A Phase 2b, Randomized, Double-Blind, Placebo-Controlled Multi-Center Study Evaluating Antiviral Effects, Pharmacokinetics, Safety, and Tolerability of GS-5806 in Hematopoietic Cell Transplant (HCT) Recipients with Respiratory Syncytial Virus (RSV) Infection of the Lower Respiratory Tract

Gilead Sciences, Inc.
199 E Blaine St.
Seattle, WA 98102

IND Number: 114498
EudraCT Number: TBD
Clinical Trials.gov Identifier: TBD

Indication: Respiratory Syncytial Virus (RSV)

Clinical Program Manager:
Name: [PPD]
Telephone: [PPD]
Fax: [PPD]

Gilead Medical Monitor:
Name: Seth Toback, MD
Telephone: [PPD]
Fax: [PPD]
Mobile: [PPD]

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PROTOCOL SYNOPSIS
Gilead Sciences, Inc.
199 E Blaine St.
Seattle, WA 98102

Study Title: A Phase 2b, Randomized, Double-Blind, Placebo-Controlled Multi-Center Study Evaluating Antiviral Effects, Pharmacokinetics, Safety, and Tolerability of GS-5806 in Hematopoietic Cell Transplant (HCT) Recipients with Respiratory Syncytial Virus (RSV) Infection of the Lower Respiratory Tract

IND Number: 114498
EudraCT Number: TBD
Clinical Trials.gov Identifier: TBD

Study Centers Planned: Approximately 30 centers in Asia Pacific, Australia, Canada, Europe, South America, and the United States

Objectives: The primary objective of this study is as follows:
- To evaluate the effect of GS-5806 on RSV viral load in autologous or allogeneic HCT recipients with an acute RSV lower respiratory tract infection (LRTI)

The secondary objectives of this study are as follows:
- To evaluate the effect of GS-5806 on rates of respiratory failure and all-cause mortality
- To evaluate the pharmacokinetics (PK), safety, and tolerability of GS-5806

Study Design: Randomized, double-blind, placebo-controlled study evaluating the effect of GS-5806 on efficacy, PK, safety, and tolerability in HCT recipients with RSV LRTI.

All subjects will be permitted to receive the standard of care therapy for RSV infection per their local medical practices, in addition to the investigational medicinal product (IMP).
Subjects will be randomized in a 1:1 ratio to receive IMP (GS-5806 or placebo) and will be stratified by 2 criteria:

1) Supplemental \( \text{O}_2 \) requirement (\( \leq 2 \text{ L/min} \) or \( > 2 \text{ L/min} \)) at the time of randomization

2) Treatment of current RSV infection (yes or no) with ribavirin (oral, intravenous, or aerosolized)

Number of Subjects Planned: Approximately 60 RSV-positive subjects

Target Population: Males and females 18 to 75 years of age who have had an allogeneic or autologous HCT and have documented RSV LRTI

Duration of Treatment: 5 doses over 17 days

Diagnosis and Eligibility Criteria: For a complete list of study inclusion and exclusion criteria, please refer to Section 4.2.

**Inclusion Criteria**

Subjects must meet *all* of the following inclusion criteria at the time of randomization to be eligible for participation in this study:

1. Received an autologous or allogeneic HCT using any conditioning regimen

2. Evidence of new abnormalities on chest X-ray obtained within 2 days prior to Screening, determined to be consistent with LRTI by the local radiologist, relative to the most recent previous chest X-ray. If chest X-ray is not available, a chest X-ray must be obtained for Screening

3. Documented RSV in both the upper (eg, nasal swab, nasopharyngeal swab, nasal wash) and lower (eg, induced sputum, bronchoalveolar lavage [BAL], lung biopsy) respiratory tract as determined by local testing (eg, polymerase chain reaction [PCR], direct fluorescence antibody [DFA], viral respiratory panel [VRP] assay, or culture). All samples must have been collected \( \leq 6 \text{ days} \) prior to Day 1

4. An informed consent document signed and dated by the subject or a legal guardian of the subject and investigator or his/her designee
5. A negative urine pregnancy test is required for female subjects (unless surgically sterile or greater than two years post-menopausal)

6. Male and female subjects of childbearing potential who engage in heterosexual intercourse must agree to use protocol specified method(s) of contraception as described in Appendix 5

7. Lactating females must agree to discontinue nursing before the IMP is administered

8. Willingness to complete necessary study procedures and have available a working telephone or email

**Exclusion Criteria**

Subjects who meet *any* of the following exclusion criteria are not to be enrolled in this study.

**Related to concomitant or previous medication use:**

1. Use of non-marketed (according to region) investigational agents within 30 days, OR use of any monoclonal anti-RSV antibodies within 4 months or 5 half-lives of screening, whichever is longer, OR use of any investigational RSV vaccines after HCT

2. Use of a strong cytochrome P450 enzyme (CYP) inducer including but not limited to rifampin, St. John’s Wort, carbamazepine, and phenytoin, within 1 week prior to the first dose of IMP

**Related to medical history:**

3. Evidence of any clinically significant ECG abnormalities on record, as determined by the investigator

4. Pregnant, breastfeeding, or lactating females

5. Unable to tolerate nasal sampling required for this study, as determined by the investigator

6. Known history of HIV/AIDS, hepatitis B or C

7. History of drug and/or alcohol abuse that, in the opinion of the investigator, may prevent adherence to study activities

**Related to medical conditions:**

8. Requiring invasive mechanical ventilation at the time of randomization

9. A relapse (including molecular relapse) of their underlying disease for which they received a transplant at Screening
10. Documented to be positive for other respiratory viruses (limited to influenza, parainfluenza, human rhinovirus, adenovirus, or human metapneumovirus), from the lower respiratory tract sample as determined by local testing

11. Clinically significant bacteremia or fungemia within 7 days prior to Screening that has not been adequately treated, as determined by the investigator

12. Clinically significant bacterial, fungal, or viral pneumonia within 2 weeks prior to Screening that has not been adequately treated, as determined by the investigator

13. Excessive nausea/vomiting at screening, as determined by the investigator, or an inability to swallow pills, that precludes administration of an oral route IMP

Related to allergies:

14. Known hypersensitivity or allergy to the IMP, its metabolites, or formulation excipients (microcrystalline cellulose, mannitol, croscarmellose sodium, magnesium stearate, polyvinyl alcohol, titanium dioxide, polyethylene glycol and talc)

15. Allergy to sulfa drugs

Related to laboratory results:

16. Creatinine clearance < 30 mL/min (calculated using the Cockcroft-Gault method)

17. AST/ALT > 3x ULN

18. Total bilirubin > 3x ULN

Study Procedures/Frequency:

For a complete overview of study procedures and visits, please refer to Section 6 and Appendix 2.

Study Procedures

Vital signs (VS): Vital signs will be measured at Visits 1, 2, 4, 6, 7, 8, 9, and 10 (Days -2 to -1, 1, 5, 9, 13, 17, 22, and 28), and will include body temperature, heart rate, respiratory rate, and blood pressure.

O₂ saturation: O₂ saturation will be recorded at Visits 1, 2, 4, 6, 7, 8, 9, and 10 (Days -2 to -1, 1, 5, 9, 13, 17, 22, and 28), while breathing room air, even if the subject is dependent on supplemental O₂. Refer to section 6.10.4 for procedure instructions.
**Laboratory tests:** When available, existing laboratory values ≤ 6 days prior to Screening (Visit 1) may be used for eligibility assessment. Study staff will perform urine pregnancy tests on site at Screening (as necessary). Blood specimens for safety at Visits 2, 4, 6, 7, 8, 9, and 10 (Days 1, 5, 9, 13, 17, 22, and 28), RSV viremia evaluation (using quantitative real time polymerase chain reaction [RT-qPCR]) at Visits 2, 4, 6, 7, 8, 9, and 10 (Days 1, 5, 9, 13, 17, 22, and 28), and serum antibody titers to RSV at Visits 2 and 10 (Days 1 and 28) will be collected prior to dosing. A blood specimen for serum creatinine will be collected 4 hours post-dose at Visit 2 (Day 1). For hospitalized subjects only, additional blood specimens for serum creatinine will be collected on Days 2, 3, and 4 (24, 48, and 72 hours [±±3 hours] post-first GS-5806 dose).

**PK blood draws:** PK samples will be collected from all subjects at the following time points: 4 hours post-dose at Visit 2 (Day 1), pre-dose at Visits 4, 6, 7 and 8 (Days 5, 9, 13, and 17), and anytime at Visit 9 (Day 22). For hospitalized subjects only, an additional PK sample will be collected from hospitalized subjects at Visit 3 (Day 3, 48 hours [±±3 hours] post-first GS-5806 dose).

**Nasal sampling:** Nasal sampling will be performed at all study visits (both scheduled and unscheduled) with the exception of the Screening visit (Visit 1), and stored and shipped to a central laboratory for testing according to specifications in the study procedures manual. All samples must be collected prior to dosing. Two nasal samples will be obtained, one from each nostril, each time nasal sampling is performed. One of the nasal samples will be used for RSV sequencing to evaluate development of resistance and a multiplex assay to identify viral co-infections.

**Induced sputum:** If an induced sputum was not used to demonstrate RSV in the lower respiratory tract at Screening (ie, another lower respiratory tract sample such as BAL was used), an induced sputum will be obtained on Day 1 prior to dosing. This sample will be analyzed at a central laboratory using RT-qPCR to determine RSV viral load and a multiplex assay to identify any viral co-infections.

**RSV testing:** RSV present in both the upper and lower respiratory tract samples as determined by local testing (eg, PCR, DFA, VRP assay, or culture) must be documented prior to Screening. All RSV samples (from upper and lower respiratory tract) used for Screening must have been collected ≤ 6 days prior to Day 1. For all study related nasal samples, one of the nasal samples collected at each study visit will be analyzed at a central laboratory using RT-qPCR to determine RSV viral load.
Study Visits

Visit 1: Screening (Day -2 to -1)
This visit must be performed in the hospital or clinic. The following Screening procedures/labs are required:

- Obtain written informed consent
- Collection of medical history and demographics
- Review of concomitant medications
- VS, including O\textsubscript{2} saturation
- Height and weight
- Chest X-ray (chest X-rays obtained < 2 days prior to Screening may be used)
- Blood draw for Screening labs for local laboratory analyses, unless existing laboratory values collected ≤ 6 days prior to Screening can be obtained for review
- Urine pregnancy test in women unable to confirm menopause, hysterectomy, and/or bilateral oophorectomy
- Review of any adverse events (AEs) occurring after signing of the consent form

Visit 2: Baseline Assessments, Randomization, and IMP Administration (Day 1)
If the subject meets all eligibility criteria, Visits 1 and 2 may occur on the same day. The IMP must be administered under supervision by the study staff. Visit 2 must occur in the hospital or clinic. Visit 2 assessments should be performed in the following order:

- VS, including O\textsubscript{2} saturation
- Weight
- Blood draw (for safety labs, serum antibody titer to RSV, and RSV viremia)
- Obtain 2 nasal samples
- Obtain induced sputum (unless induced sputum was used to demonstrate the presence of RSV ≤ 6 days prior to Day 1).
- Randomization via IXRS
- IMP administration
- Blood draw at 4 hours post-dose for PK and serum creatinine
• Assessment of AEs and concomitant medications
• For hospitalized subjects only: blood draw at 24 (Day 2) and 72 (Day 4) hours (±3 hours) post-first GS-5806 dose for serum creatinine

**Visit 3: Day 3 (+/- 24 hours)**
This visit may be performed in the hospital, clinic, or at home.
• For all subjects: obtain 2 nasal samples
• For hospitalized subjects only: blood draw at 48 hours (±3 hours) post-first GS-5806 dose for PK and serum creatinine

**Visit 4: Day 5 (+/- 24 hours)**
This visit must be performed in the hospital or clinic, and should be performed in the following order:
• VS, including O₂ saturation
• Weight
• PK blood draw: pre-dose
• Blood draw (for safety labs and RSV viremia)
• Obtain 2 nasal samples
• IMP administration
• Assessment of AEs, concomitant medications, re-hospitalizations, admission to intensive care unit (ICU) or utilization of ICU care, mechanical ventilation (invasive and non-invasive of any duration), and supplemental O₂ use (≥ 2 L/min)

**Visit 5: Day 7 (+/- 24 hours)**
This visit may be performed in the hospital, clinic, or at home.
• Obtain 2 nasal samples

**Visits 6 – 8: Days 9, 13, and 17 (+/- 24 hours)**
These visits must be performed in the hospital or clinic. Visits 6-8 assessments should be performed in the following order:
• VS, including O₂ saturation
• Weight
• PK blood draw: pre-dose
• Blood draw (for safety labs and RSV viremia)
• Obtain 2 nasal samples
• IMP administration
• Assessment of AEs, concomitant medications, re-hospitalizations, admission to ICU or utilization of ICU care, mechanical ventilation (invasive and non-invasive of any duration), and supplemental O₂ use (≥ 2 L/min)

**Visit 9 and 10: Day 22 (+/- 24 hours) and End of Study/Day 28 (+ 3 days)**

These visits must be performed in the hospital or clinic. Visit 10 may occur no earlier than Day 28 and no later than Day 31. Visit 9 and 10 assessments should be performed in the following order:

• VS, including O₂ saturation
• Weight
• PK blood draw (Day 22 only)
• Blood draw for safety labs, for serum antibody titer to RSV (Day 28 only), and for RSV viremia
• Obtain 2 nasal samples

Assessment of AEs and concomitant medications, re-hospitalizations, admission to ICU or utilization of ICU care, mechanical ventilation (invasive and non-invasive of any duration), and supplemental O₂ use (≥ 2 L/min)

<table>
<thead>
<tr>
<th>Test Product, Dose, and Mode of Administration:</th>
<th>200 mg GS-5806 (four 50 mg tablets) administered orally on Study Days 1, 5, 9, 13, and 17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The IMP must be administered after the subject has been fasting (with exception of clear liquids and medications) for at least 2 hours. The subject will remain in a fasting condition for approximately 1 hour after dosing. The entire dose must be taken within 1 hour. Tablets are not to be crushed, split, dissolved, or chewed. The subject should be observed for 30 minutes after IMP administration. If vomiting occurs within the 30 minutes observation period and undissolved tablets are present in the vomitus, the subject may receive a second dose. If a second dose is given, the subject should be observed for an additional 30 minutes.</td>
</tr>
</tbody>
</table>

| Reference Therapy, Dose, and Mode of Administration: | Placebo to Match tablets administered orally. Administration is the same as for GS-5806. |
Criteria for Evaluation:

Safety: Safety will be assessed by the reporting of AEs and serious adverse events (SAEs) throughout the study, clinical laboratory tests, and VS at various time points during the study.

Efficacy: The primary endpoint is the daily average change in nasal RSV viral load ($\log_{10}$ copies/mL) from Baseline (Day 1) to Day 9 as measured by RT-qPCR.

The key secondary endpoints are:

- Proportion of subjects developing respiratory failure (of any cause) requiring mechanical ventilation (invasive or noninvasive) through Day 28
- Proportion of all-cause mortality among subjects through Day 28

The exploratory endpoints are:

- RSV $\log_{10}$ viral load and change from baseline in RSV $\log_{10}$ viral load in the nasal samples
- Daily average RSV $\log_{10}$ viral load and daily average change from baseline in RSV $\log_{10}$ viral load in the nasal samples
- Proportion of subjects with detectable RSV in the nasal samples
- Proportion of subjects requiring supplemental $O_2$ ($\geq 2$ L/min)
- RSV $\log_{10}$ viral load and change from baseline in RSV $\log_{10}$ viral load in the blood
- Daily average RSV $\log_{10}$ viral load and daily average change from baseline in RSV $\log_{10}$ viral load in the blood
- Proportion of subjects who have detectable RSV in the blood
- Proportion of subjects whose $O_2$ saturation drops below 88% by Day 28
- $O_2$ saturation and change from baseline in $O_2$ saturation
- Daily average $O_2$ saturation and daily average change from baseline in $O_2$ saturation
- Proportion of subjects requiring ICU admission or equivalent of ICU care (due to any cause) through Day 28
- Total number of ICU admissions or equivalent of ICU care hours (for subjects receiving ICU care) through Day 28
- Total number of mechanical ventilation (invasive or non-invasive) hours through Day 28
- Duration of hospitalization through Day 28

**Statistical Methods:**

The full analysis set (FAS) will include subjects who have an RSV log_{10} viral load greater than or equal to the LLOQ of the RT-qPCR assay in the pre-dose Day 1 nasal sample, as determined by RT-qPCR at the central lab, and have received at least 1 full dose of IMP.

The primary efficacy analysis of daily average change in RSV log_{10} viral load from Day 1 through Day 9 will be performed on subjects included in the FAS. To test the null hypothesis that there is no difference between the GS-5806 and placebo treatment groups in the daily average change in RSV viral load, a parametric analysis of covariance (ANCOVA) model with corresponding Baseline RSV viral load as a covariate will be used, with a 2-sided 0.05 level. Adjusted means and 95% confidence intervals (CIs) will also be presented.

The FAS analysis set will be used for all summaries and analyses of secondary endpoints. All secondary and other endpoints will be analyzed using 2-sided tests for treatment differences. The proportion of subjects who develop respiratory failure requiring mechanical ventilation and the proportion of subjects with all-cause mortality will be analyzed using Fisher’s exact tests.

Analyses of exploratory endpoints are discussed in Section 8.5.3.

All endpoints will be summarized using descriptive statistics (sample size, mean, standard deviation [SD], median, Q1, Q3, minimum, and maximum) for continuous data and by the number and percent of subjects for categorical data.

Safety analyses will be performed on all subjects who received at least one dose of IMP. Safety data will be collected and summarized from screening through Day 28. Safety data will be listed by subject and summarized by treatment (active or placebo) using the number (percent) of subjects with events/abnormalities for categorical data and using descriptive statistics for continuous data.

Concentrations of GS-5806 in plasma will be determined using a validated bioanalytical assay(s). Individual subject GS-5806 concentration-time data will be displayed using scheduled sampling times. Descriptive statistics (eg, n, mean, standard deviation, %CV, median, and range) will be calculated for each sampling time. Pharmacokinetic/pharmacodynamic (PK/PD) relationship may be explored as appropriate.
Sample size calculations are based on results observed in a study that evaluated the efficacy of oral and aerosolized ribavirin treatment for preventing progression from upper to lower respiratory tract infection in hematopoietic cell transplant recipients with RSV infections (unpublished data from Dr. [PPD]). The sample size calculation assumes the daily average change in RSV log_{10} viral load from Day 1 to Day 9 in the placebo group will be -1.5 log_{10} copies/mL with a corresponding standard deviation (SD) of 1.75 and that 85% of the subjects will be evaluable. Based on these assumptions, with 25 subjects per group there is approximately 85% power to detect a 1.5 log difference in daily average change in log_{10} viral load treatment groups using a 2-sided 0.05-level test. Given an evaluable rate of 85%, a total of 60 subjects will need to be randomized into the study.

All safety and efficacy data will be monitored by a Data Monitoring Committee (DMC).

This study will be conducted in accordance with the guidelines of Good Clinical Practice (GCP) including archiving of essential documents.
### Glossary of Abbreviations and Definition of Terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>°C</td>
<td>degrees Celsius</td>
</tr>
<tr>
<td>°F</td>
<td>degrees Fahrenheit</td>
</tr>
<tr>
<td>AE</td>
<td>adverse event</td>
</tr>
<tr>
<td>AhR</td>
<td>aryl hydrocarbon</td>
</tr>
<tr>
<td>AIDS</td>
<td>auto-immune deficiency syndrome</td>
</tr>
<tr>
<td>ALT</td>
<td>alanine aminotransferase</td>
</tr>
<tr>
<td>ANC</td>
<td>absolute neutrophil count</td>
</tr>
<tr>
<td>ANCOVA</td>
<td>analysis of covariance</td>
</tr>
<tr>
<td>ANOVA</td>
<td>analysis of variance</td>
</tr>
<tr>
<td>AST</td>
<td>aspartate aminotransferase</td>
</tr>
<tr>
<td>AUC</td>
<td>area under the plasma/serum/peripheral blood mononuclear cell concentration versus time curve</td>
</tr>
<tr>
<td>BAL</td>
<td>bronchoalveolar lavage</td>
</tr>
<tr>
<td>BCRP</td>
<td>breast cancer resistance protein</td>
</tr>
<tr>
<td>BID</td>
<td>twice a day</td>
</tr>
<tr>
<td>BMI</td>
<td>body mass index</td>
</tr>
<tr>
<td>BUN</td>
<td>blood urea nitrogen</td>
</tr>
<tr>
<td>CBC</td>
<td>complete blood count</td>
</tr>
<tr>
<td>CCM</td>
<td>cell culture medium</td>
</tr>
<tr>
<td>CI</td>
<td>confidence interval</td>
</tr>
<tr>
<td>C&lt;sub&gt;max&lt;/sub&gt;</td>
<td>the maximum observed serum/plasma/peripheral blood mononuclear (PBMC) concentration of drug</td>
</tr>
<tr>
<td>CRF</td>
<td>case report form(s)</td>
</tr>
<tr>
<td>CRO</td>
<td>contract (or clinical) research organization</td>
</tr>
<tr>
<td>CSR</td>
<td>clinical study report</td>
</tr>
<tr>
<td>CT</td>
<td>computerized tomography</td>
</tr>
<tr>
<td>CYPxx</td>
<td>cytochrome P450 enzyme xx</td>
</tr>
<tr>
<td>DDI</td>
<td>drug-drug interactions</td>
</tr>
<tr>
<td>DFA</td>
<td>direct fluorescence antibody</td>
</tr>
<tr>
<td>DMC</td>
<td>Data Monitoring Committee</td>
</tr>
<tr>
<td>DSPH</td>
<td>Drug Safety and Public Health</td>
</tr>
<tr>
<td>EC</td>
<td>ethics committee</td>
</tr>
<tr>
<td>EC&lt;sub&gt;50&lt;/sub&gt;</td>
<td>concentration of drug to reach 50% inhibition of virus replication</td>
</tr>
<tr>
<td>ECG</td>
<td>electrocardiogram</td>
</tr>
<tr>
<td>eCRF</td>
<td>electronic case report form(s)</td>
</tr>
<tr>
<td>EDC</td>
<td>electronic data capture</td>
</tr>
<tr>
<td>ELF</td>
<td>epithelial lining fluid</td>
</tr>
<tr>
<td>EMR</td>
<td>electronic medical records</td>
</tr>
<tr>
<td>EudraCT</td>
<td>European clinical trials database</td>
</tr>
</tbody>
</table>
GLOSSARY OF ABBREVIATIONS AND DEFINITION OF TERMS (CONTINUED)

FAS full analysis set
FIH First in human
FDA (United States) Food and Drug Administration
GCP Good Clinical Practice (Guidelines)
GD gestational day
GI gastrointestinal
GLP good laboratory practice
GSi Gilead Sciences, Inc.
hr hour
HCT Hematopoietic Cell Transplant
HDPE high-density polyethylene
hERG human ether-à-go-go-related gene
HIV human immunodeficiency virus
HLGT high level group term
HLT high level term
HSP hysterosalpingogram
IB investigator’s brochure
IC₅₀ concentration of drug to reach 50% inhibition
ICH International Conference on Harmonisation
ICU Intensive Care Unit
IEC independent ethics committee
IMP Investigational Medicinal Product
IND Investigational New Drug (Application)
IRB institutional review board
IUD intrauterine device
IVIG Intravenous Immunoglobulin
IXRS interactive voice/web response system
kg kilogram
LLN lower limit of the normal range
LLOQ lower limit of quantification
LLT lower level term
LRTI lower respiratory tract infection
MedDRA Medical Dictionary for Regulatory Activities
mg milligram
min minute
mL milliliter
mmHg millimeters mercury
MMRM mixed-effect model repeated measures
NA not applicable
ND not detectable
nM nanomolar
GLOSSARY OF ABBREVIATIONS AND DEFINITION OF TERMS (CONTINUED)

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOAEL</td>
<td>no-observed-adverse-effect level</td>
</tr>
<tr>
<td>NOEL</td>
<td>no-observed-effect level</td>
</tr>
<tr>
<td>O$_2$</td>
<td>oxygen</td>
</tr>
<tr>
<td>OATP</td>
<td>organic anion transporter proteins</td>
</tr>
<tr>
<td>PD</td>
<td>Pharmacodynamic</td>
</tr>
<tr>
<td>PFUe</td>
<td>plaque forming unit equivalents</td>
</tr>
<tr>
<td>Pgp</td>
<td>P glycoprotein</td>
</tr>
<tr>
<td>PK</td>
<td>pharmacokinetic</td>
</tr>
<tr>
<td>PO</td>
<td>oral administration (per os, by mouth)</td>
</tr>
<tr>
<td>PR</td>
<td>the interval between the beginning of the P wave and the beginning of the QRS complex on ECG</td>
</tr>
<tr>
<td>PT</td>
<td>preferred term</td>
</tr>
<tr>
<td>PXR</td>
<td>pregnane x receptor</td>
</tr>
<tr>
<td>Q1</td>
<td>first quartile</td>
</tr>
<tr>
<td>Q3</td>
<td>third quartile</td>
</tr>
<tr>
<td>QA</td>
<td>quality assurance</td>
</tr>
<tr>
<td>QRS</td>
<td>part of electrocardiographic wave representing ventricular depolarization</td>
</tr>
<tr>
<td>QT</td>
<td>interval between the start of the Q wave and the end of the T wave on ECG</td>
</tr>
<tr>
<td>QTc</td>
<td>corrected QT</td>
</tr>
<tr>
<td>QTcF</td>
<td>QT interval corrected for heart rate using the Fridericia formula</td>
</tr>
<tr>
<td>RNA</td>
<td>ribonucleic acid</td>
</tr>
<tr>
<td>ROW</td>
<td>rest of world</td>
</tr>
<tr>
<td>RSV</td>
<td>respiratory syncytial virus</td>
</tr>
<tr>
<td>RT-qPCR</td>
<td>quantitative real time polymerase chain reaction</td>
</tr>
<tr>
<td>SAE</td>
<td>serious adverse event</td>
</tr>
<tr>
<td>SAP</td>
<td>Statistical Analysis Plan</td>
</tr>
<tr>
<td>SD</td>
<td>standard deviation</td>
</tr>
<tr>
<td>SOC</td>
<td>system organ class</td>
</tr>
<tr>
<td>SOP</td>
<td>standard operating procedure</td>
</tr>
<tr>
<td>SpO$_2$</td>
<td>oxygen saturation</td>
</tr>
<tr>
<td>SUSAR</td>
<td>Suspected Unexpected Serious Adverse Reaction</td>
</tr>
<tr>
<td>TBD</td>
<td>to be determined</td>
</tr>
<tr>
<td>$t_{max}$</td>
<td>the time (observed time point) of $C_{max}$</td>
</tr>
<tr>
<td>$t_{1/2}$</td>
<td>an estimate of the terminal elimination half-life of the drug in serum/plasma/PBMC, calculated by dividing the natural log of 2 by the terminal elimination rate constant ($\lambda_z$)</td>
</tr>
<tr>
<td>µL</td>
<td>microliter</td>
</tr>
<tr>
<td>ULN</td>
<td>upper limit of the normal range</td>
</tr>
<tr>
<td>URTI</td>
<td>upper respiratory tract infection</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>VRP</td>
<td>viral respiratory panel</td>
</tr>
</tbody>
</table>
GLOSSARY OF ABBREVIATIONS AND DEFINITION OF TERMS (CONTINUED)

VS       vital signs
$V_{ss}$  apparent volume of distribution at steady state
$v/v$    volume/volume
WBC      white blood cell count
1. INTRODUCTION

1.1. Background

Respiratory syncytial virus (RSV), a member of the family Paramyxoviridae, is an enveloped virus with a negative single-strand ribonucleic acid (RNA) genome. The RSV genome encodes for 11 proteins, including 3 surface glycoproteins (F, G, and SH) and several proteins that comprise the viral RNA polymerase complex (N, P, L, and M2-1). Two major antigenic subgroups of RSV are known, RSV A and RSV B, that differ primarily in the genetic sequence of the G glycoprotein while maintaining a higher degree of homology across other parts of the genome. Both subgroups show comparable pathogenicity and can co-circulate in the same community during a seasonal epidemic, but their individual prevalence usually varies from season to season.

RSV infection is the most common cause of admissions to pediatric general inpatient units in the United States (US) and Western Europe. Unfortunately, the rate of hospitalization among RSV infected children has remained unchanged in the US over the last decade. From 1997 to 2006, RSV-coded hospitalizations accounted for 24% of an estimated 5.5 million lower respiratory tract infection (LRTI) hospitalizations among children < 5 years of age. During this period, it was estimated that approximately 172,000 hospitalizations each year were caused by RSV infection among children < 5 years of age; approximately 73% of these hospitalizations occur among children < 12 months of age.

RSV infection is also a cause of respiratory disease in the adult population. Adult recipients of autologous or allogeneic hematopoietic cell transplants (HCT) are at high risk for RSV infection related morbidity and mortality. Based upon retrospective epidemiologic data, 2-17% of HCT recipients will develop RSV infection of the respiratory tract. Progression from upper respiratory tract infection (URTI) to LRTI may occur in 17-84% of these RSV infected patients. Once RSV progresses from URTI to LRTI, the morbidity and mortality is high. Progression to LRTI often requires hospitalization and at times, intensive care unit admission for supportive care (eg oxygenation, mechanical ventilation, intravenous fluids, vasopressors). LRTI is associated with high mortality rates, ranging from 6.5-26.7%. A long term sequelae seen among survivors of RSV LRTI is airflow decline documented at 1 year after the initial infection.

Currently there are no effective vaccines or approved prophylactic treatment options for RSV infection in the HCT population. Once hospitalized, treatment for RSV infection in HCT patients is supportive, with intravenous hydration, supplemental oxygen, and mechanical ventilation. Although treatment options such as antiviral agents, corticosteroids, and immunoglobulin are frequently used, there is no definitive treatment for RSV infection in the HCT population. Synagis® (palivizumab), a monoclonal antibody against RSV approved for prophylaxis against RSV infection among high risk infants, has never been evaluated in a randomized controlled study for treatment of RSV infection in the HCT population. A recent
A retrospective analysis suggests that palivizumab is not effective for treatment of RSV LRTI in the HCT population 28654. Virazole® (ribavirin), an inhaled antiviral agent, is approved for treatment of RSV infection in the pediatric population but is not used in general pediatric practice because of concerns regarding its efficacy and tolerability, as well as the complexity of the specialized aerosol delivery system that is required 19902. A randomized study of inhaled ribavirin has been attempted in the HCT population; however, due to the aforementioned concerns, only 14 subjects were recruited over a 5-year period 28640. A recent review of published epidemiologic studies suggests that ribavirin-based therapy, oral or aerosolized, had variable success rates for preventing RSV-associated morbidity or mortality in high risk HCT patients 28655. A single center retrospective analysis also suggested that ribavirin treatment, when administered during the URTI phase, resulted in lower rates of progression to LRTI in treated versus untreated patients (16% versus 45%) and mortality (35% versus 70%) 26937. Taking into account the limited available efficacy data from controlled clinical trials, the current guidelines for diagnosis and treatment of RSV infection do not provide recommendations regarding whether patients should be treated with any treatments other than supportive care at the LRTI versus URTI phase 28723. Therefore, variability in standard practices for treatment of RSV infection in HCT patients exists around the world.

1.2. GS-5806

1.2.1. General Information

GS-5806 is an oral RSV fusion inhibitor with potent and selective anti-RSV activity in vitro. When tested in vitro against 75 diverse clinical isolates of RSV type A and B, the EC_{50} values (concentration of drug to reach 50% inhibition of virus replication) ranged from 0.15 to 1.09 nM, with a mean EC_{50} value of 0.43 ± 0.22 nM. In vivo efficacy data from cotton rats infected with human RSV demonstrated that administration of GS-5806 at 0.3 to 30 mg/kg resulted in a dose-dependent reduction in viral load in both the upper respiratory tract and lungs. The steady-state pharmacokinetic (PK) volume of distribution (V_{ss}) in all nonclinical species tested was 2- to 10-fold higher than the volume of total body water and the oral bioavailability was moderate to high. The exposure to GS-5806 in the lung and lung epithelial lining fluid (ELF) was also assessed in Sprague-Dawley rats and yielded lung tissue/plasma and ELF/plasma ratios of approximately 30 and 9, respectively. Concentrations in lung tissue and ELF declined approximately in parallel to those in plasma indicating rapid equilibration between the lung and plasma compartments. GS-5806 exhibited low cytotoxicity in cell culture and did not interact with pharmacologically relevant receptors that are predictive of off-target toxicity. Based on in vitro and nonclinical pharmacokinetic studies, GS-5806 did not demonstrate the potential for significant drug-drug interactions (DDI).

Additional details regarding nonclinical pharmacokinetics, pharmacology, and toxicology can be found in the current GS-5806 Investigator’s Brochure (IB).
1.2.2. Nonclinical Pharmacokinetics

Consistent with the high, concentration-independent forward permeability across Caco-2 monolayers and low, concentration-independent efflux, GS-5806 exhibited moderate to high bioavailability in nonclinical species. Systemic clearance of GS-5806 in nonclinical species is well predicted from the rates of metabolism by hepatic microsomal fractions and primary hepatocytes. Biliary excretion is likely to be the major route of elimination of GS-5806 and its metabolites as < 2% of radiolabeled GS-5806 dosed orally to rats was recovered in urine. The major routes of metabolism of GS-5806 are oxidative deamination and N-acetylation. In humans, the deamination pathway is likely catalyzed by multiple CYP enzymes such as CYP1A2, CYP2B6, and CYP2C19. GS-5806 shows weak inhibition of OATP1B1, OATP1B3, Pgp (IC50 values of 98, 100, and 92 μM, respectively). GS-5806 is a weak inhibitor of OCT1, OCT2, and BSEP with IC50 values of 40.2, 16.7, and 29.3 μM, respectively. No inhibition of OAT1 or OAT3 was observed for GS-5806 at concentrations up to 80 μM. Therefore, drug interactions of GS-5806 with substrates of these transporters are unlikely in the expected clinically relevant concentration range.

Additional details regarding nonclinical pharmacokinetics can be found in the GS-5806 IB.

1.2.3. Nonclinical Pharmacology and Toxicology

The IC50 for the inhibitory effect of GS-5806 on hERG potassium current was 7.8 μM. Cardiovascular effects of GS-5806 were evaluated in dogs at doses up to 75 mg/kg. The principal hemodynamic findings were lower heart rate values, and higher arterial pulse and systolic pressure values. All hemodynamic effects dissipated by 22 hours post-dose. All electrocardiograms (ECGs) were qualitatively within normal limits, and no GS-5806-related arrhythmias or abnormal waveforms were detected. Slight GS-5806-related higher PR and QTc interval values were expected physiological responses secondary to concomitant GS-5806-related lower heart rate values. These changes were not considered physiologically important in the context of this study.

In a repeat dose study, GS-5806 was administered by oral gavage for 4 weeks to young adult rats once daily at doses up to 100 mg/kg/day. Two animals administered 100 mg/kg/day were found dead during the dosing phase. Although the cause of death for these 2 animals was undetermined, an association with GS-5806 cannot be excluded. Based on the results of this study, the NOAEL for GS-5806 is 70 mg/kg/day, which corresponded to mean AUC0-t and Cmax values on Day 23 of the dosing phase of 96, 316 ng·h/mL, and 6028 ng/mL, respectively. In a repeat-dose study conducted in young adult dogs, GS-5806 was administered by oral gavage for 4 weeks at doses up to 20 mg/kg/day. The NOAEL for this study is 20 mg/kg/day, which corresponded to mean AUC0-t and Cmax values on Day 27 of the dosing phase of 129,831 ng·h/mL and 8081 ng/mL, respectively.

GS-5806 was negative in the rat micronucleus study and did not cause mutations in the Ames assay or induce chromosomal damage in vitro with or without S9 metabolic activation. Thus, the potential for genetic toxicity is considered low.
In an oral gavage dose range-finding developmental toxicity study in rats, females were administered GS-5806 at doses up to 100 mg/kg/day from gestational day (GD) 6 through GD 17 (12-day period), with scheduled necropsy occurring on GD 21. GS-5806 treatment resulted in significant reductions in maternal body weight, and the NOAEL for maternal toxicity was 30 mg/kg/day. There were no effects on embryo-fetal viability and growth and no fetal anomalies, and the NOEL for developmental toxicity was 100 mg/kg/day.

In an oral gavage dose range-finding developmental toxicity study in rabbits, females were administered GS-5806 at dose levels up to 50 mg/kg/day from GD 7 through GD 19 (13-day period), with scheduled necropsy occurring on GD 29. GS-5806 treatment resulted in lower maternal body weight at doses ≥ 30 mg/kg/day. The early termination (moribund sacrifice) of 1 female in the 50 mg/kg/day group on GD 20 was attributed to GS-5806 administration, due to significant reductions in body weight and food consumption, and the NOEL for maternal toxicity was 10 mg/kg/day. There were no effects on embryo-fetal viability and growth and no treatment-related fetal anomalies. The NOEL for developmental toxicity was 50 mg/kg/day.

In a dose range-finding study in juvenile rats, GS-5806 was administered at doses up to 100 mg/kg/day on postnatal day (PND) 7 through PND 14. Noteworthy effects were limited to decreased body weight gain at doses ≥ 70 mg/kg/day and a mild to moderate (1.5- to 2.5-fold), dose-dependent increase in total bilirubin at doses ≥ 30 mg/kg/day. The NOAEL was considered to be 30 mg/kg/day, corresponding to respective mean C\text{max} and AUC\text{0-t} values on PND 14 of 2415 ng/mL and 44,179 ng·h/mL. In a definitive juvenile rat study, GS-5806 was administered beginning on PND 4 through PND 21 at doses up to 100 mg/kg/day. An increase in mortality was seen at doses ≥70 mg/kg/day. Reflux-related inflammation and epithelial degeneration/erosion/ulcer in the upper respiratory tract occurred at doses ≥70 mg/kg/day, and the mortality was likely related to decreased milk intake secondary to the reflux-related inflammation in the upper respiratory tract. This is consistent with the observation that neither clinical pathology data nor anatomic pathology data indicated specific target organ toxicity as the cause of death for the pups that had treatment-related mortalities. Surviving pups had no indications of systemic toxicity. Based on the above results, the NOEL was considered to be 30 mg/kg/day, which corresponded to respective mean C\text{max} and AUC\text{0-t} on PND 21 of 1430 ng/mL and 19,300 ng·h/mL, respectively.

In a 4-week juvenile dog study, GS-5806 was orally administered once daily on PND 11 through PND 38 at doses up to 20 mg/kg/day, with only minimal, transient effects on neonatal/juvenile development and no adverse target organ toxicity. The NOAEL was 20 mg/kg/day, corresponding to PND 38 C\text{max} and AUC\text{0-t} values of 7180 ng/mL and 139,000 ng·h/mL, respectively.

Additional details regarding nonclinical pharmacology and toxicology can be found in the GS-5806 IB.
1.2.4. Clinical Trials of GS-5806

1.2.4.1. GS-US-218-0101

This Phase 1, placebo-controlled, single- and multiple-dose ranging, first-in-human (FIH) study was conducted to evaluate safety, tolerability, and PK following oral administration of GS-5806 to up to 70 unique subjects. The study included 3 stages (Parts A, B, and C) with 8 total staggered cohorts (7 pre-specified, 1 adaptive). Within each cohort of Parts A and B, 8 unique subjects were randomized to receive blinded investigational medicinal product (IMP), either GS-5806 (n = 6) or placebo (n = 2). Within each cohort of Part C, 10 unique subjects were randomized to receive blinded IMP, either GS-5806 (n = 8) or placebo (n = 2). A maximum single dose of 300mg and multiple dose regimen of 75mg once daily for 7 days was achieved. GS-5806 PK was evaluated under fasting and fed states.

No deaths or serious adverse events (SAEs) were reported, and there were no dose-limiting toxicities. In the GS-5806-treated subjects, there were no discontinuations due to AEs. Among the 23 subjects who received single doses of GS-5806, 5 subjects (21.7%) experienced a total of 11 AEs, with the most common AEs being presyncope and dermatitis (reported by 2 subjects each). Both incidents of presyncope, and 1 of the 2 events of dermatitis, were judged by the investigator to be related to study procedures; 1 event of dermatitis was inflammation of the skin of the right antecubital and 1 event was nonspecific dermatitis on the chest. Among the 52 subjects receiving multiple doses of GS-5806, 20 subjects (38.4%) experienced a total of 45 AEs, with diarrhea and nausea reported by 4 subjects and headache and contact dermatitis reported by 3 subjects. All other AEs experienced by subjects receiving multiple doses of GS-5806 were reported by ≤ 2 subjects each.

Twelve-lead ECGs were obtained at Baseline and Days 1, 15, and 21. Analysis of these ECGs demonstrated no clinically significant increase in the PR, QRS, QT, and QTcF intervals, and no clinically significant arrhythmias associated with administration of GS-5806.

GS-5806 exposures increased in an approximately dose-proportional manner over the dose range tested following single and multiple oral administrations under fasted conditions. GS-5806 terminal half-lives ranged from 30 to 33 hours following single oral administration and approximately 36 hours following multiple oral administrations. Overall, the variability of the PK parameters was relatively low, with the majority of the PK parameters displaying CV% of 30% or lower. In addition, the food effect on GS-5806 PK following single or multiple oral administration has been evaluated. Following single administration of GS-5806 at 25, 50, or 75 mg, Cmax under fed conditions decreased approximately 20% to 40% compared to fasted conditions, but this effect was less pronounced following once daily dosing at the higher dose (75 mg) around steady-state.

1.2.4.2. Study GS-US-218-0109

This Phase 1 mass-balance study was conducted to evaluate the PK, metabolism, and excretion of GS-5806. The primary objective of this study was to determine the mass balance of GS-5806 following administration of a single, oral dose of radiolabeled [14C]-GS-5806. The secondary
objectives of this study were to evaluate the PK of GS-5806 and metabolites, where possible and to determine the metabolite profile of GS-5806 in humans following administration of a single, oral dose of radiolabeled $^{14}$C-GS-5806.

Eight subjects were enrolled and assessed for a period of a minimum of 10 days and a maximum of 21 days with a 7-day follow-up period. Following a single oral radiolabeled dose of GS-5806 (50 mg), the maximum mean concentrations of drug-derived radioactivity in blood and plasma were observed at 2 hours post-dose for both matrices. The overall recovery of radioactivity was 89.9%, with recovery primarily in feces (72.3%) versus urine (17.6%). Mean blood to plasma concentration ratios ranged from 0.450 to 0.591 through 120 hours post-dose, indicating that radioactivity was primarily in the plasma, relative to the cellular components of the blood.

The circulating radioactivity consisted mainly of GS-5806 (88%) and low levels of minor metabolites 5-chloro-2-amino (N-methanesulfonyl) benzamide (M58; 7%), oxy-GS-5806-glucuronide (M47; 3%), and GS-557855 (M30B; 1%).

The major component excreted in feces was unchanged parent GS-5806 (18.5% of the dose; coeluted with dioxy-GS-5806-2 [M63]), along with other minor metabolites (dioxy-GS-5806-3 [M64; 5.42% of the dose] and dioxy-GS-557855-2 [M70; 3.51% of the dose]). The remaining identified 8 metabolites detected in feces each accounted for less than a mean of 2.5% of the dose. In urine, unchanged parent GS-5806 was the main species (~10.0% of the dose), and metabolite M47 represented ~3.59% of the dose.

In summary, $^{14}$C-GS-5806 was primarily eliminated in the feces after oral administration to healthy subjects. Low levels of various metabolites were observed indicating the likely absence of a single dominant pathway. Radioactivity was eliminated as a combination of metabolites and unchanged parent drug. Overall, the pharmacokinetics of GS-5806 is not expected to be meaningfully altered in the setting of renal impairment (eg, mild to moderate).

1.2.4.3. Study GS-US-218-0103

This Phase 2a, randomized, double-blind, placebo-controlled study was conducted to evaluate the safety, tolerability, and efficacy of GS-5806 in healthy adult volunteers infected with an RSV challenge virus (RSV-A Memphis 37b strain). The study included 7 quarantines, each comprising approximately 20 subjects. Each subject was admitted to the Quarantine Unit and inoculated with RSV on Study Day 0. Subjects were randomized and treated with GS-5806 or placebo when infection was documented in the nasal wash, or by the fifth day after inoculation, whichever occurred first.

For Quarantines 1 through 4 (pre-specified quarantines), subjects were randomized 1:1 to receive GS-5806 or placebo, administered as a 50 mg single dose on Dose Day 1, followed by 25 mg once daily on Dose Days 2 through 5.

For Quarantines 5 through 7 (adaptive quarantines), subjects were randomized 4:1 to receive GS-5806 or placebo. Subjects in Quarantine 5 were administered a 50 mg single dose on Dose Day 1, followed by 25 mg once daily on Dose Days 2 and 3. Subjects in Quarantine 6 were administered a 100 mg single dose. Subjects in Quarantine 7 were administered a 10 mg single dose on Dose Day 1, followed by 5 mg once daily on Dose Days 2 through 5.
A total of 140 subjects were randomized into this study. All subjects completed study drug and 1 placebo subject discontinued the study due to investigator’s discretion. Baseline demographics and characteristics were similar between treatment groups across all dose cohorts. Seventy-eight (78) subjects received the pre-specified dose in quarantines 1-4 (GS-5806 n=39, placebo n=39). Of these, 54 subjects (69%) were documented to be RSV positive prior to randomization and were included in the primary and secondary analyses (GS-5806 n=27, placebo n=27). A total of 87 subjects received GS-5806 across all quarantines.

Treatment with GS-5806 resulted in the following:

Primary Endpoint:

- Treatment with GS-5806 resulted in lower mean AUC viral load from initial dose through end of quarantine. Viral load was assessed twice daily using nasal washes. The mean AUC of viral load as measured by the RT-qPCR assay from first viral load measurement post initial dose of study drug through Day 12 was significantly lower in GS-5806 subjects compared to placebo subjects ($\Delta = 506.9 \log_{10} PFUe*\text{hour/mL}$, $p<0.001$).

Secondary Endpoints:

- Treatment with GS-5806 resulted in lower mean AUC viral load during the entire quarantine period. The mean AUC of viral load post challenge through Study Day 12 as measured by the RT-qPCR assay was significantly lower in GS-5806 subjects compared to placebo subjects ($\Delta = 531.0 \log_{10} PFUe*\text{hour/mL}$, $p<0.001$).

- Treatment with GS-5806 resulted in lower mean total mucus weight during dosing. The average weight of each unused tissue was determined prior to start of study. The daily mucus weight was calculated by first counting the number of tissues used each day, then subtracting the total weight of these tissues, unused, from the daily total weight of used tissues. The mean total weight of mucus produced post-initial dose of study drug through the dose was significantly lower in the GS-5806 subjects compared to placebo subjects ($\Delta = 8.2 \text{ g}$, $p=0.028$).

- Treatment with GS-5806 resulted in a lower mean AUC of change from Baseline in total symptom score during the entire quarantine period. Ten symptoms (runny nose, stuffy nose, sneezing, sore throat, earache, malaise [tiredness], cough, shortness of breath, headache, and muscle and/or joint ache) were each scored from 0 (no symptoms) to 3 (quite bothersome most/all of the time). Total symptom scores (0-30) were the average score of questions answered by each subject, multiplied by 10. The mean AUC of change from Baseline in total symptom score post initial dose of study drug through Study Day 12 was significantly lower in the GS-5806 subjects compared to placebo subjects ($\Delta = 225.1 \text{ score*hour}$, $p=0.005$). The total symptoms score AUC was also significantly lower for GS-5806 treated subjects.
In each of the adaptive quarantines statistically significant results were also achieved in the primary endpoint and each of the secondary endpoints described above with the exception of a reduction in mean total mucus weight in Quarantine 7. In addition, an exposure response effect was noted.

No subject experienced a serious AE. All AEs were mild or moderate (Grade 1 or 2) in severity, except for three Grade 3 AEs experienced by 1 placebo-treated subject (increased blood lactate dehydrogenase, alanine aminotransferase [ALT], and aspartate aminotransferase [AST]). Grade 1 pulmonary function decrease (<10% change) was the only treatment-related AE experienced by >2 subjects in either treatment group (GS-5806: 4.6%, n=4/87; placebo: 3.8%, n=2/53). Changes in clinical laboratory values were Grade 1 or 2 in severity, except for one Grade 4 value (increased AST; reported for placebo-treated subject described above). Elevated ALT was more commonly reported among GS-5806-treated subjects (GS-5806: 14.9%; placebo: 9.4%), but elevated AST was less commonly reported (GS-5806: 5.7%; placebo: 15.1%). Low neutrophil count was reported as Grade 1 in 11 subjects (2 received placebo) and Grade 2 in 2 subjects (1 received placebo). Among the 9 subjects who experienced a Grade 1 low neutrophil count and received GS-5806, 2 had a Grade 1 low neutrophil count at Screening. Clinically relevant changes in vital signs or ECGs were not observed.

1.3. **Rationale for This Study**

There is a significant unmet medical need for a safe, convenient, and effective treatment for RSV infection. The only approved antiviral therapy for RSV, ribavarin, is approved for use in pediatric populations only, but is rarely used in clinical practice due to its limited efficacy and concerning safety profile. There is no approved antiviral therapy for RSV infection among HCT recipients, where the current standard of care is supportive or off-label use of ribavirin.

This study follows a Phase 1 FIH study (GS-US-218-0101) and a Phase 2a RSV challenge study (GS-US-218-0103), which evaluated the safety, tolerability, and PK of single and multiple doses of GS-5806 in 140 healthy adult volunteers. In Study GS-US-218-0103, GS-5806 was shown to be efficacious in reducing RSV viral load and clinical symptoms in healthy adult subjects experimentally infected with RSV.

Given these results from healthy adult volunteers studied in a controlled setting, 2 studies are being conducted to evaluate the efficacy, safety, and tolerability of GS-5806 in the HCT population. Study GS-US-218-0108 is being conducted in HCT patients with an RSV-related URTI. This study, which will be run concurrently, will enroll HCT patients with an RSV-related LRTI. Safety and efficacy data generated from these studies, together with currently available data, will be used to support further clinical development of GS-5806 in pediatric and adult patients infected with RSV.
1.4. Dose Rationale

The dose and administration schedule selected for this study is a single dose of 200 mg GS-5806 administered orally in the fasted state on Days 1, 5, 9, 13, and 17. This regimen was selected based upon the PK characteristics of GS-5806 and the pharmacokinetic/pharmacodynamic (PK/PD) relationship established in the antiviral effect study with different doses/regimens in Study GS-US-218-0103.

In Study GS-US-218-0103, a 5-day treatment regimen of GS-5806 (50 mg single dose on Dose Day 1, followed by 25 mg once daily on Dose Days 2 through 5) resulted in a significant reduction in RSV viral load. The mean AUC of RSV viral load as measured by the RT-qPCR assay from first viral load measurement post initial dose of study drug through end of quarantine (Day 12) was significantly lower in GS-5806 subjects compared to placebo subjects (Δ= 506.9 log_{10} PFUe*hour/mL, p<0.001). This 5-day regimen was able to achieve GS-5806 trough concentrations ~4-5 fold of paEC_{95} (52 ng/mL) for up to 120 hours following dose initiation for the virus used in the challenge study, the M37 strain of RSV.

In selecting the dose for the current study, the goal was to achieve GS-5806 trough concentrations above 4-fold of paEC_{95} for most of the clinical RSV isolates for the duration of RSV shedding in HCT patients. Longitudinal viral dynamics data from investigators at an academic HCT center also indicate that the majority of HCT patients shed RSV for 15 days, but some may shed for as long as 21 days (unpublished). Therefore, a total of 5 doses of GS-5806 (200 mg each dose, every 4 days) is expected to provide > 4-fold paEC_{95} coverage for ~95% of 75 wild-type clinical RSV isolates through Day 22, which is expected to result in significant durable antiviral effect.

1.5. Compliance

This study will be conducted in compliance with this protocol, Good Clinical Practice (GCP), and all applicable regulatory requirements.
2. **OBJECTIVES**

The primary objective of this study is:

- To evaluate the effect of GS-5806 on RSV viral load in autologous or allogeneic HCT recipients with an acute RSV LRTI

The secondary objectives of this study are:

- To evaluate the effect of GS-5806 on rates of respiratory failure and all-cause mortality
- To evaluate the PK, safety, and tolerability of GS-5806
3. STUDY DESIGN

3.1. Endpoints

The primary endpoint of this study is:

- The daily average change in nasal RSV viral load \( \log_{10} \text{copies/mL} \) from Baseline (Day 1) to Day 9 as measured by RT-qPCR

The key secondary endpoints of this study are:

- Proportion of subjects developing respiratory failure (of any cause) requiring mechanical ventilation (invasive or noninvasive) through Day 28
- Proportion of all-cause mortality among subjects through Day 28

The exploratory endpoints are:

- \( \log_{10} \) viral load and change from baseline in RSV \( \log_{10} \) viral load in the nasal samples
- Daily average \( \log_{10} \) viral load and daily average change from baseline in RSV \( \log_{10} \) viral load in the nasal samples
- Proportion of subjects with detectable RSV in the nasal samples
- Proportion of subjects on supplemental \( \text{O}_2 \) (\( \geq 2 \text{L/min} \))
- \( \log_{10} \) viral load and change from baseline in RSV \( \log_{10} \) viral load in the blood
- Daily average \( \log_{10} \) viral load and daily average change from baseline in RSV \( \log_{10} \) viral load in the blood
- Proportion of subjects who have detectable RSV in the blood
- Proportion of subjects whose \( \text{O}_2 \) saturation drops below 88% by Day 28
- \( \text{O}_2 \) saturation and change from baseline in \( \text{O}_2 \) saturation
- Daily average \( \text{O}_2 \) saturation and daily average change from baseline in \( \text{O}_2 \) saturation
- Proportion of subjects requiring ICU admission or equivalent of ICU care (due to any cause) through Day 28
- Total number of ICU admissions or equivalent of ICU care hours (for subjects receiving ICU care) through Day 28
• Total number of mechanical ventilation (invasive or non-invasive) hours through Day 28
• Duration of hospitalization through Day 28

3.2. Study Design

This is a randomized, double-blind, placebo-controlled study evaluating the effect of GS-5806 on efficacy, PK, safety, and tolerability in HCT recipients with RSV LRTI. This study will enroll approximately 60 subjects from approximately 30 international HCT centers. RSV positive subjects with evidence of LRTI will be randomized 1:1 to receive GS-5806 or placebo given as 200mg every 4 days for a total of 5 doses. Subjects will be followed for a total of 28 days, during which a total of 10 Study visits will be performed to follow safety, tolerability, PK, and viral loads in nasal samples and the blood.

3.3. Study Treatments

Approximately 60 subjects will be randomized 1:1 to receive 200 mg (four 50 mg tablets) of IMP (GS-5806 or placebo) as a single dose on Days 1, 5, 9, 13, and 17. The IMP will be administered after the subject has fasted (with exception of clear liquids and medications) for at least 2 hours. The entire dose must be taken within 1 hour. Subjects will remain fasting for approximately 1 hour after dosing. Tablets are not to be crushed, split, dissolved, or chewed. IMP should be dispensed with gloves.

Subjects will remain in the clinic for 30 minutes post-dose for observation. If vomiting occurs within 30 minutes after IMP administration and undisolved tablets are present in the vomitus, the subject should receive another dose. If another dose is administered, the subject should remain in the clinic for an additional 30 minutes post-dose for observation.

GS-5806 will be provided as white, plain-faced, film-coated, round tablets containing 50 mg GS-5806 (61 mg GS-5806-02, bis-hydrochloride salt dihydrate form of GS-5806). Placebo to Match will be provided as white, plain-faced, film-coated, round tablets containing no GS-5806.

The expected duration of subject participation is approximately 1 month, to include Screening through the final visit on Day 28.
3.4. **Duration of Treatment**

The treatment portion of the study is 17 days (a total of 5 doses administered as single doses on Days 1, 5, 9, 13, and 17).

3.5. **Discontinuation Criteria**

Reasons for premature discontinuation from IMP dosing include:

- Intercurrent illness that would, in the judgment of the investigator, affect the subject’s ability to receive IMP (e.g., unable to ingest oral dose).

Reasons for premature discontinuation from the Study include:

- Subject request to discontinue for any reason
- Subject noncompliance
- Pregnancy during the study; refer to section 7.7.2
- Discontinuation of the study at the request of Gilead, a regulatory agency or an institutional review board or independent ethics committee (IRB/IEC)

If a subject prematurely discontinues from IMP dosing, he/she will remain on study and will continue with all subsequent Study Visits and assessments, with the exception of IMP dosing.

If a subject prematurely discontinues from the Study, every attempt should be made to bring the subject back for the Early Termination procedures. See Section 6.8 for more information.

3.6. **Source Data**

For the purposes of this study, study specific questionnaires (i.e., respiratory symptom assessments) are considered source documents and are to be filed with the subject’s medical or study records. Electronic data (i.e., diagnostic machines that transcribe data directly to a database, or data entered directly into an Electronic Medical Record system) is considered source data, provided the data is not recorded directly on the CRF/eCRF, and provided there is a clear audit trail in the electronic record(s). Template source document worksheets will be prepared by Gilead and provided to sites to use at their discretion. If source document worksheets are used, they are to be kept with the subject’s medical or study records as original source documents. No data will be recorded directly on the CRF/eCRF, and any data recorded directly on the CRF/eCRF will not be considered source data.
4. SUBJECT POPULATION

4.1. Number of Subjects and Subject Selection

The subject population will consist of approximately 60 RSV-positive males and females 18 to 75 years of age who have had an allogeneic or autologous HCT and have documented acute RSV related LRTI symptoms, recruited from approximately 30 centers in Asia Pacific, Australia, Canada, Europe, South America, and the United States.

4.2. Inclusion Criteria

Subjects must meet all of the following inclusion criteria to be eligible for participation in this study.

1. Received an autologous or allogeneic HCT using any conditioning regimen

2. Evidence of new abnormalities on chest X-ray obtained within 2 days prior to Screening, determined to be consistent with LRTI by the local radiologist, relative to the most recent previous chest X-ray. If chest X-ray is not available, a chest X-ray must be obtained for Screening.

3. Documented RSV in both the upper (eg, nasal swab, nasopharyngeal swab, nasal wash) and lower (eg, induced sputum, BAL, lung biopsy) respiratory tract as determined by local testing (eg, PCR, DFA, VRP assay, or culture). All samples must have been collected ≤ 6 days prior to Day 1.

4. An informed consent document signed and dated by the subject or a legal guardian of the subject and investigator or his/her designee

5. A negative urine pregnancy test is required for female subjects (unless surgically sterile or greater than two years post-menopausal)

6. Male and female subjects of childbearing potential who engage in heterosexual intercourse must agree to use protocol specified method(s) of contraception as described in Appendix 5

7. Lactating females must agree to discontinue nursing before the IMP is administered

8. Willingness to complete necessary study procedures and have available a working telephone or email
4.3. **Exclusion Criteria**

Subjects who meet *any* of the following exclusion criteria are not to be enrolled in this study.

**Related to concomitant or previous medication use:**

1. Use of non-marketed (according to region) investigational agents within 30 days, **OR** use of any monoclonal anti-RSV antibodies within 4 months or 5 half-lives of screening, whichever is longer, **OR** use of any investigational RSV vaccines after HCT

2. Use of a strong cytochrome P450 enzyme (CYP) inducer including but not limited to rifampin, St. John’s Wort, carbamazepine, and phenytoin, within 1 week prior to the first dose of IMP

**Related to medical history:**

3. Evidence of any clinically significant ECG abnormalities on record, as determined by the investigator

4. Pregnant, breastfeeding, or lactating females

5. Unable to tolerate nasal sampling required for this study, as determined by the investigator

6. Known history of HIV/AIDS, hepatitis B or C

7. History of drug and/or alcohol abuse that, in the opinion of the investigator, may prevent adherence to study activities

**Related to medical conditions:**

8. Requiring invasive mechanical ventilation at the time of randomization

9. A relapse (including molecular relapse) of their underlying disease for which they received a transplant at Screening

10. Documented to be positive for other respiratory viruses (limited to influenza, parainfluenza, human rhinovirus, adenovirus, or human metapneumovirus), from the lower respiratory tract sample as determined by local testing

11. Clinically significant bacteremia or fungemia within 7 days prior to Screening that has not been adequately treated, as determined by the investigator

12. Clinically significant bacterial, fungal, or viral pneumonia within 2 weeks prior to Screening that has not been adequately treated, as determined by the investigator

13. Excessive nausea/vomiting at screening, as determined by the investigator, or an inability to swallow pills, that precludes administration of an oral route IMP
Related to allergies:

14. Known hypersensitivity or allergy to the IMP, its metabolites, or formulation excipients
   (microcrystalline cellulose, mannitol, croscarmellose sodium, magnesium stearate, polyvinyl
   alcohol, titanium dioxide, polyethylene glycol and talc)

15. Allergy to sulfa drugs

Related to laboratory results:

16. Creatinine clearance < 30 mL/min (calculated using the Cockcroft-Gault method)

17. AST/ALT > 3x ULN

18. Total bilirubin > 3x ULN
5. INVESTIGATIONAL MEDICINAL PRODUCTS

5.1. Randomization, Blinding and Treatment Codes

This is a randomized, double-blind, placebo-controlled multi-center study. Eligible subjects will be stratified by the following factors:

- Supplemental O₂ requirement (≤ 2 L/min or > 2 L/min) at the time of randomization
- Treatment of current RSV infection (yes or no) with ribavirin (oral, intravenous, or aerosolized)

Treatment of current RSV infection with ribavirin will be defined as ≥ 1 dose of ribavirin (oral, intravenous, or aerosolized) prior to randomization or with written orders for the initiation of therapy at the time of randomization. Subjects will be randomized in a 1:1 ratio to receive IMP (GS-5806 or matching placebo).

Assignment to study treatment will be blinded to the study subjects, investigational site personnel, study vendors, and the Sponsor, except for the delegated personnel who will review and check the randomization and drug allocation for accuracy.

5.1.1. Procedures for Breaking Treatment Codes

In the event of a medical emergency where breaking the blind is required to provide medical care to the subject, the investigator may obtain treatment assignment directly from the IXRS system for that subject. In the event of technology failure, the PI may call the IXRS help line to access treatment codes. Gilead recommends but does not require that the investigator contact the Gilead medical monitor before breaking the blind. Treatment assignment should remain blinded unless that knowledge is necessary to determine subject emergency medical care. The rationale for unblinding must be clearly explained in source documentation and on the case report form/ electronic case report form (CRF/eCRF), along with the date on which the treatment assignment was obtained. The investigator is requested to contact the Gilead medical monitor promptly in case of any treatment unblinding. Details of unblinding will be provided in the study-specific Unblinding Plan.

Blinding of study treatment is critical to the integrity of this clinical trial and therefore, if a subject’s treatment assignment is disclosed to the investigator, the subject will have study treatment discontinued. All subjects will be followed until study completion unless consent to do so is specifically withdrawn by the subject.

Gilead Drug Safety and Public Health (DSPH) may independently unblind cases for expedited reporting of suspected unexpected serious adverse reactions (SUSARs).
5.2. **Description and Handling of GS-5806**

5.2.1. **Formulation**

GS-5806 will be supplied as white, plain-faced, film-coated, round tablets containing 50 mg GS-5806 (61 mg GS-5806-02, bis-hydrochloride salt dihydrate form of GS-5806). In addition to the active ingredient, GS-5806 tablets contain the following inactive ingredients: microcrystalline cellulose, mannitol, croscarmellose sodium, magnesium stearate, polyvinyl alcohol, titanium dioxide, polyethylene glycol, and talc, all of which are common pharmaceutical excipients.

The supplied matching placebo tablets are identical in physical appearance to the 50 mg GS-5806 tablets and contain the same inactive ingredients.

5.2.2. **Packaging and Labeling**

GS-5806 tablets and matching placebo are packaged in white, high density polyethylene (HDPE) bottles with desiccant and polyester fiber coil. Each bottle contains 4 tablets and is capped with a white, continuous thread, child-resistant polypropylene screw cap fitted with an induction-sealed, aluminum-faced liner.

All labels for IMP distributed to investigative sites in the US and the rest of world (ROW) will meet all applicable requirements of the US Food and Drug Administration (FDA), the EU Annex 13 of Good Manufacturing Practices: Manufacture of investigational medicinal products (July 2010), and/or other local regulations, as applicable.

5.2.3. **Storage and Handling**

Sufficient quantities of GS-5806 tablets and matching placebo will be shipped to the investigator or qualified designee from Gilead Sciences Materials & Logistics (or its designee).

GS-5806 tablets should be stored at controlled room temperature of 25°C (77°F); excursions are permitted between 15°C and 30°C (59°F and 86°F). Storage conditions are specified on the label. Until dispensed to the subjects, all bottles of IMP should be stored in a securely locked area, accessible only to authorized site personnel. The study center will be required to maintain a log of daily temperature readings in the storage area for the duration of the study. To ensure the stability and proper identification, the drug products will be stored in the containers in which they were supplied until units are dispensed to individual subjects at the site.

5.3. **Dosage and Administration of GS-5806**

Eligible subjects will receive 200 mg GS-5806 or placebo on Days 1, 5, 9, 13, and 17. Doses will be administered with water, after the subject has fasted for at least 2 hours (with exception of clear liquids and medications). The entire dose must be taken within 1 hour. Subjects will remain in a fasting condition for at least 1 hour after dosing. IMP is to be dispensed with gloves. Tablets are not to be crushed, split, dissolved, or chewed.
Subjects will remain in the clinic for 30 minutes post-dose for observation. If vomiting occurs within 30 minutes after IMP administration and undissolved tablets are present in the vomitus, the subject should receive another dose. If another dose is administered, the subject should remain in the clinic for an additional 30 minutes post-dose for observation.

5.4. Prior and Concomitant Medications

GS-5806 has a low systemic clearance in humans, so significant drug-drug interactions, in which concomitantly administered drugs inhibit the metabolic clearance of GS-5806 by CYP enzymes, are unlikely. Low levels of minor metabolites were observed in the human mass balance study (GS-US-218-0109) indicating that metabolism of GS-5806 is mediated by multiple minor metabolic pathways with the likely absence of a single dominant pathway. As such, the net effect of strong induction of 1 or 2 pathways by a potent CYP inducer is unclear. Therefore, concomitant administration of strong CYP inducers (including but not limited to rifampin, St John’s Wort, carbamazepine, and phenytoin) is excluded to avoid potential drug resistance. GS-5806 is a substrate of the hepatic uptake organic anion transporter proteins (OATP) OATP1B1 and OATP1B3. Clinically, single doses of GS-5806 have been well tolerated up to 800 mg (Cmax and AUC ~3.6- and ~5-fold of 200 mg, respectively) in healthy volunteers. GS-5806 exposures may be increased upon coadministration with potent OATP inhibitors (eg, rifampin and cyclosporine).

GS-5806 may cause concentration-dependent inhibition of multidrug and toxin extrusion via transporters MATE1 and MATE2-K with IC_{50} values of 0.50 μM and 3.8 μM, respectively. When co-administered with renally eliminated concomitant medications (ie, filtration plus secretion), GS-5806 may increase the exposures of substrates secreted by the MATEs transporters, such as ganciclovir, acyclovir, levofloxacin, and cephalexin. Safety monitoring should be consistent with prescribing information, in particular for agents which require dose reductions in the setting of renal impairment.

5.5. Accountability for GS-5806

The investigator is responsible for ensuring adequate accountability of all used and unused IMP bottles. This includes acknowledgement of receipt of each shipment of IMP (quantity and condition).

GS-5806 accountability records will be provided to each study site to:

- Record the date and quantity of IMP bottles received
- Record the date, subject number, subject initials, the IMP bottle number dispensed
- Record the date, quantity of used and unused IMP bottles returned, along with the initials of the person recording the information.
5.5.1. Investigational Medicinal Product Return or Disposal

At the site initiation visit or first monitoring visit, the study monitor will evaluate each study center’s IMP disposal procedures and provide appropriate instruction for return or destruction of unused IMP supplies. If the site has an appropriate Standard Operating Procedure (SOP) for drug destruction (as reviewed and approved by Gilead Sciences, Inc [GSI]), the site may destroy used and unused IMP supplies performed in accordance with the site’s (hospital/pharmacy) SOP after reconciliation has been completed by the site monitor. If the site does not have acceptable procedures in place for drug destruction, arrangements will be made between the site and GSI (or GSI representative) for return of unused IMP supplies. A copy of the site’s SOP will be obtained for central files. Where possible, IMP will be destroyed at the site.

Upon study completion, a copy of the Investigational Drug Accountability records must be filed at the site. Another copy will be returned to GSI. If drug is destroyed on site, the investigator must maintain accurate records for all IMP destroyed. Records must show the identification and quantity of each unit destroyed, the method of destruction, and person who disposed of the drug. All IMP records must be maintained at the site and copies must be submitted to GSI at the end of the study.
6. STUDY PROCEDURES

The study procedures to be conducted for each subject enrolled in the study are presented in tabular form in Appendix 2 and described in the text that follows. Additional information is provided in the study procedures manual.

The investigator is responsible for ensuring the study is conducted in accordance with the procedures and evaluations described in this protocol. Investigators must document any deviation or departure from protocol procedures, regardless of causality, and notify the sponsor or contract research organization (CRO).

6.1. Subject Enrollment and Treatment Assignment

6.1.1. Visit 1: Screening Visit (Days -2 to -1)

Visit 1 must be performed in the hospital or clinic. Potential subjects will have a documented positive test for RSV from the upper and lower respiratory tract and be approached for informed consent. The Principal Investigator or a medically qualified Sub-Investigator (eg, MD, DO, or nurse practitioner) must review and discuss the study with each subject prior to consent. All screening assessments must be performed after obtaining written consent. All screening labs and procedures will be performed locally and results will be reviewed by the investigator prior to IMP administration at Visit 2.

The following procedures will be completed at Screening:

- Obtain written informed consent
- Collection of medical history and demographics
- Review of concomitant medications
- Vital Signs (body temperature, heart rate, respiratory rate, and blood pressure)
- Height and Weight
- O₂ saturation (on room air)
- Chest X-ray (chest X-rays obtained < 2 days prior to Screening may be used)
- Blood draw for screening labs for local laboratory analyses (labs obtained ≤ 6 days prior to Screening may be used)
  - Serum creatinine clearance
  - AST/ALT
  - Total bilirubin
• Urine pregnancy test (for women unable to confirm menopause, hysterectomy and/or bilateral oophorectomy)

• Record any SAEs and all AEs related to protocol mandated procedures occurring after signing of the consent form

Subjects meeting all of the inclusion criteria and none of the exclusion criteria will be randomized into the study. Subjects must continue to meet all inclusion criteria and none of the exclusion criteria at the time of randomization. If all lab results and procedures are available and satisfy the inclusion/exclusion criteria, Screening and Visit 2 (Day 1) may occur on the same day. From the time of obtaining informed consent through the first administration of IMP, record all SAEs, as well as any AEs related to protocol-mandated procedures on the AE case report form (eCRF). All other untoward medical occurrences observed during the Screening period, including exacerbation or changes in medical history are to be captured on the medical history eCRF. See section 7 Adverse Events and Toxicity Management for additional details.

6.1.2. Visit 2: Baseline Assessments, Randomization, and Treatment Assessments (Day 1)

6.1.2.1. Baseline Assessments

Visit 2 must be performed in the hospital or clinic and should occur within 24 hours of confirmation of the subject’s eligibility. Samples and assessments performed at Screening (Visit 1) may not be used as Visit 2 Baseline assessments. Baseline (Visit 2) assessments will be performed in the following order and documented on Day 1 prior to IMP administration:

• Review of concomitant medications, mechanical ventilation (invasive and non-invasive of any duration), and supplemental O₂ use

• Weight

• Vital Signs (body temperature, heart rate, respiratory rate, and blood pressure), obtained 5 - 10 minutes prior to IMP administration

• O₂ saturation (on room air)

• Blood draw for central laboratory analysis:
  — Safety Labs (hematology and serum chemistry to include WBC with differential, Hgb, platelets, BUN, creatinine, serum albumin, AST, ALT, and total bilirubin)
  — Serum antibody titer to RSV
  — RSV viremia
• Nasal samples (2 total, one from each nostril)

• Obtain induced sputum for central laboratory analysis (unless induced sputum was used to demonstrate the presence of RSV in the lower respiratory tract ≤6 days prior to Day 1)

6.1.2.2. Randomization and Treatment Assessments (Day 1)

After all Baseline assessments are complete, eligible subjects will be randomized via Interactive Voice/Web Response System (IXRS) and IMP will be administered.

Randomization to GS-5806 or placebo will be based on a randomization schedule prepared by Gilead and/or designee before the start of the study. Subjects must continue to satisfy all inclusion/exclusion criteria at the time of randomization. At randomization, eligible subjects will be stratified by the following:

• Supplemental O₂ requirement (≤ 2 L/min or > 2 L/min) at the time of randomization

• Treatment of current RSV infection (yes or no) with ribavirin (oral, intravenous, or aerosolized)

Treatment of current RSV infection with ribavirin will be defined as ≥ 1 dose of ribavirin (oral, intravenous, or aerosolized) prior to randomization or with written orders for the initiation of therapy at the time of randomization. Subjects will be randomized in a 1:1 ratio to receive IMP (GS-5806 or matching placebo).

Subjects will receive 200 mg (four 50 mg tablets) of GS-5806 or matching placebo at Day 1. All IMP will be administered with water, after the subject has been fasting (with exception of clear liquids and medications) for a minimum of 2 hours. The entire dose must be taken within 1 hour. Subjects will remain in a fasting condition for 1 hour post-dose. Tablets are not to be crushed, chewed, split, or dissolved, and should always be dispensed with gloves. Non-hospitalized subjects will remain in the clinic for 30 minutes post-dose for observation. If vomiting occurs within 30 minutes after IMP administration and undissolved tablets are present in the vomitus, the subject should receive another dose. If another dose is administered, the subject should remain in the clinic for an additional 30 minutes post-dose for observation.

The following procedure will be performed and documented on Day 1 after IMP dosing:

• Blood draw for central laboratory analysis:
  — Serum creatinine 4 hours post-dose
  — PK sampling 4 hours post-dose

• Review of AEs
6.1.2.3. Post-dose Follow-up for Hospitalized Subjects

For hospitalized subjects, a blood draw for central laboratory analysis of serum creatinine will be collected at 24 and 72 hours (±3 hours) post-first GS-5806 dose. Subjects who are not hospitalized during this time will not return to the hospital or clinic for these blood draws.

6.2. Visit 3: Day 3 (± 24 hours)

Visit 3 assessments may be performed in the hospital, clinic, or at the subject’s home by the study coordinator or designee.

- For all subjects: nasal samples (2 total, one from each nostril)
- For hospitalized subjects, a blood draw for central laboratory analysis at 48 hours (±3 hours) post-first GS-5806 dose:
  - Serum creatinine
  - PK sampling

6.3. Visit 4: Day 5 (± 24 hours)

Visit 4 assessments must be performed in clinic or in hospital and should be performed in the following order and documented (also refer to Appendix 2 Study Procedures Table):

- Vital Signs (body temperature, heart rate, respiratory rate, and blood pressure), obtained 5 - 10 minutes prior to IMP administration
- O₂ saturation (on room air)
- Weight
- Blood draw for central laboratory analysis:
  - Safety Labs (hematology and serum chemistry to include to include WBC with differential, Hgb, platelets, BUN, creatinine, serum albumin, AST, ALT, and total bilirubin)
  - PK sampling: pre-dose
  - RSV viremia
- Nasal samples (2 total, one from each nostril)
- IMP administration*
- Review of AEs, concomitant medications, re-hospitalizations, ICU admissions or utilization of ICU care, standard of care test results (ie, chest radiographs, microbiology, echocardiograms), mechanical ventilation (invasive and non-invasive of any duration), and supplemental O₂ use (≥ 2 L/min)
* Subjects will receive 200 mg (four 50 mg tablets) of GS-5806 or matching placebo at Day 5. IMP will be administered with water, after the subject has been fasting for a minimum of 2 hours (with exception of clear liquids and medications). The entire dose must be taken within 1 hour. Subjects will remain in a fasting condition for 1 hour post-dose. Tablets are not to be crushed, chewed, split, or dissolved, and should always be dispensed with gloves. Subjects will remain in the clinic for 30 minutes post-dose for observation. If vomiting occurs within 30 minutes after IMP administration and undissolved tablets are present in the vomitus, the subject should receive another dose. If another dose is administered, the subject should remain in the clinic for an additional 30 minutes post-dose for observation.

6.4. Visit 5: Day 7 (± 24 hours)

Visit 5 assessments may be performed in the hospital, clinic, or at the subject’s home by the study coordinator or designee.

- Nasal samples (2 total, one from each nostril)

6.5. Visits 6-8: Days 9, 13, and 17 (± 24 hours)

Visits 6-8 assessments must be performed in clinic or in hospital and should be performed in the following order and documented at these visits (also refer to Appendix 2, Study Procedures Table):

- Vital Signs (body temperature, heart rate, respiratory rate, and blood pressure), obtained 5 - 10 minutes prior to IMP administration
- O₂ saturation (on room air)
- Weight
- Blood draw for central laboratory analysis:
  - Safety Labs (hematology and serum chemistry to include to include WBC with differential, Hgb, platelets, BUN, creatinine, serum albumin, AST, ALT, and total bilirubin)
  - PK sampling: pre-dose
  - RSV viremia
- Nasal samples (2 total, one from each nostril)
- IMP administration*
- Review of AEs, concomitant medications, re-hospitalizations, ICU admissions or utilization of ICU care, standard of care test results (ie, chest radiographs, microbiology, echocardiograms), mechanical ventilation (invasive and non-invasive of any duration), and supplemental O₂ use (≥ 2 L/min)
* Subjects will receive 200 mg (four 50 mg tablets) of GS-5806 or matching placebo at Days 9, 13, and 17. All IMP will be administered with water, after the subject has been fasting for a minimum of 2 hours (with exception of clear liquids and medications). The entire dose must be taken within 1 hour. Subjects will remain in a fasting condition for 1 hour post-dose. Tablets are not to be crushed, chewed, split, or dissolved, and should always be dispensed with gloves. Subjects will remain in the clinic for 30 minutes post-dose for observation. If vomiting occurs within 30 minutes after IMP administration and undissolved tablets are present in the vomitus, the subject should receive another dose. If another dose is administered, the subject should remain in the clinic for an additional 30 minutes post-dose for observation.

6.6. **Visit 9: Day 22 (± 24 hours)**

Visit 9 assessments must be performed in clinic or in hospital and will be performed in the following order and documented (also refer to Appendix 2, Study Procedures Table):

- Vital Signs (body temperature, heart rate, respiratory rate, and blood pressure)
- $O_2$ saturation (on room air)
- Weight
- Blood draw for central laboratory analysis:
  - Safety Labs (hematology and serum chemistry to include WBC with differential, Hgb, platelets, BUN, creatinine, serum albumin, AST, ALT, and total bilirubin)
  - PK sampling
  - RSV viremia
- Nasal samples (2 total, one from each nostril)
- Review of AEs, concomitant medications, re-hospitalizations, ICU admissions or utilization of ICU care, standard of care test results (ie, chest radiographs, microbiology, echocardiograms), mechanical ventilation (invasive and non-invasive of any duration), and supplemental $O_2$ use ($\geq 2$ L/min)

6.7. **Visit 10: End of Study/Day 28 (+ 3 days)**

Visit 10 assessments must be performed in clinic or in hospital. The visit will occur no earlier than Day 28 and no later than Day 31. Visit 10 assessments will be performed in the following order and documented (also refer to Appendix 2, Study Procedures Table):

- Vital Signs (body temperature, heart rate, respiratory rate, and blood pressure)
- $O_2$ saturation (on room air)
• Weight

• Blood draw for central laboratory analysis:
  — Safety Labs (hematology and serum chemistry to include WBC with differential, Hgb, platelets, BUN, creatinine, serum albumin, AST, ALT, and total bilirubin)
  — Serum antibody titer to RSV
  — RSV viremia

• Nasal samples (2 total, one from each nostril)

• Review of AEs, concomitant medications, re-hospitalizations, ICU admissions or utilization of ICU care, standard of care test results (ie, chest radiographs, microbiology, echocardiograms), mechanical ventilation (invasive and non-invasive of any duration), and supplemental O₂ use (≥ 2 L/min)

6.8. Assessments for Premature Discontinuation from IMP dosing and Early Withdrawal

Reasons for premature discontinuation from IMP dosing or the study are outlined in Section 3.5.

6.8.1. Assessments for Premature Discontinuation from IMP Administration

If a subject prematurely discontinues IMP dosing, the subject will remain on study and will continue with all subsequent study visits and assessments through Visit 10, Day 28 (End of Study), with the exception of IMP administration.

6.8.2. Assessments for Early Termination/Withdrawal

Every attempt should be made to keep subjects in the study and to perform the required study-related and follow-up procedures (see Sections 6.2 through 6.7). If this is not possible or acceptable to the subject or investigator, the subject may be withdrawn from the study.

If a subject withdraws early from the study for any reason, every attempt should be made to bring the subject back to the clinic or hospital for the following early termination assessments:

• Vital Signs (body temperature, heart rate, respiratory rate, and blood pressure)

• O₂ saturation (on room air)

• Weight
• Blood sample collection for central laboratory analysis:
  — Safety Labs (hematology and serum chemistry to include to include WBC with
differential, Hgb, platelets, BUN, creatinine, serum albumin, AST, ALT, and total
bilirubin) (only if the subject withdraws prior to Visit 9 [Day 22])
  — Serum antibody titer to RSV
  — RSV viremia
• Nasal samples (2 total, one from each nostril)
• Review of AEs, concomitant medications, re-hospitalizations, ICU admissions or utilization
of ICU care, standard of care test results (ie, chest radiographs, microbiology,
echocardiograms), mechanical ventilation (invasive and non-invasive of any duration), and
supplemental O₂ use (≥ 2 L/min)

6.9. Assessments for Unscheduled Visits

Assessments performed between scheduled study visits for hospitalized subjects do not have to
be entered as an unscheduled visit. If non-hospitalized subjects return to the hospital or clinic
between scheduled study visits, an unscheduled visit should be performed and recorded. The
following procedures will be performed and documented at these visits:

• Vital signs, including O₂ saturation on room air
• Collection of nasal samples for analysis at the central lab
• Assessment of AEs, concomitant medications, re-hospitalizations, ICU admissions or utilization
of ICU care, standard of care test results (ie, chest radiographs, microbiology,
echocardiograms), mechanical ventilation (invasive and non-invasive of any duration), and
supplemental O₂ use (≥ 2 L/min)

6.10. Study Assessments

6.10.1. Nasal Samples, Virology, and Antibody Titer

At Screening (Visit 1), all subjects should be RSV positive in both the upper (eg, nasal swab,
nasopharyngeal swab, nasal wash) and lower (eg, induced sputum, BAL, lung biopsy) respiratory
tract, as determined by local laboratory test methods (eg, PCR, DFA, VRP assay, or culture)
≤6 days prior to Day 1. If the subject meets eligibility criteria based on results of tests completed
as part of standard of care, Visit 1 and 2 procedures, including randomization and IMP
administration, may occur on the same day provided the subject continues to satisfy all
inclusion/exclusion criteria.
Nasal samples will be obtained at each study visit, with the exception of Screening (Visit 1), for analysis at the central laboratory (Days 1, 3, 5, 7, 9, 13, 17, 22, and 28). Two samples will be collected at each time point, one from each naris. For all study related nasal samples, one of the nasal samples will be analyzed using RT-qPCR to determine RSV viral load. The other nasal sample will be used for RSV sequencing to evaluate development of resistance (see Section 6.10.2) and a multiplex assay to identify viral co-infections. All nasal samples for central laboratory analysis will be collected, placed in individual tubes, and stored/shipped to the central laboratory as per instructions outlined in the Laboratory Manual.

The procedure for collecting, storing and shipping induced sputum samples will be outlined in the Laboratory Manual.

Blood samples will be collected for RSV viremia evaluation (RT-qPCR) at Visits 2, 4, 6, 7, 8, 9, and 10 (Days 1, 5, 9, 13, 17, 22 and 28) prior to dosing, and RSV antibody titers at Visits 2 and 10 (Days 1 and 28). Samples will be processed, stored and shipped to the central laboratory as per instructions outlined in the Laboratory Manual.

6.10.2. Virology and Resistance Monitoring

To assess the potential for emergence of resistance to GS-5806, population sequencing of the RSV F gene will be conducted on evaluable nasal swab samples collected from GS-5806 and placebo-treated RSV infected patients according to the Resistance Analysis Plan. Any mutation in the F gene identified by population sequencing in GS-5806-treated subjects relative to the pretreatment baseline sequence will be characterized phenotypically following their introduction into wild-type RSV using an established reverse genetics system. The susceptibility of the F mutant recombinants to GS-5806 will be assessed in cell-based antiviral susceptibility assays to determine whether each treatment-emergent mutation (TEM) confers reduced susceptibility to the compound.

6.10.3. Vital Signs

This assessment will include body temperature, heart rate, respiratory rate, and blood pressure. The subject is required to sit quietly for approximately 2 minutes prior to obtaining VS. At Visits 2, 4, 6, 7 and 8 VS will be obtained 5 to 10 minutes prior to dosing IMP. Vital signs will be collected at all study visits performed in the hospital or clinic.

6.10.4. Oxygen Saturation

O₂ saturation assessment will begin by first asking the subject to sit quietly for 1 minute. O₂ saturation will be recorded while breathing room air, even if the subject is dependent on O₂ supplementation. If the subject is receiving supplemental O₂, the O₂ source will be removed for a period of 30 seconds prior to this assessment. The O₂ saturation will be documented in the source at regular intervals (approximately every 15 seconds) during the 2-minute testing period. O₂ saturation evaluation will be considered complete when the 2-minute period has elapsed, or when the subject achieves a saturation of 87%, whichever is achieved first. The lowest O₂ saturation recorded over the 2-minute interval will be captured in the eCRF. O₂ saturation will be
collected at all study visits performed in the hospital or clinic. Subjects undergoing invasive mechanical ventilation will **not** have the oxygen removed and “< 87%” should be recorded in the source documentation and the reason should be documented. If it is determined by the investigator that it is unsafe to remove the subject’s supplemental O\textsubscript{2} for assessment of O\textsubscript{2} saturation (eg, subject is on high-flow mask), then this should be recorded in the source documentation as “< 87%” and the reason should be documented.

### 6.10.5. Plasma PK

PK blood sampling will be performed using the site’s local procedures and analyzed at a central laboratory. PK blood samples will be processed, placed in individual tubes, and stored/shipped to the central laboratory as per instructions outlined in the Laboratory Manual. PK samples will be obtained for all subjects at Visits 2, 4, 6, 7, 8 and 9. For hospitalized subjects, an additional PK sample will be obtained at Visit 3 (48 hours [±3 hours] post-first GS-5806 dose) as outlined in Table 6-1. Subjects who are not hospitalized Visit 3 will not return to the hospital or clinic for this blood draw. These plasma PK samples may also be used to evaluate the plasma PK of co-administered agents (eg, ganciclovir, acyclovir).

#### Table 6-1. PK Timepoints

<table>
<thead>
<tr>
<th>PK samples</th>
<th>Visit 2 (Day 1) 4hrs post-dose</th>
<th>Visit 3 (Day 3) anytime</th>
<th>Visit 4 (Day 5) pre-dose</th>
<th>Visit 6 (Day 9) pre-dose</th>
<th>Visit 7 (Day 13) pre-dose</th>
<th>Visit 8 (Day 17) pre-dose</th>
<th>Visit 9 (Day 22) anytime</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X (for hospitalized subjects only)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

### 6.10.6. Safety Labs

When available, the most recent laboratory values (obtained within 7 days prior to Screening [Visit 1]) may be used for eligibility assessment, with the exception of RSV results and pregnancy testing. If an existing laboratory value is not available for eligibility assessment, the test will be performed using the local laboratory. All testing of samples obtained after the screening assessments will be performed at a central laboratory selected by GSI.

Testing of blood specimens will include WBC with differential, Hgb, platelets, BUN, creatinine, serum albumin, AST, ALT, and total bilirubin at Visits 2, 4, 6, 7, 8, 9, and 10 (Days 1, 5, 9, 13, 17, 22, and 28). Blood samples will be collected pre-dose at all visits where IMP is administered.

A blood specimen for serum creatinine will be collected 4 hours post-dose at Visit 2 (Day 1). For hospitalized subjects, blood specimens for serum creatinine will be collected on Days 2, 3, and 4 (24, 48, and 72 hours [±3 hours] post-first GS-5806 dose). Subjects who are not hospitalized during this time will not return to the hospital or clinic for these blood draws.
Urine pregnancy tests will occur for all females of child-bearing potential at Screening.

6.10.7. Chest X-ray

Results from chest X-rays and CT scans used for screening and eligibility, including the comparison chest radiograph, will be collected and stored electronically for review by the Adjudication Committee and a possible central read.
7. ADVERSE EVENTS AND TOXICITY MANAGEMENT

7.1. Definitions of Adverse Events, Adverse Reactions, and Serious Adverse Events

7.1.1. Adverse Events

An adverse event (AE) is any untoward medical occurrence in a clinical study subject administered a medicinal product, which does not necessarily have a causal relationship with the treatment. An AE can therefore be any unfavorable and/or unintended sign, symptom, or disease temporally associated with the use of a medicinal product, whether or not considered related to the medicinal product. AEs may also include pre- or post-treatment complications that occur as a result of protocol specified procedures, lack of efficacy, overdose, drug abuse/misuse reports, or occupational exposure. Preexisting events that increase in severity or change in nature during or as a consequence of participation in the clinical study will also be considered AEs.

An AE does not include the following:

- Medical or surgical procedures such as surgery, endoscopy, tooth extraction, and transfusion. The condition that led to the procedure may be an adverse event and must be reported.
- Pre-existing diseases, conditions, or laboratory abnormalities present or detected before the screening visit that do not worsen.
- Situations where an untoward medical occurrence has not occurred (e.g., hospitalization for elective surgery, social and/or convenience admissions).
- Overdose without clinical sequelae.
- Any medical condition or clinically significant laboratory abnormality with an onset date before the consent form is signed and not related to a protocol-associated procedure is not an AE. It is considered to be pre-existing and should be documented on the medical history CRF.

7.1.2. Serious Adverse Events

A serious adverse event (SAE) is defined as an event that, at any dose, results in the following:

- Death
- Life-threatening (Note: The term “life-threatening” in the definition of “serious” refers to an event in which the subject was at risk of death at the time of the event; it does not refer to an event that hypothetically might have caused death if it were more severe.)
- In-patient hospitalization or prolongation of existing hospitalization.
- Persistent or significant disability/incapacity
- A congenital anomaly/birth defect
- A medically important event or reaction: such events may not be immediately life-threatening or result in death or hospitalization but may jeopardize the subject or may require intervention to prevent one of the other outcomes constituting SAEs. Medical and scientific judgment must be exercised to determine whether such an event is a reportable under expedited reporting rules. Examples of medically important events include intensive treatment in an emergency room or at home for allergic bronchospasm; blood dyscrasias or convulsions that do not result in hospitalization; and development of drug dependency or drug abuse. For the avoidance of doubt, infections resulting from contaminated medicinal product will be considered a medically important event and subject to expedited reporting requirements.

7.1.2.1. Protocol-Specific Serious Adverse Event Instructions

Protocol-specific SAE reporting exemptions: In this study, death related to clinical progression of underlying disease requiring HCT, or graft failure will not need to be reported as an SAE. Death related to clinical progression of underlying disease requiring HCT, or graft failure should only be reported as SAEs on the eCRF, unless there is evidence suggesting a causal relationship between the IMP or study procedure and the event. In that case, the investigator must immediately report the event as an SAE in accordance with the procedure in Section 7.3 below. Such clinical progression or graft failure which are assessed as not related to IMP/procedure) will be exempt from global expedited reporting requirements for the duration of the study. The events will be collected and evaluated by Gilead and reported as appropriate in any relevant aggregate safety report, as well as the final clinical study report.

To minimize the possibility of exposing study subjects to unusual risk, the safety information from the study will also be reviewed by an independent DMC on an ongoing basis. The DMC may have access to partially blinded or unblinded data and will determine if it is safe to continue the study according to the protocol.

7.1.3. Clinical Laboratory Abnormalities and Other Abnormal Assessments as Adverse Events or Serious Adverse Events

Laboratory abnormalities without clinical significance are not recorded as AEs or SAEs. However, laboratory abnormalities (eg, clinical chemistry, hematology, and urinalysis) that require medical or surgical intervention or lead to IMP interruption, modification, or discontinuation must be recorded as an AE, as well as an SAE, if applicable. In addition, laboratory or other abnormal assessments (eg, electrocardiogram, X-rays, vital signs) that are associated with signs and/or symptoms must be recorded as an AE or SAE if they meet the definition of an AE or SAE as described in Sections 7.1.1 and 7.1.2. If the laboratory abnormality is part of a syndrome, record the syndrome or diagnosis (eg, anemia), not the laboratory result (ie, decreased hemoglobin).
For specific information on handling of clinical laboratory abnormalities in this study, please refer to Section 7.5.

7.2. **Assessment of Adverse Events and Serious Adverse Events**

The investigator or a designated qualified subinvestigator is responsible for assessing AEs and SAEs for causality and severity, and for final review and confirmation of accuracy of event information and assessments.

7.2.1. **Assessment of Causality for IMP and Procedures**

The investigator or a designated qualified subinvestigator is responsible for assessing the relationship to IMP therapy using clinical judgment and the following considerations:

- **No:** Evidence exists that the adverse event has an etiology other than the IMP. For SAEs, an alternative causality must be provided (eg, pre-existing condition, underlying disease, intercurrent illness, or concomitant medication).

- **Yes:** There is reasonable possibility that the event may have been caused by the investigational medicinal product.

It should be emphasized that ineffective treatment should not be considered as causally related in the context of adverse event reporting.

The relationship to study procedures (eg, invasive procedures such as venipuncture or biopsy) should be assessed using the following considerations:

- **No:** Evidence exists that the adverse event has an etiology other than the study procedure.

- **Yes:** The adverse event occurred as a result of protocol procedures (eg, venipuncture)

7.2.2. **Assessment of Severity**

Severity should be recorded and graded according to the GSI Grading Scale for Severity of Adverse Events and Laboratory Abnormalities For AEs or SAEs associated with laboratory abnormalities, the event should be graded on the basis of the clinical severity in the context of the underlying conditions; this may or may not be in agreement with the grading of the laboratory abnormality.

7.3. **Investigator Requirements and Instructions for Reporting Adverse Events and Serious Adverse Events to Gilead**

Requirements for collection prior to IMP initiation:

After informed consent, but prior to initiation of study medication, the following types of events should be reported on the case report form (eCRF): all SAEs and adverse events related to protocol-mandated procedures.
Adverse Events:

Following initiation of study medication, all AEs, regardless of cause or relationship, through the Day 28 End of Study visit must be reported to the eCRF database as instructed. All AEs should be followed up until resolution or until the adverse event is stable, if possible. Gilead Sciences may request that certain AEs be followed beyond the protocol defined follow up period, as determined by the Medical Monitor.

Serious Adverse Events:

All SAEs, regardless of cause or relationship, that occurs after the subject first consents to participate in the study (ie, signing the informed consent) and throughout the duration of the study, including the protocol-required post treatment follow-up period, must be reported to the eCRF database and Gilead Drug Safety and Public Health (DSPH) as instructed. This also includes any SAEs resulting from protocol-associated procedures performed after informed consent is signed.

Any SAEs and deaths that occur after the post treatment follow-up visit but within 30 days or 4-weeks of the last dose of study IMP, regardless of causality, should also be reported.

Investigators are not obligated to actively seek SAEs after the protocol defined follow up period (the Day 28 End of Study visit), however, if the investigator learns of any SAEs that occur after study participation has concluded and the event is deemed relevant to the use of IMP, he/she should promptly document and report the event to Gilead DSPH.

All AEs and SAEs will be recorded in the eCRF database within the timelines outlined in the eCRF completion guideline.

Electronic Serious Adverse Event (eSAE) Reporting Process:

• Site personnel record all SAE data in the eCRF database and from there transmit the SAE information to Gilead DSPH within 24 hours of the investigator’s knowledge of the event. Detailed instructions can be found in the eCRF completion guidelines.

• If for any reason it is not possible to record the SAE information electronically (ie, the eCRF database is not functioning), record the SAE on the paper serious adverse event reporting form and submit within 24 hours to:

  Gilead DSPH: Fax: +1-650-522-5477
  E-mail: Safety_fc@gilead.com

• As soon as it is possible to do so, any SAE reported via paper must be transcribed into the eCRF Database according to instructions in the eCRF completion guidelines.
• If an SAE has been reported via a paper form because the eCRF database has been locked, no further action is necessary.

• For fatal or life-threatening events, copies of hospital case reports, autopsy reports, and other documents are also to be submitted by e-mail or fax when requested and applicable. Transmission of such documents should occur without personal subject identification, maintaining the traceability of a document to the subject identifiers.

• Additional information may be requested to ensure the timely completion of accurate safety reports.

• Any medications necessary for treatment of the SAE must be recorded onto the concomitant medication section of the subject’s CRF/eCRF and the event description section of the SAE form.

• Site personnel should record all SAE data in the eCRF database for those protocol-specific SAEs which are exempted from expedited reporting requirements (Section 7.1.2.1). They should also transmit the SAE information to Gilead DSPH if the SAEs are assessed by the investigator as related to the IMP or study procedure.

7.4. Gilead Reporting Requirements

Depending on relevant local legislation or regulations, including the applicable US FDA Code of Federal Regulations, the EU Clinical Trials Directive (2001/20/EC) and relevant updates, and other country-specific legislation or regulations, Gilead may be required to expedite to worldwide regulatory agencies reports of SAEs, serious adverse drug reactions (SADRs), or suspected unexpected serious adverse reactions (SUSARs). In accordance with the EU Clinical Trials Directive (2001/20/EC), Gilead or a specified designee will notify worldwide regulatory agencies and the relevant Independent Ethics Committee (IEC) in concerned Member States of applicable SUSARs as outlined in current regulations.

Assessment of expectedness for SAEs will be determined by Gilead using reference safety information specified in the current GS-5806 IB or relevant local label as applicable.

All investigators will receive a safety letter notifying them of relevant SUSAR reports associated with any study IMP. The investigator should notify the IRB or IEC of SUSAR reports as soon as is practical, where this is required by local regulatory agencies, and in accordance with the local institutional policy.

7.5. Clinical Laboratory Abnormalities and Other Abnormal Assessments as Adverse Events or Serious Adverse Events

Laboratory abnormalities are usually not recorded as AEs or SAEs. However, laboratory abnormalities (eg, clinical chemistry, hematology) independent of the underlying medical condition that require medical or surgical intervention or lead to IMP interruption or discontinuation must be recorded as an AE, as well as an SAE, if applicable. In addition,
laboratory or other abnormal assessments (eg, vital signs) that are associated with signs and/or symptoms must be recorded as an AE or SAE if they meet the definition of an AE or SAE, respectively, as described in Section 7.1. If the laboratory abnormality is part of a syndrome, record the syndrome or diagnosis (ie, anemia) not the laboratory result (ie, decreased hemoglobin).

Severity should be recorded and graded according to the GSI Grading Scale for Severity of Adverse Events and Laboratory Abnormalities Appendix 4. For AEs or SAEs associated with laboratory abnormalities, the event should be graded on the basis of the clinical severity in the context of the underlying conditions; this may or may not be in agreement with the grading of the laboratory abnormality.

7.6. Toxicity Management

All clinical and clinically significant laboratory toxicities will be managed according to uniform guidelines detailed in Appendix 3.

Any questions regarding toxicity management should be directed to the Gilead Sciences Medical Monitor.

7.7. Special Situations Reports

7.7.1. Definitions of Special Situations

Special situation reports include all reports of medication error, abuse, misuse, overdose, reports of adverse events associated with product complaints, and pregnancy reports regardless of an associated AE.

Medication error is any unintentional error in the prescribing, dispensing, or administration of a medicinal product while in the control of the health care provider, subject, or consumer.

Abuse is defined as persistent or sporadic intentional excessive use of a medicinal product by a subject.

Misuse is defined as any intentional and inappropriate use of a medicinal product that is not in accordance with the protocol instructions or the local prescribing information.

An overdose is defined as an accidental or intentional administration of a quantity of a medicinal product given per administration or cumulatively which is above the maximum recommended dose as per protocol or in the product labelling (as it applies to the daily dose of the subject in question). In cases of a discrepancy in drug accountability, overdose will be established only when it is clear that the subject has taken the excess dose(s). Overdose cannot be established when the subject cannot account for the discrepancy except in cases in which the investigator has reason to suspect that the subject has taken the additional dose(s).

Product complaint is defined as complaints arising from potential deviations in the manufacture, packaging, or distribution of the medicinal product.
7.7.2. Instructions for Reporting Special Situations

7.7.2.1. Instructions for Reporting Pregnancies

The investigator should report pregnancies in female study subjects that are identified after initiation of study medication and throughout the study, including the post IMP follow-up period, to Gilead DSPH using the pregnancy report form within 24 hours of becoming aware of the pregnancy.

Refer to section 7.3 and the eCRF completion guidelines for full instructions on the mechanism of pregnancy reporting.

The pregnancy itself is not considered an AE nor is an induced elective abortion to terminate a pregnancy without medical reasons.

Any premature termination of pregnancy (eg, a spontaneous abortion, an induced therapeutic abortion due to complications or other medical reasons) must be reported within 24 hours as an SAE. The underlying medical reason for this procedure should be recorded as the AE term.

A spontaneous abortion is always considered to be an SAE and will be reported as described in section 7.3. Furthermore, any SAE occurring as an adverse pregnancy outcome post study must be reported to Gilead DSPH.

The subject should receive appropriate monitoring and care until the conclusion of the pregnancy. The outcome should be reported to Gilead DSPH using the pregnancy outcome report form. If the end of the pregnancy occurs after the study has been completed, the outcome should be reported directly to Gilead DSPH. Gilead DSPH contact information is provided in section 7.3.

Pregnancies of female partners of male study subjects exposed to Gilead or other investigational agents must also be reported and relevant information should be submitted Gilead DSPH using the pregnancy and pregnancy outcome forms within 24 hours. Monitoring of the subject should continue until the conclusion of the pregnancy. If the end of the pregnancy occurs after the study has been completed, the outcome should be reported directly to Gilead DSPH.

Refer to Appendix 5 for Pregnancy Precautions, Definition for Female of Childbearing Potential, and Contraceptive Requirements.

7.7.2.2. Reporting Other Special Situations

All other special situation reports must be reported on the special situations report form and forwarded to Gilead DSPH within 24 hours of the investigator becoming aware of the situation. These reports must consist of situations that involve study IMP and/or Gilead concomitant medications, but do not apply to non-Gilead concomitant medications.
Special situations involving non-Gilead concomitant medications does not need to be reported on the special situations report form; however, for special situations that result in AEs due to a non-Gilead concomitant medication, the AE should be reported in the eCRFs.

Any inappropriate use of concomitant medications prohibited by this protocol should not be reported as “misuse,” but may be more appropriately documented as a protocol deviation.

Refer to section 7.3 and the CRF/eCRF completion guidelines for full instructions on the mechanism of special situations reporting.

All clinical sequelae in relation to these special situation reports will be reported as AEs or SAEs at the same time using the AE CRF/eCRF and/or the SAE report form. Details of the symptoms and signs, clinical management, and outcome will be reported, when available.
8. STATISTICAL CONSIDERATIONS

8.1. Analysis Objectives and Endpoints

8.1.1. Analysis Objectives

The primary objective of this study is as follows:

- To evaluate the effect of GS-5806 on RSV viral load in autologous or allogeneic HCT recipients with an acute RSV LRTI

The secondary objectives of this study are as follows:

- To evaluate the effect of GS-5806 on rates of respiratory failure and all-cause mortality
- To evaluate the PK, safety and tolerability of GS-5806

8.1.2. Primary Endpoint

The primary endpoint is the daily average change in nasal RSV viral load \( \log_{10} \) copies/mL from Baseline (Day 1) to Day 9 as measured by RT-qPCR. The daily average change in nasal RSV viral load from Baseline to Day 9 is defined as:

\[
\sum \left\{ 0.5 \times \frac{(Y_i + a)(b - Y_i)}{(b - a)} \right\}
\]

where \( Y_i \) is the change from Baseline in RSV \( \log_{10} \) viral load at \( Visit_i \), \( t \) is the time at the specified timepoint, \( a \) is the Baseline assessment at Day 1 and \( b \) is the last assessment at or prior to Day 9.

8.1.3. Secondary Endpoint

Secondary endpoints are:

- Proportion of subjects developing respiratory failure (of any cause) requiring mechanical ventilation (invasive or noninvasive) through Day 28
- Proportion of all-cause mortality among subjects through Day 28

8.1.4. Other Endpoints of Interest

Other endpoints of interest are:

- RSV \( \log_{10} \) viral load and change from baseline in RSV \( \log_{10} \) viral load in the nasal samples
- Daily average RSV \( \log_{10} \) viral load and daily average change from baseline in RSV \( \log_{10} \) viral load in the nasal samples
• Proportion of subjects with detectable RSV in the nasal samples
• Proportion of subjects requiring supplemental O$_2$ (≥ 2 L/min)
• RSV log$_{10}$ viral load and change from baseline in RSV log$_{10}$ viral load in the blood
• Daily average RSV log$_{10}$ viral load and daily average change from baseline in RSV log$_{10}$ viral load in the blood
• Proportion of subjects who have detectable RSV in the blood
• Proportion of subjects whose O$_2$ saturation drops below 88% by Day 28
• O$_2$ saturation and change from baseline in O$_2$ saturation
• Daily average O$_2$ saturation and daily average change from baseline in O$_2$ saturation
• Proportion of subjects requiring ICU admission or equivalent ICU care (due to any cause) through Day 28
• Total number of ICU admissions or equivalent ICU care hours (for subjects receiving ICU care) through Day 28
• Total number of mechanical ventilation (invasive or non-invasive) hours through Day 28
• Duration of hospitalization through Day 28

8.2. Analysis Conventions

8.2.1. Analysis Sets

8.2.1.1. Efficacy

The full analysis set (FAS) will include subjects who have an RSV log$_{10}$ viral load greater than or equal to the LLOQ of the RT-qPCR assay in the pre-dose Day 1 nasal sample, as determined by RT-qPCR at the central lab, and have received at least 1 full dose of IMP.

8.2.1.2. Safety

The primary analysis set for safety analyses is defined as all subjects who received at least a full dose of IMP.

All data collected during treatment will be included in the safety summaries.

8.2.1.3. Pharmacokinetics

The PK analysis set will include all subjects in the safety analysis set who have evaluable on-study PK measurements.
8.3. Data Handling Conventions

Missing data can have an impact upon the interpretation of the trial data. As this study is of short duration, it is anticipated that missing data will be minimal. In general, values for missing data will not be imputed. For laboratory data, a missing Baseline value will be replaced with a screening value, if available; otherwise it will be treated as normal (ie, Grade 0; no toxicity grade) for the summary of graded laboratory abnormalities. A retest value may be used if the first test is invalidated (eg, specimen hemolyzed).

Values will not be imputed for missing vital sign and other safety data; however, a missing Baseline value will be replaced with a Screening value, if available.

Details for the handling of missing data due to subject discontinuation or other reasons, including unusable and spurious data, and rules for determining major and minor protocol deviations will be described in the SAP.

All available data for subjects that do not complete the study will be included in the data listings.

Tables that include both individual subject PK data and summary statistics will present all available data, but only subjects in the PK analysis will be included in the summary statistics.

Viral load data will be log transformed prior to analyses.

8.4. Demographic Data and Baseline Characteristics

Demographic and Baseline measurements will be summarized using standard descriptive methods.

Demographic summaries will include sex, race/ethnicity, randomization stratification group, and age.

Baseline data will include a summary of body weight, height, and BMI.

For categorical demographic and Baseline characteristics, a Fisher’s exact test will be used to compare treatment groups. For continuous demographic and Baseline characteristics, a Wilcoxon rank sum test will be used to compare treatment groups.

8.5. Efficacy Analysis

8.5.1. Primary Analysis

The primary endpoint is the daily average change in nasal RSV viral load (log_{10} copies/mL) from Day 1 to Day 9. The primary analysis will be performed on subjects included in the FAS population. To test the null hypothesis that there is no difference between the GS-5806 and placebo treatment groups in the daily average change in viral load, a parametric analysis of covariance (ANCOVA) model with corresponding Baseline viral load as a covariate will be used, with a 2-sided 0.05 level. Adjusted means and 95% confidence intervals (CIs) will also be presented.
8.5.2. Secondary Analyses

The FAS will be used for all summaries and analyses of secondary endpoints. All secondary endpoints will be analyzed using 2-sided tests to compare treatment differences.

The proportion of subjects who develop respiratory failure requiring mechanical ventilation and the proportion of subjects with all-cause mortality will be analyzed using Fisher’s exact tests.

In order to account for multiple hypothesis testing of endpoints, a family alpha spending rule will be used to control the Type 1 error rate of 0.05 across the primary and secondary endpoints, testing for differences between treatment groups. The primary endpoint analysis will serve as the gatekeeper for the secondary analyses. If the primary null hypothesis is rejected, then the following secondary endpoints will be tested sequentially at $\alpha = 0.05$ based upon the closed testing procedure \{11631\}.

- Proportion of subjects developing respiratory failure (of any cause) requiring mechanical ventilation (invasive or noninvasive) through Day 28
- Proportion of all-cause mortality among all subjects through Day 28

8.5.3. Exploratory Analyses

The FAS analysis set will be used for all summaries and analyses of exploratory endpoints. All exploratory endpoints will be analyzed using 2-sided tests to test for treatment differences.

Daily average viral load and daily average O$_2$ saturation endpoints will be analyzed using an ANCOVA model including corresponding Baseline values in the model. Adjusted means and 95% CIs will be presented for each analysis. Nonparametric methods such as rank-based ANCOVA models or Wilcoxon rank sum tests may be implemented if statistical model assumptions are not met.

RSV viral load and changes in viral load will be analyzed using MMRM models that include viral load or changes in viral load from Baseline at all post-Baseline visits, respectively. The models will include terms for Baseline value, treatment, visit, and treatment by visit interaction. Adjusted means and 95% CIs will be presented for each visit. Viral load difference at the visit the highest mean viral load was achieved among Placebo treated subjects will be compared using this model. The same analysis methods will be implemented for similar O$_2$ saturation endpoints.

The duration of hospitalization, the number of ICU or equivalent ICU care hourss, and the number of mechanical ventilation days will be analyzed using an analysis of variance (ANOVA) model. Wilcoxon rank sum tests may be implemented if statistical model assumptions are not met.

The number of subjects (n and percent) with detectable viral load, with viremia, who require supplemental O$_2$, whose O$_2$ saturation drops below 88% and who require ICU admissions, will be analyzed using Fisher’s exact tests.
P-values generated from the exploratory endpoint analyses will be used for descriptive purposes only. Descriptive statistics will be provided for all endpoints.

Subgroup analyses (eg, autologous or allogeneic transplants) may be conducted. Details of analyses will be included in the SAP.

8.6. **Safety Analysis**

All safety data collected on or after the date that IMP was first dispensed up to the date of last dose of IMP through Day 28 will be summarized by treatment group (according to the IMP received). Data for the pretreatment and treatment-free follow-up periods will be included in data listings only. Data for the treatment period will be summarized by treatment (active or placebo) using the number of subjects (n and percent) with events/abnormalities for categorical data and using descriptive statistics for continuous data.

8.7. **Extent of Exposure**

A subject’s extent of exposure to IMP data will be generated from the IMP administration data. Exposure data will be summarized by treatment group.

8.7.1. **Adverse Events**

Clinical and laboratory adverse events will be coded using the Medical Dictionary for Regulatory Activities (MedDRA). System Organ Class (SOC), High-Level Group Term (HLGT), High-Level Term (HLT), Preferred Term (PT), and Lower-Level Term (LLT) will be attached to the clinical database.

Events will be summarized on the basis of the date of onset for the event. A treatment-emergent adverse event will be defined as any adverse event that begins on or after the date of first dose of IMP up to the date of last dose of IMP through Day 28.

Summaries (number and percentage of subjects) of treatment-emergent adverse events (by SOC, and PT) will be provided by treatment group.

8.7.2. **Laboratory Evaluations**

Selected laboratory data will be summarized using only observed data. Data and change from Baseline at all scheduled time points will be summarized.

Graded laboratory abnormalities will be defined using the grading scheme in Appendix 4. Grading of laboratory abnormalities for analysis purposes will be performed by GSI.

Incidence of treatment-emergent laboratory abnormalities, defined as values that increase at least 1 toxicity grade from Baseline at any time post Baseline up to and including Day 28 will be summarized by treatment group. If Baseline data are missing, then any graded abnormality (ie, at least a Grade 1) will be considered treatment emergent.
Laboratory abnormalities that occur before the first dose of IMP or after the subject has been discontinued from treatment for at least 28 days will be included in a data listing.

8.7.3. Other Safety Evaluations

Vital signs data will be summarized using descriptive statistics by the observed data and by the change from Baseline at each time point.

8.8. Pharmacokinetic Analysis

Individual subject GS-5806 concentration-time data will be displayed using scheduled sampling times. Descriptive statistics (eg, n, mean, standard deviation, %CV, median, and range) will be calculated for each sampling time. PK/PD relationship may be explored as appropriate.

8.9. Sample Size

Sample size calculations are based on results observed in a study that evaluated the efficacy of oral and aerosolized ribavirin treatment for preventing progression from upper to lower respiratory tract infection in hematopoietic cell transplant recipients with RSV infections (unpublished data from Dr. PPD). The sample size calculation assumes the daily average change in RSV log_{10} viral load from Day 1 to Day 9 in the placebo group will be -1.5 log_{10} copies/mL with a corresponding standard deviation (SD) of 1.75 and that 85% of the subjects will be evaluable. Based on these assumptions, with 25 subjects per group there is approximately 85% power to detect a 1.5 log difference in daily average change in log_{10} viral load between treatment groups using a 2-sided 0.05-level test. Given an evaluable rate of 85%, a total of 60 subjects will need to be randomized into the study.

8.10. Data Monitoring Committee

An external multidisciplinary data monitoring committee (DMC) will review the progress of the study and perform interim reviews of safety and viral load and sequence data as specified in the DMC charter and provide recommendation to Gilead whether the nature, frequency, and severity of adverse effects associated with study treatment warrant the early termination of the study in the best interests of the participants, whether the study should continue as planned, or the study should continue with modifications.

The DMC’s specific activities will be defined by a mutually agreed charter, which will define the DMC’s membership, conduct and meeting schedule.

While the DMC will be asked to advise Gilead regarding future conduct of the study, including possible early study termination, Gilead retains final decision-making authority on all aspects of the study.
9. RESPONSIBILITIES

9.1. Investigator Responsibilities

9.1.1. Good Clinical Practice

The investigator will ensure that this study is conducted in accordance with the principles of the Declaration of Helsinki (as amended in Edinburgh, Tokyo, Venice, Hong Kong, and South Africa), International Conference on Harmonisation (ICH) guidelines, or with the laws and regulations of the country in which the research is conducted, whichever affords the greater protection to the study subject. These standards are consistent with the European Union Clinical Trials Directive 2001/20/EC and Good Clinical Practice Directive 2005/28/EC.


The investigator and all applicable subinvestigators will comply with 21 CFR, Part 54, 1998, providing documentation of their financial interest or arrangements with Gilead, or proprietary interests in the investigational drug under study. This documentation must be provided prior to the investigator’s (and any subinvestigator’s) participation in the study. The investigator and subinvestigator agree to notify Gilead of any change in reportable interests during the study and for 1 year following completion of the study. Study completion is defined as the date when the last subject completes the protocol-defined activities.

9.1.2. Institutional Review Board (IRB)/Independent Ethics Committee (IEC) Review and Approval

The investigator (or sponsor as appropriate according to local regulations) will submit this protocol, informed consent form, and any accompanying material to be provided to the subject (such as advertisements, subject information sheets, or descriptions of the study used to obtain informed consent) to an IRB/IEC, depending on region. The investigator will not begin any study subject activities until approval from the IRB/IEC has been documented and provided as a letter to the investigator.

Before implementation, the investigator will submit to and receive documented approval from the IRB/IEC for any modifications made to the protocol or any accompanying material to be provided to the subject after initial approval, with the exception of those necessary to reduce immediate risk to study subjects.

9.1.3. Informed Consent

The investigator is responsible for obtaining written informed consent from each individual participating in this study after adequate explanation of the aims, methods, objectives, and potential hazards of the study and before undertaking any study-related procedures. The
investigator must use the most current IRB or IEC-approved consent form for documenting written informed consent. Each informed consent (or assent as applicable) will be appropriately signed and dated by the subject or the subject’s legally authorized representative and the person conducting the consent discussion, and also by an impartial witness if required by IRB/IEC or local requirements.

9.1.4. Confidentiality

The investigator must assure that subjects’ anonymity will be strictly maintained and that their identities are protected from unauthorized parties. Only subject initials, date of birth, another unique identifier (as allowed by local law) and an identification code will be recorded on any form or biological sample submitted to the Sponsor, IRB/IEC, or laboratory. Laboratory specimens must be labeled in such a manner as to protect subject identity while allowing the results to be recorded to the proper subject. Refer to specific laboratory instructions. NOTE: The investigator must keep a screening log showing codes, names, and addresses for all subjects screened and for all subjects enrolled in the trial. Subject data will be processed in accordance with all applicable regulations.

The investigator agrees that all information received from Gilead, including but not limited to the investigator brochure, this protocol, CRF/eCRF, the IMP, and any other study information, remain the sole and exclusive property of Gilead during the conduct of the study and thereafter. This information is not to be disclosed to any third party (except employees or agents directly involved in the conduct of the study or as required by law) without prior written consent from Gilead. The investigator further agrees to take all reasonable precautions to prevent the disclosure by any employee or agent of the study site to any third party or otherwise into the public domain.

9.1.5. Study Files and Retention of Records

The investigator must maintain adequate and accurate records to enable the conduct of the study to be fully documented and the study data to be subsequently verified. These documents should be classified into at least the following two categories: (1) investigator’s study file, and (2) subject clinical source documents.

The investigator’s study file will contain the protocol/amendments, CRF and query forms, IRB/IEC and governmental approval with correspondence, informed consent, drug records, staff curriculum vitae and authorization forms, and other appropriate documents and correspondence.

The required source data should include sequential notes containing at least the following information for each subject:

- Subject identification (name, date of birth, gender);
- Documentation that subject meets eligibility criteria, ie, history, physical examination, and confirmation of diagnosis (to support inclusion and exclusion criteria);
• Documentation of the reason(s) a consented subject is not enrolled

• Participation in study (including study number);

• Study discussed and date of informed consent;

• Dates of all visits;

• Documentation that protocol specific procedures were performed;

• Results of efficacy parameters, as required by the protocol;

• Start and end date (including dose regimen) of IMP, including dates of dispensing and return;

• Record of all adverse events and other safety parameters (start and end date, and including causality and severity);

• Concomitant medication (including start and end date, dose if relevant; dose changes);

• Date of study completion and reason for early discontinuation, if it occurs.

All clinical study documents must be retained by the investigator until at least 2 years or according to local laws, whichever is longer, after the last approval of a marketing application in an ICH region (ie, United States, Europe, or Japan) and until there are no pending or planned marketing applications in an ICH region; or, if no application is filed or if the application is not approved for such indication, until 2 years after the investigation is discontinued and regulatory authorities have been notified. Investigators may be required to retain documents longer if specified by regulatory requirements, by local regulations, or by an agreement with Gilead. The investigator must notify Gilead before destroying any clinical study records.

Should the investigator wish to assign the study records to another party or move them to another location, Gilead must be notified in advance.

If the investigator cannot provide for this archiving requirement at the study site for any or all of the documents, special arrangements must be made between the investigator and Gilead to store these records securely away from the site so that they can be returned sealed to the investigator in case of an inspection. When source documents are required for the continued care of the subject, appropriate copies should be made for storage away from the site.

9.1.6. Case Report Forms

For each subject consented, an eCRF will be completed by an authorized study staff member whose training for this function is documented according to study procedures. eCRF should be completed on the day of the subject visit to enable the sponsor to perform central monitoring of safety data. Subsequent to data entry, a study monitor will perform source data verification within the EDC system. Original entries as well as any changes to data fields will be stored in
the audit trail of the system. Prior to database lock (or any interim time points as described in the clinical data management plan), the investigator will use his/her log in credentials to confirm that the forms have been reviewed, and that the entries accurately reflect the information in the source documents. The eCRF capture the data required per the protocol schedule of events and procedures. System-generated or manual queries will be issued to the investigative site staff as data discrepancies are identified by the monitor or internal Gilead staff, who routinely review the data for completeness, correctness, and consistency. The site coordinator is responsible for responding to the queries in a timely manner, within the system, either by confirming the data as correct or updating the original entry, and providing the reason for the update (eg, data entry error). At the conclusion of the trial, Gilead will provide the site with a read-only archive copy of the data entered by that site. This archive must be stored in accordance with the records retention requirements outlined in Section 9.1.5.

9.1.7. Data Quality Control and Quality Assurance

To insure accurate, complete, and reliable data, the Sponsor or its representatives will do the following:

- Provide instructional material to the study sites, as appropriate.

- Instruct the investigators and study personnel on the protocol, the completion of the CRFs, and study procedures.

- Make periodic visits to the study site.

- Be available to consultation and stay in contact with the study site personnel by mail, email, telephone, and/or fax.

- Monitor the subject data recorded in the CRFs against source documents at the study site.

- Review and evaluate CRF data and use standard computer edits to detect errors in data collection.

9.1.8. Investigational Medicinal Product Accountability and Return

Gilead recommends that used and unused IMP supplies be destroyed on site if possible. The study monitor will evaluate each study center’s IMP disposal procedures and provide appropriate instruction for destruction of unused IMP supplies. If the site has an appropriate standard operating procedure (SOP) for drug destruction as determined by Gilead QA, the site may destroy used (empty or partially empty) and unused IMP supplies in accordance with that site’s approved SOP. A copy of the site’s approved SOP will be obtained for central files. If IMP cannot be destroyed on site, the study monitor will provide instructions for return to Gilead or the shipping facility from which it came for eventual destruction.
If IMP is destroyed on site, the investigator must maintain accurate records for all IMP destroyed. Records must show the identification and quantity of each unit destroyed, the method of destruction, and the person who disposed of the IMP. Upon study completion, copies of the IMP accountability records must be filed at the site. Another copy will be returned to Gilead.

The study monitor will review IMP supplies and associated records at periodic intervals.

9.1.9. Inspections

The investigator will make available all source documents and other records for this trial to Gilead’s appointed study monitors, to IRB/IECs, or to regulatory authority or health authority inspectors.

9.1.10. Protocol Compliance

The investigator is responsible for ensuring the study is conducted in accordance with the procedures and evaluations described in this protocol.

9.2. Sponsor Responsibilities

9.2.1. Protocol Modifications

Protocol modifications, except those intended to reduce immediate risk to study subjects, may be made only by Gilead. The investigator must submit all protocol modifications to the IRB/IEC in accordance with local requirements and receive documented IRB/IEC approval before modifications can be implemented.

9.2.2. Study Report and Publications

A clinical study report (CSR) will be prepared and provided to the applicable regulatory agencies. Gilead will ensure that the report meets the standards set out in the ICH Guideline for Structure and Content of Clinical Study Reports (ICH E3). Note that an abbreviated report may be prepared in certain cases.

Investigators in this study may communicate, orally present, or publish in scientific journals or other scholarly media only after the following conditions have been met:

- The results of the study in their entirety have been publicly disclosed by or with the consent of Gilead in an abstract, manuscript, or presentation form or the study has been completed at all study sites for at least 2 years.

- The investigator will submit to Gilead any proposed publication or presentation along with the respective scientific journal or presentation forum at least 30 days before submission of the publication or presentation.

- No such communication, presentation, or publication will include Gilead’s confidential information (see Section 9.1.4).
• The investigator will comply with Gilead’s request to delete references to its confidential information (other than the study results) in any paper or presentation and agrees to withhold publication or presentation for an additional 60 days in order to obtain patent protection if deemed necessary.

9.3. Joint Investigator/Sponsor Responsibilities

9.3.1. Payment Reporting

Investigators and their study staff may be asked to provide services performed under this protocol (e.g., attendance at Investigator's Meetings). If required under the applicable statutory and regulatory requirements, Gilead will capture and disclose to Federal and State agencies any expenses paid or reimbursed for such services, including any clinical trial payments, meal, travel expenses or reimbursements, consulting fees, and any other transfer of value.

9.3.2. Access to Information for Monitoring

In accordance with regulations and guidelines, the study monitor must have direct access to the investigator’s source documentation in order to verify the accuracy of the data recorded in the CRF/eCRF.

The monitor is responsible for routine review of the CRF/eCRF at regular intervals throughout the study to verify adherence to the protocol and the completeness, consistency, and accuracy of the data being entered on them. The monitor should have access to any subject records needed to verify the entries on the CRF/eCRF. The investigator agrees to cooperate with the monitor to ensure that any problems detected through any type of monitoring (central, on site) are resolved.

9.3.3. Access to Information for Auditing or Inspections

Representatives of regulatory authorities or of Gilead may conduct inspections or audits of the clinical study. If the investigator is notified of an inspection by a regulatory authority the investigator agrees to notify the Gilead medical monitor immediately. The investigator agrees to provide to representatives of a regulatory agency or Gilead access to records, facilities, and personnel for the effective conduct of any inspection or audit.

9.3.4. Study Discontinuation

Both the sponsor and the investigator reserve the right to terminate the study at any time. Should this be necessary, both parties will arrange discontinuation procedures and notify the appropriate regulatory authority(ies), IRBs, and IECs. In terminating the study, Gilead and the investigator will assure that adequate consideration is given to the protection of the subjects’ interests.
10. REFERENCES

11631 Dmitrienko A, Offen WW, Westfall PH. Gatekeeping strategies for clinical trials that do not require all primary effects to be significant. Statist Med 2003;22 (15):2387-400.


11. **APPENDICES**

Appendix 1. Investigator Signature Page  
Appendix 2. Study Procedures Table  
Appendix 3. Management of Clinical and Laboratory Adverse Events  
Appendix 4. GSI Grading Scale for Severity of Adverse Events and Laboratory Abnormalities  
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GILEAD SCIENCES, INC.
199 E BLAINE ST
SEATTLE, WA 98102

STUDY ACKNOWLEDGEMENT
A Phase 2b, Randomized, Double-Blind, Placebo-Controlled Multi-Center Study Evaluating Antiviral Effects, Pharmacokinetics, Safety, and Tolerability of GS-5806 in Hematopoietic Cell Transplant (HCT) Recipients with Respiratory Syncytial Virus (RSV) Infection of the Lower Respiratory Tract

GS-US-218-1502, Original, 09 June 2014

This protocol has been approved by Gilead Sciences, Inc. The following signature documents this approval.

Name (Printed) Seth Toback
Author
Date June 09 2014

INVESTIGATOR STATEMENT

I have read the protocol, including all appendices, and I agree that it contains all necessary details for me and my staff to conduct this study as described. I will conduct this study as outlined herein and will make a reasonable effort to complete the study within the time designated.

I will provide all study personnel under my supervision copies of the protocol and access to all information provided by Gilead Sciences, Inc. I will discuss this material with them to ensure that they are fully informed about the drugs and the study.

Principal Investigator Name (Printed) Signature

Date Site Number
## Appendix 2. Study Procedures Table

<table>
<thead>
<tr>
<th></th>
<th>Visit 1: Screening (Day -2 to -1)</th>
<th>Visit 2: Baseline Assessments, Randomization, and Treatment Assessments (Day 1)</th>
<th>Visit 3: Day 3 (±24 hours)</th>
<th>Visit 4: Day 5 (±24 hours)</th>
<th>Visit 5: Day 7 (±24 hours)</th>
<th>Visit 6: Day 9 (±24 hours)</th>
<th>Visit 7: Day 13 (±24 hours)</th>
<th>Visit 8: Day 17 (±24 hours)</th>
<th>Visit 9: Day 22 (±24 hours)</th>
<th>Visit 10: End of study/Day 28 (+3 days)</th>
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</table>
Visit 1: Screening (Day -2 to -1) | Visit 2: Baseline Assessments, Randomization, and Treatment Assessments (Day 1) | Visit 3: Day 3 (±24 hours) | Visit 4: Day 5 (±24 hours) | Visit 5: Day 7 (±24 hours) | Visit 6: Day 9 (±24 hours) | Visit 7: Day 13 (±24 hours) | Visit 8: Day 17 (±24 hours) | Visit 9: Day 22 (±24 hours) | Visit 10: End of study/Day 28 (+3 days)

| Serum creatinine | X | X |
| Adverse Events | X | X | X | X | X | X | X | X | X |
| ICU admissions, re-hospitalizations, standard of care test results, mechanical ventilation, and supplemental O₂ | | X | X | X | X | X | X | X | X |
| Concomitant Medications | X | X | X | X | X | X | X | X | X |

a  Chest X-ray obtained within 2 days prior to Screening may be used
b  Existing values collected ≤ 6 days prior to Screening may be used
c  Required for women unable to confirm menopause, hysterectomy and/or bilateral oophorectomy
d  When IMP is administered at a visit, the vital signs will be obtained 5 – 10 minutes prior to IMP administration
e  On room air
f  Hematology and serum chemistry to include WBC with differential, Hgb, platelets, BUN, creatinine, serum albumin, AST, ALT, and total bilirubin
g  2 samples total, one from each nostril – collected prior to dosing on dosing days
h  Collected pre-dose if induced sputum was not used to demonstrate the presence of RSV in the lower respiratory tract ≤6 days prior to Day 1
i  PK samples collected for all subjects 4 hours post-dose Day 1; pre-dose on Days 5, 9, 13, and 17; and anytime on Day 22
j  For hospitalized subjects only: blood will be drawn for serum creatinine at 4 hours post-dose at Visit 2 (Day 1) and on Days 2, 3 and 4 (24, 48 and 72 hours [±3 hours] post-first GS-5806 dose if they remain hospitalized at those times.
k  For hospitalized subjects only: PK sample collected at Visit 3 (48 hours [±3 hours] post-first GS-5806 dose)
Appendix 3. Management of Clinical and Laboratory Adverse Events

**Grade 1**
- May continue dosing at the discretion of the investigator

**Grade 2**
- Repeat lab to confirm toxicity grade

**Grade 3**
- Repeat lab to confirm toxicity grade

**Grade 4**
- If confirmed and possibly or probably related to investigational medicinal products:
  1. Withhold investigational medicinal products until ≤ Grade 2
  2. Restart all investigational medicinal products at full dose

- If confirmed and unrelated to investigational medicinal products, dosing may continue at the discretion of the investigator

- If Grade 3 or 4 recurrence that is confirmed and possibly or probably related to investigational medicinal products, discontinue all investigational medicinal products dosing permanently

- If Grade 3 or 4 recurrence that is considered unrelated to investigational medicinal products, continue all investigational medicinal products at the same dose at the discretion of the investigator
## Appendix 4. GSI Grading Scale for Severity of Adverse Events and Laboratory Abnormalities

**Version: 18 June 2012**

### HEMATOLOGY

<table>
<thead>
<tr>
<th></th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
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</thead>
<tbody>
<tr>
<td><strong>Hemoglobin</strong></td>
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<tr>
<td><strong>HIV POSITIVE</strong></td>
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<tr>
<td><strong>Adult and Pediatric ≥ 57 Days</strong></td>
<td>8.5 to 10.0 g/dL</td>
<td>7.5 to &lt; 8.5 g/dL</td>
<td>6.5 to &lt; 7.5 g/dL</td>
<td>&lt; 6.5 g/dL</td>
</tr>
<tr>
<td></td>
<td>85 to 100 g/L</td>
<td>75 to &lt; 85 g/L</td>
<td>65 to &lt; 75 g/L</td>
<td>&lt; 65 g/L</td>
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<tr>
<td><strong>HIV NEGATIVE</strong></td>
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<tr>
<td><strong>Adult and Pediatric ≥ 57 Days</strong></td>
<td>10.0 to 10.9 g/dL</td>
<td>9.0 to &lt; 10.0 g/dL</td>
<td>7.0 to &lt; 9.0 g/dL</td>
<td>&lt; 7.0 g/dL</td>
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<tr>
<td></td>
<td>100 to 109 g/L</td>
<td>90 to &lt; 100 g/L</td>
<td>70 to &lt; 90 g/L</td>
<td>&lt; 70 g/L</td>
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<tr>
<td></td>
<td>OR</td>
<td>Any decrease from Baseline</td>
<td>Any decrease from Baseline</td>
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</tr>
<tr>
<td></td>
<td>2.5 to &lt; 3.5 g/dL</td>
<td>3.5 to &lt; 4.5 g/dL</td>
<td>≥ 4.5 g/dL</td>
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<tr>
<td></td>
<td>25 to &lt; 35 g/L</td>
<td>35 to &lt; 45 g/L</td>
<td>≥ 45 g/L</td>
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<tr>
<td><strong>Infant, 36–56 Days</strong></td>
<td>HIV POSITIVE OR NEGATIVE</td>
<td></td>
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<tr>
<td></td>
<td>8.5 to 9.4 g/dL</td>
<td>7.0 to &lt; 8.5 g/dL</td>
<td>6.0 to &lt; 7.0 g/dL</td>
<td>&lt; 6.0 g/dL</td>
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<tr>
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<td>85 to 94 g/L</td>
<td>70 to &lt; 85 g/L</td>
<td>60 to &lt; 70 g/L</td>
<td>&lt; 60 g/L</td>
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<td><strong>Infant, 22–35 Days</strong></td>
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<tr>
<td></td>
<td>9.5 to 10.5 g/dL</td>
<td>8.0 to &lt; 9.5 g/dL</td>
<td>7.0 to &lt; 8.0 g/dL</td>
<td>&lt; 7.0 g/dL</td>
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<td>95 to 105 g/L</td>
<td>80 to &lt; 95 g/L</td>
<td>70 to &lt; 80 g/L</td>
<td>&lt; 70 g/L</td>
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<tr>
<td><strong>Infant, 1–21 Days</strong></td>
<td>HIV POSITIVE OR NEGATIVE</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>12.0 to 13.0 g/dL</td>
<td>10.0 to &lt; 12.0 g/dL</td>
<td>9.0 to &lt; 10.0 g/dL</td>
<td>&lt; 9.0 g/dL</td>
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<tr>
<td></td>
<td>120 to 130 g/L</td>
<td>100 to &lt; 120 g/L</td>
<td>90 to &lt; 100 g/L</td>
<td>&lt; 90 g/L</td>
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## HEMATOLOGY

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<tr>
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<th>Grade 2</th>
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<tbody>
<tr>
<td><strong>Absolute Neutrophil Count</strong> (ANC)</td>
<td>1000 to 1300/mm³</td>
<td>750 to &lt; 1000/mm³</td>
<td>500 to &lt; 750/mm³</td>
<td>&lt; 500/mm³</td>
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<tr>
<td><strong>Adult and Pediatric, &gt; 7 Days</strong></td>
<td>1.00 to 1.30 GI/L</td>
<td>0.75 to &lt; 1.00 GI/L</td>
<td>0.50 to &lt; 0.75 GI/L</td>
<td>&lt; 0.50 GI/L</td>
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<tr>
<td><strong>Infant, 2 – ≤ 7 Days</strong></td>
<td>1250 to 1500/mm³</td>
<td>1000 to &lt; 1250/mm³</td>
<td>750 to &lt; 1000/mm³</td>
<td>&lt; 750/mm³</td>
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<tr>
<td><strong>Infant, 1 Day</strong></td>
<td>1.25 to 1.50 GI/L</td>
<td>1.00 to &lt; 1.25 GI/L</td>
<td>0.75 to &lt; 1.00 GI/L</td>
<td>&lt; 0.75 GI/L</td>
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<tr>
<td><strong>Absolute CD4+ Count</strong></td>
<td>1250 to 1500/mm³</td>
<td>1000 to &lt; 1250/mm³</td>
<td>750 to &lt; 1000/mm³</td>
<td>&lt; 750/mm³</td>
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<tr>
<td><strong>HIV NEGATIVE ONLY</strong></td>
<td>1.25 to 1.50 GI/L</td>
<td>1.00 to &lt; 1.25 GI/L</td>
<td>0.75 to &lt; 1.00 GI/L</td>
<td>&lt; 0.75 GI/L</td>
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<tr>
<td><strong>Absolute Lymphocyte Count</strong></td>
<td>4000 to 5000/mm³</td>
<td>3000 to &lt; 4000/mm³</td>
<td>1500 to &lt; 3000/mm³</td>
<td>&lt; 1500/mm³</td>
</tr>
<tr>
<td><strong>HIV NEGATIVE ONLY</strong></td>
<td>4.00 to 5.00 GI/L</td>
<td>3.00 to &lt; 4.00 GI/L</td>
<td>1.50 to &lt; 3.00 GI/L</td>
<td>&lt; 1.50 GI/L</td>
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<tr>
<td><strong>Platelets</strong></td>
<td>100,000 to &lt; 125,000/mm³</td>
<td>50,000 to &lt; 100,000/mm³</td>
<td>25,000 to &lt; 50,000/mm³</td>
<td>&lt; 25,000/mm³</td>
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<tr>
<td><strong>&gt; 13 Years</strong></td>
<td>100 to &lt; 125 GI/L</td>
<td>50 to &lt; 100 GI/L</td>
<td>25 to &lt; 50 GI/L</td>
<td>&lt; 25 GI/L</td>
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<tr>
<td><strong>WBCs</strong></td>
<td>2000/mm³ to 2500/mm³</td>
<td>1,500 to &lt; 2,000/mm³</td>
<td>1000 to &lt; 1,500/mm³</td>
<td>&lt; 1000/mm³</td>
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<tr>
<td><strong>&gt; 13 Years</strong></td>
<td>2.00 GI/L to 2.50 GI/L</td>
<td>1.50 to &lt; 2.00 GI/L</td>
<td>1.00 to &lt; 1.50 GI/L</td>
<td>&lt; 1.00 GI/L</td>
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<tr>
<td><strong>Hypofibrinogenemia</strong></td>
<td>100 to 200 mg/dL</td>
<td>75 to &lt; 100 mg/dL</td>
<td>50 to &lt; 75 mg/dL</td>
<td>&lt; 50 mg/dL</td>
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<tr>
<td><strong>&gt; 13 Years</strong></td>
<td>1.00 to 2.00 g/L</td>
<td>0.75 to &lt; 1.00 g/L</td>
<td>0.50 to &lt; 0.75 g/L</td>
<td>&lt; 0.50 g/L</td>
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</tbody>
</table>

**CONFIDENTIAL**

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<table>
<thead>
<tr>
<th></th>
<th>Grade 1</th>
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<tbody>
<tr>
<td><strong>Hyperfibrinogenemia</strong></td>
<td>&gt; ULN to 600 mg/dL</td>
<td>&gt; 600 mg/dL</td>
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<tr>
<td></td>
<td>&gt; ULN to 6.0 g/L</td>
<td>&gt; 6.0 g/L</td>
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<tr>
<td><strong>Fibrin Split Product</strong></td>
<td>20 to 40 µg/mL</td>
<td>&gt; 40 to 50 µg/mL</td>
<td>&gt; 50 to 60 µg/mL</td>
<td>&gt; 60 µg/mL</td>
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<tr>
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<td>20 to 40 mg/L</td>
<td>&gt; 40 to 50 mg/L</td>
<td>&gt; 50 to 60 mg/L</td>
<td>&gt; 60 mg/L</td>
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<tr>
<td><strong>Prothrombin Time (PT)</strong></td>
<td>&gt; 1.00 to 1.25 x ULN</td>
<td>&gt; 1.25 to 1.50 x ULN</td>
<td>&gt; 1.50 to 3.00 x ULN</td>
<td>&gt; 3.00 x ULN</td>
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<tr>
<td><strong>International Normalized Ratio of prothrombin time (INR)</strong></td>
<td>1.1 to 1.5 x ULN</td>
<td>&gt; 1.5 to 2.0 x ULN</td>
<td>&gt; 2.0 to 3.0 x ULN</td>
<td>&gt; 3.0 x ULN</td>
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<tr>
<td><strong>Activated Partial Thromboplastin Time (APTT)</strong></td>
<td>&gt; 1.00 to 1.66 x ULN</td>
<td>&gt; 1.66 to 2.33 x ULN</td>
<td>&gt; 2.33 to 3.00 x ULN</td>
<td>&gt; 3.00 x ULN</td>
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<tr>
<td><strong>Methemoglobin</strong></td>
<td>5.0 to 10.0%</td>
<td>&gt; 10.0 to 15.0%</td>
<td>&gt; 15.0 to 20.0%</td>
<td>&gt; 20.0%</td>
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### CHEMISTRY

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<tr>
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<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hyponatremia</strong></td>
<td>130 to &lt;LLN mEq/L</td>
<td>125 to &lt; 130 mEq/L</td>
<td>121 to &lt; 125 mEq/L</td>
<td>&lt; 121 mEq/L</td>
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<tr>
<td></td>
<td>130 to &lt;LLN mmol/L</td>
<td>125 to &lt; 130 mmol/L</td>
<td>121 to &lt; 125 mmol/L</td>
<td>&lt; 121 mmol/L</td>
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<tr>
<td><strong>Hypernatremia</strong></td>
<td>146 to 150 mEq/L</td>
<td>&gt; 150 to 154 mEq/L</td>
<td>&gt; 154 to 159 mEq/L</td>
<td>&gt; 159 mEq/L</td>
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<td>146 to 150 mmol/L</td>
<td>&gt; 150 to 154 mmol/L</td>
<td>&gt; 154 to 159 mmol/L</td>
<td>&gt; 159 mmol/L</td>
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<tr>
<td><strong>Hypokalemia</strong></td>
<td>3.0 to 3.4 mEq/L</td>
<td>2.5 to &lt; 3.0 mEq/L</td>
<td>2.0 to &lt; 2.5 mEq/L</td>
<td>&lt; 2.0 mEq/L</td>
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<tr>
<td></td>
<td>3.0 to 3.4 mmol/L</td>
<td>2.5 to &lt; 3.0 mmol/L</td>
<td>2.0 to &lt; 2.5 mmol/L</td>
<td>&lt; 2.0 mmol/L</td>
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<tr>
<td><strong>Hyperkalemia</strong></td>
<td>5.6 to 6.0 mEq/L</td>
<td>&gt; 6.0 to 6.5 mEq/L</td>
<td>&gt; 6.5 to 7.0 mEq/L</td>
<td>&gt; 7.0 mEq/L</td>
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<tr>
<td></td>
<td>5.6 to 6.0 mmol/L</td>
<td>&gt; 6.0 to 6.5 mmol/L</td>
<td>&gt; 6.5 to 7.0 mmol/L</td>
<td>&gt; 7.0 mmol/L</td>
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<tr>
<td><strong>Hypoglycemia</strong></td>
<td>Adult and Pediatric</td>
<td></td>
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</tr>
<tr>
<td><strong>≥ 1 Month</strong></td>
<td>55 to 64 mg/dL</td>
<td>40 to &lt; 55 mg/dL</td>
<td>30 to &lt; 40 mg/dL</td>
<td>&lt; 30 mg/dL</td>
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<tr>
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<td>3.03 to 3.58 mmol/L</td>
<td>2.20 to &lt; 3.03 mmol/L</td>
<td>1.64 to &lt; 2.20 mmol/L</td>
<td>&lt; 1.64 mmol/L</td>
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<tr>
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<td>50 to 54 mg/dL</td>
<td>40 to &lt; 50 mg/dL</td>
<td>30 to &lt; 40 mg/dL</td>
<td>&lt; 30 mg/dL</td>
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<tr>
<td></td>
<td>2.8 to 3.0 mmol/L</td>
<td>2.2 to &lt; 2.8 mmol/L</td>
<td>1.7 to &lt; 2.2 mmol/L</td>
<td>&lt; 1.7 mmol/L</td>
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<tr>
<td><strong>Infant, &lt; 1 Month</strong></td>
<td>116 to 160 mg/dL</td>
<td>&gt; 160 to 250 mg/dL</td>
<td>&gt; 250 to 500 mg/dL</td>
<td>&gt; 500 mg/dL</td>
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<td>6.42 to 8.91 mmol/L</td>
<td>&gt; 8.91 to 13.90 mmol/L</td>
<td>&gt; 13.90 to 27.79 mmol/L</td>
<td>&gt; 27.79 mmol/L</td>
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<tr>
<td><strong>Hyperglycemia, Nonfasting</strong></td>
<td>110 to 125 mg/dL</td>
<td>&gt;125 to 250 mg/dL</td>
<td>&gt;250 to 500 mg/dL</td>
<td>&gt;500 mg/dL</td>
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<td>6.08 to 6.96 mmol/L</td>
<td>&gt;6.96 to 13.90 mmol/L</td>
<td>&gt;13.90 to 27.79 mmol/L</td>
<td>&gt;27.79 mmol/L</td>
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<tr>
<td><strong>Hyperglycemia, Fasting</strong></td>
<td>7.8 to 8.4 mg/dL</td>
<td>7.0 to &lt; 7.8 mg/dL</td>
<td>6.1 to &lt; 7.0 mg/dL</td>
<td>&lt; 6.1 mg/dL</td>
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<tr>
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<td>1.94 to 2.10 mmol/L</td>
<td>1.74 to &lt; 1.94 mmol/L</td>
<td>1.51 to &lt; 1.74 mmol/L</td>
<td>&lt; 1.51 mmol/L</td>
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<tr>
<td><strong>Hypocalcemia</strong></td>
<td>(corrected for albumin if appropriate*)</td>
<td>6.5 to 7.5 mg/dL</td>
<td>6.0 to &lt; 6.5 mg/dL</td>
<td>&lt; 5.5 mg/dL</td>
</tr>
<tr>
<td><strong>Adult and Pediatric</strong></td>
<td>≥ 7 Days</td>
<td>6.0 to 6.96 mmol/L</td>
<td>5.5 to &lt; 6.0 mg/dL</td>
<td>&lt; 5.5 mg/dL</td>
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<tr>
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<td>1.61 to 1.88 mmol/L</td>
<td>1.49 to &lt; 1.61 mmol/L</td>
<td>1.36 to &lt; 1.49 mmol/L</td>
<td>&lt; 1.36 mmol/L</td>
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<tr>
<td><strong>Infant, &lt; 7 Days</strong></td>
<td>7.8 to 8.4 mg/dL</td>
<td>7.0 to &lt; 7.8 mg/dL</td>
<td>6.1 to &lt; 7.0 mg/dL</td>
<td>&lt; 6.1 mg/dL</td>
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<td>1.94 to 2.10 mmol/L</td>
<td>1.74 to &lt; 1.94 mmol/L</td>
<td>1.51 to &lt; 1.74 mmol/L</td>
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<tr>
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<td>6.5 to 7.5 mg/dL</td>
<td>6.0 to &lt; 6.5 mg/dL</td>
<td>5.5 to &lt; 6.0 mg/dL</td>
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<tr>
<td></td>
<td>1.61 to 1.88 mmol/L</td>
<td>1.49 to &lt; 1.61 mmol/L</td>
<td>1.36 to &lt; 1.49 mmol/L</td>
<td>&lt; 1.36 mmol/L</td>
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## CHEMISTRY

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</tr>
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<tbody>
<tr>
<td><em><em>Hypercalcemia (corrected for albumin if appropriate</em>)</em>*</td>
<td>&gt;ULN to 11.5 mg/dL</td>
<td>&gt; 11.5 to 12.5 mg/dL</td>
<td>&gt; 12.5 to 13.5 mg/dL</td>
<td>&gt; 13.5 mg/dL</td>
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<tr>
<td><strong>Adult and Pediatric ≥ 7 Days</strong></td>
<td>&gt;ULN to 2.88 mmol/L</td>
<td>&gt; 2.88 to 3.13 mmol/L</td>
<td>&gt; 3.13 to 3.38 mmol/L</td>
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<tr>
<td><strong>Infant, &lt; 7 Days</strong></td>
<td>11.5 to 12.4 mg/dL</td>
<td>&gt; 12.4 to 12.9 mg/dL</td>
<td>&gt; 12.9 to 13.5 mg/dL</td>
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<td>2.86 to 3.10 mmol/L</td>
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<tr>
<td><strong>Hypocalcemia (ionized)</strong></td>
<td>3.0 mg/dL to &lt; LLN</td>
<td>2.5 to &lt; 3.0 mg/dL</td>
<td>2.0 to &lt; 2.5 mg/dL</td>
<td>&lt; 2.0 mg/dL</td>
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<tr>
<td></td>
<td>0.74 mmol/L to &lt; LLN</td>
<td>0.62 to &lt; 0.74 mmol/L</td>
<td>0.49 to &lt; 0.62 mmol/L</td>
<td>&lt; 0.49 mmol/L</td>
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<tr>
<td><strong>Hypercalcemia (ionized)</strong></td>
<td>&gt; ULN to 6.0 mg/dL</td>
<td>&gt; 6.0 to 6.5 mg/dL</td>
<td>&gt; 6.5 to 7.0 mg/dL</td>
<td>&gt; 7.0 mg/dL</td>
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<td>&gt; ULN to 1.50 mmol/L</td>
<td>&gt; 1.50 to 1.63 mmol/L</td>
<td>&gt; 1.63 to 1.75 mmol/L</td>
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<td><strong>Hypomagnesemia</strong></td>
<td>1.40 to &lt; LLN mg/dL</td>
<td>1.04 to &lt; 1.40 mg/dL</td>
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<td>1.2 to &lt; LLN mEq/L</td>
<td>0.9 to &lt; 1.2 mEq/L</td>
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<td>0.58 to &lt; LLN mmol/L</td>
<td>0.43 to &lt; 0.58 mmol/L</td>
<td>0.28 to &lt; 0.43 mmol/L</td>
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<tr>
<td><strong>Hypophosphatemia</strong></td>
<td>2.0 to &lt; LLN mg/dL</td>
<td>1.5 to &lt; 2.0 mg/dL</td>
<td>1.0 to &lt; 1.5 mg/dL</td>
<td>&lt; 1.0 mg/dL</td>
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<tr>
<td><strong>Adult and Pediatric &gt; 14 Years</strong></td>
<td>0.63 to &lt; LLN mmol/L</td>
<td>0.47 to &lt; 0.63 mmol/L</td>
<td>0.31 to &lt; 0.47 mmol/L</td>
<td>&lt; 0.31 mmol/L</td>
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<td>3.0 to 3.5 mg/dL</td>
<td>2.5 to &lt; 3.0 mg/dL</td>
<td>1.5 to &lt; 2.5 mg/dL</td>
<td>&lt; 1.5 mg/dL</td>
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<tr>
<td><strong>Pediatric 1 Year–14 Years</strong></td>
<td>0.96 to 1.12 mmol/L</td>
<td>0.80 to &lt; 0.96 mmol/L</td>
<td>0.47 to &lt; 0.80 mmol/L</td>
<td>&lt; 0.47 mmol/L</td>
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<td>3.5 to 4.5 mg/dL</td>
<td>2.5 to &lt; 3.5 mg/dL</td>
<td>1.5 to &lt; 2.5 mg/dL</td>
<td>&lt; 1.5 mg/dL</td>
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<tr>
<td><strong>Pediatric &lt; 1 Year</strong></td>
<td>1.12 to 1.46 mmol/L</td>
<td>0.80 to &lt; 1.12 mmol/L</td>
<td>0.47 to &lt; 0.80 mmol/L</td>
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## CHEMISTRY

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<th>Grade 1</th>
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<th>Grade 4</th>
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</thead>
<tbody>
<tr>
<td>Hyperbilirubinemia</td>
<td>&gt; 1.0 to 1.5 × ULN</td>
<td>&gt; 1.5 to 2.5 × ULN</td>
<td>&gt; 2.5 to 5.0 × ULN</td>
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<tr>
<td><strong>Adult and Pediatric &gt; 14 Days</strong></td>
<td>NA</td>
<td>20.0 to 25.0 mg/dL</td>
<td>&gt; 25.0 to 30.0 mg/dL</td>
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<tr>
<td><strong>Infant, ≤ 14 Days</strong></td>
<td>NA</td>
<td>342 to 428 μmol/L</td>
<td>&gt; 428 to 513 μmol/L</td>
</tr>
<tr>
<td><strong>(non-hemolytic)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Infant, ≤ 14 Days</strong></td>
<td>NA</td>
<td>20.0 to 25.0 mg/dL</td>
<td>&gt; 25.0 to 30.0 mg/dL</td>
</tr>
<tr>
<td><strong>(hemolytic)</strong></td>
<td></td>
<td>342 to 428 μmol/L</td>
<td>&gt; 428 to 513 μmol/L</td>
</tr>
<tr>
<td>Blood Urea Nitrogen</td>
<td>1.25 to 2.50 × ULN</td>
<td>&gt; 2.50 to 5.00 × ULN</td>
<td>&gt; 5.00 to 10.00 × ULN</td>
</tr>
<tr>
<td>Hyperuricemia</td>
<td>&gt;ULN to 10.0 mg/dL</td>
<td>&gt; 10.0 to 12.0 mg/dL</td>
<td>&gt; 12.0 to 15.0 mg/dL</td>
</tr>
<tr>
<td></td>
<td>&gt;ULN to 597 μmol/L</td>
<td>&gt; 597 to 716 μmol/L</td>
<td>&gt; 716 to 895 μmol/L</td>
</tr>
<tr>
<td>Hypouricemia</td>
<td>1.5 mg/dL to &lt; LLN</td>
<td>1.0 to &lt; 1.5 mg/dL</td>
<td>0.5 to &lt; 1.0 mg/dL</td>
</tr>
<tr>
<td></td>
<td>87 μmol/L to &lt; LLN</td>
<td>57 to &lt; 87 μmol/L</td>
<td>27 to &lt; 57 μmol/L</td>
</tr>
<tr>
<td>Creatinine</td>
<td>&gt; 1.50 to 2.00 mg/dL</td>
<td>&gt; 2.00 to 3.00 mg/dL</td>
<td>&gt; 3.00 to 6.00 mg/dL</td>
</tr>
<tr>
<td></td>
<td>&gt; 133 to 177 μmol/L</td>
<td>&gt; 177 to 265 μmol/L</td>
<td>&gt; 265 to 530 μmol/L</td>
</tr>
<tr>
<td>Bicarbonate</td>
<td>16.0 mEq/L to &lt; LLN</td>
<td>11.0 to &lt; 16.0 mEq/L</td>
<td>8.0 to &lt; 11.0 mEq/L</td>
</tr>
<tr>
<td></td>
<td>16.0 mmol/L to &lt; LLN</td>
<td>11.0 to &lt; 16.0 mmol/L</td>
<td>8.0 to &lt; 11.0 mmol/L</td>
</tr>
<tr>
<td>Triglycerides (Fasting)</td>
<td>NA</td>
<td>500 to 750 mg/dL</td>
<td>&gt; 750 to 1200 mg/dL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.64–8.47 mmol/L</td>
<td>&gt; 8.47–13.55 mmol/L</td>
</tr>
<tr>
<td>CHEMISTRY</td>
<td>Grade 1</td>
<td>Grade 2</td>
<td>Grade 3</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------------------</td>
<td>--------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>LDL (Fasting)</td>
<td>130 to 160 mg/dL</td>
<td>&gt;160 to 190 mg/dL</td>
<td>&gt; 190 mg/dL</td>
</tr>
<tr>
<td></td>
<td>3.35 to 4.15 mmol/L</td>
<td>&gt;4.15 to 4.92 mmol/L</td>
<td>&gt;4.92 mmol/L</td>
</tr>
<tr>
<td>Pediatric &gt;2 to &lt;18 years</td>
<td>110 to 130 mg/dL</td>
<td>&gt;130 to 190 mg/dL</td>
<td>&gt; 190 mg/dL</td>
</tr>
<tr>
<td></td>
<td>2.84 to 3.37 mmol/L</td>
<td>&gt;3.37 to 4.92 mmol/L</td>
<td>&gt;4.92 mmol/L</td>
</tr>
<tr>
<td>Hypercholesterolemia (Fasting)</td>
<td>200 to 239 mg/dL</td>
<td>&gt; 239 to 300 mg/dL</td>
<td>&gt; 300 mg/dL</td>
</tr>
<tr>
<td>Pediatric &lt; 18 Years</td>
<td>5.16 to 6.19 mmol/L</td>
<td>&gt; 6.19 to 7.77 mmol/L</td>
<td>&gt; 7.77 mmol/L</td>
</tr>
<tr>
<td></td>
<td>170 to 199 mg/dL</td>
<td>&gt; 199 to 300 mg/dL</td>
<td>&gt; 300 mg/dL</td>
</tr>
<tr>
<td></td>
<td>4.39 to 5.15 mmol/L</td>
<td>&gt; 5.15 to 7.77 mmol/L</td>
<td>&gt; 7.77 mmol/L</td>
</tr>
<tr>
<td>Creatine Kinase</td>
<td>3.0 to &lt; 6.0 × ULN</td>
<td>6.0 to &lt; 10.0 × ULN</td>
<td>10.0 to &lt; 20.0 × ULN</td>
</tr>
</tbody>
</table>

*Calcium should be corrected for albumin if albumin is < 4.0 g/dL.
<table>
<thead>
<tr>
<th>ENZYMES</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>AST (SGOT)</td>
<td>1.25 to 2.50 × ULN</td>
<td>&gt; 2.50 to 5.00 × ULN</td>
<td>&gt; 5.00 to 10.00 × ULN</td>
<td>&gt; 10.00 × ULN</td>
</tr>
<tr>
<td>ALT (SGPT)</td>
<td>1.25 to 2.50 × ULN</td>
<td>&gt; 2.50 to 5.00 × ULN</td>
<td>&gt; 5.00 to 10.00 × ULN</td>
<td>&gt; 10.00 × ULN</td>
</tr>
<tr>
<td>GGT</td>
<td>1.25 to 2.50 × ULN</td>
<td>&gt; 2.50 to 5.00 × ULN</td>
<td>&gt; 5.00 to 10.00 × ULN</td>
<td>&gt; 10.00 × ULN</td>
</tr>
<tr>
<td>Alkaline Phosphatase</td>
<td>1.25 to 2.50 × ULN</td>
<td>&gt; 2.50 to 5.00 × ULN</td>
<td>&gt; 5.00 to 10.00 × ULN</td>
<td>&gt; 10.00 × ULN</td>
</tr>
<tr>
<td>Total Amylase</td>
<td>&gt; 1.0 to 1.5 × ULN</td>
<td>&gt; 1.5 to 2.0 × ULN</td>
<td>&gt; 2.0 to 5.0 × ULN</td>
<td>&gt; 5.0 × ULN</td>
</tr>
<tr>
<td>Pancreatic Amylase</td>
<td>&gt; 1.0 to 1.5 × ULN</td>
<td>&gt; 1.5 to 2.0 × ULN</td>
<td>&gt; 2.0 to 5.0 × ULN</td>
<td>&gt; 5.0 × ULN</td>
</tr>
<tr>
<td>Lipase</td>
<td>&gt; 1.0 to 1.5 × ULN</td>
<td>&gt; 1.5 to 3.0 × ULN</td>
<td>&gt; 3.0 to 5.0 × ULN</td>
<td>&gt; 5.0 × ULN</td>
</tr>
<tr>
<td>Albumin</td>
<td>3.0 g/dL to &lt; LLN</td>
<td>2.0 to &lt; 3.0 g/dL</td>
<td>&lt; 2.0 g/dL</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>30 g/L to &lt; LLN</td>
<td>20 to &lt; 30 g/L</td>
<td>&lt; 20 g/L</td>
<td></td>
</tr>
</tbody>
</table>
## URINALYSIS

<table>
<thead>
<tr>
<th></th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hematuria (Dipstick)</strong></td>
<td>1+</td>
<td>2+</td>
<td>3-4+</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Hematuria (Quantitative)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See Note below</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td>&gt;ULN - 10 RBC/HPF</td>
<td>&gt; 10-75 RBC/HPF</td>
<td>&gt; 75 RBC/HPF</td>
<td>NA</td>
</tr>
<tr>
<td>Males</td>
<td>6-10 RBC/HPF</td>
<td>&gt; 10-75 RBC/HPF</td>
<td>&gt; 75 RBC/HPF</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Proteinuria (Dipstick)</strong></td>
<td>1+</td>
<td>2–3+</td>
<td>4+</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Proteinuria, 24 Hour Collection</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult and Pediatric ≥ 10 Years</td>
<td>200 to 999 mg/24 h</td>
<td>&gt;999 to 1999 mg/24 h</td>
<td>&gt;1999 to 3500 mg/24 h</td>
<td>&gt; 3500 mg/24 h</td>
</tr>
<tr>
<td>Pediatric &gt; 3 Mo to &lt; 10 Years</td>
<td>201 to 499 mg/m²/24 h</td>
<td>&gt;499 to 799 mg/m²/24 h</td>
<td>&gt;799 to 1000 mg/m²/24 h</td>
<td>&gt; 1000 mg/m²/24 h</td>
</tr>
<tr>
<td><strong>Glycosuria (Dipstick)</strong></td>
<td>1+</td>
<td>2-3+</td>
<td>4+</td>
<td>NA</td>
</tr>
</tbody>
</table>

Notes:
- Toxicity grades for Quantitative and Dipstick Hematuria will be assigned by Covance Laboratory, however for other laboratories, toxicity grades will only be assigned to Dipstick Hematuria.
- With the exception of lipid tests, any graded laboratory test with a result that is between the LLN and ULN should be assigned Grade 0.
- If the severity of a clinical AE could fall under either one of two grades (eg, the severity of an AE could be either Grade 2 or Grade 3), select the higher of the two grades for the AE.
<table>
<thead>
<tr>
<th>CARDIOVASCULAR</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Arrhythmia (general) (By ECG or physical exam)</td>
<td>Asymptomatic AND No intervention indicated</td>
<td>Asymptomatic AND Non-urgent medical intervention indicated</td>
<td>Symptomatic, non-life-threatening AND Non-urgent medical intervention indicated</td>
<td>Life-threatening arrhythmia OR Urgent intervention indicated</td>
</tr>
<tr>
<td>Cardiac-ischemia/Infarction</td>
<td>NA</td>
<td>NA</td>
<td>Symptomatic ischemia (stable angina) OR Testing consistent with ischemia</td>
<td>Unstable angina OR Acute myocardial infarction</td>
</tr>
<tr>
<td>Hemorrhage (significant acute blood loss)</td>
<td>NA</td>
<td>Symptomatic AND No transfusion indicated</td>
<td>Symptomatic AND Transfusion of ≤ 2 units packed RBCs (for children ≤ 10 cc/kg) indicated</td>
<td>Life-threatening hypotension OR Transfusion of &gt; 2 units packed RBCs indicated (for children ≤ 10 cc/kg) indicated</td>
</tr>
<tr>
<td>Hypertension (with repeat testing at same visit)</td>
<td>140–159 mmHg systolic OR 90–99 mmHg diastolic</td>
<td>&gt; 159–179 mmHg systolic OR &gt; 99–109 mmHg diastolic</td>
<td>&gt; 179 mmHg systolic OR &gt; 109 mmHg diastolic</td>
<td>Life-threatening consequences (eg, malignant hypertension) OR Hospitalization (other than ER visit) indicated</td>
</tr>
<tr>
<td>Pediatric ≤ 17 Years (with repeat testing at same visit)</td>
<td>NA</td>
<td>91st–94th percentile adjusted for age, height, and gender (systolic and/or diastolic)</td>
<td>≥ 95th percentile adjusted for age, height, and gender (systolic and/or diastolic)</td>
<td>Life-threatening consequences (eg, malignant hypertension) OR Hospitalization indicated (other than emergency room visit)</td>
</tr>
<tr>
<td>Hypotension</td>
<td>NA</td>
<td>Symptomatic, corrected with oral fluid replacement</td>
<td>Symptomatic, IV fluids indicated</td>
<td>Shock requiring use of vasopressors or mechanical assistance to maintain blood pressure</td>
</tr>
<tr>
<td>Pericardial Effusion</td>
<td>Asymptomatic, small effusion requiring no intervention</td>
<td>Asymptomatic, moderate or larger effusion requiring no intervention</td>
<td>Effusion with non-life-threatening physiologic consequences OR Effusion with nonurgent intervention indicated</td>
<td>Life-threatening consequences (eg, tamponade) OR Urgent intervention indicated</td>
</tr>
<tr>
<td>CARDIOVASCULAR</td>
<td>Grade 1</td>
<td>Grade 2</td>
<td>Grade 3</td>
<td>Grade 4</td>
</tr>
<tr>
<td>----------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Prolonged PR Interval</strong></td>
<td>PR interval 0.21 to 0.25 sec</td>
<td>PR interval &gt; 0.25 sec</td>
<td>Type II 2nd degree AV block OR Ventricular pause &gt; 3.0 sec</td>
<td>Complete AV block</td>
</tr>
<tr>
<td><strong>Pediatric ≤ 16 Years</strong></td>
<td>1st degree AV block (PR &gt; normal for age and rate)</td>
<td>Type I 2nd degree AV block</td>
<td>Type II 2nd degree AV block</td>
<td>Complete AV block</td>
</tr>
<tr>
<td><strong>Prolonged QTc</strong></td>
<td>Asymptomatic, QTc interval 0.45 to 0.47 sec OR Increase interval &lt; 0.03 sec above baseline</td>
<td>Asymptomatic, QTc interval 0.48 to 0.49 sec OR Increase in interval 0.03 to 0.05 sec above baseline</td>
<td>Asymptomatic, QTc interval ≥ 0.50 sec OR Increase in interval ≥ 0.06 sec above baseline</td>
<td>Life-threatening consequences, eg, Torsade de pointes or other associated serious ventricular dysrhythmia</td>
</tr>
<tr>
<td><strong>Pediatric ≤ 16 Years</strong></td>
<td>Asymptomatic, QTc interval 0.450 to 0.464 sec</td>
<td>Asymptomatic, QTc interval 0.465 to 0.479 sec</td>
<td>Asymptomatic, QTc interval ≥ 0.480 sec</td>
<td>Life-threatening consequences, eg, Torsade de pointes or other associated serious ventricular dysrhythmia</td>
</tr>
<tr>
<td><strong>Thrombosis/Embolism</strong></td>
<td>NA</td>
<td>Deep vein thrombosis AND No intervention indicated (eg, anticoagulation, lysis filter, invasive procedure)</td>
<td>Deep vein thrombosis AND Intervention indicated (eg, anticoagulation, lysis filter, invasive procedure)</td>
<td>Embolic event (eg, pulmonary embolism, life-threatening thrombus)</td>
</tr>
<tr>
<td><strong>Vasovagal Episode (associated with a procedure of any kind)</strong></td>
<td>Present without loss of consciousness</td>
<td>Present with transient loss of consciousness</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Ventricular Dysfunction (congestive heart failure, CHF)</strong></td>
<td>NA</td>
<td>Asymptomatic diagnostic finding AND intervention indicated</td>
<td>New onset with symptoms OR Worsening symptomatic CHF</td>
<td>Life-threatening CHF</td>
</tr>
</tbody>
</table>
### RESPIRATORY

<table>
<thead>
<tr>
<th></th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bronchospasm (acute)</strong></td>
<td>FEV1 or peak flow reduced to 70% to 80%</td>
<td>FEV1 or peak flow 50% to 69%</td>
<td>FEV1 or peak flow 25% to 49%</td>
<td>Cyanosis OR FEV1 or peak flow &lt; 25% OR Intubation</td>
</tr>
<tr>
<td><strong>Dyspnea or Respiratory Distress</strong></td>
<td>Dyspnea on exertion with no or minimal interference with usual social &amp; functional activities</td>
<td>Dyspnea on exertion causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Dyspnea at rest causing inability to perform usual social &amp; functional activities</td>
<td>Respiratory failure with ventilatory support indicated</td>
</tr>
<tr>
<td><strong>Pediatric &lt; 14 Years</strong></td>
<td>Wheezing OR minimal increase in respiratory rate for age</td>
<td>Nasal flaring OR Intercostal retractions OR Pulse oximetry 90% to 95%</td>
<td>Dyspnea at rest causing inability to perform usual social &amp; functional activities OR Pulse oximetry &lt; 90%</td>
<td>Respiratory failure with ventilatory support indicated</td>
</tr>
</tbody>
</table>

### OCULAR/VISUAL

<table>
<thead>
<tr>
<th></th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uveitis</strong></td>
<td>Asymptomatic but detectable on exam</td>
<td>Symptomatic anterior uveitis OR Medical intervention indicated</td>
<td>Posterior or pan-uveitis OR Operative intervention indicated</td>
<td>Disabling visual loss in affected eye(s)</td>
</tr>
<tr>
<td><strong>Visual Changes (from Baseline)</strong></td>
<td>Visual changes causing no or minimal interference with usual social &amp; functional activities</td>
<td>Visual changes causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Visual changes causing inability to perform usual social &amp; functional activities</td>
<td>Disabling visual loss in affected eye(s)</td>
</tr>
</tbody>
</table>
## SKIN

<table>
<thead>
<tr>
<th></th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alopecia</td>
<td>Thinning detectable by study participant or caregiver (for disabled adults)</td>
<td>Thinning or patchy hair loss detectable by health care provider</td>
<td>Complete hair loss</td>
<td>NA</td>
</tr>
<tr>
<td>Cutaneous Reaction – Rash</td>
<td>Localized macular rash</td>
<td>Diffuse macular, maculopapular, or morbilliform rash OR Target lesions</td>
<td>Diffuse macular, maculopapular, or morbilliform rash with vesicles or limited number of bullae OR Superficial ulcerations of mucous membrane limited to one site</td>
<td>Extensive or generalized bullous lesions OR Stevens-Johnson syndrome OR Ulceration of mucous membrane involving two or more distinct mucosal sites OR Toxic epidermal necrolysis (TEN)</td>
</tr>
<tr>
<td>Hyperpigmentation</td>
<td>Slight or localized</td>
<td>Marked or generalized</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Hypopigmentation</td>
<td>Slight or localized</td>
<td>Marked or generalized</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Pruritis (itching – no skin lesions) (See also Injection Site Reactions: Pruritus associated with injection)</td>
<td>Itching causing no or minimal interference with usual social &amp; functional activities</td>
<td>Itching causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Itching causing inability to perform usual social &amp; functional activities</td>
<td>NA</td>
</tr>
<tr>
<td>GASTROINTESTINAL</td>
<td>Grade 1</td>
<td>Grade 2</td>
<td>Grade 3</td>
<td>Grade 4</td>
</tr>
<tr>
<td>------------------</td>
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</tr>
<tr>
<td>Anorexia</td>
<td>Loss of appetite without decreased oral intake</td>
<td>Loss of appetite associated with decreased oral intake without significant weight loss</td>
<td>Loss of appetite associated with significant weight loss</td>
<td>Life-threatening consequences OR Aggressive intervention indicated [eg, tube feeding or total parenteral nutrition]</td>
</tr>
<tr>
<td>Ascites</td>
<td>Asymptomatic</td>
<td>Symptomatic AND Intervention indicated (eg, diuretics or therapeutic paracentesis)</td>
<td>Symptomatic despite intervention</td>
<td>Life-threatening consequences</td>
</tr>
<tr>
<td>Cholecystitis</td>
<td>NA</td>
<td>Symptomatic AND Medical intervention indicated</td>
<td>Radiologic, endoscopic, or operative intervention indicated</td>
<td>Life-threatening consequences (eg, sepsis or perforation)</td>
</tr>
<tr>
<td>Constipation</td>
<td>NA</td>
<td>Persistent constipation requiring regular use of dietary modifications, laxatives, or enemas</td>
<td>Obstipation with manual evacuation indicated</td>
<td>Life-threatening consequences (eg, obstruction)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Transient or intermittent episodes of unformed stools OR Increase of ≤ 3 stools over baseline/24 hr</td>
<td>Persistent episodes of unformed to watery stools OR Increase of 4–6 stools over baseline per 24 hrs.</td>
<td>Bloody diarrhea OR Increase of ≥ 7 stools per 24-hour period OR IV fluid replacement indicated</td>
<td>Life-threatening consequences (eg, hypotensive shock)</td>
</tr>
<tr>
<td>Adult and Pediatric ≥ 1 Year</td>
<td>Liquid stools (more unformed than usual) but usual number of stools</td>
<td>Liquid stools with increased number of stools OR Mild dehydration</td>
<td>Liquid stools with moderate dehydration</td>
<td>Liquid stools resulting in severe dehydration with aggressive rehydration indicated OR Hypotensive shock</td>
</tr>
<tr>
<td>Pediatric &lt; 1 Year</td>
<td>Symptomatic but able to eat usual diet</td>
<td>Symptoms causing altered dietary intake without medical intervention indicated</td>
<td>Symptoms causing severely altered dietary intake with medical intervention indicated</td>
<td>Life-threatening reduction in oral intake</td>
</tr>
<tr>
<td>Dysphagia-Odynophagia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Gastrointestinal

<table>
<thead>
<tr>
<th>Condition</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mucositis/Stomatitis (clinical exam)</td>
<td>Erythema of the mucosa</td>
<td>Patchy pseudomembranes or ulcerations</td>
<td>Confluent pseudomembranes or ulcerations OR Mucosal bleeding with minor trauma</td>
<td>Tissue necrosis OR Diffuse spontaneous mucosal bleeding OR Life-threatening consequences (eg, aspiration, choking)</td>
</tr>
<tr>
<td>See also Proctitis, Dysphagia-Odynophagia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>Transient (&lt; 24 hours) or intermittent nausea with no or minimal interference with oral intake</td>
<td>Persistent nausea resulting in decreased oral intake for 24–48 hours</td>
<td>Persistent nausea resulting in minimal oral intake for &gt; 48 hours OR Aggressive rehydration indicated (eg, IV fluids)</td>
<td>Life-threatening consequences (eg, hypotensive shock)</td>
</tr>
<tr>
<td>Pancreatitis</td>
<td>NA</td>
<td>Symptomatic AND Hospitalization not indicated (other than ER visit)</td>
<td>Symptomatic AND Hospitalization indicated (other than ER visit)</td>
<td>Life-threatening consequences (eg, sepsis, circulatory failure, hemorrhage)</td>
</tr>
<tr>
<td>Proctitis (functional-symptomatic) Also see Mucositis/Stomatitis for Clinical Exam</td>
<td>Rectal discomfort AND No intervention indicated</td>
<td>Symptoms causing greater than minimal interference with usual social &amp; functional activities OR Medical intervention indicated</td>
<td>Symptoms causing inability to perform usual social/functional activities OR Operative intervention indicated</td>
<td>Life-threatening consequences (eg, perforation)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Transient or intermittent vomiting with no or minimal interference with oral intake</td>
<td>Frequent episodes of vomiting with no or mild dehydration</td>
<td>Persistent vomiting resulting in orthostatic hypotension OR Aggressive rehydration indicated</td>
<td>Life-threatening consequences (eg, hypotensive shock)</td>
</tr>
<tr>
<td>NEUROLOGICAL</td>
<td>Grade 1</td>
<td>Grade 2</td>
<td>Grade 3</td>
<td>Grade 4</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Alteration in Personality-Behavior or in Mood (eg, agitation, anxiety, depression, mania, psychosis)</td>
<td>Alteration causing no or minimal interference with usual social &amp; functional activities</td>
<td>Alteration causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Alteration causing inability to perform usual social &amp; functional activities</td>
<td>Behavior potentially harmful to self or others (eg, suicidal/homicidal ideation or attempt, acute psychosis) OR Causing inability to perform basic self-care functions</td>
</tr>
<tr>
<td>Altered Mental Status For Dementia, see Cognitive and Behavioral/Attentional Disturbance (including dementia and ADD)</td>
<td>Changes causing no or minimal interference with usual social &amp; functional activities</td>
<td>Mild lethargy or somnolence causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Confusion, memory impairment, lethargy, or somnolence causing inability to perform usual social &amp; functional activities</td>
<td>Delirium OR obtundation, OR coma</td>
</tr>
<tr>
<td>Ataxia</td>
<td>Asymptomatic ataxia detectable on exam OR Minimal ataxia causing no or minimal interference with usual social &amp; functional activities</td>
<td>Symptomatic ataxia causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Symptomatic ataxia causing inability to perform usual social &amp; functional activities</td>
<td>Disabling ataxia causing inability to perform basic self-care functions</td>
</tr>
<tr>
<td>Cognitive and Behavioral/Attentional Disturbance (including dementia and Attention Deficit Disorder)</td>
<td>Disability causing no or minimal interference with usual social &amp; functional activities OR Specialized resources not indicated</td>
<td>Disability causing greater than minimal interference with usual social &amp; functional activities OR Specialized resources on part-time basis indicated</td>
<td>Disability causing inability to perform usual social &amp; functional activities OR Specialized resources on a full-time basis indicated</td>
<td>Disability causing inability to perform basic self-care functions OR Institutionalization indicated</td>
</tr>
<tr>
<td>CNS Ischemia (acute)</td>
<td>NA</td>
<td>NA</td>
<td>Transient ischemic attack</td>
<td>Cerebral vascular accident (CVA, stroke) with neurological deficit</td>
</tr>
</tbody>
</table>
## NEUROLOGICAL

<table>
<thead>
<tr>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental delay – Pediatric ≤ 16 Years</td>
<td>Mild developmental delay, either motor or cognitive, as determined by comparison with a developmental screening tool appropriate for the setting</td>
<td>Moderate developmental delay, either motor or cognitive, as determined by comparison with a developmental screening tool appropriate for the setting</td>
<td>Severe developmental delay, either motor or cognitive, as determined by comparison with a developmental screening tool appropriate for the setting</td>
</tr>
<tr>
<td>Headache</td>
<td>Symptoms causing no or minimal interference with usual social &amp; functional activities</td>
<td>Symptoms causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Symptoms causing inability to perform usual social &amp; functional activities</td>
</tr>
<tr>
<td>Insomnia</td>
<td>NA</td>
<td>Difficulty sleeping causing greater than minimal interference with usual social/functional activities</td>
<td>Difficulty sleeping causing inability to perform usual social &amp; functional activities</td>
</tr>
<tr>
<td>Neuromuscular Weakness (including myopathy &amp; neuropathy)</td>
<td>Asymptomatic with decreased strength on exam OR Minimal muscle weakness causing no or minimal interference with usual social &amp; functional activities</td>
<td>Muscle weakness causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Muscle weakness causing inability to perform usual social &amp; functional activities</td>
</tr>
<tr>
<td>Neurosensory Alteration (including paresthesia and painful neuropathy)</td>
<td>Asymptomatic with sensory alteration on exam or minimal paresthesia causing no or minimal interference with usual social &amp; functional activities</td>
<td>Sensory alteration or paresthesia causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Sensory alteration or paresthesia causing inability to perform usual social &amp; functional activities</td>
</tr>
<tr>
<td>NEUROLOGICAL</td>
<td>Grade 1</td>
<td>Grade 2</td>
<td>Grade 3</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------</td>
<td>-----------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Seizure: (new onset)</td>
<td>NA</td>
<td>1 seizure</td>
<td>2–4 seizures</td>
</tr>
<tr>
<td>Seizure: (pre-existing)</td>
<td>NA</td>
<td>Increased frequency of pre-existing seizures (non-repetitive) without change in seizure character OR infrequent breakthrough seizures while on stable meds in a previously controlled seizure disorder</td>
<td>Change in seizure character from baseline either in duration or quality (eg, severity or focality)</td>
</tr>
<tr>
<td>For Worsening of Existing Epilepsy the Grades Should Be Based on an Increase from Previous Level of Control to Any of These Levels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure – Pediatric &lt; 18 Years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syncope (not associated with a procedure)</td>
<td>NA</td>
<td>Present</td>
<td>NA</td>
</tr>
<tr>
<td>Vertigo</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## MUSCULOSKELETAL

<table>
<thead>
<tr>
<th>Condition</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthralgia</td>
<td>Joint pain causing no or minimal interference with usual social &amp; functional activities</td>
<td>Joint pain causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Joint pain causing inability to perform usual social &amp; functional activities</td>
<td>Disabling joint pain causing inability to perform basic self-care functions</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Stiffness or joint swelling causing no or minimal interference with usual social &amp; functional activities</td>
<td>Stiffness or joint swelling causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Stiffness or joint swelling causing inability to perform usual social &amp; functional activities</td>
<td>Disabling joint stiffness or swelling causing inability to perform basic self-care functions</td>
</tr>
<tr>
<td>Bone Mineral Loss</td>
<td>BMD t-score or z-score &lt; -2.5 to -1.0</td>
<td>BMD t-score or z-score &lt; -2.5</td>
<td>Pathological fracture (including loss of vertebral height)</td>
<td>Pathologic fracture causing life-threatening consequences</td>
</tr>
<tr>
<td>Pediatric &lt; 21 Years</td>
<td>BMD z-score &lt; -2.5</td>
<td>BMD z-score &lt; -2.5</td>
<td>Pathological fracture (including loss of vertebral height)</td>
<td>Pathologic fracture causing life-threatening consequences</td>
</tr>
<tr>
<td>Myalgia</td>
<td>Muscle pain causing no or minimal interference with usual social &amp; functional activities</td>
<td>Muscle pain causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Muscle pain causing inability to perform usual social &amp; functional activities</td>
<td>Disabling muscle pain causing inability to perform basic self-care functions</td>
</tr>
<tr>
<td>Osteonecrosis</td>
<td>NA</td>
<td>Asymptomatic with radiographic findings AND No operative intervention indicated</td>
<td>Symptomatic bone pain with radiographic findings OR Operative intervention indicated</td>
<td>Disabling bone pain with radiographic findings causing inability to perform basic self-care functions</td>
</tr>
<tr>
<td>Condition</td>
<td>Grade 1</td>
<td>Grade 2</td>
<td>Grade 3</td>
<td>Grade 4</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Acute Systemic Allergic Reaction</strong></td>
<td>Localized urticaria (wheals) with no medical intervention indicated</td>
<td>Localized urticaria with medical intervention indicated OR Mild</td>
<td>Generalized urticaria OR Angioedema with medical intervention indicated OR Symptomatic mild bronchospasm</td>
<td>Acute anaphylaxis OR Life-threatening bronchospasm OR laryngeal edema</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Angioedema with no medical intervention indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chills</strong></td>
<td>Symptoms causing no or minimal interference with usual social &amp; functional activities</td>
<td>Symptoms causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Symptoms causing inability to perform usual social &amp; functional activities</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Fatigue</strong></td>
<td>Symptoms causing no or minimal interference with usual social &amp; functional activities</td>
<td>Symptoms causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Symptoms causing inability to perform usual social &amp; functional activities</td>
<td>Incapacitating fatigue/malaise symptoms causing inability to perform basic self-care functions</td>
</tr>
<tr>
<td><strong>Fever (nonaxillary)</strong></td>
<td>37.7°C to 38.6°C 99.8°F to 101.5°F</td>
<td>38.7°C to 39.3°C 101.6°F to 102.8°F</td>
<td>39.4°C to 40.5°C 102.9°F to 104.9°F</td>
<td>&gt; 40.5°C &gt; 104.9°F</td>
</tr>
<tr>
<td><strong>Pain- Indicate Body Site</strong></td>
<td>Pain causing no or minimal interference with usual social &amp; functional activities</td>
<td>Pain causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Pain causing inability to perform usual social &amp; functional activities</td>
<td>Disabling pain causing inability to perform basic self-care functions OR Hospitalization (other than ER visit) indicated</td>
</tr>
<tr>
<td>See also Injection Site</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Arthralgia, and Myalgia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unintentional Weight Loss</strong></td>
<td>NA</td>
<td>5% to 9% loss in body weight from baseline</td>
<td>10% to 19% loss in body weight from baseline</td>
<td>≥ 20% loss in body weight from baseline OR Aggressive intervention indicated [eg, tube feeding or total parenteral nutrition]</td>
</tr>
<tr>
<td>INJECTION SITE REACTION</td>
<td>Grade 1</td>
<td>Grade 2</td>
<td>Grade 3</td>
<td>Grade 4</td>
</tr>
<tr>
<td>-------------------------</td>
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</tr>
<tr>
<td>Injection Site Pain (pain without touching) Or Tenderness (pain when area is touched)</td>
<td>Pain/tenderness causing no or minimal limitation of use of limb</td>
<td>Pain/tenderness limiting use of limb OR Pain/tenderness causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Pain/tenderness causing inability to perform usual social &amp; functional activities</td>
<td>Pain/tenderness causing inability to perform basic self-care function OR Hospitalization (other than ER visit) indicated for management of pain/tenderness</td>
</tr>
<tr>
<td>Injection Site Reaction (Localized), &gt; 15 Years</td>
<td>Erythema OR Induration of 5 × 5 cm to 9 × 9 cm (or 25–81 × cm²)</td>
<td>Erythema OR Induration OR Edema &gt; 9 cm any diameter (or &gt; 81 cm²)</td>
<td>Ulceration OR Secondary infection OR Phlebitis OR Sterile abscess OR Drainage</td>
<td>Necrosis (involving dermis and deeper tissue)</td>
</tr>
<tr>
<td>Pediatric ≤ 15 Years</td>
<td>Erythema OR Induration OR Edema present but ≤ 2.5 cm diameter</td>
<td>Erythema OR Induration OR Edema &gt; 2.5 cm diameter but &lt; 50% surface area of the extremity segment (eg, upper arm/thigh)</td>
<td>Erythema OR Induration OR Edema involving ≥ 50% surface area of the extremity segment (eg, upper arm/thigh) OR Ulceration OR Secondary infection OR Phlebitis OR Sterile abscess OR Drainage</td>
<td>Necrosis (involving dermis and deeper tissue)</td>
</tr>
<tr>
<td>Pruritis Associated with Injection See also Skin: Pruritis (itching—no skin lesions)</td>
<td>Itching localized to injection site AND Relieved spontaneously or with &lt; 48 h treatment</td>
<td>Itching beyond the injection site but not generalized OR Itching localized to injection site requiring ≥ 48 h treatment</td>
<td>Generalized itching causing inability to perform usual social &amp; functional activities</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Grade 1</td>
<td>Grade 2</td>
<td>Grade 3</td>
<td>Grade 4</td>
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<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Lipodystrophy</td>
<td>Detectable by study participant or caregiver (for young children and</td>
<td>Detectable on physical exam by health care provider</td>
<td>Disfiguring OR Obvious changes on casual visual inspection</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>disabled adults)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipodystrophy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>New onset without need to initiate medication OR Modification of</td>
<td>New onset with initiation of indicated med OR Diabetes uncontrolled</td>
<td>Life-threatening consequences</td>
<td></td>
</tr>
<tr>
<td>Mellitus</td>
<td>current meds to regain glucose control</td>
<td>despite treatment modification</td>
<td>(eg, ketoacidosis, hyperosmolar non-ketotic coma)</td>
<td></td>
</tr>
<tr>
<td>Gynecomastia</td>
<td>Detectable by study participant or caregiver (for young children and</td>
<td>Detectable on physical exam by health care provider</td>
<td>Disfiguring OR Obvious on casual visual inspection</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>disabled adults)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperthyroidism</td>
<td>Asymptomatic</td>
<td>Symptomatic causing greater than minimal interference with usual</td>
<td>Symptoms causing inability to perform usual social &amp; functional</td>
<td>Life-threatening consequences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>social &amp; functional activities OR Thyroid suppression therapy</td>
<td>activities OR Uncontrolled despite treatment modification</td>
<td>(eg, thyroid storm)</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>Asymptomatic</td>
<td>Symptomatic causing greater than minimal interference with usual</td>
<td>Symptoms causing inability to perform usual social &amp; functional</td>
<td>Life-threatening consequences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>social &amp; functional activities OR Thyroid replacement therapy</td>
<td>activities OR Uncontrolled despite treatment modification</td>
<td>(eg, myxedema coma)</td>
</tr>
<tr>
<td>Lipoatrophy</td>
<td>Detectable by study participant or caregiver (for young children and</td>
<td>Detectable on physical exam by health care provider</td>
<td>Disfiguring OR Obvious on casual visual inspection</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>disabled adults)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### GENITOURINARY

<table>
<thead>
<tr>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermenstrual Bleeding (IMB)</td>
<td>Spotting observed by participant OR Minimal blood observed during clinical or colposcopic exam</td>
<td>Intermenstrual bleeding not greater in duration or amount than usual menstrual cycle</td>
<td>Intermenstrual bleeding greater in duration or amount than usual menstrual cycle</td>
</tr>
<tr>
<td>Urinary Tract obstruction (eg, stone)</td>
<td>NA</td>
<td>Signs or symptoms of urinary tract obstruction without hydronephrosis or renal dysfunction</td>
<td>Signs or symptoms of urinary tract obstruction with hydronephrosis or renal dysfunction</td>
</tr>
</tbody>
</table>

### INFECTION

<table>
<thead>
<tr>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection (any other than HIV infection)</td>
<td>Localized, no systemic antiμbial treatment indicated AND Symptoms causing no or minimal interference with usual social &amp; functional activities</td>
<td>Systemic antiμbial treatment indicated OR Symptoms causing greater than minimal interference with usual social &amp; functional activities</td>
<td>Systemic antiμbial treatment indicated AND Symptoms causing inability to perform usual social &amp; functional activities OR Operative intervention (other than simple incision and drainage) indicated</td>
</tr>
</tbody>
</table>

**Basic Self-care Functions:** Activities such as bathing, dressing, toileting, transfer/movement, continence, and feeding.

**Usual Social & Functional Activities:** Adaptive tasks and desirable activities, such as going to work, shopping, cooking, use of transportation, pursuing a hobby, etc.
Appendix 5. Pregnancy Precautions, Definition for Female of Childbearing Potential, and Contraceptive Requirements

1. Pregnancy and Contraception Requirements for Males and Females of Childbearing Potential

The risks of treatment with GS-5806 during pregnancy have not been evaluated. Data available at this time suggest that this drug does not have a drug-drug interaction (DDI) with hormones used for contraception. Please refer to the latest version of the GS-5806 IB for additional information.

2. Definition of Female of Childbearing Potential

For the purposes of this study, a female subject of childbearing potential is a woman who has not had a hysterectomy, bilateral oophorectomy, or medically documented ovarian failure. This definition includes pubertal females regardless of whether or not she has had a menses (premenarchal, Tanner Stage 3) and perimenopausal women who have had a spontaneous menses in the last 12 months. A woman who has had a tubal sterilization is considered to be of childbearing potential.

- Women ≤ 54 years of age with amenorrhea of any duration will be considered to be of childbearing potential unless they have had a hysterectomy, bilateral oophorectomy, or medically documented ovarian failure.

- Women > 54 years of age with cessation (for ≥12 months) of previously occurring menses due to ovarian failure will not be considered to be of childbearing potential.

3. Contraceptive Requirements for Females

Female subjects of childbearing potential must agree to use protocol specified method(s) of highly effective contraception from the screening/enrollment visit throughout the study period and for 30 days following the last dose of GS-5806 or choose continuous heterosexual abstinence as a lifestyle choice. The investigator should counsel subjects on the protocol specified method(s) for avoiding pregnancy during the study. These methods are recommended due to the low failure rate (ie, less than 1% per year). See Appendix Table 1 for the protocol specified highly effective contraceptive methods.

Female study subjects who are not heterosexually active must have periodic confirmation of continued abstinence from heterosexual intercourse and regular pregnancy testing while taking GS-5806. The investigator should counsel subjects on the protocol specified method(s) for avoiding pregnancy in case the subject chooses to engage in heterosexual intercourse.

Female subjects of childbearing potential must have a negative urine pregnancy test at screening. Lactating females must discontinue nursing before IMP administration.
Appendix Table 1. Protocol Specified Highly Effective* Contraceptive Methods

<table>
<thead>
<tr>
<th>Single Methods</th>
<th>Combination Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intrauterine Devices (IUDs)</strong></td>
<td><strong>Estrogen and Progesterone plus Barrier</strong></td>
</tr>
<tr>
<td>• Copper T 380A IUD</td>
<td>• Combined oral contraceptives plus barrier</td>
</tr>
<tr>
<td>• LNG 20 IUD</td>
<td>• Transdermal patch plus barrier</td>
</tr>
<tr>
<td><strong>Progestrone</strong></td>
<td>• Vaginal ring plus barrier</td>
</tr>
<tr>
<td>• Implant</td>
<td></td>
</tr>
<tr>
<td>• Injection</td>
<td></td>
</tr>
<tr>
<td><strong>Tubal Sterilization</strong></td>
<td><strong>Two Barrier Methods</strong></td>
</tr>
<tr>
<td><strong>Vasectomy with Documented Azospermia 3 months After the Procedure</strong></td>
<td>• Diaphragm/spermicide plus condom</td>
</tr>
</tbody>
</table>

*which result in a low failure rate (i.e. less than 1% per year) when used consistently and correctly

Acceptable barrier methods include diaphragm (with spermicide) and the male condom. If tubal sterilization is via the Essure procedure, verification of tubal blockage by hysterosalpingogram (HSP) must be performed approximately 3 months after microinsertion. Prior to verification, Essure is not considered a reliable form of contraception and another contraception method described above should be used.

4. Contraceptive Requirements for Males

Male subjects must agree to use condoms and avoid sperm donation from the screening/enrollment visit throughout the study period and for 90 days after administration of the last dose of GS-5806

Use of condoms, with or without spermicide, has been proven to decrease the risk of transmission of HIV and other sexually transmitted diseases. The use of spermicide is not recommended if the subject’s partner is infected with HIV.

5. Procedures to be Followed in the Event of Pregnancy

Subjects should be instructed to notify the investigator if they become pregnant at any time during the study, or if they become pregnant within 30 days of last IMP dose. Subjects who become pregnant or who suspect that they are pregnant during the study must report the information to the investigator and discontinue IMP immediately. The investigator should report all pregnancies to Gilead DSPH using the pregnancy report form within 24 hours of becoming aware of the pregnancy. The investigator should counsel the subject regarding the possible effects of prior IMP exposure on the fetus and the need to inform the study site of the outcome of the pregnancy. Subjects whose partner has become pregnant or suspects she is pregnant during the study must report the information to the investigator. Instructions for reporting pregnancy, partner pregnancy, and pregnancy outcome are outlined in Section 7.7.2.1.