

Patient A123-001-001

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-001-002**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-001-003**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-001-004

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-001-005

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-001-006

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-001-007

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-001-008**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-001-009

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-001-010

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-001-011

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-001-012**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-001-013

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-001-014

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-001-015

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-001-016

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-001-017

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-001-018

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-001-019

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-001-020

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-001-021**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-001-022**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-001-023**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-001-024

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-001-025

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-001-026

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-001-027

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-001-028**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-001-029**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-001-030

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-001-041**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-001-042**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-001-043**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-001-044

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-001-045

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-001-046

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-001-047**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-001-048**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-001-049**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-001-050

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-001-051**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-001-052**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-001-053**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-001-054

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-001-055

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-001-056

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-001-057**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-001-058**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-001-059**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-001-060

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-001-061**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-001-062**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-001-063**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-001-064

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-001-065

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-001-066

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-001-067

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-001-068**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-001-069**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-001-070

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-001-071**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-001-072**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-001-073**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-001-074

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-001-075

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-001-076

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-001-077

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-001-078**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-001-079**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-001-080

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-001-081**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-001-082

Reason for inclusion in narrative: SAE (DVT)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-001-083**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-001-084

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-001-085

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-001-086

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-001-087

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-001-088

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-001-089

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-001-090

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-001-091**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-001-092**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-001-093**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-001-094

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-001-095

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-001-096

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-001-097

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-001-098

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-001-099

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-001-100

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-002-001**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-002-002**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-002-003**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-002-004

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-002-005

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-002-006

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-002-007

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-002-008**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-002-009

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-002-010

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-002-011

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-002-012**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-002-013**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-002-014

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-002-015

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-002-016

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-002-017

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-002-018

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-002-019

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-002-020

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-002-021**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-002-022**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-002-023**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-002-024

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-002-025

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-002-026

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-002-027

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-002-028

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-002-029**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-002-030**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-002-041**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-002-042**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-002-043**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-002-044

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-002-045

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-002-046

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-002-047**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-002-048**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-002-049**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-002-050

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-002-051**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-002-052**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-002-053**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-002-054

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-002-055

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-002-056

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-002-057**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-002-058**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-002-059**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-002-060**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-002-061**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-002-062**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-002-063**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-002-064**Reason for inclusion in narrative:** SAE (Hepatic decompensation/Cirrhosis)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-002-065

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-002-066**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumber L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-002-067**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-002-068**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-002-069

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-002-070**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-002-071**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-002-072**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-002-073**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-002-074

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-002-075

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-002-076

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-002-077

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-002-078**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-002-079**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-002-080

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-002-081**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-002-082**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-002-083**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-002-084

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-002-085

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-002-086

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-002-087

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-002-088**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-002-089**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-002-090**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-002-091**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-002-092**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-002-093**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-002-094

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-002-095

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-002-096

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-002-097

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-002-098

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-002-099

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-002-100

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-003-001**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-003-002**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-003-003

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-003-004

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-003-005

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-003-006

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-003-007

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-003-008**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-003-009**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-003-010

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-003-011

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-003-012

Reason for inclusion in narrative: SAE (DVT)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-003-013**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-003-014

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-003-015

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-003-016

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-003-017

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-003-018

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-003-019**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-003-020**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-003--021**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-003--022**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-003-023**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-003-024

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-003-025

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-003-026

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-003-027**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-003-028**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-003-029**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-003-030

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-003--041**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-003--042**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-003-043**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-003-044

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-003-045

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-003-046

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-003-047**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-003-048**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-003-049**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-003-050

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-003--051**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-003--052**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-003-053**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-003-054

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-003-055

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-003-056

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-003-057**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-003-058**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-003-059**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-003-060**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-003--061**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-003--062**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-003-063**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-003-064

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-003-065

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-003-066

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-003-067**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-003-068**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-003-069**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-003-070

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-003--071**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-003--072**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-003-073**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-003-074

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-003-075

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-003-076

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-003-077**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-003-078**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-003-079**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-003-080

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-003--081**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-003--082**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-003-083**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-003-084

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-003-085

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-003-086

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-003-087

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-003-088**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-003-089**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-003-090

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-003--091**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-003--092**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-003-093**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-003-094

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-003-095

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-003-096

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-003-097

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-003-098**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-003-099**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-003-100

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-004--001**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-004--002**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-004-003**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-004-004

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-004-005

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-004-006

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-004-007

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-004-008

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-004-009

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-004-010

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-004--011**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-004--012**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-004-013

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-004-014

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-004-015

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-004-016

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-004-017

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-004-018

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-004-019

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-004-020

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-004--021**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-004--022**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-004-023**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-004-024

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-004-025

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-004-026

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-004-027

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-004-028

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-004-029**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-004-030

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-004--041**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-004--042**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-004-043**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-004-044

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-004-045

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-004-046

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-004-047**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-004-048**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-004-049**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-004-050

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-004--051**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-004--052**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-004-053**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-004-054

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-004-055

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-004-056

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-004-057**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-004-058**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-004-059

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-004-060

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-004--061**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-004--062**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-004-063**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-004-064**Reason for inclusion in narrative:** SAE (Hepatic decompensation/Cirrhosis)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-004-065

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-004-066

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-004-067

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-004-068**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-004-069**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-004-070

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-004--071**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-004--072**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-004-073**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-004-074

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-004-075

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-004-076

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-004-077**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-004-078**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-004-079**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-004-080

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-004--081**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-004--082**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-004-083

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-004-084

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-004-085

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-004-086

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-004-087

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-004-088

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-004-089

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-004-090

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-004--091**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-004--092**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-004-093

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-004-094

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-004-095

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-004-096

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-004-097

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-004-098

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-004-099

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-004-100

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-005--001**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-005--002**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-005-003**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-005-004

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-005-005

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-005-006

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-005-007

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-005-008**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-005-009**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-005-010

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-005--011**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-005--012**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-005-013

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-005-014

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-005-015

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-005-016

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-005-017

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-005-018**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-005-019

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-005-020**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-005--021**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-005--022**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-005-023**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-005-024

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-005-025

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-005-026

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-005-027**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-005-028

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-005-029**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-005-030**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-005--041**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-005--042**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-005-043**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-005-044

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-005-045

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-005-046

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-005-047**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-005-048**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-005-049**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-005-050

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-005--051**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-005--052**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-005-053**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-005-054

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-005-055

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-005-056

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-005-057**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-005-058**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-005-059**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-005-060

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-005--061**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-005--062**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-005-063**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-005-064

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-005-065

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-005-066

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-005-067**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-005-068**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-005-069**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-005-070

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-005--071**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-005--072**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-005-073**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-005-074

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-005-075

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-005-076

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-005-077

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-005-078**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-005-079**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-005-080

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-005--081**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-005--082**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-005-083**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-005-084

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-005-085

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-005-086

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-005-087

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-005-088**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-005-089**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-005-090

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-005--091**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-005--092**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-005-093**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-005-094

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-005-095

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-005-096

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-005-097**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-005-098**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-005-099

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-005-100

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-006--001**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-006--002**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-006-003**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-006-004

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-006-005

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-006-006

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-006-007

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-006-008**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-006-009

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-006-010

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-006--011**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-006--012**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-006-013

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-006-014

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-006-015

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-006-016

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-006-017

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-006-018

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-006-019

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-006-020**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-006--021**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-006--022**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-006-023**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-006-024

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-006-025

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-006-026

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-006-027

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-006-028

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-006-029**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-006-030**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-006--041**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-006--042**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-006-043**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-006-044

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-006-045

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-006-046

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-006-047**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-006-048**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-006-049**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-006-050

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-006--051**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-006--052**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-006-053**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-006-054

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-006-055

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-006-056

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-006-057

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-006-058**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-006-059**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-006-060

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-006--061**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-006--062**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-006-063**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-006-064

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-006-065

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-006-066

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-006-067**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-006-068**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-006-069**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-006-070

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-006--071**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-006--072**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-006-073**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-006-074

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-006-075

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-006-076

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-006-077

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-006-078**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-006-079**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-006-080

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-006--081**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-006--082**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-006-083

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-006-084

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-006-085

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-006-086

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-006-087

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-006-088**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-006-089**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-006-090

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-006--091**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-006--092**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-006-093**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-006-094

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-006-095

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-006-096

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-006-097

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-006-098**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-006-099**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-006-100

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-007--001**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-007--002**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-007-003**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-007-004

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-007-005

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-007-006

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-007-007

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-007-008**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-007-009

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-007-010

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-007--011**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-007--012**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-007-013**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-007-014

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-015**Reason for inclusion in narrative:** SAE (Phototoxic reaction)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-

-016

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-007-017

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-007-018

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-007-019

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-007-020

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-007-021**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-007-022**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-007-023**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-007-024

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-007-026

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumber L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-007-027**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-007-028**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-007-029**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-007-030

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-007--041**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-007--042**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-007-043**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-007-044

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-007-046**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumber L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-007--051**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-007--052**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-007-058**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-007-064

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-007-065

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-007-070**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-007-077

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

Patient A123-007--082**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-007-083**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-007-088

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-007-089**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-007-090

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-007--091**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-007--092**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-007-093**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-007-094

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-007-095

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-007-096

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-007-097**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-007-098**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-007-099**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-007-100

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-008--001**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-008--002**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-008-003

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-008-004

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-008-005

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-008-006

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-008-007

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-008-008

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-008-009

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-008-010

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-008--011**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-008--012**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-008-013

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-008-014

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-008-015

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-008-016

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-008-017

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-008-018

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-008-019

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-008-020

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-008--021**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-008--022**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-008-023

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-008-024

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-008-025

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-008-026

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-008-027

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-008-028

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-008-029**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-008-030

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-008--041**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-008--042**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-008-043**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-008-044

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-008-045

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-008-046

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-008-047**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-008-048**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-008-049**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-008-050

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-008--051**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-008--052**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-008-053**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-008-054

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-008-055

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-008-056

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-008-057

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-008-058**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-008-059

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-008-060

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-008--061**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-008--062**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-008-063**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-008-064**Reason for inclusion in narrative:** SAE (Hepatic decompensation/Cirrhosis)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-008-065

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-008-066**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-008-067

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-008-068**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-008-069**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-008-070

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-008--071**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-008--072**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-008-073**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-008-074

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-008-075

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-008-076

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-008-077

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-008-078

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-008-079**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-008-080

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-008--081**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-008--082**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-008-083

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-008-084

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-008-085

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-008-086

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-008-087

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-008-088

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-008-089

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-008-090

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-008--091**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-008--092**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-008-093

Reason for inclusion in narrative: SAE (PE)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-008-094

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-008-095

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-008-096

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-008-097

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-008-098

Reason for inclusion in narrative: SAE (TCP)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-008-099**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-008-100

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-009--001**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-009--002**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-009-003**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-009-004

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-009-005

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-009-006

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-009-007

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-009-008**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-009-009

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-009-010

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-009--011**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-009--012**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-009-013**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-009-014

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-009-015

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-009-016

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-009-017

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-009-018**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-009-019**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-009-020**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-009--021**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-009--022**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-009-023**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-009-024**Reason for inclusion in narrative:** SAE (Hepatic decompensation/Cirrhosis)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-009-025

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-009-026

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-009-027

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-009-028**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-009-029

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-009-030

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-009--041**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-009--042**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-009-043**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-009-044

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-009-045

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-009-046

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-009-047**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-009-048**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-009-049**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-009-050

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-009--051**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-009--052**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-009-053**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-009-054

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-009-055

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-009-056

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-009-057**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-009-058**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-009-059**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-009-060**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-009--061**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-009--062**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-009-063**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-009-064

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-009-065

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-009-066

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-009-067**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-009-068**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-009-069**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-009-070

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-009--071**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-009--072**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-009-073**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-009-074

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-009-075

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-009-076

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-009-077**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-009-078**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-009-079**Reason for inclusion in narrative:** SAE (severe myonecrosis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-009-080

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-009--081**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-009--082**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-009-083**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-009-084

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-009-085

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-009-086

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-009-087

Reason for inclusion in narrative: SAE (Chronic Bronchitis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-009-088**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-009-089

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-009-090

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777

Patient A123-009--091**Reason for inclusion in narrative:** SAE (TIA)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 52-year-old, male, Asian, USA.

The patient entered the study with relapsing-remitting multiple sclerosis which was originally diagnosed on 01-Feb-2010. Medical history included varicella zoster (1957), pneumonia (1962), anemia (1975), benign prostatic hyperplasia (1989), urinary frequency (1990), GERD (1995), asthma (1997), fractured elbow (2004) abdominal pain (2009), hypertension (03-Aug-2010 – ongoing) and vertigo (2011). His most recent relapse prior to entering the study was on 14-Oct-2017. His weight and height were 67.2kg and 170cm respectively.

Prior therapy included interferon beta 1b, 0.25mg subcutaneously once a week from 30-Mar-2010 to 15-Jun-2014, with relapse on 11-Jul-2012.

The patient received the first dose of the study drug on 03-Oct-2019. On Day 2 (04-Oct-2019), the patient reported irritation at the injection site. The irritation manifest as large, raised hives, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 6 (08-Oct-2019) and the administration of the study drug resumed on Day 7 (09-Oct-2019).

On Day 24 (22-Oct-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (24-Oct-2019) and the administration of the study drug resumed the following day (25-Oct-2019).

On Day 55 (22-Nov-2019), the patient complained of paresthesia and weakness on the left side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Head CT and CT angiogram were normal. However, a diffusion weighed MRI showed a lesion in the right hemisphere and the patient was diagnosed with a transient ischemic attack (TIA). The patient was prescribed 300mg aspirin stat and OD and was instructed not to drive. He was discharged the same day (22-Nov-2019).

The patient officially discontinued the study medication on Day 55 (22-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between the injection site irritation and the nausea and the study treatment, but did not suspect a relationship between the TIA and the study treatment.

Case Identifier Number: ABC2019TT12345

Patient A123-009--092**Reason for inclusion in narrative:** SAE (DVT)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 45-Year-old, Female, Asian, India.

The patient entered the study with idiopathic inflammatory myopathy which was originally diagnosed on 21-May-2014. Medical history included pancreatitis (2003), hypertension (1998), ludwig's angina (2008), dermatomyositis (2007), Vomiting (2012), CKD (2005), diabetes (2001), heart burn (1997), anemia (16- Oct-2011-ongoing). The last relapse before entering into the study was on 23- Nov-2018. Her weight and height were 52kg and 168cm respectively.

The previous medication history includes methylprednisolone, 1g, intravenously once daily from 30- Mar-2015 to 5- Apr-2015 and methotrexate, 15mg, orally once in a week from 25-Sep-2016 to 14-Oct-2016, with relapse on 27-Oct-2017.

The patient received the first dose of study drug on 16- Nov-2017. On Day 5 (21-Oct-2017), the patient reported with abdominal discomfort and heart burn. On lab investigation (22- Oct-2017) it was identified as mild splenomegaly and treated with antibiotics. The issue was resolved by Day 10 (26- Oct-2017) and the administration of study drug resumed on Day 11 (27-Oct-2017).

On Day 35 (30- Dec-2017) the patient complained of rashes and swelling all over the body and admitted to the hospital on the same day. FNAC was negative but skin biopsy showed panniculitis and DVT test confirmed deep vein thrombosis (DVT). The patient was prescribed with enoxaparin, 1.5mg OD on Day 36 (31-Dec-2017) and discharged on Day 40 (08- Jan-2018).

The patient officially discontinued the study treatment on Day 40 (08- Jan-2018) and was lost to follow-up.

The investigator suspected a relationship between panniculitis and the study treatment, but did not suspect a relationship between DVT and the study treatment.

Case Identifier Number: SDR2018UY09876

Patient A123-009-093**Reason for inclusion in narrative:** SAE (PE)**Treatment Group:** Compound 1 (20 mg subcutaneously daily)**Patient Details:** 35-Year-old, Male, Hispanic, Mexico.

The patient entered the study with nephrotic syndrome which was originally diagnosed on 12-Apr-2009. Medical history included tuberculosis (2012), hypertension (2010), pneumonia (2008), abdominal pain (2013), vomiting (2012), cough (2005), diabetes (2001), shortness of breath (1997), seizure (1992), muscle cramps (2007), edema (09- Jun-2014-ongoing). The last relapse before entering into the study was on 12- Sep-2017. His weight and height were 72kg and 172cm respectively.

Prior therapy included Prednisolone 10mg from 23-Oct-2013 to 30-Oct-2013, isoniazid 150mg, rifampicin 300mg, ethambutol 400mg, pyrazinamide 750mg and pyridoxine 10mg from 12-Nov-2016 to 30- Feb 2017 and Furosemide 40mg from 13-Aug-2010 to 21-Oct-2010.

The patient received the first dose of the study drug on 19-Mar-2016. On Day 7 (26-Mar-2016), the patient admitted to the hospital with on and off fever, dyspnea and dry cough. The patient was treated using antihistamines and antibiotics. The administration of the study drug was halted. The issues were resolved and patient back to normal by Day 12 (31- Mar-2016). The administration of the study drug resumed on Day 13 (01-Apr-2016).

On Day 30 (18-Apr-2016), the patient complained of severe chest pain and vomiting, and admitted to the hospital on the same day. The administration of the study drug was halted. The patient kept on ICU for 3 days and then shifted to ward for a week. The patient was discharged on Day 42 (30-Apr-2016) and the administration of the study drug resumed on Day 43 (01-May-2016).

On Day 58 (15-May-2016), the patient complained of hematuria, leg pain, cyanosis, chest pain and shortness of breath. The patient reported to the hospital on the same day. Blood test indicates high D dimer level which is an indication of PE (Pulmonary Embolism). Pulmonary angiography also confirms the PE. The patient was prescribed with LMWH once daily for 5 days and discharged on Day 66 (23-May-2016) with warfarin 5mg OD for 3 months.

The patient officially discontinued the study medication on Day 58 (15-May-2016) and was lost to follow-up.

The Investigator suspected a relationship between hematuria and the study treatment, but did not suspect a relationship between the PE and the study treatment.

Case Identifier Number: KJH2016MN7896

Patient A123-009-094

Reason for inclusion in narrative: SAE (Hepatic decompensation/Cirrhosis)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 60-year-old, male, Caucasian, Ukraine

The patient entered the study with relapsing-hepatitis C virus (HCV) infection which was originally diagnosed on 15-Mar-2014. Medical history included anemia needing blood transfusion (1998), estimated glomerular filtration (1989), fatigue (1989), anorexia (1991), nausea (1995), occasional vomiting (1995), steatorrhea (2000), right upper quadrant pain due to liver disorder (2001), jaundice (2002), encephalopathy (2002), increased bilirubin (2003), alcohol abuse (2013), HCV infection (2015), ascites (2015) and liver transplant (2016). His most recent relapse prior to entering the study was on 14-Oct-2015. His weight and height were 78.4kg and 170cm respectively.

Prior therapy included disulfiram 400 mg tablet once a week from 30-Mar-2000 to 15-Jun-2014, with ribavirin on 11-Jul-2012.

The patient received the first dose of the study drug on 25-Jul-2018. On Day 2 (26-Jul-2018), the patient reported bouts of vomiting which was followed by loose stools. The administration of the study drug was halted. The irritation has resolved by Day 6 (30-Jul-2018) and the administration of the study drug resumed on Day 7 (31-Jul-2018).

On Day 24 (17-Aug-2018), the patient complained of severe nausea due to anemia and was admitted to hospital the same day for blood transfusion. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (19-Aug-2018) and the administration of the study drug resumed the following day (20-Aug-2018).

On Day 55 (20-Sep-2018), the patient complained of continued nausea, vomiting, weakness and pain on the right side. His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. CT and MRI indicated liver cirrhosis and the patient was diagnosed with hepatic decompensation. The patient was prescribed 400mg sofosbuvir and was instructed not to drive. He was discharged the next day (21-Sep-2018).

The patient officially discontinued the study medication on Day 56 (21-Sep-2018) and was lost to follow-up.

The Investigator suspected a relationship between anemia and nausea with study treatment, but did not suspect a relationship between hepatic decompensation and the study treatment.

Case Identifier Number: BCE2018GG3489

Patient A123-009-095

Reason for inclusion in narrative: SAE (Phototoxic reaction)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 72-year-old, female, White, United States

On 25-Sep-2019 the patient was treated for serious local tissue damage (like sunburn) after 4 days of first dose of study drug on left arm. A similar episode had also occurred on 15-Jun-2016. Medical history included erythema, edema, blistering (2015 to 2016), hyperpigmentation (2017), dermatitis (2018), urticaria (2016 to 2018) and abstinence syndrome (since 2016). She had a history of drug dependence, altering mood and repetitive use of drug to derive euphoria. Her weight and height were 65.4kg and 160cm respectively.

Prior therapy included treatment with penicillin, tetracyclines, demeclocycline, Sulfonamides, and Corticosteroid tablets from Feb-2015 to Jul-2019.

The patient received the first dose of the study drug on 21-Sep-2019. On Day 2 (22-Sep-2019), the patient reported bouts of skin irritation, itching and hypersensitivity after exposure to sun. The condition worsened until 25-Sep-2019 and administration of the study drug was halted. The irritation has resolved by Day 7 (27-Sep-2019) and the administration of the study drug resumed on Day 8 (28-Sep-2019).

On Day 30 (21-Oct-2019), the patient complained of severe nausea, mood alteration and severe phototoxic reaction and was admitted to hospital the same day for treatment. The photo allergy persisted and administration of the study drug was halted. The patient was kept for observation for 2 days. The patient was released on Day 33 (23-Oct-2019) and the administration of the study drug resumed the following day (24-Oct-2019).

On Day 60 (21-Nov-2019), the patient complained of continued nausea, headache, itching and cutaneous reaction on the left arm. Her speech was impaired and she exhibited confusion. She was admitted to hospital the same day. The patient was diagnosed with phototoxic reaction. The patient was prescribed 400mg compound 1 and was instructed not to drive. She was discharged the next day (22-Nov-2019).

The patient officially discontinued the study medication on Day 61 (23-Nov-2019) and was lost to follow-up.

The Investigator suspected a relationship between itching and skin irritation with study treatment, but did not suspect a relationship between phototoxic and the study treatment.

Case Identifier Number: GHEF2019JH6782

Patient A123-009-096

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (20 mg subcutaneously daily)

Patient Details: 52-year-old, male, Chinese, UK,

The patient entered the study with non-small lung cancer and was assigned to receive compound 1 (40 mg). The non-small lung cancer was originally diagnosed on 19-Apr-2017.

The patient was diagnosed with pleural effusion (Grade 3) and fibrotic scar of the lung (Grade 2) Lumber L5 fracture (Grade 3). The subject was smoker (1 pack per day) and had history of alcohol consumption.

Medical history included dyspnea (from unspecified date), back pain from 24-Apr-2017 to Unknown day in Jun-2017, cough since 12-Aug-2017 and pyrexia from an unspecified date.

His weight and height were 74.6 kg and 169 cm respectively.

Prior chemotherapy included bevacizumab, pemetrexed and carboplatin all from 09 June 2017 to 30-Jul-2017. Patient did not receive any prior any radiotherapy and did not undergo any anticancer surgery. Patient received naproxen 275 mg orally 2 times a day since 24-Apr-2017, paracetamol 5 mg orally 3 times daily 17-Aug-2017 to 22-Nov-2017, paracetamol 500 mg since 29-Aug-2017, all for back pain.

The patient received the first dose of the study drug on 05-September-2017. The patients ECOG score at the entry was 0. The patient's disease stage at the time of entry was Stage IV. On 15-Sep-2017 patient presented to hospital with back and leg pain and the spinal X-Ray showed the L5 fracture. The event was considered serious due to hospitalization. The Patients treated with pain killer. On 20-Sep-2017 the pain due to lumber L5 fracture was resolved and patient was discharged from the hospital. On 30-Sep-2017 ECOG score was 1.

On 19-Nov-2017 a thorax CT scan showed metastatic target lesion with mass in upper lobe of lung. The patient was also noted with the new lesion in pleural cavity.

On 18-Dec-2017 on the same day of most recent administration patient presented with lumbar L5 fracture pain (Grade 3) related to underlying disease. CT scan and chest X-ray were performed in the emergency room and it revealed the significant progression of the disease compressing the upper lobes of lung. Thorax and lumbar CT scan also confirmed multiple pulmonary masses and pleural effusion (Grade 3), fibrotic scar of the lung (Grade 2), and lumber L5 fracture (Grade 3). The chest X-ray confirmed the malignancies. ECG was normal. The events were considered as serious as it required prolong hospitalization.

The Subject was treated with sodium chloride IV infusion 250 ml. Cloxacillin 250 mg twice a day orally, edoxaban 60 mg per day, methylprednisolone 125 µg orally as needed for management of pain and inflammation. From 18-Dec-2017 to 20-Dec-2017. Information for the treatment of pulmonary fibrotic scar was unavailable.

The administration of compound 1 was halted with last administration on 20-Dec-2017.

The subject received radiation therapy and further treatment for mass in upper lobe of lung from 25-Dec-2017 to 29-Dec-2017. Thorax CT scan and chest X-ray were performed and it revealed the further damage in lungs.

Patients discharged on the 31-Dec-2017 with summary of Stage IV non-small lung cancer, pleural effusion, fibrotic scar. The lumber L5 fracture, plural effusion and fibrotic scar were not resolved at the time of discharge from hospital.

The patient officially discontinued the study medication on 09-Jan-2018 and was lost to follow-up.

The Investigator did not suspect a relationship between lumber L5 fracture, plural effusion, fibrotic scar and the study treatment, and also did not suspect a relationship between the TIA and the study treatment. Further explanation for pleural effusion and pulmonary fibrotic scar was increased mass in upper lobe with significant disease progression.

Case Identifier Number: DGZ2017SEA9786

Patient A123-009-097**Reason for inclusion in narrative:** SAE (Chronic Bronchitis)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 45-year-old, female, Asian, India

The patient participated in the study with a diagnosis of chronic obstructive pulmonary disease (COPD), originally diagnosed on 14-Mar-2015. Medical history included intestinal tuberculosis (1980), colitis, colon injury and abdominal pain (1982), liver contusion hepatobiliary infection (1997), severe gastrointestinal reflux disease (1998), anxiety, stress and bradycardia (2007), shortness of breath and cough (2015 to present). The patient was prone to excessive smoking about 20 cigarettes per day from the last 8 years and continued till date with a maximum of 12 cigarettes per day.

Prior hospitalization and treatment therapy for cough, and dyspnea included albuterol 400 mcg oral inhalation, every 4 to 6 hours from 29-Mar-2015 to 15-Jun-2019 and amoxycillin 500 mg tablet once daily for two weeks starting from 29-Mar-2015. The respiratory distress increased despite being treated with albuterol. The patient denied fever chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. Her most recent relapse prior to entering the study was on 04-July-2018. Her weight and height were 57.8 kg and 155 cm respectively.

The patient received the first dose of the study drug on 03-Sep-2019. On Day 2 (04-Sep-2019), the patient reported abdominal pain. The pain lasts for 19 hours and was treated with antibacterial and antispasmodic drug. The administration of the study drug was halted and resumed on Day 6 (08-Sep-2019)

On Day 24 (26-Sep-2019), the patient complained of severe nausea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 26 (28-Sep-2019) and the administration of the study drug resumed the following day (29-Sep-2019).

On Day 55 (27-Oct-2019), the patient complained with excessive cough, dyspnea, and increased production of sputum. The patient was hospitalized the same day. Upon arrival at the emergency room there were few breath sounds heard with auscultation and the patient was so short of breath that she had difficulty climbing up onto the examiners table and completing a sentence without a long pause. She was placed on 4 L oxygen via nasal cannulae and given nebulized ipratropium and albuterol treatment. The patient had been compliant with her medications; however, she admits that she does not like to use ipratropium because it causes dry mouth and makes her feel edgy.

The following day, patient appeared more comfortable after receiving oxygen and bronchodilator therapy. Laboratory reports including blood test, chest X-ray, lung function test, ultrasound was reviewed. Patient was reported to be suffered with the symptoms of bronchitis. She was strictly advised to quit smoking or reduce the frequency up to maximum of 4 cigarettes per day. The study

drug medications were continued for the next 4 days and she was discharged from the hospital on Day 59 (31-Oct-2019).

The patient officially discontinued the study medication on Day 60 (01-Nov-2019) due to the chronic symptoms of the adverse event and was lost to follow-up thereafter.

The Investigator suspected a relationship between the nausea and other gastrointestinal disease symptoms with the study treatment but no conclusive relationship was reported for chronic bronchitis and the study drug.

Case Identifier Number: BDA2019AC2434

Patient A123-009-098**Reason for inclusion in narrative:** SAE (TCP)**Treatment Group:** Compound 1 (40 mg subcutaneously daily)**Patient Details:** 54-year-old, male, British, UK

The patient entered the study complaining about loss in appetite, acute pain in abdominal region malaise and weakness. He was having reddish-purple spots on the skin of lower limbs. Medical history included pneumonia (1972), asthma (1998), fractured arm (2002), hypertension (09-Aug-2012- ongoing), stroke (2014), abdominal pain (2016) and anemia (2016). His most recent blood count analysis was done on 2-Sep-2017 which resulted in low count of RBCs and platelets. His ultrasound reports suggested inflammation in splenic region and also enlarged spleen size. The weight and height of the person were 64.2kg and 162cm respectively.

Prior therapy include Nifedipine, 60mg once daily from 30-Oct-2013-ongoing, Aspirin 75mg once daily from 12-May-2014-ongoing, Alprazolam 0.5 mg twice daily from 23 Feb 2014-ongoing.

The patient received the first dose of the study drug on 08-July-2017. On Day 2 (04-Oct-2019), the patient complained irritation, joint pain, extreme discomfort and insomnia after administration of the drug orally. The irritation manifest as rashes and mild redness, which were treated using a topical anti-inflammatory. The administration of the study drug was halted. The irritation has resolved by Day 3 (11-July-2017) and the administration of the study drug resumed on Day 5 (13-July-2017).

On Day 15 (23-July-2017), the patient complained of mild fever, difficulty in breathing joint pain tingling in feet and was admitted to hospital the same day. The symptoms persisted and administration of the study drug was halted. The patient was released on Day 17 (25-July-2017) and the administration of the study drug resumed the following day (26-July-2017).

On Day 25 (3-Aug-2017), the patient complained of chest pain, severe weakness and numbness in limbs, troubled breathing, and slurred speech. He was admitted to hospital the same day. Head CT and CT angiogram were normal. The study was halted and patient was discharged after his condition was stable.

Case Identifier Number: SJS1992TT09876

Patient A123-009-099

Reason for inclusion in narrative: SAE (severe myonecrosis)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 58-year-old, male, Asian, USA

The patient entered the study with higher levels of LDL which was 282mg/dL originally diagnosed on 13-Nov-2010. Medical history included varicella zoster (1968), pneumonia (1964), anemia (1975), Diabetes (1989), GERD (2002), asthma (1997), hypertension (11-May-2010 – ongoing), lumbo-sacral fracture (2011), and vertigo (2011). His most recent complaint was anginal pain prior to entering the study was on 22-Jul-2018. His weight and height were 72.8kg and 168cm respectively.

Prior therapy included Insulin, 500 units daily from 16-Jun-1989-ongoing, Amlodipine, 5mg orally once daily from 16-Nov-2010 to 24-Jun-2018 and later was shifted to Telmisartan, 40 mg till date. Also, Esomeprazole, 40mg once daily from 26-Dec-2002-ongoing.

The patient received the first dose of the study drug on 19-Oct-2018. On Day 2 (20-Oct-2019), the patient reported constipation and abdominal pain, which was treated using an Arachis oil enema. The administration of the study drug was halted. The constipation problem was resolved by Day 4 (24-Oct-2019) and the administration of the study drug resumed on Day 5 (25-Oct-2019).

On Day 20 (9-Nov-2019), the patient complained of severe nausea, diarrhea and was admitted to hospital the same day. The nausea persisted and administration of the study drug was halted. The patient had a history of severe gastrointestinal reflux disease and was kept for observation for 2 days. The patient was released on Day 23 (12-Nov-2019) and the administration of the study drug resumed the following day (13-Nov-2019).

On Day 52 (30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

On Day 5(30-Nov-2019), the patient complained of myalgia, dizziness and weakness on His speech was impaired and he exhibited confusion. He was admitted to hospital the same day. Blood sugar level were increased to 320mg/dL, increased CPK levels were observed which was 260 U/L, however the LDL levels lowered to 198mg/dL. Also, electromyography was done which showed abnormal nerve conduction activity in muscles. The patient was prescribed few exercises and was instructed not to eat creatine and glutamine rich food. He was discharged the same day (30-Nov-2019).

Case Identifier Number: SJS1992TT12112

Patient A123-009-100

Reason for inclusion in narrative: SAE (TIA)

Treatment Group: Compound 1 (40 mg subcutaneously daily)

Patient Details: 62-year-old, female, African, UK

The patient entered the study with chronic kidney disease which was originally diagnosed on 20-Jan-2010.

Medical history included diabetes (1994), anemia (1995), high blood pressure (1996), swollen feet and ankle (1997), bone disease (1998), kidney stones (1999), Urinary tract infections (1999, 2006), proteinuria (2001), lower urinary tract obstruction (2002), dyslipidemia (2004), microalbuminuria (2006), hepatitis (2008).

The patient had family history of chronic kidney disease and is obese.

Her weight and height were 92.5kg and 150cm respectively.

Prior therapy included metformin 500 mg orally twice a day from Dec-1994 to Feb-2002, Insulin 0.3 units/kg/day from Feb-2002 to present, chlorothiazide 300mg daily from Sep-1996 to Jan-2001, Valsartan 100mg daily from Jan 2001 to present, Surgery to remove kidney stones, nitrofurantoin 100 mg daily from Jan-1999 to Jun-1999 and from Jun-2006 to Dec-2006, losartan 100mg daily from Oct-2001 to Nov-2001, extended release niacin tablets 500mg from Jul-2004 to Aug-2004, Lisinopril 5mg daily from Dec-2006 to Jan-2006, lamivudine 100 mg orally from Mar-2008 to Sep-2008.

The patient was also advised to have glycemic control and to lose weight.

The patient received the first dose of the study drug on 1-Feb-2012. On Day 2 (2-Feb-2012), the patient reported mild nausea. Nausea subsided with rest and consuming bland food for a day. On day 6 (6-Feb-2012) patient reported loss of appetite and was advised to take medicine along with food.

On day 10 (10-Feb-2012) patient reported extensive swelling of feet and was asked to reduce daily salt intake. On day 13 (13-Feb-2012) the patient still had swelling and was prescribed diuretics like furosemide. On day 16 (16-Feb-2012) patient again reported nausea and was advised to take rest and avoid strenuous activity.

On Day 22 (22-Feb-2012), the patient complained of severe tiredness, lack of energy and shortness of breath along with pounding and fluttering heartbeat. As patient already had history of anemia, a blood test was done to check CBC and was found to have reduced RBC and hemoglobin levels. The patient was administered erythropoietin injection on the same day.

On day 24 (24-Feb-2012), regular checkup showed high blood pressure and was given Enalapril 20mg orally. On day 29 (29-Feb-2012) patient reported persistent dry cough, dizziness and headaches, Enalapril was withdrawn and was asked to continue her previous medication for high blood pressure.

On day 32 (3-Mar-2012) blood report indicated borderline high cholesterol level, patient was prescribed Atorvastatin 100 mg orally. Blood report also indicated higher levels of urea and potassium. Patient was referred to a dietician for a healthy diet while reducing proteins and potassium rich food.

On day 45 (16-Mar-2012) patient again reported swelling of legs and was prescribed furosemide again.

On day 55 (26-Mar-2012) patient reported severe chest pain, shortness of breath, pain in neck and jaw. Resting ECG was performed and it showed abnormal heart rhythm. The patient was admitted to hospital the same day. Angiography was performed on the patient and it showed blockage of arteries. Angioplasty was recommended and study drug administration was halted. Angioplasty was done on day 56 (27-Mar-2012). Patient was hospitalized for 5 days (26-Mar-2012 to 30-Mar-2012).

The patient officially discontinued the study medication thereafter and was lost to follow-up.

The Investigator suspected a relationship between the nausea and study drug but did not suspect relationship between other conditions with study drug.

Case Identifier Number: XYZ2012VD7777