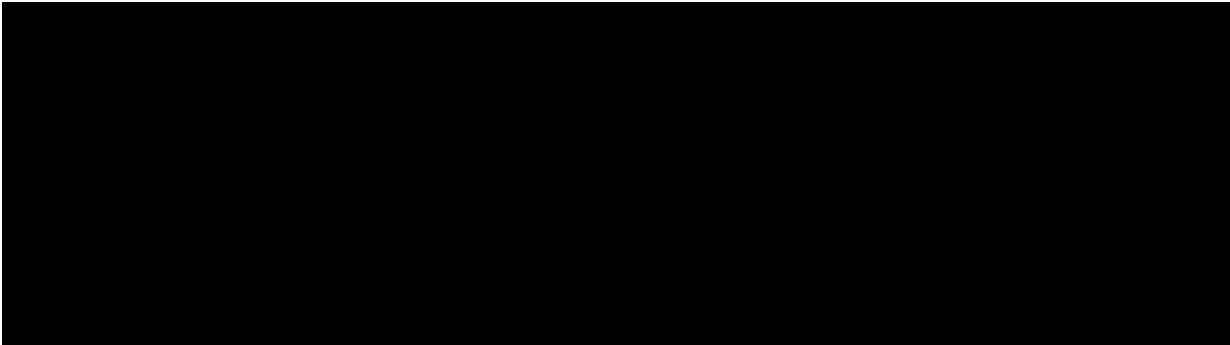


TRIAL STATISTICAL ANALYSIS PLAN

Global ID_Version:	228892_3551566_1.0
BI Trial No.:	1490-0004
Title:	A Phase IIa/IIb, randomised, double blind, placebo-controlled, parallel-group dose-finding study to examine the efficacy and safety of BI 1839100 administered orally over a 12-week treatment period in patients with idiopathic pulmonary fibrosis or progressive pulmonary fibrosis with clinically meaningful cough Revised protocol #2.
Investigational Product(s):	BI 1839100
Responsible trial statistician(s):	Phone:
Date of statistical analysis plan:	20 NOV 2025
Version:	1.0
Page 1 of 33	
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2. LIST OF ABBREVIATIONS

Term	Definition / description
ACE	Angiotensin-converting enzyme
AF	Antifibrotic
ATC	Anatomical Therapeutic Chemical
■	■
BMI	Body mass index
CC/h	Cough count per hour
CRF	Case report form
CTP	Clinical trial protocol
ECG	Electrocardiogram
FAS	Full analysis set
FVC	Forced vital capacity
GERD	Gastroesophageal reflux disease
ICE	Intercurrent event
ICH	International Council for Harmonisation
IPF	Idiopathic pulmonary fibrosis
IRT	Interactive response technology
LCQ	Leicester Cough Questionnaire
MMRM	Mixed model repeated measures
MVPA	Moderate to Vigorous Physical Activity
NRS	Numerical rating scale
■	
Q1	First Quantile: 25 th percentile
Q3	Third Quantile: 75 th percentile
■	
REML	Restricted maximum likelihood
SD	Standard deviation

Term	Definition / description
TSAP	Trial statistical analysis plan
VAS	Visual analogue scale

3. INTRODUCTION

As per ICH E9, the purpose of this document is to provide a more technical and detailed elaboration of the principal features of the analysis described in the protocol, and to include detailed procedures for executing the statistical analysis of the primary and secondary variables and other data.

This TSAP assumes familiarity with the Clinical Trial Protocol (CTP), including Protocol Amendments. In particular, the TSAP is based on the planned analysis specification as written in CTP Section 7 “Statistical Methods and Determination of Sample Size”. Therefore, TSAP readers may consult the CTP for more background information on the study, e.g., on study objectives, study design and population, treatments, definition of measurements and variables, planning of sample size, randomization.

This trial was designed to be a seamless Phase IIa/IIb trial. The primary analysis of the Phase IIa part was performed on interim data when 85 participants in the IPF cohort completed 4 weeks of treatment. Unblinded Phase IIa data were analysed and reviewed by a Development Decision Committee as described in Section 8.7.4 of the CTP and a decision was made by the Sponsor to discontinue the trial on 2-Sept-2025. Based on this decision, an abbreviated clinical trial report will be produced. Changes in the planned analyses are described in [Section 4](#).

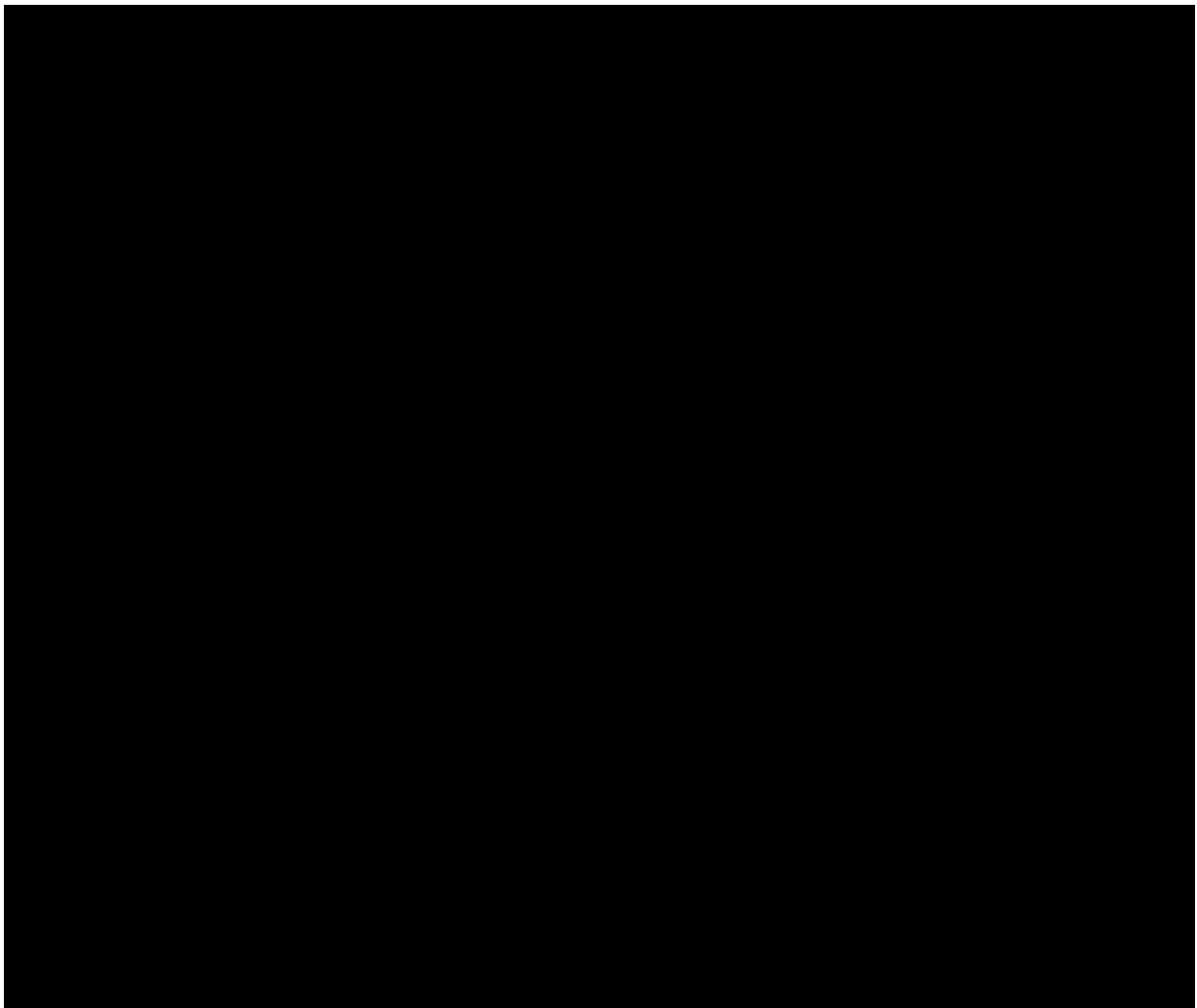
SAS® Version 9.4 will be used for all analyses.

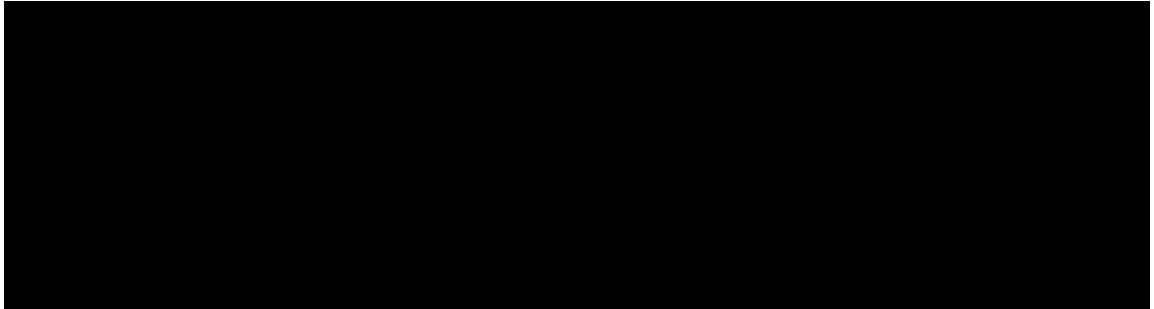
4. CHANGES IN THE PLANNED ANALYSIS OF THE STUDY

The Phase IIa analyses suggested that the observed difference in the reduction in 24-h cough frequency at Week 4 in the [REDACTED] group compared to placebo was not sufficient to continue the trial further and a decision to discontinue the trial was made. As a result, an abbreviated CTR is planned, meaning not all the analyses planned in the CTP will be performed. Additionally, there were no PPF participants enrolled in the trial, and the analyses described in this TSAP will only apply to the IPF participants .

Primary and secondary endpoints:

Analysis of the primary and secondary Phase IIa and IIb endpoints will utilize a restricted maximum likelihood (REML) based approach using a mixed model with repeated measurements (MMRM) as described in the CTP; however, the PoC analysis to test whether there is a non-flat dose-response relationship via MCP-Mod will not be performed.





5. ENDPOINT(S)

5.1 PRIMARY ENDPOINT(S)

- Phase IIa: change from baseline in 24-h cough frequency (CC/h) at Week 4
- Phase IIb: change from baseline in 24-h cough frequency (CC/h) at Week 12

The endpoints are derived from counting the total number of coughs recorded by a cough monitoring device that is worn by trial participants over a 24 hour recording period. The 24-h cough frequency is calculated by dividing the total number of recorded coughs by the hours in the recording period, which could fluctuate due to various reasons (e.g. battery being not sufficiently charged or the inadvertent turning off of the device). Recordings of less than 20 hours will be considered as missing. Note that the hours of recording will be derived as the total readable recording time minus the time the device was “off-body” as sensed by the device. Baseline measurements will be derived from the last valid cough recording completed before randomisation where valid is defined as a recording with 20 or more hours of readable recording time while also subtracting the time the device was “off body”.

For the primary analysis, 24-h cough frequency will be log transformed.

5.2 SECONDARY ENDPOINT(S)

5.2.1 Key secondary endpoint(s)

Not applicable; there are no key secondary endpoints in the trial.

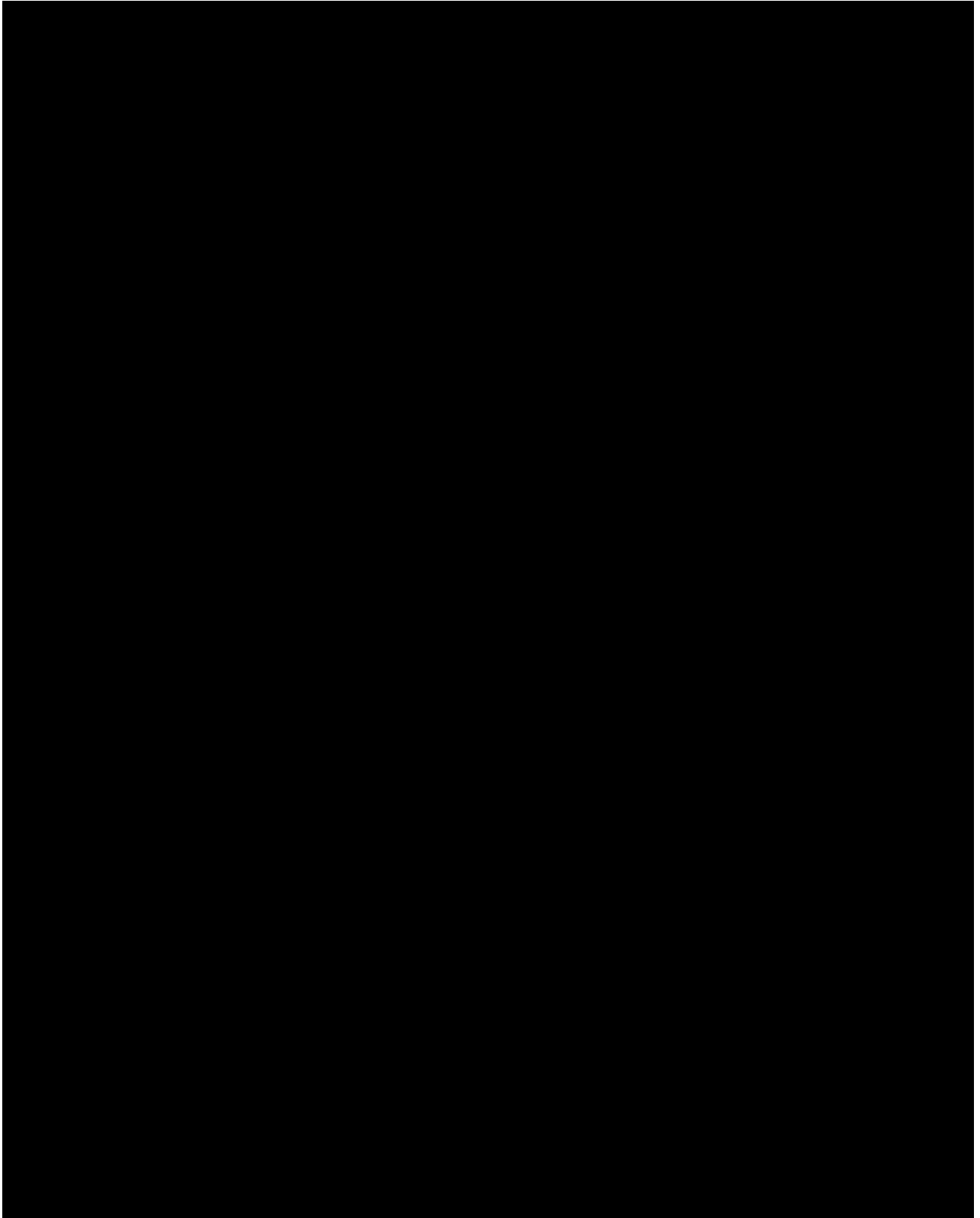
5.2.2 Secondary endpoint(s)

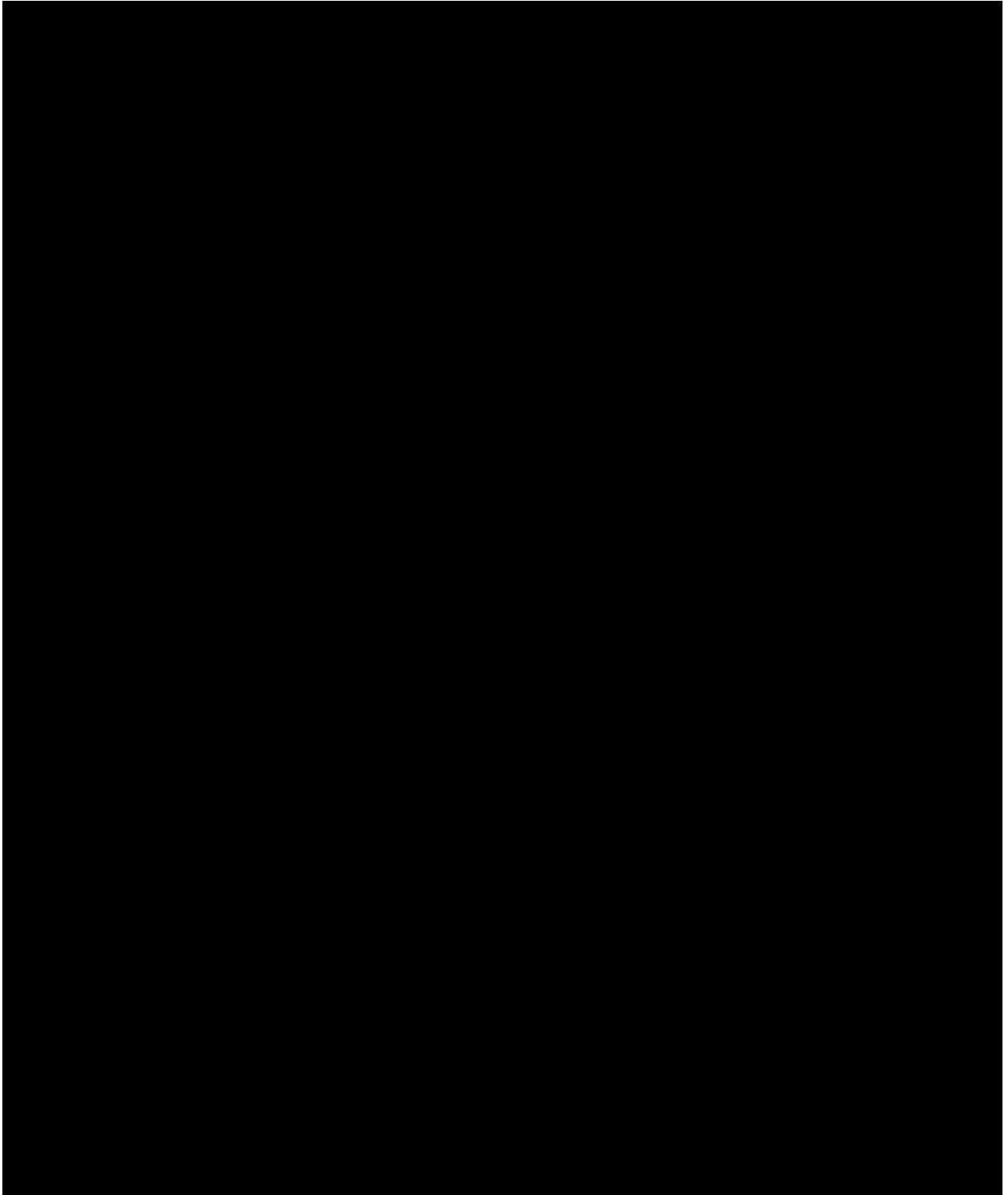
Phase IIa:

- Absolute change from baseline in Cough Severity NRS score at Week 4
- Absolute change from baseline in Cough Severity VAS score (mm) at Week 4

Phase IIb:

- Cough responder status, defined as a $\geq 30\%$ 24 h cough frequency reduction (CC/h) from baseline, at Week 12
- Absolute change from baseline in FVC (mL) at Week 12
- Absolute change from baseline in Cough Severity NRS score at Week 12
- Absolute change from baseline in Cough Severity VAS score (mm) at Week 12
- Absolute change from baseline in L-PF symptom cough domain score at Week 12
- Absolute change from baseline in LCQ physical domain score at Week 12





6. GENERAL ANALYSIS DEFINITIONS

6.1 TREATMENT(S)

For basic study information on treatments to be administered, assignment of treatment groups, selection of doses, refer to CTP Section 4.

Overall, the trial is divided into a Screening period, a randomised blinded 12-week treatment period with participants receiving either placebo or 1 of 3 doses of BI 1839100, and a 1-week follow-up period (refer to the schedule of assessments in the CTP). Start and end dates/times for these periods are defined in [Table 6.1: 1](#).

Table 6.1: 1 Study periods phases

Study analysis phase	Description	Start (included)	End (included)
Screening period	Screening	Earliest of date of informed consent, first screening procedure	Date/time of the first administration of BI 1839100
Treatment period	On-treatment period (blinded)	Date/time of first administration of BI 1839100 (Day 1)	Last date of last administration of BI 1839100 at 23:59
Follow-up period	Off-treatment	Last date of administration of BI 1839100 + 1 day at 0:00	Date of the end of study participation on the End of Study (e)EoS CRF at 23:59

Dates are defined individually per participant. If more than 1 date is associated with a specific visit, measurements associated with a specific date are assigned to a study analysis phase according to the rules specified in the table. An analysis phase will not extend beyond the start date of the following phase.

For efficacy analyses, data up to 1 day after last treatment intake of BI 1839100/placebo will be considered as on-treatment (see [Section 6.7](#) for more details).

For safety analyses, data up to the [REDACTED] after last treatment intake of BI 1839100/placebo will be considered as on-treatment (see [Section 6.7](#) for more details).

6.2 IMPORTANT PROTOCOL DEVIATIONS

Protocol deviations that affect the rights or safety of the study participants or can potentially influence the primary outcome measurement in a non-negligible way will be considered as important protocol deviations (iPDs). IPDs will be identified and documented according to BI SOPs ([9.2](#)).

Handling of iPDs in analysis is included in the DV domain specifications and stored within the TMF in EDMS. Other relevant documentation of details related to iPDs will also be stored in the TMF (e.g. in the Statistics/decision log).

6.3 INTERCURRENT EVENTS

Section 7.2.2 of the CTP: *The expected intercurrent events of interest in this trial are:*

- *Change in background AF therapy or AF dosage after randomisation*
- *Change in other background medication for cough after randomisation*
- *Start of a restricted medication other than background AF therapy or used as background medication for cough (see Section 4.2.2.1)*
- *Continuous treatment interruption ≥ 7 days or treatment discontinuation*

The primary strategy for primary and secondary endpoints will handle intercurrent events using treatment policy approach.

Treatment policy: *Estimating the effect of randomising trial participants to a treatment arm regardless of treatment actually being taken. For this, all intercurrent events will be handled according to the ‘treatment policy’ approach which uses the value of the endpoint(s) regardless of the occurrence of the intercurrent event.*

The secondary strategy for primary and secondary endpoints will handle intercurrent events using the hypothetical approach.

Hypothetical approach: *Estimating the effect of taking the randomised treatment as directed for the duration of the trial. In this approach, intercurrent events, except start of restricted medication, will be handled according to the ‘hypothetical approach’ where data collected after the occurrence of an intercurrent event will be considered missing. The intercurrent event of start of restricted medications will be handled according to the treatment policy approach.*

Further details for the hypothetical approach:

Not all restricted medications will be handled according to the treatment policy approach. Restricted medications listed in items 2.d and 2.j in Section 4.2.2.1 of the CTP will also be handled according to the hypothetical approach. Standard drug groups or “BI Tailored WHODrug Searches” that are maintained by the Dictionary Management Group will contain the list of restricted medications that will be used to select the concomitant medication records for determination of intercurrent events.

Intercurrent events from all data available at the time of the final analysis will be listed as part of the CTR.

Refer to [Table 6.3: 1](#) for a summary of intercurrent event strategies for the planned analyses.

Table 6.3: 1 Summary of intercurrent events and handling strategy for the primary and supplementary analysis

Intercurrent event	Intercurrent event handling strategy	
	Treatment policy (primary analysis)	Hypothetical approach (supplemental analysis)
Treatment discontinuation	a	b ^c
Treatment interruption ≥ 7 days	a	b
Changes in background medications that may have an impact on cough frequency ^d	a	b
Initiation or change in AF therapy during the treatment period	a	b
Restricted medications:		
• Opiates/opioids (e.g. codeine, morphine), baclofen, gabapentin, pregabalin, thalidomide, amitriptyline, inhaled cromolyn or related products, gefapixant	a	b
• Other restricted medications	a	a

a = Include all available data up to the end of trial regardless of the occurrence of an intercurrent event.

b = Include data only up to the start of the intercurrent event

^c For treatment discontinuation, include data up to 1 day after the last day of study medication

^d ACE inhibitors, inhaled corticosteroids, inhaled bronchodilators, proton pump inhibitors or histamine type-2 receptor blockers medications dose should not be changed or started during screening and treatment period.

6.4 PARTICIPANT SETS ANALYSED

The following analysis sets are defined for this trial:

Subject sets for Full analysis set (FAS) and Treated set (TS) are defined in Section 7.2.1.2 of the CTP. The definitions below include additional details.

- Randomised Set (RS): includes all participants who signed informed consent and were randomised into the trial, regardless of whether a participant was treated with trial medication. The RS will be used for the analyses of participant disposition.
- Full Analysis Set (FAS): includes all randomised participants who received at least 1 dose of trial medication. However, participants in the FAS will need to have both a baseline visit (i.e. pretreatment) and at least 1 post baseline assessment after receiving at least 1 dose of trial medication. The FAS will be used for demographics, baseline characteristics, protocol deviations, and efficacy analyses, in which participants will be analysed as according to the treatment group to which they were randomised (i.e.

planned treatment). This analysis set is meant to adhere closely to the intention-to-treat principle.

- Treated Set (TS): includes all randomised participants who received at least 1 dose of study treatment. The TS will be used for safety analysis and treatment exposure. Participants will be analysed according to the actual dose they received (e.g. according to actual treatment).

Table 6.4: 1 Subject sets analysed

Class of analysis	Subject set		
	Treated set	Full analysis set	Randomised set
Efficacy		X	
Safety & treatment exposure	X		
Demographic & baseline characteristics		X	
Disposition			X

6.6 HANDLING OF MISSING DATA AND OUTLIERS

Methods for handling missing efficacy data are described in Section 7.3 of the CTP.

Cough recordings with <20 hours of readable recording time after subtracting time the device was off the body from the total will be considered as missing for analysis. If there is a cough recording where 0 coughs are recorded, then this will be imputed as 1.0 CC/h to avoid taking the logarithm of 0. The same criteria will apply for the daytime cough frequency endpoint.

The non-response imputation (NRI) approach will be applied for the binary secondary endpoint of reduction in 24-h cough frequency of 30% from baseline. Missing values will be imputed as described in the following:

- For endpoints which are measured at multiple visits, if there are data at visits both before and after the visit with a missing outcome, then impute as success only if both neighbouring visits also represent a success (independent of whether the preceding and following observations were selected for analysis based on time windows

described in [Section 6.7](#)). If either measurement before or after a missing value is a failure, then the missing value will be imputed as a failure.

In case of (partially) missing start and end dates of concomitant medication, the dates will be imputed to enable subsequent calculation (but not for display) using the "worst case" approach, so that the extent of exposure to the concomitant therapy is maximal, i.e. the first day (month) of the month (year) for incomplete start dates and the last day (month) of the month (year) for incomplete end dates.

Distributions of $\log(\text{CC}/h)$ by visit will be monitored while data are blinded (e.g. during clinical quality review meetings). Outlying observations, defined as a $\log(\text{CC}/h) < Q1 - 1.5 * \text{IQR}$ or $\log(\text{CC}/h) > Q3 + 1.5 * \text{IQR}$, will be noted and discussed at the last blinded report planning meeting before database lock and a sensitivity analysis may be performed to assess the impact of the outlying observations on the primary analysis.

6.7 BASELINE, TIME WINDOWS AND CALCULATED VISITS

Measurements reported with a date and time and that were taken prior to start of administration of trial treatment will be considered pre-treatment values. Measurements reported with a date only (and no time) and taken on the day of first administration of trial treatment will also be considered pre-treatment values. These pre-treatment values will be assigned to visits according to the nominal visit number as recorded on the eCRF or as provided by the CRF.

Baseline, unless otherwise specified, is defined as the last measurement collected prior to the start of administration of the trial treatment.

Measurements taken during the conduct of the trial will be considered either on- or off-treatment values based on the definition in [Section 6.1](#) and will be assigned to visits for statistical analysis, if applicable, as defined below ([Table 6.7: 1](#)).

Table 6.7:1 Time windows for assignment of efficacy for statistical analysis

Visit name	Visit label	Trial day*	Time window (days)		
			Window	Start (inclusive)	End (inclusive)
Baseline selection (Cough recordings)					
V1	Screening 1	-28 to -14	n.a.	V1 date	V2A date-1
V2A	Screening 2A	-3 to -1	n.a.	V2A date	1 (First dose of study drug)
	Baseline			V1 date	1 (First dose of study drug)
Baseline selection (Other assessments)					
V1	Screening 1	-28 to -14	n.a.	V1 date	V2B date-1
V2B	Screening 2B	1	n.a.	V2B	1 (First dose of study drug)
	Baseline			V1 date	1 (First dose of study drug)
Planned post baseline visits (efficacy endpoints)					
V3	Week 4	29	-27/+14	2	43
V4	Week 8	57	-13/+14	44	71
V5	Week 12	85	-13/+14	72	Later of EoT date+1 day, time 23:59 Or V5 off treatment date, time 23:59
V6	EoT+7/EoS	EoT+7	n.a.	Later of EoT+2 days, time 0:00	Date of V6
Planned post baseline visits					
V3	Week 4	29	-27/+42	2	71
V5	Week 12	85	-13/+14	72	Later of EoT date+1 day, time 23:59 Or V5 off treatment date, time 23:59
V6	EoT+7/EoS	EoT +7	n.a.	Later of EoT or V5 off treatment+2 days, time 0:00	Date of V6

* Days are counted relative to the day of first treatment, which is defined as Day 1.

n.a.: Not applicable

Repeated and unscheduled efficacy measurements will be handled similarly to scheduled measurements and will also be assigned to a time window depending upon the date of measurement.

Only 1 observation per time window will be selected for statistical analysis at a particular visit. If there are 2 visits within the assigned time window, the value which is closest to the protocol planned visit day will be selected. If there are 2 observations which have the same difference in days to the planned day, but which are not measured on the same day, the later value will be selected. If there are 2 observations on the same day, the later value will be selected.

7. PLANNED ANALYSIS

Unless specified otherwise, the set of summary statistics for tabulations will be: N / Mean / SD / Min / Q1 / Median / Q3 / Max.

Tabulations of frequencies for categorical data will include all possible categories and will display the number of observations in a category as well as the percentage (%) relative to the respective treatment group (unless otherwise specified, all participants in the respective subject set whether they have non-missing values or not).

The precision for percentages should be 1 decimal point. The category ‘missing’ will be displayed only if there are actually missing values.

Statistical parameters and precision of continuous variables should be labeled and displayed according to Standards and Reporting of Clinical Trials and Project Summaries ([9.1](#)).

7.1 DEMOGRAPHIC AND OTHER BASELINE CHARACTERISTICS

Descriptive statistics as described above will be tabulated for demographic data and baseline characteristics.

7.2 CONCOMITANT DISEASES AND MEDICATION

Background medication use will be summarised with frequency and percentage of participants by ATC3 class and preferred name. Summaries of background antifibrotic medications being used at baseline will be tabulated as will background medications that may have an impact on cough frequency (ACE inhibitors, inhaled corticosteroids, inhaled bronchodilators, proton pump inhibitors or histamine type 2 receptor blockers). Changes in background medications and concomitant medications introduced during the treatment period will be similarly summarised.

Note that, background medications are defined as medication started at any time prior to Day 1 and continuing into the study period.

Conditions and diagnoses present at baseline will be summarised by MedDRA SOC and preferred term.

A summary table of concomitant procedures and non-drug therapies will also be provided.

7.3 TREATMENT COMPLIANCE

Responses to the “Study Medication Compliance” CRF will be tabulated by treatment and visit (refer to Section 4.3 of the CTP).

7.4 PRIMARY OBJECTIVE ANALYSIS

7.4.1 Main analysis

The primary estimand is the effect of randomising trial participants to treatment with BI 1839100 vs placebo regardless of treatment actually being taken or occurrence of intercurrent events in IPF participants with clinically meaningful cough. The Phase IIa and IIb primary endpoints of change from baseline in 24-h cough frequency at Week 4 and at Week 12, respectively, will be summarised and modeled as described in Section 7.2.3.1 of the CTP to estimate the difference between the active treatment groups and placebo.

The statistical model will be as follows:

$$y_{ijkm} = \beta_j S_i + \tau_{kj} + f_{mj} + e_{ij}$$

$$e_{ij} \sim N_Z(0, \Sigma)$$

- y_{ijkm} = change from baseline in log transformed CC/h for participant i in intake of AF treatment at baseline stratum m at visit j receiving treatment k ,
- S_i = log transformed CC/h at baseline measurement of participant i , $i = 1, 2, \dots$
- β_j = coefficient of baseline effect at visit j
- τ_{jk} = the effect of treatment k at visit j , $j = 1, \dots, Z$ and $k = 1, \dots, Y$,
- f_{mj} = the effect of baseline AF treatment stratum m at visit j , $m = 1, 2$. The concomitant medication CRF will be used as the basis to for the assigned stratification factor, AF treatment at baseline, regardless of any mis-assignment in the IRT
- e_{ij} = the random normally distributed ($\sim N$) error associated with the j^{th} visit of the i^{th} participant. Errors are independent between participants
- Σ = an unstructured covariance matrix with dimension Z (where Z is the maximum value for the visit index j)

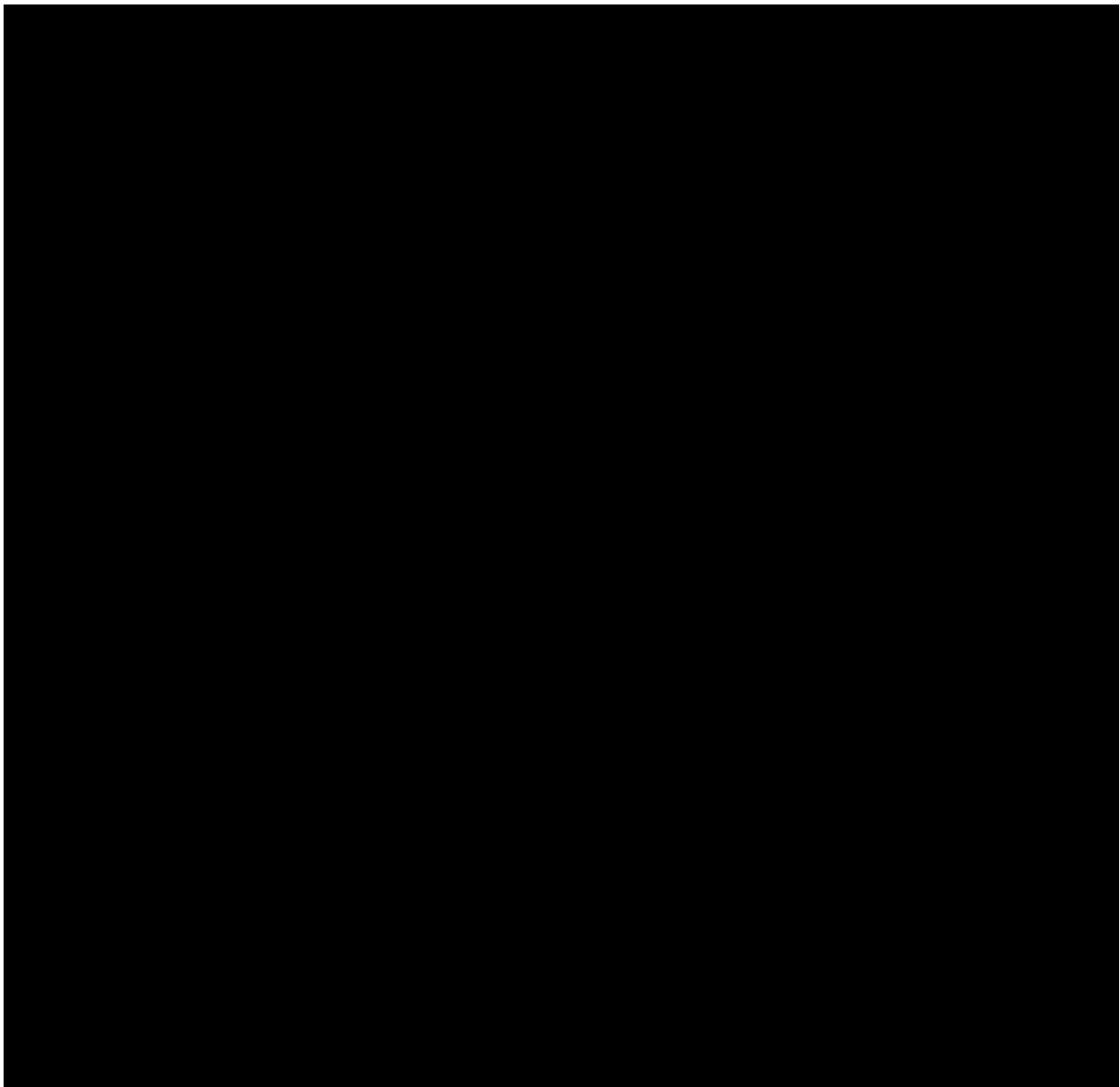
The primary analyses for both the Phase IIa and IIb endpoints will be performed using the FAS. Trial participants will be analysed according to the stratum to which they belong (regardless of any mis-assignment to treatment based on identification of the wrong stratum), as such an error occurs before randomisation and is therefore consistent with regulatory guidance.

SAS code to be used for the primary analysis can be found in [Section 10.1](#).

All intercurrent events will be handled according to the ‘treatment policy’ approach which uses the value of the endpoint(s) regardless of the occurrence of the intercurrent event.

Tabulations of descriptive statistics and associated figures of 24-h cough frequency will also be produced by treatment and visit. Descriptive statistics will include summaries based on the original scale for CC/h and the natural log scale. Summaries of geometric means and relative changes from baseline based on geometric mean ratios will also be presented.

Since the trial was discontinued after the Phase IIa part, the MCP-Mod analyses described for the Phase IIb part in the CTP will not be performed.



7.5 SECONDARY OBJECTIVE ANALYSIS

7.5.1 Key secondary objective analysis

This section is not applicable as no key secondary endpoint has been specified in the protocol.

7.5.1.1 Main analysis

Not applicable.

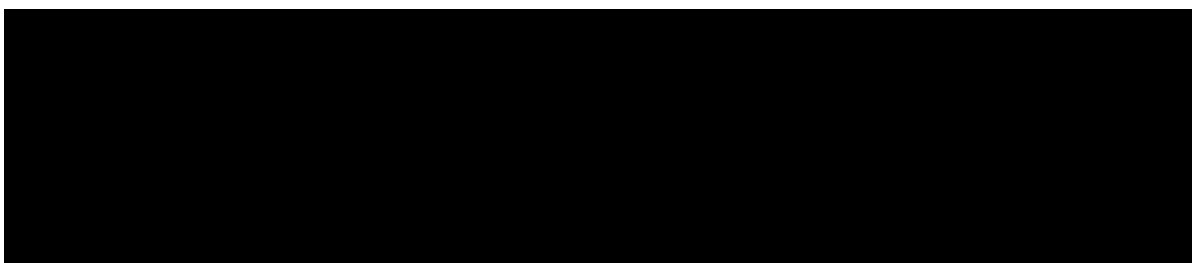
7.5.2 Secondary objective analysis

The following Phase IIa/IIb secondary endpoints will be analysed according to the same analysis method as the primary endpoint using REML-MMRM.

- Absolute change from baseline in Cough Severity NRS score at Week 4
- Absolute change from baseline in Cough Severity VAS score (mm) at Week 4
- Absolute change from baseline in FVC (mL) at Week 12
- Absolute change from baseline in Cough Severity NRS score at Week 12
- Absolute change from baseline in Cough Severity VAS score (mm) at Week 12
- Absolute change from baseline in L-PF symptom cough domain score at Week 12
- Absolute change from baseline in LCQ physical domain score at Week 12

For the Phase IIb binary secondary endpoint of cough responder, defined as achieving a $\geq 30\%$ 24h cough frequency reduction from baseline at Week 12, the proportions of participants achieving this at Week 12 along with the other time points, Week 4 and Week 8,

will be summarized. Tabulations of observed cases (no imputation for missing recordings) and non-response imputation (NRI) will be provided). Confidence intervals for these single proportions will be based on the Wilson method ([9.4](#)). Comparisons between treatment groups will be performed using a logistic regression model adjusting for background AF treatment (Yes, No) and the fixed continuous effect of baseline 24 h cough frequency (log transformed). Adjusted odds ratios for achieving a response in active treatment groups compared to Placebo (reference), together with 95% confidence intervals will be used to quantify the effect of treatment, comparing all treatments to placebo as the reference. Profile likelihood estimates will be used to calculate the confidence intervals. Refer to [Section 6.6](#) for the handling of missing observations (i.e. NRI approach) and [Section 10.1](#) for the SAS code.



7.7 EXTENT OF EXPOSURE

Treatment duration and treatment categories (as described in [Section 5.4](#)) will be summarised for BI 1839100/placebo. Descriptive statistics (N, Mean, SD, Min, Median, Max) for each will be tabulated. Frequencies and percentages of participants will also be tabulated for the exposure categories.

7.8 SAFETY ANALYSIS

All safety analyses will be performed on the treated set.

7.8.1 Adverse Events

Unless otherwise specified, the analyses of AEs will be descriptive in nature. All analyses of AEs will be based on the number of participants with AEs and NOT on the number of AEs.

The analysis of AEs will be based on the concept of treatment emergent AEs. That means that all AEs occurring between first drug intake till 2 days after last drug intake will be assigned to the randomised treatment. All AEs occurring before first drug intake will be assigned to 'screening' and all AEs occurring after last drug intake + 2 days will be assigned to 'follow-up' (for listings only). For details on the treatment definition, see [Section 6.1](#).

According to ICH E3 ([9.3](#)), in addition to deaths and serious AEs, 'other significant' AEs need to be listed in the clinical trial report. These will be any non-serious AE that led to an

action taken with study drug (e.g. discontinuation or dose reduced or interrupted). An overall summary of AEs will be presented.

The frequency of participants with AEs will be summarised by treatment, primary system organ class and PT. Separate tables will be provided for participants with SAEs, AEs leading to treatment discontinuation, AEs by intensity (Mild, Moderate, Severe), AEs by severity, related AEs, and AEs of special interest.

The system organ classes will be sorted by frequency; PTs will be sorted by frequency (within SOC). Customized sorting orders may also be used based on trial needs, e.g. SOC sorted by frequency.

Participants who experienced acute exacerbation, suspected acute exacerbation, or diahorrea by treatment will be summarised.

7.8.2 Laboratory data

The analyses of laboratory data will be descriptive in nature and will be based on BI standards.

Section 7.2.6 of the CTP: *“Laboratory data will be analysed both quantitatively as well as qualitatively. The latter will be done via comparison of laboratory data to their reference ranges. Values outside the reference range as well as values defined as clinically relevant will be summarised. Treatment groups will be compared descriptively with regard to distribution parameters as well as with regard to frequency and percentage of trial participants with abnormal values or clinically relevant abnormal values.”*

Descriptive statistics of converted laboratory values over time and for the difference from baseline will be provided by visit, including the last value on treatment, the minimum value on treatment and maximum value on treatment. Criteria for possibly clinically significant abnormal values will be listed.

7.8.3 Vital signs

The analyses of vital signs (blood pressure, pulse rate, body weight, and oxygen saturation) will be descriptive in nature.

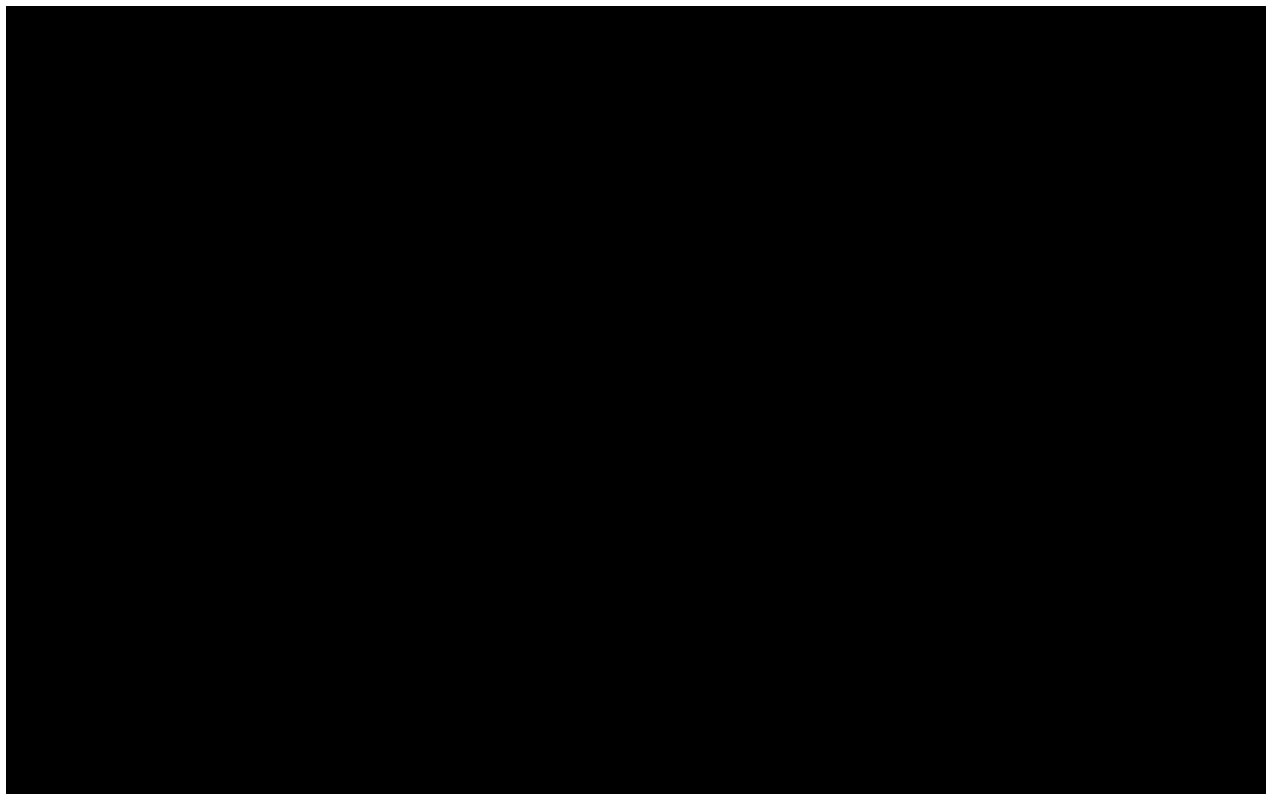
Descriptive statistics of vital signs over time and for the difference from baseline will be provided by treatment and will include the last value during on-treatment period, the minimum value during on-treatment period, and the maximum value.

7.8.4 ECG

Not applicable.

7.9 OTHER ANALYSIS

Not applicable.

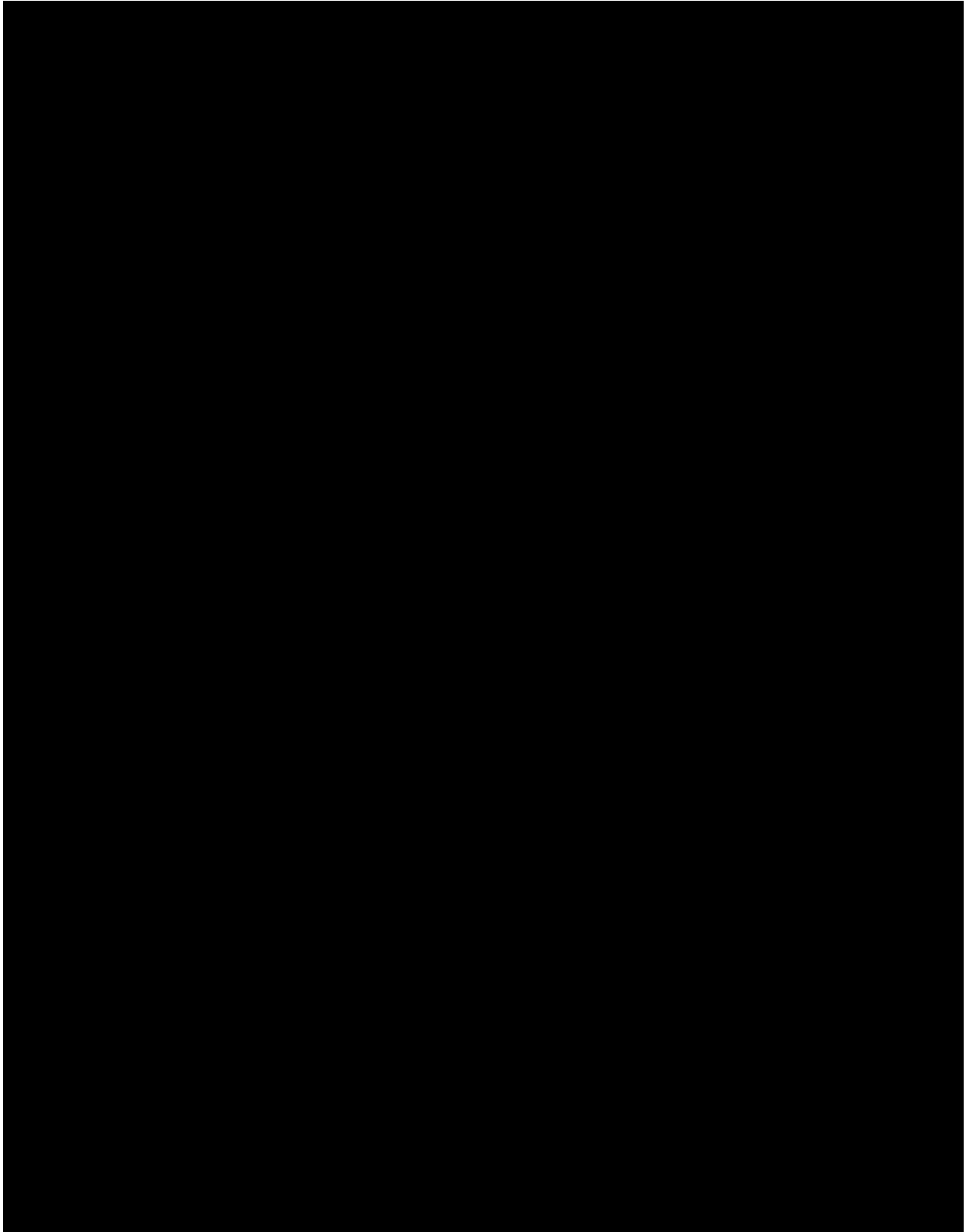


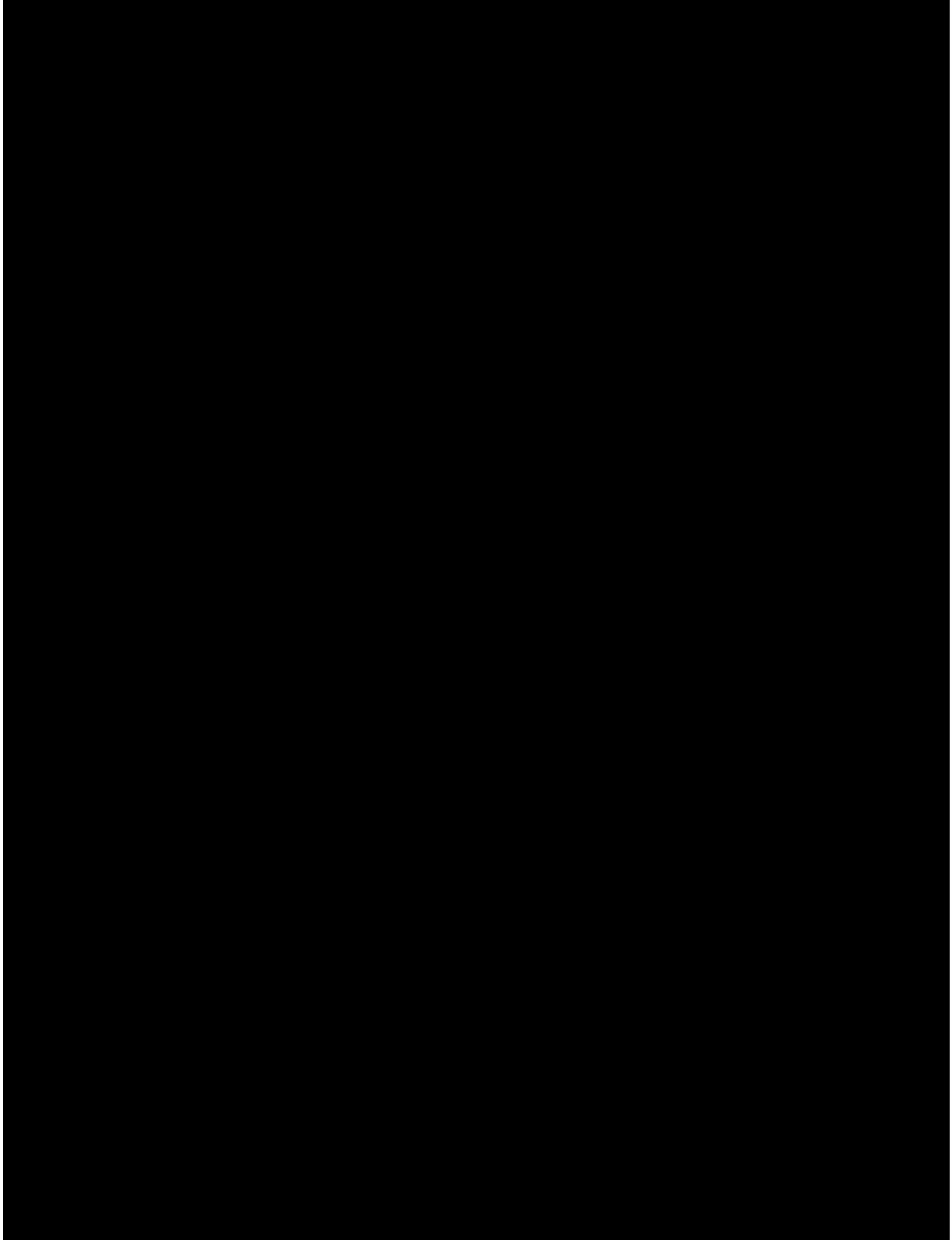
8. TIMEPOINT OF RELEASE OF TREATMENT INFORMATION

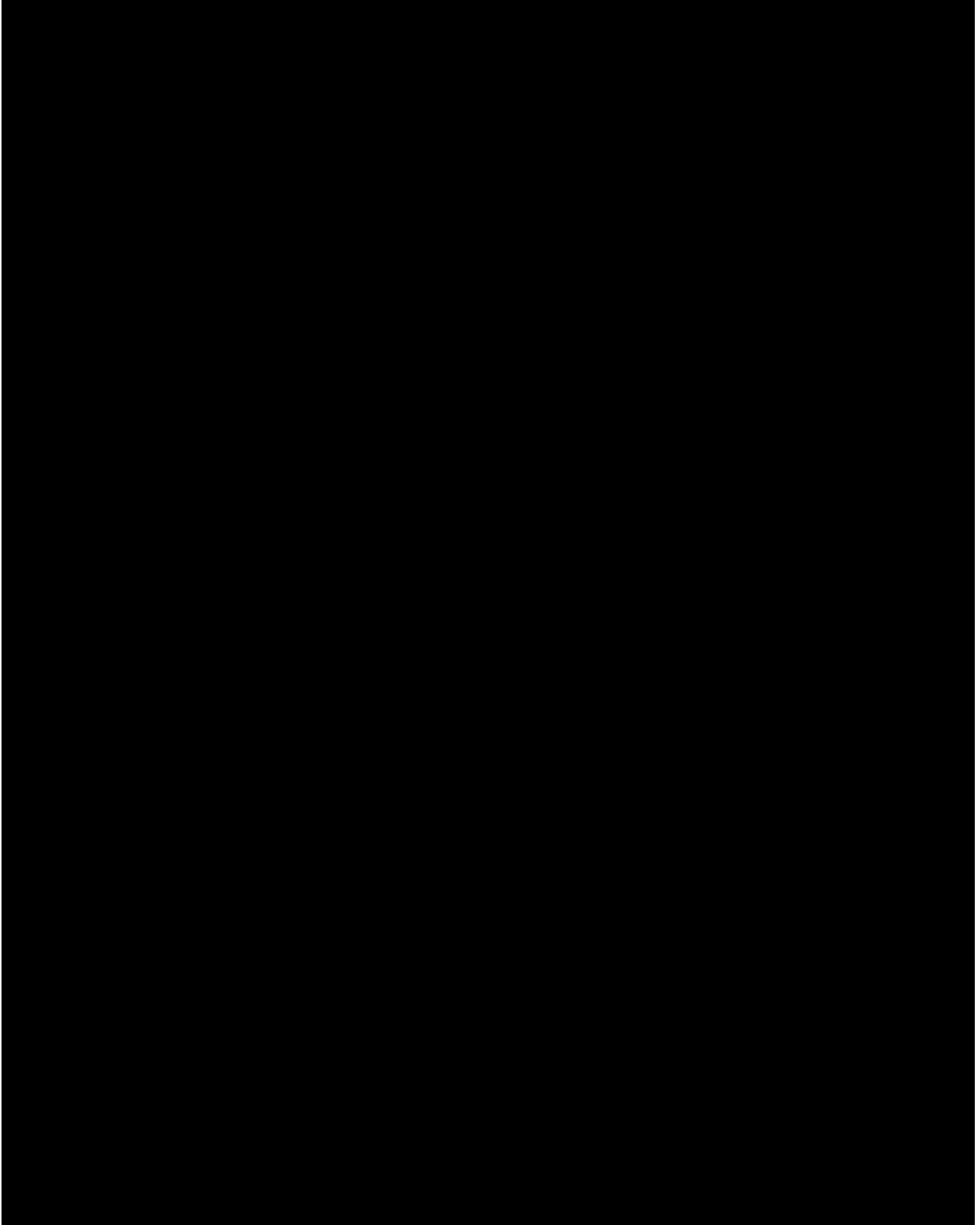
The treatment information will be released to unblind the trial database after the last participant has completed their End-of-Study/Follow-up visit and all data has been entered and cleaned as defined in the “Data Ready to be Unblinded and/or Final Trial Closure Notification” (RUN) form.

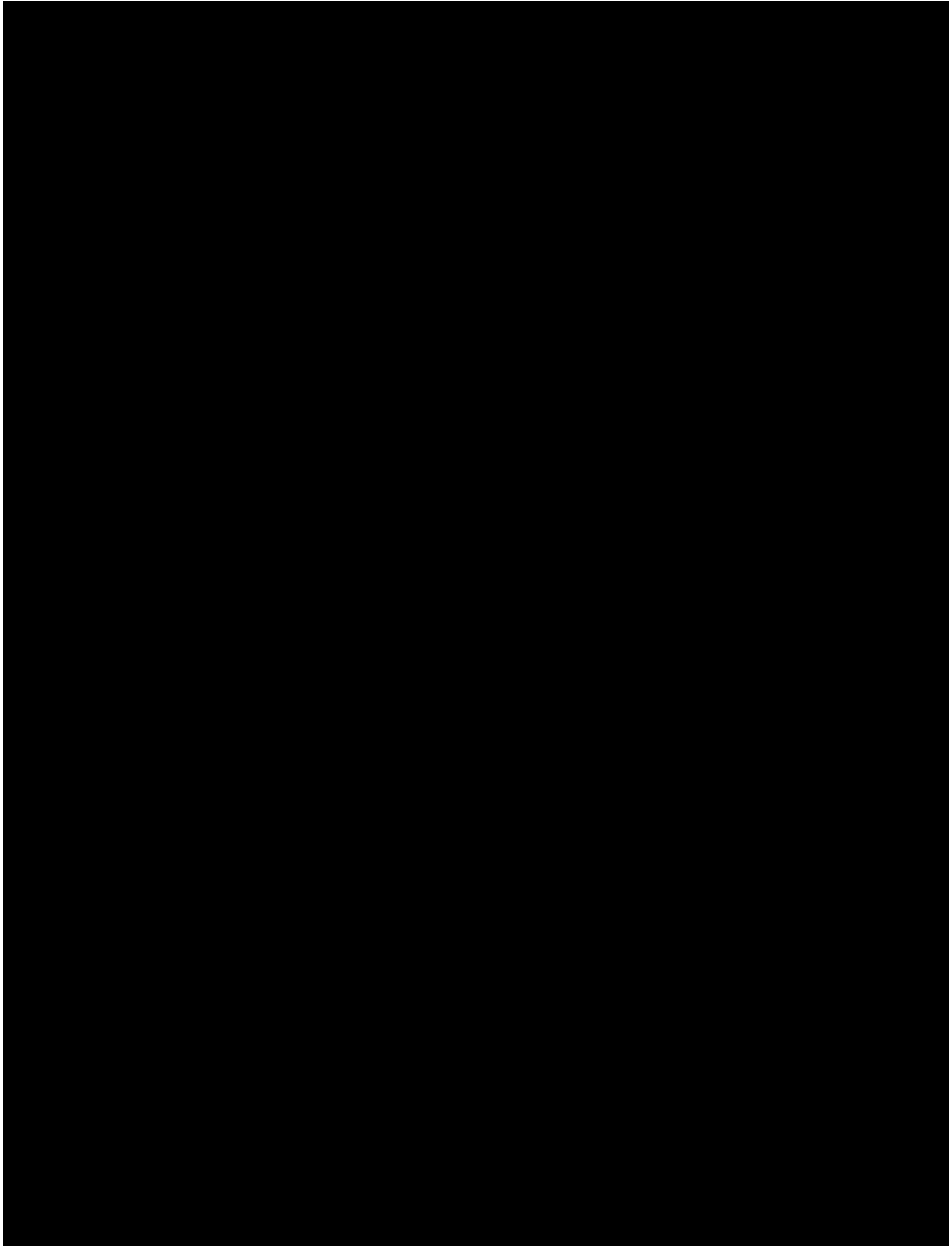
9. REFERENCES

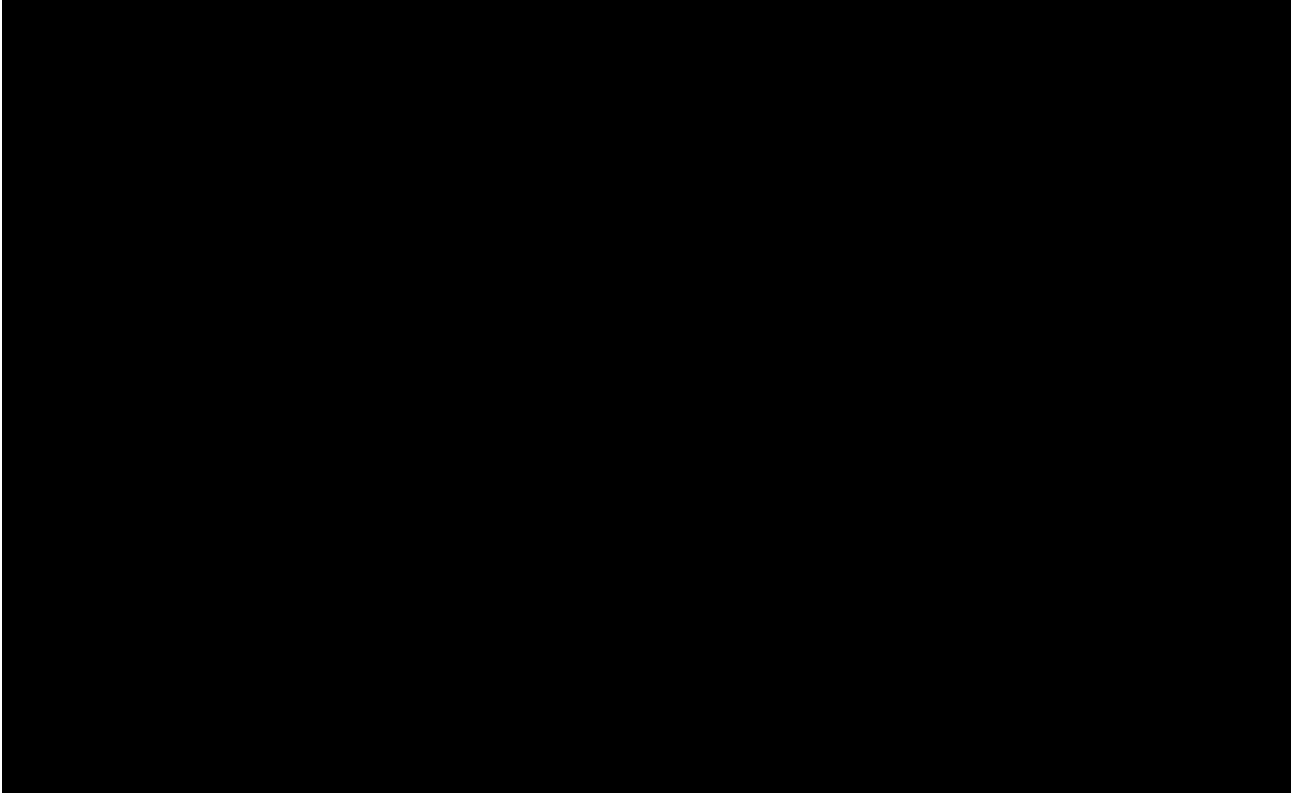
9.1	CPMP / ICH / 363 / 96: "Statistical Principles for Clinical Trials", ICH Guideline Topic E9, Note For Guidance on Statistical Principles for Clinical Trials, current version.
9.3	CPMP / ICH / 137 / 95: "Structure and Content of Clinical Study Reports", ICH Guideline Topic E3; Note For Guidance on Structure and Content of Clinical Study Reports, current version, EMA webpage.
9.4	Confidence intervals for a binomial proportion and asymptotic expansions. Ann Stat 30 (1), 160 – 201 (2002). [R12-3710]











11 HISTORY TABLE

Table 11: 1 History table

Version	Date (DD-MMM-YY)	Author	Sections changed	Brief description of change
1.0	20-NOV-25		None	This is the final TSAP.