CLINICAL STUDY PROTOCOL

Amendment No. 1 Final Version Date: 06 November 2017

Original Version Date: 05 September 2017

Open-Label Safety and Tolerability Study of Optimized Doses of NBI-98854 for the Treatment of Pediatric Subjects with Tourette Syndrome

Study No.: NBI-98854-TS2004

Development Phase: Phase 2b

Sponsor: Neurocrine Biosciences, Inc.
12780 El Camino Real
San Diego, CA 92130
Telephone: (858) 617-7600
Facsimile: (858) 617-7705

SIGNATURES:

I agree to conduct this study in accordance with the requirements of this clinical study protocol and also in accordance with the following:

- Established principles of Good Clinical Practice (GCP) (Harmonized)
- United States (US) Code of Federal Regulations (CFR); US Food and Drug Administration (FDA); Health Canada

CLINICAL STUDY TITLE:

Open-Label Safety and Tolerability Study of Optimized Doses of NBI-98854 for the Treatment of Pediatric Subjects with Tourette Syndrome

PROTOCOL No.: NBI-98854-TS2004

As Agreed:

_____ _____

Principal Investigator Signature Date

PRINCIPAL INVESTIGATOR:

_____

(Print Principal Investigator Name)

SITE:

_____

(Print Site Name)

Accepted for the Sponsor:

SPONSOR:

Neurocrine Biosciences, Inc.
12780 El Camino Real
San Diego, CA 92130
Phone: (858) 617-7600
Facsimile: (858) 617-7705

[redacted]

Date

[redacted]

LIST OF SPONSOR PERSONNEL

Neurocrine Biosciences, Inc.
12780 El Camino Real
San Diego, CA 92130

Medical Monitor: [redacted]
Telephone: [redacted]
Facsimile: [redacted]
Cell Phone: [redacted]

Medical Monitor: [redacted]
Telephone: [redacted]
Facsimile: [redacted]
Cell Phone: [redacted]

Vice President, Clinical Development: [redacted]
Telephone: [redacted]
Facsimile: [redacted]

Serious Adverse Event Reporting:
Telephone: (866) 626-7792 or (858) 617-7792
Facsimile: (888) 617-7551
Email: cds@neurocrine.com

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

2. SYNOPSIS

Protocol Title:

Open-Label Safety and Tolerability Study of Optimized Doses of NBI-98854 for the Treatment of Pediatric Subjects with Tourette Syndrome

Study Centers: Approximately 55 study centers in North America.

Objectives:

- To determine the long-term safety and tolerability of up to 24 weeks of treatment with NBI-98854 in pediatric subjects with TS.
- To evaluate the long-term pharmacodynamic (PD) effects of NBI-98854 administered once daily in pediatric subjects with TS.
- To evaluate plasma exposure of NBI-98854 and its metabolite, NBI-98782, following repeated daily doses of NBI-98854.

Methodology: This is a Phase 2b, multicenter, open-label, dose-optimization study of the safety, tolerability, PD, and plasma exposure of NBI-98854 doses in the range of 20 mg to 60 mg for subjects <50 kg and 40 mg to 80 mg for subjects ≥50 kg, administered each night at bedtime (qhs) for a total of 24 weeks of treatment in pediatric subjects with TS. This study will only include subjects who participated in and completed the previous Phase 2b clinical study NBI-98854-TS2003.

Up to 120 male and female pediatric subjects, 6 to 18 years of age, with a Diagnostic and Statistical Manual of Mental Disorders, 4th or 5th Editions (DSM-IV or -V) diagnosis of TS will participate.

The starting dose will be NBI-98854 20 mg for subjects <50 kg at baseline and NBI-98854 40 mg for subjects ≥50 kg at baseline. The dose may be escalated in increments of 20 mg every 2 weeks to a maximum of 60 mg for subjects <50 kg and 80 mg for subjects ≥50 kg to achieve an optimal dose of NBI-98854 for each subject. Dose escalations will occur at the end of Weeks 2 and 4 based on the following 2 criteria: 1) the subject's tics are not sufficiently controlled per physician investigator assessment; and 2) an evaluation by the physician investigator indicates that the subject is tolerating the study drug at the current dose and would likely be able to tolerate the next dose level. During the first 4 weeks of the treatment period, the physician investigator may escalate a subject's dose to the next dose level, continue with the subject's current dose, or reduce to the subject's prior tolerated dose (in subjects who have had a dose escalation). If a subject's optimal dose has already been established at Week 2, no further dose escalation will be allowed during the dose optimization period and the subject will continue at that dose until the end of the treatment period. After Week 4, subjects will continue to receive their optimized dose of NBI-98854 for an additional 20-week dose maintenance period. At any time after Week 2, the physician investigator may decrease the dose to the previous dose for any subject who had a dose escalation and who is unable to tolerate a given dose increase. The subject will continue at that dose until the end of the treatment period. The investigator may reduce the subject's dose only one time. Subjects who are unable to tolerate the starting dose or resumption of the previous dose will be discontinued from the study. Follow-up assessments will be conducted at the end of Week 28 (4 weeks after the last dose of the study drug).

After parental or legal guardian informed consent with signed and witnessed pediatric assent are provided for subjects ≤17 years of age, or written informed consent is provided for subjects 18 years of age, subjects will be screened to determine eligibility within 28 days (Days -28 to -1) before the start of study drug dosing on Day 1. On Day 1 (baseline), eligible subjects will return to the study center for collection of baseline safety and PD assessments. Subjects who continue to be eligible for the study will then be dispensed a 2-week supply of study drug, with assigned dose based on weight group at baseline.

Beginning on Day 1, study drug will be administered once daily at home at the subject's bedtime (under the supervision of the subject's parent/legal guardian for subjects ≤17 years of age). Subjects will continue to self-administer the study drug daily at approximately the same time for the duration of the 24-week treatment period. Subjects will return to the study center at fixed intervals (end of Weeks 2, 4, 8, 12, 16, 20, 24, and 28) for study assessments and dispensing of study drug (Weeks 2, 4, 8, 12, 16, and 20 only). As much as possible, these study visits and the follow-up visit should occur at the same time as the Day 1 visit to standardize the time of day for the assessment of safety, PD, and plasma exposure. All subjects who complete the 24-week treatment period will enter a 4-week follow-up period with a follow-up visit at Week 28 (subjects who terminate early will have Week 28 assessments conducted). Safety, PD, and study drug exposure will be assessed at scheduled times throughout the study. The treatment period visits (Weeks 2, 4, 8, 12, 16, 20, and 24) and the follow-up visit (Week 28) will have a visit window of -2 or +3 days. An independent Data Safety Monitoring Board (DSMB) will periodically review ongoing clinical safety data to ensure the safety and well-being of the study subjects.

Study Population: Up to 120 male and female pediatric subjects (6 to 18 years of age) with a DSM-IV or -V diagnosis of TS. This study will only enroll subjects who previously participated in and completed the NBI-98854-TS2003 study.

Duration of Treatment and Study Participation: The expected duration of study participation for each subject is approximately 32 weeks, including up to 28 days for screening, 24 weeks of treatment, and a follow-up period of approximately 4 weeks.

Investigational Product, Dose, and Mode of Administration: NBI-98854 will be supplied as capsules containing 20 mg or 40 mg of NBI-98854 (free base equivalent). Subjects must swallow the capsule(s) at bedtime with at least 4 oz. of water with or without food.

Reference Therapy, Dose, and Mode of Administration: Not applicable.

Criteria for Evaluation:
Plasma Drug Exposure

Blood samples for plasma study drug and metabolite concentration analyses will be collected at Day 1 (predose) and at Weeks 2, 4, 8, 12, 16, 20, 24, and 28 (final study visit or early termination). Subjects/caregivers will be asked to record and provide dosing times from the evening before the treatment period visits when these blood samples are collected.

Pharmacodynamics

The following PD assessments will be administered at Day 1 (baseline), and at Weeks 2, 4, 8, 12, 16, 20, 24, and 28 (final study visit or at early termination):

- Yale Global Tic Severity Scale (YGTSS)
- Premonitory Urge for Tics Scale (PUTS)

The Gilles de la Tourette Syndrome – Quality of Life Scale for Children and Adolescents (C&A-GTS-QOL) will be administered at Day 1 (baseline) and Weeks 12 and 24. The Clinical Global Impression of Tics-Severity scale (CGI-Tics-Severity) will be used to rate the overall severity of tics beginning at Day 1 (baseline), and then both CGI-Tics-Severity and Clinical Global Impression of Tourette Syndrome-Improvement scale (CGI-TS-Improvement) will be administered at Weeks 2, 4, 8, 12, 16, 20, 24, and 28 (final study visit or at early termination).

Safety

Safety and tolerability will be monitored throughout the study and will include the following assessments:

- Adverse events (AEs)
- Clinical laboratory tests (hematology, clinical chemistry, and urinalysis)
- Serum prolactin
- Hemoglobin A1c
- Vital signs (including orthostatic systolic and diastolic blood pressure, orthostatic pulse rate, respiratory rate, and oral body temperature)
- Physical examinations (including height and weight)
- 12-lead electrocardiograms (ECGs)
- Columbia-Suicide Severity Rating Scale (C-SSRS), Children's Version
- Children's Depression Rating Scale - Revised (CDRS-R)
- Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)
- Attention-Deficit Hyperactivity Disorder Rating Scale-5: Home Version (ADHD-5 Rating Scale)
- Extrapyramidal Symptom Rating Scale-Abbreviated (ESRS-A)

Statistical Methods:

Safety, PD, and plasma drug concentration data will be summarized by timepoint for the pooled weight groups and each weight group separately, using descriptive statistics.

3. LIST OF ABBREVIATIONS AND DEFINITIONS OF TERMS

ADHD	Attention-Deficit Hyperactivity Disorder
ADHD-5 Rating Scale	Attention-Deficit Hyperactivity Disorder Rating Scale-5: Home Version
AE	Adverse event
ALT	Alanine aminotransferase
AST	Aspartate aminotransferase
AUC	Area under the plasma concentration versus time curve
$AUC_{0-\infty}$	AUC from 0 hours extrapolated to infinity
β-hCG	β-human chorionic gonadotropin
C&A-GTS-QOL	Gilles de la Tourette Syndrome – Quality of Life Scale for Children and Adolescents
CDRS-R	Children's Depression Rating Scale - Revised
CDS	Clinical Drug Safety
CFR	Code of Federal Regulations
CGI-Tics-Severity	Clinical Global Impression of Tics-Severity scale
CGI-TS-Improvement	Clinical Global Impression of Tourette Syndrome-Improvement scale
C_{max}	Maximum plasma concentration
CRT	Controlled room temperature
C-SSRS	Columbia-Suicide Severity Rating Scale
CY-BOCS	Children's Yale-Brown Obsessive Compulsive Scale
CYP	Cytochrome P450
DSMB	Data Safety Monitoring Board
DSM-IV or -V	Diagnostic and Statistical Manual of Mental Disorders, 4th or 5th Editions
EC	Ethics Committee
ECG	Electrocardiogram
eCRF	Electronic case report form
EDC	Electronic data capture
EDTA K_2	Dipotassium ethylenediaminetetraacetic acid
ESRS-A	Extrapyramidal Symptom Rating Scale-Abbreviated
FDA	[United States] Food and Drug Administration
GCP	Good Clinical Practice
GGT	Gamma-glutamyl transferase

ICF	Informed consent form
ICH	International Conference on Harmonisation
IRB	Institutional Review Board
MAOI	Monoamine oxidase inhibitor
MedDRA	Medical Dictionary for Regulatory Activities
NBI	Neurocrine Biosciences, Inc.
PD	Pharmacodynamics
PK	Pharmacokinetic(s)
PUTS	Premonitory Urge for Tics Scale
QTcF	Corrected QT interval using Fridericia's formula
SAE	Serious adverse event
SAP	Statistical analysis plan
SOC	System organ class
$t_{½}$	Terminal half-life
TD	Tardive dyskinesia
TEAE	Treatment-emergent adverse event
t_{max}	Time to maximum plasma concentration
TS	Tourette syndrome
TTS	Total Tic Score
ULN	Upper limit of normal
US	United States
VMAT2	Vesicular monoamine transporter 2
WBC	White blood cell
WHO	World Health Organization
YGTSS	Yale Global Tic Severity Scale

4. ETHICS

The study will be conducted in accordance with Neurocrine Biosciences, Inc. (NBI) standards that meet regulations relating to Good Clinical Practice (GCP). These standards respect the following guidelines:

- Good Clinical Practice: Consolidated Guideline (International Conference on Harmonisation [ICH] of Technical Requirements for the Registration of Pharmaceuticals for Human Use [current version]).
- United States (US) Code of Federal Regulations (CFR) dealing with clinical studies (21 CFR parts 50, 54, 56, 312, and 314).
- Guidance for Clinical Trial Sponsors: Clinical Trial Applications, Effective May 29, 2013, Health Canada Therapeutic Products Directorate, Health Products and Food Branch.

The ethical requirements of Institutional Review Boards/Ethics Committees (IRBs/ECs) and the informed consent forms (ICFs) and assent forms are discussed in Section 14.

5. INTRODUCTION

5.1. Background

Tourette syndrome (TS) is a movement disorder characterized by the presence of chronic motor and one or more vocal tics that often appear in childhood or early adolescence (APA DSM-IV, 1994; APA DSM-V, 2013). Tics are defined as rapid, non-rhythmic, stereotyped motor movements or vocalizations, and are typically categorized as simple or complex based on their overt features. Simple tics are brief, meaningless actions (eg, forceful blinking of the eyes or grunting) and complex tics are slower, more purposeful behaviors (eg, gyrating or uttering phrases; Leckman et al., 1989; Cavanna and Nani, 2013; Shprecher and Kurlan, 2009). The tics follow a waxing and waning course over time, and must be recurrent for a period of more than 1 year to qualify for diagnosis. In addition to tic phenomena, TS may also present with a constellation of symptoms that are part of a broader "TS spectrum," which can include obsessive-compulsive behaviors, attention-deficit hyperactivity disorder (ADHD), and impulsive or antisocial behavior (Chen et al., 2012; Felling and Singer, 2011).

It has been well established that TS is predominantly a disorder of childhood with a mean or median age of onset of approximately 6 years of age (Leckman et al., 1998; Robertson, 2011; Jankovic and Kurlan, 2011; Swain et al., 2007). Tic symptomatology usually becomes the most severe around age 10 and by the time adulthood is achieved at 18 years of age, most patients are either tic-free or their symptoms have significantly improved (Leckman et al., 1998; Kurlan, 2010). TS symptoms may also occur in adults and these tic phenomena appear to be a re-emergence or an exacerbation of childhood onset TS (Chouinard and Ford, 2000; Jankovic and Kurlan, 2011).

Persistent tics can have a significant impact on patient quality of life and often lead to impaired psychosocial functioning. Some of these problems include social isolation, bullying, physical discomfort (with pain or injury), and poor academic performance (Roessner et al., 2013). Psychosocial stressors can, in turn, exacerbate tic symptomatology. It is under these conditions

that pharmacological interventions are often considered (Chen et al., 2012; Shprecher and Kurlan, 2009; Roessner et al., 2013).

Neuropathological models have been proposed to explain the symptomatic features of TS, and converging lines of empirical evidence consistently implicate dopaminergic dysfunction and dysregulation within prefrontal cortex-basal ganglia circuitry (Felling and Singer, 2011; Pourfar et al., 2011). Functional neuroimaging studies have identified a pattern of prefrontal cortex hypermetabolism and reduced striatal activity in TS subjects (Baxter and Guze, 1993; Braun et al., 1993; Pourfar et al., 2011). Pharmacotherapeutic approaches aimed at blocking postsynaptic dopamine-2 receptors (eg, haloperidol and pimozide) have demonstrated efficacy in reducing TS symptoms. In this regard, modulation of dopaminergic tone through the administration of a vesicular monoamine transporter 2 (VMAT2) inhibitor, like NBI-98854, may also be an effective treatment option for tic suppression.

5.2. NBI-98854

NBI-98854 (valbenazine tosylate) is a selective, orally active VMAT2 inhibitor developed by NBI. NBI-98854 is under development for the treatment of TS. NBI-98854 was approved by the US Food and Drug Administration (FDA) in April, 2017 for the treatment of adults with tardive dyskinesia (TD), under the trade name INGREZZA®.

In nonclinical studies, NBI-98854 appears to cause little or no cytochrome P450 (CYP) enzyme inhibition or induction at pharmacologically relevant concentrations. NBI-98854 is a moderate inhibitor of P-glycoprotein (P-gp), but only at concentrations that could be achieved in the gastrointestinal (GI) tract, and is not an inhibitor of a panel of other drug transporters. Metabolism of NBI-98854 is characterized by hydrolysis of NBI-98854 to NBI-98782, and CYP3A4/5-dependent mono-oxidation to NBI-136110. NBI-98782 is metabolized in part by CYP2D6. All 3 entities, namely, NBI-98854, NBI-98782, and NBI-136110, can bind to and inhibit VMAT2. However, NBI-98782 is the most potent and appears to be responsible for most of the observed pharmacological activity of VMAT2 inhibition.

NBI-98854 appears to be rapidly absorbed with a time to maximum plasma concentration (t_{max}) typically ranging from approximately 0.5 to 1.0 hours. NBI-98854 reaches steady state within 1 week. The active metabolite NBI-98782 gradually forms with a t_{max} of 4 to 8 hours and both NBI-98854 and NBI-98782 are eliminated with a terminal half-life ($t_{½}$) of 15 to 22 hours. Coadministration of ketoconazole (strong CYP3A4/5 inhibitor) with NBI-98854 led to a 1.5- and 1.6-fold increase in the maximum plasma concentration (C_{max}) of NBI-98854 and NBI-98782, respectively, and a 2.1-fold increase in the area under the plasma concentration versus time curve (AUC) from 0 hours extrapolated to infinity ($AUC_{0-\infty}$) of NBI-98854 and NBI-98782. Coadministration of NBI-98854 and rifampin (strong CYP3A4/5 inducer) led to an approximate 30% and 70% decrease in C_{max} and $AUC_{0-\infty}$, respectively, for NBI-98854, and an approximate 50% and 80% decrease, respectively, for NBI-98782 compared with administration of NBI-98854 alone. Coadministration of NBI-98854 80 mg and 0.5 mg digoxin resulted in an approximate 1.9-fold increase in the C_{max} of digoxin. The effect of NBI-98854 on digoxin $AUC_{0-\infty}$ was modest (1.4-fold increase) and the mean $t_{½}$ of digoxin was similar with and without NBI-98854 administration. Midazolam C_{max} and $AUC_{0-\infty}$ were similar with and without NBI-98854 administration.

NBI-98854 for the treatment of TS has been evaluated in 3 completed Phase 1b and Phase 2 studies in subjects with TS. These include 2 studies in pediatric subjects (NBI-98854-1403 and NBI-98854-1501) and 1 study in adults (NBI-98854-1505). The initial Phase 1b, open-label, multiple-dose study of the safety, tolerability, pharmacokinetics (PK), and pharmacodynamics (PD) of NBI-98854 (NBI-98854-1403) was conducted in children (6 to 11 years of age) and adolescents (12 to 18 years of age) with TS. Doses of NBI-98854 5 mg and 10 mg were administered in children and doses of NBI-98854 10 mg, 25 mg, or 50 mg were administered in adolescents daily over a 14-day treatment period following a multiple ascending dose protocol. Study NBI-98854-1501 was a Phase 2, multicenter, randomized, double-blind, placebo-controlled, parallel group, dose-ranging study to evaluate the efficacy, safety, and tolerability of 2 doses of NBI-98854 (10 mg and 20 mg in children [6 to 11 years of age], and 20 mg and 40 mg in adolescents [12 to 17 years of age]) relative to placebo, administered once daily for 6 weeks in 98 pediatric subjects with TS. Subjects within each age group were randomized in a 1:1:1 ratio to placebo or 1 of the 2 NBI-98854 doses. Study NBI-98854-1505 was a Phase 2, multicenter, randomized, double-blind, placebo-controlled, parallel group study to evaluate the efficacy, safety, and tolerability of 2 doses of NBI-98854 (40 mg and 80 mg) relative to placebo, administered once daily for 8 weeks in 124 adult subjects with TS. Subjects were randomized in a 1:1:1 ratio to placebo or 1 of the 2 NBI-98854 doses.

Results from Study NBI-98854-1403 revealed reductions from baseline (Day -1) to Day 14 in the Yale Global Tic Severity Scale (YGTSS) total tic score (TTS) in both children and adolescents, and this decrease was observed irrespective of dose. The mean point reduction in TTS for all subjects across all doses tested was -9.4 points at Day 14, which represents a 31% decrease from the mean baseline score. Mean reductions from baseline were also observed in the YGTSS impairment score for both age groups. The Phase 2, NBI-98854-1501 study in children and adolescents did not meet its primary efficacy endpoint of a significant change from baseline to Week 6 in the TTS between the placebo and active groups. A comprehensive exposure-response analysis indicated that the doses selected for this study were too low to provide adequate plasma exposures for tic reduction in most pediatric subjects. For the subset of subjects with NBI-98854 exposures in the relevant range, there was a reduction in tics (range: -11.3 to -13.7 points on the TTS) compared with the subset of subjects with sub-therapeutic exposures (range: -4.7 to -8.3 points on the TTS). Although the efficacy results in participating adults in the NBI-98854-1505 study showed an improvement in overall symptoms of TS as measured by the secondary endpoint, Clinical Global Impression of Change ($p=0.015$ [nominal]), the pre-specified primary endpoint, the change from baseline in the YGTSS at Week 8 was not met ($p=0.18$).

NBI-98854 has been generally well tolerated in single doses up to 300 mg and in multiple doses of up to 100 mg in healthy volunteers and subjects with TD. Over 850 subjects have been exposed to NBI-98854 in TD clinical studies. In TS subjects, safety results from Study NBI-98854-1403 show that the doses were well-tolerated in both child and adolescent age groups. There were no deaths or serious adverse events (SAEs) reported during the study and no child discontinued due to an adverse event (AE). Two adolescents (both in the NBI-98854 50 mg group) discontinued due to AEs. One subject discontinued on Day 2 due to the AEs of agitation, headache, visual impairment, vomiting, and worsening of bradycardia and the other subject discontinued on Day 4 due to the AEs of increased anxiety and insomnia. Preliminary safety results from the Phase 2, NBI-98854-1501 pediatric study suggest that all doses tested

(NBI-98854 10 mg and 20 mg in children and NBI-98854 20 mg and 40 mg in adolescents) were well-tolerated. The most frequently reported AEs were headache, somnolence, upper respiratory tract infection, insomnia, and sedation. There were no deaths and only one SAE in the placebo group (conversion disorder). Preliminary results from Study NBI-98854-1505 showed that the most frequently reported AEs were somnolence (20.2% NBI-98854-treated subjects and 2.5% of placebo subjects), fatigue (14.3% NBI-98854 and 2.5% placebo), and akathisia (13.1% NBI-98854 and 0% placebo). Seventeen subjects (13.7%) discontinued from the study due to AEs, and most of these subjects received NBI-98854 80 mg (13/17 subjects) and the most common reason for AE discontinuation was akathisia (reported in 5 subjects). Four subjects experienced SAEs during the study; the SAEs included pelvic inflammatory disease (placebo subject; moderate and not related to NBI-98854), pneumothorax (80 mg subject; moderate and unlikely related to NBI-98854), hypersensitivity (80 mg subject; moderate and possibly related to NBI-98854), and pneumonia streptococcal, septic shock, renal failure acute, and brachial plexus injury (40 mg subject; severe and unlikely related to NBI-98854).

5.3. Study and Dose Rationale

This is a Phase 2b, multicenter, open-label, dose-optimization study of the safety, tolerability, PD, and plasma exposure of NBI-98854 in the range of 20 mg to 60 mg for subjects <50 kg and 40 mg to 80 mg for subjects ≥50 kg, administered each night at bedtime (qhs) for a total of 24 weeks of treatment in pediatric subjects with TS. This study will only include subjects who participated in and completed the previous Phase 2b placebo-controlled clinical study NBI-98854-TS2003.

Rationale for Dose Selection and Regimen

The current starting doses of NBI-98854 (ie, 20 mg or 40 mg) have been well tolerated in previous studies in pediatric subjects with TS (NBI-98854-1403 and NBI-98854-1501). The dose optimization scheme based on PD, tolerability, and safety assessments, as well as bedtime dosing will allow subjects to potentially receive an optimal dose (ie, one that is both well tolerated and efficacious) during the treatment period.

6. STUDY OBJECTIVES

The objectives of this clinical study are as follows:

- To determine the long-term safety and tolerability of up to 24 weeks of treatment with NBI-98854 in pediatric subjects with TS.
- To evaluate the long-term PD effects of NBI-98854 administered once daily in pediatric subjects with TS.
- To evaluate plasma exposure of NBI-98854 and its metabolite, NBI-98782, following repeated daily doses of NBI-98854.

7. OVERVIEW OF STUDY DESIGN

This is a Phase 2b, multicenter, open-label, dose-optimization study of the safety, tolerability, PD, and plasma exposure of NBI-98854 doses in the range of 20 mg to 60 mg for subjects <50 kg and 40 mg to 80 mg for subjects ≥50 kg, administered each night at bedtime (qhs) for a total of 24 weeks of treatment in pediatric subjects with TS. This study will only include subjects who participated in and completed the previous Phase 2b clinical study NBI-98854-TS2003.

Up to 120 male and female pediatric subjects, 6 to 18 years of age, with a Diagnostic and Statistical Manual of Mental Disorders, 4th or 5th Editions (DSM-IV or -V) diagnosis of TS will participate.

The starting dose will be NBI-98854 20 mg for subjects <50 kg at baseline and NBI-98854 40 mg for subjects ≥50 kg at baseline. The dose may be escalated in increments of 20 mg every 2 weeks to a maximum of 60 mg for subjects <50 kg and 80 mg for subjects ≥50 kg to achieve an optimal dose of NBI-98854 for each subject. Dose escalations will occur at the end of Weeks 2 and 4 based on the following 2 criteria: 1) the subject's tics are not sufficiently controlled per physician investigator assessment; and 2) an evaluation by the physician investigator indicates that the subject is tolerating the study drug at the current dose and would likely be able to tolerate the next dose level. During the first 4 weeks of the treatment period, the physician investigator may escalate a subject's dose to the next dose level, continue with the subject's current dose, or reduce to the subject's prior tolerated dose (in subjects who have had a dose escalation). After Week 4, subjects will continue to receive their optimized dose of NBI-98854 for an additional 20-week dose maintenance period. If a subject's optimal dose has already been established at Week 2, no further dose escalation will be allowed during the dose optimization period and the subject will continue at that dose until the end of the treatment period. At any time after Week 2, the physician investigator may decrease the dose to the previous dose for any subject who had a dose escalation and who is unable to tolerate a given dose increase. The subject will continue at that dose until the end of the treatment period. The investigator may reduce the subject's dose only one time. Subjects who are unable to tolerate the starting dose or resumption of the previous dose will be discontinued from the study. Follow-up assessments will be conducted at the end of Week 28 (4 weeks after the last dose of the study drug).

After parental or legal guardian informed consent with signed and witnessed pediatric assent are provided for subjects ≤17 years of age, or written informed consent is provided for subjects 18 years of age, subjects will be screened to determine eligibility within 28 days (Days -28 to -1) before the start of study drug dosing on Day 1. On Day 1 (baseline), eligible subjects will return to the study center for collection of baseline safety and PD assessments. Subjects who continue to be eligible for the study will then be dispensed a 2-week supply of study drug, with assigned dose based on weight group at baseline.

Beginning on Day 1, study drug will be administered once daily at home at the subject's bedtime (under the supervision of the subject's parent/legal guardian in subjects ≤17 years of age). Subjects will continue to self-administer the study drug daily at approximately the same time for the duration of the 24-week treatment period. Subjects will return to the study center at fixed intervals (end of Weeks 2, 4, 8, 12, 16, 20, 24, and 28) for study assessments and

dispensing of study drug (Weeks 2, 4, 8, 12, 16, and 20 only). As much as possible, these study visits and the follow-up visit should occur at the same time as the Day 1 visit to standardize the time of day for the assessment of safety, PD, and plasma exposure. All subjects who complete the 24-week treatment period will enter a 4-week follow-up period with a follow-up visit at Week 28 (subjects who terminate early will have Week 28 assessments conducted). Safety, PD, and study drug exposure will be assessed at scheduled times throughout the study. The treatment period visits (Weeks 2, 4, 8, 12, 16, 20, and 24) and the follow-up visit (Week 28) will have a visit window of -2 or +3 days. An independent Data Safety Monitoring Board (DSMB) will periodically review ongoing clinical safety data to ensure the safety and well-being of the study subjects.

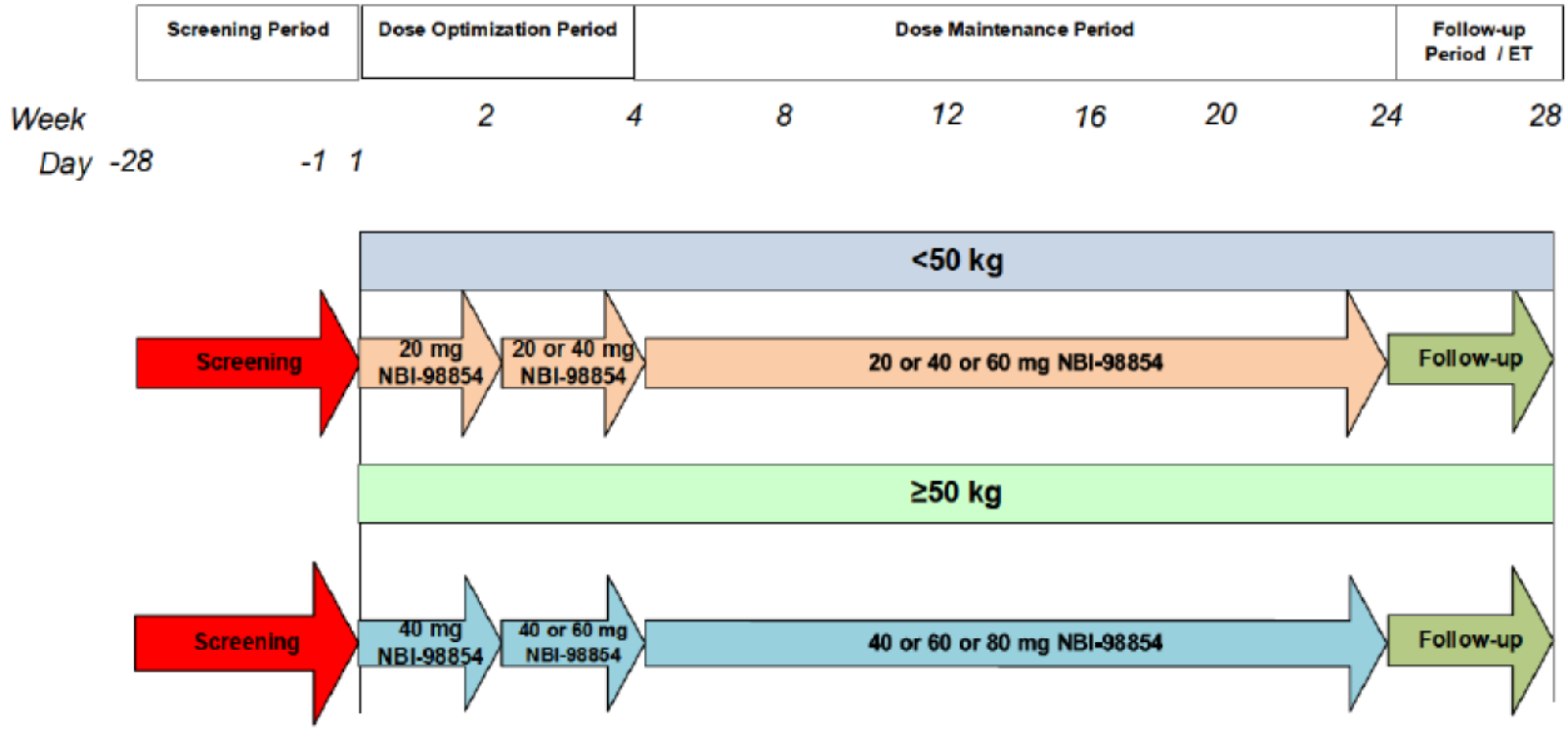
PD assessments for TS are the YGTSS, the Clinical Global Impression of Tourette Syndrome-Improvement scale (CGI-TS-Improvement), Clinical Global Impression of Tics-Severity scale (CGI-Tics-Severity), the Premonitory Urge for Tics Scale (PUTS), and the Gilles de la Tourette Syndrome – Quality of Life Scale for Children and Adolescents (C&A-GTS-QOL).

Safety assessments including AE monitoring, clinical laboratory tests (hematology, clinical chemistry, urinalysis, hemoglobin A1c, and serum prolactin), vital sign measurements, physical examinations, 12-lead electrocardiogram (ECG), Columbia-Suicide Severity Rating Scale (C-SSRS, Children's Version), Children's Depression Rating Scale - Revised (CDRS-R), the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS), the Attention-Deficit Hyperactivity Disorder Rating Scale-5: Home Version (ADHD-5 Rating Scale), and Extrapyramidal Symptom Rating Scale-Abbreviated (ESRS-A) will also be collected at scheduled times throughout the study.

Blood samples for plasma drug and metabolite concentration analyses will be obtained at Day 1 (baseline) and at Weeks 2, 4, 8, 12, 16, 20, 24, and 28 (final study visit or at early termination). Subjects/caregivers will be asked to record and provide dosing times from the evening before the treatment period visits when these blood samples are collected.

A schematic of the study design is shown in Figure 1.

Figure 1: Study Design Schematic



8. STUDY POPULATION

This study will be conducted in up to 120 male and female pediatric subjects (6 to 18 years of age) with a DSM-IV or -V diagnosis of TS. Subjects must meet all the inclusion criteria and none of the exclusion criteria to enter the study.

8.1. Inclusion Criteria

To participate in this study, subjects must meet the following criteria:

1. Have participated in and completed the Phase 2b NBI-98854-TS2003 study.
2. Have documentation of written and witnessed assent from the subject and written informed consent from the subject's parents or legal guardian for subjects ≤17 years of age; written informed consent from subjects 18 years of age.
3. Be male or female, aged 6 to 18 years, inclusive.
4. Be in good general health as determined by medical history, physical examination, clinical laboratory assessments, and 12-lead ECG.
5. Have a DSM-IV or -V diagnosis of TS.
6. Subjects must have a stable psychiatric status (such as TS spectrum diagnoses [eg, obsessive-compulsive disorder, ADHD]) as clinically determined by the investigator.
7. If medications are being used to treat TS symptoms and/or TS spectrum diagnoses, subjects must be on stable doses of these medications for a minimum of 30 days before Day 1 (baseline), and the medication regimen is expected to remain stable throughout the study period. The use of concomitant dopamine antagonists (eg, pimozide, haloperidol, aripiprazole) and/or tetrabenazine to treat TS symptoms is prohibited. Other nondopaminergic tic suppression therapy (eg, clonidine, guanfacine) is allowed during the study period if the dose regimen has been stable for a minimum of 30 days before Day 1 (baseline).
8. Subjects with stable medical conditions requiring medications that are not prohibited per protocol must be on stable doses of these medications for a minimum of 30 days before Day 1 (baseline), and the medication regimen is expected to remain stable throughout the study period.
9. Subjects of childbearing potential must agree to use contraception consistently from screening until 30 days (females) or 90 days (males) after the last dose of study drug. A female subject of childbearing potential is defined as a female capable of becoming pregnant, which includes subjects who have had their first menstrual cycle (ie, menarche) and are not surgically sterile (ie, bilateral oophorectomy, hysterectomy or bilateral tubal ligation for at least 3 months prior to screening). A male subject of childbearing potential is defined as a subject who has reached spermarche and has not been vasectomized for at least 3 months prior to screening.

   Acceptable methods of contraception include the following:

   - Condom with spermicide (cream, spray, foam, gel, suppository, or polymer film).

- Diaphragm with spermicide (with or without condom).
- Cervical cap with spermicide (with or without condom).
- Vaginal sponge impregnated with spermicide used with a condom.
- Intrauterine device (IUD).
- Hormonal contraception being taken for at least 3 months prior to screening.

Subjects who practice total abstinence from sexual intercourse as the preferred lifestyle are not required to use contraception (periodic abstinence is not acceptable).

10. Female subjects of childbearing potential must have a negative serum β-human chorionic gonadotropin (β-hCG) pregnancy test at screening and negative urine pregnancy test at Day 1 (baseline). A female subject of childbearing potential is defined as a premenopausal female capable of becoming pregnant, which includes subjects who have had their first menstrual cycle (ie, menarche) and are not surgically sterilized.
11. Adolescent subjects (12 to 18 years of age) must have a negative urine drug screen (negative for amphetamines, barbiturates, benzodiazepine, phencyclidine, cocaine, opiates, or cannabinoids) at screening (based on results from central laboratory) and baseline (Day 1; based on results from on-site urine drug screen kit). Subjects who are on stable doses of prescribed and supervised (not as needed [prn]) benzodiazepines, opiates, or psychostimulants (for subjects with comorbid ADHD) can participate in the study.
12. Adolescent subjects (12 to 18 years of age) must have a negative alcohol breath test at screening and Day 1 (baseline).
13. Be willing and able to adhere to the study regimen and study procedures described in the protocol and informed consent/assent forms, including all requirements at the study center and return for the follow-up visit.

8.2. Exclusion Criteria

Subjects will be excluded from the study if they:

1. Have an unstable medical or psychiatric condition or chronic disease (including significant neurological, hepatic, renal, cardiovascular, gastrointestinal, pulmonary, or endocrine disease), or malignancy that could confound interpretation of study outcome.
2. Had a medically significant illness within 30 days of screening.
3. Excessive use of tobacco and/or nicotine-containing products (based on the investigator's assessment) within 30 days of screening.
4. Have a history of substance (drug or alcohol) dependence or abuse within the 3 months before Day 1 (baseline), as defined in the DSM-IV (Substance Dependence or Abuse) or DSM-V (Substance Use Disorder).
5. Are currently pregnant or lactating.
6. Have a known history of neuroleptic malignant syndrome.
7. Have a known history of long QT syndrome or cardiac arrhythmia.

8. Have a screening or Day 1 average triplicate ECG corrected QT interval using Fridericia's formula (QTcF) of >450 msec or the presence of any clinically significant cardiac abnormality.
9. Have serum creatinine levels greater than the upper limit of normal (ULN) at screening, or aspartate aminotransferase (AST), alanine aminotransferase (ALT), gamma-glutamyl transferase (GGT), or total bilirubin >1.5 times the ULN at screening. Subjects with a documented diagnosis of Gilbert's syndrome are not required to meet the bilirubin criteria.
10. Have any of the following hematologic abnormalities at screening:
    - Hemoglobin <11.0 g/dL.
    - White blood cell (WBC) count $<4.0 \times 10^3/mm^3$.
    - Platelet count $<100,000/mm^3$.
11. Have a hematologic malignancy or solid tumor diagnosed within 3 years prior to screening, except for localized skin cancer or carcinoma in situ of the cervix.
12. Have a clinical chemistry, hematology, or urinalysis result not within the laboratory's reference range and deemed by the investigator to be clinically significant at screening.
13. Have received any investigational product (other than NBI-98854) within a time period equal to 5 half-lives of the product, if known, or a minimum of 30 days before screening, whichever is longer, or plan to use an investigational drug (other than NBI-98854) during the study.
14. Have received any prohibited concomitant medication as detailed in Section 9.7.1.
15. Have a blood loss ≥250 mL or donated blood within 56 days or donated plasma within 7 days of Day 1 (baseline).
16. Have a significant risk of suicidal or violent behavior. Subjects with any lifetime history of suicidal behavior, or suicidal ideation of type 4 (active suicidal ideation with some intent to act, without specific plan) or type 5 (active suicidal ideation with specific plan and intent) in the past year before screening based on the C-SSRS Children's Version should be excluded.
17. Have an allergy, hypersensitivity, or intolerance to VMAT2 inhibitors (eg, tetrabenazine).
18. Have a history of or suspected poor compliance in clinical research studies.

8.3. Subject Identification and Replacement

Subjects will be identified by their unique subject number and initials (first, middle, last; a hyphen may be used if the subject has no middle name). The subject initials and subject number will be noted on electronic case report forms (eCRFs), all source documentation, laboratory documents, and ECG tracings. Subjects who discontinue from the study will not be replaced.

8.4. Randomization

This is an open-label study.

9. STUDY EVALUATIONS

9.1. Schedule of Assessments

A schedule of assessments that summarizes the frequency and timing of all assessments is provided in Table 1. Subject-related events and activities including specific instructions, procedures, concomitant medications, dispensing of study drug, and descriptions of AEs should be recorded in the appropriate source documents and eCRFs.

Table 1: Schedule of Assessments

Procedure[a]	Screening Period	Treatment Period									Follow-up Period/ ET
		Day 1[b]		Dose Optimization		Dose Maintenance					
Week	Day -28 to -1	Baseline	Dosing	2	4	8	12	16	20	24	28[c]
Visit[d]	1	2	--	3	4	5	6	7	8	9	10
Informed consent/assent	X										
Inclusion/exclusion criteria	X	update									
Medical history	X	update									
PE (including weight)	X	X		X				X		X	X
Height	X										
Vital signs	X	X		X	X	X	X	X	X	X	X
12-lead ECG[e]	X	X		X	X	X	X	X	X	X	X
Pregnancy test[f]	X (s)	X (u)		X (u)	X (u)	X (u)	X (u)	X (u)	X (u)	X (u)	X (u)
Clinical laboratory tests[g]	X	X		X	X	X	X	X	X	X	X
Urine drug screen (adolescents)[h]	X	X									
Alcohol breath test (adolescents)	X	X									
Hemoglobin A1c	X	X					X			X	
Blood sample for prolactin		X					X			X	X
PK blood sample		X		X	X	X	X	X	X	X	X
YGTSS (including video recording)		X		X	X	X	X	X	X	X	X
PUTS		X		X	X	X	X	X	X	X	X
CGI-Tics-Severity		X		X	X	X	X	X	X	X	X
CGI-TS-Improvement				X	X	X	X	X	X	X	X
C-SSRS	X	X		X	X	X	X	X	X	X	X
CY-BOCS and CDRS-R		X		X	X	X	X	X	X	X	X
ADHD-5 Rating Scale		X					X			X	X
ESRS-A		X		X	X	X	X	X	X	X	X
C&A-GTS-QOL		X					X			X	
Study drug dosing at home[i]			X	X	X	X	X	X	X	X	
Dispense study drug		X		X	X	X	X	X	X		
Study drug accountability[j]				X	X	X	X	X	X	X	
AE monitoring	X	X	X	X	X	X	X	X	X	X	X
Prior and concomitant medications	X	X	X	X	X	X	X	X	X	X	X

ADHD=attention deficit-hyperactivity disorder; AE=adverse event; C&A-GTS-QOL=Gilles de la Tourette Syndrome – Quality of Life for Children and Adolescents; CDRS-R=Children's Depression Rating Scale - Revised; CGI-Tics-Severity= Clinical Global Impression of Tics-Severity scale; CGI-TS-Improvement= Clinical Global Impression of Tourette Syndrome-Improvement scale; C-SSRS=Columbia Suicide Severity Rating Scale; CY-BOCS=Children's Yale-Brown Obsessive-Compulsive Scale; ECG=electrocardiogram; ESRS-A=Extrapyramidal Symptoms Rating Scale-Abbreviated; ET=early termination; QTcF=corrected QT interval using Fridericia's formula; PE=physical examination; PK=pharmacokinetics; PUTS=Premonitory Urge for Tics Scale; s=serum; u =urine; YGTSS=Yale Global Tic Severity Scale.

[a] As much as possible, study visits should occur at approximately the same time as the Day 1 visit to standardize the time of day for the assessment of pharmcodynamics, safety, and plasma exposure throughout the study period.
[b] Day 1 is the day of baseline assessments. Day 1 is also the first day of dosing; study drug will be administered at home at bedtime.
[c] Final study visit for subjects who complete the study (or early termination).
[d] Visits (other than screening and Day 1) will have a window of -2 to +3 days.
[e] A standard 12-lead ECG will be conducted in triplicate (at least 1 minute apart and within 15 minutes) after the subject has rested supine for at least 5 minutes. The ECG parameters will be based on the ECG machine readings (QTcF may be calculated).
[f] A serum pregnancy test will be conducted at screening and urine pregnancy tests will be conducted at all other study visits only for female subjects of childbearing potential.
[g] Clinical laboratory tests include hematology, clinical chemistry, and urinalysis. All blood samples will be obtained under nonfasted conditions.
[h] An on-site urine drug screen should be performed prior to dispensing study drug.
[i] Study drug will be administered once daily at the subject's bedtime at home (under the supervision of their parent/guardian for subjects ≤17 years of age). The date and time of each dosing of study drug will be recorded.
[j] Subjects will return all used and unused study drug, and a compliance check will be performed by counting the capsules returned at each study visit.

9.2. Pharmacodynamic Assessments

9.2.1. Yale Global Tic Severity Scale

The YGTSS will be used to assess tic behaviors associated with TS (Leckman et al., 1989). The YGTSS is designed to rate the overall severity of motor and phonic tic symptoms across a range of dimensions: number, frequency, intensity, complexity, and interference. The scale also includes an impairment assessment. The YGTSS will be administered by the investigator (or qualified designee) using a computer-based structured clinical interview. At each timepoint, the YGTSS interview will be video recorded. The video recording will follow a standardized set of guidelines and the recorded video will be uploaded to a secure central server. A blinded, external video reviewer, not affiliated with the site, will access the central server to view the recording and determine if the YGTSS interview program was administered properly. The computer software system for the YGTSS administration, Rater Station™ (Bracket Global, LLC; Philadelphia, PA), will prompt the investigator (or a qualified designee), a trained and certified rater, to enter a score for each item of the scale based on subject and parent responses during the structured clinical interview. As much as possible, a given subject should have the same rater throughout the study. The software will also generate individual scores for each item of the scale (tandem rating) and will generate the TTS and the Global Tic Severity Score.

The YGTSS will be administered at Day 1 (baseline), Weeks 2, 4, 8, 12, 16, 20, 24, and at the follow-up visit (Week 28), or early termination. A copy of the YGTSS is provided in Appendix 17.1.

9.2.2. Premonitory Urge for Tics Scale

The PUTS is a valid and reliable instrument for quantifying the premonitory urge phenomena associated with tics (Woods et al., 2005). Each of the 9 items in the PUTS is rated on a 4-point scale (1=not at all true, 2=a little true, 3=pretty much true, 4=very much true) and summed to yield a total score reflecting the presence and frequency of pre-tic (ie, premonitory) urges along with relief that may be experienced after tics have been completed.

The investigator (or designee) will administer the PUTS at Day 1 (baseline), Weeks 2, 4, 8, 12, 16, 20, 24, and at the follow-up visit (Week 28), or early termination. A copy of the PUTS is provided in Appendix 17.2.

9.2.3. Clinical Global Impression Scales

The CGI-Tics–Severity and CGI-TS–Improvement scales will be used to rate the subject's overall severity of tics and overall improvement of TS.

The CGI-Tics-Severity scale will be used to assess overall severity on a 7-point scale (range; 1=normal, not at all ill to 7=among the most extremely ill subjects). The CGI-Tics-Severity will be assessed by the investigator at Day 1 (baseline), Weeks 2, 4, 8, 12, 16, 20, 24, and at the follow-up visit (Week 28), or early termination. A copy of the CGI-Tics-Severity scale is provided in Appendix 17.3.

The CGI-TS–Improvement scale will be used to assess overall improvement since the initiation of study drug dosing on a 7-point scale (range; 1=very much improved to 7=very much worse). CGI-TS-Improvement scales will be assessed by the investigator at Weeks 2, 4, 8, 12, 16, 20,

24, and at the follow-up visit (Week 28), or early termination. A copy of the CGI-TS– Improvement scale is provided in Appendix 17.4.

9.2.4. Gilles de la Tourette Syndrome-Quality of Life for Children and Adolescents

The C&A-GTS-QOL is a valid and reliable instrument to assess the quality of life in children and adolescents with TS (Cavanna et al., 2013; Su et al., 2017). It consists of 27 items and 4 subscales (psychological, physical, obsessive-compulsive, and cognitive). Each item is rated across 5 response options: "Never," "Rarely," "Sometimes," "Often," and "Always." There are 2 versions of this instrument: 1 version for children aged 6 to 12 years and 1 version for adolescents aged 13 to 18 years. The C&A-GTS-QOL also includes a visual analog scale, assessing how satisfied the subject feels with his/her life (range of 0-100, with 100 representing the greatest satisfaction).

The subject will complete the C&A-GTS-QOL at Day 1 (baseline), and Weeks 12 and 24. The subject can receive assistance filling out the questionnaire if needed. Copies of both versions of the C&A-GTS-QOL are provided in Appendix 17.5.

9.3. Plasma Drug Exposure

Blood samples to evaluate plasma concentrations of NBI-98854 and the metabolite NBI-98782 will be collected at Day 1 (predose) and at Weeks 2, 4, 8, 12, 16, 20, 24, and at the follow-up visit (Week 28), or early termination. The exact time of collection will be recorded on the eCRF.

For each plasma sample, approximately 2 mL of blood will be collected in tubes containing dipotassium ethylenediaminetetraacetic acid (EDTA K_2). The blood samples will be processed and stored according to the procedure as specified in the laboratory manual. These samples will be shipped on dry ice to the central laboratory for analysis. Refer to the laboratory manual for additional details.

9.4. Safety Assessments

Concomitant medication use and AEs will be monitored throughout the study as described in Section 9.7.1 and Section 11, respectively. Additional safety assessments are described in the following sections.

Any abnormal vital sign measurement, physical examination finding, clinical laboratory test, or ECG parameter deemed clinically significant by the investigator will be repeated, including test results obtained at the final study visit or upon early termination, until the value returns to baseline (or within normal limits), or the investigator deems the abnormality to be of no clinical significance. If the investigator determines that a subject has a clinically significant finding of treatment-emergent depression, suicidal ideation, psychiatric symptoms (based upon the C-SSRS, CDRS-R, CY-BOCS, ADHD-5 Rating Scale, or clinical assessment), the finding will be documented as an AE, and appropriate psychiatric evaluation and intervention will be provided.

9.4.1. Data Safety Monitoring Board

An independent DSMB will periodically review ongoing clinical safety data to ensure the safety and well-being of the study subjects. The safety data review may result in recommendation for early termination of the study or changes to the protocol and informed consent. A DSMB charter will describe the responsibilities, timing of meetings, and data review procedures for the members to follow.

9.4.2. Vital Sign Measurements

Vital signs will include orthostatic systolic and diastolic blood pressure, orthostatic pulse rate, respiratory rate (recorded only supine), and oral body temperature. Blood pressure will be measured using a calibrated automatic blood pressure cuff after the subject has been supine for at least 5 minutes and after approximately 2 minutes of standing.

Vital sign measurements will be collected at screening, Day 1 (baseline), Weeks 2, 4, 8, 12, 16, 20, 24, and at the follow-up visit (Week 28), or early termination. Vital sign measurements will be obtained before any scheduled blood sample collection.

9.4.3. Medical History

A medical history will be taken at the screening visit and updated on Day 1. The age at TS diagnosis will be documented for all subjects; if necessary, subject age at TS onset can be estimated by the investigator based upon available clinical information.

9.4.4. Physical Examination, Including Height and Weight

The complete physical examination will consist of an assessment of general appearance, skin and mucosae, head, eyes, ears, nose, throat, neck (including thyroid), lymph nodes, chest/lungs, cardiovascular, abdomen, extremities, musculoskeletal, and neurological system. A complete physical examination including weight will be performed at screening, Day 1 (baseline), and at Weeks 2, 16, 24, and at the follow-up visit (Week 28), or early termination. Height will be measured at screening only. Height and weight will be measured with subjects not wearing shoes.

9.4.5. Electrocardiogram

A standard 12-lead ECG will be recorded in triplicate (at least 1 minute apart and within 15 minutes) after the subject has rested supine for at least 5 minutes. The ECG parameters that will be assessed include heart rate (HR), PR interval, QRS duration, corrected QT interval, and QTcF (machine readings or calculated). Additionally, the occurrence of de- and re-polarization and rhythm disorders or other abnormalities will be assessed. Based on the review of these parameters, the investigator or designee will note if the ECG is Normal, Abnormal not Clinically Significant, or Abnormal Clinically Significant. If the ECG is Abnormal Clinically Significant, the investigator or designee will provide a description of the abnormality recorded on the AE eCRF.

The 12-lead ECG recordings will be conducted at screening, Day 1 (baseline), and at Weeks 2, 4, 8, 12, 16, 20, 24, and at the follow-up visit (Week 28), or early termination.

9.4.6. Clinical Laboratory Assessments

All clinical laboratory assessments will be performed by a central laboratory, which will provide instructions and supplies to the study staff before study initiation. The instructions will be included in a laboratory manual. The laboratory test battery will include routine and screening laboratory tests.

Clinical safety laboratory assessments will be performed at screening, Day 1 (baseline), and at Weeks 2, 4, 8, 12, 16, 20, 24, and at the follow-up visit (Week 28), or early termination. There are no fasting requirements for laboratory assessments.

The following clinical safety laboratory assays will be performed:

Hematology: complete blood count including WBC count with differential, red blood cell count, hemoglobin, hematocrit, platelet count, mean corpuscular hemoglobin (MCH), mean corpuscular hemoglobin concentration (MCHC), mean corpuscular volume (MCV), red cell distribution width (RDW), and mean platelet volume (MPV).

Clinical Chemistry: sodium, potassium, calcium, magnesium, chloride, blood urea nitrogen, bicarbonate, creatinine, uric acid, albumin, alkaline phosphatase, lactate dehydrogenase, ALT, AST, GGT, creatine kinase, total bilirubin, total cholesterol, triglycerides, total protein, and glucose.

Urinalysis: specific gravity, nitrites, ketones, protein, urobilinogen, glucose, bilirubin, leukocyte esterase, occult blood, and pH; microscopic examination of sediment will be performed only if the results of the urinalysis dipstick evaluation are positive for nitrites, protein, leukocyte esterase, or blood.

The following additional laboratory tests will be performed:

Hemoglobin A1c: Blood samples for hemoglobin A1c will be collected at screening, Day 1 (baseline), and at the end of Weeks 12 and 24. Approximately 2 mL in EDTA K_2 will be collected in all subjects.

Serum Prolactin: Blood samples to determine serum prolactin concentration will be collected at Day 1 (baseline), at Weeks 12 and 24, and at the follow-up visit (Week 28), or early termination. Serum prolactin samples will be shipped to a central laboratory for analysis.

Urine Drug Screen and Alcohol Breath Test: The urine drug screen will test for amphetamines, barbiturates, phencyclidine, benzodiazepines, cannabinoids, cocaine, and opiates. Urine testing kits will be provided by the central laboratory for preliminary confirmation of negative drug screen at the site prior to dosing. A separate urine sample will also be sent to the central laboratory for analysis. A urine drug screen and alcohol breathalyzer test will be performed at screening and on Day 1. The urine drug screen and alcohol breathalyzer test will be performed only in adolescent subjects (12 to 18 years of age). A urine drug screen using a kit provided by the central laboratory may be conducted at the clinical site at any time during the study if the subject (adolescent subjects only) is suspected of substance or drug abuse.

Pregnancy Tests: A pregnancy test will be conducted for female subjects of childbearing potential. A serum pregnancy test will be conducted at screening and a urine pregnancy test will be conducted on Day 1, Weeks 2, 4, 8, 12, 16, 20, 24, and at the follow-up visit (Week 28), or early termination.

9.4.7. Columbia-Suicide Severity Rating Scale Children's Versions

The C-SSRS is a validated instrument to prospectively assess suicidal ideation and behavior (http://www.cssrs.columbia.edu). There are versions of the questionnaire designed for use at screening (Children's Baseline/Screening version) and at baseline and visits throughout the study (Children's Since Last Visit version). All versions of the C-SSRS include a series of screening questions related to suicidal ideation and suicidal behavior. Subject responses of "yes" to one or more screening questions will prompt additional questions that evaluate frequency and intensity of suicidal ideation and/or behavior. Subjects with any lifetime suicidal behavior or suicidal ideation of type 4 (active suicidal ideation with some intent to act, without specific plan) or type 5 (active suicidal ideation with specific plan and intent) in the 1 year before screening based on the C-SSRS Children's version should be excluded (see exclusion criterion #16).

The C-SSRS will be administered and scored by the investigator or qualified study center personnel at screening, Day 1 (baseline), and Weeks 2, 4, 8, 12, 16, 20, 24, and at the follow-up visit (Week 28), or early termination. A copy of each Children's version of the C-SSRS is provided in Appendix 17.6 and Appendix 17.7, respectively.

9.4.8. Children's Depression Rating Scale, Revised

The CDRS-R is a 17-item, semi-structured interview to determine the severity of depression in children. The investigator (or designee) will administer the CDRS-R on Day 1 (baseline) and at Weeks 2, 4, 8, 12, 16, 20, 24, and at the follow-up visit (Week 28), or early termination. A copy of the CDRS-R is provided in Appendix 17.8.

9.4.9. Children's Yale-Brown Obsessive Compulsive Scale

The CY-BOCS is a semi-structured interview designed to rate the severity of obsessive and compulsive symptoms in children. The investigator (or designee) will administer the CY-BOCS at Day 1 (baseline), Weeks 2, 4, 8, 12, 16, 20, 24, and at the follow-up visit (Week 28), or early termination. A copy of the CY-BOCS is provided in Appendix 17.9.

9.4.10. Attention-Deficit Hyperactivity Disorder Rating Scale-5: Home Version

The ADHD Rating Scale-5: Home Version will be used to determine the frequency and severity of ADHD symptoms and impairments over the past 2 weeks. The scale comes in 2 versions: child (ages 5-10 years) and adolescent (ages 11-17 years; subjects 18 years of age will also use this version). Both versions consist of 2 symptom subscales, Inattention (9 items), and Hyperactivity–Impulsivity (9 items), as well as a Total Scale (18 items). In addition, 6 domains of impairment that are common among children with ADHD are assessed: relationships with significant others (family members for the home version and teachers for the school version), peer relationships, academic functioning, behavioral functioning, homework performance, and self-esteem.

It will be completed independently by the subject's parent or guardian at Day 1 (baseline), Weeks 12 and 24, and at the follow-up visit (Week 28), or early termination. A copy of both versions of the ADHD Rating Scale-5: Home Version is provided in Appendix 17.10.

9.4.11. Extrapyramidal Symptom Rating Scale-Abbreviated

The ESRS-A is a psychometrically validated instrument that assesses 4 types of movement disorders: parkinsonism, akathisia, dystonia, and dyskinesia (Chouinard and Margolese, 2005). The investigator (or designee) will administer the ESRS-A on Day 1 (baseline), Weeks 2, 4, 8, 12, 16, 20, 24, and at the follow-up visit (Week 28), or early termination. A copy of the ESRS-A is provided in Appendix 17.11.

9.4.12. Estimated Total Blood Sample Volume Required by Study

The estimated total blood sample volume for each subject is presented in Table 2. These estimates include samples to be collected during screening, the treatment period, and the final visit (Week 28 or upon early termination).

Table 2: Estimated Total Blood Sample Volume

Parameter	Number of Samples Required	Approximate Volume (mL)	Approximate Total Volume (mL)
Children (6 to 11 years of age)			
Clinical chemistry[a]	10	2.5	25
Hematology	10	3	30
Hemoglobin A1c	4	2	8
Serum prolactin	4	2.5	10
Pharmacokinetics	9	2	18
Approximate Maximum Total Blood Sample Volume per Subject (mL):			**91**
Adolescents (12 to 18 years of age)			
Clinical chemistry[a]	10	5	50
Hematology	10	4	40
Hemoglobin A1c	4	2	8
Serum prolactin	4	5	20
Pharmacokinetics	9	2	18
Approximate Maximum Total Blood Sample Volume per Subject (mL):			**136**

a. Includes pregnancy test for female subjects who are of childbearing potential at screening.

9.5. Specific Study Information

After providing parental or legal guardian informed consent with signed and witnessed pediatric assent for subjects ≤17 years of age, or written informed consent for subjects 18 years of age (as required by the governing IRB), subjects will undergo screening procedures within 28 days of Day -1.

9.5.1. Screening (Days -28 to -1)

During screening, the following study evaluations and tasks will be performed at the study center:

- Obtain informed consent/assent.
- Assess inclusion/exclusion criteria.
- Collect medical history.
- Perform a physical examination (including height and weight).
- Collect vital signs, including orthostatic systolic and diastolic blood pressures, orthostatic pulse rate, respiratory rate, and body temperature.
- Perform 12-lead ECG in triplicate (at least 1 minute apart and within 15 minutes).
- Perform a serum pregnancy test (β-hCG) only for female subjects of childbearing potential.
- Collect blood sample for hematology and clinical chemistry.
- Collect urine sample for urinalysis.
- Perform alcohol breathalyzer test and urine drug screen (both only in adolescent subjects).
- Collect blood sample for hemoglobin A1c.
- Administer the C-SSRS (Children's Screening/Baseline version).
- AE monitoring.
- Record prior medications.

All screening procedures must be completed and results must be evaluated by the investigator before the baseline procedures are performed on Day 1.

The following items will also be conducted at screening:

- Instruct subjects of childbearing potential who do not practice total abstinence to continue using contraception (see inclusion criterion #9 in Section 8.1).
- Eligible subjects will be instructed to return to the study center on Day 1. The following should be considered for scheduling purposes: as much as possible, visits should occur at approximately the same time as the Day 1 (baseline) visit to standardize the time of day for the assessment of PD, safety, and plasma exposure throughout the study period.

9.5.2. Day 1 (Baseline Assessments and Start of Dosing)

Subjects (and parents/legal guardians for subjects ≤17 years of age) will return to the study center on Day 1.

On Day 1, the following baseline study evaluations and tasks will be performed at the study center:

- Update inclusion and exclusion criteria.
- Update medical history.
- Perform a physical examination including weight.
- Collect vital signs, including orthostatic systolic and diastolic blood pressures, orthostatic pulse rate, respiratory rate, and body temperature.

- Perform 12-lead ECG in triplicate (at least 1 minute apart and within 15 minutes).
- Perform a urine pregnancy test only for female subjects of childbearing potential.
- Collect blood sample for hematology and clinical chemistry.
- Collect urine sample for urinalysis.
- Perform alcohol breathalyzer test and urine drug screen (both only in adolescent subjects).
- Collect blood sample for hemoglobin A1c.
- Collect blood sample for serum prolactin.
- Collect PK blood sample for NBI-98854 and metabolite concentrations.
- Administer the YGTSS, including video recording.
- Administer the PUTS.
- Administer the CGI-Tics-Severity scale.
- Administer the C-SSRS (Children's Since Last Visit version).
- Administer the CY-BOCS and CDRS-R.
- Administer the ADHD-5 Rating Scale.
- Administer the ESRS-A.
- Administer the C&A-GTS-QOL.
- Dispense a 2-week supply of study drug and provide instructions on storage and administration of the study drug.
- Instruct subjects to record the date and time of each dose on the labels provided on the study drug kit packaging form.
- Instruct subjects to begin taking study drug daily at bedtime (under supervision of their parents/legal guardians for subjects ≤17 years of age), beginning on Day 1. (The timing of study drug administration should remain consistent throughout the treatment period).
- Instruct subjects (and parents/legal guardians for subjects ≤17 years of age) to return to the study center at Week 2 (-2 to +3 days) and to bring their study drug kit.
- AE monitoring.
- Record concomitant medications.

The following will also be conducted before subjects may leave the study center:

- Instruct subjects of childbearing potential who do not practice total abstinence to continue using contraception (see inclusion criterion #9 in Section 8.1).
- Instruct subjects (and parents/legal guardians for subjects ≤17 years of age) to notify the investigator by telephone if they experience any AEs and before taking any new concomitant medications.

Note, subsequent study visits during the dose optimization period will be 14 days from the previous visit (28 days from the previous visit during the dose maintenance period and follow-up period); for example, the Week 2 visit will be on Day 15 (-2 to +3 days) and the Week 4 visit will be on Day 29 (-2 to +3 days).

9.5.3. Dose Optimization Period: Weeks 2 and 4 (-2 to +3 days for each visit)

Subjects (and parents/legal guardians for subjects ≤17 years of age) will return to the study center at Weeks 2 and 4.

The following study evaluations and tasks will be performed at the study center:

- Perform a physical examination including weight (Week 2 only).
- Collect vital signs, including orthostatic systolic and diastolic blood pressures, orthostatic pulse rate, respiratory rate, and body temperature.
- Perform 12-lead ECG in triplicate (at least 1 minute apart and within 15 minutes).
- Perform a urine pregnancy test only for female subjects of childbearing potential.
- Collect blood sample for hematology and clinical chemistry.
- Collect urine sample for urinalysis.
- Collect PK blood sample for NBI-98854 and metabolite concentrations.
- Administer the YGTSS, including video recording.
- Administer the PUTS.
- Administer the CGI-Tics-Severity scale.
- Administer the CGI-TS-Improvement scale.
- Administer the C-SSRS (Children's Since Last Visit version).
- Administer the CY-BOCS and CDRS-R.
- Administer the ESRS-A.
- Perform compliance check by counting the capsules returned.
- AE monitoring.
- Record concomitant medications.

Dose Escalation Assessment

At the end of Week 2 and Week 4 visits, a dose escalation will occur based on the following 2 criteria: 1) the subject's tics are not sufficiently controlled per physician investigator assessment; and 2) an evaluation by the physician investigator indicates that the subject is tolerating the study drug at the current dose and would likely be able to tolerate the next dose level. Based on these criteria, the physician investigator will choose 1 of the following dosing options:

- Dose escalation, which will occur in 20 mg increments:
  - Subjects <50 kg at baseline: from 20 mg to 40 mg (Week 2); from 40 mg to 60 mg (Week 4).
  - Subjects ≥50 kg at baseline: from 40 mg to 60 mg (Week 2); from 60 mg to 80 mg (Week 4).
- Maintenance of current dose (with no further dose increases).
- Dose reduction to previous dose in subjects who have had a dose escalation (only a single dose reduction is allowed during the study). The physician investigator may decrease the dose to the previous dose at any time after the end of Week 2 (including between scheduled

study visits) for any subject who is unable to tolerate a given dose increase. Subjects will receive this dose for the remainder of the treatment period.

Once a determination of dose escalation, maintenance, or reduction is made, the interactive web response system (IWRS) will be accessed to obtain an identification number for a kit containing a 2-week (Week 2) or 4-week (Week 4) supply of study drug to be dispensed to the subject.

The following will also be conducted before subjects may leave the study center:

- Instruct subjects of childbearing potential who do not practice total abstinence to continue using contraception (see inclusion criterion #9 in Section 8.1).
- Instruct subjects (and parents/legal guardians for subjects ≤17 years of age) to notify the investigator by telephone if they experience any AEs and before taking any new concomitant medications.
- Instruct subjects to record the date and time of each dose on the labels provided on the study drug packaging form.

9.5.4. Dose Maintenance Period: Weeks 8, 12, 16, 20, and 24 (-2 to +3 days for each visit)

At Weeks 8, 12, 16, 20, and 24 the following study evaluations and tasks will be performed at the study center:

- Perform a physical examination including weight (Weeks 16 and 24 only).
- Collect vital signs, including orthostatic systolic and diastolic blood pressures, orthostatic pulse rate, respiratory rate, and body temperature.
- Perform 12-lead ECG in triplicate (at least 1 minute apart and within 15 minutes).
- Perform a urine pregnancy test only for female subjects of childbearing potential.
- Collect blood sample for hematology and clinical chemistry.
- Collect urine sample for urinalysis.
- Collect blood sample for hemoglobin A1c (Weeks 12 and 24 only).
- Collect blood sample for serum prolactin (Weeks 12 and 24 only).
- Collect PK blood sample for NBI-98854 and metabolite concentrations.
- Administer the YGTSS, including video recording.
- Administer the PUTS.
- Administer the CGI-Tics–Severity scale
- Administer the CGI-TS–Improvement scale.
- Administer the C-SSRS (Children's Since Last Visit version).
- Administer the CY-BOCS and CDRS-R.
- Administer the ADHD-5 Rating Scale (Weeks 12 and 24 only).
- Administer the ESRS-A.
- Administer the C&A-GTS-QOL (Weeks 12 and 24 only).
- Dispense a 4-week supply of study drug (Weeks 8, 12, 16, and 20 only).

- Perform compliance check by counting the capsules returned.
- AE monitoring.
- Record concomitant medications.

The following will also be conducted before subjects may leave the study center:

- Instruct subjects of childbearing potential who do not practice total abstinence to continue using contraception (see inclusion criterion #9 in Section 8.1).
- Instruct subjects (and parents/legal guardians for subjects ≤17 years of age) to notify the investigator by telephone if they experience any AEs and before taking any new concomitant medications.
- Instruct subjects to record the date and time of each dose on the labels provided on the study drug packaging form.

9.5.5. Follow-up Period/Early Termination: Week 28 (-2 to +3 days)

At Week 28 (or upon early termination) the following study evaluations and tasks will be performed at the study center:

- Perform a physical examination including weight.
- Collect vital signs, including orthostatic systolic and diastolic blood pressures, orthostatic pulse rate, respiratory rate, and body temperature.
- Perform 12-lead ECG in triplicate (at least 1 minute apart and within 15 minutes).
- Perform a urine pregnancy test only for female subjects of childbearing potential.
- Collect blood sample for hematology and clinical chemistry.
- Collect urine sample for urinalysis.
- Collect blood sample for serum prolactin.
- Collect PK blood sample for NBI-98854 and metabolite concentrations.
- Administer the YGTSS, including video recording.
- Administer the PUTS.
- Administer the CGI-Tics–Severity scale.
- Administer the CGI-TS–Improvement scale.
- Administer the C-SSRS (Children's Since Last Visit version).
- Administer the CY-BOCS and CDRS-R.
- Administer the ADHD-5 Rating Scale.
- Administer the ESRS-A.
- AE monitoring.
- Record concomitant medications.

9.6. Study Duration

The expected duration of study participation for each subject is approximately 32 weeks, including up to 28 days for screening, 24 weeks of treatment, and a follow-up period of approximately 4 weeks.

9.7. Prohibitions and Restrictions

9.7.1. Prior and Concomitant Medications

All prescription and over the counter medications, including dietary and herbal supplements, taken by subjects during the 30 days before baseline (Day 1) and during the study will be entered on the Prior and Concomitant Medications eCRF. Any additions, deletions, or changes in the dose of these medications will be entered on the eCRF with indication, dose, route, and dates of drug administration.

The following medications are prohibited from 14 days before Day 1 (baseline) (unless otherwise stated) until the final study visit (or upon early termination) as described below:

- Antiemetics: Metoclopramide, prochlorperazine, and promethazine.
- Botulinum toxin: Botulinum toxin injections for treatment of TS are prohibited starting 90 days prior to Day 1 (baseline).
- CYP3A4 inducers: Strong inducers of CYP3A4 (eg, phenytoin, phenobarbital, rifabutin, rifampin, primidone, St. John's Wort, carbamazepine).
- CYP3A4 inhibitors: Strong inhibitors of CYP3A4 (eg, itraconazole, ketoconazole, clarithromycin).
- Dopamine agonists and precursors: Dopamine agonists (eg, ropinirole) and precursors (eg, carbidopa/levodopa).
- Dopamine antagonist: Dopamine antagonists (eg, pimozide, haloperidol, aripiprazole, risperidone, clozapine, olanzapine, ziprasidone). Depot neuroleptics are prohibited starting 15 weeks prior to Day 1 (baseline).
- Monoamine oxidase inhibitors (MAOIs): All MAOIs (eg, isocarboxazid, phenelzine, selegiline, tranylcypromine).
- VMAT2 inhibitors: VMAT2 inhibitor medications (eg, tetrabenazine, reserpine) are prohibited, except for study drug.
- As needed use of the following medications: anticholinergics, benzodiazepines, antipsychotics, psychostimulants, mood stabilizers, antidepressants, opiates, cannabinoids, and strong CYP2D6 inhibitors.

9.7.2. Dietary Restrictions

Subjects are not permitted to consume more than 6 caffeine-containing beverages a day.

Grapefruit juice or grapefruit products are prohibited from 7 days before Day 1 until the follow-up visit. Alcohol is prohibited from 48 hours before Day 1 until the follow-up visit.

9.7.3. Other Restrictions

Excessive use of tobacco and other products containing nicotine (including nicotine gum and patches) are prohibited during the study (ie, from 30 days before screening to the follow-up visit or upon early termination). Subjects must agree not to donate blood during the study, including the screening period, and for 4 weeks after completion of the study. Male subjects must agree to refrain from donating sperm during the study and for 90 days after the last dose of study drug.

9.8. Withdrawal Criteria

Subjects are free to discontinue their participation in the study at any time. The investigator must withdraw any subject from the study if that subject requests to be withdrawn.

The investigator must withdraw the subject from the study if the subject experiences any of the following:

- If the type, frequency, or severity of any AE becomes unacceptable/intolerable.
- If the subject is unable to tolerate the starting dose or resumption of the previous dose.
- QTcF value >500 msec (cardiologist verified) on any ECG tracing.
- If the subject exhibits suicidal behavior, or suicidal ideation of type 4 (active suicidal ideation with some intent to act, without specific plan) or type 5 (active suicidal ideation with specific plan and intent) based on the C-SSRS.
- Is lost to follow-up.
- Subject is confirmed to be pregnant.

The investigator or NBI may withdraw the subject from the study for other reasons as described below. These should be discussed on a case-by-case basis with the NBI medical monitor (or designee) prior to withdrawing the subject from the study.

- Develops a clinically significant laboratory (eg, ALT or AST ≥2.5 times ULN) or ECG abnormality.
- Requires a medication that is prohibited by the protocol (refer to Section 9.7.1).
- Is non-compliant with the dosing regimen (<80% dosing compliance) as verified by drug accountability (Refer to Section 10.6).

All subjects prematurely discontinuing the study, regardless of cause, should have all early termination assessments performed (see Section 9.5.5).

9.8.1. Handling of Withdrawals

If a subject prematurely withdraws from the study, either at his/her request, at the request of the parent or legal guardian, or at the investigator's discretion, the investigator will record the reason for withdrawal on the relevant eCRF. All subjects who withdraw from the study prematurely should have all early termination assessments performed.

It is crucial to obtain follow-up data for any subject withdrawn because of an AE, abnormal laboratory test, vital sign measurement, physical examination, or ECG finding. In any case, every effort must be made to undertake safety follow-up procedures.

9.8.2. Sponsor's Termination of Study

NBI reserves the right to discontinue the study at any time for clinical or administrative reasons.

Such a termination must be implemented by the investigator, if instructed to do so by NBI in a time frame that is compatible with the subjects' well-being.

10. STUDY DRUG

10.1. Study Drug Supplies

NBI or its designee will provide the study centers with subject-specific study drug kits sufficient for the completion of the treatment period of the study.

NBI-98854 will be supplied as capsules containing 20 mg or 40 mg of NBI-98854 (free base equivalent). The NBI-98854 capsules are a [redacted]

All subjects will receive the starting dose of study drug beginning on Day 1. At Weeks 2 and 4, subjects may have their dose increased based on protocol-specified criteria.

If a subject's optimal dose has already been established at Week 2, no further dose escalation will be allowed during the dose optimization period and the subject will continue at that dose until the end of the 24-week treatment period. However, subjects who had a dose escalation may have a dose reduction at any time.

10.2. Study Drug Storage

NBI-98854 must be stored at controlled room temperature (CRT) (20˚C to 25˚C or 68˚F to 77˚F) under the conditions specified in the Investigator's Brochure and in a locked area accessible only to the pharmacist (or designee) until dispensing. Excursions outside this range will be allowed provided they meet the following conditions:

[redacted]

10.3. Study Drug Packaging and Labeling

All packaging and labeling operations will be performed according to Good Manufacturing Practice (GMP) and GCP. Study drug will be sent to designated staff at the study site who must complete and return the Drug Supply Confirmation to NBI or its designee verifying the receipt of the drug.

Study drug will be supplied as capsules [redacted] will contain capsules of NBI-98854 20 mg and/or 40 mg.

Label text will include but is not limited to the protocol number, dosage form, route of administration, sponsor name and address, storage condition, and the statement "Caution – New Drug: Limited by Federal (or US) Law to Investigational Use."

10.4. Blinding

This is an open-label study.

10.5. Study Drug Administration

Study drug will be administered once daily at bedtime at home (under the supervision of the subject's parent/legal guardian for subjects ≤17 years of age) and the capsules must be swallowed with at least 4 oz. of water, with or without food, every day at approximately the same time for the 24-week treatment period. If a subject forgets or is unable to take the study drug on a given day, the subject should skip that dose and resume normal dosing the following day. Subjects or their parents/legal guardians will record the date and time of study drug dosing each day on the labels provided on the study drug packaging form.

10.6. Drug Compliance and Accountability

Subjects will bring all unused study drug and empty study drug packaging material to the center at each study visit for drug accountability and reconciliation by study center personnel. A compliance check will be performed by counting the capsules returned at each study visit.

The quantity of study drug dispensed, used, and returned will be recorded on a dispensing log or otherwise documented. The quantity of study drug lost or destroyed must also be accounted for and documented. The designated pharmacist or qualified personnel will be responsible for maintaining accurate records of the quantity and dates of all study drug supplies received, dispensed, and returned.

10.7. Study Drug Return

Written documentation to account for study drug and study drug materials is mandatory; all unused study drug and study drug materials must be kept in a secure location for final accountability and reconciliation. Returned study drug and study drug material must be accounted for on a study drug return form provided by NBI or designee. The investigator must provide a written explanation for any destroyed or missing study drug or study drug materials.

Returns will be shipped to NBI or its designee at the completion of the study according to instructions provided by NBI or its designee. Study drug return forms must be completed for the shipment of returns and sent with the study drug and study drug materials. One copy of the study drug return form will be retained in the investigator's study file.

All returned study drug and study drug materials should be stored, inventoried, reconciled, and returned according to applicable state and federal regulations and study procedures.

11. ADVERSE EVENTS

All AEs, whether observed by the investigator, reported by the subject, noted from laboratory findings, or identified by other means, will be recorded from the time the subject signed the ICF until the subject's final study visit (Week 28 or upon early termination).

11.1. Definition

An AE is any untoward medical occurrence associated with the use of a drug in humans, whether or not considered drug related. During the study, clinically significant adverse changes in clinical status, ECGs, laboratory values (not associated with an AE or concurrent medical condition), or physical examinations are considered AEs. Any subject complaint associated with such an abnormal finding will also be reported as an AE.

Adverse events include, but are not limited to: (1) a worsening or change in nature, severity, or frequency of conditions present at the start of the study; (2) subject deterioration due to primary illness; (3) intercurrent illness; and (4) drug interaction.

If at any time after the baseline visit (Day 1), the subject's response to the suicidal ideation section of the C-SSRS is worse than the baseline assessment it will be documented as an AE. All suicidal behaviors will be documented as an AE.

Subjects should be questioned in a general way, without asking about the occurrence of any specific symptom. The investigator should attempt to establish a diagnosis of the event based on signs, symptoms, and/or other clinical information. In such cases, the diagnosis should be documented as the AE and not the individual signs/symptoms. Following questioning and evaluation, all AEs, whether believed by the investigator to be related or unrelated to the study drug, must be documented in the subject's medical records, in accordance with the investigator's normal clinical practice and on the AE eCRF. Each AE is to be evaluated for duration, intensity, frequency, seriousness, outcome, other actions taken, and relationship to the study drug.

The following are not considered AEs:

- Continuous persistent disease/symptom present before drug administration, unless it unexpectedly progresses, or increases in severity following drug administration.
- Recurrence of TS symptoms, unless worsened from baseline.
- Pregnancy.

11.2. Intensity of Adverse Events

Adverse events must be graded for intensity. An intensity category of mild, moderate, or severe, as defined in Table 3, must be entered on the AE eCRF. It should be noted that the term "severe" used to grade intensity is not synonymous with the term "serious."

Table 3: Intensity of Adverse Events

Grade	Intensity
Mild	An AE that is usually transient and may require only minimal treatment or therapeutic intervention. The event does not generally interfere with usual activities of daily living.
Moderate	An AE that is usually alleviated with additional specific therapeutic intervention. The event interferes with usual activities of daily living, causing discomfort but poses no significant or permanent risk of harm to the research participant.
Severe	An AE that interrupts usual activities of daily living, or significantly affects clinical status, or may require intensive therapeutic intervention.

11.3. Relationship to Study Drug

The investigator will document his/her opinion of the relationship of the AE to treatment with study drug using the criteria outlined in Table 4. An AE is deemed associated with the use of the study drug "if there is a reasonable possibility that the drug caused the AE" (otherwise referred to as a suspected adverse reaction). Reasonable possibility means there is evidence to suggest a causal relationship between the drug and the AE (Title 21 CFR 312.32 [a]).

Table 4: Relationship of Adverse Events to Study Drug

Relationship	Description
Definite	A reaction that follows a reasonable temporal sequence from administration of the drug or in which the drug level has been established in body fluids or tissue; that follows a known or expected response pattern to the suspected drug; and that is confirmed by improvement on stopping or reducing the dosage of the drug, and reappearance of the reaction on repeated exposure.
Possible	An adverse event in which there is reasonable possibility that the drug caused the event. Reasonable possibility means there is evidence to suggest a causal relationship between the drug and the adverse event.
Unlikely	A reaction that follows a reasonable temporal sequence from administration of the drug; that follows a known or suspected response pattern to the suspected drug; but that could reasonably be explained by known characteristics of the subject's clinical state.
Not Related	Any event that does not meet the above criteria.

11.4. Recording Adverse Events

For enrolled subjects, each AE will be listed as a separate entry on an AE eCRF. Screen failure subjects will have AE information noted in the source documentation. The investigator (or designee) will provide information on dates and times of onset and resolution, intensity, seriousness, frequency, action(s) taken, changes in study drug usage, relationship to study drug, and outcome.

The following categories of medical events that could occur during participation in a clinical study must be reported within 24 hours to NBI or its designee:

- Serious adverse event, including death (Refer to Section 11.6).
- Pregnancy (refer to Section 11.7).

- Events of suicidal behavior or suicidal ideation of type 4 (active suicidal ideation with some intent to act, without specific plan) or type 5 (active suicidal ideation with specific plan and intent) based on the C-SSRS.

11.5. Post-Study Follow-Up of Adverse Events

All AEs, including clinically significant changes in ECGs, physical examination findings, or isolated clinically significant laboratory findings must be followed until the event resolves, the condition stabilizes, the event is otherwise explained, or the subject is lost to follow-up. If resolved, a resolution date should be documented on the eCRF.

Adverse events ongoing at the final visit or upon early termination will be followed for as long as necessary to adequately evaluate the subject's safety or until the event stabilizes or resolves or until the subject is lost to follow-up. The investigator is responsible for ensuring that follow up includes any supplemental investigations as may be indicated to elucidate the nature and/or causality of the AE. This may include additional laboratory tests or investigations, histopathological examinations, or consultation with other health care professionals, as is practical.

11.6. Serious Adverse Events

All SAEs will be recorded from the time the subject has signed the ICF until 30 days after the last dose of study drug.

11.6.1. Definition of a Serious Adverse Event

An SAE is any AE that results in any of the following outcomes:

- Death.
- A life-threatening AE. Life threatening means that the subject was, in the view of the investigator or sponsor, at immediate risk of death from the reaction as it occurred. It does not mean that hypothetically the event might have caused death if it occurred in a more serious form.
- Inpatient hospitalization or prolongation of existing hospitalization. Hospitalization for elective treatment or a preexisting condition that did not worsen during the clinical investigation is not considered an AE. Hospitalization or nursing home admission for the purpose of caregiver respite is not considered an AE. Complications that occur during hospitalization are AEs, and if a complication prolongs hospitalization, the event is considered serious. Treatment in a hospital emergency room is not a hospitalization.
- A persistent or significant incapacity or substantial disruption of a person's ability to conduct normal life functions.
- A congenital anomaly/birth defect.
- Important medical events that may not result in death, be life threatening, or require hospitalization. These events may be considered serious when, based on appropriate medical judgment, they may jeopardize the health of the subject and may require medical or surgical intervention to prevent one of the outcomes listed. Any other event thought by the investigator to be serious should also be reported, following the reporting requirements detailed in this section. Examples of such medical events include allergic bronchospasm

requiring intensive treatment in an emergency room or at home, blood dyscrasias, convulsions that do not result in inpatient hospitalization, or the development of drug dependency or drug abuse.

11.6.2. Managing Serious Adverse Events

Subjects experiencing an SAE or an emergency situation will be examined by a physician as soon as possible. The physician in attendance will do whatever is medically needed for the safety and well-being of the subject. The subject will remain under observation as long as medically indicated. Appropriate laboratory studies will be conducted until all parameters return to normal or are otherwise explained or stable. The subject will be followed until the SAE resolves or until the subject is medically stabilized. The investigator (or designee) will notify the NBI Medical Monitor (and the IRB, if necessary) immediately (within 24 hours) of the SAE and the outcome of the SAE.

If within the time of informed consent until 30 days after the last dose of study drug, an investigator becomes aware of an SAE, then the event must be documented and reported as described in Section 11.6.3.

11.6.3. Reporting Serious Adverse Events and Other Immediately Reportable Events

Serious AEs and other immediately reportable events (defined in Section 11.4) must be reported within 24 hours of first knowledge of the event by study personnel to the NBI Medical Monitor or NBI Clinical Drug Safety (CDS) Department. Reports of SAEs or pregnancies should be followed by a fax or email of the SAE or Pregnancy Form. It is important that the investigator provides his or her assessment of relationship to study drug at the time of the initial SAE report.

For SAEs or Other Immediately Reportable Events, contact CDS:

CDS telephone: **(866) 626-7792 or (858) 617-7792**

CDS facsimile: **(888) 617-7551**

CDS e-mail: **cds@neurocrine.com**

NBI Medical Monitor: **Telephone:** [redacted]

Cell phone: [redacted]

11.6.4. Expedited Safety Reports

Neurocrine Biosciences, Inc. or its representatives will submit an Expedited Safety Report for any suspected adverse reaction (as defined in Section 11.3) that is considered both serious and unexpected within 15 calendar days and for any unexpected fatal or life threatening experience within 7 calendar days via telephone or facsimile; or according to country specific regulations.

Neurocrine Biosciences, Inc. or its representatives will send copies of each safety report submitted to regulatory authorities to the investigators. The safety report must be submitted to the appropriate IRB as soon as possible. Documentation of the submission to the IRB and receipt by the IRB (if applicable) must be retained for each safety report.

11.7. Pregnancy

Pregnancy is neither an AE nor an SAE unless the criteria for an SAE are met. However, all pregnancies in female subjects who received NBI-98854 will be followed to assess for congenital anomaly. Subjects must be counseled at all visits to continue using contraception (see inclusion criterion #9 in Section 8.1) until 30 days (females) or 90 days (males) after the last dose of study drug. If at any time between the time the subject signs the ICF and the last study visit a subject believes she is pregnant, the subject will be instructed to stop taking the study medication and return to the study center within 24 hours and undergo a serum pregnancy test to confirm pregnancy.

All confirmed pregnancies, in subjects who received study drug, must be immediately reported to NBI (refer to Section 11.6.3 for contact information), followed by fax or email of the pregnancy form to NBI CDS. A first trimester ultrasound will be required for all confirmed pregnancies. Pregnancies in subjects who received NBI-98854 will be followed until resolution (ie, termination [voluntary or spontaneous] or birth).

12. DOCUMENTATION OF DATA

12.1. Case Report Form

The CRF data for this study are being collected with an electronic data capture (EDC) system [redacted]. The EDC system and the study-specific eCRFs will comply with Title 21 CFR Part 11. The documentation related to the validation of the EDC system is available through the vendor, [redacted], while the validation of the study specific eCRFs will be conducted by NBI and the required documentation will be maintained in the Trial Master File.

The investigator will document subject data in his/her own subject files. These subject files will serve as source data for the study. All eCRF data required by this protocol will be recorded by authorized study personnel in the EDC system, with the exception of data captured in an electronic format, which will be loaded electronically into the appropriate eCRFs. All data entered into the eCRF will be supported by source documentation. The eCRF for each subject must be reviewed by the investigator and signed on the appropriate eCRF page(s). This should be done as soon as possible after the subject completes the study.

The investigator or an authorized member of the investigator's staff will make any necessary additions/corrections to the eCRF. All change information, including the date, person performing the corrections, and reason for the change will be available via the electronic audit trail, which is part of the EDC system. The eCRFs will be reviewed periodically for completeness, legibility, and acceptability by NBI (or designee). NBI will also be allowed access to all source documents and medical records pertinent to the study in order to verify eCRF entries. The Principal Investigator will review the eCRFs for completeness and accuracy and enter his or her electronic signature on the eCRFs as evidence thereof.

[redacted] will provide access to the NBI portal of the EDC system for the duration of the study through a password-protected method of internet access. Such access will be removed from investigator sites at the end of the site's participation in the study. Data from the EDC system

will be archived on appropriate data media (CD ROM, etc.) and provided to the investigator at that time as a durable record of the site's eCRF data. Although not required, the investigator may make paper printouts from that media.

All clinical work conducted under this protocol is subject to GCP regulations. This includes an inspection by NBI and/or health authority representatives at any time. The Principal Investigator will agree to the inspection of study-related records by health authority representatives and/or NBI.

12.2. Data Capture, Review, and Validation

Data entered in the EDC system will be verified against the source data by NBI (or designee). Any discrepancies will be corrected on-line by authorized site personnel. After completion of the entry process, automated (computer-generated) logic checks will run in order to identify items such as inconsistent study dates. In addition, manual review/checks may be performed by NBI on the data. Any inconsistencies/errors/omissions identified will be sent to the site (via an electronic query) for the necessary corrections to be made to the eCRF. Once entered and saved in an eCRF, data immediately become part of the study database and are available to NBI.

12.3. Coding Dictionaries

Adverse events and medical history will be coded using the chosen version of the Medical Dictionary for Regulatory Activities (MedDRA). Prior and concomitant medications will be coded using the chosen version of the World Health Organization Drug Dictionary (WHO Drug).

13. STATISTICAL AND ANALYTICAL PLAN

Descriptive statistical methods will be used to evaluate and summarize the data from this study. The term "descriptive statistics" refers to the number of subjects (n), mean, median, standard deviation (SD), standard error of the mean (SEM), minimum, and maximum for continuous and ordinal categorical variables; and refers to the number and percentage of subjects for categorical variables. Descriptive statistics will be presented for each weight group (note that additional summaries may be specified in the detailed statistical analysis plan [SAP]).

The analysis plan provided in this protocol represents a brief description of the planned analyses. The comprehensive SAP will be generated prior to final study database lock. The SAP may include several additional analyses and data summaries not described in this protocol.

13.1. Analysis Sets

A single analysis set, the safety analysis set, will be defined for this study. The safety analysis set will include all subjects who take at least 1 dose of study drug and have any postdosing safety data.

13.2. Sample Size

The sample size for this open-label safety study is based on practical considerations and not on a statistical power calculation.

13.3. Handling of Missing Data

Conventions for the handling of missing data will be described in the SAP.

13.4. Enrollment and Disposition of Subjects

The summary of subject enrollment and disposition will display the number of subjects who were included in each weight group, who completed the dose optimization period (ie, up to Week 4), who completed the dose maintenance period (ie, up to Week 24), and who completed the study. The number of subjects who did not complete the study will also be summarized, both overall and according to the reason for early discontinuation.

13.5. Demographics and Baseline Characteristics

Demographic data (age, gender, race, and ethnicity) and baseline characteristics (including height, weight, body mass index [BMI], CYP2D6 genotype status [carried over from NBI-98854-TS2003 study], age at TS diagnosis, and baseline values for the YGTSS TTS) will be summarized with descriptive statistics. Medical history will be summarized according to MedDRA System Organ Class (SOC) and Preferred Term (PT).

13.6. Study Drug Dosing and Compliance

The number and percentage of subjects who are dose compliant (at least 80% of expected number of doses taken) will be summarized with descriptive statistics by visit (Weeks 2, 4, 8, 12, 16, 20, and 24) and for the full treatment period.

The number and percentage of subjects with dose adjustments will be summarized.

13.7. Pharmacodynamic Data

The PD measures in this study include the YGTSS, PUTS, CGI-Tics-Severity, CGI-TS-Improvement, and C&A-GTS-QOL. Several derived variables based on these measures (eg, the YGTSS TTS) will be summarized with descriptive statistics. For each PD measure, descriptive statistics will be presented for each visit and for the changes from Day 1 (baseline) to each postbaseline visit.

The SAP will provide a full description of the derived variables that will be summarized for these PD measures.

13.8. Plasma Drug Exposure Data

The plasma concentrations of NBI-98854 and the metabolite NBI-98782 will be summarized with descriptive statistics by visit (Day 1 and Weeks 2, 4, 8, 12, 16, 20, 24, and 28) and dose (last dose received prior to blood sample being drawn). Concentrations below the lower limit of quantification will be set equal to zero for all plasma concentration summaries. These data will be summarized for each weight group separately.

13.9. Safety Data

Treatment-emergent adverse events (TEAEs), categorized by MedDRA SOC and/or PT will be summarized in frequency tables. The TEAE summary tables will include the number of events,

number of unique subjects experiencing each event, and percentage of subjects experiencing each event.

Summary tables will be presented including all TEAEs, only TEAEs that are considered to be possibly or definitely related to study drug, and TEAEs according to maximum intensity.

Additional summaries will be presented for TEAEs leading to study drug dose reductions, premature discontinuations from the study, SAEs, and deaths.

Clinical laboratory, vital signs, ECG, C-SSRS, ESRS-A, CY-BOCS, CDRS-R, and ADHD-5 Rating Scale data will be summarized with descriptive statistics. Potentially clinically significant (PCS) values for selected clinical laboratory and vital signs variables will be summarized. Clinically significant physical examination findings will be displayed in a data listing. Prior and concomitant medications will be summarized according to WHO Drug Anatomical Therapeutic Chemical Classification (ATC) categories.

13.10. Software

Statistical calculations and summaries will be generated using [redacted].

13.11. Interim Analysis

An interim analysis is not planned for this study.

14. REGULATORY AND ETHICAL ISSUES

14.1. General Legal References

The study will be carried out according to the provision of the US CFR, the US FDA, Health Canada, and the ICH Guidelines for GCP. All clinical work conducted under this protocol is subject to GCP rules. This includes an inspection by NBI or its representative, health authority, or IRB representatives at any time. The investigator must agree to the inspection of study-related records by health authority representatives and/or NBI or its designee.

14.2. Institutional Review Board

The final approved protocol, the ICF, and assent document will be reviewed by the IRB for the clinical site. The committee's decision concerning conduct of the study will be sent in writing to the investigator and a copy will be forwarded to NBI. The investigator must agree to make any required progress reports to the IRB, as well as reports of SAEs, life threatening problems, or death.

14.3. Protocol Adherence and Amendments

The protocol must be read thoroughly and the instructions must be followed exactly. Any changes in the protocol will require a formal amendment. Such amendments will be agreed upon and approved in writing by the investigator and NBI. The IRB will be notified of all

amendments to the protocol. Amendments to the protocol will not be implemented until written IRB approval has been received.

14.4. Required Documents

The investigator must provide to NBI or its representatives the following documents before the enrollment of any subject (originals should be kept by the investigator in the investigator's regulatory document binder):

- Signed copy of the approved protocol.
- Investigator's Brochure acknowledgement page.
- Completed and signed statement of investigator (Form FDA 1572 and/or Clinical Trial Site Information Form – as applicable).
- Curriculum vitae and current medical license of the investigator and subinvestigators.
- Financial disclosure information as required.
- Letter of approval from the IRB for the protocol, consent form, and assent form.
- Copy of the IRB approved written ICF and assent to be used.
- Laboratory documents (certifications/accreditations, normal ranges) if not provided by a central laboratory.

14.5. Informed Consent

All parents or legal guardians will provide informed consent with signed and witnessed pediatric assent before the performance of any study-related procedures for subjects ≤17 years of age. Subjects 18 years of age will provide their written informed consent before the performance of any study-related procedures.

Each subject's chart will include the signed ICF with signed and witnessed pediatric assent for study participation. When the study treatment is completed and the eCRF has been monitored, the ICF and signed and witnessed pediatric assent will be kept in the investigator's central study file. Regulatory authorities may check the existence of the signed ICF and the signed and witnessed pediatric assent in this central study folder.

14.6. Study Monitoring

Throughout the course of the study, the study monitor will make frequent contacts with the investigator. This will include emails, telephone calls, and on-site visits. During the on-site visits, the eCRFs will be reviewed for completeness and adherence to the protocol. As part of the data audit, source documents will be made available for review by the study monitor. The study monitor will also perform drug accountability checks and may periodically request review of the investigator study file to ensure completeness of documentation in all respects of clinical study conduct.

Upon completion of the study, the study monitor will arrange for a final review of the study files after which the files should be secured for the appropriate time period. The investigator or appointed delegate will receive the study monitor during these on-site visits, will cooperate in

providing the documents for inspection, and respond to inquiries. In addition, the investigator will permit inspection of the study files by authorized representatives of the regulatory agencies.

14.7. Quality Assurance

The study will be conducted in accordance with NBI's standard operating procedures designed to ensure that all procedures are in compliance with GCP and FDA Guidelines, Health Canada Guidelines, and according to national law. Quality assurance audits may be performed at the discretion of NBI.

14.8. Record Retention

Federal regulations require that records of drug disposition, eCRFs, and all reports of this investigation shall be retained by the investigator for a minimum of 2 years after notification by NBI that the regulatory authorities have been notified of the study's termination, or 2 years after approval of the marketing application. If the investigator is unable to retain the study documents for the required amount of time, NBI must be informed of the individual who will be assuming this responsibility.

14.9. Confidentiality

NBI and the clinical site affirm and uphold the principle of the subject's right to protection against invasion of privacy. Throughout this study, all data will be identified only by an identification number and, where applicable, subject's initials and birth date.

All information concerning this study and which was not previously published is considered confidential information. This confidential information shall remain the sole property of NBI; it shall not be disclosed to others without written consent of NBI; and shall not be used except in the performance of this study.

The information compiled during the conduct of this clinical study is also considered confidential and may be disclosed and/or used only by NBI as deemed necessary. To allow the use of the information derived from this clinical study and to ensure compliance with current federal regulations, the investigator is obliged to furnish NBI with the complete test results and all data compiled in this study.

15. STUDY COMMENCEMENT AND DISCONTINUATION

Upon satisfactory receipt of all required regulatory documents, NBI (or designee) will arrange that all study material be delivered to the study site. Subject entry should not begin until after the required regulatory documents are confirmed as received and the Investigator Meeting/Initiation Meeting has occurred. All personnel expected to be involved in the conduct of the study will undergo orientation to include review of study protocol, instructions for eCRF completion, AE reporting, and overall responsibilities including those for drug accountability and study file maintenance.

If the study is discontinued, all subjects should undergo a complete follow-up examination. Any clinically relevant finding, including laboratory values of potential clinical concern, and adverse experiences will be followed until they resolve or return to a clinically acceptable level.

16. REFERENCES

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. 1994.

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. 2013.

Baxter LR, Guze BH. Neuroimaging. In: Kurlan, R. (Ed), Handbook of Tourette syndrome and related tic and behavioral disorders. Rochester: Marcel Decker Inc.; 1993.

Braun AR, Stoetter B, Randolph C, Hsiao JK, Vladar K, Gernert J, et al. The functional neuroanatomy of Tourette's syndrome: an FDG-PET study. I. Regional changes in cerebral glucose metabolism differentiating patients and controls. Neuropsychopharmacology. 1993 Dec;9(4):277-91.

Cavanna AE, Nani A. Tourette syndrome and consciousness of action. Tremor Other Hyperkinet Mov (NY). 2013 Sep 23;3.

Cavanna AE, Luoni C, Selvini C, Blangiardo R, Eddy CM, Silvestri PR, et al. The Gilles de la Tourette Syndrome-Quality of Life Scale for children and adolescents (C&A-GTS-QOL): development and validation of the Italian version. Behav Neurol. 2013;27(1):95-103.

Chen JJ, Ondo WG, Dashtipour K, Swope DM. Tetrabenazine for the treatment of hyperkinetic movement disorders: a review of the literature. Clin Ther. 2012 Jul;34(7):1487-504.

Chouinard S, Ford B. Adult onset tic disorders. J Neurol Neurosurg Psychiatry. 2000 Jun;68(6):738-43.

Chouinard G, Margolese HC. Manual for the Extrapyramidal Symptom Rating Scale (ESRS). Schizophr Res. 2005 Jul 15;76(2-3):247-65.

Felling RJ, Singer HS. Neurobiology of tourette syndrome: current status and need for further investigation. J Neurosci. 2011 Aug 31;31(35):12387-95.

Jankovic J, Kurlan R. Tourette syndrome: evolving concepts. Mov Disord. 2011 May;26(6):1149-56.

Kurlan R. Clinical practice. Tourette's Syndrome. N Engl J Med. 2010 Dec 9;363(24):2332-8.

Leckman JF, Riddle MA, Hardin MT, Ort SI, Swartz KL, Stevenson J, et al. The Yale Global Tic Severity Scale: initial testing of a clinician-rated scale of tic severity. J Am Acad Child Adolesc Psychiatry. 1989 Jul;28(4):566-73.

Leckman JF, Zhang H, Vitale A, Lahnin F, Lynch K, Bondi C, et al. Course of tic severity in Tourette syndrome: the first two decades. Pediatrics. 1998 Jul;102(1 Pt 1):14-9.

Pourfar M, Feigin A, Tang CC, Carbon-Correll M, Bussa M, Budman C, et al. Abnormal metabolic brain networks in Tourette syndrome. Neurology. 2011 Mar 15;76(11):944-52.

Robertson MM. Gilles de la Tourette syndrome: the complexities of phenotype and treatment. Br J Hosp Med (Lond). 2011 Feb;72(2):100–7.

Roessner V, Schoenefeld K, Buse J, Bender S, Ehrlich S, Münchau A. Pharmacological treatment of tic disorders and Tourette Syndrome. Neuropharmacology. 2013 May;68:143-9.

Shprecher D, Kurlan R. The management of tics. Mov Disord. 2009 Jan 15;24(1):15-24.

Su MT, McFarlane F, Cavanna AE, Termine C, Murray I, Heidemeyer L, et al. The English version of the Gilles de la Tourette Syndrome-Quality of Life Scale for Children and Adolescents (C&A-GTS-QOL). J Child Neurol. 2017 Jan;32(1):76-83.

Swain JE, Scahill L, Lombroso PJ, King RA, Leckman JF. Tourette syndrome and tic disorders: a decade of progress. J Am Acad Child Adolesc Psychiatry. 2007 Aug;46(8):947–68.

Woods DW, Piacentini J, Himle MB, Chang S. Premonitory Urge for Tics Scale (PUTS): initial psychometric results and examination of the premonitory urge phenomenon in youths with Tic disorders. J Dev Behav Pediatr. 2005 Dec;26(6):397-403.

17. APPENDICES

17.1. Yale Global Tic Severity Scale (YGTSS)