Statistical Analysis Plan

A Phase I Randomized, Double-blinded, Parallel Controlled, Single-dose Clinical Study, Comparing Pharmacokinetic Characteristics, Safety, Tolerance, and Immunogenicity of IBI305 and Bevacizumab in Male Healthy Subjects

Generic Name of the Investigational Drug:	Recombinant Anti-Vascular Endothelial Growth Factor (VEGF) Humanized Monoclonal Antibody (IBI305)
Sponsor:	Innovent Biologics (Suzhou) Co., Ltd.
Statistical Analysis Institution:	WuXi Clinical Development Services (Shanghai) Co., Ltd.
Version No.:	V 1.0
Version Date:	September 30, 2017
NCT Number:	NCT03083990

Signature Page for Approval

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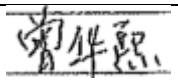
Signature: 	Date: September 30, 2017
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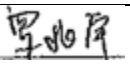
Signature: 	Date: September 30, 2017
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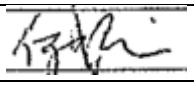
Signature: 	Date: September 30, 2017
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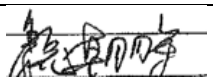
Signature: 	Date: September 30, 2017
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1. Introduction

The Statistical Analysis Plan (SAP) is intended to describe statistical methods used in the Clinical Trial, Project Protocol No. CIBI305A201. The clinical trial is intended to compare pharmacokinetic characteristics, safety, tolerance, and immunogenicity of IBI305 and Bevacizumab in male healthy populations, and its main objective is to demonstrate pharmacokinetics similarity of IBI305 and Bevacizumab in male healthy volunteers.

The Statistical Analysis Plan is based on the Clinical Study Protocol version 1.0 (date: Aug 3, 2016), and Case Report form (CRF) version 1.0 (date: Oct 24, 2016). Any revision of the trial protocol or CRF would result in update of the Statistical Analysis Plan as required.

The Statistical Analysis Plan must be finalized prior to locking of the final database, and after approval by the Sponsor.

2. Objective of the Trial

Primary Objective: PK comparison is carried out after male healthy subjects are infused intravenously with a single dose of IBI305 or Bevacizumab.

Secondary Objectives: Comparison of safety, tolerance, and immunogenicity between IBI305 and Bevacizumab is carried out after male healthy subjects are infused intravenously with a single dose of IBI305 or Bevacizumab.

3. Design of the Trial

The study is a Phase I, randomized, doubled-blinded, parallel controlled, single-dose study. It is planned to enroll 100 male healthy subjects aged 18-50 years, who are randomly assigned in the ratio of 1:1 into the IBI305 or Bevacizumab Groups. The subjects are infused with 3 mg/kg Bevacizumab or IBI305, to carry out PK analysis and immunogenicity (anti-drug antibodies and antibodies [ADA/NAb]) analysis.

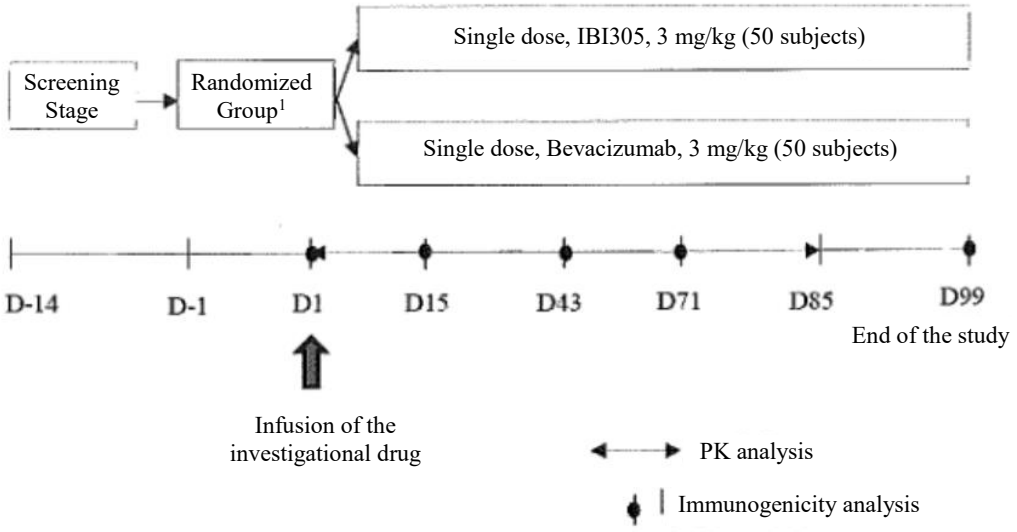

Figure 1 Principle for Study Design

[1]Randomization may be carried out after review of the D-1 inclusion/exclusion criteria, and prior to dosing.

3.1 Estimation of Sample Size

Fifty (50) subjects per group (100 subjects in total) would provide 85% test power to demonstrate bioequivalence between IBI305 and Bevacizumab. The significance level for the one- and two-sided t test for the hypothesis of the estimated sample size is 0.05, the coefficient of variation (CV) is 35%, and the drop-out rate is 10%. It may consider that IBI305 and Bevacizumab are equivalent if the 90% confidence interval (CI) for the treatment reference ratio of log-transformed AUC_{0-t} and $AUC_{0-\infty}$ are within 80%-125%.

3.2 Randomization

Random No. of subjects: The study is a Phase I, randomized, doubled-blinded, parallel controlled, single-dose clinical study. One hundred (100) male healthy subjects aged 18-50 years are planned to be enrolled, and are randomly assigned in the ratio of 1:1 into the IBI305 or Bevacizumab Groups. The subjects are infused with 3 mg/kg Bevacizumab or IBI305, to carry out PK analysis and immunogenicity analysis. So a random list and labels for 100 subjects should be prepared.

Random no. of the drugs: The subjects in the study will receive a single dose (3 mg/kg) of IBI305 or Bevacizumab, intravenous infusion over 90 min. The required dose of the drug is calculated, based on the subject's body weight: Dose (mg) = 3 mg/kg × Subject's Body Weight (kg). The strength of the investigational injectable drug (IBI305 or

Bevacizumab) is 100 mg/vial. It is estimated that each subject (in a body weight of e.g., 80 kg) requires 3 vials. So it is planned to enroll 100 male healthy subjects, and it is expected that approximately 300 vials are required. Considering comprehensively the Sponsor's requirements and system requirements, the random number for the drugs are set as 6 effective digits (XXXXXX). The Statistical Analysis Institution must produce drug randomization no. and grouping information, based on the number of drugs no., expiration date of the drugs, and corresponding quantity of the drugs, provided by the Sponsor. The random number of the drugs is produced concurrently with the Phase III clinical study (Protocol No.: CIBI305A301, Random Analysis Plan version 2.0, dated Oct 28, 2016) of the drug product; so for the project, no dossier is provided to the Drug Packaging Institution (Fisher) and QA Department of the Sponsor. The encrypted electronic documents that the supplier for eCOS Stochastic System complies with the requirements are provided. The information includes: Drug No., Lot No., and Serial No. Notes: The lot no. consists of 5 digits (XXXXX): The 1st and 2nd digits denote the blinding number, the 3 digit denotes the group (for example, 1 denotes the Trial Group, and 2 denotes the Control Group), and the last 2 digits denote the expiration date.

4. Research Parameters

4.1 Bioequivalence Evaluation Indicators

1) Evaluation of the Primary Endpoint

- Area under the plasma drug concentration-time curve from time 0 to t (AUC_{0-t})
- Area under the plasma drug concentration-time curve from time 0 to infinity (∞) ($AUC_{0-\infty}$)

2) Evaluation of the Secondary Endpoints

- Maximal plasma drug concentration (C_{max}) observed after administration of the drug
- Elimination half-life ($t_{½}$)
- Clearance (CL)
- Apparent volume of distribution (V)

4.2 Safety Evaluation Indicators

- Vital signs
- Physical examination
- Laboratory tests (hematology, blood biochemistry, and coagulation test, and urine test)

- 12-Lead ECG
- Adverse events (AE)
- Immunogenicity: Positive rate of anti-drug antibody (ADA), and positive rate of neutralizing antibody (NAb)

5. Definition

5.1 Baseline

Baseline value of the trial: Defined as last non-missing measured value of the subject prior to administration of the investigational drug.

5.2 Change Since Baseline

Change since baseline: Defined as difference of the measured value and the measured baseline value

5.3 Number of Research Days

Number of Research days: The number of research days is calculated according to the date when the subject is administered with the investigational drug; the research date when the investigational drug is used is counted as Day1.

If the event occurs on or after the date when the investigational drug is used: Number of Research Days = Event Date - Date when the Investigational Drug is used + 1;

If the event occurs before the date when the investigational drug is used: Number of Research Days = Event Date - Date when the Investigational Drug is used;

6. Analysis Dataset

Full analysis set (FAS):

The full analysis set is defined as subjects who are randomized and administered with the investigational drug.

Safety Analysis Population Set (SS):

The safety analysis population set includes all subjects who are randomized and administered with the investigational drug, and have safety evaluation data after administration of the drug; they will be analyzed by group. SS is used for all safety analyses.

Pharmacokinetic Analysis Set (PKAS):

The pharmacokinetic analysis set includes all the subjects who are randomized and administered with the investigational drug but without any severe influence on drug absorption, distribution, metabolism, and elimination, and baseline ADA positivity, etc., for whom AUC_{0-t} and $AUC_{0-\infty}$ may be calculated at least. The PK analysis set will be

used for PK equivalence analysis, as main analysis set. The PK analysis set and SS are used for demographic and baseline characteristic analyses.

Immunogenicity Analysis Set (ADA-AS):

The immunogenicity analysis population of the study consists of all subjects who are enrolled, and administered with the investigational drug, and have immunogenicity evaluation data after administration of the drug.

7. Interim Analysis

In this study, 1 interim analysis is planned, in which safety data are evaluated only, without considering α adjustment. The analysis timepoint is when the first 50 patients complete Day 29 observation.

8. Data Review

The data used for final data are cleaned data.

8.1 Data Processing and Transfer

eCRP table data will be exported from the EDC system by the data management team, and transferred as SAS dataset to the statistical programming team. Pharmacokinetic analysis data will be transferred to the data management team, and will be provided by the data management team to the pharmacokinetic analysts. The calculated pharmacokinetic parameters will be transferred in EXCEL to the statistical programming team for further statistical analysis.

8.2 Data Screening

In addition to data screening based on the data management protocol, additional data screening are provided for the analysis data set and chart programming by the Analysis and Report Department. The expected data problems will be exported and confirmed as “problems” by the SAS Log, and picked out by SAS Macro and transferred to the Data Management Department.

Prior to database lock, a further data screening will be provided for review of charts produced, based on the cleaned subset of the subjects. Prior to database lock, those charts will be discussed in the data review conference with the Sponsor, to confirm any data problem and seek for correction.

9. Statistical Method

9.1 General Considerations for Statistical Analysis

9.1.1 General Rules

All trial tables will be summarized by the trial groups (investigational drug and the reference drug), respectively. For quantitative indicators, the descriptive statistics include number, mean, standard deviation, median, minimum, and maximum; for counting indicators, the descriptive statistics include number and percentage.

Unless otherwise specified, the default significance level is 5%; the confidence interval (CI) is 95%, and all the tests are two-sided.

For quantitative measurements, the change since baseline is calculated as:

- Change since Baseline = Measured Value at Visit X - Baseline Value

The percentage since baseline is calculated as:

- Percentage Change since Baseline = (Measured Value at Visit X - Baseline Value)/Baseline × 100

9.1.2 Processing of Missing Value or Date

Processing of missing value: No missing value would be imputed.

Processing of missing date: As the trial stage is relatively short, any adverse event with missing date will be further checked. Any other missing date would not be interpolated.

9.1.3 Export of Statistical Results

All statistical results will be exported directly by SAS. See separate documents for samples of the figures, tables, and listings. The export template is used to standardize the programmer's work. In this Plan, it is not required to revise and review any non-substantial or modificatory adjustment to the export template that does not influence the Plan.

9.2 Subject Disposition

The subject disposition is summarized for all subjects. Screening failure and screening failure cause, number and percentage of enrolled subjects, and number and percentage of subjects who complete the study and not complete the study will be calculated by the trial group (Investigational Drug and Reference Drug). Subjects withdraw early will be summarized by the main causes for withdrawal from the trial. Number and percentage of subjects will be calculated by group, according to disposition of subjects in the analysis populations.

The list for disposition of subjects will be provided by trial group and by subject no.

9.2.1 Protocol Deviations

The protocol deviation data will be listed by trial group and subject no., and table is

also provided for summarize protocol deviations.

In case of any protocol deviation, its processing will be determined, on the basis of listening to the opinions from the principal investigator or the statistician, etc., in the case conference that is held as required.

- Missing data for plasma drug concentration, laboratory test values, and vital signs, etc.: Test value data with low confidence due to data missing and hemolysis will not be included into dataset analysis.
- Not observed/examined at the specified times: When a test value has time deviation, its processing is determined, based on the deviation degree.

9.3 Demographics and Other Baseline Characteristics

Analyses of demographics and other baseline characteristics are based on SS and PKAS.

9.3.1 Demographics

Demographic variables will be analyzed by descriptive statistics by trial group. For continuous variables, t test is used to calculate statistics and P value for inter-group differences; for discrete variables, Chi (X2) square test or Fisher exact test (if the number of subjects in any one group is <5) is used to calculate P value for inter-group differences. The following information will be tabulated and summarized.

- Age (years) = Integer [(Date of Signature of the Informed Consent - Date of Birth + 1)/365.25].
- Sex: Male
- Nationality: Han Nationality, Other
- Height (cm)
- Body Weight (kg)
- Body Mass Index BMI (kg/m^2)

The demographics list is provided by trial group and subject no.

9.3.2 Prior Medical History and Surgical History

The prior medical history and surgical history are coded in accordance with the Medical Dictionary for Regulatory Activities (MedDRA) version 19.1, and tabulated by preferred term and trial group (investigational drug and reference drug).

A list for whole prior medical history and surgical history is provided.

9.3.3 Prior and Concurrent Medications

Names of prior and concurrent medications are coded by WHO-Drug (version date: June 1, 2016) and ATC, and are summarized by ATC Code Levels 1-3 and by trial group.

"Prior" medications are drugs that are used and stopped prior to the first dose of the study drug.

"Concurrent" medications are drugs of which:

- The start date is earlier, the same as, or later than the date of the first dose of the study drug;
- The stop date is the same or later than the date of the first dose of the study drug, or is still ongoing when the study is ended.

A list for all concurrent medications will be provided.

9.4 Pharmacokinetic and Bioequivalence Analyses

Pharmacokinetic and bioequivalence analyses will be based on the pharmacokinetic analysis set.

9.4.1 Pharmacokinetic Parameter Analysis

Pharmacokinetic parameters will be estimated by WinNolin Software, using non-compartmental model. The pharmacokinetic parameters of each subject will be calculated by the following method.

Parameter	Definition	Computational Method
AUC_{0-t}	Area [μg.h/mL] under the plasma drug concentration-time curve from time 0 to the last sample collection timepoint t when the concentration may be measured accurately	Calculated by trapezoidal method (Linear Up/Log Down)
$AUC_{0-\infty}$	Area [μg.h/mL] under the plasma drug concentration-time curve from time 0 to infinity (∞)	$AUC_{0-\infty}=AUC_{0-t}+(C_{last}/\lambda_z)$; where C_{last} is the plasma drug concentration corresponding to the last measurable timepoint T_{last}
C_{max}	Maximal plasma blood concentration [μg/mL]	Derived directly from observed data
λ_z	Apparent elimination rate constant [1/h]	If the log-transformed values of the final test timepoint, as well as several points traced from it (more than 3 timepoints, and the first timepoints must be more than T_{max}) show a linear shift, then they are calculated by linear regression.
$t_{½}$	elimination half-life [h]	Ln^2/λ_z
CL	Apparent Clearance [mL/h/kg]	Dose / $AUC_{0-\infty}$
V_z	Apparent volume of distribution [mL/kg]	Dose / ($\lambda_z \times AUC_{0-\infty}$)
AUC_% Extrap	Extrapolated Area Percentage [%]	($AUC_{0-\infty}$-AUC_{0-t})/ $AUC_{0-\infty} \times 100\%$
T_{max}	Time to Peak [h]	Derived directly from observed data

The non-transformed data of plasma concentration, AUC_{0-t}, $AUC_{0-\infty}$, C_{max}, λ_z, $t_{½}$, CL, V_z, AUC_% Extrap, and T_{max} of the investigational drug product and the reference drug

product at the time points are summarized with descriptive statistics by stage. The average and individual plasma drug concentration-time curves are plotted by trial group.

Basic rules for pharmacokinetic data processing

1) How to process values below the lower limit of quantification (BLQ, below lower limit of quantification).

If one or more non-quantifiable (NQ) values occur prior to the first measurable concentration, they should be set as 0. If one single NQ value occurs between two measurable concentrations, then it should be set as missing. If two or more NQ values occur between two measurable concentrations, then the curve should end at the last measurable concentration prior to NQ. If the NQ concentration occurs after the last measurable concentration, then the curve should end at the last measurable concentration prior to NQ.

2) AUC_% Extrap ≥ 20%

Generally, AUC_% Extrap is less than 20%. According to the PKAS definition in the protocol, it is required that AUC_{0-t} and $AUC_{0-\infty}$ can be calculated reliably. Therefore, when AUC_% Extrap ≥20%, $AUC_{0-\infty}$ cannot be calculated reliably, and should be excluded.

3) NCA Computational Method

Using the practical sampling times, PK parameters are calculated by Linear Up/Log Down method.

4) Selection of Concentration Points for Computation of λ_z

For log transformed concentration vs time data, the linear regression method is used to estimate elimination rate constant. For computation of λ_z, at least 3 data points are required, and the analysis method for λ_z is set as Best fit. Ideally, R^2 value is more than 0.85; however in some cases, a lower R^2 may also be acceptable.

5) Decimal Point Reservation

Concentration-time data and PK parameters are not rounded prior to statistical analysis.

9.4.2 Judgment of Bioequivalence

The primary objective of the study is to test bioequivalence between IBI305 and Bevacizumab. After log transformation, the primary PK endpoints (AUC_{0-t} and $AUC_{0-\infty}$) are analyzed by the analysis of variance model. The difference of the least square means between IBI305 and Bevacizumab, and its corresponding 90% CI are calculated. Geometric mean ratio and its 90%CI are obtained after anti-logarithmic transformation.

If 90% CI for the geometric mean ratio of AUC_{0-t} and $AUC_{0-\infty}$ (trial/control) ranges between 0.8-1.25, then it is considered that IBI305 and Bevacizumab are bioequivalent. The secondary PK endpoint of the study is C_{max}. Log transformed C_{max} is analyzed by the analysis of variance model; the difference of the least square mean of the parameter between IBI305 and Bevacizumab, and its corresponding 90% CI are calculated, and the geometric mean ratio and its 90% CI are calculated by after anti-logarithmic transformation.

If the ADA positive rate after administration of the drug is >10%, then PK parameter and its bioequivalence analysis are carried out for the subgroup of ADA negative subjects.

9.5 Safety Analysis

The safety analysis is based on the safety analysis set.

9.5.1 Drug Exposure

The total drug exposure will be calculated, and t test is used to calculate P value for inter-group differences; the following summaries are provided:

- Practical dose (mg)
- Infusion duration (min)

9.5.2 Adverse Events

All adverse events (AEs) will be classified in accordance with the System Organ Class (SOC) and Preferred Term (PT) of the ICH Medical Dictionary for Regulatory Activities (MedDRA).

In this clinical trial, any adverse event of subjects, occurred from start of the investigational drug to end of the study, will be considered as “treatment-emergent adverse event (TEAE)”.

Number and percentages of subjects with treatment-emergent adverse events (TEAEs), Grade 3 or higher TEAEs, severe adverse events (SAEs), TEAEs related with the investigational drug, TEAEs leading to discontinuation of the study, TEAEs leading to discontinuation of the drug, and adverse events of special interest (AESIs), and important adverse events will be summarized by System Organ Class, preferred term, and group; P values for incidences of those adverse events will be calculated by Chi square test or Fisher exact test (the number of subjects in at least one group is <5). Additionally, the severity of TEAEs, and relationship with the investigational drug will be also summarized by organ system, preferred term, and group.

In the table for overall incidences of adverse events, subjects with the same AE once but with different severities will be only counted once in the frequency table; its maximum severity will be used, applicable for SOC and PT.

Lists for all AEs (including non-TEAE), SAEs, AEs leading to death, AEs leading to discontinuation of the study, AESIs, and important adverse events will be provided.

Severity

Severity of each TEAE will be classified as one of 5 grades (Grades 1-5) in accordance with the National Cancer Institute - Common Terminology Criteria for Adverse Events (NCICTCAE) V4.03. The incidence (frequency and percentage) will be provided by SOC and PT.

TEAEs with missing severity, occurred after the first dose of the investigational drug, would be counted as severe. If a subject reports one TEAE more than once in SOC/PT, then AE with the maximum severity will be used in the summary of corresponding severities.

Relationship with the Investigational Drug

The investigator will indicate the relationship with the investigational drug, classified as “Related”, “Possibly Related”, “Unlikely Related”, “Unrelated”, and “Cannot Be Judged”. TEAE with missing relationship with the investigational drug would be considered as “Possibly Related” with the investigational drug. If a subject reports the same AE more than once in SOC/PT, then AE with the maximum severity will be used in the summary of corresponding relationships. Relevant TEAEs in the summary table include TEAEs which are “Related”, “Possibly related”, and “Cannot be judged” with the investigational drug.

Adverse Events of Special Interest (AESI)

Incidence (Frequency and Percentage) of Adverse Events of Special Interest (AESI) will be summarized. Including the following adverse events:

- Hypertension
- Proteinuria
- Gastrointestinal perforation
- Hemorrhagic events
- Cardiac toxicity
- Phlebitis
- Thrombus

- Intestinal fistula
- Posterior reversible encephalopathy syndrome
- Hypersensitivity reaction, infusion reaction

For infusion reaction, duration of TEAE, and the interval from the injection time of the drug will be summarized, which are calculated as follows:

- Duration of Infusion Reaction (min) = End Date and Time of the Infusion Reaction - Start Date and Time of the Infusion Reaction
- Interval (min) from the Injection Time of the Drug = Start Date and Time of the Infusion Reaction - Date and Time of the Last Infusion prior to Start of the Infusion Reaction

Important Adverse Events

Important adverse events means adverse events, significant hematological abnormalities or other significant laboratory test abnormalities requiring specific medical measures (such as discontinuation of the drug, reduced dose, and symptomatic therapy), except severe adverse events.

Important adverse events will be determined and confirmed one by one by the medical team.

9.5.3 Clinical laboratory Test Value

The computational formula for blood urea nitrogen is: Blood Urea Nitrogen (mg/dL) = Urea (mg/dL) × 0.466; the remaining laboratory data are originated from eCRF.

Continuous trial data will be described by summary statistics (number of patients, mean, standard deviation, median, minimum, and maximum) of measured values and changes since baseline by planned time point and trial group. The baseline laboratory evaluation results, and the worst results during the trial will be summarized in cross table.

A list for all laboratory test values, and abnormalities converted from normal condition will be provided.

9.5.4 Vital Signs

For parameters of vital signs, measured values and changes since baseline will be summarized by planned time point and trial group. Abnormal values of vital signs will be summarized.

See the table below for abnormal values of vital signs:

Parameter	Unit	Low	High

Systolic blood pressure	mmHg	≤90 mmHg, or change ≤ -20 mmHg since baseline	≥140 mmHg, and change ≥ 20 mmHg since baseline
Diastolic blood pressure	mmHg	≤50 mmHg, and change ≤ -15 mmHg since baseline	≥90 mmHg, and change ≥ 15 mmHg since baseline
Pulse	Bpm	≤50 bpm, and change ≤ -15 bpm since baseline	≥120 bpm, and change ≥ 15 bpm since baseline
Body temperature	℃	NA	≥37℃, AND change 1.0℃ since baseline
Body weight	Kg	Percentage change ≤ -10.0% since baseline	Percentage change ≥ 10.0% since baseline

A list for all parameter values of vital signs and abnormal values will be provided

9.5.5 12-Lead ECG

QTc intervals in the table and list are corrected by calculated QTc F; the formula is provided below:

$$\text{QTc interval (msec)} = \sqrt[3]{QT/(\frac{60}{hr})}$$

For parameters of 12-lead ECG, measured values and changes since baseline will be summarized by planned timepoint and trial group. The baseline laboratory evaluation results of 12-lead ECG, and the worst results during the trial will be summarized in cross table.

Abnormal values of QTc intervals will be summarized:

Absolute values of QTc intervals will be classified as:

- >450 msec
- >480 msec
- >500 msec

Changes of QTC intervals since baseline will be classified as:

- Prolongation >30 msec
- Prolongation >60 msec

A list of all parameter values and prolonged QTc intervals will be provided.

9.5.6 Physical Examination

Physical examination results will not be summarized. A list of all physical examination results will be provided and abnormal values will be indicated.

9.6 Immunogenicity Analysis

Immunogenicity analysis dataset will be used for analysis.

Positive rate of anti-drug antibody (ADA), and positive rate of neutralizing antibody

(Nab) will be summarized by planned timepoint and trial group. A list for all immunogenicity parameters will be provided.

10. Quality Control

To ensure that TFL results are delivered each time at high quality level, the quality control procedure of TFL will be defined detailedly in the Quality Control Plan Document.

Appendix 1. Abbreviations

AE	Adverse Events
ADA	Anti-Drug Antibody
ADA-AS	Immunogenicity Analysis Set
AESI	Adverse Event of Special Interest
ATC	Anatomic Therapeutic Chemical Classification
$AUC_{0-\infty}$	Area under the Plasma Drug Concentration-Time Curve from Time 0 to Infinity
AUC_{0-t}	Area under the Plasma Drug Concentration-Time Curve from Time 0 to t
AUC_%Extrap	Extrapolated Area Percentage [%]
BLQ	Less than the Lower Limit of Quantitation
BMI	Body Weight Index
CFDA	National Medical Products Administration
CI	Confidence Interval
CL	Plasma Clearance Rate
C_{max}	Maximal Plasma Concentration
CRO	Contract Research Organization
CTCAE	Common Terminology Criteria for Adverse Events
CV	Variation Coefficient
eCRF	Electronic Case Report Form
EDC	Electronic Data Capture System of Clinical Trial
FAS	Full Analysis Set
ICH	International Conference of Harmonization
MedDRA	ICH Medical Dictionary for Regulatory Activities
NAb	Neutralizing Antibody
NQ	Not Quantified
PK	Pharmacokinetics
PKAS	Pharmacokinetic Analysis Set
PT	Preferred Term
QA	Quality Assurance
SAE	Serious Adverse Event
SAP	Statistical Analysis Plan
SOC	Organ System
SS	Safety Dataset
$t_{½}$	Elimination Half-Life
T_{max}	Time to Peak [h]
TEAE	Treatment-Emergent Adverse Event
TFL	Table, Figure, and List
VEGF	Vascular Endothelial Growth Factor
V_z	Apparent volume of Distribution
WHO-DD	World Health Organization Drug Dictionaries
λ_z	Apparent Elimination Rate Constant [1/h]

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