

# Association of Donanemab Treatment With Exploratory Plasma Biomarkers in Early Symptomatic Alzheimer Disease

## A Secondary Analysis of the TRAILBLAZER-ALZ Randomized Clinical Trial

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 Supplemental content

**IMPORTANCE** Plasma biomarkers of Alzheimer disease may be useful as minimally invasive pharmacodynamic measures of treatment outcomes.

**OBJECTIVE** To analyze the association of donanemab treatment with plasma biomarkers associated with Alzheimer disease.

**DESIGN, SETTING, AND PARTICIPANTS** TRAILBLAZER-ALZ was a randomized, double-blind, placebo-controlled clinical trial conducted from December 18, 2017, to December 4, 2020, across 56 sites in the US and Canada. Exploratory biomarkers were prespecified with the post hoc addition of plasma glial fibrillary acidic protein and amyloid- $\beta$ . Men and women aged 60 to 85 years with gradual and progressive change in memory function for at least 6 months were included. A total of 1955 participants were assessed for eligibility. Key eligibility criteria include Mini-Mental State Examination scores of 20 to 28 and elevated amyloid and intermediate tau levels.

**INTERVENTIONS** Randomized participants received donanemab or placebo every 4 weeks for up to 72 weeks. The first 3 doses of donanemab were given at 700 mg and then increased to 1400 mg with blinded dose reductions as specified based on amyloid reduction.

**MAIN OUTCOMES AND MEASURES** Change in plasma biomarker levels after donanemab treatment.

**RESULTS** In TRAILBLAZER-ALZ, 272 participants (mean [SD] age, 75.2 [5.5] years; 145 [53.3%] female) were randomized. Plasma levels of phosphorylated tau<sub>217</sub> (pTau<sub>217</sub>) and glial fibrillary acidic protein were significantly lower with donanemab treatment compared with placebo as early as 12 weeks after the start of treatment (least square mean change difference vs placebo, -0.04 [95% CI, -0.07 to -0.02];  $P = .002$  and -0.04 [95% CI, -0.07 to -0.01];  $P = .01$ , respectively). No significant differences in plasma levels of amyloid- $\beta$  42/40 and neurofilament light chain were observed between treatment arms at the end of treatment. Changes in plasma pTau<sub>217</sub> and glial fibrillary acidic protein were significantly correlated with the Centiloid percent change in amyloid (Spearman rank correlation coefficient [ $R$ ] = 0.484 [95% CI, 0.359-0.592];  $P < .001$  and  $R = 0.453$  [95% CI, 0.306-0.579];  $P < .001$ , respectively) following treatment. Additionally, plasma levels of pTau<sub>217</sub> and glial fibrillary acidic protein were significantly correlated at baseline and following treatment ( $R = 0.399$  [95% CI, 0.278-0.508],  $P < .001$  and  $R = 0.393$  [95% CI, 0.254-0.517];  $P < .001$ , respectively).

**CONCLUSIONS AND RELEVANCE** Significant reductions in plasma biomarkers pTau<sub>217</sub> and glial fibrillary acidic protein compared with placebo were observed following donanemab treatment in patients with early symptomatic Alzheimer disease. These easily accessible plasma biomarkers might provide additional evidence of Alzheimer disease pathology change through anti-amyloid therapy. Usefulness in assessing treatment response will require further evaluation.

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The hallmark pathological findings in Alzheimer disease (AD) are amyloid plaques and neurofibrillary tangles due to the accumulation of amyloid- $\beta$  (A $\beta$ ) peptide, and aggregation of tau protein, respectively.<sup>1</sup> Extensive research on AD biomarkers aims to allow timely detection and accurate diagnosis of AD.<sup>2,3</sup> In addition to imaging and cerebrospinal fluid (CSF) biomarkers, blood measurements, including phosphorylated tau (pTau), glial fibrillary acidic protein (GFAP), neurofilament light chain (NfL), and A $\beta$ , are being explored as biomarkers of AD.<sup>3,4</sup> Plasma pTau<sub>217</sub> is elevated in pathologically and clinically diagnosed patients with AD and typically not in other common neurodegenerative dementias.<sup>5-7</sup> GFAP is a marker of glial activation, and plasma levels are elevated in AD, as well as in cognitively normal individuals with amyloid-positive positron emission tomography (PET) results.<sup>8,9</sup> Plasma levels of NfL, a marker of neurodegeneration, are correlated with CSF NfL levels in AD and with the severity of postmortem neurofibrillary tangle pathology.<sup>10,11</sup> Levels of the A $\beta$  42/40 ratio in plasma are reduced in AD.<sup>12,13</sup> When plasma pTau<sub>217</sub> and A $\beta$  42/40 assay results are combined, the accuracy of identifying amyloid-positive PET results in cognitively unimpaired individuals is improved.<sup>14</sup>

Donanemab, an antibody specific for the N-terminal pyroglutamate A $\beta$  epitope that is only present in amyloid plaques, is being investigated for the treatment of AD.<sup>15-17</sup> In the TRAILBLAZER-ALZ phase 2 registration study, donanemab demonstrated robust amyloid plaque reduction as measured on PET in patients with early symptomatic AD.<sup>17</sup> Donanemab was superior to placebo in the primary outcome, showing 32% slowing of disease progression from baseline to 76 weeks in the score on the Integrated Alzheimer's Disease Rating Scale (iADRS).<sup>17</sup> The aim of the present exploratory, post hoc analysis is to assess the correlation of donanemab treatment with plasma levels of the biomarkers pTau<sub>217</sub>, GFAP, NfL, and A $\beta$  42/40 in patients with early symptomatic AD.

## Methods

### Patients and Study Design

TRAILBLAZER-ALZ was a randomized, double-blind, placebo-controlled phase 2 study conducted from December 18, 2017, to December 4, 2020, at 56 sites in the US and Canada. Written informed consent was obtained from participants or their legal representatives and from study partners. The protocol (Supplement 1) was reviewed and approved by study site ethical review boards. The study was conducted according to international ethics guidelines, including the Declaration of Helsinki<sup>18</sup> and Council for International Organizations of Medical Sciences International Ethical Guidelines and applicable International Council for Harmonization Good Clinical Practice guidelines.

Participants included were aged 60 to 85 years, diagnosed with early symptomatic AD (prodromal AD or AD with mild dementia), met elevated amyloid and intermediate tau PET-based criteria, and had Mini-Mental State Examination scores of 20 to 28.<sup>17</sup> Participant race and ethnicity were col-

### Key Points

**Question** Does donanemab induce changes in plasma biomarkers?

**Findings** In this secondary analysis of the TRAILBLAZER-ALZ randomized clinical trial, plasma levels of phosphorylated tau<sub>217</sub> and glial fibrillary acidic protein were significantly lowered with donanemab treatment compared with placebo, whereas no significant changes in plasma levels of amyloid  $\beta$  42/40 and neurofilament light chain were observed between treatment arms at the end of the study. Changes in plasma phosphorylated tau<sub>217</sub> and glial fibrillary acidic protein were positively correlated with change in brain amyloid plaques.

**Meaning** These plasma biomarkers are promising candidates for use as pharmacodynamic measures of the effect of donanemab and potentially other anti-amyloid therapies in early symptomatic Alzheimer disease.

lected by self report and have already been described in the primary publication by Mintun et al.<sup>17</sup>

Participants included in this analysis were 1:1 randomized to receive intravenous donanemab or placebo every 4 weeks for up to 72 weeks. The first 3 doses of donanemab were given at 700 mg and then increased to 1400 mg. A blinded dose change occurred at weeks 24 and 52 based on amyloid PET scan results.<sup>17</sup> If amyloid levels ranged from 11 to 25 Centiloids (CL) on a single scan, donanemab was decreased to 700 mg. If amyloid levels were less than 11 CL on a single scan or less than 25 CL on 2 consecutive scans, donanemab dosing was stopped and participants received placebo. Eligibility criteria and study design of TRAILBLAZER-ALZ were previously reported.<sup>17</sup>

### PET

The effect of donanemab on brain amyloid and tau pathology was assessed using the specific PET tracers <sup>18</sup>F-florbetapir (detecting amyloid plaque at baseline and weeks 24, 52, and 76), and <sup>18</sup>F-flortaucipir (detecting tau neurofibrillary tangles at baseline and week 76). Additional PET details can be found in the eMethods in Supplement 2.

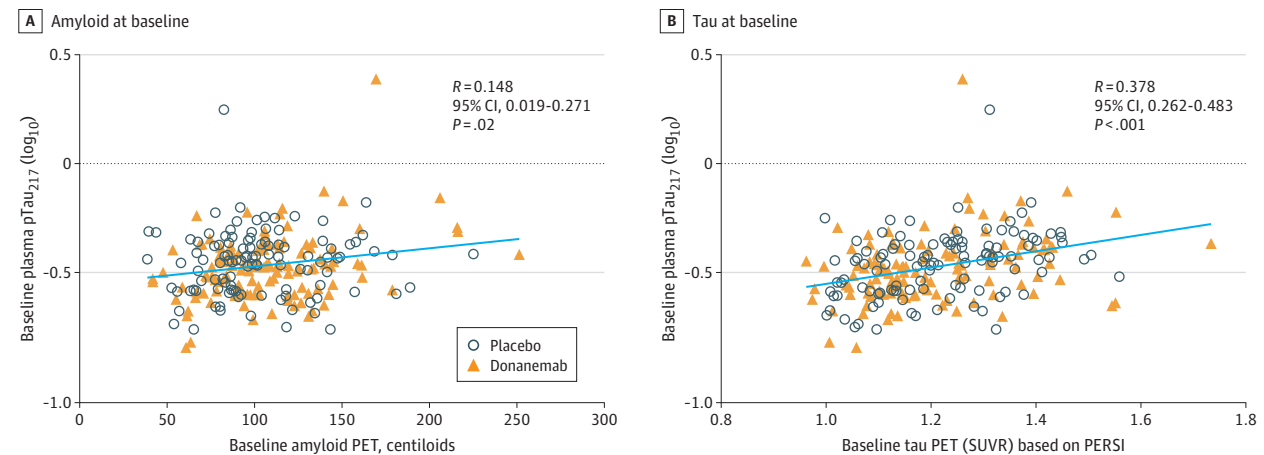
### Plasma Assays

Plasma samples were collected at baseline and weeks 12, 24, 36, 52, 64, and 76. Due to the quantity of plasma collected, not all analyses were able to be completed for every participant at every time point. Plasma pTau<sub>217</sub> was measured using a custom Simoa-HD-X assay (Quanterix) made specifically for Eli Lilly and Company. The Simoa Neurology 4-Plex E Advantage Kit (Quanterix) was used for plasma levels of GFAP, NfL, A $\beta$ 40, and A $\beta$ 42. Additional plasma assay details can be found in the eMethods in Supplement 2.

### Statistical Analyses

Plasma pTau<sub>217</sub>, GFAP, NfL, and A $\beta$  42/40 values were log<sub>10</sub> transformed to normalize the data. Mixed models with repeated measurements were conducted to compare the change from baseline values by treatment arms at each scheduled visit. The mixed models with repeated measurements included fixed categorical effects of treatment, visit,

**Figure 1. Baseline Plasma Phosphorylated Tau<sub>217</sub> (pTau<sub>217</sub>) Levels Correlated With Baseline Amyloid and Tau Positron Emission Tomography (PET) End Points**



Baseline amyloid PET (placebo  $n = 111$ ; donanemab  $n = 121$ ) (A), and tau PET (placebo  $n = 112$ ; donanemab  $n = 120$ ) (B) levels compared with baseline plasma pTau<sub>217</sub> levels. Plasma levels were log<sub>10</sub> transformed. Linear regression of all data points, regardless of treatment, is indicated by the straight line. Spearman rank was used for correlation coefficient. PERSI indicates parametric estimation of reference signal intensity; SUVR, standardized uptake value ratio.

and treatment-by-visit interaction and were adjusted for continuous effect of age and corresponding baseline values. Overall, 74% of participants were apolipoprotein (APOE)  $\epsilon 4$  carriers and adding APOE  $\epsilon 4$  status to the models produced no evidence of interaction, so APOE  $\epsilon 4$  status was not included in the model. Minimal clinically important difference (MCID) on iADRS change has been reported as 5-point or 9-point deterioration for individual participants with mild cognitive impairment and AD with mild dementia, respectively.<sup>19</sup> A marginal logistic regression model was conducted to assess the association between pTau<sub>217</sub> change with the odds of having MCID across the follow-up visits. The model was adjusted for baseline iADRS scale, pTau<sub>217</sub>, and age. The intraparticipant correlation was adjusted using general estimating equation method. Scatterplots were generated to describe the relationships and associations between biomarkers, and Spearman rank correlation coefficients were provided to quantify these relationships and associations. All analyses were exploratory or post hoc and not corrected for multiplicity. The data analysis for this paper was generated using SAS software, version 9.4 (SAS Institute). Statistical significance was set at a 2-sided  $P$  value of .05.

## Results

### Participants

Of 1955 participants assessed for eligibility, 272 men and women aged 60 to 85 years were randomized (eFigure 1 in Supplement 2). The mean (SD) age was 75.2 (5.5) years, and 145 (53.3%) were female. Baseline characteristics of participants included in these analyses are listed in eTable 1 in Supplement 2. Additional study details were previously reported.<sup>17</sup>

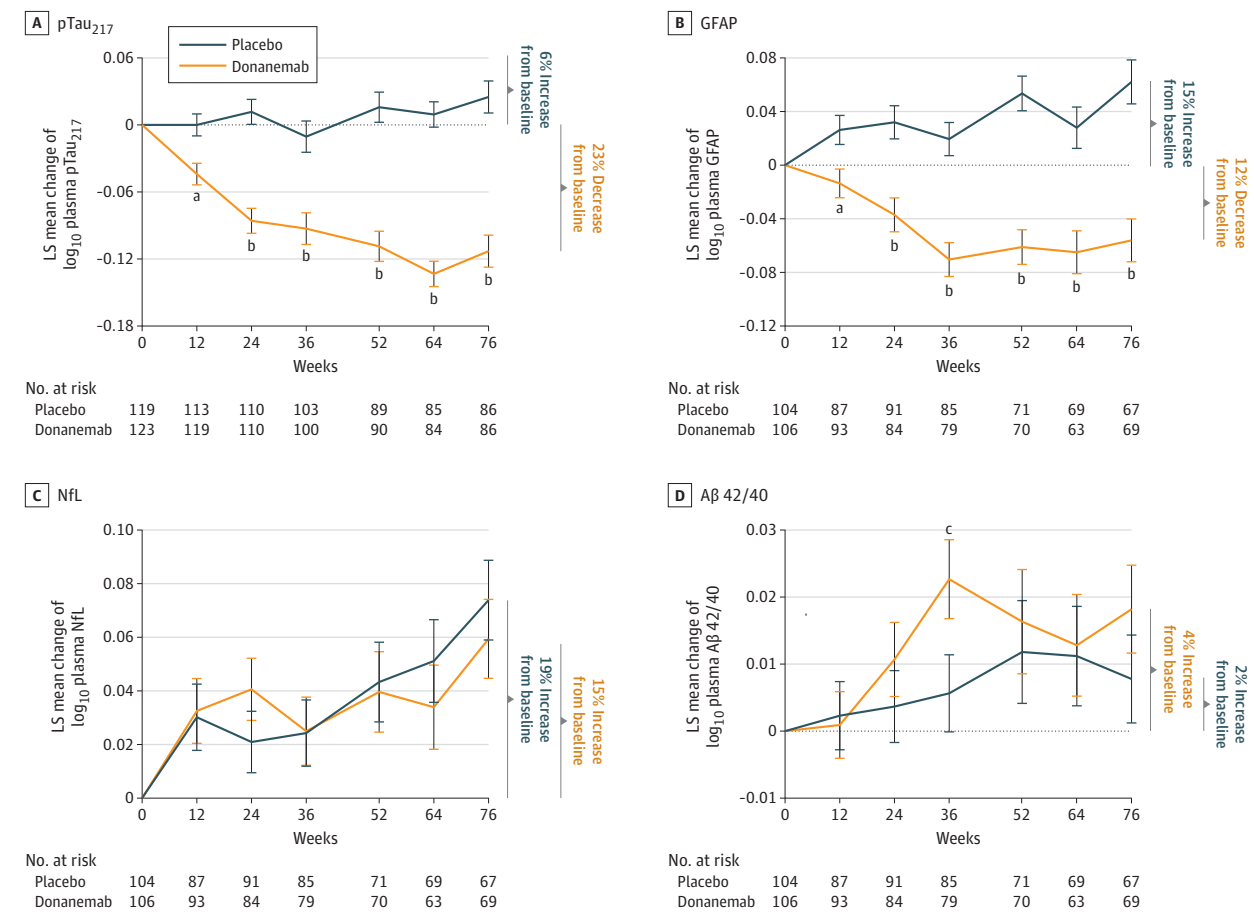
### Baseline Plasma Biomarker Level Correlation With Baseline Amyloid and Tau PET End Points

Baseline plasma pTau<sub>217</sub> levels were positively associated with both baseline amyloid plaque level as measured by amyloid PET imaging (Spearman rank correlation coefficient [ $R$ ] = 0.148 [95% CI, 0.019-0.271];  $P = .02$ ) (Figure 1A), and global tau deposition as measured by tau PET imaging ( $R = 0.378$  [95% CI, 0.262-0.483];  $P < .001$ ) (Figure 1B). However, baseline plasma levels of GFAP, NfL, and A $\beta$  42/40 were not significantly correlated with baseline amyloid or tau PET end points (eFigure 2 in Supplement 2).

### Change in Plasma Biomarker Levels Following Donanemab Treatment

A significant decrease in plasma pTau<sub>217</sub> levels compared with placebo was observed after 12 weeks of donanemab treatment and continued throughout the 76 weeks of the study (Figure 2A and eTable 2 in Supplement 2). Mean plasma pTau<sub>217</sub> levels decreased by 23% from baseline after donanemab treatment. In contrast, mean placebo plasma pTau<sub>217</sub> levels continued to rise by 6% from baseline to the end of the study. A significant decrease in plasma GFAP levels was observed after 12 weeks of donanemab treatment compared with placebo and continued throughout the 76 weeks of the study (Figure 2B and eTable 2 in Supplement 2). Mean plasma GFAP levels decreased by 12% from baseline after donanemab treatment whereas with placebo, mean levels continued to rise by 15% from baseline to the end of the study. There was no significant difference in plasma NfL levels between treatment arms at the end of the study (Figure 2C and eTable 2 in Supplement 2). At 76 weeks, mean plasma NfL levels were increased 15% from baseline after donanemab treatment compared with 19% for placebo. To determine whether amyloid levels increase in the plasma as donanemab reduces amyloid plaque

Figure 2. Change in Plasma Levels Following Donanemab Treatment



Least square (LS) mean change from baseline in plasma phosphorylated tau<sub>217</sub> (pTau<sub>217</sub>) (A), glial fibrillary acidic protein (GFAP) (B), neurofilament light chain (NfL) (C), and amyloid-β (Aβ) 42/40 (D) for placebo and donanemab. Plasma values were log<sub>10</sub> transformed. Error bars indicate standard error. The dotted line indicates baseline.

<sup>a</sup>  $P < .01$  vs placebo.

<sup>b</sup>  $P < .001$  vs placebo.

<sup>c</sup>  $P < .05$  vs placebo.

levels in the brain, we measured plasma Aβ 42/40 levels. However, there was no significant difference in plasma Aβ 42/40 levels between treatment arms at the end of the study (Figure 2D and eTable 2 in Supplement 2). At 76 weeks, mean plasma Aβ 42/40 levels were increased 4% from baseline with donanemab treatment vs 2% for placebo. Of note, there was a significant increase in the Aβ 42/40 ratio with donanemab treatment compared with placebo at week 36 only.

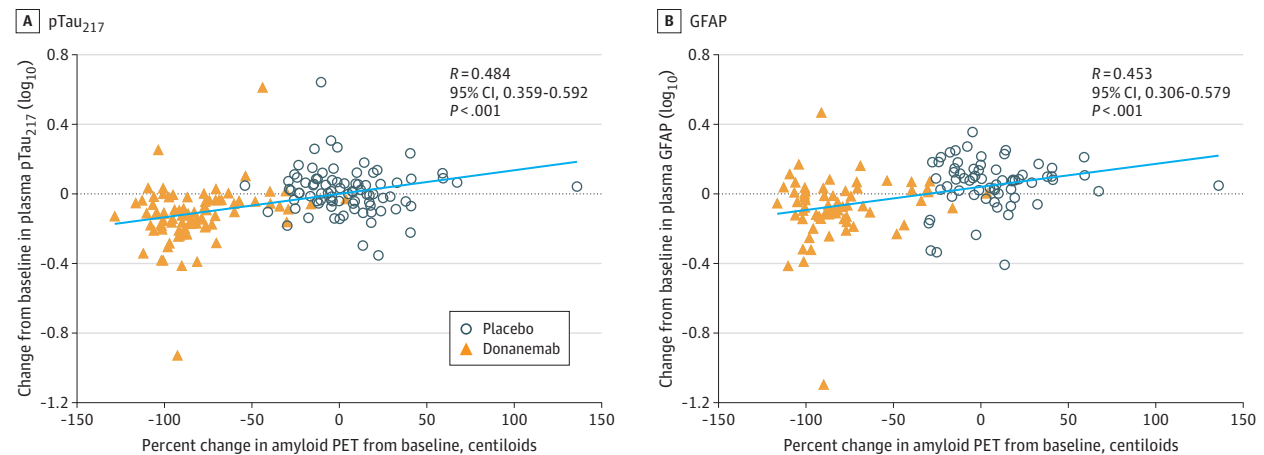
We further explored the significant reductions in plasma levels of pTau<sub>217</sub> and GFAP by separating data from participants who were switched from donanemab to placebo at 24 weeks due to amyloid levels below 11 CL and those who continued receiving donanemab treatment. At the end of the study, plasma levels of pTau<sub>217</sub> (eFigure 3A and eTable 3 in Supplement 2) and GFAP (eFigure 3B and eTable 3 in Supplement 2) were significantly lower in participants treated with donanemab compared with placebo, regardless of stopping or continuing treatment. The results from participants who stopped donanemab treatment at 24 weeks reveal that the effect of donanemab on plasma levels of pTau<sub>217</sub> and GFAP

persist up to 1 year beyond the end of treatment (eFigure 3A-B in Supplement 2). Further, the decrease in plasma levels of pTau<sub>217</sub> and GFAP in participants who continued treatment was not significantly greater than those who stopped treatment at 24 weeks (eFigure 3A-B and eTable 3 in Supplement 2). The reductions in plasma levels of pTau<sub>217</sub> and GFAP observed with donanemab treatment are independent of amyloid-related imaging abnormalities-E; significant reductions compared with placebo were still observed when those with amyloid-related imaging abnormalities-E were removed from analysis (eFigure 3C-D and eTable 3 in Supplement 2).

### Correlations of Change in Plasma Biomarker Levels With Change in Amyloid PET End Point

The change in plasma pTau<sub>217</sub> was positively correlated with the percent change in amyloid plaque (CL units) observed at 76 weeks ( $R = 0.484$  [95% CI, 0.359-0.592];  $P < .001$ ) (Figure 3A). Additionally, the change in plasma GFAP was positively correlated with the percent change in amyloid plaque

**Figure 3. Correlations of Change in Plasma Phosphorylated tau<sub>217</sub> (pTau<sub>217</sub>) and Glial Fibrillary Acidic Protein (GFAP) With Change in Amyloid Positron Emission Tomography (PET) End Points**



Percent change in amyloid PET levels from baseline to 76 weeks compared with change in plasma levels of pTau<sub>217</sub> (placebo  $n = 85$ ; donanemab  $n = 84$ ) (A) and GFAP (placebo  $n = 66$ ; donanemab  $n = 66$ ) (B) from baseline to 76 weeks. Plasma levels were log<sub>10</sub> transformed. Linear regression of all data points, regardless of treatment, is shown in light blue. Spearman rank was used for correlation coefficient.

observed at 76 weeks ( $R = 0.453$  [95% CI, 0.306-0.579];  $P < .001$ ) (Figure 3B).

#### Correlations of Change in Plasma pTau<sub>217</sub> and GFAP Levels With Change in Tau PET Imaging

Regionally, we found significant positive correlations between change in plasma pTau<sub>217</sub> and change in frontal tau standardized uptake value ratio (SUVR) ( $R = 0.243$  [95% CI, 0.092-0.383];  $P = .002$ ) (Figure 4A) and change in temporal tau SUVR ( $R = 0.177$  [95% CI, 0.023-0.323];  $P = .02$ ) (Figure 4B). There were no significant correlations between change in plasma pTau<sub>217</sub> and change in parietal tau SUVR (Figure 4C) or occipital tau SUVR (Figure 4D). Globally, there was a significant positive correlation between change in plasma pTau<sub>217</sub> and change in tau SUVR ( $R = 0.170$  [95% CI, 0.016-0.317];  $P = .03$ ) (Figure 4E). Correlations between change in plasma GFAP and change in tau PET imaging were not statistically significant (eFigure 4 in Supplement 2).

#### Correlations of Plasma pTau<sub>217</sub> Levels With Plasma GFAP Levels

At baseline, plasma levels of pTau<sub>217</sub> and GFAP were significantly correlated ( $R = 0.399$  [95% CI, 0.278-0.508];  $P < .001$ ) (Figure 5A). The positive correlation at baseline persisted through week 76, the end of the study ( $R = 0.393$  [95% CI, 0.254-0.517];  $P < .001$ ) (Figure 5B). Additionally, the changes in plasma levels of pTau<sub>217</sub> and GFAP from baseline to 76 weeks were also significantly correlated ( $R = 0.475$  [95% CI, 0.334-0.596];  $P < .001$ ) (Figure 5C).

#### Correlations of Plasma Biomarkers With Volumetric Magnetic Resonance Imaging

There were no significant correlations between baseline pTau<sub>217</sub>, GFAP, NfL, or Aβ 42/40 with baseline whole brain, ventricular, or hippocampal volumes (eTable 4 in Supplement 2).

When looking at change in plasma biomarker vs change in volumetric magnetic resonance imaging (MRI), only NfL showed a significant correlation with change in whole brain volume ( $R = -0.1710$  [95% CI, -0.3205 to -0.0132];  $P = .03$ ) (eTable 4 in Supplement 2).

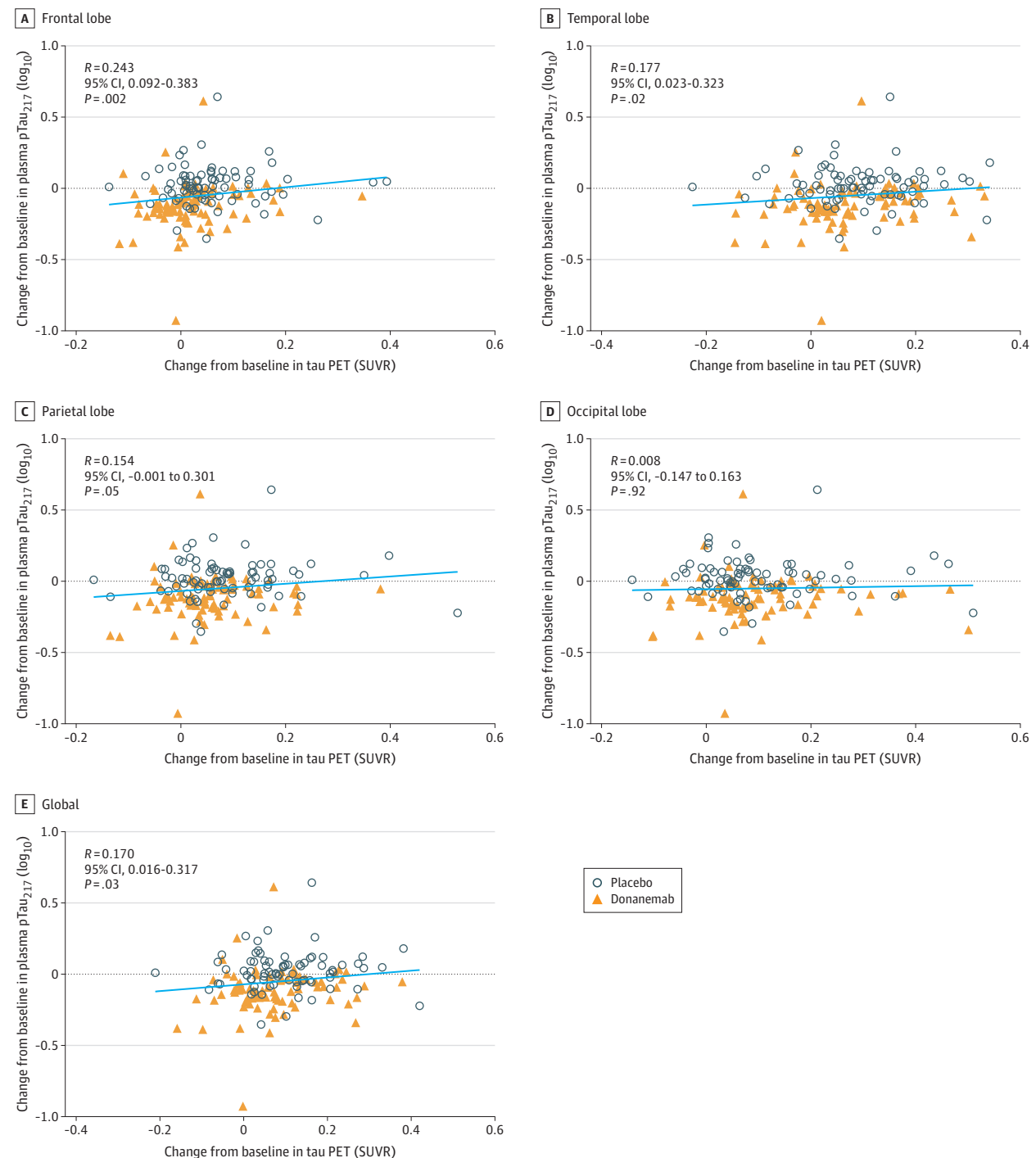
#### Relationship of Plasma Biomarkers With iADRS

There were no significant correlations between plasma pTau<sub>217</sub>, GFAP, NfL, or Aβ 42/40 and baseline iADRS (eTable 5 in Supplement 2). Only change in plasma NfL showed a significant correlation with change in iADRS ( $R = -0.182$  [95% CI, -0.322 to -0.035];  $P = .02$ ) (eTable 5 in Supplement 2). However, the marginal logistical analysis, classifying individual participants as exhibiting a meaningful worsening (MCID) on iADRS, or not, showed that pTau<sub>217</sub> change at 24 weeks was positively associated with the odds of exhibiting an iADRS MCID (coefficient estimate, 0.704 [95% CI, 0.022-1.386];  $P = .04$ ) (eTable 6 in Supplement 2). That is, the decline in pTau<sub>217</sub> values is associated with lower odds of within-patient change in iADRS consistent with meaningful worsening. The analyses on GFAP did not show any association (eTable 6 in Supplement 2).

## Discussion

Exploratory, post hoc analysis of plasma biomarkers from the TRAILBLAZER-ALZ study demonstrated that donanemab treatment reduces plasma levels of pTau<sub>217</sub> and GFAP compared with placebo. Further, the changes in plasma pTau<sub>217</sub> and GFAP significantly correlate with percent change in amyloid plaque level as measured by amyloid PET imaging. These results are consistent with, and extend, findings of changes in CSF and plasma biomarkers with other anti-Aβ antibodies.<sup>20-22</sup> They add weight to the hypothesis that reduction of amyloid by anti-Aβ antibodies could have downstream effects consistent with dis-

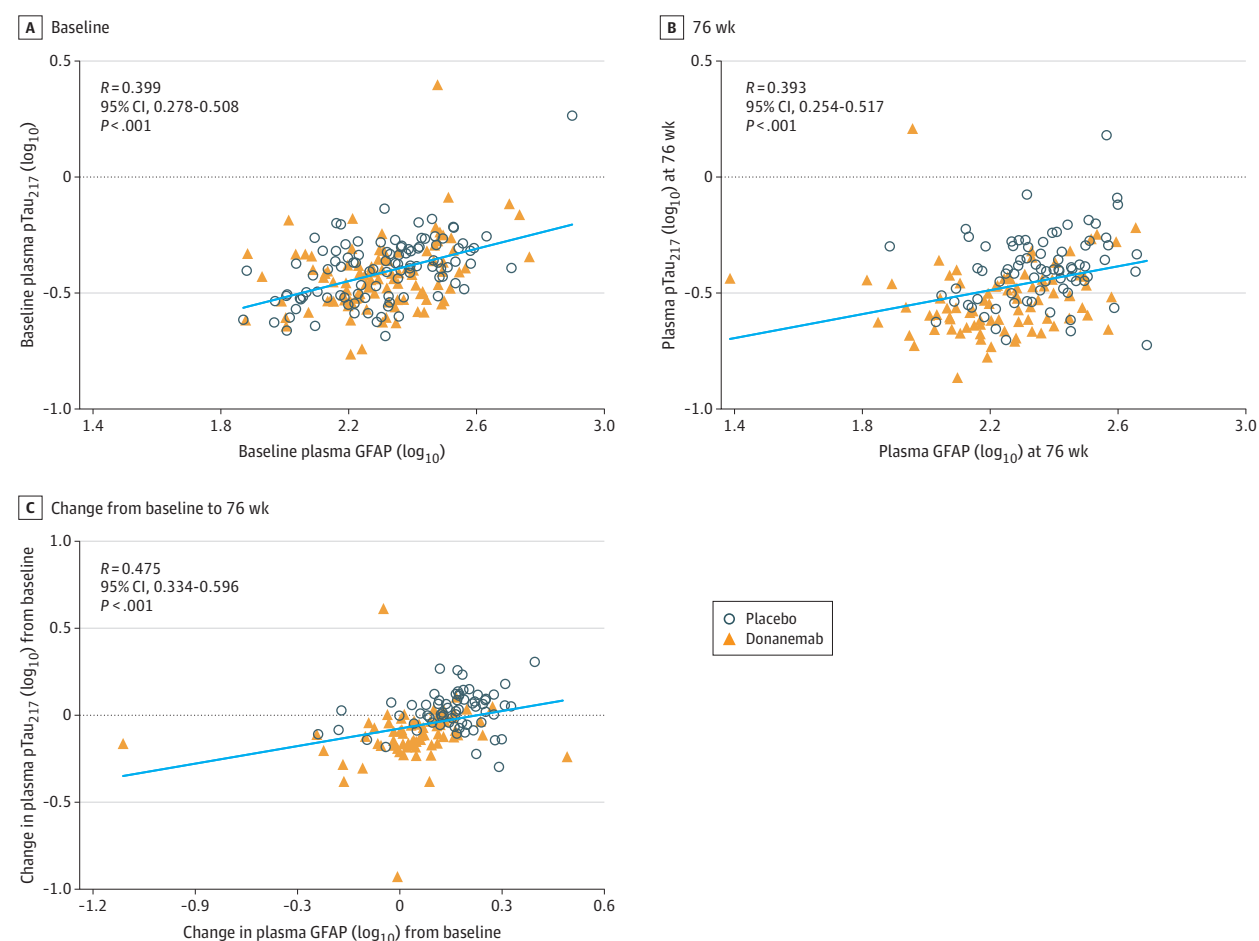


Figure 4. Correlations of Change in Plasma Phosphorylated Tau<sub>217</sub> (pTau<sub>217</sub>) With Change in Tau Positron Emission Tomography (PET) End Points

Change in tau PET levels compared with change in plasma pTau<sub>217</sub> levels from baseline to 76 weeks in frontal (A), temporal (B), parietal (C), and occipital (D) lobes as well as globally (E). Plasma levels were log<sub>10</sub> transformed. Linear regression of all data points, regardless of treatment, is shown in light blue. Spearman rank was used for correlation coefficient. There were 78 individuals in the placebo group and 83 in the donanemab group. SUVR indicates standardized uptake value ratio.

ease modification and suggest that fluid biomarkers could have a role in monitoring response to treatments (at least as a group measure of target engagement/amyloid clearance) in future clinical trials.

Using blood-based biomarkers as a minimally invasive way to assess disease is an emerging topic in AD research.<sup>3</sup> In a 2020 report, plasma pTau<sub>217</sub> was able to distinguish between AD and other neurodegenerative diseases with similar accuracy

Figure 5. Correlations of Plasma Phosphorylated tau<sub>217</sub> (pTau<sub>217</sub>) Levels With Plasma Glial Fibrillary Acidic Protein (GFAP) Levels

Plasma GFAP levels compared with plasma pTau<sub>217</sub> levels at baseline (placebo  $n = 103$ , donanemab  $n = 104$ ) (A), 76 weeks (placebo  $n = 78$ , donanemab  $n = 83$ ) (B), and change from baseline to 76 weeks (placebo  $n = 67$ , donanemab  $n = 69$ ) (C). Plasma levels were log<sub>10</sub> transformed. Linear regression of all data points, regardless of treatment, is shown in light blue. Spearman rank was used for correlation coefficient.

to CSF and PET imaging measures.<sup>7</sup> Our results showing baseline plasma pTau<sub>217</sub> levels are correlated with both amyloid and tau PET end points are in line with previously published results. These associations demonstrating statistical significance in our data are especially striking considering the study enrollment criteria restricted participants to those who had elevated amyloid and intermediate tau level determined by PET, thereby limiting the dynamic range of the data. Our analyses further revealed plasma pTau<sub>217</sub> levels were significantly reduced with donanemab treatment compared with placebo, and the reduction persisted to the end of the study even in participants who switched to placebo at 24 weeks after achieving the target level of amyloid reduction.

GFAP is an important regulator of astrocytic function that is associated with activated astrocytes in AD and other inflammatory conditions.<sup>23</sup> Previous studies using a similar Simoa-based assay found plasma GFAP levels are positively associated with amyloid PET.<sup>9,24</sup> Although we saw plasma GFAP levels decrease with donanemab treatment, we did not see a significant correlation between baseline plasma GFAP levels

and baseline amyloid or tau PET end points. However, as with plasma pTau<sub>217</sub>, changes in plasma GFAP significantly correlated with change in amyloid PET level at 76 weeks. Unlike plasma pTau<sub>217</sub>, changes in plasma GFAP were not significantly correlated with changes in tau PET signal, but there were correlations between plasma GFAP and plasma pTau<sub>217</sub> both at baseline and end point/change from baseline. These results are consistent with studies suggesting GFAP reflects activation of astrocytes in response to amyloid in AD.<sup>25</sup>

In a head-to-head comparison of different plasma A $\beta$  42/40 assays, Simoa immunoassays, as used in this study, were less accurate than mass spectrometry-based assays.<sup>26</sup> However, even when using a mass spectrometry-based assay, there was not a good correlation between plasma A $\beta$  42/40 and amyloid PET results within the subset of amyloid-positive participants.<sup>27</sup> Therefore, it is not surprising that we did not see significant baseline correlations since our study includes only amyloid PET-positive participants. Further, lack of assay precision could hinder our ability to detect small changes in plasma A $\beta$  42/40 levels following treatment. While we do

see greater normalization of plasma A $\beta$  42/40 levels with donanemab compared with placebo, significant differences only occurred at 1 time point. Using a more precise assay in future studies may reveal significant drug effects on plasma A $\beta$  42/40 levels.

Plasma NfL levels continued to increase in both groups with no significant differences in plasma NfL levels between placebo and donanemab treatment arms. One possible explanation for the lack of significant effect of donanemab/amyloid reduction on plasma NfL is that factors unrelated to amyloid/AD may contribute significantly to plasma NfL values. Plasma NfL is a nonspecific marker of neurodegeneration and elevated levels can be attributed to many neurological conditions.<sup>28</sup> Plasma NfL levels also increase with age in cognitively normal individuals as well as those with AD.<sup>29</sup> Further, plasma NfL levels increase with age, independent of A $\beta$  status, and among individuals with cognitive impairment, NfL was not significantly associated with amyloid PET status but did increase in association with myocardial infarction and hypertension.<sup>30</sup> Similarly, longitudinal change was increased in patients with elevated tau or neurodegeneration at baseline, regardless of baseline amyloid status.<sup>31</sup> Thus, changes in NfL may reflect the intensity of neuronal injury that may occur independent of A $\beta$  pathology<sup>31</sup> or as a downstream effect of A $\beta$  pathology. A second consideration relevant to the present finding is that we do not presently know the time lag between onset of A $\beta$  pathology and downstream neurodegeneration, but it may be significant. Thus, NfL changes over a 76-week trial, such as the present, may reflect the impact of the amyloid pathology that was present at baseline rather than the impact of removing amyloid over the course of the trial.

In contrast to the associations among changes in plasma pTau<sub>217</sub> and GFAP with PET, the only significant relationship between plasma biomarkers and MRI measures was a modest correlation between increasing NfL and decreasing whole brain volume. The absence of other correlations may in fact reflect weaknesses in global MRI measures; regional measures, eg, of cortical thickness, might be more sensitive. MRI volume results may also be confounded by decreased amyloid plaque volume.<sup>17</sup> The association of MRI volume change with NfL and lack of relationship with the presumed amyloid-driven plasma markers (pTau<sub>217</sub>, GFAP) again suggests that increases in NfL and atrophy may be sufficiently downstream that the 76-week NfL/MRI result is reflective of amyloid status at the start of the trial, rather than amyloid removal during the trial. Future studies will need to investigate later time points after the initiation of treatment.

PET and plasma biomarker data each provide unique information on insoluble pathology and soluble proteoforms.<sup>32</sup> Understanding how the information from each relates to each other is of great importance to the field in how they should be used in the future. The results of the present study align with recent studies supporting the hypothesis that A $\beta$  accumulation facilitates an increase in plasma pTau<sub>217</sub>, which reflects an ongoing process of tau misfolding, mislocalization, and hyperphosphorylation that are precursors to tau aggregation and deposition in neurofibrillary tangles.<sup>33</sup> Increased pTau<sub>217</sub> levels have been detected early in disease in cognitively unim-

paired, A $\beta$ -positive individuals, even before tau is detectable on PET imaging.<sup>5,34</sup> The present results suggest A $\beta$  may be important in facilitating the increase in plasma pTau<sub>217</sub> prior to tau aggregation. Thus, we see a relatively modest correlation between plasma pTau<sub>217</sub> and amyloid PET at baseline, since all participants were amyloid PET positive as defined by inclusion criteria. Plasma pTau<sub>217</sub> levels drop rapidly, by 12 weeks, following donanemab treatment. As A $\beta$  is removed and plasma pTau<sub>217</sub> generation is impeded, tau deposition is expected to slow, but deposition from tau fibrils already present may continue for some time after A $\beta$  reduction. Hence, it could be expected that the correlation between change in tau PET and change in plasma pTau<sub>217</sub> is weaker than correlation between change in amyloid PET and change in plasma pTau<sub>217</sub>.

We see plasma GFAP levels drop with similar timing as plasma pTau<sub>217</sub> levels and plasma levels of both are significantly correlated with each other at the beginning and end of the study. Therefore, our GFAP results seem to support a similar hypothesis in which plasma GFAP is elevated in response to A $\beta$  accumulation. In AD, amyloid plaques are infiltrated by reactive astrocytes, which have increased expression of GFAP.<sup>35</sup> Accordingly, removal of amyloid plaques should reduce the activation state of the astrocytes, leading to decreased plasma GFAP levels with donanemab treatment. We observed a weaker correlation between change in plasma GFAP and change in tau PET compared with the correlation between plasma GFAP and change in amyloid PET, consistent with the hypothesis that elevations of GFAP in AD are more directly related to the presence of pathological amyloid than to presence of aggregated deposited tau, which may be further downstream of A $\beta$  and on a separate parallel pathway from GFAP.

The primary outcome of the TRAILBLAZER-ALZ clinical trial was change from baseline in the iADRS score. As previously reported, donanemab significantly slowed disease progression as measured by the iADRS score.<sup>17</sup> We do not see associations between change in iADRS and change in plasma pTau<sub>217</sub> or GFAP, except a borderline significant association between plasma pTau<sub>217</sub> change at 24 weeks with the marginal odds of exhibiting a meaningful worsening (MCID) on iADRS. The lack of significant associations may be due in part to the small number of participants and the variability of the assays. Systematic factors may contribute to the observed absence of correlation. Specifically, the participants with the highest baseline assay values have the largest room to show reductions, eg, in plasma pTau<sub>217</sub> and GFAP, but these same participants also should be expected to have generally higher levels of ongoing pathology (ie, abnormal tau phosphorylation and inflammation) and thus would be expected to have a greater degree of cognitive decline, confounding potential correlation between reduction in plasma pTau<sub>217</sub> or GFAP levels and slower cognitive decline. Additionally, in a relatively short trial, rate of pathology reduction/time to clearance may be more important than the amount of change seen at end point. Finally, despite our best efforts, change in cognitive functional scales may not be linearly related to clinical impact; a given amount of change may have greater clinical importance to a patient earlier in disease than a patient later in disease.<sup>19</sup> Modeling the relationship between plasma pTau<sub>217</sub> and MCID iADRS



score showed a modest but statistically significant association between of plasma pTau<sub>217</sub> change at 26 weeks and the odds of an individual achieving a minimally clinically important decline. Given that this analysis was performed post hoc, and the result is not corrected for multiplicity, it should be considered only as hypothesis generating. However, it serves as a reminder of the potential complexity in interpreting correlations between biomarker and clinical change. Longer follow-up and larger studies are needed to further explore whether changes in the plasma biomarkers are associated with slowing of cognitive decline.

## Limitations

The exploratory, post hoc analyses reported here have several additional limitations. Importantly, the small trial size limits the power of the analyses and further makes it difficult to interpret effects in subgroups, eg, as a function of age, APOE ε4 status, or early stopping vs continuation of donanemab therapy. The conclusions drawn from this data need to be confirmed in a larger trial. Additional analyses such as the impact

of race and ethnicity on plasma biomarkers also needs to be addressed in larger trials.

There are caveats to our correlation analyses as well. The biomarker analyses are exploratory and thus not corrected for multiple testing. Correlation coefficients are small as the dynamic range of the data are limited due to inclusion criteria limiting participants to those who had elevated amyloid and intermediate tau levels. Data from the phase 3 study, TRAILBLAZER-ALZ2, of donanemab in early symptomatic AD will be important to confirm the results for all the plasma biomarkers analyzed here with a greater sample size.

## Conclusions

In summary, the present study showed plasma biomarker improvement following treatment in exploratory analyses and suggests that amyloid reduction driven by anti-Aβ antibodies influences downstream effects potentially associated with disease modification.

## ARTICLE INFORMATION

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**Author Contributions:** Dr Pontecorvo had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

**Concept and design:** Pontecorvo, Dage, Sims, Mintun.

**Acquisition, analysis, or interpretation of data:** Pontecorvo, Lu, Burnham, Schade, Dage, Shcherbinin, Collins, Mintun.

**Drafting of the manuscript:** Pontecorvo, Lu, Sims. **Critical revision of the manuscript for important intellectual content:** Pontecorvo, Lu, Burnham, Schade, Dage, Shcherbinin, Collins, Mintun.

**Statistical analysis:** Lu, Burnham.

**Obtained funding:** Mintun.

**Administrative, technical, or material support:** Schade, Shcherbinin, Collins, Mintun.

**Supervision:** Collins, Sims, Mintun.

**Conflict of Interest Disclosures:** Drs Pontecorvo, Lu, Burnham, Schade, Shcherbinin, Collins, Sims, Mintun, and Dage are minor stockholders of Eli Lilly and Company. Dr Burnham reported a patent for 20140086836, a method for detection of a neurological disease, issued. Dr Dage reported personal fees, nonfinancial support, and research support from Eli Lilly and Company; personal fees from AlzPath Inc, Genotix Biotechnologies Inc, Gates Ventures, Karuna Therapeutics, and Cognito; nonfinancial support from ADx Neurosciences; grants from Roche Diagnostics outside the submitted work; and is an inventor on patents associated with the pTau<sub>217</sub> assay used in this work. Drs Shcherbinin, Sims, and Mintun have a patent for Eli Lilly and Company relevant to this research. No other disclosures were reported.

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**Data Sharing Statement:** See [Supplement 3](#).

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## Supplemental Online Content

Pontecorvo MJ, Lu M, Burnham SC, et al. Association of donanemab treatment with exploratory plasma biomarkers in early symptomatic Alzheimer disease: a secondary analysis of the TRAILBLAZER-ALZ randomized clinical trial. *JAMA Neurol*. Published online October 17, 2022. doi:10.1001/jamaneurol.2022.3392

### eMethods

**eFigure 1.** Participant flow diagram

**eFigure 2.** Correlations between baseline plasma GFAP, NfL, A $\beta$  42/40, and baseline amyloid and tau PET endpoints

**eFigure 3.** Change in plasma levels after discontinuing donanemab treatment

**eFigure 4.** Correlations of change in plasma GFAP with change in tau PET imaging

**eTable 1.** Baseline characteristics and biomarker levels

**eTable 2.** Plasma biomarker change from baseline

**eTable 3.** Plasma biomarker change from baseline after discontinuing donanemab treatment

**eTable 4.** Correlations of plasma biomarkers with vMRI

**eTable 5.** Correlations of plasma biomarkers with iADRS

**eTable 6.** Effect of plasma biomarker change at weeks 24 on iADRS MCID

### eReferences

This supplemental material has been provided by the authors to give readers additional information about their work.

## eMethods

### Positron Emission Tomography (PET)

For amyloid PET imaging, a target dose of 10 millicurie (mCi) (370 megabecquerel (MBq)) of florbetapir was injected 50 minutes prior to acquisition of a 20-minute PET brain scan (4 frames x 5 minutes). The composite standardized uptake value ratio (SUVR) was calculated from 6 predetermined cortical regions with the whole cerebellum as a reference region <sup>1</sup>. The SUVR was then converted to Centiloid (CL) units <sup>2</sup>.

For tau PET imaging, a target dose of 10 mCi (370 MBq) of flortaucipir was injected 75 minutes prior to acquisition of a 30-minute PET brain scan (6 frames x 5 minutes). For study eligibility, global neurofibrillary tangle density was estimated by the SUVR of tau PET signal in a weighted cortical target region (Multiblock barycentric discriminant analysis (MUBADA) derived region) relative to a parametrically derived white matter reference region (parametric estimate of reference signal intensity (PERSI)) <sup>3,4</sup>. For measuring tau neurofibrillary tangle change with treatment, regional tau SUVRs for the cerebral lobes were calculated using the Automated Anatomical Labelling atlas <sup>5</sup> while MUBADA region was used for global tau measurements. For tau PET longitudinal change assessments, a cerebellar gray matter region derived from the cerebellar crustaneous atlas-based region was used as a reference in our regional and global tau SUVR calculations <sup>6</sup>.

### Plasma Assays

The P-tau217 assay is a digital immunoassay for the quantitative determination of tau phosphorylated at threonine 217 in human K2EDTA plasma. The Simoa HD-X analyzer uses P-tau217 immunoassay reagent to perform jobs (one job equals a single value, so if run in duplicate, that equals two jobs) using Single Molecule Array (Simoa) technology. This is a three-step P-tau217 digital immunoassay. In the first step, target antibody-coated paramagnetic capture beads are combined with sample. Target molecules present in the sample are captured by the anti-phospho-tau217 antibody coated capture beads. After washing, biotinylated detector anti-total tau antibodies are mixed with the capture beads. The detector antibodies bind to the captured target. Following a second wash, a conjugate of streptavidin- $\beta$ -galactosidase (SBG) is mixed with the capture beads. SBG binds to the biotinylated detector antibodies, resulting in enzyme labeling of captured target. Following a third wash, the capture beads are resuspended in a resorufin  $\beta$ -D-galactopyranoside (RGP) substrate solution and transferred to the Simoa Disc. Individual capture beads are then sealed within microwells in the array. If target has been captured and labeled, the  $\beta$ -galactosidase hydrolyzes the RGP substrate into a fluorescent product that provides the signal for measurement. A single-labeled target molecule results in a sufficient fluorescent signal to be detected and counted in 30 seconds by the Simoa optical system. At low target concentration, the percentage of bead-containing wells in the array that have a positive signal is proportional to the amount of target present in the sample. At a higher target concentration, when most of the bead-containing wells have one or more labeled target molecules, the total fluorescence signal is proportional to the amount of target present in the sample. The concentration of target in unknown samples is interpolated from the calibration curve using a log-log power regression without weighting.

**Precision:** Precision was determined by running validation samples with a minimum of two (2) replicates. A minimum of twenty (20) runs (no more than one [1] run per day for at least twenty (20) days) was performed by multiple scientists (within-lab) on multiple analyzers. The cumulative data from the minimum of twenty (20) runs described above was analyzed for repeatability and within-lab (total) precision.

Validation samples were placed in a random sequence on the plate or within the run. *A priori* criteria for within-lab and total precision was a  $\leq 20\%$  CV for 80% (16/20) of samples.

*Precision criteria were met with 100% of samples (20/20) having a  $\leq 20\%$  CV (and 80% of samples (16/20) having a  $\leq 15\%$  CV). Furthermore, 10 of the 20 samples used for the precision study covered a range of 0.2 U/ml – 0.4 U/ml.*

**Accuracy (analytical):** Accuracy was assessed via percentage agreement studies, which utilized appropriate sample matrix spiked with known levels of P-tau217 calibrator material to span the range. Results were compared with expected results and expressed as recovery (%RE). Percent (%) agreement was calculated by dividing the number of

correct results by the total number of results and multiplying by 100. *A priori* acceptance criteria for accuracy were 80 – 120% RE with 80% agreement across samples.

*Accuracy (analytical) criteria were met with 83% of samples with valid points (15/18) were within 80-120% RE*

**Analytical measurement range (AMR):** The analytical measurement range (AMR) is the range of values that the P-tau217 method can directly measure on a specimen without additional dilution beyond the standard dilution, concentration, or other pretreatment that is not part of the standard assay process. Precision criteria established in the Validation Plan are met throughout the AMR.

*The AMR is 0.200 U/ml to 6.04 U/ml*

**Sensitivity (analytical):** Defined here as the Lower Limit of Quantitation, it was characterized as the lowest level of P-tau217 (after correction for standard dilution) that can be measured with acceptable precision as defined in the method specifications.

*The sensitivity is 0.200 U/ml*

**Specificity (analytical):** Specificity was tested using an irrelevant primary antibody- bead conjugate (Neuro 4-Plex E, Quanterix, 103653) and secondary detection antibody (N4PE, Quanterix, 103655). The testing will be completed on separate runs / same sample(s). The concentration of the samples assessed was  $\geq 0.4$  U/mL.

*The method demonstrated specificity in that no signal was generated with the irrelevant antibody pairs.*

**Cross-reactivity:** Cross reactivity was tested using Quanterix non-phosphorylated Tau (Cat# 101552). This was spiked into two (2) separate K2EDTA plasma samples.

*No cross reactivity was seen with spiked Tau protein in the P-tau217 assay.*

**Parallelism:** Parallelism was measured using a sample that had a high endogenous concentration of P-tau217. One sample was run on instrument at the standard 1:2 dilution and further dilutions of 1:4 and 1:8. *A priori* acceptance criteria for parallelism was a mean of 80-120% RE of the standard 1:2 dilution.

*%RE failed for dilutions 1:4 and 1:8. No dilutions further than the standard 1:2 dilution are allowable for this assay*

**Dilutional Linearity:** Dilutional linearity was measured using a sample spiked with P-tau217 peptide (CPC Scientific). One sample was run on instrument at the standard 1:2 dilution and further onboard dilutions of 1:4 and 1:8. *A priori* acceptance criteria for dilutional linearity was a mean of 80-120% RE of the standard 1:2 dilution.

*%RE passed for dilutions 1:4 and 1:8. Together with the Parallelism experiments, no dilutions further than the standard 1:2 dilution is allowable for this assay.*

**Interference:**

**Hemolysis:** Acceptance criteria are defined as hemolytic sample results 80–120% RE of baseline established with the 0 hemolytic sample.

*Based on studies performed with this assay method, Hemolysis is not an interfering substance for this method.*

**Lipemia:** Acceptance criteria are defined as lipemic sample results 80–120% RE of baseline established with the 0 lipemia sample.

*Based on studies performed with this assay method, Lipemia is not an interfering substance for this method.*

**Drug tolerance (donanemab):** Acceptance criteria are defined as donanemab spiked sample results 80–120% RE of baseline established with sample diluent controls.

*At expected plasma concentrations based on pharmacokinetic analysis, donanemab is tolerated in this method. Note this is only a relevant issue for measuring P-tau217 in patients who have been dosed with donanemab.*



Reportable range: The Reportable Range was determined based upon the acceptability of the precision experiments in conjunction with the acceptability of the parallelism experiment

*Reportable range is 0.200 – 6.04 U/ml*

Sample stability:

Freeze/thaw: Samples demonstrated acceptable stability up to at least five freeze/thaw cycles, defined as mean of 80-120% RE of baseline.

Short term stability: Room temperature up to at least 6 hours is acceptable. 4°C up to at least 168 hours is acceptable. For both, acceptable is defined as mean of 80-120% RE of baseline.

Long-term stability: is being assessed to a planned four years.

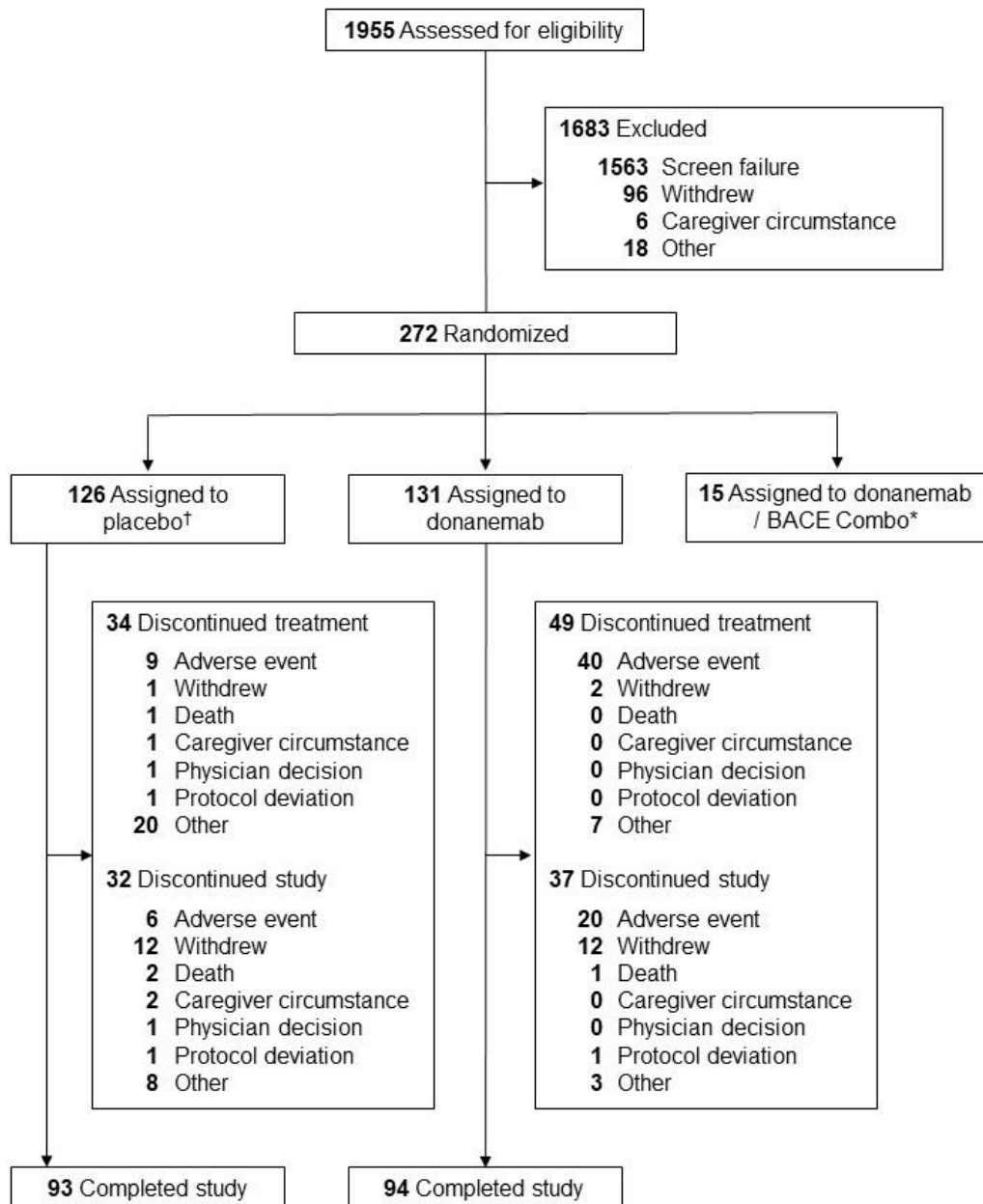
### **Volumetric Magnetic Resonance Imaging (vMRI)**

The brain volumes were assessed by means of 3D T1 weighted, structural MRI scans at baseline and week 76. Global (whole brain volume and ventricular volume) and regional (hippocampal volume) vMRI measures were estimated.

### **Integrated Alzheimer's Disease Rating Scale (iADRS)**

Details on the use of iADRS in TRAILBLAZER-ALZ have been previously reported <sup>4</sup>. Briefly, the iADRS score is a combination of results from ADAS-Cog<sub>13</sub> and ADCS-iADL measures. Scores range from 0 to 144. Lower scores indicate lower cognition and function <sup>4,7</sup>. Cognitive measurements were taken at baseline and weeks 12, 24, 36, 52, 64 and 76.

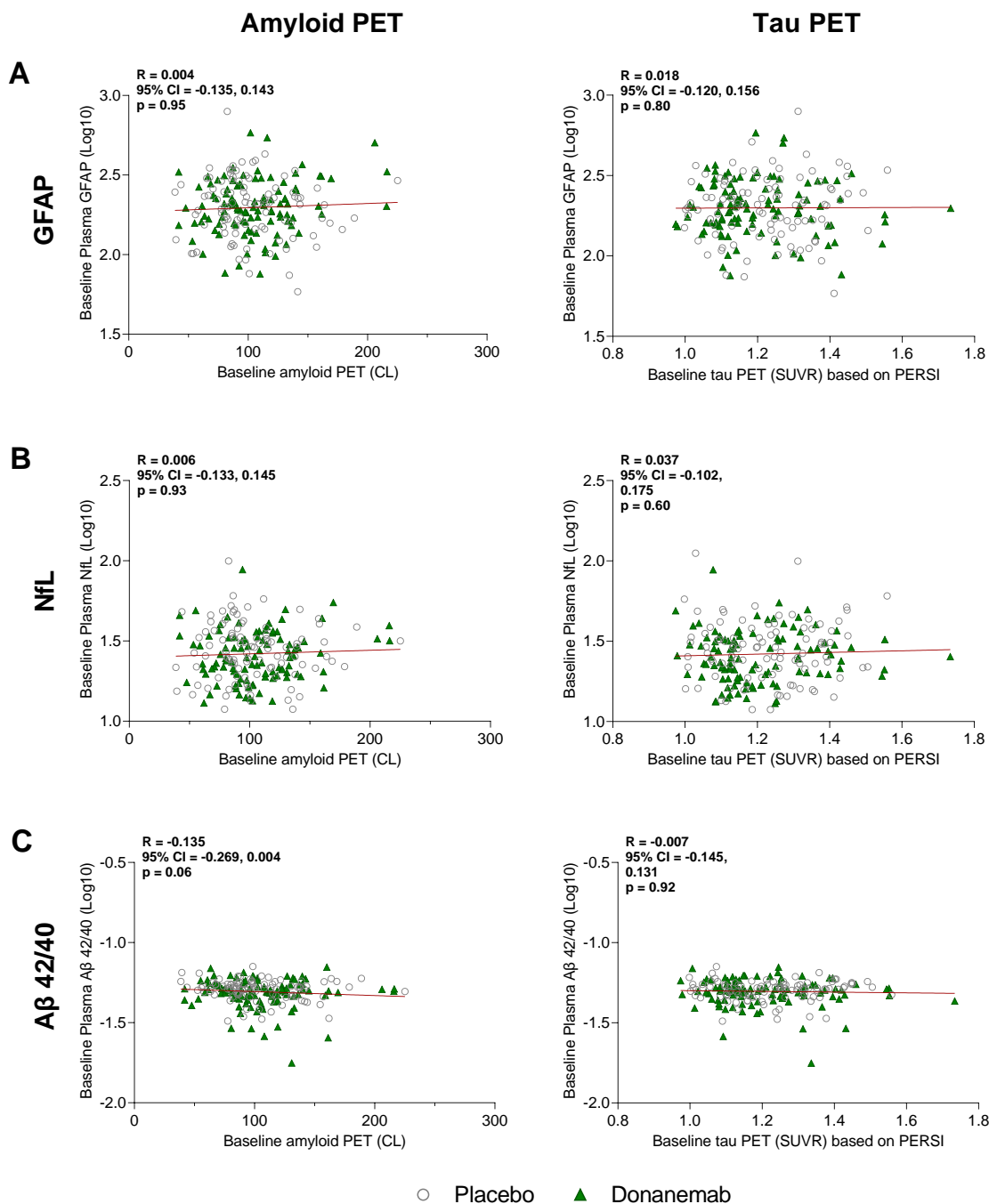
**eFigure 1. Participant flow diagram**



<sup>†</sup>One participant was randomized to placebo but discontinued before receiving an infusion.

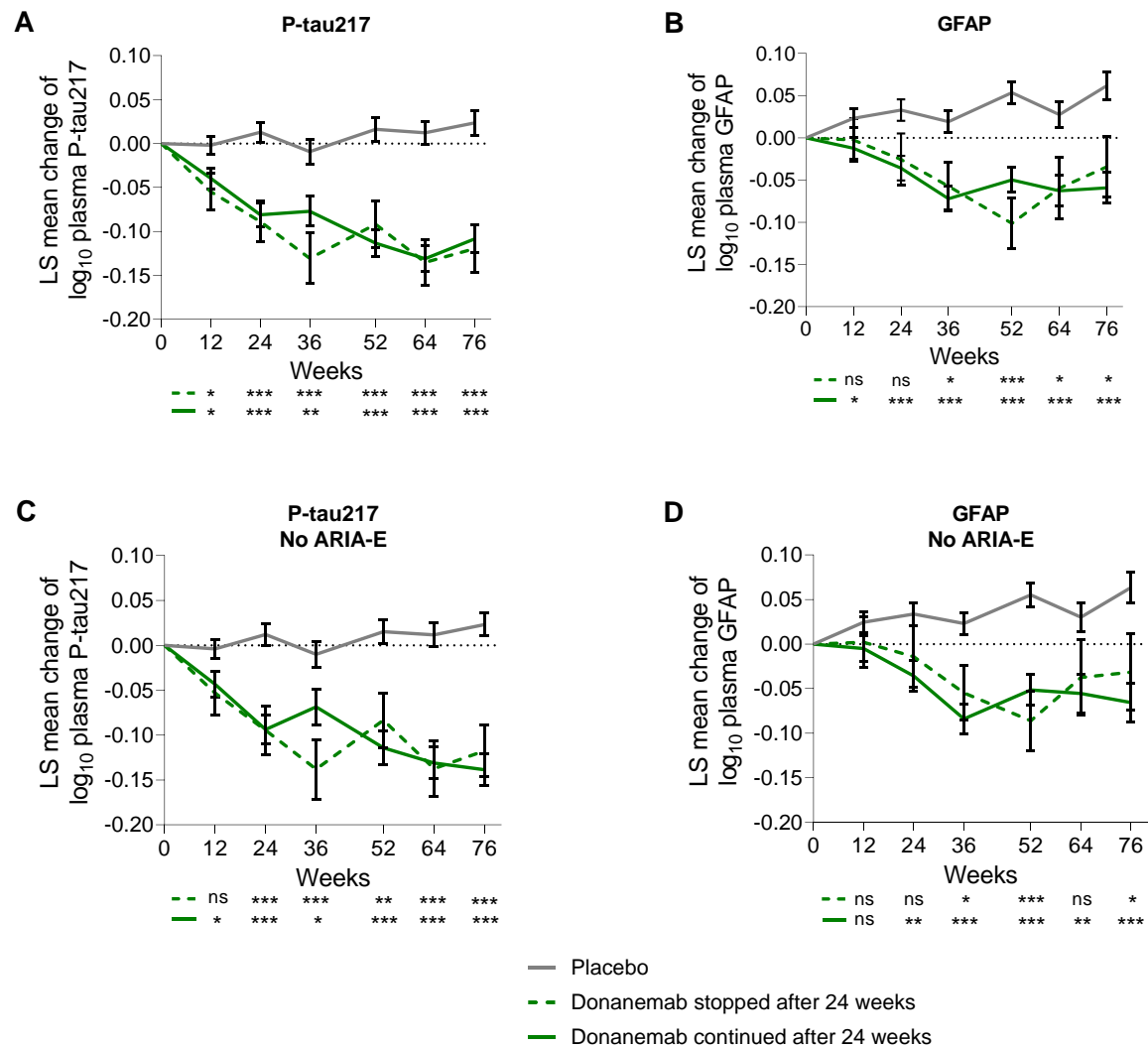
<sup>\*</sup>Combination therapy was discontinued from the study in a protocol change.

**eFigure 2. Correlations between baseline plasma GFAP, NfL, A $\beta$  42/40, and baseline amyloid and tau PET endpoints**



Baseline amyloid PET and tau PET levels compared with baseline plasma levels of GFAP (A), NfL (B), and A $\beta$  42/40 (C). Plasma levels were log10 transformed. Placebo is represented by gray circles and donanemab by green triangles. Linear regression of all data points, regardless of treatment, shown in red. Spearman's rank was used for correlation coefficient. Amyloid PET: placebo N=97; donanemab N=102. Tau PET: placebo N=98; donanemab N=103. CI = confidence interval, CL = Centiloids, GFAP = glial fibrillary acidic protein p = p-value, PERSI = parametric estimation of reference signal intensity, PET = positron emission tomography, N = number of participants, NfL = neurofilament light chain, R = Spearman's rank correlation coefficient, SUVR = standardized uptake value ratio.

**eFigure 3. Change in plasma levels after discontinuing donanemab treatment**



Least square mean change from baseline in plasma P-tau217 (A), GFAP (B), plasma P-tau217 excluding ARIA-E cases (C) and plasma GFAP excluding ARIA-E cases (D). Participants received placebo (gray line), stopped donanemab treatment at 24 weeks and switched to placebo due to amyloid levels <11 CL (dashed green line), or continued donanemab after 24 weeks (solid green line). Significance versus placebo is denoted below graph. No significant differences were observed between donanemab groups. Plasma values were log10 transformed. Error bars indicate standard error. Black dashed line indicates baseline.

P-tau 217 (A) placebo: week 12, N=107; week 24, N=108; week 36, N= 103; week 52, N=89; week 64, N=85; week 76, N=86.

P-tau 217 (A) donanemab stopped at 24 weeks: week 12, N=27; week 24, N=26; week 36, N= 25; week 52, N=22; week 64, N=20; week 76, N=22.

P-tau 217 (A) donanemab continued through 76 weeks: week 12, N=84; week 24, N=81; week 36, N= 74; week 52, N=67; week 64, N=63; week 76, N=63.

GFAP (B) placebo: week 12, N=82; week 24, N=89; week 36, N= 85; week 52, N=71; week 64, N=69; week 76, N=67.

GFAP (B) donanemab stopped at 24 weeks: week 12, N=18; week 24, N=15; week 36, N= 17; week 52, N=13; week 64, N=12; week 76, N=13.

GFAP (B) donanemab continued through 76 weeks: week 12, N=68; week 24, N=66; week 36, N= 61; week 52, N=56; week 64, N=50; week 76, N=55.

P-tau 217 no ARIA-E (C) placebo: week 12, N=106; week 24, N=107; week 36, N= 102; week 52, N=89; week 64, N=85; week 76, N=86.

P-tau 217 no ARIA-E (C) donanemab stopped at 24 weeks: week 12, N=22; week 24, N=21; week 36, N= 20; week 52, N=19; week 64, N=15; week 76, N=17.

P-tau 217 no ARIA-E (C) donanemab continued through 76 weeks: week 12, N=59; week 24, N=57; week 36, N= 54; week 52, N=50; week 64, N=46; week 76, N=45.

GFAP no ARIA-E (B) placebo: week 12, N=82; week 24, N=88; week 36, N= 84; week 52, N=71; week 64, N=69; week 76, N=67.

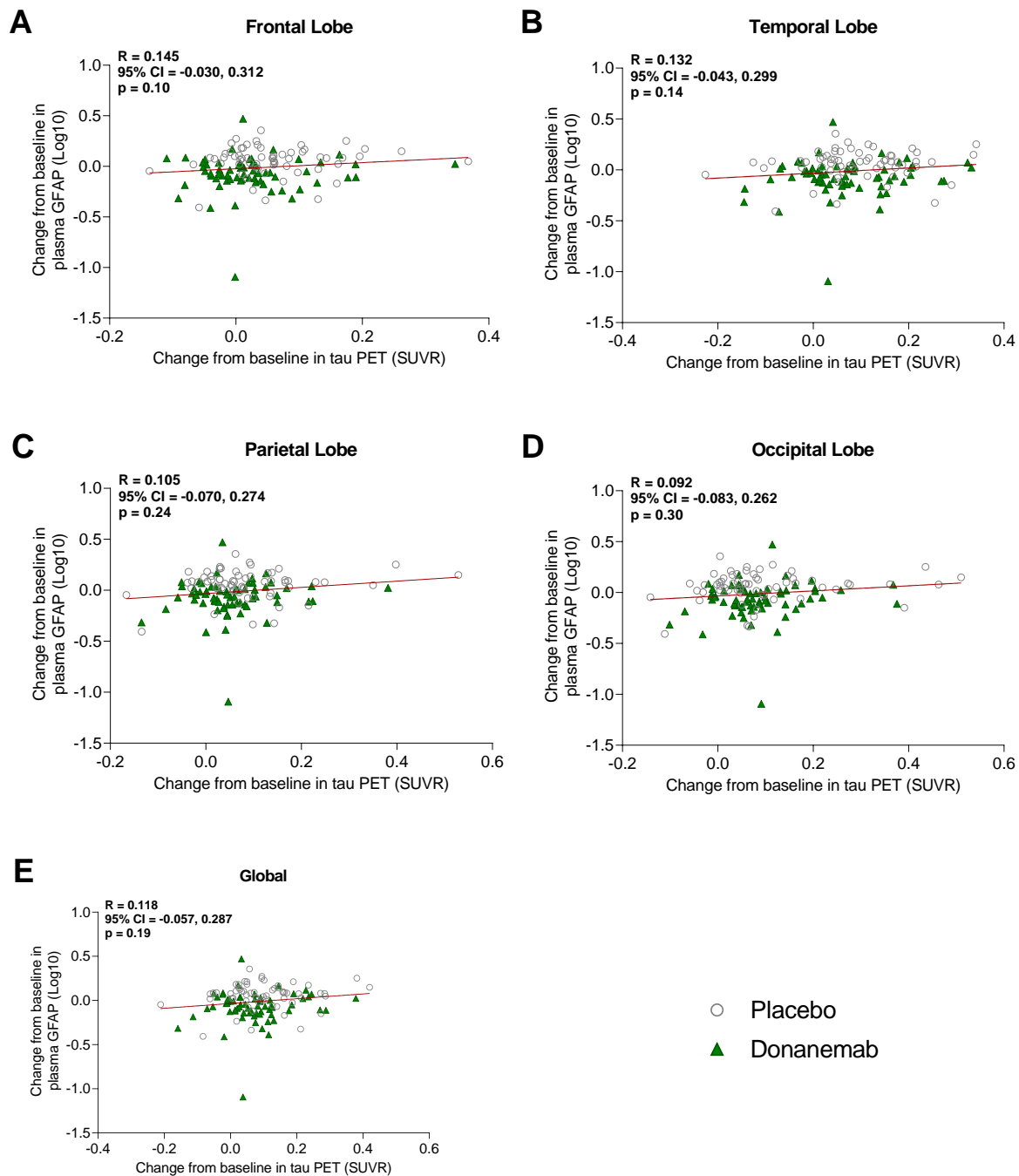
GFAP no ARIA-E (B) donanemab stopped at 24 weeks: week 12, N=14; week 24, N=12; week 36, N= 14; week 52, N=11; week 64, N=10; week 76, N=9.

GFAP no ARIA-E (B) donanemab continued through 76 weeks: week 12, N=50; week 24, N=47; week 36, N= 45; week 52, N=44; week 64, N=38; week 76, N=41.

(ARIA)-E = amyloid related imaging abnormalities-E, GFAP = glial fibrillary acidic protein, LS = least square, N = number of participants, ns = not significant, \* p-value <0.05 versus placebo. \*\* p-value < 0.01 versus placebo.



## eFigure 4. Correlations of change in plasma GFAP with change in tau PET imaging



Change in tau PET levels compared with change in plasma GFAP levels from baseline to 76 weeks in frontal (A), temporal (B), parietal (C), and occipital (D) lobes as well as globally (E). Plasma levels were log10 transformed. Placebo is represented by gray circles and donanemab by green triangles. Linear regression of all data points, regardless of treatment, is shown in red. Spearman's rank was used for correlation coefficient. Placebo N=62; donanemab N=65. CI = confidence interval, N = number of participants, p = p-value, PET = positron emission tomography, R = Spearman's rank correlation coefficient, SUVR = standardized uptake value ratio.

**eTable 1. Baseline characteristics and biomarker levels**

	Placebo	Donanemab
<b>Baseline Characteristics</b>		
Age (years) - N, mean (SD)	120, 75.29 (5.438)	125, 74.90 (5.504)
Sex N (%)		
Female	61 (50.8)	64 (51.2)
Male	59 (49.2)	61 (48.8)
Race N (%)		
American Indian or Alaska Native	0 (0.00)	2 (1.60)
Asian	1 (0.83)	1 (0.80)
Black or African American	3 (2.50)	5 (4.00)
Multiple	0 (0.00)	1 (0.80)
White	116 (96.67)	116 (92.80)
Ethnicity N (%)		
Hispanic or Latino	3 (2.5)	4 (3.2)
Not Hispanic or Latino	117 (97.5)	121 (96.8)
Amyloid (CL)- N, mean (SD)	112, 103.09 (33.841)	121, 107.18 (33.938)
Global Tau (SUVR)- N, mean (SD)	113, 1.22 (0.132)	122, 1.21 (0.142)
MMSE- N, mean (SD)	115, 23.77 (2.878)	121, 23.56 (3.033)
iADRS- N, mean (SD)	120, 106.06 (13.050)	125 106.30 (12.730)
APOE ε4 N (%)		
Carriers	88 (73.9)	92 (73.6)
non-carriers	31 (26.1)	33 (26.4)
P-tau217 (U/mL)- N, mean (SD)	119, 0.42 (0.172)	123, 0.41 (0.232)
GFAP (pg/mL)- N, mean (SD)	103, 222.07 (103.406)	104, 214.43 (88.891)
NfL (pg/mL)- N, mean (SD)	119, 26.82 (24.847)	121, 21.91 (8.491)
Aβ 42 (pg/mL)- N, mean (SD)	103, 5.93 (1.382)	104, 5.54 (1.395)
Aβ 40 (pg/mL)- N, mean (SD)	103, 117.75 (29.559)	104, 114.23 (28.395)
Aβ 42/40- N, mean (SD)	103, 0.051 (0.0069)	104, 0.049 (0.0089)
<b>Week 24</b>		
P-tau217 (U/mL)- N, mean (SD)	110, 0.45 (0.257)	111, 0.34 (0.120)
GFAP (pg/mL)- N, mean (SD)	102, 234.40 (103.238)	98, 203.12 (90.661)
NfL (pg/mL)- n, mean (SD)	111, 28.12 (25.906)	110, 25.56 (11.390)
Aβ 42 (pg/mL)- N, mean (SD)	102, 6.33 (1.657)	98, 6.04 (1.500)
Aβ 40- N, mean (SD)	102, 127.35 (36.264)	98, 120.53 (31.935)
Aβ 42/40- N, mean (SD)	102, 0.051 (0.0083)	98, 0.051 (0.0096)
<b>Week 52</b>		
P-tau217 (U/mL)- N, mean (SD)	90, 0.45 (0.225)	90, 0.32 (0.178)
GFAP (pg/mL)- N, mean (SD)	78, 228.14 (76.810)	82, 188.10 (80.199)
NfL (pg/mL)- n, mean (SD)	93, 29.47 (30.087)	90, 23.43 (11.193)
Aβ 42 (pg/mL)- N, mean (SD)	78, 6.19 (1.735)	82, 6.17 (1.552)
Aβ 40 (pg/mL)- N, mean (SD)	78, 121.42 (40.220)	82, 120.68 (27.122)
Aβ 42/40- N, mean (SD)	78, 0.052 (0.0075)	82, 0.052 (0.0094)
<b>Week 76</b>		
P-tau217(U/mL)- N, mean (SD)	87, 0.46 (0.245)	86, 0.32 (0.167)
GFAP (pg/mL)- N, mean (SD)	78, 242.25 (87.293)	83, 189.99 (83.675)
NfL (pg/mL)- N, mean (SD)	90, 26.05 (11.431)	92, 23.86 (10.529)
Aβ 42 (pg/mL)- N, mean (SD)	78, 6.65 (2.116)	83, 6.31 (1.718)
Aβ 40 (pg/mL)- N, mean (SD)	78, 132.30 (44.026)	83, 123.68 (29.815)
Aβ 42/40- N, mean (SD)	78, 0.051 (0.0090)	83, 0.051 (0.0090)

CL = Centiloids, GFAP = glial fibrillary acidic protein, iADRS = Integrated Alzheimer's Disease Rating Scale, MMSE = Mini-Mental State Examination, N = number of participants, NfL = neurofilament light chain, SD = standard deviation, SUVR = standardized uptake value ratio

**eTable 2. Plasma biomarker change from baseline**

		Placebo	Donanemab
<b>P-tau217 (U/mL) log10 transformed</b>			
Week 12	LS Mean Change (SE), N	0.00 (0.010), 113	-0.04 (0.010), 119
	LS Mean Diff (95% CI) vs. placebo		-0.04 (-0.07, -0.02)
	P-value vs. placebo		0.002
Week 24	LS Mean Change (SE), N	0.01 (0.011), 110	-0.09 (0.011), 110
	LS Mean Diff (95% CI) vs. placebo		-0.10 (-0.13, -0.07)
	P-value vs. placebo		<0.001
Week 36	LS Mean Change (SE), N	-0.01 (0.014), 103	-0.09 (0.014), 100
	LS Mean Diff (95% CI) vs. placebo		-0.08 (-0.12, -0.04)
	P-value vs. placebo		<0.001
Week 52	LS Mean Change (SE), N	0.02 (0.014), 89	-0.11 (0.014), 90
	LS Mean Diff (95% CI) vs. placebo		-0.12 (-0.16, -0.09)
	P-value vs. placebo		<0.001
Week 64	LS Mean Change (SE), N	0.01 (0.011), 85	-0.13 (0.011), 84
	LS Mean Diff (95% CI) vs. placebo		-0.14 (-0.17, -0.11)
	P-value vs. placebo		<0.001
Week 76	LS Mean Change (SE), N	0.03 (0.014), 86	-0.11 (0.014), 86
	LS Mean Diff (95% CI) vs. placebo		-0.14 (-0.18, -0.10)
	P-value vs. placebo		<0.001
<b>GFAP (pg/mL) log10 transformed</b>			
Week 12	LS Mean Change (SE), N	0.03 (0.011), 87	-0.01 (0.011), 93
	LS Mean Diff (95% CI) vs. placebo		-0.04 (-0.07, -0.01)
	P-value vs. placebo		0.01
Week 24	LS Mean Change (SE), N	0.03 (0.012), 91	-0.04 (0.013), 84
	LS Mean Diff (95% CI) vs. placebo		-0.07 (-0.10, -0.03)
	P-value vs. placebo		<0.001
Week 36	LS Mean Change (SE), N	0.02 (0.012), 85	-0.07 (0.013), 79
	LS Mean Diff (95% CI) vs. placebo		-0.09 (-0.12, -0.06)
	P-value vs. placebo		<0.001
Week 52	LS Mean Change (SE), N	0.05 (0.013), 71	-0.06 (0.013), 70
	LS Mean Diff (95% CI) vs. placebo		-0.11 (-0.15, -0.08)
	P-value (vs. placebo)		<0.001
Week 64	LS Mean Change (SE), N	0.03 (0.015), 69	-0.06 (0.016), 63
	LS Mean Diff (95% CI) vs. placebo		-0.09 (-0.14, -0.05)
	P-value (vs. placebo)		<0.001
Week 76	LS Mean Change (SE), N	0.06 (0.016), 67	-0.06 (0.016), 69
	LS Mean Diff (95% CI) vs. placebo		-0.12 (-0.16, -0.07)

		Placebo	Donanemab
	P-value (vs. placebo)		<0.001
<b>NfL (pg/mL) log10 transformed</b>			
Week 12	LS Mean Change (SE), N	0.03 (0.012), 87	0.03 (0.012), 93
	LS Mean Diff (95% CI) vs. placebo		0.00 (-0.03, 0.04)
	P-value (vs. placebo)		0.89
Week 24	LS Mean Change (SE), N	0.02 (0.011), 91	0.04 (0.012), 84
	LS Mean Diff (95% CI) vs. placebo		0.02 (-0.01, 0.05)
	P-value (vs. placebo)		0.23
Week 36	LS Mean Change (SE), N	0.02 (0.012), 85	0.02 (0.013), 79
	LS Mean Diff (95% CI) vs. placebo		0.00 (-0.03, 0.04)
	P-value (vs. placebo)		0.97
Week 52	LS Mean Change (SE), N	0.04 (0.015), 71	0.04 (0.015), 70
	LS Mean Diff (95% CI) vs. placebo		-0.00 (-0.05, 0.04)
	P-value (vs. placebo)		0.86
Week 64	LS Mean Change (SE), N	0.05 (0.015), 69	0.03 (0.016), 63
	LS Mean Diff (95% CI) vs. placebo		-0.02 (-0.06, 0.03)
	P-value (vs. placebo)		0.44
Week 76	LS Mean Change (SE), N	0.07 (0.015), 67	0.06 (0.015), 69
	LS Mean Diff (95% CI) vs. placebo		-0.01 (-0.06, 0.03)
	P-value (vs. placebo)		0.49
<b>Aβ 42/40 log10 transformed</b>			
Week 12	LS Mean Change (SE), N	0.00 (0.005), 87	0.00 (0.005), 93
	LS Mean Diff (95% CI) vs. placebo		-0.00 (-0.02, 0.01)
	P-value (vs. placebo)		0.85
Week 24	LS Mean Change (SE), N	0.00 (0.005), 91	0.01 (0.006), 84
	LS Mean Diff (95% CI) vs. placebo		0.01 (-0.01, 0.02)
	P-value (vs. placebo)		0.36
Week 36	LS Mean Change (SE), N	0.01 (0.006), 85	0.02 (0.006), 79
	LS Mean Diff (95% CI) vs. placebo		0.02 (0.00, 0.03)
	P-value (vs. placebo)		0.04
Week 52	LS Mean Change (SE), N	0.01 (0.008), 71	0.02 (0.008), 70
	LS Mean Diff (95% CI) vs. placebo		0.00 (-0.02, 0.03)
	P-value (vs. placebo)		0.68
Week 64	LS Mean Change (SE), N	0.01 (0.007), 69	0.01 (0.008), 63
	LS Mean Diff (95% CI) vs. placebo		0.00 (-0.02, 0.02)
	P-value (vs. placebo)		0.88
Week 76	LS Mean Change (SE), N	0.01 (0.007), 67	0.02 (0.007), 69
	LS Mean Diff (95% CI) vs. placebo		0.01 (-0.01, 0.03)
	P-value (vs. placebo)		0.26

CI = confidence interval, Diff = difference, GFAP = glial fibrillary acidic protein, LS = least square, N = number of participants, NfL = neurofilament light chain, SE = standard error



**eTable 3. Plasma biomarker change from baseline after discontinuing donanemab treatment**

		Placebo	Donanemab Stopped after 24 weeks	Donanemab Continued after 24 weeks
<b>P-tau217 (U/mL) log10 transformed</b>				
Week 12	LS Mean Change (SE), N	-0.0020 (0.0104), 107	-0.0550 (0.0210), 27	-0.0397 (0.0118), 84
	LS Mean Diff (95% CI) vs. placebo		-0.0530 (-0.0992, -0.0067)	-0.0377 (-0.0688, -0.0065)
	P-value vs. placebo		0.02	0.02
	LS Mean Diff (95% CI) vs. stopped			-0.0153 (-0.0630, 0.0324)
	P-value vs. stopped			0.53
Week 24	LS Mean Change (SE), N	0.0128 (0.0114), 108	-0.0888 (0.0233), 26	-0.0811 (0.0131), 81
	LS Mean Diff (95% CI) vs. placebo		-0.1016 (-0.1526, -0.0505)	-0.0939 (-0.1282, -0.0596)
	P-value vs. placebo		<0.001	<0.001
	LS Mean Diff (95% CI) vs. stopped			-0.0076 (-0.0605, 0.0452)
	P-value vs. stopped			0.78
Week 36	LS Mean Change (SE), N	-0.0093 (0.0142), 103	-0.1308 (0.0289), 25	-0.0772 (0.0168), 74
	LS Mean Diff (95% CI) vs. placebo		-0.1215 (-0.1850, -0.0579)	-0.0679 (-0.1113, -0.0246)
	P-value vs. placebo		<0.001	0.002
	LS Mean Diff (95% CI) vs. stopped			-0.0535 (-0.1196, 0.0125)
	P-value vs. stopped			0.11
Week 52	LS Mean Change (SE), N	0.0161 (0.0133), 89	-0.0920 (0.0269), 22	-0.1134 (0.0153), 67
	LS Mean Diff (95% CI) vs. placebo		-0.1081 (-0.1671, -0.0490)	-0.1295 (-0.1695, -0.0895)
	P-value vs. placebo		<0.001	<0.001
	LS Mean Diff (95% CI) vs. stopped			0.0214 (-0.0397, 0.0825)
	P-value vs. stopped			0.49
Week 64	LS Mean Change (SE), N	0.0122 (0.0127), 85	-0.1353 (0.0262), 20	-0.1311 (0.0147), 63
	LS Mean Diff (95% CI) vs. placebo		-0.1475 (-0.2048, -0.0902)	-0.1433 (-0.1817, -0.1049)
	P-value vs. placebo		<0.001	<0.001
	LS Mean Diff (95% CI) vs. stopped			-0.0042 (-0.0635, 0.0551)
	P-value vs. stopped			0.89
Week 76	LS Mean Change (SE), N	0.0234 (0.0138), 86	-0.1196 (0.0275), 22	-0.1087 (0.0161), 63
	LS Mean Diff (95% CI) vs. placebo		-0.1430 (-0.2035, -0.0825)	-0.1321 (-0.1739, -0.0902)
	P-value vs. placebo		<0.001	<0.001
	LS Mean Diff (95% CI) vs. stopped			-0.0109 (-0.0738, 0.0519)
	P-value vs. stopped			0.73
<b>GFAP (pg/mL) log10 transformed</b>				
Week 12	LS Mean Change (SE), N	0.0231 (0.0114), 82	-0.0025 (0.0250), 18	-0.0124 (0.0126), 68
	LS Mean Diff (95% CI) vs. placebo		-0.0256 (-0.0798, 0.0286)	-0.0355 (-0.0691, -0.0020)
	P-value vs. placebo		0.35	0.04
	LS Mean Diff (95% CI) vs. stopped			0.0099 (-0.0456, 0.0654)

		Placebo	Donanemab Stopped after 24 weeks	Donanemab Continued after 24 weeks
	P-value vs. stopped			0.72
Week 24	LS Mean Change (SE), N	0.0328 (0.0127), 89	-0.0257 (0.0309), 15	-0.0360 (0.0147), 66
	LS Mean Diff (95% CI) vs. placebo		-0.0585 (-0.1243, 0.0073)	-0.0688 (-0.1071, -0.0305)
	P-value vs. placebo		0.08	<0.001
	LS Mean Diff (95% CI) vs. stopped			0.0103 (-0.0572, 0.0778)
	P-value vs. stopped			0.76
Week 36	LS Mean Change (SE), N	0.0190 (0.0126), 85	-0.0574 (0.0282), 17	-0.0721 (0.0146), 61
	LS Mean Diff (95% CI) vs. placebo		-0.0763 (-0.1371, -0.0155)	-0.0910 (-0.1290, -0.0531)
	P-value vs. placebo		0.01	<0.001
	LS Mean Diff (95% CI) vs. stopped			0.0147 (-0.0479, 0.0773)
	P-value vs. stopped			0.64
Week 52	LS Mean Change (SE), N	0.0534 (0.0130), 71	-0.1013 (0.0298), 13	-0.0499 (0.0147), 56
	LS Mean Diff (95% CI) vs. placebo		-0.1548 (-0.2188, -0.0907)	-0.1033 (-0.1420, -0.0647)
	P-value vs. placebo		<0.001	<0.001
	LS Mean Diff (95% CI) vs. stopped			-0.0514 (-0.1170, 0.0141)
	P-value vs. stopped			0.12
Week 64	LS Mean Change (SE), N	0.0274 (0.0155), 69	-0.0596 (0.0366), 12	-0.0628 (0.0182), 50
	LS Mean Diff (95% CI) vs. placebo		-0.0870 (-0.1653, -0.0088)	-0.0902 (-0.1372, -0.0432)
	P-value vs. placebo		0.03	<0.001
	LS Mean Diff (95% CI) vs. stopped			0.0032 (-0.0774, 0.0837)
	P-value vs. stopped			0.94
Week 76	LS Mean Change (SE), N	0.0618 (0.0163), 67	-0.0343 (0.0358), 13	-0.0593 (0.0181), 55
	LS Mean Diff (95% CI) vs. placebo		-0.0961 (-0.1737, -0.0185)	-0.1211 (-0.1692, -0.0730)
	P-value vs. placebo		0.02	<0.001
	LS Mean Diff (95% CI) vs. stopped			0.0250 (-0.0542, 0.1042)
	P-value vs. stopped			0.53
<b>P-tau217 (U/mL) log10 transformed no ARIA-E</b>				
Week 12	LS Mean Change (SE), N	-0.0040 (0.0109), 106	-0.0533 (0.0241), 22	-0.0434 (0.0146), 59
	LS Mean Diff (95% CI) vs. placebo		-0.0493 (-0.1014, 0.0028)	-0.0394 (-0.0754, -0.0035)
	P-value vs. placebo		0.06	0.03
	LS Mean Diff (95% CI) vs. stopped			-0.0099 (-0.0656, 0.0458)
	P-value vs. stopped			0.73
Week 24	LS Mean Change (SE), N	0.0120 (0.0119), 107	-0.0947 (0.0268), 21	-0.0938 (0.0163), 57
	LS Mean Diff (95% CI) vs. placebo		-0.1066 (-0.1645, -0.0488)	-0.1057 (-0.1455, -0.0659)
	P-value vs. placebo		<0.001	<0.001
	LS Mean Diff (95% CI) vs. stopped			-0.0009 (-0.0629, 0.0611)
	P-value vs. stopped			0.98
	LS Mean Change (SE), N	-0.0102 (0.0147), 102	-0.1380 (0.0331, 20)	-0.0687 (0.0203), 54

		Placebo	Donanemab Stopped after 24 weeks	Donanemab Continued after 24 weeks
Week 36	LS Mean Diff (95% CI) vs. placebo		-0.1278 (-0.1991, -0.0565)	-0.0585 (-0.1079, -0.0091)
	P-value vs. placebo		<0.001	0.02
	LS Mean Diff (95% CI) vs. stopped			-0.0693 (-0.1459, 0.0073)
	P-value vs. stopped			0.08
Week 52	LS Mean Change (SE), N	0.0150 (0.0138), 89	-0.0835 (0.0302), 19	-0.1143 (0.0185), 50
	LS Mean Diff (95% CI) vs. placebo		-0.0986 (-0.1641, -0.0330)	-0.1294 (-0.1749, -0.0838)
	P-value vs. placebo		0.003	<0.001
	LS Mean Diff (95% CI) vs. stopped			0.0308 (-0.0392, 0.1008)
	P-value vs. stopped			0.39
Week 64	LS Mean Change (SE), N	0.0116 (0.0132), 85	-0.1373 (0.0306), 15	-0.1311 (0.0178), 46
	LS Mean Diff (95% CI) vs. placebo		-0.1488 (-0.2146, -0.0831)	-0.1426 (-0.1864, -0.0989)
	P-value vs. placebo		<0.001	<0.001
	LS Mean Diff (95% CI) vs. stopped			-0.0062 (-0.0762, 0.0638)
	P-value vs. stopped			0.86
Week 76	LS Mean Change (SE), N	0.0230 (0.0127), 86	-0.1176 (0.0289), 17	-0.1386 (0.0174), 45
	LS Mean Diff (95% CI) vs. placebo		-0.1406 (-0.2028, -0.0784)	-0.1616 (-0.2042, -0.1190)
	P-value vs. placebo		<0.001	<0.001
	LS Mean Diff (95% CI) vs. stopped			0.0210 (-0.0457, 0.0877)
	P-value vs. stopped			0.54
<b>GFAP (pg/mL) log10 transformed no ARIA-E</b>				
Week 12	LS Mean Change (SE), N	0.0244 (0.0114), 82	0.0019 (0.0284), 14	-0.0051 (0.0149), 50
	LS Mean Diff (95% CI) vs. placebo		-0.0226 (-0.0830, 0.0379)	-0.0296 (-0.0666, 0.0075)
	P-value vs. placebo		0.46	0.12
	LS Mean Diff (95% CI) vs. stopped			0.0070 (-0.0564, 0.0704)
	P-value vs. stopped			0.83
Week 24	LS Mean Change (SE), N	0.0337 (0.0128), 88	-0.0143 (0.0344), 12	-0.0360 (0.0174), 47
	LS Mean Diff (95% CI) vs. placebo		-0.0480 (-0.1204, 0.0244)	-0.0698 (-0.1124, -0.0272)
	P-value vs. placebo		0.19	0.002
	LS Mean Diff (95% CI) vs. stopped			0.0217 (-0.0544, 0.0979)
	P-value vs. stopped			0.57
Week 36	LS Mean Change (SE), N	0.0231 (0.0125), 84	-0.0548 (0.0310), 14	-0.0841 (0.0170), 45
	LS Mean Diff (95% CI) vs. placebo		-0.0780 (-0.1440, -0.0120)	-0.1072 (-0.1489, -0.0656)
	P-value vs. placebo		0.02	<0.001
	LS Mean Diff (95% CI) vs. stopped			0.0292 (-0.0406, 0.0990)
	P-value vs. stopped			0.41
Week 52	LS Mean Change (SE), N	0.0551 (0.0132), 71	-0.0862 (0.0333), 11	-0.0516 (0.0171), 44
	LS Mean Diff (95% CI) vs. placebo		-0.1412 (-0.2119, -0.0706)	-0.1067 (-0.1493, -0.0640)
	P-value vs. placebo		<0.001	<0.001

		Placebo	Donanemab Stopped after 24 weeks	Donanemab Continued after 24 weeks
	LS Mean Diff (95% CI) vs. stopped			-0.0346 (-0.1085, 0.0394)
	P-value vs. stopped			0.36
Week 64	LS Mean Change (SE), N	0.0302 (0.0160), 69	-0.0375 (0.0422), 10	-0.0555 (0.0216), 38
	LS Mean Diff (95% CI) vs. placebo		-0.0677 (-0.1566, 0.0212)	-0.0857 (-0.1387, -0.0327)
	P-value vs. placebo		0.14	0.002
	LS Mean Diff (95% CI) vs. stopped			0.0180 (-0.0754, 0.1115)
	P-value vs. stopped			0.70
Week 76	LS Mean Change (SE), N	0.0635 (0.0169), 67	-0.0316 (0.0430), 9	-0.0657 (0.0219), 41
	LS Mean Diff (95% CI) vs. placebo		-0.0951 (-0.1862, -0.0040)	-0.1292 (-0.1838, -0.0745)
	P-value vs. placebo		0.04	<0.001
	LS Mean Diff (95% CI) vs. stopped			0.0341 (-0.0611, 0.1292)
	P-value vs. stopped			0.48

CI = confidence interval, Diff = difference, GFAP = glial fibrillary acidic protein, LS = least square, N = number of participants, NfL = neurofilament light chain, SE = standard error

**eTable 4. Correlations of plasma biomarkers with vMRI**

	Baseline	76-Week Change
<b>P-tau217: (R (95% CI), p)</b>	N=239	N=152
Whole brain volume	-0.0777 (-0.2034, 0.0505), 0.23	0.1359 (-0.0255, 0.2903), 0.10
Ventricular volume	-0.0199 (-0.1473, 0.1080), 0.76	-0.1006 (-0.2573, 0.0612), 0.22
Hippocampal volume	-0.0544 (-0.1809, 0.0738), 0.41	0.0875 (-0.0744, 0.2448), 0.29
<b>GFAP: (R (95%CI), p)</b>	N=204	N=118
Whole brain volume	0.0951 (-0.0439, 0.2304), 0.18	0.0615 (-0.1230, 0.2419), 0.51
Ventricular volume	0.0457 (-0.0932, 0.1830), 0.52	0.0532 (-0.1312, 0.2340), 0.57
Hippocampal volume	0.1209 (-0.0178, 0.2551), 0.09	0.0183 (-0.1653, 0.2008), 0.85
<b>NfL: (R (95% CI), p)</b>	N=237	N=157
Whole brain volume	0.0121 (-0.1163, 0.1401), 0.85	-0.1710 (-0.3205, -0.0132), 0.03
Ventricular volume	0.0828 (-0.0459, 0.2089), 0.21	0.1207 (-0.0382, 0.2737), 0.14
Hippocampal volume	-0.0992 (-0.2246, 0.0294), 0.13	-0.1454 (-0.2967, 0.0131), 0.07
<b>A<math>\beta</math> 42/40: (R (95%CI), p)</b>	N=204	N=118
Whole brain volume	-0.0339 (-0.1715, 0.1050), 0.63	-0.1599 (-0.3332, 0.0239), 0.09
Ventricular volume	0.0605 (-0.0785, 0.1973), 0.39	0.0379 (-0.1463, 0.2195), 0.69
Hippocampal volume	0.0312 (-0.1077, 0.1689), 0.66	-0.0032 (-0.1862, 0.1800), 0.97

CI = confidence interval, GFAP = glial fibrillary acidic protein, N = number of participants, NfL = neurofilament light chain, p = p-value, R = Spearman's rank correlation coefficient.



**eTable 5. Correlations of plasma biomarkers with iADRS**

	Baseline	76-Week Change
<b>P-tau217</b> (N, R, (95% CI), p)	241, -0.0838, (-0.2087, 0.0439), 0.20	170, -0.0397, (-0.1904, 0.1129), 0.61
<b>GFAP</b> (N, R, (95% CI), p)	206, -0.0477, (-0.1842, 0.0906), 0.50	135, -0.0759, (-0.2436, 0.0962), 0.39
<b>NfL</b> (N, R, (95% CI), p)	239, -0.1096, (-0.2340, 0.0184), 0.09	177, -0.1823, (-0.3223, -0.0345), 0.02
<b>A<math>\beta</math> 42/40</b> (N, R, (95% CI), p)	206, 0.1032, (-0.0350, 0.2375), 0.14	135, -0.0761, (-0.2438, 0.0960), 0.38

CI = confidence interval, GFAP = glial fibrillary acidic protein, N = number of participants, NfL = neurofilament light chain, p = p-value, R = Spearman's rank correlation coefficient.

**eTable 6. Effect of plasma biomarker change at weeks 24 on iADRS MCID**

	P-tau217	GFAP
	Coefficient estimate (SE), (95% CI), p-value	
<b>Baseline iADRS</b>	-0.0011 (0.0095), (-0.0197, 0.0175), 0.91	0.0013 (0.0099), (-0.0180, 0.0207), 0.89
<b>Baseline biomarker</b>	0.6849 (0.4954), (-0.2861, 1.6559), 0.17	0.0009 (0.0014), (-0.0019, 0.0036), 0.54
<b>Age</b>	0.0309 (0.0210), (-0.0103, 0.0721), 0.14	0.0365 (0.0270), (-0.0163, 0.0893), 0.18
<b>Biomarker change</b>	0.7042 (0.3480), (0.0222, 1.3862), 0.04	-0.0015 (0.0018), (-0.0051, 0.0021), 0.41

MCID: 5-point or more decrease for mild cognitive impairment and 9-point or more decrease for mild AD

P-values are computed using the following GEE model

MCID = baseline iADRS value, baseline parameter value, age, parameter value/dist = binomial link = logit Irci

Abbreviation: AD = Alzheimer's disease, CI = confidence interval, GEE = general estimating equation, GFAP = glial fibrillary acidic protein, iADRS = Integrated Alzheimer's Disease Rating Scale, MCID = minimal clinically important difference, SE = standard error

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**Protocol I5T-MC-AACG(d)**  
**Assessment of Safety, Tolerability, and Efficacy of**  
**LY3002813 in Early Symptomatic Alzheimer's Disease**

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**LY3002813**

Multicenter, randomized, double-blind, placebo-controlled, Phase 2 study comparing up to 1400 mg of LY3002813 with placebo over 76 weeks in approximately 250 patients with early symptomatic AD.

Eli Lilly and Company  
Indianapolis, Indiana USA 46285

Protocol Electronically Signed and Approved by Lilly: 30 August 2017  
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Amendment (b) Electronically Signed and Approved by Lilly: 12 December 2017  
Amendment (c) Electronically Signed and Approved by Lilly: 21 May 2018  
Amendment (d) Electronically Signed and Approved by Lilly  
on approval date provided below.

Please note that strikethroughs used in Appendix 7 do not indicate redacted content but instead describe content removed during a protocol amendment.

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## 1. Synopsis

**Title of Study:**

Protocol I5T-MC-AACG(d). Assessment of Safety, Tolerability, and Efficacy of LY3002813 in Early Symptomatic Alzheimer's Disease.

**Rationale:**

LY3002813 is an antibody directed at the pyroglutamate modification of the third amino acid of amyloid beta (N3pG A $\beta$ ) epitope that is present only in brain amyloid plaques. It is being studied for the treatment of Alzheimer's disease (AD). The mechanism of action of LY3002813 is considered to be the targeting and removal of existing amyloid plaque, which is a key pathological hallmark of AD. The clinical strategy for LY3002813 targets the N3pG A $\beta$  specific to amyloid plaque in the population of early symptomatic AD patients with existing brain amyloid load, as measured using the amyloid plaque biomarker, florbetapir F18 positron emission tomography (PET) imaging. This rationale is based on the amyloid hypothesis of AD, which states that the production and deposition of A $\beta$  is an early and necessary event in the pathogenesis of AD (Selkoe 2000). Clinical support for this hypothesis comes from the demonstration that parenchymal A $\beta$  levels are elevated before the appearance of symptoms of AD, and supported by genetic variants of AD that overproduce brain A $\beta$  and genetic variants that protect against A $\beta$  production (Jonsson et al. 2012; Fleisher et al. 2015). Furthermore, early in the disease, the presence of brain amyloid appears to increase the risk of conversion from mild cognitive impairment (MCI) to AD dementia (Doraiswamy et al. 2012). This suggests that enhanced clearance of A $\beta$  will lead to slowing of AD progression.

Study I5T-MC-AACG (AACG) is a Phase 2, double-blind, placebo-controlled, study to evaluate the safety and efficacy of N3pG antibody (LY3002813) in patients with early symptomatic AD (prodromal AD and mild dementia due to AD). Study AACG will assess whether removal of existing amyloid plaque can slow the progression of disease as assessed by clinical measures and biomarkers of disease pathology and neurodegeneration over up to 72 weeks of treatment.

Multiple biomarkers of disease progress will also be evaluated. The biomarker florbetapir F18 is a PET ligand that binds to fibrillar amyloid plaque. This biomarker can provide a qualitative and quantitative measurement of brain plaque load in patients with prodromal AD or mild AD dementia. The absence of significant florbetapir F18 signal on a visual read indicates that those patients clinically manifesting cognitive impairment have sparse to no amyloid plaques. As such, implementation of florbetapir F18 will provide a screening tool for entry into the clinical trial and provide a confirmation of amyloid pathology. Florbetapir F18 PET also provides quantitative assessment of fibrillar amyloid plaque in the brain and can assess amyloid plaque reductions from the brain by LY3002813.

Alzheimer's disease progression is also associated with cerebral tauopathy, which will be assessed by flortaucipir F18 PET scans, a cortical marker of paired helical filaments. Brain atrophy, as an indicator of neurodegeneration, will be assessed by volumetric resonance imaging (vMRI).

The patient population for the clinical trial is selected to be AD patients with early symptomatic disease defined both clinically (prodromal to mild AD dementia) and by biomarkers (low to medium tau burden, plus amyloid plaque presence). The 2018 NIA-AA draft AD research framework (Alzheimer's Association 2017a) proposes that AD is defined by its underlying pathophysiologic processes which can be documented in vivo by biomarkers (such as tau and amyloid PET) or by post-mortem examination. This framework will enable a more precise approach to therapeutic intervention trials where specific pathways can be targeted at specific points in the disease process and to the appropriate people (Alzheimer's Association 2017b). Clinical-pathological correlations also strongly suggest that baseline imaging that allows staging on the basis of neurofibrillary tangles could substantially improve the power of clinical trials aimed at changing the rate of progression of the disease (Qian et al. 2017). An early AD population defined clinically and pathologically is anticipated to be more homogeneous than populations defined without tau PET, and will be sufficiently early to respond to treatments prior to more advanced irreversible neuronal loss.

**Objective(s)/Endpoints:**

<b>Primary Objective</b>	<b>Primary Endpoint</b>
To test the hypothesis that LY3002813 administered for up to 72 weeks will decrease the cognitive and/or functional decline in patients with early symptomatic AD	Change in cognition and function as measured by the change in integrated Alzheimer's Disease Rating Scale (iADRS) score from baseline to 18 months
<b>Secondary Objectives</b>	<b>Secondary Endpoints</b>
To assess the effect of LY3002813 vs. placebo on clinical progression in patients with early symptomatic AD	Change in cognition from baseline to 18 months as measured by: <ul style="list-style-type: none"> <li>the change in Alzheimer's Disease Assessment Scale—Cognitive subscale (ADAS-Cog<sub>13</sub>) score</li> <li>the change in Clinical Dementia Rating Scale Sum of Boxes (CDR-SB) score</li> <li>the change in Mini-Mental State Examination (MMSE) score</li> <li>the change in Alzheimer's Disease Cooperative Study-instrumental Activities of Daily Living scale (ADCS-iADL) score</li> </ul>
To assess the effect of LY3002813 vs. placebo on brain amyloid deposition	Change in brain amyloid plaque deposition from baseline through 18 months as measured by florbetapir F18 PET scan
To assess the effect of LY3002813 vs. placebo on brain tau deposition	Change in brain tau deposition from baseline to 18 months as measured by flortaucipir F18 PET scan
To assess the effect of LY3002813 vs. placebo on brain volume measures	Change in volumetric MRI measures from baseline to 18 months.
<b>Safety Objective</b>	<b>Safety Endpoints</b>
To evaluate safety and tolerability of LY3002813	<ul style="list-style-type: none"> <li>Standard safety assessments: <ul style="list-style-type: none"> <li>spontaneously reported adverse events (AEs)</li> <li>clinical laboratory tests</li> <li>vital sign and body weight measurements</li> <li>12-lead electrocardiograms (ECGs)</li> <li>physical and neurological examinations</li> </ul> </li> <li>MRI (amyloid-related imaging abnormalities [ARIAs] and emergent radiological findings)</li> <li>Columbia Suicide Severity Rating Scale (C-SSRS)</li> </ul>

**Summary of Study Design:**

Study AACG is a multicenter, randomized, double-blind, placebo-controlled, Phase 2 study of LY3002813 in subjects with early symptomatic AD. The 133-week study includes a screening

period of up to 9 weeks, a treatment period of up to 72 weeks with final evaluations occurring 4 weeks later at Week 76, and a 48-week immunogenicity and safety follow-up period.

**Treatment Arms and Duration:**

Patients will receive the following treatments for up to 72 weeks:

- **LY3002813**: intravenous LY3002813 (700 mg Q4WK for the first 3 doses, then 1400 mg Q4WK) for up to 72 weeks or
- **Placebo**: intravenous placebo Q4WK for up to 72 weeks.

**Approximate Number of Patients:**

Screened – 1497

Randomized – 266

**Statistical Analysis:**

All efficacy analyses will follow the intent-to-treat (ITT) principle unless otherwise specified. An ITT analysis is an analysis of data by the groups to which subjects are assigned by random allocation, even if the subject does not take the assigned treatment, does not receive the correct treatment, or otherwise does not follow the protocol. Unless otherwise noted, all pairwise tests of treatment effects will be conducted at a 2-sided alpha level of 0.05; 2-sided confidence intervals (CIs) will be displayed with a 95% confidence level.

**Efficacy:**

The primary objective of this study is to test the hypothesis that intravenous infusion of LY3002813 will slow the cognitive and/or functional decline of AD as measured by the composite measure iADRS compared with placebo in patients with early symptomatic AD. The change from baseline score on the iADRS at each scheduled postbaseline visit during the treatment period will be analyzed using an MMRM model, which includes the following terms: baseline score, pooled investigator, treatment, visit, treatment-by-visit interaction, baseline-by-visit interaction, concomitant AChEI and/or memantine use at baseline (yes/no), and age at baseline. The primary time point for treatment comparison will be at the end of the double blind treatment period (Week 76). The treatment group contrast in least-squares mean progression and its associated p-value and 95% CI will be calculated for the treatment comparison of LY3002813 vs. placebo. In addition, Bayesian posterior probability of the active treatment arm being superior to placebo by at least a margin of interest (25% slowing of placebo progression) will also be calculated.

Change from baseline at each scheduled postbaseline visit during the treatment period in secondary efficacy outcomes, including ADAS-Cog13, ADCS-iADL<sub>7</sub>, CDR-SB, and MMSE, will be analyzed using the same MMRM model described for the primary analysis.

**Safety:**

Safety will be assessed by summarizing and analyzing AEs, laboratory analytes, vital signs, MRI scans, ECGs, immunogenicity during the double-blind treatment period.

**Pharmacokinetics/Pharmacodynamics:**

Compartmental modeling of LY3002813 PK data using nonlinear mixed effects modeling or other appropriate software may be explored, and population estimates for clearance and central volume of distribution may be reported. Depending on the model selected, other PK parameters may also be reported. Exploratory graphical analyses of the effect of dose level or demographic factors on PK parameters may be conducted. If appropriate, data from other studies of LY3002813 may be used in this analysis.

Pharmacokinetic/pharmacodynamic (PK/PD) relationships between plasma LY3002813 concentration and SUVr, cognitive endpoints, ARIA incidence rate or other markers of PD activity may be explored graphically. The relationship between the presence of antibodies to LY3002813 and PK, PD, safety and/or efficacy may be assessed graphically. If warranted, additional analysis may be explored to evaluate potential interactions for ADA, PD and other endpoints (PET scan, ARIA-E, etc.). Additional modeling may be performed based on the results of the graphical analyses.



## **2. Schedule of Activities**

## Schedule of Activities Protocol - I5T-MC-AACG Visit 1 (Screening Period)

Period: Procedure	
Visit No.:	V1
End of Week Relative to Study Medication Start <sup>a</sup>	Wk -9 through Wk -1
Tolerance Interval for Visit (days) <sup>a,b</sup>	63
<b>PRELIMINARY SCREENING</b>	
<b>Entry and Administrative</b>	
Abbreviated (or full) Informed Consent – participant and study partner <sup>c</sup>	X
Patient number assigned via IWRS	X
Demographics and habits	X
<b>Entry Diagnostics</b>	
MMSE <sup>c,d,s</sup>	X
CBB <sup>c</sup>	X
<b>SCREENING</b>	
Full Informed Consent – participant and study partner <sup>d</sup>	X
Inclusion/exclusion review	X
Physical/neurological examination <sup>e</sup>	X
Previous/concomitant medications	X
Preexisting conditions	X
<b>Entry Diagnostics</b>	
MHIS	X
<b>Safety Assessments</b>	
Vital signs <sup>f</sup>	X
Height and weight <sup>g</sup>	X
ECG in triplicate <sup>h</sup>	X
C-SSRS/SHSF/SHFU <sup>i,j</sup>	X
<b>Laboratory Specimens</b>	
Human chorionic gonadotropin (HCG) (if applicable) <sup>k,l,m</sup>	X <sup>b</sup>
Clinical chemistry, hematology	X <sup>b</sup>
High sensitivity C-reactive protein	X
HBsAg <sup>n</sup>	X
HCV RNA PCR <sup>o</sup>	X
Urinalysis	X
<b>Screening PET Scans and MRI</b>	
Flortaucipir F18 PET scan <sup>l,p</sup>	X
MRI <sup>q</sup>	X
Florbetapir F18 PET scan <sup>b,m,r</sup>	X

**Schedule of Activities, Protocol I5T-MC-AACG, Visit 1 (Screening Period) Abbreviations and Footnotes**

Abbreviations: A $\beta$  = amyloid  $\beta$ ; CBB = CogState Brief Battery; C-SSRS = Columbia Suicide Severity Rating Scale; ECG = electrocardiogram; ED = early discontinuation visit; HBsAg = hepatitis B surface antigen; HCG = human chorionic gonadotropin; HCV = hepatitis C virus; IWRS = interactive web response system; MHIS = Modified Hachinski Ischemia Scale; Examination; MMSE = Mini-Mental State Examination; MRI = magnetic resonance imaging; No. = number; PCR = polymerase chain reaction; PET = positron emission tomography; SHSF = Self-Harm Supplement form; SHFU = Self-Harm Follow-Up; V = visit; Wk = week.

- a The interval between V1 and V2 may be up to 63 days to allow for completion of V1 screening procedures, assessments, and evaluation of results from laboratory tests and ECGs. V1 is not considered complete until all screening procedures have been completed and results reviewed by the investigator to determine patient eligibility. V1 may be conducted over more than 1 day. Subjects in screening at the time screening was paused are allowed to continue screening beyond the 63 days to allow for completion of V1 screening procedures; this will not be a protocol deviation. Additional details are provided in Section 5.1.1. Subjects who had completed screening but were not yet randomized at the time randomization was paused are allowed to be randomized beyond 63 days; this will not be a protocol deviation. Additional details are provided in Section 5.1.1.
- b A florbetapir F18 PET scan is the final screening criterion for establishing patient eligibility, although the MRI may be performed after the florbetapir F18 PET scan. Patients whose screening florbetapir F18 PET scan results are not available within the 63 day screening window will remain eligible within V1 until these results become available if all other eligibility criteria have been met. Note: If a patient's screening florbetapir F18 PET scan result confirming eligibility for the study has not been received by the site by Day 63 of the screening period, then repeat the following laboratory tests: blood hematology, chemistry, and serum pregnancy test (HCG) for women of childbearing potential (WOCBP). Results of the repeated labs are to be reviewed by the investigator or qualified designee for assessment of the patient's continued eligibility. Repeat screening for MMSE, CBB, C-SSRS, ECG, flortaucipir F18 PET, MRI, and laboratory testing for HBsAg and HCV RNA PCR is not required. V1 is not considered complete until all screening procedures have been completed and results reviewed by the investigator or qualified designee to determine patient eligibility.
- c A preliminary screening informed consent may be obtained to conduct initial screening to collect demographics data and administer the MMSE and CBB. Patients who do not meet the MMSE screening criteria are not to have any other screening procedures performed with the exception of the CBB. The CBB should be administered to all patients at the screening visit, regardless of the MMSE score. They may be rescreened for the MMSE 8 weeks after the first screen. Study partners are not required to complete the preliminary screening informed consent.
- d Patients who meet the MMSE screening criteria may proceed to the remaining screening procedures once they have given signed/dated informed consent for the full study and their study partner has given signed/dated informed consent to participate as a study partner.
- e A complete physical and neurological exam is to be performed at this visit. Additional details are provided in Section 9.4.1.
- f Sitting blood pressure and pulse will be measured after 5 minutes in the sitting position only. Temperature will be collected with sitting vital signs.
- g Height and weight will be measured with shoes removed.
- h ECGs should be taken in triplicate at approximately 1-minute intervals. ECGs should be collected at approximately the same time of day, as much as possible, to minimize diurnal variation.
- i The baseline version of the C-SSRS is to be administered at V1. Patients at imminent risk of suicide (positive response to question 4 or 5 on the C-SSRS) will be excluded from participating in the study.

- j The SHSF is completed after each C-SSRS administration to enter the number of discrete events of suicidal behavior identified. If, based on administration of the C-SSRS, it is determined that suicide-related behaviors have occurred, then the SHFU form will be used to collect additional information to allow for a more complete assessment of these behaviors.
- k Females of childbearing potential are to have a serum pregnancy test (HCG) at V1 (if applicable).
- l Females of childbearing potential are to have a urine pregnancy test (HCG) on the day of flortaucipir F18 PET imaging before the flortaucipir F18 dose is administered.
- m Females of childbearing potential are to have a urine pregnancy test (HCG) on the day of florbetapir F18 PET imaging before the florbetapir F18 dose is administered.
- n Patients with a past history of Hepatitis B are to have a serum HBsAg test at screening V1 and are excluded if the HBsAg test is positive.
- o Patients with a past history of Hepatitis C are to have a HCV RNA PCR test at screening V1 and are excluded if the HCV RNA PCR test is positive.
- p A screening flortaucipir F18 PET scan will be performed as part of the study eligibility criteria at all sites to determine patient eligibility for participation in Study AACG (see [Appendix 5](#)). With the exception of an MRI and a florbetapir F18 PET scan, a patient should meet all other V1 eligibility criteria before having a screening flortaucipir F18 PET scan. The flortaucipir F18 PET scan will be submitted to a centralized PET imaging vendor designated by Lilly for an assessment of patient's eligibility. A historical flortaucipir F18 PET scan may be submitted to be considered for eligibility if performed within 6 months of V1.
- q A local screening MRI will be performed at V1 as part of the study eligibility criteria. With the exception of the evidence of amyloid pathology by florbetapir F18 PET scan, a patient should meet all other V1 eligibility criteria before having an MRI scan. The MRI scans will be reviewed by the investigator or qualified designee for immediate patient management. After the MRI scan is read locally, the scan is to be submitted to the centralized MRI vendor designated by Lilly for final determination of MRI eligibility. Results of centrally read MRIs will be used for data analysis and report-writing purposes and patient safety and eligibility will be reported back to sites.
- r A screening florbetapir F18 PET scan will be performed as part of the study eligibility criteria to determine patient eligibility for participation in Study AACG (see [Appendix 6](#)). With the exception of an MRI, a patient should meet all other V1 eligibility criteria before having a screening florbetapir F18 PET scan. The PET scan will be submitted to a centralized PET imaging vendor designated by Lilly for assessment of patient's eligibility. The florbetapir F18 PET screening criteria must be met (scan results consistent with the presence of amyloid pathology) in order for the patient to proceed to V2 and be randomized to treatment assignment.
- s Assessment is to include the audio voice recording of the rater's questions and the patient and caregiver responses to assessment questions.

Schedule of Activities, Protocol I5T-MC-AACG, Visit 2 through Visit 14 (Double-Blind Period)

Period: Procedure	Rand												
Visit No.:	V2 <sup>a,b</sup>	V3	V4	V5	V6	V7	V8	V9	V10	V11	V12	V13	V14
End of Week Relative to Study Medication Start	0	4	8	12	16	20	24	28	32	36	40	44	48
Tolerance Interval for Visit (days)	0	±7	±7	±7	±7	±7	±7	±7	±7	±7	±7	±7	±7
Inclusion/exclusion review	X	X	X	X	X	X	X	X	X	X	X	X	X
Contact IWRS – dispensation of study medication (LY3002813)	X	X	X	X	X	X	X	X	X	X	X	X	X
Physical/neurological examination <sup>e</sup>	X <sup>f</sup>			X <sup>f</sup>			X <sup>f</sup>			X <sup>g</sup>			
Ophthalmological examination <sup>h</sup>	j			X <sup>h</sup>				X <sup>h</sup>					
Dermatological examination <sup>i</sup>	j			X <sup>i</sup>			X <sup>i</sup>						
Previous/concomitant medications	X	X	X	X	X	X	X	X	X	X	X	X	X
Preexisting conditions/adverse events <sup>e</sup>	X	X	X	X	X	X	X	X	X	X	X	X	X
LY3002813 study medication administered <sup>k</sup>	X	X	X	X	X	X	X	X	X	X	X	X	X
<b>Efficacy Measures</b>													
ADAS-Cog <sub>13</sub> <sup>l,ff</sup>	X			X			X			X			
ADCS-ADL <sup>l,ff</sup>	X			X			X			X			
CDR-SB <sup>l,ff</sup>	X			X			X			X			
MMSE <sup>l,ff</sup>				X			X			X			
<b>Safety Assessment</b>													
C-SSRS/SHSF/SHFU <sup>m,n</sup>	<sup>m</sup>	X	X	X	X	X	X	X	X	X	X	X	X

Schedule of Activities, Protocol I5T-MC-AACG, Visit 2 through Visit 14 (Double-Blind Period)

Period: Procedure	Rand												
Visit No.:	V2 <sup>a,b</sup>	V3	V4	V5	V6	V7	V8	V9	V10	V11	V12	V13	V14
End of Week Relative to Study Medication Start	0	4	8	12	16	20	24	28	32	36	40	44	48
Tolerance Interval for Visit (days)	0	±7	±7	±7	±7	±7	±7	±7	±7	±7	±7	±7	±7
<b>Laboratory Specimens<sup>o</sup></b>													
Clinical chemistry, hematology <sup>p</sup>	X	X	X	X			X			X			
High sensitivity C-reactive protein <sup>p</sup>	X	X	X	X			X			X			
Urinalysis <sup>p</sup>	X												
Serum for anti-LY3002813 antibody <sup>p</sup>	X	X	X	X	X		X			X			
Serum LY3002813 <sup>q,r</sup>	X <sup>q</sup>	X <sup>r</sup>	X <sup>r</sup>	X <sup>q</sup>	X <sup>r</sup>		X <sup>q</sup>			X <sup>r</sup>			
Blood for assessment of APOE genotype <sup>p,s</sup>	X												
Whole blood, plasma and serum for biomarker storage <sup>p,t</sup>	X			X			X			X			
Blood for pharmacogenomics <sup>p,t,u</sup>	X												
<b>Other Safety Measures</b>													
Weight	X			X			X			X			
Vital signs and temperature <sup>v,w</sup>	X <sup>w</sup>	X	X	X <sup>w</sup>	X	X	X <sup>w</sup>	X	X	X <sup>w</sup>	X	X	X
ECG in triplicate <sup>x</sup>	X	X	X	X			X			X			
MRI <sup>y</sup>	z	X		X <sup>aa</sup>	X		X			X			
<b>Additional Efficacy Measures</b>													
Flortaucipir F18 PET scan <sup>bb,cc</sup>	z												
Florbetapir F18 PET scan <sup>bb,dd</sup>	z						X <sup>bb,dd</sup>						

Schedule of Activities, Protocol I5T-MC-AACG, Visit 15 through Visit 21 (Double-Blind Period) and Follow-Up

Period: Procedure									
Visit No.:	V15	V16	V17	V18	V19	V20	V21	ED <sup>c</sup>	V801- V804 <sup>d,ee</sup>
End of Week Relative to Study Medication Start	52	56	60	64	68	72	76		88-124
Tolerance Interval for Visit (days)	±7	±7	±7	±7	±7	±7	±7		±14
Inclusion/exclusion review	X	X	X	X	X	X			
Contact IWRS – dispensation of study medications (LY3002813)	X	X	X	X	X	X			
Physical/neurological examination <sup>e</sup>	X <sup>f</sup>			X <sup>g</sup>			X <sup>f</sup>	X <sup>f</sup>	
Ophthalmological examination <sup>h,j</sup>								X <sup>h</sup>	
Dermatological examination <sup>i,j</sup>								X <sup>i</sup>	
Previous/concomitant medications	X	X	X	X	X	X	X	X	X
Preexisting conditions/adverse events <sup>e</sup>	X	X	X	X	X	X	X	X	X
LY3002813 study medication administered <sup>k</sup>	X	X	X	X	X	X			
<b>Efficacy Measures</b>									
ADAS-Cog <sub>13</sub> <sup>l,ff</sup>	X			X			X	X	
ADCS-ADL <sup>l,ff</sup>	X			X			X	X	
CDR-SB <sup>l,ff</sup>	X			X			X	X	
MMSE <sup>l,ff</sup>	X			X			X	X	
<b>Safety Assessment</b>									
C-SSRS/SHSF/SHFU <sup>m,n</sup>	X	X	X	X	X	X	X	X	X

Schedule of Activities, Protocol I5T-MC-AACG, Visit 15 through Visit 21 (Double-Blind Period) and Follow-Up

Period: Procedure									
Visit No.:	V15	V16	V17	V18	V19	V20	V21	ED <sup>c</sup>	V801- V804 <sup>d,ee</sup>
End of Week Relative to Study Medication Start	52	56	60	64	68	72	76		88-124
Tolerance Interval for Visit (days)	±7	±7	±7	±7	±7	±7	±7		±14
<b>Laboratory Specimens<sup>o</sup></b>									
Clinical chemistry, hematology <sup>p</sup>	X			X			X	X	
High sensitivity C-reactive protein <sup>p</sup>	X			X			X	X	
Urinalysis <sup>p</sup>	X			X			X	X	
Serum for anti-LY3002813 antibody <sup>p</sup>	X						X	X	X
Serum LY3002813 <sup>q,r</sup>	X <sup>q</sup>			X <sup>r</sup>		X <sup>q</sup>	X <sup>r</sup>	X <sup>r</sup>	X <sup>r</sup>
Blood for assessment of APOE genotype <sup>p,s</sup>									
Whole blood, plasma and serum for biomarker storage <sup>p,t</sup>	X			X			X	X	
Blood for pharmacogenomics <sup>p,t,u</sup>									
<b>Other Safety Measures</b>									
Weight	X			X			X	X	
Vital signs and temperature <sup>v,w</sup>	X <sup>w</sup>	X	X	X <sup>w</sup>	X	X	X <sup>w</sup>	X <sup>w</sup>	X
ECG in triplicate	X			X			X	X	
MRP <sup>f</sup>	X						X	X	
<b>Additional Efficacy Measures</b>									
Flortaucipir F18 PET Scan <sup>bb,cc</sup>							X <sup>bb,cc</sup>	X <sup>bb,cc</sup>	
Florbetapir F18 PET scan <sup>bb,dd</sup>	X <sup>bb,dd</sup>						X <sup>bb,dd</sup>	X <sup>bb,dd</sup>	



**Schedule of Activities, Protocol I5T-MC-AACG, Visit 2 through Visit 21 (Double-Blind Period) and Follow-Up Abbreviations and Footnotes**

Abbreviations: A $\beta$  = amyloid  $\beta$ ; ADA = anti-drug antibodies; ADAS-Cog<sub>13</sub> = 13-item Alzheimer's Disease

Assessment Scale-Cognitive subscore; ADCS-ADL = Alzheimer's Disease Cooperative Study Activities of Daily Living Inventory; APOE = apolipoprotein subtype E; ARIA-E = amyloid related imaging abnormalities—edema/effusions; CDR-SB = Clinical Dementia Rating-Sum of Boxes; CRF = case report form; C-SSRS = Columbia Suicide Severity Rating Scale; ECG = electrocardiogram; ED = early discontinuation visit; HCG = human chorionic gonadotropin; IWRS = interactive web response system; MMSE = Mini-Mental State Examination; MRI = magnetic resonance imaging; No. = number; PET = positron emission tomography; SHFU = Self-Harm Follow-Up form; SHSF = Self-Harm Supplement form; TE = treatment-emergent; V = visit.

- a Confirm that the patient has met all V1 eligibility criteria before proceeding with V2 procedures.
- b At V2, appointments should be made for all remaining visits and should be scheduled as close as possible to the target date, relative to V2. Procedures for some visits may take more than 1 day.
- c If a patient discontinues before the double-blind period endpoint (V21 at Week 76), complete the Early Discontinuation CRFs. The patient should be encouraged to return to the site beginning 12 weeks after the ED visit for an immunogenicity follow-up visit (V801 through V804).
- d Patients are to return to the site for collection of blood samples and safety assessments for assessment of immunogenicity status at V801 (Week 88). Follow-up for patients experiencing clinically significant events associated with TEADA status is described in Section 9.4.7.2.
- e Any clinically significant changes from baseline on follow-up physical/neurological examinations should be noted on the AE page.
- f A complete physical and neurological exam is to be performed at this visit. Additional details are provided in Section 9.4.1.
- g A brief physical and neurological exam is to be performed at this visit. Additional details are provided in Section 9.4.1.
- h Ophthalmological examinations will be performed only in patients who previously received LY3202626/oral placebo in this study. The final examination for each patient will be the next scheduled ophthalmological examination after the final administration of LY3202626/oral placebo. It will not be considered a protocol deviation if this examination is scheduled sooner than indicated above in order to accommodate patient and/or site preference. Patients who received LY3202626/oral placebo after their V9 ophthalmological examination are to have an unscheduled ophthalmological examination at the next available opportunity. These examinations must be conducted by an ophthalmologist or optometrist (where permitted by law). Additional details are provided in Section 9.4.6.3.
- i Dermatological examinations will be performed only in patients who previously received LY3202626/oral placebo in this study. The final examination for each patient will be the next scheduled dermatological evaluation after the final administration of LY3202626/oral placebo. It will not be considered a protocol deviation if this examination is scheduled sooner than indicated above in order to accommodate patient and/or site preference. Patients who received LY3202626/oral placebo after their V8 dermatological examination are to have an unscheduled dermatological examination at the next available opportunity. These examinations must be conducted by a dermatologist. Additional details are provided in Section 9.4.6.4.
- j For subjects randomized prior to amendment (d), the ophthalmological and dermatological examination performed at screening will serve as the baseline ophthalmological and dermatological examination.
- k Study drug will be administered by intravenous administration at investigative study site. Patients should be observed for approximately 2 hours following each infusion of LY3002813 for the first 6 infusions. After the first six doses, a minimal post-infusion observation time of 60 minutes will be required for all subsequent infusions. However, patients who have had dosing restarted after ARIA-E are required to be monitored for 2 hours following infusion for a minimum of 3 subsequent infusions, and a minimum of 60 minutes post-infusion observation thereafter.

- l When administered, cognitive and functional assessments (ADAS-Cog<sub>13</sub>, ADCS-ADL, CDR, and MMSE) should be performed first, before medical procedures that could be stressful for the patient (e.g., blood draws).
- m The C-SSRS administered at screening will serve as the baseline C-SSRS.
- n The 'since last visit' version of the C-SSRS will be administered at visits after V2 (Week 0) to the patient with the study partner/study informant present, after the cognitive and functional assessments. The SHSF is completed after each C-SSRS administration to enter the number of discrete events of suicidal behavior identified. If, based on administration of the C-SSRS, it is determined that suicide-related behaviors have occurred, then the SHFU form will be used to collect additional information to allow for a more complete assessment of these behaviors.
- o Unscheduled laboratory tests may be performed at the discretion of the investigator.
- p Labs are to be collected prior to administration of the intravenous study medication (LY3002813 or IV placebo). Record the date and times of sample collection on the Lab Requisition Form.
- q **Pre-dose** (before beginning the infusion) samples for intravenous study medication (LY3002813) may be collected from the intravenous site prior to beginning the infusion. **Post-dose** (within 30 minutes of completion of the infusion) samples for intravenous study medication (LY3002813) should be collected from the arm that did not receive the infusion at V2 (Week 0), V5 (Week 12), V8 (Week 24), V15 (Week 52), and V20 (Week 72).
- r A single pre-dose LY3002813 sample should be collected before beginning the infusion at V3 (Week 4), V4 (Week 8), V6 (Week 16), V11 (Week 36), and V18 (Week 64). In addition, a single sample for serum LY3002813 should be collected at V21 (Week 76), or ED, and V801 (visits at which the patient may not receive a study drug infusion). If LY3002813 infusion is permanently discontinued but the patient remains in the study, one PK sample should be collected at the soonest scheduled visit regardless if serum LY3002813 is on the Schedule of Activities at that visit. Subsequent PK sample collection should follow the protocol Schedule of Activities for serum LY3002813 collection unless the scheduled visit exceeds 6 months since discontinuation of infusions. No additional serum collection for LY3002813 is required once the patient exceeds 6 months since discontinuation of LY3002813 infusions. Record the actual date and times of sample collection on the Lab Requisition Form.
- s A blood sample will be collected to determine APOE genotype. The APOE genotype sample may be collected at an alternative visit if it cannot be collected at V2.
- t Blood for biomarker storage, and blood for pharmacogenomic samples are to be collected unless not allowed or unfeasible due to local regulations prohibiting sample transport outside of the country.
- u Pharmacogenomic samples may be collected at an alternative visit if they cannot be collected at V2. It will not be a protocol deviation if a biomarker storage sample cannot be collected for technical reasons (e.g., if the site is unable to collect enough blood via venipuncture).
- v Sitting blood pressure and pulse will be measured after 5 minutes in the sitting position at **all** visits. Temperature will be collected with sitting vital signs.
- w In addition, orthostatic blood pressure and pulse will be measured at V2 (Week 0), V5 (Week 12), V8 (Week 24), V11 (Week 36), V15 (Week 52), V18 (Week 64), V21 (Week 76), or ED, and at unscheduled visits after 5 minutes in the supine position and after 3 minutes standing.
- x Electrocardiograms should be taken in triplicate at approximately 1-minute intervals. ECGs should be collected at approximately the same time of day, as much as possible, to minimize diurnal variation. ECGs are to be performed prior to the administration of intravenous study medication (LY3002813 and IV placebo).
- y If MRI is done on the same day as cognitive and functional assessments, then it should be done after cognitive and functional tests. MRI may be done before other visit procedures, including cognitive and functional tests, but in that case must be done at least 1 day before other visit procedures.
- z The screening flortaucipir F18 PET scan, MRI, and florbetapir F18 PET scan done at V1 serve as the baseline flortaucipir F18 PET scan, MRI, and florbetapir F18 PET scan, respectively.
- aa The V5 MRI is to be performed 2 weeks prior to the V5 (Week 12) LY3002813 infusion to allow for receipt and review of the central vendor MRI report prior to a possible LY3002813 dose change at V5 (Week 12).

- bb Females of childbearing potential are to have a urine pregnancy test (HCG) performed on the day of florbetapir F18 PET and flortaucipir F18 PET imaging before the florbetapir F18 dose or flortaucipir F18 dose is administered to confirm that they are not pregnant.
- cc All patients will have a flortaucipir F18 PET scan done at V21 (Week 76) or ED (if ED occurs more than 36 weeks after randomization) (see [Appendix 5](#)). Before the flortaucipir F18 PET scan, the investigator should review the patient's medical history and concomitant medications to verify there is no risk factor for torsades de pointes and review the most recent ECG. If clinically meaningful abnormalities are noted on the ECG, the advisability of the flortaucipir scan should be considered by the investigator in consultation with the Lilly-designated medical monitor. ***The study investigator and site clinical study team will not have access to the flortaucipir F18 follow-up scans, as the site clinical study team must remain blinded to any potential changes in tau deposition.***
- dd All patients will have double-blind period florbetapir F18 PET scans done at V8 (Week 24), V15 (Week 52), and V21 (Week 76) or ED (if ED occurs more than 8 weeks after a florbetapir F18 PET scan has been performed at a previous visit) (see [Appendix 6](#)). ***The study investigator and site clinical study team will not have access to any florbetapir F18 follow-up scans, as the site clinical study team must remain blinded to any potential changes in amyloid deposition.***
- ee Patients are to return to the site for an immunogenicity and safety follow-up visit (V801) at Week 88 (or 12 weeks after the ED visit) for collection of blood samples for anti-drug antibody (ADA) measurements and assessment of adverse events and concomitant medications. The need for additional study visits after V801 will be determined by results of the ADA sample taken at V801. A patient will stop immunogenicity follow-up visits when they either complete 3 additional quarterly visits (Week 100, Week 112, and Week 124) or complete a visit at which their ADA returns to baseline (2-fold titer from baseline), whichever occurs first. See Section [5.1.3](#) and Section [9.4.7.2](#) for details.
- ff Assessment is to include the audio voice recording of the rater's questions and the patient and caregiver responses to assessment questions.

### 3. Introduction

#### 3.1. Study Rationale

LY3002813 is an antibody directed at the pyroglutamate modification of the third amino acid of amyloid beta (N3pG A $\beta$ ) epitope that is present only in brain amyloid plaques. It is being studied for the treatment of Alzheimer's disease (AD). The mechanism of action of LY3002813 is considered to be the targeting and removal of existing amyloid plaque, which is a key pathological hallmark of AD. The clinical strategy for LY3002813 targets the N3pG A $\beta$  specific to amyloid plaque in the population of early symptomatic AD patients with existing brain amyloid load, as measured using the amyloid plaque biomarker, florbetapir F18 positron emission tomography (PET) imaging. This rationale is based on the amyloid hypothesis of AD, which states that the production and deposition of A $\beta$  is an early and necessary event in the pathogenesis of AD (Selkoe 2000). Clinical support for this hypothesis comes from the demonstration that parenchymal A $\beta$  levels are elevated before the appearance of symptoms of AD, and supported by genetic variants of AD that overproduce brain A $\beta$  and genetic variants that protect against A $\beta$  production (Jonsson et al. 2012; Fleisher et al. 2015). Furthermore, early in the disease, the presence of brain amyloid appears to increase the risk of conversion from mild cognitive impairment (MCI) to AD dementia (Doraiswamy et al. 2012). This suggests that enhanced clearance of A $\beta$  will lead to slowing of AD progression.

Study I5T-MC-AACG (AACG) is a Phase 2, double-blind, placebo-controlled study to evaluate the safety and efficacy of N3pG antibody (LY3002813) in patients with early symptomatic AD (prodromal AD and mild dementia due to AD). Study AACG will assess whether removal of existing amyloid plaque can slow the progression of disease as assessed by clinical measures and biomarkers of disease pathology and neurodegeneration over up to 72 weeks of treatment.

Multiple biomarkers of disease progress will also be evaluated. The biomarker florbetapir F18 is a PET ligand that binds to fibrillar amyloid plaque. This biomarker can provide a qualitative and quantitative measurement of brain plaque load in patients with prodromal AD or mild AD dementia. The absence of significant florbetapir F18 signal on a visual read indicates that those patients clinically manifesting cognitive impairment have sparse to no amyloid plaques. As such, implementation of florbetapir F18 will provide a screening tool for entry into the clinical trial and provide a confirmation of amyloid pathology. Florbetapir F18 PET also provides quantitative assessment of fibrillar amyloid plaque in the brain and can assess amyloid plaque reductions from the brain by LY3002813.

Alzheimer's disease progression is also associated with cerebral tauopathy, which will be assessed by flortaucipir F18 PET scan, a cortical marker of paired helical filaments. Brain atrophy, as an indicator of neurodegeneration, will be assessed by volumetric resonance imaging (vMRI).

The patient population for the clinical trial is selected to be AD patients with early symptomatic disease defined both clinically (prodromal to mild AD dementia) and by biomarkers (low to medium tau burden, plus amyloid plaque presence). The 2018 NIA-AA draft AD research

framework (Alzheimer's Association 2017a) proposes that AD is defined by its underlying pathophysiologic processes which can be documented in vivo by biomarkers (such as tau and amyloid PET) or by post-mortem examination. This framework will enable a more precise approach to therapeutic intervention trials where specific pathways can be targeted at specific points in the disease process and to the appropriate people (Alzheimer's Association 2017b). Clinical-pathological correlations also strongly suggest that baseline imaging that allows staging on the basis of neurofibrillary tangles could substantially improve the power of clinical trials aimed at changing the rate of progression of the disease (Qian et al. 2017). An early AD population defined clinically and pathologically is anticipated to be more homogeneous than populations defined without tau PET, and will be sufficiently early to respond to treatments prior to more advanced irreversible neuronal loss.

### 3.2. Background

Alzheimer's disease is an age-related neurodegenerative disorder characterized by progressive decline in cognitive function and the ability to perform activities of daily living, ultimately resulting in dementia, typically with fatal complications. The amyloid hypothesis of AD postulates that the accumulation of amyloid- $\beta$  peptide ( $A\beta$ ) is an early and necessary event in the pathogenesis of AD. This hypothesis suggests that treatments that slow the accumulation of  $A\beta$  plaque in the brain or increase clearance of  $A\beta$  may be able to slow the progression of the AD clinical syndrome. The other hallmark neuropathological lesion of AD, intraneuronal neurofibrillary tangles consisting of tau proteins, is thought to be another marker for disease progression (Braak and Braak 1996). The relationship between these 2 pathologies is still unclear, although the presence of both is necessary for the diagnosis of definite AD.

Converging evidence from both genetic at-risk and age at-risk cohorts suggests that the pathophysiological process of AD begins well more than a decade before the clinical stage now recognized as AD dementia, and that neurodegeneration is already apparent on magnetic resonance imaging (MRI) by the stage of MCI. Like many disorders, AD occurs on a continuum from asymptomatic (preclinical) to MCI, then to dementia in mild, moderate, and severe stages. Recent clinical trial results in mild-to-moderate AD dementia, as well as evidence from transgenic animal experiments, suggest that treating AD during the earlier stages could have the greatest potential benefit on the disease and its progression, particularly when considering therapies targeted at  $A\beta$  reduction (Doody et al. 2014; Fleisher et al. 2015; Siemers et al. 2016).

#### 3.2.1. LY3002813 Nonclinical Studies

The safety of LY3002813, a plaque-specific monoclonal antibody, was assessed in a 6-week toxicity study in cynomolgus monkeys, including evaluations of safety pharmacology and toxicokinetics. The administration of LY3002813 in monkeys of up to a maximum dose of 100 mg/kg/week (bolus intravenous [IV]) for 6 weeks resulted in no drug-related findings. Repeat-dose hazard identification studies of up to 6 months' duration were conducted in the aged PDAPP (APPV717F) transgenic mouse model of  $A\beta$  deposition to investigate potential effects related to clearance of  $A\beta$  from the brain. In addition, a specialized 3-month study to investigate the potential for cerebral amyloid angiopathy (CAA)-associated microhemorrhage was



conducted in aged PDAPP transgenic mice. These studies in the PDAPP mouse were conducted with mE8c (LSN3026818), a murine analog antibody of LY3002813, to avoid limitations due to potential immunogenicity from repeated administration of the humanized antibody to the mouse. No drug-related findings occurred in the hazard identification studies in PDAPP mice at mE8c doses of up to 100 mg/kg/week (the highest dose tested). Treatment of PDAPP mice with mE8c at 12.5 mg/kg/week for 3 months did not exacerbate CAA-associated microhemorrhage at a dose that produced a maximum pharmacological response (reduction in deposited brain A $\beta$ ) in these animals. See the Investigator's Brochure (IB) for details regarding nonclinical LY3002813 studies.

### **3.2.2. LY3002813 Phase 1 Studies**

The first human dose study of LY3002813 was I5T-MC-AACC (Study AACC). Study AACC was a Phase 1, patient- and investigator-blind, randomized within cohort, placebo-controlled, parallel-group, single-dose followed by multiple-dose, dose-escalation study in patients with MCI due to AD or mild-to-moderate AD to assess the safety, tolerability, pharmacodynamics (PD), and pharmacokinetics (PK) of single and multiple IV doses of LY3002813. The study included Japanese and non-Japanese patients. Patients with AD were enrolled into the single-ascending dose (SAD) phase and were each administered a single IV dose of LY3002813 (5 dosing cohorts from 0.1 mg/kg IV to 10 mg/kg IV) or placebo followed by a 12-week follow-up period for each dose level. After the follow-up period, the same patients proceeded into the multiple-ascending dose (MAD) phase (5 cohorts) and were administered IV doses of LY3002813 (0.3 mg/kg IV to 10 mg/kg IV; subjects in the 0.1 mg/kg SAD cohort received 0.3 mg/kg in the MAD phase) or placebo approximately once per month for up to 4 doses, depending on the initial dose level. This phase concluded with a 12-week follow-up period. The relative exposure assessment of an unblinded single subcutaneous (SC) dose of 3 mg/kg LY3002813 in AD patients was also performed, followed by a 12-week follow-up assessment. The PK of an unblinded single IV dose of 1 mg/kg LY3002813 in young, healthy male subjects was assessed to determine whether the absence of the amyloid target affected the PK as compared with amyloid-positive AD patients.

After single-dose administration from 0.1 mg/kg to 3.0 mg/kg, the mean terminal elimination half-life was approximately 4 days, increasing to approximately 10 days (243 hours) at the 10-mg/kg dose level. The PK of a single dose of 1.0 mg/kg IV LY3002813 in young, healthy subjects was indistinguishable from the PK in AD patients at the same dose level.

In AACC, florbetapir F18 scans were performed at baseline and after the last MAD, separated by approximately 7 months, to assess the PD effects of LY3002813. The change from baseline in grey matter standardized uptake value ratio (SUVr) with cerebellum as a reference region was compared across dose cohorts. There was a highly significant reduction from baseline in cerebral amyloid by PET at the highest dose, 10 mg/kg ( $p < .0002$ ). The analysis showed consistent reduction in cortical amyloid among these patients who received 3 to 5 doses of 10 mg/kg LY3002813. The mean observed reduction in florbetapir F18 PET signal corresponds to a mean 50% reduction in total brain fibrillar amyloid. Meaningful target engagement (amyloid reduction) was likely not achieved at doses smaller than or equal to 3 mg/kg IV every

4 weeks (Q4W) because of the rapid elimination of LY3002813 and the lack of sustained exposure.

I5T-MC-AACD (Study AACD) is an ongoing Phase 1b single- and multiple-dose study to assess the safety, tolerability, PK, and PD of single and multiple IV doses of LY3002813 in patients with mild cognitive impairment due to AD or mild to moderate Alzheimer's dementia. It is evaluating up to 150 patients in 6 different dosing cohorts receiving single, every 2 weeks, or every 4 weeks dosing of either 10 mg/kg, 20 mg/kg or 40 mg/kg of LY3002813. Treatment durations being assessed include single dose, six month dosing every two weeks, or up to 72 weeks of every 4 week dosing. Safety, PK and PD data from this ongoing study are used to inform further development of LY3002813. See Section 3.3 and the IB for detailed safety and PK information regarding LY3002813.

### 3.3. Benefit/Risk Assessment

#### 3.3.1. Benefit

There is a large unmet medical need for disease-modifying treatments for AD. Data from the completed Phase 1a Study AACC and from the ongoing Phase 1b Study AACD indicate a dramatic reduction in cerebral amyloid (as assessed by florbetapir F18 PET imaging) in individuals who received repeated doses of at least 10 mg/kg (IB; Fleisher et al. 2018). Along with assessment of safety and tolerability of LY3002813, this study will assess whether removal of existing amyloid plaque will show evidence of slowed clinical decline and change in biomarkers of disease progression relative to placebo treatment.

Although there are currently no available disease-modifying agents for the treatment of AD, there are several medications approved by the Food and Drug Administration (FDA) and Health Canada for the treatment of symptoms of AD; these include acetylcholinesterase inhibitors (e.g., donepezil, galantamine, and rivastigmine) and the N-methyl D-aspartate receptor antagonist memantine. Because these medications are considered standard of care for the treatment of AD, participants in this trial will be permitted to take these medications during the course of the study, provided that they have been on a stable dose at the time of randomization and remain on a stable dose throughout the study.

#### 3.3.2. Risks

Potential risks (discussed below) for LY3002813 include, but are not limited to, formation of anti-drug antibodies (ADA), hypersensitivity (immediate and non-immediate, including infusion-related reactions), and amyloid-related imaging abnormalities (ARIA).

**Anti-Drug Antibodies:** High incidences of treatment-emergent anti-drug antibodies (TEADAs) have been observed in clinical studies with LY3002813. Although there were no serious adverse events (SAEs) related to the development of ADAs in Study AACC, the incidence of TEADAs in LY3002813-exposed patients and subjects was >90%; in Study AACD, the incidence of TEADAs to date (final protocol) in LY3002813-exposed patients and subjects is approximately 75%. In AACD, on 10 mg/kg Q2WK dosing, one patient was observed with a highly elevated

ADA titer of 1:163840 on Day 144 postbaseline, with no clinical consequences. Anti-drug antibodies levels may affect PD levels of drug effect. Infusion reactions and ADAs are potential risks common to all large molecules. See the IB for details regarding TEADAs.

As a high prevalence of ADAs was observed in Study AACC, a risk management plan for immune safety will be incorporated into the clinical trial including a protocol for management of infusion reactions, and standardized data collection for infusion reaction AEs.

**Hypersensitivity (Immediate and Non-immediate, including infusion-related reactions):** There is a risk of an infusion-related reaction with LY3002813 therapy. In Study AACC, AEs of mild or moderate infusion reactions were reported in 6 of 37 patients with AD who received multiple IV doses of LY3002813 and in 0 of the 6 healthy volunteers. In AACD one patient receiving 10 mg/kg IV every 2 weeks had a mild infusion-related reaction and 2 mild injection site reactions. To mitigate the risk of hypersensitivity (immediate and non-immediate), including infusion-related reactions, specific study exclusion criteria related to allergy are defined in the clinical protocol; guidance regarding use of premedications and slowing or stopping the LY3002813 infusion is provided in Sections 9.4.7.1.1 and 9.4.7.1.2, respectively; and a protocol for management of infusion reactions is included in the trial Manual of Operations.

**Amyloid-Related Imaging Abnormalities:** Some anti-amyloid therapies designed to remove amyloid have been associated with ARIA—edema/effusions and –hemorrhage/hemosiderin deposition (ARIA-E and ARIA-H; also known as vasogenic edema and cerebral microhemorrhage, respectively) (Sperling et al. 2011). These abnormalities are best detected on an MRI using fluid attenuation inversion recovery (FLAIR) sequences for ARIA-E and the T2\* gradient-recalled echo for ARIA-H.

Potential symptoms of ARIA-E include headache, gait instability, dizziness, tremor, worsening cognitive function, alteration of consciousness, seizures, unsteadiness, and vomiting (Ostrowitzki et al. 2012; Sperling et al. 2012). However, ARIA-E can also be unaccompanied by any symptoms.

Microhemorrhages and superficial siderosis (ARIA-H) are often associated with ARIA-E and both are thought to be possibly related to removal of vascular A $\beta$  or amyloid trafficking at the blood–brain barrier (Ketter et al. 2017). Moreover, ARIA-H are believed to indicate a higher risk for macrohemorrhage as well as for the presence of significant cerebral amyloid angiopathy. While ARIA does occur during the natural course of AD, there appears to be an increased risk of microhemorrhage with anti-amyloid antibody treatment in preclinical models and ARIA-H and ARIA-E in humans (e.g., bapineuzumab, gantenerumab, aducanumab [Black et al. 2010]) as well.

In Study AACC, two cases of asymptomatic ARIA-H, but no ARIA-E were detected by MRI. In the ongoing study AACD 42 subjects received up to 13 doses of LY3002813 (~32 subjects) or placebo (~10 subjects) as of 03 August 2017. Of these, one mildly symptomatic and four asymptomatic cases of ARIA-E, and 5 events of ARIA-H in 4 patients (including in 3 patients who also experienced ARIA-E) have been reported. Two cases occurred in subjects dosed with 10 mg/kg Q2WK, 2 occurred in subjects who received a single dose of 20 mg/kg, and one in a



patient who received 10 mg/kg Q4WK. There was no clear relationship to APOE4 carrier status, ADA, PK or PD in these cases. All ARIA-E resolved without clinical consequence after treatment discontinuation, except for one patient with asymptomatic ARIA-E that was ongoing on MRI as of 10 August 2017.

To mitigate the potential risk of ARIA-H and ARIA-E during treatment with LY3002813, a dose titration regimen will be employed utilizing an initial dose that has lower risk of ARIA-E prior to increasing to full study dose. In addition, a dose reduction algorithm will be employed for incident ARIA during the trial (see Section 7.4.1). No cases of ARIA will have dose-reintroduction if permanent dose discontinuation rules (described in Section 8.1) are met.

To further aid in mitigation of potential risks of ARIA-H and ARIA-E during treatment with LY3002813, the current study includes a screening MRI scan that will be used to exclude patients with preexisting ARIA-E, >4 microhemorrhages or more than one area of superficial siderosis. In addition to scheduled MRIs, unscheduled MRIs may be obtained at the discretion of the investigator upon suspicion of ARIA. It is recommended to repeat MRIs approximately every 4 to 6 weeks until resolution of ARIA-E or stabilization of incident ARIA-H is documented.

Further guidance for management of ARIA-E and incident ARIA-H is provided in the Operations Manual and the protocol includes guidance on dose reduction (Section 7.4.1), temporary treatment discontinuation (Section 8.1.1, permanent treatment discontinuation (Section 8.1), and continued safety monitoring and treatment options (Section 9.4.7.4).

### **3.3.3. Benefit/Risk Assessment Summary**

To mitigate the potential risks described in Section 3.3.2, the current study will include standard safety assessments; i.e., reported AEs, clinical laboratory tests, immunogenicity assessments, vital sign and body weight measurements, 12-lead electrocardiograms (ECGs), and physical examinations.

Additional safety assessments will include neurological examinations (as part of each physical examination), MRI examinations, and suicidality evaluations using the Columbia-Suicide Severity Rating Scale (C-SSRS). The current study will use an independent external Data Monitoring Committee (DMC) to monitor data on an ongoing basis to ensure the continuing safety of patients enrolled in this study.

The current study includes placebo as a comparator, and approximately one-half of the patients will be randomized to placebo. In addition, all patients participating in the study will have a designated study partner who will have regular contact with the patient, accompany the patient to study visits, and liaise with the study staff between visits as needed (see Section 6.1 for additional information about the role of the study partner).

In conclusion, the available non-clinical and clinical data support the intravenous administration of LY3002813 to the intended study population according to the proposed clinical investigation plan and also provide a sufficient margin of safety for the proposed design and doses. There are

currently no disease-modifying treatments for AD. The potential benefits of LY3002813 showing disease-modifying properties in AD are considered to outweigh the potential risks.

More information about the known and expected benefits, risks, SAEs and reasonably anticipated AEs of LY3002813 are to be found in the IB.

## 4. Objectives and Endpoints

Table AACG.4.1 shows the objectives and endpoints of the study.

**Table AACG.4.1. Objectives and Endpoints**

<b>Primary Objective</b>	<b>Primary Endpoint</b>
To test the hypothesis that LY3002813 administered for up to 72 weeks will decrease the cognitive and/or functional decline in patients with early symptomatic AD	Change in cognition and function as measured by the change in integrated Alzheimer's Disease Rating Scale (iADRS) score from baseline to 18 months
<b>Secondary Objectives</b> To assess the effect of LY3002813 vs. placebo on clinical progression in patients with early symptomatic AD	<b>Secondary Endpoints</b> Change from baseline to 18 months as measured by: <ul style="list-style-type: none"> <li>the change in Alzheimer's Disease Assessment Scale-Cognitive subscale (ADAS-Cog<sub>13</sub>) score</li> <li>the change in Clinical Dementia Rating Scale Sum of Boxes (CDR-SB) score</li> <li>the change in Mini Mental State Examination (MMSE) score</li> <li>the change in Alzheimer's Disease Cooperative Study-instrumental Activities of Daily Living scale (ADCS-iADL) score</li> </ul>
To assess the effect of LY3002813 vs. placebo on brain amyloid deposition	Change in brain amyloid plaque deposition from baseline through 18 months as measured by florbetapir F18 PET scan
To assess the effect of LY3002813 vs. placebo on brain tau deposition	Change in brain tau deposition from baseline to 18 months as measured by flortaucipir F18 PET scan
To assess the effect of LY3002813 vs. placebo on brain volume measures	Change in volumetric MRI measures from baseline to 18 months.

Safety Objective	Safety Endpoints
To evaluate safety and tolerability of LY3002813	<ul style="list-style-type: none"> <li>• Standard safety assessments:               <ul style="list-style-type: none"> <li>○ spontaneously reported adverse events (AEs)</li> <li>○ clinical laboratory tests</li> <li>○ vital sign and body weight measurements</li> <li>○ 12-lead ECGs</li> <li>○ physical and neurological examinations</li> </ul> </li> <li>• MRI (ARIA and emergent radiological findings)</li> <li>• Columbia Suicide Severity Rating Scale (C-SSRS)</li> </ul>
Exploratory Objectives	Exploratory Endpoints
To assess the effect of LY3002813 vs. placebo on clinical progression in patients with early symptomatic AD	<ul style="list-style-type: none"> <li>• the change in dependence level derived from ADCS-ADL scale scores</li> </ul>
To assess peripheral PK and presence of anti-LY3002813 antibodies over 72 weeks	<ul style="list-style-type: none"> <li>• Plasma Pharmacokinetics of LY3002813</li> <li>• Anti-drug-antibodies (ADA) against LY3002813 including treatment-emergent ADA and neutralizing antibodies.</li> </ul>

## 5. Study Design

### 5.1. Overall Design

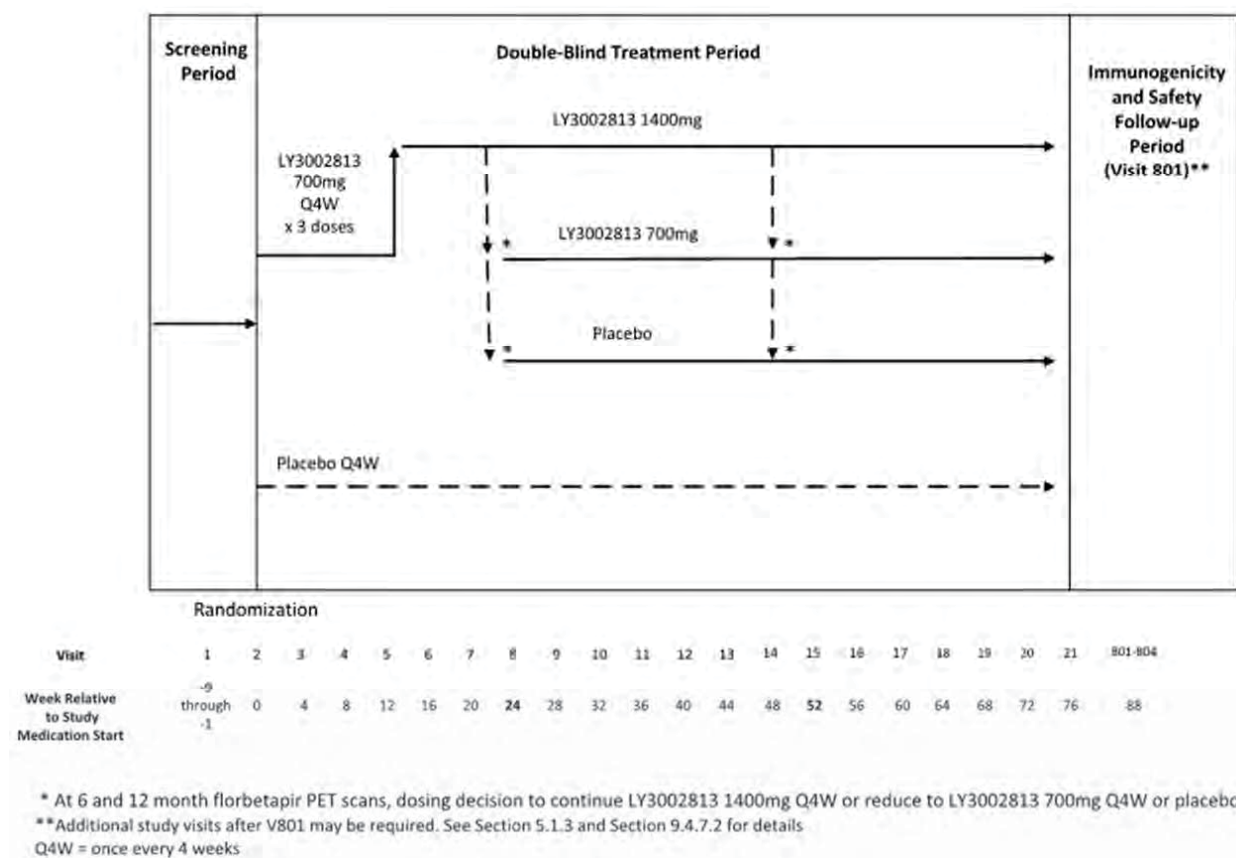
Study AACG is a multicenter, randomized, double-blind, placebo-controlled, Phase 2 study of LY3002813 in subjects with early symptomatic AD. The 133-week study includes a screening period of up to 9 weeks, a treatment period of up to 72 weeks with final evaluations occurring 4 weeks later at Week 76, and a 48-week immunogenicity and safety follow-up period. Subjects who meet entry criteria will be randomized in a 1:1 ratio to one of the following treatments:

- **LY3002813**: IV LY3002813 (700 mg Q4WK for the first 3 doses, then 1400 mg Q4WK) for up to 72 weeks or
- **Placebo**: IV placebo Q4WK for up to 72 weeks.

The primary hypothesis being tested is that LY3002813 administered for up to 72 weeks will result in a significant slowing in cognitive/functional decline compared with placebo as measured by the change from baseline to the end of the double blind treatment period (Week 76) on the integrated Alzheimer's Disease Rating Scale (iADRS), in subjects with early symptomatic AD (where early symptomatic AD refers to the combination of 2 stages: prodromal AD [MCI-AD] and mild AD dementia; Alaka et al. 2015).

Under previous versions of this protocol, LY3002813 was administered in combination with LY3202626, an inhibitor of  $\beta$ -site amyloid precursor protein cleaving enzyme (BACE)1. However, as of this amendment (d), the combination therapy and the oral placebo have been discontinued from the study.

Abbreviations and definitions are provided in [Appendix 1](#); clinical laboratory tests are described in [Appendix 2](#); Study governance considerations are described in detail in [Appendix 3](#); and Hepatic monitoring tests for treatment-emergent abnormality is provided in [Appendix 4](#).



**Figure AACG.5.1. Illustration of study design for Clinical Protocol 15T-MC-AACG.**

LY3002813

### 5.1.1. Screening Period (Visit 1)

At or before Visit 1, the study will be explained to the patient (and his or her legal representative, if applicable) and study partner. Informed consent must be obtained before any study procedures are conducted. The screening period spans the time between Visit 1 to Visit 2. Study assessments are shown in the Schedule of Activities (Section 2).

A preliminary screening informed consent may be obtained to conduct initial screening to collect demographics data and administer the Mini-Mental State Examination (MMSE) and CogState Brief Battery (CBB). Patients who do not meet the MMSE screening criteria are not to have any other screening procedures performed with the exception of the CBB. The CBB should be administered to all patients at the screening visit, regardless of the MMSE score. They may be rescreened for the MMSE 8 weeks or more after the first screen (see Section 6.4). Patients who screen failed on the CBB in the previous version of this protocol may be reconsented and immediately rescreened using the MMSE (see Section 6.4).

Patients who meet the MMSE screening criteria may proceed to the remaining screening procedures once they have given signed/dated informed consent for the full study.

Once the MMSE criteria are met, 63 days are allowed for completion of Visit 1 screening assessments, procedures, and evaluation of results from laboratory tests, ECGs, physical and neurological examination, flortaucipir F18 PET, MRI, and florbetapir F18 PET. Even though florbetapir F18 PET imaging may be the last screening procedure of the study, it is expected that the centrally read florbetapir F18 PET results will be available within the timeframe of 63 days. However, it will not be a protocol deviation should the screening florbetapir F18 PET results not be available until after 63 days.

Patients whose screening florbetapir F18 PET results are not available until after 63 days will remain eligible within Visit 1 until these results become available. **Note:** If a patient's screening florbetapir F18 PET results confirming evidence of amyloid burden are received by the site after 63 days, laboratory tests (blood hematology, chemistry, and serum human chorionic gonadotropin [HCG] for females of childbearing potential) are to be repeated for that patient. Results of the repeated labs are to be reviewed by the investigator or qualified designee for assessment of the patient's continued eligibility. Repeat screening for MMSE, CBB, C-SSRS, ECG, flortaucipir F18 PET imaging, and MRI, and laboratory testing for hepatitis B surface antigen (HBsAg) and hepatitis C virus (HCV) RNA polymerase chain reaction (PCR), is not required.

Patients in active screening prior to implementation of amendment (d) remain eligible within Visit 1 until all screening procedures are completed and results are available. This will not be a protocol deviation. Patients who complete Visit 1 beyond 63 days are to repeat laboratory tests (blood hematology, chemistry, and serum HCG for females of childbearing potential) prior to being randomized. The results of these laboratory tests are to be reviewed by the investigator or qualified designee for assessment of the patient's continued eligibility. Repeat screening for MMSE, CBB, C-SSRS, ECG, flortaucipir F18 PET imaging, MRI, and laboratory testing for HBsAg and HCV RNA PCR is not required.

Visit 1 is not considered complete until all screening procedures have been completed, results have been reviewed by the investigator or qualified designee, and the investigator or qualified designee has confirmed that the patient is eligible to be randomized. Only then can the patient proceed to Visit 2.

Current or planned use of concomitant medications, the effects of vacations or absences on protocol compliance, and general compliance with the protocol will be discussed at Visit 1. Patients must meet eligibility criteria (Section 6.1 and Section 6.2) to continue to Visit 2. Patients who do not meet all inclusion criteria or who meet any exclusion criteria may be discontinued from the study.

#### **5.1.1.1. Screening Procedures**

Screening entry and administrative procedures, cognitive assessments, safety assessments, and laboratory assessments (see Schedule of Activities in Section 2) are to be done at Visit 1 before the screening flortaucipir F18 PET scan, MRI, and florbetapir F18 PET scan procedures.

##### **5.1.1.1.1. Modified Hachinski Ischemic Scale (MHIS)**

The Modified Hachinski Ischemic Scale (MHIS) will be completed at Visit 1 to exclude patients likely to have dementia of vascular etiology. The MHIS (Hachinski et al. 1975) is an 8-item scale that examines clinical features that may be consistent with vascular dementia and is commonly used as a screening tool to exclude patients with multi-infarct dementia from entrance into clinical trials assessing neuropsychopharmacologic therapy in patients with AD. The scale is completed by the physician based on clinical information obtained from diagnostic information and physical examination. The scale takes about 10 to 15 minutes to complete, depending on the availability of the data needed. Scores for the 8 items are added together for a total score. Patients who score  $\geq 4$  are more likely to have a dementia of vascular etiology and are excluded from participating in the trial.

##### **5.1.1.1.2. Mini-Mental State Examination (MMSE)**

The MMSE will be administered to patients at Visit 1 to determine if the patient meets entry criteria for cognitive impairment. The MMSE is a brief instrument used to assess cognitive function in patients (Folstein et al. 1975). The MMSE should be administered by the same rater from visit to visit to reduce potential variability. The instrument is divided into 2 sections. The first section measures orientation, memory, and attention. The maximum score for the first section is 21. The second section tests the ability of the patient to name objects, follow verbal and written commands, write a sentence, and copy figures. The maximum score for the second section is 9. The range for the total MMSE score is 0 to 30, with lower scores indicating great level of impairment.

##### **5.1.1.1.3. CogState Brief Battery**

The CBB is a brief (15-18 minute), computer-based cognitive test battery designed to measure psychomotor function, attention, working memory, and memory (Maruff et al. 2009, 2013; Fredrickson et al. 2010; Darby et al. 2012). The CBB has been shown to be sensitive to AD-related cognitive decline in healthy older adults and in adults with amnesic MCI (Darby et



al. 2002, 2012; Lim et al. 2013a, b) as well as to improvement in cognition arising from treatment with cognitive-enhancing drugs (Davison et al. 2011; Jaeger et al. 2011; Nathan et al. 2013). The CBB will be administered at Visit 1 to better understand the utility of this test in assessment of cognitive impairment, but patient eligibility will not depend on the CBB results to determine if the patient meets the cognitive criteria for the study. The CBB will be administered to patients at Visit 1 after administration of the MMSE regardless of whether the patient meets MMSE entry criteria. Prior to performing the screening CBB, patients must perform a practice CBB to familiarize themselves with the instrument.

#### **5.1.1.1.4. *Columbia Suicide Severity Rating Scale – Adult Version***

The C-SSRS will be administered to patients at Visit 1 to assess psychological health. The C-SSRS is a scale that captures the occurrence, severity, and frequency of suicide-related thoughts and behaviors during the corresponding assessment period. The C-SSRS, included here as a screening assessment, is described in detail in Section 9.4.6.1. The C-SSRS “Baseline” version will be used at screening, and the findings will constitute the baseline assessment. Patients at imminent risk of suicide (positive response to question 4 or 5 on the C-SSRS) will be excluded from participating in the study.

The C-SSRS will be administered to the subject after the cognitive assessments. Responses from subject will be considered when administering the scale. The Self-Harm Supplement form (SHSF) will be completed after each C-SSRS administration to enter the number of discrete events of suicidal behavior identified. If, based on administration of the C-SSRS, it is determined that suicide-related behaviors have occurred, then the Lilly Self-Harm Follow-Up form will be used to collect additional information to allow for a more complete assessment of these behaviors.

#### **5.1.1.1.5. *Screening Positron Emission Tomography and Magnetic Resonance Imaging***

All other screening criteria should be met in order for the patient to proceed with flortaucipir F18 PET scan, followed by MRI, and a florbetapir F18 PET scan procedure.

##### **5.1.1.1.5.1. *Screening Flortaucipir F18 PET Scan***

A screening flortaucipir F18 PET scan will be performed as part of the study eligibility criteria (see [Appendix 5](#)). The flortaucipir F18 PET scan will be submitted to a centralized PET imaging vendor designated by Lilly for assessment of patient’s eligibility.

A historical flortaucipir F18 PET scan may be submitted to be considered for eligibility if the PET scan was performed within 6 months of Visit 1. If a historical flortaucipir PET scan is deemed acceptable for meeting entry criteria, then the MMSE, which is still to be administered at Visit 1, will serve as the baseline MMSE for statistical analyses, but will **not** be used for meeting entry criteria.

The flortaucipir F18 PET screening criteria should be met (scan results consistent with sponsor-derived eligibility limits for flortaucipir F18 PET) before the patient can undergo the MRI and florbetapir F18 PET scan.

Specific instructions for the flortaucipir F18 PET scan itself will be provided in the PET Imaging Manual.

#### **5.1.1.1.5.2. Screening MRI**

A local screening MRI will be performed at Visit 1 as part of the study eligibility criteria. With the exception of the evidence of amyloid pathology by florbetapir F18 PET scan, a patient should meet all other Visit 1 eligibility criteria before having an MRI. The MRI scans will be reviewed by the investigator or qualified designee for immediate patient management. After the MRI scan is read locally, the scan is to be submitted to the centralized MRI vendor designated by Lilly for final determination of MRI eligibility. Results of centrally read MRIs will be used for data analysis and report-writing purposes and patient safety and eligibility will be reported back to sites.

#### **5.1.1.1.5.3. Screening Florbetapir F18 PET Scan**

A screening florbetapir F18 PET scan will be performed as part of the study eligibility criteria (see [Appendix 6](#)). With the exception of the MRI, a patient should meet all other Visit 1 eligibility criteria before having a screening florbetapir F18 PET scan. The florbetapir F18 PET scan will be submitted to a centralized PET imaging vendor designated by Lilly for assessment of patient's eligibility.

The florbetapir F18 PET screening criteria must be met (scan results consistent with sponsor-derived eligibility limits for amyloid plaque pathology) in order for the patient to proceed to Visit 2 and be randomized to treatment assignment.

Specific instructions for the florbetapir F18 PET scan itself will be provided in the PET Imaging Manual.

### **5.1.2. Double-Blind Period (Visit 2 through Visit 21)**

The treatment period is a double-blind treatment phase beginning at Visit 2. At Visit 2, appointments should be made for all remaining visits and should be scheduled as close as possible to the target date, relative to Visit 2. Patients who meet entry criteria will be enrolled and randomized to receive up to 72 weeks of treatment with LY3002813 or placebo.

Every 4 weeks during this treatment period, all patients will be administered IV study medication (placebo or LY3002813) onsite as an IV infusion of approximately 140 mL over a minimum of 30 minutes, and assessments will be made.

Final endpoint measures and safety assessments for the double-blind period will be performed at Visit 21 (Week 76) 4 weeks following the patient's last dose of study medication. See the Schedule of Activities (Section 2) for the timing of events and the measures to be assessed. Procedures for some visits may take more than 1 day.

***The study investigator and site clinical study team will not have access to any florbetapir F18 and flortaucipir F18 follow-up PET scans, as the investigator and site clinical study team must remain blinded to any potential changes in amyloid deposition.***

### 5.1.3. Immunogenicity and Safety Follow-up Visits (Visits 801 through 804)

Patients are to return to the site for an immunogenicity and safety follow-up visits (Visit 801 through Visit 804) beginning at Week 88 (or 12 weeks after their last dose of LY3002813) for collection of blood samples for anti-drug antibody (ADA; anti-LY3002813 antibody) and PK measurement, assessment of adverse events, C-SSRS, concomitant medications, and vital signs.

A patient will continue to return to the site for quarterly immunogenicity and safety follow-up visits (V802 [Week 100], V803 [Week 112], and V804 [Week 124]) until the patient completes V804 or the site is notified that the patient meets criteria for discharge from immunogenicity and safety follow-up, whichever occurs first (see Section 9.4.7.2 for details). See the Schedule of Activities (Section 2) for the timing of events and the measures to be assessed.

## 5.2. Number of Participants

Approximately 266 participants will be randomized.

## 5.3. End of Study Definition

End of the study is the date of the last visit or last scheduled procedure shown in the Schedule of Activities (Section 2) for the last patient.

## 5.4. Scientific Rationale for Study Design

**Continuing Standard of Care.** Patients may take AD symptomatic medications such as concomitant acetylcholinesterase inhibitors (AChEIs) and/or memantine and/or Axona if such medications are standard of care (SOC) in the patient's country and have been given for at least 4 months and stable dosing has been maintained for at least 2 months before Visit 2. During the double-blind treatment period (V2 to V21), changes in doses of available symptomatic medications for MCI or AD will require reporting to the sponsor and these changes should occur only when necessary for the adequate overall care of the patient. The effect of LY3002813 treatment plus SOC will be compared with placebo plus SOC.

**Dosing.** As described more fully in Section 7.1, LY3002813 (700 mg or 1400 mg) will be administered every 4 weeks as an IV infusion of approximately 140 mL over a minimum of 30 minutes.

**Design.** Study AACG is a multicenter, randomized, double-blind, placebo-controlled study of LY3002813 in patients with early symptomatic AD (where early symptomatic AD refers to the combination of 2 stages: prodromal AD [MCI-AD] and mild AD dementia) (Alaka et al. 2015). The study is intended to characterize the benefits and risks of treatment with LY3002813 versus placebo in patients early symptomatic AD.

Study AACG includes a placebo treatment arm and allows all patients to continue their AD standard of care concomitant medications. Inclusion of a placebo treatment arm is acceptable in Study AACG because there are no available disease-modifying treatments for AD; this approach is in agreement with the use of placebo described in the Declaration of Helsinki (World Medical

Association 2013). The use of a placebo comparator in Study AACG is needed to determine efficacy and safety of LY3002813 therapy.

The study includes a screening visit, which can last up to 63 days, at which patients are required to have PET flortaucipir F18 PET and florbetapir F18 PET imaging results consistent with tau and amyloid pathology in order to be randomized to the double-blind period. The duration of the double-blind period of the study is 76 weeks and includes up to 72 weeks of treatment, with endpoint measures and safety assessments at the end of the double-blind treatment period (Week 76), to assess the safety, tolerability and efficacy of LY3002813 versus placebo.

In addition to AE reporting, safety measures such as laboratory assessments, immunogenicity testing, vital signs and weight monitoring, ECG monitoring, physical examinations, neurological examinations, MRI assessments, and assessments of suicidal ideation and behavior are included to facilitate a comprehensive safety evaluation. For patients enrolled under previous versions of this protocol, which included a combination arm of LY3002813 (N3pG) and LY3202626 (BACE inhibitor-IV), final dermatological examinations by a dermatologist and final comprehensive ophthalmological examinations by an ophthalmologist or optometrist (where permitted by law) will be performed at the next visit occurring after the patient stopped receiving LY3202626/oral placebo.

## 5.5. Justification for Dose

LY3002813 doses of 700 mg and 1400 mg administered intravenously once every 4 weeks were selected based on current preclinical pharmacology and toxicology data and clinical PK, PD, and safety data. Prior and ongoing exposures include 0.1 mg/kg, 0.3 mg/kg, 1 mg/kg, 3 mg/kg, 10 mg/kg, 20 mg/kg, and 40 mg/kg in single and/or multi-dose dosing schedules. Data from Study AACC and AACD suggested that PK of LY3002813 is linear when the dose is not less than 10 mg/kg. Mean half-life was about 9-11 days when dose is  $\geq 10$  mg/kg, so minimal accumulation in plasma PK was predicted for 700 mg and 1400 mg Q4 week IV dosing. High levels of florbetapir F18 PET signal reductions were seen with a single dose of 20 mg/kg, and were comparable to florbetapir F18 PET reductions seen with a 10 mg/kg Q2 week dosing schedule at 3 months (see Section 3.2 and the IB for details). Based on this as well as decreased patient burden with an every 4 week dosing schedule compared with an every 2 week dosing schedule and comparable safety (see Section 3.3), 1400 mg Q4 week dosing was selected as the highest dose regimen for robust amyloid plaque lowering. As noted in Section 3.3.2, the lowest rate of ARIA-E has been observed with 10 mg/kg monthly dosing. For this reason, a titration schedule (700 mg Q4 week for the first 3 doses, then 1400 mg Q4 week) is proposed to reduce ARIA incidence while enabling patients to achieve high PD effects. In addition, dose reduction rules have been established for incident ARIA-E (see Section 7.4.1).

## 6. Study Population

Prospective approval of protocol deviations to recruitment and enrollment criteria, also known as protocol waivers or exemptions, are not permitted.

### 6.1. Inclusion Criteria

Patients are eligible for enrollment in the study only if they meet all of the following criteria:

#### Type of Patient and Disease Characteristics

- [1] Gradual and progressive change in memory function reported by patients or informants for  $\geq 6$  months.
- [50] [Note: Criterion #50 has been replaced by criterion #59.]
- [59] An MMSE score of 20 to 28 (inclusive) at Visit 1 or an acceptable historical flortaucipir PET scan within 6 months prior to Visit 1 that meets the central read criteria.
- [51] Meet flortaucipir F18 scan (central read) criteria.
- [52] Meet florbetapir F18 scan (central read) criteria.

#### Patient/Subject Characteristics

- [2] Men or women, 60 to 85 years of age, inclusive, at the time of informed consent.
- [3] Contraception
  - a. Male subjects
    - i. Male subjects, regardless of their fertility status, with non-pregnant female partners of childbearing potential must agree to either remain abstinent (if this is their preferred and usual lifestyle) or use condoms as well as one additional highly effective (less than 1% failure rate) method of contraception (such as combination oral contraceptives, implanted contraceptives, or intrauterine devices) or effective method of contraception (such as diaphragms with spermicide or cervical sponges) for 90 days after study drug dosing.
    - ii. Men and their partners may choose to use a double-barrier method of contraception. Barrier protection methods without concomitant use of a spermicide are not an effective or acceptable method of contraception. Thus, each barrier method must include use of a spermicide. It should be noted, however, that the use of male and female condoms as a double barrier method is not considered acceptable due to the high failure rate when these barrier methods are combined.
    - iii. Male subjects with pregnant partners should use condoms during intercourse for the duration of the study and until the end of estimated relevant potential exposure in women of childbearing potential, predicted to be 90 days following last dose of study drug.

iv. Male subjects should refrain from sperm donation for the duration of the study and until 90 days following last dose of study drug.

v. Male subjects who are in exclusively same sex relationships (as their preferred and usual lifestyle) are not required to use contraception.

b. Women

i. Women of childbearing potential (WOCBP) must be using or willing to use two forms of effective contraception (e.g., combined oral contraceptive, intrauterine device, spermicide), for the duration of their participation in the trial and for an additional 3 months after their participation ends or

ii. Women not of childbearing potential are defined as those who are:

a) Infertile due to surgical sterilization (hysterectomy, bilateral oophorectomy, or tubal ligation),

b) Post-menopausal – defined as either

i) A woman 55 or older not on hormone therapy, who has had at least 6 months of spontaneous amenorrhea; or

ii) A woman at least 55 years of age with a diagnosis of menopause prior to starting hormone replacement therapy.

iii. All female patients of child-bearing potential must test negative for pregnancy at Visit 1 based on serum pregnancy test.

- [4] Have a study partner who will provide written informed consent to participate, is in frequent contact with the patient (defined as at least 10 hours per week), and will accompany the patient to study visits or be available by telephone at designated times.

A second study partner may serve as backup. The study partner(s) is/are required to accompany the patient for signing consent. One study partner is requested to be present on all days the C-SSRS/Self-Harm Supplement Form is administered and must be present on all days the cognitive and functional scales are administered (i.e., Visits 1, 2, 5, 8, 11, 15, 18, and 21/early discontinuation [ED]). If a patient has a second study partner, it is preferred that one study partner be primarily responsible for the CDR and ADCS-ADL assessments. If a study partner(s) is not able to accompany the patient in person for visits other than those listed above, they must be available by telephone for the following assessments:

- AEs and concomitant medications
- relevant portions of the C-SSRS/Self-Harm Supplement Forms

If a study partner must withdraw from study participation, a replacement may be allowed at the investigator's discretion. The replacement will need to sign a separate informed consent on the first visit that he/she accompanies the patient to participate.



Study partners must be able to communicate with site personnel and be willing to comply with protocol requirements, and in the investigator's opinion must have adequate literacy to complete the protocol-specified questionnaires.

- [5] Have adequate premorbid literacy, vision, and hearing for neuropsychological testing in the opinion of the investigator.
- [6] Have given written informed consent approved by Lilly and the ethical review board (ERB) governing the site.
- [7] Are reliable and willing to make themselves available for the duration of the study and are willing to follow study procedures.

## 6.2. Exclusion Criteria

Patients will be excluded from study enrollment if they meet any of the following criteria:

### Medical Conditions

- [8] Have a Modified Hachinski Ischemia Scale (MHIS; Hachinski et al. 1975) score of  $\geq 4$ .
- [9] Lack, in the investigator's opinion, of adequate premorbid literacy, adequate vision, or adequate hearing to complete the required psychometric tests.
- [10] Significant neurological disease affecting the central nervous system (CNS), other than AD, that may affect cognition or ability to complete the study, including but not limited to, other dementias, serious infection of the brain, Parkinson's disease, multiple concussions, or epilepsy or recurrent seizures (except febrile childhood seizures).
- [11] Current serious or unstable illnesses including cardiovascular, hepatic, renal, gastroenterologic, respiratory, endocrinologic, neurologic (other than AD), psychiatric, immunologic, or hematologic disease and other conditions that, in the investigator's opinion, could interfere with the analyses in this study; or has a life expectancy of  $< 24$  months.
- [12] History of cancer within the last 5 years, with the exception of non-metastatic basal and/or squamous cell carcinoma of the skin, in situ cervical cancer, non-progressive prostate cancer, or other cancers with low risk of recurrence or spread.
- [13] Patients with any current primary psychiatric diagnosis other than AD if, in the judgment of the investigator, the psychiatric disorder or symptom is likely to confound interpretation of drug effect, affect cognitive assessment, or affect the patient's ability to complete the study. [Patients with history of schizophrenia or other chronic psychosis are excluded.]
- [14] Have a history of long QT syndrome.
- [15] Are clinically judged by the investigator to be at serious risk for suicide as assessed by medical history, examination, or the C-SSRS.
- [16] [Note: Criterion #16 has been replaced by criterion #57.]

- [57] [Note: Criterion #57 has been deleted.]
- [17] History of alcohol or drug use disorder (except tobacco use disorder) within 2 years before the screening visit.
- [18] [Note: Criterion #18 has been deleted.]
- [19] Have a history of clinically significant multiple or severe drug allergies, or severe post-treatment hypersensitivity reactions (including but not limited to erythema multiforme major, linear immunoglobulin A dermatosis, toxic epidermal necrolysis, and/or exfoliative dermatitis).
- [20] Known positive serologic findings for human immunodeficiency virus (HIV) antibodies. Local laws and regulations may apply to whether testing is required.

### **Magnetic Resonance Imaging, Vital Signs, Electrocardiograms, Laboratory Tests, and Physical Examination**

- [21] Have any clinically important abnormality at screening, as determined by investigator, in physical or neurological examination, vital signs, ECG, or clinical laboratory test results that could be detrimental to the patient, could compromise the study, or show evidence of other etiologies for dementia.
- [22] Screening MRI which shows evidence of significant abnormality that would suggest another potential etiology for progressive dementia or a clinically significant finding that may impact the patient's ability to safely participate in the study.
- [23] Have any contraindications for MRI, including claustrophobia or the presence of contraindicated metal (ferromagnetic) implants/cardiac pacemaker.
- [24] [Note: Criterion #24 has been replaced by criterion #58.]
- [58] Have a centrally read MRI demonstrating presence of ARIA-E, >4 cerebral microhemorrhages, more than 1 area of superficial siderosis, any macrohemorrhage or severe white matter disease.
- [25] An average (ECG in triplicate) corrected QT (QTcF) interval measurement >450 msec (men) or >470 msec (women) at screening (as determined at the investigational site). The site may request a central read prior to making determination of this criterion.
- [26] [Note: Criterion #26 has been replaced by criterion #53.]
- [53] Patients with a past history of Hepatitis B should have HBsAg testing at screening and are excluded if HBsAg is positive.
- [27] [Note: Criterion #27 has been replaced by criterion #54.]
- [54] Patients with past history of Hepatitis C should have HCV RNA PCR testing at screening and are excluded if HCV RNA PCR is positive.
- [28] Calculated creatinine clearance <30 mL/min (Cockcroft-Gault formula; Cockcroft and Gault 1976) at screening.



- [29] Alanine transaminase (ALT)  $\geq 2X$  the upper limit of normal (ULN) of the performing laboratory, aspartate aminotransferase (AST)  $\geq 2X$  ULN, total bilirubin level (TBL)  $\geq 1.5X$  ULN, or alkaline phosphatase (ALP)  $\geq 1.5X$  ULN at screening.

NOTE: Patients with TBL  $\geq 1.5X$  ULN are not excluded if they meet all of the following criteria for Gilbert syndrome:

1. Bilirubin is predominantly indirect (unconjugated) at screening (direct bilirubin within normal limits).
2. Absence of liver disease.
3. ALT, AST, and ALP  $\leq 1X$  ULN at screening.
4. Hemoglobin is not significantly decreased at screening.

### Prior/Concomitant Therapy

- [30] Have received treatment with a stable dose of an acetylcholinesterase inhibitor (AChEI) and/or memantine for less than 2 months before randomization. [If a patient has recently stopped an AChEI and/or memantine, he or she must have discontinued treatment at least 2 months before randomization.]
- [31] Changes in concomitant medications that could potentially affect cognition and their dosing should be stable for at least 1 month before screening, and between screening and randomization (does not apply to medications discontinued due to exclusions or with limited duration of use, such as antibiotics).
- [32] [Note: Criterion #32 has been deleted.]
- [33] Current use of drugs known to significantly prolong the QT interval (see the Manual of Operations for a list of excluded drugs).
- [34] Have had prior treatment with a passive anti-amyloid immunotherapy  $< 5$  half-lives prior to randomization.
- [35] Have received active immunization against A $\beta$  in any other study.
- [36] Have known allergies to LY3002813, related compounds, or any components of the formulation; or history of significant atopy.
- [37] [Note: Criterion #37 has been deleted.]
- [38] Have allergies to either monoclonal antibodies, diphenhydramine, epinephrine, or methylprednisolone.

### Procedural

- [39] Sensitivity to florbetapir F18 or flortaucipir F18.
- [40] Intend to use drugs known to significantly prolong the QT interval within 14 days or 5 half-lives, whichever is longer, of a scheduled screening/baseline flortaucipir F18 PET scan, or have a medical history of a risk factor of torsades de pointes.
- [41] Poor venous access.

- [42] Contraindication to MRI.
- [43] Contraindication to PET.
- [44] Present or planned exposure to ionizing radiation that, in combination with the planned administration of study PET ligands, would result in a cumulative exposure that exceeds local recommended exposure limits.

### **Prior/Concurrent Clinical Trial Experience**

- [45] Are currently enrolled in any other interventional clinical trial involving an investigational product or any other type of medical research judged not to be scientifically or medically compatible with this study.
- [46] Have participated, within the last 30 days (4 months for studies conducted in Japan; 3 months for studies conducted in the UK), in a clinical trial involving an investigational product. If the previous investigational product is scientifically or medically incompatible with this study and has a long half-life, 3 months or 5 half-lives (whichever is longer) should have passed prior to screening (Participation in observational studies may be permitted upon review of the observational study protocol and approval by the sponsor).
- [47] [Note: Criterion #47 has been replaced by criterion #55.]
- [55] Have previously completed or withdrawn from this study or received LY3002813 in any prior investigational study. (This exclusion criterion does not apply to patients who are allowed to rescreen before randomization in this study).
- [56] [Note: Criterion #56 has been deleted.]

### **Other Exclusions**

- [48] Are investigator site personnel directly affiliated with this study and/or their immediate families. Immediate family is defined as a spouse, parent, child, or sibling, whether biological or legally adopted.
- [49] Are Lilly employees or are employees of third-party organizations (TPOs) involved in study who require exclusion of their employees, or have study partners who are Lilly employees or are employees of TPOs involved in a study which require exclusion of their employees.

### **6.2.1. Rationale for Exclusion of Certain Study Candidates**

The use of LY3002813 in older patients is anticipated; thus this study will specifically examine the efficacy and safety in an elderly population. Criterion [2] defines the population age range for the purposes of this study. Therefore, patients not meeting the age criterion are excluded.

### **6.3. Lifestyle Restrictions**

1. Patients should refrain from donating blood or blood products from the time of their screening visit until 6 months following the last dose of study drug.

2. Patients should avoid excessive use of alcohol from the screening visit until the study ends. Excessive alcohol consumption is defined for men as consuming an average of more than 3 drinks per day, or more than 21 drinks per week. For women, excessive use of alcohol is defined as consuming an average of more than 2 drinks per day, or more than 14 drinks per week.

#### **6.4. Screen Failures**

Individuals who do not meet the criteria for participation in this study (screen failure) may not be rescreened if the screen failure is due to non-eligible imaging results. If the screen failure is due to not meeting cognitive criteria on the MMSE, then one rescreen will be allowed after 8 weeks. If a patient failed the CBB screening in the previous version of this protocol, then the patient may be reconsented and immediately rescreened using the MMSE. Other reasons for screen fail will require sponsor approval for rescreen.

## 7. Treatments

### 7.1. Treatments Administered

This study involves a comparison of LY3002813 administered as an IV infusion of approximately 140 mL over a minimum of 30 minutes compared with placebo. In the double-blind period, the treatment groups will be given an IV infusion of LY3002813 or placebo for up to 72 weeks.

Patients whose amyloid plaque reduction as measured by florbetapir F18 PET scans at Visit 8 (Week 24) and/or Visit 15 (Week 52) meet criteria will have a double-blinded dose reduction of LY3002813 to 700 mg or IV placebo, based on the specific level of florbetapir F18 PET signal at that time, for the remaining duration of the double-blind treatment period. These dose reduction rules may be modified by the sponsor based on ongoing collection of PD and safety data. If ARIA-E occurs prior to Visit 5 (Week 12), the LY3002813 dose will not be escalated.

Table AACG.7.1 shows the 2 treatment regimens during the double-blind period.

The study also includes the use of the diagnostics flortaucipir F18 PET (for the determination of paired helical filament deposits of tau [tau PHF deposits]) and florbetapir F18 PET (for the determination of brain amyloid plaque deposits). Information regarding the use of these diagnostics in the study is provided in Appendix 5 and Appendix 6, respectively.

**Table AACG.7.1. Treatment Regimens, Double-Blind Period**

Regimen	Dose
	Visit 2 (Week 0) through Visit 21 (Week 76)
<b>LY3002813</b>	LY3002813 (700 mg intravenous infusion every 4 weeks x 3 doses, then 1400 mg intravenous infusion every 4 weeks for up to 72 weeks)
<b>Placebo</b>	Intravenously dosed placebo infusion every 4 weeks for up to 72 weeks

LY3002813 will be prepared by an unblinded pharmacist or other qualified unblinded personnel. LY3002813 will be administered by a blinded nurse or other qualified blinded personnel. The investigator or his/her designee is responsible for the following:

- explaining the correct use of the investigational agent(s) to the subject and/or legal representative
- verifying that instructions are followed properly
- maintaining accurate records of investigational product dispensing and collection
- at the end of the study returning all unused medication to Lilly, or its designee, unless the sponsor and sites have agreed all unused medication is to be destroyed by the site, as allowed by local law

#### 7.1.1. Packaging and Labelling

Clinical study materials will be labeled according to the country's regulatory requirements.

#### 7.1.1.1. LY3002813 Packaging and Labelling

The drug product LY3002813 is supplied CCI

. The drug product should be stored according to instructions on the label. CCI

Placebo is 0.9% (normal) saline.

### 7.2. Method of Treatment Assignment

Patients who meet all criteria for enrollment will be assigned a study (patient) number at Visit 1 and randomized to double-blind treatment at Visit 2. Patients will be randomized to LY3002813 or Placebo in a 1:1 ratio. For between-group comparability for site factor, patient randomization will be stratified by investigative site. Assignment to treatment groups will be determined by a computer-generated random sequence using an interactive web response system (IWRS).

The IWRS will be used to assign a dosing regimen to each patient. Site personnel will confirm that they have located the correct packages by entering a confirmation number found on the label into the IWRS.

#### 7.2.1. Selection and Timing of Doses

Assessment of LY3002813 safety and tolerability is a central objective; therefore, monitoring 100 patients on LY3002813 over 72 weeks provides data to assess safety for further clinical development.

The actual time of LY3002813 dose administration on the day of study visits will be recorded in the subject's case report form (CRF).

Note that at visits at which cognitive assessments are to be done, all cognitive scales are to be administered before IV study medication (LY3002813 or IV placebo) is administered.

##### 7.2.1.1. LY3002813: Selection and Timing of Doses

The actual time of LY3002813 dose administrations on the day of study visits will be recorded in the subject's CRF. Intravenous study medication (i.e., IV placebo or LY3002813) is to be administered once every 4 weeks. Based on the permitted visit window (see Section 2), IV study medication could theoretically be administered at a 2-week interval. However, IV study medication must not be given at a dosing interval of less than 21 days at any time during the study. Intravenous study medication given at a dosing interval of less than 21 days at any time during the study will be considered a protocol deviation. The dose of LY3002813 was chosen based on PK/PD and safety from Studies AACC and AACD (see Section 5.5).

Infusions should occur over the course of a minimum of 30 minutes. If a patient demonstrates an infusion reaction to LY3002813, rescue medications may be administered at the discretion of the investigator (see Section 7.7). If indicated, the patient may be premedicated for subsequent infusions. See Section 9.4.7.1.1 or contact sponsor for further guidance. Patients should be observed for approximately 2 hours following each infusion of LY3002813 for the first 6 infusions. After the first 6 doses, a minimal post-infusion observation time of 60 minutes will be required for all subsequent infusions. However, patients who have had dosing restarted after ARIA-E are required to be monitored for 2 hours following infusion for a minimum of 3 subsequent infusions, and a minimum of 60 minutes postinfusion observation thereafter.

Sites must have resuscitation equipment available.

### 7.3. Blinding

This is a double-blind study, with design to maintain blinding to treatment. To preserve the blinding of the study, a minimal number of Lilly personnel will see the randomization table and treatment assignments before the study is complete. The independent external DMC will potentially be unblinded for safety evaluations and dose reduction decisions related to safety.

Emergency unblinding for AEs may be performed through the IWRS. This option may be used ONLY if the subject's well-being requires knowledge of the subject's treatment assignment. All unblinding events are recorded and reported by the IWRS.

If an investigator, site personnel performing assessments, or subject is unblinded, the subject must be discontinued from the study. In cases where there are ethical reasons to have the subject remain in the study, the investigator must obtain specific approval from a Lilly clinical research physician (CRP) for the subject to continue in the study.

In case of an emergency, the investigator has the sole responsibility for determining if unblinding of a patient's treatment assignment is warranted for medical management of the event. The patient's safety must always be the first consideration in making such a determination. If a patient's treatment assignment is unblinded, Lilly must be notified immediately. If the investigator decides that unblinding is warranted, it is the responsibility of the investigator to promptly document the decision and rationale and notify Lilly as soon as possible.

### 7.4. Dosage Modification

#### 7.4.1. LY3002813 Dosage Modification for ARIA-E

LY3002813 dosage modifications will be done for the occurrence of ARIA-E in the following instances shown in [Table AACG.7.2](#).

If a dosage reduction is required, then the LY3002813 dose will be reduced to the next lower dose (from 1400 mg to 700 mg or from 700 mg to placebo).

**Table AACG.7.2. LY3002813 Dosage Modifications for First Occurrence of ARIA-E**

ARIA-E SYMPTOMS	ARIA-E on MRI		
	Mild	Moderate	Severe
<b>No symptoms</b>	Continue on current dosing <sup>a</sup>	LY3002813 Dose reduction <sup>a,b</sup>	Temporary Discontinuation of LY3002813 (refer to Section 8.1.1.1) <sup>b</sup>
<b>Mild</b>	LY3002813 Dose reduction <sup>a,b</sup>	Temporary Discontinuation of LY3002813 (refer to Section 8.1.1.1) <sup>b</sup>	Temporary Discontinuation of LY3002813 (refer to Section 8.1.1.1) <sup>b</sup>
<b>Moderate</b>	Temporary Discontinuation of LY3002813 (refer to Section 8.1.1.1) <sup>b</sup>	Temporary Discontinuation of LY3002813 (refer to Section 8.1.1.1) <sup>b</sup>	Temporary Discontinuation of LY3002813 (refer to Section 8.1.1.1) <sup>b</sup>
<b>Severe</b>	Temporary Discontinuation of LY3002813 (refer to Section 8.1.1.1) <sup>b</sup>	Temporary Discontinuation of LY3002813 (refer to Section 8.1.1.1) <sup>b</sup>	Temporary Discontinuation of LY3002813 (refer to Section 8.1.1.1) <sup>b</sup>

<sup>a</sup> Investigator may choose to temporarily discontinue LY3002813 after discussion with the sponsor.

<sup>b</sup> If the patient has a second incidence of ARIA-E and has previously been dose reduced or temporarily discontinued from LY3002813, then LY3002813 will be permanently discontinued (see Section 8.1).

*All Cases of ARIA-E will require unscheduled MRI scans every 4-6 weeks until ARIA-E has resolved. Further details are provided in the Operations Manual.*

#### **7.4.2. LY3002813 Dosage Modification for ARIA-H**

There will be no dose reductions for changes in ARIA-H. Patients will be discontinued from dosing and IV administration if ARIA-H discontinuation rules are met (see Section 8.1). Patients will not be re-challenged with LY3002813 after dose discontinuation for ARIA-H.

All new cases of ARIA-H will require unscheduled MRI scans every 4-6 weeks until ARIA-H has stabilized without new findings.

### **7.5. Preparation/Handling/Storage/Accountability**

The investigator or his/her designee is responsible for the following:

- confirming appropriate temperature conditions have been maintained during transit for all study treatment received and any discrepancies are reported and resolved before use of the study treatment.
- ensuring that only participants enrolled in the study may receive study treatment and only authorized site staff may supply or administer study treatment. All study treatments must be stored in a secure, environmentally controlled, and monitored (manual or automated) area in accordance with the labeled storage conditions with access limited to the investigator and authorized site staff.



- the investigator, institution, or the head of the medical institution (where applicable) is responsible for study treatment accountability, reconciliation, and record maintenance (such as receipt, reconciliation and final disposition records).

## 7.6. Treatment Compliance

The administration of all study medication should be recorded in the appropriate sections of the electronic case report form (eCRF).

### 7.6.1. LY3002813 Treatment Compliance

Because dosing occurs at study visits, patients who attend all visits and successfully receive LY3002813 infusions are automatically compliant with this treatment. Any infusion at which 75% (approximately 105 mL) or more of the infusion solution is given will be considered a complete infusion.

If a patient attends a visit but does not receive a complete infusion (e.g., due to technical complications), every effort should be made to complete the infusion within 24 hours if possible. If less than 75% of the infusion solution is given, this must be recorded as an incomplete infusion on the CRF.

Missed infusions should be recorded on the CRF.

## 7.7. Concomitant Therapy

All concomitant medication taken during the study must be recorded on the Concomitant Medication CRF. Patients and their study partners will be instructed to consult the investigator or other appropriate study personnel at the site before initiation of any new medications or supplements and before changing dose of any current concomitant medications or supplements.

To ensure standard of care for AD, use of approved treatments for AD is permitted in this study, and no medications are explicitly excluded from use. The section below provides additional guidance on managing concomitant medication use.

*Allowed Medications.* Use of approved or standard of care treatments for AD is permitted during the study, provided that such medications dose has been unchanged for 2 months before Visit 2. Doses of these medications should remain constant throughout the double-blind period (Visit 2 to Visit 21).

If a patient has recently stopped AChEIs and/or memantine, he or she must have discontinued treatment at least 2 months before Visit 2.

Other vitamins, medical food, or nutraceuticals given for their possible effects on AD may be continued on stable doses beginning 2 months before Visit 2.

***Prior to V21, before a patient starts, stops, or changes doses of AChEIs and/or memantine or other treatments for their AD, the Sponsor or designee must be contacted to determine whether or not the patient should continue in the study and whether or not clinical outcome measures should be performed. Failure to notify Lilly or its designee regarding starting,***



***stopping or changing doses of AChEIs and/or memantine or other treatments for their AD prior to V21 will be considered a protocol deviation.***

Nonmedication treatments for AD such as behavioral management are permitted but are subject to the same restrictions as medication treatment taken for AD.

Other concomitant medications that affect CNS function may be given if the dose remains unchanged throughout the study. Doses of these compounds should remain constant from 1 month before screening (Visit 1).

If unforeseen starting, stopping, or changing of stable doses of drugs affecting CNS function occurs prior to V21 of the study, Lilly or its designee must be contacted to determine whether or not the patient should continue in the study and whether or not outcome measures should be performed. ***Failure to notify Lilly or its designee regarding starting, stopping or changing doses of CNS medications prior to V21 of the study will be considered a protocol deviation.***

Use of benzodiazepines for treatment on an as-needed basis for insomnia or daily dosing as anxiolytics is permitted. Use of sedatives or hypnotics should be avoided for 8 hours before administration of the cognitive and functional tests unless they are given chronically.

If an infusion reaction occurs, rescue medications such as, but not limited to, diphenhydramine, epinephrine, and/or methylprednisolone may be administered at the discretion of the investigator. Administration of medications before an infusion to prevent a reaction does not cause a discontinuation of the patient from the study. If the need for concomitant medication arises, inclusion or continuation of the patient may be at the discretion of the investigator after consultation with a Lilly CRP. Concomitant therapy administered to treat an infusion reaction or as premedication for infusions should be documented.

#### ***Excluded Medications.***

IgG therapy (also known as gamma globulin or intravenous immunoglobulin [IVIG]) is not allowed during the study.

## **7.8. Treatment after the End of the Study**

### ***7.8.1. Treatment after Study Completion***

There is no planned open label extension at this time, or plan to otherwise make LY3002813 available to patients after conclusion of the study.

## 8. Discontinuation Criteria

### 8.1. Discontinuation from Study Treatment

Possible reasons leading to permanent discontinuation of study treatment:

- Subject Decision
  - the subject or the subject's designee; for example, legal guardian requests to discontinue investigational product.
- Discontinuation due to a hepatic event or liver test abnormality

Subjects who are discontinued from investigational product due to a hepatic event or liver test abnormality should have additional hepatic safety data collected via CRF/electronic data entry.

Discontinuation of the investigational product for abnormal liver tests **should be considered** by the investigator when a subject meets one of the following conditions after consultation with the Lilly-designated medical monitor:

- alanine aminotransferase (ALT) or aspartate aminotransferase (AST) >8X upper limit of normal (ULN)
- ALT or AST >5X ULN for more than 2 weeks
- ALT or AST >3X ULN and total bilirubin level (TBL) >2X ULN or international normalized ratio (INR) >1.5
- ALT or AST >3X ULN with the appearance of fatigue, nausea, vomiting, right upper-quadrant pain or tenderness, fever, rash, and/or eosinophilia (>5%)
- alkaline phosphatase (ALP) >3X ULN
- ALP >2.5X ULN and TBL >2X ULN
- ALP >2.5X ULN with the appearance of fatigue, nausea, vomiting, right quadrant pain or tenderness, fever, rash, and/or eosinophilia (>5%)

In addition, subjects will be discontinued from the investigational product in the following circumstances:

- Treatment with LY3002813 will be permanently discontinued in patients with:
  - a second incidence of ARIA-E after a previous dose reduction or temporary discontinuation of LY3002813
  - any increase in ARIA-H accompanied by clinically significant symptoms
  - >4 new microhemorrhages, >1 new area of superficial siderosis or significant worsening of pre-existing superficial siderosis, or any macrohemorrhage regardless of symptoms
  - an ARIA-E event reported as an SAE, regardless of severity of symptoms or MRI findings

- Treatment with LY3002813 will also be permanently discontinued in patients with:
  - Prolonged acute infusion reaction (i.e., not responsive to medication such as antihistamines, nonsteroidal anti-inflammatory drugs, and/or narcotics and/or brief interruption of infusion).
  - Adverse event or clinically significant laboratory value, ECG result, physical examination finding, MRI finding (such as symptomatic ischemic stroke), C-SSRS result, or vital sign measurement of such severity that, in the opinion of the investigator or Lilly-designated medical monitor, continued treatment is not in the best interest of the patient.
  - Severe non-compliance to the study protocol that results in a safety concern, in the judgment of the investigator.
  - The patient, for any reason, requires a treatment with an excluded therapeutic agent and temporary discontinuation criteria cannot be met (see Section 8.1.1.2).

Patients may permanently discontinue study treatment and remain in the trial. If LY3002813 infusion is permanently discontinued but the patient remains in the study, one PK sample should be collected at the soonest scheduled visit regardless if serum LY3002813 is on the Schedule of Activities at that visit. Dosing dates and times should be collected. Subsequent PK sample collection should follow the protocol Schedule of Activities for serum LY3002813 collection unless the scheduled visit exceeds 6 months since discontinuation of infusions. No additional serum collection for LY3002813 is required once the patient exceeds 6 months since discontinuation of LY3002813 infusions.

Subjects permanently discontinuing from the study prematurely for any reason should complete AE and other follow-up procedures per Section 2 (Schedule of Activities), Section 9.2 (Adverse Events), and Section 9.4 (Safety) of this protocol.

### **8.1.1. Temporary Discontinuation from Study Treatment**

#### **8.1.1.1. Temporary Discontinuation from LY3002813 Study Treatment Due to ARIA-E**

Temporary discontinuation from LY3002813 treatment is allowed for ARIA-E if the ARIA-E meets the temporary discontinuation criteria shown in [Table AACG.7.2](#).

In cases of ARIA-E where the protocol indicates continued dosing or a dose reduction rather than temporary discontinuation (see [Table AACG.7.2](#)), the investigator may choose to temporarily discontinue LY3002813 after discussion with the sponsor. This will require choosing not to dispense LY3002813 through IWRS at relevant visits.

Study drug (LY3002813) may be restarted following a first incidence of ARIA-E at the discretion of the investigator if dosing is temporarily discontinued due to ARIA-E and there is complete resolution of symptoms and radiologic findings within 16 weeks after the temporary drug discontinuation.

If ARIA-E symptoms and radiologic findings have not completely resolved within 16 weeks, then the patient will be permanently discontinued from LY3002813 treatment.

Study drug may be restarted at either 700 mg or placebo, double blinded, depending on the original study arm to which the patient is randomized.

An unscheduled safety MRI scan will be required 4-6 weeks after dose restarts.

#### **8.1.1.2. Temporary Discontinuation from LY3002813 Study Treatment for Reasons Other than ARIA-E**

Temporary discontinuation from LY3002813 treatment is allowed if a short-term treatment of an excluded medication is necessary, secondary to hospitalization, personal circumstances or to evaluate the study drug impact on an uncertain AE. Study drug may be restarted at the investigator's discretion. If temporary discontinuation is due to an AE, it should be reported to the Lilly CRP. Temporary treatment discontinuation and re-starting should be documented. Restarting treatment after a discontinuation period that is greater than 12 weeks should be discussed between the investigator and Lilly CRP.

#### **8.1.2. Discontinuation of Inadvertently Enrolled Subjects**

If the sponsor or investigator identify a subject who did not meet enrollment criteria and was inadvertently enrolled, then the subject should be discontinued from study treatment unless there are extenuating circumstances that make it medically necessary for the subject to continue on study treatment. If the investigator and the sponsor CRP/CRS agree it is medically appropriate to continue, the investigator must obtain documented approval from the sponsor CRP/CRS to allow the inadvertently enrolled subject to continue in the study with or without treatment with investigational product.

Safety follow-up is as outlined in Section 2 (Schedule of Activities), Section 9.2 (Adverse Events) and Section 9.4 (Safety) of this protocol.

### **8.2. Discontinuation from the Study**

Patients who do not meet entry criteria or who are excluded by exclusion criteria from Visit 1 tests and procedures should be discontinued from the study before randomization as an entry failure.

Patients who exhibit any of the following conditions during the study that may possibly be related to study drug will be discontinued from the study, but will be encouraged to undergo final assessment visits and procedures as outlined in the Schedule of Activities (Section 2):

- Patients who require a ferromagnetic implant or insertion of a cardiac pacemaker that is not MRI-compatible will be discontinued from study drug and from the study; and, with the exception of an MRI, should have end-of-therapy and/or end-of-study procedures performed as shown in the Schedule of Activities (Section 2).

Subjects will also be discontinued from the study in the following circumstances:

- enrollment in any other clinical study involving an investigational product or enrollment in any other type of medical research judged by sponsor not to be scientifically or medically compatible with this study

- participation in the study needs to be stopped for medical, safety, regulatory, or other reasons consistent with applicable laws, regulations, and good clinical practice (GCP)
- investigator decision
  - the investigator decides that the subject should be discontinued from the study
  - if the subject, for any reason, requires treatment with another therapeutic agent that has been demonstrated to be effective for treatment of the study indication, discontinuation from the study occurs prior to introduction of the new agent
- subject decision
  - the subject or the subject's legal representative requests to be withdrawn from the study

Subjects discontinuing from the study prematurely for any reason must complete AE and other safety follow-up per Section 2 (Schedule of Activities), Section 9.2 (Adverse Events), and Section 9.4 (Safety) of this protocol. In addition, subjects discontinuing from the study prematurely should be encouraged to return to the site beginning 12 weeks after their ED visit for immunogenicity and safety assessments (Visits 801 through 804, as described in Section 5.1.3).

### 8.3. Lost to Follow-Up

A subject will be considered lost to follow-up if he or she repeatedly fails to return for scheduled visits and is unable to be contacted by the study site. Site personnel are expected to make diligent attempts to contact subjects who fail to return for a scheduled visit or who were otherwise unable to be followed up by the site.

Site personnel, or an independent third party, will attempt to collect the vital status of the subject within legal and ethical boundaries for all subjects randomized, including those who did not get investigational product. Public sources may be searched for vital status information. If vital status is determined, this will be documented and the subject will not be considered lost to follow-up.

Lilly personnel will not be involved in any attempts to collect vital status information.

## 9. Study Assessments and Procedures

Section 2 lists the Schedule of Activities, with the study procedures and their timing (including tolerance limits for timing).

Appendix 2 lists the clinical laboratory tests that will be performed for this study.

Unless otherwise stated in the subsections below, all samples collected for specified laboratory tests will be destroyed within 60 days of receipt of confirmed test results. Certain samples may be retained for a longer period, if necessary, to comply with applicable laws, regulations, or laboratory certification standards.

### 9.1. Efficacy Assessments

Screening measures used for diagnosis and establishment of study eligibility are described elsewhere (Section 5.1.1.1).

Cognitive and functional testing will be administered using an eCOA tablet. The audio voice recordings of the rater's questions and the patient's and study partner's responses will also be collected via the eCOA tablet during administration of the cognitive and functional testing for central monitoring of rater scale administration (Appendix 3, 3.2.1). Cognitive and functional testing for each patient should be performed at approximately the same time on each day that testing occurs to reduce potential variability. Note that the ADAS-Cog and MMSE must be administered by a different rater than the ADCS-ADL and CDR. These 2 raters should continue doing the same scale with the same patient throughout the study. If possible, each assessment should be performed on a given patient by the same rater at each visit. The principal investigator (PI) has the responsibility of selecting the raters who will administer the instruments at the site, as long as all training requirements have been met by those raters (Appendix 3, 3.1.5).

When administered, cognitive and functional testing should be performed first, before medical procedures that could be stressful for the patient (e.g., blood draws). Note that some procedures (MRI, flortaucipir F18 PET tau imaging, florbetapir F18 PET amyloid imaging) can be conducted on other days within the visit window.

#### 9.1.1. Primary Efficacy Assessments

**Integrated Alzheimer's Disease Rating Scale (iADRS;** Wessels et al. 2015). The iADRS represents a composite that was developed using both a theory-driven approach (incorporating measures of both cognition and function) and a data-mining approach (identifying the most sensitive combination of scales through analysis of data from the Alzheimer's Disease Neuroimaging Initiative and the LY2062430 EXPEDITION, EXPEDITION2, and EXPEDITION3 studies). The iADRS is a simple linear combination of scores from 2 well-established, therapeutically sensitive, widely accepted measures in AD, the ADAS-Cog<sub>13</sub> and the ADCS-iADL, measuring the core domains of AD. All items of these 2 scales are included without additional weighting of items, yielding face validity and ease of interpretation of the composite relative to its components.



The iADRS score will be derived from the ADAS-Cog<sub>13</sub> and the ADCS-iADL and will be the primary efficacy measure. The ADAS-Cog<sub>13</sub> and the ADCS-ADL will be the actual scales administered to patients.

### **9.1.2. Secondary Efficacy Assessments**

Additional clinical outcome measures should be administered in the same order at every visit, immediately following assessment of the ADAS-Cog<sub>13</sub>. To minimize missing data, the rater should include each measure orally with the patient or study partner (as designated in instructions), recording responses appropriately. The same study partner should be used as the informant at all visits.

#### **9.1.2.1. Alzheimer's Disease Assessment Scale—Cognitive subscale (ADAS-Cog<sub>13</sub>)**

The ADAS-Cog<sub>13</sub> is a rater-administered instrument that was designed to assess the severity of the dysfunction in the cognitive and noncognitive behaviors characteristic of persons with AD (Rosen et al. 1984). The ADAS-Cog<sub>13</sub> should be administered by the same rater from visit to visit to reduce potential variability. The cognitive subscale of the ADAS, the ADAS-Cog<sub>13</sub>, consists of 13 items assessing areas of cognitive function most typically impaired in AD: orientation, verbal memory, language, praxis, delayed free recall, digit cancellation, and maze-completion measures (Mohs et al. 1997). The ADAS-Cog<sub>13</sub> allows better discrimination of differences among mild patients than the ADAS-Cog<sub>11</sub>, which will be included as a secondary outcome. The ADAS-Cog<sub>13</sub> scale ranges from 0 to 85, with higher scores indicating greater disease severity.

#### **9.1.2.2. Alzheimer's Disease Cooperative Study—Activities of Daily Living Inventory (ADCS-ADL)**

The ADCS-ADL is a 23-item inventory developed as a rater-administered questionnaire that is to be answered by the patient's study partner (Galasko et al. 1997, 2004). The ADCS-ADL should be administered by the same rater from visit to visit to reduce potential variability. The ADCS-ADL subset of items (items 7 to 23) for instrumental activities of daily living (ADCS-iADL) will be used as a secondary efficacy measure. The focus in the early symptomatic AD population is on the instrumental activities of daily living (iADLs) rather than the basic activities of daily living (bADLs), which are thought to be affected in more severe stages of the disease. The range for the iADL score is 0 to 56, with lower scores indicating greater disease severity. For each of the specific items, the study partner is first asked if the patient attempted the ADL during the past 4 weeks. If the patient did attempt the ADL, the study partner is asked to rate the patient's performance level based on a set of performance descriptions. Scores for each item and the overall score for the tool are calculated. The range for the total ADCS-ADL score is 0 to 78, with higher scores indicating greater level of impairment. Separate scores for the bADLs (0 to 22) will also be computed.

### 9.1.2.3. Clinical Dementia Rating Scale (CDR-SB)

The CDR is a semi-structured interview performed with the patient and study partner (informant) that provides an index of global functioning (Berg et al. 1992). The CDR should be administered by the same rater from visit to visit to reduce potential variability. The informant is queried about the patient's memory, orientation, judgment and problem solving, community affairs, home and hobbies, and personal care. The patient's memory, orientation, judgment, and problem-solving ability are assessed. Higher scores indicate greater disease severity. By assigning a severity score for each of the 6 domains, a total score known as sum of boxes is obtained—hence the abbreviation, CDR-SB.

### 9.1.2.4. Mini-Mental State Examination (MMSE)

The MMSE is a brief instrument used to assess cognitive function in patients (Folstein et al. 1975). The MMSE should be administered by the same rater from visit to visit to reduce potential variability. The instrument is divided into 2 sections. The first section measures orientation, memory, and attention. The maximum score for the first section is 21. The second section tests the ability of the patient to name objects, follow verbal and written commands, write a sentence, and copy figures. The maximum score for the second section is 9. The range for the total MMSE score is 0 to 30, with lower scores indicating great level of impairment.

### 9.1.3. Biomarker Efficacy Measures (Double-Blind Period)

**Florbetapir F18 PET scan.** Change in amyloid burden (as assessed by florbetapir F18 PET signal) will be compared in LY3002813- and placebo-treated patients for those patients who undergo florbetapir F18 PET scans at baseline, Week 52 [Visit 15], and Week 76 [Visit 21] or ED) as described in the Schedule of Activities (Section 2).

**Flortaucipir F18 PET scan.** Change in tau burden (as assessed by flortaucipir F18 PET signal) will be compared in LY3002813- and placebo-treated patients for those patients who undergo both baseline and endpoint (Visit 21 [Week 76] or ED) flortaucipir F18 scans as described in the Schedule of Activities (Section 2).

**Volumetric MRI.** Magnetic resonance imaging of the brain will be performed according to the Schedule of Activities (Section 2). LY3002813- and placebo-treatment effects on volumetric MRI will be assessed and compared to evaluate the loss of brain volume that occurs in AD patients.

### 9.1.4. Appropriateness of Efficacy Assessments

The iADRS, the primary efficacy measure, is a simple linear combination of scores from 2 well-established, therapeutically sensitive, widely accepted measures in AD, the ADAS-Cog<sub>13</sub> and the ADCS-iADL, measuring the core domains of AD. It represents a composite that was developed using both a theory-driven approach (incorporating measures of both cognition and function) and a data-mining approach (identifying the most sensitive combination of scales through analysis of data from the Alzheimer's Disease Neuroimaging Initiative and the LY2062430 EXPEDITION, EXPEDITION2, and EXPEDITION3 studies). Composite endpoints have been increasingly used as primary endpoints in clinical trials (Freemantle et al.



2003). Liu-Seifert et al. (2017) demonstrated that the treatment effect size of the iADRS composite is greater than the minimum treatment effect size of its components and that above certain thresholds of correlations of components and ratios of component effect sizes, the composite may outperform its components.

The secondary efficacy measures described in Section 9.1.2 are established measures of cognitive and functional outcomes, as well as behavioral symptoms associated with AD dementia, and considered appropriate assessments for the early symptomatic AD population.

In addition, the primary target engagement outcome is the reduction of cerebral amyloid as measured by quantitative amyloid PET imaging (florbetapir F18\_PET SUVR) assessed at baseline, 24 weeks, 52 weeks and at 76 weeks after starting treatment. The postbaseline amyloid PET scans are aimed to assess the time course of amyloid reduction and sustainability of amyloid reduction. Reduction of paired helical filaments of cortical tau will be quantitatively assessed by tau PET imaging at baseline and 76 weeks.

## 9.2. Adverse Events

Investigators are responsible for monitoring the safety of patients who have entered this study and for alerting Lilly or its designee to any event that seems unusual, even if this event may be considered an unanticipated benefit to the patient.

The investigator is responsible for the appropriate medical care of patients during the study.

Investigators must document their review of each laboratory safety report.

The investigator remains responsible for following, through an appropriate health care option, AEs that are serious or otherwise medically important, considered related to the investigational product or the study, or that caused the patient to discontinue the investigational product before completing the study. The patient should be followed until the event resolves, stabilizes with appropriate diagnostic evaluation, or is reasonably explained. The frequency of follow-up evaluations of the AE is left to the discretion of the investigator.

Lack of drug effect is not an AE in clinical studies, because the purpose of the clinical study is to establish treatment effect.

After the informed consent form (ICF) is signed, study site personnel will record via CRF/electronic data entry the occurrence and nature of each patient's preexisting conditions, including clinically significant signs and symptoms of the disease under treatment in the study. In addition, site personnel will record any change in the condition(s) and any new conditions as AEs. Investigators should record their assessment of the potential relatedness of each AE to protocol procedure, investigational product, including radiopharmaceutical tracers, via CRF/electronic data entry.

The investigator will interpret and document whether or not an AE has a reasonable possibility of being related to study treatment, study device, or a study procedure, taking into account the disease, concomitant treatment or pathologies.

A “reasonable possibility” means that there is a cause and effect relationship between the investigational product, study device and/or study procedure and the AE.

The investigator answers yes/no when making this assessment.

Planned surgeries and nonsurgical interventions should not be reported as AEs unless the underlying medical condition has worsened during the course of the study.

If a patient’s investigational product is discontinued as a result of an AE, study site personnel must report this to Lilly or its designee via CRF/electronic data entry, clarifying if possible, the circumstances leading to any dosage modifications, or discontinuations of treatment.

### **9.2.1. Serious Adverse Events**

An SAE is any AE from this study that results in one of the following outcomes:

- death
- initial or prolonged inpatient hospitalization
- a life-threatening experience (i.e., immediate risk of dying)
- persistent or significant disability/incapacity
- congenital anomaly/birth defect
- important medical events that may not be immediately life-threatening or result in death or hospitalization but may jeopardize the patient or may require intervention to prevent one of the other outcomes listed in the definition above. Examples of such medical events include allergic bronchospasm requiring intensive treatment in an emergency room or at home, blood dyscrasias or convulsions that do not result in inpatient hospitalization, or the development of drug dependency or drug abuse.

All AEs occurring after signing the ICF are recorded in the CRF/electronic data entry and assessed for serious criteria. The SAE reporting to the sponsor begins after the patient has signed the ICF and has received investigational product, including radiopharmaceutical tracers. However, if an SAE occurs after signing the ICF, but prior to receiving investigational product, the SAE should be reported to the sponsor as per SAE reporting requirements and timelines (see Section 9.2) if it is considered reasonably possibly related to study procedure.

Study site personnel must alert Lilly or its designee of any SAE within 24 hours of investigator awareness of the event via a sponsor-approved method. If alerts are issued via telephone, they are to be immediately followed with official notification on study-specific SAE forms. This 24-hour notification requirement refers to the initial SAE information and all follow-up SAE information. Patients with a serious hepatic AE should have additional data collected using the CRF/electronic data entry.

Pregnancy (during maternal or paternal exposure to investigational product) does not meet the definition of an AE. However, to fulfill regulatory requirements any pregnancy should be reported following the SAE process to collect data on the outcome for both mother and fetus.

Investigators are not obligated to actively seek AEs or SAEs in subjects once they have discontinued and/or completed the study (the patient disposition CRF has been completed). However, if the investigator learns of any SAE, including a death, at any time after a subject has been discharged from the study, and he/she considers the event reasonably possibly related to the study treatment or study participation, the investigator must promptly notify Lilly.

#### **9.2.1.1. Suspected Unexpected Serious Adverse Reactions**

Suspected unexpected serious adverse reactions (SUSARs) are serious events that are not listed in the IB and that the investigator identifies as related to investigational product or procedure. United States 21 CFR 312.32 and European Union Clinical Trial Directive 2001/20/EC and the associated detailed guidances or national regulatory requirements in participating countries require the reporting of SUSARs. Lilly has procedures that will be followed for the identification, recording and expedited reporting of SUSARs that are consistent with global regulations and the associated detailed guidances.

#### **9.2.1.2. Adverse Events of Special Interest**

Specific safety topics of interest for this study include, but are not limited to, the following:

- ARIA-E
- ARIA-H
- Hypersensitivity (immediate and non-immediate), including infusion-related reactions
- Peripheral nervous system, central nervous system and muscle effects

The topics listed above, as well as other topics which may be subsequently determined by the sponsor, will be subject to enhanced surveillance activities. Additionally, the topics above will be analyzed for presentation in the Clinical Study Report in accordance with the Statistical Analysis Plan.

#### **9.2.2. Complaint Handling**

Lilly collects product complaints on investigational products and drug delivery systems used in clinical studies in order to ensure the safety of study participants, monitor quality, and to facilitate process and product improvements.

Patients will be instructed to contact the investigator as soon as possible if he or she has a complaint or problem with the investigational product so that the situation can be assessed.

### **9.3. Treatment of Overdose**

There is no known antidote to LY3002813. In case of overdose, use appropriate monitoring and supportive therapy.

## 9.4. Safety

### 9.4.1. *Physical and Neurological Examinations*

Complete physical examinations will be performed at screening, baseline, and Weeks 12, 24, 52, 76, and ED as indicated in the Schedule of Activities (Section 2). Brief physical examinations will be performed at Weeks 36 and 64. The complete physical examination will include assessment of the following: general appearance; skin, head and neck; lymph nodes; thyroid; abdomen (bowel sounds, liver and spleen palpation); back (costovertebral angle tenderness); and musculoskeletal, cardiovascular, and respiratory systems. The brief physical examination will include assessments of the skin, lungs, cardiovascular system, and abdomen (bowel sounds, liver and spleen palpation).

Complete neurological examinations will be performed as indicated in the Schedule of Activities (Section 2). The examinations will include a thorough assessment of gait, balance, coordination, cranial nerves, sensory and motor systems, and reflexes. If necessary given the training of the principal investigator, a neurologist will be consulted in the event of significant new findings.

If a clinically meaningful change in an MRI is noted during the study, an additional full neurological exam will be performed as soon as possible, along with any other medical follow-up deemed necessary by the investigator.

### 9.4.2. *Electrocardiograms*

For each patient, 12-lead digital ECGs will be collected as triplicates during the double-blind period according to the Schedule of Activities (Section 2). Patients must be supine for approximately 5 to 10 minutes before ECG collection and remain supine but awake during ECG collection.

Consecutive replicate ECGs will be obtained at approximately 1-minute intervals.

Electrocardiograms may be obtained at additional times, when deemed clinically necessary. Collection of more ECGs (more replicates) than expected at a particular time point is allowed when needed to ensure high-quality records.

Electrocardiograms will initially be interpreted by a qualified physician (the investigator or qualified designee) at the site as soon after the time of ECG collection as possible, and ideally while the patient is still present, to determine whether the subject meets entry criteria at the relevant visit(s) and for immediate patient management, should any clinically relevant findings be identified.

After enrollment, if a clinically significant increase in the QT/corrected QT (QTc) interval from baseline or other clinically significant quantitative or qualitative change from baseline is identified, the patient will be assessed by the investigator for symptoms (e.g., palpitations, near syncope, syncope) and to determine whether the patient can continue in the study. The investigator or qualified designee is responsible for determining if any change in patient management is needed. The investigator or qualified designee must document his/her review of

the ECG printed at the time of evaluation from at least 1 of the replicate ECGs from each time point.

All digital ECGs will be electronically transmitted to a designated central ECG laboratory. A cardiologist at the central ECG laboratory will then conduct a full overread on 1 of the replicates (including all intervals). A report based on data from this overread will be issued to the investigative site. For each set of replicates, the cardiologist will determine the RR and QT intervals, and heart rate on the ECGs that were not fully overread. These data are not routinely reported back to the investigative site. All data from the overreads will be placed in the Lilly database for analytical and study report purposes.

When there are differences in ECG interpretation between the investigator (or qualified designee) and the cardiologist at the central ECG laboratory, the investigator's (or qualified designee's) interpretation will be used for study entry and immediate patient management. Interpretations from the cardiologist at the central ECG laboratory will be used for data analysis and report writing purposes.

The investigator (or qualified designee) must document his/her review of 1 of the replicate ECGs printed at the time of collection, the final overread ECG report issued by the central ECG laboratory, and any alert reports.

### **9.4.3. Vital Signs**

Vital signs, including temperature, will be measured at all visits.

#### **9.4.3.1. Blood Pressure**

Sitting blood pressure and pulse will be measured after 5 minutes in the sitting position at **all** visits. In addition, orthostatic blood pressure and pulse will be measured supine and standing at designated visits, as detailed in the Schedule of Activities (Section 2).

**Orthostatic Blood Pressure Monitoring:** For orthostatic blood pressure monitoring, subjects should be supine for at least 5 minutes and stand for at least 3 minutes prior to taking the respective measurements. If the subject feels unable to stand, only supine vital signs will be recorded.

Unscheduled orthostatic vital signs should be assessed, if possible, during any AE of dizziness or posture-induced symptoms.

Any clinically significant findings from vital signs measurement that result in a diagnosis and that occur after the patient receives the first dose of study treatment should be reported to Lilly or its designee as an AE via CRF/electronic data entry.

#### **9.4.3.2. Height, Weight, and Body Temperature**

Height and body weight will be measured. Measurements should be taken without shoes and, when possible, the same scale should be used for all measurements. Body mass index (BMI) will be calculated from the height and body weight. Temperature will be recorded using an oral or tympanic (or other acceptable route) thermometer.

Body weight will be collected on the laboratory requisition for creatinine clearance calculations. Any body weight data entered into the eCRF will be used for the overall data analysis.

#### **9.4.4. Laboratory Tests**

For each patient, laboratory tests detailed in ([Appendix 2](#)) should be conducted according to the Schedule of Activities (Section 2).

With the exception of laboratory test results that may unblind the study, Lilly or its designee will provide the investigator with the results of laboratory tests analyzed by a central vendor, if a central vendor is used for the clinical trial.

Any clinically significant findings from laboratory tests that result in a diagnosis and that occur after the patient receives the first dose of investigational product should be reported to Lilly or its designee as an AE via CRF/electronic data entry.

#### **9.4.5. Immunogenicity Assessments**

Where local regulations and ERBs allow, at the visits and times specified in the Schedule of Activities (Section 2), venous blood samples of approximately 10 mL each will be collected to determine antibody production against LY3002813. To interpret the results of immunogenicity, a venous blood sample will be collected, if warranted, at the same time points to determine the serum concentrations of LY3002813. All samples for immunogenicity should be taken predose when applicable and possible.

Immunogenicity will be assessed by a validated assay designed to detect ADAs in the presence of LY3002813 at a laboratory approved by the sponsor. Antibodies may be further characterized and/or evaluated for their ability to neutralize the activity of LY3002813. The testing paradigm is outlined in Section [10.3.4.6](#).

Samples will be retained for a maximum of 15 years after the last patient visit, or for a shorter period if local regulations and ERBs allow, at a facility selected by the sponsor. The duration allows the sponsor to respond to future regulatory requests related to LY3002813. Any samples remaining after 15 years will be destroyed.

#### **9.4.6. Other Tests**

##### **9.4.6.1. Columbia Suicide Severity Rating Scale – Adult Version**

Consistent with Food and Drug Administration (FDA) regulatory guidance (FDA 2012), any occurrence of suicide-related thoughts and behaviors will be assessed as indicated in the Schedule of Activities (Section 2). The C-SSRS is a scale that captures the occurrence, severity, and frequency of suicide-related thoughts and behaviors during the corresponding assessment period. The scale includes suggested questions to elicit the type of information needed to determine if a suicide-related thought or behavior occurred.

The first time the scale is administered in this study, the C-SSRS “Baseline” version will be used, and the findings will constitute the baseline assessment. The C-SSRS “Since Last Visit” scale will be used for all subsequent assessments.



The C-SSRS will be administered to the patient with the study partner/study informant present or available by telephone, after the cognitive and functional assessments. Responses from both the study partner/study informant and patient will be considered when administering the scale. If a suicide-related thought or behavior is identified at any time during the study, a thorough evaluation will be performed by a study physician, and appropriate medical care will be provided.

The Lilly Self-Harm Supplement should be completed every time the C-SSRS is administered. If, based on administration of the C-SSRS, it is determined that suicide-related behaviors have occurred, then the Lilly Self-Harm Follow-Up form will be used to collect additional information to allow for a more complete assessment of these behaviors.

#### **9.4.6.2. Magnetic Resonance Imaging**

Magnetic resonance imaging of the brain will be performed according to the Schedule of Activities (Section 2) and as clinically indicated. This technology will be used to check for evidence of ARIA-H or ARIA-E, and other clinically relevant inclusion/exclusion and safety findings (The MRI data will also be used to calculate brain volumes, as noted in Section 9.1.3).

The MRI scans will be reviewed by the investigator or qualified designee for immediate patient management. Any clinically significant findings noted at baseline that result in a diagnosis should be recorded as a preexisting condition or AE. After the MRI scan is read locally, the MRI scans will be sent for analysis to a centralized MRI vendor designated by Lilly. Final MRI eligibility at screening will be determined by the centralized MRI vendor designated by Lilly and the MRI results will be reported to the site as “does” or “does not” meet MRI eligibility criteria. Specific analyses of the scans including assessments of ARIA-H and ARIA-E and calculations of brain volumes will be interpreted by the centralized MRI vendor for data analysis and report-writing purposes. Results of centrally read MRIs regarding patient care/safety will be reported back to sites.

#### **9.4.6.3. Ophthalmological Examination**

While the BACE inhibitor LY3202626 is no longer being administered in this study (see Section 5.1), ophthalmological examinations in patients who previously received LY3202626 or oral placebo will be performed at the next scheduled examination time point after their final dose of oral study medication (see the Schedule of Activities [Section 2]). Patients who received LY3202626/oral placebo after their Visit 9 ophthalmological examination are to have an unscheduled ophthalmological examination at the next available opportunity. Patients screened or randomized under the current amendment are not required to undergo any ophthalmological examinations at baseline or any other study visits.

Patients who previously received LY3202626 or oral placebo will undergo comprehensive ophthalmological examinations performed by an ophthalmologist or optometrist (where permitted by law) to assess visual function and morphology. Scheduled examinations will include the following: visual acuity, intraocular pressure, dilated funduscopy exam (dilation only performed in patients without contraindication to mydriatics), slit lamp exam, color photography of the retina, and optical coherence tomography (OCT) or equivalent; examinations

will also include color vision assessment. Assessments will preferably be performed by the same ophthalmologist or optometrist for each patient's visit. Patients who complain of vision disturbance, such as change in field of vision, color, acuity or anything potentially localizable to the retina, during the clinical trial should be referred to the ophthalmologist or optometrist (where permitted by law) for unscheduled evaluation.

Data from the ophthalmological examination visits will be provided from the local ophthalmologist or optometrist to the investigator.

The local ophthalmologist or optometrist will review the color photography and OCT to aid in immediate patient management. Additionally, the color photography of retina and OCT will be analyzed by a central reader.

Unblinded results of the eye safety data will be reviewed by the DMC.

Any clinically significant findings that result in a diagnosis should be reported to Lilly or its designee as a pre-existing condition or AE via eCRF per Section 9.2. The PI will make all final determinations of AEs in consultation with performing eye examiner, if applicable.

#### **9.4.6.4. Dermatological Examination**

While the BACE inhibitor LY3202626 is no longer being administered in this study, complete dermatological examinations in patients who previously received LY3202626 or oral placebo will be performed at the next scheduled examination time point after their final dose of oral study medication (see the Schedule of Activities [Section 2]). Patients who received LY3202626/oral placebo after their Visit 8 dermatological examination are to have an unscheduled dermatological examination at the next available opportunity. Patients screened or randomized under the current amendment are not required to undergo any skin exams at baseline or any other study visits.

This examination will preferably be performed by the same dermatologist for each patient's visit. All dermatological examinations must be performed by a dermatologist who will inspect the patient's unclothed full body using an ultraviolet (UV) light. The initial examination will include Fitzpatrick skin-type classification scale.

At each examination, abnormal hypopigmentation will be assessed by location, percentage of body surface area involvement, degree (partial/decreased pigmentation to complete depigmentation), and other findings in or around the hypopigmented area (such as redness or induration). A static physician's global assessment (sPGA) will be used to determine the patient's overall hypopigmentation severity at a given time point using a visual analog scale (VAS) ranging from 0 to 100. In addition, patients noted to have evidence of hypopigmentation will be asked to record how bothersome they find the hypopigmentation on a VAS ranging from 0 to 100. Skin photographs may be taken as appropriate for generating supporting documentation, but not for the purpose of primary clinical dermatologic evaluation or for data generation or analysis. A punch biopsy may be obtained at the discretion of the dermatologist.

Unblinded results of the dermatological safety data will be reviewed by the DMC.



Any clinically significant findings that result in a diagnosis should be reported to Lilly or its designee as a pre-existing condition or AE via eCRF per Section 9.2. The PI will make all final determinations of AEs in consultation with the dermatologist.

#### **9.4.7. Safety Monitoring**

Lilly will periodically review evolving aggregate safety data within the study by appropriate methods.

In the event that safety monitoring uncovers an issue that needs to be addressed by unblinding at the group level, only members of the data monitoring board (an advisory group for this study formed to protect the integrity of data; refer to Interim Analyses section [Section 10.3.6]) can conduct additional analyses of the safety data.

Lilly will review SAEs within time frames mandated by company procedures. The Lilly clinical research physician or scientist will, as appropriate, consult with the functionally independent Global Patient Safety therapeutic area physician or clinical scientist, and periodically review:

- trends in safety data
- laboratory analytes including blood hematology, chemistry, and urinalysis
- AEs including monitoring of hypersensitivity and infusion reactions, AEs associated with anti-LY3002813 antibodies (immunogenicity), ARIA-H, ARIA-E, ECG findings, neurological findings, hemorrhagic stroke, microhemorrhage (cerebral microhemorrhage, cerebellar microhemorrhage, brain stem microhemorrhage) as identified by investigator, and suicide-related thoughts and behaviors.

##### **9.4.7.1. LY3002813 Hypersensitivity (Immediate and Non-immediate), Including Infusion-Related Reactions**

###### **9.4.7.1.1. Premedication for Infusions**

Premedication for dosing is not planned. However, if an infusion reaction occurs, appropriate medication may be used as determined by the study investigators (see Section 7.7). The patient may be premedicated for subsequent infusions. If infusion reactions are observed, but review of the data suggests that dosing may continue, administration of medicines such as acetaminophen (500 to 1000 mg) and/or an antihistamine, and/or methylprednisolone (or other corticosteroid) may be administered before starting subsequent infusions at the discretion of the investigator. Any premedication given will be documented as a concomitant therapy (see Section 7.7).

###### **9.4.7.1.2. Management of Infusion Reactions**

There is a risk of an infusion reaction with any biological agent; therefore, all patients should be monitored closely. Symptoms and signs that may occur as part of an infusion reaction include, but are not limited to, fever, chills, nausea, headache, bronchospasm, hypotension, angioedema, throat irritation, rash, pruritus, myalgia, and dizziness. In the event that an infusion reaction occurs, the following guidance should be followed:

- the investigational product infusion should be slowed or stopped, depending on the symptoms/signs present
- if slowed, the infusion should be completed at the slower rate, as tolerated and documented in the CRF
- if stopped, no further attempts to administer the investigational product will be made, and this will be documented in the CRF
- supportive care should be employed in accordance with the symptoms/signs.

Management of the infusion reaction should proceed according to the severity of the reaction as per the flowchart in the Manual of Operations. This may include, but is not limited to, rescue medications such as diphenhydramine, epinephrine, and/or methylprednisolone.

Additional data should also be collected via the CRF/electronic data entry. Please see the Operations Manual for more detail.

Additional, unscheduled stored serum samples for possible immune safety laboratory testing (including but not limited to  $\beta$  tryptase, total immunoglobulin E, and immune complex testing) should also be collected as close to the onset of the event as possible, but within 120 minutes, and 4-6 weeks after moderate or severe infusion reactions.

#### 9.4.7.2. LY3002813 Immunogenicity

Patients are to return to the site for immunogenicity and safety follow-up visits (Visit 801 through Visit 804) beginning at Week 88 (or 12 weeks after their last dose of LY3002813) for collection of blood samples for anti-drug antibody (ADA; anti-LY3002813 antibody) and PK measurement, assessment of adverse events, C-SSRS, concomitant medications, and vital signs. The results of ADA testing remain blinded.

In order to preserve the blind, patients will need to complete Visits 801 through 804 until all patients in the trial have reached Visit 21 and datalock for the treatment period has been achieved. After **datalock**, the central laboratory will notify the sites and sponsor (or designee) as to whether a patient requires additional clinic visits beyond Visit 801, or meets criteria for discharge from immunogenicity follow-up. A patient will stop immunogenicity follow-up visits when he or she either completes 3 additional quarterly visits (e.g., Week 100, Week 112, and Week 124) or completes a visit at which his or her ADA returns to baseline (2-fold titer from baseline), whichever occurs first. Each subsequent visit after V801 will be scheduled only for those patients who meet the criteria for continued testing. Once the patient meets the criteria for discharge from follow-up, either a telephone contact or clinic visit should be conducted to complete the patient's participation in the study. See the Schedule of Activities (Section 2) for the timing of events and the measures to be assessed.

Treatment-emergent ADAs are defined in Section 10.3.4.6. A PK sample may be collected at the follow-up immunogenicity assessment(s) if warranted and agreed upon between both the investigator and sponsor.

In the event of drug hypersensitivity reactions (immediate or non-immediate), additional samples will be collected as close to the onset of the event as possible, but within 120 minutes, at the

resolution of the event, and 4-6 weeks following the event. Instructions for the collection and handling of blood samples will be provided by the sponsor. The actual date and time (24-hour clock time) of each sampling will be recorded. In the event of a finding of hypersensitivity, the investigator is to complete the CRF regarding the presence or absence of symptoms related to the hypersensitivity.

#### 9.4.7.3. Hepatic Safety Monitoring

If a study patient experiences elevated ALT  $\geq 3X$  ULN, ALP  $\geq 2X$  ULN, or elevated TBL  $\geq 2X$  ULN, liver testing ([Appendix 4](#)) should be repeated within 3 to 5 days including ALT, AST, ALP, TBL, direct bilirubin, gamma-glutamyl transferase, and creatine kinase to confirm the abnormality and to determine if it is increasing or decreasing. If the abnormality persists or worsens, clinical and laboratory monitoring should be initiated by the investigator and in consultation with the study medical monitor. Monitoring of ALT, AST, TBL, and ALP should continue until levels normalize or return to approximate baseline levels.

#### Hepatic Safety Data Collection

Additional safety data should be collected via the CRF/electronic data entry if 1 or more of the following conditions occur:

- elevation of serum ALT to  $\geq 5X$  ULN on 2 or more consecutive blood tests
- elevated serum TBL to  $\geq 2X$  ULN (except for cases of known Gilbert's syndrome)
- elevation of serum ALP to  $\geq 2X$  ULN on 2 or more consecutive blood tests
- patient discontinued from treatment due to a hepatic event or abnormality of liver tests
- hepatic event considered to be a SAE

#### 9.4.7.4. Amyloid-Related Imaging Abnormalities (ARIA-E and ARIA-H)

To ensure patient safety and to comply with regulatory guidance, the investigator is to consult with the Lilly-designated Medical Monitor regarding collection of specific recommended clinical information and follow-up MRIs. In the event of a finding of ARIA-E on MRI, the investigator is to complete the CRF regarding the presence or absence of symptoms related to the ARIA-E. While most cases of ARIA-E are asymptomatic, when symptoms do occur, they are reported to be most commonly headache, worsening of cognitive function, alteration of consciousness, seizures, unsteadiness, and vomiting. Even when symptomatic ARIA-E is present, in most cases, treatment is not required beyond a dose reduction (see [Section 7.4.1](#)) or temporary (see [Section 8.1.1.1](#)) or permanent (see [Section 8.1](#)) discontinuation of the LY3002813 treatment until the imaging abnormalities have resolved. If a patient simultaneously develops more than one of the symptoms suggestive of ARIA-E, then an unscheduled MRI should be performed. A single symptom suggestive of ARIA-E of sufficient severity may also warrant an MRI.

If the above-mentioned symptoms are reported, and ARIA-E is suspected, then the abnormality is best detected by fluid attenuation inversion recovery (FLAIR) sequences on MRI and ARIA-H is best detected with the T2\* gradient-recalled echo on MRI.

An unscheduled MRI with these imaging sequences should be obtained upon suspicion of ARIA. If ARIA is present, it is recommended to repeat MRIs with these sequences every 4 to 6 weeks until resolution of ARIA-E or stabilization of ARIA-H is documented. For asymptomatic or mild symptoms, the patient can be observed; for moderate symptoms associated with ARIA-E, the use of oral or IV steroids can be considered. In the case of severe symptoms associated with ARIA-E, it is recommended to hospitalize the patient for close observation and consider the use of IV steroids such as high-dose dexamethasone or a similar agent.

The unscheduled MRI should be performed in the same manner as the currently scheduled MRIs in the protocol, which includes sending the images for central review.

#### **9.4.8. Appropriateness of Safety Assessments**

The clinical safety measurements (AE reporting, physical examinations, neurological examinations, vital signs, ECGs, and clinical safety laboratory tests [including immunogenicity]; Section 9.2 and Section 9.4) are well-established methods in drug development research and are standard procedures for clinical trials.

Performance of MRIs is indicated based on the potential for the occurrence of ARIA during treatment with LY3002813. Therefore, Study AACG will include serial MRIs beginning at baseline and following dosing according to the Schedule of Activities for assessment of ARIA.

LY3002813 is an antibody therapy. As noted previously, a high prevalence of LY3002813 ADAs was observed in Study AACC and AACD; therefore, immunogenicity analyses are indicated. Blood samples for the assessment of immunogenicity will be taken at regular intervals throughout the dosing and follow-up periods.

Performance of ophthalmological and dermatological examinations is indicated in subjects who were previously treated with LY3202626, based on the potential for the occurrence of adverse retinal effects and hypopigmentation, respectively, during treatment with LY3202626. While LY3202626 is no longer being administered in this study, dermatological and ophthalmological examinations in subjects who previously received this therapy or oral placebo will be performed at the next scheduled examination time point after their final dose of oral study medication, in accordance with the Schedule of Activities (Section 2). Patients who received LY3202626/oral placebo after their Visit 8 or 9 dermatological or ophthalmological examination are to have an unscheduled examination at the next available opportunity. Patients screened or randomized under the current amendment are not required to undergo any dermatological or ophthalmological examinations at baseline or any other study visits.

### **9.5. Pharmacokinetics**

At the visits and times specified in the Schedule of Activities (Section 2), venous blood samples of approximately 4 mL each will be collected to determine the serum concentrations of

LY3002813. Instructions for the collection and handling of blood samples will be provided by the sponsor. The actual date and time (24-hour clock time) of each sampling will be recorded.

Drug concentration information that may unblind the study will not be reported to investigative sites or blinded personnel until the study has been unblinded.

A maximum of 3 blood samples per patient may be drawn at additional time points during the study, if warranted and agreed upon between both the investigator and sponsor. Instructions for the collection and handling of blood samples will be provided by the sponsor.

If LY3002813 infusion is permanently discontinued but the patient remains in the study, one PK sample should be collected at the soonest scheduled visit regardless if serum LY3002813 is on the Schedule of Activities at that visit. Dosing dates and times should be collected. Subsequent PK sample collection should follow the protocol Schedule of Activities for serum LY3002813 collection unless the scheduled visit exceeds 6 months since discontinuation of infusions. No additional serum collection for LY3002813 is required once the patient exceeds 6 months since discontinuation of LY3002813 infusions.

Bioanalytical samples collected to measure LY3002813 or LY3202626 concentrations will be retained for a maximum of 1 year following last subject visit for the study. During this time, samples remaining after the bioanalyses may be used for exploratory analyses such as metabolism, protein binding, or bioanalytical method development/validation work.

## 9.6. Pharmacodynamics

### 9.6.1. Clearance of Amyloid Deposits

Florbetapir F18 PET provides quantitative assessment of amyloid plaque deposition in the brain and can serve as a PD biomarker of clearance of amyloid deposits.

Clearance of amyloid deposits (as assessed by florbetapir F18 PET signal) will be compared in LY3002813- and placebo-treated patients for those patients who undergo baseline, Visit 8 (Week 24), Visit 15 (Week 52) and endpoint Visit 21(Week 76) or ED florbetapir F18 PET scans as described in the Schedule of Activities (Section 2).

### 9.6.2. Accumulation of Tau Deposits

Flortaucipir F18 PET provides quantitative assessment of tau PHF in the brain and can serve as a PD biomarker of accumulation of tau deposits as AD progresses.

Extent of accumulation of tau PHF deposits (as assessed by flortaucipir F18 PET signal) will be compared in LY3002813- and placebo-treated patients for those patients who undergo baseline and endpoint Visit 21 (Week 76) or ED) flortaucipir F18 PET scans as described in the Schedule of Activities (Section 2).

## 9.7. Pharmacogenomics [OR] Genetics

### 9.7.1. *Apolipoprotein E Genotyping*

Apolipoprotein E (APOE) genotyping is a mandatory part of this study, unless country-specific laws and regulations prohibit this type of testing. Blood sampling for APOE genotyping will be performed as shown in the Schedule of Activities (Section 2). Neither patients nor investigators will receive the genotype results unless there is a country-specific law or regulation that requires notification of the results. Failure to collect samples for APOE will not be considered a protocol deviation if country-specific regulations prohibit the testing of genetic material or transportation of such material outside of the country.

### 9.7.2. *Whole Blood Samples for Pharmacogenetic Research*

A whole blood sample will be collected for pharmacogenetic analysis as specified in the Schedule of Activities (Section 2) where local regulations allow.

Samples will not be used to conduct unspecified disease or population genetic research either now or in the future. Samples will be used to investigate variable response to LY3002813 and to investigate genetic variants thought to play a role in AD. Assessment of variable response may include evaluation of AEs or differences in efficacy.

All samples will be coded with the patient number. These samples and any data generated can be linked back to the patient only by the investigator site personnel.

Samples will be retained at a facility selected by Lilly or its designee for a maximum of 15 years after the last patient visit for the study, or for a shorter period if local regulations and/or ERBs/investigational review boards (IRBs) impose shorter time limits. This retention period enables use of new technologies, response to regulatory questions, and investigation of variable response that may not be observed until later in the development of LY3002813 and LY3202626 or after LY3002813 and LY3202626 become commercially available.

Molecular technologies are expected to improve during the 15-year storage period and therefore cannot be specifically named. However, existing approaches include whole genome or exome sequencing, genome wide association studies, and candidate gene studies. Regardless of technology utilized, genotyping data generated will be used only for the specific research scope described in this section.

## 9.8. Biomarkers

Biomarker research is performed to address questions of relevance to drug disposition, target engagement, PD, mechanism of action, variability of patient response (including safety), and clinical outcome. Sample collection is incorporated into clinical studies to enable examination of these questions through measurement of biomolecules including deoxyribonucleic acid (DNA), ribonucleic acid (RNA), proteins, lipids, and other cellular elements.

Serum, plasma, and whole blood RNA samples for biomarker research will be collected at the times specified in the Schedule of Activities (Section 2) where local regulations allow.



Samples will be used for research on the drug target, disease process, variable response to LY3002813 and/or LY3202626, pathways associated with AD, mechanism of action of LY3002813 and LY3202626, and/or research method or in validating diagnostic tools or assay(s) related to AD.

All samples will be coded with the patient number. These samples and any data generated can be linked back to the patient only by the investigator site personnel.

Samples will be retained at a facility selected by Lilly or its designee for a maximum 15 years after the last patient visit for the study, or for a shorter period if local regulations and ERBs impose shorter time limits. This retention period enables use of new technologies, response to regulatory questions, and investigation of variable response that may not be observed until later in the development of LY3002813 and LY3202626 or after LY3002813 and LY3202626 become commercially available.

### **9.9. Medical Resource Utilization and Health Economics**

Dependence, or the level of assistance required by a patient, has been suggested as a construct for assessing the effect of AD treatment. The process of increasing dependence on others is intended as a complementary measure to existing clinical measures in order to help explain the impact of AD on economic issues such as the risk of institutionalization and caregiver burden (McLaughlin et al. 2010; Spackman et al. 2013). Recently, the Alzheimer's Disease Cooperative Study Activities of Daily Living Inventory (ADCS-ADL) scores were used to map individuals into one of six dependence levels (0 to 5): Level 0 – No iADL/bADL impairment; Level 1 – Some supervision needed on isolated iADLs; Level 2 – Supervision on multiple iADLs or loss of at least 1 household activity; Level 3 – Supervision on all types of iADLs or homebound; Level 4 – Supervision on some bADLs; and Level 5 – Impaired transfer or complete incontinence (Kahle-Wroblewski et al. 2015). An approach to transforming continuous functional scale scores into discrete levels of dependence was examined previously in a longitudinal observational study, with preliminary results suggesting acceptable validity and progression in dependence level over time (Kahle-Wroblewski et al. 2017). At baseline, 49.6% of those with mild AD dementia were dependence level 2 and 42.7% were at levels 3 or 4. At 18 months, the proportion of patients at level 2 declined to 31.2% while that at levels 3 and 4 rose to 58.8%. Analyses will be conducted to examine changes in dependence levels across the trial population as well as potential differences on dependence level by treatment group assignment.

## 10. Statistical Considerations

### 10.1. Sample Size Determination

Approximately 250 subjects will be enrolled and randomized in a 1:1 ratio to the 2 treatment arms (placebo and LY3002813). It is expected that approximately 200 subjects will complete the double-blind treatment period of the study (approximately 100 per treatment arm). This sample size will provide approximately 84% power to demonstrate that the active treatment arm has a  $\geq 0.6$  posterior probability of slowing down iADRS progression over placebo by at least 3 points. The assumption for power calculation is that mean progression levels in the placebo and LY3002813 arms are approximately 12 and 6 points (50% slowing) over 18 months, respectively, with common standard deviation of 17. If the active treatment arm is placebo-like with no efficacy, the probability of passing the efficacy criterion specified above (i.e., false positive) is approximately 6%. The simulation for the power calculation and sample size determination was carried out in FACTS Version 6.0.

### 10.2. Populations for Analyses

For purposes of analysis, in general the following populations are defined unless otherwise specified:

For efficacy analysis, the Full Analysis Set will group patients according to randomized treatment assignment (LY3002813 or placebo), even if the patient does not take the assigned treatment, does not receive the correct treatment, or otherwise does not follow the protocol. When change from baseline is assessed, patients will be included in the analysis only if both a baseline and at least 1 valid post-baseline measure are available.

For safety analysis, all patients who received at least 1 dose of randomized study treatment (LY3002813 or placebo) will be included in the safety analysis set. In safety data presentations, erroneously treated patients (e.g., those randomized to “Treatment A” but actually given “Treatment B”) will be accounted for in their actual treatment groups.

There were approximately 48 patients randomized before the removal of LY3202626 treatment in protocol amendment (d) (about 16 each in the LY3002813 and LY3202626 combination therapy arm, LY3002813 monotherapy arm, and placebo arm). Patients already randomized to the former LY3002813 monotherapy arm and placebo arm will be pooled with patients randomized after protocol amendment (d) to form the Full Analysis Set and safety analysis set specified above. Data from patients randomized to the LY3002813 and LY3202626 combination therapy arm will be summarized separately and will not be included in treatment comparisons on efficacy and safety endpoints. The total number of patients to be randomized in the study is approximately 266.



## 10.3. Statistical Analyses

### 10.3.1. General Statistical Considerations

Unless otherwise noted, all pairwise tests of treatment effects will be conducted at a 2-sided alpha level of 0.05; 2-sided CIs will be displayed with a 95% confidence level. All tests of interactions between treatment and other factors will be conducted at an alpha level of 0.05. Bretz' graphical approach may be utilized to provide strong control of the study wise Type I error rate for the primary and key secondary hypotheses at alpha level of 0.05 (Bretz et al. 2009; Bretz et al. 2011). Details on the graphical approach and testing strategy will be specified in the statistical analysis plan (SAP).

All efficacy analyses will follow the intent-to-treat (ITT) principle unless otherwise specified. An ITT analysis is an analysis of data by the groups to which subjects are assigned by random allocation, even if the subject does not take the assigned treatment, does not receive the correct treatment, or otherwise does not follow the protocol.

When change from baseline is assessed, subjects will be included in the analysis only if both a baseline and a postbaseline measure are available. Unless otherwise defined, a baseline measure is the last nonmissing observation collected prior to the first administration of study medications. Endpoint is the last nonmissing postbaseline measurement.

For MMRM models, observations collected at nonscheduled visits will not be included in the analyses.

A database lock is expected to occur after all randomized subjects have had chance to complete double-blind period of the study. Efficacy and safety analyses will be conducted based on data collected during double-blind period. Data collected during immunogenicity and safety follow-up period will be summarized and analyzed separately.

Any change to the data analysis methods described in the protocol will require an amendment ONLY if it changes a principal feature of the protocol. Any other change to the data analysis methods described in the protocol and the justification for making the change will be described in the SAP and clinical study report. Additional exploratory analyses of the data will be conducted as deemed appropriate.

Details of the statistical methods are specified in the SAP for Study AACG.

#### 10.3.1.1. Handling of Missing Items for Scales

If any of the individual items for ADAS-Cog or ADCS-ADL are missing or unknown, every effort will be made to obtain the score for the missing item or items.

For ADAS-Cog<sub>13</sub>, if 4 or fewer of a total of 13 items are missing, the total score (maximum = 85) will be imputed as follows: The total from remaining items will be multiplied by a factor that includes the maximum score for the missing items. For example, if the first item, "Word-Recall Task," which ranges from a score of 0 through 10 (maximum = 10), is missing, and the second item "Commands," which ranges from a score of 0 to 5 (maximum = 5), is missing, then the

multiplication factor =  $85 / (85 - [10 + 5]) = 85 / 70 = 1.21$ . Thus, the total score for this example will be the sum of the remaining 12 items multiplied by 1.21. The imputed number will be rounded up to the nearest integer. If more than 4 items are missing, the total score for ADAS-Cog<sub>13</sub> at that visit will be considered missing.

For the ADCS-iADL, if <30% of the items are missing, the total score will be imputed. The sum of the nonmissing items will be prorated to the sum of total items. The imputed number will be rounded up to the nearest integer. If the nearest integer is greater than the maximum possible score, the imputed score will be equal to the maximum score. If >30% of the items are missing, the total score for ADCS-iADL at that visit will be considered missing. The same imputation technique will be applied to the ADCS-ADL total score. Note that, depending on the specific item responses that are missing, it is possible to have an imputed total score for both the ADCS-iADL and the ADCS-ADL, an imputed total score for one but not the other, or both total scores missing.

The same imputation technique will be applied to the CDR-SB. If only 1 box (of 6) of the CDR is missing, the sum of the boxes will be imputed by prorating the sum from the other 5 boxes. If the score from more than 1 box is not available, the CDR-SB at that visit will be considered missing.

iADRS score is calculated as – ADAS-Cog<sub>13</sub> score + 85 + ADCS-iADL score. If either ADAS-Cog<sub>13</sub> or ADCS-iADL is missing, iADRS score will be considered missing.

For all other scales, if any item is missing, any total or sum involving that item will be considered missing.

### **10.3.2. Treatment Group Comparability**

#### **10.3.2.1. Subject Disposition**

All patients who discontinue from the study will be identified, and the extent of their participation in the study will be reported. If known, a reason for their discontinuation will be given.

The reasons for discontinuation will be collected when the patient's participation in the study ends and will be summarized by treatment group for all randomized subjects. The percentage of subjects discontinuing from each treatment group will be compared between groups using Fisher's exact test. The comparisons will be done for the overall percentage of patients who discontinue and for select specific reasons for discontinuation.

#### **10.3.2.2. Subject Characteristics**

The patient's age, gender, race, height, body weight, BMI (weight (kg) / [height (m)]<sup>2</sup>), tobacco use, alcohol use, caffeine use, years of education, work status, time since onset of first AD symptoms, time since diagnosis, baseline MMSE, CBB score at Visit 1, apolipoprotein E (APOE) genotype (E4 carrier vs. non-carrier), having 1 or more first degree relatives with AD, and AChEI and/or memantine use at baseline will be recorded.

Baseline characteristics will be summarized by treatment group and overall. Summaries will include descriptive statistics for continuous and categorical measures. Fisher's exact test or Pearson's chi-square test will be used for treatment-group comparisons of categorical data. For continuous data, analysis of variance (ANOVA), with independent factors for treatment and investigator, will be used.

#### **10.3.2.3. Prior and Concomitant Therapy**

Prior medications are defined as those that stop before randomization (Visit 2). Concomitant medications are defined as those being taken on or after randomization (Visit 2). A summary of concomitant medications will be presented as frequencies and percentages for each treatment group. Fisher's exact test will be used to test for treatment differences between groups.

If the start or stop dates of therapies are missing or partial to the degree that determination cannot be made of whether the therapy is prior or concomitant, the therapy will be deemed concomitant.

Prior and concomitant medications will be listed.

Summary tables will also be provided for concomitant anticholinergics that affect cognitive function and AChEI/memantine medications.

Medications will be coded using the World Health Organization (WHO) drug dictionary.

#### **10.3.2.4. Treatment Compliance**

Summary statistics for LY3002813 treatment compliance will be provided for the total number of complete infusions received, duration of complete infusion, and volume of complete infusion by treatment group.

Frequencies and percentages of reasons why infusion was stopped will also be presented.

Summary statistics for LY3202626 treatment compliance will be provided for the proportion of patients who are compliant and noncompliant as noted in Section 7.6 of this protocol by treatment group.

### **10.3.3. Efficacy Analyses**

#### **10.3.3.1. Primary Analyses**

The primary objective of this study is to test the hypothesis that IV infusion of LY3002813 will slow the cognitive and/or functional decline of AD as measured by the composite measure iADRS compared with placebo in patients with early symptomatic AD. This will be assessed using an MMRM analysis.

The change from baseline score on the iADRS at each scheduled postbaseline visit (according to the Schedule of Activities) during the treatment period will be the dependent variable. The model for the fixed effects will include the following terms: baseline score, pooled investigator, treatment, visit, treatment-by-visit interaction, baseline-by-visit interaction, concomitant AChEI and/or memantine use at baseline (yes/no), and age at baseline. Visit will be considered a categorical variable. The null hypothesis is that the contrast between the LY3002813 group versus placebo at the last visit equals zero. An unstructured covariance matrix will be used to

model the within-subject variance-covariance errors. If the unstructured covariance structure matrix results in a lack of convergence, the following tests will be used in sequence: heterogeneous Toeplitz covariance structure, heterogeneous autoregressive covariance structure, heterogeneous compound symmetry covariance structure, and compound symmetry covariance structure. The Kenward-Roger approximation will be used to estimate the denominator degrees of freedom.

The primary time point for treatment comparison will be at Week 76. The treatment group contrast in least-squares mean progression and its associated p-value and 95% CI will be calculated for the treatment comparison of LY3002813 vs. placebo using the MMRM model specified above. In addition, Bayesian posterior probability of the active treatment arm being superior to placebo by at least a margin of interest (25% slowing of placebo progression) will also be calculated assuming a non-informative prior.

#### **10.3.3.2. Secondary Efficacy Analyses**

Similar to the primary analysis, each of the secondary efficacy outcomes will be assessed using an MMRM analysis. These secondary efficacy outcomes include ADAS-Cog<sub>13</sub>, ADCS-iADL<sub>2</sub>, CDR-SB, and MMSE. For each secondary efficacy measure, the change from baseline score at each scheduled postbaseline visit (according to the Schedule of Activities) during the treatment period will be analyzed using the same MMRM model described for the primary analysis.

Longitudinal changes from baseline in amyloid plaque (as measured by florbetapir F18 PET scan) and vMRI parameters will be analyzed using MMRM including the following terms in the model: baseline biomarker value, treatment, visit, treatment-by-visit interaction, and baseline-by-visit interaction. The change from baseline to endpoint in tau SUVR (as measured by flortaucipir PET scan) will be analyzed using an analysis of covariance (ANCOVA) model with terms of baseline value and treatment.

Any additional analyses of secondary efficacy outcomes and biomarkers will be specified in the SAP.

#### **10.3.4. Safety Analyses**

All subjects who receive at least 1 dose of LY3002813 will be evaluated for safety and tolerability. Safety parameters (AEs, laboratory analytes, vital signs, ECGs, and MRIs) will be summarized using descriptive statistics for continuous variables and frequencies along with percentages for categorical variables during the treatment period.

##### **10.3.4.1. Adverse Events**

Treatment-emergent adverse events will be defined as events that first occurred or worsened on or after randomization (Visit 2). Should there be insufficient data for AE start date and stop date the AE will be considered treatment emergent.

Treatment-emergent adverse events will be calculated based on adverse event identifier (AEID) and coded according to established Medical Dictionary for Regulatory Activities (MedDRA) terms and summarized by MedDRA System Organ Class (SOC) and Preferred Term.

An overview of AEs, including the number and percentage of subjects who died, had SAEs, discontinued due to AEs, and who had treatment-emergent AEs (TEAEs), will be summarized by treatment group.

#### 10.3.4.2. Vital Signs and Weight

Vital sign measurements and weight will be analyzed using continuous data (change from baseline) and categorical data (proportion of treatment-emergent abnormalities).

Summary statistics will be presented for observed values at baseline and for change from baseline results at each scheduled postbaseline visit and at endpoint(s). Systolic and diastolic blood pressure and pulse (collected in sitting position), temperature, and weight will be summarized.

The incidence of treatment-emergent abnormal high or low vital signs and weight will be summarized by treatment groups. Treatment-emergent vital sign evaluations are defined for evaluations collected after the initiation of study medication. Abnormal criteria for vital signs and weight are presented in [Table AACG.10.1](#). Any vital sign or weight outside the criterion values will be considered abnormal.

**Table AACG.10.1. Criteria for Abnormal Vital Signs**

Vital Sign Parameter (Unit)	Postbaseline Low Criteria	Postbaseline High Criteria
Sitting Systolic Blood Pressure (mmHg)	Absolute value $\leq 90$ and $\geq 20$ decrease from baseline	Absolute value $\geq 160$ and $\geq 20$ increase from baseline
Sitting Diastolic Blood Pressure (mmHg)	Absolute value $\leq 50$ and $\geq 10$ decrease from baseline	Absolute value $\geq 100$ and $\geq 10$ increase from baseline
Sitting Pulse (bpm)	Absolute value $< 50$ and $\geq 15$ decrease from baseline	Absolute value $> 100$ and $\geq 15$ increase from baseline
Weight	$\geq 4\%$ decrease	$\geq 4\%$ increase
Vital Sign Parameter (Unit)	Postbaseline Criteria for Abnormality	
Orthostatic Systolic Blood Pressure (mmHg)	$\geq 20$ mmHg decrease in systolic blood pressure (supine to standing) (i.e., supine minus standing $\geq 20$ )	
Orthostatic Diastolic Blood Pressure (mmHg)	$\geq 10$ mmHg decrease in diastolic blood pressure (supine to standing) (i.e., supine minus standing $\geq 10$ mm Hg)	
Orthostatic Pulse (bpm)	$\geq 30$ increase in bpm (standing to supine) (i.e., standing minus supine $\geq 30$ )	
Temperature	Absolute value $\geq 38.3^{\circ}\text{C}$ and $\geq 1.1^{\circ}\text{C}$ increase from baseline (Absolute value $\geq 101^{\circ}\text{F}$ and $\geq 2^{\circ}\text{F}$ increase from baseline)	

Abbreviation: bpm = beats per minute.

#### 10.3.4.3. Laboratory Analyses

Laboratory measurements will be analyzed as continuous data (change from baseline) measured as International System Units (SI) or as categorical data (proportion of treatment-emergent abnormalities).

If there are multiple records of laboratory measurements at baseline or postbaseline visits, the last record will be used.

Change from baseline to postbaseline visits at which laboratory measurements are taken will be summarized using descriptive statistics.

For all laboratory analytes, frequencies of subjects with notable changes (i.e., increases or decreases of a prespecified amount unique to each analyte) from baseline to each postbaseline visit will also be summarized for all subjects and stratified by low, normal, or high at baseline.

#### **10.3.4.4. Electrocardiograms**

The ECG measurements will be analyzed using continuous data (change from baseline) and categorical data (proportion of treatment-emergent abnormalities).

Since ECG is measured in triplicates during the double-blind period, the average of triplicates will be used at baseline and each double-blind period visit. If there are multiple records after averaging ECG triplicates within a visit, the last record of averages will be used.

The analysis will be done for the following ECG measurements: heart rate, PR, QT, QTc, and RR intervals and QRS duration. All analyses of QTc will be carried out using the Fridericia correction (QTcF) method. These summaries will include data from each visit ECG measures are performed.

Change from baseline to each postbaseline visit at which ECG measurements are taken will be assessed using an MMRM model. The model for the fixed effects will include terms for the following independent effects: baseline ECG score, pooled investigator, treatment, visit, treatment-by-visit interaction, baseline-by-visit interaction and age at baseline. This analysis will be done separately for each ECG parameter.

Incidence of treatment-emergent abnormal ECGs will be assessed by comparisons at (1) anytime and (2) each postbaseline visit between treatment groups with Fisher's exact test. For analyses of treatment-emergent abnormal ECGs, baseline will be considered as all visits before the initiation of drug dose.

Abnormal ECG criteria are presented in [Table AACG.10.2](#) and criteria for abnormal QTcF prolongation are presented in [Table AACG.10.3](#).



**Table AACG.10.2. Criteria for Abnormal ECG Parameters**

ECG Parameter	Low Criteria	High Criteria
Heart Rate	<50 bpm	>100 bpm
PR Interval	<120 msec	≥220 msec
QRS Duration	<60 msec	≥120 msec
QTc Interval		
males	<330 msec	≥450 msec
females	<340 msec	≥470 msec
males and females		> 500 msec

Abbreviations: bpm = beats per minute; ECG = electrocardiogram; QTc = corrected QT.

**Table AACG.10.3. Criteria for Prolonged ECG QTcF Interval**

QTc Delta Changes (msec)
>30
>60
>75

Abbreviations: QTc = corrected QT; QTcF = Fridericia-corrected QT.

Treatment-emergent high ECG parameters (heart rate, PR interval, QRS duration, and QT and QTcF intervals) are the values that are low or normal at all baseline visits and fall into the high abnormal categories in [Table AACG.10.2](#) and [Table AACG.10.3](#) postbaseline. Similarly, treatment-emergent low ECG parameters (heart rate, PR interval, and QRS duration) are the values that are high or normal at all baseline visits and fall into the low abnormal categories above.

For each treatment-emergent high ECG parameter in [Table AACG.10.2](#), only subjects who were low or normal at baseline and have at least 1 postbaseline value will be included in the denominator when computing the proportion of subjects with treatment-emergent high values. Similarly, only subjects who were high or normal at baseline and have at least 1 postbaseline value will be included in the denominator when computing the proportion of subjects with treatment-emergent low values.

For prolonged QTcF interval assessments, when computing the proportion of subjects with treatment-emergent high abnormalities, only subjects who were normal at baseline and had a nonmissing result at that postbaseline visit will be included in the denominator. A treatment-emergent high value is defined as a change from normal value at all baseline assessments to a value greater than 450 msec for males and 470 msec for females at postbaseline.

In addition, treatment differences in the proportion of subjects who have normal baselines with a change to abnormal high or abnormal low values at any postbaseline visits will be summarized. Treatment-emergent qualitative ECG findings will also be summarized.

**10.3.4.5. ARIA-E and ARIA-H**

The incidence of ARIA-E will be summarized. Change in ARIA-E status from baseline, to each subsequent MRI (in the event of unscheduled MRIs), and to double-blind period endpoint (Visit 21) will be compared between treatment groups using Fisher's exact test.

The incidence of changes in ARIA-H will be summarized. Change in ARIA-H status from baseline to endpoint will be compared between treatment groups using Fisher's exact test. The number and percentage of subjects with increases in size of preexisting ARIA-H, number of subjects with increases in number of ARIA-H, and number of subjects with increases in size of preexisting and/or number of ARIA-H from baseline to endpoint will be summarized for both treatment groups and compared using Fisher's exact test.

Subjects with ARIA-E and subjects with ARIA-H that increased in size and/or number postbaseline, and subjects with any other MRI findings will be listed.

**10.3.4.6. Evaluation of Immunogenicity**

Subject samples will be analyzed using a 4-tiered approach. All samples will be assessed in Tier 1 (screening) for the possible presence of ADA. Samples found to produce a signal above or equal to the screening cut point will be assessed in Tier 2 to confirm specificity to LY3002813 (confirmation). Any samples confirmed as specific for anti-LY3002813 antibodies will be reported as "detected." All samples below the screening cut point (Tier 1) or not confirmed (Tier 2) will be reported as "not detected." Any "detected" sample in Tier 2 will be assessed in Tier 3 (titer assessment) and Tier 4 (neutralizing antibodies). Anti-drug antibodies titer values will be reported from Tier 3 titer assessment. Any samples above the Tier 4 assay cut point will be reported as "detected for neutralizing antibodies"; samples below the assay cut point in Tier 4 will be reported as "not detected for neutralizing antibodies."

The frequency and percentage of subjects with preexisting (baseline) ADA, ADA at any time after baseline, and TE ADA to LY3002813 will be tabulated. If no ADAs are detected at baseline, TE ADA are defined as those with a titer 2 fold (1 dilution) greater than the MRD of the assay. For samples with ADA detected at baseline TE ADA are defined as those with a 4-fold (2 dilutions) increase in titer compared to baseline. For the TE ADA subjects, the distribution of maximum titers will be described. The frequency of neutralizing antibodies may also be tabulated. The relationship between the presence of antibodies to LY3002813 and PK, PD, safety and/or efficacy assessment may be assessed.

**10.3.4.7. Suicidal Ideation and Behavior**

Suicide-related thoughts and behaviors, based on the C-SSRS, will be listed by subject and visit. Only subjects that show suicidal ideation/behavior will be displayed (i.e., if a subject's answers are all "no" for the C-SSRS, then that subject will not be displayed). However, if a subject reported any ideation or behavior at any time point, then all their ideation and behavior will be displayed, even if not positive.



### **10.3.5. Pharmacokinetic/Pharmacodynamic Analyses**

Compartmental modeling of LY3002813 PK data using nonlinear mixed effects modeling or other appropriate software may be explored, and population estimates for clearance and central volume of distribution may be reported. Depending on the model selected, other PK parameters may also be reported. Exploratory graphical analyses of the effect of dose level or demographic factors on PK parameters may be conducted. If appropriate, data from other studies of LY3002813 may be used in this analysis.

Concentrations of LY3202626 were collected under the original version of this protocol, as well as amendments (a-c). These data will be summarized in the final study report and may be analyzed graphically. If appropriate, exploratory analyses may be conducted to evaluate potential relationships between LY3202626 concentrations and LY3002813 concentration.

The PK/PD relationships between plasma LY3002813 concentration and SUV<sub>r</sub>, cognitive endpoints, ARIA incidence rate or other markers of PD activity may be explored graphically. The relationship between the presence of antibodies to LY3002813 and PK, PD, safety and/or efficacy may be assessed graphically.

Additional modeling may be performed based on the results of the graphical analyses.

### **10.3.6. Interim Analyses**

A limited number of pre-identified individuals may gain access to the limited unblinded data, as specified in the unblinding plan, prior to the interim or final database lock, in order to initiate the final population PK/PD model development processes for interim or final analyses. Information that may unblind the study during the analyses will not be reported to study sites or blinded study team until the study has been unblinded. It is intended that access prior to the final database lock will be granted after the last patient completes Visit 18 (after 64 weeks of treatment).

An independent external Data Monitoring Committee (DMC) is to monitor data on an ongoing basis to ensure the continuing safety of patients enrolled in this study. There will be periodic safety data reviews during the study and the external DMC is authorized to evaluate results from unblinded safety data reviews. The timing and operational details of the DMC safety data reviews are defined in DMC charter.

At least one interim analysis may be conducted for Study AACG; for example, when all randomized subjects have had a chance to complete 52 weeks of treatment (Visit 15) and data will be used to evaluate whether to stop the study for futility. Additional assessment of efficacy may also be evaluated at the interim analyses to inform future development of the compounds and platform. For such futility and efficacy analyses, an internal assessment committee (IAC), but external to the study team, is authorized to evaluate results from the unblinded interim analyses. Operational details and a quantitative framework to provide information for these decisions will be documented in the statistical analysis plan (SAP). Study sites will receive information about interim results ONLY if they need to know for the safety of their patients.

Unblinding details are specified in the unblinding plan section of the SAP or a separate unblinding plan document.

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## 12. Appendices



## Appendix 1. Abbreviations and Definitions

Term	Definition
<b>A<math>\beta</math></b>	amyloid $\beta$
<b>AD</b>	Alzheimer's disease
<b>ADA</b>	anti-drug antibodies
<b>ADAS-COG<sub>13</sub></b>	Alzheimer's Disease Assessment Scale – Cognitive subscale 13
<b>ADCS-ADL</b>	Alzheimer's Disease Cooperative Study—Activities of Daily Living Inventory
<b>ADCS-bADL</b>	Alzheimer's Disease Cooperative Study—basic activities of daily living
<b>ADCS-iADL</b>	Alzheimer's Disease Cooperative Study—instrumental activities of daily living
<b>AE</b>	adverse event: Any untoward medical occurrence in a patient or clinical investigation subject administered a pharmaceutical product that does not necessarily have a causal relationship with this treatment. An adverse event can therefore be any unfavorable and unintended sign (including an abnormal laboratory finding), symptom, or disease temporally associated with the use of a medicinal (investigational) product, whether or not related to the medicinal (investigational) product.
<b>ALT</b>	alanine aminotransferase
<b>APOE</b>	Apolipoprotein subtype E
<b>ARIA-E</b>	amyloid-related imaging abnormalities—edema/effusions (also known as vasogenic edema)
<b>ARIA-H</b>	amyloid-related imaging abnormalities—hemorrhage/hemosiderin deposition (also known as cerebral microhemorrhage)
<b>AST</b>	aspartate aminotransferase
<b>BACE</b>	$\beta$ -site amyloid precursor protein cleaving enzyme
<b>blinding/masking</b>	<p>A single-blind study is one in which the investigator and/or his staff are aware of the treatment but the patient is not, or vice versa, or when the sponsor is aware of the treatment but the investigator and/his staff and the patients are not.</p> <p>A double-blind study is one in which neither the patient nor any of the investigator or sponsor staff who are involved in the treatment or clinical evaluation of the subjects are aware of the treatment received.</p>
<b>BMI</b>	body mass index



<b>bpm</b>	beats per minute
<b>CBB</b>	CogState Brief Battery
<b>CDR-SB</b>	Clinical Dementia Rating Scale – Sum of Boxes
<b>CIOMS</b>	Council for International Organizations of Medical Sciences
<b>Companion diagnostic</b>	An in vitro diagnostic device (assay or test) that provides information that is essential for the safe and effective use of a corresponding therapeutic product
<b>complaint</b>	A complaint is any written, electronic, or oral communication that alleges deficiencies related to the identity, quality, purity, durability, reliability, safety or effectiveness, or performance of a drug or drug delivery system.
<b>compliance</b>	Adherence to all study-related, good clinical practice (GCP), and applicable regulatory requirements.
<b>CRF</b>	case report form
<b>CRP</b>	clinical research physician: Individual responsible for the medical conduct of the study. Responsibilities of the CRP may be performed by a physician, clinical research scientist, global safety physician or other medical officer.
<b>C-SSRS</b>	Columbia Suicide Severity Rating Scale
<b>CTCAE</b>	Common Terminology Criteria for Adverse Events
<b>CYP3A</b>	cytochrome P450 3A
<b>DMC</b>	data monitoring committee
<b>ECG</b>	electrocardiogram
<b>eCOA</b>	Electronic Clinical Outcome Assessment
<b>ED</b>	early discontinuation
<b>ELISA</b>	enzyme-linked immunosorbent assay
<b>End of Study</b>	End of the study is the date of the last visit or last scheduled procedure shown in the Schedule of Activities (Section 2) for the last patient.
<b>enroll</b>	The act of assigning a patient to a treatment. Patients who are enrolled in the study are those who have been assigned to a treatment.
<b>enter</b>	Patients entered into a study are those who sign the informed consent form directly or through their legally acceptable representatives.
<b>FAS</b>	full analysis set
<b>FDA</b>	Food and Drug Administration
<b>GCP</b>	good clinical practice

<b>HBsAg</b>	hepatitis B surface antigen
<b>HCG</b>	human chorionic gonadotropin
<b>HCV</b>	hepatitis C virus
<b>IAC</b>	internal assessment committee
<b>iADRS</b>	integrated Alzheimer's Disease Rating Scale (iADRS)
<b>IB</b>	Investigator's Brochure
<b>ICF</b>	informed consent form
<b>ICH</b>	International Council for Harmonisation
<b>Informed consent</b>	A process by which a patient voluntarily confirms his or her willingness to participate in a particular study, after having been informed of all aspects of the study that are relevant to the patient's decision to participate. Informed consent is documented by means of a written, signed and dated informed consent form.
<b>interim analysis</b>	An interim analysis is an analysis of clinical study data, separated into treatment groups, that is conducted before the final reporting database is created/locked.
<b>investigational product</b>	A pharmaceutical form of an active ingredient or placebo being tested or used as a reference in a clinical trial, including products already on the market when used or assembled (formulated or packaged) in a way different from the authorized form, or marketed products used for an unauthorized indication, or marketed products used to gain further information about the authorized form.
<b>ITT</b>	intention to treat: The principle that asserts that the effect of a treatment policy can be best assessed by evaluating on the basis of the intention to treat a patient (i.e., the planned treatment regimen) rather than the actual treatment given. It has the consequence that patients allocated to a treatment group should be followed up, assessed, and analyzed as members of that group irrespective of their compliance to the planned course of treatment.
<b>IVRS/IWRS</b>	interactive voice-response system/interactive web-response system
<b>MedDRA</b>	Medical Dictionary for Regulatory Activities
<b>MHIS</b>	Modified Hachinski Ischemic Scale
<b>MMRM</b>	mixed-model repeated-measures
<b>MMSE</b>	Mini-Mental State Examination
<b>MOA</b>	mechanism of action
<b>MRI</b>	magnetic resonance imaging
<b>NIA-AA</b>	National Institute on Aging (NIA) and the Alzheimer's Association (AA)
<b>No</b>	number

<b>PCR</b>	polymerase chain reaction
<b>PET</b>	positron emission tomography
<b>PHF</b>	paired helical filament deposits
<b>PK/PD</b>	pharmacokinetics/pharmacodynamics
<b>PPS</b>	per-protocol set: The set of data generated by the subset of patients who sufficiently complied with the protocol to ensure that these data would be likely to exhibit the effects of treatment, according to the underlying scientific model.
<b>PRO/ePRO</b>	patient-reported outcomes/electronic patient-reported outcomes
<b>Q2WK</b>	once every 2 weeks
<b>Q4WK</b>	once every 4 weeks
<b>QD</b>	once a day
<b>QW</b>	once a week
<b>QT</b>	QT interval on the ECG
<b>QTc</b>	corrected QT interval
<b>QTcF</b>	Fridericia's corrected QT interval
<b>RBC</b>	red blood cell
<b>SAE</b>	serious adverse event
<b>SAP</b>	statistical analysis plan
<b>screen</b>	The act of determining if an individual meets minimum requirements to become part of a pool of potential candidates for participation in a clinical study.
<b>SHSF</b>	Self-Harm Supplement form
<b>SPF</b>	skin protection factor
<b>SUSARs</b>	suspected unexpected serious adverse reactions
<b>TE</b>	treatment-emergent
<b>TEADA</b>	treatment-emergent anti-drug antibody
<b>TEAE</b>	treatment-emergent adverse event: An untoward medical occurrence that emerges during a defined treatment period, having been absent pretreatment, or worsens relative to the pretreatment state, and does not necessarily have to have a causal relationship with this treatment.
<b>V</b>	visit

<b>WBC</b>	white blood cell
<b>Wk</b>	week
<b>WOCBP</b>	women of child-bearing potential

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## Appendix 2. Clinical Laboratory Tests

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### Clinical Laboratory Tests

#### Hematology<sup>a,b</sup>

Hemoglobin  
Hematocrit  
Erythrocyte count (RBC)  
Mean cell volume  
Mean cell hemoglobin concentration  
Leukocytes (WBC)  
Neutrophils, segmented  
Lymphocytes  
Monocytes  
Eosinophils  
Basophils  
Platelets

#### Urinalysis<sup>a,b</sup>

Specific gravity  
pH  
Protein  
Glucose  
Ketones  
Blood  
Urine leukocyte esterase

#### Clinical Chemistry<sup>a,b,c</sup>

##### Serum Concentrations of:

Sodium  
Potassium  
Total bilirubin  
Direct bilirubin  
Alkaline phosphatase (ALP)  
Alanine aminotransferase (ALT)  
Aspartate aminotransferase (AST)  
Blood urea nitrogen (BUN)  
Creatinine  
Uric acid  
Calcium  
Glucose, nonfasting  
Albumin  
Cholesterol  
Creatine kinase (CK)

##### Other Tests

Human chorionic gonadotropin (HCG) (females)<sup>d,e,f</sup>  
APOE genotyping<sup>a,c,g</sup>  
High sensitivity C-reactive protein<sup>c</sup>  
Calculated creatinine clearance (Cockcroft and Gault 1976)

HBsAg<sup>h</sup>

HCV RNA PCR<sup>i</sup>

##### Immune Safety Labs<sup>i</sup>

B tryptase  
Total Immunoglobulin E  
Immune complex testing

Abbreviations: RBC = red blood cells; WBC = white blood cells.

- <sup>a</sup> Assayed by Lilly-designated (central) laboratory.
- <sup>b</sup> Results will be confirmed by the Lilly-designated (central) laboratory at the time of initial testing.
- <sup>c</sup> Samples collected for specified laboratory tests will be destroyed within 60 days of receipt of confirmed test results. Certain samples may be retained for a longer period, if necessary, to comply with applicable laws, regulations, or laboratory certification standards.
- <sup>d</sup> Females of childbearing potential are to have a central lab serum pregnancy test (HCG) at V1. The serum pregnancy test will need to be repeated if the screening period lasts more than 63 days.
- <sup>e</sup> Females of childbearing potential are to have a local urine pregnancy test (HCG) on the day of flortaucipir F18 PET imaging before the scan is done to confirm they are not pregnant.
- <sup>f</sup> Females of childbearing potential are to have a local urine pregnancy test (HCG) on the day of florbetapir F18 PET imaging before the scan is done to confirm they are not pregnant.

- g Neither patients nor investigators will receive the genotype results unless there is a country-specific law or regulation that requires notification of the results. Failure to collect samples for APOE genotyping will not be considered a protocol deviation if country-specific regulations prohibit the testing of genetic material or transportation of such material outside of the country.
- h laboratory test to be performed only for patients with a past history of Hepatitis B
- i laboratory test to be performed only for patients with a past history of Hepatitis C
- j laboratory tests to be performed only for patients with moderate to severe infusion reaction (see Section [9.4.7.1.2](#) for timing of sample collection).

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## **Appendix 3. Study Governance Considerations**

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## **Appendix 3.1. Regulatory and Ethical Considerations, Including the Informed Consent Process**

### ***Appendix 3.1.1. Informed Consent***

The investigator is responsible for:

- ensuring that the subject/subject's legal representative understands the nature of the study, the potential risks and benefits of participating in the study, and that their participation is voluntary.
- ensuring that informed consent is given by each subject or legal representative. This includes obtaining the appropriate signatures and dates on the ICF prior to the performance of any protocol procedures and prior to the administration of investigational product.
- answering any questions the subject/ subject's legal representative may have throughout the study and sharing in a timely manner any new information that may be relevant to the subjects/ subject's legal representative's willingness to continue his or her participation in the study.
- ensuring that a copy of the ICF is provided to the subject or the subject's legal representative and is kept on file.
- ensuring that the medical record includes a statement that written informed consent was obtained before the subject was enrolled in the study and the date the written consent was obtained. The authorized person obtaining the informed consent must also sign the ICF.

Study partners will also sign the informed consent. If it is not known that the study partner will change, the new study partner would need to sign the ICF when he/she takes over the care for the subject and study participation. The change in study partner would also need to be documented on the eCRF.

As used in this protocol, the term “informed consent” includes all consent and assent given by subject or their legal representatives and by study partners.

### ***Appendix 3.1.2. Recruitment***

Lilly or its designee is responsible for the central recruitment strategy for subjects. Individual investigators may have additional local requirements or processes.

### ***Appendix 3.1.3. Ethical Review***

The investigator or an appropriate local representative must give assurance that the ethical review board (ERB) was properly constituted and convened as required by International Council for Harmonisation (ICH) guidelines and other applicable laws and regulations.

Documentation of ERB approval of the protocol and the ICF must be provided to Lilly before the study may begin at the investigative site(s). Lilly or its representatives must approve the ICF, including any changes made by the ERBs, before it is used at the investigative site(s). All ICFs must be compliant with the ICH guideline on Good Clinical Practice (GCP).



The study site's ERB(s) should be provided with the following:

- the protocol and related amendments and addenda, current Investigator Brochure (IB) and updates during the course of the study
- informed consent form
- other relevant documents (e.g., curricula vitae, advertisements)

#### ***Appendix 3.1.4. Regulatory Considerations***

This study will be conducted in accordance with the protocol and with the:

- consensus ethics principles derived from international ethics guidelines, including the Declaration of Helsinki and Council for International Organizations of Medical Sciences (CIOMS) International Ethical Guidelines
- applicable ICH GCP Guidelines
- applicable laws and regulations

Some of the obligations of the sponsor will be assigned to a third-party.

#### ***Appendix 3.1.5. Investigator Information***

Physicians with expertise in neurology, geriatrics, or psychiatry who have clearly documented extensive experience in AD trials will participate as investigators in this clinical study. In addition, licensed clinicians who have clearly documented extensive experience in AD trials may participate as investigators in this clinical study upon approval by the Sponsor. Contact information for investigators, clinical laboratories, and other medical and/or technical department(s) and/or institutions involved in the clinical study is maintained in the study records.

Cognitive assessments must be administered by an individual trained in the use of these instruments. Investigators and site personnel who will perform ratings will be trained and approved by Lilly or its designee prior to participating in the study. In most cases, evaluation and notification will occur at the investigator meeting. Individuals who do not attend the rater evaluation and training portion of the investigator meeting and who wish to perform the ratings in this study must be evaluated and approved by Lilly or its designee prior to performing any ratings. Note that the ADAS-Cog and MMSE must be administered by different rater than the ADCS-ADL and CDR. These 2 raters should continue doing the same scale with the same patient throughout the study. These 2 or 3 raters should continue doing the same scale with the same patient throughout the study. If possible, the measurements should be performed on a given patient by the same rater at each visit. The PI has the responsibility of selecting who will administer the instruments at the site, as long as all training requirements have been met by those raters.

**Appendix 3.1.6. Protocol Signatures**

The sponsor's responsible medical officer will approve the protocol, confirming that, to the best of his or her knowledge, the protocol accurately describes the planned design and conduct of the study.

After reading the protocol, each principal investigator will sign the protocol signature page and send a copy of the signed page to a Lilly representative.

**Appendix 3.1.7. Final Report Signature**

The CSR coordinating investigator will sign the final CSR for this study, indicating agreement that, to the best of his or her knowledge, the report accurately describes the conduct and results of the study.

The investigator with the most qualified subjects will serve as the CSR coordinating investigator. If this investigator is unable to fulfill this function, another investigator will be chosen by Lilly to serve as the CSR coordinating investigator.

The sponsor's responsible medical officer and statistician will approve the final CSR for this study, confirming that, to the best of his or her knowledge, the report accurately describes the conduct and results of the study.

**Appendix 3.2. Data Quality Assurance**

To ensure accurate, complete, and reliable data, Lilly or its representatives will do the following:

- provide instructional material to the study sites, as appropriate
- sponsor investigator study site trainings to instruct the investigators and study coordinators. This training will give instruction on the protocol, the completion of the CRFs, and study procedures.
- make periodic visits to the study site
- be available for consultation and stay in contact with the study site personnel by mail, telephone, and/or fax
- review and evaluate eCRF data and use standard computer edits to detect errors in data collection
- conduct a quality review of the database

In addition, Lilly or its representatives will periodically check a sample of the subject data recorded against source documents at the study site. The study may be audited by Lilly or its representatives, and/or regulatory agencies at any time. Investigators will be given notice before an audit occurs.

The investigator will keep records of all original source data. This might include laboratory tests, medical records, and clinical notes. If requested, the investigator will provide the sponsor, applicable regulatory agencies, and applicable ERBs with direct access to original source documents.

**Appendix 3.2.1. Data Capture System**

An electronic data capture system will be used in this study. The site maintains a separate source for the data entered by the site into the sponsor-provided electronic data capture system.

Electronic Clinical Outcome Assessment (eCOA) measures (e.g., a rating scale, including audio voice recordings of the rater's questions and the patient's and study partner's responses) are entered into an eCOA instrument (at the time that the information is obtained). The eCOA tablet has both keyboard entry and audio voice recording capabilities. In these instances where there is no prior written or electronic source data at the site, the eCOA instrument record will serve as the source.

If eCOA records are stored at a third party site, investigator sites will have continuous access to the source documents during the study and will receive an archival copy at the end of the study for retention.

Any data for which the eCOA instrument record will serve to collect source data will be identified and documented by each site in that site's study file.

Case report form data will be encoded and stored in a clinical trial database. Data managed by a central vendor, such as audio voice recordings, laboratory test data, or ECG data, will be stored electronically in the central vendor's database system. With the exception of the audio voice recordings, which are only used for central monitoring purposes, data will subsequently be transferred from the central vendor to the Lilly data warehouse.

Any data for which paper documentation provided by the subject will serve as the source document will be identified and documented by each site in that site's study file.

Data from complaint forms submitted to Lilly will be encoded and stored in the global product complaint management system.

**Appendix 3.3. Study and Site Closure****Appendix 3.3.1. Discontinuation of Study Sites**

Study site participation may be discontinued if Lilly or its designee, the investigator, or the ERB of the study site judges it necessary for medical, safety, regulatory, or other reasons consistent with applicable laws, regulations, and GCP.

**Appendix 3.3.2. Discontinuation of the Study**

The study will be discontinued if Lilly or its designee judges it necessary for medical, safety, regulatory, or other reasons consistent with applicable laws, regulations, and GCP.

**Appendix 3.4. Publication Policy**

The publication policy for Study AACG is described in the Clinical Trial Agreement.

## Appendix 4. Hepatic Monitoring Tests for Treatment-Emergent Abnormality

Selected tests may be obtained in the event of a treatment-emergent hepatic abnormality and may be required in follow-up with patients in consultation with the Lilly, or its designee, clinical research physician.

### Hepatic Monitoring Tests

<b>Hepatic Hematology<sup>a</sup></b>	<b>Haptoglobina<sup>a</sup></b>
Hemoglobin	
Hematocrit	<b>Hepatic Coagulation<sup>a</sup></b>
RBC	Prothrombin Time
WBC	Prothrombin Time, INR
Neutrophils, segmented	
Lymphocytes	<b>Hepatic Serologies<sup>a,b</sup></b>
Monocytes	Hepatitis A antibody, total
Eosinophils	Hepatitis A antibody, IgM
Basophils	Hepatitis B surface antigen
Platelets	Hepatitis B surface antibody
	Hepatitis B Core antibody
<b>Hepatic Chemistry<sup>a</sup></b>	Hepatitis C antibody
Total bilirubin	Hepatitis E antibody, IgG
Direct bilirubin	Hepatitis E antibody, IgM
Alkaline phosphatase	
ALT	<b>Anti-nuclear antibody<sup>a</sup></b>
AST	
GGT	<b>Alkaline Phosphatase Isoenzymes<sup>a</sup></b>
CPK	
	<b>Anti-smooth muscle antibody (or anti-actin antibody)<sup>a</sup></b>

Abbreviations: ALT = alanine aminotransferase; AST = aspartate aminotransferase; CPK = creatinine phosphokinase; GGT = gamma-glutamyl transferase; Ig = immunoglobulin; INR = international normalized ratio; RBC = red blood cells; WBC = white blood cells.

<sup>a</sup> Assayed by Lilly-designated or local laboratory.

<sup>b</sup> Reflex/confirmation dependent on regulatory requirements and/or testing availability.

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## Appendix 5. Flortaucipir F18 Tau PET Imaging

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A screening flortaucipir F18 PET scan will be performed as part of the study eligibility criteria. An additional flortaucipir F18 PET scan will be performed at Visit 21 or at early discontinuation (if ED occurs more than 36 weeks after randomization Visit 2).

“Specific instructions for the flortaucipir F18 PET scan itself will be provided in the PET Imaging Manual.

### Inclusion Criteria for Flortaucipir F18 PET Scans

With the exception of the MRI and florbetapir F18 PET scan, a patient should meet all other Visit 1 eligibility criteria before having a flortaucipir F18 PET scan.

- [1] For female patients of childbearing potential, a negative urine pregnancy (HCG) test must be observed on the day of flortaucipir F18 imaging before beginning imaging procedures.

### Exclusion Criteria for Flortaucipir F18 PET Scans

A patient will be excluded from participation in flortaucipir F18 imaging if he or she meets any of the criteria below:

- [2] Has any condition that, in the investigator’s opinion, could increase risk to the patient, limit the patient’s ability to tolerate the experimental procedures, or interfere with analysis of the data. (For example, patients with chronic back pain might not be able to lie still during the scanning procedures.)
- [3] Has abnormal findings on physical examination, laboratory screening tests, or screening ECGs that suggest the patient might have a condition that could, in the opinion of the investigator, affect his or her response to the radiopharmaceutical and related testing procedures.
- [4] Is deemed likely to be unable to complete the imaging procedure for any reason.
- [5] Is receiving other radiation exposure that, when added to the flortaucipir F18 PET scan, would exceed local or national regulatory limits for a patient.

Site investigators, patients, and study partners will not be informed of the results of PET scans obtained following randomization, as they relate to the study. Any findings that may be of potential medical concern will be provided for appropriate follow-up.

## PET Scan-Specific Information

### PET Scan Procedures

Specific imaging acquisition protocols designed to ensure consistency across sites will be provided in an PET Imaging Manual. The scanning technologists will be blinded to patients' treatment assignments.

### Scan Safety

The primary risk related to flortaucipir F18 PET is radiation exposure. Details on the amount of exposure estimated to occur on each imaging occasion and cumulatively are shown in Table APP.5.1 and will be provided in the ICF. In addition, the tau ligand flortaucipir F18 continues to be in clinical evaluation, and risks from the agent are not fully known. Details on the clinical information to date regarding flortaucipir F18 exposure will be provided in the ICF. More detailed information about the known and expected benefits and risks of flortaucipir F18 may be found in the Investigator's Brochure.

Patients must minimize movement during each PET procedure, which can last 10 to 30 minutes for each scan. Most state-of-the-art imaging systems are designed to reduce head motion and patient discomfort.

**Table APP.5.1. Effective Radiation Dose (mSv)**

	Effective Dose (mSv) per Scan*	Number of Scans in First Year**	Effective Dose (mSv) for Scans in First Year	Number of Scans in Second Year**	Effective Dose (mSv) for Scans in Second Year	Effective Dose (mSv) for – Years 1 and 2
Flortaucipir F 18 Scan (10 mCi iv)	9.10	1	9.10	1	9.10	18.20
Florbetapir F 18 Scan (10 mCi iv)	7.43	2	14.86	2	14.86	29.72
Totals		3	23.96	3	23.96	47.92

Abbreviations: CT = computerized tomography; IV = intravenous infusion; PET = positron emission tomography.

\*Dose shown includes radiation exposure from the radiotracer and also assumes a non-clinical CT scan is obtained (estimated at 0.4 mSv) as part of the PET scan attenuation correction process when the scan is done on a PET/CT scanner. A clinical CT scan is not needed during the PET scan session and because it will add additional radiation exposure is not recommended.

\*\* In the event that the patient is discontinued from the Study AACG, the subject will be asked to participate in a discontinuation visit. A flortaucipir F18 scan will not be done at the ET visit if it has been  $\leq 12$  weeks since the previous scan.

In the case of early discontinuation from Study AACG, the final flortaucipir F18 PET scan will be obtained at the time of the early discontinuation visit (ED) if at least 36 weeks have passed since the most recent flortaucipir F18 PET scan.

Visits that include imaging should be completed over adjacent days. Note that florbetapir F18 PET amyloid imaging and flortaucipir F18 PET tau imaging can be performed 1 or 2 days after cognitive and functional testing and additional timing considerations apply:

- flortaucipir F18 PET scans should be performed at least 16 hours apart from the florbetapir F18 PET scans due to the half-life of fluorine 18.

With respect to other compound-related risks, flortaucipir was positive in the in vitro hERG assay. Although the margin of safety appears high, and in vivo cardiovascular assessments in dogs showed no evidence of QT prolongation, subjects with a history of risk factors for torsades de pointes and patients taking drugs known to prolong the QT interval will be excluded from this study.

If it becomes necessary for a patient to start taking a medication known to prolong QT interval prior to performance of any postbaseline flortaucipir F18 scan, do not perform the scan. The patient may, however remain in the study. Nonperformance of postbaseline flortaucipir F18 PET scans in patients taking a medication known to prolong QT interval will not be considered a protocol deviation.

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## **Appendix 6.      Florbetapir F18 Amyloid PET Imaging**

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Screening florbetapir F18 PET scans will be performed as part of the study eligibility criteria to determine patient eligibility for participation in Study AACG. Additional florbetapir F18 PET scans will be performed at Visit 8 (Week 24), Visit 15 (Week 52), and Visit 21 (Week 76) or at early discontinuation (if ED occurs more than 8 weeks after the previous visit at which a florbetapir F18 PET scan was done). Specific instructions for the florbetapir F18 PET scan itself will be provided in the PET Imaging Manual.

### **Inclusion Criteria for Florbetapir F18 PET Scans**

With the exception of the MRI, a patient should meet all other Visit 1 eligibility criteria before having a florbetapir F18 PET scan.

- [1] For female patients of childbearing potential, a negative urine pregnancy (HCG) test must be observed on the day of florbetapir F18 PET imaging before beginning imaging procedures.

### **Exclusion Criteria for Florbetapir F18 PET Scans**

A patient will be excluded from participation in florbetapir F18 PET amyloid imaging if he or she meets any of the criteria below:

- [2] Has any condition that, in the investigator's opinion, could increase risk to the patient, limit the patient's ability to tolerate the experimental procedures, or interfere with analysis of the data. (For example, patients with chronic back pain might not be able to lie still during the scanning procedures.)
- [3] Has abnormal findings on physical examination, laboratory screening tests, or screening MRI or ECGs that suggest the patient might have a condition that could, in the opinion of the investigator, affect his or her response to the radiopharmaceutical and related testing procedures.
- [4] Is deemed likely to be unable to complete the imaging procedure for any reason.
- [5] Is receiving other radiation exposure that, when added to the florbetapir F18 PET scan, would exceed local or national regulatory limits for a patient.

Site investigators, patients, and study partners will not be informed of the results of PET scans obtained following randomization, as they relate to the study. Any findings that may be of potential medical concern will be provided for appropriate follow-up.



## PET Scan-Specific Information

### *PET Scan Procedures*

Specific imaging acquisition protocols designed to ensure consistency across sites will be provided in a PET Imaging Manual. The scanning technologists will be blinded to patients' treatment assignments.

### *PET Scan Safety*

The primary risk related to florbetapir F18 PET is radiation exposure. Details on the amount of exposure estimated to occur on each imaging occasion and cumulatively are presented in Table APP.5.1 above and will be provided in the ICF. Details on the clinical information to date regarding florbetapir F18 exposure will be provided in the ICF. More detailed information about the known and expected benefits and risks of florbetapir F18 may be found in the United States Package Insert for florbetapir F18 Injection (Amyvid™).

Patients must minimize movement during each PET procedure, which can last 10 to 30 minutes for each scan. Most state-of-the-art imaging systems are designed to reduce head motion and patient discomfort.

In the case of early discontinuation from Study AACG, the final florbetapir F18 PET scan will be obtained at the time of the early discontinuation visit (ED) if at least 8 weeks have passed since the most recent florbetapir F18 PET scan.

Visits that include imaging should be completed over adjacent days. Note that florbetapir F18 PET amyloid imaging and flortaucipir F18 PET tau imaging can be performed 1 or 2 days after cognitive and functional testing and additional timing considerations apply:

- florbetapir F18 PET scans should be performed at least 16 hours apart from the flortaucipir F18 PET scan due to the half-life of fluorine 18.

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## **Appendix 7. Protocol Amendment [I5T-MC-AACG(c)] Summary [Assessment of Safety, Tolerability, and Efficacy of LY3002813 in Early Symptomatic Alzheimer's Disease]**

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### **Overview**

Protocol I5T-MC-AACG Assessment of Safety, Tolerability, and Efficacy of LY3002813 in Early Symptomatic Alzheimer's Disease has been amended. The new protocol is indicated by amendment (d) and will be used to conduct the study in place of any preceding version of the protocol.

The main changes to this protocol include removing LY3202626 as a combination therapy.

The overall changes and rationale for the changes made to this protocol are described in the following table. Note that minor edits have been made throughout the protocol, which are not captured in the amendment summary table.

## Amendment Summary for Protocol I5T-MC-AACG Amendment (d)

Section # and Name	Description of Change	Brief Rationale
<b>Title page</b>	Removed mention of LY3202626 and combination therapy. Added amendment (d) to the list of amendments. Changed date of current protocol.	To reflect the content of the current amendment.
<b>Section 1. Synopsis</b>	<p>Changed study title and removed mention of LY3202626 and combination therapy from the study description and the study objectives. Changed numbers of patients to reflect the elimination of the LY3202626 treatment arm.</p> <p>Deleted the row for “Evaluable” under “Approximate Number of Patients.”</p>	<p>To reflect the elimination of the LY3202626 treatment arm.</p> <p>Deleted to prevent confusion. Details are provided in Section 10.</p>
<b>Section 2. Schedule of Activities</b>	Removed ophthalmological and dermatological exams from screening assessments and changed timing of these assessments during the treatment period to reflect the elimination of the LY3202626 treatment arm. Removed mention of LY3202626 administration, compliance checks, and plasma PK sampling. Deleted the column for Visit 22, as this visit is no longer needed.	To reflect the elimination of the LY3202626 treatment arm.
<b>Section 3. Introduction</b>	Removed mention of LY3202626 as part of the combination. Removed background specific to LY3202626 and its mechanism of action.	To reflect the elimination of the LY3202626 treatment arm.
<b>Section 3.2.2. LYL3002813 Phase 1 Studies</b>	Updated information about ongoing Phase 1b single- and multiple-dose study I5T-MC-AACD (Study AACD).	To provide updated information about this ongoing study.
<b>Section 4. Objectives and Endpoints</b>	Removed mention of LY3202626 and combination therapy from the study objectives. Removed ophthalmological and dermatological examinations from safety endpoints.	To reflect the elimination of the LY3202626 treatment arm.
<b>Section 5. Study Design</b>	Removed mention of LY3202626 and combination therapy from the study design. Added description of screening policy for patients in active screening	To reflect the elimination of the LY3202626 treatment arm.

Section # and Name	Description of Change	Brief Rationale
	<p>prior to implementation of amendment (d). Changed duration of double-blind period to 76 weeks, with up to 72 weeks of treatment. Modified study design illustration and visits throughout.</p> <p>Changed number of study participants.</p> <p>Removed ophthalmological and dermatological evaluation from Screening.</p>	To delete examinations and visit no longer needed after elimination of the LY3202626 treatment arm.
<b>Section 5.1. Overall Design</b>	Changed “124-week study” to “133-week study.”	Correction
<b>Section 5.1.3. Immunogenicity and Safety Follow-up Visits (Visit 801)</b>	Changed heading to “Immunogenicity and Safety Follow-up Visits (Visits 801 through 804)”	Clarification (made consistent with text)
<b>Section 6.1. Inclusion Criteria</b>	From Inclusion Criterion #4, deleted the bullet regarding study partners being available by telephone for CDR and ADCS-ADL.	Correction; this scale is not administered over the phone.
<b>Section 6.2. Exclusion Criteria</b>	<p>From Exclusion Criterion #11, deleted “retinal” from the list of exclusionary conditions.</p> <p>Deleted Exclusion Criterion #18, #32, #37, #56, and #57.</p>	To remove criteria specific to LY3202626.
<b>Section 6.3. Lifestyle Restrictions</b>	Restrictions #2 and #3 were removed.	To remove restrictions specific to LY3202626.
<b>Section 7. Treatments</b>	Deleted mention of LY3202626 dosage, administration, and packaging.	To reflect the elimination of the LY3202626 treatment arm.
<b>Section 8. Discontinuation Criteria</b>	Deleted ophthalmological and dermatological examinations as a factor in permanent treatment discontinuation. Rephrased discontinuation to remove mention of discontinuing one treatment but continuing the other. Deleted criteria specific to discontinuing treatment with LY3202626. Changed timing of follow-up after early discontinuation visit.	To reflect the elimination of the LY3202626 treatment arm.
<b>Section 9. Study Assessments and Procedures</b>	Deleted administration of LY3202626. Removed AESIs specific to LY3202626. Deleted information	To reflect the elimination of the LY3202626 treatment arm.

Section # and Name	Description of Change	Brief Rationale
	<p>about treatment of LY3202626 overdose. Edited text about ophthalmological and dermatological examinations to clarify that these will be done only in patients who received LY3202626 or oral placebo and only at 1 visit (scheduled or unscheduled) after the final dose of LY3202626/oral placebo. Deleted information about PK sampling for LY3202626.</p> <p>Added statements about completing CRFs for hypersensitivity and ARIA-E.</p> <p>In Section 9.1 (and Appendix 3.1.5), changed the statement that ADAS-Cog and MMSE “should” be administered by a different rater than ADCS-ADL and CDR to “must” be administered by a different rater.</p>	<p>Clarification</p> <p>Clarification</p>
<b>Section 10. Statistical Considerations</b>	<p>Changed numbers of patients and power calculations to reflect the elimination of the LY3202626 treatment arm. Deleted mentions of combination therapy. Provided information about how data from patients previously randomized to LY3202626 treatment will be handled.</p>	<p>To reflect the elimination of the LY3202626 treatment arm.</p>

## Revised Protocol Sections

**Note:** Deletions have been identified by ~~strikethroughs~~.  
Additions have been identified by the use of underscores.

The numbering system used for inclusion and exclusion criteria provides a unique number for each criterion and allows for efficiency in data collection.

In case an amendment to the protocol adds a criterion, that criterion will receive the next available number, regardless of whether it is an inclusion or exclusion criterion.

### Title Page

Protocol I5T-MC-AACG(de) Assessment of Safety, Tolerability, and Efficacy of LY3002813 ~~Alone and in Combination with LY3202626~~ in Early Symptomatic Alzheimer's Disease

#### Confidential Information

The information contained in this document is confidential and is intended for the use of clinical investigators. It is the property of Eli Lilly and Company or its subsidiaries and should not be copied by or distributed to persons not involved in the clinical investigation of LY3002813 ~~and LY3002813/LY3202626 combination~~, unless such persons are bound by a confidentiality agreement with Eli Lilly and Company or its subsidiaries.

LY3002813

&

~~LY3202626~~

Multicenter, randomized, double-blind, placebo-controlled, Phase 2 study comparing up to 1400 mg of LY3002813 ~~alone and in combination with 12 mg of LY3202626~~ with placebo over ~~76~~80 weeks in approximately ~~250~~300 patients with early symptomatic AD.

### Section 1. Synopsis

#### Title of Study:

Protocol I5T-MC-AACG(c). Assessment of Safety, Tolerability and Efficacy of LY3002813 ~~Alone and in Combination with LY3202626~~ in Early Symptomatic Alzheimer's Disease.

**Rationale:**

~~This study evaluates use of two anti-amyloid therapies with different mechanisms of action targeting the amyloid cascade.~~ LY3002813 is an antibody directed at the pyroglutamate modification of the third amino acid of amyloid beta (N3pG A $\beta$ ) epitope that is present only in brain amyloid plaques. It is being studied for the treatment of Alzheimer's disease (AD). The mechanism of action of LY3002813 is considered to be the targeting and removal of existing amyloid plaque, which is a key pathological hallmark of AD. The clinical strategy for LY3002813 targets the N3pG A $\beta$  specific to amyloid plaque in the population of early symptomatic AD patients with existing brain amyloid load, as measured using the amyloid plaque biomarker, florbetapir F18 positron emission tomography (PET) imaging.

~~This~~LY3202626 is a synthetic small molecule, an inhibitor of  $\beta$ -site amyloid precursor protein (APP)-cleaving enzyme [BACE]1, being assessed for the treatment of AD in an ongoing phase 2 study. The mechanism of action of LY3202626 is considered to be the reduction of A $\beta$  monomer production through BACE 1 inhibition. Combination therapy rationale is based on the amyloid hypothesis of AD, which states that the production and deposition of A $\beta$  is an early and necessary event in the pathogenesis of AD (Selkoe 2000). Clinical support for this hypothesis comes from the demonstration that parenchymal A $\beta$  levels are elevated before the appearance of symptoms of AD, and supported by genetic variants of AD that overproduce brain A $\beta$  and genetic variants that protect against A $\beta$  production (Jonsson et al. 2012; Fleisher et al. 2015). Furthermore, early in the disease, the presence of brain amyloid appears to increase the risk of conversion from mild cognitive impairment (MCI) to AD dementia (Doraiswamy et al. 2012). This suggests that enhanced clearance of A $\beta$  will lead to slowing of AD progression.

~~This study, I5T-MC-AACG (AACG), is evaluating LY3002813 alone or in combination with LY3202626 compared with placebo. There is evidence suggesting that different forms of amyloid (monomeric, oligomeric and insoluble plaques) may all contribute neurotoxicity independently (Selkoe 2008). Animal models suggest that treatment with a combination of a BACE inhibitor and an anti-plaque antibody will reduce soluble forms of amyloid and contribute to a greater reduction of deposited plaques compared with a plaque-specific antibody alone (Jacobsen et al. 2014). This may also provide synergistic effects on plaque removal compared to either drug given independently with more rapid and quantitatively greater amyloid removal (DeMattos 2016). Increased and more rapid removal of amyloid plaque plus removal of soluble forms of amyloid by parallel administration of both LY3002813 and LY3202626 over time is therefore hypothesized to have the potential for greater clinical efficacy than either drug given alone, with broader target engagement. Combination of therapeutics has been standard of care in most disease clinical practices, such as oncology, cardiology, and endocrinology. Of late, there has been much discussion of the need for combination therapies in AD, as an ultimate path toward finding beneficial treatments for patients (Hendrix 2016).~~

Study I5T-MC-AACG (AACG) is a Phase 2, double-blind, placebo-controlled, study to evaluate the safety and efficacy of N3pG antibody (LY3002813) ~~alone or in combination with BACE inhibitor (LY3202626)~~ in patients with early symptomatic AD (prodromal AD and mild dementia due to AD). Study AACG will assess whether removal of existing amyloid plaque

~~alone or in combination with lowering of A $\beta$  production via BACE inhibition~~ can slow the progression of disease as assessed by clinical measures and biomarkers of disease pathology and neurodegeneration over up to ~~72~~76 weeks of treatment.

Multiple biomarkers of disease progress will also be evaluated. The biomarker florbetapir F18 is a PET ligand that binds to fibrillar amyloid plaque. This biomarker can provide a qualitative and quantitative measurement of brain plaque load in patients with prodromal AD or mild AD dementia. The absence of significant florbetapir F18 signal on a visual read indicates that those patients clinically manifesting cognitive impairment have sparse to no amyloid plaques. As such, implementation of florbetapir F18 will provide a screening tool for entry into the clinical ~~trial~~ trials and provide a confirmation of amyloid pathology. Florbetapir F18 PET also provides quantitative assessment of fibrillar amyloid plaque in the brain and can assess amyloid plaque reductions from the brain by LY3002813 ~~and in combination with BACE inhibition with LY3202626~~.

### Objective(s)/Endpoints:

Primary Objective	Primary Endpoint
To test the hypothesis that LY3002813 <del>alone and/or in combination with LY3202626</del> administered for up to <del>72</del> 76 weeks will decrease the cognitive and/or functional decline in patients with early symptomatic AD	Change in cognition and function as measured by the change in integrated Alzheimer's Disease Rating Scale (iADRS) score from baseline to 18 months
<b>Secondary Objectives</b> To assess the effect of LY3002813 <del>alone and in combination with LY3202626</del> vs. <u>placebos</u> on clinical progression in patients with early symptomatic AD	<b>Secondary Endpoints</b> Change in cognition from baseline to 18 months as measured by: <ul style="list-style-type: none"> <li>the change in Alzheimer's Disease Assessment Scale—Cognitive subscale (ADAS-Cog<sub>13</sub>) score</li> <li>the change in Clinical Dementia Rating Scale Sum of Boxes (CDR-SB) score</li> <li>the change in Mini-Mental State Examination (MMSE) score</li> <li>the change in Alzheimer's Disease Cooperative Study-instrumental Activities of Daily Living scale (ADCS-iADL) score</li> </ul>
To assess the effect of LY3002813 <del>alone and in combination with LY3202626</del> vs. placebo on brain amyloid deposition	Change in brain amyloid plaque deposition from baseline through 18 months as measured by florbetapir F18 PET scan
To assess the effect of LY3002813 <del>alone and in combination with LY3202626</del> vs. placebo on brain tau deposition	Change in brain tau deposition from baseline to 18 months as measured by flortaucipir F18 PET scan
To assess the effect of LY3002813 <del>alone and in combination with LY3202626</del> vs. placebo on brain volume measures	Change in volumetric MRI measures from baseline to 18 months.



To assess the effect of combination therapy with LY3002813 and LY3202626 vs LY3002813 alone on clinical progression in patients with early symptomatic AD	Change from baseline to 18 months in iADRS score, ADAS-Cog <sub>13</sub> score, CDR-SB score, MMSE score, ADCS-iADL score
<b>Safety Objective</b>	<b>Safety Endpoints</b>
To evaluate safety and tolerability of LY3002813 alone and in combination with LY3202626	<ul style="list-style-type: none"> <li>Standard safety assessments: <ul style="list-style-type: none"> <li>spontaneously reported adverse events (AEs)</li> <li>clinical laboratory tests</li> <li>vital sign and body weight measurements</li> <li>12-lead ECGs</li> <li>physical and neurological examinations</li> </ul> </li> <li>MRI (<u>amyloid-related imaging abnormalities</u> [ARIAs] and emergent radiological findings)</li> <li><del>Skin examination</del></li> <li><del>Eye examination</del></li> <li>Columbia Suicide Severity Rating Scale (C-SSRS)</li> </ul>

### Summary of Study Design:

Study AACG is a multicenter, randomized, double-blind, placebo-controlled, Phase 2 study of LY3002813 ~~alone and in combination with LY3202626~~ in subjects with early symptomatic AD. The ~~133~~124-week study includes a screening period of up to 9 weeks, a treatment period of up to ~~72~~76 weeks with final evaluations occurring 4 weeks later at Week 76, and ~~; a 484-week posttreatment follow-up, and a 44-week immunogenicity and safety follow-up period.~~

### Treatment Arms and Duration:

Patients will receive the following treatments for up to ~~72~~76 weeks:

- ~~LY3002813 monotherapy (LY3002813-M):~~ intravenous LY3002813 (700 mg Q4WK for the first 3 doses, then 1400 mg Q4WK) for up to 72 weeks,~~in combination with daily oral placebo,~~
- ~~LY3002813 in combination with LY3202626 (LY3002813-C):~~ intravenous LY3002813 (700 mg Q4WK for the first 3 doses, then 1400 mg Q4WK) in combination with daily oral LY3202626 (12 mg), or
- Placebo:** intravenous placebo Q4WK for up to 72 weeks~~in combination with daily oral placebo.~~

Abbreviations: C = combination therapy; M = monotherapy

**Approximate Number of Patients:**

Screened – 1497

Randomized – ~~266~~375

Evaluable ~~300 (approximately 100 per treatment group)~~

**Statistical Analysis:****Efficacy:**

The primary objective of this study is to test the hypothesis that intravenous infusion of LY3002813 ~~alone or in combination with LY3202626~~ will slow the cognitive and/or functional decline of AD as measured by the composite measure iADRS compared with placebo in patients with early symptomatic AD. The change from baseline score on the iADRS at each scheduled postbaseline visit during the treatment period will be analyzed using an MMRM model, which includes the following terms: baseline score, pooled investigator, treatment, visit, treatment-by-visit interaction, baseline-by-visit interaction, concomitant AChEI and/or memantine use at baseline (yes/no), and age at baseline. The primary time point for treatment comparison will be at the end of the double blind treatment period (Week 76). The treatment group contrast in least-squares mean progression and its associated p-value and 95% CI will be calculated for the treatment comparison of LY3002813-C vs. placebo ~~and LY3002813-M vs. placebo~~. In addition, Bayesian posterior probability of the active treatment arm being superior to placebo by at least a margin of interest (25% slowing of placebo progression) will also be calculated.

**Pharmacokinetics/Pharmacodynamics:**

Compartmental modeling of LY3002813 ~~and LY3202626~~ PK data using nonlinear mixed effects modeling or other appropriate software may be explored, and population estimates for clearance and central volume of distribution may be reported. Depending on the model selected, other PK parameters may also be reported. Exploratory graphical analyses of the effect of dose level or demographic factors on PK parameters may be conducted. If appropriate, data from other studies of LY3002813 ~~or LY3202626~~ may be used in this analysis.

Pharmacokinetic/pharmacodynamic (PK/PD) relationships between plasma LY3002813 concentration and SUVR, cognitive endpoints, ARIA incidence rate or other markers of PD activity may be explored graphically. The relationship between the presence of antibodies to LY3002813 and PK, PD, safety and/or efficacy may be assessed graphically. ~~The effect of LY3202626 exposure on SUVR, cognitive endpoints, or other markers of PD activity may also be explored graphically. Graphical and/or descriptive analyses may be explored to evaluate potential interactions between LY3002813 and LY3202626 for PK.~~ If warranted, additional analysis may be explored to evaluate potential interactions for ADA, PD and other endpoints (PET scan, ARIA-E, etc.). Additional modeling may be performed based on the results of the graphical analyses.

**Section 2. Schedule of Activities**

## Schedule of Activities Protocol - I5T-MC-AACG Visit 1 (Screening Period)

Period: Procedure	
Visit No.:	V1
End of Week Relative to Study Medication Start <sup>a</sup>	Wk -9 through Wk -1
Tolerance Interval for Visit (days) <sup>a,b</sup>	63
<b>PRELIMINARY SCREENING</b>	
<b>Entry Diagnostics</b>	
MMSE <sup>c,d,g</sup>	X
<b>SCREENING</b>	
<del>Ophthalmological examination<sup>f</sup></del>	<del>X</del>
<del>Dermatological examination<sup>g</sup></del>	<del>X</del>
<b>Safety Assessments</b>	
Vital signs <sup>h</sup>	X
Height and Weight <sup>i</sup>	X
ECG in triplicate <sup>h,j</sup>	X
C-SSRS/SHSF/SHFU <sup>i,j,k,l</sup>	X
<b>Laboratory Specimens</b>	
Human chorionic gonadotropin (HCG) (if applicable) <sup>k,l,m,n,o</sup>	X <sup>b</sup>
HBsAg <sup>n,p</sup>	X
HCV RNA PCR <sup>q</sup>	X
<b>Screening PET Scans and MRI</b>	
Flortaucipir F18 PET Scan <sup>l,p,n,r</sup>	X
MRI <sup>s</sup>	X
Florbetapir F18 PET scan <sup>b,m,r,o,t</sup>	X

Abbreviations: HBsAg = hepatitis B surface antigen; HCV = hepatitis C virus; MRI = ~~M~~magnetic Resonance Imaging; PCR = polymerase chain reaction; SHFU = Self-Harm Follow-Up.

- a The interval between V1 and V2 may be up to 63 days to allow for completion of V1 screening procedures, assessments, and evaluation of results from laboratory tests and ECGs. V1 is not considered complete until all screening procedures have been completed and results reviewed by the investigator to determine patient eligibility. V1 may be conducted over more than 1 day. Subjects in screening at the time screening was paused are allowed to continue screening beyond the 63 days to allow for completion of V1 screening procedures; this will not be a protocol deviation. Additional details are provided in Section 5.1.1. Subjects who had completed screening but were not yet randomized at the time randomization was paused are allowed to be randomized beyond 63 days; this will not be a protocol deviation. Additional details are provided in Section 5.1.1.
- b A florbetapir F18 PET scan is the final screening criterion for establishing patient eligibility, although the MRI, ophthalmological and dermatological exams may be performed after the florbetapir F18 PET scan. Patients whose screening florbetapir F18 PET scan results are not available within the 63 day screening window will remain eligible within V1 until these results become available if all other eligibility criteria have been met. Note: If a patient's screening florbetapir F18 PET scan result confirming eligibility for the study has not been received by the site by Day 63 of the screening period, then repeat the following laboratory tests: blood hematology, chemistry, and serum pregnancy test (HCG) for women of childbearing potential (WOCBP). Results of the repeated labs are to be reviewed by the investigator or qualified designee for assessment of the patient's continued eligibility. Repeat screening for MMSE, CBB, C-SSRS, ECG, ~~dermatological and ophthalmological examinations~~, flortaucipir F18 PET, MRI, and laboratory testing for HBsAg, and HCV RNA PCR is not required. V1 is not considered complete until all screening procedures have been completed and results reviewed by the investigator or qualified designee to determine patient eligibility.
- c A preliminary screening informed consent may be obtained to conduct initial screening to collect demographics data and administer the MMSE and CBB. Patients who do not meet the MMSE screening criteria are not to have any other screening procedures performed with the exception of the CBB. The CBB should be administered to all patients at the screening visit, regardless of the MMSE score. They may be rescreened for the MMSE 8 weeks after the first screen. Study partners are not required to complete the preliminary screening informed consent.
- d Patients who meet the MMSE screening criteria may proceed to the remaining screening procedures once they have given signed/dated informed consent for the full study and their study partner has given signed/dated informed consent to participate as a study partner.
- e A complete physical and neurological exam is to be performed at this visit. Additional details are provided in Section 9.4.1.
- ~~f Eye examinations must be conducted by an ophthalmologist or optometrist (where permitted by law). Additional details are provided in Section 9.4.6.3.~~
- ~~g Skin examinations must be conducted by a dermatologist. Additional details are provided in Section 9.4.6.4~~
- ~~h~~ Sitting Blood pressure and pulse will be measured after 5 minutes in the sitting position only. Temperature will be collected with sitting vital signs.
- ~~g~~<sup>i</sup> Height and weight will be measured with shoes removed.
- ~~h~~<sup>j</sup> ECGs should be taken in triplicate at approximately 1-minute intervals. ECGs should be collected at approximately the same time of day, as much as possible, to minimize diurnal variation.
- ~~ik~~ The baseline version of the C-SSRS is to be administered at V1. Patients at imminent risk of suicide (positive response to question 4 or 5 on the C-SSRS) will be excluded from participating in the study.

- i<sup>1</sup> The ~~Self-Harm Supplement form~~SHSF is completed after each C-SSRS administration to enter the number of discrete events of suicidal behavior identified. If, based on administration of the C-SSRS, it is determined that suicide-related behaviors have occurred, then the ~~Self-Harm Follow-Up (SHFU)~~ form will be used to collect additional information to allow for a more complete assessment of these behaviors.
- k<sup>m</sup> Females of childbearing potential are to have a serum pregnancy test (HCG) at V1 (if applicable).
- l<sup>n</sup> Females of childbearing potential are to have a urine pregnancy test (HCG) on the day of flortaucipir F18 PET imaging before the flortaucipir F18 dose is administered.
- m<sup>o</sup> Females of childbearing potential are to have a urine pregnancy test (HCG) on the day of florbetapir F18 PET imaging before the florbetapir F18 dose is administered.
- n<sup>p</sup> Patients with a past history of Hepatitis B are to have a serum HBsAg test at screening V1 and are excluded if the HBsAg test is positive.
- o<sup>q</sup> Patients with a past history of Hepatitis C are to have a HCV RNA PCR test at screening V1 and are excluded if the HCV RNA PCR test is positive.
- p<sup>r</sup> A screening flortaucipir F18 PET scan will be performed as part of the study eligibility criteria at all sites to determine patient eligibility for participation in Study AACG (see Appendix 5). With the exception of an MRI and a florbetapir F18 PET scan, ~~ophthalmological, and dermatological exams,~~ a patient should meet all other V1 eligibility criteria before having a screening flortaucipir F18 PET scan. The flortaucipir F18 PET scan will be submitted to a centralized PET imaging vendor designated by Lilly for an assessment of patient's eligibility. A historical flortaucipir F18 PET scan may be submitted to be considered for eligibility if performed within 6 months of V1.
- q<sup>s</sup> A local screening MRI will be performed at V1 as part of the study eligibility criteria. With the exception of the evidence of amyloid pathology by florbetapir F18 PET scan, ~~and ophthalmological and dermatological exams,~~ a patient should meet all other V1 eligibility criteria before having an MRI scan. The MRI scans will be reviewed by the investigator or qualified designee for immediate patient management. After the MRI scan is read locally, the scan is to be submitted to the centralized MRI vendor designated by Lilly for final determination of MRI eligibility. Results of centrally read MRIs will be used for data analysis and report-writing purposes and patient safety and eligibility will be reported back to sites.
- r<sup>t</sup> A screening florbetapir F18 PET scan will be performed as part of the study eligibility criteria to determine patient eligibility for participation in Study AACG (see Appendix 6). With the exception of an MRI ~~and ophthalmological and dermatological exams,~~ a patient should meet all other V1 eligibility criteria before having a screening florbetapir F18 PET scan. The PET scan will be submitted to a centralized PET imaging vendor designated by Lilly for assessment of patient's eligibility. The florbetapir F18 PET screening criteria must be met (scan results consistent with the presence of amyloid pathology) in order for the patient to proceed to V2 and be randomized to treatment assignment.
- s<sup>u</sup> Assessment is to include the audio voice recording of the rater's questions and the patient and caregiver responses to assessment questions.

Schedule of Activities, Protocol I5T-MC-AACG, Visit 2 through Visit 14 (Double-Blind Period)

Period: Procedure	Rand												
Visit No.:	V2 <sup>a,b</sup>	V3	V4	V5	V6	V7	V8	V9	V10	V11	V12	V13	V14
End of Week Relative to Study Medication Start	0	4	8	12	16	20	24	28	32	36	40	44	48
Tolerance Interval for Visit (days)	0	±7	±7	±7	±7	±7	±7	±7	±7	±7	±7	±7	±7
Inclusion/exclusion review	X	X	X	X	X	X	X	X	X	X	X	X	X
Contact IWRS – dispensation of study medication (LY3002813 and LY3202626)	X <sup>e</sup>	X	X	X	X	X	X	X	X	X	X	X	X
Physical/neurological examination <sup>ef</sup>	X <sup>fg</sup>			X <sup>fg</sup>			X <sup>fg</sup>			X <sup>gh</sup>			
Ophthalmological examination <sup>hi</sup>	j <sup>k</sup>			X <sup>h</sup>				X <sup>h</sup>					X
Dermatological examination <sup>ij</sup>	j <sup>k</sup>			X <sup>i</sup>			X <sup>i</sup>						
Previous/concomitant medications	X	X	X	X	X	X	X	X	X	X	X	X	X
Preexisting conditions/adverse events <sup>ef</sup>	X	X	X	X	X	X	X	X	X	X	X	X	X
LY3002813 study medication administered <sup>k</sup> Assess LY3202626 compliance	X	X	X	X	X	X	X	X	X	X	X	X	X
LY3202626 study medication administered at site <sup>t</sup>		X			X								
LY3002813 Study medication administered <sup>l</sup>	X	X	X	X	X	X	X	X	X	X	X	X	X
<b>Efficacy Measures</b>													
ADAS-Cog <sup>l,j</sup> <sub>13</sub> <sup>l,ffm,jj</sup>	X			X			X			X			
ADCS-ADL <sup>l,ffm,jj</sup>	X			X			X			X			
CDR-SB <sup>l,ffm,jj</sup>	X			X			X			X			
MMSE <sup>l,ffm,jj</sup>				X			X			X			
<b>Safety Assessment</b>													
C-SSRS/SHSF/SHFU <sup>m,nn</sup>	<sup>mm</sup>	X	X	X	X	X	X	X	X	X	X	X	X

Schedule of Activities, Protocol I5T-MC-AACG, Visit 2 through Visit 14 (Double-Blind Period)

Period: Procedure	Rand												
Visit No.:	V2 <sup>a,b</sup>	V3	V4	V5	V6	V7	V8	V9	V10	V11	V12	V13	V14
End of Week Relative to Study Medication Start	0	4	8	12	16	20	24	28	32	36	40	44	48
Tolerance Interval for Visit (days)	0	±7	±7	±7	±7	±7	±7	±7	±7	±7	±7	±7	±7
<b>Laboratory Specimens<sup>op</sup></b>													
Clinical chemistry, hematology <sup>pq</sup>	X	X	X	X			X			X			
High sensitivity C-reactive protein <sup>pq</sup>	X	X	X	X			X			X			
Urinalysis <sup>pq</sup>	X												
Serum for anti-LY3002813 antibody <sup>pq</sup>	X	X	X	X	X		X			X			
Serum LY3002813 <sup>q,rrs</sup>	X <sup>q</sup>	X <sup>rs</sup>	X <sup>rs</sup>	X <sup>ur</sup>	X <sup>rs</sup>		X <sup>ur</sup>			X <sup>rs</sup>			
Plasma LY3202626 <sup>ts,v</sup>		X <sup>ts</sup>	X <sup>v</sup>	X <sup>v</sup>	X <sup>ts</sup>		X <sup>v</sup>			X <sup>v</sup>			
Blood for assessment of APOE genotype <sup>p,sgqw</sup>	X												
Whole blood, plasma and serum for biomarker storage <sup>p,lq,x</sup>	X			X			X			X			
Blood for pharmacogenomics <sup>p,t,uq,x,y</sup>	X												
<b>Other Safety Measures</b>													
Weight	X			X			X			X			
Vital signs and temperature <sup>v,wx,zz</sup>	X <sup>ww</sup>	X	X	X <sup>ww</sup>	X	X	X <sup>ww</sup>	X	X	X <sup>ww</sup>	X	X	X
ECG in triplicate <sup>xbb</sup>	X	X	X	X			X			X			
MRP <sup>see</sup>	zdd	X		X <sup>aace</sup>	X		X			X			
<b>Additional Efficacy Measures</b>													
Flortaucipir F18 PET scan <sup>bb,ccffgg</sup>	zdd												
Florbetapir F18 PET scan <sup>bb,ddff,hh</sup>	zdd						X <sup>bb,ddff,hh</sup>						

## Schedule of Activities, Protocol I5T-MC-AACG, Visit 15 through Visit 2122 (Double-Blind Period) and Follow-Up

Period: Procedure										
Visit No.:	V15	V16	V17	V18	V19	V20	V21	V22	ED <sup>c</sup>	V801- V804d <sup>g,h,i</sup>
End of Week Relative to Study Medication Start	52	56	60	64	68	72	76	80		88-124
Tolerance Interval for Visit (days)	±7	±7	±7	±7	±7	±7	±7	±7		±14
Inclusion/exclusion review	X	X	X	X	X	X	X			
Contact IWRS – dispensation of study medications (LY3002813 and LY3202626)	X	X	X	X	X	X				
Physical/neurological examination <sup>f</sup>	X <sup>fg</sup>			X <sup>gh</sup>			X <sup>fg</sup>	X <sup>g</sup>	X <sup>fg</sup>	
Ophthalmological examination <sup>h,i</sup>					X			X	X <sup>h</sup>	
Dermatological examination <sup>h,i</sup>	X							X	X <sup>i</sup>	
Previous/concomitant medications	X	X	X	X	X	X	X	X	X	X
Preexisting conditions/adverse events <sup>f</sup>	X	X	X	X	X	X	X	X	X	X
Assess LY3202626 compliance	X	X	X	X	X	X	X		X	
LY3002813 study medication administered <sup>h</sup>	X	X	X	X	X	X				
<b>Efficacy Measures</b>										
ADAS-Cog <sup>13</sup> <sub>LY3002813</sub>	X			X			X		X	
ADCS-ADL <sub>LY3002813</sub>	X			X			X		X	
CDR-SB <sub>LY3002813</sub>	X			X			X		X	
MMSE <sub>LY3002813</sub>	X			X			X		X	
<b>Safety Assessment</b>										
C-SSRS/SHSF/SHFUM <sub>LY3002813</sub>	X	X	X	X	X	X	X	X	X	X



Schedule of Activities, Protocol I5T-MC-AACG, Visit 15 through Visit 2122 (Double-Blind Period) and Follow-Up

Period: Procedure										
Visit No.:	V15	V16	V17	V18	V19	V20	V21	V22	ED <sup>c</sup>	V801- V804 <sup>d,ee,ii</sup>
End of Week Relative to Study Medication Start	52	56	60	64	68	72	76	80		88-124
Tolerance Interval for Visit (days)	±7	±7	±7	±7	±7	±7	±7	±7		±14
Laboratory Specimens <sup>ap</sup>										
Clinical chemistry, hematology <sup>ap</sup>	X			X			X	X	X	
High sensitivity C-reactive protein <sup>ap</sup>	X			X			X	X	X	
Urinalysis <sup>ap</sup>	X			X			X	X	X	
Serum for anti-LY3002813 antibody <sup>ap</sup>	X						X		X	X
Serum LY3002813 <sup>bb,dd,ff,gg</sup>	X <sup>gg</sup>			X <sup>ff</sup>		X <sup>gg</sup>	X <sup>ff</sup>		X <sup>ff</sup>	X <sup>ff</sup>
Plasma LY3002813 <sup>bb,dd,ff,gg</sup>	X <sup>gg</sup>			X <sup>ff</sup>			X <sup>ff</sup>		X <sup>ff</sup>	
Blood for assessment of APOE genotype <sup>bb,dd,ff,gg</sup>										
Whole blood, plasma and serum for biomarker storage <sup>bb,dd,ff,gg</sup>	X			X			X		X	
Blood for pharmacogenomics <sup>bb,dd,ff,gg</sup>										
Other Safety Measures										
Weight	X			X			X	X	X	
Vital signs and temperature <sup>bb,dd,ff,gg</sup>	X <sup>gg</sup>	X	X	X <sup>ff</sup>	X	X	X <sup>ff</sup>	X <sup>ff</sup>	X <sup>ff</sup>	X
ECG in triplicate <sup>bb,dd,ff,gg</sup>	X			X			X	X	X	
MRI <sup>bb,dd,ff,gg</sup>	X						X		X	
Additional Efficacy Measures										
Flortaucipir F18 PET Scan <sup>bb,dd,ff,gg</sup>							X <sup>bb,dd,ff,gg</sup>		X <sup>bb,dd,ff,gg</sup>	
Florbetapir F18 PET scan <sup>bb,dd,ff,gg</sup>	X <sup>bb,dd,ff,gg</sup>						X <sup>bb,dd,ff,gg</sup>		X <sup>bb,dd,ff,gg</sup>	

**Schedule of Activities, Protocol I5T-MC-AACG, Visit 2 through Visit ~~21~~22 (Double-Blind Period) and Follow-Up Abbreviations and Footnotes**

Abbreviations: APOE = ~~a~~Apolipoprotein subtype E; ARIA-E = amyloid related imaging abnormalities–edema/effusions

- a Confirm that the patient has met all V1 eligibility criteria before proceeding with V2 procedures.
- b At V2, appointments should be made for all remaining visits and should be scheduled as close as possible to the target date, relative to V2. Procedures for some visits may take more than 1 day.
- c If a patient discontinues before the double-blind period endpoint (V~~21~~V22 at Week ~~76~~80), complete the Early Discontinuation CRFs. The patient should be encouraged to return to the site beginning 12 weeks after the ED visit for an immunogenicity follow-up visit (Visit-801 through V804).
- d Patients are to return to the site for collection of blood samples and safety assessments for assessment of immunogenicity status at Visit-801 (Week 88). Follow-up for patients experiencing clinically significant events associated with TEADA status is described in Section 9.4.7.2.
- ~~e~~ Patients are to take oral study medication (placebo or LY3202626) once per day in the morning. The first dose should be taken the morning after the first dispensing of oral study medication at Visit 2.
- ~~ef~~ Any clinically significant changes from baseline on follow-up physical/neurological examinations should be noted on the AE page.
- ~~fg~~ A complete physical and neurological exam is to be performed at this visit. Additional details are provided in Section 9.4.1.
- ~~gh~~ A brief physical and neurological exam is to be performed at this visit. Additional details are provided in Section 9.4.1.
- h Eye Ophthalmological examinations will be performed only in patients who previously received LY3202626/oral placebo in this study. The final examination for each patient will be the next scheduled ophthalmological examination after the final administration of LY3202626/oral placebo. It will not be considered a protocol deviation if this examination is scheduled sooner than indicated above in order to accommodate patient and/or site preference. Patients who received LY3202626/oral placebo after their V9 ophthalmological examination are to have an unscheduled ophthalmological examination at the next available opportunity. These Eye examinations must be conducted by an ophthalmologist or optometrist (where permitted by law). Additional details are provided in Section 9.4.6.3.
- i Dermatological examinations will be performed only in patients who previously received LY3202626/oral placebo in this study. The final examination for each patient will be the next scheduled dermatological evaluation after the final administration of LY3202626/oral placebo. It will not be considered a protocol deviation if this examination is scheduled sooner than indicated above in order to accommodate patient and/or site preference. Patients who received LY3202626/oral placebo after their V8 dermatological examination are to have an unscheduled dermatological examination at the next available opportunity. These examinations must be conducted by a dermatologist. Additional details are provided in Section 9.4.6.4.
- i For subjects randomized prior to amendment (d), the eye ophthalmological and skin dermatological examination performed at screening will serve as the baseline eye ophthalmological and skin dermatological examination.
- ~~kl~~ Study drug will be administered by intravenous administration at investigative study site. Patients should be observed for approximately 2 hours following each infusion of LY3002813 for the first 6 infusions. After the first six doses, a minimal post-infusion observation time of 60 minutes will be required for all subsequent infusions. However, patients who have had dosing restarted after ARIA-E are required to be monitored for 2 hours following infusion for a minimum of 3 subsequent infusions, and a minimum of 60 minutes post-infusion observation thereafter.
- ~~lm~~ When administered, cognitive and functional assessments (ADAS-Cog<sub>13</sub>, ADCS-ADL, CDR, and MMSE) should be performed first, before medical procedures that could be stressful for the patient (e.g., blood draws).
- ~~mn~~ The C-SSRS administered at screening will serve as the baseline C-SSRS.

- 19 The 'since last visit' version of the C-SSRS will be administered at visits after V2 (Week 0) to the patient with the study partner/study informant present, after the cognitive and functional assessments. The Self-Harm Supplement form (SHSF) is completed after each C-SSRS administration to enter the number of discrete events of suicidal behavior identified. If, based on administration of the C-SSRS, it is determined that suicide-related behaviors have occurred, then the SHFU form will be used to collect additional information to allow for a more complete assessment of these behaviors
- 20 Unscheduled laboratory tests may be performed at the discretion of the investigator.
- 21 Labs are to be collected prior to administration of the intravenous study medication (LY3002813 or IV placebo). Record the date and times of sample collection on the Lab Requisition Form.
- 22 **Pre-dose** (before beginning the infusion) samples for intravenous study medication (LY3002813) may be collected from the intravenous site prior to beginning the infusion. **Post-dose** (within 30 minutes of completion of the infusion) samples for intravenous study medication (LY3002813) should be collected from the arm that did not receive the infusion at V2 (Week 0), V5 (Week 12), V8 (Week 24), V15 (Week 52), and V20 (Week 72).
- 23 A single pre-dose LY3002813 sample should be collected before beginning the infusion at V3 (Week 4), V4 (Week 8), V6 (Week 16), V11 (Week 36), and V18 (Week 64). In addition, a single sample for serum LY3002813 should be collected at V21 (Week 76), or ED, and V801 (visits at which the patient may not receive a study drug infusion). If LY3002813 infusion is permanently discontinued but the patient remains in the study, one PK sample should be collected at the soonest scheduled visit regardless if serum LY3002813 is on the Schedule of Activities at that visit. Subsequent PK sample collection should follow the protocol Schedule of Activities for serum LY3002813 collection unless the scheduled visit exceeds 6 months since discontinuation of infusions. No additional serum collection for LY3002813 is required once the patient exceeds 6 months since discontinuation of LY3002813 infusions. Record the actual date and times of sample collection on the Lab Requisition Form.
- ~~24 Prior to V3 (Week 4) and V6 (Week 16), a phone call should be made approximately 1 business day before the clinic visit to remind patients to hold the morning dose of oral study medication (LY3202626) on the day of the visit and to bring the dose to the clinic.~~
- ~~25 Pre dose (before taking oral study medication) and post dose (prior to the patient departing the site) samples for oral study medication (LY3202626) should be collected at V3 (Week 4) and V6 (Week 16). Record the date and times of sample collection on the Lab Requisition Form. The actual time of LY3202626 dose administrations on the day of study visits will be recorded in the subject's case report form (CRF). In addition, the actual time of LY3202626 dose administration for the 2 days prior to each visit at which LY3202626 PK samples will be collected will be recorded in the subject's CRF.~~
- ~~26 A single LY3202626 sample should be collected at V4 (Week 8), V5 (Week 12), V8 (Week 24), V11 (Week 36), V15 (Week 52), V18 (Week 64), and V21 (Week 76) or ED. Record the date and times of sample collection on the Lab Requisition Form. The actual time of LY3202626 dose administrations on the day of study visits will be recorded in the subject's CRF. If LY3202626 is permanently discontinued but the patient remains in the study, a final sample should be collected, provided the last dose of LY3202626 is within 3 days of the visit. No other PK samples for LY3202626 are required after the final sample. In addition, the actual time of LY3202626 dose administration for the 2 days prior to each visit at which LY3202626 PK samples will be collected will be recorded in the subject's CRF.~~
- 27 A blood sample will be collected to determine APOE genotype. The APOE genotype sample may be collected at an alternative visit if it cannot be collected at V2.
- 28 Blood for biomarker storage, and blood for pharmacogenomic samples are to be collected unless not allowed or unfeasible due to local regulations prohibiting sample transport outside of the country.
- 29 Pharmacogenomic samples may be collected at an alternative visit if they cannot be collected at V2. It will not be a protocol ~~deviation~~violation if a biomarker storage sample cannot be collected for technical reasons (e.g., if the site is unable to collect enough blood via venipuncture).
- 30 Sitting blood pressure and pulse will be measured after 5 minutes in the sitting position at **all** visits. Temperature will be collected with sitting vital signs.

- ~~was~~ In addition, orthostatic blood pressure and pulse will be measured at V2 (Week 0), V5 (Week 12), V8 (Week 24), V11 (Week 36), V15 (Week 52), V18 (Week 64), V21 (Week 76), ~~V22 (Week 80)~~ or ED, and at unscheduled visits after 5 minutes in the supine position and after 3 minutes standing.
- ~~xxx~~ Electrocardiograms should be taken in triplicate at approximately 1-minute intervals. ECGs should be collected at approximately the same time of day, as much as possible, to minimize diurnal variation. ECGs are to be performed prior to the administration of intravenous study medication (LY3002813 and IV placebo).
- ~~yee~~ If MRI is done on the same day as cognitive and functional assessments, then it should be done after cognitive and functional tests. MRI may be done before other visit procedures, including cognitive and functional tests, but in that case must be done at least 1 day before other visit procedures.
- ~~zed~~ The screening flortaucipir F18 PET scan, MRI, and florbetapir F18 PET scan done at V1 serve as the baseline flortaucipir F18 PET scan, MRI and florbetapir F18 PET scan, respectively.
- ~~aee~~ The V5 MRI is to be performed 2 weeks prior to the V5 (Week 12) LY3002813 infusion to allow for receipt and review of the central vendor MRI report prior to a possible LY3002813 dose change at V5 (Week 12).
- ~~bbf~~ Females of childbearing potential are to have a urine pregnancy test (HCG) performed on the day of florbetapir F18 PET and flortaucipir F18 PET imaging before the florbetapir F18 dose or flortaucipir F18 dose is administered to confirm that they are not pregnant.
- ~~ceg~~ All patients will have a flortaucipir F18 PET scan done at V21 (Week 76) or ED (if ED occurs more than 36 weeks after randomization) (see Appendix 5). Before the flortaucipir F18 PET scan, the investigator should review the patient's medical history and concomitant medications to verify there is no risk factor for ~~Torsades de Pointes~~ and review the most recent ECG. If clinically meaningful abnormalities are noted on the ECG, the advisability of the flortaucipir scan should be considered by the investigator in consultation with the Lilly-designated medical monitor. ~~Patients permanently discontinued from LY3202626 study treatment due to initiation of a prohibited medication known to prolong the QT interval should not have an ED flortaucipir scan unless the scan can be performed prior to initiation of the prohibited medication.~~ ***The study investigator and site clinical study team will not have access to the flortaucipir F18 follow-up scans, as the site clinical study team must remain blinded to any potential changes in tau deposition.***
- ~~ddh~~ All patients will have double-blind period florbetapir F18 PET scans done at V8 (Week 24), V15 (Week 52), and V21 (Week 76) or ED (if ED occurs more than 8 weeks after a florbetapir F18 PET scan has been performed at a previous visit) (see Appendix 6). The study investigator and site clinical study team will not have access to any florbetapir F18 follow-up scans, as the site clinical study team must remain blinded to any potential changes in amyloid deposition.
- ~~eei~~ Patients are to return to the site for an immunogenicity and safety follow-up visit (~~Visit~~ 801) at Week 88 (or 12 weeks after the ED visit) for collection of blood samples for anti-drug antibody (ADA) measurements and assessment of adverse events and concomitant medications. The need for additional study visits after V801 will be determined by results of the ADA sample taken at V801. A patient will stop immunogenicity follow-up visits when they either complete 3 additional quarterly visits (Week 100, Week 112, and Week 124) or complete a visit at which their ADA returns to baseline (2-fold titer from baseline), whichever occurs first. See Section 5.1.3 and Section 9.4.7.2 for details.
- ~~ffj~~ Assessment is to include the audio voice recording of the rater's questions and the patient and caregiver responses to assessment questions.

### 3. Introduction

#### 3.1. Study Rationale

~~This study evaluates use of two anti-amyloid therapies with different mechanisms of action targeting the amyloid cascade.~~ LY3002813 is an antibody directed at the pyroglutamate modification of the third amino acid of amyloid beta (N3pG A $\beta$ ) epitope that is present only in

brain amyloid plaques. It is being studied for the treatment of Alzheimer's disease (AD). The mechanism of action of LY3002813 is considered to be the targeting and removal of existing amyloid plaque, which is a key pathological hallmark of AD. The clinical strategy for LY3002813 targets the N3pG A $\beta$  specific to amyloid plaque in the population of early symptomatic AD patients with existing brain amyloid load, as measured using the amyloid plaque biomarker, florbetapir F18 positron emission tomography (PET) imaging. ~~This LY3202626 is a synthetic small molecule, an inhibitor of  $\beta$ -site amyloid precursor protein (APP)-cleaving enzyme [BACE]1, being assessed for the treatment of AD in an ongoing phase 2 study. The mechanism of action of LY3202626 is considered to be the reduction of A $\beta$  monomer production through BACE-1 inhibition.~~ Combination therapy rationale is based on the amyloid hypothesis of AD, which states that the production and deposition of A $\beta$  is an early and necessary event in the pathogenesis of AD (Selkoe 2000). Clinical support for this hypothesis comes from the demonstration that parenchymal A $\beta$  levels are elevated before the appearance of symptoms of AD, and supported by genetic variants of AD that overproduce brain A $\beta$  and genetic variants that protect against A $\beta$  production (Jonsson et al. 2012; Fleisher et al. 2015). Furthermore, early in the disease, the presence of brain amyloid appears to increase the risk of conversion from mild cognitive impairment (MCI) to AD dementia (Doraiswamy et al. 2012). This suggests that enhanced clearance of A $\beta$  will lead to slowing of AD progression.

~~This study, I5T-MC-AACG (AACG), is evaluating LY3002813, alone or in combination with LY3202626, compared with placebo. There is evidence suggesting that different forms of amyloid (monomeric, oligomeric and insoluble plaques) may all contribute to neurotoxicity independently (Selkoe 2008). Animal models suggest that treatment with a combination of a BACE inhibitor and an anti-plaque antibody will reduce soluble forms of amyloid and contribute to a greater reduction of deposited plaques compared with a plaque-specific antibody alone (Jacobsen et al. 2014). This may also provide synergistic effects on plaque removal compared to either drug given independently with more rapid and quantitatively greater amyloid removal (DeMattos 2016). Increased and more rapid removal of amyloid plaque plus removal of soluble forms of amyloid by parallel administration of both LY3002813 and LY3202626 over time is therefore hypothesized to have the potential for greater clinical efficacy than either drug given alone, with broader target engagement. Combination of therapeutics has been standard of care in most disease clinical practices, such as oncology, cardiology, and endocrinology. Of late there has been much discussion of the need for combination therapies in AD, as an ultimate path toward finding beneficial treatments for patients (Hendrix 2016).~~

Study I5T-MC-AACG (AACG) is a Phase 2, double-blind, placebo-controlled study to evaluate the safety and efficacy of N3pG antibody (LY3002813) ~~alone or in combination with BACE inhibitor (LY3202626)~~ in patients with early symptomatic AD (prodromal AD and mild dementia due to AD). Study AACG will assess whether removal of existing amyloid plaque ~~alone or in combination with lowering of A $\beta$  production via BACE inhibition~~ can slow the progression of disease as assessed by clinical measures and biomarkers of disease pathology and neurodegeneration over up to 72 weeks of treatment~~76 weeks of treatment~~. ~~No LY3202626 monotherapy arm is included in this proof of concept study. Clinical trials using LY3202626~~



~~and other BACE inhibitors as monotherapies are being conducted which may provide further understanding of the safety and efficacy data collected in this study.~~

Multiple biomarkers of disease progress will also be evaluated. The biomarker florbetapir F18 is a PET ligand that binds to fibrillar amyloid plaque. This biomarker can provide a qualitative and quantitative measurement of brain plaque load in patients with prodromal AD or mild AD dementia. The absence of significant florbetapir F18 signal on a visual read indicates that those patients clinically manifesting cognitive impairment have sparse to no amyloid plaques. As such, implementation of florbetapir F18 will provide a screening tool for entry into the clinical trials and provide a confirmation of amyloid pathology. Florbetapir F18 PET also provides quantitative assessment of fibrillar amyloid plaque in the brain and can assess amyloid plaque reductions from the brain by LY3002813 ~~and in combination with BACE inhibition with LY3202626.~~

## 3.2. Background

Alzheimer's disease is an age-related neurodegenerative disorder characterized by progressive decline in cognitive function and the ability to perform activities of daily living, ultimately resulting in dementia, typically with fatal complications. The amyloid hypothesis of AD postulates that the accumulation of amyloid- $\beta$  peptide ( $A\beta$ ) is an early and necessary event in the pathogenesis of AD. This hypothesis suggests that treatments that slow the accumulation of  $A\beta$  plaque in the brain or increase clearance of  $A\beta$  may be able to slow the progression of the AD clinical syndrome. ~~It is further postulated that combination of treatments that target both removal of  $A\beta$  plaque in the brain and reduce production of  $A\beta$  monomers may have added benefit.~~ The other hallmark neuropathological lesion of AD, intraneuronal neurofibrillary tangles consisting of tau proteins, is thought to be another marker for disease progression (Braak and Braak 1996). The relationship between these 2 pathologies is still unclear, although the presence of both is necessary for the diagnosis of definite AD.

~~Amyloid  $\beta$  is part of the APP, which is a transmembrane protein widely expressed on the cell surface, particularly in neurons. The APP has been found to be cleaved through 2 cleavage pathways involving 3 secretase enzymes:  $\alpha$ -secretase,  $\gamma$ -secretase, and  $\beta$ -secretase (now called  $\beta$ -site APP-cleaving enzyme [BACE]1). Cleavage of APP by  $\alpha$ -secretase precludes the formation of  $A\beta$  as the site is located within the  $A\beta$  sequence. In the second pathway,  $\beta$ -secretase cleaves the APP molecule, generating membrane-associated C99 and releasing a larger secreted fragment called secreted APP (sAPP) $\beta$ .  $\gamma$ -Secretase then cleaves C99 in a heterogeneous fashion within the membrane releasing a variety of  $A\beta$  species that aggregate in protofibrils, then fibrils, which seem to comprise the mass of  $A\beta$  plaques in AD brain tissue (Turner et al. 2003). While both  $\gamma$  and  $\beta$ -secretase inhibition represent effective means of precluding the formation of  $A\beta$ ,  $\beta$ -secretase inhibition may provide improved safety and tolerability (Doody et al. 2013).~~

### 3.2.2. LY3002813 Phase 1 Studies

I5T-MC-AACD (Study AACD) is an ongoing Phase 1b single- and multiple-dose study to assess the safety, tolerability, PK, and PD of single and multiple IV doses of LY3002813 in

patients with mild cognitive impairment due to AD or mild to moderate Alzheimer's dementia. It is ~~evaluating currently enrolling, with~~ up to 150 patients in ~~6~~<sup>seven</sup> different dosing cohorts receiving single, every 2 weeks, or every 4 weeks dosing of either 10 mg/kg, 20 mg/kg or 40 mg/kg of LY3002813. Treatment durations being assessed include single dose, six month dosing every two weeks, or up to 72 weeks of every 4 week dosing. Safety, PK and PD data from this ongoing study are used to inform further development of LY3002813. See Section 3.3 and the IB for detailed safety and PK information regarding LY3002813.

### **3.2.3. LY3202626 Nonclinical Studies**

[Section deleted]

### **3.2.4. LY3202626 Clinical Studies**

[Section deleted]

### **3.2.5. LY3002813/LY3202626 Combination Therapy - Nonclinical Findings**

[Section deleted]

## **3.3. Benefit/Risk Assessment**

### **3.3.1. Benefit**

There is a large unmet medical need for disease-modifying treatments for AD. Data from the completed Phase 1a Study AACC ~~Animal models suggest that combination of a BACE inhibitor with an anti-plaque antibody will reduce soluble forms of amyloid and from the ongoing Phase 1b Study AACD indicate a dramatic~~contribute to reduction in cerebral amyloid (as assessed by florbetapir F18 PET imaging) in individuals who received repeated doses of at least 10 mg/kg (IB; Fleisher~~of insoluble plaques compared to a plaque-specific antibody alone. This may also provide synergistic effects on plaque removal compared to either drug given independently with more rapid and quantitatively greater amyloid removal (DeMattos 2016; Hole et al. 2016).~~Along with 2016). Increased and more rapid removal of amyloid plaque plus removal of soluble forms of amyloid by parallel administration of both LY3002813 and LY3202626 over time is therefore hypothesized to have greater clinical efficacy than either drug given alone, with broader target engagement.

~~In addition to assessment of safety and tolerability of LY3002813 single and combined therapies,~~ this study will assess whether removal of existing amyloid plaque ~~alone or in conjunction with inhibition of A $\beta$  production in the brain~~ will show evidence of slowed clinical decline and change in biomarkers of disease progression relative to placebo treatment.

Although there are currently no available disease-modifying agents for the treatment of AD, there are several medications approved by the Food and Drug Administration (FDA) and Health Canada for the treatment of symptoms of AD; these include acetylcholinesterase inhibitors (e.g., donepezil, galantamine, and rivastigmine) and the N methyl D aspartate receptor antagonist memantine. Because these medications are considered standard of care for the treatment of AD,

participants in this trial will be permitted to take these medications during the course of the study, provided that they have been on a stable dose at the time of randomization and remain on a stable dose throughout the study.

### **3.3.2. Risks**

Potential risks (discussed below) for LY3002813 ~~and LY3202626 given alone~~ include, but are not limited to, ~~1) LY3002813— formation of anti-drug antibodies (ADA), hypersensitivity (immediate and non-immediate, including infusion-related reactions), and amyloid related imaging abnormalities (ARIA).) and 2) LY3202626— hepatic effects, QT prolongation with overdose, skin or hair hypopigmentation, rash, retinal changes, and potential interactions with other drugs.~~

**LY3002813—Anti-Drug Antibodies:** High incidences of treatment-emergent anti-drug antibodies (TEADAs) have been observed in clinical studies with LY3002813. Although there were no serious adverse events (SAEs) related to the development of ADAs in Study AACC, the incidence of TEADAs in LY3002813-exposed patients and subjects was >90 %; in Study AACD, the incidence of TEADAs to date (final protocol) in LY3002813-exposed patients and subjects is approximately 75 %. In AACD, on 10 mg/kg Q2WK dosing, one patient was observed with a highly elevated ADA titer of 1:163840 on Day 144 postbaseline, with no clinical consequences. Anti-drug antibodies levels may affect PD levels of drug effect. Infusion reactions and ADAs are potential risks common to all large molecules. See the IB for details regarding TEADAs.

**LY3002813—Hypersensitivity (Immediate and Non-immediate), including infusion-related reactions):**

**LY3002813— Amyloid-Related Imaging Abnormalities:**

**LY3202626—Hepatic effects:** In nonclinical studies, liver enzyme elevations were observed with LY3202626 in rats and dogs. These changes in the 1-month rat and dog studies occurred at exposures  $\geq 245$ -fold the projected exposure at the high dose (12 mg) in the Phase 2 study. In the 6-month toxicology study in rats, mild alanine aminotransferase (ALT)/aspartate aminotransferase (AST) increases occurred in the high-dose group; these analytes remained increased at similar levels at the end of the 1-month recovery period, indicating lack of reversibility. In the 6-month rat study, ALT/AST increases did not occur at the mid-dose, and AUC-based margins at the mid-dose no-observed-adverse-effect level (NOAEL) of 4.5 mg/kg are 23- and 6-fold relative to the Phase 2 doses of 3 and 12 mg, respectively. No liver changes occurred in the 9-month toxicology study in dogs (AUC-based margin 39-fold relative to 12 mg dose in the Phase 2 study). Liver-related clinical chemistry analytes will be monitored in the clinical trial. In addition, the investigator may perform additional tests when clinically indicated. Clinical manifestations of hepatic injury may include fatigue, jaundice, steatosis, nausea, vomiting, right upper quadrant pain or tenderness, fever, rash, or pruritus.

**LY3202626—QT Prolongation:** Dose-dependent QT corrected for heart rate (QTc) prolongation (10 to 25 msec) occurred following repeated administration in dogs, at plasma unbound



maximum observed drug concentration ( $C_{max}$ ) values approximately 3-fold of those projected for the highest planned Phase 2 clinical dose of 12 mg. Specific study exclusion criteria related to QTc are defined in the clinical protocol. Electrocardiograms and vital signs will be carefully monitored during the clinical trial. Cardiac signs and symptoms should be closely monitored in the presence of overdose.

**LY3202626 – Hypopigmentation:** Dose-dependent decreased pigmentation of the skin and haircoat of dogs has been observed in preclinical studies with LY3202626. The lightening of haircoat and mucocutaneous junction epithelium did not impact the well-being of the dogs and was reversible during the treatment-free recovery period. Scheduled skin examinations will be performed by a dermatologist in the clinical trial, and are defined in the clinical protocol. If hypopigmentation is observed, patients may continue treatment. The location of hypopigmentation, occurrence of any associated cutaneous changes, and response after the treatment period should be monitored.

**LY3202626 – Retinal effects:** Adverse retinal effects occurred in both the 1-month and 6-month toxicology studies with LY3202626 in rats, which included autofluorescent granule accumulation and hypertrophy of the retinal pigmented epithelium with photoreceptor degeneration. In the 6-month rat study, these retinal findings occurred only in the high-dose group (25 mg/kg) and did not reverse during the 1-month, treatment-free period. No retinal effects occurred at the NOAEL (4 mg/kg) in the 6-month rat toxicology study, providing area under the drug-plasma concentration versus time curve (AUC)-based MOS of 23- and 6-fold to the Phase 2 doses of 3 and 12 mg. No adverse retinal changes occurred in dogs. Scheduled eye examinations by an ophthalmologist or optometrist (where permitted by law) will be performed in the clinical trial, and are defined in the clinical protocol. Patients who complain of vision disturbance during the clinical trial should be referred to the ophthalmologist or optometrist (where permitted by law) for unscheduled evaluation.

**LY3202626 – Potential Drug Interactions:** LY3202626 has been shown to be a substrate of CYP3A and potentially a time-dependent inhibitor of CYP3A. Co-administration with a strong CYP3A inhibitor led to an approximate 20% increase in LY3202626 exposure, which is not thought to be clinically significant. The effect of LY3202626 on other CYP3A substrates is predicted to be modest. Accordingly, clinically meaningful drug interactions are not anticipated with LY3202626 administration. See the IB for a detailed assessment of clinical and nonclinical data regarding the potential for drug interactions.

### **3.3.3. Benefit/Risk Assessment Summary**

To mitigate the potential risks described in Section 3.3.2, the current study will include standard safety assessments; i.e., reported AEs, clinical laboratory tests, immunogenicity assessments, vital sign and body weight measurements, 12-lead electrocardiograms (ECGs), and physical examinations.

Additional safety assessments will include neurological examinations (as part of each physical examination), comprehensive eye examinations by an ophthalmologist or optometrist (where permitted by law), skin examinations by a dermatologist, MRI examinations, and suicidality

evaluations using the Columbia-Suicide Severity Rating Scale (C SSRS). The current study will use an independent external Data Monitoring Committee (DMC) to monitor data on an ongoing basis to ensure the continuing safety of patients enrolled in this study.

The current study includes placebos of both LY3002813 intravenously and LY3202626 orally as a comparator, and approximately one-half<sup>third</sup> of the patients will be randomized to placebo. In addition, all patients participating in the study will have a designated study partner who will have regular contact with the patient, accompany the patient to study visits, and liaise with the study staff between visits as needed (see Section 6.1 for additional information about the role of the study partner).

In conclusion, the available non-clinical and clinical data support the intravenous administration of LY3002813 and the IV administration of LY3002813 in combination with the oral administration of LY3202626 to the intended study population according to the proposed clinical investigation plan and also provide a sufficient margin of safety for the proposed design and doses. There are currently no disease-modifying treatments for AD. The potential benefits of LY3002813 and LY3002813 in combination with LY3202626 showing disease-modifying properties in AD are considered to outweigh the potential risks.

More information about the known and expected benefits, risks, SAEs and reasonably anticipated AEs of LY3002813 and LY3202626 are to be found in the respective IB(s).

## 4. Objectives and Endpoints

**Table AACG.4.1. Objectives and Endpoints**

Primary Objective	Primary Endpoint
To test the hypothesis that LY3002813 <del>alone and/or in combination with LY3202626</del> administered for up to <del>72</del> 76 weeks will decrease the cognitive and/or functional decline in patients with early symptomatic AD	Change in cognition and function as measured by the change in integrated Alzheimer's Disease Rating Scale (iADRS) score from baseline to 18 months
<b>Secondary Objectives</b> To assess the effect of LY3002813 <del>alone and in combination with LY3202626</del> vs. <u>placebos</u> on clinical progression in patients with early symptomatic AD	<b>Secondary Endpoints</b> Change in cognition from baseline to 18 months as measured by: <ul style="list-style-type: none"> <li>the change in Alzheimer's Disease Assessment Scale—Cognitive subscale (ADAS-Cog<sub>13</sub>) score</li> <li>the change in Clinical Dementia Rating Scale Sum of Boxes (CDR-SB) score</li> <li>the change in Mini Mental State Examination (MMSE) score</li> <li>the change in Alzheimer's Disease Cooperative Study-instrumental Activities of Daily Living scale (ADCS-iADL) score</li> </ul>

To assess the effect of LY3002813 <del>alone and in combination with LY3202626</del> vs. placebo on brain amyloid deposition	Change in brain amyloid plaque deposition from baseline through 18 months as measured by florbetapir F18 PET scan
To assess the effect of LY3002813 <del>alone and in combination with LY3202626</del> vs. placebo on brain tau deposition	Change in brain tau deposition from baseline to 18 months as measured by flortaucipir F18 PET scan
To assess the effect of LY3002813 <del>alone and in combination with LY3202626</del> vs. placebo on brain volume measures	Change in volumetric MRI measures from baseline to 18 months.
To assess the effect of combination therapy with LY3002813 and LY3202626 vs LY3002813 <del>alone</del> on clinical progression in patients with early symptomatic AD	<del>Change from baseline to 18 months in iADRS score, ADAS-Cog<sub>13</sub> score, CDR-SB score, MMSE score, ADCS-iADL score</del>
<b>Safety Objective</b>	<b>Safety Endpoints</b>
To evaluate safety and tolerability of LY3002813 <del>alone and in combination with LY3202626</del>	<ul style="list-style-type: none"> <li>Standard safety assessments: <ul style="list-style-type: none"> <li>spontaneously reported adverse events (AEs)</li> <li>clinical laboratory tests</li> <li>vital sign and body weight measurements</li> <li>12-lead <del>electrocardiograms</del> (ECGs)</li> <li>physical and neurological examinations</li> </ul> </li> <li>MRI (ARIA and emergent radiological findings)</li> <li><del>Skin examination</del></li> <li><del>Eye examination</del></li> <li>Columbia Suicide Severity Rating Scale (C-SSRS)</li> </ul>
<b>Exploratory Objectives</b>	<b>Exploratory Endpoints</b>
To assess the effect of LY3002813 <del>alone and in combination with LY3202626</del> vs. placebos, as well as combination therapy with LY3002813 and LY3202626 vs LY3002813 <del>alone</del> on clinical progression in patients with early symptomatic AD	<ul style="list-style-type: none"> <li>the change in dependence level derived from ADCS-ADL scale scores</li> </ul>
To assess peripheral PK and presence of anti-LY3002813 antibodies <u>over 72 in</u> LY3002813 <del>alone and in combination with LY3202626</del> over 76 weeks	<ul style="list-style-type: none"> <li>Plasma pharmacokinetics of LY3002813</li> <li>Anti-drug-antibodies (ADA) against LY3002813 including treatment-emergent ADA and neutralizing antibodies.</li> </ul>
To assess peripheral PK of LY3202626 <del>in combination with LY3002813</del> over 76 weeks	<ul style="list-style-type: none"> <li><del>Plasma Pharmacokinetics of LY3202626</del></li> </ul>
To assess the effect of combination therapy with LY3002813 and LY3202626 vs LY3002813 <del>alone</del> on brain amyloid deposition	<ul style="list-style-type: none"> <li><del>Change in brain amyloid plaque deposition from baseline through 18 months as measured by florbetapir F18 PET scan</del></li> </ul>

To assess the effect of combination therapy with LY3002813 and LY3202626 vs LY3002813 alone on brain tau deposition	<ul style="list-style-type: none"> <li>• <del>Change in brain tau deposition from baseline to 18 months as measured by flortaucipir F18 PET scan</del></li> </ul>
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## 5. Study Design

### 5.1. Overall Design

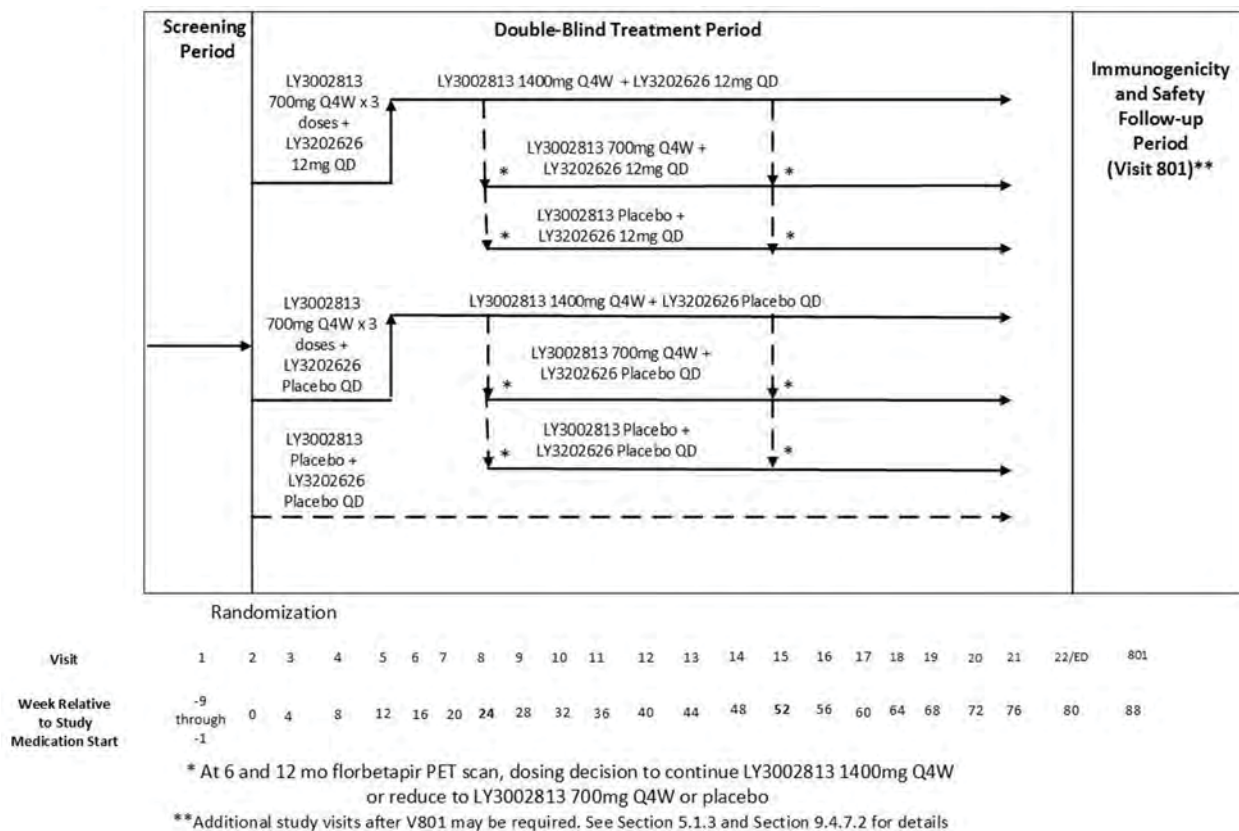
Study AACG is a multicenter, randomized, double-blind, placebo-controlled, Phase 2 study of LY3002813, ~~alone and in combination with LY3202626~~, in subjects with early symptomatic AD. The ~~133-124-week~~ study includes a screening period of up to 9 weeks, a treatment period of up to ~~72-76~~ weeks with final evaluations occurring 4 weeks later at Week 76, and ~~a 48-4-week posttreatment follow-up, and a 44-week immunogenicity and safety follow-up period.~~ Subjects who meet entry criteria will be randomized in a 1:1:1 ratio to one of the following treatments:

- LY3002813: ~~monotherapy (LY3002813-M):~~ IV LY3002813 (700 mg Q4WK for the first 3 doses, then 1400 mg Q4WK) ~~for in combination with daily oral placebo~~ up to ~~72-76~~ weeks,
- ~~LY3002813 in combination with LY3202626 (LY3002813-C):~~ IV LY3002813 (700 mg Q4WK for the first 3 doses, then 1400 mg Q4WK) ~~in combination with daily oral LY3202626 (12 mg) up to 76 weeks, or~~
- Placebo: IV placebo Q4WK ~~in combination with daily oral placebo~~ for up to ~~72-76~~ weeks.

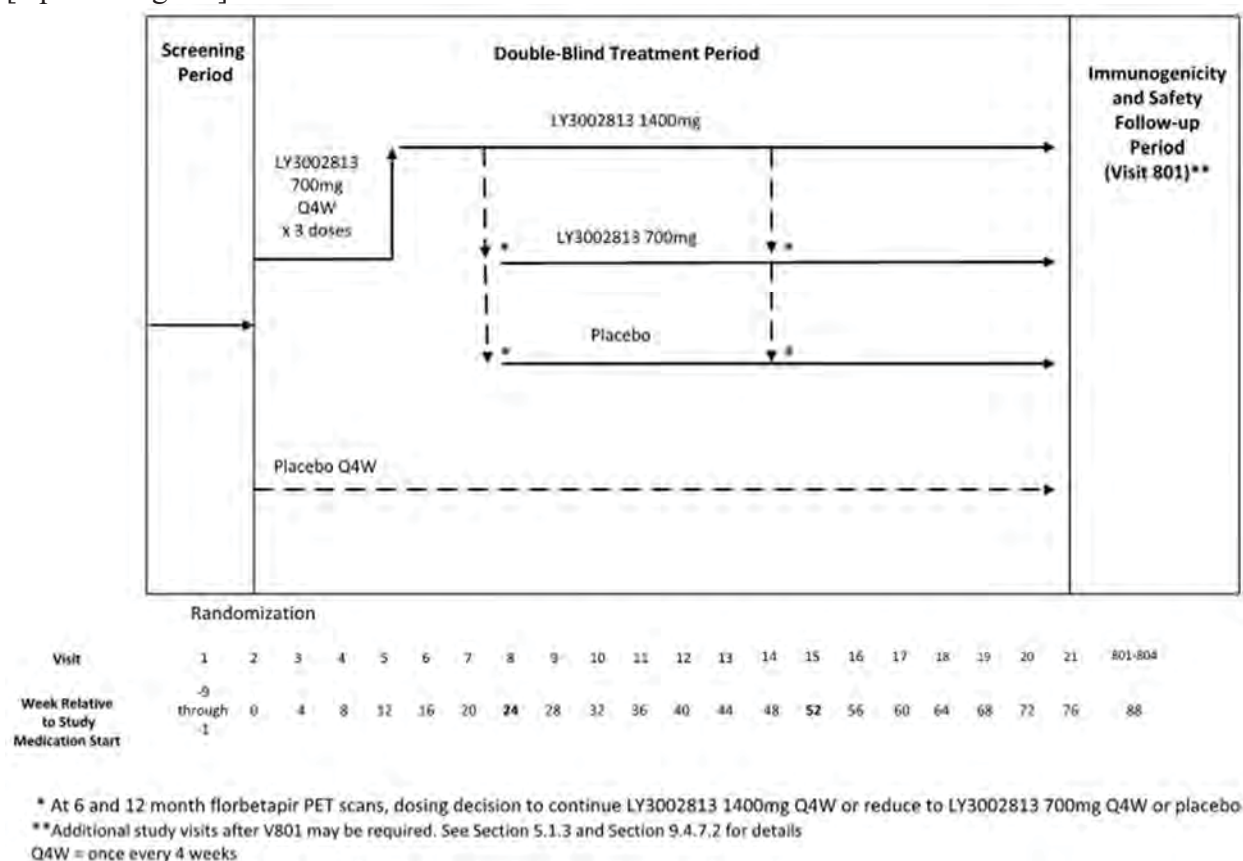
The primary hypothesis being tested is that LY3002813 administered ~~alone, or in combination with LY3202626~~, for up to ~~72-76~~ weeks will result in a significant slowing in cognitive/functional decline compared with placebo as measured by the change from baseline to the end of the double blind treatment period (Week 76) on the integrated Alzheimer's Disease Rating Scale (iADRS), in subjects with early symptomatic AD (where early symptomatic AD refers to the combination of 2 stages: prodromal AD [MCI -AD] and mild AD dementia; Alaka et al. 2015).

Under previous versions of this protocol, LY3002813 was administered in combination with LY3202626, an inhibitor of  $\beta$  site amyloid precursor protein cleaving enzyme (BACE)1. However, as of this amendment (d), the combination therapy and the oral placebo have been discontinued from the study.

[Old figure:]



[Updated figure:]



**Figure AACG.5.1. Illustration of study design for Clinical Protocol I5T-MC-AACG.**

### 5.1.1. Screening Period (Visit 1)

Once the MMSE criteria are met, 63 days are allowed for completion of Visit 1 screening assessments, procedures, and evaluation of results from laboratory tests, ECGs, physical and neurological examination, ~~ophthalmological and dermatological exams~~, flortaucipir F18 PET, MRI, and florbetapir F18 PET. Even though florbetapir F18 PET imaging may be the last screening procedure of the study, it is expected that the centrally read florbetapir F18 PET results will be available within the timeframe of 63 days. However, it will not be a protocol ~~deviation~~violation should the screening florbetapir F18 PET results not be available until after 63 days.

Patients whose screening florbetapir F18 PET results are not available until after 63 days will remain eligible within Visit 1 until these results become available. **Note:** If a patient's screening florbetapir F18 PET results confirming evidence of amyloid burden are received by the site after 63 days, laboratory tests (blood hematology, chemistry, and serum human chorionic gonadotropin [HCG] for females of childbearing potential) are to be repeated for that patient. Results of the repeated labs are to be reviewed by the investigator or qualified designee for assessment of the patient's continued eligibility. Repeat screening for MMSE, CBB, C-SSRS,



ECG, ~~ophthalmological and dermatological exams~~, flortaucipir F18 PET imaging, and MRI, and laboratory testing for hepatitis B surface antigen (HBsAg), and hepatitis C virus (HCV) RNA polymerase chain reaction (PCR), is not required.

Patients in active screening prior to implementation of amendment (d) remain eligible within Visit 1 until all screening procedures are completed and results are available. This will not be a protocol deviation. Patients who complete Visit 1 beyond 63 days are to repeat laboratory tests (blood hematology, chemistry, and serum HCG for females of childbearing potential) prior to being randomized. The results of these laboratory tests are to be reviewed by the investigator or qualified designee for assessment of the patient's continued eligibility. Repeat screening for MMSE, CBB, C-SSRS, ECG, flortaucipir F18 PET imaging, MRI, and laboratory testing for HBsAg and HCV RNA PCR is not required.

#### **5.1.1.1. Screening Procedures**

Screening entry and administrative procedures, cognitive assessments, safety assessments, ~~(with the exception of ophthalmological and dermatological exams)~~, and laboratory assessments (see Schedule of Activities in Section 2) are to be done at Visit 1 before the screening flortaucipir F18 PET scan, MRI, and florbetapir F18 PET scan procedures.

##### **5.1.1.1.1. Modified Hachinski Ischemic Scale (MHIS)**

Patients who score  $\geq 4$  are more likely to have a dementia of vascular etiology and are excluded from participating in the trial.

##### **5.1.1.1.2. Mini-Mental State Examination (MMSE)**

The MMSE is a brief instrument used to assess cognitive function in ~~elderly~~ patients (Folstein et al).

##### **5.1.1.1.5. Screening Ophthalmological and Dermatological Examinations**

[Section deleted]

##### **~~5.1.1.1.6.~~5.1.1.1.5. Screening Positron Emission Tomography and Magnetic Resonance Imaging**

~~With the exception of ophthalmological and dermatological exams,~~ All other screening criteria should be met in order for the patient to proceed with flortaucipir F18 PET scan, followed by MRI, and a florbetapir F18 PET scan procedure.

##### **~~5.1.1.1.6.2.~~5.1.1.1.5.2. Screening MRI**

A local screening MRI will be performed at Visit 1 as part of the study eligibility criteria. With the exception of the evidence of amyloid pathology by florbetapir F18 PET scan, ~~and ophthalmological and dermatological exams~~, a patient should meet all other Visit 1 eligibility criteria before having an MRI.

##### **~~5.1.1.1.6.3.~~5.1.1.1.5.3. Screening Florbetapir F18 PET Scan**

With the exception of ~~the MRI and ophthalmological and dermatological exams~~, a patient should meet all other Visit 1 eligibility criteria before having a screening florbetapir F18 PET scan.

### **5.1.2. Double-Blind Period (Visit 2 through Visit 2122)**

Patients who meet entry criteria will be enrolled and randomized to receive up to ~~72~~76 weeks of treatment with LY3002813-M, LY3002813-C, or placebo.

~~Patients are to take oral study medication (oral placebo or LY3202626) once per day in the morning. The first dose should be taken the morning after the first dispensing of oral study medication at Visit 2.~~

~~A final~~ Final endpoint measures and safety assessments ~~visit~~ for the double-blind period will be performed at Visit ~~2122~~ (Week ~~76~~80) 4 weeks following the patient's last dose of study medication.

### **5.1.3. Immunogenicity and Safety Follow-up Visits (Visits 801 through 804)**

Patients are to return to the site for an immunogenicity and safety follow-up visits (Visit 801 through Visit 804) beginning at Week 88 (or 12 weeks after their last dose of LY3002813 for collection of blood samples for anti-drug antibody [(ADA; anti-LY3002813 antibody)] and PK measurement, ~~and~~ assessment of adverse events, C-SSRS, ~~and~~ concomitant medications, and vital signs.

## **5.2. Number of Participants**

Approximately ~~266~~375 participants will be randomized.

## **5.4. Scientific Rationale for Study Design**

**Continuing Standard of Care.** During the double-blind treatment period (V2 to ~~V21~~V22), changes in doses of available symptomatic medications for MCI or AD will require reporting to the sponsor and these changes should occur only when necessary for the adequate overall care of the patient. The effect of LY3002813 treatment ~~alone or in combination with LY3202626~~ plus SOC will be compared with placebo plus SOC.

**Dosing.** As described more fully in Section 7.1, LY3002813 (700 mg or 1400 mg) will be administered every 4 weeks as an IV infusion of approximately 140 mL over a minimum of 30 minutes ~~and LY3202626 (12 mg) will be administered orally once a day.~~

**Design.** Study AACG is a multicenter, randomized, double-blind, placebo-controlled study of LY3002813, ~~alone and in combination with LY3202626~~, in patients with early symptomatic AD (where early symptomatic AD refers to the combination of 2 stages: prodromal AD [MCI AD] and mild AD dementia) (Alaka et al. 2015). The study is intended to characterize the benefits and risks of treatment with LY3002813 ~~alone or in combination with LY3202626~~ versus placebo in patients early symptomatic AD.

.... The use of a placebo comparator in Study AACG is needed to determine efficacy and safety of LY3002813 ~~monotherapy and LY3002813 combination~~ therapy.



The duration of the double-blind period of the study is ~~7680~~ weeks and includes up to ~~7276~~ weeks of treatment, with endpoint measures and safety assessments at the end of the double-blind treatment period (Week 76), to assess the safety, tolerability and efficacy of LY3002813 ~~alone or in combination with LY3202626 versus placebo, as well as LY3002813 alone versus LY3002813 in combination with LY3202626, and safety assessments at 80 weeks.~~

In addition to AE reporting, safety measures such as laboratory assessments, immunogenicity testing, vital signs and weight monitoring, ECG monitoring, physical examinations, neurological examinations ~~dermatological examinations, ophthalmological examinations~~, MRI assessments, and assessments of suicidal ideation and behavior are included to facilitate a comprehensive safety evaluation. For patients enrolled under previous versions of this protocol, which included a combination arm of LY3002813 (N3pG) and LY3202626 (BACE inhibitor-IV), final dermatological examinations by a dermatologist and final comprehensive ophthalmological examinations by an ophthalmologist or optometrist (where permitted by law) will be performed at the next visit occurring after the patient stopped receiving LY3202626/oral placebo.

## 5.5. Justification for Dose

....

~~The LY3202626 dose of 12 mg administered orally once a day was selected based on current nonclinical pharmacology and toxicology data and clinical PK, PD and safety data. Doses of LY3202626 chosen for this study were based on central and peripheral PK/PD data from healthy subjects collected in a previous single and multiple dose study that were used to estimate the exposures necessary to achieve the desired levels of CSF A $\beta$  reduction. These exposure targets were then used to select a daily dose of 12 mg LY3202626 for this study. This dose is less than the highest doses previously evaluated in healthy subjects (45 mg as a single dose, or 26 mg once a day for 14 days), which were found to be well tolerated. As described in Section 3.2.4, LY3202626 appears to be well tolerated in an ongoing Phase 2 study investigating the effect of 3 mg and 12 mg LY3202626. Together, these data suggest that a dose of 12 mg LY3202626 will be well tolerated in an AD population and will allow evaluation of near maximal inhibition of A $\beta$  production.~~

## 6. Study Population

### 6.1. Inclusion Criteria

....

#### Patient/Subject Characteristics

[4] ....

A second study partner may serve as backup. The study partner(s) is/are required to accompany the patient for signing consent. One study partner is requested to be present on all days the Columbia Suicide Severity Rating Scale (C-SSRS)/Self-Harm Supplement Form is administered and must be present on all days the ~~and~~ cognitive and functional scales are administered (i.e., Visits 1, 2, 5, 8, 11, 15, 18, and 21/ED). If a patient has a

second study partner, it is preferred that one study partner be primarily responsible for the CDR and ADCS-ADL assessments. If a study partner(s) is not able to accompany the patient in person for visits other than those listed above, they must be available by telephone for the following assessments:

- AEs and concomitant medications
- relevant portions of the C-SSRS/Self-Harm Supplement Forms
- ~~CDR and ADCS-ADL (primary study partner if possible)~~

## 6.2. Exclusion Criteria

### Medical Conditions

- [11] Current serious or unstable illnesses including ~~retinal~~, cardiovascular, hepatic, renal, gastroenterologic, respiratory, endocrinologic, neurologic (other than AD), psychiatric, immunologic, or hematologic disease and other conditions that, in the investigator's opinion, could interfere with the analyses in this study; or has a life expectancy of <24 months.
- ~~[57] [Note: Criterion #57 has been deleted.] Ocular pathology that significantly limits ability to reliably evaluate vision or the retina, or puts participant at undue risk for vision loss during the study.~~
- ~~[18] [Note: Criterion #18 has been deleted.] History of vitiligo and/or current evidence of post-inflammatory hypopigmentation.~~

### Magnetic Resonance Imaging, Vital Signs, Electrocardiograms, Laboratory Tests, and Physical Examination

- [54] Patients with past history of Hepatitis C should have ~~hepatitis C virus (HCV) ribonucleic acid (RNA) polymerase chain reaction (PCR)~~ testing at screening and are excluded if HCV RNA PCR is positive.

### Prior/Concomitant Therapy

- [32] ~~[Note: Criterion #32 has been deleted.] Current use of strong inducers of CYP3A (see the Manual of Operations for a list of excluded drugs).~~
- [37] ~~[Note: Criterion #37 has been deleted.] Have known allergies to LY3202626, related compounds, or any components of the formulation.~~

### Prior/Concurrent Clinical Trial Experience

- [47] [Note: Criterion #47 has been replaced by criteriona #55 and #56.]
- [56] ~~[Note: Criterion #56 has been deleted.] Have previously had LY3202626 treatment discontinued due to treatment related adverse event.~~

#### 6.2.1. Rationale for Exclusion of Certain Study Candidates

The use of LY3002813 and LY3202626 in older patients is anticipated; thus this study will specifically examine the efficacy and safety in an elderly population. Criterion [2] defines the population age range for the purposes of this study. Therefore, patients not meeting the age criterion are excluded.

### 6.3. Lifestyle Restrictions

2. ~~Patients should avoid use of tanning beds and self tanning products.~~
3. ~~Patients should wear a hat and appropriate clothing when exposed to sunlight; use a sunscreen with a skin protection factor (SPF) of at least 15; and protect their lips with a lip balm containing sunblock.~~

## 7. Treatments

### 7.1. Treatments Administered

This study involves a comparison of LY3002813 administered as an IV infusion of approximately 140 mL over a minimum of 30 minutes compared ~~with LY3002813 in combination with LY3202626 administered orally once a day, and placebo.~~ In the double-blind period, the treatment groups will be given either an IV infusion of LY3002813 ~~monotherapy (LY3002813-M), LY3002813 combination therapy (LY3002813-C), or Placebo for up to 72/76~~ weeks.

....

~~The LY3202626 dose will remain 12 mg throughout the double-blind treatment period.~~ Table AACG.7.1 shows the 23 treatment regimens during the double-blind period.

**Table AACG.7.1. Treatment Regimens, Double-Blind Period**

Regimen	Dose Visit 2 (Week 0) through Visit 21 (Week 76)
<b>LY3002813-M</b>	<del>LY3002813 (700 mg intravenous infusion every 4 weeks x 3 doses, then 1400 mg intravenous infusion every 4 weeks for up to 72 weeks) in combination with orally dosed placebo tablet once per day in the morning x 76 weeks</del>
<b>LY3002813-C</b>	LY3002813 (700 mg intravenous infusion every 4 weeks x 3 doses, then 1400 mg intravenous infusion every 4 weeks for <u>up to 72 weeks</u> ) <del>in combination with LY3202626 (12 mg tablet orally once a day in the morning for 76 weeks)</del>
<b>Placebo</b>	Intravenously dosed placebo infusion every 4 weeks for <u>up to 72 weeks</u> <del>in combination with orally dosed placebo tablet once per day in the morning x 76 weeks</del>

Abbreviations: C = combination therapy; M = monotherapy.

### **~~7.1.1.2. LY3202626 Packaging and Labelling~~**

~~LY3202626 will be supplied as 12 mg tablets. The study drug and placebo will be identical in appearance and will be packaged in blister packs.~~

## **7.2. Method of Treatment Assignment**

Patients will be randomized to LY3002813-M, ~~LY3002813-C~~, or Placebo in a 1:1:1 ratio.

### **7.2.1. Selection and Timing of Doses**

Assessment of LY3002813 ~~and LY3202626~~ safety and tolerability is a central objective; therefore, monitoring 100 patients on LY3002813-M over ~~72~~76 weeks ~~in parallel with approximately 100 patients on LY3002813-C over 76 weeks of exposure~~ provides data to assess safety for further clinical development.

The actual time of ~~both~~ LY3002813 ~~and LY3202626~~ dose administrations on the day of study visits will be recorded in the subject's case report form (CRF). ~~In addition, the actual time of LY3202626 dose administration for the 2 days prior to each visit at which LY3202626 PK samples will be collected will be recorded in the subject's CRF.~~

#### **7.2.1.1. LY3002813: Selection and Timing of Doses**

.... Intravenous study medication given at a dosing interval of less than 21 days at any time during the study will be considered a protocol ~~deviation~~violation.

#### **7.2.1.2. LY3202626: Selection and Timing of Doses**

[Section deleted]

## **7.3. Blinding**

This is a double-blind study, with design to maintain blinding to ~~treatment~~~~both LY3002813 and LY3202626 treatments~~.

## **7.4. Dosage Modification**

### **7.4.1. LY3002813 Dosage Modification for ARIA-E**

#### **~~7.4.1.1. LY3002813 Dosage Modification for ARIA-E~~**

~~Patients will continue LY3202626 at 12 mg per day.~~

#### **~~7.4.1.2.~~ 7.4.2 LY3002813 Dosage Modification for ARIA-H**

~~Patients will continue LY3202626 at 12 mg per day.~~

~~Patients permanently discontinued from LY3002813 are to continue taking LY3202626 unless they are permanently discontinued from LY3202626 treatment or from the trial.~~

#### **7.4.2. LY3202626 Dosage Modification**

[Section deleted]

### **7.6.2.LY3202626 Treatment Compliance**

[Section deleted]

## **7.7. Concomitant Therapy**

*Allowed Medications.* Use of approved or standard of care treatments for AD is permitted during the study, provided that such medications dose has been unchanged for 2 months before Visit 2. Doses of these medications should remain constant throughout the double-blind period (Visit 2 to Visit ~~21~~22).

*Prior to ~~V21~~V22, before a patient starts, stops, or changes doses of AChEIs and/or memantine or other treatments for their AD, the Sponsor or designee must be contacted to determine whether or not the patient should continue in the study and whether or not clinical outcome measures should be performed. Failure to notify Lilly or its designee regarding starting, stopping or changing doses of AChEIs and/or memantine or other treatments for their AD prior to ~~V21~~V22 will be considered a protocol deviation~~violation~~.*

If unforeseen starting, stopping, or changing of stable doses of drugs affecting CNS function occurs prior to ~~V21~~V22 of the study, Lilly or its designee must be contacted to determine whether or not the patient should continue in the study and whether or not outcome measures should be performed. *Failure to notify Lilly or its designee regarding starting, stopping or changing doses of CNS medications prior to ~~V21~~V22 of the study will be considered a protocol deviation~~violation~~.*

*Excluded Medications.*

~~*Concomitant therapies that are prohibited during treatment with LY3002813:*~~ IgG therapy (also known as gamma globulin or intravenous immunoglobulin [IVIG]) is not allowed during the study.

~~*Concomitant therapies that are prohibited during treatment with LY3202626:*~~

- ~~• Use of depigmenting agents, such as, hydroquinone~~
- ~~• Current use of strong inducers of CYP3A (See the Manual of Operations for a list of excluded drugs)~~
- ~~• Current use of drugs known to significantly prolong the QT interval (See the Manual of Operations for a list of excluded drugs)~~
- ~~• Use of any drug of abuse, including but not limited to cannabis, illicit amphetamine, cocaine, illicit opiates, propoxyphene, methadone, methaqualone, phenylcyclidine, or illicit barbiturate~~

## **7.8. Treatment after the End of the Study**

### **7.8.1. Treatment after Study Completion**

There is no planned open label extension at this time, or plan to otherwise make LY3002813 or LY3202626 available to patients after conclusion of the study.

## 8. Discontinuation Criteria

### 8.1. Discontinuation from Study Treatment

- Treatment with LY3002813 will also be permanently discontinued in patients with:
  - o Adverse event or clinically significant laboratory value, ECG result, physical examination finding, ~~(including eye or skin examination)~~, MRI finding (such as symptomatic ischemic stroke), C-SSRS result, or vital sign measurement of such severity that, in the opinion of the investigator or Lilly-designated medical monitor, continued treatment is not in the best interest of the patient.

~~Patients permanently discontinued from one treatment may continue to receive the other treatment and continue in the trial. Patients may also permanently discontinue study treatment both treatments and remain in the trial.~~

~~If LY3202626 oral dose is permanently discontinued but the patient remains in the study, a final sample should be collected, provided the last dose of LY3202626 is within 3 days of the visit. Dosing dates and times should be collected. No other PK samples for LY3202626 are required after the final sample.~~

#### 8.1.1. Temporary Discontinuation from Study Treatment

##### 8.1.1.1. Temporary Discontinuation from LY3002813 Study Treatment Due to ARIA-E

~~8.1.1.1.1. Temporary Discontinuation from LY3002813 Study Treatment Due to ARIA-E~~

##### 8.1.1.2. Temporary Discontinuation from LY3202626 Study Treatment

[Section deleted]

### 8.2. Discontinuation from the Study

Subjects discontinuing from the study prematurely for any reason must complete AE and other safety follow-up per Section 2 (Schedule of Activities), Section 9.2 (Adverse Events), and Section 9.4 (Safety) of this protocol. In addition, subjects discontinuing from the study prematurely should be encouraged to return to the site beginning 12 weeks after their ED visit for an immunogenicity and safety assessments (Visits ~~assessment visit~~ (Visit 801 through 804, as described in Section 5.1.3).

## 9. Study Assessments and Procedures

### 9.1. Efficacy Assessments

Note that the ADAS-Cog and MMSE ~~should~~ must be administered by a different rater than the ADCS-ADL and CDR.

### 9.1.2. Secondary Efficacy Assessments

#### 9.1.2.4. Mini-Mental State Examination (MMSE)

The MMSE is a brief instrument used to assess cognitive function in elderly patients (Folstein et al. 1975).

### 9.1.3. Biomarker Efficacy Measures (Double-Blind Period)

**Florbetapir F18 PET scan.** Change in amyloid burden (as assessed by florbetapir F18 PET signal) will be compared in LY3002813-; ~~LY3002813/LY3202626-~~ and placebo-treated patients for those patients who undergo florbetapir F18 PET scans at baseline, Week 52 [Visit 15], and Week 76 [Visit 21] or ~~early discontinuation [ED]~~ as described in the Schedule of Activities (Section 2).

**Flortaucipir F18 PET scan.** Change in tau burden (as assessed by flortaucipir F18 PET signal) will be compared in LY3002813-; ~~LY3002813/LY3202626-~~ and placebo-treated patients for those patients who undergo both baseline and endpoint (Visit 21 [Week 76] or ED) flortaucipir F18 scans as described in the Schedule of Activities (Section 2).

**Volumetric MRI.** Magnetic resonance imaging of the brain will be performed according to the Schedule of Activities (Section 2). LY3002813-; ~~LY3002813/LY3202626-~~ and placebo-treatment effects on volumetric MRI will be assessed and compared to evaluate the loss of brain volume that occurs in AD patients.

#### 9.2.1.2. Adverse Events of Special Interest

Specific safety topics of interest for this study include, but are not limited to, the following:

- ~~QT prolongation~~
- ~~Adverse eye effects~~
- ~~Adverse skin effects including rash and hypopigmentation~~
- ~~Liver toxicity~~

### 9.3. Treatment of Overdose

#### 9.3.1. ~~Treatment of LY3002813 Overdose~~

There is no known antidote to LY3002813. In case of overdose, use appropriate monitoring and supportive therapy.

#### 9.3.2. ~~Treatment of LY3202626 Overdose~~

~~There is no known antidote to LY3202626. In the case of known or suspected overdose, monitoring of cardiac, hepatic, and hematological effects is essential, and appropriate supportive therapy should be initiated, as appropriate. Refer to the LY3202626 IB.~~

### 9.4. Safety



### 9.4.1 Physical and Neurological Examinations

Complete physical examinations will be performed at screening, baseline, and Weeks 12, 24, 52, 76, 80, and ED as indicated in the Schedule of Activities (Section 2).

### 9.4.6 Other Tests

#### 9.4.6.3. Ophthalmological Examination

While the BACE inhibitor LY3202626 is no longer being administered in this study (see Section 5.1), ophthalmological examinations in patients who previously received LY3202626 or oral placebo will be performed at the next scheduled examination time point after their final dose of oral study medication (see the Schedule of Activities [Section 2]). Patients who received LY3202626/oral placebo after their Visit 9 ophthalmological examination are to have an unscheduled ophthalmological examination at the next available opportunity. Patients screened or randomized under the current amendment are not required to undergo any ophthalmological examinations at baseline or any other study visits.

~~All~~ Patients who previously received LY3202626 or oral placebo will undergo comprehensive ophthalmological examinations performed by an ophthalmologist or optometrist (where permitted by law) to assess visual function and morphology. Scheduled examinations will include the following: visual acuity, intraocular pressure, dilated funduscopy exam (dilation only performed in patients without contraindication to mydriatics), slit lamp exam, color photography of the retina, and optical coherence tomography (OCT) or equivalent; examinations will also include color vision assessment. Assessments will preferably be performed ~~at times shown in the Schedule of Activities (Section 2), preferably~~ by the same ophthalmologist or optometrist for each patient's visit. Patients who complain of vision disturbance, such as change in field of vision, color, acuity or anything potentially localizable to the retina, during the clinical trial should be referred to the ophthalmologist or optometrist (where permitted by law) for unscheduled evaluation.

Data from the ~~eye~~ ophthalmological examination visits will be provided from the local ophthalmologist or optometrist to the investigator. ~~Based on the morphological and functional results, the investigator will include or exclude the patient in consultation with the performing eye examiner.~~

The local ophthalmologist or optometrist will review the color photography and OCT to aid in ~~the investigator's assessment of study eligibility and for~~ immediate patient management. Additionally, the color photography of retina and OCT will be analyzed by a central reader.

#### 9.4.6.4. Dermatological Examination

While the BACE inhibitor LY3202626 is no longer being administered in this study, A complete dermatological examinations in patients who previously received LY3202626 or oral placebo will ~~skin examination~~ be performed at the next scheduled examination time point after their final dose of oral study medication (see ~~times shown in~~ the Schedule of Activities ([Section 2]). Patients who received LY3202626/oral placebo after their Visit 8 dermatological examination



are to have an unscheduled dermatological examination at the next available opportunity. Patients screened or randomized under the current amendment are not required to undergo any skin exams at baseline or any other study visits.

This examination will ~~), preferably~~ be performed by the same dermatologist for each patient's visit. All ~~skin~~ dermatological examinations must be performed by a dermatologist who will inspect the patient's unclothed full body using an ultraviolet (UV) light. The initial examination will include Fitzpatrick skin-type classification scale.

#### **9.4.7. Safety Monitoring**

The Lilly clinical research physician or scientist will, as appropriate, consult with the functionally independent Global Patient Safety therapeutic area physician or clinical scientist, and periodically review:

- AEs including monitoring of hypersensitivity and infusion reactions, AEs associated with anti-LY3002813 antibodies (immunogenicity), ARIA-H, ARIA-E-E, ~~eye and skin~~, ECG findings, neurological findings, hemorrhagic stroke, microhemorrhage (cerebral microhemorrhage, cerebellar microhemorrhage, brain stem microhemorrhage) as identified by investigator, and suicide-related thoughts and behaviors.

##### **9.4.7.1.2. Management of Infusion Reactions**

Additional data should also be collected via the CRF/electronic data entry. ~~P~~please see the Operations Manual for more detail.

##### **9.4.7.2. LY3002813 Immunogenicity**

In order to preserve the blind, patients will need to complete Visits 801 ~~through~~to 804 until all patients in the trial have reached Visit ~~21~~22 and datalock for the treatment period has been achieved.

In the event of a finding of hypersensitivity, the investigator is to complete the CRF regarding the presence or absence of symptoms related to the hypersensitivity.

##### **9.4.7.4. Amyloid-Related Imaging Abnormalities (ARIA-E and ARIA-H)**

In the event of a finding of ARIA E on MRI, the investigator is to complete the CRF regarding the presence or absence of symptoms related to the ARIA-E.

If the above mentioned symptoms are reported, and ARIA E is suspected, then the abnormality is best detected by fluid attenuation inversion recovery (FLAIR) sequences on ~~magnetic resonance imaging~~ (MRI) and ARIA H is best detected with the T2\* gradient recalled echo on MRI.

#### **9.4.8. Appropriateness of Safety Assessments**

The clinical safety measurements (AE reporting, physical examinations, neurological examinations, ~~ophthalmological examinations, dermatological examinations~~, vital signs, ECGs, and clinical safety laboratory tests [including immunogenicity]; Section 9.2 and Section 9.4) are

well-established methods in drug development research and are standard procedures for clinical trials.

Performance of ophthalmological and dermatological examinations ~~is~~ indicated in subjects who were previously treated with LY3202626, based on the potential for the occurrence of adverse retinal effects and hypopigmentation, respectively, during treatment with LY3202626. While LY3202626 is no longer being administered in this study, dermatological and ophthalmological examinations in subjects who previously received this therapy or oral placebo will be performed at the next scheduled examination time point after their final dose of oral study medication, in accordance with the Schedule of Activities (Section 2). Patients who received LY3202626/oral placebo after their Visit 8 or 9 dermatological or ophthalmological examination are to have an unscheduled examination at the next available opportunity. Patients screened or randomized under the current amendment are not required to undergo any dermatological or ophthalmological examinations at baseline or any other study visits.

## 9.5. Pharmacokinetics

At the visits and times specified in the Schedule of Activities (Section 2), venous blood samples of approximately 4 mL each will be collected to determine the serum concentrations of LY3002813 ~~and venous blood samples of approximately 2 mL each will be collected to determine plasma concentrations of LY3202626~~. Instructions for the collection and handling of blood samples will be provided by the sponsor. The actual date and time (24-hour clock time) of each sampling will be recorded.

~~If LY3202626 oral dose is permanently discontinued but the patient remains in the study, a final sample should be collected, provided the last dose of LY3202626 is within 3 days of the visit. Dosing dates and times should be collected. No other PK samples for LY3202626 are required after the final sample.~~

## 9.7. Pharmacogenomics [OR] Genetics

### 9.7.1. Apolipoprotein E Genotyping

Blood sampling for APOE genotyping will be performed as shown in the ~~in the~~ Schedule of Activities (Section 2).

# 10. Statistical Considerations

## 10.1. Sample Size Determination

Approximately ~~250375~~ subjects will be enrolled and randomized in a 1:1:1 ratio to the ~~2~~three treatment arms (placebo, LY3002813-M, and LY3002813-C). It is expected that approximately ~~200300~~ subjects will complete the double-blind treatment period of the study (approximately 100 per treatment arm). This sample size will provide approximately ~~8486~~% power to demonstrate that ~~the at least one~~ active treatment arm has a  $\geq 0.6$  posterior probability of slowing down iADRS progression over placebo by at least 3 points. The assumption for power calculation is that mean progression levels in the placebo, LY3002813-M and LY3002813-C arms are approximately 12, ~~8 (33% slowing)~~, and 6 points (50% slowing) over 18 months, respectively,

with common standard deviation of 17. If ~~the both~~ active treatment arm is~~arms are~~ placebo-like with no efficacy, the probability of passing the efficacy criterion specified above (i.e., false positive) is approximately ~~64~~%. The simulation for the power calculation and sample size determination was carried out in FACTS Version ~~6.05.5~~.

## 10.2. Populations for Analyses

For purposes of analysis, in general the following populations are defined unless otherwise specified:

For efficacy analysis, the Full Analysis Set will group patients according to randomized treatment assignment (LY3002813 or placebo), even if the patient does not take the assigned treatment, does not receive the correct treatment, or otherwise does not follow the protocol. When change from baseline is assessed, patients will be included in the analysis only if both a baseline and at least 1 valid post-baseline measure are available.

For safety analysis, all patients who received at least 1 dose of randomized study treatment (LY3002813, ~~LY3202626~~ or placebo) will be included in the safety analysis set. In safety data presentations, erroneously treated patients (e.g., those randomized to “Treatment A” but actually given “Treatment B”) will be accounted for in their actual treatment groups.

There were approximately 48 patients randomized before the removal of LY3202626 treatment in protocol amendment (d) (about 16 each in the LY3002813 and LY3202626 combination therapy arm, LY3002813 monotherapy arm, and placebo arm). Patients already randomized to the former LY3002813 monotherapy arm and placebo arm will be pooled with patients randomized after protocol amendment (d) to form the Full Analysis Set and safety analysis set specified above. Data from patients randomized to the LY3002813 and LY3202626 combination therapy arm will be summarized separately and will not be included in treatment comparisons on efficacy and safety endpoints. The total number of patients to be randomized in the study is approximately 266.

### 10.3.2. *Treatment Group Comparability*

#### 10.3.2.2. **Subject Characteristics**

The patient’s age, gender, race, height, body weight, BMI (weight (kg) / [height (m)]<sup>2</sup>), tobacco use, alcohol use, caffeine use, years of education, work status, time since onset of first AD symptoms, time since diagnosis, baseline MMSE, CBB score at Visit 1, apolipoprotein E (APOE) genotype (E4 carrier vs. non-carrier), having 1 or more first degree relatives with AD, and AChEI and/or memantine use at baseline will be recorded.

### 10.3.3. *Efficacy Analyses*

#### 10.3.3.1. **Primary Analyses**

The primary objective of this study is to test the hypothesis that IV infusion of LY3002813 ~~alone or in combination with LY3202626~~ will slow the cognitive and/or functional decline of AD as

measured by the composite measure iADRS compared with placebo in patients with early symptomatic AD. This will be assessed using an MMRM analysis.

The primary time point for treatment comparison will be at Week 76. The treatment group contrast in least-squares mean progression and its associated p-value and 95% CI will be calculated for the treatment comparisons of LY3002813-~~M~~ vs. placebo ~~and LY3002813-C vs. placebo~~, using the MMRM model specified above. In addition, Bayesian posterior probability of the active treatment arm being superior to placebo by at least a margin of interest (25% slowing of placebo progression) will also be calculated assuming a non-informative prior.

### **10.3.4. Safety Analyses**

#### **10.3.4.5. ARIA-E and ARIA-H**

The incidence of ARIA-E will be summarized. Change in ARIA-E status from baseline, to each subsequent MRI (in the event of unscheduled MRIs), and to double-blind period endpoint (Visit ~~21~~~~22~~) will be compared between treatment groups using Fisher's exact test.

### **10.3.5. Pharmacokinetic/Pharmacodynamic Analyses**

Compartmental modeling of LY3002813 ~~and LY3202626~~ PK data using nonlinear mixed effects modeling or other appropriate software may be explored, and population estimates for clearance and central volume of distribution may be reported. Depending on the model selected, other PK parameters may also be reported. Exploratory graphical analyses of the effect of dose level or demographic factors on PK parameters may be conducted. If appropriate, data from other studies of LY3002813 ~~or LY3202626~~ may ~~in be~~ be used in this analysis.

Concentrations of LY3202626 were collected under the original version of this protocol, as well as amendments (a-c). These data will be summarized in the final study report and may be analyzed graphically. If appropriate, exploratory analyses may be conducted to evaluate potential relationships between LY3202626 concentrations and LY3002813 concentration.

The PK/PD relationships between plasma LY3002813 concentration and SUVR, cognitive endpoints, ARIA incidence rate or other markers of PD activity may be explored graphically. The relationship between the presence of antibodies to LY3002813 and PK, PD, safety and/or efficacy may be assessed graphically. ~~The effect of LY3202626 exposure on SUVR, cognitive endpoints, or other markers of PD activity may also be explored graphically. Graphical and/or descriptive analyses may be explored to evaluate potential interactions between LY3002813 and LY3202626 for PK. If warranted, additional analysis may be explored to evaluate potential interactions for ADA, PD and other endpoints (PET scan, ARIA-E, etc.).~~

### **10.3.6. Interim Analyses**

There will be periodic safety data reviews during the study and the external DMC is authorized to evaluate results from unblinded safety data reviews.

## 11. References

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## Appendix 5. Flortaucipir F18 Tau PET Imaging

### Inclusion Criteria for Flortaucipir F18 PET Scans

With the exception of the ophthalmological and dermatological examinations, MRI and florbetapir F18 PET scan, a patient should meet all other Visit 1 eligibility criteria before having a flortaucipir F18 PET scan.

### PET Scan-Specific Information

#### PET Scan Procedures

**Scan Safety**

The primary risk related to flortaucipir F18 PET is F18's radiation exposure.

....

- flortaucipir F18 PET scans should ~~to~~ be performed at least 16 hours apart from the florbetapir F18 PET scans due to the half-life of fluorine 18.

With respect to other compound-related risks, flortaucipir~~AV-1451~~ was positive in the in vitro hERG assay.

Nonperformance of postbaseline flortaucipir F18 PET scans in patients taking a medication known to prolong QT interval will not be considered a protocol ~~deviation~~violation.

**Appendix 6. Florbetapir F18 Amyloid PET Imaging****Inclusion Criteria for Florbetapir F18 PET Scans**

With the exception of the MRI, ~~ophthalmological and dermatological exams~~, a patient should meet all other Visit 1 eligibility criteria before having a florbetapir F18 PET scan.

**PET Scan-Specific Information*****PET Scan Procedures******PET Scan Safety***

- florbetapir F18 PET scans should ~~to~~ be performed at least 16 hours apart from the ~~18F~~ flortaucipir F18 PET scan due to the half-life of fluorine 18.

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Signature meaning: Approved

# 1. Statistical Analysis Plan: I5T-MC-AACG: Assessment of Safety, Tolerability, and Efficacy of LY3002813 in Early Symptomatic Alzheimer's Disease

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## LY3002813 for Early Symptomatic Alzheimer's Disease

Multicenter, randomized, double-blind, placebo-controlled, Phase 2 study comparing up to 1400 mg of LY3002813 with placebo over 76 weeks in approximately 250 patients with early symptomatic AD.

Eli Lilly and Company  
Indianapolis, Indiana USA 46285  
[Protocol I5T-MC-AACG]  
[Phase 2]

SAP electronically signed and approved by Lilly on date provided below.

Approval Date: 07-Dec-2020 GMT



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### 3. Revision History

SAP Version 1 was approved on April 20, 2020 prior to unblinding any efficacy data to Lilly senior management or Lilly study team members. SAP Version 2 was approved prior to unblinding of the placebo-controlled period in January 2021 and included the following revisions:

- Added summary of the treatment arm LY-C (6.1.2)
- Added COVID-19 summaries to general considerations (6.1.3)
- Added pooled LY population combining LY-M and LY-C (6.6)
- Revised the multiplicity graph (6.11.2)
- Added summary of the pooled LY population (6.11.5)
- Dropped health outcomes analysis of categorically defined function levels based on the ADCS-ADL
- Added description of hypersensitivity and infusion-related reactions programming (6.13.3)
- Added blinded dose reduction summary (6.13.1)
- Revised clinical lab evaluation analyses (6.13.4)
- Revised analyses of vital signs and weight (6.13.5)
- Revised ECG analyses (6.13.6)

## 4. Study Objectives

### 4.1. Primary Objective

Error! Reference source not found.. shows the primary objective and endpoint for the study.

**Table AACG.4.1. Primary Objective and Endpoint**

Primary Objective	Primary Endpoint
To test the hypothesis that LY3002813 administered for up to 72 weeks will decrease the cognitive and/or functional decline in patients with early symptomatic AD	Change in cognition and function as measured by the change in integrated Alzheimer's Disease Rating Scale (iADRS) score from baseline to 18 months

### 4.2. Secondary Objectives

Error! Reference source not found.. shows the secondary objectives and endpoints for the study.

**Table AACG.4.2. Secondary Objectives and Endpoints**

Secondary Objectives	Secondary Endpoints
To assess the effect of LY3002813 vs. placebo on clinical progression in patients with early symptomatic AD	Change from baseline to 18 months as measured by: <ul style="list-style-type: none"> <li>• change in Alzheimer's Disease Assessment Scale-Cognitive subscale (ADAS-Cog13) score</li> <li>• change in Clinical Dementia Rating Scale Sum of Boxes (CDR-SB) score</li> <li>• change in Mini Mental State Examination (MMSE) score</li> <li>• change in Alzheimer's Disease Cooperative Study-instrumental Activities of Daily Living scale (ADCS-iADL) score</li> </ul>
To assess the effect of LY3002813 vs. placebo on brain amyloid deposition	Change in brain amyloid plaque deposition from baseline through 18 months as measured by florbetapir F18 PET scan
To assess the effect of LY3002813 vs. placebo on brain tau deposition	Change in brain tau deposition from baseline to 18 months as measured by flortaucipir F18

	PET scan
To assess the effect of LY3002813 vs. placebo on brain volume measures	Change in volumetric MRI measures from baseline to 18 months
To evaluate safety and tolerability of LY3002813	Standard safety assessments: <ul style="list-style-type: none"> <li>• spontaneously reported adverse events (AEs)</li> <li>• clinical laboratory tests</li> <li>• vital sign and body weight measurements</li> <li>• 12-lead ECGs</li> <li>• physical and neurological examinations</li> <li>• MRI (ARIA and emergent radiological findings)</li> <li>• Columbia Suicide Severity Rating Scale (C-SSRS)</li> </ul>

### 4.3. Exploratory Objectives

**Error! Reference source not found..** shows the exploratory objectives and endpoints for the study.

**Table AACG.4.3. Exploratory Objectives and Endpoints**

Exploratory Objectives	Exploratory Endpoints
To assess the effect of LY3002813 vs. placebo on clinical progression in patients with early symptomatic AD	change in dependence level derived from ADCS-ADL scale scores
To assess peripheral PK and presence of anti-LY3002813 antibodies over 72 weeks	<ul style="list-style-type: none"> <li>• Plasma Pharmacokinetics of LY3002813</li> <li>• Anti-drug-antibodies (ADA) against LY3002813 including treatment-emergent ADA and neutralizing antibodies.</li> </ul>

## 5. Study Design

### 5.1. Summary of Study Design

Study I5T-MC-AACG (AACG) is a Phase 2, double-blind, placebo-controlled, study to evaluate the safety and efficacy of N3pG antibody (LY3002813) in patients with early symptomatic AD (prodromal AD and mild dementia due to AD). Study AACG will assess whether removal of existing amyloid plaque can slow the progression of disease as assessed by clinical measures and biomarkers of disease pathology and neurodegeneration over up to 76 weeks of treatment.

Multiple biomarkers of disease progression will also be evaluated. The biomarker florbetapir F18 is a PET ligand that binds to fibrillar amyloid plaque. This biomarker can provide a qualitative and quantitative measurement of brain plaque load in AD patients. Implementation of baseline florbetapir F18 inclusion criteria will provide a screening tool for entry into the clinical trial and provide a confirmation of amyloid pathology. Florbetapir F18 PET also provides quantitative assessment of fibrillar amyloid plaque in the brain and can assess amyloid plaque reductions from the brain by LY3002813.

Alzheimer's disease progression is also associated with cerebral tauopathy, which will be assessed by flortaucipir F18 PET scans, a cortical marker of paired helical filaments. Brain atrophy, as an indicator of neurodegeneration, will be assessed by volumetric Magnetic Resonance Imaging (vMRI).

The patient population for the clinical trial is selected to be AD patients with early symptomatic disease defined both clinically (prodromal to mild AD dementia) and by biomarkers (low to medium tau burden, plus amyloid plaque presence). The 2018 NIA-AA draft AD research framework (Alzheimer's Association 2017a) proposes that AD is defined by its underlying pathophysiologic processes which can be documented in vivo by biomarkers (such as tau and amyloid PET). This framework will enable a more precise approach to therapeutic intervention trials where specific pathways can be targeted at specific points in the disease process and to the appropriate people (Alzheimer's Association 2017b). Clinical-pathological correlations also strongly suggest that baseline imaging that allows staging on the basis of neurofibrillary tangles could substantially improve the power of clinical trials aimed at changing the rate of progression of the disease (Qian et al. 2017). An early AD population defined clinically and pathologically is anticipated to be more homogeneous than populations defined without tau PET, and will be sufficiently early to respond to treatments prior to more advanced irreversible neuronal loss.

### 5.2. Determination of Sample Size

Approximately 250 subjects will be enrolled and randomized in a 1:1 ratio to the 2 treatment arms (placebo and LY3002813). It is expected that approximately 200 subjects will complete the double-blind treatment period of the study (approximately 100 per treatment arm). This sample size will provide approximately 84% power to demonstrate that the active treatment arm has a  $\geq 0.6$  posterior probability of slowing down iADRS progression over placebo by at least 3 points. The assumption for power calculation is that mean progression levels in the placebo and LY3002813 arms are approximately 12 and 6 points (50% slowing) over 18 months,

respectively, with common standard deviation of 17. If the active treatment arm is placebo-like with no efficacy, the probability of passing the efficacy criterion specified above (i.e., false positive) is approximately 6%. The simulation for the power calculation and sample size determination was carried out in FACTS Version 6.0.

### **5.3. Method of Assignment to Treatment**

Patients who meet all criteria for enrollment will be assigned a study (patient) number at Visit 1 and randomized to double-blind treatment at Visit 2. Patients will be randomized to LY3002813 or Placebo in a 1:1 ratio. For between-group comparability for site factor, patient randomization will be stratified by investigative site. Assignment to treatment groups will be determined by a computer-generated random sequence using an interactive web response system (IWRS).

The IWRS will be used to assign a dosing regimen to each patient. Site personnel will confirm that they have located the correct packages by entering a confirmation number found on the label into the IWRS.

### **5.4. Blinding**

This is a double-blind study, with design to maintain blinding to treatment. To preserve the blinding of the study, a minimal number of Lilly personnel will see the randomization table and treatment assignments before the study is complete. The independent external DMC will potentially be unblinded for safety evaluations and dose reduction decisions related to safety. A separate blinding/unblinding plan contains a more detailed description of blinding.

## 6. A Priori Statistical Methods

### 6.1. General Considerations

#### 6.1.1. Overall

As Study AACG is a Phase 2 study, the appropriate estimand is a de-jure estimand where efficacy of LY3303560 is assessed under the paradigm of all patients taking study drug as intended. Intercurrent events for AACG are defined to be when patients discontinue the study prior to completing the 76 weeks of treatment or stop taking study drug temporarily during the study. Currently, there is no regulatory-approved, disease-modifying standard of care. Accordingly, initiation of standard of care is not considered an intercurrent event. The primary analysis is to use a mixed-model repeated measures (MMRM) analysis of the iADRS to compare the cognitive and functional decline between treatment groups at 76 weeks. This MMRM analysis assumes the intercurrent events lead to data that is missing at random (MAR). The MAR assumption will be assessed by the Tipping Point Delta Adjustment analysis described in section 6.11.3.2.

All analyses will follow the intention-to-treat (ITT) principle unless otherwise specified. An ITT analysis is an analysis of data by the groups to which subjects are assigned by random allocation, even if the subject does not take the assigned treatment, does not receive the correct treatment, or otherwise does not follow the protocol. Unless otherwise noted, all pairwise tests of treatment effects will be conducted at a 2-sided alpha level of 0.05; 2-sided confidence intervals (CIs) will be displayed with a 95% confidence level. All tests of interactions between treatment and other factors will be conducted at an alpha level of 0.05.

Unless otherwise noted baseline is defined as the last measurement prior to dosing. When change from baseline is assessed, subjects will only contribute to the analysis if both a baseline and a post-baseline measurement are available. Endpoint is the last non-missing post-baseline measurement within the time period for the given analysis. For mixed-effect model for repeated measures (MMRM) models, observations collected at nonscheduled visits will not be included in the analyses (Andersen and Millen 2013). For analyses using last observation carried forward (LOCF), the last nonmissing post-baseline observation (scheduled or unscheduled) will be used to calculate change from baseline.

Any change to the data analysis methods described in the protocol will require an amendment ONLY if it changes a principal feature of the protocol. Any other change to the data analysis methods described in the protocol and the justification for making the change will be described within this SAP and clinical study report. Additional exploratory analyses of the data will be conducted as deemed appropriate.

#### 6.1.2. LY3002813 in combination with LY3202626

Study AACG was originally designed as a three arm study comparing LY3002813 alone (LY-M) and in combination with LY3202626 (LY-C) versus placebo (PL). Study AACG was amended to drop the LY-C arm after a small number of patients had been enrolled to one of those three arms. Patients randomized to LY-C were allowed to continue in the study getting monthly infusions of



LY3002813 without the co-administration of the oral LY3202626. For this clinical study report, all analyses of the Randomized Population will include all three arms (LY-M, LY-C, and PL). The remainder of this SAP describe analyses comparing LY-M and PL. The following summaries will be made of LY-C alone:

- Mean change summary of efficacy scales (iADRS, CDR-SB, ADAS-Cog13, iADL, and MMSE), amyloid PET, tau PET, and vMRI
- Exposure summary
- Adverse events (TEAEs, SAEs, and DCAEs) summary
- Labs' boxplots
- Vitals' boxplots
- ECGs' boxplots
- Safety MRI summary
- Immunogenicity summary
- CSSRS summary

### **6.1.3. COVID-19**

Study AACG was fully enrolled at the time the COVID-19 pandemic impacted the countries participating in AACG (US and Canada). Based on the [FDA's guidance document](#) regarding the conduct of clinical trials during the COVID-19 pandemic, a patient listing will be created detailing all of the trial participants impacted by COVID-19.

In the primary analysis, only scales administered on-site will be evaluated. Any scale administered via telephone, video conference or at the participant's home will be included in a sensitivity analysis of the primary endpoint. Additionally, if a scale at the final timepoint is administered more than 28 days past the planned timepoint, it will not be included in the primary analysis but will be included in the sensitivity analysis.

As a sensitivity analysis for the primary analysis, the ICH E9 "while on treatment strategy" will be assessed. For this strategy, response to treatment prior to the occurrence of an intercurrent event is of interest. Temporary discontinuation of study drug, including stoppages resulting from the COVID-19 pandemic, is considered the intercurrent event. The primary MMRM analysis will be repeated on all data up to temporary discontinuation of study drug. In other words, patients' data after a temporary discontinuation of study drug will be censored.

## **6.2. Adjustments for Covariates**

The repeated measures models will include the fixed, categorical effects of baseline score, pooled investigator, treatment, visit, treatment-by-visit interaction, baseline-by-visit interaction, concomitant AChEI and/or memantine use at baseline (yes/no), and age at baseline.

When an analysis of covariance (ANCOVA) model is used to analyze a continuous efficacy variable, the model will contain the main effects of treatment, APOE4 status, and appropriate baseline value included as a covariate. When an ANCOVA model is used to analyze a continuous safety variable, the model will contain the main effects of treatment, age, and appropriate baseline value included as a covariate.

### 6.3. Handling of Dropouts or Missing Data

#### 6.3.1. *Handling Missing Data from Patient Dropouts*

A likelihood-based mixed effects model for repeated measures will be used to handle missing data. The model parameters are simultaneously estimated using restricted likelihood estimation incorporating all of the observed data. Estimates have been shown to be unbiased when the missing data are missing at random and when there is ignorable non-random missing data.

Repeated measures analyses will only use data from visits where the data was scheduled to be collected (Andersen and Millen 2013). When patients discontinue from the study early, there may be efficacy or safety data measurements at visits where the variables were not scheduled to be collected. This data will be used in all other analyses.

#### 6.3.2. *Handling Missing Items in Calculating Totals*

If any of the individual items for ADAS-Cog or ADCS-ADL are missing or unknown, every effort will be made to obtain the score for the missing item or items.

For ADAS-Cog<sub>13</sub>, if 4 or fewer of a total of 13 items are missing, the total score (maximum = 85) will be imputed as follows: the total from the remaining items will be multiplied by a factor that includes the maximum score for the missing items. For example, if the first item, “Word-Recall Task,” which ranges from a score of 0 through 10 (maximum = 10), is missing, and the second item “Commands,” which ranges from a score of 0 to 5 (maximum = 5), is missing, then the multiplication factor =  $85 / (85 - [10 + 5]) = 85 / 70 = 1.21$ . Thus, the total score for this example will be the sum of the remaining 11 items multiplied by 1.21. The imputed number will be rounded up to the nearest integer. If more than 4 items are missing, the total score for ADAS-Cog<sub>13</sub> at that visit will be considered missing.

For the ADCS-iADL, if <30% of the items are missing, the total score will be imputed. The sum of the nonmissing items will be prorated to the sum of total items. The imputed number will be rounded up to the nearest integer. If the nearest integer is greater than the maximum possible score, the imputed score will be equal to the maximum score. If >30% of the items are missing, the total score for ADCS-iADL at that visit will be considered missing. The same imputation technique will be applied to the ADCS-ADL total score. Note that, depending on the specific item responses that are missing, it is possible to have an imputed total score for both the ADCS-iADL and the ADCS-ADL, an imputed total score for one but not the other, or both total scores missing.

The same imputation technique will be applied to the CDR-SB. If only 1 box (of 6) of the CDR is missing, the sum of the boxes will be imputed by prorating the sum from the other 5 boxes. If

the score from more than 1 box is not available, the CDR-SB at that visit will be considered missing.

If either ADAS-Cog<sub>13</sub> or ADCS-iADL is missing, iADRS score will be considered missing. The iADRS score is calculated as follows:

$$\text{iADRS score} = [-1(\text{ADAS} - \text{Cog}_{13}) + 85] + \text{ADCS-iADL} \text{ (Wessels et al. 2015).}$$

For all other scales, if any item is missing, any total or sum involving that item will be considered missing.

## 6.4. Multicenter Studies

This study will be conducted by multiple investigators at multiple sites internationally. In the event that any investigator has an inadequate number of subjects (defined as 1 or 0 randomized subjects per treatment group) for the planned analyses, the following strategy will be implemented. Data from all such investigators will be pooled. The pooling will be done first within a country. If the resulting pool within a country is still inadequate (1 or 0 randomized subjects to 1 or more treatment arms), no further pooling will be performed. A listing including country, investigator site with address, number of patients enrolled (randomized) by each site, and unique patient IDs will be presented.

## 6.5. Multiple Comparisons/Multiplicity

A graphical strategy may be used for testing key secondary hypotheses to protect against Type I error of falsely rejecting a null hypothesis (Section 6.11.2.). The use of a prespecified analysis plan that employs Bretz' graphical approach will provide strong control of the study-wise Type I error rate for the primary and key secondary hypotheses at level  $\alpha=0.05$  (Bretz et al. 2009, 2011). The graph is detailed in section 6.11.2.

## 6.6. Analysis Populations

For purposes of analysis, populations are defined in **Error! Reference source not found.** and Table 6.6.2. These tables also list the study measures that will be summarized and/or analyzed for each population.

**Table AACG.6.1. Analysis Populations**

Population	Description
Entered	All participants who sign informed consent
Randomized	All entered patients who are randomized to study treatment
Full Analysis Set	All randomized patients to LY-M or placebo with a baseline and at least one post-baseline iADRS result

Full Analysis Set (Pooled LY)	All randomized patients to LY-M, LY-C or placebo with a baseline and at least one post-baseline iADRS result
Safety	All randomized participants to LY-M or placebo who take at least 1 dose of double-blind study treatment. Participants will be analyzed according to the treatment group to which they were randomized
Safety (Combination Arm)	All randomized participants LY-C who take at least 1 dose of double-blind study treatment.
Per-Protocol	All subjects in the Full Analysis Set who also: <ul style="list-style-type: none"> <li>• signed the informed consent form</li> <li>• had an assessment of the primary endpoint at each scheduled visit completed</li> <li>• had no violations of inclusion/exclusion criteria</li> <li>• had no study dosing algorithm violation (such as if subjects randomized to treatment A were given treatment B or subjects randomized to treatment A never received the assigned study drug)</li> <li>• had no unqualified raters and no raters with substantial scoring errors for the primary measure</li> <li>• were not considered non-compliant with regard to study drug</li> </ul>
Completers	All Full Analysis Set subjects who have disposition status of complete or have at least 2 weeks exposure in visit interval 21.

**Table 6.6.2. Efficacy and Safety Measures Summarized and/or Analyzed per Analysis Population**

Population	Variables Assessed
Entered	Listings
Randomized	Tables and listings for patient characteristics, baseline severity, and patient disposition
Full Analysis Set	Tables, listings, and figures of the following: iADRS, CDR-SB, ADAS-Cog <sub>13</sub> , ADCS-ADL (basic, instrumental, and total), MMSE, plasma P-tau <sub>217</sub> , amyloid PET, tau PET, volumetric

	MRI measurements, and concomitant medications
Full Analysis Set (Pooled LY)	Tables, listings, and figures of the following: iADRS, CDR-SB, ADAS-Cog <sub>13</sub> , ADCS-ADL (basic, instrumental, and total), MMSE, plasma P-tau <sub>217</sub> , amyloid PET, tau PET, and volumetric MRI measurements
Safety	Tables, listings, and figures of the following: compliance, adverse events, laboratory results, vital signs, weight, ECG, safety MRIs, C-SSRS
Safety (Combination arm)	Tables, listings, and figures of the following: iADRS, CDR-SB, ADAS-Cog <sub>13</sub> , ADCS-ADL (basic, instrumental, and total), MMSE, amyloid PET, tau PET, volumetric MRI measurements, compliance, adverse events, laboratory results, vital signs, weight, ECG, safety MRIs, C-SSRS
Per-Protocol	Tables, listings, and figures of the following: iADRS, CDR-SB, ADAS-Cog <sub>13</sub> , ADCS-ADL (basic, instrumental, and total), MMSE
Completers	Tables, listings, and figures of the following: iADRS, CDR-SB, ADAS-Cog <sub>13</sub> , ADCS-ADL (basic, instrumental, and total), MMSE, plasma P-tau <sub>217</sub> , amyloid PET, tau PET, and volumetric MRI measurements

## 6.7. Patient Disposition

Because this is a long-term study in a patient population that is elderly with multiple comorbidities, patient withdrawal is of particular concern. Additional efforts will be undertaken to reduce patient withdrawals and to obtain information on patients who are initially categorized as lost to follow-up.

From the randomized population, the percentage of patients withdrawing from each treatment group will be summarized. From the safety population, the percentage of patients withdrawing from each treatment group will be summarized. Summaries will be done for the overall percentage of patients who withdraw and also for each specific reason for withdrawal.

## 6.8. Patient Characteristics

Baseline characteristics will be summarized for the randomized population by treatment group and overall. Summaries will include descriptive statistics for continuous and categorical measures. Patient characteristics to be presented include:

- age
- gender
- race
- ethnicity
- height
- body weight
- body mass index (weight (kg) / [height (m)]<sup>2</sup>)
- tobacco use
- alcohol use
- years of education
- work status
- time since onset of first AD symptoms
- tau PET burden (various measures)
- time since diagnosis
- APOE4 carrier status (carrier [ $\epsilon 2/\epsilon 4$ ,  $\epsilon 3/\epsilon 4$ ,  $\epsilon 4/\epsilon 4$ ], noncarrier [ $\epsilon 3/\epsilon 3$ ,  $\epsilon 2/\epsilon 2$ ,  $\epsilon 3/\epsilon 2$ ])
- APOE4 genotype ( $\epsilon 2/\epsilon 4$ ,  $\epsilon 3/\epsilon 4$ ,  $\epsilon 4/\epsilon 4$ , no  $\epsilon 4$ )
- having 1 or more first degree relatives with AD
- AChEI and/or memantine use at baseline

Baseline severity of impairment as measured by CDR-SB, ADAS-Cog<sub>13</sub>, ADCS-ADL total score and instrumental (ADCS-iADL) and basic subscores (ADCS-bADL), and MMSE will be summarized. Baseline characteristics and baseline severity will also be listed.

## 6.9. Treatment Compliance

Because dosing occurs at study visits, patients who attend all visits and successfully receive donanemab or placebo infusions are automatically compliant with this treatment. Any infusion at which 75% (approximately 105 mL) or more of the infusion solution is given will be considered a complete infusion.

Summary statistics for treatment compliance will be provided for the total number of complete infusions received, duration of complete infusion, and volume of complete infusion by treatment group. Frequencies and percentages of reasons why infusion was stopped will also be presented.

## 6.10. Concomitant Therapy

Prior medications are defined as those that stop before randomization (the day prior to the first administration of study drug). Concomitant medications are defined as those being taken on or after randomization (the day prior to the first administration of study drug). A summary of concomitant medications will be presented as frequencies and percentages for each treatment

group. If the start or stop dates of therapies are missing or partial to the degree that determination cannot be made of whether the therapy is prior or concomitant, the therapy will be deemed concomitant. A summary table will also be provided for concomitant AChEI/memantine medications. Medications will be coded using the World Health Organization (WHO) drug dictionary. Concomitant medications will be listed.

## 6.11. Efficacy Analyses

### 6.11.1. *Primary Outcome and Methodology*

As stated in section 6.1, the appropriate estimand is a de-jure estimand of treatment effect where efficacy of LY3303560 is assessed under the paradigm of all patients taking study drug as intended. The primary analysis is considered a treatment policy strategy as outlined by ICH E9 guidelines. The primary objective of this study is to test the hypothesis that IV infusion of donanemab will slow the cognitive and/or functional decline of AD as measured by the composite measure iADRS compared with placebo in patients with early symptomatic AD. This will be assessed using an MMRM analysis comparing LY-M vs. PL.

The change from baseline score on the iADRS at each scheduled postbaseline visit (according to the SoA) during the treatment period will be the dependent variable. The model for the fixed effects will include the following terms: baseline score, pooled investigator, treatment, visit, treatment-by-visit interaction, baseline-by-visit interaction, concomitant AChEI and/or memantine use at baseline (yes/no), and age at baseline. Visit will be considered a categorical variable. The null hypothesis is that the contrast between the donanemab group versus placebo at the last visit equals 0. An unstructured covariance matrix will be used to model the within-subject variance-covariance errors. If the unstructured covariance structure matrix results in a lack of convergence, the following tests will be used in sequence:

- heterogeneous Toeplitz covariance structure
- heterogeneous autoregressive covariance structure
- heterogeneous compound symmetry covariance structure
- compound symmetry covariance structure

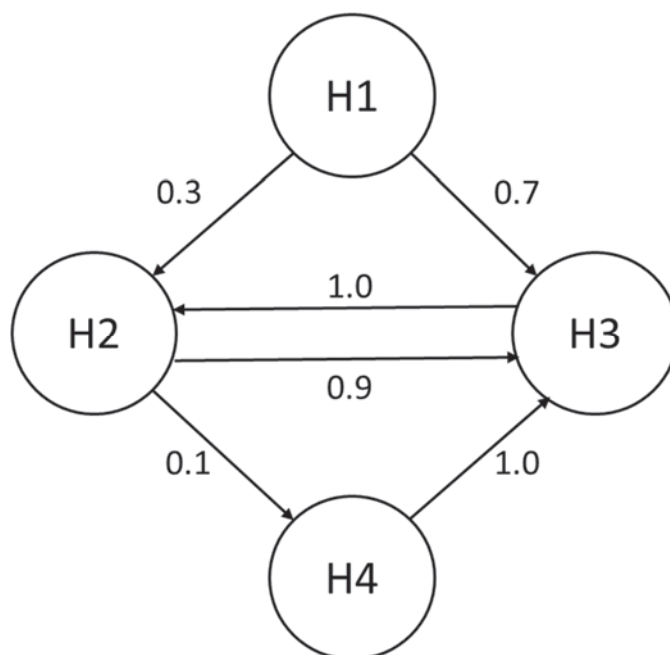
The Kenward-Roger approximation will be used to estimate the denominator degrees of freedom.

The primary time point for treatment comparison will be at Week 76. The treatment group contrast in least-squares mean progression and its associated p-value and 95% CI will be calculated for the treatment comparison of donanemab versus placebo using the MMRM model specified above. In addition, Bayesian posterior probability of the active treatment arm being superior to placebo by at least a margin of interest (25% slowing of placebo progression) will also be calculated using a non-informative prior.

### **6.11.2. *Gated Secondary Efficacy Analyses***

Bretz's graphical approach will be utilized to provide strong control of the study-wise type I error rate for the primary and key secondary hypotheses at alpha level of 0.05 (Bretz et al. 2009, 2011). Assuming the primary analysis is statistically significant, the MMRM analyses described for the primary analysis will be conducted on the CDR-SB, ADAS-Cog13, iADL and MMSE scores and statistical significance will be determined based on the following multiplicity graph of hypotheses regarding the IV infusion of donanemab slowing the cognitive and/or functional decline of AD:





- H1. MMRM analysis of CDR-SB at Week 76
- H2. MMRM analysis of ADAS-Cog13 total score at Week 76
- H3. MMRM analysis of iADL subscore at Week 76
- H4. MMRM analysis of MMSE at Week 76

### 6.11.3. Additional Analyses of the Primary Outcome Comparing LY-M vs. PL

#### 6.11.3.1. ICH E9: While on Treatment Strategy

For this strategy, response to treatment prior to the occurrence of an intercurrent event is of interest. Temporary discontinuation of study drug, including stoppages resulting from the COVID-19 pandemic, is considered the intercurrent event. The primary MMRM analysis will be repeated on all data up to temporary discontinuation of study drug. In other words, patients' data after a temporary discontinuation of study drug will be censored.

#### 6.11.3.2. Delta Adjustment Tipping Point Analysis

Sensitivity to departures from the missing-at-random (MAR) assumption will be investigated using a tipping point analysis (Carpenter and Kenward 2013). This method is a sensitivity analysis in multiple imputation under the missing-not-at-random (MNAR) assumption that searches for a tipping point that reverses the study conclusion. Departures from MAR in the donanemab treatment group will be assessed assuming that patients who discontinue the study have, on average, efficacy outcomes after discontinuation that are worse by some amount  $\delta$

compared to other similar patients with observed data (ie, compared to a value which would have been assumed under an MAR model). A series of analyses will be performed with increasing values of  $\delta$  until the analysis conclusion of a statistically significant treatment effect no longer holds. The value of  $\delta$  that overturns the primary results will represent a tipping point. An interpretation of clinical plausibility of the assumption underlying the tipping point will be provided.

Mean changes from baseline in iADRS scores will be analyzed based on data observed while the patient remains on study as well as data imputed using multiple imputation (MI) methodology for time points at which no value is observed. Imputed values in the donanemab treatment group will first be sampled from an MAR-based multiple imputation model and then  $\delta$ -adjusted as described below.

Missing-at-random-based imputations will be generated for iADRS scores at each time point, and then a value of  $\delta = \{\Delta\}$  will be added to all imputed values in the donanemab treatment group prior to analyzing multiply imputed data. This approach assumes that the marginal mean of imputed patient measurements is worse by  $\delta$  at each time point after discontinuation compared to the marginal mean of patients with observed data at the same time point. Analyses will be conducted with values of  $\delta$  starting from 0 with increments of 0.10 until the null hypothesis can no longer be rejected.

#### 6.11.3.3. Bayesian Analysis of Shared Control

Sensitivity of comparative inference for slowing the cognitive and/or functional decline of AD based on the shared control may be accomplished via Bayesian mixture modeling. Supplementing the iADRS analyses with placebo data from studies I8G-MC-LMDC, I8D-MC-AZES, and H8A-MC-LZAX will be explored and potentially based on matching baseline tau PET scan results (Viele, 2014).

#### 6.11.3.4. Disease Progression Model

A Bayesian disease progression mixed model for repeated measures with a proportional treatment effect and noninformative prior will be used to assess statistical differences in the rate of decline of the iADRS between the donanemab group and the placebo group. The analysis is testing the hypothesis that the disease cognitive progression ratio (CPR), defined as the rate of decline of the donanemab arm to the rate of decline of the placebo arm, is less than 1.

$$H_0: \text{CPR} = 1$$

$$H_1: \text{CPR} < 1$$

To test the hypothesis of a cognitive disease progression benefit we calculate the posterior probability of the alternative hypothesis and if it is greater than a pre-specified threshold then the claim of superiority (cognitive disease progression slowing) will be made. A 95% credible interval (from the 2.5th to 97.5th percentiles) and posterior mean and median cognitive disease progression ratio will be presented.

#### 6.11.3.5. Random Slopes Analysis

Slopes of the iADRS will be assessed using an MMRM analysis. The change from baseline score at each post-baseline visit during the treatment period will be the dependent variable. The model will include the fixed, categorical effects of treatment, APOE4 status (carrier versus non-carrier), concomitant AChEI or memantine use at baseline (yes/no), pooled investigator, and continuous effects of baseline score, time, time-by-treatment interaction, and age at baseline. Time will be assumed to be a continuous variable calculated as number of days between baseline and each postbaseline visit (ie, [visit-baseline]+1) during the treatment period. The actual visit dates will be used to calculate number of days (time). The null hypothesis is that the contrasts of slopes of donanemab versus placebo equal zero.

A quadratic slopes model may also be fit to these same scales. The quadratic model would include the linear component of time (TIME) and a quadratic component of time (TIME\*TIME), the linear component of time and treatment interaction (TIME\*TREATMENT) and quadratic component of time and treatment interaction (TIME\*TIME\*TREATMENT).

#### 6.11.3.6. Completer Analysis

The primary efficacy outcome, iADRS, from the dataset of those patients who remained in the study and on treatment through Week 76 (“completers”) will be analyzed using an ANCOVA. The change from baseline at Week 76 will be the dependent variable. The model will include the fixed, categorical effects of treatment, concomitant AChEI use at baseline (yes/no), pooled investigator, and the continuous effects of baseline iADRS score and age at baseline. The null hypothesis is that the differences in least-squares means between donanemab and placebo at Week 76 equals zero.

#### 6.11.3.7. Per Protocol Analysis

The primary efficacy outcome, iADRS, from the per-protocol dataset will be analyzed using the MMRM analysis from the primary analysis. The change from baseline at each scheduled postbaseline visit will be the dependent variable. The model for the fixed effects will include the following terms (same as primary efficacy analysis): baseline score, pooled investigator, treatment, visit, treatment-by-visit interaction, baseline-by-visit interaction, concomitant AChEI and/or memantine use at baseline (yes/no), and age at baseline. The null hypothesis is that the differences in least-squares means between donanemab and placebo at Week 76 equals zero.

#### 6.11.4. *Other Secondary Efficacy Analyses Comparing LY-M vs. PL*

The additional clinical and outcome measurements listed below will be analyzed using an MMRM analysis. The change from baseline at each scheduled postbaseline visit will be the dependent variable. The model for the fixed effects will include the following terms (same as primary efficacy analysis): baseline score, pooled investigator, treatment, visit, treatment-by-visit interaction, baseline-by-visit interaction, concomitant AChEI and/or memantine use at baseline (yes/no), and age at baseline. The null hypothesis is that the differences in least-squares means between donanemab and placebo at Week 76 equals zero. The outcomes that will be analyzed are:

- Change from baseline in CDR-SB
- Change from baseline ADAS-Cog13 total score
- Change from baseline in ADCS-ADL total score
- Change from baseline in ADCS-iADL score
- Change from baseline in ADCS-bADL score
- Change from baseline in MMSE

#### **6.11.5. Efficacy Analyses of Pooled LY3002813 (Monotherapy plus Combination)**

The primary analysis described in 6.11.1 on the iADRS13, CDR-SB, ADAS-Cog13, ADCS-ADL, ADCS-iADL, ADCS-bADL, and MMSE will be repeated on the Full Analysis Set (Pooled LY). Treatment comparisons will be made between LY (pooled LY-M and LY-C) and placebo.

### **6.12. Bioanalytical and Pharmacokinetic/Pharmacodynamic Methods**

#### **6.12.1. Analysis of Amyloid PET**

At baseline, standardized uptake value ratio (SUVR) and centiloid value will be calculated as a ratio of the composite summary region that is an average of 6 different cortical regions (anterior cingulate, posterior cingulate, medial orbital frontal, lateral temporal, lateral parietal, precuneus) with whole cerebellum as a reference region (SUVRCAA). The SUVRCAA was also used at visits 8 and 15 in order to determine if the amyloid level had been reduced enough in LY-treated patients to reduce the dose of LY.

To evaluate the amyloid PET longitudinal change from baseline (SUVRCLAA), an MMRM analysis will be used to compare change from baseline in SUVR at 76 weeks in the Evaluable Efficacy dataset. The model will include the fixed, categorical effects of treatment, visit, and treatment-by-visit interaction, as well as continuous effects of baseline SUVR and age at baseline. Visit will be considered a categorical variable with values equal to the visit numbers at which tau imaging is assessed. The null hypothesis is that the difference in LSM between the donanemab and placebo equals zero.

Annualized change in the composite summary SUVRCLAA for each patient will be calculated using the change at the last post-baseline visit. The annualized change will be compared between the treatment groups with an ANCOVA. The ANCOVA model will include the fixed effect of treatment as well as continuous effects of baseline amyloid PET and age at baseline. The null hypothesis is that the difference in LSM between donanemab and placebo equals zero.

Spearman's rank correlation coefficient will be calculated to assess the relationship of change in amyloid PET at Week 76 to change from baseline to Week 76 in iADRS, CDR-SB, ADCS-iADL and MMSE by treatment. Partial correlation analyses will be conducted using only patients who have the amyloid PET and scale result at Week 76 and adjusted for APOE4 carrier (Y/N), age and sex. Additionally, a linear regression analysis of change in iADRS versus change in amyloid PET endpoint in centiloids (SUVRCLAA) will be graphed. The graph will include the

regression line, p-value for the explanatory variable (amyloid PET), and color to differentiate patients who are ‘amyloid negative’ (amyloid PET endpoint < 24.1 centiloids).

Change and annualized change analyses described above will be repeated on the Full Analysis Set (Pooled LY). Treatment comparisons will be made between LY (pooled LY-M and LY-C) and placebo.

### **6.12.2. Analysis of Tau PET**

To evaluate the change from baseline in tau imaging parameters, an MMRM analysis will be used to compare change from baseline in global tau load measurement at 76 weeks in the Evaluable Efficacy dataset. The model will include the fixed, categorical effects of treatment, visit, and treatment-by-visit interaction, as well as continuous effects of baseline global tau load measurement and age at baseline. Visit will be considered a categorical variable with values equal to the visit numbers at which tau imaging is assessed. The null hypothesis is that the difference in LSM between donanemab and placebo equals zero. The same MMRM analysis will be conducted on the tau PET MUBADA.

Change from baseline and annualized change from baseline analyses will be conducted on global tau load measurement computed from the Tau IQ algorithm. The annualized change will be compared between the treatment groups with an ANCOVA on the full efficacy dataset. The ANCOVA model will include the fixed effect of treatment as well as continuous effects of baseline global tau PET value and age at baseline. The null hypothesis is that the difference in LSM between donanemab and placebo equal zero.

To assess the relationship of biomarker with cognition and function by treatment, Spearman’s rank correlation coefficient will be obtained on change from baseline to Week 76 for the global tau load computed from the Tau IQ algorithm and with change from baseline to Week 76 for CDR-SB, iADRS, ADAS-Cog13, ADCS-iADL, and MMSE. Partial correlation analyses by treatment group will be conducted using only patients who have the clinical outcome and global tau load measurement at Week 76; adjusted for APOE4 carrier (Y/N), age and sex.

Change and annualized change analyses described above will be repeated on the Full Analysis Set (Pooled LY). Treatment comparisons will be made between LY (pooled LY-M and LY-C) and placebo.

### **6.12.3. Analysis of Volumetric MRI**

Analyses of the following volumetric MRI (vMRI) parameters will be conducted (right + left for all but whole brain volume, whole cortical volume, and ventricular volume):

- Hippocampal volume (cm<sup>3</sup>)
- Entorhinal cortex (cm<sup>3</sup>)
- Inferior parietal lobe (cm<sup>3</sup>)
- Isthmus cingulate (cm<sup>3</sup>)
- Lateral parietal lobe (cm<sup>3</sup>)
- Medial temporal lobe (cm<sup>3</sup>)

- Precuneus (cm<sup>3</sup>)
- Prefrontal lobe (cm<sup>3</sup>)
- Superior temporal lobe (cm<sup>3</sup>)
- Cortical (cm<sup>3</sup>)
- Whole temporal lobe (cm<sup>3</sup>)
- Atrophy of total whole brain volume (cm<sup>3</sup>)
- Enlargement of Ventricular volume (cm<sup>3</sup>)

All of the above volumes will be corrected for intracranial volume (ICV) in analyses by including ICV as an explanatory variable in the modeling. To evaluate the atrophy in the volumes, an MMRM analysis will be used in the Evaluable Efficacy dataset. The model will include the fixed, categorical effects of treatment, visit, and treatment-by-visit interaction, as well as continuous effects of baseline volume of interest, baseline ICV, and age at baseline. Visit will be considered a categorical variable with values equal to the visit numbers at which the MRI is assessed. The null hypothesis is that the difference in LSM between donanemab and placebo equals zero.

Annualized change in vMRI for each patient will be calculated using the change in vMRI at the last post-baseline visit. The annualized change will be compared between the treatment groups with an ANCOVA model on the full efficacy dataset. The ANCOVA model will include fixed, categorical effect of treatment as well as the continuous effects of baseline vMRI value, baseline ICV, and age at baseline. The null hypothesis is that the difference in LSM between donanemab and placebo equals zero.

To assess the relationship of vMRI with cognition and function by treatment, Spearman's rank correlation coefficient will be obtained on change from baseline to Week 76 for vMRI parameters with change from baseline to Week 76 for iADRS, ADAS-Cog13, ADCS-ADL, MMSE, and CDR-SB. Partial correlation analyses will be conducted using only patients who have the clinical outcome and vMRI result at Week 76; adjusted for APOE4 carrier (Y/N), age, baseline ICV and sex; and include patients from both treatment groups.

Spearman's rank correlation coefficient will be calculated to assess the relationship of change in vMRI to week 76 with change in amyloid PET to Week 76 by treatment. Partial correlation analyses will be conducted using only patients who have the PETSCAN and vMRI result at Week 76 and adjusted for APOE4 carrier (Y/N), age, baseline ICV and sex.

Spearman's rank correlation coefficient will be calculated to assess the relationship of change in vMRI to week 76 with change in tau PET to week 76 by treatment. Partial correlation analyses will be conducted using only patients who have the PETSCAN and vMRI result at Week 76 and adjusted for APOE4 carrier (Y/N), age, baseline ICV and sex.

Change and annualized change analyses described above will be repeated on the Full Analysis Set (Pooled LY). Treatment comparisons will be made between LY (pooled LY-M and LY-C) and placebo.



## 6.13. Safety Analyses

### 6.13.1. *Extent of Exposure*

Days of exposure will be calculated for each patient (date of last dose – date of first dose + 28). Summary statistics will be provided for the total number of days and patient-years of exposure by treatment. Blinded dose reduction was implemented based on the amount of amyloid measured by the PET scans at weeks 24 and 52. The amounts of amyloid PET in centiloids will be categorized ( $\geq 25$ ,  $\geq 11$  and  $< 25$ , and  $< 11$ ) and tabulated at weeks 24, 52, and 76 for patients randomized to LY.

Study drug treatment assignment will be listed.

### 6.13.2. *Adverse Events*

Treatment-emergent adverse events (TEAEs) will be defined as events that first occurred or worsened after the randomization date (Visit 2 date). Should there be insufficient data for AE start date, stop date, and time to make this comparison, the AE will be considered treatment-emergent. The MedDRA lower-level term (LLT) will be used in the treatment-emergent computation. The maximum severity for each lower-level term (LLT) during the baseline period will be used as baseline.

An overview of AEs, including the number and percentage of patients who died, suffered serious adverse events (SAEs), discontinued due to AEs and who suffered TEAEs, will be provided. Comparison between treatments will be performed using Fisher's Exact Test.

TEAEs by decreasing frequency of PT within SOC will be summarized. Summaries of adverse events by decreasing frequency will be provided for the following:

- TEAEs
- TEAEs by maximum severity
- TEAEs occurring in greater than or equal to 2% of patients by PT
- Serious adverse events
- Adverse events reported as reason for study treatment discontinuation

These summaries will include number and percentages of patients with AEs. Treatment comparisons will be carried out using Fisher's Exact Test.

Preexisting conditions, TEAEs, SAEs, and discontinuations due to AEs will be listed.

### 6.13.3. *Deaths, Other Serious Adverse Events, and Other Notable Adverse Events*

An overview of AEs, including the number and percentage of patients who died or suffered SAEs during the study, discontinued due to AEs and who suffered TEAEs, will be provided. Comparison between treatments will be performed using Fisher's Exact Test.

Hypersensitivity and Infusion-Related Reactions (IRR) will be summarized and compared between treatment groups using Fisher's Exact test. Hypersensitivity and IRR will be broken out

between Potential Immediate (defined as TEAEs occurring on the date of infusions) and Potential Non-Immediate (defined as TEAEs not occurring on the date of infusions but prior to the administration of a subsequent infusion). The following will be used to identify such TEAEs:

- Anaphylactic reaction SMQ (20000021; narrow, algorithm per SMQ guide, and broad)
- Hypersensitivity SMQ (20000214; narrow and broad)
- Angioedema SMQ (20000024; narrow and broad)
- Event maps to Preferred Term (PT) of Infusion related reaction (10051792)

The number and percentage of patients who experienced a TEAE for the following will be analyzed for each of the two time periods:

- Any narrow or algorithmic term from any one of the 3 SMQs indicated above (that is, combined search across narrow and algorithmic portions of all 3 SMQs)
- Any narrow scope term within each SMQ, separately (that is, narrow SMQ search)
- Any term within each SMQ, separately (that is, broad SMQ search)

Within query, individual PTs that satisfy the queries will be summarized. For Infusion related reaction (PT), the individual Lower Level Terms (LLTs) will be summarized.

The Anaphylactic reaction SMQ algorithm will be run only for Potential Immediate TEAEs. The SMQ defines a category (A, B, C, D) for each SMQ PT. All Narrow terms have category A, and the occurrence of a Narrow term satisfies the algorithm. Additionally, a pair of PTs *following the same drug administration* satisfies the algorithm if the two events are from different categories (i.e., B&C, or B&D, or C&D). Both contributing events must begin on the same infusion date. Tables will summarize (the number of patients experiencing) each PT that contributes to such an algorithmic pair, and include such terms in the combined narrow and algorithmic search. Broad events that do not contribute to the algorithm will be summarized in a distinct portion of the table.

#### **6.13.4. Clinical Laboratory Evaluation**

Laboratory measurements will be analyzed using continuous data (change from baseline) and categorical or ordinal data (proportion of treatment-emergent abnormalities). If there are multiple records of laboratory measurements at baseline or postbaseline visit, the last record will be used. Summaries and analyses of continuous data (change from baseline) will be performed using both conventional and International System of Units (SI units).

Measures of central tendency for planned lab analytes' raw measurements and change from baseline (in CN and SI units) will be summarized with boxplots. Boxplots will display results semi-annually (visits 8, 15, and 21) and for the last visit (LOCF) and will include summary tables of N, mean, median, quartiles, min, max, standard deviation, and p-value (for change scores). If there are considerable missing visits, the measures of central tendency may be based on MMRM analyses.

Treatment differences in the proportion of patients with treatment-emergent high or treatment-emergent low or treatment-emergent abnormal laboratory values at (1) anytime and (2) semi-annually (visits 8, 15, and 21) will be assessed using Fisher's exact test. Treatment-emergent



high or low laboratory abnormality will be based on SI unit. For each laboratory analyte, only patients who were low or normal at baseline and have at least 1 post-baseline will be included in the denominator when computing the proportion of patient with treatment-emergent high. Similarly, only patients who were high or normal at baseline and have at least 1 post baseline will be included in the denominator when computing the proportion of patient with treatment-emergent low. In addition, treatment differences in the proportion of patients who have normal baselines with a change to abnormal high or abnormal low values at any post-baseline visits will be summarized.

For urinalysis parameters, baseline to post-baseline shifts will be summarized at each protocol-specified visit. Likelihood ratio chi-square tests will be used to compare increase, no change, and decrease shifts in urinalysis parameters between treatment groups at each visit.

The proportion of patients with treatment-emergent clinically significant changes from a low value or normal value at all baselines at any time in ALT and total bilirubin will be summarized by treatment group. Clinically significant changes of interest at any time are: ALT  $\geq 3$  x upper limit of normal (ULN) and total bilirubin  $\geq 2$  x ULN, AST  $\geq 3$  x ULN, ALT  $\geq 5$  x ULN, ALT  $\geq 10$  x ULN, and total bilirubin  $\geq 2$  x ULN. Additionally, Hy's Law analysis will be conducted by comparing treatment groups with regard to the proportion of patients with (ALT  $\geq 3$  x ULN OR AST  $\geq 3$  x ULN) AND total bilirubin  $\geq 2$  x ULN at any time. Comparisons between treatment groups will be carried out using Fisher's Exact test. When criteria are met for hepatic evaluation and completion of the hepatic safety case report form (CRF), investigators are required to answer a list of questions pertaining to the patient's history, relevant pre-existing medical conditions, and other possible causes of liver injury. A listing of the information collected on the hepatic-safety CRF will be generated.

### **6.13.5. Vital Signs and Other Physical Findings**

Vital sign measurements and weight will be analyzed using continuous data (change from baseline) and categorical data (proportion of potentially clinically significant changes) using the Safety Dataset.

If there are multiple records of vital sign or weight measurements at baseline or postbaseline visit, the last record will be used. Summary statistics will be presented for observed values at baseline and for change from baseline results at each semi-annual postbaseline visit. Systolic and diastolic blood pressure and pulse (collected in sitting position), orthostatic diastolic and orthostatic systolic blood pressures and orthostatic pulse, temperature, and weight by treatment group for all patients in the safety population will be summarized.

Measures of central tendency for vital sign or weight raw measurements and change from baseline will be summarized with boxplots. Boxplots will display results semi-annually (visits 8, 15, and 21) and for the last visit (LOCF) and will include summary tables of N, mean, median, quartiles, min, max, standard deviation, and p-value (for change scores). If there are considerable missing visits, the measures of central tendency may be based on MMRM analyses.

In order to assess outliers and potentially clinically significant changes from baseline, the number and percent of patients meeting criteria for treatment-emergent abnormalities in vital signs and weight at any time during study will be summarized. Treatment group comparisons will be performed using Fisher's exact test. Baseline is defined as the entire screening period (visits 1 and 2). Vital signs and weight limits, presented in [Appendix 1](#), will be used to define low and high. Treatment differences in the proportion of patients with treatment-emergent abnormal high or low vital signs and weight will be assessed between treatment groups using Fisher's exact test at (1) any time (2) semi-annually (visits 8, 15, and 21).

A listing of patients with vital signs or weight exceeding limits will be generated.

### **6.13.6. *Electrocardiograms***

ECG measurements will be analyzed using continuous data (change from baseline) and categorical data (proportion of treatment-emergent abnormalities) using the Safety Dataset. The ECG measurements are derived from three 10 second readings taken every 30 seconds. These 3 readings are to be averaged prior to analysis. Additionally, whenever ECG is measured in triplicate, the average of these readings will be used in the analysis. If there are multiple records after averaging ECG triplicates within a visit, the last record of averages will be used. The analysis will be done for the following ECG measurements: heart rate, PR, QT, QTc, and RR intervals and QRS duration. All analyses of QTc will be carried out using the Fridericia correction (QTcF) method.

Measures of central tendency for ECG raw measurements and change from baseline will be summarized with boxplots. Boxplots will display results semi-annually (visits 8, 15, and 21) and for the last visit (LOCF) and will include summary tables of N, mean, median, quartiles, min, max, standard deviation, and p-value (for change scores). If there are considerable missing visits, the measures of central tendency may be based on MMRM analyses.

In order to assess outliers and potentially clinically significant changes from baseline, the number and percent of patients meeting criteria for treatment-emergent abnormalities in ECGs will be summarized. Treatment group comparisons will be performed using Fisher's exact test. Baseline is defined as the entire screening period (visits 1 and 2). Incidence of treatment-emergent abnormal ECGs will be assessed by comparisons at (1) anytime and (2) semi-annually (visits 8, 15, 22, and 28).

Abnormal ECG criteria and criteria for abnormal QTcF prolongation are presented in [Appendix 2](#).

Treatment-emergent high ECG parameters (heart rate, PR interval, QRS duration, QT and QTcF intervals) are the values which are low or normal at all baseline visits and fall into the high abnormal categories post-baseline. Similarly, treatment-emergent low ECG parameters (heart rate, PR interval, QRS duration) are the values which are high or normal at all baseline visits and fall into the low abnormal categories above.

In addition, treatment differences in the proportion of patients who have normal baselines with a change to abnormal high or abnormal low values at any post-baseline visits will be summarized.

### **6.13.7. Safety MRIs**

The frequency and percentage of subjects with any ARIA (ARIA-E or ARIA-H), ARIA-E, and ARIA-H will be compared between treatments. The frequency and percentages of ARIA-E will be further broken out by asymptomatic vs. symptomatic and by ApoE genotype. A shift table of ARIA-E from baseline by visit will be created, and a shift table of ARIA-H from baseline by visit will be created.

The frequency and percentage of subjects with ARIA-H microhemorrhage, ARIA-H superficial siderosis, and ARIA-H macrohemorrhage will be compared separately between treatments. Changes in ARIA-H microhemorrhages will be further categorized from less than or equal to 4 to greater than 4 by visit.

### **6.13.8. Immunogenicity**

The frequency and percentage of subjects with preexisting (baseline) ADA, ADA at any time after baseline, and TE-ADAs to donanemab will be summarized. If no ADAs are detected at baseline, TE-ADAs are defined as those with a titer 2-fold (1 dilution) greater than the MRD of the assay. For samples with ADA detected at baseline, TE-ADA are defined as those with a 4-fold (2 dilutions) increase in titer compared to baseline. For the TE-ADA subjects, the distribution of maximum titers will be summarized. The frequency of subjects with neutralizing antibodies (subset of the TE-ADA patients) will also be summarized. If the number of subjects experiencing TE-ADA is sufficiently high, further exploratory analyses will be performed using Spotfire to characterize their impact on exposure and clinical outcomes.

### **6.13.9. Columbia Suicide Severity Rating Scale**

Suicidal ideation, suicidal behavior, and self-injurious behavior without suicidal intent occurring during treatment, based on the Columbia-Suicide Severity Rating Scale (C-SSRS), will be summarized by treatment. In particular, for each of the following events, the number and percent of patients with the event will be enumerated by treatment: completed suicide, nonfatal suicide attempt, interrupted attempt, aborted attempt, preparatory acts or behavior, active suicidal ideation with specific plan and intent, active suicidal ideation with some intent to act without specific plan, active suicidal ideation with any methods (no plan) without intent to act, nonspecific active suicidal thoughts, wish to be dead, and self-injurious behavior without suicidal intent. Although not suicide-related, the number and percent of patients with non-suicidal self-injurious behavior occurring during the treatment period will also be summarized by treatment.

In addition, the number and percent of patients who experienced at least one of various composite measures during treatment will be presented and compared. These include suicidal behavior (completed suicide, non-fatal suicidal attempts, interrupted attempts, aborted attempts, and preparatory acts or behavior), suicidal ideation [active suicidal ideation with specific plan and intent, active suicidal ideation with some intent to act without specific plan, active suicidal ideation with any methods (no plan) without intent to act, non-specific active suicidal thoughts, and wish to be dead], and suicidal ideation or behavior.

The number and percent of patients who experienced at least one of various comparative measures during treatment will be presented and compared. These include treatment-emergent suicidal ideation compared to recent history, treatment-emergent serious suicidal ideation compared to recent history, emergence of serious suicidal ideation compared to recent history, improvement in suicidal ideation at endpoint compared to baseline, and emergence of suicidal behavior compared to all prior history.

Specifically, the following outcomes are C-SSRS categories and have binary responses (yes/no). The categories have been re-ordered from the actual scale to facilitate the definitions of the composite and comparative endpoints, and to enable clarity in the presentation of the results.

Category 1 – Wish to be Dead

Category 2 – Non-specific Active Suicidal Thoughts

Category 3 – Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act

Category 4 – Active Suicidal Ideation with Some Intent to Act, without Specific Plan

Category 5 – Active Suicidal Ideation with Specific Plan and Intent

Category 6 – Preparatory Acts or Behavior

Category 7 – Aborted Attempt

Category 8 – Interrupted Attempt

Category 9 – Actual Attempt (non-fatal)

Category 10 – Completed Suicide

Self-injurious behavior without suicidal intent is also a C-SSRS outcome (although not suicide-related) and has a binary response (yes/no).

Composite endpoints based on the above categories are defined below.

- Suicidal ideation: A “yes” answer at any time during treatment to any one of the five suicidal ideation questions (Categories 1-5) on the C-SSRS.
- Suicidal behavior: A “yes” answer at any time during treatment to any one of the five suicidal behavior questions (Categories 6-10) on the C-SSRS.
- Suicidal ideation or behavior: A “yes” answer at any time during treatment to any one of the ten suicidal ideation and behavior questions (Categories 1-10) on the C-SSRS.

The following outcome is a numerical score derived from the C-SSRS categories. The score is created at each assessment for each patient and is used for determining treatment emergence.

- Suicidal Ideation Score: The maximum suicidal ideation category (1-5 on the C-SSRS) present at the assessment. Assign a score of 0 if no ideation is present.

Comparative endpoints of interest are defined below. “Treatment emergence” is used for outcomes that include events that first emerge or worsen. “Emergence” is used for outcomes that include events that first emerge.

- Treatment-emergent suicidal ideation compared to recent history:

An increase in the maximum suicidal ideation score during treatment (Visits Y1-Y2) from the maximum suicidal ideation category during the screening and lead-in periods (C-SSRS scales taken at Visits X1-X2). Recent history excludes “lifetime” scores from the Baseline C-SSRS scale or Baseline/Screening C-SSRS scale.

- Treatment-emergent serious suicidal ideation compared to recent history: An increase in the maximum suicidal ideation score to 4 or 5 on the C-SSRS during treatment (Visits Y1-Y2) from not having serious suicidal ideation (scores of 0-3) during the screening and lead-in periods (C-SSRS scales taken at Visits X1-X2). Recent history excludes “lifetime” scores from the Baseline C-SSRS scale or Baseline/Screening C-SSRS scale.
- Emergence of serious suicidal ideation compared to recent history:  
An increase in the maximum suicidal ideation score to 4 or 5 on the C-SSRS during treatment (Visits Y1-Y2) from no suicidal ideation (scores of 0) during the screening and lead-in periods (C-SSRS scales taken at Visits X1-X2). Recent history excludes “lifetime” scores from the Baseline C-SSRS scale or Baseline/Screening C-SSRS scale.
- Improvement in suicidal ideation at endpoint compared to baseline:  
A decrease in suicidal ideation score at endpoint (the last measurement during treatment; Visits Y1-Y2) from the baseline measurement (the measurement taken just prior to treatment; (Visit X2). This analysis should only be performed for a non-lifetime baseline measurement (i.e., having improvement from the worse event over a lifetime is not clinically meaningful). A specific point in time can be used instead of endpoint.
- Emergence of suicidal behavior compared to all prior history:  
The occurrence of suicidal behavior (Categories 6-10) during treatment (Visits Y1-Y2) from not having suicidal behavior (Categories 6-10) prior to treatment (Visits X1-X2). Prior to treatment includes “lifetime” and/or “screening” scores from the Baseline C-SSRS scale, Screening C-SSRS scale, or Baseline/Screening C-SSRS scale, and any “Since Last Visit” from the Since Last Visit C-SSRS scales taken prior to treatment.

Patients who discontinued from the study with no postbaseline C-SSRS value will be considered unevaluable for analyses of suicide-related events. Only evaluable patients will be considered in the analyses. Fisher’s exact test will be used for treatment comparisons.

## 6.14. Subgroup Analyses

To assess the effects of baseline characteristics on treatment outcome, subgroup analyses for the change in iADRS, CDR-SB, and amyloid PET will be conducted:

- APOE4 Carrier Status – Carrier defined as E2/E4, E3/E4, or E4/E4 genotype; No-Carrier defined as all other genotypes
- Clinical staging at baseline – MCI (defined as  $27 \leq \text{MMSE} \leq 30$ ) or mild AD (defined as  $20 \leq \text{MMSE} \leq 26$ )
- Tau PET level at baseline – no tau ( $\text{SUVR} < 1.10$ ), low tau ( $1.10 \leq \text{SUVR} < 1.23$ ), and medium tau ( $\text{SUVR} \geq 1.23$ )

The outcome measure will be modeled using a MMRM approach. This general model will include terms for baseline, treatment, pooled investigator, visit, concomitant AChEI/memantine

use at baseline (yes/no), baseline age, treatment by visit, subgroup by treatment, subgroup by visit, and treatment by visit by subgroup. Redundant terms will be dropped from the model in those cases where the subgroup of interest is overlapping with this general model. In order to run these analyses, at least 20 patients are required in each strata-treatment combination. If there are insufficient numbers of patients across the three tau PET levels at baseline, the no tau and low tau groups will be combined.

## 6.15. Protocol Violations

Listings of patients with significant protocol violations will be provided for the Randomized population. The following list of significant protocol violations will be determined from the clinical database and from the clinical/medical group:

- Informed consent violation detected as a missing date of informed consent.
- Did not have an assessment of either the ADAS-Cog or ADL at any of the visits at which the scales were scheduled to be assessed.
- Incomplete infusions (any infusion at which less than 75%, approximately 105 mL, of the infusion solution is given).

The following list of significant protocol violations will be determined by clinical/medical group:

- Protocol violations of inclusion/exclusion criteria.
- Had a study dosing algorithm violation (such as if patients randomized to treatment A were given treatment B or patients randomized to treatment A never received the assigned study drug.)
- Unqualified raters for the ADAS-Cog or ADL.

Other protocol violations reported through the monitoring process will be reviewed by the study team and if judged to be significant, will be added to the final reported listing.

## 6.16. Interim Analyses and Data Monitoring

An external DMC is authorized to evaluate results from unblinded interim analyses for the assessment of safety and futility and to recommend any modifications to the study (including stopping the study). Operational details and the decision rules will be provided in the DMC charter or separate interim Statistical Analysis Plan. The DMC will have the responsibility to review accumulating unblinded study data and make recommendations to protect the safety of patients. Each member of the DMC is a recognized expert in the fields of Alzheimer's Disease, neurology, cardiology, or biostatistics. All members will be external to the Sponsor. The approved DMC charter enumerates the roles of the DMC members, the frequency with which it meets, and the structure of their meetings. Study sites will receive information about interim results ONLY if relevant for the safety of their patients.

The DMC will meet quarterly to review unblinded safety data. At least 1 interim analysis may be conducted for Study AACG. Operational details and a quantitative framework to provide



information for decisions resulting from the interim analyses will be documented in the interim analysis Statistical Analysis Plan.

## 6.17. Planned Exploratory Analyses

### 6.17.1. *Analysis of Neurofilament Light Chain (NfL)*

To evaluate the change from baseline in Neurofilament Light chain (NfL), an MMRM analysis will be used to compare change from baseline at 76 weeks in the Evaluable Efficacy dataset. The model will include the fixed, categorical effects of treatment, visit, and treatment-by-visit interaction, as well as continuous effects of baseline NfL and age at baseline. Visit will be considered a categorical variable with values equal to the visit numbers at NfL is assessed. The null hypothesis is that the difference in LSM between donanemab and placebo equals zero. The values for NfL may be log transformed to fit the normality assumption of the model.

Change from baseline and annualized change from baseline analyses will be conducted on NfL. The annualized change will be compared between the treatment groups with an ANCOVA on the full efficacy dataset. The ANCOVA model will include the fixed effect of treatment as well as continuous effects of baseline NfL value and age at baseline. The null hypothesis is that the difference in LSM between donanemab and placebo equals zero.

To assess the relationship of biomarker with cognition and function by treatment, Spearman's rank correlation coefficient will be obtained on change from baseline to Week 76 for the NfL and with change from baseline to Week 76 for CDR-SB, iADRS, ADAS-Cog13, ADCS-iADL, and MMSE. Partial correlation analyses will be conducted using only patients who have the clinical outcome and biomarker result at Week 76; adjusted for APOE4 carrier (Y/N), age and sex; and include patients from both treatment groups.

### 6.17.2. *Analysis of Plasma P-tau217*

To evaluate the change in plasma P-tau analyte (P-tau217) after treatment, an MMRM will be used to compare change from baseline to 76 weeks. This analysis will be run using the Evaluable Efficacy dataset. The model will include the fixed, categorical effects of treatment, visit, and treatment-by-visit interaction, as well as the continuous effect of baseline plasma tau. Visit will be considered a categorical variable with values equal to the visit numbers at which plasma tau is assessed. The values for P-tau217 may be log transformed to fit the normality assumption of the model.

Change from baseline and annualized change from baseline analyses will be conducted on P-tau217. The annualized change will be compared between the treatment groups with an ANCOVA on the full efficacy dataset. The ANCOVA model will include the fixed effect of treatment as well as continuous effects of baseline P-tau217 value and age at baseline. The null hypothesis is that the difference in LSM between donanemab and placebo equals zero.

To assess the relationship of plasma tau with cognition and function by treatment, Spearman's rank correlation coefficient will be obtained on change in plasma tau from baseline to Week 76 and with change from baseline to Week 76 for CDR-SB, iADRS, ADAS-Cog13, ADCS-iADL,

and MMSE. Partial correlation analyses will be conducted using only patients who have the clinical outcome and biomarker result at Week 76; adjusted for APOE4 carrier (Y/N), age and sex; and include patients from both treatment groups.

### 6.17.3. PK/PD Analyses

Compartmental modeling of donanemab PK data using nonlinear mixed effects modeling or other appropriate methods may be explored, and population estimates for clearance and central volume of distribution may be reported. Depending on the model selected, other PK parameters may also be reported. Exploratory graphical analyses of the effect of dose level or demographic factors on PK parameters may be conducted. If appropriate, data from other studies of donanemab may be used in this analysis.

The PK/PD relationships between plasma donanemab concentration and SUV<sub>r</sub>, cognitive endpoints, or other markers of PD activity may be explored graphically. The relationship between the presence of antibodies to donanemab and PK, PD, safety, and/or efficacy may be assessed graphically. If warranted, additional analysis may be explored to evaluate potential interactions for ADA, PD, and other endpoints (PET scan, safety, etc.).

## 6.18. Clinical Trial Registry Analyses

Additional analyses will be performed for the purpose of fulfilling the Clinical Trial Registry (CTR) requirements.

Analyses provided for the CTR requirements include the following:

Summary of adverse events, provided as a dataset which will be converted to an XML file. Both Serious Adverse Events and ‘Other’ Adverse Events are summarized: by treatment group, by MedDRA preferred term.

- An adverse event is considered ‘Serious’ whether or not it is a treatment emergent adverse event (TEAE).
- An adverse event is considered in the ‘Other’ category if it is both a TEAE and is not serious. For each Serious AE and ‘Other’ AE, for each term and treatment group, the following are provided:
  - the number of participants at risk of an event
  - the number of participants who experienced each event term
  - the number of events experienced.
- Consistent with [www.ClinicalTrials.gov](http://www.ClinicalTrials.gov) requirements, ‘Other’ AEs that occur in fewer than 5% of patients/subjects in every treatment group may not be included if a 5% threshold is chosen (5% is the minimum threshold).
- AE reporting is consistent with other document disclosures for example, the CSR, manuscripts, and so forth.





## 7. References

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## 8. Appendices

## Appendix 1. Potentially Clinically Significant Changes in Vital Signs and Weight

<b>Vital Sign Parameter (Unit)</b>	<b>Postbaseline Low Criteria</b>	<b>Postbaseline High Criteria</b>
Sitting systolic blood pressure (mmHg)	Absolute value $\leq 90$ and $\geq 20$ decrease from baseline	Absolute value $\geq 160$ and $\geq 20$ increase from baseline
Sitting diastolic blood pressure (mmHg)	Absolute value $\leq 50$ and $\geq 10$ decrease from baseline	Absolute value $\geq 100$ and $\geq 10$ increase from baseline
Sitting pulse (bpm)	Absolute value $< 50$ and $\geq 15$ decrease from baseline	Absolute value $> 100$ and $\geq 15$ increase from baseline
Weight	$\geq 7\%$ decrease	$\geq 7\%$ increase
<b>Vital Sign Parameter (Unit)</b>	<b>Postbaseline Criteria for Abnormality</b>	
Orthostatic systolic blood pressure (mmHg)	$\geq 20$ mmHg decrease in systolic blood pressure (supine to standing) (i.e., supine minus standing $\geq 20$ )	
Orthostatic diastolic blood pressure (mmHg)	$\geq 10$ mmHg decrease in diastolic blood pressure (supine to standing) (i.e., supine minus standing $\geq 10$ mm Hg)	
Orthostatic pulse (bpm)	$\geq 30$ increase in bpm (supine to standing) (i.e., standing minus supine $\geq 30$ )	
Temperature	Absolute value $\geq 38.3^\circ\text{C}$ and $\geq 1.1^\circ\text{C}$ increase from baseline (Absolute value $\geq 101^\circ\text{F}$ and $\geq 2^\circ\text{F}$ increase from baseline)	

Abbreviation: bpm = beats per minute.

## Appendix 2. Potentially Clinically Significant Changes in ECGs

ECG Parameter	Low Criteria	High Criteria
Heart Rate	<50 bpm	>100 bpm
PR Interval	<120 msec	≥220 msec
QRS Duration	<60 msec	≥120 msec
QTcF Interval		
Males	<330 msec	≥450 msec
Females	<340 msec	≥470 msec
Males and females		> 500 msec
QTcF Delta Changes		
i)		> 30 msec
ii)		> 60 msec
iii)		> 75 msec

Abbreviations: bpm = beats per minute; ECG = electrocardiogram; QTcF = Fridericia-corrected QT interval.

# Data Sharing Statement

Pontecorvo. Association of Donanemab Treatment With Exploratory Plasma Biomarkers in Early Symptomatic Alzheimer Disease. *JAMA Neurol*. Published October 17, 2022.  
doi:10.1001/jamaneurol.2022.3392

## Data

**Data available:** Yes

**Data types:** Other (please specify)

**Additional Information:** All of the individual participant data collected during the trial, after anonymization with the exception of pharmacokinetic or genetic data.

**How to access data:** Proposals should be submitted at [www.vivli.org](http://www.vivli.org) data requestors will need to sign a data sharing agreement. Data for each proposal are available in a controlled access environment.

**When available:** beginning date: 01-31-2024

## Supporting Documents

**Document types:** Other (please specify)

**Additional Information:** Study protocol, statistical analysis plan, clinical study report, blank or annotated case report forms

**How to access documents:** Proposals should be submitted at [www.vivli.org](http://www.vivli.org) data requestors will need to sign a data sharing agreement. Data for each proposal are available in a controlled access environment.

**When available:** beginning date: 01-31-2024

## Additional Information

**Who can access the data:** Investigators whose proposed use of the data has been approved by an independent review committee ("learned intermediary") identified for this purpose.

**Types of analyses:** To achieve aims in the approved proposal

**Mechanisms of data availability:** Proposals should be submitted at [www.vivli.org](http://www.vivli.org) data requestors will need to sign a data sharing agreement. Data for each proposal are available in a controlled access environment.

**Any additional restrictions:** Data are available 6 months after the primary publication and approval of the indication studied in the US and EU, whichever is later. The data are available indefinitely.