | |

## 1.3 Trial Design

This is a global, open-label, multicenter Phase 1/2 study to evaluate the safety, tolerability, PK, and antitumor activity of GEN1107 in patients with advanced solid tumors. This study consists of 2 parts, Part A: dose escalation and dose level expansion, and Part B: tumor specific expansion. The study design is depicted in Figure 1.

Up to 280 patients may be enrolled in this study (up to 120 patients in Part A and up to 160 patients in Part B).

**For Dose escalation in Part A**, the trial will evaluate 7 dose levels. GEN1107 will initially be administered on Day 1 of a 21-day cycle via IV infusion at the planned doses outlined in Table 2. (Q3W, Dose Regimen 1)

**Table 2 Dose Escalation Schema for Q3W regimen**

| GEN1107 Dose ($mg/m^2$) |
|---|
| 8 |
| 15 |
| 30 |
| 45 |
| 60 |
| 75 |
| 90 |

The DEC may recommend investigation of lower or intermediate dose levels based on emerging clinical data

Two alternative dosing regimens may also be investigated based on review of safety, antitumor activity, and PK data. In the first alternative dosing regimen (2Q4W, Dose Regimen 2), the dose would be administered on Day 1 and 8 of each 28-day cycle. CCI [redacted] The 2Q4W regimen will be evaluated as the first alternative dosing regimen. The CCI [redacted] will be based on review of safety, antitumor activity, and PK data from Q3W and 2Q4W regimens evaluated in clinic.

**Table 3 Dose Escalation Schema for 2Q4W regimen**

| GEN1107 Dose ($mg/m^2$) |
|---|
| 30 |
| 40 |
| 50 |

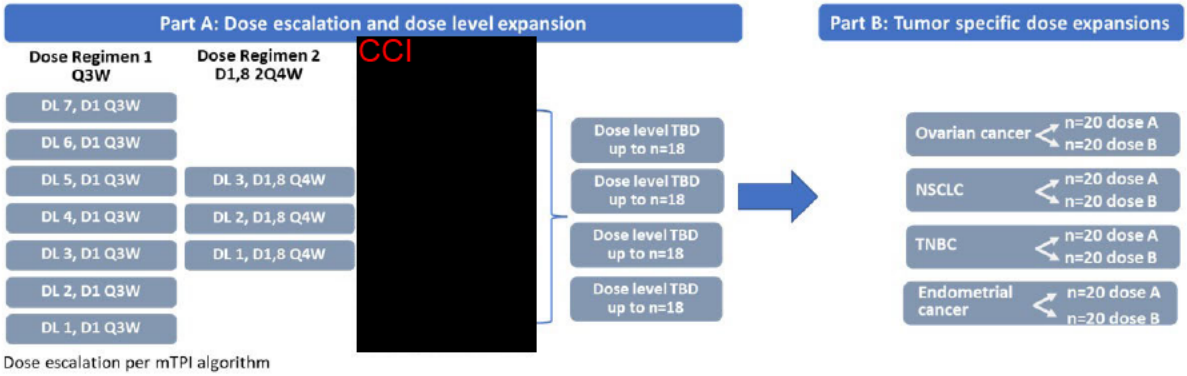
The DEC may recommend investigation of additional (intermediate) dose levels based on emerging clinical data

**For Dose level expansion in Part A**, If recommended by the DEC, up to 4 dose cohorts across dose regimens may be expanded up to a total of up to approximately 18 patients per dose level to obtain additional safety, pharmacokinetic(s)(PK), pharmacodynamics, and activity data to estimate the optimal biological dose(s) and inform selection of the recommended expansion doses, to further support dose optimization in Part B. Patients enrolled at these dose levels may be selected based on their tumor types to inform Part B dose expansion decisions.

**For Tumor-specific expansion in Part B**, to further support dose optimization, Part B will be initiated at 2 or more expansion doses based on a comprehensive analysis of safety, tolerability, PK, pharmacokinetic(s), and antitumor activity data from Part A in up to 4 different tumor-specific cohorts of up to 40 patients per cohort, each cohort evaluating up to 2 dose levels. The dose expansions may be the MTD or a lower dose level from Part A and different dose levels may be selected for each expansion cohort. Patients in each cohort will be randomized with a 1:1 ratio to receive 1 of the dose expansions of GEN1107 (approximately 20 patients in each dose level). If the Safety Committee determines that only one dose level is appropriate for further testing for a particular tumor type, an initial 20 patients may be evaluated at that dose level. Additional dose levels may be tested based on the totality of available data.

Safety and antitumor activity will be continuously monitored throughout the study by the Sponsor. An ongoing, quarterly review of patient safety and SAEs will be conducted by the Safety Committee during Part B.

**Figure 1 Overview of Trial Design Schema**




Abbreviations: DL=dose level; mTPI= Modified Toxicity Probability Interval; NSCLC= non-small cell lung cancer; Q3W=every 3 weeks; Q4W=every 4 weeks;TBD=to be determined; TNBC= triple-negative breast cancer
Note: In Part A, up to 18 patients can be enrolled at a single dose level (9 patients in dose escalation and 9 patients in dose level expansion). Dotted line indicates that the dose regimen may be evaluated based on accumulated data in the future.

## 1.4 Randomization and Blinding

Not applicable as this is an open-label study.

# 2 STATISTICAL HYPOTHESES

No formal statistical hypothesis testing will be performed.

# 3 ANALYSIS SETS

Analysis sets in this study are defined in the following:

**All-treated Subjects Analysis Set**: The All-treated Subjects (ATS) analysis set includes all patients who receive any amount of GEN1107. The ATS set will be used for the presentation of safety data and may be used for sensitivity analyses of efficacy endpoints.

**DLT-evaluable Analysis Set:** The DLT-evaluable (DE) analysis set includes all treated patients with one dose received for Q3W and two doses received for 2Q4W who either experienced a DLT or remained on study for the full DLT evaluation period.

**Efficacy-evaluable Analysis Set:** The efficacy-evaluable (EE) analysis set includes all treated patients who had a baseline and at least 1 postbaseline disease assessment according to RECIST Version 1.1, or who had investigator claim of clinical progression after the first dose of GEN1107.

**Response-Evaluable Analysis Set:** The response-evaluable (RES) analysis set includes all treated subjects who have measurable disease at baseline and have at least 1 post-baseline disease evaluation or die within 60 days of first dose of trial drug.

Measurable disease based on investigator assessment is defined as: ≥1 measurable nodal lesion (long axis >1.5 cm and short axis >1.0 cm) or ≥1 measurable extra-nodal lesion (long axis >1.0 cm) on computerized tomography (CT) scan or magnetic resonance imagining (MRI) scan.

**PK-evaluable Analysis Set:** The PK-evaluable (PKE) analysis set includes all patients who receive any amount of GEN1107 and have at least one postbaseline concentration measurement.

# 4 STATISTICAL ANALYSES

## 4.1 General Considerations

Analyses will be carried out using SAS (Version 9.4 or higher), unless otherwise noted.

The primary analyses on efficacy endpoints will be analyzed using the ATS.

Subgroup analysis may be applied if needed.

In general, continuous variables will be summarized using descriptive statistics such as mean,

Std Dev, median, and range. Categorical variables will be summarized using frequency and percentage. Time to event variables will be analyzed using KM estimates (median time, first and third quartiles) with the number and percentage of subjects with events or censoring reported. If specified, 95% confidence intervals will be provided using Brookmeyer and Crowley method with log-log transformation. For the calculation of time-to-event and duration-of-event variables, the difference between the start date and the end date plus one will be used.

For the dose escalation part, the listings of DLTs observed during DLT period, subject information including demographic and disease characteristic, concomitant medications, medical history, AE, and efficacy will be provided for subjects enrolled in dose escalation part.

Data values below the lower limit of quantification (e.g., PK concentration values) will be handled as LLOQ/2 in summary statistics (tables and figures) and reported as is in data listings.

Any missing data values will not be imputed (dates expected).

### *4.1.1 Study Cycle, Days and Periods*

Study Day 1 or Day 1 refers to the reference start date (the first dose of trial drug for treated subjects). All efficacy and safety assessments at all visits will be assigned a day relative to this date.

Study day or relative day for a visit is defined as:

- Visit date - (date of Day 1) +1, if visit date ≥ date of Day 1
- Visit date - date of Day 1, if visit date < date of Day 1
- There is no “Day 0”.

Cycle day is presented by both cycle number and cycle day number, where C2D1 represents Day 1 of Cycle 2. The day of the first dosing of trial drug for a given cycle is considered Day 1 of that cycle, and cycle day in general is calculated as for study day:

- Cycle day = Assessment date – Date of first dose of trial drug in that specific cycle + 1, where assessment date is on or after the date of first dose.

Cycle day is not defined for dates prior to the first dose of trial drug, or for dates greater than 21 (Q3W cycles)/28 (Q4W cycles) days after the last dose of trial drug.

In infrequent cases, a new cycle might be delayed; the days between the 21st (Q3W cycles)/28th (Q4W cycles) day of the last cycle and the 1st day of the new cycle will be considered off-cycle days, and cycle day will not be defined. If a new cycle starts slightly earlier than the planned day for any reason, the first day of dosing in that cycle will be considered Cycle x Day 1, and the prior cycle will have <21 (Q3W cycles)/<28 (Q4W cycles) days.

The overall observation period will be divided into 3 mutually exclusive segments:

- Pre-treatment period: from day of subject's informed consent to the day before first dose of trial drug
- On-treatment period (treatment-emergent): from day and time of first dose of trial medication to 30 days after last dose of trial medication, or initiation of new anti-cancer therapy, whichever comes first
- Post-treatment period: starting at one day after the end of on-treatment period

If incomplete data makes it impossible to definitively assign an observation to one of these periods, the data will be assigned to the on-treatment period.

### *4.1.2 Visit Windows*

Any efficacy analysis that utilizes time-to-event approach will be based on an exact determination of time from Cycle 1 Day 1 to the date of event/censoring.

### *4.1.3 Derivation of Endpoints Related to RECIST v1.1*

#### *4.1.3.1 BOR regardless of confirmation*

The Best Overall Response (BOR) regardless of confirmation for a subject is defined as the best timepoint response in the order of Complete Response (CR), Partial Response (PR), Stable Disease (SD), Progressive Disease (PD) and Non-Evaluable (NE). The minimum time from first dose of trial treatment required to qualify for an assessment of SD is 5 weeks (35 days), corresponding to the minimum planned time of the first investigator's assessment timepoint.

#### *4.1.3.2 BOR with confirmation*

Confirmation of CR and PR should occur at the next assessment. The confirmation should occur no less than 4 weeks following the initial assessment at which CR or PR is observed. Confirmed BOR of CR or PR is derived per RECIST v1.1 (Table 4).

**Table 4 Best Overall Response When Confirmation of CR and PR Required per RECIST 1.1**

| Overall Response First Time Point | Overall Response Subsequent Time Point (≥4 Weeks from First Time Point) | Best Overall Response with Confirmation |
|---|---|---|
| CR | CR | CR |
| CR | PR | Data check or data cleaning – this should never happen. |
| CR | SD | Data check or data cleaning – this should never happen. |

| | | |
|---|---|---|
| CR | PD | SD if CR is at least 5 weeks from first dose, otherwise PD |
| CR | NE | SD if CR is at least 5 weeks from first dose, otherwise NE |
| PR | CR | PR |
| PR | PR | PR |
| PR | SD | SD |
| PR | PD | SD if PR is at least 5 weeks from first dose, otherwise PD |
| PR | NE | SD if PR is at least 5 weeks from first dose, otherwise NE |

Abbreviations: CR=complete response; NE=non-evaluable; PD=progressive disease; PR=partial response; SD=stable disease.
Note: Intermediate missing (NE) scan evaluations between the response scan and the confirmation scan are allowed, e.g. the sequences PR-NE-PR and PR-NE-NE-PR will be considered PR confirmed. CR-NE-NE-CR will be considered CR confirmed, PR-SD-PR or PR-SD-CR will also be considered as PR confirmed.

#### *4.1.3.3 Date of RECIST response at each on-trial assessment*

For any one response assessment, scans to evaluate all sites of disease can be performed on multiple dates. Nonetheless, a single date is required for the associated response.
The rules that are dependent on the overall response, described in the subsections below, are used to assign dates to responses (Paules et al., 2011).

***Date of PD***
The date of PD is the earliest date that PD has been documented, i.e., the earliest of:

- Dates of target lesion assessments when the target lesion response is PD
- Dates of non-target assessments where the lesion status is PD
- Date(s) documenting new lesion(s)

***Date of SD***
The date of SD is the earliest date of lesion assessment at a visit. The earliest date provides the most conservative method of determining SD because all scans used to determine SD are dated the same as or later than the 35 days cut-off for SD (see Section 4.1.3.1).

***Date of CR or PR***
The date of CR or PR is the latest date of a lesion assessment at the visit. If any assessment dates are missing or not reported, then a date of response cannot be assigned. Use of the latest date aligns with the requirement to assess all target lesions when assigning response.

### *4.1.4 Imputation of Missing or Partial Dates*

The following conventions will be used for imputing missing or partial dates, unless specified otherwise.

- If a date is completely missing, there will be no imputation.
- If only the day of the month is missing, the 15th of the month will be used to impute the missing day
- If both the day and the month are missing, 01JUL will be used to impute the missing Information

For analysis and reporting purpose, partial/missing dates such as adverse event onset/end date, concomitant therapies start/end date, disease initial diagnosis date, and start date of subsequent anti-cancer therapy will be imputed. The detailed imputation rules will be specified in separate documents (ADaM specification and Data Presentation Plan).

Imputed dates are for analysis only. Original dates will be displayed in the relevant listings.

#### *4.1.5 Year and Month*

One-year equals 365.25 days and one-month equals 30.4375 days.

#### *4.1.6 Treatment Emergent Adverse Events*

A Treatment-emergent adverse event (TEAE) is defined as any AE with an onset date or worsening grade within the on-treatment period, which is from day of first dose of trial drug and within 30 days after last dose of the trial drug. On-treatment period is defined in section 4.1.1.

A pre-treatment AE is defined as any AE that is not treatment-emergent, with an onset before administration of first dose and no worsening during the treatment emergent period. Pre-treatment period is defined in section 4.1.1.

A post-treatment AE is defined as any AE with onset date during the post-treatment period. Post-treatment period is defined in section 4.1.1.

### 4.2 Subject Information

#### *4.2.1 Subject Disposition*

Subject enrollment will be summarized by region and country.

The following disposition information will be summarized:

- Number of screened subjects
- Number of subjects enrolled to each arm and number of subjects considered DLT evaluable for safety run-in part

- Number of subjects enrolled to each arm and overall
- Number of screen failures and the corresponding reason
- Number and percentage of subjects who are treated
- Number and percentage of subjects who are not treated and the corresponding reason
- Number and percentage of subjects who discontinue GEN1107 and the corresponding reason
- Number and percentage of subjects who discontinue trial and the corresponding reason

A listing of screen failures will be provided, including the eligibility criteria that were not met. A listing of subject disposition will be provided, including the status/reason of treatment discontinuation and trial discontinuation for the ATS.

Time to treatment discontinuation for each trial drug, defined as the time from first infusion of the drug to discontinuation of the drug, will be presented per treatment discontinuation due to: adverse events, clinical disease progression, or other as per collected in the CRF.

In addition, summary for duration of follow-up will be provided. The median duration of follow-up will be estimated using the Kaplan-Meier method.

### *4.2.2 Protocol Deviations*

Protocol deviations will be based on clinical review, e.g., including but not limited to the following: eligibility criteria, treatment compliance (including receiving disallowed concomitant medication and/or incorrect treatment/dose), safety assessment deviation, efficacy assessment deviation, and others which might significantly impact safety/efficacy assessment.

Protocol deviations will be closely monitored during the execution of the trial and the final set of protocol deviation criteria will be finalized before database lock.

Subjects with important protocol deviations will be summarized by types of deviation and listed Separately in the ATS.

### *4.2.3 Demographics and Disease Characteristics*

The following baseline demographic information will be presented: age (continuous/categorical), sex at birth, race, ethnicity, weight (kg), height (cm), body mass index ($kg/m^2$), and body surface area ($m^2$).

The following baseline disease characteristics will be summarized: primary tumor type, histology type, time from initial diagnosis to first dose, Ann Arbor staging, Mismatch Repair (MMR) Status, Microsatellite Instability (MSI) Status, Tumor Mutational Burden (TMB) High, Platinum sensitivity Status, and ECOG performance score.

### *4.2.4 Medical History*

Medical history findings reported by the investigator will be coded using the most recent MedDRA version before database lock and summarized by system organ class and preferred term. The diseases will be classified as follows:

- Previous medical conditions (or surgeries), ie, conditions that stopped prior to first dose.
- Ongoing (concomitant) medical conditions (or surgeries), ie, conditions still present at first dose.

The frequency of medical history conditions will be presented after classification into previous and concomitant conditions by SOC as well as the frequencies of preferred term (PT) within each system organ class (SOC).

Pre-existing conditions (i.e., disorders present before the AE reporting period started and noted in the medical history/physical examination form) will be coded by MedDRA. Noted medical history will be tabulated by system organ class and preferred term in the ATS.

### *4.2.5 Prior and Concomitant Medications*

Medications will be coded to preferred term and ATC therapeutic class according to WHO Drug dictionary.

Medications will be classified as either prior or concomitant. Prior medication is defined as medication that ended prior to the first dose of trial treatment. Concomitant medication includes medications taken (or ongoing) on or after first dose of trial treatment through to the end date of the on-treatment period as defined in Section 4.1.1.

The number and frequency of subjects using prior medications and concomitant medications will be summarized by ATC and preferred term name.

### *4.2.6 Prior and Subsequent Anti-Cancer Therapies*

Prior cancer therapies, including prior systemic anti-cancer therapy, prior anti-cancer radiotherapy and prior cancer surgery, will be summarized by each dose level and overall.

The number of prior lines of systemic therapy and number of prior lines of therapy will be summarized descriptively. In addition, time from end of last line of systemic therapy to first dosing date and time from end of last line of therapy to first dosing date will be summarized descriptively.

Summaries will include the following:

- Number of subjects received any prior systemic anti-cancer therapy
- Number of subjects received any prior anti-cancer radiotherapy
- Number of subjects received any prior cancer surgery

All prior systemic therapies will also be summarized by Anatomical Therapeutic Chemical (ATC) class according to World Health Organization (WHO) Drug Dictionary.

All prior systemic therapies, radiotherapy and surgery will be listed by subject.

Subsequent anti-cancer therapies are defined as any therapy (systemic, radiotherapy, surgery) started after trial treatment has been permanently discontinued. Subsequent anti-cancer therapies will be coded to preferred drug name and Anatomical Therapeutic Chemical (ATC) class according to World Health Organization (WHO) Drug dictionary.

The number and percentage of subjects who received any subsequent anti-cancer therapy will be Summarized by each dose level and overall and in the categories systemic therapy, radiotherapy, surgeries. All subsequent anti-cancer therapies will also be presented by therapeutic class (ATC) and preferred drug name if applicable.

#### *4.2.7 Exposure and Compliance*

The following analysis will be summarized in ATS:

Administration of GEN1107 will be summarized by descriptive statistics for the following: number of cycles received, duration of treatment, number of doses received, and relative dose intensity.

Duration of treatment is defined as the time between the first dose date and the last dose date+1. Dose intensity will be calculated and summarized by dose level.

Relative dose intensity (%) is derived as the actual dose intensity divided by the corresponding planned full dose intensity in the analysis period. The relative dose intensity (%) will be calculated for trial drug using descriptive statistics by dose level.

A list of dose modifications by each subject maybe be provided per data collection.

### 4.3 Primary/Secondary Endpoint(s) Analysis

The detailed analysis approaches for the primary and secondary endpoints in this trial as mentioned in section 1.2 are included in this section.

The efficacy endpoints of this study, such as Objective Response Rate (ORR), Duration of Response (DOR), and Progression-Free Survival (PFS), are determined by RECIST v1.1 per investigator assessment.

### *4.3.1 Incidence of DLTs*

In the Dose Escalation Part, the DE will be used to summarize the incidence of DLTs as observed during the DLT period.

The observed number and proportion of patients experiencing DLTs will be reported for the dose-escalation part.

Both summary tables and listings of DLTs will be provided.

### *4.3.2 ORR*

#### *4.3.2.1 Definition of Endpoint(s)*

ORR is defined as the proportion of subjects with a confirmed BOR of partial response (PR) or complete response (CR) according to RECIST v1.1 criteria. Please refer to section 4.1.3.2 for further details on derivation of confirmed BOR.

#### *4.3.2.2 Main Analytical Approach*

Primary analysis of ORR will be investigator-assessed per RECIST v1.1 in the EE analysis set. ORR and the corresponding 2-sided 95% CI calculated by Clopper-Pearson (exact) will be provided for each dose level.

Best overall response prior to initiation of subsequent anti-cancer therapy per response criteria will be summarized. Number and percentage of subjects within each response category (confirmed CR, confirmed PR, SD, PD and NE) per RECIST v1.1 will be calculated based on the EE set and ATS and presented for each dose level and overall.

The best percentage change in target lesions from baseline (maximal reduction in the percentage change of the sum of the target lesions diameters from baseline) at any time on trial till the first PD and including the first PD, will be presented using waterfall plots. Spider plot and swim lane will also be provided per data.

### *4.3.3 Disease Control Rate*

#### *4.3.3.1 Definition of Endpoint(s)*

The DCR is defined as the percentage of patients having SD or achieving a PR or CR (DCR=SD + PR + CR).

#### *4.3.3.2 Main Analytical Approach*

Disease control rate (DCR) is defined as the proportion of subjects with BOR of confirmed CR, confirmed PR, or SD, per RECIST v1.1 as assessed by investigator. The DCR will be conducted similarly as ORR. DCR will be calculated based on the EE analysis set, and its exact 95% CI, calculated by the Clopper-Pearson method, will be presented for each dose level.

### *4.3.4 Duration of Response*

#### *4.3.4.1 Definition of Endpoint(s)*

Duration of Response (DOR) is defined for confirmed responders as the time from the first documentation of an objective tumor response (CR or PR) to the first documentation of tumor progression or to death due to any cause, whichever comes first. DOR will be derived for subjects who achieved BOR of PR or CR.

#### *4.3.4.2 Main Analytical Approach*

Main analysis for DOR will be based on disease assessment per investigator assessment by RECIST v1.1 in the EE analysis set. DOR will be analyzed for each dose level using the Kaplan-Meier method, censoring at the date of the last evaluable response assessment before the earliest of start of new anti-cancer therapy, trial discontinuation, and data cutoff date in case of no prior progression event (death or radiographic progression). In case of a progression event after 2 consecutive missing radiographic assessments, censoring will be done at the date of last progression assessment with documented non-progression prior to the missed assessments. Response assessments will be continued until disease progression, start of subsequent anti-cancer therapy, withdrawal of consent, death, or loss to follow up, whichever occurs first. See the table below for further details on censoring.

The DOR will be displayed graphically. A summary table will be produced presenting numbers of events and censored, minimum, maximum, median, first and third quantile, and landmark DOR rates at certain months (for example. 3, 6, 9, etc. per data availability). Median and first and third quantile along with two-sided 95% CI.

**Table 5 Censoring events and time for DOR and PFS**

| **Situation** | **Date of Progression or Censoring** | **Censoring Rule** |
|---|---|---|
| Death before first tumor assessment | Date of death | Event |
| Documented PD between adequate** assessment visits | First date of assessment demonstrating documented PD | Event |

| | | |
|---|---|---|
| Death between adequate** assessment visits | Date of death | Event |
| Death or documented PD after two or more consecutive missed visits*** | Date of last progression assessment with documented non-progression assessment prior to the missed visits* | Censored |
| No documented PD or death prior to analysis data cutoff, trial discontinuation, start of new anti-cancer treatment# | Date of last adequate tumor assessment with no documented PD before the situation* | Censored |
| Incomplete or no baseline tumor assessments | Cycle 1 Day 1 | Censored |

Note: an adequate assessment is defined as a tumor assessment where response is CR, PR, or SD, i.e., not NE.
* Excluding tumor assessments with NE as overall time point response. If no such assessment exists, the censoring date will be Cycle 1 Day 1. Should PD or death occur at same date as analysis data cutoff, trial discontinuation date, or start of new anti-cancer therapy, they will yield as events (not a censoring situation).
** No more than one missed visit, no anti-cancer therapy etc. before the death or documented progression.
*** This includes visits where response is assessed as NE. If xx or more days passed between 'no documented PD'-visit and 'documented PD'-visit, or death. xx is defined as 91 days if the non-documented PD visit occurs during the first 6 weeks, 133 days if it occurs during Week 48 and 175 days if it occurs during or after Week 60. In case there is no RECIST assessment (that is not 'NE'), the check for 2 or more missed visits (91 days) will be done against Cycle 1 Day 1 to evaluate if an event occurred. For more details refer to the DPS.

# Anti-cancer therapy for efficacy purpose: systemic treatment, radiotherapy to target lesion(s), non-palliative radiotherapy to non-target lesion(s), surgery to target lesion(s), all new transplants, and CAR-T.

General note: Should an event occur on the same date as a censoring mechanism, it will not be censored.

### *4.3.5 Progression-free Survival*

#### *4.3.5.1 Definition of Endpoint(s)*

PFS is defined as the time from the start of any study treatment to first documentation of disease progression or to death due to any cause, whichever comes first. Disease progression includes objective evidence of tumor progression or clinical progression per Investigator.

#### *4.3.5.2 Main Analytical Approach*

PFS will be analyzed using the Kaplan-Meier method applying the same censoring rules as described for DOR in section 4.3.4.

PFS at certain months (for example. 3, 6, 9 and 12 months as needed) estimated via the Kaplan-Meier method (i.e., percentage of subjects with PFS ≥3 months, PFS ≥6 months, PFS ≥9 months, and ≥12 months respectively) will also be summarized upon data availability.

#### *4.3.6 Supportive Secondary Endpoint(s)*

For details on supportive secondary endpoints analyses of pharmacodynamic parameters, ADAs, and PK parameters endpoints, see Section 4.6.

##### *4.3.6.1 CA-125 response per GCIG criteria for ovarian cancer*

For patients with ovarian cancer, a CA-125 response per the GCIG criteria (Rustin et al. 2011) is defined as a ≥50% reduction in CA-125 levels from baseline. The following must also apply:

- CA-125 levels must be ≥2.0 times the ULN within 2 weeks before starting treatment
- The CA-125 response must be confirmed and maintained for at least 28 days

The date of response corresponds to the date when the CA-125 level is first reduced by 50%.

The CA-125 response rate is defined as the percentage of patients achieving a CA-125 reduction per the GCIG criteria during treatment. The CA-125 response rate may be calculated for the subset of applicable patients.

A summary table of CA-125 response may be provided for ovarian cancer as needed.

### 4.4 Exploratory Endpoint(s) Analysis

For details on exploratory analyses of biomarker endpoints, please see Section 4.6.

#### *4.4.1 Overall Survival*

##### *4.4.1.1 Definition of Endpoint(s)*

OS is defined as the time from first infusion of trial drug to death due to any cause.

OS = date of death - date of first dose of any study treatment +1.

##### *4.4.1.2 Main Analytical Approach*

OS will be analyzed using the Kaplan-Meier method censoring at last contact/alive date in case of no observed death. If the last recorded date where a patient is known to be alive is the date of first dose of any study treatment, survival time will be censored on the date of first dose of any study treatment (i.e., OS duration of 1 day).

OS at certain months (for example 6, 12, 18 and 24 months as needed) estimated via the Kaplan-Meier method (i.e., percentage of subjects with OS ≥6 months, OS ≥12 months, OS ≥18 months, and ≥24 months respectively) will also be summarized upon data availability.

## 4.5 Safety Analyses

All safety analyses will be analyzed based on the ATS analysis set.

### *4.5.1 Adverse Events*

Adverse events will be summarized for treatment-emergent adverse events (TEAEs), treatment-related TEAEs, serious TEAEs (SAEs), treatment-related SAEs, AEs leading to treatment discontinuation, AEs leading to treatment dose modification, and Other Safety Topics of Interest.

Refer to section 4.1.1 for definition of pre-treatment, treatment-emergent, and post-treatment adverse events. All AE verbatim terms reported in the eCRF by investigators will be coded using the latest version of MedDRA coding dictionary and graded according to or guided by NCI-CTCAE. version 5.0 and Appendix K in protocol for ocular toxicities.

All TEAEs will be included in the analysis.

All summaries of AEs will be based on TEAEs. Unless otherwise specified, when reporting the overall incidence of an AE, a subject is counted only once in the SOC/PT summary even if this

SOC/PT was reported more than one time. Pre-treatment and post-treatment AEs will be included in listings (marked with a flag).

#### *4.5.1.1 Treatment Emergent Adverse Events*

The following summaries of TEAEs will be provided:

- Overview of TEAEs
- TEAEs by SOC, PT
- TEAEs relationship to treatment by SOC, PT
- Related TEAEs by SOC, PT
- TEAEs by SOC, PT, and worst toxicity grade
- Related TEAEs by SOC, PT and worst toxicity grade
- Grade 3 or 4 TEAEs by SOC, PT, and relationship to treatment
- Fatal TEAEs by SOC, PT, and relationship to treatment

- Serious TEAEs by SOC, PT, and relationship to treatment
- Serious TEAEs by SOC, PT, and worst toxicity grade
- Serious TEAEs by PT
- TEAEs leading to treatment dose modification by SOC, PT and relationship to treatment
- TEAEs leading to treatment discontinuation by SOC, PT and relationship to treatment
- TEAEs leading to treatment discontinuation by SOC, PT, and worst toxicity grade

AEs will be tabulated by SOC and/or PT. Tables will be presented by descending frequency of SOC and then, within a SOC, by descending frequency of PT calculated across all arms.

For summaries by SOC, PT, and worst toxicity grade, a subject will be counted once at the highest intensity level for which the event occurred at the SOC level and the highest intensity level for each unique PT within that SOC level. Therefore, subjects may only contribute once to each PT and once to each SOC level.

#### *4.5.1.2 Deaths*

Death will be summarized for the SAF in the following:

- All deaths (with reason)
- Deaths within 60 days of administration of first dose of trial drug (with reason)
- Deaths within 60 days of administration of last dose of trial drug (with reason)

#### 4.5.1.3 Other Safety Topics of Interest

Other safety topics of interest, including the identified and potential risks of GEN1107, and the criteria for identifying these events may be explored as needed.

Two main safety topics will be explored: Ocular Toxicity and Infusion-related Reactions (IRR).

Both subject-level and event-level summaries will be provided for ocular toxicity. A listing of eye examinations will be provided by each subject who had ocular toxicity.

A listing of ocular toxicity will be provided.

A listing of all IRR events will be provided

Other details analysis, please refer to the Data Presentation Specification (ADaM specifications and DPS).

### *4.5.2 Additional Safety Assessments*

#### *4.5.2.1 Laboratory Results*

The laboratory assessments outlined in Table 6 will be performed by the local laboratories at scheduled time points per SOE in protocol during the study. Other safety tests may be conducted as clinically indicated, at the discretion of the Investigator.

**Table 6 Clinical Laboratory Assessments**

| Category | Test |
|---|---|
| Glycemic control: | • fasting glucose<br>• Hgb A1c |
| Serum chemistry: | • albumin<br>• alkaline phosphatase<br>• ALT<br>• AST<br>• blood urea nitrogen<br>• calcium<br>• carbon dioxide<br>• creatinine<br>• chloride<br>• lactate dehydrogenase<br>• phosphorus<br>• potassium<br>• sodium<br>• total bilirubin |
| Blood hematology: | • red blood cell count<br>• white blood cell count with 5-part differential (neutrophils, lymphocytes, monocytes, eosinophils, and basophils),<br>• absolute neutrophil count<br>• platelet count<br>• Hgb<br>• hematocrit |
| Fasting lipid panel: | • total cholesterol<br>• LDL<br>• HDL<br>• triglycerides |
| Pancreatic function: | • amylase<br>• lipase |

| | |
|---|---|
| Coagulation: | • PT/aPTT/INR (aPTT is also acceptable) |
| Urinalysis: | • standard urinalysis (with reflexive microscopy for abnormal results) |
| Pregnancy: | • Baseline serum β-hCG pregnancy test for patients of childbearing potential. Post baseline urine pregnancy test is acceptable and any positive should be confirmed by serum. |
| Viral testing: | • HIV<br>• Hepatitis B virus surface antigen<br>• Hepatitis B virus core antibody<br>• Hepatitis C virus rt-PCR |
| Biomarkers | • CA-125 (ovarian cancer and endometrial cancer with elevated CA-125 at baseline) |

Shift tables (from baseline grade to the worst post-baseline grade) will be provided for selected laboratory tests. Summary statistics for selected laboratory tests may be tabulated as appropriate by scheduled visit. Laboratory values will be listed with grade per NCI CTCAE, Version 5.0 and flagged when values are outside the normal reference range.

#### *4.5.2.2 Vital Signs and Body weight*

Vital signs results over time will be summarized descriptively.

The number and percentage of subjects meeting the criteria below at any post-baseline assessment will be summarized by arm.

Definition of clinically notable elevated vital sign values:

- Systolic blood pressure (BP): ≥180 mmHg and an increase ≥20 mmHg from baseline
- Diastolic BP: ≥105 mmHg and an increase ≥15 mmHg from baseline
- Weight: Increase of ≥10% from baseline
- Heart rate: ≥120 bpm with an increase of ≥15 bpm from baseline
- Temperature: >38° C

Definition of clinically notable decreased vital sign values:

- Systolic BP: ≤90 mmHg and a decrease ≥20 mmHg from baseline
- Diastolic BP: ≤50 mmHg and a decrease ≥15 mmHg from baseline
- Weight: decrease of ≥10% from baseline
- Heart rate: ≤50 bpm and a decrease ≥15 bpm from baseline
- Temperature: <35° C
- Pulse oximetry: <92% oxygen saturation

#### *4.5.2.3 Electrocardiogram (ECG)*

The number and percentage of subjects with abnormal ECG findings will be summarized by visits.

ECG data will be listed by subject at all visit time points per SOE in protocol.

#### *4.5.2.4 ECOG Performance Score*

Frequencies of ECOG score will be reported over time.

Shifts table from baseline to the best and worst post-baseline score may be tabulated.

ECOG data will be listed by subject at all visit time points per SOE in protocol.

## 4.6 Other Analyses

### *4.6.1 Pharmacokinetics (PK) and Immunogenicity*

Ac-MMAE, TAb, and u-MMAE concentrations will be summarized with descriptive statistics for each cohort and at each PK sampling timepoint using the PKE analysis set. PK parameters will be estimated from concentration-time data using noncompartmental analysis and summarized by descriptive statistics. As the data allow, the following PK parameters to be assessed include but are not limited to:

- AUC
- $C_{eoi}$ or $C_{max}$
- $T_{max}$
- $C_{trough}$
- t1/2
- $V_z$
- CL

The incidence of ADAs will be summarized using descriptive statistics by treatment group, including time to first ADA and titer of ADA against GEN1107. The relationship between ADA and PK may be evaluated per the data availability. The relationship between ADA and PD,

safety, and/or clinical outcome may also be explored. Archived samples confirmed positive for ADA may be explored later for neutralizing activity.

#### *4.6.2 Biomarker*

Relationships of biomarker parameters (eg, baseline values, absolute and relative changes from baseline) to efficacy, safety, and PK parameters may be explored. Correlations between pharmacodynamic assessments and PK parameters may be explored in concentration-QT plots and regression analysis. Relationships and associated data that are determined to be of interest may be summarized.

#### *4.6.3 Subgroup Analyses*

For selected endpoints, subgroup analyses may be conducted including but not limited to the following categories, as appropriate:

- Prior therapies (1L, 2L, 3L+)
- Disease subtype (OC, TNBC, NSCLC, etc)
- Baseline PTK7 tumor expression level

### 4.7 Planned Analyses

#### *4.7.1 Interim Analyses*

Not applicable.

#### *4.7.2 Independent Data Monitoring Committee or Other Review Board*

No data monitoring committee is planned for this trial.

## 5 SAMPLE SIZE DETERMINATION

Up to approximately 280 patients are expected to be enrolled in this study. This number assumes that up to approximately 120 patients may be enrolled in Part A and up to an additional approximately 160 patients will be enrolled in Part B (up to approximately 40 patients in 4 tumor-specific expansion cohorts).

No formal hypothesis testing is planned for the expansion cohorts in Part B. Table 7 provides the precision for various observed ORRs with a sample size of 20.

**Table 7 Sample Size Calculations**

| Number of Responders | Observed ORR | 95% CI[a] | 80% CI[a] |
|---|---|---|---|
| 8 out of 20 | 40% | (19%, 64%) | (25%, 57%) |
| 6 out of 20 | 30% | (12%, 54%) | (17%, 47%) |
| 4 out of 20 | 20% | (6%, 44%) | (9%, 36%) |

a Based on the Clopper-Pearson method (Clopper and Pearson 1934)
CI=confidence interval

Analysis for futility will be performed separately for each cohort after at least 10 patients of a given cohort have been treated and had at least one response assessment post-baseline. A Bayesian predictive probability (PPoS) approach is used to determine the futility criteria.

PPoS is the predictive probability of achieving "success" should the cohort be continued to the 20 patients. Given the data observed at interim, it is a "success" if the predictive probability that the ORR exceeds the response rate of current standard of care (p0) is greater than 80%. If PPoS is less than 10%, stopping further enrollment may be considered. Table 8 shows any cohort futility bars (Lee and Liu, 2008) based on PPoS for monotherapy.

**Table 8 Non-Binding Futility Boundaries in Expansion Part**

| Number of response evaluable subjects per dose level | First 10 subjects | Total 20 subjects |
|---|---|---|
| **Any cohort** | 0 | ≤3 |

Number of responses as assessed by investigators (including those pending confirmation)

For the Bayesian modelling, the prior response rate is assumed to follow a beta distribution with hyperparameters of a0=p0, b0=1-p0.

Operating characteristics for three different scenarios for a true underlying ORR (10%, 30% and 40%) are provided in Table 9 by evaluating the cumulative probability density function of the binomial distribution, and assuming that possible earlier crossing(s) of the futility boundary are ignored.

**Table 9 Operating Characteristics in the Expansion Part**

| Underlying ORR | Pass Futility at n=10 | Pass Futility at n=20 |
|---|---|---|
| **10%** | **65%** | **13%** |

| | | |
|---|---|---|
| **30%** | 97% | 89% |
| **40%** | 99% | 98% |

# 6 SUPPORTING DOCUMENTATION

## 6.1 Appendix 2: Definition of Baseline

Baseline value is defined as the last observation on or prior to the first dosing.

For analysis purposes, baseline period will include the following evaluations or events:

- Evaluations or events occurring before the date and time of the first dose of trial treatment

- Evaluations on the same date of the first dose of trial treatment but the time component (onset time of event or evaluation time and dosing time) is missing or not collected, then the following definitions will apply.

  - Laboratory tests, vital signs (including weight and height), and ECOG performance status on the same date of the first dose of trial treatment will be considered as baseline evaluations.

  - Adverse events onset on the same date of the first dose of trial treatment will not be considered as pre-treatment events.

If there are multiple valid assessments, the assessment that is closest to the day (and time if collected) of the first dose of trial treatment will be used as the baseline in the analyses. If multiple assessments are collected on the same date (and time if collected), the assessment with the latest visit will be considered as baseline, unless stated otherwise.

Similarly, for analysis purposes, on-treatment period will include:

- On-treatment AEs as defined for those AEs onset during on-treatment period (onset date and time on or after the date and time of first dose of trial treatment or with an onset date on and after the day of first dose of trial treatment if time is not collected or is missing), and AEs with onset date and time prior to the first dose of trial treatment and worsening during on-treatment period.

- On-treatment evaluations (laboratory tests, vital signs, ECOG performance status, etc.) will be defined as evaluations taken during on-treatment (after the day [and time if collected and not missing] of first dose of trial treatment).

If dates are incomplete in such a way that clear assignment to pre-, on-, post-treatment period cannot be made, then the respective data will be assigned to the on-treatment period.

## 6.2 Appendix 3: Demographics and Baseline Characteristics

Descriptive statistics will be provided for the following demographic and baseline disease characteristics.

• Age (<65 years, 65- <75 years; ≥75 years; summary statistics)

• Race (White, Black or African American, Asian, Other)

• Ethnicity (Hispanic or Latino, Not Hispanic or Latino)

• Gender at birth (Male, Female)

• Weight (summary statistics)

• Height (summary statistics)

• BSA (summary statistics, and by categories: < 1.5, 1.5 - < 2 and ≥2)

• BMI (<18.5, 18.5 - <25.0, 25.0 - <30.0, ≥30)

• Country of Participation

• ECOG performance status (0, 1, 2,etc)

• Tumor type

• Histologic grade

• Time from initial diagnosis to first trial drug administration (summary statistics)

• Ann Arbor Staging at baseline (I, IE, II, etc.)

• Ann Arbor Staging at screening (I, IE, II, etc.)

• Initial diagnosis disease stage

• Baseline diagnosis disease stage

# 7 REFERENCES

Clopper, C. J., & Pearson, E. S. (1934). The use of confidence or fiducial limits illustrated in the case of the binomial. *Biometrika*, *26*(4), 404-413.

Eisenhauer, E. A., P. Therasse, J. Bogaerts, L. H. Schwartz, D. Sargent, R. Ford, J. Dancey, S. Arbuck, S. Gwyther, M. Mooney, L. Rubinstein, L. Shankar, L. Dodd, R. Kaplan, D. Lacombe, and J. Verweij. 2009. 'New response evaluation criteria in solid tumours: revised RECIST guideline (version 1.1)', *Eur J Cancer*, 45: 228-47.

Lee, J. J., and Liu, D. D. (2008). A predictive probability design for phase II cancer clinical trials. Clin Trials *5*, 93-106.

NCCN. 2023. 'NCCN Guidelines: Ovarian Cancer'.