

**Neoadjuvant Nivolumab, or Nivolumab in combination with Ipilimumab, in Resectable  
Non-Small-Cell Lung Cancer**

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## 1. Summary

Host immunity is fundamental to the suppression of human cancer, and conversely host immune evasion by tumor cells is an essential feature in the development and progression of human cancer. PD-1 is a co-inhibitory receptor expressed on the surface of activated and exhausted T-cells, B-cells and certain myeloid cells<sup>1</sup>. PD-L1 (programmed death – ligand-1), one of two ligands for PD-1, is highly expressed in certain human tumors and expression has been associated with a poor prognosis<sup>2,3</sup>. Little is known about expression of the second ligand PD-L2 in solid cancers, nor its role in immune evasion.

An ongoing early phase clinical trial of the anti-PD-1 antibody, nivolumab, has demonstrated durable responses in heavily pretreated patients with advanced melanoma, renal cell (RCC) and non-small-cell lung cancer (NSCLC), a tumor which was previously thought to be non-immunogenic<sup>4</sup>. In an interim analysis of this study, 10% of NSCLC patients were free of tumor progression at 6 months, and 22 of 129 patients (17%) had an objective tumor response by RECIST 1.0 with a median duration of response lasting 17 months<sup>5</sup>. Patients with both squamous and non-squamous lung cancers showed durable objective responses. Median overall survival was 9.6 months, and the one-year landmark survival rate was 42%. These are promising results, given that most of these patients had exhausted standard treatment options: 53% of those with NSCLC had received 3-5 prior lines of treatment.

More recently, in two phase 3 clinical trials, nivolumab has demonstrated a survival advantage over second line chemotherapy with docetaxel in platinum-pretreated metastatic squamous and non-squamous NSCLC<sup>6,7</sup>. In both of these studies nivolumab was associated with a lower incidence of both grade 3-4 and any grade toxicity than docetaxel. In the first-line treatment of metastatic NSCLC, nivolumab has also shown promise in a large phase 1 study with an objective response rate (ORR) of 23% in patients unselected by PD-L1 status<sup>8</sup>.

Given the potentially harmful effects of multiple chemotherapy treatment regimens on the immune system, it is quite possible that application of PD-1 pathway blockade in lung cancer patients prior to receiving chemotherapy may significantly enhance its ability to induce immune-mediated cancer regression. In addition, it is postulated that PD-L1 and other immune biomarkers may be induced by prior anti-cancer therapy therefore interrogating the tumor immune micro-environment in non-pretreated disease may help to better define the immune signature of developing tumors.

In total, 306 patients with advanced solid tumors (129 with NSCLC) received nivolumab every two weeks continuously for up to 2 years<sup>77</sup>. Treatment was generally well tolerated, with grade 3-4 drug-related toxicities occurring in 17% of patients. As of March 2013, there were 3 nivolumab-related deaths on this trial (1%) associated with pneumonitis (two patients with NSCLC, one with colorectal cancer). This incidence of high-grade pneumonitis is similar to that

seen with standard cytotoxic chemotherapies and kinase inhibitors. Early diagnosis of nivolumab-related pneumonitis with administration of immunosuppression including steroids and other agents has mitigated pulmonary toxicity. However, the mechanisms causing pneumonitis require elucidation in order to develop more effective detection and treatment algorithms.

Exploratory analysis of archived pretreatment tumor biopsies from a limited number of NSCLC patients treated with nivolumab indicates that PD-L1 expression on tumor cells may be a candidate biomarker of sensitivity to anti-PD-1 therapy<sup>4</sup>(and Taube & Topalian, unpublished). However, this preliminary finding remains to be validated in larger cohorts.

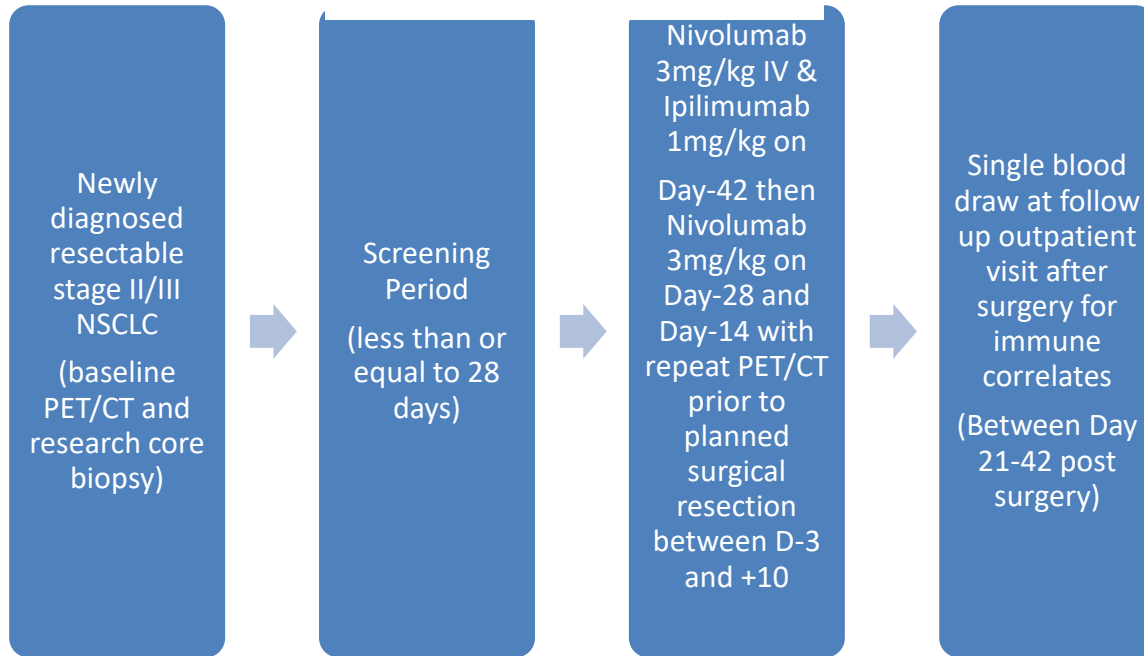
The proposed study will evaluate the safety and feasibility of preoperative administration nivolumab +/- ipilimumab in patients with high-risk resectable NSCLC, and will facilitate a comprehensive exploratory characterization of the tumor immune milieu and circulating immune cells and soluble factors in these patients. Data obtained in this study will provide valuable information for planning further prospective clinical trials of anti-PD-1 and other immunotherapies in NSCLC, both in the peri-operative and advanced disease setting. Ultimately, it is highly desirable to discover prospective biomarkers of response and toxicity to allow patients with NSCLC who are most likely to derive benefit to receive anti-PD-1 treatment, and conversely to minimize the risk of toxicity and ineffective treatment for patients who are unlikely to benefit.

In addition, an amendment to this study allows evaluation of the combination of nivolumab and the anti-CTLA4 antibody, ipilimumab in the neoadjuvant setting for the treatment of resectable NSCLC. In a large, multicohort, phase 1 trial, the ORR to combination ipilimumab and nivolumab therapy in patients unselected by PD-L1 status ranged from 39-47%<sup>9</sup>. Incidence of grade 3-4 toxicity ranged from 33-37% across the combination ipilimumab and nivolumab cohorts which compares favorably with the rates of toxicity due to platinum doublet chemotherapy in this disease setting.<sup>9</sup>

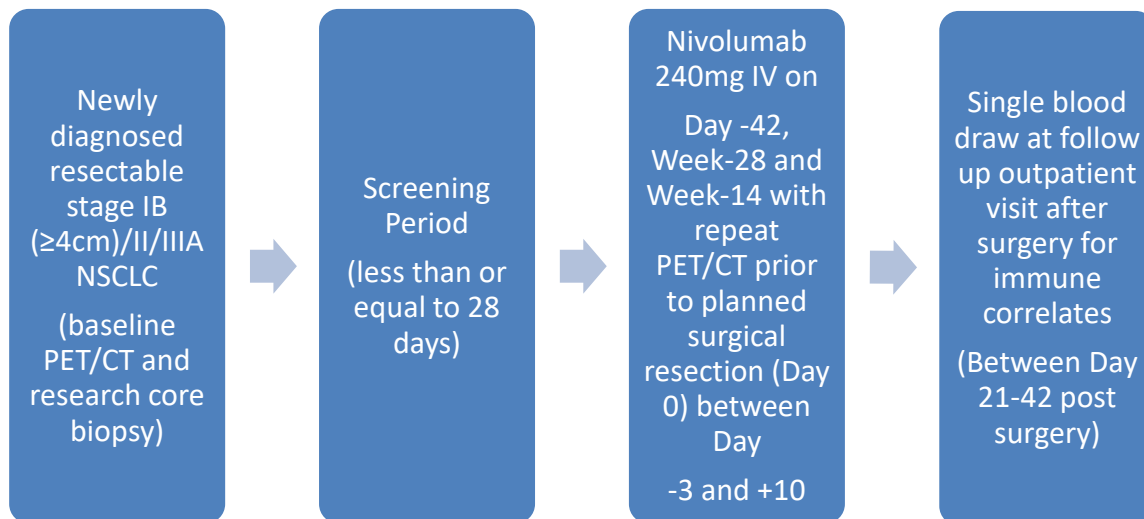


## 2. Schema

### ARM A (N=15)



### ARM B (N=15)



### **3. Hypotheses**

**3.1** Anti-PD-1 (nivolumab) administration with or without anti-CTLA4 (ipilimumab) in the pre-operative setting will be safe and feasible in patients with resectable NSCLC.

**3.2** Neoadjuvant administration of nivolumab with or without ipilimumab will change cellular and molecular characteristics of the tumor microenvironment that can be quantitatively measured.

**3.3** Failure to respond to immune checkpoint inhibition in NSCLC results from either pre-existing or compensatory (i.e. adaptive) up-regulation of additional immune “checkpoint” pathways in the tumor, draining lymph nodes, and/or peripheral blood that inhibit immune recognition and killing of tumor cells. Characterization of these pathways (i.e. ligands and receptors) in patients receiving preoperative therapy, and comparison with a cohort of patients who proceed to surgical resection without preoperative therapy, will illuminate mechanisms of adaptation and immune resistance to directly guide future therapeutic development of anti-PD-1 as monotherapy and in combination with other immunomodulators in NSCLC.

### **4. Objectives**

#### **4.1 Primary**

4.1.1 To investigate the safety and feasibility of neoadjuvant nivolumab + ipilimumab administration in subjects with resectable high-risk NSCLC [stage IB, II and IIIA], including squamous and non-squamous histologies.

4.1.2 To investigate the safety and feasibility of 3 doses of neoadjuvant nivolumab in subjects with resectable high-risk NSCLC [stage IB, II and IIIA], including squamous and non-squamous histologies.

#### **4.2 Secondary**

4.2.1 To assess pathologic response to neoadjuvant nivolumab and nivolumab plus ipilimumab in resected tumor and lymph nodes. The rate of major pathologic response, defined as <10% residual viable tumor cells in the resection specimen will be compared to historic data with neoadjuvant chemotherapy.

4.2.2 To assess radiographic response to neoadjuvant nivolumab and nivolumab plus ipilimumab using RECIST 1.1.

#### **4.3 Exploratory**

4.3.1 To determine changes in expression of selected immune markers compared to baseline, in the blood, primary tumor tissue and draining lymph nodes from patients receiving neoadjuvant therapy; to determine changes in the quality and quantity of tumor

infiltrating lymphocytes; and to compare findings in tumor and draining lymph nodes from treated patients, to findings in a parallel stage-matched cohort of untreated patients on a companion tissue collection protocol.

- 4.3.2 To evaluate the potential effects of neoadjuvant therapy on normal lung tissue, by comparing tissues obtained on this study to those obtained from untreated patients undergoing lung tumor resection on a parallel tissue collection protocol.
- 4.3.3 To compare immunologic markers in squamous versus non-squamous lung tumors.
- 4.3.4 To explore the association between nivolumab +/- ipilimumab exposure and selected pharmaco-dynamic markers in the peripheral blood and in the tumor microenvironment, including measurement of PD-1 receptor occupancy on tumor infiltrating lymphocytes.
- 4.3.5 To explore features of the gut microbiota of NSCLC patients before and after neoadjuvant nivolumab +/- ipilimumab, that may correlate with clinical response.
- 4.3.6 To assess recurrence-free survival in patients receiving preoperative therapy in this study
- 4.3.7 To assess overall survival in high-risk patients with NSCLC receiving neoadjuvant therapy.

## **5. Background and Rationale**

Lung cancer is the most common invasive cancer and cause of cancer death worldwide. In 2008, the most recent year for which global statistics are available, there were an estimated 1.61 million cases and 1.38 million deaths<sup>12</sup>. In the United States, the estimated number of new lung cancer cases for 2012 is 226,160 (116,470 men and 109,690 women) while 160,340 people will die of the condition<sup>13</sup>. Adjuvant systemic chemotherapy improves disease free and overall survival for patients with stage II NSCLC and for some patients with Stage IB NSCLC and is likely to remain an integral part of therapy<sup>14</sup>. However, many patients still suffer recurrences and die of their disease emphasizing the need for new treatments or approaches.

Host immunity is fundamental to the suppression of human cancer and conversely host immune evasion by tumor cells is an essential pathway in the development of human cancer. The concept of cancer immune editing is well described in animal models whereby tumors are capable of subverting host immunity despite developing frequent genetic aberrations with the potential to generate immunogenic neo-antigens<sup>15</sup>. The three phases of immune editing are as follows: elimination (host immune system responds to tumor neo-antigens and destroys tumor cells), equilibrium (immune evasive tumor cells persist; however, growth and metastasis is restrained by residual host immunity) and escape (tumor cells overcome immune control and can develop into clinically evident cancers). The development of clinically apparent tumors

indicates failure of the host immune system to recognize and destroy incipient cancers. This is due to induction of immune tolerance among tumor-specific T cells as well as expression of immune inhibitory ligands termed checkpoints. These ligands bind to receptors on T cells that signal to down-modulate effector functions such as cytokine production and killing activity. Consequently, strategies aimed at augmenting host anti-tumor immunity are attractive with potential for long-term tumor control or even cure if persistent immune responsiveness can be engendered particularly in earlier stages of disease.

### **5.1 Cancer immunotherapy**

Attempts have been made over many years to potentiate the host immune response to human cancer with limited success until recently and, in some cases, significant toxicity<sup>16-18</sup>. While occasional dramatic tumor responses have been seen with interleukin-2 treatment in particular, these responses are difficult to predict based on clinical criteria and a dependable biological marker of response in the patient or tumor has yet to be described<sup>19-21</sup>.

### **5.2 Rational Immunotherapy Targets – CTLA-4**

Recent breakthroughs in bringing years of preclinical work on the adaptive immune response to tumor to the clinic have led to the regulatory approval of two immune-modulatory anti-cancer therapies for advanced disease, the autologous dendritic cell vaccine, sipuleucel-T, for castration-resistant prostate cancer and the anti-cytotoxic T lymphocyte antigen- 4 (anti-CTLA-4) immune checkpoint inhibitor, ipilimumab, for metastatic melanoma<sup>22,23</sup>. CTLA-4, first described in 1987, is the prototypical immune checkpoint, a molecule whose expression is induced by T cell activation leading to down-regulation of T cell responses and consequent suppression of the innate response to foreign tumor neo-antigen<sup>24,25</sup>. The subsequent discovery of multiple non-redundant intrinsic T cell molecules that act to limit immune responses have led to the advent of antibodies to block these inhibitory checkpoints as a strategy to enable anti-tumor immune responses and elicit durable clinical benefit in cancer patients. Ipilimumab, which inhibits CTLA-4, thus releasing the block on antitumor immunity, has become the first systemic treatment to demonstrate a durable overall survival advantage in a phase III study for metastatic melanoma with responses in 10 – 20% of patients treated<sup>23</sup>. Despite these promising results, many patients do not respond to treatment, and toxicity can be serious or fatal in certain cases, illustrating the need for prospective biomarkers of immune response and sensitivity.

### **5.3 Programmed death-1 – Molecular Biology**

Programmed death-1 (PD-1 or CD279), primarily expressed on activated T cells, B cells and myeloid cells<sup>1</sup>, is a 55 kD type I transmembrane protein that is a member of the CD28 family of T-cell co-stimulatory receptors that also includes CD28, CTLA-4, ICOS and BTLA<sup>26</sup>. Two ligands

specific for PD-1 have been identified: PD-L1 (also known as B7-H1 or CD274) and PD-L2 (also known as B7-DC or CD273), each of which are primarily expressed on antigen presenting cells. PD-L1 and PD-L2 have been shown to downregulate T-cell activation upon binding to PD-1 in both murine and human systems<sup>27-29</sup>. PD-1 has been shown to inhibit CD28-mediated upregulation of IL-2, IL-10, IL-13, IFN- $\gamma$  and Bcl-xL. PD-1 expression has also been noted to inhibit T cell activation and expansion of previously activated cells. PD-1 contains an intracellular membrane proximal immunoreceptor tyrosine inhibitory motif (ITIM) and a membrane distal immunoreceptor tyrosine based switch motif (ITSM). Both Src homology region 2 domain-containing phosphatase (SHP) -1 and -2 have been found to bind to the cytoplasmic tail of PD-1 and mediate its signaling. Once this signaling has occurred, PD-1 binds to the phosphorylated tyrosine residue in the ITSM in its cytoplasmic region and mediates the suppressive effects of PD-1<sup>30,31</sup>.

#### **5.4 Programmed death-1 – Preclinical Studies**

Further evidence for a negative regulatory role of PD-1 comes from studies of PD-1-deficient mice. PD-1-deficient mice develop various autoimmune phenotypes, including dilated cardiomyopathy, a lupus-like syndrome with arthritis and nephritis, and accelerated diabetes mellitus<sup>32-35</sup>. The emergence of these autoimmune phenotypes is dependent upon the genetic background of the mouse strain and many of these phenotypes emerge at different times (almost always after 6 months of age) and show variable penetrance. Thus PD-1 plays a more subtle regulatory role than CTLA-4. In addition to the phenotypes of null mutations, PD-1 inhibition by antibody-mediated blockade in several murine models has been found to play a role in the development of autoimmune diseases such as encephalomyelitis<sup>32</sup>, graft-versus-host disease<sup>37</sup>, and type I diabetes<sup>34</sup>. Taken together, these results suggest that PD-1 modulates immune responses in tissues undergoing inflammatory responses and PD-1 blockade has the potential to enhance inflammatory (including “anti-self”) responses in tissue, but these responses are variable and dependent upon various host genetic factors. Thus, PD-1 deficiency or inhibition is not accompanied by a universal loss of tolerance to self-antigens. Preclinical animal models of tumors have shown that blockade of PD-1 by monoclonal antibodies (mAbs) can enhance the anti-tumor immune response and result in tumor rejection. The effects of anti-PD-1 blockade in combination with a variety of chemotherapeutic agents were tested in several murine tumor models (MC38, SA1/N and PAN02).

#### **5.5 Programmed Death Ligand -1 – Expression in Humans**

In humans, constitutive PD-L1 expression is normally limited to macrophage-lineage cells, although expression of PD-L1 can be induced on other hematologic cells as well, including activated T cells. Aberrant expression of PD-L1 by tumor cells (retrospectively detected by

immunohistochemistry, IHC) has been reported in a number of human malignancies<sup>38-44</sup>. In renal cell carcinoma, high surface expression levels of PD-L1 on tumor cells is related to tumor aggressiveness<sup>41,45</sup> and subjects with high tumor and/or lymphocyte PD-L1 levels are 4.5 times more likely to die from cancer than subjects exhibiting low levels of PD-L1 expression. These findings may be explained by the notion that high PD-L1 expression leads to immune evasion. This hypothesis is supported by separate studies demonstrating that PD-L1 expressed by tumor cells enhances apoptosis of activated tumor-specific T cells in vitro<sup>27</sup> and that the expression of PD-L1 protects tumor cells from the induction of apoptosis by effector T cells<sup>45</sup>. Preclinical data suggests that antitumor activity by PD-1 blockade functions in both PD-L1-expressing and -negative tumors suggesting that it may act in immune priming as well as at the tumor microenvironment level<sup>2,46-50</sup>. This suggests that host mechanisms (i.e. expression of PD-L1 on antigen-presenting cells) limit the antitumor response. Consequently, it is possible that both PD-L1 positive and negative tumors may be targeted using this approach.

## **5.6 Early stage non-small-cell lung cancer – Background and treatments**

Approximately 80% of lung cancer cases are NSCLC with most patients presenting with late stage disease. Of patients with NSCLC, 20% present with stage I or II disease, whereas 30% present with stage III disease and 50% with stage IV disease<sup>9</sup>. A standard TNM staging system is used to determine the staging for NSCLC (Appendix A). Patients with pathologic stage I NSCLC have approximately a 60% 5-year survival. Stage II NSCLC patients have approximately 25% to 40% 5-year survival. Surgical resection remains the mainstay of treatment for stage I and II patients. However, despite apparently curative surgery approximately 50% of stage IB and 70% of stage II NSCLC patients will relapse and eventually die of their disease<sup>13</sup>. A rational approach to eradicate micrometastatic disease and minimize the risk of relapse is treatment with adjuvant or neoadjuvant chemotherapy. Many adjuvant studies have been performed and these trials are summarized in [Table 1](#). Although there are some conflicting results, the overall evidence from these studies suggests that adjuvant platinum doublet chemotherapy is beneficial for good performance status patients with stage II disease. The benefit for stage IB patients is less clear and may depend on the size of the primary tumor and other risk factors<sup>51-56</sup>. The LACE meta-analysis of modern adjuvant and neoadjuvant trials, all of which used cisplatin-based chemotherapy, suggested a 5% survival advantage at 5 years from adjuvant chemotherapy with the benefit being greatest for stage II and IIIA patients. A 2010 meta-analysis including both older and more recent trials confirmed the survival benefit shown in the LACE meta-analysis and also suggested a benefit of adjuvant chemotherapy for stage IB disease patients<sup>57,58</sup>.

<b>Table 1 - Selected Adjuvant NSCLC Studies</b>						
<b>Trial</b>	<b>Stage</b>	<b>Treatment</b>	<b>Pt No</b>	<b>5 yr OS</b>	<b>HR</b>	<b>p value</b>
ALPI	I - III	Surg MVP	603 601	45% 50%	0.96	0.59
IALT	I – III	Surg Cis-based	935 932	40% 44.5%	0.86	<0.03
ANITA	IB - IIIA	Surg Cis-Vin	433 407	43% 51%	0.80	0.017
BLT	I - IIIA	Surg Cis-based	189 192	58% 60%	1.02	0.90
NCIC/JBR10	IB – II	Surg Cis-Vin	240 242	54% 69%	0.69	0.03
CALGB	IB	Surg Carb-pac	171 173	57% 59%	0.80	0.10
Abbreviations – OS, overall survival; HR, hazard ratio; ALPI, Adjuvant Lung Cancer Project Italy; IALT, International Adjuvant Lung Cancer Trial; ANITA, Adjuvant Navelbine International Triallist Association; BLT, Big Lung Trial; NCI-C, National Cancer Institute-Canada; CALGB, Cancer and Leukemia Group B; MVP, mitomycin, vindesine, cisplatin; Cis-Vin, cisplatin-vinorelbine; Carb-pac, carboplatin-paclitaxel.						

### **5.7 Rationale for preoperative systemic therapy in NSCLC**

Traditionally, surgery has preceded systemic therapy in patients with resectable NSCLC. New systemic approaches are generally investigated in the metastatic setting and later in large adjuvant clinical trials. However, patients in the metastatic setting may have received multiple previous treatments, may have poor performance status and compromised organ function which makes new drug investigation challenging. Furthermore, randomization and follow-up of adjuvant trials may require decades until a new treatment can be introduced into clinical care. Preoperative chemotherapy has been assessed in a number of trials for patients with resectable NSCLC, though most were closed early when the adjuvant chemotherapy data revealed a survival advantage. A meta-analysis based upon seven trials involving 988 patients suggested that neoadjuvant chemotherapy improved overall survival when given preoperatively (five-year survival 20 versus 14 percent without neoadjuvant chemotherapy), this improvement in survival being similar to that noted in the meta-analyses of predominantly adjuvant chemotherapy<sup>59</sup>. Furthermore, preoperative systemic therapy offers the possibility for the identification of surrogate clinical and biological markers that may correlate with response to therapy and, in some cases, long term outcome. In addition, preoperative therapy may be a useful platform for the development of new targeted therapies. Efficient strategies to screen promising agents in early phase development are essential for rapid progress in lung cancer treatment and prevention.

Several studies have shown preoperative systemic therapy to be safe prior to surgical resection of NSCLC with no difference in extent of surgical procedures performed, operative morbidity and mortality<sup>60-62</sup>.

## 5.8 Immunology of NSCLC – Preclinical Findings

Cancer cells characteristically have six intrinsic phenomena that lead to oncogenesis. These include self-sufficiency of growth signals, insensitivity to growth-inhibitory signals, avoidance of apoptosis, limitless replicative potential, development and sustaining of angiogenesis, and tissue invasion and metastasis. An additional phenomenon, avoidance of immunosurveillance, has been proposed since lung cancer cells escape innate and adaptive immune responses<sup>63,64</sup>. This concept is based upon the idea that the immune system can recognize precursors of cancer and destroy them. One strategy of eluding a T-cell-mediated immune response is through the downregulation or loss of expression of HLA class I molecules that is noted to be common in lung cancer. It has been postulated that only immunoselected tumor cells that lack HLA class I expression can escape immune attack and develop into cancers. Tumors often down-modulate antigen processing molecules such as transporter associated with antigen processing 1 (TAP1), low-molecular-mass protein (LMP) 2, LMP7, and tapasin. The overexpression of the serine-protease inhibitor P19 by tumor cells blocks the granzyme-B-perforin pathway of target cell lysis. However, silencing of these genes in lung cancer is reversible and they are usually upregulated by IFN- $\gamma$ , suggesting that, in the presence of a T cell or NK response, this escape mechanism can be overcome. Additional outcomes of immunoselection include down regulation or mutation of death receptors, methylation or mutation of the gene encoding caspase-8, and overexpression of FLIP (caspase-8 (FLICE)-like inhibitory protein) or decoy receptors for TRAIL. All of these cause resistance to CTL-induced killing of tumor cells<sup>65</sup>. Key findings that led to greater understanding of immunosurveillance included the discovery that endogenously produced interferon- $\gamma$ (IFN- $\gamma$ ) protected hosts against transplanted, spontaneous, or chemically induced tumors in mice. Another finding showed that C57BL/6 mice lacking perforin (perforin -/-) were more prone to methylcholanthrene-induced tumor formation compared with their wild-type counterparts. It was noted that the perforin -/- mice lack functional cytotoxic T cells and NK cells<sup>65,66</sup>. Additional research has shown an overlap between the tumor suppressor pathways that depend upon IFN- $\gamma$  and lymphocyte function. 129/SvEv mice lacking IFN- $\gamma$  responsiveness (IFNGR1 receptor -/- or STAT1 -/- mice) were compared with mice lacking recombination activating gene (RAG-2) (which fail to rearrange lymphocyte antigen receptors and completely lack natural killer T cells, T and B cells) and RAG-2 and STAT1 negative mice. No difference was noted in the tumor development in the mice as compared with wild-type mice. It was also felt that the IFN- $\gamma$  and lymphocyte function overlapped with one another<sup>65,66</sup>.



## 5.9 Immunology of NSCLC – Clinical Findings

Data have been reported regarding a correlation between the presence of tumoral lymphocytes and patient survival. The presence of tumor-infiltrating lymphocytes (TILs) has been noted in cancer cell nests and central cancer stroma<sup>67,69</sup>. TILs are stimulated in the presence of IFN- $\gamma$  and tumor-necrosis factor- $\alpha$  (TNF- $\alpha$ ). TILs attempt to regulate the proliferation and metastatic activity of the tumor and interrupt angiogenesis, in addition to their function in host immunity against cancers. The activity of the TILs is noted to be increased in early stage NSCLC, but fails to control tumor cell growth in later stages of cancer<sup>69,71</sup>. Anti-tumor immune system activity may become suppressed by the expansion of regulatory T (Treg) cells in the tumor and the draining N1 and N2 lymph nodes with a compensatory reduction in natural killer (NK) cells<sup>70</sup>, stimulation of mature and immature dendritic cells providing immunosuppressive cytokines like interleukin-10 (IL-10) or transforming growth factor- $\beta$  (TGF- $\beta$ ), and further inhibition of dendritic cell maturation by VEGF, IL-6, IL-10, TGF- $\beta$ , macrophage colony-stimulating factor, NOS2, arginase-1, IDO, PGE2, COX2 and gangliosides<sup>71,72</sup>. PD-1 expression is upregulated on TILs in patients with a variety of tumors including NSCLC<sup>38</sup>. Zhang et al<sup>73</sup> analyzed peripheral blood mononuclear cells (PBMCs) and TILs and noted that PD-1 levels were highest on CD8+ TILs and over 2-fold higher on PBMCs of patients with NSCLC than on control patients. Other inhibitory receptors, such as CTLA-4, were not expressed on the TILs. In vitro, blocking the interaction between PD-1 and its ligands PD-L1 and PD-L2 resulted in TIL proliferation and increased production of IFN- $\gamma$ . Aberrant expression of PD-L1 by tumor cells has been reported in NSCLC. It is notable that fewer TILs were found in tumors that expressed B7-H1/PD-L1, though it remains to be seen whether some of the PD-L1 staining procedures reported in the literature are valid<sup>38,74,75</sup>.

A study has been performed using the anti-CTLA-4 monoclonal antibody ipilimumab in combination with carboplatin/paclitaxel chemotherapy (CA184041) in advanced NSCLC. This showed a statistically significant improvement in PFS and OS when immunotherapy was added to chemotherapy<sup>76</sup>. Further randomized studies of ipilimumab in squamous NSCLC are ongoing at this time.

## 5.10 Development of nivolumab

Nivolumab (BMS-936558, ONO-5438, MDX-1106) is a fully human, IgG4 (kappa) monoclonal antibody that binds PD-1 with high affinity blocking its interactions with its ligands PD-L1 (B7-H1) and PD-L2 (B7-DC) and increasing tumor antigen specific T cell proliferation and cytokine secretion<sup>63</sup>.

Nivolumab is currently FDA-approved for the treatment of metastatic NSCLC in patients with progression on or after platinum-based chemotherapy. Many studies are ongoing of nivolumab

in combination with other agents in the first-line setting. Nivolumab is also undergoing clinical trial evaluation for unresectable stage III NSCLC and as adjuvant therapy for resected NSCLC. .

In the proposed study, the safety and feasibility of preoperative nivolumab will be assessed as well as the impact of preoperative anti-PD-1 blockade on anti-tumor immunity.

### **5.11 Clinical experience with nivolumab**

A phase 1 single dose, dose-escalation study of nivolumab in 39 heavily pretreated patients with solid tumors (CA209-001, NCT00441337) demonstrated good tolerance and signals of efficacy<sup>11</sup>. Patients with advanced NSCLC, melanoma, RCC, metastatic castration-resistant prostate cancer (mCRPC) and metastatic colorectal cancer (CRC) in this study received a single IV infusion of nivolumab over 1 hour in escalating cohorts of 0.3, 1, 3 or 10 mg/kg. Restaging was performed radiologically at 8 and 12 weeks, and patients with no adverse event (AE)  $\geq 3$  and stable disease or response by RECIST received additional doses of nivolumab at weeks 12 and 16 followed by further restaging at 3 months. Those with continued clinical benefit could receive two more doses, spaced by 4 weeks. Treatment could continue for up to 2 years.

Nivolumab was in general well-tolerated with most frequent adverse events being hematologic (notably a grade 3 reduction in CD4 count in 17.9% of patients), fatigue and mild musculoskeletal symptoms. A maximum tolerated-dose (MTD) was not reached.

Immune-related colitis, well described with CTLA-4 inhibition, occurred in 1 patient and resolved with treatment with infliximab and steroids.

Grade 2 hypothyroidism and grade 2 polyarthritis were noted in 1 and 2 patients respectively. Efficacy was promising with a durable complete response (CR) in a CRC patient, 2 partial responses (PRs) in RCC and melanoma patients, and a transient response not meeting PR criteria in a NSCLC patient. PD-L1 (B7-H1) expression was assessed by immunohistochemistry in pretreatment tumor specimens from 9 patients. Of these, 3 of 4 patients with membranous (cell surface) tumor cell expression of PD-L1 experienced tumor regression; none of 5 patients without expression of PD-L1 experienced a tumor response, suggesting a marker for further investigation. Pharmacodynamic analyses suggested that high level occupancy of the PD-1 receptor on circulating T cells persisted for up to 85 days after a single dose of nivolumab.

Safety, efficacy and immune correlative data from a multicenter phase 1b expansion study of single agent nivolumab in a multi-dose regimen were published in 2012 and updated at the ASCO Annual Meeting in 2013<sup>4,77</sup>. Nivolumab was administered as an intravenous infusion every 2 weeks of an 8 week treatment cycle, to patients with advanced treatment-refractory NSCLC, melanoma, RCC, CRC or mCRPC. Patients with partial response or stable disease received treatment for up to 2 years (12 cycles), and after 2 years of treatment, patients were

followed for up to 1 year and offered retreatment for an additional year in the event of disease progression. MTD was not reached in this study, and five expansion cohorts of 16 patients each were enrolled at the 10mg/kg dose for each tumor type. After initial assessment of activity, pharmacokinetics and receptor occupancy, additional expansion cohorts of 16 patients each were enrolled for melanoma (0.1, 0.3, 1.0, 3.0mg/kg) NSCLC (squamous and non-squamous, 1.0, 3.0, 10.0mg/kg) and RCC (1.0mg/kg). This study enrolled 306 patients between 10/2008 and 1/2012. The cohort was heavily pretreated with 47% having received  $\geq 3$  prior treatments.

Tolerance in general was good with grade 3 or grade 4 treatment related adverse events (most commonly fatigue, diarrhea) noted in 17% of patients. Of particular importance, drug-related pneumonitis occurred in 3% of patients with three (1%) drug-related deaths associated with pneumonitis. Subsequent care in excluding patients with underlying pulmonary inflammatory processes, careful monitoring of lung function and routine institution of systemic steroids upon altered lung function or radiologic changes appears to have mitigated pneumonitis-related mortality. Objective tumor response or prolonged stabilization of disease was seen in 31% and 7 % of melanoma patients, respectively; 29% and 27% of kidney cancer patients; and 17% and 10% of NSCLC patients. In addition, at the time of report several other patients had unconventional response patterns consistent with “immune-related” responses<sup>78</sup>. No responses to nivolumab were noted in patients with CRC or mCRPC.

In a subgroup of 42 patients for whom PD-L1 expression in pretreatment tumor biopsy was evaluated, 9 of 25 patients responded to nivolumab treatment in the PD-L1-positive group whereas none of 17 patients with PD-L1-negative tumors had a response, suggesting tumor PD-L1 expression as a candidate predictive marker for future investigation. However, only 10 NSCLC patients were included in this evaluation and thus, the consequences of PD-L1 expression in lung cancer in the context of therapeutic PD-1 pathway blockade remain to be fully elucidated.

PD-1 receptor occupancy was assessed on circulating CD3+ T cells and median receptor occupancy was 64 to 70% among the various dose levels. However, the level of PD-1 occupancy among tumor-infiltrating T cells, an important pharmacodynamic measurement, has never been assessed.

Despite early indications that PD-L1 may be a biomarker for response to anti-PD-1, recently reported data using different immunohistochemical assays for PD-L1 have suggested that some patients without PD-L1 expression on their tumors may indeed still respond to modulation of the PD-1 /PD-L1 axis<sup>79-81</sup>. Many questions remain for this issue, including the quality of biopsy sample and the antibody and immunohistochemistry assay used.

Recently, in two phase 3 clinical trials, nivolumab has demonstrated a survival advantage over second line chemotherapy with docetaxel in platinum-pretreated metastatic squamous and non-squamous NSCLC<sup>6,7</sup>. In both of these studies nivolumab was associated with a lower incidence of both grade 3-4 and any grade toxicity than docetaxel. In the first-line treatment of metastatic NSCLC, nivolumab has also shown promise in a large phase 1 study with an objective response rate (ORR) of 23% in patients unselected by PD-L1 status<sup>8</sup>.

Further information on nivolumab is available in the current version of the investigator's brochure.

### **5.12 Development of Ipilimumab**

Ipilimumab is a fully human monoclonal IgG1k that binds to the CTLA-4 antigen expressed on a subset of T cells from human and nonhuman primates. CTLA-4 is a negative regulator of T-cell activity. Ipilimumab is a monoclonal antibody that binds to CTLA-4 and blocks the interaction of CTLA-4 with its ligands, CD80/CD86. Blockade of CTLA-4 has been shown to augment T-cell activation and proliferation, including the activation and proliferation of tumor infiltrating T-effector cells. Inhibition of CTLA-4 signaling can also reduce T-regulatory cell function, which may contribute to a general increase in T-cell responsiveness, including the anti-tumor response. Ipilimumab is currently under development for the treatment of subjects with cancer.

### **5.13 Clinical Experience with Ipilimumab**

BMS and Medarex (acquired by BMS in Sep-2009) have co-sponsored an extensive clinical development program for ipilimumab, encompassing more than 19,500 subjects (total number of subjects enrolled in ipilimumab studies) in several cancer types in completed and ongoing studies, including a compassionate use. The focus of the clinical program is in melanoma, prostate cancer, and lung cancer, with advanced melanoma being the most comprehensively studied indication. Ipilimumab is being investigated both as monotherapy and in combination with other modalities such as chemotherapy, radiation therapy, and other immunotherapies.

Phase 3 programs are ongoing in melanoma, prostate cancer, and lung cancer. In melanoma, 2 completed Phase 3 studies (MDX010-20 and CA184024) have demonstrated a clinically meaningful and statistically significant survival benefit in pretreated advanced melanoma and previously untreated advanced melanoma with a manageable safety profile, respectively. A recent phase 3 study in melanoma demonstrated an improvement in recurrence-free survival for ipilimumab as adjuvant monotherapy for high-risk Stage III melanoma (CA184029).<sup>82</sup> In addition, a Phase 3 study comparing the safety and efficacy of 3 versus 10 mg/kg ipilimumab monotherapy in pretreated or treatment-naïve subjects with unresectable or metastatic

melanoma is ongoing (CA184169).

Toxicities and efficacy of ipilimumab both as a single agent and in combination with nivolumab and other agents are detailed in the current version of the ipilimumab investigator's brochure.

#### **5.14 Rationale for preoperative nivolumab and ipilimumab in NSCLC, dosing and schedule and inclusion/exclusion criteria**

##### Rationale for Peri-operative Systemic Therapy in NSCLC

Several studies have shown preoperative cytotoxic chemotherapy to be safe prior to surgical resection of NSCLC with no difference in extent of surgical procedures performed, operative morbidity and mortality<sup>60-62</sup>. Immune checkpoint inhibition has the potential to provide benefits in early stage disease and the anti-CTLA-4 antibody, ipilimumab, is currently in phase III trial investigation in the adjuvant setting for melanoma<sup>82</sup>. Patients with early stage bladder cancer have been treated with preoperative ipilimumab in a phase I study which utilized a similar dosing schedule and design to our study<sup>86</sup>. Preoperative ipilimumab was found to have a tolerable safety profile without an increase in perioperative complications after 1 or 2 doses of preoperative therapy. Valuable information on the immunological effects of ipilimumab was gleaned from studying the resected bladder tumors in these patients<sup>86</sup>.

Prior early phase clinical trials with anti-PD-1 therapy including in NSCLC have enrolled patients with metastatic disease, who rarely undergo surgical biopsies or procedures; therefore, there have been limitations in accessing sufficient tumor tissues for phenotypic and functional immunologic studies. Laboratory studies from these prior trials focused primarily on assessing immune responses in peripheral blood and expression of PD-L1 in archived pretreatment tumor specimens; however, these studies have not yet led to the identification of immunologic markers that clearly predict clinical outcomes and could guide future investigation of immune checkpoint inhibition in NSCLC. The primary aim of our study is to establish the safety and feasibility of using neoadjuvant immunotherapy in the preoperative setting for resectable stage IB, II and IIIA NSCLC. Data obtained from this study will facilitate potential further investigation of nivolumab and ipilimumab as a possible therapy in early stage NSCLC by establishing safety and feasibility, and will also provide a comprehensive data set on the immune response to immunotherapy in serial peripheral blood samples and tumor and biopsies obtained pre/post treatment. Because the patient population to be included in this trial has a high risk of tumor relapse, it is possible that a large effect of neoadjuvant immunotherapy on relapse rate may be observed, this would provide further impetus for future randomized studies evaluating the efficacy of nivolumab and ipilimumab in this setting.

In the initial portion of the current study, 20 patients with stage I-IIIa NSCLC were planned to be enrolled and receive two doses of nivolumab 3mg/kg IV at 4 and 2 weeks prior surgical resection. The primary endpoint of the study was safety and feasibility of nivolumab administration for two doses in the neoadjuvant setting. At the time of data cutoff (10/12/2016) 18 patients had successfully undergone surgery and 2 were still receiving neoadjuvant therapy. Nineteen patients were evaluable for safety and feasibility. One of the nineteen patients was found to have small cell carcinoma on review of the research biopsy, in this case neoadjuvant therapy was stopped, the patient did not proceed to surgery and instead underwent definitive chemoradiation.

The regimen has been feasible with no treatment-related delays to surgery. One patient from 19 experienced an SAE which was assessed by the investigator as being possibly related to nivolumab therapy. This patient proceeded to surgery after a single dose of nivolumab and the rest of his course has been uncomplicated. Further details of this event are noted in the safety section of this protocol. Seven of 18 patients enrolled in the study have had major pathologic responses to nivolumab as defined by <10% viable residual tumor in the resection specimen.

Given the early indications that single agent nivolumab is well tolerated and may have anti-tumor activity in early stage NSCLC, two further arms have been added to the protocol to evaluate the safety and feasibility of a longer course of neoadjuvant nivolumab therapy (3 doses over 6 weeks prior to surgery) and the combination of nivolumab with ipilimumab in the neoadjuvant setting.

#### Rationale for Dosing and Schedule

The planned schedule in arm B of 3 preoperative doses of nivolumab, flat dose 240mg, given once every 2 weeks (+/- 3 days) with surgery scheduled for approximately 2 weeks after the third dose. The rationale for flat dosing is noted below. The duration of preoperative treatment of approximately 4 weeks was initially chosen as a short time period unlikely to allow significant progression of disease which might preclude complete surgical resection. Given the excellent tolerability and signals of antitumor efficacy of the initial regimen, the current amendment to this protocol explores longer durations of nivolumab treatment (arm B), which may lead to greater pathologic response, and also the addition of a single dose of ipilimumab in combination with nivolumab (Arm A). The combination of ipilimumab (1mg/kg) given every 6 weeks and nivolumab 3mg/kg given every 2 weeks has been shown to be safe and associated with a promising ORR in early phase clinical trials in NSCLC and other solid tumors. This combination therapy is being actively evaluated in phase 3 clinical trials in advanced NSCLC hence the interest in developing this regimen for early stage disease.

Flat (standardized) dosing of nivolumab as a single agent:

Nivolumab monotherapy has been extensively studied in a number of tumor types including NSCLC, MEL, RCC, and CRC with body weight normalized dosing (mg/kg). Nivolumab pharmacokinetics (PK) and exposures of subjects in these studies have been characterized by population pharmacokinetic (PPK) analysis of data collected in these studies, together with PK data from several phase 1, 2, and 3 clinical studies of nivolumab monotherapy in solid tumors. Population PK (PPK) analyses have shown that the PK of nivolumab are linear, with dose proportional exposures over a dose range of 0.1 mg/kg to 10 mg/kg, and are similar across tumor types. Nivolumab clearance and volume of distribution were found to increase with increasing body weight, but the increase was less than proportional, indicating that a mg/kg dose represents an over-adjustment for the effect of body weight on nivolumab PK. Given the relationship between nivolumab PK and body weight, a flat dose is expected to lead to lower exposures in heavier patients, relative to the exposures in lighter patients.

Using the PPK model, nivolumab steady-state trough, peak and time-averaged concentration ( $C_{minss}$ ,  $C_{maxss}$ , and  $C_{avgss}$ , respectively) were predicted for a flat nivolumab dose of 240 mg Q2W and compared to those following administration of 3 mg/kg Q2W in NSCLC subjects. A dose of 240 mg nivolumab is identical to a dose of 3 mg/kg for subjects weighing 80 kg, which is the approximate median body weight of NSCLC subjects in the 3 Phase 2 and 3 BMS clinical studies of nivolumab monotherapy. The geometric mean values of  $C_{minss}$ ,  $C_{maxss}$ , and  $C_{avgss}$  with flat dosing are slightly (< 15%) higher than that produced by a 3 mg/kg dose, and the coefficient of variation (cv%) in these measures of exposure are only slightly (< 10%) greater than that of 3 mg/kg dosing.

Across the various tumor types in the BMS clinical program, nivolumab has been shown to be safe and well tolerated up to a dose level of 10 mg/kg, and the relationship between nivolumab exposure produced by 3 mg/kg and efficacy has been found to be relatively flat. Taken together, the PK, safety, and efficacy data indicate that the safety and efficacy profile of 240 mg nivolumab will be similar to that of 3 mg/kg nivolumab.

Thus a flat dose of 240 mg every 2 weeks is recommended for investigation in arm B of this study.

#### Rationale for Main Inclusion and Exclusion Criteria

The choice of resectable stage IB, II and IIIA NSCLC was made as these patients have a high risk of tumor relapse and death with current standard therapy, including surgery with preoperative or postoperative chemotherapy. There is an urgent need for improved, novel therapies in this group of patients. Patients with stage IB NSCLC have been included as these patients are also at high risk of tumor relapse and may be considered candidates for standard adjuvant chemotherapy<sup>53, 54, 57, 58</sup>.

This study initially included patients with primary tumors greater than 4cm in diameter and did not include patients with resectable stage IIIA NSCLC if they had N2 nodal involvement. Data from phase 3 clinical trials of nivolumab versus standard of care docetaxel chemotherapy reported subsequent to this trial commencing accrual, have demonstrated a significant survival advantage for nivolumab over chemotherapy in platinum-pretreated advanced squamous and non-squamous NSCLC<sup>59,60</sup>. In addition, there was approximately a 5 fold reduction in grade 3-4 toxicity with nivolumab compared with docetaxel. These data have led to the approval by the FDA of nivolumab for the treatment of patients with platinum-pretreated metastatic NSCLC. We have also now refined the immunologic analyses (proposed in the exploratory aims of this study) and are confident we can perform them successfully on smaller primary tumors ( $\geq 2$ cm diameter). Discussions with our co-investigators and colleagues at MSKCC have also led to a consensus to include patients with stage IIIA N2 node positive patients that are deemed resectable at the time of diagnosis in this study. Given these new positive data and in conjunction with our thoracic surgical, radiation oncology and medical oncology colleagues at JHU and MSKCC, we have expanded eligibility for this study to include resectable stage IB, II and IIIA NSCLC.

It is anticipated that the majority of patients enrolled on this study will require adjuvant platinum-based chemotherapy. This will commence, if deemed clinically indicated in the postoperative period, according to standard schedules.

Patients who were assessed clinically by their surgeon as possibly requiring a pneumonectomy to obtain complete surgical resection of their primary tumor were initially excluded from this study, as these patients have a significantly higher risk of postoperative complications including respiratory distress. Given the good tolerability of the regimen in patients enrolled to date, it is now the consensus of surgical, medical oncology and radiation oncology colleagues at JHU and MSKCC to include patients who may require pneumonectomy in this study. This will allow the population enrolled to reflect a real-life cohort of patients with NSCLC rather than a select group.

The current amendment to the protocol will allow exploration of longer durations of neoadjuvant nivolumab treatment and also the potential synergy between neoadjuvant nivolumab and ipilimumab in early stage NSCLC.

## **6. Patient Population**

### **6.1 Subjects**

#### **6.1.1 Inclusion Criteria**

**6.1.1.1** Men and women aged  $\geq 18$  years old.



**6.1.1.2** Histologically proven non-small-cell lung cancer (core biopsy required).

- Squamous or non-squamous histology.
- Diagnostic core biopsy specimens must be reviewed by a faculty pathologist at SKCCC or MSKCC.
- Either a formalin fixed paraffin block that has been confirmed by a pathologist to contain tumor or a minimum of twenty 5-micron tissue sections (slides) of tumor biopsy sample must be available for biomarker evaluation (study pathologist must review for adequacy of sampling). This can be obtained from archived tissues if adequate, or from a new biopsy as needed. (For details of handling of new tissue biopsies, please refer to the lab manual).

**6.1.1.3** Stage - NSCLC with primary resection option for potential cure, as assessed by a faculty surgeon at SKCCC or MSKCC. This may include clinical stage IB ( $\geq 4\text{cm}$ ), II and IIIA (see Appendix A). Subjects with N3 nodal involvement are not included.

**6.1.1.4** ECOG performance status 0-1 (see Appendix B).

**6.1.1.5** Adequate organ function as follows:

- Leukocytes  $\geq 2,000/\text{mm}^3$
- Absolute neutrophil count (ANC)  $\geq 1000/\text{mm}^3$
- Platelet count  $\geq 100,000/\text{mm}^3$
- Hemoglobin  $\geq 9 \text{ g/dL}$
- Creatinine  $\leq 1.5 \times \text{ULN}$  or creatinine clearance (CrCl)  $\geq 40 \text{ mL/min}$  (if using the Cockcroft-Gault formula below):

$$\text{Female CrCl} = \frac{(140 - \text{age in years}) \times \text{weight in kg} \times 0.85}{72 \times \text{serum creatinine in mg/dL}}$$

$$\text{Male CrCl} = \frac{(140 - \text{age in years}) \times \text{weight in kg} \times 1.00}{72 \times \text{serum creatinine in mg/dL}}$$

- Total Bilirubin  $\leq 1.5 \times \text{ULN}$  (except subjects with Gilbert Syndrome, who can have total bilirubin  $< 3.0 \text{ mg/dL}$ )
- AST(SGOT), ALT(SGPT), and alkaline phosphatase  $\leq 3$  times the upper limit of normal
- Subjects must have adequate lung function to permit surgical resection determined by pre-enrollment pulmonary function tests to include DLCO

**6.1.1.6** The effects of nivolumab on the developing human fetus are unknown. For this reason, women of child-bearing potential (WOCBP) and men must agree to use adequate contraception (hormonal or barrier method of birth control; abstinence) prior to study entry and for the duration of study participation and for up to 23 weeks after the last dose of nivolumab. Should a woman become pregnant or suspect she is pregnant while she or her partner is participating in this study, she should inform her treating physician immediately. Sexually active fertile men must use effective barrier birth control if their partners are WOCBP for up to 31 weeks after the last dose of nivolumab. WOCBP must have a negative serum or urine pregnancy test (minimum sensitivity 25 IU/L or equivalent units of HCG) within two weeks of registration. Women must not be breastfeeding.

**6.1.1.7** Patient understands the study regimen, its requirements, risks and discomforts and is able and willing to sign the informed consent form. Voluntary signed and dated IRB/IEC approved written informed consent form in accordance with regulatory and institutional guidelines must be obtained before the performance of any protocol related procedures that are not part of normal patient care. Subjects must be competent to report AEs, understand the drug dosing schedule and use of medications to control AEs.

## **6.1.2 Exclusion Criteria**

**6.1.2.1** Subjects are excluded if they have an active, known or suspected autoimmune disease. Subjects are permitted to enroll if they have vitiligo, type I diabetes mellitus, residual hypothyroidism due to autoimmune condition only requiring hormone replacement, psoriasis not requiring systemic treatment, or conditions not expected to recur in the absence of an external trigger.

**6.1.2.2** Subjects are excluded if they have a condition requiring systemic treatment with either corticosteroids (> 10 mg daily prednisone equivalents) or other immunosuppressive medications within 14 days of study drug administration. Inhaled or topical steroids and adrenal replacement doses > 10 mg daily prednisone equivalents are permitted in the absence of active autoimmune disease. As there is potential for hepatic toxicity with nivolumab or nivolumab/ipilimumab combinations, drugs with a predisposition to hepatotoxicity should be used with caution in patients treated with nivolumab-containing regimen.

**6.1.2.3** Administration of chemotherapy or any other cancer therapy in the pre-operative period.

**6.1.2.4** Subjects with **active** concurrent malignancies are excluded i.e. cancers other than NSCLC (except non melanoma skin cancers, in situ bladder, gastric, breast, colon or cervical cancers/dysplasia).

**6.1.2.5** Subjects with brain metastasis are excluded from this study, and all patients should have brain imaging (either MRI brain or CT brain with contrast) prior to enrollment.

**6.1.2.6** Subjects with a history of symptomatic interstitial lung disease.

**6.1.2.7** Active systemic infection requiring therapy, positive tests for Hepatitis B surface antigen or Hepatitis C Antibody.

**6.1.2.8** Known positive history or positive test for Human Immunodeficiency Virus or Acquired ImmunoDeficiency Syndrome (AIDS).

**6.1.2.9** History of allergy to study drug components.

**6.1.2.10** Women who are pregnant or nursing.

**6.1.2.11** Men with female partners (WOCBP) that are not willing to use contraception.

**6.1.2.12** Prior therapy with an anti-PD-1, anti-PD-L1, anti-PDL-2, or anti-CTLA-4 antibody (or any other antibody targeting T cell co-regulatory pathways).

**6.1.2.13** Underlying medical conditions that, in the Investigator's opinion, will make the administration of study drug hazardous or obscure the interpretation of toxicity or adverse events.

**6.1.2.16** Prisoners or subjects who are involuntarily incarcerated or compulsorily detained for treatment of either a psychiatric or physical (e.g. infectious disease) illness.

## **6.2 Inclusion of Genders and Minorities**

Individuals of all races and ethnic groups are eligible for this trial. There is no bias towards age, gender or race in the clinical trial outlined. This trial is open to the accrual of men and women who meet the inclusion/exclusion criteria outlined.

## **7. Overview of Study Design and Treatment Plan**

## 7.1 Recruitment

Patients will be recruited through the thoracic oncology clinics at Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins (SKCCC) and at Memorial Sloan-Kettering Cancer Center (MSKCC). Each enrolled subject will be assigned a participant sequential subject number at the time of consent e.g., 1-001, 1-002, etc.

## 7.2 Determination of Eligibility

After eligibility is established, the study staff will register participants. The following are required to be submitted for successful registration:

- Registration forms
- Copy of subject consent
- If an archival tumor sample is being used to satisfy eligibility then it should be evaluated by a study pathologist to confirm it meets the study requirements (see section 7.4.2) prior to the patient commencing therapy.
- Copies of the following documents:
  - Diagnostic pathology report(s)
  - PET/CT scan report, MRI brain or CT brain with contrast report
  - Laboratory reports including:
    - Complete blood count (CBC) with differential (including absolute lymphocyte count) and direct platelet count.
    - Chemistry: Albumin, SGOT (AST), SGPT (ALT), Bilirubin (direct and total), Calcium, Creatinine, Glucose, Total protein, Urea nitrogen, Uric Acid, Electrolytes (including sodium, potassium, chloride and bicarbonate).
    - Baseline thyroid immune safety assay: Thyroid Stimulating Hormone (TSH). Abnormal endocrine results should be followed up per standard of care, and may require an endocrine consult and additional testing.
  - Other documents, if requested.

Study treatment cannot begin until the patient is registered and randomized to either Arm A (nivolumab + ipilimumab) or Arm B (nivolumab).

Subjects who sign a consent form but do not initiate protocol treatment for any reason (e.g., subjects who are screen failures), and patients who do not undergo surgical resection will be replaced and will not count towards our accrual goal.

## 7.3 Study Design and Toxicity Assessments

This is a two arm study that will be conducted at SKCCC and MSKCC.

**7.3.1 Screening** - Eligible subjects will be consented to receive the investigational treatments (nivolumab +/- ipilimumab). The total study sample size for the amended protocol (version 3.3) will consist of 30 patients comprising 15 patients in Arm A and 15 patients

in Arm B. The staff at the treating center (SKCCC or MSKCC) will arrange drug supply and treatment. Nivolumab and ipilimumab will be supplied by Bristol-Myers Squibb Pharmaceuticals.

**7.3.2** Treatment and collection of biological specimens—For Arm A 15 patients with resectable stage IB( $\geq 4$ cm), II or IIIA NSCLC (squamous and non-squamous) will be enrolled and receive preoperative nivolumab, 3mg/kg IV, on Day -42, -28 and Day -14 (+/- two days for each timepoint) + ipilimumab 1mg/kg IV on Day -42 prior to planned surgery on Day 0 (to allow for scheduling surgery may take place between Day -3 and Day +10). See section 9 for details on nivolumab and ipilimumab administration. Subsequent to full accrual to Arm A, 15 patients with resectable stage IB ( $\geq 4$ cm), II or IIIA NSCLC will be enrolled and receive nivolumab 240mg IV on Day -42, -28 and -14 (+/- 2 days for each timepoint) prior to planned surgery on Day 0 (to allow for scheduling delays surgery may take place between Day -3 and Day +10). Serial peripheral blood samples for exploratory analyses will be collected prior to each dose of study drug(s), once within the 3 days prior to surgery, and at 3-6 weeks after surgery. To explore gut microbial correlates of response to neoadjuvant nivolumab +/- ipilimumab, stool samples will be collected at baseline (within 48h of D -42) and prior to surgery (D -3 to Day 0). Subjects will also be asked to fill out a medical and dietary questionnaire that will be used to assess whether antibiotic use or dietary patterns correlate with features of the gut microbiome.

Postoperatively subjects will receive standard of care treatment and will be followed every 3-6 months with clinic visits and research blood draws. Preoperative core biopsies of the primary tumor, and optional preoperative mediastinal lymph node biopsies, will be obtained. Archived (if sufficient tissue is available) or new tissue specimens will fulfill these criteria. Patients will have a PET/CT scan during the 7 days prior to surgery to assess response to treatment.

**7.3.3** Toxicity assessments – Safety will be monitored continuously by the study investigators for the thirty patients through day 100 following the last dose of study drug. The initial six patients to be enrolled in Arm A (ipilimumab + nivolumab) will be monitored continually through day 100 following the last dose of study drug (or day 30 post surgery, whichever is longer). Safety will be monitored on a continuous basis by the study investigators. A detailed statistical analysis plan for safety and feasibility is contained in section 14 of this protocol.

Dose Delays due to Toxicity – No dose delays due to toxicity will be permitted for patients enrolled on this study. For example, if patients, after receiving the first dose of nivolumab (Day -42) are unable to receive the second dose on Day -28 (+/-2 days) due to treatment-related toxicity, they will be discontinued from study drug and will proceed to surgery after standard preoperative evaluation. Prior to surgery, any treatment-related toxicity should have resolved to  $\leq$ grade 1.

**General Management Algorithms for potential nivolumab (and/or ipilimumab)-related toxicities are contained in Appendix D of this protocol and in the Investigators Brochure.**

**7.3.4** Dose-Limiting toxicity (DLT) is defined as any of the items listed below that occur through day 100 following the last dose of nivolumab (+/- ipilimumab) (or day 30 post surgery, whichever is longer).

Any patient who experiences a DLT will be permanently discontinued from treatment and will proceed to surgery after standard preoperative evaluation by a surgeon and anesthesiologist. Prior to surgery any treatment-related toxicity should have resolved to  $\leq$ grade 1.

- Any  $\geq$  Grade 2 drug-related pneumonitis or interstitial lung disease that does not resolve to Grade 0 or 1 within 2 weeks with systemic steroids. The management algorithm for pneumonitis or pulmonary toxicity can be found in the appendix of current Investigator Brochure for nivolumab
- Any  $\geq$  Grade 2 drug-related uveitis or eye pain that does not respond to topical therapy and does not improve to Grade 1 severity within the re-treatment period OR requires systemic treatment. If uveitis occurs during nivolumab treatment, workup and treatment should follow the nivolumab uveitis toxicity treatment algorithm located in the appendix of the nivolumab Investigators Brochure.
- Any Grade 3 non-skin drug-related adverse event lasting  $\geq$  7 days with the exception of asymptomatic laboratory abnormalities.
- Grade 3 drug-related bronchospasm, allergic reaction, or infusion-related reaction will be recorded and treated as per the guidelines in 7.4.3; however, it will not count as a dose-limiting toxicity for study purposes.
- Any Grade 3 drug-related diarrhea that does not respond to dose delay and the use of systemic steroids within 2 weeks. If diarrhea occurs during nivolumab treatment, workup and treatment should follow the nivolumab diarrhea toxicity treatment algorithm located in the appendix of the nivolumab Investigators Brochure.

- Any Grade 4 drug-related adverse event, including laboratory abnormalities apart from isolated Grade 4 electrolyte imbalances/abnormalities that are not associated with clinical sequelae and are corrected with appropriate management within 72 hours of their onset.
- Any of the following drug-related hepatic function laboratory abnormalities or potential Drug Induced Liver Injury (DILI):
  - AST or ALT > 5-10x ULN for > 2 weeks
  - AST or ALT >10x ULN
  - Total bilirubin > 5 x ULN
  - Concurrent AST or ALT >3 x ULN and total bilirubin >2 x ULN
- If suspected DILI occurs, workup and treatment should follow the nivolumab DILI treatment algorithm located in the appendix of the nivolumab Investigators Brochure.
- Any other toxicity which is assessed by the principal investigator as having directly led to a delay in surgical resection more than 40 days past the planned Day 0.
- Failure to complete all protocol specified treatment doses due to toxicity (at the discretion of the PI).
- **Note** - Adverse events of special interest are nivolumab-related events with potential immune-mediated causalities. For example, this may include cutaneous toxicities, colitis, liver function abnormalities (AST, ALT, total bilirubin, alkaline phosphatase), endocrine abnormalities (hyperthyroidism, hypothyroidism, hypophysitis and secondary adrenal insufficiency), interstitial pneumonitis and nephritis. These events will be noted. However, it may not constitute DLT's unless they fulfill the previously outlined DLT criteria in section 7.3.3 above

## 7.4 Diagnostic and surgical evaluation of participants

### 7.4.1 Diagnostic evaluation and pre-surgical workup

All patients enrolled on this protocol must be surgical candidates with clinical stage IB, II or IIIA NSCLC. Patients will have undergone radiographic evaluation indicating no evidence of distant disease and no evidence of unresectable loco-regional tumor extension before surgical resection. Any further preoperative testing that is recommended by the surgeon or anesthesiologist will be performed as part of standard of care. Surgery for patients enrolled on this protocol will be according to generally accepted standards of care. It is advised that patients have at least 3 mediastinal and

hilar lymph node stations sampled during surgery. Patients should have a PET/CT scan and CT of chest with IV contrast performed after completing 3 doses of neoadjuvant therapy and within the 7 days prior to planned surgery to assess response.

#### 7.4.2 Tumor sample acquisition

Patients enrolled on this study will be required to have pretreatment primary tumor biopsy material available for diagnosis and exploratory immunological studies. This may consist of diagnostic biopsies that have been previously performed, or biopsies conducted by the study team in the case of inadequate pre-existing material. Excisional biopsies, or ideally 6 (minimum 4) core needle biopsies ( $\leq 19$  gauge diameter) of the primary tumor are required; the first 3 core needle biopsies obtained from a research biopsy will be placed in formalin and paraffin embedded while any subsequent core needle biopsies obtained should be flash frozen; fine needle aspirates will not be adequate. A minimum of twenty 5-micron paraffin tissue sections or a paraffin-embedded tumor block is required. If an archival paraffin embedded block is used the presence of tumor in the block must be confirmed by a pathologist. If archival slides are being used they must have been cut with DNA precautions. Biopsies may be obtained by the following approaches: transbronchial, radiographically-guided transthoracic approach, or video-assisted thoracoscopy. Biopsies that are formalin-fixed and paraffin embedded (FFPE) are required. Fresh frozen biopsy specimens may be analyzed in addition to, but not in place of, FFPE specimens. Pretreatment biopsies of draining lymph nodes are desirable but not required; fine-needle aspirations of lymph nodes ( $>21$  gauge diameter) are acceptable.

Primary tumor, draining lymph nodes and normal lung specimens will be collected from patients who undergo surgical resection, after receiving nivolumab. After removal of tissue necessary for clinical assessment, remaining tissue specimens for research purposes will be divided in surgical pathology into 1) fresh tissue that will be transported to the laboratory for viable cell isolation, 2) fixation and paraffin embedding (FFPE), and 3) flash frozen for DNA and RNA analysis. If additional tissue remains, it will be flash frozen.

Specific procedures for accessioning specimens are outlined in detail in the laboratory manual.

### 7.5 Postoperative treatment of participants

#### 7.5.1 Adjuvant chemotherapy



Postoperative chemotherapy will be administered at the discretion of the treating oncologist based on established standard indications. Postoperative chemotherapy will start at a time based on the standard of care approach at the institution taking into account postoperative recovery time for the subject. Postoperative chemotherapy should not commence until treatment-related toxicity due to study drug(s) has resolved to <grade 2.

#### **7.5.2 Postoperative radiation therapy**

Postoperative radiation therapy (PORT) will be administered based on a standard of care at the discretion of the treating oncologist. Subjects who are recommended PORT should have a CT scan of thorax (non-contrast or contrast) to exclude subclinical changes suggestive of pneumonitis prior to commencing PORT. In the event that subjects have radiological findings suggestive of pneumonitis on this scan, then further assessment +/- treatment may be required prior to commencing PORT.

#### **7.6 Evaluation of peri-operative safety**

The subject's medical record will be reviewed on a weekly basis from the start of therapy until 100 days after the last dose of study treatment or 30 days following surgery, whichever is longer, for information regarding operative complications including delay in planned surgery and in particular potential immune related toxicities (Note: Only those subjects who initiate protocol treatment will be followed). Toxicities will be reviewed at regular meetings of study investigators and minutes of these meetings will be documented by the clinical research staff. In the event that a subject does not continue his or her peri-operative care at the institution, every attempt will be made to collect this information either by direct contact or through communication with the subjects outside physician(s).

#### **7.7 Discontinuation, withdrawal and replacement of subjects**

All patients who receive at least one dose of study treatment (including those who do not undergo surgical resection of their tumor) will be included in the overall evaluation of safety (intention-to-treat analysis). All reasons for discontinuation of therapy should be documented clearly in the medical record. If a subject discontinues or withdraws from the study, every attempt will be made to obtain an off-study blood collection if the subject is able and willing to do so.

Subjects who do not undergo surgical resection of their tumor, while evaluable for safety, will be replaced and will not count toward the 15 patient accrual target for each arm.

### **7.7.1 Discontinuation of Treatment**

The reasons for discontinuation of protocol treatment include:

- Evidence of significant disease progression during the preoperative phase at the discretion of the treating investigator.
- Non-compliance with the study protocol; including, but not limited to not attending the majority of scheduled visits. The principal investigator will determine when non-compliance should lead to removal from study. Note: The patients will still be included in the overall evaluation of safety (intent-to-treat analysis).
- Unacceptable toxicity. Note: The patients will still be included in the overall evaluation of safety (intent-to-treat analysis).
- Intercurrent illness or condition that would, in the judgment of the treating investigator, affect assessment of clinical status to a significant degree or require discontinuation of study treatment.
- At subject's own request. Note: The reason for discontinuation from the study must be documented. The patients will be included in the overall evaluation of safety (intent-to-treat analysis) if any protocol therapy was administered prior to withdrawal.
- Study is closed for any reason (e.g. new information shows that the patient's welfare would be at risk if he or she continued study treatment).

### **7.7.2 Withdrawal from study**

The reasons for withdrawal from the study include:

- Subject withdraws consent.
- Subject is lost to follow-up.
- Study is terminated for any reason.

## 8. Study Assessments and Procedures

<b>Table 2: Screening procedural outline</b>		
<b>Procedure</b>	<b>Screening Visit<sup>a</sup></b>	<b>Notes</b>
<b>Eligibility Assessments</b>		
Informed Consent	X	
Inclusion/Exclusion Criteria	X	
Medical History	X	
<b>Safety Assessments</b>		
Physical Examination	X	
Smoking History	X	
Con-medication Review	X	
Vital Signs	X	
Assessment of Signs and Symptoms	X	
Laboratory Tests	X	CBC with differential, serum chemistry (BUN or serum urea level, serum creatinine, albumin, sodium, potassium, chloride, bicarbonate, and glucose levels),AST, ALT, total bilirubin, Alk phosphatase, T3/T4/TSH and urinalysis, hepatitis B and C Antibody.
Pregnancy Test	X	This is only for WOCBP. Serum or Urine pregnancy test is required to be conducted within 2 weeks prior to registration
Physical measurements including ECOG status, Height and Weight	X	
Archived Tumor or Repeat Research Tumor Core Biopsy	X	This is mandatory for study entry. Sample should be received prior to first dose of study treatment. Submit a copy of the original pathology report along with the sample.
Imaging (this is standard of care and may have been performed prior study enrollment however within 28 days prior to the first dose of study drug)	X	PET/CT Scan <i>and</i> CT of chest with IV contrast  And  MRI brain or CT brain with IV contrast

<b>Table 3: Study Calendar</b>						
<b>Procedure</b>	<b>Baseline (Preoperative D -42 +/- 2 days)</b>	<b>Day -28 (+/- 2 days) prior to 2<sup>nd</sup> dose of study drug)</b>	<b>Day -14 (+/-2 days) (prior to 3<sup>rd</sup> dose of study drug)</b>	<b>Once within the 72 hours prior to planned date of surgery (+/- 7 days)</b>	<b>Post Surgery (Once during postoperative period day 21-42)</b>	<b>Follow up for RFS and OS (H+P and research blood draw every 3-6 months for 2 years and then every 6-12 months until 5 years)</b>
<b>Clinical Assessments</b>						
Physical Exam	X	X		X	X	X
Vital Signs	X	X		X	X	X
ECOG PS	X	X		X	X	X
<b>Laboratory Tests</b>						
CBC with diff	X	X	X	X	X	
Chemistry including LFTs	X	X	X	X	X	
TSH (TSH + T4/T3 at screening only)	X		X		X	
PT/INR, PTT				X		
Pregnancy Test (WOCBP only) <sup>a</sup>	X		X		X	
<b>Treatment</b>						
Nivolumab	X	X	X			
Ipilimumab (only for subjects enrolled to Arm A)	X					
<b>Correlative Blood/Tissue/Stool Studies</b>						
PBMCs, Serum, plasma	X	X		X	X	X
Tumor biopsy/sample	X				X (i.e. resection specimen)	
Stool Sample	X		X			
Medical & Dietary Questionnaire*	X					
<b>Other Assessments</b>						
PET/CT	X (may have been performed during screening or up to 28 days)			X		

	prior to first dose)					
CT Chest with IV contrast	X (may have been performed during screening or up to 28 days prior to first dose)			X	X (only required if postoperative radiation is planned)	
Con meds	X				X	
Symptom/ Toxicity Assessment	X	X		X	X	X
Follow up					X	X

WOCBP, women of child-bearing potential. OS, Overall Survival. RFS, recurrence-free survival  
a = Repeat pregnancy test 4-10 weeks post nivolumab for WOCBP,  
PBMCs, peripheral blood mononuclear cells  
\*See Appendix E; Samples are required for JHU participants and optional for MSKCC participants

## 9. Pharmacology, safety and administration of study drugs

### 9.1 Availability

Nivolumab and Ipilimumab will be supplied by Bristol-Myer Squibb Pharmaceuticals free of charge to subjects for the duration of participation in this study via the Investigational Drug Service Pharmacies at SKCCC and MSKCC ([Table 3](#)).

#### 9.1.1 Nivolumab – Clinical Pharmacology Summary

Following single dose, maximum concentration (C<sub>max</sub>), and area under the curve (AUC) of nivolumab were found to be dose proportional within the studied dose range of 0.3-10 mg/kg<sup>6</sup>. The terminal half-life of nivolumab from single dose was 17-25 days. Following multiple doses of 0.1 to 10 mg/kg administered every 2 weeks, C<sub>max</sub> and AUC of nivolumab were found dose proportional. The steady-state was reached by the sixth dose.

#### 9.1.2 Safety Summary and Adverse effects of Nivolumab +/- Ipilimumab

**General Management Algorithms for potential immune-related toxicities are contained in Appendix D of this protocol.**

**Please refer to the current version of the Investigators Brochure for detailed information on safety and adverse events.**

## 9.2 Nivolumab and Ipilimumab administration

Three doses of nivolumab will be administered to enrolled patients on Day -42 and Day-28 and Day-14 prior to planned surgery on Day 0 or up to -3 or +10 days. Subjects enrolled in Arm A of this protocol will also receive ipilimumab on day -42.

When study drugs (ipilimumab or nivolumab) are to be administered on the same day, separate infusion bags and filters must be used for each infusion. It is recommended that nivolumab be administered first. The second infusion will always be ipilimumab, and will start approximately 30 minutes after completion of the nivolumab infusion.

Nivolumab is to be administered as a 60 minute IV infusion. Ipilimumab should be administered as a 90 minute infusion following.

Ipilimumab and nivolumab may be diluted in 0.9% Sodium Chloride Solution or 5% Dextrose solution.

The dosing calculations for Arm A (nivolumab + ipilimumab) should be based on the body weight. If the subject's weight on the day of dosing differs by > 10% from the weight used to calculate the dose, the dose must be recalculated. All doses should be rounded up or to the nearest milligram per institutional standard. Subjects in Arm B will receive nivolumab at a flat dose of 240mg IV. [\(Table 3\)](#).

<b>Table 3 Product Description</b>					
<b>Product Description and Dosage Form</b>	<b>Potency</b>	<b>Primary Packaging (Volume)/ Label Type</b>	<b>Secondary Packaging (Qty) /Label Type</b>	<b>Appearance</b>	<b>Storage Conditions (per label)</b>
Nivolumab BMS-936558-01 Solution for Injection <sup>a</sup>	100 mg (10 mg/mL)	10 mL viall	5-10 vials per carton/ Open-label	Clear to opalescent colorless to pale yellow liquid. May contain particles	2 to 8°C. Protect form light and freezing
Ipilimumab Solution for Injection	200 mg (5 mg/mL)	40 mL vial	4 vials per carton/Open-label	Clear, colorless to pale yellow liquid. May contain particles	2 to 8°C. Protect from light and freezing.
If stored in a glass front refrigerator, vials should be stored in the carton. Recommended safety measures for preparation and handling of nivolumab and ipilimumab include laboratory coats and gloves.					

### **9.2.1 Investigational product**

An investigational product, also known as investigational medicinal product in some regions, is defined as follows: A pharmaceutical form of an active substance or placebo being tested or used as a reference in a clinical study, including products already with a marketing authorization but used or assembled (formulated or packaged) in a way different from the authorized form, or used for an unauthorized indication, or when used to gain further information about the authorized form<sup>87</sup>.

The investigational product should be stored in a secure area according to local regulations. It is the responsibility of the investigator to ensure that investigational product is only dispensed to study subjects. The investigational product must be dispensed only from official study sites by authorized personnel according to local regulations.

In this protocol the investigational products are nivolumab and ipilimumab.

### **9.2.2 Handling and dispensing of nivolumab and ipilimumab**

If stored in a glass front refrigerator, vials should be stored in the carton. Recommended safety measures for preparation and handling of nivolumab and ipilimumab include laboratory coats and gloves.

For additional details on prepared drug storage and use time of nivolumab or ipilimumab under room temperature/light and refrigeration, please refer to the BMS-936558 (nivolumab) and Ipilimumab Investigator Brochure section for “Recommended Storage and Use Conditions”. There will be no dose escalations or reductions of study drugs allowed. There are no premedications recommended for nivolumab or ipilimumab on the first dose.

### **9.2.3 Treatment of Nivolumab or Ipilimumab-Related Infusion Reactions**

- Since nivolumab and ipilimumab contain only human immunoglobulin protein sequences, it is unlikely to be immunogenic and induce infusion or hypersensitivity reactions. However, if such a reaction were to occur, it might manifest with fever, chills, rigors, headache, rash, pruritis, arthralgias, hypo- or hypertension, bronchospasm, or other symptoms.
- All Grade 3 or 4 infusion reactions should be reported as an SAE if criteria are met. Infusion reactions should be graded according to NCI CTCAE (Insert version e.g.: 4.0) guidelines.
- Treatment recommendations are provided below and may be modified based on local treatment standards and guidelines as appropriate:

- For Grade 1 symptoms: (Mild reaction; infusion interruption not indicated; intervention not indicated)

Remain at bedside and monitor subject until recovery from symptoms. The following prophylactic premedications are recommended for future infusions: diphenhydramine 50 mg (or equivalent) and/or paracetamol 325 to 1000 mg (acetaminophen) at least 30 minutes before additional nivolumab administrations.

- For Grade 2 symptoms: (Moderate reaction requires therapy or infusion interruption but responds promptly to symptomatic treatment [eg, antihistamines, non-steroidal anti-inflammatory drugs, narcotics, corticosteroids, bronchodilators, IV fluids]; prophylactic medications indicated for 24 hours).
- Stop the nivolumab or ipilimumab infusion, begin an IV infusion of normal saline, and treat the subject with diphenhydramine 50 mg IV (or equivalent) and/or paracetamol 325 to 1000 mg (acetaminophen); remain at bedside and monitor subject until resolution of symptoms. Corticosteroid or bronchodilator therapy may also be administered as appropriate. If the infusion is interrupted, then restart the infusion at 50% of the original infusion rate when symptoms resolve; if no further complications ensue after 30 minutes, the rate may be increased to 100% of the original infusion rate. Monitor subject closely. If symptoms recur then no further nivolumab or ipilimumab will be administered at that visit. Administer diphenhydramine 50 mg IV, and remain at bedside and monitor the subject until resolution of symptoms. The amount of study drug infused must be recorded on the electronic case report form (eCRF). The following prophylactic premedications are recommended for future infusions: diphenhydramine 50 mg (or equivalent) and/or paracetamol 325 to 1000 mg (acetaminophen) should be administered at least 30 minutes before additional nivolumab or ipilimumab administrations. If necessary, corticosteroids (recommended dose: up to 25 mg of IV hydrocortisone or equivalent) may be used. For Grade 3 or Grade 4 symptoms: (Severe reaction, Grade 3: prolonged [ie, not rapidly responsive to symptomatic medication and/or brief interruption of infusion]; recurrence of symptoms following initial improvement; hospitalization indicated for other clinical sequelae [eg, renal impairment, pulmonary infiltrates]). Grade 4: (life threatening; pressor or ventilatory support indicated). Immediately discontinue infusion of nivolumab or ipilimumab. Begin an IV infusion of normal saline, and treat the subject as follows. Recommend bronchodilators, epinephrine 0.2 to 1 mg of a 1:1,000 solution for subcutaneous administration or 0.1 to 0.25 mg of a 1:10,000 solution injected slowly for IV administration, and/or diphenhydramine 50 mg IV with methylprednisolone 100 mg IV (or equivalent), as needed. Subject should be monitored until the investigator is comfortable that the symptoms will not recur. Nivolumab or



ipilimumab will be permanently discontinued. Investigators should follow their institutional guidelines for the treatment of anaphylaxis. Remain at bedside and monitor subject until recovery from symptoms. In the case of late-occurring hypersensitivity symptoms (eg, appearance of a localized or generalized pruritis within 1 week after treatment), symptomatic treatment may be given (eg, oral antihistamine, or corticosteroids).

#### **9.2.4 Treatment Compliance**

Treatment compliance will be monitored by drug accountability as well as the subject's medical record and eCRF.

#### **9.2.5 Destruction of Study Drug**

The investigator will ensure that arrangements are made for the disposal of study drug according to applicable regulations, guidelines and institutional procedures, and appropriate records of the disposal have been documented.

### **10. Exploratory immunologic studies**

#### **10.1 Immunologic correlates**

All patients will undergo the same laboratory correlate studies on tumor biopsy, resection specimen and serum samples as subsequently enrolled patients.

#### **10.2 Tumor Tissue Samples**

##### **10.2.1 Collection of pretreatment tumor and lymph node biopsies**

Archived FFPE specimens from the original diagnostic lung tumor biopsy may be utilized. If they do not provide sufficient material for study, then new biopsies will be performed. Ideally 6 (minimum of 4 core) needle biopsies of the primary tumor will be required at the time of diagnosis (prior to first dose of study drug); fine needle aspiration biopsy is sufficient for hilar or mediastinal lymph node sampling, but not for primary tumor biopsy.

Where possible, and after a consent form has been signed, attempts will be made to coordinate diagnostic and study biopsies.

##### **10.2.2 Pretreatment Biopsy Handling, Transportation, Storage, and Processing**

Please see flow diagram in appendix C for overview of tissue collection and the laboratory manual for detailed procedures. The study staff will be notified when a biopsy is taking place. The following procedures will be followed:

If a core needle biopsy is being performed specifically for entry to the study, then at least four (and ideally 6) core-biopsy specimens will be obtained, the first 2-3 of these cores obtained will be suspended in 10% buffered formalin while subsequent cores will be flash frozen in liquid nitrogen (see lab manual). After approximately 24 hours of suspension in formalin, the cores will be embedded in paraffin. As required for correlative analyses slides will be cut for the appropriate studies listed below. For fine needle aspiration biopsies of draining lymph nodes, cells will be collected by centrifugation, fixed in formalin and embedded in a paraffin block using standard pathology procedures.

The study coordinator will keep a log with the study number, the patient's study number, the date and time, and a consecutive sample number; thus, the samples will be numbered serially and will not contain identifying information.

### **10.2.3 Operative specimens (tumor, normal lung, draining lymph nodes)**

Tissue specimens obtained at the time of surgery will be dissociated enzymatically into single cell suspensions and will be viably cryopreserved according to a protocol provided in a companion laboratory manual. Additional specimens will fixed in formalin and embedded in paraffin blocks, for routine pathologic studies and immunohistochemistry. Tissue will also be flash-frozen at -80°C for subsequent RNA/DNA analysis. If there is additional tissue available, it will be embedded in OCT (Optimal Cutting Tissue) compound for analysis of frozen sections.

## **10.3 Blood Samples**

### **10.3.1 Collection schedule**

Blood samples will be drawn at the time points identified on the study calendar (section 8, [Table 3](#)).

Time points include:

- Day -42 (prior to nivolumab +/- ipilimumab administration): 80 ml whole blood or local protocol for collection accepted for peripheral blood mononuclear cell (PBMC) isolation, 20ml of whole blood for plasma isolation and 20 ml whole blood for serum isolation
- Day -28 (+/- 1 day) (prior to nivolumab administration): 80 ml, 20ml and 20 ml whole blood, for PBMCs, plasma and serum, respectively.
- Once between Day -3 to D0 (+/- 2 days; must be prior to surgery): 80 ml, 20ml and 20 ml whole blood, for PBMCs, plasma and serum, respectively.
- Once between Week 3-6 postoperatively (postoperative visit, prior to chemotherapy or radiation therapy): 80 ml whole blood or local protocol for

collection accepted for PBMC isolation, 20ml whole blood for plasma isolation and 20 ml whole blood for serum preparation

### 10.3.2 Specimen handling, transportation, storage, processing (Appendix D)

- Serum samples: Whole blood will be collected in serum separator tubes (Becton-Dickinson SST tube or equivalent), processed per manufacturer's instructions and stored at -70°C or below until transfer for analysis.
- PBMCs: Whole blood will be collected into K<sub>2</sub>EDTA tubes and processed per manufacturer's instructions. Viable PBMCs will be stored in cryopreservation medium, at 5e6-1e7 per vial, in liquid nitrogen.
- Plasma samples: Whole blood will be collected in K<sub>2</sub>EDTA tubes, kept at 4 degrees C and processed as per lab manual.

### 10.4 Stool Samples

- **Stool must be collected by subjects using a kit that will be mailed or given to participants by study team. Upon collection, subjects will be asked to store specimen in a refrigerator or cool place until it can be brought with them to the clinic. Time points include:**
- **Once between Day -44 and -42 (prior to nivolumab +/- ipilimumab administration)**
- **Once between Day -16 to -14 (prior to nivolumab +/- ipilimumab administration)**

### 10.5 Methods of Analysis

#### 10.5.1 Immunohistochemistry

Tumor and lymph node biopsies will be stained using commercially available and locally developed monoclonal antibodies. Analyses may include phosphorylated proteins of signaling pathways including but not limited to NF-kB, STAT3, RAS, MEK, and ERK; and phenotypes of infiltrating immune cell populations including but not limited to CD3, CD4, FoxP3, CD25, CD8, CD68, CD56, CD20, CD45RO and granzyme B. Peritumoral versus intratumoral infiltrates will be scored, since these staining patterns have been shown to correlate with clinical outcomes<sup>84, 86-90</sup>. Pathologists will assign an intratumoral and peritumoral immune cell infiltrate grade of (0) none, (1) rare lymphocytes (2) focal lymphohistocytic aggregates or (3) severe diffuse infiltration<sup>91</sup>. Pathologists will

designate 3 representative fields to be evaluated by image analysis, which will allow for the data to be reported as a percentage of area with positive staining.

Immunohistochemical analysis of exploratory markers will focus on areas where the pathology co-investigators have established expertise, including but not limited to: the B7 family ligands PD-L1 (B7-H1), PD-L2 (B7-DC), B7-H3 and B7-H4, as well as inhibitory receptors on lymphocytes, including PD-1, 2B4, LAG-3, BTLA, and Tim-3; these cell surface molecules are candidates for therapeutic combinatorial antibody blockade. Expression of the ligands for Tim-3, BTLA and 2B4 (galectin 9, HVEM, and CD48, respectively) may also be evaluated as well as cytokine expression. These studies will provide a comprehensive view of cellular subsets and immune checkpoint molecule expression in tumors from untreated patients and how cellular subsets and key immune regulatory molecules are impacted intratumorally after treatment with anti-PD-1. Multiplex immunofluorescence may be performed in selected cases.

PD-L1 expression in FFPE specimens will be assessed with the DAKO 28-8 PharmDx Assay (+/- mAb 5H1 in selected cases)<sup>4</sup>.

PD-L1 testing with the BMS assay and JHU assay will be prioritized above other exploratory testing of the tissue specimens.

#### **10.5.2 Amplified In Situ Hybridization (ISH)**

ISH will be performed on FFPE sections using the RNAscope method from Advanced Cell Diagnostics. Genes to be probed include specific cytokines, such as IFN-g, IL-17, IL-10, IL-22, TGF-b, IL-4, TNF-a and certain chemokines e.g. CXCR4. These studies will provide information on functional capacity of tumor infiltrating lymphocytes. Additionally, ISH will be performed for selected molecules, such as LAG-3, that are also being assessed by IHC. This will provide cross-validation for the two techniques.

#### **10.5.3 Laser Capture Microdissection (LCM) and RNA Analysis**

Complimentary to the ISH, LCM followed by RNA Analysis may be performed on FFPE sections. LCM will be performed by trained pathologists. RNA analysis may consist of qRT-PCR for selected immune genes, some of which are going to be analyzed in parallel by ISH, and also by whole genome microarray, using the DASL system. These analyses will provide a broader gene expression profile for broadly defined areas of the tumor (ie infiltrating tumor rests vs peri-tumoral vs surrounding stroma) and will complement ISH and IHC analyses. In addition, fresh frozen tumor samples will be used for expression analyses by means of RNA sequencing.

#### **10.5.4 Flow cytometric analysis of tumor and lymph nodes**

Cryopreserved viable single cell suspensions will be thawed, and cells will be stained with specific monoclonal antibodies to assess coordinate expression of co-regulatory molecules by tumor infiltrating lymphocytes, draining lymph node cells and tumor cells. Multicolor flow cytometric analyses will be conducted. We will enumerate and characterize T cell subsets (e.g., CD4, CD8, CD25, HLA-DR, CD45RO, FoxP3, LAP, PD-1, PD-L1, PD-L2, LAG-3, ICOS, OX40, 41BB, central memory, effector memory), B cells (e.g., CD19, CD20, PD-1, PD-L2, ICOSL), dendritic cells and macrophages (e.g., CD68, CD83, CD1a, PD-L2, HLA-DR) and natural killer cells (CD56). Functional data and further demonstration of relevant T cell subsets will be gained from intracellular cytokine staining on T cells before and after non-specific CD3/28 activation (e.g., IFN-g, TNF-a, granzyme, IL-4, IL-10, and IL-17). The importance of these specific cytokines is that they mark distinct subsets of T cells with specific roles in pro- vs. anti-cancer immunity. In addition, blood samples will also be analyzed for the similar markers, and for cytokines by multiplex assays.

#### **10.5.5 PBMC analysis**

Assessments of coordinate expression of co-regulatory molecules by PBMCs will be performed using multicolor flow cytometric analyses. T cell subsets (including CD4, CD8, and Treg with CD25 and Foxp3) will be analyzed as well as co-stimulatory and co-inhibitory molecule expression and markers for T cell activation state (e.g., CD25, HLA-DR, CD45RO, LAP, PD-1, PD-L1, LAG-3, ICOS, OX40, 41BB, central memory, effector memory). B cells (CD19, CD20, PD-1, PD-L1, PD-L2, ICOSL), dendritic cells and macrophages (CD68, CD83, CD1a, PD-L1, PD-L2, 4-1BB, 4-1BBL, ICOSL, HLA-DR) and natural killer cells (CD56) will be enumerated and characterized. Myeloid derived suppressor cells (MDSCs) will be enumerated by staining for CD14, CD11b, and HLA-DR expression. Further cytokines produced by T cells, will be analyzed by intracellular cytokine staining and multiplex assay. In certain cases, tetramer staining for populations of antigen-specific T cell populations may be performed.

#### **10.5.6 Pharmacodynamic assessment of nivolumab**

Approximate quantitation of infused nivolumab bound to PD-1 receptors on the surface of T cells in the peripheral blood and within the resected tumor and lymph node specimens will be performed in Dr. Topalian's laboratory, according to published procedures<sup>7</sup>. This will provide information about tissue penetration of nivolumab, which has not been obtainable in prior studies.

#### **10.5.7 Molecular pathway analysis**

Genes and pathways that are significantly altered in post-therapy tumor tissues as compared to stage-matched untreated tumor tissues or pre-therapy tissues will be assessed by whole-genome analyses and confirmed by methods such as RNAseq or equivalent.

Whole blood collection will be performed for germline subtraction.

Serial circulating tumor DNA analyses will be performed and correlated with findings from analyses of the primary tumor and with response to treatment.

#### **10.5.8 Serum analysis**

Serum will be assessed for immunological factors which may include antibodies, cytokines and chemokines, as well as potentially for circulating tumor DNA.. This may include analysis of antibodies to angiopoietin-1/2, MIF, and VEGF-A with ELISAs, as previously reported<sup>93</sup>. Patients that demonstrate high titer humoral reactions will then undergo detailed evaluation to isolate specific monoclonal antibodies.

#### **10.5.9 Genomic and Mutation-associated neoantigen (MANA) Analyses**

Genomic analyses will be performed by whole-exome sequencing in pre and post-treatment tumor tissue and matched normal tissue, to assess dynamics in the mutational landscape using described methods. A multi-dimensional neoantigen prediction algorithm that incorporates MHC binding affinity, epitope processing, self-similarity and gene expression to generate neoantigen candidates tailored to each individual's HLA haplotype will be used. The TCR repertoire will be assessed serially by means of TCR sequencing.

#### **10.5.10 Liquid Biopsy Analysis**

ctDNA dynamics will be assessed by targeted sequencing of serial plasma samples collected at the time intervals specified in the study timeline. For these analyses, a custom capture and sequencing approach called targeted error correction sequencing (TEC-Seq) will be used that allows for sensitive and specific detection of low abundance sequence alterations using next generation sequencing.

### **10.6 Leftover Samples**

Any leftover study blood and tissue samples will be stored in the Laboratories of co-investigators at Johns Hopkins and Memorial Sloan-Kettering Cancer Center for future research studies. These samples may be released for use in future studies after approval by the principal investigator and other regulatory bodies, as appropriate. Subjects will be asked to consent to the future use of samples in the consent document.

### **10.6.1 Additional Information**

The study coordinator will keep a log (separate logs will be kept for the blood and tissue samples) that includes the study number, a specimen serial number, the patient's name, time point in therapy, and the date and time that the sample was drawn. The sample will be labeled with a serial number only. The laboratory technician will keep a log with the specimen number, conditions, processing and storage information.

The laboratory investigators will be blinded to the subject identifiers and clinical data while generating the research data; additionally, the reported results will not disclose any unique patient identifiers.

Note: The correlative sample collection schedules outlined above are based on an ideal subject. The sample schedule should be followed as closely as is realistically possible; however, the schedule may be modified due to problems such as scheduling delays or conflicts (e.g., clinic closure, poor weather conditions, vacations, etc.).

## **11. Adverse Events**

### **11.1 General**

This study will use the descriptions and grading scales found in the revised National Cancer Institute Common Terminology Criteria for Adverse Events (CTCAE) Version 4.0 for adverse event reporting that can be found at <http://ctep.cancer.gov/reporting/ctc.html>.

Information about all adverse events, whether volunteered by the subject, discovered by investigator questioning, or detected through physical examination, laboratory test or other means, will be collected, recorded, and followed as appropriate.

All adverse events experienced by subjects will be collected from the time of first dose of study medication, throughout the study and until the final assessment as outlined in the Study Calendar ([Section 8](#)). Subjects continuing to experience toxicity after discontinuation of the study drug may be contacted for additional assessments until the toxicity has resolved or is deemed irreversible.

Any adverse event experienced during additional preoperative treatment or after the surgical procedure that the investigator feels is related to study treatment will be captured.

## **11.2 Definitions**

### **11.2.1 Adverse Event (AE)**

Defined as any new untoward medical occurrence or worsening of a pre-existing medical condition in a patient or clinical investigation subject administered an investigational (medicinal) product and that does not necessarily have a causal relationship with this treatment. An AE can therefore be any unfavorable and unintended sign (including an abnormal laboratory finding, for example), symptom, or disease temporally associated with the use of investigational product, whether or not considered related to the investigational product.

Adverse events can be spontaneously reported or elicited during open-ended questioning, examination, or evaluation of a subject. In order to prevent reporting bias, subjects should not be questioned regarding the specific occurrence of one or more AEs. Medical conditions/diseases present before starting study treatment are only considered adverse events if they worsen after starting study treatment (any procedures specified in the protocol). Adverse events occurring before starting study treatment but after signing the informed consent form will be recorded. Abnormal laboratory values or test results constitute adverse events only if they induce clinical signs or symptoms or require therapy.

### **11.2.2 Serious Adverse Event (SAE):**

A serious AE (SAE) is any untoward medical occurrence that:

- results in death
- is life-threatening (defined as an event in which the subject was at risk of death at the time of the event; it does not refer to an event which hypothetically might have caused death if it were more severe)
- requires inpatient hospitalization or causes prolongation of existing hospitalization (see NOTE below)
- results in persistent or significant disability/incapacity
- is a congenital anomaly/birth defect
- is an important medical event (defined as a medical event(s) that may not be immediately life-threatening or result in death or hospitalization but, based upon appropriate medical and scientific judgment, may jeopardize the subject or may require intervention [i.e. medical, surgical] to prevent one of the other serious outcomes listed in the definition above.) Examples of such events include, but are not limited to, intensive treatment in an emergency room or at home for allergic bronchospasm; blood dyscrasias or convulsions that do not result in hospitalization.) Potential drug induced liver injury (DILI) is also considered an important medical event. (See [Section 7.3.4](#) for the definition of potential DLT.)



Suspected transmission of an infectious agent (ie, any organism, virus or infectious particle, pathogenic or non-pathogenic) via the study drug is an SAE.

Although pregnancy, overdose, cancer, and potential drug induced liver injury (DILI) are not always serious by regulatory definition, these events must be handled as SAEs.

The following hospitalizations are not considered SAEs for the purposes of this study:

- a visit to the emergency room or other hospital department lasting < 24 hours, that does not result in admission (unless considered "important medical event" or event life threatening)
- elective surgery, planned prior to signing consent
- admissions as per protocol for a planned medical/surgical procedure
- routine health assessment requiring admission for baseline/trending of health status (ie, routine colonoscopy)
- medical/surgical admission for purpose other than remedying ill health state and was planned prior to entry into the study. Appropriate documentation is required in these cases.
- admission encountered for another life circumstance that carries no bearing on health status and requires no medical/surgical intervention (ie, lack of housing, economic inadequacy, care-giver respite, family circumstances, administrative).

**11.2.3 Unexpected adverse event:** An adverse event, which varies in nature, intensity or frequency from information on the investigational drug/agent provided in the Investigator's Brochure, package insert or safety reports. Any adverse event that is not included in the informed consent is considered "unexpected".

**11.2.4 Expected (known) adverse event:** An adverse event, which has been reported in the Investigator's Brochure. An adverse event is considered "expected", only if it is included in the informed consent document as a risk.

#### **11.2.5 Relationship**

The relationship of all adverse events and serious adverse events to study medication will be assessed by an investigator and assigned as follows:

**Definitely:** An adverse event which has a timely relationship to the administration of the investigational drug/agent, follows a known pattern of response, for which no alternative cause is present.

**Probably:** An adverse event, which has a timely relationship to the administration of the investigational drug/agent, follows a known pattern of response, but for which a potential alternative cause may be present.

**Possibly:** An adverse event, which has a timely relationship to the administration of the investigational drug/agent, follows no known pattern of response, but a potential alternative cause does not exist.

**Unlikely:** An adverse event which does not have a timely relationship to the administration of the investigational drug/agent, follows no known pattern of response, does not reappear or worsen after re-administration of the investigational drug/agent (if applicable), and for which there is evidence that it is related to a cause other than the investigational drug/agent.

**Unrelated:** An adverse event, for which there is evidence that it is definitely related to a cause other than the investigational drug/agent. In general, there is no timely relationship to the administration of the investigational drug/agent, or if there is a timely relationship, the event does not follow a known pattern of response, and there is an alternative cause.

### **11.3 Serious Adverse Event Collection and Reporting**

Following the subject's written consent to participate in the study, all SAEs, whether related or not related to study drug, must be collected, including those thought to be associated with protocol-specified procedures.

**General Management Algorithms for potential nivolumab-related toxicities are contained in Appendix D of this protocol and in the Investigators Brochure.**

All SAEs, must be collected after a study informed consent is signed that occur during the screening period and within 100 days of discontinuation of dosing for those subjects that receive study therapy (within 30 days of last visit for enrollment failure). The investigator should report any SAE occurring after these time periods that is believed to be related to study drug or protocol-specified procedure.

An SAE report should be completed for any event where doubt exists regarding its status of seriousness. If the investigator believes that an SAE is not related to study drug, but is potentially related to the conditions of the study (such as withdrawal of previous therapy, or a complication of a study procedure), the relationship should be specified in the narrative section of the SAE Report Form.

All SAEs, whether related or unrelated to nivolumab and all pregnancies must be reported to BMS (by the investigator or designee) and the Coordinating Center within 24 hours.

The principal investigator will notify the appropriate regulatory agencies of any serious adverse event due to any cause during the course of this investigation. These include the Johns Hopkins Cancer Center Data and Safety Monitoring Committee, and the Johns

Hopkins Medical Institutional Review Board (JHM-IRB) of The Johns Hopkins Medical Institutions. The required reporting time period is 3 days for fatal events, and 10 days for all other events.

For studies conducted under an Investigator IND, any event that is both serious and unexpected must be reported to the Food and Drug Administration (FDA) as soon as possible and **no later than 7 days** (for a death or life-threatening event) or **15 days** (for all other SAEs) **after the investigator's or institution's initial receipt of the information.** BMS will be provided with a simultaneous copy of all adverse events filed with the FDA. SAEs should be reported on MedWatch Form 3500A or similar form. It MUST include the institutional **AND** BMS study ID [per study Agreement]

MedWatch SAE forms should be sent to the FDA at:

MEDWATCH

5600 Fishers Lane

Rockville, MD 20852-9787

Fax: 1-800-FDA-0178 (1-800-332-0178)

<http://www.accessdata.fda.gov/scripts/medwatch/>

All SAEs should simultaneously be faxed or e-mailed to BMS at:

Global Pharmacovigilance & Epidemiology

Bristol-Myers Squibb Company

Fax Number: 609-818-3804

SAE Email Address: [Worldwide.Safety@BMS.com](mailto:Worldwide.Safety@BMS.com)

The study period during which adverse events will be reported is from the initiation of study procedures to the end of the study treatment follow-up, defined as 100 days following the last administration of nivolumab or ipilimumab treatment.

If only limited information is initially available, follow-up reports are required. (Note: Follow-up SAE reports should include the same investigator term(s) initially reported.) If an ongoing SAE changes in its intensity or relationship to study drug or if new information becomes available, a follow-up SAE report should be sent to BMS using the same procedure used for transmitting the initial SAE report.

In accordance with local regulations, BMS will notify investigators of all SAEs that are suspected (related to the investigational product) and unexpected (ie, not previously described in the Investigator Brochure). In the European Union (EU), an event meeting these criteria is termed a Suspected, Unexpected Serious Adverse Reaction (SUSAR).

Investigator notification of these events will be in the form of an expedited safety report (ESR).

SAEs must be recorded on the SAE Report Form. If only limited information is initially available, follow-up reports are required. (Note: Follow-up SAE reports should include the same investigator term(s) initially reported.) If an ongoing SAE changes in its intensity or relationship to study drug or if new information becomes available, a follow-up SAE report should be sent within 24 hours. All SAEs should be followed to resolution or stabilization.

#### **11.4 Non-serious Adverse Events**

A non-serious adverse event is an AE not classified as serious.

##### **11.4.1 Non-serious Adverse Event Collection and Reporting**

The collection of non-serious AE information should begin at initiation of study drug. Non-serious AE information should also be collected from the start of a lead-in period or other observational period intended to establish a baseline status for the subjects. All non-serious adverse events (not only those deemed to be treatment-related) should be collected continuously during the treatment period and for a minimum of 90 days following the last dose of study treatment.

Non-serious AEs should be followed to resolution or stabilization, or reported as SAEs if they become serious (see [Section 11.3](#)). Follow-up is also required for non-serious AEs that cause interruption or discontinuation of study drug, or those that are present at the end of study treatment as appropriate. All identified non-serious AEs must be recorded and described on the non-serious AE page of the CRF (paper or electronic).

#### **11.5 Laboratory Test Abnormalities**

Completion of supplemental CRFs may be requested for AEs and/or laboratory abnormalities that are reported/identified during the course of the study.

Serious AE CRF page or SAE Report Form (paper or electronic) as appropriate:

- Any laboratory test result that is clinically significant or meets the definition of an SAE
- Any laboratory abnormality that required the subject to have study drug discontinued
- Any laboratory abnormality that required the subject to receive specific corrective therapy.

It is expected that wherever possible, the clinical, rather than the laboratory term would be used by the reporting investigator (ie, anemia versus low hemoglobin value).

### **11.6 Pregnancy**

If, following initiation of the investigational product, it is subsequently discovered that a study subject is pregnant or may have been pregnant at the time of investigational product exposure, including during at least 6 half-lives after product administration, the investigational product will be permanently discontinued in an appropriate manner. Protocol-required procedures for study discontinuation and follow-up must be performed on the subject unless contraindicated by pregnancy (ie, x-ray studies). Other appropriate pregnancy follow-up procedures should be considered if indicated. The investigator must immediately notify the Johns Hopkins IRB of this event and complete and forward a Pregnancy Surveillance Form to BMS PVG within 24 hours and in accordance with SAE reporting procedures described in [Section 11.3](#).

Follow-up information regarding the course of the pregnancy, including perinatal and neonatal outcome and, where applicable, offspring information must be reported on the Pregnancy Surveillance Form.

Any pregnancy that occurs in a female partner of a male study participant should be reported to the sponsor. Information on this pregnancy will be collected on the Pregnancy Surveillance Form.

### **11.7 Overdose**

An overdose is defined as the accidental or intentional administration of any dose of a product that is considered both excessive and medically important. All occurrences of overdose must be reported as SAEs (see Section 11.3 for reporting details).

### **11.8 Other Safety Considerations**

Any significant worsening noted during interim or final physical examinations, electrocardiograms, x-rays, and any other potential safety assessments, whether or not these procedures are required by the protocol, should also be recorded as a non-serious or serious AE, as appropriate, and reported accordingly.

## **12. Data and Safety Monitoring**

### **12.1 Data Management**

All information will be collected on study-specific case report forms by the study staff.

The completed forms will be forwarded for central review and inclusion in the study dataset with relevant source documentation as outlined in the case report forms. The data submission schedule is as follows:

At the time of registration:

- Registration Form
- Informed Consent Form (signed by the subject)
- Eligibility Checklist
- Source documents related to eligibility and randomization

Within 2 weeks after registration:

- Baseline study case report forms
- Pertinent source documents

Within 2 weeks after final dose of study medication:

- On study case report forms
- Pertinent source documents

The investigator will permit study-related monitoring, audits, and inspections by the IRB, government regulatory bodies, and University compliance and quality assurance groups of all study related documents. The investigator will ensure the capability for inspections of applicable study-related facilities (e.g. pharmacy, diagnostic laboratory, etc.).

This is a DSMP Level II study under the SKCCC Data Safety Monitoring Plan (12/06/2012). Data monitoring of this protocol will occur on a regular basis with the frequency dependent on the rate of subject accrual and the progress of the study. The protocol will be monitored internally (Johns Hopkins East Baltimore and Bayview Medical Center Campuses) at SKCCC by the Principal Investigator and externally by the SKCCC CRO in accordance with SKCCC guidelines. Trial monitoring and reporting will be done through the Safety Monitoring Committee (SMC) at SKCCC. The Johns Hopkins SKCCC UAD data management team will be responsible for data monitor at MSKCC.

The study team will follow the SKCCC Coordinating Center Operations Manual to verify the following items:

- Confirmation that the coordinating center PI has contact information for all centers
- Plan for review of each site's IRB approval documents and consent forms
- If federally funded research, confirmation that each participating site has on file an FWA with OHRP

- Method of assuring that all centers have the most current version of the protocol and amendments to the protocol will be communicated to all centers
- Plan for collection and management of data from all centers
- Process for reporting and evaluating protocol events and deviations from all centers

## **12.2 Meetings**

Teleconferences of all investigators, research nurses and other study staff involved in the study will take place, starting once both sites have enrolled a subject. The following study team members involved with the conduct of the trial will be included as appropriate: study coordinators, data managers, research nurses, sub-investigators, collaborators (if applicable), and statistician.

During these meetings, matters related to the following will be discussed: enrollment rate relative to expectation, characteristics of participants, retention of participants, adherence to protocol (potential or real protocol violations), validity and integrity of the data, toxicities, acquisition of serum samples and transfer to lab, and progress of data for objectives.

## **12.3 Monitoring**

Evaluation of safety will be monitored continuously through day 100 following the last dose of nivolumab. The evaluations will be conducted under the direction of Dr. Patrick Forde and the study statistician; additional information may be found in the statistical section.

## **13. Administrative Procedures**

### **13.1 Protocol Amendments**

Any changes to the protocol will be made in the form of an amendment and must be approved by the IRB before implementation. The Principal Investigator is responsible for the coordination and development of all protocol amendments.

### **13.2 Informed Consent**

An investigator will explain to each subject the nature of the study, its purpose, procedures involved, expected duration, potential risks and benefits. Each subject will be informed that participation in the study is voluntary and that she may withdraw from the study at any time, and that withdrawal of consent will not affect her subsequent medical treatment. This informed consent will be given by means of a standard written statement and will be submitted for IRB approval prior to use. No patient will enter the study before her informed consent has been obtained. In accordance with the Health

Information Portability and Accountability Act (HIPAA), the written informed consent document (or a separate document to be given in conjunction with the consent document) will include a subject authorization to release medical information to the study sponsor and supporting agencies and/or allow these bodies, a regulatory authority, or Institutional Review Board access to subjects' medical information that includes all hospital records relevant to the study, including subjects' medical history.

### **13.3 Ethics and Good Clinical Practice**

This study must be carried out in compliance with the protocol and Good Clinical Practice, as described in:

1. ICH Harmonized Tripartite Guidelines for Good Clinical Practice 1996.
2. US 21 Code of Federal Regulations dealing with clinical studies (including parts 50 and 56 concerning informed consent and IRB regulations).
3. Declaration of Helsinki, concerning medical research in humans (Recommendations Guiding Physicians in Biomedical Research Involving Human Subjects, Helsinki 1964, amended Tokyo 1975, Venice 1983, Hong Kong 1989, Somerset West 1996).

The investigator agrees to adhere to the instructions and procedures described in it and thereby to adhere to the principles of Good Clinical Practice that it conforms to.

### **13.4 Regulatory Authorities**

#### **13.4.1 Institutional Review Board**

Information regarding study conduct and progress will be reported to the Institutional Review Board (IRB) per the current institutional standards of each participating center.

#### **13.4.2 Food and Drug Administration (FDA)**

### **13.5 Principal Investigator Responsibilities**

The Protocol Chair is responsible for performing the following tasks:

- Coordinating, developing, submitting, and obtaining approval for the protocol as well as its subsequent amendments.
- Assuring that the correct version of the protocol is used.
- Taking responsibility for the overall conduct of the study and for monitoring the progress of the study.
- Reviewing and ensuring reporting of Serious Adverse Events (SAE).
- Reviewing data from all sites.

## **14. Statistical Considerations**

**Addition of two expansion cohorts:**



This protocol is investigating the safety and feasibility of neoadjuvant immune checkpoint inhibition in subjects with resectable stage IB, II and IIIA NSCLC. The original arm of the protocol consisted of a six patient run-in phase followed by a 10 patient expansion cohort. While encouraging pathological responses were seen with the original treatment plan, most patients had remaining tumor after two doses of nivolumab over one month of treatment. It is possible that six weeks of therapy and/or dual immune checkpoint inhibition is necessary to get maximal immune infiltration and tumor regression with neoadjuvant immune checkpoint inhibition. We, therefore, seek to expand the current 20-patient study to include two new treatment arms with a longer duration of treatment: a 15-patient arm treated with a six week course of nivolumab and a 15-patient arm treated with nivolumab and ipilimumab for six weeks.

Patients will initially be enrolled to Arm A of this protocol, this arm will include 15 patients to receive nivolumab (on day -42, -28 and -14) and ipilimumab (on day -42 only) . Similar to the first portion of the study, there will be a six patient run-in for Arm A (nivolumab + ipilimumab) only to preliminarily assess safety. After the patients in the run-in complete the observation period, Arm A will complete enrollment to a total of 15 patients. The primary objective of this arm will be safety and feasibility of nivolumab + ipilimumab. Subsequently 15 patients will be enrolled to Arm B (nivolumab single agent on day -42, -28 and -14). A 6 patient safety run-in will not be performed for Arm B. The primary objective of this arm will be safety and feasibility of neoadjuvant nivolumab x 3 doses. Along with the original patient set, these two arms will provide information about the effect of a longer course of therapy on immune correlates, as well as the effect on pathologic regression of a combination anti-PD1 and anti-CTLA4 treatment approach and longer course of single agent anti-PD1.

#### **14.1 Study Design**

Patients with operable stage I, II and IIIA non-small cell lung cancer (NSCLC) enrolled in arm A will receive nivolumab 3mg/kg IV for 3 doses (day -42, -28 and -14) with ipilimumab 1mg/kg IV for 1 dose on day -42 prior to surgical resection (between day -3 and day +10) while (subsequent to full accrual of 15 patients to Arm A), patients enrolled to arm B will receive single agent nivolumab 240mg IV for 3 doses on the same schedule. Patients will be observed for perioperative grade 3-4 adverse events through day 100 (or day 30 post surgery – whichever is longer) following the last dose of study drug(s). Safety and feasibility will be monitored continually throughout the study through biweekly meetings with investigators. A set of markers of immune reactivity measured in lung tumor resection specimens, draining lymph nodes, and peripheral blood will be evaluated. Feasibility in this study means the successful completion of preoperative treatment and proceeding to surgery without any extended treatment-related delays. Extended treatment-related delay is defined as >24 days from

preplanned Day 0 in this context (>14 days from preplanned day 0 plus 10 extra days to allow for OR scheduling constraints etc.).

The primary endpoint statistical calculations will be based on a planned enrollment of 15 treated patients in Arm A (nivolumab + ipilimumab) and subsequently 15 treated patients in Arm B (nivolumab x 3).

## **14.2 Objectives**

### **14.2.1 Primary Objective**

To investigate the safety and feasibility of neoadjuvant nivolumab +/- ipilimumab in subjects with resectable stage IB, II and IIIA NSCLC.

### **14.2.2 Secondary Objectives**

- i. To evaluate pathologic response to neoadjuvant nivolumab +/- ipilimumab in terms of percent tumor regression
- ii. To evaluate the frequency of major pathologic response (MPR) to neoadjuvant treatment. MPR is defined as <10% remaining viable tumor in the resection specimen after neoadjuvant treatment
- iii. To evaluate radiographic response to neoadjuvant therapy using RECIST 1.1
- iv. To evaluate baseline and serial markers of immunogenicity in preoperatively immunotherapy- treated NSCLC tumors, normal lung tissue and peripheral blood and compare with tumor, normal lung and peripheral blood samples from a group of patients who do not receive preoperative immunotherapy prior to surgery on a parallel tissue collection protocol.
- v. To explore biologic features of the gut microbiome(s) of NSCLC patients receiving neoadjuvant nivolumab +/- ipilimumab and correlate these with clinical response.

## **14.3 Primary Endpoint Definition**

### **14.3.1 Primary Endpoints**

Safety of nivolumab +/- ipilimumab administered preoperatively according to the planned schema in NSCLC.

Safety will be measured by:

- Frequency of drug related adverse events occurring up to 100 days after the last dose of study treatment or 30 days after surgery (whichever is longer).
- Frequency of serious adverse events occurring up to 100 days after the last dose of study treatment or 30 days after surgery (whichever is longer).

- Frequency of clinical laboratory test by worst toxicity grade using NCI CTC v4.0 (as assessed at the time intervals outlined in the study calendar in section 8, [Table 3](#))

Feasibility of preoperative administration of nivolumab +/- ipilimumab in NSCLC.

Feasibility will be evaluated as the successful completion of preoperative treatment and proceeding to surgery without any extended treatment-related delays defined as >24 days from preplanned Day 0 in this context.

#### 14.4 Safety Endpoint

##### **Safety stopping rule:**

Nivolumab, 3 mg/kg IV, on days -28 and -14 prior to surgery has been tested for safety and feasibility in 19 patients enrolled in the first part of the study, all of these patients are in postoperative follow upAs of October 1, 2016, there were no delays to surgery, meaning this treatment plan was feasible for all enrolled patients. Eighteen of nineteen patients were able to receive both neoadjuvant doses. The one patient not receiving both doses of nivolumab developed fevers on day 7 with tumor cavitation possibly related to treatment (grade 3 SAE) and proceeded directly to surgery without the second dose of nivolumab. Surgery and recovery postoperatively was uncomplicated.

The primary DLTs of concern for safety monitoring in the new expansion cohorts will be grade 3-4 toxicities of the types listed in section 7.3.4. These include liver, GI, renal, pneumonitis and any other grade 3-4 toxicity that in the opinion of the investigator significantly interfered with the subjects' optimal perioperative management. They will be monitored continuously for fifteen patients in each arm through day 100 following the last dose of study treatment (or day 30 post surgery, whichever is longer).

For the first part of the study, we assumed that the risk of grade 3-4 toxicities in advanced NSCLC and other solid tumors is 25% and we used a Beta prior distribution with parameters 1 and 3. With this prior, there is 90% probability that this proportion is between 1.7% and 53.6%. The safety stopping rule for the new expansion cohorts will apply this prior distribution to the observed number of patients experiencing DLT and will compute the resulting probability of DLT. If the posterior probability of risk >.25, based on Bayes rule and the assumption implied by the prior, is 70% or higher the study will stop.

In the first six patients enrolled to Arm A there will be two modifications to the above stopping rule:

1. If the first patient on study experiences a DLT, we will not stop, but treat one additional patient before making a decision.
2. In the first six patients, if there has been one DLT and a second DLT is seen in the fifth or sixth patient, the study will be paused for an additional safety review and may or may not continue.

**Table 1. Stopping rule for safety.**

Stop if DLTs	2	3	4	5
and N patients	2- 4	5- 8	9- 11	12- 15

As an example, the rule will call for stopping the study if 4 patients out of the first 9 experiences grade 3-4 DLT. The following table shows the percent of the time that the stopping rule will stop the study under different hypothetical risks of toxicity, along with the average sample size (based on 5000 simulations). The third row of the table gives the percentage of simulated studies where a second toxicity in the fifth or sixth patient would have caused the study to be paused for a review and possibly stopped.

**Table 2. Operating characteristics based on 5,000 simulations with 15 patients and safety stopping rule.**

Simulated Risk of DLT	.10	.15	.20	.25	.30	.35	.40	.50
% of Time Study Stops	7.8%	19.4%	32.2%	48.0%	63.0%	75.7%	86.5%	96.3%
Expected Sample Size	14.2	13.2	12.1	10.7	9.3	8.0	6.6	4.8
% with additional safety review.	4.7%	6.7%	8.5%	8.2%	5.7%	4.0%	2.2%	0.7%

## 14.5 Feasibility Endpoint

**14.5.1 Early stopping guideline for feasibility:** The feasibility of neoadjuvant nivolumab+/- ipilimumab will be based on patients proceeding to surgery without extended treatment related delays. A treatment related delay will be considered “extended” if it is greater than 24 days following the initially planned surgery date. For feasibility, a toxicity of any grade, that in the judgment of the investigator or surgeon could adversely impact perioperative morbidity or mortality, should delay the planned operative date. We will use a probability-based decision rule for the study to decide if the probability successfully proceeding to surgery as planned is convincingly less than .90.

Previously we expected, *a priori*, the feasibility to be high and that 90% of patients would not have their surgery delayed. Based on results in the first arm of this study, where all 19 patients were feasible and proceeded to surgery without delay, we expect this will be true for the expansion cohorts as well. The monitoring rule for the expansion cohorts will therefore use an *a priori* optimistic Beta(9,1) prior distribution. This distribution corresponds to an assumption that 9 out of 10 patients will proceed to surgery as planned and 90% certainty that feasibility is between .715 and .994. This stopping rule will hold enrollment if, given the data, there is at least 90% probability that fewer than 90% of patients can continue to surgery without treatment related delays. The feasibility stopping rule calls for the study to be paused for a review if the number of patients successfully proceeding to surgery is too low. For example, if neither of the first 2 patients

are able to proceed to surgery without a delay, the study should stop. If only 1 of the first 3 patients goes to surgery as planned, the study continues, but the study would be paused for a review if the fourth patient does not. If the feasibility stopping boundary is reached, we will reevaluate the clinical advantages of the treatment, pathological tumor response and prolonged PFS, against the risks and consider re-designing the regimen to allow more time between the last dose of study treatment and surgery to better manage potential side effects. While an optimistic prior is used to define the stopping boundary, we will use a uniform prior in the analysis phase.

**Table 3. Stopping Rule for Feasibility.**

No. patients for whom the regimen is feasible	0	1	2	3	4	5	6	7
No. of patients	2	4	5	6	8	10	12	14

**14.5.2 Operating characteristics:** The operating characteristics of this feasibility rule have been calculated based on 5000 simulations. If the posterior certainty is 90% or higher that feasibility is less than 0.90, based on Bayes rule and the assumption of a Beta(9,1) prior, further study will be reconsidered. For data simulated with known probabilities of feasibility ( $\theta$ ), the second row in the table below shows the percent of time that the feasibility rule will determine that the underlying proportion of patients who can continue to surgery is below the benchmark of 90% and the study should be stopped early or after the 15<sup>th</sup> patient based on the feasibility rule. The fourth row in the table gives the additional percentage of studies for which the posterior probability of not being feasible at the end of the study is greater than the posterior probability being feasible. These studies would also be considered as having failed feasibility.

**Table 4. Operating characteristics of feasibility rule based on 5,000 simulations.**

True feasibility ( $\theta$ )	0.30	0.40	0.50	0.60	0.70	0.75	0.80	0.85	0.90
% studies stopped	100%	99.8%	98.8%	92.4%	74.1%	58.3%	40.4%	22.0%	7.7%
Expected sample size	3.5	4.5	5.6	7.4	9.7	11.2	12.4	13.7	14.5
Additional studies with posterior probability infeasible >50% at final analysis	0.0%	0.2%	1.2%	7.1%	22.2%	33.7%	42.3%	44.7%	37.8%

### 14.5.3 Feasibility Sample Size and Accrual

The accrual rate for this study is expected to be 2-3 patients per month. Arm A will have enrolled fifteen patients if the study does not stop early. We will provide the posterior estimate and a 90% posterior credible interval. The final analysis will use a uniform

reference prior for the proportion of patients for whom the neoadjuvant regimen is feasible in this setting. For example, if at least 11 patients were able to proceed directly to surgery after the regimen, then the posterior estimate will be 0.71, and the 90% credible interval will be (0.52, 0.87). Since this credible interval does not include 0.90, we will not consider neoadjuvant immunotherapy feasible in this setting. Using this criterion, at least 12 of 15 patients will have to have been able to go to surgery without problems (i.e., no issues relating to feasibility) for us to consider the regimen feasible. If the neoadjuvant treatment is feasible for 12 of 15 patients, then the estimate of the chance the regimen is feasible will be 0.76 and the 90% credible interval will be (0.58, 0.91), which includes 0.90.

## 14.6 Statistical Analysis Plans

### 14.6.1 Analysis plan for safety

The proportion of DLTs will be reported with exact binomial 95% confidence intervals. All other adverse events will be similarly summarized by type and grade.

### 14.6.2 Analysis plan for feasibility

The following table shows the 90% credible intervals for the underlying probability of feasibility, based on different numbers of patients going to surgery without extensive delay, using a Beta (1,1) prior. The analysis plan is two-sided (5% in each tail), allowing for the full range of possible outcomes, while sample size is based on a one-sided consideration (10% in the upper tail). As an example of the final inference, if 14 out of 15 patients go to surgery without an extended delay, we will be fairly confident that feasibility is adequate. We will require that 12 out of 15 patients not have extended surgery delays for neoadjuvant immunotherapy to be considered for further study in this setting.

<b>Number feasible out of 15, posterior estimate, and (90% Credible Interval)</b>	<b>Decision</b>
7 out of 15    47.1    (27.9, 66.7)	Not Feasible
8 out of 15    53.0    (33.3, 72.1)	Not Feasible
9 out of 15    58.8    (39.1, 77.3)	Not Feasible

10 out of 15	64.7	(45.2, 82.2)	Not Feasible
11 out of 15	70.6	(51.6, 86.8)	Not Feasible
12 out of 15	76.5	(58.3, 91.0)	Feasible
13 out of 15	82.4	(65.6, 94.7)	Feasible
14 out of 15	88.2	(73.6, 97.7)	Feasible
15 out of 15	94.1	(86.6, 1.0)	Feasible

## 14.7 Exploratory Immune Endpoints

### 14.7.1. Markers of response to anti-PD-1

Markers of immune reactivity will be prospectively measured in lung tumor resection specimens, draining lymph nodes (DLNs) and serial peripheral blood samples from stage IB/II/IIIA NSCLC patients who receive preoperative immune checkpoint inhibition. All samples will be analyzed using whole exome sequencing, RNA sequencing, TCR sequencing, multicolor flow cytometry, immunohistochemistry and in situ hybridization for candidate surrogate markers of immune response to anti-PD-1, depending on tissue availability. These analyses include assessment of frequency of coordinate expression of co-regulatory molecules ([Table 5](#)) by peripheral blood lymphocytes, tumor infiltrating lymphocytes, DLN cells and tumor cells. PD-L1, CD3, CD4, CD8, granzyme B, CD20, and CD56 staining will be performed on biopsy and resection specimen and frequency of expression tabulated. Analysis of circulating cell-free tumor DNA will be performed at serial timepoints. Additional molecules may be assessed as well.

<b>T Cell Subset</b>	<b>Principle Role</b>
CD4, CD8	Interaction of TCR with APC
CD25	Forms receptor for IL-2, may suppress anti-tumor immunity
HLA-DR	Presentation of antigens for immune recognition
CD45RO	Expression may potentiate anti-tumor immunity
FoxP3	Essential for production of Tregs, may suppress anti-tumor immunity
LAP	Potential marker for activated Tregs
PD-1/PD-L1	Inhibit anti-tumor immunity, PD-1 is primary target of nivolumab
LAG-3	Inhibitory co-receptor may synergize with PD-1 to suppress anti-tumor immunity
ICOS	Stimulates T cell response to tumor
CTLA-4	Immune checkpoint inhibits anti-tumor immune response
OX40	Co-stimulatory, contributes to memory T cell response
4-1BB	Anti-4-1BB antibody may potentiate anti-tumor response

Abbreviations – CD, cluster differentiation; TCR, T-cell receptor; APC, antigen presenting cell; HLA-DR, human leukocyte antigen-D related; FoxP3, forkhead box P3; LAP, latency associated peptide; LAG-3, lymphocyte –activation gene 3; ICOS, Inducible T-cell costimulator; CTLA-4, cytotoxic T-lymphocyte antigen-4; PD-L1, Programmed death-ligand 1;
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#### **14.7.2 Analysis of exploratory immunologic endpoints**

These exploratory analyses will be descriptive/graphical in nature, and are designed to generate new hypotheses to be tested in future clinical studies. When parameters of immune response are measured, continuous variables will be summarized with means and standard deviations. Dichotomous and categorical variables will be summarized using proportions with exact 95% confidence intervals and counts, respectively. These summaries will be computed for each treated patient at multiple time points before and after nivolumab administration as indicated in the study schema. Plots will be used to show the changes in immune response over time both for each individual. For each patient, comparisons in the pre and post-nivolumab responses will be compared using paired t-tests (or Wilcoxon signed rank tests if appropriate) for continuous variables and McNemar’s test for dichotomous or categorical variables. Associations between immune responses will be explored graphically (e.g. scatterplots, boxplots) and numerically (e.g. correlations,  $\chi^2$  tests). Similar comparisons will be performed between immunotherapy-treated patients, and control patients with resectable NSCLC who do not receive nivolumab or nivolumab and ipilimumab but are enrolled on a companion tissue collection protocol.

#### **14.7.3 Analysis of exploratory features of gut microbiota that correlate with clinical response.**

Integration of microbiome science into cancer therapeutics is a new field of study. There are as yet no prospective human studies to determine if the microbiome influences the response to cancer therapies. However, two recent mouse papers published in Science (insert PMID: 26541606 and PMID: 26541610) have suggested that cancer immunotherapy is impacted by the composition of the microbiome and that certain bacterial species can promote improved therapeutic responses to checkpoint inhibitor therapy. Thus, the goal of this sample collection is to facilitate exploratory, correlative analyses between the gut microbiome communities and responses to neoadjuvant checkpoint blockade therapy.

We will consider using 16S rRNA, shotgun metagenomics and/or RNA-seq for analyses. 16S rRNA sequencing data will be filtered for poor quality and contaminant/chimeric sequences, followed by taxonomic assignment using standard bioinformatic pipelines such as QIIME and Resphera Insight. To detect differentially abundant taxa between responders and non-responders, we will utilize the



nonparametric Mann-Whitney test with correction for multiple hypothesis testing using the False Discovery Rate. To evaluate beta-diversity between responders and non-responders (i.e. shared total community composition), we will compute the UniFrac distance metric for all sample pairs, followed by principal coordinate analysis and significance testing with PERMANOVA. Functional inference of gene content from 16S rRNA data may also be performed using tools such as PICRUSt. While 16S rRNA identifies only bacterial sequences, metagenomics permits detection of viruses and fungi among others. Metagenomic analyses will be designed to remove human contaminant sequences followed by taxonomic assignment using Kraken and Pathoscope. Functional characterization of metagenomic data will be performed using the HUMAnN tool. Additionally, RNA-seq analysis (meta-transcriptomics) enables characterization of actively transcribed microbial genes and RNA viruses, with the potential to explore the combined host:microbial interaction(s).

## References

1. Zhang X, Schwartz JC, Guo X et al Structural and functional analysis of the costimulatory receptor programmed death-1 Immunity. 2004 Mar; 20(3):337-47
2. Dong H, Strome SE, Salomao DR et al Tumor-associated B7-H1 promotes T-cell apoptosis: A potential mechanism of immune evasion Nat Med. 2002 Aug;8(8):793-800
3. Thompson RH, Kuntz SM, Leibovich BC et al Tumor B7-H1 is associated with poor prognosis in renal cell carcinoma patients with long-term follow-up Cancer Res. 2006 Apr 1;66(7):3381-5
4. Topalian SL, Hodi FS, Brahmer JR et al Safety, activity and immune correlates of anti-PD-1 antibody in cancer N Engl J Med. 2012 Jun 28;366(26):2443-54
5. Brahmer JR, Horn L, Antonia SJ et al Survival and long-term follow-up of the phase I trial of nivolumab (Anti-PD-1; BMS-936558; ONO-4538) in patients with previously treated advanced non-small cell lung cancer Journal of Clinical Oncology, 2013 ASCO Annual Meeting Proceedings (Post-Meeting Edition). Vol 31, No 15\_suppl (May 20 Supplement), 2013: 8030
6. Brahmer J, Reckamp KL, Baas P, et al. Nivolumab versus Docetaxel in Advanced Squamous-Cell Non-Small-Cell Lung Cancer. N Engl J Med. 2015 Jul 9;373(2):123-35.
7. Borghaei H, Paz-Ares L, Horn L, et al. Nivolumab versus Docetaxel in Advanced Nonsquamous Non-Small-Cell Lung Cancer. N Engl J Med. 2015 Oct 22;373(17):1627-39.
8. Gettinger S, Rizvi NA, Chow LQ, et al. Nivolumab Monotherapy for First-Line Treatment of Advanced Non-Small-Cell Lung Cancer. J Clin Oncol. 2016 Jun 27. [Epub ahead of print]
9. Hellmann MD, Gettinger SN, Goldman J, et al. Presented at the 2016 ASCO Annual Meeting, Chicago, IL, USA.
10. Chen L Co-inhibitory molecules of the B7-CD28 family in the control of T-cell immunity Nat Rev Immunol. 2004 May;4(5):336-47
11. Brahmer JR, Drake CG, Wollner I et al Phase I study of single-agent anti-programmed death-1 (MDX-1106) in refractory solid tumors: safety, clinical activity, pharmacodynamics, and immunologic correlates J Clin Oncol. 2010 Jul 1;28(19):3167-75
12. Ferlay J, Shin HR, Bray F, Forman D, Mathers CD, Parkin D. GLOBOCAN 2008, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10. Lyon, France: International Agency for Research on Cancer; Year 2010 Available at: <http://globocan.iarc.fr>
13. [www.seer.cancer.gov](http://www.seer.cancer.gov) . Accessed 08/08/2012
14. Arriagada R, Auperin A, Burdett S et al Adjuvant chemotherapy, with or without postoperative radiotherapy, in operable non-small-cell lung cancer: two meta-analyses of individual patient data Lancet. 2010 Apr 10;375(9722):1267-77.

15. Dunn GP, Bruce AT, Ikeda H et al Cancer immunoediting: from surveillance to tumor escape *Nat Immunol.* 2002 Nov;3(11):991-8
16. Retsas S, Priestman TJ, Newton KA et al Evaluation of human lymphoblastoid interferon in advanced malignant melanoma *Cancer.* 1983 Jan 15;51(2):273-6
17. West WH, Tauer KW, Yannelli JR et al Constant-infusion recombinant interleukin-2 in adoptive immunotherapy of advanced cancer *N Engl J Med.* 1987 Apr 9;316(15):898-905
18. Tao MH, Levy R Idiotypic /granulocyte-macrophage colony-stimulating factor fusion protein as a vaccine for B-cell lymphoma *Nature.* 1993 Apr 22;362(6422):755-8
19. Phan GQ, Attia P, Steinberg SM et al Factors associated with response to high-dose interleukin-2 in patients with metastatic melanoma *J Clin Oncol.* 2001 Aug 1;19(15):3477-82
20. Sabatino M, Kim-Schulze S, Panelli MC et al Serum vascular endothelial growth factor and fibronectin predict clinical response to high-dose interleukin-2 therapy *J Clin Oncol.* 2009 Jun 1;27(16):2645-52
21. Joseph RW, Sullivan RJ, Harrell R et al Correlation of NRAS mutations with clinical response to high-dose IL-2 in patients with advanced melanoma *J Immunother.* 2012 Jan;35(1):66-72.
22. Kantoff PW, Higano CS, Shore ND et al Sipuleucel-T immunotherapy for castration-resistant prostate cancer *N Engl J Med.* 2010 Jul 29;363(5):411-22
23. Hodi FS, O'Day SJ, McDermott DF et al Improved survival with ipilimumab in patients with metastatic melanoma *N Engl J Med.* 2010 Aug 19;363(8):711-23
24. Krummel MF, Allison JP CD28 and CTLA-4 have opposing effects on the response of T cells to stimulation *J Exp Med.* 1995 Aug 1;182(2):459-65
25. Leach DR, Krummel MF, Allison JP Enhancement of anti-tumor immunity by CTLA-4 blockade *Science.* 1996 Mar 22;271(5256):1734-6
26. Nishimura H, Honjo T PD-1: an inhibitory immunoreceptor involved in peripheral tolerance *Trends Immunol.* 2001 May;22(5):265-8.
27. Freeman GJ, Long AJ, Iwai Y et al Engagement of the PD-1 immunoinhibitory receptor by a novel B7 family member leads to negative regulation of lymphocyte activation *J Exp Med.* 2000 Oct 2;192(7):1027-34.
28. Latchman Y, Wood CR, Chernova T et al PD-L2 is a second ligand for PD-1 and inhibits T cell activation *Nat Immunol.* 2001 Mar;2(3):261-8
29. Carter L, Fouser LA, Jussif J et al PD-1:PD-L inhibitory pathway affects both CD4(+) and CD8(+) T cells and is overcome by IL-2 *Eur J Immunol.* 2002 Mar;32(3):634-43
30. Chemnitz JM, Parry RV, Nichols KE et al. SHP-1 and SHP-2 associate with immunoreceptor tyrosine-based switch motif of programmed death 1 upon primary human T cell stimulation, but only receptor ligation prevents T cell activation *J Immunol.* 2004 Jul 15;173(2):945-54

31. Sheppard KA, Fitz LJ, Lee JM et al PD-1 inhibits T-cell receptor induced phosphorylation of the ZAP70/CD3zeta signalosome and downstream signaling to PKC $\theta$  FEBS Lett. 2004 Sep 10;574(1-3):37-41
32. Nishimura H, Nose M, Hiai H et al Development of lupus-like autoimmune diseases by disruption of the PD-1 gene encoding an ITIM motif-carrying immunoreceptor Immunity. 1999 Aug;11(2):141-51
33. Nishimura H, Okazaki T, Tanaka Y et al Autoimmune dilated cardiomyopathy in PD-1 receptor-deficient mice Science. 2001 Jan 12;291(5502):319-22
34. Wang J, Yoshida T, Nakaki F et al Establishment of NOD-Pdcd1<sup>-/-</sup> mice as an efficient animal model of type I diabetes Proc Natl Acad Sci U S A. 2005 Aug 16;102(33):11823-8
35. Okazaki T, Tanaka Y, Nishio R et al Autoantibodies against cardiac troponin I are responsible for dilated cardiomyopathy in PD-1-deficient mice Nat Med. 2003 Dec;9(12):1477-83
36. Salama AD, Chitnis T, Imitola J et al Critical role of the programmed death-1 (PD-1) pathway in regulation of experimental autoimmune encephalomyelitis J Exp Med. 2003 Jul 7;198(1):71-8
37. Blazar BR, Carreno BM, Panoskaltsis-Mortari A et al Blockade of programmed death-1 engagement accelerates graft-versus-host disease lethality by an IFN- $\gamma$ -dependent mechanism J Immunol. 2003 Aug 1;171(3):1272-7
38. Konishi J, Yamazaki K, Azuma M et al B7-H1 expression on non-small cell lung cancer cells and its relationship with tumor-infiltrating lymphocytes and their PD-1 expression Clin Cancer Res. 2004 Aug 1;10(15):5094-100
39. Thompson RH, Gillett MD, Cheville JC et al Costimulatory B7-H1 in renal cell carcinoma patients: Indicator of tumor aggressiveness and potential therapeutic target Proc Natl Acad Sci U S A. 2004 Dec 7;101(49):17174-9
40. Ohigashi Y, Sho M, Yamada Y et al Clinical significance of programmed death-1 ligand-1 and programmed death-1 ligand-2 expression in human esophageal cancer Clin Cancer Res. 2005 Apr 15;11(8):2947-53
41. Tsushima F, Tanaka K, Otsuki N et al Predominant expression of B7-H1 and its immunoregulatory roles in oral squamous cell carcinoma Oral Oncol. 2006 Mar;42(3):268-74
42. Thompson RH, Webster WS, Cheville JC et al B7-H1 glycoprotein blockade: a novel strategy to enhance immunotherapy in patients with renal cell carcinoma Urology. 2005 Nov;66(5 Suppl):10-4
43. Thompson RH, Gillett MD, Cheville JC et al Costimulatory molecule B7-H1 in primary and metastatic clear cell renal cell carcinoma Cancer. 2005 Nov 15;104(10):2084-91
44. Dong H, Chen L B7-H1 pathway and its role in the evasion of tumor immunity J Mol Med (Berl). 2003 May;81(5):281-7

45. Azuma T, Yao S, Zhu G et al B7-H1 is a ubiquitous antiapoptotic receptor on cancer cells *Blood*. 2008 Apr 1;111(7):3635-43
46. Iwai Y, Terawaki S, Honjo T PD-1 blockade inhibits hematogenous spread of poorly immunogenic tumor cells by enhanced recruitment of effector T cells *Int Immunol*. 2005 Feb;17(2):133-44
47. Iwai Y, Ishida M, Tanaka Y et al Involvement of PD-L1 on tumor cells in the escape from host immune system and tumor immunotherapy by PD-L1 blockade *Proc Natl Acad Sci U S A*. 2002 Sep 17;99(19):12293-7
48. Strome SE, Dong H, Tamura H et al B7-H1 blockade augments adoptive T-cell immunotherapy for squamous cell carcinoma *Cancer Res*. 2003 Oct 1;63(19):6501-5.
49. Hirano F, Kaneko K, Tamura H et al Blockade of B7-H1 and PD-1 by monoclonal antibodies potentiates cancer therapeutic immunity *Cancer Res*. 2005 Feb 1;65(3):1089-96
50. Blank C, Brown I Peterson AC et al PD-L1/B7H-1 inhibits the effector phase of tumor rejection by T cell receptor (TCR) transgenic CD8+ T cells *Cancer Res*. 2004 Feb 1;64(3):1140-5
51. Scagliotti GV, Fossati R, Torri V, et al. Randomized study of adjuvant chemotherapy for completely resected stage I, II, or IIIA non-small-cell lung cancer. *J Natl Cancer Inst* 2003;95:1453–61
52. The International Adjuvant Lung Cancer Trial Collaborative Group. Cisplatin-based adjuvant chemotherapy in patients with resected non-small cell lung cancer. *N Engl J Med* 2004;350:351–60
53. Douillard JY, Rosell R, De Lena M et al Adjuvant vinorelbine plus cisplatin versus observation in patients with completely resected stage IB-IIIa non-small-cell lung cancer (Adjuvant Navelbine International Trialist Association [ANITA]): a randomised controlled trial *Lancet Oncol*. 2006 Sep;7(9):719-27
54. Waller D, Peake MD, Stephens RJ et al Chemotherapy for patients with non-small cell lung cancer: the surgical setting of the Big Lung Trial *Eur J Cardiothorac Surg*. 2004 Jul;26(1):173-82
55. Butts CA, Ding K, Seymour L et al Randomized phase III trial of vinorelbine plus cisplatin compared with observation in completely resected stage IB and II non-small-cell lung cancer: updated survival analysis of JBR-10 *J Clin Oncol*. 2010 Jan 1;28(1):29-34
56. Strauss GM, Herndon JE 2nd, Maddaus MA et al Adjuvant paclitaxel plus carboplatin compared with observation in stage IB non-small-cell lung cancer: CALGB 9633 with the Cancer and Leukemia Group B, Radiation Therapy Oncology Group, and North Central Cancer Treatment Group Study Groups *J Clin Oncol*. 2008 Nov 1;26(31):5043-51
57. Pignon JP, Tribodet H, Scagliotti GV et al Lung adjuvant cisplatin evaluation: a pooled analysis by the LACE Collaborative Group *J Clin Oncol*. 2008 Jul 20;26(21):3552-9

58. NSCLC Meta-analyses Collaborative Group Adjuvant chemotherapy, with or without postoperative radiotherapy, in operable non-small-cell lung cancer: two meta-analyses of individual patient data *Lancet*. 2010 Apr 10;375(9722):1267-77
59. Brahmer J, Reckamp KL, Baas P, et al. Nivolumab versus Docetaxel in Advanced Squamous-Cell Non-Small-Cell Lung Cancer. *N Engl J Med*. 2015 May 31. [Epub ahead of print]
60. Paz-Ares L, Horn L, Borghaei H, et al. Phase III, Randomized Trial (CheckMate 057) of Nivolumab versus Docetaxel in Advanced Non-squamous (non-SQ) Cell Non-small Cell Lung Cancer (NSCLC). Presented at ASCO Annual Meeting 2015, May 29-June 2, 2015.
61. Burdett S, Stewart LA, Rydzewska L A systematic review and meta-analysis of the literature: chemotherapy and surgery versus surgery alone in non-small cell lung cancer *J Thorac Oncol*. 2006 Sep;1(7):611-21
62. Depierre A, Milleron B, Moro-Sibilot D et al Preoperative chemotherapy followed by surgery compared with primary surgery in resectable stage I (except T1N0), II, and IIIa non-small-cell lung cancer *J Clin Oncol*. 2002 Jan 1;20(1):247-53
63. Gilligan D, Nicolson M, Smith et al Preoperative chemotherapy in patients with resectable non-small cell lung cancer: results of the MRC LU22/NVALT 2/EORTC 08012 multicentre randomised trial and update of systematic review *Lancet*. 2007 Jun 9;369(9577):1929-37
64. Scagliotti GV, Pastorino U, Vansteenkiste JF et al Randomized phase III study of surgery alone or surgery plus preoperative cisplatin and gemcitabine in stages IB to IIIA non-small-cell lung cancer *J Clin Oncol*. 2012 Jan 10;30(2):172-8
65. Zitvogel L, Tesniere A, Kroemer G Cancer despite immunosurveillance: immunoselection and immunosubversion *Nat Rev Immunol*. 2006 Oct;6(10):715-27
66. Dunn GP, Bruce AT, Ikeda H Cancer immunoediting: from immunosurveillance to tumor escape *Nat Immunol*. 2002 Nov;3(11):991-8
67. Street SE, Cretney E, Smyth MJ Perforin and interferon-gamma activities independently control tumor initiation, growth, and metastasis *Blood*. 2001 Jan 1;97(1):192-7
68. Shankaran V, Ikeda H, Bruce AT et al IFN gamma and lymphocytes prevent primary tumour development and shape tumour immunogenicity *Nature*. 2001 Apr 26;410(6832):1107-11
69. Al-Shibli KI, Donnem T, Al-Saad S et al Prognostic effect of epithelial and stromal lymphocyte infiltration in non-small cell lung cancer *Clin Cancer Res*. 2008 Aug 15;14(16):5220-7
70. Törmänen-Näpänkangas U, Soini Y, Pääkkö P High number of tumour-infiltrating lymphocytes is associated with apoptosis in non-small cell lung carcinoma *APMIS*. 2001 Jul-Aug;109(7-8):525-32

71. Bremnes RM, Al-Shibli K, Donnem T et al The role of tumor-infiltrating immune cells and chronic inflammation at the tumor site on cancer development, progression, and prognosis: emphasis on non-small cell lung cancer J Thorac Oncol. 2011 Apr;6(4):824-33
72. Schneider T, Kimpfler S, Warth A et al Foxp3(+) regulatory T cells and natural killer cells distinctly infiltrate primary tumors and draining lymph nodes in pulmonary adenocarcinoma J Thorac Oncol. 2011 Mar;6(3):432-8
73. Shimizu K, Nakata M, Hirami Y et al Tumor-infiltrating Foxp3+ regulatory T cells are correlated with cyclooxygenase-2 expression and are associated with recurrence in resected non-small cell lung cancer J Thorac Oncol. 2010 May;5(5):585-90
74. Woo EY, Yeh H, Chu CS et al Cutting edge: Regulatory T cells from lung cancer patients directly inhibit autologous T cell proliferation J Immunol. 2002 May 1;168(9):4272-6
75. Zhang Y, Huang S, Gong D et al Programmed death-1 upregulation is correlated with dysfunction of tumor-infiltrating CD8+ T lymphocytes in human non-small cell lung cancer Cell Mol Immunol. 2010 Sep;7(5):389-95
76. Wong RM, Scotland RR, Lau RL et al Programmed death-1 blockade enhances expansion and functional capacity of human melanoma antigen-specific CTLs Int Immunol. 2007 Oct;19(10):1223-34
77. Wong RM, Scotland RR, Lau RL et al Programmed death-1 blockade enhances expansion and functional capacity of human melanoma antigen-specific CTLs Int Immunol. 2007 Oct;19(10):1223-34
78. Lynch TJ, Bondarenko I, Luft A et al Ipilimumab in combination with paclitaxel and carboplatin as first-line treatment in stage IIIB/IV non-small-cell lung cancer: results from a randomized, double-blind, multicenter phase II study J Clin Oncol. 2012 Jun 10;30(17):2046-54
79. Topalian SL, Sznol M, Brahmer JR et al Nivolumab (anti-PD-1; BMS-936558; ONO-4538) in patients with advanced solid tumors: Survival and long-term safety in a phase I trial Journal of Clinical Oncology, 2013 ASCO Annual Meeting Proceedings (Post-Meeting Edition). Vol 31, No 15\_suppl (May 20 Supplement), 2013: 3002
80. Wolchok JD, Hoos A, O'Day S *et al.* Guidelines for the evaluation of immune therapy activity in solid tumors:immune-related response criteria Clin Cancer Res. 2009;15:7412-7420
81. Grosso J, Horak CE, Inzunza D et al Association of tumor PD-L1 expression and immune biomarkers with clinical activity in patients (pts) with advanced solid tumors treated with nivolumab (anti-PD-1; BMS-936558; ONO-4538) ASCO MEETING ABSTRACTS Jun 17, 2013:3016
82. Eggermont AM, Chiarion-Sileni V, Grob JJ, et al. Adjuvant ipilimumab versus placebo after complete resection of high-risk stage III melanoma (EORTC 18071): a randomised, double-blind, phase 3 trial. Lancet Oncol. 2015 May;16(5):522-30.

83. Spigel DR, Gettinger SN, Horn L et al Clinical activity, safety, and biomarkers of MPDL3280A, an engineered PD-L1 antibody in patients with locally advanced or metastatic non-small cell lung cancer (NSCLC). ASCO MEETING ABSTRACTS Jun 17, 2013:8008
84. Powderly JD, Koeppen H, Hodi FS et al Biomarkers and associations with the clinical activity of PD-L1 blockade in a MPDL3280A study. ASCO MEETING ABSTRACTS Jun 17, 2013:3001
85. <http://www.clinicaltrials.gov/ct2/show/NCT01274338>
86. Carthon BC, Wolchok JD, Yuan J et al Preoperative CTLA-4 blockade: tolerability and immune monitoring in the setting of a presurgical clinical trial Clin Cancer Res. 2010 May 15;16(10):2861-71
87. Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001. Official Journal of the European Communities 2001;L 121/34-44.
88. Woo SR, Turnis ME, Goldberg MV et al Immune inhibitory molecules LAG-3 and PD-1 synergistically regulate T-cell function to promote tumoral immune escape Cancer Res. 2012 Feb 15;72(4):917-27
89. Chen H, Liakou CI, Kamat A et al Anti-CTLA-4 therapy results in higher CD4+ICOShi T cell frequency and IFN-gamma levels in both nonmalignant and malignant prostate tissues Proc Natl Acad Sci U S A. 2009 Feb 24;106(8):2729-34
90. Liakou CI, Kamat A, Tang DN et al CTLA-4 blockade increases IFN-gamma-producing CD4+ICOShi cells to shift the ratio of effector to regulatory T cells in cancer patients Proc Natl Acad Sci U S A. 2008 Sep 30;105(39):14987-92
91. Fu T, He Q, Sharma P The ICOS/ICOSL pathway is required for optimal antitumor responses mediated by anti-CTLA-4 therapy Cancer Res. 2011 Aug 15;71(16):5445-54
92. Taube JM, Anders RA, Young GD et al Colocalization of inflammatory response with B7-h1 expression in human melanocytic lesions supports an adaptive resistance mechanism of immune escape Sci Transl Med. 2012 Mar 28;4(127):127ra37
93. Schoenfeld J, Jinushi M, Nakazaki Y et al Active immunotherapy induces antibody responses that target tumor angiogenesis. Cancer Res. 2010 Dec 15;70(24):10150-60
94. Sivan et al. Commensal Bifidobacterium promotes antitumor immunity and facilitates anti-PD-L1 efficacy PMID 26541606
95. Vétizou et al. Anticancer immunotherapy by CTLA-4 blockade relies on the gut microbiota PMID 26541610



## Appendix A: TNM staging system for lung cancer (7th edition)

TNM staging system for lung cancer (7th edition)

Primary tumor (T)			
T1	Tumor ≤3 cm diameter, surrounded by lung or visceral pleura, without invasion more proximal than lobar bronchus		
T1a	Tumor ≤2 cm in diameter		
T1b	Tumor >2 cm but ≤3 cm in diameter		
T2	Tumor >3 cm but ≤7 cm, or tumor with any of the following features: Involves main bronchus, ≥2 cm distal to carina Invades visceral pleura Associated with atelectasis or obstructive pneumonitis that extends to the hilar region but does not involve the entire lung		
T2a	Tumor >3 cm but ≤5 cm		
T2b	Tumor >5 cm but ≤7 cm		
T3	Tumor >7 cm or any of the following: Directly invades any of the following: chest wall, diaphragm, phrenic nerve, mediastinal pleura, parietal pericardium, main bronchus <2 cm from carina (without involvement of carina) Atelectasis or obstructive pneumonitis of the entire lung Separate tumor nodules in the same lobe		
T4	Tumor of any size that invades the mediastinum, heart, great vessels, trachea, recurrent laryngeal nerve, esophagus, vertebral body, carina, or with separate tumor nodules in a different ipsilateral lobe		
Regional lymph nodes (N)			
N0	No regional lymph node metastases		
N1	Metastasis in ipsilateral peribronchial and/or ipsilateral hilar lymph nodes and intrapulmonary nodes, including involvement by direct extension		
N2	Metastasis in ipsilateral mediastinal and/or subcarinal lymph node(s)		
N3	Metastasis in contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene, or supraclavicular lymph node(s)		
Distant metastasis (M)			
M0	No distant metastasis		
M1	Distant metastasis		
M1a	Separate tumor nodule(s) in a contralateral lobe; tumor with pleural nodules or malignant pleural or pericardial effusion		
M1b	Distant metastasis (in extrathoracic organs)		
Stage groupings			
Stage IA	T1a-T1b	N0	M0
Stage IB	T2a	N0	M0
Stage IIA	T1a,T1b,T2a	N1	M0
	T2b	N0	M0
Stage IIB	T2b	N1	M0
	T3	N0	M0
Stage IIIA	T1a,T1b,T2a,T2b	N2	M0
	T3	N1,N2	M0
	T4	N0,N1	M0
Stage IIIB	T4	N2	M0
	Any T	N3	M0
Stage IV	Any T	Any N	M1a or M1b

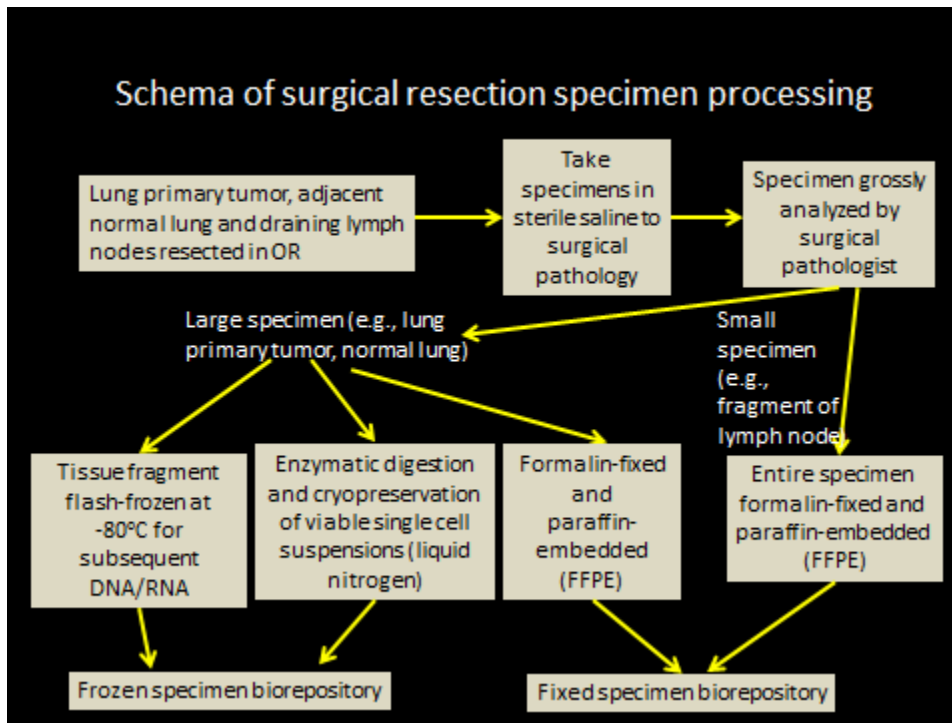
Adapted from: Goldstraw P, Crowley J, Chansky K, et al. The IASLC Lung Cancer Staging Project: Proposals for the revision of the TNM stage groups in the forthcoming (seventh) edition of the TNM classification of malignant tumours. *J Thorac Oncol* 2007; 2:706.



## Appendix B: ECOG Performance Status Scale

Score	Definition
0	Asymptomatic
1	Symptomatic, fully ambulatory
2	Symptomatic, in bed less than 50% of day
3	Symptomatic, in bed more than 50% of day, but not bedridden
4	Bedridden

## Appendix C: Guidelines for Tissue Banking Process



**Note: Only tissue that is absolutely not needed for clinical diagnosis or staging should be collected for tissue banking. If in doubt about this, do NOT submit specimens for banking.**

### Banking of Frozen Tissue

1. Place a single tissue specimen flat in the plastic bag. A single tissue specimen's overall volume should be at least 1 cm<sup>3</sup>, and at most 3 – 4 cm<sup>3</sup>, with at least one dimension measuring 0.5 cm thick or less to facilitate quick freezing.
2. For a given case (patient), please collect sufficient **non-malignant and malignant** tissue. Tissue selected should be grossly viable, and grossly consistent with tumor or adjacent normal tissue (see #5 below for contraindications). Non-malignant (i.e. "adjacent normal") tissue should be collected at least **2 cm** from the primary tumor, subject to any limitations from the specimen's physical dimensions. Do not place tumor and non-malignant tissue in the same bag. For large tumors, do not place large pieces of tissue in a single bag. Rather, divide the tissue according to size guidelines in #1 above, and place each in an individual bag. Collect and separately identify both: 1) primary tumor and 2) metastatic lesions to lymph nodes or other tissues. Tissue will typically be taken by scalpel or dissection blade, though the use of 5 -7 mm skin punch biopsy tools could be considered in certain situations.
3. Immediately place the specimens for freezing in an isopentane or 2-methylbutane cryobath, or other effective liquid freezing agent. If no cryobath is available, then liquid N<sub>2</sub> can be used as the freezing agent, in a properly insulated container and with sufficient safety precautions. The goal is to have

bankable tissue immersed in the bath **within 30 minutes of the OR's procurement** from the patient. If more cryobath space is needed, move **already frozen** tissue to a -80C freezer in order to make sufficient room. Make sure to check periodically for cryobath problems (e.g. not maintaining temperature, refrigerant level low), and call for appropriate maintenance as needed. **Do not freeze tissue by placing it fresh directly in the -80C freezer.**

4. On receipt by the tissue bank laboratory, the frozen tissue is embedded in OCT (Optimal Cutting Temperature medium), and a frozen section is stained with H&E and the section evaluated by the tissue bank pathologist for quality assurance (QA) purposes. A report on the histopathologic findings is filed or communicated as needed. The frozen section evaluation can also count for adjacent pieces of tissue if they were taken as a "mirror image" section to the surface cut for the frozen section.

#### 5. General contraindications to tissue banking

DON'T bank tissue from these specimen types or situations:

- small tumors and other cases where all or most of the lesional tissue is needed for diagnosis
- surgical margins of resection specimens where tumor and benign areas cannot be clearly delineated grossly grossly visible areas of primarily necrosis, hemorrhage, or fat
- specimens which are known to have been delayed significantly more than 30 minutes past their procurement time in the OR
- tissue previously freeze-thawed, or frozen slowly (e.g. in the cryostat or -80 freezer)
- areas of deepest invasion, tumor/normal interface, tumor/capsule interface, extranodal extension of tumor, and other key landmarks needed for surgical pathology evaluation and/or tumor staging
- chemotherapy- or radiation-treated tumors
- diagnostic biopsies where most or all tissue must be submitted for pathology evaluation...most lymph node, GI, bone marrow, and liver biopsies fall in this category
- tissue clearly marked as intended for a special study such as immunofluorescence

## **Appendix D: MANAGEMENT ALGORITHMS**

These general guidelines constitute guidance to the Investigator and may be supplemented by discussions with the Principal Investigator. The guidance applies to all immuno-oncology agents and regimens.

A general principle is that differential diagnoses should be diligently evaluated according to standard medical practice. Non-inflammatory etiologies should be considered and appropriately treated.

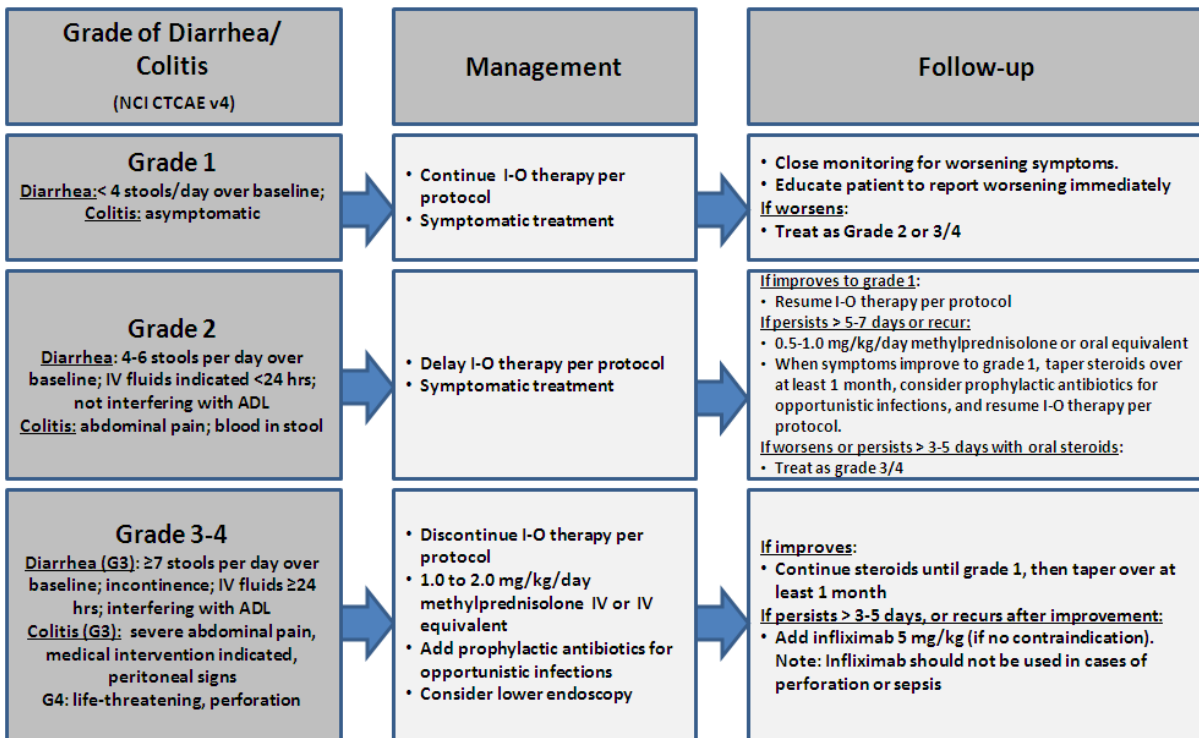
Corticosteroids are a primary therapy for immuno-oncology drug-related adverse events. The oral equivalent of the recommended IV doses may be considered for ambulatory patients with low-grade toxicity. The lower bioavailability of oral corticosteroids should be taken into account when switching to the equivalent dose of oral corticosteroids.

Consultation with a medical or surgical specialist, especially prior to an invasive diagnostic or therapeutic procedure, is recommended.

The frequency and severity of the related adverse events covered by these algorithms will depend on the immuno-oncology agent or regimen being used.

## GI Adverse Event Management Algorithm

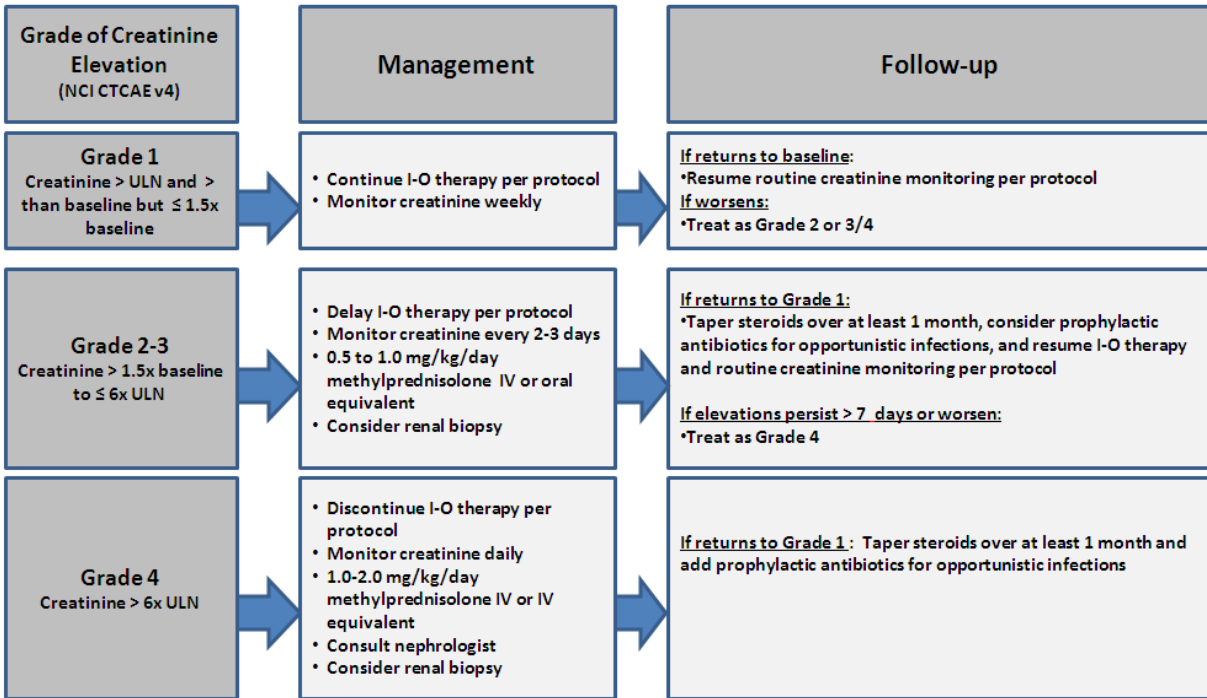
Rule out non-inflammatory causes. If non-inflammatory cause is identified, treat accordingly and continue I-O therapy. Opiates/narcotics may mask symptoms of perforation. Infliximab should not be used in cases of perforation or sepsis.



Patients on IV steroids may be switched to an equivalent dose of oral corticosteroids (e.g. prednisone) at start of tapering or earlier, once sustained clinical improvement is observed. Lower bioavailability of oral corticosteroids should be taken into account when switching to the equivalent dose of oral corticosteroids.

## Renal Adverse Event Management Algorithm

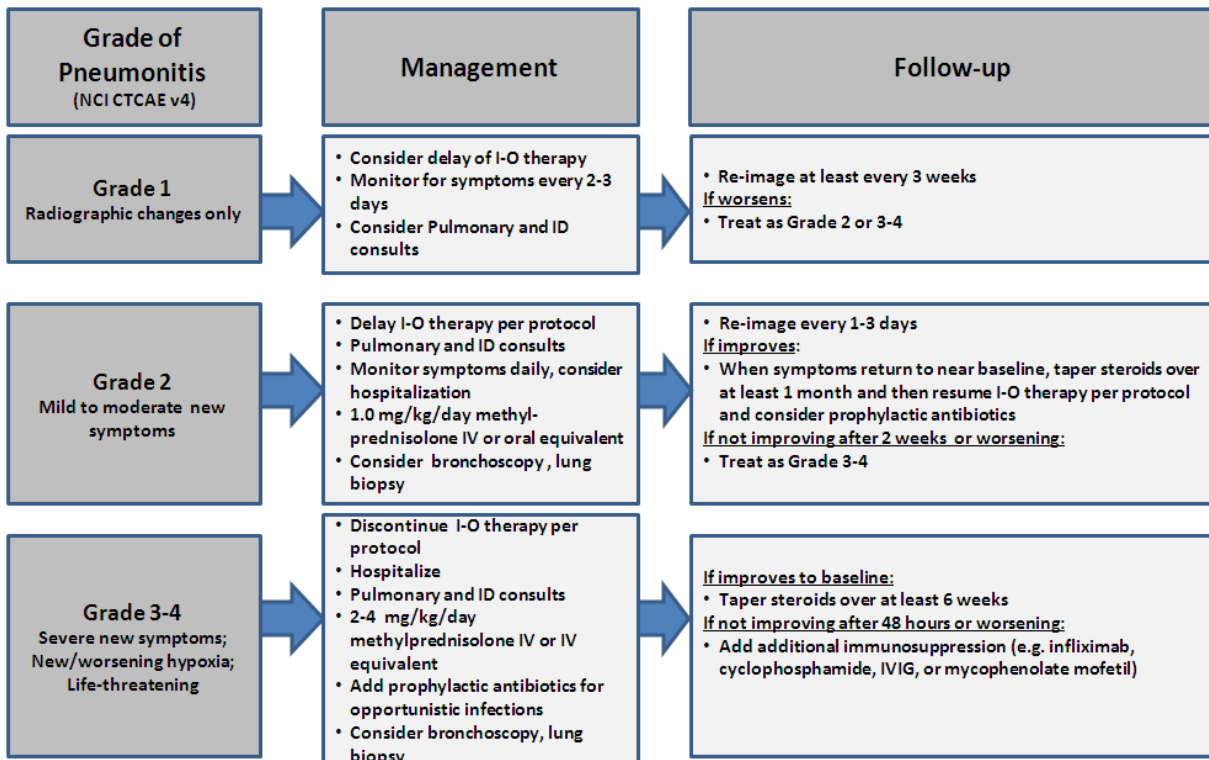
Rule out non-inflammatory causes. If non-inflammatory cause, treat accordingly and continue I-O therapy



Patients on IV steroids may be switched to an equivalent dose of oral corticosteroids (e.g. prednisone) at start of tapering or earlier, once sustained clinical improvement is observed. Lower bioavailability of oral corticosteroids should be taken into account when switching to the equivalent dose of oral corticosteroids.

## Pulmonary Adverse Event Management Algorithm

Rule out non-inflammatory causes. If non-inflammatory cause, treat accordingly and continue I-O therapy. Evaluate with imaging and pulmonary consultation.

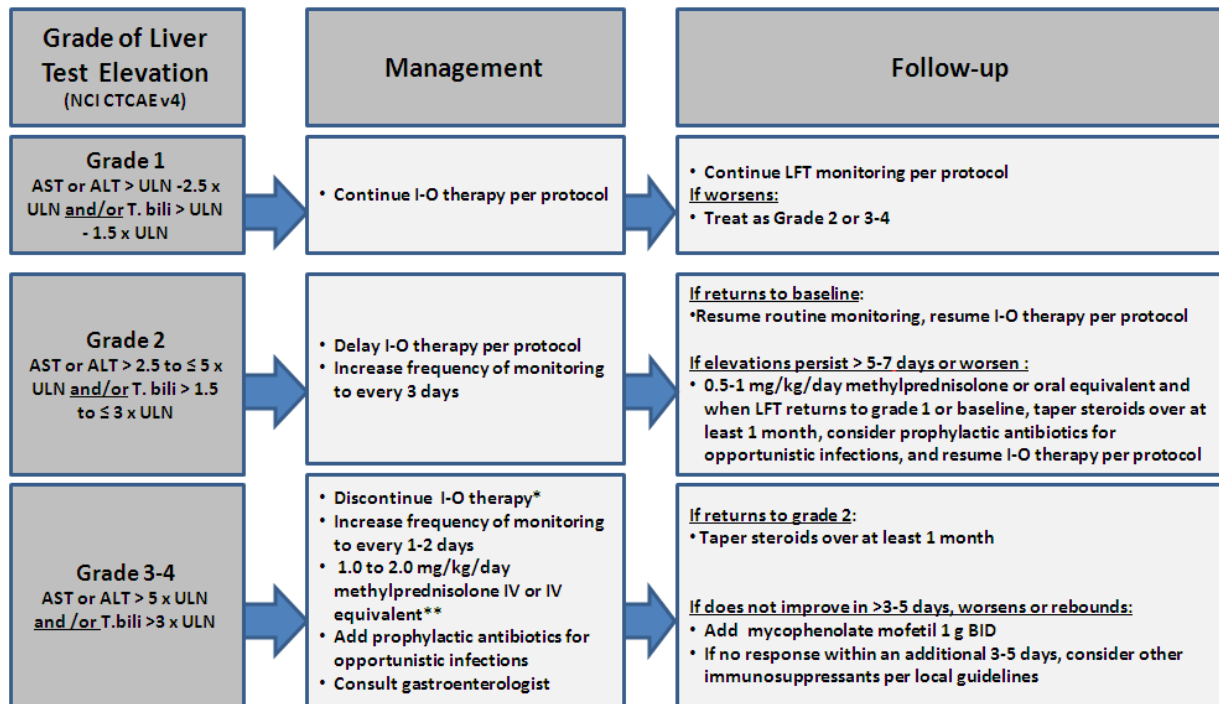


Patients on IV steroids may be switched to an equivalent dose of oral corticosteroids (e.g. prednisone) at start of tapering or earlier, once sustained clinical improvement is observed. Lower bioavailability of oral corticosteroids should be taken into account when switching to the equivalent dose of oral corticosteroids.



## Hepatic Adverse Event Management Algorithm

Rule out non-inflammatory causes. If non-inflammatory cause, treat accordingly and continue I-O therapy. Consider imaging for obstruction.



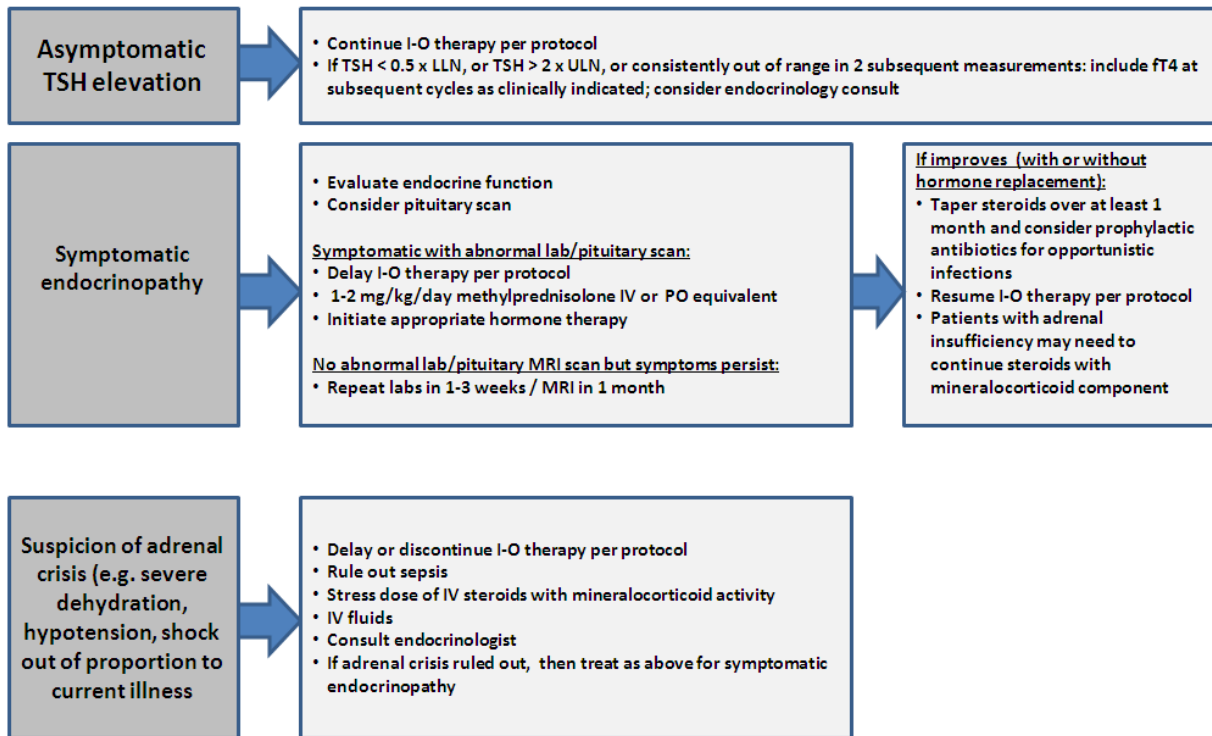
Patients on IV steroids may be switched to an equivalent dose of oral corticosteroids (e.g. prednisone) at start of tapering or earlier, once sustained clinical improvement is observed. Lower bioavailability of oral corticosteroids should be taken into account when switching to the equivalent dose of oral corticosteroids.

\*I-O therapy may be delayed rather than discontinued if AST/ALT ≤ 8 x ULN and T.bili ≤ 5 x ULN.

\*\*The recommended starting dose for grade 4 hepatitis is 2 mg/kg/day methylprednisolone IV.

## Endocrinopathy Management Algorithm

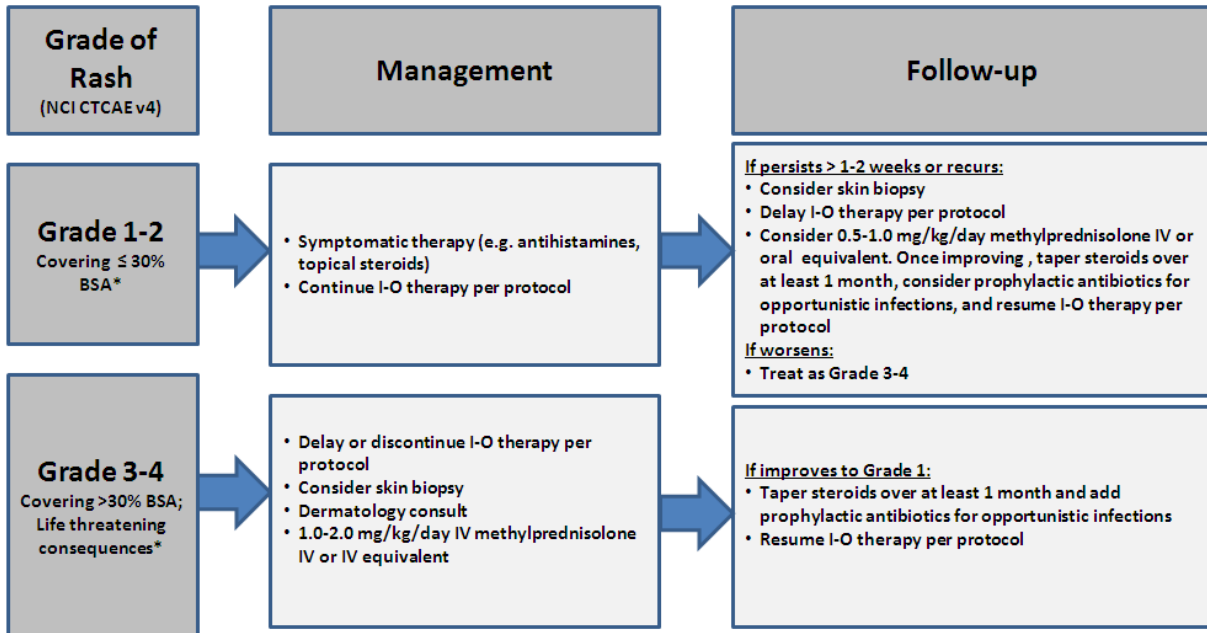
Rule out non-inflammatory causes. If non-inflammatory cause, treat accordingly and continue I-O therapy. Consider visual field testing, endocrinology consultation, and imaging.



Patients on IV steroids may be switched to an equivalent dose of oral corticosteroids (e.g. prednisone) at start of tapering or earlier, once sustained clinical improvement is observed. Lower bioavailability of oral corticosteroids should be taken into account when switching to the equivalent dose of oral corticosteroids.

## Skin Adverse Event Management Algorithm

Rule out non-inflammatory causes. If non-inflammatory cause, treat accordingly and continue I-O therapy.

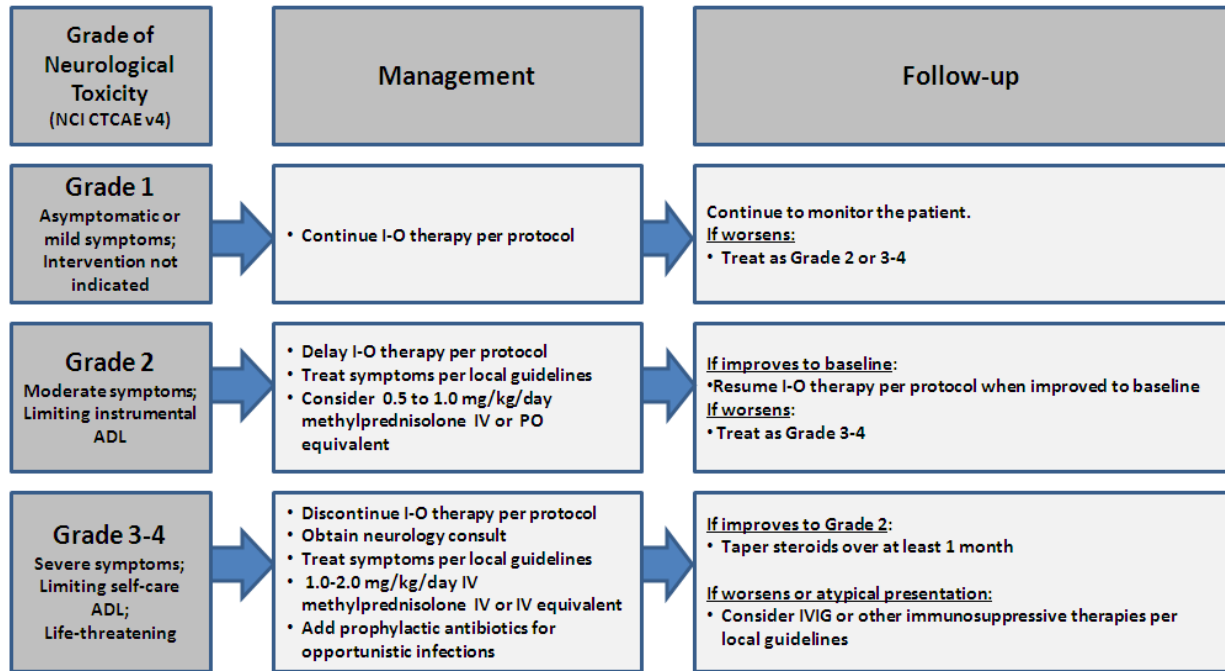


Patients on IV steroids may be switched to an equivalent dose of oral corticosteroids (e.g. prednisone) at start of tapering or earlier, once sustained clinical improvement is observed. Lower bioavailability of oral corticosteroids should be taken into account when switching to the equivalent dose of oral corticosteroids.

\*Refer to NCI CTCAE v4 for term-specific grading criteria.

## Neurological Adverse Event Management Algorithm

Rule out non-inflammatory causes. If non-inflammatory cause, treat accordingly and continue I-O therapy.



Patients on IV steroids may be switched to an equivalent dose of oral corticosteroids (e.g. prednisone) at start of tapering or earlier, once sustained clinical improvement is observed. Lower bioavailability of oral corticosteroids should be taken into account when switching to the equivalent dose of oral corticosteroids.

## APPENDIX E: Sociodemographic Characteristics Questionnaire

Date: Month \_\_\_\_ / Day \_\_\_\_ / Year \_\_\_\_  
Study ID Number: \_\_\_\_\_

### SOCIODEMOGRAPHIC CHARACTERISTICS QUESTIONNAIRE

### FAMILY QUESTIONS

Both genetics and environment could be risk factors for the development of cancer. For this reason, it is important to determine your biological relationship with your family.

5. Are you adopted?  Yes  No

6. How many of each of the following family members do you have?

Brothers: \_\_\_\_\_ Sisters: \_\_\_\_\_ Sons: \_\_\_\_\_ Daughters: \_\_\_\_\_

### SMOKING QUESTIONS

7. Do you smoke cigarettes?  Yes  No, never  
 Not currently but I have in the past
8. At what age did you start smoking? \_\_\_\_\_
9. When did you quit smoking cigarettes? \_\_\_\_\_
10. How many total years have you or did you regularly smoke cigarettes? \_\_\_\_\_
11. During the time you usually smoked regularly, how many cigarettes do or did you usually smoke per day? \_\_\_\_\_
12. Do you smoke cigars?  Yes  No, never  Not currently but I have in the Past
13. At what age did you start smoking cigars? \_\_\_\_\_
14. When did you quit smoking cigars? \_\_\_\_\_
15. How many years in total did you regularly smoke cigars? \_\_\_\_\_
16. Do you use smokeless tobacco or other nicotine products? (i.e. chewing tobacco, snuff, e-cigarette, nicotine patch or gum)  Yes  No

If yes, please indicate type(s):

\_\_\_\_\_

17. Were you exposed to asbestos, that you know of?  Yes  No, never

18. Were you exposed to any other potential harmful exposures to your lung?  Yes  No, never

**ALCOHOL QUESTIONS**

19. Have you ever drunk alcoholic beverages, such as beer, wine, or liquor regularly, that is at least once a month?  Yes  No

20. At what age did you start drinking alcoholic beverages regularly, i.e. at least once a month?

\_\_\_\_\_ years of age

21. Before the age of 40, how many drinks of beer (12 oz.), wine (5oz.), or liquor (1 oz.) did you usually drink per week?

More than one per week. Please indicate number \_\_\_\_\_

Less than one per week \_\_\_\_\_

Never drank before age 40 \_\_\_\_\_

22. After the age of 40, how many drinks of beer (12 oz.), wine (5 oz.), or liquor (1 oz.) did you usually drink per week?

More than one per week. Please indicate number \_\_\_\_\_

Less than one per week \_\_\_\_\_

Never drank after age 40 \_\_\_\_\_

Currently aged less than 40 years \_\_\_\_\_

**MEDICAL QUESTIONS**

23. Have you taken antibiotics in the last 3 months?  Yes  No  
A list of antibiotics is attached for you to refer to. If no, skip to question 25.

24. If you know the name of the antibiotic(s), please write it here.

\_\_\_\_\_  
\_\_\_\_\_

25. Have you had a bronchoscopy in the last 3 months?  Yes  No

26. Have you taken oral corticosteroids in the last 2 weeks?  Yes  No  
(Oral corticosteroids examples: prednisone, dexamethasone, methylprednisone, hydrocortisone)

27. If you answered Yes to (26), please write the name and dose here and when you took these.

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28. Have you taken inhaled corticosteroids in the last 2 weeks?  Yes  No  
(Inhaled corticosteroids examples: budesonide, fluticasone, beclomethasone, ciclesonide)

29. If you answered Yes to (28), please write the name and dose here and when you took these.

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30. Do you have sleep apnea?  Yes  No

31. Do you have reflux disease?  Yes  No

32. Do you have any other chronic lung conditions?  Yes  No

33. If you answered Yes to (32), please write the name of the condition here

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<b>DENTAL HEALTH</b>
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34. About how often do you visit a dentist?

- Less than every 6 months.
- Between every 6-12 months.
- Greater than every 12 months.
- I have never been to a dentist.

35. Overall, how would you rate the health of your teeth and gums?

- Excellent  Good  Fair  Poor

36. Have you ever had treatment for gum disease such as scaling and root planing, sometimes called deep cleaning?

- Yes  No

37. Have you ever had any teeth become loose on their own, without an injury? (Not including baby teeth).

- Yes  No

**DIET QUESTIONS**

38. Do you eat meat? Meat is defined as beef, chicken, pork, lamb or venison:
- A. I do not eat meat.
  - B. I have eaten meat in the last year.
  - C. I have eaten meat one or more times a month during the last year.
  - D. I have eaten meat one or more times a week during the last year.
39. Do you eat Fish? Fish is defined as all fish and shellfish:
- A. I do not eat fish.
  - B. I have eaten fish in the last year.
  - C. I have eaten fish one or more times a month during the last year.
  - D. I have eaten fish one or more times a week during the last year
40. Do you eat Eggs?
- A. I do not eat eggs
  - B. I have eaten eggs in the last year
  - C. I have eaten eggs one or more times a month during the last year
  - D. I have eaten eggs one or more times a week during the last year
41. Do you eat Cheese? (This includes fresh, soft, aged or cottage cheese as well as sour cream):
- A. I do not eat cheese
  - B. I have eaten cheese in the last year
  - C. I have eaten cheese one or more times a month during the last year
  - D. I have eaten cheese one or more times a week during the last year
42. Do you drink Milk? Milk is defined as milk from a cow, goat or sheep (not soy, coconut or almond milk, for example). If you put milk on your cereal, you should not answer (A).
- A. I do not drink milk
  - B. I drank milk in the last year
  - C. I drank milk one or more times a month during the last year
  - D. I drank milk one or more times a week during the last year
43. Do you eat yogurt?
- A. I do not eat yogurt
  - B. I have eaten yogurt in the last year
  - C. I have eaten yogurt one or more times a month during the last year
  - D. I have eaten yogurt one or more times a week during the last year
44. Do you take probiotics (live bacteria supplement)?  Yes  No



**If yes (question 44) and if you know the name of the probiotic product(s), please write here:**

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**45. Do you take vitamin supplements?**  Yes  No

**If yes (question 45) and if you know the name of the vitamin supplement(s), please write it/them here:**

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**WORK AND PHYSICAL ACTIVITY**

46. What is your current employment status?

Employed/self-employed  Unemployed  Retired  Disabled

47. How would you categorize your physical activity on the job?

Mostly sedentary or light activity (e.g. mostly sitting, standing, lifting light objects of less than 3 kilos).

Mostly medium activity (e.g. much walking, climbing stairs).

Mostly intense activity (e.g. heavy construction work).

Unemployed/retired/disabled

48. What type of exercise (physical activity) do you do regularly (at least 3 times per week)?

Mostly moderate activity (slow walking, gardening, golfing etc.)

Mostly vigorous activity (running, swimming, bicycling, football etc.)

I do not exercise regularly

49. At age 20, what type of exercise did you do regularly (at least 3 times per week)?

Mostly moderate activity (slow walking, gardening, golfing etc.)

Mostly vigorous activity (running, swimming, bicycling, football etc.)

I did not exercise regularly