

1. TABLE OF CONTENTS

TITLE PAGE	1
1. TABLE OF CONTENTS.....	2
LIST OF TABLES	4
2. LIST OF ABBREVIATIONS	5
3. INTRODUCTION.....	7
4. CHANGES IN THE PLANNED ANALYSIS OF THE STUDY	8
5. ENDPOINTS	9
5.1 PRIMARY ENDPOINTS	9
5.2 SECONDARY ENDPOINTS	9
5.2.1 Key secondary endpoint	9
5.2.2 Secondary endpoints.....	9
5.3 FURTHER ENDPOINTS.....	9
5.3.2 Safety parameters	9
6. GENERAL ANALYSIS DEFINITIONS	11
6.1 TREATMENTS.....	11
6.2 IMPORTANT PROTOCOL VIOLATIONS	12
6.3 SUBJECT SETS ANALYSED.....	12
.....	13
6.5 POOLING OF CENTRES	13
6.6 HANDLING OF MISSING DATA AND OUTLIERS	13
6.7 BASELINE, TIME WINDOWS AND CALCULATED VISITS	14
7. PLANNED ANALYSIS	15
7.1 DEMOGRAPHIC AND OTHER BASELINE CHARACTERISTICS.....	15
7.2 CONCOMITANT DISEASES AND MEDICATION	15
7.3 TREATMENT COMPLIANCE	16
7.4 PRIMARY ENDPOINTS	16
7.5 SECONDARY ENDPOINTS	17
7.5.1 Key secondary endpoint	17
7.5.2 Secondary endpoints.....	17
.....	17
.....	17
.....	17
.....	17
7.7 EXTENT OF EXPOSURE.....	17
7.8 SAFETY ANALYSIS.....	17
7.8.1 Adverse events	17

7.8.2	Laboratory data	19
7.8.3	Vital signs.....	19
7.8.4	ECG.....	19
7.8.5	Others.....	19
8.	REFERENCES.....	20
	21
10.	HISTORY TABLE.....	22

LIST OF TABLES

Table 6.1: 1	Flow chart of analysis phases for statistical analyses of AEs, safety laboratory data and vital signs	11
Table 6.1: 2	Overview of treatments for intra-individual comparison	11
Table 6.2: 1	Important protocol violations	12
Table 6.3: 1	Subject sets analysed	13
Table 10: 1	History table	22

2. LIST OF ABBREVIATIONS

Term	Definition / description
ADME	Absorption, distribution, metabolism and excretion
AE	Adverse event
AESI	Adverse event of special interest
ANOVA	Analysis of variance
AUC _{0-∞}	Area under the concentration-time curve of the analyte over the time interval from 0 extrapolated to infinity
AUC ₀₋₂₄	Area under the concentration-time curve of the analyte over the time interval from 0 to 24
BLQ	Below the lower limit of quantification
BMI	Body mass index
BI	Boehringer Ingelheim
[C-14]BI 1467335	[14C]-labelled BI 1467335
CARE	Clinical data analysis and reporting environment
CL	Clearance of the analyte
C _{max}	Maximum measured concentration of the analyte in plasma
CTP	Clinical trial protocol
CTR	Clinical trial report
CV	Arithmetic coefficient of variation
DBLM	Data base lock meeting
eCRF	Electronic case report form
F	Absolute bioavailability
gCV	Geometric coefficient of variation
gMean	Geometric mean
ICH	International Conference On Harmonisation
IPV	Important protocol violation
LLT	Lower level term
MedDRA	Medical Dictionary For Regulatory Activities
NOA	Not analysed
NOR	No valid result
NOS	No sample available
PK	Pharmacokinetics

Term	Definition / description
PKS	Pharmacokinetic parameter analysis set
PV	Protocol violation
Q1	Lower quartile
Q3	Upper quartile
qd	Per day (quaque die)
RAGe	Report appendix generator
RPM	Report planning meeting
SD	Standard deviation
$t_{1/2}$	Observed terminal half-life of the analyte
t_{max}	Time from dosing to the maximum measured concentration of the analyte
TS	Treated set
TSAP	Trial statistical analysis plan
ULN	Upper limit of normal range
V_z	Volume of distribution of the analyte

3. INTRODUCTION

As per ICH E9 (1), the purpose of this document is to provide a more technical and detailed elaboration of the principal features of the analysis described in the revised CTP, 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 CTP and its amendment. 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, randomisation.

Study data will be stored in a trial database within the Oracle Clinical™ system.

The statistical analyses will be performed within the validated working environment CARE, including SAS™ (current Version 9.4, by SAS Institute Inc., Cary, NC, USA), and a number of SAS™-based tools (e.g., macros for the analyses of AE data or laboratory data; RAGe system for compilation/formatting of the CTR appendices).

PK parameters will be calculated using WinNonlin™ software (professional Network version Phoenix 6.3, Pharsight Corporation, Mountain View, CA 94041-1530, USA).

4. CHANGES IN THE PLANNED ANALYSIS OF THE STUDY

All analyses described in this TSAP are in accordance with the statistical methods described in the CTP.

5. ENDPOINTS

5.1 PRIMARY ENDPOINTS

Primary endpoints after the first dose at Day 1 are C_{\max} and $AUC_{0-\infty}$ of BI 1467335 in plasma after oral (po) and after intravenous (iv) administration.

Primary endpoints after the first dose at Day 28 are $C_{\max,28}$ and $AUC_{0-24,28}$ of BI 1467335 in plasma after oral administration and $C_{\max,28}$ and $AUC_{0-\infty,28}$ of BI 1467335 in plasma after intravenous administration.

5.2 SECONDARY ENDPOINTS

5.2.1 Key secondary endpoint

Not applicable.

5.2.2 Secondary endpoints

Secondary endpoints are:

- t_{\max} , $t_{\max,28}$ and $t_{1/2}$ of [C-14]BI 1467335 and of BI 1467335 after oral and iv administration
- $t_{1/2,28}$ of [C-14]BI 1467335 and of BI 1467335 after iv administration
- CL , CL_{28} , V_z , and $V_{z,28}$ of [C-14]BI 1467335 after oral and iv administration
- F of BI 1467335 at Day 1 and at Day 28, whereas F is derived as
 $F = (AUC_{0-\infty} / Dose)_{\text{oral}} / (AUC_{0-\infty} / Dose)_{\text{iv}} * 100$ at Day 1
 $F = (AUC_{\tau} / Dose)_{\text{oral}} / (AUC_{0-\infty,28} / Dose)_{\text{iv}} * 100$ at Day 28

5.3 FURTHER ENDPOINTS

5.3.2 Safety parameters

Further safety parameters will be used as defined in Section 5.2.1 of the CTP:

CTP:

- *Adverse events (including clinically relevant findings from the physical examination)*
- *Safety laboratory tests*
- *12-lead ECG*
- *Vital signs (blood pressure, pulse rate)*

6. GENERAL ANALYSIS DEFINITIONS

6.1 TREATMENTS

For basic study information on treatments to be administered, assignments of dose groups, and selection of doses, cf. Section 4 of the CTP.

All subjects were planned to be treated with

- a single iv infusion of the microtracer on Day 1 and Day 28 (reference treatment)
- and non-radiolabelled film-coated tablets once a day from Day 1 to Day 28 (test treatment)

For statistical analysis of AEs, safety laboratory data and vital signs, the following analysis phases are defined for each subject:

Table 6.1: 1 Flow chart of analysis phases for statistical analyses of AEs, safety laboratory data and vital signs

Study analysis phase	Label	Start (inclusive)	End (exclusive)
Screening	Screening	Date of informed consent	Date/time of first administration of study drug
On-treatment	BI 1467335	Date/time of first administration of study drug	12:00 a.m. on day after subject's trial termination date

It will not be differentiated between intravenous or oral administration of the drug.

AE displays will present results for the screening phase, on-treatment phase and additionally, the following total will be provided:

- "**Total**", defined as the total over all study phases (screening + on-treatment)

The following labels will be used for the comparison of treatments:

Table 6.1: 2 Overview of treatments for intra-individual comparison

Treatment	Short label
T BI 1467335 10 mg tablet, qd	BI 10 mg tab
R1 8.85 µg [C-14] BI 1467335 free base in 10 mL solution, qd	BI 8.85 mg iv
R2 5 µg [C-14] BI 1467335 free base in 10 mL solution, qd	BI 5 mg iv

More details on the technical implementation of these analyses are provided in the ADS Plan of this TSAP.

6.2 IMPORTANT PROTOCOL VIOLATIONS

Consistency check listings (for identification of violations of time windows) and a list of protocol deviations (e.g. deviations in drug administration, in blood sampling times, etc.) will be provided to be discussed at the RPM/DBLM. At this meeting, it will be decided whether a discrepant data value can be used in analyses or whether it must be corrected in the clinical database. Each protocol deviation must be assessed to determine whether it is an IPV. For definition of IPV, and for the process of identification of these, refer to the BI reference document "Protocol Violation Handling Definitions" (2)

If any IPV, they are to be summarised into categories and will be captured in the RPM/DBLM minutes via an accompanying Excel spreadsheet (3). The following table contains the categories which are considered to be IPV, this table will be supplemented accordingly by the time of the RPM/DBLM.

IPV, they will be summarised and listed.

Table 6.2: 1 Important protocol violations

Category / Code	Description
A	Entrance criteria not met
A1	Inclusion criteria violated
A2	Exclusion criteria violated
B	Informed consent
B1	Informed consent not available
B2	Informed consent too late
C	Trial medication and randomisation
C1	Incorrect trial medication taken
C3	Non-compliance
C5	Incorrect intake of trial medication
D	Concomitant medication
D1	Prohibited medication use
E	Missing data
	None ¹
G	Other trial specific important violations
G1	Certain violations of procedures used to measure secondary PK data

Violations C1, C5 and G1 can only be detected at the trial site.

¹ Missing visits, evaluations, and tests will be considered missing data, not PVs

Source: BI reference document "Protocol Violation Handling Definitions" (2).

6.3 SUBJECT SETS ANALYSED

All entered subjects who received study medication will be included in the safety analysis and in the PK analysis depending on the availability of measurement values, and on their adherence to the CTP.

The following subject sets will be defined for statistical analysis:

- **Treated set (TS):**
This subject set includes all subjects who received at least one dose of study drug. This is the full analysis set population in the sense of ICH-E9. It will be used for analysis of safety, demographic data and baseline characteristics.
- **Pharmacokinetic parameter set (PKS):**
This subject set includes all subjects in the TS who provide at least one primary PK parameter that was not excluded because of PVs relevant to the statistical evaluation of PK endpoints as defined in Section 7.3 of the CTP.

The discussion of all exceptional cases and problems and the decisions on the allocation of subjects to analysis sets will be made at latest at the RPM/DBLM.

Table 6.3: 1 Subject sets analysed

Class of endpoint	Subject set	
	TS	PKS
Disposition	X	
Exposure	X	
IPVs	X	
Demographic/baseline endpoints	X	
Safety parameters	X	
Primary PK endpoints		X
Secondary PK endpoints		X
Further PK endpoints		X

6.5 POOLING OF CENTRES

This section is not applicable, because the study was performed in only one centre.

6.6 HANDLING OF MISSING DATA AND OUTLIERS

Data of screened subjects who were withdrawn from the trial prior to first administration of any study drug will not be reported in the CTR.

Data of treated subjects who failed to complete the study (dropouts or withdrawals) will be reported in the CTR as far as their data are available. All withdrawals will be documented and the reason for withdrawal recorded in the CTR.

CTP: With respect to safety evaluations, it is not planned to impute missing values.

The only exception where imputation might be necessary for safety evaluation are AE dates. Missing or incomplete AE dates are imputed according to BI standards (4) [001-MCG-156_RD-01].

Missing data and outliers of PK data are handled according to BI standards (5) [001-MCS-36-472_RD-01]. *CTP: Drug concentration data identified with NOS (no sample available), NOR (no valid result), NOA (not analysed), or BLQ (below the lower limit of quantification) will be displayed as such and not replaced by zero at any time point (this rule also applies also to the lag phase, including the predose values)..*

CTP: For the non-compartmental analysis, concentration data identified with NOS, NOR or NOA will generally not be considered. Concentration values in the lag phase identified as BLQ will be set to zero. All other BLQ values of the profile will be ignored. The lag phase is defined as the period between time zero and the first time point with a concentration above the quantification limit.

6.7 BASELINE, TIME WINDOWS AND CALCULATED VISITS

The last non-missing value determined prior to the first study drug administration will be defined as baseline.

Time windows are defined in Section 6.1 of the CTP. Adherence to time windows will be checked at the RPM/DBLM.

7. PLANNED ANALYSIS

The format of the listings and tables will follow the BI guideline "Reporting of clinical trials and project summaries" (6).

The individual values of all subjects will be listed, sorted by sequence group, subject number and visit. AE listings will be sorted by assigned treatment (see [Section 7.8.1](#) below for details). The listings will be contained in Appendix 16.2 (SDL) of the CTR.

The following standard descriptive statistical parameters will be displayed in summary tables of continuous variables:

N	number of non-missing observations
Mean	arithmetic mean
SD	standard deviation
Min	minimum
Median	median
Max	maximum

For plasma concentrations as well as for all PK parameters, the following descriptive statistics will additionally be calculated:

CV	arithmetic coefficient of variation
gMean	geometric mean
gCV	geometric coefficient of variation

The data format for descriptive statistics of concentrations will be identical with the data format of the respective concentrations. The descriptive statistics of PK parameters will be calculated using the individual values with the number of decimal places as provided by the evaluation program. Then the individual values as well as the descriptive statistics will be reported with three significant digits in the CTR.

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. Percentages will be rounded to one decimal place. The category missing will be displayed if and only if there are actually missing values. Percentages will be based on all subjects in the respective subject set whether they have non-missing values or not.

7.1 DEMOGRAPHIC AND OTHER BASELINE CHARACTERISTICS

Only descriptive statistics are planned for this section of the report. These will be based on the TS.

7.2 CONCOMITANT DISEASES AND MEDICATION

Concomitant diseases will be coded according to the most recent version of MedDRA. Concomitant medication will be coded according to the most recent version of the World Health Organisation – Drug Dictionary.

Only descriptive statistics are planned for this section of the report.

A medication will be considered concomitant to a dose group, if it

- is ongoing at the time of first administration of this treatment, or
- starts within the analysis phase of the respective treatment (see [Section 6.1](#) for a definition of treatments and analysis phases).

The relevance of the concomitant therapies to the evaluation of PK will be decided no later than at the RPM/DBLM.

7.3 TREATMENT COMPLIANCE

Treatment compliance will not be analysed as a specific endpoint (cf. [Section 5.4.2](#)). Any deviations from complete intake will be addressed in the RPM/DBLM (cf. [Section 6.2](#)) and described in the CTR.

7.4 PRIMARY ENDPOINTS

Analysis of absolute oral bioavailability of dose-normalised primary endpoints will be performed as defined in Sections 7.1.3 and 7.3.1 of the CTP.

The statistical model for the primary analysis defined in the CTP is an analysis of variance (ANOVA) model on the logarithmic scale.

Primary PK endpoints will also be assessed descriptively. The analysis of standard PK parameters is performed according to BI standards (5) [001-MCS-36-472_RD-01].

Exclusion of PK parameters

The ADS ADPP contains column variables APEXC and APEXCO indicating inclusion/exclusion (APEXC) of a PK parameter and an analysis flag comment (APEXCO). All analyses based on the PKS are based on PK parameter values which are not flagged for exclusion, i.e. with APEXC equal to 'Included'.

Exclusion of plasma concentrations

The ADS ADPC (PK concentrations per time-point or per time-interval) contains column variables ACEXC or ACEXCO indicating inclusion/exclusion (ACEXC) of a concentration and an analysis flag comment (ACEXCO). Exclusion of a concentration depends on the analysis flag comment ACEXCO. For example, if ACEXCO is set to 'ALL CALC', the value will be excluded for all types of analyses based on concentrations. If ACEXCO is set to 'DESC STATS' the value will be excluded from descriptive evaluations per planned time point/time interval. If ACEXCO contains the addition 'TIME VIOLATION' or 'TIME DEVIATION', the value can be used for further analyses based on actual times. If ACEXCO is set to 'HALF LIFE', the value will be excluded from half-life calculation only; the value is included for all other analyses. Excluded concentration itself will be listed in the CTP trial associated with an appropriate flag.

Further details are given in "Noncompartmental Pharmacokinetic / Pharmacodynamic Analyses of Clinical Studies" ([5](#)) and "Description of Analytical Transfer Files and PK/PD Data Files" ([7](#)).

7.5 SECONDARY ENDPOINTS

7.5.1 Key secondary endpoint

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

7.5.2 Secondary endpoints

Secondary PK endpoints will be assessed descriptively. The analysis of standard PK parameters is performed according to BI standards ([5](#)) [001-MCS-36-472_RD-01].

See [Section 7.4](#) of this TSAP for details regarding exclusion of PK parameters and plasma concentrations.

7.7 EXTENT OF EXPOSURE

Treatment exposure will only be listed by means of the date and time of drug administration.

7.8 SAFETY ANALYSIS

All safety analyses will be performed on the TS.

7.8.1 Adverse events

AEs will be coded with the most recent version of MedDRA.

The analyses of AEs will be descriptive in nature. All analyses of AEs will be based on the number of subjects with AEs and not on the number of AEs.

For analysis, multiple AE occurrence data on the electronic case report form (eCRF) will be collapsed into an AE event provided that all of the following applies:

- All AE attributes are identical (LLT, intensity, action taken, therapy required, seriousness, reason for seriousness, relationship, outcome, AESI)
- The occurrences were time-overlapping or time-adjacent (time-adjacency of two occurrences is given if the second occurrence started at most 1 hour after the first occurrence ended).

For further details on summarisation of AE data, please refer to "Analysis and presentation of adverse event data from Clinical Trials" (8) and "Handling of missing and incomplete AE dates" (4).

The analysis of AEs will be based on the concept of treatment-emergent AEs. That means that all AEs will be assigned to the screening or treatment phases as defined in [Section 6.1](#). AEs will be analysed based on actual treatments, as defined in [Table 6.1: 1](#).

An overall summary of AEs will be presented. This overall summary will comprise summary statistics for the class of other significant AEs according to ICH E3 and for the class of AESIs.

CTP: *The following are considered as AESIs in this trial:*

- *Hepatic injury*
A hepatic injury is defined by the following alterations of hepatic laboratory parameters::
 - *an elevation of AST and/or ALT ≥ 3 -fold ULN combined with an elevation of total bilirubin ≥ 2 -fold ULN measured in the same blood sample, and/or*
 - *aminotransferase (ALT, and/or AST) elevations ≥ 10 fold ULN*

The investigator had to classify on the eCRF whether an observed AE was an AESI or not.

According to ICH E3 (9), AEs classified as 'other significant' need to be reported and will include those non-serious and non-significant AEs

- (i) which are marked haematological or other lab abnormalities, or
- (ii) which were reported with 'action taken = discontinuation' or 'action taken = reduced', or
- (iii) which lead to significant concomitant therapy as identified by the Clinical Monitor/Investigator at a Medical Quality Review Meeting.

The frequency of subjects with AEs will be summarised by treatment, primary system organ class and preferred term. AEs which were considered by the investigator to be drug related will be summarised separately. Separate tables will also be provided for subjects with SAEs, subjects with AESIs and subjects with other significant AEs (according to ICH E3 (9)). AEs will also be summarised by maximum intensity.

The system organ classes will be sorted by total frequency, preferred terms will be sorted by total frequency (within system organ class).

For disclosure of AE data on ClinicalTrials.gov, the frequency of subjects with non-serious AEs occurring with an incidence of greater than 5 % (in preferred terms) will be summarised by treatment, primary system organ class and preferred term. The frequency of subjects with SAEs will also be summarised.

For disclosure of AE data in the EudraCT register, the frequency of AEs, the frequency of non-serious AEs with an incidence of greater than 5 % (in preferred terms) and the frequency of SAEs will be summarised.

For support of lay summaries, the frequency of subjects with drug-related SAEs will be summarised by treatment, primary system organ class and preferred term.

7.8.2 Laboratory data

The analyses of laboratory data will be descriptive in nature and will be based on BI standard "Display and Analysis of Laboratory Data" ([10](#)).

Descriptive statistics of laboratory values over time and for the difference from baseline (see [Section 6.7](#)) will be provided. Frequency tables of changes between baseline and last value on treatment with respect to the reference range will be presented.

Possibly clinically significant abnormal laboratory values are only those identified either in the Investigator's comments on the eCRF or at the RPM/DBLM at the latest. It is the Investigator's responsibility to decide whether a lab value is clinically significant abnormal or not. Standard or project-specific rules for flagging clinically significant values will not be applied in this study.

Clinically relevant findings in laboratory data will be reported as AEs and will be analysed as part of AE analysis.

7.8.3 Vital signs

The analysis of vital signs will be descriptive in nature. Descriptive statistics of vital signs over time and for the difference from baseline (see [Section 6.7](#)) will be provided.

Clinically relevant findings in vital signs data will be reported as baseline conditions (at screening) or as AEs (during the trial) if judged clinically relevant by the investigator, and will be analysed as such.

7.8.4 ECG

Abnormal findings in 12-lead ECG will be reported as baseline conditions (at screening) or as AEs (during the trial) if judged clinically relevant by the investigator, and will be analysed as such. No separate listing or analysis of ECG data will be prepared.

7.8.5 Others

Physical examination findings will be reported as relevant medical history/baseline condition (i.e., a condition already existent before intake of first study drug) or as AE and will be summarised as such. No separate listing or analysis of physical examination findings will be prepared.

8. REFERENCES

1	<i>CPMP/ICH/363/96: "Statistical Principles for Clinical Trials", ICH Guideline Topic E9; Note For Guidance on Design, Conduct, Analysis and Evaluation of Clinical Trials, current version</i>
2	<i>001-MCS-50-413_RD-01: "Protocol Violation Handling Definitions", current version; IDEA for CON</i>
3	<i>001-MCS-50-413_RD-02: "Important Manual Protocol Violations Spreadsheet", current version; IDEA for CON</i>
4	<i>001-MCG-156_RD-01: "Handling of missing and incomplete AE dates", current version; IDEA for CON</i>
5	<i>001-MCS-36-472_RD-01: "Noncompartmental Pharmacokinetic / Pharmacodynamic Analyses of Clinical Studies", current version; IDEA for CON</i>
6	<i>001-MCG-159: "Reporting of Clinical Trials and Project Summaries", current version; IDEA for CON</i>
7	<i>001-MCS-36-472_RD-03: "Description of Analytical Transfer Files and PK/PD Data Files", current version; IDEA for CON</i>
8	<i>001-MCG-156: "Analysis and Presentation of Adverse Event Data from Clinical Trials", current version; IDEA for CON</i>
9	<i>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</i>
10	<i>001-MCG-157: "Display and Analysis of Laboratory Data", current version; IDEA for CON</i>

10. HISTORY TABLE

Table 10: 1 History table

Version	Date (DD-MMM-YY)	Author	Sections changed	Brief description of change
Final	23-JUL-18		None	This is the final TSAP without any modification