

# Protocol

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

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This supplement contains the following items with personal information redacted:

1. Original AURA3 clinical study protocol (edition 1): pages 2–109
2. Final AURA3 clinical study protocol (edition 3): 110–227
3. Summary of amendments to AURA3 clinical study protocol: 228–383
4. Original AURA3 statistical analysis plan (edition 1): 384–434
5. Final AURA3 statistical analysis plan (edition 4): 435–492



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**Clinical Study Protocol**

Drug Substance     AZD9291  
Study Code         D5160C00003  
Edition Number     1  
Date \_\_\_\_\_

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**A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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Sponsor: AstraZeneca

The following Amendment(s) and Administrative Changes have been made to this protocol since the date of preparation:

<b>Amendment No.</b>	<b>Date of Amendment</b>	<b>Local Amendment No:</b>	<b>Date of Local Amendment</b>
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This submission document contains confidential commercial information, disclosure of which is prohibited without providing advance notice to AstraZeneca and opportunity to object.



This Clinical Study Protocol has been subject to a peer review according to AstraZeneca Standard procedures. The clinical study protocol is publicly registered and the results are disclosed and/or published according to the AstraZeneca Global Policy on Bioethics and in compliance with prevailing laws and regulations.

## PROTOCOL SYNOPSIS

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### **A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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#### **International Coordinating Principal Investigators:**

#### **Study site(s) and number of subjects planned**

Approximately 610 subjects will be recruited from approximately 17 countries across approximately 140 centres in North America, Asia and Europe.

<b>Study period</b>	<b>Phase of development</b>	
Estimated date of first subject enrolled	Q3 2014	III
Estimated date of last subject completed	Q1 2018	

#### **Study Design**

This is a phase III, open-label, randomized study assessing the safety and efficacy of AZD9291 (80 mg, orally, once daily) versus platinum-based doublet chemotherapy in patients with Epidermal Growth Factor Receptor Mutation and T790M Mutation Positive

(EGFRm+/T790M+), locally advanced or metastatic NSCLC who have progressed following treatment with an approved Epidermal Growth Factor Tyrosine Kinase Inhibitor (EGFR-TKI) agent.

In order to randomize approximately 610 subjects it is expected that an estimated 1540 subjects will be screened.

A biopsy will be needed for central testing of T790M mutation status following confirmed disease progression on first line treatment with an EGFR TKI.

Suitable subjects will then be randomized to receive either AZD9291 (80mg orally, once daily) or platinum-based doublet chemotherapy (pemetrexed 500 mg/m<sup>2</sup> + carboplatin area under the plasma concentration–time curve AUC 5 or pemetrexed 500 mg/m<sup>2</sup> + cisplatin 75 mg/m<sup>2</sup>) on Day 1 of every 21-day cycle in a 2:1 (AZD9291: platinum-based doublet chemotherapy) ratio.

Subjects should continue on investigational product AZD9291 until a treatment discontinuation criterion is met. Subjects may continue to receive AZD9291 beyond RECIST 1.1 defined progression as long as they are continuing to show clinical benefit, as judged by the investigator.

Subjects can receive up to 6 cycles of pemetrexed + carboplatin/cisplatin as initial treatment. Subjects whose disease has not progressed after four cycles of platinum-based first-line chemotherapy may receive pemetrexed maintenance therapy.

Subjects must be followed until evidence of RECIST 1.1 defined progression (regardless of reason for treatment discontinuation). It is important that subjects are assessed according to the intended scanning schedule to prevent the bias in analysis that can occur if one treatment group is assessed more or less often than the other.

Note: Throughout this document the term “platinum-based doublet chemotherapy”, refers to “platinum” as both carboplatin and cisplatin.

## Objectives

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### Primary Objective:

To assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy by assessment of Progression Free Survival (PFS).

### Outcome Measure:

Progression Free Survival (PFS) using investigator assessments according to Response Evaluation Criteria in Solid Tumours (RECIST 1.1).  
Sensitivity analysis of Progression Free Survival using Blinded Independent Central Review (BICR).

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<b>Secondary Objective:</b>	<b>Outcome Measure:</b>
<p>To further assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy in terms of:</p> <ul style="list-style-type: none"> <li>- Objective Response Rate (ORR)</li> <li>- Duration of Response (DoR)</li> <li>- Disease Control Rate (DCR)</li> <li>- Tumour shrinkage</li> <li>- Overall Survival (OS)</li> </ul>	<p>ORR, DoR, DCR and tumour shrinkage using investigator assessments according to Response Evaluation Criteria in Solid Tumours (RECIST 1.1).</p> <p>Analysis of overall survival.</p>
<p>To assess the effect of AZD9291 compared to platinum-based doublet chemotherapy on subjects' disease-related symptoms and health related quality of life (HRQoL).</p>	<p>European Organization for Research and Treatment of Cancer Quality of Life Questionnaire – Core 30 items (EORTC QLQ-C30) and European Organization for Research and Treatment of Cancer Quality of Life Questionnaire – Lung Cancer 13 items (EORTC QLQ-LC13).</p> <p>EORTC QLQ-C30:  Questionnaire consisting of 30 items measuring subjects general cancer symptoms and functioning.</p> <p>EORTC QLQ-LC13:  A complementary questionnaire measuring lung cancer symptoms.</p>
<p>To characterise the pharmacokinetics (PK) of AZD9291 and metabolites in subjects receiving AZD9291.</p>	<p>PK exposure parameters derived from plasma concentrations of AZD9291, and metabolites AZ5104 and AZ7550.</p> <p>PK Parameters (CL<sub>ss</sub>/F, C<sub>ss, min</sub> and C<sub>ss, max</sub>, AUC<sub>ss</sub>) will be derived using population PK analysis and reported separately to the CSR. Data from this study may form part of a pooled analysis with data from other studies.</p>

**Safety Objective:**

**Outcome Measure:**

<p>To assess the safety and tolerability profile of AZD9291 compared with platinum-based doublet chemotherapy.</p>	<p>Adverse events (graded by Common Terminology Criteria for Adverse Event (CTCAE v4)</p> <ul style="list-style-type: none"> <li>- Clinical chemistry, haematology and urinalysis</li> <li>- Vital signs (pulse and blood pressure), Physical Examination, Weight</li> <li>- Centrally reviewed digital Electrocardiogram (ECG)</li> <li>- Echocardiogram/ Multi Gated Acquisition Scan (MUGA) (for Left Ventricular Ejection Fraction)</li> <li>- World Health Organization (WHO) performance status</li> </ul>
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**Exploratory Objectives:**

**Outcome Measure:**

<p>To explore the relationship between PK and selected endpoints (which may include efficacy, safety and/or Patient Reported Outcome [PRO]), where deemed appropriate.</p>	<p>Correlation of PK with other primary /secondary/ exploratory endpoints in subjects treated with AZD9291.</p> <p>Results from such analyses will be reported separately from the Clinical Study Report (CSR).</p> <p>Data from this study may also form part of a pooled analysis with other AZD9291 studies.</p>
<p>To compare the effects of AZD9291 compared with chemotherapy on post progression outcomes</p>	<p>Time from randomization to second progression (PFS2)</p> <p>Time to subsequent treatments</p> <p>Time to change in symptoms (including post progression assessments)</p>
<p>To further characterise the effects of AZD9291 on survival outcomes.</p>	<p>Assess the impact on overall survival of baseline potentially prognostic factors (e.g. tumour stage, performance status, sex, baseline lactate dehydrogenase [LDH])</p> <p>Assess the impact on OS of subsequent treatments and other potential covariates (e.g. changes in performance status)</p>
<p>To compare adverse events by subject self-reporting of specific CTCAE symptoms (where applicable) between AZD9291 and chemotherapy.</p>	<p>Collection of approximately 28 PRO-CTCAE symptoms via an electronic device solution (in countries where language is available).</p>



**Exploratory Objectives:**

**Outcome Measure:**

<p>To compare AZD9291 treatment with chemotherapy treatment on health state utility.</p>	<p>The EQ-5D-5L health state utility index will be used to derive health state utility based on subject reported data.</p>
<p>To compare health resource use associated with AZD9291 treatment with chemotherapy treatment.</p>	<p>Health resource utilisation measures including hospitalization, outpatient visits, or emergency department visits.</p>
<p>To characterise the pharmacokinetics (PK) of AZD9291 and metabolites in cerebrospinal fluid (CSF).</p>	<p>Concentration of AZD9291, AZ5104 and AZ7550. Ratio of metabolites to AZD9291.  Ratio of CSF to plasma concentration.  Summaries of PK concentration data.</p>
<p>To collect and store deoxyribonucleic acid (DNA) for future exploratory research into genes/genetic variation that may influence PK or response to AZD9291, platinum-based doublet chemotherapy (ie, absorption, distribution, metabolism, excretion, safety and efficacy) and/or susceptibility to/development of cancers.</p>	<p>Correlation of polymorphisms with variation in Pharmacokinetics (PK), Pharmacodynamics (PD), safety or response observed in subjects treated with AZD9291 or comparator.  Data generated may be reported separately and may also form part of a pooled analysis with other AZD9291 studies.</p>
<p>To collect and store tumour samples and blood-based samples for potential for exploratory research into factors that may influence susceptibility to/development of NSCLC/cancer and/or response to AZD9291 (where response is defined broadly to include efficacy, tolerability or safety).</p>	<p>Analysis of key genetic and proteomic markers to include, but not limited to, EGFR mutations, Human Epidermal Growth Factor Receptor 2 (HER2) &amp; CMET expression and/or amplication.  Collection of plasma samples to include, but not be limited to, extraction of circulating tumour DNA (ctDNA) for investigation of blood borne biomarkers. The sample may be used to investigate the relationship between PK and blood-borne biomarkers.  Samples may be analysed retrospectively. Any biomarker data generated may be reported separately and may also form part of a pooled analysis with other AZD9291 studies.</p>

**Exploratory Objectives:**

**Outcome Measure:**

<p>To collect and store plasma for isolation of ctDNA. Extracted ctDNA will be assessed for the presence of genetic aberrations including, but not limited to, EGFR mutations (T790M, L858R, etc). These samples may be shared with a diagnostic partner for development of a ctDNA test for T790M detection.</p>	<p>Retrospective/real-time analysis of EGFR (and other) mutations in ctDNA from all study subjects (mandatory).</p>
<p>To collect and store residual CSF for potential exploratory research of factors that may influence development of NSCLC and/or response to AZD9291 (where response is defined broadly to include efficacy, tolerability or safety).</p>	<p>Collection of CSF for the investigation of PK and/or biomarkers. Samples may be analysed retrospectively.</p>

**Target subject population**

Male and female subjects aged 18 years and over (subjects from Japan aged at least 20 years) who have histologically or cytologically proven NSCLC that is locally advanced or metastatic and not amenable to further surgery or radiotherapy with curative intent and whose disease has progressed with previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy.

Subjects must be eligible to receive treatment with the selected platinum-based doublet chemotherapy (pemetrexed + cisplatin /carboplatin) in accordance with local prescribing information and have documentation of EGFR Mutation (at any time since a diagnosis of NSCLC was made) and T790M Mutation positive tumour. Subjects must have measurable disease (using Computer Tomography [CT]/Magnetic Resonance Imaging [MRI]) as defined by RECIST 1.1 guidelines and WHO Performance Status of 0-1.

**Duration of treatment**

Treatment with AZD9291 80 mg (once daily) will commence following randomization. Subjects may continue to receive treatment with AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria (see Section 3.7).

Treatment with intravenous platinum-based doublet chemotherapy (on Day 1 of every 21 day cycle) will commence following randomization up to a total of 6 cycles or until progression (whichever occurs first). Patients whose disease has not progressed after four cycles of platinum-based first-line chemotherapy may receive pemetrexed maintenance therapy.

### **Investigational product, dosage and mode of administration**

AZD9291 is an oral, potent, selective, irreversible inhibitor of both EGFR-TKI sensitising and resistance mutations in NSCLC with a significant selectivity margin over wild-type EGFR. AZD9291 will be administered orally as one 80 mg tablet once a day. A cycle of treatment is defined as 21 days of once daily AZD9291 treatment.

### **Comparator product, dosage and mode of administration**

Platinum-based doublet chemotherapy will be administered intravenously on Day 1 of every 21-day cycle of either:

- Pemetrexed 500mg/m<sup>2</sup> + carboplatin AUC5.
- Or
- Pemetrexed 500mg/m<sup>2</sup> + cisplatin 75mg/m<sup>2</sup>.

In order to reduce the incidence and severity of skin reactions, a corticosteroid should be given the day prior to, on the day of, and the day after pemetrexed administration. The corticosteroid should be equivalent to 4mg of dexamethasone administered orally twice a day.

To reduce toxicity, subjects treated with pemetrexed must also receive vitamin supplementation. Subjects must take oral folic acid or a multivitamin containing folic acid (350 to 1000 micrograms) on a daily basis. At least five doses of folic acid must be taken during the seven days preceding the first dose of pemetrexed, and dosing must continue during the full course of therapy and for 21 days after the last dose of pemetrexed. Subjects must also receive an intramuscular injection of vitamin B12 (1,000 micrograms) in the week preceding the first dose of pemetrexed and once every three cycles thereafter. Subsequent vitamin B12 injections may be given on the same day as pemetrexed. Subjects may also receive other pre-treatment / concomitant treatment as recommended by approved label for pemetrexed, carboplatin or cisplatin as clinically indicated by the investigator.

### **Statistical methods**

Subjects will be randomized to the trial in a 2:1 ratio:

- AZD9291 80mg will be administered orally once a day
- Or
- Platinum-based doublet chemotherapy will be administered intravenously on Day 1 of every 21-day cycle of either:
  - o pemetrexed 500mg/m<sup>2</sup> + carboplatin AUC5
  - Or
  - o pemetrexed 500mg/m<sup>2</sup> + cisplatin 75mg/m<sup>2</sup>.

Subjects will be stratified at randomization based on ethnicity (Asian/Non-Asian).

PFS is the primary endpoint for this study. The study has been sized to also characterise the overall survival (OS). Approximately 610 subjects will be randomized in a 2:1 ratio (AZD9291: platinum-based doublet chemotherapy) in this study.

The primary analysis of PFS will occur when approximately 400 progression events have been observed. With 400 progression events, the study will have >95% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were HR 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed.

If the true OS hazard ratio for the comparison of AZD9291 versus doublet chemotherapy is 0.75, 427 death events will provide approximately 80% power to demonstrate a statistically significant difference in OS at 5% 2-sided significance level. For example, this translates to an approximate 5-6 month improvement in median OS over an assumed 16-19 month median OS on chemotherapy, assuming OS is exponentially distributed.

Two interim analyses of overall survival will be conducted, one at the time of the primary analysis of PFS, and one when the OS data are approximately 50% mature (approximately 305 death events). A final optional analysis of overall survival may be performed when the OS data are approximately 70% mature (approximately 430 death events).

PFS will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian). The primary analysis will be based on investigator-recorded assessment of disease progression by RECIST; a sensitivity analysis will also be performed using a blinded independent central review (BICR) from a random sample of scans from approximately 200 patients.

All secondary endpoints of ORR, DoR, DCR and Tumour Shrinkage will be analyzed at the time of the primary analysis.

In order to provide strong control of the type I error rate, the primary endpoint (PFS) and key secondary endpoints (ORR and OS) will be tested in a sequential order. If any previous analysis in the sequence is not statistically significant, the alpha spending cannot be transferred to subsequent analyses. Since three analyses of OS are planned, the alpha will be split between the two interim and final analyses of overall survival to maintain a 2-sided 5% type I error.

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## LIST OF ABBREVIATIONS AND DEFINITION OF TERMS

The following abbreviations and special terms are used in this study Clinical Study Protocol.

<b>Abbreviation or special term</b>	<b>Explanation</b>
AE	Adverse event
ALP	Alkaline Phosphatase
ALT	Alanine Aminotransferase
AnLK	Anaplastic lymphoma kinase
ANSM	Agence Nationale de Securite du Medicaments
ASCO	American Society of Clinical Oncology
AST	Aspartate Aminotransferase
ATP	Adenosine Triphosphate
AUC	Area under the curve (plasma concentration / time curve)
AUC5	Area under the plasma concentration–time curve 5 mg/ml per minute
AUC (0-24)	Area under the curve (plasma concentration / time curve from zero to 24 hours)
AUCss	Plasma Clearance at Steady State
AZ	AstraZeneca
BCRP	Breast Cancer Resistance Protein
BICR	Blinded Independent Central Review
BoR	Best Overall Response
BP	Blood Pressure
BSA	Body Surface Area
BUN	Blood urea nitrogen
ctDNA	Circulating free tumour deoxyribonucleic acid
CI	Confidence Interval
CK	Creatine Kinase
CLss/F	Plasma Clearance at Steady State
Cmax	Maximum plasma concentration
CMET	Proto-oncogene encoding Hepatocyte Growth Factor Receptor
CR	Complete response
CRF	Case Report Form (electronic/paper)

<b>Abbreviation or special term</b>	<b>Explanation</b>
CRO	Clinical Research Organization
CSF	Cerebrospinal Fluid
CSR	Clinical Study Report
Css	Concentration at Study State
CT	Computer Tomography
CTCAE	Common Terminology Criteria for Adverse Event
<i>ct</i> DNA	Circulating tumour Deoxyribonucleic acid
CYP	Cytochrome P450
DAE	Discontinuation of Investigational Product due to Adverse Event
DCO	Data cut off
DCR	Disease Control Rate
DLT	Dose limiting toxicity
DMC	Data Monitoring Committee
DNA	Deoxyribonucleic acid
DoR	Duration of Response
DUS	Disease under Study
EC	Ethics Committee, synonymous to Institutional Review Board (IRB) and Independent Ethics Committee (IEC)
ECG	Electrocardiogram
EDoR	Expected Duration of Response
EGFR	Epidermal Growth Factor Receptor
EGFRm+	EGFR Mutation positive
EORTC QLQ-C30	European Organization for Research and Treatment of Cancer Quality of Life Questionnaire – Core 30 items
EORTC QLQ LC13	European Organization for Research and Treatment of Cancer Quality of Life Questionnaire – Lung Cancer 13 items
EU	European Union
Ex19Del	Deletions in exon 19
FDA	Food and Drug Administration
FFPE	Formalin Fixed and Paraffin Embedded
FFST	Time to First Subsequent Therapy or Death
FSH	Follicle-Stimulating Hormone

<b>Abbreviation or special term</b>	<b>Explanation</b>
FSI	First Subject In
G719X	An in-frame amino acid (glycine (G)) deletion at position 719 in EGFR
GCP	Good Clinical Practice
GFR	Glomerular Filtration Rate
GMP	Good Manufacturing Practice
HDPE	High-Density-Polyethylene
HER2	Human Epidermal Growth Factor Receptor 2
HR	Hazard Ratio
HIV	Human Immunodeficiency Virus
HRQoL	Health Related Quality of Life
IB	Investigator's Brochure
ICF	Informed Consent Form
ICH	International Conference on Harmonisation
ICR	Independent Central Review
ILD	Interstitial Lung Disease
INR	International Normalized Ratio
International Co-ordinating investigator	If a study is conducted in several countries the International Co-ordinating Investigator is the Investigator co-ordinating the investigators and/or activities internationally.
IP	Investigational Product
IUS	Intra Uterine System
iv	Intravenous
IVRS	Interactive Voice Response System
IWRS	Interactive Web Response System
KRAS	Kirsten Rat Sarcoma Viral Oncogene Homolog
LDH	Lactate Dehydrogenase
LDL	Low-density Lipoprotein
LH	Luteinizing Hormone
LSLV	Last Subject Last Visit
LVEF	Left Ventricular Ejection Fraction
MedDRA	Medical Dictionary for Regulatory Activities
MPA	Medical Products Agency

<b>Abbreviation or special term</b>	<b>Explanation</b>
MRI	Magnetic resonance imaging
MUGA	Multi Gated Acquisition Scan
NCI	National Cancer Institute
NE	Not evaluable
NSCLC	Non-Small Cell Lung Cancer
NTL	Non-target Lesion
NYHA	New York Heart Association
OAE	Other Significant Adverse Event
ORR	Objective Response Rate
OS	Overall Survival
P	Probability
PD	Progression of disease
PD	Pharmacodynamics
PFS	Progression Free Survival
PFSs	Time from Randomization to Second Progression
PGx	Pharmacogenetics
PI	Principal Investigator
PK	Pharmacokinetics
PR	Partial Response
PRO	Patient Reported Outcome
QD	Once daily
QT	Interval on the electrocardiogram representing the duration of depolarization and repolarization of the heart
QTc	The QT interval corrected for heart rate
RAC	Accumulation on Multiple Dosing
RECIST 1.1	Response Evaluation Criteria in Solid Tumors version 1.1
RR	Response Rate
SAE	Serious adverse event
SDV	Source Data Verification
SAP	Statistical Analysis Plan
SD	Stable disease

<b>Abbreviation or special term</b>	<b>Explanation</b>
SDV	Source Data Verification
SoC	Standard of Care
SPC	EU Summary of Product Characteristics
T790M	An amino acid substitution at position 790 in EGFR, from a Threonine (T) to a Methionine (M)
T790M+	T790M mutation positive
TKI	Tyrosine Kinase Inhibitor
TL	Target Lesion
tmax	Time to Cmax
tss max	Time to Css max
TSST	Time to Second Subsequent Therapy or Death
ULN	Upper Limit of Normal
US	United States
WBDC	Web Based Data Capture
WHO	World Health Organization

## 1. INTRODUCTION

### 1.1 Non-small Cell Lung Cancer (NSCLC)

Lung cancer has been the most common cancer in the world for several decades, and by 2008, there were an estimated 1.61 million new cases, representing 12.7% of all new cancers. It was also the most common cause of death from cancer, with 1.38 million deaths (18.2% of the total) ([GLOBOCAN 2008](#)). NSCLC represents approximately 80% to 85% of all lung cancers. Unfortunately, at the time of diagnosis approximately 70% of NSCLC patients already have advanced or metastatic disease not amenable to surgical resection. Furthermore, a significant percentage of early stage NSCLC patients who have undergone surgery subsequently develop distant recurrence and die as a result of their lung cancer ([Pisters & Le Chevalier 2005](#)). Patients presenting with unselected advanced NSCLC have a median overall survival (OS) of 10 to 12 months ([Bonomi 2010](#)).

Treatment of advanced NSCLC can be guided by the presence of certain molecular drivers such as EGFR, anaplastic lymphoma kinase (AnLK) and KRAS mutations. The incidence of Epidermal Growth Factor Receptor mutation positive (EGFRm+) NSCLC is approximately 10-15% and 30-40% of patients in the West and Asia, respectively.

Although first- (eg, erlotinib, gefitinib) and second-generation (eg, afatinib) Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitors (EGFR TKIs) are established therapies for patients with NSCLC known to have activating mutations in EGFR (EGFRm+), the emergence of a secondary T790M mutation in patients treated with an EGFR TKI agent has been described as a major route of development of resistance to this class of therapy ([Pao et al 2005](#), [Kobayashi et al 2005](#)) in approximately 60% of patients ([Yu et al 2013](#)).

In the advanced NSCLC post-EGFR TKI treatment failure setting, prolonged survival rates remain very low (median OS in the region of 1 to 2 years, [Wang et al 2012](#), [Wu et al 2010](#), [Fukuoka et al 2011](#)). No approved therapy is currently available for patients with T790M mutation positive (T790M+) tumours that have acquired EGFR TKI resistance or refractoriness. There is no data on response rates (RRs) with single agent chemotherapy in the specific subset of T790M+ patients after failure of EGFR TKI.

Treatment guidelines for 2<sup>nd</sup> line treatment of EGFRm+ NSCLC include using platinum based chemotherapy doublet treatment (e.g. U.S. [NCCN 2012](#) guidelines). Second-line platinum-based chemotherapy post EGFR TKI for EGFRm+ NSCLC generally provides RRs in the range of 20 to 30% ([Gridelli et al 2012](#), [Goldberg et al 2012](#), [Maemondo et al 2010](#), [Wang et al 2012](#), [Wu et al 2010](#)). Although slightly better than the RRs that can be expected with single-agent chemotherapy in later lines, these data together with the toxicity burden associated with doublet chemotherapy (that includes nausea, vomiting, bone marrow suppression resulting in high risk of infection and bleeding, alopecia, fatigue, and peripheral neuropathy) confirm the unmet medical need that exists in this patient population.



## 1.2 Background and rationale for conducting this study

Activation of the EGFR tyrosine kinase triggers a cascade of intracellular downstream signalling events affecting cell proliferation, survival, angiogenesis and, potentially, metastases. Selective inhibition of EGFR tyrosine kinase has demonstrated clinical benefit in approximately 70% of patients with advanced NSCLC harbouring the sensitivity mutations (the most common of which are L858R and deletions in exon 19 (Ex19del), described collectively as EGFR mutation). The tumours initially respond to EGFR-TKIs, but subsequently develop resistance to therapy, with a median time to progression of nine months. In approximately 60% of these initially EGFR-TKI responsive patients (Yu et al 2013), disease progression is associated with the emergence of a secondary EGFR mutation, T790M in exon 20 of EGFR, which confers resistance to EGFR-TKI therapy (Pao et al 2005). The T790M resistance mutation is located in the hinge region of the kinase domain of the adenosine triphosphate (ATP) binding pocket of the EGFR protein, where the bulky methionine side chain prevents binding of the EGFR-TKIs (Heuckmann et al 2012).

AZD9291 is a potent irreversible inhibitor of both the single EGFR<sup>m+</sup> (TKI sensitivity conferring mutation) and dual EGFR<sup>m+</sup>/T790M<sup>+</sup> (TKI resistance conferring mutation) receptor forms of EGFR with a significant selectivity margin over wild-type EGFR. Therefore AZD9291 has the potential to provide clinical benefit to patients with advanced NSCLC harbouring both the single sensitivity mutations and the resistance mutation following prior therapy with an EGFR-TKI. The clinical development programme with AZD9291 will initially assess the safety and efficacy of AZD9291 in patients with advanced NSCLC whose cancers have progressed following an EGFR-TKI regimen (with or without additional chemotherapy regimens), as they currently represent a major unmet medical need population. Importantly, preliminary data from an ongoing phase I study (D5160C00001) in this patient population has demonstrated good evidence of efficacy in patients who have progressed on or after an approved EGFR TKI only or additional therapies ( $\geq$  2nd line), while treatment with AZD9291 has been well tolerated across a range of doses (refer to the latest edition of the Investigator Brochure for further details) (Ranson et al WCLC 2013).

## 1.3 Rationale for study design, doses and control groups

No approved therapies currently exist to specifically target T790M<sup>+</sup> acquired EGFR-TKI resistance, which represents the most common resistance mechanism in the majority of NSCLC patients with acquired EGFR-TKI resistance. The purpose of this study is to further characterise and confirm the efficacy and safety of AZD9291 in EGFR<sup>m+</sup>/T790M<sup>+</sup> NSCLC patients who have acquired resistance to an EGFR-TKI (and who are chemotherapy naive) observed in the ongoing phase I study (D5160C00001).

The majority of patients with EGFR<sup>m+</sup> NSCLC respond well initially to treatment with EGFR-TKIs with an Objective Response Rate (ORR) of approximately 60 to 70%, but eventually develop resistance with a median time to progression of around 9-11 months. In at least half of initially TKI-responsive patients, disease progression is associated with the emergence of a secondary EGFR mutation, called T790M mutation in exon 20 of the EGFR gene. There are no current effective recommended standard of care therapies for these

NSCLC patients with acquired EGFR-TKI resistance who are T790M+. Treatment guidelines for 2<sup>nd</sup> line treatment of EGFRm+ NSCLC include using platinum based chemotherapy doublet treatment (e.g. [NCCN 2012](#)).

A commonly used platinum doublet is pemetrexed in combination with cisplatin or carboplatin. Pemetrexed in combination with cisplatin demonstrated superior OS compared to Gemcitabine in combination with cisplatin in previously untreated advanced NSCLC patients with non-squamous histology (adenocarcinoma and large cell carcinoma) in a randomised phase III trial: 10.4 vs 6.7 months respectively ([Scagliotti et al 2008](#)). Pemetrexed in combination with either Cisplatin or Carboplatin is therefore an appropriate control arm treatment in this phase III trial.

This patient population with a major unmet medical need is therefore appropriate to evaluate the efficacy and safety of AZD9291 in this study.

The study design has been discussed with the US Food and Drug Administration (FDA), Swedish Medical Products Agency (MPA) and French Agence Nationale de Securite du Medicaments (ANSM) during Scientific Advice consultations and all key aspects of the Phase III 2<sup>nd</sup> line study design including Progression Free Survival (PFS) as primary endpoint, dose rationale and patient population were supported.

Given the unmet medical need that exists in the aforementioned patient population alongside the lack of well-proven treatment options, and given the good evidence of efficacy with AZD9291 (>50% RR in T790M+ population) and well tolerated profile reported in ongoing phase I study in T790M+ patient population ([Ranson et al WCLC 2013](#)), it is considered appropriate to assess efficacy and safety of AZD9291 in a randomised open-label phase III study in 2<sup>nd</sup> line NSCLC versus pemetrexed in combination with cisplatin or carboplatin.

The primary objective of this study is PFS. This is an appropriate primary efficacy endpoint in this NSCLC population and may be associated with an improvement in OS, delay to time of initiation of subsequent therapies, symptom control, and quality of life. Secondary efficacy endpoints are those that are appropriate to this patient population and include, Duration of response (DoR), Disease Control Rate (DCR) [DCR: Complete response (CR) + Partial Response (PR) + Stable disease (SD)] and overall survival. Characterisation of pharmacokinetics (PK) as well as the safety and tolerability of AZD9291 will also be assessed as a secondary endpoint.

Several exploratory endpoints will be evaluated (see Section 2.3). These include assessment of the effect of AZD9291 compared with chemotherapy on post progression outcomes such as time from randomization to second progression and time to subsequent treatments. Additional exploratory endpoints will include comparisons of AZD9291 with chemotherapy on health state utility (using EQ-5D-5L health state utility index) and resource utilization (e.g. hospital visits), patient self-reporting of adverse events, the relationship between PK and selected endpoints, tumour samples and biomarkers (ctDNA for the assessment of biomarkers) and tumour biopsy for companion diagnostic development.

The collection of cerebrospinal fluid (CSF) from a select number of subjects who provide voluntary optional consent will enable the investigation of the ability of AZD9291, AZ5104 and AZ7550 to cross the blood brain barrier. Brain metastases occur in 20-30% of patients with advanced NSCLC, and are associated with poor prognosis ([Porta et al 2011](#)). The first generation EGFR TKI agents have demonstrated only limited efficacy in treating brain metastases ([Bai & Han 2013](#), [Shimato et al 2006](#)), however, preclinical data suggests that AZD9291 may be capable of crossing the blood brain barrier (see Investigator Brochure) and potentially may offer better exposures in this anatomically protected location.

Overall, the totality of primary, secondary and exploratory endpoints in this study will allow a robust characterisation of overall benefit / risk of AZD9291 for patients with metastatic, EGFR T790M+ mutation-positive, non-small cell lung cancer (NSCLC) whose NSCLC has progressed during treatment with an FDA-approved, EGFR tyrosine kinase inhibitor.

The dose of 80 mg once daily was selected from a review of all available safety, tolerability, PK and efficacy data from study D5160C00001, in patients with advanced NSCLC who have progressed following prior therapy with a prior EGFR TKI agent. At the Investigator Brochure (IB) data cut-off of 19 November 2013, AZD9291 had been administered as a capsule formulation across the dose range of 20 to 240mg once daily in this study: 20 mg (n=21), 40 mg (n=55), 80 mg (n=47), 160 mg (n=40) and 240 mg (n=7). No dose limiting toxicities (DLTs) have been reported at any dose level in the escalation cohorts during the 21-day DLT evaluation period. Subjects have once daily doses of AZD9291 for durations of at least 10 months depending on the dose level. Emerging efficacy data has demonstrated durable objective responses from the starting dose level of 20 mg once daily ([Ranson et al WCLC 2013](#)). The selected 80 mg dose is four fold higher than the minimum efficacious dose tested in study D5160C00001, whilst still being one third of the maximum dose level investigated (240 mg). The 80 mg dose level is considered to have a safety and tolerability profile appropriate for chronic administration to subjects with advanced NSCLC.

#### **1.4 Benefit/risk and ethical assessment**

In the advanced NSCLC post-EGFR TKI treatment failure setting that has been chosen for initial study with AZD9291, median survival is modest (~16 months for second line therapy, ~10 months for third line therapy) with no effective treatment options currently available. This population therefore represents a major unmet medical need. Although there can be no certainty of clinical benefit to patients, the biological hypothesis, non-clinical and, in particular, the preliminary clinical efficacy and safety data with AZD9291 in the ongoing phase I trial (D5160C00001) support the notion that dual EGFR mutation inhibition may be a valid target for the treatment of EGFR T790M mutation-positive NSCLC tumours driven. Specifically the safety profile of AZD9291 is (in the ongoing phase I trial) modest with the majority of adverse events being non-clinically significant EGFR-related adverse events ie, diarrhoea and skin rash. All trials of AZD9291 exclude patients with clinically significant toxicities related to prior treatments in addition to specifically excluding patients with a history of interstitial lung disease (ILD) or clinically active interstitial lung disease as this is

an uncommon but well documented EGFR related toxicity. All patients will be assessed for possible known EGFR-related toxicities and detailed information on the management of EGFR-related gastrointestinal, dermatological and ophthalmic is being provided for all AZD9291 studies.

It is therefore reasonable and appropriate to evaluate the oral administration of AZD9291 in comparison to standard platinum-based doublet chemotherapy as a second-line therapy in this unmet medical need post-EGFR TKI EGFR T790M mutation-positive NSCLC patient population, according to the proposed study design.

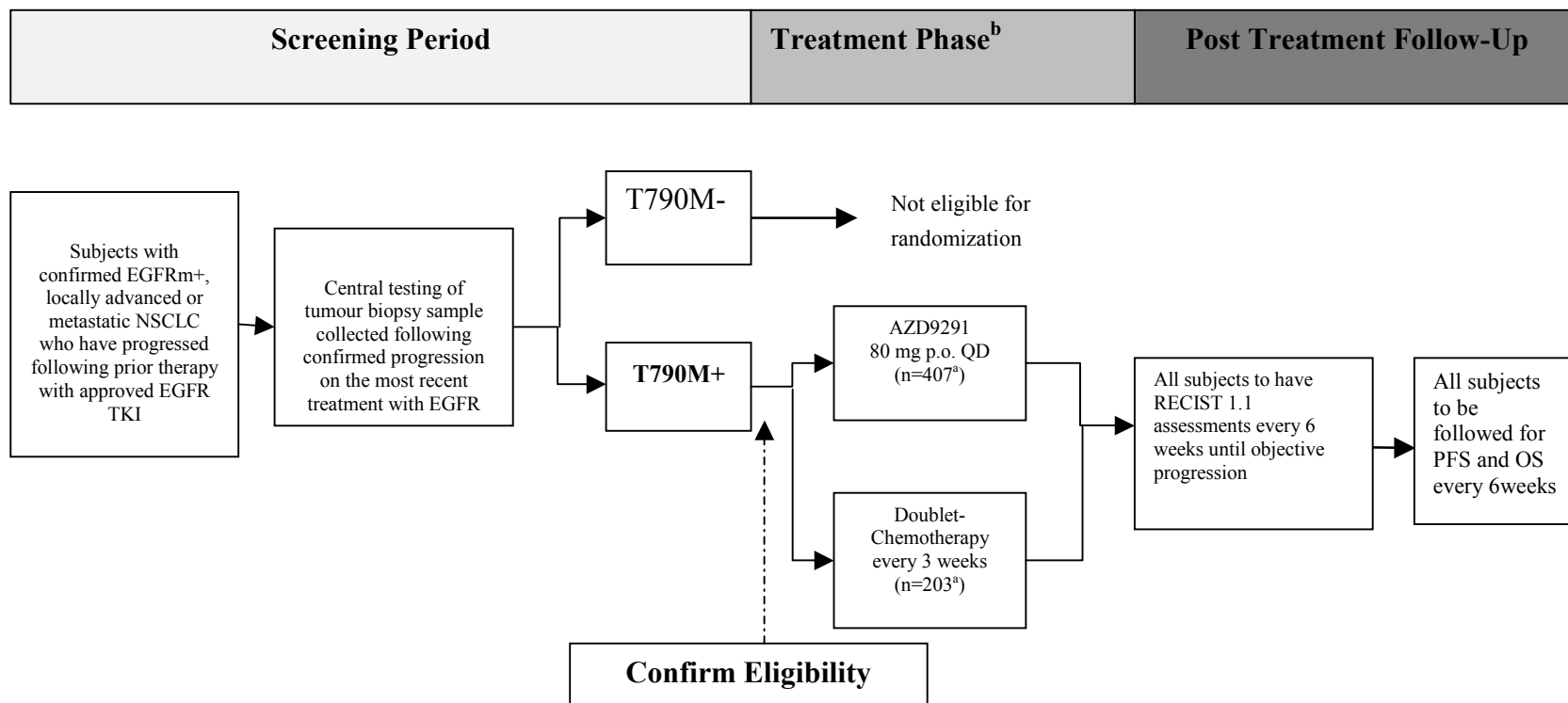
## **1.5 Study Design**

This is a phase III, open label, randomized study to assess the safety and efficacy of AZD9291 (80 mg, orally, once daily) versus platinum-based doublet chemotherapy in second-line patients with EGFR T790M mutation-positive, locally advanced or metastatic NSCLC, who have progressed following treatment with an approved epidermal growth factor tyrosine kinase inhibitor agent.

Subjects will have to provide a mandatory biopsy sample for central testing of T790M mutation status following confirmed disease progression on the most recent treatment regimen. The T790M mutation status of the subject's tumour must be determined by a designated central laboratory using the cobas<sup>®</sup> EGFR Mutation Test (Roche Molecular Systems).

Subjects should continue on study treatment until Response Evaluation Criteria in Solid Tumors version 1.1 (RECIST 1.1) defined progression or until a treatment discontinuation criterion is met. There is no maximum duration of treatment as subjects may continue to receive investigational product beyond RECIST 1.1 defined progression as long as they are continuing to show clinical benefit, as judged by the investigator.

**Figure 1 Study flow chart**



(a) Approximately 610 subjects will be randomized into the trial; from these approximately 407 subjects will be treated with AZD9291 and approximately 203 subjects will be treated with a platinum based doublet-chemotherapy.  
 (b) Subjects will be considered in “Treatment phase” at the time AZD9291/Doublet-Chemotherapy (study treatment) is started. Subjects will continue to receive study treatment until objective disease progression (according to RECIST 1.1). Subjects randomized to AZD9291 may continue to receive AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria

## 2. STUDY OBJECTIVES

### 2.1 Primary objective

Primary Objective:	Outcome Measure:
To assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy by assessment of Progression Free Survival (PFS).	PFS using investigator assessments according to Response Evaluation Criteria in Solid Tumours (RECIST 1.1). Sensitivity analysis of PFS using Blinded Independent Central Review (BICR).

### 2.2 Secondary objectives

Secondary Objective:	Outcome Measure:
To further assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy in terms of: <ul style="list-style-type: none"> <li>- Objective Response Rate (ORR)</li> <li>- Duration of Response (DoR)</li> <li>- Disease Control Rate (DCR)</li> <li>- Tumour shrinkage</li> <li>- Overall Survival (OS)</li> </ul>	ORR, DoR, DCR and tumour shrinkage using investigator assessments according to Response Evaluation Criteria in Solid Tumours (RECIST 1.1).  Analysis of overall survival.
To assess the effect of AZD9291 compared to platinum-based doublet chemotherapy on subjects' disease-related symptoms and health related quality of life (HRQoL).	EORTC QLQ-C30 and EORTC QLQ-LC13. EORTC QLQ-C30: Questionnaire consisting of 30 items measuring subjects general cancer symptoms and functioning. EORTC QLQ-LC13: A complementary questionnaire measuring lung cancer symptoms.
To characterise the pharmacokinetics (PK) of AZD9291 and metabolites in subjects receiving AZD9291.	PK exposure parameters derived from plasma concentrations of AZD9291, and metabolites AZ5104 and AZ7550.  PK Parameters (CL <sub>ss</sub> /F, C <sub>ss, min</sub> and C <sub>ss, max</sub> , AUC <sub>ss</sub> ) will be derived using population PK analysis and reported separately to the CSR. Data from this study may form part of a pooled analysis with data from other studies

### 2.3 Safety objectives

**Safety Objective:**

**Outcome Measure:**

<p>To assess the safety and tolerability profile of AZD9291 compared with platinum-based doublet chemotherapy.</p>	<p>Adverse events (graded by CTCAE v4)</p> <ul style="list-style-type: none"> <li>- Clinical chemistry, haematology and urinalysis</li> <li>- Vital signs (pulse and BP), Physical Examination, Weight</li> <li>- Central Digital ECG</li> <li>- Echocardiogram/MUGA (for LVEF)</li> <li>- WHO performance status</li> </ul>
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**2.4 Exploratory objectives**

Results from such analyses outlined below may be reported separately from the Clinical Study Report (CSR).

**Exploratory Objectives:**

**Outcome Measure:**

<p>To explore the relationship between PK and selected endpoints (which may include efficacy, safety and/or PRO), where deemed appropriate.</p>	<p>Correlation of PK with other primary /secondary/ exploratory endpoints in subjects treated with AZD9291.</p> <p>Results from such analyses will be reported separately from the Clinical Study Report (CSR). Data from this study may also form part of a pooled analysis with other AZD9291 studies.</p>
<p>To compare the effects of AZD9291 compared with platinum-based chemotherapy on post progression outcomes</p>	<p>Time from randomization to second progression (PFS2)</p> <p>Time to subsequent treatments</p> <p>Time to change in symptoms (including post progression assessments)</p>
<p>To further characterise the effects of AZD9291 on survival outcomes.</p>	<p>Assess the impact on overall survival of baseline potentially prognostic factors (e.g. tumour stage, performance status, sex, baseline LDH)</p> <p>Assess the impact on overall survival of subsequent treatments and other potential covariates (e.g. changes in performance status)</p>
<p>To compare adverse events by subject self-reporting of specific CTCAE symptoms (where applicable) between AZD9291 and chemotherapy.</p>	<p>Collection of approximately 28 PRO-CTCAE symptoms via an electronic device solution (in countries where language is available).</p>
<p>To compare AZD9291 treatment with platinum-based chemotherapy treatment on health state utility.</p>	<p>The EQ-5D-5L health state utility index will be used to derive health state utility based on subject reported data.</p>

**Exploratory Objectives:**

**Outcome Measure:**

<p>To compare health resource use associated with AZD9291 treatment with platinum-based chemotherapy treatment.</p>	<p>Health resource utilisation measures including hospitalization, outpatient visits, or emergency department visits.</p>
<p>To characterise the pharmacokinetics (PK) of AZD9291 and metabolites in cerebrospinal fluid (CSF).</p>	<p>Concentration of AZD9291, AZ5104 and AZ7550. Ratio of metabolites to AZD9291.  Ratio of CSF to plasma concentration.  Summaries of PK concentration data.</p>
<p>To collect and store deoxyribonucleic acid (DNA) for future exploratory research into genes/genetic variation that may influence PK or response to AZD9291, platinum-based doublet chemotherapy (ie, absorption, distribution, metabolism, excretion, safety and efficacy) and/or susceptibility to/development of cancers.</p>	<p>Correlation of polymorphisms with variation in PK, PD, safety or response observed in subjects treated with AZD9291 or comparator.  Data generated may be reported separately and may also form part of a pooled analysis with other AZD9291 studies.</p>
<p>To collect and store tumour samples and blood-based samples for potential for exploratory research into factors that may influence susceptibility to/development of NSCLC/cancer and/or response to AZD9291 (where response is defined broadly to include efficacy, tolerability or safety).</p>	<p>Analysis of key genetic and proteomic markers to include, but not limited to, EGFR mutations, HER2 &amp; CMET expression and/or amplification.  Collection of plasma samples to include, but not be limited to, extraction of circulating tumour DNA (ctDNA) for investigation of blood borne biomarkers. The sample may be used to investigate the relationship between PK and blood-borne biomarkers.  Samples may be analysed retrospectively. Any biomarker data generated may be reported separately and may also form part of a pooled analysis with other AZD9291 studies.</p>
<p>To collect and store plasma for isolation of ctDNA. Extracted ctDNA will be assessed for the presence of genetic aberrations including, but not limited to, EGFR mutations (T790M, L858R, etc). These samples may be shared with a diagnostic partner for development of a ctDNA test for T790M detection.</p>	<p>Retrospective/real-time analysis of EGFR (and other) mutations in ctDNA from all study subjects (mandatory).</p>



**Exploratory Objectives:**

**Outcome Measure:**

To collect and store residual CSF for potential exploratory research of factors that may influence development of NSCLC and/or response to AZD9291 (where response is defined broadly to include efficacy, tolerability or safety).	Collection of CSF for the investigation of PK and/or biomarkers. Samples may be analysed retrospectively.
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**3. SUBJECT SELECTION, SCREENING, RANDOMIZATION, RESTRICTIONS, DISCONTINUATION AND WITHDRAWAL**

Each subject should meet all of the inclusion criteria and none of the exclusion criteria for this study. Under no circumstances can there be exceptions to this rule.

**3.1 Inclusion criteria**

For inclusion in the study subjects should fulfil the following criteria:

1. Provision of signed and dated, written informed consent prior to any study specific procedures, sampling and analyses. *If a subject declines to participate in any voluntary exploratory research and/or genetic component of the study, there will be no penalty or loss of benefit to the subject and he/she will not be excluded from other aspects of the study.*
2. Female and male subjects aged at least 18 years. Subjects from Japan aged at least 20 years.
3. Subjects with histologically- or cytologically-documented NSCLC.
4. Locally advanced or metastatic NSCLC, not amenable to curative surgery or radiotherapy
5. Evidence of radiological disease progression following 1st line EGFR TKI (ie, 1<sup>st</sup> line treatment for advanced/metastatic disease) without any further treatment.
6. Subjects must have a diagnosis of “Nonsquamous Non-Small Cell Lung Cancer” in order to be eligible to receive treatment with pemetrexed platinum-based doublet chemotherapy in accordance with local prescribing information.
7. Documented EGFR mutation (at any time since the initial diagnosis of NSCLC) known to be associated with EGFR TKI sensitivity (including G719X, exon 19 deletion, L858R, L861Q).
8. Subjects must have central confirmation of tumour T790M+ mutation status from a tissue biopsy sample taken after documented disease progression on first line treatment with an approved, EGFR tyrosine kinase inhibitor.
9. WHO performance status 0-1 with no deterioration over the previous 2 weeks and a minimum life expectancy of 12 weeks.

10. At least one lesion, not previously irradiated and not chosen for biopsy during the study screening period, that can be accurately measured at baseline as  $\geq 10$ mm in the longest diameter (except lymph nodes which must have short axis  $\geq 15$ mm) with computerised tomography (CT) or magnetic resonance imaging (MRI) which is suitable for accurate repeated measurements.
11. Females should be using adequate contraceptive measures, should not be breast feeding and must have a negative pregnancy test prior to start of dosing if of child-bearing potential or must have evidence of non-child-bearing potential by fulfilling one of the following criteria at screening:
  - Post-menopausal defined as aged more than 50 years and amenorrhoeic for at least 12 months following cessation of all exogenous hormonal treatments
  - Women under 50 years old would be considered postmenopausal if they have been amenorrhoeic for 12 months or more following cessation of exogenous hormonal treatments and with Luteinizing Hormone (LH) and Follicle-Stimulating Hormone (FSH) levels in the post-menopausal range for the institution
  - Documentation of irreversible surgical sterilisation by hysterectomy, bilateral oophorectomy or bilateral salpingectomy but not tubal ligation.
12. Male subjects should be willing to use barrier contraception ie, condoms.
13. For inclusion in **optional genetic research**, subject must provide informed consent for genetic research.

If a subject declines to participate in any voluntary exploratory research and/or genetic component of the study, there will be no penalty or loss of benefit to the subject and he/she will not be excluded from other aspects of the study.

### 3.2 Exclusion criteria

Subjects should not enter the study if any of the following exclusion criteria are fulfilled:

1. Treatment with any of the following:
  - Treatment with more than one prior line of treatment for advanced NSCLC
  - Treatment with an EGFR-TKI (e.g., erlotinib, gefitinib or afatinib) within 8 days or approximately 5x half-life, whichever is the longer, of the first dose of study treatment. (If sufficient washout time has not occurred due to schedule or PK properties, an alternative appropriate washout time based on known duration and time to reversibility of drug related adverse events could be agreed upon by AstraZeneca and the Investigator)
  - Any cytotoxic chemotherapy, investigational agents or other anticancer drugs from a previous treatment regimen or clinical study within 14 days of randomization
  - Previous treatment with AZD9291, or a 3<sup>rd</sup> generation EGFR TKI

- Major surgery (excluding placement of vascular access) within 4 weeks of randomization
  - Radiotherapy treatment to more than 30% of the bone marrow or with a wide field of radiation within 4 weeks of randomization
  - Subjects currently receiving (or unable to stop use at least 1 week prior to receiving the first dose of AZD9291) medications or herbal supplements known to be potent inhibitors or inducers of CYP3A4 (Appendix F)
  - Treatment with an investigational drug within five half-lives of the compound
2. Any unresolved toxicities from prior therapy greater than CTCAE grade 1 (with the exception of alopecia grade 2) at the time of starting study treatment.
  3. Spinal cord compression or brain metastases unless asymptomatic, stable and not requiring steroids for at least 4 weeks prior to start of study treatment.
  4. Any evidence of severe or uncontrolled systemic diseases, including uncontrolled hypertension and active bleeding diatheses, which in the investigator's opinion makes it undesirable for the subject to participate in the trial or which would jeopardise compliance with the protocol, or active infection including hepatitis B, hepatitis C and human immunodeficiency virus (HIV). Screening for chronic conditions is not required.
  5. Refractory nausea and vomiting, chronic gastrointestinal diseases, inability to swallow the formulated product or previous significant bowel resection that would preclude adequate absorption of AZD9291.
  6. Any of the following cardiac criteria:
    - Mean resting corrected QT interval (QTc) > 470 msec, obtained from 3 electrocardiograms (ECGs)
    - Any clinically important abnormalities in rhythm, conduction or morphology of resting ECG e.g., complete left bundle branch block, third degree heart block, second degree heart block, PR interval >250msec
    - Any factors that increase the risk of QTc prolongation or risk of arrhythmic events such as heart failure, hypokalaemia, congenital long QT syndrome, family history of long QT syndrome or unexplained sudden death under 40 years of age in first degree relatives or any concomitant medication known to prolong the QT interval.
  7. Past medical history of ILD, drug-induced ILD, radiation pneumonitis which required steroid treatment, or any evidence of clinically active interstitial lung disease.

8. Inadequate bone marrow reserve or organ function as demonstrated by any of the following laboratory values:
    - Absolute neutrophil count  $< 1.5 \times 10^9/L$
    - Platelet count  $< 100 \times 10^9/L$
    - Haemoglobin  $< 90 \text{ g/L}$
    - Alanine aminotransferase (ALT)  $> 2.5$  times the upper limit of normal (ULN) if no demonstrable liver metastases or  $> 5$  times ULN in the presence of liver metastases
    - Aspartate aminotransferase (AST)  $> 2.5$  times ULN if no demonstrable liver metastases or  $> 5$  times ULN in the presence of liver metastases
    - Total bilirubin  $> 1.5$  times ULN if no liver metastases or  $> 3$  times ULN in the presence of documented Gilbert's Syndrome (unconjugated hyperbilirubinaemia) or liver metastases
    - Creatinine  $> 1.5$  times ULN concurrent with creatinine clearance  $< 50 \text{ ml/min}$  (measured or calculated by Cockcroft and Gault equation); confirmation of creatinine clearance is only required when creatinine is  $> 1.5$  times ULN.
  9. History of hypersensitivity of AZD9291 (or drugs with a similar chemical structure or class to AZD9291) or carboplatin or pemetrexed or cisplatin, or any excipients of these agents.
  10. Women who are breast-feeding.
  11. Males and females of reproductive potential who are not using an effective method of birth control and females who are pregnant or breastfeeding or have a positive (urine or serum) pregnancy test prior to study entry.
  12. Contraindication for pemetrexed and cisplatin/carboplatin (e.g. predominantly squamous cell histology).
  13. Involvement in the planning and conduct of the study (applies to AstraZeneca staff or staff at the study site).
  14. Judgment by the investigator that the subject should not participate in the study if the subject is unlikely to comply with study procedures, restrictions and requirements.
- In addition, the following is considered a criterion for exclusion from the exploratory genetic research:
15. Previous allogenic bone marrow transplant.

16. Non-leukocyte depleted whole blood transfusion within 120 days of the date of the genetic sample collection.

Procedures for withdrawal of incorrectly randomized subjects see Section 3.4.

### 3.3 Subject screening and randomization

Investigator(s) should keep a subject pre-screening log of subjects considered for the study.

The Investigator(s) will:

1. Obtain signed informed consent from the potential subject, or their guardian or legal representative before any study specific procedures are performed.
2. Determine subject eligibility. See Section 3.1 and 3.2.
3. Obtain a unique 7-digit **enrolment** number (E-code) through the Interactive Voice Response System (IVRS)/ Interactive Web Response System (IWRS) in the following format ECCNN3XX: CC being the country code, NN being the centre number and 3XX being the subject enrolment code at the centre into AURA3 study.

At Visit 2, once the subject is deemed eligible, the Principal Investigator or suitably trained delegate will:

4. Obtain a unique randomization number via IVRS/IWRS.

Randomization codes will be assigned as subjects become eligible for randomization.

If a subject is re-screened, always a new E-code will be assigned.

If a subject withdraws from participation in the study, then his/her enrolment/randomization code cannot be reused.

Note: Section 4.1 describes the procedures to be carried out during screening/enrolment period. Section 4.2 describes procedures to be carried out during randomization period.

### 3.4 Procedures for handling incorrectly randomized subjects

Subjects who fail to meet the eligibility criteria should not, under any circumstances, be randomized or receive study medication. There can be no exceptions to this rule. Subjects who are randomized, but subsequently found not to meet all the eligibility criteria must not be initiated on treatment, and must be withdrawn from the study.

Where a subject does not meet all the eligibility criteria but is started on treatment in error, the Investigator should inform the AstraZeneca study physician immediately, and a discussion should occur between the AstraZeneca study physician and the investigator regarding whether to continue or discontinue the subject from treatment. The AstraZeneca study physician must ensure all decisions are appropriately documented.

### 3.5 Methods for assigning treatment groups

Suitable subjects will be centrally randomized to receive either AZD9291 80mg QD p.o. or platinum-based doublet chemotherapy (pemetrexed 500mg/m<sup>2</sup> + carboplatin AUC5 or pemetrexed 500mg/m<sup>2</sup> + cisplatin 75mg/m<sup>2</sup>) on Day 1 of every 21d cycle in a 2:1 (AZD9291: platinum-based doublet chemotherapy) ratio using the IVRS/IWRS system. The investigational site must declare (in IVRS/IWRS), prior to randomization, their choice of chemotherapy for that subject.

Subjects will be stratified at randomization based on ethnicity (Asian/Non-Asian).

### 3.6 Restrictions

The following restrictions apply while the subject is receiving AZD9291 and for the specified times before and after:

1. Females of child-bearing potential should use reliable methods of contraception from the time of screening until 3 months after discontinuing study treatment. Acceptable methods of contraception include total and true sexual abstinence, tubal ligation, hormonal contraceptives that are not prone to drug-drug interactions (IUS Levonorgestrel Intra Uterine System (Mirena), Medroxyprogesterone injections (Depo-Provera)), copper-banded intra-uterine devices and vasectomised partner. All hormonal methods of contraception should be used in combination with the use of a condom by their male sexual partner for intercourse. For subjects receiving platinum-based doublet-chemotherapy, the reliable methods of contraception chosen should be in accordance with the local prescribing label.
2. Male subjects should be asked to use barrier contraceptives (ie, by use of condoms) during sex with all partners during the trial and for a washout period of 3 months. Subjects should not father a child for 6 months after completion of study treatment. Subjects should refrain from donating sperm from the start of dosing until 6 months after discontinuing study treatment. If male subjects wish to father children they should be advised to arrange for freezing of sperm samples prior to the start of study treatment. For subjects receiving platinum-based doublet chemotherapy, above recommendations should be in accordance with the local prescribing label.
3. All subjects must try to avoid concomitant use of medications, herbal supplements and/or ingestion of foods with known potent inhibitors or inducers of CYP3A4 whenever feasible. Subjects may receive any medication that is clinically indicated for treatment of adverse events. Such drugs must have been discontinued for an appropriate period before they enter screening and for a period of 3 months after the last dose of AZD9291. All concomitant medications should be captured on the eCRF. Guidance on medicines to avoid, medications that require close monitoring and on washout periods is provided (see Appendix F).
4. If medically feasible, subjects taking regular medication, with the exception of potent inhibitors or inducers of CYP3A4 (see above), should be maintained on it

throughout the study period. Subjects randomized to AZD9291 taking concomitant medications whose disposition is dependent upon CYP3A4, CYP2C8 or CYP3A4 and Breast cancer resistance protein (BCRP) and which have a narrow therapeutic index should be closely monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst receiving AZD9291. Subjects taking concomitant medications whose disposition is dependent upon CYP3A4, CYP1A2, CYP2C or p-glycoprotein and which have a narrow therapeutic index should be closely monitored for reduction in therapeutic activity as a result of the reduced exposure of the concomitant medication whilst receiving AZD9291. Guidance on medications to avoid, medications that require close monitoring and on washout periods should be provided (see Appendix F).

Up to 3 fold increase in exposure may occur in statin exposure when coadministered with AZD9291. It is recommended that the starting and maintenance dose of statins should be as low as possible and should be guided by the statin label. Monitoring of low-density lipoprotein (LDL) cholesterol levels is advised. If the subject experiences any potentially relevant adverse events suggestive of muscle toxicity including unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever, the statin should be stopped, creatine kinase (CK) levels should be checked, and any appropriate further management should be taken.

Subjects taking warfarin should be monitored regularly for changes in prothrombin time or international normalized ratio (INR).

5. Subjects who wear contact lenses must discontinue wearing their lenses if they have any mild to moderate eye symptoms (CTCAE grade  $\leq 2$ ) while receiving treatment with AZD9291 until at least one week after symptoms have resolved. If a subject has a recurrence of eye symptoms or experiences any severe (CTCAE grade  $\geq 3$ ) ocular events they must discontinue wearing their contact lenses until at least one week after treatment with AZD9291 is permanently discontinued. Subjects must not use any eye drops or ointment for treatment of eye symptoms, unless agreed by a study doctor, at any time during the study until 1 week after AZD9291 has been permanently discontinued. Subject should consult the clinic promptly if they have any concerns.

### **3.7 Discontinuation from study treatment**

Subjects may be discontinued from study treatment in the following situations:

- Subject decision. The subject is at any time free to discontinue treatment, without prejudice to further treatment
- Adverse Event
- Pregnancy
- Severe non-compliance with the study protocol as judged by the investigator and/or AstraZeneca
- Subject incorrectly initiated on study treatment

- Objective disease progression or subject is no longer receiving clinical benefit
- Lost to follow up.

### **3.7.1 Procedures for discontinuation of a subject from study treatment**

The Principal Investigator/Investigator will perform the best possible observation(s), test(s) and evaluation(s) as well as give appropriate medication and all possible measures for the safety of the subject. They will also immediately inform AstraZeneca of the withdrawal. Adverse events will be followed up (See Section 6); electronic questionnaire devices (e.g., for patient reported outcomes) and all unused study drug should be returned by the subject or representative (e.g. caretaker, family member).

Any subject who discontinues study treatment for reasons other than objective disease progression should have tumour assessments performed as scheduled in the protocol (see Table 1 or Table 2) until objective disease progression is documented or death occurs, unless consent is withdrawn. Study procedures related to PROs, SAEs and anti-cancer treatment must be captured until permanent withdrawal from the study.

If a subject is withdrawn from study, see Section 3.8.

## **3.8 Criteria for withdrawal**

At any time, subjects are free to discontinue study treatment or withdraw from the study (ie, study treatment and assessments), without prejudice to further treatment. A subject that decides to discontinue investigational product will always be asked about the reason(s) and the presence of any adverse events. If possible, they will be seen and assessed by an Investigator(s). Adverse events will be followed up (See Section 6); electronic questionnaire devices (ePRO) and all investigational products should be returned by the subject or representative. The term withdrawal from the study refers to both discontinuation from study treatment and study assessments.

Reasons for withdrawal from the study:

- Eligibility criteria not fulfilled
- Death
- Withdrawal of consent.

If a subject wishes to withdraw their consent to both treatment and study assessments, they should be asked if they are willing to continue with survival follow-up (which can be conducted by telephone). If a subject wishes to withdraw their consent to further participation in the study entirely, including survival follow-up, this should be clearly documented in the subject notes and in the clinical study database (eCRF).

The status of ongoing, withdrawn (from the study) and “lost to follow-up” subjects at the time of an overall survival analysis should be obtained by the site personnel by checking the subjects notes, hospital records, contacting the subjects general practitioner and checking publicly available death registries. In the event that the subject has actively withdrawn consent



to the processing of their personal data, the vital status of the subject can be obtained by site personnel from publicly available resources where it is possible to do so under applicable local laws.

Withdrawn subjects will not be replaced.

### **3.8.1 Screen/enrolment failures**

Screen/enrolment failures are subjects who do not fulfil the eligibility criteria for the study, and therefore must not receive AZD9291. These subjects should have the reason for study withdrawal recorded as “Eligibility Criteria not fulfilled” (ie, subject does not meet the required inclusion/exclusion criteria). This reason for study withdrawal is only valid for screen/enrolment failures (not subjects who have received investigational product).

### **3.8.2 Withdrawal of the informed consent**

Subjects are free to withdraw from the study at any time (investigational product and assessments), without prejudice to further treatment.

A subject who withdraws consent will always be asked about the reason(s) and the presence of any adverse events (AE). The Investigator will follow up AEs outside of the clinical study. The subject or representative will return the ePRO device and unused AZD9291 tablets.

If a subject withdraws from participation in the study, then his/her enrolment/randomization code cannot be reused.

## **3.9 Termination of the study**

The study may be stopped if, in the judgment of AstraZeneca, trial subjects are placed at undue risk because of clinically significant findings that:

- meet individual stopping criteria or are otherwise considered significant
- are assessed as causally related to investigational product
- are not considered to be consistent with continuation of the study.

Regardless of the reason for termination, all data available for the subject at the time of discontinuation of follow-up must be recorded in the eCRF. All reasons for discontinuation of treatment must be documented.

In the case of terminating the study, the Sponsor will ensure that adequate consideration is given to the protection of the subjects’ interests.

## **4. STUDY PLAN AND TIMING OF PROCEDURES**

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> + D1	NA	NA	NA	NA	
Day	-28	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days)	NA	0	±2	±2	±7	±7	±7	±7	NA	+7	± 7	± 7	<b>SECTION:</b>
Informed consent <sup>c</sup>	X												3.3, 4.1, 4.2, 4.3
Submit tumour tissue sample for mutation analysis <sup>d</sup>	X												4.1 & 5.6
Collect/submit optional tumour biopsy for exploratory research & diagnostic development	X								X <sup>u</sup>		X <sup>u</sup>		4.1 & 5.6
Archival tumour tissue <sup>e</sup>	X												5.6
Demography & baseline characteristics	X												4.1
Medical/surgical history	X												4.1
Inclusion/exclusion criteria	X												3
Physical examination, including weight	X	X <sup>f</sup>			X	X	X	X	X				5.2.3, 5.2.6.1
Height	X												5.2.6.1
WHO Performance status	X	X			X	X	X	X	X		X	X	4.1
Pregnancy test (pre-menaopausal females only)	X												5.2.1

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> + D1	NA	NA	NA	NA	
Day	-28	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days)	NA	0	±2	±2	±7	±7	±7	±7	NA	+7	± 7	± 7	<b>SECTION:</b>
Ophthalmologic assessment	X	← as clinically indicated →											5.2.7.1
Plasma sample for ctDNA <sup>m</sup> and blood borne biomarkers	X <sup>h</sup>	X	X	X	X	X	X	X	← every 6 weeks in line with RECIST assessments <sup>i</sup> →				5.6.2
Vital signs (pulse and BP) <sup>m</sup>	X	X	X	X	X	X	X	X	X				5.2.6
Clinical chemistry/ Haematology/Urinalysis <sup>m</sup>	X <sup>f</sup>	X	X	X	X	X	X	X	X				5.2.1
PK blood sample (including metabolites)		X				X	X C5 only	X <sup>v</sup>					5.4
Digital ECG <sup>g</sup>	X	X	X	X	X	X	X	X	X				5.2.4
Echocardiogram/MUGA (for LVEF)	X	← every 12 weeks relative to randomization →											5.2.5
Optional genetic consent and sample	X <sup>j</sup>												5.5
Optional CSF sample					X (once only) <sup>k</sup>								5.4.4
Tumour assessments <sup>l</sup> (RECIST v1.1)	X	← every 6 weeks relative to randomization until disease progression →											4.1, 4.2, 4.3.3, 5.1.1, 5.1.2
EORTC QLQ-C30 and EQ-5D-5L (by e-device)		X <sup>m</sup>	← every 6 weeks relative to randomization →						X		X <sup>n</sup>	X <sup>n</sup>	5.3.2

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrollment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section	
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b+</sup> D1	NA	NA	NA	NA		
Day	-28	1	8	15	22	43	64-106	127+	NA	NA	NA	NA		
Window (days)	NA	0	±2	±2	±7	±7	±7	±7	NA	+7	±7	±7	SECTION:	
EORTC QLQ LC13 (by e-device)		X <sup>m</sup>	← weekly relative to randomization →		← every 3 weeks relative to randomization →				X		X <sup>o</sup>	X <sup>o</sup>	5.3.2	
PRO-CTCAE (by e-device) <sup>p</sup>		X <sup>m</sup>	← weekly for first 18 weeks of treatment →					X <sup>q</sup>	X		X <sup>o</sup>	X <sup>o</sup>	5.3.2	
Healthcare Resource Use			← asked for at every visit →											5.3.2.5
IVRS/IWRS	X	X			X	X	X	X <sup>b</sup>	X				3.3, 3.5	
Dispense study medication		X			X	X	X	X <sup>b</sup>					3.3	
Dose with AZD9291			← Daily dosing →											7.1
Concomitant medication & procedures			← →											7.7
Adverse events			← →									X <sup>f</sup>		6.3 & 6.4
Survival Status												X <sup>s</sup>	4.3.4	
Anti-cancer treatment	X										X	X <sup>s</sup>	4.2	
Subsequent response /progression data												X <sup>t</sup>	5.7.5	

- a A cycle is defined as 21-day treatment period
- b Visit schedule changes after Cycle 7 Day 1 from every 21 days (3 weeks) to every 42 days (6 weeks)
- c Consent may be taken prior to 28-day window if required. Screening period will then start with first study-related assessment
- d Taken following progression on the latest line of therapy
- e Archival tumour sample only to be submitted after T790M positive status confirmed by central testing. Not required for T790M negative patients
- f If screening assessments have been performed within 14 days prior to starting study treatment they do not have to be repeated on Visit 2 if the subject's condition has not changed
- g There is a potential to move from centrally reviewed to locally reviewed ECGs upon review of QT data of approximately 100 subjects
- h To be taken at the same time as the screening biopsy is taken or prior to mutation screening. All screening plasma samples required by AstraZeneca, regardless of the outcome of the mutation screening
- i Collect every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation in absence of disease progression). If patient discontinues from study, please collect a sample at treatment discontinuation and at Progression follow-up
- j If for any reason the sample is not drawn prior to randomization it may be taken at any visit until the last study visit
- k To be obtained at one time point at any time from Cycle 2 Day 1 onwards
- l At least one lesion, not previously irradiated and not chosen for biopsy during the study-screening period, that can be accurately measured
- m To be completed pre-dose
- n Assess every 6 weeks relative to randomization until end of study (including survival follow-up period) and at the time of progression
- o Assess every 3 weeks relative to randomization until end of study (including survival follow-up period) and at the time of progression
- p PRO-CTCAE will only be administered in those countries where a linguistically validated version exists
- q Assessed at Cycle 7 Day 1 then every 3 weeks relative to randomization thereafter until end of study (including survival follow-up period) and at the time of progression
- r Following AZD9291 discontinuation, SAEs considered related to study procedures should continue to be collected until disease progression
- s Survival status including anti-cancer treatment to be performed every 6 weeks (relative to randomization) following disease progression or withdrawal from treatment. [Note: Additional survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis.]
- t Record subsequent response/progression data every 6 weeks until first confirmed disease progression on a subsequent treatment
- u Discontinuation biopsy can be taken at discontinuation or progression, whichever comes first
- v After Cycle 7, every other cycle up to and including Cycle 13

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> + D1	NA	NA	NA	NA	
Day	-28	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days)	NA	±7	±2	±2	±7	±7	±7	±7	NA	+7	±7	±7	SECTION:
Informed consent <sup>c</sup>	X												3.3, 4.1, 4.2, 4.3
Submit tumour tissue sample for mutation analysis <sup>d</sup>	X												4.1 & 5.6
Collect and submit optional tumour biopsy for exploratory research and diagnostic development	X								X <sup>u</sup>		X <sup>u</sup>		4.1 & 5.6
Archival tumour tissue <sup>e</sup>	X												5.6
Demography & baseline characteristics	X												4.1
Medical/surgical history	X												4.1
Inclusion/exclusion criteria	X												3
Physical examination, including weight	X	X <sup>g</sup>			X	X	X	X <sup>v</sup>	X				5.2.3, 5.2.6.1
Height	X												5.2.6.1
WHO Performance status	X	X			X	X	X	X	X		X	X	4.1

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b+</sup> D1	NA	NA	NA	NA	
Day	-28	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days)	NA	±7	±2	±2	±7	±7	±7	±7	NA	+7	±7	±7	SECTION:
Pregnancy test (pre-menopausal females only)	X												5.2.1
Ophthalmologic assessment	X	← as clinically indicated →											5.2.7.1
Vital signs (pulse and BP) <sup>g</sup>	X	X	X	X	X	X	X	X	X				5.2.6
Clinical chemistry/ Haematology/Urinalysis <sup>g</sup>	X <sup>m</sup>	X	X	X	X	X	X	X <sup>v</sup>	X				5.2.1
Plasma sample for ctDNA <sup>m</sup> and blood borne biomarkers	X <sup>h</sup>	X	X	X	X	X	X		← every 6 weeks in line with RECIST assessments <sup>i</sup> →			5.6.2	
Digital ECG <sup>k</sup>	X	X	X	X	X	X	X	X <sup>v</sup>	X				5.2.4
Echocardiogram/MUGA (for LVEF)	X	← every 12 weeks relative to randomization →											5.2.5
Optional genetic consent and sample	X <sup>j</sup>												5.5
Tumour assessments (RECIST v1.1) <sup>l</sup>	X	← every 6 weeks relative to randomization until disease progression →											4.1, 4.2, 4.3.3, 5.1.1, 5.1.2
EORTC QLQ-C30 and EQ-5D-5L (by e-device)		X <sup>m</sup>	← every 6 weeks relative to randomization →						X		X <sup>n</sup>	X <sup>n</sup>	5.3.2
EORTC QLQ LC13 (by e-device)		X <sup>m</sup>	← weekly relative to randomization →		← every 3 weeks relative to randomization →				X		X <sup>o</sup>	X <sup>o</sup>	5.3.2

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrollment	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b+</sup> D1	NA	NA	NA	NA	
Day	-28	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days)	NA	±7	±2	±2	±7	±7	±7	±7	NA	+7	±7	±7	<b>SECTION:</b>
PRO-CTCAE (by e-device) <sup>p</sup>		X <sup>m</sup>	← weekly for first 18 weeks of treatment →					X <sup>q</sup>	X		X <sup>o</sup>	X <sup>o</sup>	5.3.2
Healthcare Resource Use		← asked for at every visit →											5.3.2.5
IVRS/TWRS	X	X							X				3.3, 3.5, 7.2
Folic Acid administration (pre-treatment)		5-7d prior to 1 <sup>st</sup> infusion	← Daily during treatment period →										4.2
Vitamin B12 (pre-treatment)		Within 7d prior to 1 <sup>st</sup> infusion	← Every 9 weeks during treatment period →										4.2
Corticosteroid administration (pre-treatment)		← On the day prior to, on the day, and on the day after infusion →											4.2
Platinum-based Doublet Chemotherapy		X <sup>f</sup>			X	X	X						3.3, 7.2
Concomitant medication & procedures		← →											7.7
Adverse events		← →									X <sup>r</sup>		6.3 & 6.4



**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b+</sup> D1	NA	NA	NA	NA	
Day	-28	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days)	NA	±7	±2	±2	±7	±7	±7	±7	NA	+7	± 7	± 7	<b>SECTION:</b>
Survival Status												X <sup>s</sup>	4.3.4
Anti-cancer treatment	X										X	X <sup>s</sup>	4.2
Subsequent response /progression data												X <sup>t</sup>	5.7.5

- <sup>a</sup> A cycle is defined as 21-day treatment period
- <sup>b</sup> Visit schedule changes after Cycle 7 Day 1 from every 21 days (3 weeks) to every 42 days (6 weeks). Platinum-based doublet chemotherapy will be administered every 21 days from previous cycle day 1. Subjects can continue to receive platinum-based doublet-chemotherapy until matching discontinuation criteria (see section 3.9) or up to a total of 6 cycles or until progression (whichever occurs first). Each cycle treatment may be interrupted maximum 14 days for safety reasons. Subjects whose disease has not progressed after four cycles of platinum-based first-line chemotherapy may receive pemetrexed maintenance therapy.
- <sup>c</sup> Consent may be taken prior to 28-day window if required. Screening period will then start with first study-related assessment
- <sup>d</sup> Taken following progression on the latest line of therapy
- <sup>e</sup> Archival tumour sample only to be submitted after T790M positive status confirmed by central testing. Not required for T790M negative patients
- <sup>f</sup> Chemotherapy may start within 1 week after randomization to allow Vitamin B12, Folic acid and corticosteroid treatment
- <sup>g</sup> If screening assessments have been performed within 14 days prior to starting study treatment they do not have to be repeated on Visit 2 if the subject's condition has not changed
- <sup>h</sup> To be taken at the same time as the screening biopsy is taken or prior to mutation screening. All screening plasma samples required by AZ, regardless of the outcome of the mutation screening
- <sup>i</sup> Collect every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation in absence of disease progression). If patient discontinues from study, please collect a sample at treatment discontinuation and at Progression follow-up

- j If for any reason the sample is not drawn prior to randomization it may be taken at any visit until the last study visit
- k There is a potential to move from centrally reviewed to locally reviewed ECGs upon review of QT data of approximately 100 subjects
- l At least one lesion, not previously irradiated and not chosen for biopsy during the study-screening period, that can be accurately measured
- m To be completed pre-dose
- n Assess every 6 weeks relative to randomization until end of study (including survival follow-up period) and at the time of progression
- o Assess every 3 weeks relative to randomization until end of study (including survival follow-up period) and at the time of progression
- p PRO-CTCAE will only be administered in those countries where a linguistically validated version exists
- q Assessed at Cycle 7 Day 1 then every 3 weeks relative to randomization thereafter until end of study (including survival follow-up period) and at the time of progression
- r Following chemotherapy discontinuation, SAEs considered related to study procedures should continue to be collected until disease progression
- s Survival status including anti-cancer treatment to be performed every 6 weeks (relative to randomization) following disease progression or withdrawal from treatment. Additional survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis
- t Record subsequent response/progression data every 6 weeks until first confirmed disease progression on a subsequent treatment
- u Discontinuation biopsy can be taken at discontinuation or progression, whichever comes first
- v After V12 every 6 weeks

## 4.1 Screening period

It is recommended the screening assessments be performed in a stepwise process beginning with the confirmation of T790M mutation status as determined by the designated central laboratory. However, screening assessments may be done in parallel to the T790M mutation assessment, as appropriate. Procedures will be performed according to the Study Plan ([Table 1](#) or [Table 2](#)). Tumour assessments and other clinical data obtained as standard of care prior to consent may be used for the study, provided the assessments fall within the protocol specified period prior to randomization.

At screening, consenting subjects are assessed to ensure that they meet eligibility criteria. Subjects who do not meet these criteria must not be randomized into the study. Demographic data and other characteristics will be recorded and will include date of birth or age, gender, smoking history, race and/or ethnicity according to local regulations.

Subjects will be considered in screening/enrolment period until all Visit 1 assessments are completed and eligibility is confirmed. Subjects will be considered randomized and in the treatment period once study treatment has been initiated.

### **Written informed consent/Assignment of subject enrolment/randomization number:**

- Each potential subject will provide written informed consent prior to starting any study specific procedures (see [Section 10.4](#)).
- All subjects will be required to provide consent to supply a tumour biopsy sample taken during the screening period for entry into this study. This consent is included in the main subject informed consent form. Please note that subjects are asked to provide separate consent for provision of optional tumour biopsy samples, if willing (see [section 5.6](#)).
- Additionally, subjects will be given the option to consent to the host pharmacogenetics research component and the CSF analysis of the study in separate Informed Consent Forms (ICF).
- As per standard, enrolment number (E-code) is assigned to the subject and Principal Investigator or delegate should perform screening/enrolment call (see [section 3.3](#)). During the randomization visit (Visit 2), subject will receive randomization number and randomized arm information via IVRS/IWRS. For chemotherapy, administration may occur approximately 7 days after randomization due to pre-treatment requirements.

### **Mandatory screening tumour biopsy sample for mutation analysis:**

Tumour sample must be formalin fixed and paraffin embedded (FFPE) and must be biopsied following progression on the latest line of therapy. Samples may be collected from primary or

metastatic tumour deposits. Sites should ship the FFPE tumour sample to the testing laboratory as soon as it is available. Blocks must be provided wherever possible. If this is not possible, 10-20 slides of freshly prepared unstained 5-micron sections from this screening tumour block may be provided. See Section 5.6.

The mandatory screening tumour biopsy must not be taken from a previously irradiated lesion or the lesion(s) selected for Inclusion criterion # 10. This biopsy sample is not subject to the 28-day screening window; if tissue is already available from a biopsy taken since documentation of disease progression on the most recent treatment regimen then there is no need for a further biopsy as this sample can be submitted for T790M mutation status. If the first biopsy is not confirmed as T790M mutation positive (ie, due to test failure or if test is negative for the T790M mutation) a further biopsy sample may be submitted for central testing.

**Optional second tissue sample for diagnostic development:**

The optional second tissue sample (FFPE) may be provided to facilitate diagnostic development and pre-market approval of the diagnostic test. This should be obtained at the same time and as part of the same procedure as the mandatory screening biopsy. Optional tumour biopsy tissue may also be used for companion diagnostic development.

**The following will be collected at screening:**

**Demography:**

Demographic data and other characteristics will be recorded and will include date of birth or age, gender, smoking history, race and/or ethnicity according to local regulations.

**Medical/surgical history:**

A standard medical and surgical history will be obtained.

**Physical examination including vital signs (pulse and BP), height, weight:**

Physical examination includes an assessment of the following: general appearance, respiratory, cardiovascular, skin, head and neck (including ears, eyes, nose and throat), abdomen, lymph nodes, thyroid, musculo-skeletal (including spine and extremities) and neurological systems.

**Ophthalmologic assessment:**

Measurements of best-corrected visual acuity, intraocular pressure and slit-lamp fundoscopy should be obtained.

**Eligibility criteria:**

Subjects must not be randomized unless all eligibility criteria have been fully met.

**World Health Organization (WHO) Performance Status:**

Performance status will be assessed at the visits indicated in the Study Plan (see [Table 1](#) and [Table 2](#)) according to WHO criteria as follows:

0 = Fully active, able to carry out all pre-disease activities without restrictions

- 1 = Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature e.g., light housework, office work
- 2 = Ambulatory and capable of self-care, but unable to carry out any work activities. Up and about more than 50% of waking hours
- 3 = Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
- 4 = Completely disabled, cannot carry on self-care, totally confined to bed or chair.

**Pregnancy test:**

Pregnancy test (blood or urine tests are acceptable based on the site's standard clinical practice) for women of childbearing potential only.

**Archival tumour sample (if available):**

All subjects will be asked to provide consent to supply a sample of their archival tumour blocks if a sample taken at the time of diagnosis is available. Any archival biopsy samples taken following previous lines of therapy will also be requested, if available. In each case the previous subject treatment must be clearly indicated for each sample provided.

Tumour samples will preferably be in the form of a formalin fixed paraffin embedded block (sample derived from the diagnostic tumour or a metastatic site). If this is not possible, 12-20 slides of freshly prepared unstained 5 micron sections from the archival tumour block may be provided.

**Laboratory safety assessments:**

Blood and urine samples for determination of clinical chemistry, haematology, and urinalysis should be taken. See Section 5.2.1.

If clinical chemistry, haematology and urinalysis assessments have been performed within 14 days pre-randomization they do not have to be repeated prior to commencing treatment on visit 2 Day 1 if the subject's condition has not changed (no new treatment during this period of time, no new complication or aggravation).

**Plasma for ctDNA and blood borne biomarkers:**

All subjects will be requested to provide two plasma samples at screening and one sample pre-dose Day1. All plasma samples should be sent to the AstraZeneca (AZ) appointed Clinical Research Organisation (CRO) for retrospective analysis (regardless of the outcome of the EGFR tissue test). See Section 5.6.2.

**Screening plasma samples:**

All subjects are required to provide a plasma sample regardless of T790M mutation status.

**Pharmacogenetics (optional):**

Optional genetic blood sample should be taken from consenting subjects at screening. If for any reason the sample is not drawn prior to dosing it may be taken at any visit until the last study visit. See Section 5.5.

### **Tumour Assessments (RECIST 1.1):**

The imaging modalities used for RECIST 1.1 assessments will be CT or MRI scans of chest and abdomen (including liver and adrenal glands). Any other sites where disease is suspected or known at baseline must be also imaged. Baseline assessments should be performed as close as possible to the start of treatment (and prior to randomization). See Section 5.1.1.

All imaging assessments including unscheduled visit scans should be collected on an ongoing basis and sent to the AZ appointed CRO to enable central analyses if required.

According to the therapy area standards, base-line assessment should be within 28days of the study treatment start and follow-up assessments will be relative to the date of randomization.

Subjects with known or suspected brain metastases at screening should have a CT/MRI of the brain prior to starting study treatment. These subjects should be followed up on study with repeated CT/MRI assessment, using the same frequency as RECIST assessments. The same modality for CT/MRI should be used for a subject throughout the study. Brain metastases will be assessed as non-target lesions. See Section 5.1.1.

### **Anti-cancer treatment:**

All prior anti-cancer therapy will be collected at screening and end of the study and recorded in the eCRF.

### **Concomitant medication use:**

Information on any treatment in the 4 weeks prior to starting study treatment and all concomitant treatments given during the study, with reasons for the treatment, will be recorded in the Case Report Form (CRF). See Section 7.7

### **Digital ECG:**

Three 12-lead ECG should be performed. See section 5.2.4.

### **Echocardiogram/ MUGA:**

An Echocardiogram or MUGA scan to assess LVEF will be performed at screening (prior to study medication). The modality of the cardiac function assessments must be consistent within a subject ie, if echocardiogram is used for the screening assessment then echocardiogram should also be used for subsequent scans. The subjects should also be examined using the same machine and operator whenever possible.

## **4.2 Treatment period**

### **For subjects receiving AZD9291:**

A cycle of treatment is defined as 21 days of once daily AZD9291 treatment. After Cycle 7 Day 1, the duration between study visits will change from every 21 days (3 weeks) to every 42 days (6 weeks).

If a subject continues to receive treatment with AZD9291 beyond RECIST 1.1 defined progression they must continue to follow the treatment visit schedule and assessments excluding study specific RECIST 1.1 assessments.

For subjects receiving AZD9291, please follow the study schedule described in Table 1.

**For subjects receiving platinum-based doublet-chemotherapy:**

Folic acid will be administered 5-7 days prior to the 1<sup>st</sup> dose, then daily during the treatment period until 21 days post the last dose. Vitamin B12 will be administered within 7 days of first infusion and every 9 weeks during the treatment period. Corticosteroid will be administered on the day prior to, on the day, and on the day after infusion. Subjects may also receive other pre-treatment/ concomitant treatment as recommended by approved label for pemetrexed, carboplatin or cisplatin as clinically indicated by the investigator.

Platinum-based doublet chemotherapy will be administered every 21 days from previous cycle Day 1. Subjects can continue to receive platinum-based doublet-chemotherapy until matching discontinuation criteria (see section 3.9) or up to a total of 6 cycles or until progression (whichever occurs first). Each cycle treatment can be interrupted maximum 14 days for safety reasons. If appropriate, and according to the approved label use or local practice guidelines, pemetrexed may be continued as maintenance treatment.

For subjects receiving platinum-based doublet-chemotherapy, please follow the study schedule in [Table 2](#).

In order to adequately assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy on overall survival, cross-over (switching treatment) will not be allowed.

**The following will be collected during the Treatment Period** (described mainly what is not already mentioned under Screening Period, Section 4.1):

**Ophthalmologic examination:**

To be performed as clinically indicated. A 30-day follow-up assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

**Echocardiogram/MUGA:**

To be performed every 12 weeks and as clinically indicated. A 30-day follow-up assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

**Physical examination, including vital signs (weight and body temperature), laboratory parameters, ECG:**

A 30-day follow-up assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

**Optional second tissue sample for diagnostic development:**

The optional second tissue sample (FFPE) may be provided to facilitate diagnostic development and pre-market approval of the diagnostic test. This should be obtained at the same time and as part of the same procedure as the mandatory screening biopsy.

**PK Blood Samples (including metabolites):**

For subjects randomized to AZD9291, blood samples (plasma) will be taken to determine concentrations of AZD9291, AZ5104 and AZ7550.

**EORTC QLQ-C30, EQ-5D-5L, EORTC QLQ-LC13 and PRO-CTCAE:**

Patient reported outcomes will be collected for all subjects throughout the study period via a hand-held electronic device.

**Healthcare Resource Use:**

Healthcare resource use assessment will be completed by the Investigational Site for any such healthcare resource use between visits.

**Concomitant Medication Use:**

For subjects randomized to doublet-chemotherapy, Folic acid, Vitamin B12 and Corticosteroid administration will be initiated prior to the start of study treatment.

Descriptions of the procedures for this treatment period are included in [Table 1](#) and [Table 2](#).

**4.3 Follow-up period**

**4.3.1 Discontinuation visit**

A Discontinuation Visit will be performed at the time investigational product is permanently stopped. Refer to [Table 1](#) or [Table 2](#) for details.

**4.3.2 Twenty-eight Day follow-up**

As a minimum, telephone contact should be made with the subject 28(+7) days following the discontinuation of investigational product to collect new AEs and follow up on any ongoing AEs and concomitant medications (including any subsequent cancer therapy). Refer to Section [6.3](#) for full details on AE recordings during follow-up.

**4.3.3 Progression follow-up**

Subjects who discontinue study medication for reasons other than objective disease progression will continue RECIST 1.1 assessments every 6 weeks (relative to date of randomization) for objective progression. In addition to RECIST 1.1 assessments, the following assessments are also required during this follow-up period as detailed in the Study Plan [Table 1](#) and [Table 2](#).

- EORTC QLQ-C30 and EQ-5D-5L every 6 weeks and at the time of progression.
- EORTC QLQ LC13 and PRO-CTCAE every 3 weeks and at the time of progression.
- Plasma for ctDNA collected every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation if this is in absence of progression)
- Adverse event collection detailed in [6.3](#)
- Anti-cancer therapy and surgery collected every 6 weeks



- WHO performance status should also be collected at other site visits that the subject attends, if appropriate site staff are available to collect such information. In addition, where possible, please provide WHO performance status when information on subsequent anticancer therapy is provided.

#### **4.3.4 Survival follow-up**

Assessments for survival should be made every 6 weeks following objective disease progression. Survival information may be obtained via telephone contact with the subject, the subject's family or caretaker or by contact with the subject's current physician. In addition to the survival status, the following assessments are also required post progression as detailed in the study plan (see [Table 1](#) or [Table 2](#)):

- EORTC QLQ-C30 and EQ-5D-5L every 6 weeks.
- EORTC QLQ LC13 and PRO-CTCAE every 3 weeks.
- Anti-cancer therapy and surgery collected every 6 weeks.
- Subsequent response/progression data every 6 weeks until the first confirmed disease progression on a subsequent treatment (to inform PFS2 endpoint).
- WHO performance status should also be collected at other site visits that the subject attends, if appropriate site staff are available to collect such information. In addition, where possible, please provide WHO performance status when information on subsequent anticancer therapy is provided.

Survival data will be collected up to the time of the final OS analysis. Subjects should be contacted in the week following the data cut-off for the final survival analyses to provide complete survival data.

The status of ongoing, withdrawn (from the study) and "lost to follow-up" subjects at the time of an OS analysis should be obtained by the site personnel by checking the subjects notes, hospital records, contacting the subjects general practitioner and checking publicly available death registries. In the event that the subject has actively withdrawn consent to the processing of their personal data, the vital status of the subject can be obtained by site personnel from publicly available resources where it is possible to do so under applicable local laws.

## **5. STUDY ASSESSMENTS**

The RAVE Web Based Data Capture (WBDC) system will be used for data collection and query handling. The investigator will ensure that data are recorded on the electronic Case Report Forms as specified in the study protocol and in accordance with the instructions provided.

The investigator ensures the accuracy, completeness and timeliness of the data recorded and of the provision of answers to data queries according to the Clinical Study Agreement. The

Investigator will sign the completed electronic Case Report Forms. A copy of the completed electronic Case Report Forms will be archived at the study site.

For details of data and study management see Section 9.4 of Clinical Study Protocol.

## **5.1 Efficacy assessments**

### **5.1.1 RECIST 1.1**

All imaging assessments including unscheduled visit scans should be collected on an ongoing basis and sent to an AstraZeneca (AZ) appointed Clinical Research Organisation (CRO) to enable independent central analyses.

For both investigator and Blinded Independent Central Review (BICR) RECIST 1.1 criteria will be used to assess each subject's tumour response to treatment and allow calculation of PFS, ORR, DCR, DoR and assess tumour shrinkage. The RECIST 1.1 guidelines for measurable, non-measurable, target and non-target lesions and the objective tumour response criteria [CR (complete response), PR (partial response), SD (stable disease) or PD (progression of disease)] are presented in Appendix H. For ORR, a visit response of CR or PR must be confirmed by a later scan conducted at least 4 weeks after the initial response is observed. See Section 4 for considerations related to RECIST 1.1 assessments.

The methods used at baseline for assessment of tumour burden [CT or MRI scans of chest and abdomen (including liver and adrenal glands)] must be used at each subsequent follow-up assessment. Any other areas of disease involvement should be additionally investigated based on the signs and symptoms of individual subjects. The baseline assessment should be performed within 28 days of treatment start. Subsequent assessments are to be performed every 6 weeks relative to randomization until objective disease progression. It is important to follow the assessment schedule as closely as possible. If scans are performed outside of the scheduled visit ( $\pm 1$  week window interval) and the subject has not progressed, every attempt should be made to perform the subsequent scans at their scheduled time points. Any other sites at which new disease is suspected should also be appropriately imaged.

Subjects with known or suspected brain metastases at screening should have a CT/MRI of the brain prior to starting study treatment. These subjects should be followed up on study with repeated CT/MRI assessment, using the same frequency as RECIST assessments. The same modality for CT/MRI should be used for a subject throughout the study. Brain metastases will be assessed as non-target lesions.

If the investigator is in doubt as to whether progression has occurred, particularly with response to non-target lesions (NTLs) or the appearance of a new lesion, it is advisable to continue treatment until the next scheduled assessment or sooner if clinically indicated and reassess the subject's status. If repeat scans confirm progression, then the date of the initial scan should be declared as the date of progression.

To achieve “unequivocal progression” on the basis of non-target disease, there must be an overall substantial worsening in non-target disease such that, even in the presence of SD or PR in target disease, the overall tumour burden has increased sufficiently to merit discontinuation of therapy. A modest “increase” in size of one or more non-target lesions is usually not sufficient to qualify for unequivocal progression status.

Categorisation of objective tumour response assessment at each visit will be based on the RECIST 1.1 criteria of response: CR, PR, SD and PD. Target lesion (TL) progression will be calculated in comparison to when the tumour burden was at a minimum (ie, smallest sum of diameters previously recorded on study). In the absence of progression, tumour response (CR, PR, SD) will be calculated in comparison to the baseline tumour measurements obtained before starting treatment.

The primary analysis for this study will be based on the tumour assessments using investigator site assessments according to RECIST 1.1.

### **5.1.2 RECIST 1.1 - Blinded Independent Central Review (BICR) Assessment**

A planned BICR of a subset of scans, from approximately 200 evaluable subjects (with both progressive and non-progressive disease by investigator assessment), used in the assessment of tumours using RECIST 1.1 will be conducted. However, imaging assessments for all subjects will be collected in case BICR of additional subjects is required at a later date. All imaging assessments including unscheduled visit scans will be collected on an ongoing basis and sent to an AstraZeneca appointed CRO to enable central analysis. Results of this independent review will not be communicated to Investigators and the management of subjects will be based solely upon the results of the RECIST 1.1 assessment conducted by the Investigator. A sensitivity analysis will be conducted to identify any potential biases in the investigator assessments compared with BICR according to RECIST 1.1 (see Section 8.5.1). If any potential biases are identified, a BICR of additional subject scans may be performed.

In order to ensure 200 evaluable subjects have BICR data available, 220 subjects will be identified to be reviewed by BICR. This has been chosen to allow a 10% overage for any selected subjects who may not be evaluable by central review, for example because of poor imaging quality. The method of generating the random sample of subjects will be detailed in the Statistical Analysis Plan (SAP). Subject selection for BICR will be performed once all subjects have been randomized and BICR of subjects will be completed before database lock for the primary analysis of PFS.

## **5.2 Safety assessments**

### **5.2.1 Laboratory safety assessments**

Blood and urine samples for determination of clinical chemistry, haematology and urinalysis will be taken at the times indicated in the Study Plan ([Table 1](#) or [Table 2](#)).

Additional safety samples may be collected if clinically indicated at the discretion of the Investigator. The date, time of collection and results (values, units and reference ranges) will be recorded on the appropriate eCRF.

The clinical chemistry, haematology and urinalysis will be performed at a local laboratory at or near to the Investigator site. Sample tubes and sample sizes may vary depending on laboratory method used and routine practice at the site. The number of samples/blood volumes is therefore subject to site-specific change.

The following laboratory variables will be measured:

**Table 3 Laboratory Safety Variables**

<b>Clinical chemistry</b>	<b>Haematology</b>
Serum (S)/Plasma (P)-Albumin	Blood (B)-Haemoglobin
S/P-ALT	B-Leukocyte
S/P-AST	B-Haematocrit
S/P-Alkaline phosphatase	B-Red blood cell (RBC) count
S/P-Bilirubin, total	B-Absolute leukocyte differential count:
S/P-Calcium, total	Neutrophils
S/P-Creatinine	Lymphocytes
S/P-Glucose (fasting, on PK days only) <sup>1</sup>	Monocytes
S/P-Lactate dehydrogenase (LDH) <sup>2</sup>	
S/P-HbA1C	Basophils
S/P-Magnesium	Eosinophils
S/P-Potassium	B-Platelet count
S/P-Sodium	B-Reticulocytes
S/P-Urea nitrogen/Blood urea nitrogen (BUN)	Urinalysis
	U-Glucose
	U-Protein
	U-Blood

<sup>1</sup> Patients will be required to fast (water only) for at least 8 hours prior to the collection of a fasting glucose sample required on PK days.

Random glucose sample will be collected on non-PK days.

<sup>2</sup> LDH is an additional variable collected at Visit 1 only.

Additionally, at the Screening Visit, a pregnancy test (blood or urine tests are acceptable based on the site's standard clinical practice) will be collected from all females of child bearing potential only.

The Investigator should make an assessment of the available results with regard to clinically relevant abnormalities. The laboratory results should be signed and dated and retained at centre as source data for laboratory variables. For information on how Adverse Events (AEs) based on laboratory tests should be recorded and reported, see Section 6.3.

**NB.** In case a subject shows an AST **or** ALT  $\geq 3 \times \text{ULN}$  **or** total bilirubin  $\geq 2 \times \text{ULN}$  please refer to Appendix E ‘Actions required in cases of combined increase of Aminotransferase and Total Bilirubin – Hy’s Law’, for further instructions (section 6.3.7 and Appendix E).

### 5.2.2 Volume of blood

Total mandatory blood volume for AZD9291 subjects in first 9 weeks is 178 mL (Table 4).

**Table 4 Blood sample volumes AZD9291 subjects**

Visit	Safety (mL) <sup>1</sup>	PK Analysis (mL)	Plasma (mL)	PGx (mL)
Screening	15		20	10 (optional)
Cycle 1	45	9	30	
Cycle 2	15	NA	10	
Cycle 3 (onwards)	15	9 (3 x 3ml)	10	
<b>SUBTOTAL (mandatory)</b>	<b>90</b>	<b>18</b>	<b>70</b>	

<sup>1</sup>For safety, assumes 6 mL clinical chemistry and 9 mL haematology per visit

Total mandatory blood volume for Platinum-based Doublet-chemotherapy subjects in first 9 weeks is 160 mL (Table 5).

**Table 5 Blood sample volumes Platinum-based Doublet-chemotherapy subjects**

Visit	Safety (mL) <sup>1</sup>	PK Analysis (mL)	Plasma (mL)	PGx (mL)
Screening	15		20	10 (optional)
Cycle 1	45	NA	30	
Cycle 2	15	NA	10	
Cycle 3 (onwards)	15	NA	10	
<b>TOTAL (mandatory)</b>	<b>90</b>		<b>70</b>	

<sup>1</sup> For safety, assumes 6 mL clinical chemistry and 9 mL haematology per visit

### 5.2.3 Physical examination

All subjects will have a physical examination performed at the time points indicated in the Study Plan (Table 1 or Table 2), which includes an assessment of the following: general appearance, skin, head and neck (including ears, eyes, nose and throat), respiratory, cardiovascular, abdomen, lymph nodes, thyroid, musculo-skeletal (including spine and extremities), and neurological systems.

## **5.2.4 ECG**

All subjects will have three 12-lead ECG performed at the time points indicated in Study Plan (Table 1 or Table 2). A twelve-lead ECG will be obtained after the subject has been resting semi-supine for at least 10 minutes prior to times indicated and should be recorded at 25 mm/sec. All ECGs should be recorded with the subject in the same physical position. The three ECG recordings should be taken within an approximate 5 minute period. Digital ECG recordings will be collected, analyzed and stored by a central ECG vendor. A 30-day follow-up assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

## **5.2.5 Echocardiogram/MUGA scan**

An Echocardiogram or MUGA scan to assess LVEF will be performed at screening (prior to study medication) and every 12 weeks relative to randomization. The modality of the cardiac function assessments must be consistent throughout ie, if echocardiogram is used for the screening assessment then echocardiogram should also be used for subsequent scans. The subjects should also be examined using the same machine and operator whenever possible. To be performed every 12 weeks and as clinically indicated. A 30-day follow-up assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

## **5.2.6 Vital signs**

### **5.2.6.1 Pulse, blood pressure, weight and height**

Supine blood pressure and pulse rate will be measured after 10 minutes rest. Assessments will be performed at the visits as shown in the Study Plan (see Table 1 or Table 2). Additionally at the discretion of the investigator if clinically indicated.

Weight will be performed at screening and then Day 1 of each cycle and at the discontinuation visit. Weight will be documented in kilogram (e.g. 68.5 kg) in eCRF.

Height will be assessed at screening only and will be documented in centimeters (e.g, 168 cm) in eCRF.

Any changes in vital signs (pulse and BP) should be recorded as an AE if applicable.

## **5.2.7 Other safety assessments**

### **5.2.7.1 Ophthalmologic exam**

At screening, a full ophthalmic assessment (measurements of best-corrected visual acuity, intraocular pressure and slit-lamp fundoscopy) should be obtained. For any subject who experiences visual symptoms (including blurring of vision), additional tests may be conducted throughout the study period, if clinically indicated (see Table 1 or Table 2).

Any clinically significant findings, including those confirmed by the ophthalmologist must be reported as an AE. Photographs should be performed to record any clinically significant

findings. These photographs should be available for central review by AstraZeneca and AstraZeneca representatives if necessary.

Subjects experiencing corneal ulceration will not be permitted to restart study treatment.

Ophthalmologic exams to be performed as clinically indicated. A 30-day follow-up assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

Ophthalmology examination results should be collected in the eCRF.

## **5.3 Other assessments**

### **5.3.1 Baseline characteristics**

Baseline demographics, disease history, previous treatments and EGFR mutation information will be collected.

### **5.3.2 Patient reported outcomes**

Patient reported outcomes (PROs), an umbrella term referring to all outcomes and symptoms, are directly reported by the subject. PROs have become a significant endpoint when evaluating effectiveness of treatments in clinical trials. The following PROs will be administered: EORTC QLQ C-30, QLQ-LC13, EQ-5D-5L and PRO CTCAE (see Appendix G).

#### **5.3.2.1 EORTC QLQ-C30 and QLQ-LC13**

The EORTC QLQ-C30 was developed by the EORTC Quality of Life Group 1993. It consists of 30 items and measures cancer patients' functioning (HRQoL) and symptoms ([Aaronson et al 1993](#)) for all cancer types. Questions can be grouped into 5 multi-item functional scales (physical, role, emotional, cognitive and social); 3 multi-item symptom scales (fatigue, pain, nausea and vomiting); a 2-item global HRQoL scale; 5 single items assessing additional symptoms commonly reported by cancer patients (dyspnoea, loss of appetite, insomnia, constipation, diarrhoea) and 1 item on the financial impact of the disease.

The QLQ LC13 is a well-validated complementary module measuring lung cancer associated symptoms and side effects from conventional chemotherapy and radiotherapy ([Bergman et al 1994](#)). Refer to Appendix G. The QLQ LC13 includes questions assessing cough, haemoptysis, dyspnoea and site specific pain (symptoms), sore mouth, dysphagia, peripheral neuropathy and alopecia (treatment-related side effects) and pain medication.

#### **5.3.2.2 EQ-5D-5L**

The EQ-5D is a standardised measure of health status developed by the EuroQol Group in order to provide a simple, generic measure of health for clinical and economic appraisal ([EuroQol Group 1990](#)). Applicable to a wide range of health conditions and treatments, it provides a simple descriptive profile and a single index value for health status that can be used in the clinical and economic evaluation of health care as well as in population health surveys.

The questionnaire assesses 5 dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has 5 response options (no problems, slight problems, moderate problems, severe problems, and extreme problems) that reflect increasing levels of difficulty ([EuroQol Group 2013](#)).

Since 2009, the EuroQol group has been developing a more sensitive version of the EQ-5D (the EQ-5D-5L), which expands the range of responses to each dimension from 3 to 5 levels of increasing severity ([Herdman et al 2011](#)). Preliminary studies indicate that the 5L version improves upon the properties of the 3L measure in terms of reduced ceiling effect, increased reliability and an improved ability to differentiate between different levels of health ([Pickard et al 2007](#), [Janssen et al 2008](#), [Janssen et al 2008b](#)).

The subject will be asked to indicate his/her current health state by selecting the most appropriate level in each of the 5 dimensions. The questionnaire also includes a visual analogue scale, where the subject will be asked to rate current health status on a scale of zero to 100, with zero being the worst imaginable health state (see Appendix G).

### **5.3.2.3 PRO-CTCAE**

The Patient-Reported Outcomes version of the Common Terminology Criteria for Adverse Events (PRO-CTCAE) system has been developed by the National Cancer Institute (NCI). The PRO-CTCAE will only be administered in those countries where a linguistically validated version exists, currently English, Japanese, Korean and Chinese. PRO-CTCAE is an item-bank of symptoms experienced by patients while undergoing treatment of their cancer. It was developed in recognition that collecting symptom data directly from patients using PRO tools can improve the accuracy and efficiency of symptomatic AE data collection. This was based on findings from multiple studies demonstrating that physicians and nurses underestimate symptom onset, frequency, and severity in comparison with patient ratings ([Sprangers et al 1992](#); [Litwin et al 1988-1992](#); [Basch et al 2009](#)). To date, 81 symptoms of the CTCAE (version 4) have been identified to be amenable to patient reporting. These symptoms have been converted to patient terms (e.g., CTCAE term “myalgia” converted to “aching muscles”). For several symptoms, like fatigue and pain, additional questions are asked about symptom frequency, severity, and interference with usual activities. For other symptoms like rash, additional questions focus on the presence on the body. The items included in the PRO-CTCAE have undergone extensive qualitative review among experts and patients. Using cognitive testing methods, these items and the additional questions for some of the symptoms have been extensively evaluated by cancer patients, so that symptoms of interest are clear, comprehensible and measurable. Not all items are administered in any one clinical trial. The intention is to only ask patients to complete those items, which are considered relevant for the trial, site of cancer, and cancer treatment (see Appendix G).

### **5.3.2.4 Administration of electronic PROs**

Subjects will complete the PRO assessments by using a handheld electronic device (ePRO). The following best practise guidelines should be followed when collecting PRO data via an electronic device:



- Site staff to explain the value and relevance of participation to subjects that we are asking these questions because we are interested in hearing directly from them how they feel. The research nurse or appointed site staff should also stress that the information is confidential. Therefore, if the subject has any medical problems he/she should discuss them with the doctor or research nurse separately from the ePRO assessment
- Remind subjects that there are no right or wrong answers, avoid bias by not clarifying items
- Train the subject on how to use the ePRO device using the materials and training provided by the ePRO vendor. Also provide guidance on whom to call if there are problems with the device by providing the patient information pamphlet provided by the ePRO vendor.

In order to minimize missing data, compliance must be checked frequently to identify problems early. If compliance drops below 85%, a check-in call from the site to ask the subject if he/she has any difficulties is highly recommended.

### **5.3.2.5 Healthcare resource use**

The site will ask subjects for any healthcare resource use between visits (ie, excluding routine follow up clinic visits associated with the clinical trial but including both planned and unplanned admissions) during the treatment period and at the 28-day follow-up.

For the purposes of economic evaluation it is necessary to capture healthcare resource use related to the treatment and the underlying disease. Within the study the following resource use will be captured:

- Hospital episodes including the type of contact (hospitalisations, outpatient, day case), reason, length of stay (including intensive care unit) and concomitant medications and procedures
- Treatment related to Adverse Events (including the method of delivery of the treatment)
- Treatment not related to the study.

The above resource use data will mainly come from the subject's medical record and will be captured by site staff using WBDC.

## **5.4 Pharmacokinetics**

### **5.4.1 Collection of samples for subjects randomized to AZD9291**

Three venous blood samples per visit in time windows Pre-dose, 0.5 to 1.5, and 2 to 4 hours for determination of total and free concentrations of AZD9291 and metabolites (AZ5104 and AZ7550) in plasma will be taken at the times presented in [Table 6](#).

The date and time of collection of each sample and the date and time of dose will be recorded.

**Table 6** PK blood sample schedule (Pre-dose, 0.5 to 1.5, and 2 to 4 hours)

<b>Time relative to dose</b>	<b>Cycle 1 - Visit 2</b>	<b>Cycle 3 - Visit 6</b>	<b>Cycle 5 - Visit 8</b>	<b>Cycle 7 -Visit 10</b> and every other cycle up to and including Cycle 13
<b>mL</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>

Samples will be collected, labelled stored and shipped as detailed in the Laboratory Manual.

#### **5.4.2 Determination of drug concentration**

Samples for determination of AZD9291 (and metabolite) concentrations in plasma and cerebrospinal fluid (CSP) will be collected and analysed by Covance on behalf of AstraZeneca, using an appropriate bioanalytical method. Full details of the analytical method used will be described in a separate bioanalytical report. All samples still within the known stability of the analytes of interest (ie, AZD9291, AZ5104 and AZ7550) at the time of receipt by the bioanalytical laboratory will be analysed.

In addition, the pharmacokinetic samples may be subjected to further analyses by AstraZeneca in order to further investigate the presence and/or identity of additional drug metabolites. Any results from such analyses will be reported separately from the Clinical Study Report.

Details on sample processing, handling, shipment and storage are provided in the Laboratory Manual.

Full details of the analytical method used will be described in a separate bioanalytical report.

#### **5.4.3 Storage and destruction of pharmacokinetic samples**

Pharmacokinetic samples will be disposed of after the Bioanalytical Report finalization or six months after issuance of the draft Bioanalytical Report (whichever is earlier), unless requested for future analyses.

Pharmacokinetic samples may be disposed of or destroyed and anonymised by pooling. Additional analyses may be conducted on the anonymised, pooled pharmacokinetic samples to further evaluate and validate the analytical method. Any results from such analyses may be reported separately from the CSR.

Incurred sample reproducibility analysis, if any, will be performed alongside the bioanalysis of the test samples. The results from the evaluation will not be reported in the Clinical Study Report but separately in a Bioanalytical Report.

Any residual back-up PK samples may be used for future exploratory biomarker research (in this case, residual back-up PK samples will be shipped to AZ Biobank; see details in the Laboratory Manual).

#### **5.4.4 Collection of cerebrospinal fluid - optional**

**For subjects on AZD9291:** If the subject agrees, and upon signature of optional ICF, a sample of CSF will be obtained at one time point taken at any time from Cycle 2 Day 1 onwards. Samples will be collected, labelled and stored and shipped as detailed in the laboratory manual.

Any residual CSF after PK analysis may be used for exploratory research into factors that may influence development of NSCLC and/or response to AZD9291. If possible, the CSF sample should be taken on the same day as planned PK samples.

### **5.5 Pharmacogenetics**

If a subject agrees to participate in the host pharmacogenetics research component of the study a blood sample will be collected.

AstraZeneca intends to perform genetic research in the AZD9291 clinical development programme to explore how genetic variations may affect the clinical parameters associated with AZD9291.

The benefits of being able to explore associations between genes and clinical outcomes within the AZD9291 programme are potentially many and include:

- analysis of genes that may affect efficacy, safety and tolerability (for example, but not limited to, drug metabolising enzymes and drug transporters)
- genetic research into genes that may contribute to the risk of NSCLC (for example, but not limited to, mutations in the gene encoding EGFR)

The results of this pharmacogenetic research will be reported separately and will not form part of the Clinical Study Report.

#### **5.5.1 Collection of pharmacogenetic samples**

The subject's consent to participate in the pharmacogenetic research components of the study is optional.

The single blood sample (10 mL) for genetic research will be obtained from the subjects immediately prior to the first administration of AZD9291 in the study. Although genotype is a stable parameter, early sample collection is preferred to avoid introducing bias through excluding subjects who may withdraw due to an adverse event. Such subjects would be important to include in any genetic analysis. If for any reason the sample is not drawn prior to dosing it may be taken at any visit until the last study visit. Only one sample should be collected per subject for genetics during the study.

Samples will be collected, labelled, stored and shipped as detailed in the Laboratory Manual.

#### **5.5.2 Storage, re-use and destruction of pharmacogenetic samples**

The processes adopted for the coding and storage of samples for genetic analysis are important to maintain subject confidentiality. Samples will be stored for a maximum of 15 years from the date of the Last Subject's Last Visit, after which they will be destroyed. DNA

is a finite resource that may be used up during analyses. The results of any further analyses will be reported either in the Clinical Study Report itself or as an addendum, or separately in a scientific report or publication. Samples will be stored and used until no further analyses are possible or the maximum storage time has been reached.

Refer to Appendix D for details of the optional (DNA) genetic research.

## **5.6 Exploratory Research**

If a subject agrees to participate in the exploratory biomarker research component of the study biological samples (e.g., plasma, serum, archived and study-obtained tumour, etc) will be collected and may be analysed for exploratory biomarkers to assess correlations with disease activity, effects of investigational product and clinical outcomes.

The results of this exploratory biomarker research will be reported separately and will not form part of the Clinical Study Report.

The results of this exploratory biomarker research may be pooled with biomarker data from other studies with the investigational product to generate hypotheses to be tested in future studies.

### **5.6.1 Collection of Tumour Biopsy Samples**

#### **5.6.1.1 Archival Tumour**

All subjects eligible for the study will be asked to provide consent to supply a sample of their archival tumour blocks if a sample taken at the time of diagnosis is available (blocks preferred, slides acceptable).

Only submit samples for subjects who have a centrally confirmed T790M+ mutation. Any archival biopsy samples taken following previous lines of therapy will also be requested, if available. In each case the previous patient treatment must be clearly indicated for each sample provided. This sample will be used to support exploratory biomarker analyses (see [5.6](#)).

#### **5.6.1.2 Optional Tissue Collection at Screening**

Subjects will be asked to consent to provide additional tumour tissue at screening, which can be collected at the same time as the mandatory screening tumour biopsy (see [Section 4.1](#)), where appropriate to do so. This biopsy will be used to support the development of the diagnostic test for pre-market approval by FDA (US) and/or for exploratory biomarker analyses (see [Section 5.6](#)).

#### **5.6.1.3 Discontinuation Biopsy**

Subjects will also be asked to consent to a further optional biopsy, to be collected at discontinuation of study treatment. This sample will be used to support exploratory biomarker analyses (see [5.6](#)).

For timings of tumour biopsies see [Table 7](#).

**Table 7**                      **Tumour biopsy samples**

<b>Time relative to dose</b>	<b>Requirement</b>
Archival	M*
Screening	M + O
Discontinuation or progression <sup>1</sup>	O

<sup>1</sup> To be taken at discontinuation or progression, whichever occurs first

**M = Mandatory**      **O = Optional**                      **M\* = mandatory if available**

Tumour samples should be provided in the form of a formalin fixed paraffin embedded block (tissue derived from the diagnostic tumour or a metastatic site). If this is not possible, the following may be provided:

- 12-20 slides of freshly prepared unstained 5-micron sections from the mandatory screening FFPE tumour block may be provided
- 10-20 slides of freshly prepared unstained 5-micron sections from the archival tumour block may be provided.

Further details on sample processing, handling and shipment are provided in the Laboratory Manual.

### **5.6.2 Collection of exploratory samples - blood-borne biomarkers and ctDNA**

All subjects will be requested to provide a series of blood samples to generate plasma samples. These samples will be used for the extraction and analysis of ctDNA. The ctDNA may be used to further investigate the relationship between PK and blood-borne biomarkers.

Plasma samples will be taken at the following times (pre-dose):

- Screening
- Cycle 1 - Day 1, Day 8 & 15; Cycle 2, 3, 4, 5, 6 – Day 1; thereafter
- Every 6 weeks up to and including progression (corresponding with the RECIST assessments)
- Discontinuation of study drug (if subject continues after progression on AZD9291)

The samples will be analysed for a range of oncology biomarkers, which may correlate with drug response.

Details on sample processing, handling, shipment and storage are provided in the Laboratory Manual.

## **5.7 Management of Biological Samples**

### **5.7.1 Storage, re-use and destruction of biological samples**

Samples will be stored for a maximum of 15 years from the date of the Last Subject's Last Visit, after which they will be destroyed. The results of this biomarker research will be reported either in the Clinical Study Report itself or as an addendum, or separately in a scientific report or publication. The results of this biomarker research may be pooled with biomarker data from other studies with the investigational product to generate hypotheses to be tested in future research.

### **5.7.2 Labelling and shipment of biological samples**

The Principal Investigator ensures that samples are labelled and shipped in accordance with the Laboratory Manual and the Biological Substance, Category B Regulations (materials containing or suspected to contain infectious substances that do not meet Category A criteria), see Appendix C 'IATA 6.2 Guidance Document'.

Any samples identified as Infectious Category A materials are not shipped and no further samples will be taken from the subject unless agreed with AstraZeneca and appropriate labelling, shipment and containment provisions are approved.

All tumour samples should be shipped at ambient temperature as per the Laboratory Manual to the AstraZeneca designated central Contract Research Organisation.

### **5.7.3 Chain of custody of biological samples**

A full chain of custody is maintained for all samples throughout their lifecycle.

The Principal Investigator at each centre keeps full traceability of collected biological samples from the subjects while in storage at the centre until shipment or disposal (where appropriate) and keeps documentation of receipt of arrival.

The sample receiver keeps full traceability of the samples while in storage and during use until used or disposed of or until further shipment and keeps documentation of receipt of arrival.

AstraZeneca keeps oversight of the entire life cycle through internal procedures, monitoring of study sites and auditing of external laboratory providers.

Samples retained for further use are registered in the AstraZeneca Biobank during the entire life cycle.

### **5.7.4 Withdrawal of Informed Consent for donated biological samples**

If a subject withdraws consent to the use of donated biological samples, the samples will be disposed of/destroyed, and the action documented. If samples are already analysed, AstraZeneca is not obliged to destroy the results of this research.

As collection of the biological samples is an optional part of the study, then the subject may continue in the study.

The Principal Investigator:

- Ensures subjects' withdrawal of informed consent to the use of donated samples is notified immediately to AstraZeneca
- Ensures that biological samples from that subject, if stored at the study site, are immediately identified, disposed of /destroyed, and the action documented
- Ensures the laboratory(ies) holding the samples is/are informed about the withdrawn consent immediately and that samples are disposed of/destroyed, the action documented and the signed document returned to the study site
- Ensures that the subject and AstraZeneca are informed about the sample disposal.

AstraZeneca ensures the central laboratory(ies) holding the samples is/are informed about the withdrawn consent immediately and that samples are disposed of/destroyed and the action documented and returned to the study site.

AstraZeneca ensures that biological samples are destroyed at the end of a specified period as described in the informed consent.

### **5.7.5 Post progression outcomes**

The date of second progression (PFS2) will be recorded by the Investigator and defined according to local standard clinical practice and may involve any of the following: objective radiological evidence (preferred), symptomatic progression or death. Second progression status will be reviewed every 6 weeks following the progression event used for the primary variable PFS (the first progression) and status recorded.

The start and stop date, and details of the type of all subsequent anticancer treatments will be recorded.

PRO data and WHO performance status will be collected post progression (see Section 4).

## **6. SAFETY REPORTING AND MEDICAL MANAGEMENT**

The Principal Investigator is responsible for ensuring that all staff involved in the study are familiar with the content of this section.

### **6.1 Definition of adverse events**

An adverse event is the development of an undesirable medical condition or the deterioration of a pre-existing medical condition following or during exposure to a pharmaceutical product, whether or not considered causally related to the product. An undesirable medical condition

can be symptoms (e.g., nausea, chest pain), signs (e.g., tachycardia, enlarged liver) or the abnormal results of an investigation (e.g., laboratory findings, electrocardiogram). In clinical studies, an AE can include an undesirable medical condition occurring at any time, including run-in or washout periods, even if no study treatment has been administered.

The term AE is used to include both serious and non-serious AEs.

For cases where it could be suspected that a tissue-derived medicine has been contaminated by a pathogen, information about any of the above conditions (including infection) should be collected. The following should be included if the target disease is progressive: Any deterioration of the disease targeted in the study and associated symptoms should not be regarded as an adverse event as far as the deterioration can be anticipated.

## **6.2 Definitions of serious adverse event**

A serious adverse event is an AE occurring during any study phase (ie, run-in, treatment, washout, follow-up), that fulfils one or more of the following criteria:

- Results in death
- Is immediately life-threatening
- Requires in-patient hospitalisation or prolongation of existing hospitalisation
- Results in persistent or significant disability/incapacity or substantial disruption of the ability to conduct normal life functions
- Is a congenital abnormality or birth defect
- Is an important medical event that may jeopardise the subject or may require medical intervention to prevent one of the outcomes listed above.

For further guidance on the definition of a SAE, see Appendix B to the Clinical Study Protocol.

## **6.3 Recording of adverse events**

### **6.3.1 Time period for collection of adverse events**

Adverse Events will be collected from time of signature of informed consent throughout the treatment period and including the safety follow-up period. The follow-up period is defined as 28 days after study treatment is discontinued. SAEs occurring in the follow-up period should be reported to AstraZeneca in the usual manner (see Section 6.4).

Following discontinuation of study treatment, SAEs considered related to study procedures should continue to be collected while subjects are followed up for disease progression as outlined in [Table 8](#).



After the final database lock, there may be some subjects remaining on study treatment. For these subjects who are continuing to receive AZD9291 AstraZeneca will collect information (during the treatment period and for 28 (+ 7) days after last dose) on SAEs, deaths (including those due to disease progression), discontinuation due to AEs/SAEs and drug accountability only.

For each subject who discontinues study treatment for a reason other than disease progression:

- Follow-up information on all ongoing AEs should continue to be collected to the survival follow-up
- SAEs considered related to study procedures must continue to be collected and reported to AstraZeneca using standard SAE timelines and process until the end of progression follow up (ie, disease progression)
- All deaths must continue to be collected after progression and during the survival follow-up

**Table 8 Summary of recording and follow-up of adverse events and deaths**

	<b>From ICF to Treatment Period (Screening Period)</b>	<b>Until 28-day Follow-up Visit (safety follow-up period)</b>	<b>Post 28-day Follow-up visit but prior to progression (if applicable)</b>	<b>Post 28-day Follow-up visit and post progression (survival follow-up period)</b>
<b>Collect all new AEs in CRF</b>	Yes	Yes	No	No
<b>Collect all ongoing AEs in CRF</b>	Yes	Yes	Yes	Yes
<b>Collect all study procedure-related SAEs in CRF</b>	Yes	Yes	Yes	Yes
<b>Death due to AE, or unknown cause<sup>1</sup></b>	Yes	Yes	No	No

<sup>1</sup> for example, death not due to disease progression or related to study procedure - refer to Section 6.3.10

### 6.3.2 Follow-up of unresolved adverse events

Any AEs that are unresolved at the subject’s last visit in the study are followed up by the investigator for as long as medically indicated, but without further recording in the CRF. AstraZeneca retains the right to request additional information for any subject with ongoing AE(s) at the end of the study, if judged necessary.

### 6.3.3 Variables

The following variables will be collect for each AE:

- AE (verbatim)
- The date when the AE started and stopped

- Maximum CTCAE grade
- Whether the AE is serious or not
- Investigator causality rating against the Investigational Product (yes or no)
- Action taken with regard to investigational product
- Outcome.

In addition, the following variables will be collected for SAEs:

- Date AE met criteria for serious AE
- Date Investigator became aware of serious AE
- AE is serious due to
- Date of hospitalisation
- Date of discharge
- Probable cause of death
- Date of death
- Autopsy performed
- Causality assessment in relation to Study procedure(s)
- Description of AE.

It is important to distinguish between serious and severe AEs. Severity is a measure of intensity whereas seriousness is defined by the criteria in Section 6.2. An AE of severe intensity need not necessarily be considered serious. For example, nausea that persists for several hours may be considered severe nausea, but not a SAE unless it meets the criteria shown in Section 6.2. On the other hand, a stroke that results in only a limited degree of disability may be considered a mild stroke but would be a SAE when it satisfies the criteria shown in Section 6.2.

#### **6.3.4 Causality collection**

The Investigator will assess causal relationship between Investigational Product and each Adverse Event, and answer ‘yes’ or ‘no’ to the question ‘Do you consider that there is a reasonable possibility that the event may have been caused by the investigational product?’

For SAEs causal relationship will also be assessed for other medication and study procedures. Note that for SAEs that could be associated with any study procedure the causal relationship is implied as ‘yes’.

A guide to the interpretation of the causality question is found in Appendix B to the Clinical Study Protocol.

#### **6.3.5 Adverse events based on signs and symptoms**

All AEs spontaneously reported by the subject or care provider or reported in response to the open question from the study personnel: ‘Have you/the child had any health problems since

the previous visit/you were last asked?’ or revealed by observation will be collected and recorded in the CRF. When collecting AEs, the recording of diagnoses is preferred (when possible) to recording a list of signs and symptoms. However, if a diagnosis is known and there are other signs or symptoms that are not generally part of the diagnosis, the diagnosis and each sign or symptom will be recorded separately.

### **6.3.6 Adverse events based on examinations and tests**

The results from protocol mandated laboratory tests and vital signs (pulse and BP) will be summarised in the clinical study report. Deterioration as compared to baseline in protocol-mandated parameters should therefore only be reported as AEs if they fulfil any of the SAE criteria or are the reason for discontinuation of treatment with the investigational product unless clearly due to progression of disease under study (see 6.3.8).

If deterioration in a laboratory value, vital sign, ECG, or other safety assessment is associated with clinical signs and symptoms, the sign or symptom will be reported as an AE and the associated laboratory result or other finding will be considered as additional information. Wherever possible the reporting Investigator uses the clinical, rather than the laboratory term (e.g., anaemia versus low haemoglobin value). In the absence of clinical signs or symptoms, clinically relevant deteriorations in non-mandated parameters should be reported as AE(s).

Deterioration of a laboratory value, which is unequivocally due to disease progression, should not be reported as an AE/SAE.

Any new or aggravated clinically relevant abnormal medical finding at a physical examination as compared with the baseline assessment will be reported as an AE.

### **6.3.7 Hy’s Law**

Cases where a subject shows an AST or ALT  $\geq 3xULN$  or total bilirubin  $\geq 2xULN$  may need to be reported as SAEs. Prompt reporting of cases meeting Hy’s law criteria (via the SAE expedited reporting system) is required for compliance with regulatory guidelines. The investigator is responsible for, without delay, determining whether a subject meets potential Hy’s law (PHL) criteria.

Details of identification of PHL cases and actions to take are detailed in Appendix F.

### **6.3.8 Disease progression**

Disease progression can be considered as a worsening of a subject’s condition attributable to the disease for which the investigational product is being studied. It may be an increase in the severity of the disease under study and/or increases in the symptoms of the disease. The development of new, or progression of existing metastasis to the primary cancer under study should be considered as disease progression and not an AE.

Progression of the malignancy under study, including signs and symptoms progression, should not be reported as a serious adverse event. Hospitalization due to signs and symptoms of disease progression should not be reported as serious adverse event.

### 6.3.9 New cancers

The development of a new cancer should be regarded as an AE and will generally meet at least one of the serious criteria. New cancers are those that are not the primary reason for the administration of the study treatment and have been identified after the subject's inclusion in this study. They do not include metastases of the original cancer.

### 6.3.10 Handling of deaths

All deaths that occur during the study, or within the follow-up period after the administration of the last dose of investigational product, should be reported as follows:

- Death, which is unequivocally due to disease progression, should be communicated to the study monitor at the next monitoring visit and should be documented in the CRF module, but should not be reported as a SAE during the study
- Where death is not clearly due to disease progression of the disease under study the AE causing the death should be reported to the study monitor as an SAE within 24 hours. The report should contain a comment regarding the co-involvement of progression of disease, if appropriate, and should assign a single primary cause of death together with any contributory causes
- Deaths with an unknown cause should always be reported as a SAE but every effort should be made to establish a cause of death. A post-mortem may be helpful in the assessment of the cause of death, and if performed a copy of the post-mortem results (with translation of important parts into English) should be reported in an expedited fashion to an AstraZeneca representative within the usual timeframes.

## 6.4 Reporting of serious adverse events

All SAEs have to be reported, whether or not considered causally related to the investigational product, or to the study procedure(s). All SAEs will be recorded in the CRF.

If any SAE occurs in the course of the study, then Investigators or other site personnel inform the appropriate AstraZeneca representatives within one day ie, immediately but **no later than 24 hours** of when he or she becomes aware of it.

The designated AstraZeneca representative works with the Investigator to ensure that all the necessary information is provided to the AstraZeneca Patient Safety data entry site **within 1 calendar day** of initial receipt for fatal and life threatening events **and within 5 calendar days** of initial receipt for all other SAEs.

For fatal or life-threatening adverse events where important or relevant information is missing, active follow-up is undertaken immediately. Investigators or other site personnel inform AstraZeneca representatives of any follow-up information on a previously reported SAE within one calendar day ie, immediately but **no later than 24 hours** of when he or she becomes aware of it.

Once the Investigators or other site personnel indicate an AE is serious in the WBDC system, an automated email alert is sent to the designated AstraZeneca representative.

If the WBDC system is not available, then the Investigator or other study site personnel reports a SAE to the appropriate AstraZeneca representative by telephone.

The AstraZeneca representative will advise the Investigator/study site personnel how to proceed.

The reference document for definition of expectedness is the IB for the AstraZeneca drug AZD9291 and the EU Summary of Product Characteristics (SPC) for the active comparator product (including any AstraZeneca comparator).

## 6.5 Overdose

Investigators are advised that any subject, who receives a higher dose than intended should be monitored closely, managed with appropriate supportive care and followed up expectantly.

Such overdoses should be recorded as follows:

- An overdose with associated AEs is recorded as the AE diagnosis/symptoms on the relevant AE modules in the CRF and on the Overdose CRF module
- An overdose without associated symptoms is only reported on the Overdose CRF module

If an overdose occurs in the course of the study, then the Investigator or other site personnel inform appropriate AstraZeneca representatives immediately, or **no later than 24 hours** of when he or she becomes aware of it.

The designated AstraZeneca representative works with the Investigator to ensure that all relevant information is provided to the AstraZeneca Patient Safety data entry site.

For overdoses associated with a SAE, the standard reporting timelines apply, see Section 6.4. For other overdoses, reporting must occur within 30 days.

## 6.6 Pregnancy

All pregnancies and outcomes of pregnancy should be reported to AstraZeneca during the course of the study and within 28 days of the last dose of study treatment.

### 6.6.1 Maternal exposure

If a subject becomes pregnant during the course of the study, study treatment should be discontinued immediately.

Pregnancy itself is not regarded as an adverse event unless there is a suspicion that the investigational product under study may have interfered with the effectiveness of a contraceptive medication. Congenital abnormalities/birth defects and spontaneous

miscarriages should be reported and handled as SAEs. Elective abortions without complications should not be handled as AEs. The outcome of all pregnancies (spontaneous miscarriage, elective termination, ectopic pregnancy, normal birth or congenital abnormality) should be followed up and documented even if the subject was discontinued from the study.

If any pregnancy occurs in the course of the study or within 28 days of the final dose of the investigational product then the Investigator or other site personnel informs the appropriate AstraZeneca representatives within 1 day ie, immediately but **no later than 24 hours** of when he or she becomes aware of it.

The designated AstraZeneca representative works with the Investigator to ensure that all relevant information is provided to the AstraZeneca Patient Safety data entry site within 1 or 5 calendar days for SAEs (see Section 6.4) and within 30 days for all other pregnancies.

The same timelines apply when outcome information is available.

### **6.6.2 Paternal exposure**

Pregnancy of the subject's partners is not considered to be an adverse event. However, the outcome of all pregnancies (spontaneous miscarriage, elective termination, ectopic pregnancy, normal birth or congenital abnormality) should if possible be followed up and documented. To capture information about a pregnancy from the partner of a male subject, the male subject's partner consent must be obtained to collect information related to the pregnancy and outcome; the male subject should not be asked to provide this information. A consent form specific to this situation must be used. The outcome of any conception occurring from the date of the first dose until six months after dosing should be followed up and documented.

## **6.7 Management of toxicities related to AZD9291**

If a subject experiences a CTCAE grade 3 or higher and/or unacceptable toxicity (any grade) not attributable to the disease or disease-related processes under investigation, where the Investigator considers the AE of concern to be specifically associated with AZD9291, dosing will be interrupted and supportive therapy administered as required in accordance with local practice/guidelines. Subjects with QTc prolongation (ie, confirmed QTc prolongation to >500 msec absolute or a > 60 msec increase from baseline) should have study treatment interrupted and regular ECGs performed until resolution to baseline.

If the toxicity resolves or reverts to  $\leq$ CTCAE grade 2 within 3 weeks of onset, treatment with AZD9291 may be restarted at the same dose (80 mg) or a lower dose (40 mg) using the rules below for dose modifications (Table 9) and with discussion and agreement with the AstraZeneca Study Team Physician as needed. There will be no individual modifications to dosing schedule in response to toxicity, only potential dose reduction or dose interruption.

If the toxicity does not resolve to  $\leq$ CTCAE grade 2 after 3 weeks, then the subject should be withdrawn from the study and observed until resolution of the toxicity.

**Table 9**                      **Dose Interventions**

<b>Intervention</b>	<b>AZD9291 Dose</b>
Starting Dose	80 mg
Reduced Dose	40 mg

On resolution of toxicity within 3 weeks:

If an AE subsequently requires dose interruption, AZD9291 may restart at the same dose or the reduced dose, on resolution/improvement of the AE at the discretion of the Investigator.

If new or worsening pulmonary symptoms (e.g., dyspnoea) or radiological abnormality suggestive of interstitial lung disease is observed, an interruption in study treatment dosing is recommended, and the AstraZeneca study team should be informed. A questionnaire regarding the results of the full diagnostic workup (including high-resolution computed tomography (HRCT), blood and sputum culture, haematological parameters) will be sent to Investigators. It is strongly recommended to perform a full diagnostic workup, to exclude alternative causes such as lymphangitic carcinomatosis, infection, allergy, cardiogenic edema, or pulmonary hemorrhage. In the presence of confirmatory HRCT scans where other causes of respiratory symptoms have been excluded, a diagnosis of interstitial lung disease should be considered and study treatment permanently discontinued.

In the absence of a diagnosis of interstitial lung disease study treatment may be restarted following consultation with the AstraZeneca Study Team Physician.

Subjects with QTcF prolongation fulfilling the following criteria (ie, confirmed QTcF prolongation to > 500 msec absolute or a > 60 msec increase from baseline) should have study treatment interrupted and regular ECGs performed until resolution to baseline. If the toxicity does not resolve to ≤ grade 1 within 3 weeks the subject will be permanently withdrawn from study treatment.

Subjects experiencing corneal ulceration or Interstitial Lung Disease will not be permitted to restart study treatment.

### **6.7.1 Skin reactions**

Recommendations for appropriate management of skin reactions, including guidance on dose-adjustments for clinically significant and/or intolerable skin reactions that are considered by the investigator to be causally related to AZD9291 will be provided to investigators.

Skin reactions are to be reported as AEs in the CRF, with additional details captured in the "SKNREAC" CRF:

Changes in the characteristics of skin reactions will be collected in the "SKNREAC" CRF.

Changes in the CTCAE grade of skin reactions will be collected in the AE CRF.

Photographs of skin reactions may be collected and these photographs should be available for central review by AstraZeneca and for external expert dermatological review if required.

Skin biopsies of skin reactions may be taken.

### 6.7.2 Diarrhoea

Recommendations for appropriate management of diarrhoea, including dose-adjustments for adverse events of diarrhoea that are of CTCAE grade  $\geq 3$  or that are clinically significant and/or intolerable and considered by the investigator to be causally related to AZD9291, will be provided to investigators.

For further guidance on skin reactions and diarrhoea, please refer to “Guidance for the Management of Adverse Events in Studies using 80mg AZD9291”.

## 6.8 Management of toxicities related to Platinum-Based Doublet Chemotherapy

Detailed here, as guidance, are the US (FDA) approved toxicity management guidelines for pemetrexed, carboplatin and cisplatin (US Prescribing Information).

For toxicity management please adhere to these guidelines or, where appropriate, to local approved or clinical practice guidelines. A discussion with AZ study physician would be indicated in case of using local clinical practice guidelines.

### 6.8.1 Dose Adjustment Recommendations for Carboplatin

Pretreatment platelet count and performance status are important prognostic factors for severity of myelosuppression in previously treated patients.

The suggested dose adjustments for single agent or combination therapy shown in the table below are modified from controlled trials in previously treated and untreated patients with ovarian carcinoma. Blood counts were done weekly, and the recommendations are based on the lowest post-treatment platelet or neutrophil value.

Platelets	Neutrophils	Adjusted Dose* (From Prior Course)
>100 000	>2 000	125%
50-100 000	500-2 000	No Adjustment
<50 000	<500	75%

\* Percentages apply to carboplatin for Injection, USP as a single-agent or to both carboplatin and cyclophosphamide in combination. In the controlled studies, dosages were also adjusted at a lower level (50% to 60%) for severe myelosuppression. Escalations above 125% were not recommended for these studies.

Carboplatin is usually administered by an infusion lasting 15 minutes or longer. No pre- or post-treatment hydration or forced diuresis is required.



**Patients with Impaired Kidney Function:**

<b>Baseline Creatinine Clearance</b>	<b>Recommended Dose on Day 1</b>
41 mL/min - 59 mL/min	250 mg/m <sup>2</sup>
16 mL/min - 40 mL/min	200 mg/m <sup>2</sup>

Patients with creatinine clearance values below 60 mL/min are at increased risk of severe bone marrow suppression. In renally impaired patients who received single-agent carboplatin therapy, the incidence of severe leukopenia, neutropenia, or thrombocytopenia has been about 25% when the dosage modifications in the table below have been used.

The data available for patients with severely impaired kidney function (creatinine clearance below 15 mL/min) are too limited to permit a recommendation for treatment.

These dosing recommendations apply to the initial course of treatment. Subsequent dosages should be adjusted according to the patient’s tolerance based on the degree of bone marrow suppression.

**6.8.2 Precaution for Cisplatin**

Peripheral blood counts should be monitored weekly. Liver function should be monitored periodically. Neurologic examination should also be performed regularly.

**6.8.3 Dose Adjustment Recommendations for Pemetrexed**

Dose adjustments at the start of a subsequent cycle should be based on nadir hematologic counts or maximum nonhematologic toxicity from the preceding cycle of therapy. Treatment may be delayed to allow sufficient time for recovery. Upon recovery, patients should be retreated using the guidelines in below Tables, which are suitable for using pemetrexed as a single-agent or in combination with cisplatin.

**Dose Reduction for Pemetrexed (single-agent or in combination) and Cisplatin - Hematologic Toxicities:**

Nadir ANC <500/mm <sup>3</sup> and nadir platelets ≥50000/mm <sup>3</sup>	75% of previous dose (pemetrexed and cisplatin).
Nadir platelets <50 000/mm <sup>3</sup> without bleeding regardless of nadir ANC	75% of previous dose (pemetrexed and cisplatin).
Nadir platelets <50 000/mm <sup>3</sup> with bleeding, regardless of nadir ANC	50% of previous dose (pemetrexed and cisplatin).

If patients develop nonhematologic toxicities (excluding neurotoxicity) ≥Grade 3, treatment should be withheld until resolution to less than or equal to the patient’s pre-therapy value. Treatment should be resumed according to guidelines in below Table.

**Dose Reduction for Pemetrexed (single-agent or in combination) and Cisplatin - Nonhematologic Toxicities<sup>a,b</sup>**

	<b>Dose of Pemetrexed (mg/m<sup>2</sup>)</b>	<b>Dose of Cisplatin (mg/m<sup>2</sup>)</b>
Any Grade 3 or 4 toxicities except mucositis	75% of previous dose	75% of previous dose
Any diarrhea requiring hospitalization (irrespective of Grade) or Grade 3 or 4 diarrhea	75% of previous dose	75% of previous dose
Grade 3 or 4 mucositis	50% of previous dose	100% of previous dose

<sup>a</sup> NCI Common Toxicity Criteria (CTC)

<sup>b</sup> excluding neurotoxicity (see Table below).

In the event of neurotoxicity, the recommended dose adjustments for Pemetrexed and cisplatin are described in below Table. Patients should discontinue therapy if Grade 3 or 4 neurotoxicity is experienced.

**Dose Reduction for Pemetrexed (single-agent or in combination) and Cisplatin – Neurotoxicity:**

<b>CTC Grade</b>	<b>Dose of Pemetrexed (mg/m<sup>2</sup>)</b>	<b>Dose of Cisplatin (mg/m<sup>2</sup>)</b>
0-1	100% of previous dose	100% of previous dose
2	100% of previous dose	50% of previous dose

Discontinuation Recommendation: Pemetrexed therapy should be discontinued if patient experiences any hematologic or nonhematologic Grade 3 or 4 toxicity after two dose reductions or immediately if Grade 3 or 4 neurotoxicity is observed.

Renally Impaired Patients: In clinical studies, patients with creatinine clearance  $\geq 45$  mL/min required no dose adjustments other than those recommended for all patients. Insufficient numbers of patients with creatinine clearance below 45 mL/min have been treated to make dosage recommendations for this group of patients. Therefore, Pemetrexed should not be administered to patients whose creatinine clearance is  $< 45$  mL/min using the standard Cockcroft and Gault formula (below) or GFR measured by Tc99m-DPTA serum clearance method:

<b>Males:</b>	$\frac{[140 - \text{Age in years}] \times \text{Actual Body Weight (kg)}}{72 \times \text{Serum Creatinine (mg/dL)}} = \text{mL/min}$
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<b>Females:</b>	Estimated creatinine clearance for males $\times$ 0.85
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Caution should be exercised when administering Pemetrexed concurrently with NSAIDs to patients whose creatinine clearance is  $<80$  mL/min.

## 6.9 Study governance and oversight

### 6.9.1 Steering Committee

A Steering Committee comprising of the principal investigators for study D5160C00003, in addition to principal investigators from the other AZD9291 pivotal studies will provide advice on any aspect of the study design or conduct based on requests from the sponsor and assure consistency across the entire AZD9291 pivotal programme.

No Data Monitoring Committee (DMC) is planned, as the safety profile of AZD9291 from the ongoing phase I trial in a similar NSCLC patient population is modest, predictable with no reported life-threatening adverse events. There is therefore no requirement for pre-planned specified expert independent safety reviews in this study.

## 7. INVESTIGATIONAL PRODUCT AND OTHER TREATMENTS

### 7.1 Identity and Dose of investigational product – AZD9291

Investigational product	Dosage form and strength	Manufacturer
AZD9291	40mg Tablets 80mg Tablets	AstraZeneca

AstraZeneca will supply AZD9291 as tablets for oral administration as a single daily dose of 80 mg. Subjects (with the exception of subjects with insulin dependent diabetes) must fast for  $\geq 1$  hours prior to taking a dose to  $\geq 2$  hour post dose. Water is permitted during this fasting period. Subjects will be required to fast (water only) for at least 8 hours prior to the collection of a fasting glucose sample as per the study plan ([Table 1](#)) and Section [5.2.1](#).

If data is generated that demonstrates that it is not necessary to maintain the fasting restriction, this will be communicated to Investigational Sites.

At each dispensing visit, sufficient AZD9291 for 21 days treatment, plus overage, will be distributed. Individual bottles will be dispensed in accordance with the medication identification numbers provided by the IVRS/IWRS.

Subjects should swallow one AZD9291 80 mg tablets once daily, commencing on Cycle 1 Day 1. Tablets should be taken whole with water.

The initial dose of 80 mg AZD9291 can be reduced to 40 mg AZD9291 once daily under circumstances described in Section 6.7

On clinic days on which PK samples are scheduled, the dosing should be delayed until arrival at the clinic. Subjects should not take their dose until instructed to do so by site personnel.

Doses should be taken approximately 24 hours apart at the same time point each day. Doses should not be missed. If a subject misses taking a scheduled dose, within a window of 12 hours, it is acceptable to take the dose. If it is more than 12 hours after the dose time, the missed dose should not be taken, and subjects should be instructed to take the next dose at the next scheduled time. If a subject vomits after taking their AZD9291, they should not make up for this dose, but should take the next scheduled dose.

Any change from dosing schedule, dose interruptions, dose reductions should be recorded in the eCRF.

Tablets will be packed in high-density polyethylene (HDPE) bottles with child-resistant closures. Bottles will be dispensed to subjects in the AstraZeneca packing provided. The packaging includes bottles, caps and a label. Bottle tampers should not be broken prior to dispensing investigational product to a subject.

Additional information about the Investigational product may be found in the Investigators' Brochure.

## 7.2 Identity and Dose of Comparator Product – Platinum-based Doublet-Chemotherapy

Investigational product	Dosage form
pemetrexed + carboplatin	500mg/m <sup>2</sup> AUC5 on Day 1 of every 21d cycle
pemetrexed + cisplatin	500mg/m <sup>2</sup> 75mg/m <sup>2</sup> on Day 1 of every 21d cycle

Platinum-based Doublet-chemotherapy is available in a range of strengths and will be sourced locally or centrally and should be administered according to local prescribing information, including any treatment restrictions.

To reduce the incidence and severity of skin reactions, a corticosteroid should be given the day prior to, on the day of, and the day after pemetrexed administration. The corticosteroid should be equivalent to 4mg of dexamethasone administered orally twice a day.

To reduce toxicity, subjects treated with pemetrexed must also receive vitamin supplementation. Subjects must take oral folic acid or a multivitamin containing folic acid (350 to 1000 micrograms) on a daily basis. At least five doses of folic acid must be taken during the approximately 7 days preceding the first dose of pemetrexed, and dosing must

continue during the full course of therapy and for 21 days after the last dose of pemetrexed. Subjects must also receive vitamin B12 (e.g. i.m. 1000 micrograms or equivalent) in the week preceding the first dose of pemetrexed and once every three cycles thereafter. Subsequent vitamin B12 doses may be given on the same day as pemetrexed. Subjects may also receive other pre-treatment / concomitant treatment as recommended by approved label for pemetrexed, carboplatin or cisplatin as clinically indicated by the investigator.

Anticipated treatment duration is approximately six months.

### **7.3 Labelling**

Labels for IP (if required also for chemotherapy) will be prepared in accordance with Good Manufacturing Practice (GMP) and local regulatory guidelines. Label text will be translated into local language.

The label will include the Name of the Sponsor, Study Code, For Clinical trial use only and/or any other market specific requirements.

### **7.4 Storage**

All investigational products should be kept in a secure place under appropriate storage conditions. The investigational product label on the IP specifies the appropriate storage.

### **7.5 Compliance**

The administration of all study treatments (including investigational products) should be recorded in the appropriate sections of the Case Report Form.

Subjects should return all unused investigational product and empty containers to the investigator.

### **7.6 Accountability**

The investigational product provided for this study will be used only as directed in the study protocol.

The study personnel will account for all investigational products dispensed to and returned from the subject.

The study personnel at the investigational site will account for all treatments dispensed and for appropriate destruction. Certificates of delivery and destruction should be signed.

### **7.7 Concomitant and other treatments**

Information on any treatment in the 4 weeks prior to starting study treatment and all concomitant treatments given during the study, with reasons for the treatment, will be recorded in the CRF. After permanent discontinuation of study treatment and 28 day follow up, only subsequent regimens of anti-cancer therapy will be recored in CRF. If medically

feasible, subjects taking regular medication, with the exception of potent inhibitors or inducers of CYP3A4 (see Appendix F), should be maintained on it throughout the study period. Subjects taking concomitant medications whose disposition is dependent upon CYP3A4 or BCRP and which have a narrow therapeutic index should be closely monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst receiving AZD9291. Subjects taking concomitant medications whose disposition is dependent upon CYP3A4, CYP1A2, CYP2C or p-glycoprotein and which have a narrow therapeutic index should be closely monitored for reduction in therapeutic activity as a result of the reduced exposure of the concomitant medication whilst receiving AZD9291. Guidance on medications that require close monitoring is given in Appendix F.

Up to 3 fold increase in exposure may occur in statin exposure when coadministered with AZD9291. It is recommended that the starting and maintenance dose of statins should be as low as possible and should be guided by the statin label. Monitoring of low-density lipoprotein (LDL) cholesterol levels is advised. If the subject experiences any potentially relevant adverse events suggestive of muscle toxicity including unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever, the statin should be stopped, creatine kinase (CK) levels should be checked, and any appropriate further management should be taken.

Subjects taking warfarin should be monitored regularly for changes in prothrombin time or INR.

Other anticancer agents, investigational agents and radiotherapy should not be given while the subject is on study treatment.

Pre-medication will be allowed after, but not before the first dose of study treatment. This includes management of diarrhoea, nausea and vomiting.

Leukocyte-depleted blood transfusions are allowed at any time during the study.

Granulocyte colony stimulating factors should not be used prophylactically during Cycle 1. Use of prophylactic colony stimulating factors may be considered after Cycle 1 following discussion with the AstraZeneca Study Team Physician.

Subjects may receive treatment with corticosteroids and/or bisphosphonates for the treatment of bone metastases. Subjects may also receive radiotherapy or medication (e.g. denosumab) for painful bony metastases. For questions related to specific mediations, please contact the Study Physician.

Supportive care and other medications that are considered necessary for the subject's well-being, may be given at the discretion of the investigator.

### **Study Treatment (Subjects randomized to AZD9291)**

Subjects (with the exception of subjects with insulin dependent diabetes) must fast for  $\geq 1$  hours prior to taking a dose to  $\geq 2$  hour post dose. Water is permitted during this fasting period.

### Study Treatment (Subjects randomized to platinum-based doublet chemotherapy)

Platinum-based doublet chemotherapy should be administered according to local prescribing information, including any treatment restrictions.

<b>Prohibited Medication/Class of drug:</b>	<b>Usage:</b>
Other anticancer agents, investigational agents and radiotherapy	Should not be given while the subject is on study treatment.

<b>Rescue/Supportive Medication/Class of drug:</b>	<b>Usage:</b>
Pre-medication will be allowed after, but not before the first dose of study treatment.	To be administered as directed by the investigator. This includes management of diarrhoea, nausea and vomiting.
Blood transfusions	Allowed at any time during the study.
Granulocyte colony stimulating factors	Should not be used prophylactically during Cycle 1. Use of prophylactic colony stimulating factors may be considered after Cycle 1 following discussion with the AstraZeneca Study Team Physician.
Corticosteroids and/or bisphosphonates	Subjects may receive treatment with corticosteroids and/or bisphosphonates for the treatment of bone metastases. Subjects may also receive radiotherapy for painful bony metastases.
Palliative radiation	Subjects may receive radiotherapy for painful bony metastases.
Supportive care and other medications that are considered necessary for the subject's well-being	To be administered as directed by the investigator (e.g. denosumab for painful bony metastases).

#### 7.7.1 Other concomitant treatment

Other medication other than that described above, which is considered necessary for the subject's safety and well being, may be given at the discretion of the Investigator and recorded in the appropriate sections of the Case Report Form. Some medications may be limited due to their QT potential, please refer to Appendix F.

#### 7.8 Post Study Access to Study Treatment

Subjects receiving AZD9291 at the time of study completion (ie, after final data cut-off date) may continue to receive AZD9291, if in the opinion of their treating physician they are

continuing to derive clinical benefit from continued treatment. Such subjects will continue to be monitored and all safety assessments will be performed until AZD9291 is discontinued. These subjects will then be followed up for a period of 28 days after the last AZD9291 dose is administered for any new treatment-related serious adverse events. A CSR addendum will be prepared to summarise any additional safety data collected.

## **8. STATISTICAL ANALYSES BY ASTRAZENECA**

### **8.1 Statistical considerations**

A comprehensive Statistical Analysis Plan (SAP) will be prepared and finalised prior to first subject in (FSI). The aim of the study is to compare the efficacy and safety of AZD9291 versus platinum-based doublet chemotherapy. All analyses will be performed by AstraZeneca or its representatives.

The primary analysis will be performed when approximately 400 PFS events have occurred, so that the PFS data are approximately 65% mature. Three analyses of OS are planned; two interim analyses and an optional final analysis. The first interim analysis of overall survival will be conducted at the time of the primary analysis of PFS and the second interim analysis will be conducted when the OS data are approximately 50% mature (approximately 305 death events). A final analysis of overall survival may be performed when the OS data are approximately 70% mature (approximately 430 death events).

#### **Multiple Testing Strategy**

In order to describe the benefits of AZD9291 treatment, the primary and secondary endpoints will be tested at a 2-sided significance level of 5%.

However, in order to provide strong control of the type I error rate, the primary endpoint of PFS and key secondary endpoints, ORR and OS will be tested in this sequential order. If any previous analysis in the sequence is not statistically significant, the alpha spending cannot be transferred to subsequent analyses. The analyses of primary and all secondary endpoints will all occur at the time of primary analysis of PFS. A 2-sided 5% alpha will be used in all testing, with the exception of overall survival endpoint. Since three analyses of OS are planned, the alpha will be split between the three analyses, in order to control the overall type I error, as follows: 2% will be allocated to the first interim analysis, 2.5% will be allocated to the second interim analysis and the remaining alpha will be allocated to the final analysis. Therefore, any non-statistically significant analyses at the interims will not preclude further testing of OS. However, if, at the 2<sup>nd</sup> interim analysis, when the OS data are expected to be 50% mature, a statistically significant improvement in OS is not observed, AstraZeneca may decide not to perform the final OS analysis.



## **8.2 Sample size estimate**

PFS is the primary endpoint for this study. The study has been sized to also characterize the overall survival benefit of AZD9291. Approximately 610 subjects will be randomized in a 2:1 ratio (AZD9291: chemotherapy) to this study.

The primary analysis of PFS will occur when approximately 400 progression events have been observed. With 400 progression events, the study will provide >95% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were HR 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed.

Assuming 12 months non-linear recruitment, 400 PFS events are expected to occur approximately 20 months after the first subject is enrolled in the study.

If the true OS hazard ratio for the comparison of AZD9291 versus chemotherapy is 0.75, 427 death events will provide approximately 80% power to demonstrate a statistically significant difference in OS at 5% 2-sided significance level. For example, this translates to an approximate 5-6 month improvement in median OS over an assumed 16-19 month median OS on chemotherapy, assuming OS is exponentially distributed.

In order to randomize 610 subjects (assuming a 10% screen failure rate), 678 (55%) (T790M+) subjects will need to be enrolled. With a 20% attrition rate, and 1232 subjects with known T790M status, approximately 1540 subjects will need to be screened.

## **8.3 Definitions of analysis sets**

### **8.3.1 Full analysis set**

The full analysis set will include all randomized subjects. The full analysis set will be used for all efficacy analyses and treatment groups will be compared on the basis of randomized treatment, regardless of the treatment actually received.

### **8.3.2 Safety analysis set**

The safety analysis set will consist of all subjects who received at least one dose of randomized treatment and for whom post dose data are available. Safety data will not be formally analysed but summarised using the safety analysis set, according to the treatment received, ie, erroneously treated subjects (e.g., those randomized to treatment A but actually given treatment B) will be summarised according to the treatment they actually received.

### **8.3.3 PK analysis set**

Subjects in the Full Analysis Set who have at least one measurable PK concentration, supported by the relevant date and time of this sample and for each time a PK sample was taken the dosing data for that day and for samples taken after multiple dosing the dosing data for the 2 days prior to the sample day as well as the sample day. For any individual sample to

be included in the PK analysis set the full sample data and dosing data needs to be present for that sample.

## **8.4 Outcome measures for analyses**

### **8.4.1 Calculation or derivation of efficacy variables**

#### **Investigator RECIST based assessments**

From the investigators review of the imaging scans, the RECIST tumour response data will be used to determine each subject's visit response according to RECIST version 1.1.

At each visit, subjects will be programmatically assigned a RECIST 1.1 visit response of CR, PR, SD or PD depending on the status of their disease compared with baseline and previous assessments. If a subject has had a tumour assessment, which cannot be evaluated, then the subject will be assigned a visit response of not evaluable (NE) (unless there is evidence of progression in which case the response will be assigned as PD).

Please refer to Appendix H for the definitions of Complete Response, Partial Response, Stable Disease and Progressive Disease.

#### **Blinded Independent Central Review of RECIST based assessments**

The Blinded Independent Central Review of radiological imaging data will be carried out using RECIST version 1.1. All radiological scans for all subjects (including those at unscheduled visits, or outside visit windows) will be provided to the BICR. Prior radiotherapy reports for subjects (at baseline) and information on biopsied lesions will also be provided to the BICR to allow the selection of appropriate target lesions. However, only a subset of scans will be reviewed by the BICR. The method of generating the random sample of subjects will be detailed in the Statistical Analysis Plan (SAP). The subset of imaging scans will be reviewed by two independent radiologists using RECIST 1.1 criteria and will be adjudicated if required. The independent reviewers will be blinded to treatment. For each subject, the BICR will define the overall visit response data (CR, PR, SD, PD or NE) and the relevant scan dates for each time point (ie, for visits where response or progression is/is not identified). If a subject has had a tumour assessment, which cannot be evaluated, then the subject will be assigned a visit response of not evaluable (NE) (unless there is evidence of progression in which case the response will be assigned as PD). Endpoints (ORR, DoR, DCR, PFS) will be derived from the overall visit response date and the scan dates. ORR will only include subjects whose response has been confirmed by a second scan at least 4 weeks after the initial response. The endpoint of tumour shrinkage will be assessed from tumour size measurements based on the primary independent radiologist assessment.

Note, all imaging assessments for all subjects will be collected and stored in case a full BICR of all subjects is required at a later date.

Further details of the Blinded Independent Central Review will be documented in the Blinded Independent Review Charter.

### **Progression Free Survival (PFS)**

PFS is defined as the time from randomization until the date of objective disease progression or death (by any cause in the absence of progression) regardless of whether the subject withdraws from randomized therapy or receives another anti-cancer therapy prior to progression. Subjects who have not progressed or died at the time of analysis will be censored at the time of the latest date of assessment from their last evaluable RECIST assessment.

However, if the subject progresses or dies after two or more missed visits, the subject will be censored at the time of the latest evaluable RECIST assessment. If the subject has no evaluable visits or does not have baseline data they will be censored at 0 days unless they die within two visits of baseline.

The PFS time will always be derived based on scan/assessment dates not visit dates.

RECIST assessments/scans contributing towards a particular visit may be performed on different dates. The following rules will be applied:

- Date of progression will be determined based on the earliest of the dates of the component that triggered the progression
- When censoring a subject for PFS the subject will be censored at the latest of the dates contributing to a particular overall visit assessment

### **Objective Response Rate (ORR)**

ORR rate is defined as the number (%) of subjects with measurable disease with at least one visit response of CR or PR that is confirmed at least 4 weeks later. Data obtained up until progression, or last evaluable assessment in the absence of progression, will be included in the assessment of ORR. However, any complete response or partial response, which occurred after a further anticancer therapy was received, will not be included in the numerator for the ORR calculation.

In the case where a subject has two non-consecutive visit responses of PR, then, as long as the time between the 2 visits of PR is greater than 4 weeks and there is no PD between the PR visits, the subject will be defined as a responder. Similarly, if a subject has visit responses of CR, NE, CR, then, as long as the time between the 2 visits of CR is greater than 4 weeks, then a best response of CR will be assigned.

### **Duration of Response (DoR)**

Duration of response will be defined as the time from the date of first documented response, (that is subsequently confirmed) until date of documented progression or death in the absence of disease progression, the end of response should coincide with the date of progression or death from any cause used for the PFS endpoint. The time of the initial response will be defined as the latest of the dates contributing towards the first visit response of PR or CR. If the response is not confirmed, it will not be included.

If a subject does not progress following a response, then their duration of response will use the PFS censoring time.

### **Disease control rate (DCR)**

Disease control rate is defined as the percentage of subjects who have a best overall response of CR or PR or SD.

### **Tumour shrinkage**

Tumour shrinkage will be assessed using RECIST tumour response. The absolute change and percentage change from baseline in sum of tumour size at each assessment will be calculated. The best change in tumour size will include all assessments prior to progression or start of subsequent anticancer therapy.

### **Overall Survival (OS)**

Overall survival is defined as the time from the date of first dose until death due to any cause. Any subject not known to have died at the time of analysis will be censored based on the last recorded date on which the subject was known to be alive.

Note: Survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis, and if subjects are confirmed to be alive, or if the death date is post the final data cut-off date, these subjects will be censored at the date of the final data cut off. Death dates may be found by checking publicly available death registries.

### **HRQoL & Symptoms**

Patient reported outcomes will be assessed using the EORTC QLQ-C30 and QLQ-LC13 questionnaires. The QLQ-C30 consists of 30 questions, which can be combined to produce 5 functional scales (Physical, Role, Cognitive, Emotional, Social), 3 symptom scales (Fatigue, Pain, Nausea/vomiting), 5 individual items (dyspnoea, insomnia, appetite loss, constipation, diarrhoea) and a global measure of health status. The QLQ-LC13 is a lung cancer specific module comprising 13 questions to assess lung cancer symptoms (cough, haemoptysis, dyspnoea and site-specific pain), treatment related side-effects (sore mouth, dysphagia, peripheral neuropathy and alopecia) and pain medication. With the exception of a multi-item scale for dyspnoea, all are single items.

An outcome variable consisting of a score from 0 to 100 will be derived for each of the symptom scales/symptom items, the functional scales and the global health status scale in the QLQ-C30 and for each of the symptom scales/items in the QLQ-LC13 according to the EORTC QLQ-C30 Scoring Manual and EORTC QLQ-LC13 instructions.

Higher scores on the global health status and functioning scales indicate better health status/function. Higher scores on the symptoms scales indicate greater symptom burden.

The primary PRO outcome measures will be patient-reported lung cancer symptoms assessed using the EORTC QLQ-LC13, namely

- dyspnoea (multi-item scale based on three questions: “Were you short of breath when you rested; walked; climbed stairs”),
- cough: one item (“How much did you cough?”),
- haemoptysis: one item (“Did you cough up blood?”),
- pain: three individual items (“Have you had pain in your chest; your arm or shoulder; other parts of your body?”).

***Definition of clinically meaningful changes***

Changes in score compared to baseline will be evaluated. A minimum clinically meaningful change is defined as a change in the score from baseline of  $\geq 5$  for scales/items from the QLQ-LC13 and  $\geq 10$  for scales/items from the QLQ-C30 (Obosa et al 1998).

For example, a clinically meaningful deterioration or worsening in chest pain (as assessed by QLQ-LC13) is defined as an increase in the score from baseline of  $\geq 5$ . A clinically meaningful improvement in fatigue (as assessed by QLQ-C30) is defined as a decrease in the score from baseline of  $\geq 10$ .

At each post-baseline assessment, change in symptoms/functioning from baseline will be categorised as improved, stable or worsening as shown in Table 10.

**Table 10 Visit Response for HRQoL and disease-related symptoms**

Score	Change from baseline	Visit Response
LC13 symptom scales/items	$\geq +5$	Worsened
	$\leq -5$	Improved
	Otherwise	Stable
C30 symptom scales/items	$\geq +10$	Worsened
	$\leq -10$	Improved
	Otherwise	Stable
C30 functional scales and Global health status	$\geq +10$	Improved
	$\leq -10$	Worsened
	Otherwise	Stable

***Time to symptom deterioration***

For each of the symptoms scales/items in QLQ-LC13, time to symptom deterioration will be defined as the time from randomization until the date of first clinically meaningful symptom deterioration (an increase in the score from baseline of  $\geq 5$ ) or death (by any cause) in the absence of a clinically meaningful symptom deterioration, regardless of whether the subject withdraws from randomized therapy or receives another anticancer therapy prior to symptom deterioration. Death will be included as an event only if the death occurs within two visits of the last PRO assessment where the symptom change could be evaluated.

Subjects whose symptoms (as measured by QLQ-LC13) have not shown a clinically meaningful deterioration and who are alive at the time of the analysis will be censored at the time of their last PRO assessment where the symptom could be evaluated. Also, if symptoms progress after two or more missed PRO assessment visits or the subject dies after two or more missed PRO assessment visits, the subject will be censored at the time of the last PRO

assessment where the symptom could be evaluated. If a subject has no evaluable visits or does not have baseline data they will be censored at day 1. The population for analysis of time to symptom deterioration will include a subset of the ITT population who have baseline scores  $\leq 95$ .

### ***Symptom Improvement Rate***

The symptom improvement rate will be defined as the number (%) of subjects with two consecutive assessments at least 18 days apart (ie, 21 days allowing a visit window of 3 days), which showed a clinically meaningful improvement (a decrease from baseline score  $\geq 5$  for LC13 scales/items or  $>10$  for C30 scales/items) in that symptom from baseline. The denominator will consist of a subset of the ITT population who have a baseline symptom score  $\geq 5$  (LC13 scales/items) or  $\geq 10$  (C30 scales/items).

### ***Time from randomization to second progression (PFS2) (exploratory)***

Time from randomization to second progression (PFS2) is defined as the time from the date of randomization to the earliest of the progression event subsequent to that used for the primary variable PFS or death. Subjects alive and for whom a second disease progression has not been observed should be censored at the last time known to be alive and without a second disease progression, ie, censored at the last progression assessment date if the subject has not had a second progression or death.

### ***Time to first subsequent therapy or death (TFST)***

Time to first subsequent therapy or death is defined as the time from the date of randomization to the earlier of the date of anticancer therapy start date following study treatment discontinuation, or death. Any subject not known to have had a subsequent therapy or not known to have died at the time of the analysis will be censored at the last known time to have not received subsequent therapy, ie, the last follow-up visit where this was confirmed.

### ***Time to second subsequent therapy or death (TSST)***

Time to second subsequent therapy or death is defined as the time from the date of randomization to the earlier of the date of second subsequent anticancer therapy start date following study treatment discontinuation, or death. Any subject not known to have died at the time of the analysis and not known to have had a second further intervention of this type will be censored at the last known time to have not received second subsequent therapy, ie, the last follow-up visit where this was confirmed.

### **Patient reporting of CTCAE symptoms**

The PRO-CTCAE questionnaire will be used to derive subject reporting of CTCAE symptoms.

### **Health State Utility**

The EQ-5D-5L index comprises 5 dimensions of health (mobility, self-care, usual activities, pain/discomfort and anxiety/depression). For each dimension, respondents select which statement best describes their health on that day from a possible 5 options of increasing levels of severity (no problems, slight problems, moderate problems, severe problems and unable to/extreme problems). A unique EQ-5D health state is referred to by a 5-digit code allowing

for a total of 3125 health states. For example, state 11111 indicates no problems on any of the 5 dimensions. These data will be converted into a weighted health state index by applying scores from EQ5D value sets elicited from general population samples (the base case will be the United Kingdom valuation set, with other country value sets applied in scenario analyses). Where values sets are not available, the EQ-5D-5L to EQ-5D-3L crosswalk will be applied. In addition to the descriptive system, respondents also assess their health on the day of assessment on a visual analogue scale, ranging from 0 (worst imaginable health) to 100 (best imaginable health). This score is reported separately.

### **Health Resource Utilisation**

Health resource utilisation will be assessed in terms of hospitalization, outpatient visits and emergency department visits

#### **8.4.2 Calculation or derivation of safety variable(s)**

Safety and tolerability will be assessed in terms of AEs, deaths, laboratory data, vital signs (pulse and BP) and ECG. These will be collected for all subjects.

#### **Adverse events**

AEs (both in terms of MedDRA preferred terms and CTCAE grade) will be listed individually by subject.

Any AE occurring before treatment with AZD9291 will be included in the data listings but will not be included in the summary tables of AEs.

Any AE occurring within 90 days of discontinuation of investigational product (ie, the last dose of AZD9291/chemotherapy) will be included in the AE summaries. Any events in this period that occur after a subject has received further therapy for cancer (following discontinuation of AZD9291) will be flagged in the data listings. Please refer to section [6.3.1](#)

#### **Other significant adverse events (OAEs)**

During the evaluation of the AE data, an AstraZeneca medically qualified expert will review the list of AEs that were not reported as SAEs and AEs leading to discontinuation. Based on the expert's judgement, significant AEs of particular clinical importance may, after consultation with the Global Patient Safety Physician, be considered OAEs and reported as such in the CSR. A similar review of laboratory/vital signs (pulse and BP)/ECG data will be performed for identification of OAEs.

Examples of these could be marked haematological and other laboratory abnormalities, and certain events that lead to intervention (other than those already classified as serious), dose reduction or significant additional treatment.

#### **8.4.3 Calculation or derivation of pharmacokinetic variables**

Pharmacokinetic analysis of the plasma concentration data for AZD9291 and AZ5104 and AZ7550 will be performed by Quantitative Clinical Pharmacology, AZ or delegate on behalf

of Quantitative Clinical Pharmacology. The actual sampling times will be used in the parameter calculations.

The ratio of metabolite to AZD9291 will be calculated. The plasma concentration data for AZD9291 and metabolites will also be analysed using a population pharmacokinetic approach, which may include exploring the influence of covariates on PK, if the data allows. The data collected in this study may also be combined with similar data from other studies and explored using population pharmacokinetic and/or pharmacokinetic-pharmacodynamic method. The results of any such analyses will be reported separately from the Clinical Study Report.

C<sub>max</sub>, C<sub>ss</sub> max, t<sub>max</sub> and t<sub>ss</sub> max will be determined by inspection of the concentration-time profiles. AUC(0-24) and AUC<sub>ss</sub> will be calculated using the linear up / log down trapezoidal rule. CL<sub>ss</sub>/F will be determined from the ratio of dose/AUC<sub>ss</sub> and accumulation ratio (RAC) will be calculated as the ratio of AUC<sub>ss</sub> after multiple dosing to AUC(0-24) after single dose.

Where possible the appropriate pharmacokinetic parameters will also be determined for the metabolites of AZD9291.

The ratio of metabolite to AZD9291 will be calculated.

The plasma concentration data for AZD9291 and metabolites will also be analysed using a population pharmacokinetic approach, which may include exploring the influence of covariates on PK, if the data allows. A pharmacokinetic-pharmacodynamic approach will be used to investigate the relationship between PK and selected primary, secondary and/or exploratory endpoints, where deemed appropriate. Results may be reported separately from the Clinical Study Report for the main study.

The data collected in this study may also be combined with similar data from other studies and explored using population pharmacokinetic and/or pharmacokinetic-pharmacodynamic method. The results of any such analyses will be reported separately from the Clinical Study Report

## **8.5 Methods for statistical analyses**

All efficacy analyses will be performed on the FAS population. Results of all statistical analyses will be presented using a 95% confidence interval and 2-sided p-value.

### **8.5.1 Analysis of the primary variable(s)**

PFS will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian) for generation of the p-value and using the Breslow approach for handling ties. The hazard ratio (HR) and confidence interval will be obtained directly from the U and V statistics as follows (Berry G et al 1991, Selke & Siegmund 1982):



$$HR = \exp(U/V)$$

$$95\% \text{ CI for HR} = (\exp\{U/V - 1.96/\sqrt{V}\}, \exp\{U/V + 1.96/\sqrt{V}\})$$

Where  $U = \sum_i(d_{1i} - e_{1i})$  is the log-rank test statistic (with  $d_{1i}$  and  $e_{1i}$  the observed and expected events in group 1) and  $\sqrt{V}$  the standard deviation of the log-rank test statistic obtained from the LIFETEST procedure with a STRATA term for the stratification variable.

The assumption of proportionality will be assessed. In the event on non-proportionality, the HR will be interpreted as an average HR over the observed extent of follow-up. Proportionality will be tested firstly by examining the plots of complementary log-log (event times) versus log (time) and, if necessary, a time dependent covariate will be fitted to assess the extent to which this represents random variation.

A Kaplan-Meier (KM) plot of PFS will be presented by treatment group.

### **Subgroup analysis**

Subgroup analyses will be conducted by comparing PFS between treatments in the following groups:

- Ethnicity (Asian versus Non-Asian)
- Gender (Male versus Female)
- Age at randomisation (<65 versus ≥65)
- Mutation status prior to start of study (ex19 versus L858R)
- Duration of prior EGFR TKI (<6 months, ≥6 months)
- Brain metastases at entry
- Smoking history.

The HR (AZD9291: chemotherapy) and associated CI will be calculated from a Cox proportional hazards model (ties=Efron) that contains the treatment term, factor and treatment-by-factor interaction term. The treatment effect HRs for each treatment comparison along with their confidence intervals will be obtained for each level of the subgroup from this single model. The HRs and 95% CIs will be presented on a forest plot including the HR and 95% CI from the overall population (using the primary analysis).

No adjustment to the significance level for testing will be made since the subgroup analysis will be considered exploratory and may only be supportive of the primary analysis of PFS.

The presence of quantitative interactions will be assessed by means of an overall global interaction test. This will be performed in the overall population by comparing the fit of a Cox proportional hazards model including treatment, all covariates, and all covariate-by-treatment interaction terms, with one that excludes the interaction terms and will be assessed at the 2-sided 10% significance level. If the fit of the model is not significantly improved then it will be concluded that overall the treatment effect is consistent across the subgroups.

If the global interaction test is found to be statistically significant, an attempt to determine the cause and type of interaction will be made. Stepwise backwards selection will be performed on the saturated model, whereby (using a 10% level throughout) the least significant interaction terms are removed one-by-one and any newly significant interactions re-included until a final model is reached where all included interactions are significant and all excluded interactions are non-significant. Throughout this process all main effects will be included in the model regardless of whether the corresponding interaction term is still present. This approach will identify the factors that independently alter the treatment effect and prevent identification of multiple correlated interactions.

Any quantitative interactions identified using this procedure will then be tested to rule out any qualitative interaction using the approach of [Gail and Simon 1985](#).

### **Sensitivity analyses**

#### **(a) Ascertainment bias**

The possibility of bias in assessment and measurement of PFS by investigators will be assessed using the blinded independent central review assessment of disease progression by RECIST. The hazard ratios from investigator assessment and BICR assessment of PFS will be assessed. If they are sufficiently close, no more scans will be reviewed. If they are not sufficiently close, all scans will be reviewed and a HR calculated from the BICR of all patients. Further details will be provided in the SAP.

#### **(b) Evaluation-time bias**

In order to assess possible evaluation-time bias, that could occur if scans are not performed at the protocol-scheduled time points, the midpoint between the time of progression and the previous evaluable RECIST assessment will be analyzed using a stratified log rank test, as described for the primary analysis of PFS. For patients who die in the absence of progression, the date of death will be used to derive the PFS time used in the analysis.

#### **(c) Attrition bias**

Possible attrition bias will be assessed by repeating the primary PFS analysis, except that the actual PFS event times, rather than the censored times, of subjects who progressed or died in the absence of progression immediately following two, or more, non-evaluable tumour assessments will be included. In addition, subjects who take subsequent therapy prior to progression or death will be censored at their last evaluable assessment prior to taking the subsequent therapy. A Kaplan-Meier plot of the time to censoring, where the censoring indicator of the primary PFS analysis is reversed, will be presented.

## **8.5.2 Analysis of the secondary variable(s)**

### **8.5.2.1 Analysis of ORR**

ORR will be analyzed using a logistic regression with a covariate for ethnicity (Asian, Non-Asian). The results of the analysis will be presented in terms of an odds ratio together with its associated 95% profile likelihood confidence interval and 2-sided p-value. The p-value will be based on twice the change in log-likelihood resulting from the addition of a treatment factor to a model that contains the covariates defined above.

### **8.5.2.2 Analysis of DoR**

In order to analyze the secondary outcome variable of Duration of Response between arms the Expected Duration of Response (EDoR) will be derived for each treatment arm (Ellis S et al 2008). The EDoR is the product of the proportion of subjects responding to treatment and the mean DoR in responding subjects, and provides an estimate based on all randomized subjects. Treatments will be compared by calculating the ratio of EDoRs using an appropriate probability distribution for duration of response in responding subjects. The choice of probability distribution will be detailed in the SAP. The analysis of DoR will be stratified by the same covariates as the primary analysis, weighting each stratum inversely proportional to the within stratum variance of the log of the ratio of EDoRs. Additionally, descriptive data will be provided for the duration of response in responding subjects, including associated Kaplan-Meier curves (without any formal comparison of or p-value attached).

### **8.5.2.3 Analysis of DCR**

DCR will be analyzed using a logistic regression with a covariate for ethnicity (Asian, Non-Asian). The results of the analysis will be presented in terms of an odds ratio together with its associated 95% profile likelihood confidence interval and 2-sided p-value. The p-value will be based on twice the change in log-likelihood resulting from the addition of a treatment factor to a model that contains the covariates defined above.

### **8.5.2.4 Analysis of Tumour Shrinkage**

The best absolute change in target lesion tumour size from baseline and percentage change in target lesion tumour size from baseline will be summarized using descriptive statistics and presented at each timepoint and by randomized treatment group. The effect of AZD9291 on percentage change in tumour size will be estimated from an analysis of covariance (ANCOVA) model with a covariate for ethnicity (Asian, Non-Asian). The number of subjects, unadjusted mean and lsmeans for each treatment group will be presented, together with the difference in lsmeans, 95% confidence interval and corresponding p-value.

### **8.5.2.5 Analysis of OS**

OS data will be analyzed using the same methodology and model as for the analysis of PFS (provided there are sufficient events available for a meaningful analysis [ $>20$  deaths], if not descriptive summaries will be provided). Two interim analyses of OS will be performed and a final, optional analysis of OS may be performed. The first interim analysis of OS will be

performed at the time of the primary analysis of PFS. The second interim analysis of OS will be performed when the OS data are approximately 50% mature.

#### **8.5.2.6 Analysis of Time to PRO Symptom Deterioration**

Time to PRO symptom deterioration will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian) for generation of the p-value and using the Breslow approach for handling ties. The hazard ratio (HR) and confidence interval will be estimated using the same methods as for the primary endpoint of PFS, as described in Section 8.5.1.

#### **8.5.2.7 Analysis of PRO Symptom Improvement Rate**

Symptom Improvement Rate will be analyzed using a logistic regression with a covariate for ethnicity (Asian, Non-Asian). The results of the analysis will be presented in terms of an odds ratio together with its associated 95% profile likelihood confidence interval and 2-sided p-value. The p-value will be based on twice the change in log-likelihood resulting from the addition of a treatment factor to a model that contains the covariates defined above.

#### **8.5.2.8 Pharmacokinetics**

Pharmacokinetic concentration data will be summarised using appropriate summary statistics and further details will be provided in the SAP.

#### **8.5.2.9 Patients with EGFR T790M mutation status detected in baseline plasma sample (ctDNA)**

The efficacy of AZD9291 versus chemotherapy will be evaluated for the subgroups of patients with T790M detected in their baseline plasma sample and patients that are T790M negative by the plasma test. For PFS, the HR and associated 95% CI will be calculated and KM plots presented for each group. For ORR, the odds ratio and associated 95% CI will be presented for each group.

### **8.5.3 Exploratory analysis**

#### **PRO-CTCAE**

PRO-CTCAE data will be presented using summaries and descriptive statistics based on the Full Analysis Set and further details will be provided in the SAP.

#### **Healthcare Resource Use**

Healthcare Resource Use data will be presented using summaries and descriptive statistics, based on the Full Analysis Set and further details will be provided in the SAP.

#### **Exploratory analysis of post progression outcomes**

PFS2 will be analysed using the same method as the analysis of PFS. Time to first subsequent therapy, time to second subsequent therapy and time to change in symptoms (measured by PRO HRQoL questionnaires) will be summarised as appropriate and further details will be provided in the SAP.

#### **Exploratory analysis of characterising survival**

All further analysis of overall survival will be exploratory. The effect of baseline characteristics on overall survival in each randomized treatment arm will be summarised. As appropriate, time-varying outcomes measured during the study treatment and post progression phases will also be summarised. All subsequent treatments in each treatment arm will be summarised, including duration of treatments. For summaries, anti-cancer treatments will be grouped by mode of action (e.g. 1<sup>st</sup>/2<sup>nd</sup> generation EGFR TKIs, 3<sup>rd</sup> generation EGFR TKIs with T790M activity (e.g. AZD9291, others), platinum-based doublet chemotherapy, single agent chemotherapy).

Additional analysis of overall survival adjusting for the impact of subjects randomized to chemotherapy, who subsequently receive a 3<sup>rd</sup> generation EGFR TKI with T790M activity (ie, those who “switch” treatment) may be completed if this treatment sequence occurs in a significant proportion of subjects. Methods such as Rank Preserving Structural Failure Time (RPSFT) (Robins et al 1991), Inverse Probability of Censoring Weighting (IPCW) (Robins 1993) and other methods in development may be explored. The decision to adjust and final choice of methods will be based on a blinded review of the data and the plausibility of the underlying assumptions.

Further detail will be provided in the SAP and Payer Analysis Plan.

Summaries and analyses for other exploratory objectives will be documented in a separate analysis plan and will be reported outside the CSR in a separate report.

## **9. STUDY AND DATA MANAGEMENT BY ASTRAZENECA**

### **9.1 Training of study site personnel**

Before the first subject is entered into the study, an AstraZeneca representative will review and discuss the requirements of the Clinical Study Protocol and related documents with the investigational staff and also train them in any study specific procedures and the WBDC and ePRO system(s) utilised.

The Principal Investigator will ensure that appropriate training relevant to the study is given to all of these staff, and that any new information relevant to the performance of this study is forwarded to the staff involved.

The Principal Investigator will maintain a record of all individuals involved in the study (medical, nursing and other staff).

### **9.2 Monitoring of the study**

During the study, an AstraZeneca representative will have regular contacts with the study site, including visits to:

- Provide information and support to the Investigator(s)

- Confirm that facilities remain acceptable
- Confirm that the investigational team is adhering to the protocol, that data are being accurately and timely recorded in the CRFs, that biological samples are handled in accordance with the Laboratory Manual and that investigational product accountability checks are being performed
- This study plans to follow the principles of targeted monitoring and perform 100% Source Data Verification (SDV) on critical variables (including eligibility criteria) only. The expected overall SDV will be at least 50%
- Perform source data verification (a comparison of the data in the CRFs with the subject's medical records at the hospital or practice, and other records relevant to the study) including verification of informed consent of participating subjects. This will require direct access to all original records for each subject (e.g., clinic charts)
- Ensure withdrawal of informed consent to the use of the subject's biological samples is reported and biological samples are identified and disposed of/destroyed accordingly, and the action is documented, and reported to the subject.

The AstraZeneca representative will be available between visits if the Investigator(s) or other staff at the centre needs information and advice about the study conduct.

### **9.2.1 Source data**

Refer to the Clinical Study Agreement for location of source data.

### **9.2.2 Study agreements**

The Principal Investigator at each/the centre should comply with all the terms, conditions, and obligations of the Clinical Study Agreement, or equivalent, for this study. In the event of any inconsistency between this Clinical Study Protocol and the Clinical Study Agreement, the terms of Clinical Study Protocol shall prevail with respect to the conduct of the study and the treatment of subjects and in all other respects, not relating to study conduct or treatment of subjects, the terms of the Clinical Study Agreement shall prevail.

Agreements between AstraZeneca and the Principal Investigator should be in place before any study-related procedures can take place, or subjects are screened.

### **9.2.3 Archiving of study documents**

The Investigator follows the principles outlined in the Clinical Study Agreement (CSA).

## **9.3 Study timetable and end of study**

The end of the study is defined as 'the last visit of the last subject undergoing the study'.

The study is expected to start in Q3 2014 and to end by Q1 2018.

The study may be terminated at individual centres if the study procedures are not being performed according to GCP, or if recruitment is slow. AstraZeneca may also terminate the entire study prematurely if concerns for safety arise within this study or in any other study with AZD9291.

#### **9.4 Data management by AstraZeneca**

Data management will be performed by Cognizant Data Management Centre staff, according to the Data Management Plan. Adverse events and medical/surgical history will be classified according to the terminology of the latest version the Medical Dictionary for Regulatory Activities (MedDRA). Medications will be classified according to the AstraZeneca Drug Dictionary. Classification coding will be performed by the Medical Coding Team at the Cognizant Data Management Centre.

The data collected through third party sources will be obtained and reconciled against study data.

Data queries will be raised for inconsistent, impossible or missing data. All entries to the study database will be available in an audit trail.

The data will be validated as defined in the Data Management Plan. Quality control procedures will be applied to each stage of data handling to ensure that all data are reliable and have been processed correctly. The Data Management Plan will also clarify the roles and responsibilities of the various functions and personnel involved in the data management process.

When all data have been coded, validated, signed and locked, clean file will be declared. Any treatment revealing data may thereafter be added and the final database will be locked.

#### **Serious Adverse Event (SAE) Reconciliation**

SAE reconciliation reports are produced and reconciled with the Patient Safety database and/or the investigational site.

#### **Data Management of Genotype Data**

Any genotype data generated in this study will be stored in the AstraZeneca genotyping Laboratory Information Management System (LIMS) database, or other appropriate secure System within AstraZeneca and/or third party contracted to work with AstraZeneca to analyse samples.

#### **Data Associated with Human Biological Samples**

Data associated with biological samples will be transferred from laboratory(ies) internal or external to AstraZeneca.

## **Management of External Data**

Data associated with ePRO will be transferred from vendor to Cognizant Data Management Centre.

## **10. ETHICAL AND REGULATORY REQUIREMENTS**

### **10.1 Ethical conduct of the study**

The study will be performed in accordance with ethical principles that have their origin in the Declaration of Helsinki and are consistent with ICH/Good Clinical Practice, applicable regulatory requirements and the AstraZeneca policy on Bioethics and Human Biological Samples.

### **10.2 Subject data protection**

The Informed Consent Form will incorporate (or, in some cases, be accompanied by a separate document incorporating) wording that complies with relevant data protection and privacy legislation.

AstraZeneca will not provide individual genotype results to subjects, any insurance company, any employer, their family members, general physician or any other third party, unless required to do so by law.

Precautions are taken to preserve confidentiality and prevent genetic data being linked to the identity of the subject. In exceptional circumstances, however, certain individuals might see both the genetic data and the personal identifiers of a subject. For example, in the case of a medical emergency, an AstraZeneca Physician or an Investigator might know a subject's identity and also have access to his or her genetic data. Also Regulatory authorities may require access to the relevant files, though the subject's medical information and the genetic files would remain physically separate.

### **10.3 Ethics and regulatory review**

An Ethics Committee should approve the final study protocol, including the final version of the Informed Consent Form and any other written information and/or materials to be provided to the subjects. The Investigator will ensure the distribution of these documents to the applicable Ethics Committee, and to the study site staff.

The opinion of the Ethics Committee should be given in writing. The Investigator should submit the written approval to AstraZeneca before enrolment of any subject into the study.

The Ethics Committee should approve all advertising used to recruit subjects for the study.

AstraZeneca should approve any modifications to the Informed Consent Form that are needed to meet local requirements.



If required by local regulations, the protocol should be re-approved by the Ethics Committee annually.

Before enrolment of any subject into the study, the final study protocol, including the final version of the Informed Consent Form are to be approved by the national regulatory authority or a notification to the national regulatory authority is done, according to local regulations.

AstraZeneca will handle the distribution of any of these documents to the national regulatory authorities.

AstraZeneca will provide Regulatory Authorities, Ethics Committees and Principal Investigators with safety updates/reports according to local requirements.

Each Principal Investigator is responsible for providing the Ethics Committees/IRB with reports of any serious and unexpected adverse drug reactions from any other study conducted with the investigational product. AstraZeneca will provide this information to the Principal Investigator so that he/she can meet these reporting requirements.

#### **10.4 Informed consent**

The Principal Investigator(s) at each centre will:

- Ensure each subject is given full and adequate oral and written information about the nature, purpose, possible risk and benefit of the study
- Ensure each subject is notified that they are free to discontinue from the study at any time
- Ensure that each subject is given the opportunity to ask questions and allowed time to consider the information provided
- Ensure each subject provides signed and dated informed consent before conducting any procedure specifically for the study
- Ensure the original, signed Informed Consent Form(s) is/are stored in the Investigator's Study File
- Ensure a copy of the signed Informed Consent Form is given to the subject
- Ensure that any incentives for subjects who participate in the study as well as any provisions for subjects harmed as a consequence of study participation are described in the informed consent form that is approved by an Ethics Committee.

#### **10.5 Changes to the protocol and informed consent form**

Study procedures will not be changed without the mutual agreement of the International coordinating Investigators and AstraZeneca.

If there are any substantial changes to the study protocol, then these changes will be documented in a study protocol amendment and where required in a new version of the study protocol (Revised Clinical Study Protocol).

The amendment is to be approved by the relevant Ethics Committee and if applicable, also the national regulatory authority approval, before implementation. Local requirements are to be followed for revised protocols.

AstraZeneca will distribute any subsequent amendments and new versions of the protocol to each Principal Investigator(s). For distribution to Ethics Committee see Section 10.3.

If a protocol amendment requires a change to a centre's Informed Consent Form, AstraZeneca and the centre's Ethics Committee are to approve the revised Informed Consent Form before the revised form is used.

If local regulations require, any administrative change will be communicated to or approved by each Ethics Committee.

## **10.6 Audits and inspections**

Authorised representatives of AstraZeneca, a regulatory authority, or an Ethics Committee may perform audits or inspections at the centre, including source data verification. The purpose of an audit or inspection is to systematically and independently examine all study-related activities and documents, to determine whether these activities were conducted, and data were recorded, analysed, and accurately reported according to the protocol, Good Clinical Practice (GCP), guidelines of the International Conference on Harmonisation (ICH), and any applicable regulatory requirements. The Investigator will contact AstraZeneca immediately if contacted by a regulatory agency about an inspection at the centre.

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**Revised Clinical Study Protocol**

Drug Substance      AZD9291  
 Study Code            D5160C00003  
 Edition Number      3  
 Date \_\_\_\_\_

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**A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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Sponsor: AstraZeneca AB, 151 85 Södertälje, Sweden

AstraZeneca Research and Development  
 site representative

\_\_\_\_\_ Date  
 Clinical Development Manager  
 AZ Canada Inc.

The following Amendment(s) and Administrative Changes have been made to this protocol since the date of preparation:

Amendment No.	Date of Amendment	Local Amendment No:	Date of Local Amendment
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
Administrative Change No.	Date of Administrative Change	Local Administrative Change No.	Date of Local Administrative Change
1	_____	_____	_____
_____	_____	_____	_____

This submission document contains confidential commercial information, disclosure of which is prohibited without providing advance notice to AstraZeneca and opportunity to object.

Revised Clinical Study Protocol  
Drug Substance AZD9291  
Study Code D5160C00003  
Edition Number 3  
Date

This Clinical Study Protocol has been subject to a peer review according to AstraZeneca Standard procedures. The clinical study protocol is publicly registered and the results are disclosed and/or published according to the AstraZeneca Global Policy on Bioethics and in compliance with prevailing laws and regulations.



## **PROTOCOL SYNOPSIS**

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**A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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**International Coordinating Principal Investigators:**

### **Study site(s) and number of subjects planned**

Approximately 410 subjects will be randomized from 19 countries across approximately 160 centres in North America, Asia and Europe. Once 410 subjects have been randomized globally, recruitment will continue only in mainland China until approximately 50 Chinese subjects have been randomized.

<b>Study period</b>	<b>Phase of development</b>	
Estimated date of first subject enrolled globally	Q3 2014	III
Estimated date of last subject completed	Q1 2018	

## Study Design

This is a phase III, open-label, randomized study assessing the safety and efficacy of AZD9291 (80 mg, orally, once daily) versus platinum-based doublet chemotherapy in patients with Epidermal Growth Factor Receptor Mutation and T790M Mutation Positive (EGFRm+/T790M+), locally advanced or metastatic NSCLC who have progressed following treatment with an approved Epidermal Growth Factor Tyrosine Kinase Inhibitor (EGFR-TKI) agent.

In order to randomize approximately 410 subjects it is expected that an estimated 1034 subjects will be screened. Once 410 subjects have been randomized globally, recruitment will continue only in mainland China until approximately 50 Chinese subjects have been randomized.

A biopsy will be needed for central testing of T790M mutation status following confirmed disease progression on first line treatment with an EGFR TKI.

Suitable subjects will then be randomized to receive either AZD9291 (80mg orally, once daily) or platinum-based doublet chemotherapy (pemetrexed 500 mg/m<sup>2</sup> + carboplatin area under the plasma concentration–time curve AUC 5 or pemetrexed 500 mg/m<sup>2</sup> + cisplatin 75 mg/m<sup>2</sup>) on Day 1 of every 21-day cycle in a 2:1 (AZD9291: platinum-based doublet chemotherapy) ratio.

Subjects should continue on investigational product AZD9291 until a treatment discontinuation criterion is met. Subjects may continue to receive AZD9291 beyond RECIST 1.1 defined progression as long as they are continuing to show clinical benefit, as judged by the investigator.

Subjects can receive up to 6 cycles of pemetrexed + carboplatin/cisplatin as initial treatment. Subjects whose disease has not progressed after four cycles of platinum-based first-line chemotherapy may receive pemetrexed maintenance therapy. Subjects who progress according to RECIST 1.1 criteria prior to completion of initial doublet chemotherapy treatment or during pemetrexed maintenance monotherapy, may continue with chemotherapy treatment as long as they show clinical benefit, as judged by the investigator.

Subjects must be followed until evidence of RECIST 1.1 defined progression (regardless of reason for treatment discontinuation). It is important that subjects are assessed according to the intended scanning schedule to prevent the bias in analysis that can occur if one treatment group is assessed more or less often than the other.

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be given the opportunity to begin treatment with AZD9291 80mg, once daily. These subjects may continue treatment with AZD9291, as long as they show clinical benefit, as judged by the investigator.

If a subject has been deemed to have objective disease progression according to Investigator tumour assessment by RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subject's best interest, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy. Sites are to submit the next scheduled tumour assessment for central imaging review according to [Table 2](#).

If subjects are not eligible to cross-over to AZD9291, they will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.

Note: Throughout this document the term "platinum-based doublet chemotherapy", refers to "platinum" as both carboplatin and cisplatin.

## Objectives

### Primary Objective:

To assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy by assessment of Progression Free Survival (PFS).

### Outcome Measure:

Progression Free Survival (PFS) using investigator assessments according to Response Evaluation Criteria in Solid Tumours (RECIST 1.1).  
Sensitivity analysis of Progression Free Survival using Blinded Independent Central Review (BICR).

<b>Secondary Objective:</b>	<b>Outcome Measure:</b>
<p>To further assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy in terms of:</p> <ul style="list-style-type: none"> <li>- Objective Response Rate (ORR)</li> <li>- Duration of Response (DoR)</li> <li>- Disease Control Rate (DCR)</li> <li>- Tumour shrinkage</li> <li>- Overall Survival (OS)</li> </ul>	<p>ORR, DoR, DCR and tumour shrinkage using investigator assessments according to Response Evaluation Criteria in Solid Tumours (RECIST 1.1).</p> <p>Analysis of overall survival.</p>
<p>To assess the effect of AZD9291 compared to platinum-based doublet chemotherapy on subjects' disease-related symptoms and health related quality of life (HRQoL).</p>	<p>European Organization for Research and Treatment of Cancer Quality of Life Questionnaire – Core 30 items (EORTC QLQ-C30) and European Organization for Research and Treatment of Cancer Quality of Life Questionnaire – Lung Cancer 13 items (EORTC QLQ-LC13).</p> <p>EORTC QLQ-C30:  Questionnaire consisting of 30 items measuring subjects general cancer symptoms and functioning.</p> <p>EORTC QLQ-LC13:  A complementary questionnaire measuring lung cancer symptoms.</p>
<p>To characterise the pharmacokinetics (PK) of AZD9291 and metabolites in subjects receiving AZD9291.</p>	<p>PK exposure parameters derived from plasma concentrations of AZD9291, and metabolites AZ5104 and AZ7550.</p> <p>PK Parameters (CL<sub>ss</sub>/F, C<sub>ss</sub>, min and C<sub>ss</sub>, max AUC<sub>ss</sub>) will be derived using population PK analysis and reported separately to the CSR. Data from this study may form part of a pooled analysis with data from other studies.</p>

**Safety Objective:**

**Outcome Measure:**

<p>To assess the safety and tolerability profile of AZD9291 compared with platinum-based doublet chemotherapy.</p>	<p>Adverse events (graded by Common Terminology Criteria for Adverse Event (CTCAE v4)</p> <ul style="list-style-type: none"> <li>- Clinical chemistry, haematology and urinalysis</li> <li>- Vital signs (pulse and blood pressure), Physical Examination, Weight</li> <li>- Centrally reviewed digital Electrocardiogram (ECG)</li> <li>- Echocardiogram/ Multi Gated Acquisition Scan (MUGA) (for Left Ventricular Ejection Fraction)</li> <li>- World Health Organization (WHO) performance status</li> </ul>
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**Exploratory Objectives:**

**Outcome Measure:**

<p>To explore the relationship between PK and selected endpoints (which may include efficacy, safety and/or Patient Reported Outcome [PRO]), where deemed appropriate.</p>	<p>Correlation of PK with other primary /secondary/ exploratory endpoints in subjects treated with AZD9291.</p> <p>Results from such analyses will be reported separately from the Clinical Study Report (CSR).</p> <p>Data from this study may also form part of a pooled analysis with other AZD9291 studies.</p>
<p>To compare the effects of AZD9291 compared with chemotherapy on post progression outcomes</p>	<p>Time from randomization to second progression (PFS2)</p> <p>Time to subsequent treatments</p> <p>Time to change in symptoms (including post progression assessments)</p>
<p>To further characterise the effects of AZD9291 on survival outcomes.</p>	<p>Assess the impact on overall survival of baseline potentially prognostic factors (e.g. tumour stage, performance status, sex, baseline lactate dehydrogenase [LDH])</p> <p>Assess the impact on OS of subsequent treatments and other potential covariates (e.g. changes in performance status)</p>
<p>To compare adverse events by subject self-reporting of specific CTCAE symptoms (where applicable) between AZD9291 and chemotherapy.</p>	<p>Collection of approximately 28 PRO-CTCAE symptoms via an electronic device solution (in countries where language is available).</p>

**Exploratory Objectives:**

**Outcome Measure:**

<p>To compare AZD9291 treatment with chemotherapy treatment on health state utility.</p>	<p>The EQ-5D-5L health state utility index will be used to derive health state utility based on subject reported data.</p>
<p>To compare health resource use associated with AZD9291 treatment with chemotherapy treatment.</p>	<p>Health resource utilisation measures including hospitalization, outpatient visits, or emergency department visits.</p>
<p>To characterise the pharmacokinetics (PK) of AZD9291 and metabolites in cerebrospinal fluid (CSF).</p>	<p>Concentration of AZD9291, AZ5104 and AZ7550. Ratio of metabolites to AZD9291.  Ratio of CSF to plasma concentration.  Summaries of PK concentration data.</p>
<p>To collect and store deoxyribonucleic acid (DNA) for future exploratory research into genes/genetic variation that may influence PK or response to AZD9291, platinum-based doublet chemotherapy (ie, absorption, distribution, metabolism, excretion, safety and efficacy) and/or susceptibility to/development of cancers.</p>	<p>Correlation of polymorphisms with variation in Pharmacokinetics (PK), Pharmacodynamics (PD), safety or response observed in subjects treated with AZD9291 or comparator.  Data generated may be reported separately and may also form part of a pooled analysis with other AZD9291 studies.</p>
<p>To collect and store tumour samples and blood-based samples for potential for exploratory research into factors that may influence susceptibility to/development of NSCLC/cancer and/or response to AZD9291 (where response is defined broadly to include efficacy, tolerability or safety).</p>	<p>Analysis of key genetic and proteomic markers to include, but not limited to, EGFR mutations, Human Epidermal Growth Factor Receptor 2 (HER2) &amp; CMET expression and/or amplication.  Collection of plasma samples to include, but not be limited to, extraction of circulating tumour DNA (ctDNA) for investigation of blood borne biomarkers. The sample may be used to investigate the relationship between PK and blood-borne biomarkers.  Samples may be analysed retrospectively. Any biomarker data generated may be reported separately and may also form part of a pooled analysis with other AZD9291 studies.</p>

**Exploratory Objectives:**

**Outcome Measure:**

<p>To collect and store plasma for isolation of ctDNA. Extracted ctDNA will be assessed for the presence of genetic aberrations including, but not limited to, EGFR mutations (T790M, L858R, etc). These samples may be shared with a diagnostic partner for development of a ctDNA test for T790M detection.</p>	<p>Retrospective/real-time analysis of EGFR (and other) mutations in ctDNA from all study subjects (mandatory).</p>
<p>To collect and store residual CSF for potential exploratory research of factors that may influence development of NSCLC and/or response to AZD9291 (where response is defined broadly to include efficacy, tolerability or safety).</p>	<p>Collection of CSF for the investigation of PK and/or biomarkers. Samples may be analysed retrospectively.</p>

**Target subject population**

Male and female subjects aged 18 years and over (subjects from Japan aged at least 20 years) who have histologically or cytologically proven NSCLC that is locally advanced or metastatic and not amenable to further surgery or radiotherapy with curative intent and whose disease has progressed with previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy.

Subjects must be eligible to receive treatment with the selected platinum-based doublet chemotherapy (pemetrexed + cisplatin /carboplatin) in accordance with local prescribing information and have documentation of EGFR Mutation (at any time since a diagnosis of NSCLC was made) and T790M Mutation positive tumour. Subjects must have measurable disease (using Computer Tomography [CT]/Magnetic Resonance Imaging [MRI]) as defined by RECIST 1.1 guidelines and WHO Performance Status of 0-1.

**Duration of treatment**

Treatment with AZD9291 80 mg, once daily, will commence following randomization. Subjects may continue to receive treatment with AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria (see Section 3.7).

Treatment with intravenous platinum-based doublet chemotherapy (on Day 1 of every 21 day cycle) will commence following randomization up to a total of 6 cycles. Patients whose disease has not progressed after four cycles of platinum-based first-line chemotherapy may receive pemetrexed maintenance therapy.

Subjects who progress according to RECIST 1.1 criteria prior to completion of initial doublet chemotherapy treatment or during pemetrexed maintenance monotherapy, may continue with treatment as long as they show clinical benefit, as judged by the investigator.

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be given the opportunity to begin treatment with AZD9291 80mg, once daily. These subjects may continue treatment with AZD9291 as long as they show clinical benefit, as judged by the investigator.

If a subject has been deemed to have objective disease progression according to Investigator tumour assessment by RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subject's best interest, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy. Sites are to submit the next scheduled tumour assessment for central imaging review according to [Table 2](#).

### **Investigational product, dosage and mode of administration**

AZD9291 is an oral, potent, selective, irreversible inhibitor of both EGFR-TKI sensitising and resistance mutations in NSCLC with a significant selectivity margin over wild-type EGFR. AZD9291 will be administered orally as one 80 mg tablet once a day. A cycle of treatment is defined as 21 days of once daily AZD9291 treatment.

### **Comparator product, dosage and mode of administration**

- Platinum-based doublet chemotherapy will be administered intravenously on Day 1 of every 21-day cycle of either:
  - Pemetrexed 500mg/m<sup>2</sup> + carboplatin AUC5.
- Or
- Pemetrexed 500mg/m<sup>2</sup> + cisplatin 75mg/m<sup>2</sup>.

In order to reduce the incidence and severity of skin reactions, a corticosteroid should be given the day prior to, on the day of, and the day after pemetrexed administration. The corticosteroid should be equivalent to 4mg of dexamethasone administered orally twice a day.

To reduce toxicity, subjects treated with pemetrexed must also receive vitamin supplementation. Subjects must take oral folic acid or a multivitamin containing folic acid (350 to 1000 micrograms) on a daily basis. At least five doses of folic acid must be taken during the seven days preceding the first dose of pemetrexed, and dosing must continue during the full course of therapy and for 21 days after the last dose of pemetrexed. Subjects must also receive an intramuscular injection of vitamin B12 (1,000 micrograms) in the week preceding the first dose of pemetrexed and once every three cycles thereafter. Subsequent vitamin B12 injections may be given on the same day as pemetrexed. Subjects may also receive other pre-



treatment / concomitant treatment as recommended by approved label for pemetrexed, carboplatin or cisplatin as clinically indicated by the investigator.

The wash out period between stopping the randomized chemotherapy and/or associated supportive treatments (i.e. corticosteroids, radiation), and starting AZD9291 80mg, once daily, in subjects eligible for cross-over is at least 14 days. Any unresolved toxicities from prior therapy should be controlled, and be no greater than CTCAE grade 1 (with the exception of alopecia which may be grade 2) at the time of starting AZD9291 treatment.

### **Statistical methods**

Subjects will be randomized to the trial in a 2:1 ratio:

- AZD9291 80mg will be administered orally once a day
- Or
- Platinum-based doublet chemotherapy will be administered intravenously on Day 1 of every 21-day cycle of either:
  - o pemetrexed 500mg/m<sup>2</sup> + carboplatin AUC5
  - Or
  - o pemetrexed 500mg/m<sup>2</sup> + cisplatin 75mg/m<sup>2</sup>

Subjects will be stratified at randomization based on ethnicity (Asian/Non-Asian).

PFS is the primary endpoint for this study. Approximately 410 subjects will be randomized in a 2:1 ratio (AZD9291: platinum-based doublet chemotherapy) in this study.

The primary analysis of PFS will occur when at least 221 progression events have been observed out of the 410 globally randomized subjects. With 221 progression events, the study will have at least 80% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were HR 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed. The smallest treatment difference that would be statistically significant is a PFS HR of 0.76 (this translates into an approximate 2 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed). Assuming 15 months non-linear recruitment, 221 PFS events are expected to occur approximately 20 months after the first subject is randomized in the study.

Three analyses of overall survival will be conducted. The data cut-off for the first analysis will be performed approximately 4 months after data cut-off for the primary analysis of PFS, and the second analysis will be performed when the OS data are approximately 50% mature (approximately 205 death events). The final (third) analysis of overall survival will be performed when the OS data are approximately 70% mature (approximately 287 death events).

PFS will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian). The primary analysis will be based on investigator-recorded assessment of disease progression by RECIST; a sensitivity analysis will also be performed using a blinded independent central review (BICR).

Secondary endpoints of ORR, DoR, DCR and Tumour Shrinkage will be analyzed at the time of the primary PFS analysis. OS will be summarised only at the time of the primary analysis (a summary of the frequency of deaths and primary cause of death will be provided for safety purposes); the analysis of OS will be performed approximately 4 months after the data cut-off for the primary analysis of PFS.

In order to provide strong control of the type I error rate (2-sided 5%), the primary endpoint (PFS) and key secondary endpoints (ORR and OS) will be tested in a sequential order. If any previous analysis in the sequence is not statistically significant, the alpha spending cannot be transferred to subsequent analyses. Since three OS analyses are planned, the Lan DeMets approach that approximates the O'Brien and Fleming spending function will be used to maintain an overall 2-sided 5% type I error across the testing of three planned analyses of OS.

The safety and efficacy data collected for Chinese subjects after global recruitment has closed will be combined with data from the Chinese subjects recruited prior to the end of global recruitment, and summarised and analysed separately. This China cohort will provide standalone safety and efficacy analyses of subjects from China and will be reported separately from the Clinical Study Report. These analyses may be performed at the time of the primary PFS analysis if at least 20 PFS events have been observed out of approximately 50 Chinese subjects, otherwise summaries of efficacy will be provided only. Additional follow-up of Chinese subjects if deemed appropriate may be performed when the PFS data are more mature (for example, 70% maturity, as consistent with the primary global PFS analysis).

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## LIST OF ABBREVIATIONS AND DEFINITION OF TERMS

The following abbreviations and special terms are used in this study Clinical Study Protocol.

<b>Abbreviation or special term</b>	<b>Explanation</b>
AE	Adverse event
ALP	Alkaline Phosphatase
ALT	Alanine Aminotransferase
AnLK	Anaplastic lymphoma kinase
ANSM	Agence Nationale de Securite du Medicaments
ASCO	American Society of Clinical Oncology
AST	Aspartate Aminotransferase
ATP	Adenosine Triphosphate
AUC	Area under the curve (plasma concentration / time curve)
AUC5	Area under the plasma concentration–time curve 5 mg/ml per minute
AUC (0-24)	Area under the curve (plasma concentration / time curve from zero to 24 hours)
AUC <sub>ss</sub>	Plasma Clearance at Steady State
AZ	AstraZeneca
BCRP	Breast Cancer Resistance Protein
BICR	Blinded Independent Central Review
BoR	Best Overall Response
BP	Blood Pressure
BSA	Body Surface Area
BUN	Blood urea nitrogen
CI	Confidence Interval
CK	Creatine Kinase
CL <sub>ss</sub> /F	Plasma Clearance at Steady State
C <sub>max</sub>	Maximum plasma concentration
CMET	Proto-oncogene encoding Hepatocyte Growth Factor Receptor
CR	Complete response
CRF	Case Report Form (electronic/paper)
CRO	Clinical Research Organization

<b>Abbreviation or special term</b>	<b>Explanation</b>
CSF	Cerebrospinal Fluid
CSR	Clinical Study Report
Css	Concentration at Study State
CT	Computer Tomography
CTCAE	Common Terminology Criteria for Adverse Event
<i>ct</i> DNA	Circulating tumour Deoxyribonucleic acid
CYP	Cytochrome P450
DAE	Discontinuation of Investigational Product due to Adverse Event
DCO	Data cut off
DCR	Disease Control Rate
DLT	Dose limiting toxicity
DMC	Data Monitoring Committee
DNA	Deoxyribonucleic acid
DoR	Duration of Response
DUS	Disease under Study
EC	Ethics Committee, synonymous to Institutional Review Board (IRB) and Independent Ethics Committee (IEC)
ECG	Electrocardiogram
EDoR	Expected Duration of Response
EGFR	Epidermal Growth Factor Receptor
EGFRm+	EGFR Mutation positive
EORTC QLQ-C30	European Organization for Research and Treatment of Cancer Quality of Life Questionnaire – Core 30 items
EORTC QLQ LC13	European Organization for Research and Treatment of Cancer Quality of Life Questionnaire – Lung Cancer 13 items
EU	European Union
Ex19Del	Deletions in exon 19
FDA	Food and Drug Administration
FFPE	Formalin Fixed and Paraffin Embedded
FFST	Time to First Subsequent Therapy or Death
FSH	Follicle-Stimulating Hormone
FSI	First Subject In
G719X	An in-frame amino acid (glycine (G)) deletion at position 719 in EGFR

<b>Abbreviation or special term</b>	<b>Explanation</b>
GCP	Good Clinical Practice
GFR	Glomerular Filtration Rate
GMP	Good Manufacturing Practice
HDPE	High-Density-Polyethylene
HER2	Human Epidermal Growth Factor Receptor 2
HR	Hazard Ratio
HIV	Human Immunodeficiency Virus
HRQoL	Health Related Quality of Life
IB	Investigator's Brochure
ICF	Informed Consent Form
ICH	International Conference on Harmonisation
ICR	Independent Central Review
ILD	Interstitial Lung Disease
INR	International Normalized Ratio
International Co-ordinating investigator	If a study is conducted in several countries the International Co-ordinating Investigator is the Investigator co-ordinating the investigators and/or activities internationally.
IP	Investigational Product
IUS	Intra Uterine System
iv	Intravenous
IVRS	Interactive Voice Response System
IWRS	Interactive Web Response System
KRAS	Kirsten Rat Sarcoma Viral Oncogene Homolog
LDH	Lactate Dehydrogenase
LDL	Low-density Lipoprotein
LH	Luteinizing Hormone
LSLV	Last Subject Last Visit
LVEF	Left Ventricular Ejection Fraction
MedDRA	Medical Dictionary for Regulatory Activities
MPA	Medical Products Agency
MRI	Magnetic resonance imaging
MUGA	Multi Gated Acquisition Scan

<b>Abbreviation or special term</b>	<b>Explanation</b>
NCI	National Cancer Institute
NE	Not evaluable
NSCLC	Non-Small Cell Lung Cancer
NTL	Non-target Lesion
NYHA	New York Heart Association
OAE	Other Significant Adverse Event
ORR	Objective Response Rate
OS	Overall Survival
P	Probability
PD	Progression of disease
PD	Pharmacodynamics
PFS	Progression Free Survival
PFSs	Time from Randomization to Second Progression
PGx	Pharmacogenetics
PI	Principal Investigator
PK	Pharmacokinetics
PR	Partial Response
Pre-treatment:	Medication used before chemotherapy, e.g., folic acid, corticosteroid and vitamin B12 or anti-emetic drugs according to the respective chemotherapy local labels (cisplatin, carboplatin and pemetrexed).
Pre-medication:	Medication used to prevent study drug side effects, for example, to treat diarrhoea once it is detected, and used as long as needed. It can also be used prophylactically in case subjects are prone to develop a particular adverse event.
PRO	Patient Reported Outcome
QD	Once daily
QT	Interval on the electrocardiogram representing the duration of depolarization and repolarization of the heart
QTc	The QT interval corrected for heart rate
RAC	Accumulation on Multiple Dosing
RECIST 1.1	Response Evaluation Criteria in Solid Tumors version 1.1
RR	Response Rate
SAE	Serious adverse event
SDV	Source Data Verification

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<b>Abbreviation or special term</b>	<b>Explanation</b>
SAP	Statistical Analysis Plan
SD	Stable disease
SDV	Source Data Verification
SoC	Standard of Care
SPC	EU Summary of Product Characteristics
T790M	An amino acid substitution at position 790 in EGFR, from a Threonine (T) to a Methionine (M)
T790M+	T790M mutation positive
TKI	Tyrosine Kinase Inhibitor
TL	Target Lesion
tmax	Time to Cmax
tss max	Time to Css max
TSST	Time to Second Subsequent Therapy or Death
ULN	Upper Limit of Normal
US	United States
WBDC	Web Based Data Capture
WHO	World Health Organization

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## 1. INTRODUCTION

### 1.1 Non-small Cell Lung Cancer (NSCLC)

Lung cancer has been the most common cancer in the world for several decades, and by 2008, there were an estimated 1.61 million new cases, representing 12.7% of all new cancers. It was also the most common cause of death from cancer, with 1.38 million deaths (18.2% of the total) ([GLOBOCAN 2008](#)). NSCLC represents approximately 80% to 85% of all lung cancers. Unfortunately, at the time of diagnosis approximately 70% of NSCLC patients already have advanced or metastatic disease not amenable to surgical resection. Furthermore, a significant percentage of early stage NSCLC patients who have undergone surgery subsequently develop distant recurrence and die as a result of their lung cancer ([Pisters & Le Chevalier 2005](#)). Patients presenting with unselected advanced NSCLC have a median overall survival (OS) of 10 to 12 months ([Bonomi 2010](#)).

Treatment of advanced NSCLC can be guided by the presence of certain molecular drivers such as EGFR, anaplastic lymphoma kinase (AnLK) and KRAS mutations. The incidence of Epidermal Growth Factor Receptor mutation positive (EGFRm+) NSCLC is approximately 10-15% and 30-40% of patients in the West and Asia, respectively.

Although first- (eg, erlotinib, gefitinib) and second-generation (eg, afatinib) Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitors (EGFR TKIs) are established therapies for patients with NSCLC known to have activating mutations in EGFR (EGFRm+), the emergence of a secondary T790M mutation in patients treated with an EGFR TKI agent has been described as a major route of development of resistance to this class of therapy ([Pao et al 2005](#), [Kobayashi et al 2005](#)) in approximately 60% of patients ([Yu et al 2013](#)).

In the advanced NSCLC post-EGFR TKI treatment failure setting, prolonged survival rates remain very low (median OS in the region of 1 to 2 years, [Wang et al 2012](#), [Wu et al 2010](#), [Fukuoka et al 2011](#)). No approved therapy is currently available for patients with T790M mutation positive (T790M+) tumours that have acquired EGFR TKI resistance or refractoriness. There is no data on response rates (RRs) with single agent chemotherapy in the specific subset of T790M+ patients after failure of EGFR TKI.

Treatment guidelines for 2<sup>nd</sup> line treatment of EGFRm+ NSCLC include using platinum based chemotherapy doublet treatment (e.g. U.S. [NCCN 2012](#) guidelines). Second-line platinum-based chemotherapy post EGFR TKI for EGFRm+ NSCLC generally provides RRs in the range of 20 to 30% ([Gridelli et al 2012](#), [Goldberg et al 2012](#), [Maemondo et al 2010](#), [Wang et al 2012](#), [Wu et al 2010](#)). Although slightly better than the RRs that can be expected with single-agent chemotherapy in later lines, these data together with the toxicity burden associated with doublet chemotherapy (that includes nausea, vomiting, bone marrow suppression resulting in high risk of infection and bleeding, alopecia, fatigue, and peripheral neuropathy) confirm the unmet medical need that exists in this patient population.

## 1.2 Background and rationale for conducting this study

Activation of the EGFR tyrosine kinase triggers a cascade of intracellular downstream signalling events affecting cell proliferation, survival, angiogenesis and, potentially, metastases. Selective inhibition of EGFR tyrosine kinase has demonstrated clinical benefit in approximately 70% of patients with advanced NSCLC harbouring the sensitivity mutations (the most common of which are L858R and deletions in exon 19 (Ex19del), described collectively as EGFR mutation). The tumours initially respond to EGFR-TKIs, but subsequently develop resistance to therapy, with a median time to progression of nine months. In approximately 60% of these initially EGFR-TKI responsive patients (Yu et al 2013), disease progression is associated with the emergence of a secondary EGFR mutation, T790M in exon 20 of EGFR, which confers resistance to EGFR-TKI therapy (Pao et al 2005). The T790M resistance mutation is located in the hinge region of the kinase domain of the adenosine triphosphate (ATP) binding pocket of the EGFR protein, where the bulky methionine side chain prevents binding of the EGFR-TKIs (Heuckmann et al 2012).

AZD9291 is a potent irreversible inhibitor of both the single EGFR<sup>m+</sup> (TKI sensitivity conferring mutation) and dual EGFR<sup>m+</sup>/T790M<sup>+</sup> (TKI resistance conferring mutation) receptor forms of EGFR with a significant selectivity margin over wild-type EGFR. Therefore AZD9291 has the potential to provide clinical benefit to patients with advanced NSCLC harbouring both the single sensitivity mutations and the resistance mutation following prior therapy with an EGFR-TKI. The clinical development programme with AZD9291 will initially assess the safety and efficacy of AZD9291 in patients with advanced NSCLC whose cancers have progressed following an EGFR-TKI regimen (with or without additional chemotherapy regimens), as they currently represent a major unmet medical need population. Importantly, preliminary data from an ongoing phase I study (D5160C00001) in this patient population has demonstrated good evidence of efficacy in patients who have progressed on or after an approved EGFR TKI only or additional therapies ( $\geq$  2nd line), while treatment with AZD9291 has been well tolerated across a range of doses (refer to the latest edition of the Investigator Brochure for further details) (Ranson et al WCLC 2013).

## 1.3 Rationale for study design, doses and control groups

No approved therapies currently exist to specifically target T790M<sup>+</sup> acquired EGFR-TKI resistance, which represents the most common resistance mechanism in the majority of NSCLC patients with acquired EGFR-TKI resistance. The purpose of this study is to further characterise and confirm the efficacy and safety of AZD9291 in EGFR<sup>m+</sup>/T790M<sup>+</sup> NSCLC patients who have acquired resistance to an EGFR-TKI (and who are chemotherapy naive) observed in the ongoing phase I study (D5160C00001).

The majority of patients with EGFR<sup>m+</sup> NSCLC respond well initially to treatment with EGFR-TKIs with an Objective Response Rate (ORR) of approximately 60 to 70%, but eventually develop resistance with a median time to progression of around 9-11 months. In at least half of initially TKI-responsive patients, disease progression is associated with the emergence of a secondary EGFR mutation, called T790M mutation in exon 20 of the EGFR

gene. There are no current effective recommended standard of care therapies for these NSCLC patients with acquired EGFR-TKI resistance who are T790M+. Treatment guidelines for 2<sup>nd</sup> line treatment of EGFRm+ NSCLC include using platinum based chemotherapy doublet treatment (e.g. [NCCN 2012](#)).

A commonly used platinum doublet is pemetrexed in combination with cisplatin or carboplatin. Pemetrexed in combination with cisplatin demonstrated superior OS compared to Gemcitabine in combination with cisplatin in previously untreated advanced NSCLC patients with non-squamous histology (adenocarcinoma and large cell carcinoma) in a randomised phase III trial: 12.6 vs. 10.9 (with adenocarcinoma) and 10.4 vs 6.7 months (with large-cell carcinoma) respectively ([Scagliotti et al 2008](#)). Pemetrexed in combination with cisplatin reported lower rates of grade 3 or 4 neutropenia, anaemia, thrombocytopenia, febrile neutropenia and alopecia, and higher rates of grade 3 or 4 nausea, compared to Gemcitabine in combination with cisplatin. Pemetrexed in combination with either Cisplatin or Carboplatin is therefore an appropriate control arm treatment in this phase III trial.

This patient population with a major unmet medical need is therefore appropriate to evaluate the efficacy and safety of AZD9291 in this study.

The study design has been discussed with the US Food and Drug Administration (FDA), Swedish Medical Products Agency (MPA) and French Agence Nationale de Securite du Medicaments (ANSM) during Scientific Advice consultations and all key aspects of the Phase III 2<sup>nd</sup> line study design including Progression Free Survival (PFS) as primary endpoint, dose rationale and patient population were supported.

Given the unmet medical need that exists in the aforementioned patient population alongside the lack of well-proven treatment options, and given the good evidence of efficacy with AZD9291 (>50% RR in T790M+ population) and well tolerated profile reported in ongoing phase I study in T790M+ patient population ([Ranson et al WCLC 2013](#)), it is considered appropriate to assess efficacy and safety of AZD9291 in a randomised open-label phase III study in 2<sup>nd</sup> line NSCLC versus pemetrexed in combination with cisplatin or carboplatin.

Once 410 subjects have been randomized globally, recruitment will continue only in mainland China until approximately 50 Chinese subjects have been randomized. This is to ensure adequate Chinese subject participation to satisfy China Regulatory Authority requirements; it is anticipated that this target may not be met before the global recruitment of 410 is achieved.

The primary objective of this study is PFS. This is an appropriate primary efficacy endpoint in this NSCLC population and may be associated with an improvement in OS, delay to time of initiation of subsequent therapies, symptom control, and quality of life. Secondary efficacy endpoints are those that are appropriate to this patient population and include, Duration of response (DoR), Disease Control Rate (DCR) [DCR: Complete response (CR) + Partial Response (PR) + Stable disease (SD)] and overall survival. Characterisation of pharmacokinetics (PK) as well as the safety and tolerability of AZD9291 will also be assessed as a secondary endpoint.



Several exploratory endpoints will be evaluated (see Section 2.4). These include assessment of the effect of AZD9291 compared with chemotherapy on post progression outcomes such as time from randomization to second progression and time to subsequent treatments. Additional exploratory endpoints will include comparisons of AZD9291 with chemotherapy on health state utility (using EQ-5D-5L health state utility index) and resource utilization (e.g. hospital visits), patient self-reporting of adverse events, the relationship between PK and selected endpoints, tumour samples and biomarkers (ctDNA for the assessment of biomarkers) and tumour biopsy for companion diagnostic development.

The collection of cerebrospinal fluid (CSF) from a select number of subjects who provide voluntary optional consent will enable the investigation of the ability of AZD9291, AZ5104 and AZ7550 to cross the blood brain barrier. Brain metastases occur in 20-30% of patients with advanced NSCLC, and are associated with poor prognosis (Porta et al 2011). The first generation EGFR TKI agents have demonstrated only limited efficacy in treating brain metastases (Bai & Han 2013, Shimato et al 2006), however, preclinical data suggests that AZD9291 may be capable of crossing the blood brain barrier (see Investigator Brochure) and potentially may offer better exposures in this anatomically protected location.

Overall, the totality of primary, secondary and exploratory endpoints in this study will allow a robust characterisation of overall benefit / risk of AZD9291 for patients with metastatic, EGFR T790M+ mutation-positive, non-small cell lung cancer (NSCLC) whose NSCLC has progressed during treatment with an FDA-approved, EGFR tyrosine kinase inhibitor.

The dose of 80 mg once daily was selected from a review of all available safety, tolerability, PK and efficacy data from study D5160C00001, in patients with advanced NSCLC who have progressed following prior therapy with a prior EGFR TKI agent. At the Investigator Brochure (IB) data cut-off of 19 November 2013, AZD9291 had been administered as a capsule formulation across the dose range of 20 to 240mg once daily in this study: 20 mg (n=21), 40 mg (n=55), 80 mg (n=47), 160 mg (n=40) and 240 mg (n=7). No dose limiting toxicities (DLTs) have been reported at any dose level in the escalation cohorts during the 21-day DLT evaluation period. Subjects have once daily doses of AZD9291 for durations of at least 10 months depending on the dose level. Emerging efficacy data has demonstrated durable objective responses from the starting dose level of 20 mg once daily (Ranson et al WCLC 2013). The selected 80 mg dose is four fold higher than the minimum efficacious dose tested in study D5160C00001, whilst still being one third of the maximum dose level investigated (240 mg). The 80 mg dose level is considered to have a safety and tolerability profile appropriate for chronic administration to subjects with advanced NSCLC.

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be given the opportunity to begin treatment with AZD9291 80mg, once daily. These subjects may continue treatment with AZD9291 as long as they show clinical benefit, as judged by the investigator.

If a subject has been deemed to have objective disease progression according to Investigator tumour assessment by RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subject's best interest, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy. Sites are to submit the next scheduled tumour assessment for central imaging review according to [Table 2](#).

If subjects are not eligible to cross-over to AZD9291, they will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.

#### **1.4 Benefit/risk and ethical assessment**

In the advanced NSCLC post-EGFR TKI treatment failure setting that has been chosen for initial study with AZD9291, median survival is modest (~16 months for second line therapy, ~10 months for third line therapy) with no effective treatment options currently available. This population therefore represents a major unmet medical need. Although there can be no certainty of clinical benefit to patients, the biological hypothesis, non-clinical and, in particular, the preliminary clinical efficacy and safety data with AZD9291 in the ongoing phase I trial (D5160C00001) support the notion that dual EGFR mutation inhibition may be a valid target for the treatment of EGFR T790M mutation-positive NSCLC tumours driven. Specifically the safety profile of AZD9291 is (in the ongoing phase I trial) modest with the majority of adverse events being non-clinically significant EGFR-related adverse events ie, diarrhoea and skin rash. All trials of AZD9291 exclude patients with clinically significant toxicities related to prior treatments in addition to specifically excluding patients with a history of interstitial lung disease (ILD) or clinically active interstitial lung disease as this is an uncommon but well documented EGFR related toxicity. All patients will be assessed for possible known EGFR-related toxicities and detailed information on the management of EGFR-related gastrointestinal, dermatological and ophthalmic is being provided for all AZD9291 studies.

It is therefore reasonable and appropriate to evaluate the oral administration of AZD9291 in comparison to standard platinum-based doublet chemotherapy as a second-line therapy in this unmet medical need post-EGFR TKI EGFR T790M mutation-positive NSCLC patient population, according to the proposed study design.

#### **1.5 Study Design**

This is a phase III, open label, randomized study to assess the safety and efficacy of AZD9291 (80 mg, orally, once daily) versus platinum-based doublet chemotherapy in second-line patients with EGFR T790M mutation-positive, locally advanced or metastatic NSCLC, who have progressed following treatment with an approved epidermal growth factor tyrosine kinase inhibitor agent.

Subjects will have to provide a mandatory biopsy sample for central testing of T790M mutation status following confirmed disease progression on the most recent treatment

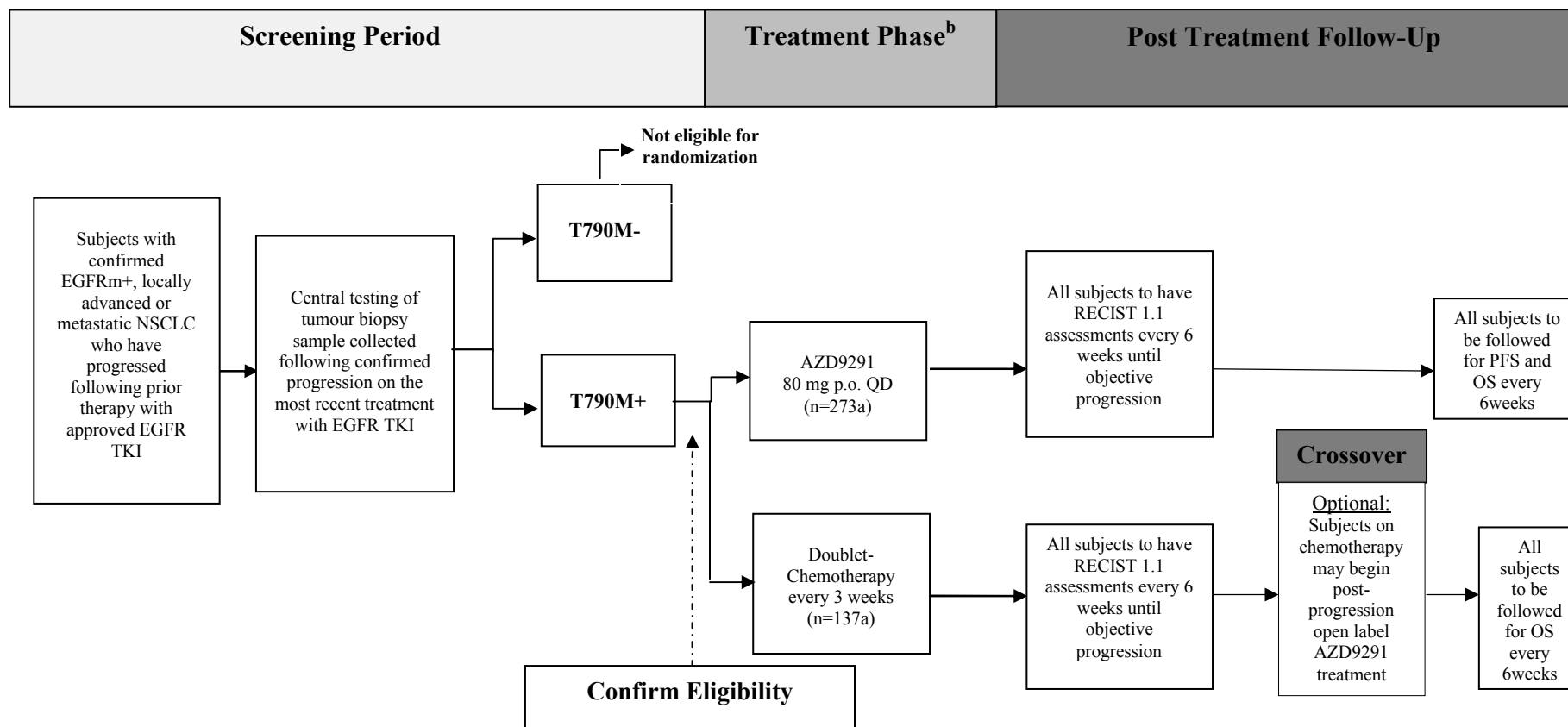
regimen. The T790M mutation status of the subject's tumour must be determined by a designated central laboratory using the cobas<sup>®</sup> EGFR Mutation Test (Roche Molecular Systems).

Subjects should continue on study treatment until Response Evaluation Criteria in Solid Tumors version 1.1 (RECIST 1.1) defined progression or until a treatment discontinuation criterion is met. There is no maximum duration of treatment as subjects may continue to receive randomized treatment beyond RECIST 1.1 defined progression as long as they show clinical benefit, as judged by the investigator.

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be given the opportunity to begin treatment with AZD9291 80mg, once daily. These subjects may continue treatment with AZD9291 as long as they show clinical benefit, as judged by the investigator.

If a subject has been deemed to have objective disease progression according to Investigator tumour assessment by RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subject's best interest, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy. Sites are to submit the next scheduled tumour assessment for central imaging review according to [Table 2](#).

**Figure 1 Study flow chart**



- (a) Approximately 410 subjects will be randomized into the trial; from these approximately 273 subjects will be treated with AZD9291 and approximately 137 subjects will be treated with a platinum based doublet-chemotherapy.
- (b) Subjects will be considered in “Treatment phase” at the time AZD9291/Doublet-Chemotherapy (study treatment) is started. Subjects will continue to receive study treatment until objective disease progression (according to RECIST 1.1). Subjects randomized to AZD9291 may continue to receive AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria. Subjects randomized to the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291, 80 mg once daily.

## 2. STUDY OBJECTIVES

### 2.1 Primary objective

Primary Objective:	Outcome Measure:
To assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy by assessment of Progression Free Survival (PFS).	PFS using investigator assessments according to Response Evaluation Criteria in Solid Tumours (RECIST 1.1). Sensitivity analysis of PFS using Blinded Independent Central Review (BICR).

### 2.2 Secondary objectives

Secondary Objective:	Outcome Measure:
To further assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy in terms of: - Objective Response Rate (ORR) - Duration of Response (DoR) - Disease Control Rate (DCR) - Tumour shrinkage - Overall Survival (OS)	ORR, DoR, DCR and tumour shrinkage using investigator assessments according to Response Evaluation Criteria in Solid Tumours (RECIST 1.1).  Analysis of overall survival.
To assess the effect of AZD9291 compared to platinum-based doublet chemotherapy on subjects' disease-related symptoms and health related quality of life (HRQoL).	EORTC QLQ-C30 and EORTC QLQ-LC13. EORTC QLQ-C30: Questionnaire consisting of 30 items measuring subjects general cancer symptoms and functioning. EORTC QLQ-LC13: A complementary questionnaire measuring lung cancer symptoms.
To characterise the pharmacokinetics (PK) of AZD9291 and metabolites in subjects receiving AZD9291.	PK exposure parameters derived from plasma concentrations of AZD9291, and metabolites AZ5104 and AZ7550.  PK Parameters (CL <sub>ss</sub> /F, C <sub>ss</sub> , min and C <sub>ss</sub> , max AUC <sub>ss</sub> ) will be derived using population PK analysis and reported separately to the CSR. Data from this study may form part of a pooled analysis with data from other studies

### 2.3 Safety objectives

**Safety Objective:**

**Outcome Measure:**

<p>To assess the safety and tolerability profile of AZD9291 compared with platinum-based doublet chemotherapy.</p>	<p>Adverse events (graded by CTCAE v4)</p> <ul style="list-style-type: none"> <li>- Clinical chemistry, haematology and urinalysis</li> <li>- Vital signs (pulse and BP), Physical Examination, Weight</li> <li>- Central Digital ECG</li> <li>- Echocardiogram/MUGA (for LVEF)</li> <li>- WHO performance status</li> </ul>
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**2.4 Exploratory objectives**

Results from such analyses outlined below may be reported separately from the Clinical Study Report (CSR).

**Exploratory Objectives:**

**Outcome Measure:**

<p>To explore the relationship between PK and selected endpoints (which may include efficacy, safety and/or PRO), where deemed appropriate.</p>	<p>Correlation of PK with other primary /secondary/ exploratory endpoints in subjects treated with AZD9291.</p> <p>Results from such analyses will be reported separately from the Clinical Study Report (CSR). Data from this study may also form part of a pooled analysis with other AZD9291 studies.</p>
<p>To compare the effects of AZD9291 compared with platinum-based chemotherapy on post progression outcomes</p>	<p>Time from randomization to second progression (PFS2)</p> <p>Time to subsequent treatments</p> <p>Time to change in symptoms (including post progression assessments)</p>
<p>To further characterise the effects of AZD9291 on survival outcomes.</p>	<p>Assess the impact on overall survival of baseline potentially prognostic factors (e.g. tumour stage, performance status, sex, baseline LDH)</p> <p>Assess the impact on overall survival of subsequent treatments and other potential covariates (e.g. changes in performance status)</p>
<p>To compare adverse events by subject self-reporting of specific CTCAE symptoms (where applicable) between AZD9291 and chemotherapy.</p>	<p>Collection of approximately 28 PRO-CTCAE symptoms via an electronic device solution (in countries where language is available).</p>
<p>To compare AZD9291 treatment with platinum-based chemotherapy treatment on health state utility.</p>	<p>The EQ-5D-5L health state utility index will be used to derive health state utility based on subject reported data.</p>

**Exploratory Objectives:**

**Outcome Measure:**

<p>To compare health resource use associated with AZD9291 treatment with platinum-based chemotherapy treatment.</p>	<p>Health resource utilisation measures including hospitalization, outpatient visits, or emergency department visits.</p>
<p>To characterise the pharmacokinetics (PK) of AZD9291 and metabolites in cerebrospinal fluid (CSF).</p>	<p>Concentration of AZD9291, AZ5104 and AZ7550. Ratio of metabolites to AZD9291.  Ratio of CSF to plasma concentration.  Summaries of PK concentration data.</p>
<p>To collect and store deoxyribonucleic acid (DNA) for future exploratory research into genes/genetic variation that may influence PK or response to AZD9291, platinum-based doublet chemotherapy (ie, absorption, distribution, metabolism, excretion, safety and efficacy) and/or susceptibility to/development of cancers.</p>	<p>Correlation of polymorphisms with variation in PK, PD, safety or response observed in subjects treated with AZD9291 or comparator.  Data generated may be reported separately and may also form part of a pooled analysis with other AZD9291 studies.</p>
<p>To collect and store tumour samples and blood-based samples for potential for exploratory research into factors that may influence susceptibility to/development of NSCLC/cancer and/or response to AZD9291 (where response is defined broadly to include efficacy, tolerability or safety).</p>	<p>Analysis of key genetic and proteomic markers to include, but not limited to, EGFR mutations, HER2 &amp; CMET expression and/or amplification.  Collection of plasma samples to include, but not be limited to, extraction of circulating tumour DNA (ctDNA) for investigation of blood borne biomarkers. The sample may be used to investigate the relationship between PK and blood-borne biomarkers.  Samples may be analysed retrospectively. Any biomarker data generated may be reported separately and may also form part of a pooled analysis with other AZD9291 studies.</p>
<p>To collect and store plasma for isolation of ctDNA. Extracted ctDNA will be assessed for the presence of genetic aberrations including, but not limited to, EGFR mutations (T790M, L858R, etc). These samples may be shared with a diagnostic partner for development of a ctDNA test for T790M detection.</p>	<p>Retrospective/real-time analysis of EGFR (and other) mutations in ctDNA from all study subjects (mandatory).</p>

**Exploratory Objectives:**

**Outcome Measure:**

To collect and store residual CSF for potential exploratory research of factors that may influence development of NSCLC and/or response to AZD9291 (where response is defined broadly to include efficacy, tolerability or safety).	Collection of CSF for the investigation of PK and/or biomarkers. Samples may be analysed retrospectively.
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**3. SUBJECT SELECTION, SCREENING, RANDOMIZATION, RESTRICTIONS, DISCONTINUATION AND WITHDRAWAL**

Each subject should meet all of the inclusion criteria and none of the exclusion criteria for this study. Under no circumstances can there be exceptions to this rule.

**3.1 Inclusion criteria**

For inclusion in the study subjects should fulfil the following criteria:

1. Provision of signed and dated, written informed consent prior to any study specific procedures, sampling and analyses. *If a subject declines to participate in any voluntary exploratory research and/or genetic component of the study, there will be no penalty or loss of benefit to the subject and he/she will not be excluded from other aspects of the study.*
2. Female and male subjects aged at least 18 years. Subjects from Japan aged at least 20 years.
3. Subjects with histologically- or cytologically-documented NSCLC.
4. Locally advanced or metastatic NSCLC, not amenable to curative surgery or radiotherapy
5. Evidence of radiological disease progression following 1st line EGFR TKI (ie, 1<sup>st</sup> line treatment for advanced/metastatic disease) without any further treatment.
6. Subjects must have a diagnosis of “Nonsquamous Non-Small Cell Lung Cancer” in order to be eligible to receive treatment with pemetrexed platinum-based doublet chemotherapy in accordance with local prescribing information.
7. Documented EGFR mutation (at any time since the initial diagnosis of NSCLC) known to be associated with EGFR TKI sensitivity (including G719X, exon 19 deletion, L858R, L861Q).
8. Subjects must have central confirmation of tumour T790M+ mutation status from a tissue biopsy sample taken after documented disease progression on first line treatment with an approved, EGFR tyrosine kinase inhibitor.
9. WHO performance status 0-1 with no deterioration over the previous 2 weeks and a minimum life expectancy of 12 weeks.



10. At least one lesion, not previously irradiated and not chosen for biopsy during the study screening period, that can be accurately measured at baseline as  $\geq 10$ mm in the longest diameter (except lymph nodes which must have short axis  $\geq 15$ mm) with computerised tomography (CT) or magnetic resonance imaging (MRI) which is suitable for accurate repeated measurements. If only one measurable lesion exists, it is acceptable to be used as long as it has not been previously irradiated and baseline tumour assessment scans are done at least 14 days after the screening biopsy is performed.
11. Females should be using adequate contraceptive measures, should not be breast feeding and must have a negative pregnancy test prior to start of dosing if of child-bearing potential or must have evidence of non-child-bearing potential by fulfilling one of the following criteria at screening:
  - Post-menopausal defined as aged more than 50 years and amenorrhoeic for at least 12 months following cessation of all exogenous hormonal treatments
  - Women under 50 years old would be considered postmenopausal if they have been amenorrhoeic for 12 months or more following cessation of exogenous hormonal treatments and with Luteinizing Hormone (LH) and Follicle-Stimulating Hormone (FSH) levels in the post-menopausal range for the institution
  - Documentation of irreversible surgical sterilisation by hysterectomy, bilateral oophorectomy or bilateral salpingectomy but not tubal ligation.
12. Male subjects should be willing to use barrier contraception ie, condoms.
13. For inclusion in **optional genetic research**, subject must provide informed consent for genetic research.

If a subject declines to participate in any voluntary exploratory research and/or genetic component of the study, there will be no penalty or loss of benefit to the subject and he/she will not be excluded from other aspects of the study.

### 3.2 Exclusion criteria

Subjects should not enter the study if any of the following exclusion criteria are fulfilled:

1. Treatment with any of the following:
  - Treatment with more than one prior line of treatment for advanced NSCLC
  - Treatment with an EGFR-TKI (e.g., erlotinib, gefitinib or afatinib) within 8 days or approximately 5x half-life, whichever is the longer, of the first dose of study treatment. (If sufficient washout time has not occurred due to schedule or PK properties, an alternative appropriate washout time based on known duration and time to reversibility of drug related adverse events could be agreed upon by AstraZeneca and the Investigator)

- Any investigational agents or other anticancer drugs from a previous treatment regimen or clinical study within 14 days of randomization
  - Previous treatment with AZD9291, or a 3<sup>rd</sup> generation EGFR TKI
  - Prior neo-adjuvant or adjuvant chemotherapy treatment within 6 months of starting 1<sup>st</sup> EGFR TKI treatment
  - Major surgery (excluding placement of vascular access) within 4 weeks of randomization
  - Radiotherapy treatment to more than 30% of the bone marrow or with a wide field of radiation within 4 weeks of randomization
  - Subjects currently receiving (or unable to stop use at least 1 week prior to receiving the first dose of AZD9291) medications or herbal supplements known to be potent inhibitors or inducers of CYP3A4 (Appendix F)
  - Treatment with an investigational drug within five half-lives of the compound
2. Any unresolved toxicities from prior therapy greater than CTCAE grade 1 (with the exception of alopecia grade 2) at the time of starting study treatment.
  3. Spinal cord compression or brain metastases unless asymptomatic, stable and not requiring steroids for at least 4 weeks prior to start of study treatment.
  4. Any evidence of severe or uncontrolled systemic diseases, including uncontrolled hypertension and active bleeding diatheses, which in the investigator's opinion makes it undesirable for the subject to participate in the trial or which would jeopardise compliance with the protocol, or active infection including hepatitis B, hepatitis C and human immunodeficiency virus (HIV). Screening for chronic conditions is not required.
  5. Refractory nausea and vomiting, chronic gastrointestinal diseases, inability to swallow the formulated product or previous significant bowel resection that would preclude adequate absorption of AZD9291.
  6. Any of the following cardiac criteria:
    - Mean resting corrected QT interval (QTc) > 470 msec, obtained from 3 electrocardiograms (ECGs)
    - Any clinically important abnormalities in rhythm, conduction or morphology of resting ECG e.g., complete left bundle branch block, third degree heart block, second degree heart block, PR interval >250msec

- Any factors that increase the risk of QTc prolongation or risk of arrhythmic events such as heart failure, hypokalaemia, congenital long QT syndrome, family history of long QT syndrome or unexplained sudden death under 40 years of age in first degree relatives or any concomitant medication known to prolong the QT interval.
7. Past medical history of ILD, drug-induced ILD, radiation pneumonitis which required steroid treatment, or any evidence of clinically active interstitial lung disease.
  8. Inadequate bone marrow reserve or organ function as demonstrated by any of the following laboratory values:
    - Absolute neutrophil count  $< 1.5 \times 10^9/L$
    - Platelet count  $< 100 \times 10^9/L$
    - Haemoglobin  $< 90 \text{ g/L}$
    - Alanine aminotransferase (ALT)  $> 2.5$  times the upper limit of normal (ULN) if no demonstrable liver metastases or  $> 5$  times ULN in the presence of liver metastases
    - Aspartate aminotransferase (AST)  $> 2.5$  times ULN if no demonstrable liver metastases or  $> 5$  times ULN in the presence of liver metastases
    - Total bilirubin  $> 1.5$  times ULN if no liver metastases or  $> 3$  times ULN in the presence of documented Gilbert's Syndrome (unconjugated hyperbilirubinaemia) or liver metastases
    - Creatinine  $> 1.5$  times ULN concurrent with creatinine clearance  $< 50 \text{ ml/min}$  (measured or calculated by Cockcroft and Gault equation); confirmation of creatinine clearance is only required when creatinine is  $> 1.5$  times ULN.
  9. History of hypersensitivity of AZD9291 (or drugs with a similar chemical structure or class to AZD9291) or carboplatin or pemetrexed or cisplatin, or any excipients of these agents.
  10. Women who are breast-feeding.
  11. Males and females of reproductive potential who are not using an effective method of birth control and females who are pregnant or breastfeeding or have a positive (urine or serum) pregnancy test prior to study entry.
  12. Contraindication for pemetrexed and cisplatin/carboplatin (e.g. predominantly squamous cell histology).
  13. Involvement in the planning and conduct of the study (applies to AstraZeneca staff or staff at the study site).

14. Judgment by the investigator that the subject should not participate in the study if the subject is unlikely to comply with study procedures, restrictions and requirements.

In addition, the following is considered a criterion for exclusion from the exploratory genetic research:

15. Previous allogenic bone marrow transplant.
16. Non-leukocyte depleted whole blood transfusion within 120 days of the date of the genetic sample collection.

Procedures for withdrawal of incorrectly randomized subjects see Section 3.4

### 3.3 Subject screening and randomization

Investigator(s) should keep a subject pre-screening log of subjects considered for the study.

The Investigator(s) will:

1. Obtain signed informed consent from the potential subject, or their guardian or legal representative before any study specific procedures are performed.
2. Determine subject eligibility. See Section 3.1 and 3.2.
3. Obtain a unique 7-digit **enrolment** number (E-code) through the Interactive Voice Response System (IVRS)/ Interactive Web Response System (IWRS) in the following format ECCNN3XX: CC being the country code, NN being the centre number and 3XX being the subject enrolment code at the centre into AURA3 study.

At Visit 2, once the subject is deemed eligible, the Principal Investigator or suitably trained delegate will:

4. Obtain a unique randomization number via IVRS/IWRS.

Randomization codes will be assigned as subjects become eligible for randomization.

If a subject is re-screened, always a new E-code will be assigned. Any repeated tests and/or procedures will be performed as per documented local standards. Subjects will reconfirm their consent to participate in the study by resigning and dating their original consent form(s), next to their initial signature and date. A subject with a valid negative T790M result cannot be re-screened.

The following assessments need to be repeated for subjects who are re-screened and where >28 days will have lapsed since their last screening period to the date of proposed randomization:

- Demography & baseline characteristics

- Medical/surgical history
- Inclusion/exclusion criteria
- Physical examination, including weight
- WHO performance status
- Pregnancy test (if applicable)
- Vital signs (pulse and BP)
- Clinical chemistry/haematology/urinalysis
- Digital ECG
- Echocardiogram/MUGA (if clinically needed)
- Tumour assessments (RECIST 1.1)
- Concomitant medications & procedures
- Adverse events
- Anti-cancer treatment

A subject randomized to platinum-based doublet chemotherapy who crosses over to AZD9291 will be managed via IVRS/IWRS.

If a subject withdraws from participation in the study, then his/her enrolment/randomization code cannot be reused.

Note: Section 4.1 describes the procedures to be carried out during screening/enrolment period. Section 4.2 describes procedures to be carried out during randomization period.

### **3.4 Procedures for handling incorrectly randomized subjects**

Subjects who fail to meet the eligibility criteria should not, under any circumstances, be randomized or receive study medication. There can be no exceptions to this rule. Subjects who are randomized, but subsequently found not to meet all the eligibility criteria must not be initiated on treatment, and must be withdrawn from the study.

Where a subject does not meet all the eligibility criteria but is started on treatment in error, the Investigator should inform the AstraZeneca study physician immediately, and a discussion should occur between the AstraZeneca study physician and the investigator regarding whether to continue or discontinue the subject from treatment. The AstraZeneca study physician must ensure all decisions are appropriately documented.

### **3.5 Methods for assigning treatment groups**

Suitable subjects will be centrally randomized to receive either AZD9291 80mg QD p.o. or platinum-based doublet chemotherapy (pemetrexed 500mg/m<sup>2</sup> + carboplatin AUC5 or pemetrexed 500mg/m<sup>2</sup> + cisplatin 75mg/m<sup>2</sup>) on Day 1 of every 21d cycle in a 2:1 (AZD9291: platinum-based doublet chemotherapy) ratio using the IVRS/IWRS system. The investigational site must declare (in IVRS/IWRS), prior to randomization, their choice of chemotherapy for that subject.

Subjects will be stratified at randomization based on ethnicity (Asian/Non-Asian).

Investigators will have the option to provide AZD9291 80mg, once daily, to subjects randomized to platinum-based doublet chemotherapy, who are determined by them to have objective radiological progression according to RECIST 1.1, and who have objective disease progression confirmed by the independent central imaging review.

### **3.6 Restrictions**

The following restrictions apply while the subject is receiving AZD9291 and for the specified times before and after:

1. Females of child-bearing potential should use reliable methods of contraception from the time of screening until 6 weeks after discontinuing study treatment. Acceptable methods of contraception include total and true sexual abstinence, tubal ligation, hormonal contraceptives that are not prone to drug-drug interactions (IUS Levonorgestrel Intra Uterine System (Mirena), Medroxyprogesterone injections (Depo-Provera)), copper-banded intra-uterine devices and vasectomised partner. All hormonal methods of contraception should be used in combination with the use of a condom by their male sexual partner for intercourse. For subjects receiving platinum-based doublet-chemotherapy, the reliable methods of contraception chosen should be in accordance with the local prescribing label.
2. Male subjects should be asked to use barrier contraceptives (ie, by use of condoms) during sex with all partners during the trial and for a washout period of 4 months. Subjects should not father a child for 6 months after completion of study treatment. Subjects should refrain from donating sperm from the start of dosing until 6 months after discontinuing study treatment. If male subjects wish to father children they should be advised to arrange for freezing of sperm samples prior to the start of study treatment. For subjects receiving platinum-based doublet chemotherapy, above recommendations should be in accordance with the local prescribing label.
3. All subjects must try to avoid concomitant use of medications, herbal supplements and/or ingestion of foods that are known potent inducers of CYP3A4 whenever feasible. Subjects may receive any medication that is clinically indicated for treatment of adverse events. Such drugs must have been discontinued for an appropriate period before they enter screening and for a period of 3 months after the last dose of AZD9291. All concomitant medications should be captured on the

eCRF. Guidance on medicines to avoid, medications that require close monitoring and on washout periods is provided (see Appendix F).

4. If medically feasible, subjects taking regular medication, with the exception of potent inducers of CYP3A4 (see above), should be maintained on it throughout the study period. Subjects randomized to AZD9291 taking concomitant medications whose disposition is dependent upon Breast cancer resistance protein (BCRP) and which have a narrow therapeutic index should be closely monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst receiving AZD9291. Guidance on medications to avoid, medications that require close monitoring and on washout periods is provided (see Appendix F).

Patients taking rosuvastatin should have creatine phosphokinase levels monitored (due to BCRP mediated increase in exposure.) If the subject experiences any potentially relevant adverse events suggestive of muscle toxicity including unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever, rosuvastatin should be stopped, creatine kinase (CK) levels should be checked, and any appropriate further management should be taken.

Subjects taking warfarin should be monitored regularly for changes in prothrombin time or international normalized ratio (INR).

5. Subjects who wear contact lenses must discontinue wearing their lenses if they have any mild to moderate eye symptoms (CTCAE grade  $\leq 2$ ) while receiving treatment with AZD9291 until at least one week after symptoms have resolved. If a subject has a recurrence of eye symptoms or experiences any severe (CTCAE grade  $\geq 3$ ) ocular events they must discontinue wearing their contact lenses until at least one week after treatment with AZD9291 is permanently discontinued. Subjects must not use any eye drops or ointment for treatment of eye symptoms, unless agreed by a study doctor, at any time during the study until 1 week after AZD9291 has been permanently discontinued. Subject should consult the clinic promptly if they have any concerns.

### **3.7 Discontinuation from study treatment**

Subjects may be discontinued from study treatment in the following situations:

- Subject decision. The subject is at any time free to discontinue treatment, without prejudice to further treatment
- Adverse Event
- Pregnancy
- Severe non-compliance with the study protocol as judged by the investigator and/or AstraZeneca
- Subject incorrectly initiated on study treatment
- Objective disease progression or subject is no longer receiving clinical benefit

- Lost to follow up.

### **3.7.1 Procedures for discontinuation of a subject from study treatment**

The Principal Investigator/Investigator will perform the best possible observation(s), test(s) and evaluation(s) as well as give appropriate medication and all possible measures for the safety of the subject. They will also immediately inform AstraZeneca of the withdrawal. Adverse events will be followed up (See Section 6); electronic questionnaire devices (e.g., for patient reported outcomes) and all unused study drug should be returned by the subject or representative (e.g. caretaker, family member).

Any subject who discontinues study treatment for reasons other than objective disease progression should have tumour assessments performed as scheduled in the protocol (see Table 1 or Table 2) until objective disease progression is documented or death occurs, unless consent is withdrawn. Study procedures related to PROs, SAEs and anti-cancer treatment must be captured until permanent withdrawal from the study.

If a subject is withdrawn from study, see Section 3.8.

## **3.8 Criteria for withdrawal**

At any time, subjects are free to discontinue study treatment or withdraw from the study (ie, study treatment and assessments), without prejudice to further treatment. A subject that decides to discontinue investigational product will always be asked about the reason(s) and the presence of any adverse events. If possible, they will be seen and assessed by an Investigator(s). Adverse events will be followed up (See Section 6); electronic questionnaire devices (ePRO) and all investigational products should be returned by the subject or representative. The term withdrawal from the study refers to both discontinuation from study treatment and study assessments.

Reasons for withdrawal from the study:

- Eligibility criteria not fulfilled
- Death
- Withdrawal of consent.

If a subject wishes to withdraw their consent to both treatment and study assessments, they should be asked if they are willing to continue with survival follow-up (which can be conducted by telephone). If a subject wishes to withdraw their consent to further participation in the study entirely, including survival follow-up, this should be clearly documented in the subject notes and in the clinical study database (eCRF).

The status of ongoing, withdrawn (from the study) and “lost to follow-up” subjects at the time of an overall survival analysis should be obtained by the site personnel by checking the subjects notes, hospital records, contacting the subjects general practitioner and checking publicly available death registries. In the event that the subject has actively withdrawn consent



to the processing of their personal data, the vital status of the subject can be obtained by site personnel from publicly available resources where it is possible to do so under applicable local laws.

Withdrawn subjects will not be replaced.

### **3.8.1 Screen/enrolment failures**

Screen/enrolment failures are subjects who do not fulfil the eligibility criteria for the study, and therefore must not receive AZD9291. These subjects should have the reason for study withdrawal recorded as “Eligibility Criteria not fulfilled” (ie, subject does not meet the required inclusion/exclusion criteria). This reason for study withdrawal is only valid for screen/enrolment failures (not subjects who have received investigational product).

### **3.8.2 Withdrawal of the informed consent**

Subjects are free to withdraw from the study at any time (investigational product and assessments), without prejudice to further treatment.

A subject who withdraws consent will always be asked about the reason(s) and the presence of any adverse events (AE). The Investigator will follow up AEs outside of the clinical study. The subject or representative will return the ePRO device and unused AZD9291 tablets.

If a subject withdraws from participation in the study, then his/her enrolment/randomization code cannot be reused.

## **3.9 Termination of the study**

The study may be stopped if, in the judgment of AstraZeneca, trial subjects are placed at undue risk because of clinically significant findings that:

- meet individual stopping criteria or are otherwise considered significant
- are assessed as causally related to investigational product
- are not considered to be consistent with continuation of the study.

Regardless of the reason for termination, all data available for the subject at the time of discontinuation of follow-up must be recorded in the eCRF. All reasons for discontinuation of treatment must be documented.

In the case of terminating the study, the Sponsor will ensure that adequate consideration is given to the protection of the subject’s interest.

## **4. STUDY PLAN AND TIMING OF PROCEDURES**

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section	
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> + D1	NA	NA	NA	NA		
Day	-28 to 1	1	8	15	22	43	64-106	127+	NA	NA	NA	NA		
Window (days) <sup>y</sup>	NA	0	±2	±2	±7	±7	±7	±7	0	+7	±7	±7		
Informed consent <sup>c</sup>	X													3.3, 4.1, 4.2, 4.3
Submit tumour tissue sample for mutation analysis <sup>d</sup>	X													4.1 & 5.6
Collect/submit optional tumour biopsy for exploratory research & diagnostic development	X								X <sup>u</sup>		X <sup>u</sup>			4.1 & 5.6
Archival tumour tissue <sup>e</sup>	X													5.6
Demography & baseline characteristics	X													4.1
Medical/surgical history	X													4.1
Inclusion/exclusion criteria	X													3
Physical examination, including weight <sup>m</sup>	X	X <sup>f</sup>			X	X	X	X	X	X <sup>w</sup>				5.2.3, 5.2.6.1
Height	X												5.2.6.1	
WHO Performance status <sup>m</sup>	X	X			X	X	X	X	X		X	X	4.1	

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section	
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> + D1	NA	NA	NA	NA		
Day	-28 to 1	1	8	15	22	43	64-106	127+	NA	NA	NA	NA		
Window (days) <sup>y</sup>	NA	0	±2	±2	±7	±7	±7	±7	0	+7	±7	±7		<b>SECTION:</b>
Pregnancy test (pre-menopausal females only)	X													5.2.1
Ophthalmologic assessment	X	← as clinically indicated →												5.2.7.1
Plasma sample for ctDNA <sup>m</sup> and blood borne biomarkers	X <sup>h</sup>	X	X	X	X	X	X	X	← every 6 weeks in line with RECIST assessments <sup>1</sup> →					5.6.2
Vital signs (pulse and BP) <sup>m</sup>	X	X	X	X	X	X	X	X	X	X <sup>w</sup>				5.2.6
Clinical chemistry/ Haematology/Urinalysis <sup>m</sup>	X	X	X	X	X	X	X	X	X	X <sup>w</sup>				5.2.1
PK blood sample (including metabolites)		X				X	X C5 only	X <sup>v</sup>						5.4
Digital ECG <sup>g</sup>	X	X	X	X	X	X	X	X	X	X <sup>w</sup>				5.2.4
Echocardiogram/MUGA (for LVEF)	X	← every 12 weeks (± 1 week) relative to randomization →								X <sup>w</sup>				5.2.5
Optional genetic consent and sample	X <sup>j</sup>												5.5	
Optional CSF sample					X (once only) <sup>k</sup>								5.4.4	
Tumour assessments <sup>1</sup> (RECIST v1.1)	X	← every 6 weeks (± 1 week) relative to randomization until disease progression →											4.1, 4.2, 4.3.3, 5.1.1, 5.1.2	

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> + D1	NA	NA	NA	NA	
Day	-28 to 1	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	0	±2	±2	±7	±7	±7	±7	0	+7	±7	±7	<b>SECTION:</b>
EORTC QLQ-C30 and EQ-5D-5L (by e-device) <sup>x</sup>		X <sup>m</sup>	← every 6 weeks (± 1 week) relative to randomization →						X		X <sup>n</sup>	X <sup>n</sup>	5.3.2
EORTC QLQ LC13 (by e-device) <sup>x</sup>		X <sup>m</sup>	← weekly (± 2 days) relative to randomization →		← every 3 weeks (± 3 days) relative to randomization →				X		X <sup>o</sup>	X <sup>o</sup>	5.3.2
PRO-CTCAE (by e-device) <sup>p, x</sup>		X <sup>m</sup>	← weekly (± 2 days) for first 18 weeks from randomization →				X <sup>q</sup>		X		X <sup>o</sup>	X <sup>o</sup>	5.3.2
Healthcare Resource Use		← asked for at every visit →											5.3.2.5
IVRS/TWRS	X	X			X	X	X	X <sup>b</sup>	X				3.3, 3.5
Dispense study medication		X			X	X	X	X <sup>b</sup>					3.3
Dose with AZD9291		← Daily dosing →											7.1
Concomitant medication & procedures		← →											7.7
Adverse events		← →										X <sup>f</sup>	6.3 & 6.4
Survival Status												X <sup>s</sup>	4.3.4
Anti-cancer treatment	X										X	X <sup>s</sup>	4.2

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section	
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> + D1	NA	NA	NA	NA		
Day	-28 to 1	1	8	15	22	43	64-106	127+	NA	NA	NA	NA		
Window (days) <sup>y</sup>	NA	0	±2	±2	±7	±7	±7	±7	0	+7	±7	±7		SECTION:
Subsequent response/ progression data												X <sup>t</sup>	5.8	

- a A cycle is defined as 21-day treatment period.
- b Visit schedule changes after Cycle 7 Day 1 from every 21 days (3 weeks) to every 42 days (6 weeks).
- c Consent may be taken prior to the 28-day window if required. The screening period will then start with first study-related assessment, excluding the collection of the tumour tissue sample for central mutation analysis.
- d Taken following progression on the latest line of therapy. The collection of this tumour tissue sample for central mutation analysis is not included in the 28-day screening period.
- e Archival tumour sample only to be submitted after T790M positive status confirmed by central testing. Not required for T790M negative patients.
- f If assessments are not done at Visit 2, but have been done at Visit 1 and within 14 day window prior to starting study treatment, with no change in condition and no clinical indication to do so, they do not have to be repeated on Visit 2 (except for fasting glucose).
- g There is a potential to move from centrally reviewed to locally reviewed ECGs upon review of QT data of approximately 100 subjects.
- h To be taken prior to receiving the central T790M mutation result. All screening plasma samples are required by AstraZeneca, regardless of the outcome of the mutation screening.
- i Collect every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation in absence of disease progression). If patient discontinues from study, please collect a sample at treatment discontinuation and at Progression follow-up.
- j If for any reason the sample is not drawn prior to randomization it may be taken at any visit until the last study visit.
- k To be obtained at one time point at any time from Cycle 2 Day 1 onwards.
- l At least one lesion, not previously irradiated that can be accurately measured.
- m To be completed pre-dose.

- n Assess every 6 weeks ( $\pm$  1 week) relative to the date of randomization until end of study (including survival follow-up period) and at the time of progression.
- o Assess every 3 weeks ( $\pm$  3 days) relative to the date of randomization until end of study (including survival follow-up period) and at the time of progression.
- p PRO-CTCAE will only be administered in those languages where a linguistically validated version exists.
- q Assessed at Cycle 7 Day 1 then every 3 weeks ( $\pm$  3 days) relative to the date of randomization thereafter until end of study (including survival follow-up period) and at the time of progression.
- r Following AZD9291 discontinuation, SAEs considered related to study procedures should continue to be collected until disease progression.
- s Survival status including anti-cancer treatment to be performed every 6 weeks (relative to randomization) following disease progression or withdrawal from treatment. [Note: Additional survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis.]
- t Record subsequent response/progression data every 6 weeks until first confirmed disease progression on a subsequent treatment.
- u Discontinuation biopsy can be taken at discontinuation or progression, whichever comes first.
- v After Cycle 7, every other cycle up to and including Cycle 13.
- w A 28-day follow-up assessment will be required if on treatment assessment was abnormal at treatment discontinuation.
- x ePRO LogPads must be assigned to subjects only on the day of randomization; baseline ePROs should be completed by subjects prior to dosing, when they are still in the clinic on the day of randomization, to ensure these are done properly.
- y Visit windows are always calculated in relation to Cycle 1, Day 1.

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrolment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 D1 <sup>f</sup>	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> +	NA	NA	NA	NA		
Day	-28 to 1	-7 to 1	1	8	15	22	43	64-106	127 +	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	-7	0	±2	±2	±7	±7	±7	±7	0	+7	±7	±7	SECTION:
Informed consent <sup>c</sup>	X													3.3, 4.1, 4.2, 4.3
Submit tumour tissue sample for mutation analysis <sup>d</sup>	X													4.1 & 5.6
Collect and submit optional tumour biopsy for exploratory research and diagnostic development	X									X <sup>u</sup>		X <sup>u</sup>		4.1 & 5.6
Archival tumour tissue <sup>e</sup>	X													5.6
Demography & baseline characteristics	X													4.1
Medical/surgical history	X													4.1
Inclusion/exclusion criteria	X													3

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrollment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)							Follow-up Period				For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 D1 <sup>f</sup>	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> +	NA	NA	NA	NA		
Day	-28 to 1	-7 to 1	1	8	15	22	43	64-106	127 +	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	-7	0	±2	±2	±7	±7	±7	±7	0	+7	±7	±7	SECTION:
Physical examination, including weight <sup>m</sup>	X	X <sup>g</sup>				X	X	X	X <sup>v</sup>	X	X <sup>v</sup>			5.2.3, 5.2.6.1
Height	X													5.2.6.1
WHO Performance status <sup>m</sup>	X	X				X	X	X	X	X		X	X	4.1
Pregnancy test (premenopausal females only)	X													5.2.1
Ophthalmologic assessment	X	← as clinically indicated →												5.2.7.1
Vital signs (pulse and BP) <sup>m</sup>	X	X	X	X	X	X	X	X	X	X	X <sup>v</sup>			5.2.6
Clinical chemistry/ Haematology/ Urinalysis <sup>m</sup>	X	X <sup>g</sup>	X	X	X	X	X	X	X <sup>v</sup>	X	X <sup>v</sup>			5.2.1



**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrollment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)							Follow-up Period				For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 D1 <sup>f</sup>	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> +	NA	NA	NA	NA		
Day	-28 to 1	-7 to 1	1	8	15	22	43	64-106	127 +	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	-7	0	±2	±2	±7	±7	±7	±7	0	+7	±7	±7	SECTION:
Plasma sample for ctDNA <sup>m</sup> and blood borne biomarkers	X <sup>h</sup>	X	X	X	X	X	X	X	← every 6 weeks in line with RECIST assessments →				5.6.2	
Digital ECG <sup>k</sup>	X	X	X	X	X	X	X	X	X <sup>v</sup>	X	X <sup>v</sup>			5.2.4
Echocardiogram/MUG A (for LVEF)	X		← every 12 weeks (± 1 week) relative to randomization →								X <sup>v</sup>			5.2.5
Optional genetic consent and sample	X <sup>j</sup>													5.5
Tumour assessments (RECIST v1.1) <sup>l</sup>	X	← every 6 weeks (± 1 week) relative to randomization until disease progression →											4.1, 4.2, 4.3.3, 5.1.1, 5.1.2	
EORTC QLQ-C30 and EQ-5D-5L (by e-device) <sup>w</sup>		X	← every 6 weeks (± 1 week) relative to randomization →							X		X <sup>n</sup>	X <sup>n</sup>	5.3.2
EORTC QLQ LC13 (by e-device) <sup>w</sup>		X	← weekly (± 2 days) relative to randomization →			← every 3 weeks (± 3 days) relative to randomization →				X		X <sup>o</sup>	X <sup>o</sup>	5.3.2
PRO-CTCAE (by e-device) <sup>p, w</sup>		X	← weekly (± 2 days) for first 18 weeks from randomization →						X <sup>q</sup>	X		X <sup>o</sup>	X <sup>o</sup>	5.3.2

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrollment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)							Follow-up Period				For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day			C1 D1 <sup>f</sup>	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> +	NA	NA	NA	NA	
Day	-28 to 1	-7 to 1	1	8	15	22	43	64-106	127 +	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	-7	0	±2	±2	±7	±7	±7	±7	0	+7	±7	±7	<b>SECTION:</b>
Healthcare Resource Use			← asked for at every visit →										5.3.2.5	
IVRS/IWRS	X	X								X				3.3, 3.5, 7.2
Folic Acid administration (pre-treatment)			← 5-7d prior to 1 <sup>st</sup> infusion; daily during treatment period →											4.2
Vitamin B12 (pre-treatment)			← Within 7d prior to 1 <sup>st</sup> infusion; every 9 weeks during treatment period →											4.2
Corticosteroid administration (pre-treatment)			← On the day prior to, on the day, and on the day after infusion →											4.2
Platinum-based Doublet Chemotherapy <sup>x</sup>			X			X	X	X						3.3, 7.2
Concomitant medication & procedures	← →												7.7	
Adverse events	← →											X <sup>r</sup>	6.3 & 6.4	

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrollment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	28-day follow-up		Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day			C1 D1 <sup>f</sup>	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> +	NA	NA	NA	NA	
Day	-28 to 1	-7 to 1	1	8	15	22	43	64-106	127 +	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	-7	0	±2	±2	±7	±7	±7	±7	0	+7	±7	±7	SECTION:
Survival Status													X <sup>s</sup>	4.3.4
Anti-cancer treatment	X											X	X <sup>s</sup>	4.2
Subsequent response/ progression data													X <sup>t</sup>	5.8

- <sup>a</sup> A cycle is defined as 21-day treatment period.
- <sup>b</sup> Visit schedule changes after Cycle 7 Day 1 from every 21 days (3 weeks) to every 42 days (6 weeks). Platinum-based doublet chemotherapy will be administered every 21 days from previous cycle’s day 1. Subjects can continue to receive platinum-based doublet-chemotherapy until meeting discontinuation criteria (see Section 3.9) or up to a total of 6 cycles or until progression (whichever occurs first). Each cycle treatment may be interrupted for a maximum of 21 days. If cycle treatment is delayed by more than 21 days, subject will be permanently discontinued from doublet-chemotherapy. If appropriate, and according to the approved label use or local practice guidelines, pemetrexed may be continued as maintenance treatment. In case of treatment interruption, other assessments are to be done as originally planned. Subjects whose disease has not progressed after four cycles of platinum-based doublet chemotherapy may receive pemetrexed maintenance therapy.
- <sup>c</sup> Consent may be taken prior to the 28-day window if required. The screening period will then start with first study-related assessment, excluding the collection of the tumour tissue sample for central mutation analysis.
- <sup>d</sup> Taken following progression on the latest line of therapy. The collection of this tumour tissue sample for central mutation analysis is not included in the 28-day screening period.
- <sup>e</sup> Archival tumour sample only to be submitted after T790M positive status confirmed by central testing. Not required for T790M negative patients.

- f Chemotherapy may start within 1 week after randomization to allow Vitamin B12, Folic acid and corticosteroid treatment, as well as any other assessments for this visit, with the exception of the ePROs, which must be assigned to the subject on the date of randomization.
- g If assessments are not done at Visit 2, but have been done at Visit 1 and within 14 day window prior to starting study treatment, with no change in condition and no clinical indication to do so, they do not have to be repeated on Visit 2 (Except for fasting glucose).
- h To be taken prior to receiving the central T790M mutation result. All screening plasma sample are required by AstraZeneca, regardless of the outcome of the mutation screening.
- i Collect every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation in absence of disease progression). If patient discontinues from study, please collect a sample at treatment discontinuation and at Progression follow-up.
- j If for any reason the sample is not drawn prior to randomization it may be taken at any visit until the last study visit.
- k There is a potential to move from centrally reviewed to locally reviewed ECGs upon review of QT data of approximately 100 subjects.
- l At least one lesion, not previously irradiated, that can be accurately measured. Subjects randomized to the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 confirmed by the Investigator and by independent central imaging review will be given the opportunity to cross-over and begin treatment with AZD9291 80mg, once daily. For subjects under consideration for cross-over to AZD9291, scheduled tumour assessments will continue until confirmation of objective radiological disease progression by independent central imaging review.
- m To be completed pre-dose for all cycles.
- n Assess every 6 weeks ( $\pm$  1 week) relative to the date of randomization until end of study (including survival follow-up period) and at the time of progression.
- o Assess every 3 weeks ( $\pm$  3 days) relative to the date of randomization until end of study (including survival follow-up period) and at the time of progression.
- p PRO-CTCAE will only be administered in those languages where a linguistically validated version exists.
- q Assessed at Cycle 7 Day 1 then every 3 weeks ( $\pm$  3 days) relative to the date of randomization thereafter until end of study (including survival follow-up period) and at the time of progression.
- r Following chemotherapy discontinuation, SAEs considered related to study procedures should continue to be collected until disease progression.
- s Survival status including anti-cancer treatment to be performed every 6 weeks (relative to randomization) following disease progression or withdrawal from treatment. Additional survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis.
- t Record subsequent response/progression data every 6 weeks until first confirmed disease progression on a subsequent treatment.
- u Discontinuation biopsy can be taken at discontinuation or progression, whichever comes first.
- v A 28-day follow-up assessment will be required if on treatment assessment was abnormal at treatment discontinuation.
- w ePRO LogPads must be assigned to subjects only on the day of randomization; baseline ePROs should be completed prior to dosing, by subjects when they are still in the clinic on the day of randomization, to ensure these are done properly.
- x Platinum-based doublet chemotherapy must be administered no less than every 21 days from previous cycle Day 1
- y Visit windows are always calculated in relation to Cycle 1 Day 1.

**Table 3 Study Plan for Subjects crossing over to AZD9291**

Visit	Cross-over AZD9291 Treatment Visit	AZD9291 Treatment Discontinuation	Survival follow-up	For details see Protocol Section
Cycle <sup>a</sup> / Day	Each cycle	NA	NA	
Day	1	NA	NA	
Window (days) <sup>j</sup>	± 7	0	± 7	SECTION:
Cross-over Informed Consent	X			3.3, 4.1, 4.2, 4.3
Physical examination, including weight <sup>h</sup>	X	X		5.2.3, 5.2.6.1
WHO Performance status <sup>h</sup>	X	X	X	4.1
Vital signs (pulse and BP) <sup>h</sup>	X	X		5.2.6
Clinical chemistry/ Haematology/Urinalysis <sup>h</sup>	X	X		5.2.1
Digital ECG <sup>h</sup>	X	X		5.2.4
EORTC QLQ-C30 and EQ-5D-5L (by e-device)	X <sup>c</sup>	X	X <sup>c</sup>	5.3.2
EORTC QLQ LC13 (by e-device)	X <sup>d</sup>	X	X <sup>d</sup>	5.3.2
PRO-CTCAE (by e-device) <sup>e</sup>	X <sup>d</sup>	X	X <sup>d</sup>	5.3.2
IVRS/IWRS	X	X		3.3, 3.5
Dose with AZD9291 <sup>i</sup>	X			7.1
Concomitant medication & procedures	X			6.7
Adverse events	X <sup>f</sup>			6.3 & 6.4
Survival Status			X <sup>g</sup>	4.3.4
Anti-cancer treatment	X		X <sup>g</sup>	4.3

<sup>a</sup> A cycle for subjects crossing over to AZD9291 is defined as 42-day treatment period.

<sup>b</sup> Cross-over consent must be given prior to cross-over from platinum doublet-chemotherapy to AZD9291 treatment.

<sup>c</sup> Assess every 6 weeks (± 1 week) relative to the date of randomization until end of study (including survival follow-up period)

<sup>d</sup> Assess every 3 weeks (± 3 days) relative to the date of randomization until end of study (including survival follow-up period)

<sup>e</sup> PRO-CTCAE will only be administered in those languages where a linguistically validated version exists.

<sup>f</sup> Following platinum-based doublet chemotherapy discontinuation, SAEs considered related to study procedures should continue to be collected until resolution.

<sup>g</sup> Survival status including anti-cancer treatment to be performed every 6 weeks (relative to the date of randomization) following subsequent disease progression with cross-over AZD9291 treatment, or withdrawal from treatment. [Note: Additional survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis.]

<sup>h</sup> To be completed pre-dose on each cross-over AZD9291 treatment visit day

<sup>i</sup> AZD9291 will be dispensed every 42 days.

<sup>j</sup> Cross-over visit windows are always calculated in relation to Cycle 1 Day 1 of cross-over AZD9291 treatment.

## 4.1 Screening period

It is recommended the screening assessments be performed in a stepwise process beginning with the confirmation of T790M mutation status as determined by the designated central laboratory. However, certain screening assessments must be done in parallel to the T790M mutation assessment, as appropriate (e.g. Baseline ctDNA and blood borne biomarkers plasma samples must be taken before central T790M status result is known). Procedures will be performed according to the Study Plan (Table 1 or Table 2). Tumour assessments and other clinical data obtained as standard of care prior to consent may be used for the study, provided the assessments fall within the protocol specified period prior to randomization.

At screening, consenting subjects are assessed to ensure that they meet eligibility criteria. Subjects who do not meet these criteria must not be randomized into the study. Demographic data and other characteristics will be recorded and will include date of birth or age, gender, smoking history, race and/or ethnicity according to local regulations.

Subjects will be considered in screening/enrolment period until all Visit 1 assessments are completed and eligibility is confirmed. Subjects will be considered randomized and in the treatment period once study treatment has been initiated.

### **Written informed consent/Assignment of subject enrolment/randomization number:**

- Each potential subject will provide written informed consent prior to starting any study specific procedures (see Section 10.4).
- All subjects will be required to provide consent to supply a tumour biopsy sample taken during the screening period for entry into this study. This consent is included in the main subject informed consent form. Please note that subjects are asked to provide separate consent for provision of optional tumour biopsy samples, if willing (see Section 5.6).
- Additionally, subjects will be given the option to consent to the host pharmacogenetics research component and the CSF analysis of the study in separate Informed Consent Forms (ICF).
- As per standard, enrolment number (E-code) is assigned to the subject and Principal Investigator or delegate should perform screening/enrolment call (see Section 3.3). During the randomization visit (Visit 2), subject will receive randomization number and randomized arm information via IVRS/IWRS. For chemotherapy, administration may occur approximately 7 days after randomization due to pre-treatment requirements.

**Mandatory screening tumour biopsy sample for mutation analysis:**

Tumour sample must be formalin fixed and paraffin embedded (FFPE) and must be biopsied following progression on the latest line of therapy. Samples may be collected from primary or metastatic tumour deposits. Bone samples (including soft tissue tumoral masses emerging from the bone) cannot be accepted for testing. Sites should ship the FFPE tumour sample to the testing laboratory as soon as it is available. Tissue should be less than 60 days old from date of sectioning to date of testing. Blocks must be provided wherever possible. If this is not possible, a minimum of 6 slides of freshly prepared unstained 5-micron sections from this screening tumour block may be provided. See Section 5.6.

The mandatory screening tumour biopsy must not be taken from a previously irradiated lesion (please refer to Inclusion criterion # 10 for details). This biopsy sample is not subject to the 28-day screening window; if tissue is already available from a biopsy taken since documentation of disease progression on the most recent treatment regimen then there is no need for a further biopsy as this sample can be submitted for T790M mutation status. If the first biopsy is not confirmed as T790M mutation positive due to test failure (i.e. an invalid result or invalid run occurred), testing will be repeated and an additional biopsy sample may be requested. If the T790M mutation is not detected in the first biopsy (and the cobas® EGFR Mutation Test indicates a valid result), no additional testing for the subject will be performed for this study and an additional biopsy sample WILL NOT be accepted.

**Optional second tissue sample for diagnostic development:**

The optional second tissue sample (FFPE) may be provided to facilitate diagnostic development and pre-market approval of the diagnostic test. This should be obtained at the same time and as part of the same procedure as the mandatory screening biopsy. Optional tumour biopsy tissue may also be used for companion diagnostic development.

**The following will be collected at screening:**

**Demography:**

Demographic data and other characteristics will be recorded and will include date of birth or age, gender, smoking history, race and/or ethnicity according to local regulations.

**Medical/surgical history:**

A standard medical and surgical history will be obtained.

**Physical examination including vital signs (pulse and BP), height, weight:**

Physical examination includes an assessment of the following: general appearance, respiratory, cardiovascular, skin, head and neck (including ears, eyes, nose and throat), abdomen, lymph nodes, thyroid, musculo-skeletal (including spine and extremities) and neurological systems.

**Ophthalmologic assessment:**

Measurements of best-corrected visual acuity, intraocular pressure and slit-lamp fundoscopy should be obtained.

**Eligibility criteria:**

Subjects must not be randomized unless all eligibility criteria have been fully met.

**World Health Organization (WHO) Performance Status:**

Performance status will be assessed at the visits indicated in the Study Plan (see [Table 1](#), [Table 2](#) and [Table 3](#)) according to WHO criteria as follows:

- 0 = Fully active, able to carry out all pre-disease activities without restrictions
- 1 = Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature e.g., light housework, office work
- 2 = Ambulatory and capable of self-care, but unable to carry out any work activities. Up and about more than 50% of waking hours
- 3 = Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
- 4 = Completely disabled, cannot carry on self-care, totally confined to bed or chair.

**Pregnancy test:**

Pregnancy test (blood or urine tests are acceptable based on the site's standard clinical practice) for women of childbearing potential only.

**Archival tumour sample (if available):**

All subjects will be asked to provide consent to supply a sample of their archival tumour blocks if a sample taken at the time of diagnosis is available. Any archival biopsy samples taken following previous lines of therapy will also be requested, if available. In each case the previous subject treatment must be clearly indicated for each sample provided.

Tumour samples will preferably be in the form of a formalin fixed paraffin embedded block (sample derived from the diagnostic tumour or a metastatic site). If this is not possible, 10-20 slides of freshly prepared unstained 5 micron sections from the archival tumour block may be provided.

**Laboratory safety assessments:**

Blood and urine samples for determination of clinical chemistry, haematology, and urinalysis should be taken. See Section [5.2.1](#).

If clinical chemistry, haematology and urinalysis assessments have been performed within 14 days pre-randomization they do not have to be repeated prior to commencing treatment on visit 2 Day 1 if the subject's condition has not changed (no new treatment during this period of time, no new complication or aggravation).



**Plasma for ctDNA and blood borne biomarkers:**

All subjects are required to provide two baseline plasma samples prior to receiving the result of their T790M mutation status result. These baseline samples are not required to be taken again, if the subject is re-screened. All screening plasma samples should be sent to the AstraZeneca (AZ) appointed Clinical Research Organisation (CRO) for retrospective analysis. See Section 5.6.2.

**Pharmacogenetics (optional):**

Optional genetic blood sample should be taken from consenting subjects at screening. If for any reason the sample is not drawn prior to dosing it may be taken at any visit until the last study visit. See Section 5.5.

**Tumour Assessments (RECIST 1.1):**

The imaging modalities used for RECIST 1.1 assessments will be CT or MRI scans of chest and abdomen (including liver and adrenal glands). Any other sites where disease is suspected or known at baseline must be also imaged. Baseline assessments should be performed as close as possible to the start of treatment (and prior to randomization). See Section 5.1.1. All imaging assessments including unscheduled visit scans should be collected on an ongoing basis and sent to the AZ appointed CRO to enable central analyses if required.

According to the therapy area standards, base-line assessment should be within 28days of the study treatment start and follow-up assessments will be relative to the date of randomization.

Subjects with known or suspected brain metastases at screening should have a CT/MRI of the brain prior to starting study treatment. These subjects should be followed up on study with repeated CT/MRI assessment, using the same frequency as RECIST assessments. The same modality for CT/MRI should be used for a subject throughout the study. Brain metastases will be assessed as non-target lesions. See Section 5.1.1.

**Anti-cancer treatment:**

All prior anti-cancer therapy will be collected at screening and end of the study and recorded in the eCRF.

**Concomitant medication use:**

Information on any treatment in the 4 weeks prior to starting study treatment and all concomitant treatments given during the study, with reasons for the treatment, will be recorded in the Case Report Form (CRF). See Section 7.7

**Digital ECG:**

Three 12-lead ECG should be performed. See Section 5.2.4.

### **Echocardiogram/ MUGA:**

An Echocardiogram or MUGA scan to assess LVEF will be performed at screening (prior to study medication). The modality of the cardiac function assessments must be consistent within a subject ie, if echocardiogram is used for the screening assessment then echocardiogram should also be used for subsequent scans. The subjects should also be examined using the same machine and operator whenever possible.

## **4.2 Treatment period**

### **For subjects receiving AZD9291:**

A cycle of treatment is defined as 21 days of once daily AZD9291 treatment. After Cycle 7 Day 1, the duration between study visits will change from every 21 days (3 weeks) to every 42 days (6 weeks).

If a subject continues to receive treatment with AZD9291 beyond RECIST 1.1 defined progression they must continue to follow the treatment visit schedule and assessments excluding study specific RECIST 1.1 assessments.

For subjects randomized to AZD9291, please follow the study schedule described in [Table 1](#).

### **For subjects receiving platinum-based doublet-chemotherapy:**

Folic acid will be administered 5-7 days prior to the 1<sup>st</sup> dose, then daily during the treatment period until 21 days post the last dose. Vitamin B12 will be administered within 7 days of first infusion and every 9 weeks during the treatment period. Corticosteroid will be administered on the day prior to, on the day, and on the day after infusion. Subjects may also receive other pre-treatment/ concomitant treatment as recommended by approved label for pemetrexed, carboplatin or cisplatin as clinically indicated by the investigator.

Platinum-based doublet chemotherapy will be administered every 21 days from previous cycle Day 1. Subjects can continue to receive platinum-based doublet-chemotherapy until matching discontinuation criteria (see Section 3.9) or up to a total of 6 cycles. Each cycle treatment can be interrupted maximum of 21 days. If cycle treatment is delayed by more than 21 days, subject will be permanently discontinued from doublet-chemotherapy. If appropriate, and according to the approved label use or local practice guidelines, pemetrexed may be continued as maintenance treatment.

Subjects who progress according to RECIST 1.1 criteria prior to completion of initial doublet chemotherapy treatment or during pemetrexed maintenance monotherapy may continue with chemotherapy treatment as long as they show clinical benefit, as judged by the investigator.

For subjects receiving platinum-based doublet-chemotherapy, please follow the study schedule in [Table 2](#).

**For subjects who cross-over to AZD9291:**

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be eligible to receive AZD9291 80mg, once daily and will follow the assessments as per [Table 3](#).

If a subject has been deemed to have objective disease progression according to Investigator tumour assessment by RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subject's best interest, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy. Sites are to submit the next scheduled tumour assessment for central imaging review according to [Table 2](#).

The following criteria must be met for a subject to cross-over to AZD9291:

- No intervening systemic anti-cancer therapy following discontinuation of randomized chemotherapy treatment.
- At least a 14 day washout period between last dose of randomized chemotherapy and/or associated supportive treatments (i.e. corticosteroids, radiation), and starting cross-over AZD9291 treatment.
- Any unresolved toxicities from prior therapy should be controlled, and be no greater than CTCAE grade 1 (with the exception of alopecia which may be grade 2) at the time of starting AZD9291 treatment.

These subjects may continue treatment with AZD9291 as long as they show clinical benefit, as judged by the investigator.

While RECIST 1.1 assessments are not required to be reported in the RAVE eCRF following confirmation of progression by Independent Central Review, tumour assessments should be done in accordance to local clinical practices.

If subjects are not eligible to cross-over to AZD9291, they will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.

**The following will be collected during the Treatment Period** (described mainly what is not already mentioned under Screening Period, Section [4.1](#)):

**Ophthalmologic examination:**

To be performed as clinically indicated. A 28-day follow-up assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

### **Echocardiogram/MUGA:**

To be performed every 12 weeks and as clinically indicated. A 28-day follow-up assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

### **Physical examination, including vital signs (pulse and blood pressure), laboratory parameters, ECG:**

A 28-day follow-up assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

### **Plasma for ctDNA and blood borne biomarkers:**

All subjects will be requested to provide one plasma sample prior to dosing, at each treatment period study visit.

### **PK Blood Samples (including metabolites):**

For subjects randomized to AZD9291, blood samples (plasma) will be taken to determine concentrations of AZD9291, AZ5104 and AZ7550.

### **EORTC QLQ-C30, EQ-5D-5L, EORTC QLQ-LC13 and PRO-CTCAE:**

Patient reported outcomes will be collected for all subjects throughout the study period via a hand-held electronic device.

### **Healthcare Resource Use:**

Healthcare resource use assessment will be completed by the Investigational Site for any such healthcare resource use between visits.

### **Concomitant Medication Use:**

For subjects randomized to doublet-chemotherapy, Folic acid, Vitamin B12 and Corticosteroid administration will be initiated prior to the start of study treatment.

Descriptions of the procedures for this treatment period are included in [Table 1](#), [Table 2](#) and [Table 3](#).

## **4.3 Follow-up period**

### **4.3.1 Discontinuation visit**

A Discontinuation Visit will be performed at the time randomized treatment is permanently stopped. A second Discontinuation Visit will be performed for those subjects that stop AZD9291 in the Cross-over Treatment Phase.

For subjects randomized to the Platinum-based Doublet-Chemotherapy, the discontinuation visit should be done after central confirmation of disease progression. The Chemotherapy discontinuation visit and Cross-Over visit can be done on the same day, as long as all other parameters are met.

Refer to [Table 1](#), [Table 2](#) or [Table 3](#) for details.

#### **4.3.2 Twenty-eight Day follow-up**

As a minimum, telephone contact should be made with the subject 28(+7) days following the discontinuation of investigational product to collect new AEs and follow up on any ongoing AEs and concomitant medications (including any subsequent cancer therapy). Refer to [Section 6.3](#) for full details on AE recordings during follow-up.

#### **4.3.3 Progression follow-up**

Subjects who discontinue study medication for reasons other than objective disease progression will continue RECIST 1.1 assessments every 6 weeks (relative to date of randomization) for objective progression.

If a subject has been deemed to have objective disease progression according to Investigator tumour assessment by RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subject's best interest, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy. Sites are to submit the next scheduled tumour assessment for central imaging review according to [Table 2](#).

In addition to RECIST 1.1 assessments, the following assessments are also required during this follow-up period as detailed in the Study Plan [Table 1](#), [Table 2](#) or [Table 3](#).

- EORTC QLQ-C30 and EQ-5D-5L every 6 weeks and at the time of progression.
- EORTC QLQ LC13 and PRO-CTCAE every 3 weeks and at the time of progression.
- Plasma for ctDNA collected every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation if this is in absence of progression)
- Adverse event collection detailed in [Section 6.3](#)
- Anti-cancer therapy and surgery collected every 6 weeks
- WHO performance status should also be collected at other site visits that the subject attends, if appropriate site staff are available to collect such information. In addition, where possible, please provide WHO performance status when information on subsequent anticancer therapy is provided.
- Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will receive AZD9291 80mg, once daily and will follow the assessments as per [Table 3](#). These subjects may continue treatment with AZD9291 as long as they show clinical benefit, as judged by the investigator.

- Subjects who are not be eligible to cross-over to AZD9291 will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.

#### **4.3.4 Survival follow-up**

Assessments for survival should be made every 6 weeks following objective disease progression. Survival information may be obtained via telephone contact with the subject, the subject's family or caretaker or by contact with the subject's current physician. In addition to the survival status, the following assessments are also required post progression as detailed in the study plan (see [Table 1](#), [Table 2](#) or [Table 3](#)):

- EORTC QLQ-C30 and EQ-5D-5L every 6 weeks.
- EORTC QLQ LC13 and PRO-CTCAE every 3 weeks.
- Anti-cancer therapy and surgery collected every 6 weeks.
- Subsequent response/progression data every 6 weeks until the first confirmed disease progression on a subsequent treatment (to inform PFS2 endpoint).
- WHO performance status should also be collected at other site visits that the subject attends, if appropriate site staff are available to collect such information. In addition, where possible, please provide WHO performance status when information on subsequent anticancer therapy is provided.

Survival data will be collected up to the time of the final OS analysis. Subjects should be contacted in the week following the data cut-off for the final survival analyses to provide complete survival data.

The status of ongoing, withdrawn (from the study) and "lost to follow-up" subjects at the time of an OS analysis should be obtained by the site personnel by checking the subjects notes, hospital records, contacting the subjects general practitioner and checking publicly available death registries. In the event that the subject has actively withdrawn consent to the processing of their personal data, the vital status of the subject can be obtained by site personnel from publicly available resources where it is possible to do so under applicable local laws.

## **5. STUDY ASSESSMENTS**

The RAVE Web Based Data Capture (WBDC) system will be used for data collection and query handling. The investigator will ensure that data are recorded on the electronic Case Report Forms as specified in the study protocol and in accordance with the instructions provided.

The investigator ensures the accuracy, completeness and timeliness of the data recorded and of the provision of answers to data queries according to the Clinical Study Agreement. The Investigator will sign the completed electronic Case Report Forms. A copy of the completed electronic Case Report Forms will be archived at the study site.

For details of data and study management see Section [9.4](#) of Clinical Study Protocol.

## **5.1 Efficacy assessments**

### **5.1.1 RECIST 1.1**

All imaging assessments including unscheduled visit scans should be collected on an ongoing basis and sent to an AstraZeneca (AZ) appointed Clinical Research Organisation (CRO) to enable independent central analyses.

For both investigator and Blinded Independent Central Review (BICR) RECIST 1.1 criteria will be used to assess each subject's tumour response to treatment and allow calculation of PFS, ORR, DCR, DoR and assess tumour shrinkage. The RECIST 1.1 guidelines for measurable, non-measurable, target and non-target lesions and the objective tumour response criteria [CR (complete response), PR (partial response), SD (stable disease) or PD (progression of disease)] are presented in Appendix H. For ORR, a visit response of CR or PR must be confirmed by a later scan conducted at least 4 weeks after the initial response is observed. See Section 4 for considerations related to RECIST 1.1 assessments.

The methods used at baseline for assessment of tumour burden [CT or MRI scans of chest and abdomen (including liver and adrenal glands)] must be used at each subsequent follow-up assessment. Any other areas of disease involvement should be additionally investigated based on the signs and symptoms of individual subjects. The baseline assessment should be performed within 28 days of the start of randomized treatment. Subsequent assessments are to be performed every 6 weeks relative to randomization until objective disease progression. It is important to follow the assessment schedule as closely as possible. If scans are performed outside of the scheduled visit ( $\pm$  1 week window interval) and the subject has not progressed, every attempt should be made to perform the subsequent scans at their scheduled time points. Any other sites at which new disease is suspected should also be appropriately imaged. For subjects under consideration for cross-over to AZD9291, scheduled tumour assessments will continue until confirmation of objective radiological disease progression by independent central imaging review according to RECIST 1.1, if even after investigator has deemed objective disease progression.

For subjects not or no longer under consideration, or ineligible to cross-over to AZD9291 (e.g. subjects randomized to the chemotherapy arm, but not meeting criteria to cross-over to AZD9291; subjects originally randomized to the AZD9291 arm; or subjects who already crossed-over to AZD9291), no subsequent tumour assessments are expected to be sent for independent central imaging analysis after the investigator confirms objective disease progression.

Subjects with known or suspected brain metastases at screening should have a CT/MRI of the brain prior to starting study treatment. These subjects should be followed up on study with repeated CT/MRI assessment, using the same frequency as RECIST assessments. The same modality for CT/MRI should be used for a subject throughout the study. Brain metastases will be assessed as non-target lesions.

If the investigator is in doubt as to whether progression has occurred, particularly with response to non-target lesions (NTLs) or the appearance of a new lesion, it is advisable to continue treatment until the next scheduled assessment or sooner if clinically indicated and reassess the subject's status. If repeat scans confirm progression, then the date of the initial scan should be declared as the date of progression.

To achieve "unequivocal progression" on the basis of non-target disease, there must be an overall substantial worsening in non-target disease such that, even in the presence of SD or PR in target disease, the overall tumour burden has increased sufficiently to merit discontinuation of therapy. A modest "increase" in size of one or more non-target lesions is usually not sufficient to qualify for unequivocal progression status.

Categorisation of objective tumour response assessment at each visit will be based on the RECIST 1.1 criteria of response: CR, PR, SD and PD. Target lesion (TL) progression will be calculated in comparison to when the tumour burden was at a minimum (ie, smallest sum of diameters previously recorded on study). In the absence of progression, tumour response (CR, PR, SD) will be calculated in comparison to the baseline tumour measurements obtained before starting treatment.

The primary analysis for this study will be based on the tumour assessments using investigator site assessments according to RECIST 1.1.

### **5.1.2 RECIST 1.1 - Blinded Independent Central Review (BICR) Assessment**

All imaging assessments including unscheduled visit scans will be collected on an ongoing basis and sent to an AstraZeneca appointed CRO to enable central analysis. The central review will provide confirmation of progression for patients on platinum-based doublet chemotherapy who have progressed, as assessed by the investigator, at the request of the investigational site for confirmation of progression prior to starting AZD9291. Otherwise, the results of this independent central review will not be communicated to the investigational site, and the management of subjects will be based on the result of RECIST 1.1 assessments conducted by the investigator. Since confirmation by central imaging review is required for subjects to cross-over to AZD9291, no subjects will be permitted to cross-over without the aforementioned confirmation. A sensitivity analysis will be conducted to identify any potential biases in the investigator assessments compared with BICR according to RECIST 1.1 (see Section 8.5.1).

## **5.2 Safety assessments**

### **5.2.1 Laboratory safety assessments**

Blood and urine samples for determination of clinical chemistry, haematology and urinalysis will be taken at the times indicated in the Study Plan (Table 1, Table 2, or Table 3).

Additional safety samples may be collected if clinically indicated at the discretion of the Investigator. The date, time of collection and results (values, units and reference ranges) will be recorded on the appropriate eCRF.



The clinical chemistry, haematology and urinalysis will be performed at a local laboratory at or near to the Investigator site. Sample tubes and sample sizes may vary depending on laboratory method used and routine practice at the site. The number of samples/blood volumes is therefore subject to site-specific change.

The following laboratory variables will be measured:

**Table 4 Laboratory Safety Variables**

<b>Clinical chemistry</b>	<b>Haematology</b>
Serum (S)/Plasma (P)-Albumin	Blood (B)-Haemoglobin
S/P-ALT	B-Leukocyte
S/P-AST	B-Haematocrit
S/P-Alkaline phosphatase	B-Red blood cell (RBC) count
S/P-Bilirubin, total	B-Absolute leukocyte differential count:
S/P-Calcium, total	Neutrophils
S/P-Creatinine	Lymphocytes
S/P-Glucose (fasting, on PK days only) <sup>1</sup>	Monocytes
S/P-Lactate dehydrogenase (LDH) <sup>2</sup>	
S/P-HbA1C	Basophils
S/P-Magnesium	Eosinophils
S/P-Potassium	B-Platelet count
S/P-Sodium	B-Reticulocytes
S/P-Urea nitrogen/Blood urea nitrogen (BUN)	Urinalysis
	U-Glucose
	U-Protein
	U-Blood

<sup>1</sup> Patients in AZD9291 cohort will be required to fast (water only) for at least 8 hours prior to the collection of a fasting glucose sample required on PK days. Random glucose sample will be collected on non-PK days. Fasting is not required for patients in chemo cohort.

<sup>2</sup> LDH is an additional variable collected at Visit 1 only.

Additionally, at the Screening Visit, a pregnancy test (blood or urine tests are acceptable based on the site's standard clinical practice) will be collected from all females of child bearing potential only.

The Investigator should make an assessment of the available results with regard to clinically relevant abnormalities. The laboratory results should be signed and dated and retained at centre as source data for laboratory variables. For information on how Adverse Events (AEs) based on laboratory tests should be recorded and reported, see Section 6.3.

**NB.** In case a subject shows an AST or ALT  $\geq 3 \times \text{ULN}$  and total bilirubin  $\geq 2 \times \text{ULN}$  please refer to Appendix E ‘Actions required in cases of combined increase of Aminotransferase and Total Bilirubin – Hy’s Law’, for further instructions (Section 6.3.7 and Appendix E).

### 5.2.2 Volume of blood

Total mandatory blood volume for AZD9291 subjects in first 9 weeks is 172 mL (

[Table 5](#)).

**Table 5 Blood sample volumes AZD9291 subjects**

Visit	Safety (mL) <sup>1</sup>	PK Analysis (mL)	Plasma (mL)	PGx (mL)
Screening	15		20	10 (optional)
Cycle 1	45	6	30	
Cycle 2	15	NA	10	
Cycle 3	15	6	10	
<b>SUBTOTAL (mandatory)</b>	<b>90</b>	<b>12</b>	<b>70</b>	

<sup>1</sup>For safety, assumes 6 mL clinical chemistry and 9 mL haematology per visit

Total mandatory blood volume for Platinum-based Doublet-chemotherapy subjects in first 9 weeks is 160 mL ([Table 6](#)).

**Table 6 Blood sample volumes Platinum-based Doublet-chemotherapy subjects**

Visit	Safety (mL) <sup>1</sup>	PK Analysis (mL)	Plasma (mL)	PGx (mL)
Screening	15		20	10 (optional)
Cycle 1	45	NA	30	
Cycle 2	15	NA	10	
Cycle 3 (onwards)	15	NA	10	
<b>TOTAL (mandatory)</b>	<b>90</b>		<b>70</b>	

<sup>1</sup> For safety, assumes 6 mL clinical chemistry and 9 mL haematology per visit

### 5.2.3 Physical examination

All subjects will have a physical examination performed at the time points indicated in the Study Plan ([Table 1](#), [Table 2](#) or [Table 3](#)), which includes an assessment of the following: general appearance, skin, head and neck (including ears, eyes, nose and throat), respiratory, cardiovascular, abdomen, lymph nodes, thyroid, musculo-skeletal (including spine and extremities), and neurological systems.

#### **5.2.4 ECG**

All subjects will have three 12-lead ECG performed at the time points indicated in Study Plan (Table 1, Table 2 or Table 3). A twelve-lead ECG will be obtained after the subject has been resting semi-supine for at least 10 minutes prior to times indicated and should be recorded at 25 mm/sec. All ECGs should be recorded with the subject in the same physical position. The three ECG recordings should be taken within an approximate 5 minute period. A standardised ECG machine should be used and the patient should be examined using the same machine throughout the study if possible.

After paper ECGs have been recorded, the investigator or designated physician will review each of the ECGs and may refer to a local cardiologist if appropriate. A paper copy should be filed in the patient's medical records. If an abnormal ECG finding at screening or baseline is considered to be clinically significant by the investigator, it should be reported as a concurrent condition. For all ECGs details of rhythm, ECG intervals and an overall evaluation will be recorded.

ECG data will be collected digitally and will be transferred electronically for central analysis as described in the study specific ECG manual.

Heart rate, PR, R-R, QRS and QT intervals will be determined and reviewed by an external cardiologist.

If there is a clinically significant abnormal ECG finding during the Treatment period, this should be recorded on the AE eCRF, according to standard adverse events collection and reporting processes. A 28-day follow-up assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

Patients who experience a QTc interval greater than 500 msec on at least 2 separate ECGs must have AZD9291 treatment interrupted until the QTc interval is less than 481 msec or recovery to baseline if baseline QTc is greater than or equal to 481 msec, then restart at a reduced dose (40 mg).

Patients experiencing QTc interval prolongation with signs/symptoms of serious arrhythmia will not be permitted to restart study treatment.

#### **5.2.5 Echocardiogram/MUGA scan**

An Echocardiogram or MUGA scan to assess LVEF will be performed at screening (prior to study medication) and every 12 weeks ( $\pm$  1 week window interval) relative to randomization. The modality of the cardiac function assessments must be consistent throughout ie, if echocardiogram is used for the screening assessment then echocardiogram should also be used for subsequent scans. The subjects should also be examined using the same machine and operator whenever possible. To be performed every 12 weeks and as clinically indicated. A 28-day follow-up assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

## **5.2.6 Vital signs**

### **5.2.6.1 Pulse, blood pressure, weight and height**

Supine blood pressure and pulse rate will be measured after 10 minutes rest. Assessments will be performed at the visits as shown in the Study Plan (see [Table 1](#), [Table 2](#) or [Table 3](#)). Additionally at the discretion of the investigator if clinically indicated.

Weight will be performed at screening and then Day 1 of each cycle and at the discontinuation visit. Weight will be documented in kilogram (e.g. 68.5 kg) in eCRF.

Height will be assessed at screening only and will be documented in centimeters (e.g. 168 cm) in eCRF.

Any changes in vital signs (pulse and BP) should be recorded as an AE if applicable.

## **5.2.7 Other safety assessments**

### **5.2.7.1 Ophthalmologic exam**

At screening, a full ophthalmic assessment (measurements of best-corrected visual acuity, intraocular pressure and slit-lamp fundoscopy) should be obtained. For any subject who experiences visual symptoms (including blurring of vision), additional tests may be conducted throughout the study period, if clinically indicated (see [Table 1](#) or [Table 2](#)).

Any clinically significant findings, including those confirmed by the ophthalmologist must be reported as an AE. Photographs should be performed to record any clinically significant findings. These photographs should be available for central review by AstraZeneca and AstraZeneca representatives if necessary.

Subjects experiencing corneal ulceration will not be permitted to restart study treatment.

Ophthalmologic exams to be performed as clinically indicated. A 28-day follow-up assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

Ophthalmology examination results should be collected in the eCRF.

## **5.3 Other assessments**

### **5.3.1 Baseline characteristics**

Baseline demographics, disease history, previous treatments and EGFR mutation information will be collected.

### **5.3.2 Patient reported outcomes**

Patient reported outcomes (PROs), an umbrella term referring to all outcomes and symptoms, are directly reported by the subject. PROs have become a significant endpoint when evaluating effectiveness of treatments in clinical trials. The following PROs will be

administered: EORTC QLQ C-30, QLQ-LC13, EQ-5D-5L and PRO CTCAE (see Appendix G).

### **5.3.2.1 EORTC QLQ-C30 and QLQ-LC13**

The EORTC QLQ-C30 was developed by the EORTC Quality of Life Group 1993. It consists of 30 items and measures cancer patients' functioning (HRQoL) and symptoms ([Aaronson et al 1993](#)) for all cancer types. Questions can be grouped into 5 multi-item functional scales (physical, role, emotional, cognitive and social); 3 multi-item symptom scales (fatigue, pain, nausea and vomiting); a 2-item global HRQoL scale; 5 single items assessing additional symptoms commonly reported by cancer patients (dyspnoea, loss of appetite, insomnia, constipation, diarrhoea) and 1 item on the financial impact of the disease.

The QLQ LC13 is a well-validated complementary module measuring lung cancer associated symptoms and side effects from conventional chemotherapy and radiotherapy ([Bergman et al 1994](#)). Refer to Appendix G. The QLQ LC13 includes questions assessing cough, haemoptysis, dyspnoea and site specific pain (symptoms), sore mouth, dysphagia, peripheral neuropathy and alopecia (treatment-related side effects) and pain medication.

### **5.3.2.2 EQ-5D-5L**

The EQ-5D is a standardised measure of health status developed by the EuroQol Group in order to provide a simple, generic measure of health for clinical and economic appraisal ([EuroQol Group 1990](#)). Applicable to a wide range of health conditions and treatments, it provides a simple descriptive profile and a single index value for health status that can be used in the clinical and economic evaluation of health care as well as in population health surveys.

The questionnaire assesses 5 dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has 5 response options (no problems, slight problems, moderate problems, severe problems, and extreme problems) that reflect increasing levels of difficulty ([EuroQol Group 2013](#)).

Since 2009, the EuroQol group has been developing a more sensitive version of the EQ-5D (the EQ-5D-5L), which expands the range of responses to each dimension from 3 to 5 levels of increasing severity ([Herdman et al 2011](#)). Preliminary studies indicate that the 5L version improves upon the properties of the 3L measure in terms of reduced ceiling effect, increased reliability and an improved ability to differentiate between different levels of health ([Pickard et al 2007](#), [Janssen et al 2008](#), [Janssen et al 2008b](#)).

The subject will be asked to indicate his/her current health state by selecting the most appropriate level in each of the 5 dimensions. The questionnaire also includes a visual analogue scale, where the subject will be asked to rate current health status on a scale of zero to 100, with zero being the worst imaginable health state (see Appendix G).

### **5.3.2.3 PRO-CTCAE**

The Patient-Reported Outcomes version of the Common Terminology Criteria for Adverse Events (PRO-CTCAE) system has been developed by the National Cancer Institute (NCI).

The PRO-CTCAE will only be administered in those countries where a linguistically validated version exists, currently English, Japanese, German and Spanish. PRO-CTCAE is an item-bank of symptoms experienced by patients while undergoing treatment of their cancer. It was developed in recognition that collecting symptom data directly from patients using PRO tools can improve the accuracy and efficiency of symptomatic AE data collection. This was based on findings from multiple studies demonstrating that physicians and nurses underestimate symptom onset, frequency, and severity in comparison with patient ratings (Sprangers et al 1992; Litwin et al 1988-1992; Basch et al 2009). To date, 81 symptoms of the CTCAE (version 4) have been identified to be amenable to patient reporting. These symptoms have been converted to patient terms (e.g., CTCAE term “myalgia” converted to “aching muscles”). For several symptoms, like fatigue and pain, additional questions are asked about symptom frequency, severity, and interference with usual activities. For other symptoms like rash, additional questions focus on the presence on the body. The items included in the PRO-CTCAE have undergone extensive qualitative review among experts and patients. Using cognitive testing methods, these items and the additional questions for some of the symptoms have been extensively evaluated by cancer patients, so that symptoms of interest are clear, comprehensible and measurable. Not all items are administered in any one clinical trial. The intention is to only ask patients to complete those items, which are considered relevant for the trial, site of cancer, and cancer treatment (see Appendix G).

#### **5.3.2.4 Administration of electronic PROs**

Subjects will complete the PRO assessments by using a handheld electronic device (ePRO). The following best practise guidelines should be followed when collecting PRO data via an electronic device:

- Site staff to explain the value and relevance of participation to subjects that we are asking these questions because we are interested in hearing directly from them how they feel. The research nurse or appointed site staff should also stress that the information is confidential. Therefore, if the subject has any medical problems he/she should discuss them with the doctor or research nurse separately from the ePRO assessment
- Remind subjects that there are no right or wrong answers, avoid bias by not clarifying items
- Train the subject on how to use the ePRO device using the materials and training provided by the ePRO vendor. Also provide guidance on whom to call if there are problems with the device by providing the patient information pamphlet provided by the ePRO vendor.

In order to minimize missing data, compliance must be checked frequently to identify problems early. If compliance drops below 85%, a check-in call from the site to ask the subject if he/she has any difficulties is highly recommended.

#### **5.3.2.5 Healthcare resource use**

The site will ask subjects for any healthcare resource use between visits (ie, excluding routine follow up clinic visits associated with the clinical trial but including both planned and unplanned admissions) during the treatment period and at the 28-day follow-up.

For the purposes of economic evaluation it is necessary to capture healthcare resource use related to the treatment and the underlying disease. Within the study the following resource use will be captured:

- Hospital episodes including the type of contact (hospitalisations, outpatient, day case), reason, length of stay (including intensive care unit) and concomitant medications and procedures
- Treatment related to Adverse Events (including the method of delivery of the treatment)
- Treatment not related to the study.

The above resource use data will mainly come from the subject's medical record and will be captured by site staff using WBDC.

## 5.4 Pharmacokinetics

### 5.4.1 Collection of samples for subjects randomized to AZD9291

Three venous blood samples per visit in time windows Pre-dose, 0.5 to 1.5, and 2 to 4 hours for determination of total concentrations of AZD9291 and metabolites (AZ5104 and AZ7550) in plasma will be taken at the times presented in [Table 7](#).

The date and time of collection of each sample and the date and time of dose (on PK sampling day and for previous dose) will be recorded.

**Table 7 PK blood sample schedule (Pre-dose, 0.5 to 1.5, and 2 to 4 hours)**

<b>Time relative to dose</b>	<b>Cycle 1 -Visit 2</b>	<b>Cycle 3 -Visit 6</b>	<b>Cycle 5 -Visit 8</b>	<b>Cycle 7 -Visit 10 and every other cycle up to and including Cycle 13</b>
<b>mL</b>	<b>6 (2 mL x 3)</b>	<b>6 (2 mL x 3)</b>	<b>6 (2 mL x 3)</b>	<b>6 (2 mL x 3)</b>

Samples will be collected, labelled stored and shipped as detailed in the Laboratory Manual.

### 5.4.2 Determination of drug concentration

Samples for determination of AZD9291 (and metabolite) concentrations in plasma and cerebrospinal fluid (CSF) will be collected and analysed by Covance on behalf of AstraZeneca, using an appropriate bioanalytical method. Full details of the analytical method used will be described in a separate bioanalytical report. All samples still within the known stability of the analytes of interest (ie, AZD9291, AZ5104 and AZ7550) at the time of receipt by the bioanalytical laboratory will be analysed.

In addition, the pharmacokinetic samples may be subjected to further analyses by AstraZeneca in order to further investigate the presence and/or identity of additional drug metabolites. Any results from such analyses will be reported separately from the Clinical Study Report.

Details on sample processing, handling, shipment and storage are provided in the Laboratory Manual.

Full details of the analytical method used will be described in a separate bioanalytical report.

### **5.4.3 Storage and destruction of pharmacokinetic samples**

Pharmacokinetic samples will be disposed of after the Bioanalytical Report finalization or six months after issuance of the draft Bioanalytical Report (whichever is earlier), unless requested for future analyses.

Pharmacokinetic samples may be disposed of or destroyed and anonymised by pooling. Additional analyses may be conducted on the anonymised, pooled pharmacokinetic samples to further evaluate and validate the analytical method. Any results from such analyses may be reported separately from the CSR.

Incurred sample reproducibility analysis, if any, will be performed alongside the bioanalysis of the test samples. The results from the evaluation will not be reported in the Clinical Study Report but separately in a Bioanalytical Report.

Any residual back-up PK samples may be used for future exploratory biomarker research (in this case, residual back-up PK samples will be shipped to the AZ Biobank or its designee; see details in the Laboratory Manual).

### **5.4.4 Collection of cerebrospinal fluid - optional**

**For subjects randomized to AZD9291:** If the subject agrees, and upon signature of optional ICF, a sample of CSF will be obtained at one time point taken at any time from Cycle 2 Day 1 onwards. Samples will be collected, labelled and stored and shipped as detailed in the laboratory manual.

Any residual CSF after PK analysis may be used for exploratory research into factors that may influence development of NSCLC and/or response to AZD9291. If possible, the CSF sample should be taken on the same day as planned PK samples.

## **5.5 Pharmacogenetics**

If a subject agrees to participate in the host pharmacogenetics research component of the study a blood sample will be collected.

AstraZeneca intends to perform genetic research in the AZD9291 clinical development programme to explore how genetic variations may affect the clinical parameters associated with AZD9291.

The benefits of being able to explore associations between genes and clinical outcomes within the AZD9291 programme are potentially many and include:

- analysis of genes that may affect efficacy, safety and tolerability (for example, but not limited to, drug metabolising enzymes and drug transporters)



- genetic research into genes that may contribute to the risk of NSCLC (for example, but not limited to, mutations in the gene encoding EGFR)

The results of this pharmacogenetic research will be reported separately and will not form part of the Clinical Study Report.

### **5.5.1 Collection of pharmacogenetic samples**

The subject's consent to participate in the pharmacogenetic research components of the study is optional.

The single blood sample (10 mL) for genetic research will be obtained from the subjects immediately prior to the first administration of AZD9291 in the study. Although genotype is a stable parameter, early sample collection is preferred to avoid introducing bias through excluding subjects who may withdraw due to an adverse event. Such subjects would be important to include in any genetic analysis. If for any reason the sample is not drawn prior to dosing it may be taken at any visit until the last study visit. Only one sample should be collected per subject for genetics during the study.

Samples will be collected, labelled, stored and shipped as detailed in the Laboratory Manual.

### **5.5.2 Storage, re-use and destruction of pharmacogenetic samples**

The processes adopted for the coding and storage of samples for genetic analysis are important to maintain subject confidentiality. Samples will be stored for a maximum of 15 years from the date of the Last Subject's Last Visit, after which they will be destroyed. DNA is a finite resource that may be used up during analyses. The results of any further analyses will be reported either in the Clinical Study Report itself or as an addendum, or separately in a scientific report or publication. Samples will be stored and used until no further analyses are possible or the maximum storage time has been reached.

Refer to Appendix D for details of the optional (DNA) genetic research.

## **5.6 Exploratory Research**

If a subject agrees to participate in the exploratory biomarker research component of the study biological samples (e.g., plasma, serum, archived and study-obtained tumour, etc.) will be collected and may be analysed for exploratory biomarkers to assess correlations with disease activity, effects of investigational product and clinical outcomes.

The results of this exploratory biomarker research will be reported separately and will not form part of the Clinical Study Report.

The results of this exploratory biomarker research may be pooled with biomarker data from other studies with the investigational product to generate hypotheses to be tested in future studies.

## 5.6.1 Collection of Tumour Biopsy Samples

### 5.6.1.1 Archival Tumour

All subjects eligible for the study will be asked to provide consent to supply a sample of their archival tumour blocks if a sample taken at the time of diagnosis is available (blocks preferred, slides acceptable).

Only submit samples for subjects who have a centrally confirmed T790M+ mutation. Any archival biopsy samples taken following previous lines of therapy will also be requested, if available. In each case the previous patient treatment must be clearly indicated for each sample provided. This sample will be used to support exploratory biomarker analyses (see Section 5.6).

### 5.6.1.2 Optional Tissue Collection at Screening

Subjects will be asked to consent to provide additional tumour tissue at screening, which can be collected at the same time as the mandatory screening tumour biopsy (see Section 4.1), where appropriate to do so. This biopsy will be used to support the development of the diagnostic test for pre-market approval by FDA (US) and/or for exploratory biomarker analyses (see Section 5.6).

### 5.6.1.3 Discontinuation Biopsy

Subjects will also be asked to consent to a further optional biopsy, to be collected at discontinuation of study treatment. This sample will be used to support exploratory biomarker analyses (see Section 5.6).

For timings of tumour biopsies see

#### Table 8.

**Table 8 Tumour biopsy samples**

Time relative to dose	Requirement
Archival	M*
Screening	M + O <sup>2</sup>
Discontinuation or progression <sup>1</sup>	O

<sup>1</sup> To be taken at discontinuation or progression, whichever occurs first

<sup>2</sup> Only block tissue sample will be accepted

M = Mandatory    O = Optional    M\* = mandatory if available

Tumour samples should be provided in the form of a formalin fixed paraffin embedded block (tissue derived from the diagnostic tumour or a metastatic site). If this is not possible, the following may be provided:

- 12-20 slides of freshly prepared unstained 5-micron sections from the mandatory screening FFPE tumour block may be provided
- 10-20 slides of freshly prepared unstained 5-micron sections from the archival tumour block may be provided.

Further details on sample processing, handling and shipment are provided in the Laboratory Manual.

### **5.6.2 Collection of exploratory samples - blood-borne biomarkers and ctDNA**

All subjects will be requested to provide a series of blood samples to generate plasma samples. These samples will be used for the extraction and analysis of ctDNA. The ctDNA may be used to further investigate the relationship between PK and blood-borne biomarkers. The ctDNA samples will be used to further explore EGFR (and other gene) mutation status and may be used to develop a plasma-based diagnostic test.

Plasma samples will be taken at the following times (pre-dose):

- Screening
- Cycle 1 - Day 1, Day 8 & 15; Cycle 2, 3, 4, 5, 6 – Day 1; thereafter
- Every 6 weeks up to and including progression (corresponding with the RECIST assessments)
- Discontinuation of study drug (if subject continues after progression on AZD9291)

The samples will be analysed for a range of oncology biomarkers, which may correlate with drug response.

Details on sample processing, handling, shipment and storage are provided in the Laboratory Manual.

## **5.7 Management of Biological Samples**

### **5.7.1 Storage, re-use and destruction of biological samples**

Biological samples for future research will be retained at AstraZeneca or its designee for a maximum of 15 years following the finalisation of the Clinical Study Report, after which they will be destroyed. The results of this biomarker research will be reported either in the Clinical Study Report itself or as an addendum, or separately in a scientific report or publication. The results of this biomarker research may be pooled with biomarker data from other studies with the investigational product to generate hypotheses to be tested in future research.

### **5.7.2 Labelling and shipment of biological samples**

The Principal Investigator ensures that samples are labelled and shipped in accordance with the Laboratory Manual and the Biological Substance, Category B Regulations (materials containing or suspected to contain infectious substances that do not meet Category A criteria), see Appendix C 'IATA 6.2 Guidance Document'.

Any samples identified as Infectious Category A materials are not shipped and no further samples will be taken from the subject unless agreed with AstraZeneca and appropriate labelling, shipment and containment provisions are approved.

All tumour samples should be shipped at ambient temperature as per the Laboratory Manual to the AstraZeneca designated central Contract Research Organisation.

### **5.7.3 Chain of custody of biological samples**

A full chain of custody is maintained for all samples throughout their lifecycle.

The Principal Investigator at each centre keeps full traceability of collected biological samples from the subjects while in storage at the centre until shipment or disposal (where appropriate) and keeps documentation of receipt of arrival.

The sample receiver keeps full traceability of the samples while in storage and during use until used or disposed of or until further shipment and keeps documentation of receipt of arrival.

AstraZeneca keeps oversight of the entire life cycle through internal procedures, monitoring of study sites and auditing of external laboratory providers.

Samples retained for further use are registered in the AstraZeneca Biobank system during the entire life cycle.

### **5.7.4 Withdrawal of Informed Consent for donated biological samples**

If a subject withdraws consent to the use of donated biological samples, the samples will be disposed of/destroyed, and the action documented. If samples are already analysed, AstraZeneca is not obliged to destroy the results of this research.

As collection of the biological samples is an optional part of the study, then the subject may continue in the study.

The Principal Investigator:

- Ensures subjects' withdrawal of informed consent to the use of donated samples is notified immediately to AstraZeneca
- Ensures that biological samples from that subject, if stored at the study site, are immediately identified, disposed of/destroyed, and the action documented
- Ensures the laboratory(ies) holding the samples is/are informed about the withdrawn consent immediately and that samples are disposed of/destroyed, the action documented and the signed document returned to the study site
- Ensures that the subject and AstraZeneca are informed about the sample disposal.

AstraZeneca ensures the central laboratory(ies) holding the samples is/are informed about the withdrawn consent immediately and that samples are disposed of/destroyed and the action documented and returned to the study site.

AstraZeneca ensures that biological samples are destroyed at the end of a specified period as described in the informed consent.

## **5.8 Post progression outcomes**

The date of second progression (PFS2) will be recorded by the Investigator and defined according to local standard clinical practice and may involve any of the following: objective radiological evidence (preferred), symptomatic progression or death. Second progression status will be reviewed every 6 weeks following the progression event used for the primary variable PFS (the first progression) and status recorded.

The start and stop date, and details of the type of all subsequent anticancer treatments will be recorded.

PRO data and WHO performance status will be collected post progression (see Section 4).

## **6. SAFETY REPORTING AND MEDICAL MANAGEMENT**

The Principal Investigator is responsible for ensuring that all staff involved in the study are familiar with the content of this section.

### **6.1 Definition of adverse events**

An adverse event is the development of an undesirable medical condition or the deterioration of a pre-existing medical condition following or during exposure to a pharmaceutical product, whether or not considered causally related to the product. An undesirable medical condition can be symptoms (e.g., nausea, chest pain), signs (e.g., tachycardia, enlarged liver) or the abnormal results of an investigation (e.g., laboratory findings, electrocardiogram). In clinical studies, an AE can include an undesirable medical condition occurring at any time, including run-in or washout periods, even if no study treatment has been administered.

The term AE is used to include both serious and non-serious AEs.

For cases where it could be suspected that a tissue-derived medicine has been contaminated by a pathogen, information about any of the above conditions (including infection) should be collected. Any deterioration of the disease targeted in the study and associated symptoms should not be regarded as an adverse event.

### **6.2 Definitions of serious adverse event**

A serious adverse event is an AE occurring during any study phase (ie, run-in, treatment, washout, follow-up), that fulfils one or more of the following criteria:

- Results in death
- Is immediately life-threatening
- Requires in-patient hospitalisation or prolongation of existing hospitalisation

- Results in persistent or significant disability/incapacity or substantial disruption of the ability to conduct normal life functions
- Is a congenital abnormality or birth defect
- Is an important medical event that may jeopardise the subject or may require medical intervention to prevent one of the outcomes listed above.

For further guidance on the definition of a SAE, see Appendix B to the Clinical Study Protocol.

## 6.3 Recording of adverse events

### 6.3.1 Time period for collection of adverse events

Adverse Events will be collected from time of signature of informed consent throughout the treatment period and including the safety follow-up period. The follow-up period is defined as 28 days after study treatment is discontinued. SAEs occurring in the follow-up period should be reported to AstraZeneca in the usual manner (see Section 6.4).

Following discontinuation of study treatment, SAEs considered related to study procedures should continue to be collected while subjects are followed up for disease progression as outlined in Table 9.

After the final database lock, there may be some subjects remaining on study treatment. For these subjects who are continuing to receive AZD9291 AstraZeneca will collect information (during the treatment period and for 28 (+ 7) days after last dose) on SAEs, deaths (including those due to disease progression), discontinuation due to AEs/SAEs and drug accountability only.

For each subject who discontinues study treatment for a reason other than disease progression:

- Follow-up information on all ongoing AEs should continue to be collected to the survival follow-up
- SAEs considered related to study procedures must continue to be collected and reported to AstraZeneca using standard SAE timelines and process until the end of progression follow up (ie, disease progression)
- All deaths must continue to be collected after progression and during the survival follow-up

**Table 9 Summary of recording and follow-up of adverse events and deaths**

	<b>From ICF to Treatment Period (Screening Period)</b>	<b>Until 28-day Follow-up Visit (safety follow-up period)</b>	<b>Post 28-day Follow-up visit but prior to progression (if applicable)</b>	<b>Post 28-day Follow-up visit and post progression (survival follow-up period)</b>
<b>Collect all new AEs in CRF</b>	Yes	Yes	No	No

	<b>From ICF to Treatment Period (Screening Period)</b>	<b>Until 28-day Follow-up Visit (safety follow-up period)</b>	<b>Post 28-day Follow-up visit but prior to progression (if applicable)</b>	<b>Post 28-day Follow-up visit and post progression (survival follow-up period)</b>
<b>Collect all ongoing AEs in CRF</b>	Yes	Yes	Yes	Yes
<b>Collect all study procedure-related SAEs in CRF</b>	Yes	Yes	Yes	Yes
<b>Death due to AE, or unknown cause<sup>1</sup></b>	Yes	Yes	No	No

<sup>1</sup> for example, death not due to disease progression or related to study procedure - refer to Section [6.3.10](#)

### 6.3.2 Follow-up of unresolved adverse events

Any AEs that are unresolved at the subject's last visit in the study are followed up by the investigator for as long as medically indicated, but without further recording in the CRF. AstraZeneca retains the right to request additional information for any subject with ongoing AE(s) at the end of the study, if judged necessary.

### 6.3.3 Variables

The following variables will be collect for each AE:

- AE (verbatim)
- The date when the AE started and stopped
- Changes in CTCAE grade (for skin reactions and diarrhoea only); maximum CTCAE grade for all other AEs
- Whether the AE is serious or not
- Investigator causality rating against the Investigational Product (yes or no)
- Action taken with regard to investigational product
- Outcome

In addition, the following variables will be collected for SAEs:

- Date AE met criteria for serious AE
- Date Investigator became aware of serious AE
- AE is serious due to
- Date of hospitalisation
- Date of discharge
- Probable cause of death
- Date of death
- Autopsy performed

- Causality assessment in relation to Study procedure(s)
- Description of AE.

It is important to distinguish between serious and severe AEs. Severity is a measure of intensity whereas seriousness is defined by the criteria in Section 6.2. An AE of severe intensity need not necessarily be considered serious. For example, nausea that persists for several hours may be considered severe nausea, but not a SAE unless it meets the criteria shown in Section 6.2. On the other hand, a stroke that results in only a limited degree of disability may be considered a mild stroke but would be a SAE when it satisfies the criteria shown in Section 6.2.

#### **6.3.4 Causality collection**

The Investigator will assess causal relationship between Investigational Product and each Adverse Event, and answer ‘yes’ or ‘no’ to the question ‘Do you consider that there is a reasonable possibility that the event may have been caused by the investigational product?’

For SAEs causal relationship will also be assessed for other medication and study procedures. Note that for SAEs that could be associated with any study procedure the causal relationship is implied as ‘yes’.

A guide to the interpretation of the causality question is found in Appendix B to the Clinical Study Protocol.

#### **6.3.5 Adverse events based on signs and symptoms**

All AEs spontaneously reported by the subject or care provider or reported in response to the open question from the study personnel: ‘Have you/the child had any health problems since the previous visit/you were last asked?’ or revealed by observation will be collected and recorded in the CRF. When collecting AEs, the recording of diagnoses is preferred (when possible) to recording a list of signs and symptoms. However, if a diagnosis is known and there are other signs or symptoms that are not generally part of the diagnosis, the diagnosis and each sign or symptom will be recorded separately.

#### **6.3.6 Adverse events based on examinations and tests**

The results from protocol mandated laboratory tests and vital signs (pulse and BP) will be summarised in the clinical study report. Deterioration as compared to baseline in protocol-mandated parameters should therefore only be reported as AEs if they fulfil any of the SAE criteria or are the reason for discontinuation of treatment with the investigational product unless clearly due to progression of disease under study (see Section 6.3.8).

If deterioration in a laboratory value, vital sign, ECG, or other safety assessment is associated with clinical signs and symptoms, the sign or symptom will be reported as an AE and the associated laboratory result or other finding will be considered as additional information. Wherever possible the reporting Investigator uses the clinical, rather than the laboratory term



(e.g., anaemia versus low haemoglobin value). In the absence of clinical signs or symptoms, clinically relevant deteriorations in non-mandated parameters should be reported as AE(s).

Deterioration of a laboratory value, which is unequivocally due to disease progression, should not be reported as an AE/SAE.

Any new or aggravated clinically relevant abnormal medical finding at a physical examination as compared with the baseline assessment will be reported as an AE.

### **6.3.7 Hy's Law**

Cases where a subject shows an AST or ALT  $\geq 3 \times \text{ULN}$  and total bilirubin  $\geq 2 \times \text{ULN}$  may need to be reported as SAEs. Prompt reporting of cases meeting Hy's law criteria (via the SAE expedited reporting system) is required for compliance with regulatory guidelines. The investigator is responsible for, without delay, determining whether a subject meets potential Hy's law (PHL) criteria.

Details of identification of PHL cases and actions to take are detailed in Appendix E.

### **6.3.8 Disease progression**

Disease progression can be considered as a worsening of a subject's condition attributable to the disease for which the investigational product is being studied. It may be an increase in the severity of the disease under study and/or increases in the symptoms of the disease. The development of new, or progression of existing metastasis to the primary cancer under study should be considered as disease progression and not an AE.

Progression of the malignancy under study, including signs and symptoms progression, should not be reported as a serious adverse event. Hospitalization due to signs and symptoms of disease progression should not be reported as serious adverse event.

### **6.3.9 New cancers**

The development of a new cancer should be regarded as an AE and will generally meet at least one of the serious criteria. New cancers are those that are not the primary reason for the administration of the study treatment and have been identified after the subject's inclusion in this study. They do not include metastases of the original cancer.

### **6.3.10 Handling of deaths**

All deaths that occur during the study, or within the follow-up period after the administration of the last dose of investigational product, should be reported as follows:

- Death, which is unequivocally due to disease progression, should be communicated to the study monitor at the next monitoring visit and should be documented in the CRF module, but should not be reported as a SAE during the study
- Where death is not clearly due to disease progression of the disease under study the AE causing the death should be reported to the study monitor as an SAE within 24 hours. The

report should contain a comment regarding the co-involvement of progression of disease, if appropriate, and should assign a single primary cause of death together with any contributory causes

- Deaths with an unknown cause should always be reported as a SAE but every effort should be made to establish a cause of death. A post-mortem may be helpful in the assessment of the cause of death, and if performed a copy of the post-mortem results (with translation of important parts into English) should be reported in an expedited fashion to an AstraZeneca representative within the usual timeframes.

## 6.4 Reporting of serious adverse events

All SAEs have to be reported, whether or not considered causally related to the investigational product, or to the study procedure(s). All SAEs will be recorded in the CRF.

If any SAE occurs in the course of the study, then Investigators or other site personnel inform the appropriate AstraZeneca representatives within one day ie, immediately but **no later than 24 hours** of when he or she becomes aware of it.

The designated AstraZeneca representative works with the Investigator to ensure that all the necessary information is provided to the AstraZeneca Patient Safety data entry site **within 1 calendar day** of initial receipt for fatal and life threatening events **and within 5 calendar days** of initial receipt for all other SAEs.

For fatal or life-threatening adverse events where important or relevant information is missing, active follow-up is undertaken immediately. Investigators or other site personnel inform AstraZeneca representatives of any follow-up information on a previously reported SAE within one calendar day ie, immediately but **no later than 24 hours** of when he or she becomes aware of it.

Once the Investigators or other site personnel indicate an AE is serious in the WBDC system, an automated email alert is sent to the designated AstraZeneca representative.

If the WBDC system is not available, then the Investigator or other study site personnel reports a SAE to the appropriate AstraZeneca representative by telephone.

The AstraZeneca representative will advise the Investigator/study site personnel how to proceed.

The reference document for definition of expectedness is the IB for the AstraZeneca drug AZD9291 and the EU Summary of Product Characteristics (SPC) for the active comparator product (including any AstraZeneca comparator).

## 6.5 Overdose

There is no definition of what constitutes an overdose. In the Phase I study, 355 patients with advanced NSCLC were administered AZD9291 at single and multiple oral doses ranging from 20 mg to 240 mg daily (as of data cut-off date **02 December 2014**). All doses were well

tolerated. Experiences of excessive doses (i.e. in excess of the optimal 80 mg indicated dose) in this study did not show any DLTs or acute toxicities.

There is no known antidote. Investigators will be advised that any patient who receives a higher dose than that intended should be monitored closely, managed with appropriate supportive care and followed up expectantly. Such overdoses should be recorded as follows:

- An overdose with associated AEs is recorded as the AE diagnosis/symptoms on the relevant AE modules in the CRF and on the Overdose CRF module
- An overdose without associated symptoms is only reported on the Overdose CRF module

If an overdose occurs in the course of the study, then the Investigator or other site personnel inform appropriate AstraZeneca representatives immediately, or **no later than 24 hours** of when he or she becomes aware of it.

The designated AstraZeneca representative works with the Investigator to ensure that all relevant information is provided to the AstraZeneca Patient Safety data entry site.

For overdoses associated with a SAE, the standard reporting timelines apply, see Section 6.4. For other overdoses, reporting must occur within 30 days.

## 6.6 Pregnancy

All pregnancies and outcomes of pregnancy should be reported to AstraZeneca during the course of the study and within 28 days of the last dose of study treatment.

### 6.6.1 Maternal exposure

If a subject becomes pregnant during the course of the study, study treatment should be discontinued immediately.

Pregnancy itself is not regarded as an adverse event unless there is a suspicion that the investigational product under study may have interfered with the effectiveness of a contraceptive medication. Congenital abnormalities/birth defects and spontaneous miscarriages should be reported and handled as SAEs. Elective abortions without complications should not be handled as AEs. The outcome of all pregnancies (spontaneous miscarriage, elective termination, ectopic pregnancy, normal birth or congenital abnormality) should be followed up and documented even if the subject was discontinued from the study.

If any pregnancy occurs in the course of the study or within 28 days of the final dose of the investigational product then the Investigator or other site personnel informs the appropriate AstraZeneca representatives within 1 day ie, immediately but **no later than 24 hours** of when he or she becomes aware of it.

The designated AstraZeneca representative works with the Investigator to ensure that all relevant information is provided to the AstraZeneca Patient Safety data entry site within 1 or 5 calendar days for SAEs (see Section 6.4) and within 30 days for all other pregnancies.

The same timelines apply when outcome information is available.

### 6.6.2 Paternal exposure

Pregnancy of the subject's partners is not considered to be an adverse event. However, the outcome of all pregnancies (spontaneous miscarriage, elective termination, ectopic pregnancy, normal birth or congenital abnormality) should if possible be followed up and documented. To capture information about a pregnancy from the partner of a male subject, the male subject's partner consent must be obtained to collect information related to the pregnancy and outcome; the male subject should not be asked to provide this information. A consent form specific to this situation must be used. The outcome of any conception occurring from the date of the first dose until six months after dosing should be followed up and documented.

## 6.7 Management of toxicities related to AZD9291

If a subject experiences a CTCAE grade 3 or higher and/or unacceptable toxicity (any grade) not attributable to the disease or disease-related processes under investigation, where the Investigator considers the AE of concern to be specifically associated with AZD9291, dosing will be interrupted and supportive therapy administered as required in accordance with local practice/guidelines.

If the toxicity resolves or reverts to  $\leq$ CTCAE grade 2 within 3 weeks of onset, treatment with AZD9291 may be restarted at the same dose (80 mg) or a lower dose (40 mg) using the rules below for dose modifications (Table 10) and with discussion and agreement with the AstraZeneca Study Team Physician as needed. There will be no individual modifications to dosing schedule in response to toxicity, only potential dose reduction or dose interruption.

If the toxicity does not resolve to  $\leq$ CTCAE grade 2 after 3 weeks, then the subject should be withdrawn from the study and observed until resolution of the toxicity.

**Table 10** Dose Interventions

Intervention	AZD9291 Dose
Starting Dose	80 mg
Reduced Dose	40 mg

On resolution of toxicity within 3 weeks:

If an AE subsequently requires dose interruption, AZD9291 may restart at the same dose or the reduced dose, on resolution/improvement of the AE at the discretion of the Investigator.

If new or worsening pulmonary symptoms (e.g., dyspnoea) or radiological abnormality suggestive of interstitial lung disease is observed, an interruption in study treatment dosing is recommended, and the AstraZeneca study team should be informed. The results of the full diagnostic workup (including high-resolution computed tomography (HRCT), blood and sputum culture, haematological parameters) will be captured in the RAVE eCRF. All image data should also be provided to AstraZeneca. It is strongly recommended to perform a full diagnostic workup, to exclude alternative causes such as lymphangitic carcinomatosis,

infection, allergy, cardiogenic edema, or pulmonary hemorrhage. In the presence of confirmatory HRCT scans where other causes of respiratory symptoms have been excluded, a diagnosis of interstitial lung disease should be considered and study treatment permanently discontinued.

In the absence of a diagnosis of interstitial lung disease study treatment may be restarted following consultation with the AstraZeneca Study Team Physician.

Subjects who experience a QTc interval greater than 500 msec on at least 2 separate ECGs must have AZD9291 treatment interrupted until the QTc interval is less than 481 msec or recovery to baseline if baseline QTc is greater than or equal to 481 msec, then restart at a reduced dose (40 mg). Subjects experiencing QTc interval prolongation with signs/symptoms of serious arrhythmia will not be permitted to restart study treatment.

Subjects experiencing any of the following will not be permitted to restart study treatment:

- Corneal ulceration
- Interstitial Lung Disease (ILD)
- QTc interval prolongation with signs/symptoms of serious arrhythmia

### **6.7.1 Skin reactions**

Recommendations for appropriate management of skin reactions, including guidance on dose-adjustments for clinically significant and/or intolerable skin reactions that are considered by the investigator to be causally related to AZD9291 will be provided to investigators.

Skin reactions are to be reported as AEs in the CRF, with additional details captured in the "SKNREAC" CRF:

Changes in the characteristics of skin reactions will be collected in the "SKNREAC" CRF.

Changes in the CTCAE grade of skin reactions will be collected in the AE CRF.

Photographs of skin reactions may be collected and these photographs should be available for central review by AstraZeneca and for external expert dermatological review if required.

Skin biopsies of skin reactions may be taken as per investigator discretion, as per the standard local medical practice. Skin biopsies should ideally be taken in subjects with clinically significant or grade  $\geq 3$  skin reaction.

### **6.7.2 Diarrhoea**

Recommendations for appropriate management of diarrhoea, including dose-adjustments for adverse events of diarrhoea that are of CTCAE grade  $\geq 3$  or that are clinically significant and/or intolerable and considered by the investigator to be causally related to AZD9291, will be provided to investigators. Changes in CTCAE grade of diarrhoea will be captured in the AE eCRF.

For further guidance on skin reactions and diarrhoea, please refer to “Guidance for the Management of Adverse Events in Studies using 80mg AZD9291”.

## 6.8 Management of toxicities related to Platinum-Based Doublet Chemotherapy

Detailed here, as guidance, are the US (FDA) approved toxicity management guidelines for pemetrexed, carboplatin and cisplatin (US Prescribing Information).

For toxicity management please adhere to these guidelines or, where appropriate, to local approved or clinical practice guidelines. A discussion with AZ study physician would be indicated in case of using local clinical practice guidelines.

### 6.8.1 Dose Adjustment Recommendations for Carboplatin

Pretreatment platelet count and performance status are important prognostic factors for severity of myelosuppression in previously treated patients.

The suggested dose adjustments for single agent or combination therapy shown in the table below are modified from controlled trials in previously treated and untreated patients with ovarian carcinoma. Blood counts were done weekly, and the recommendations are based on the lowest post-treatment platelet or neutrophil value.

Platelets	Neutrophils	Adjusted Dose* (From Prior Course)
>100 000	>2 000	125%
50-100 000	500-2 000	No Adjustment
<50 000	<500	75%

\* Percentages apply to carboplatin for Injection, USP as a single-agent or to both carboplatin and cyclophosphamide in combination. In the controlled studies, dosages were also adjusted at a lower level (50% to 60%) for severe myelosuppression. Escalations above 125% were not recommended for these studies.

Carboplatin is usually administered by an infusion lasting 15 minutes or longer. No pre- or post-treatment hydration or forced diuresis is required.

#### Patients with Impaired Kidney Function:

Baseline Creatinine Clearance	Recommended Dose on Day 1
41 mL/min - 59 mL/min	250 mg/m <sup>2</sup>
16 mL/min - 40 mL/min	200 mg/m <sup>2</sup>

Patients with creatinine clearance values below 60 mL/min are at increased risk of severe bone marrow suppression. In renally impaired patients who received single-agent carboplatin therapy, the incidence of severe leukopenia, neutropenia, or thrombocytopenia has been about 25% when the dosage modifications in the table below have been used.

The data available for patients with severely impaired kidney function (creatinine clearance below 15 mL/min) are too limited to permit a recommendation for treatment.

These dosing recommendations apply to the initial course of treatment. Subsequent dosages should be adjusted according to the patient's tolerance based on the degree of bone marrow suppression.

### 6.8.2 Precaution for Cisplatin

Peripheral blood counts should be monitored weekly. Liver function should be monitored periodically. Neurologic examination should also be performed regularly.

### 6.8.3 Dose Adjustment Recommendations for Pemetrexed and Cisplatin

Dose adjustments at the start of a subsequent cycle should be based on nadir hematologic counts or maximum nonhematologic toxicity from the preceding cycle of therapy. Treatment may be delayed to allow sufficient time for recovery. Upon recovery, patients should be retreated using the guidelines in below Tables, which are suitable for using pemetrexed as a single-agent or in combination with cisplatin. Please follow this recommendation for Pemetrexed when dosed together with Carboplatin

#### Dose Reduction for Pemetrexed (single-agent or in combination) and Cisplatin - Hematologic Toxicities:

Nadir ANC $<500/\text{mm}^3$ and nadir platelets $\geq 50000/\text{mm}^3$	75% of previous dose (pemetrexed and cisplatin).
Nadir platelets $<50\ 000/\text{mm}^3$ without bleeding regardless of nadir ANC	75% of previous dose (pemetrexed and cisplatin).
Nadir platelets $<50\ 000/\text{mm}^3$ with bleeding, regardless of nadir ANC	50% of previous dose (pemetrexed and cisplatin).

If patients develop nonhematologic toxicities (excluding neurotoxicity)  $\geq$  Grade 3, treatment should be withheld until resolution to less than or equal to the patient's pre-therapy value. Treatment should be resumed according to guidelines in below Table.

#### Dose Reduction for Pemetrexed (single-agent or in combination) and Cisplatin - Nonhematologic Toxicities<sup>a,b</sup>

	Dose of Pemetrexed (mg/m <sup>2</sup> )	Dose of Cisplatin (mg/m <sup>2</sup> )
Any Grade 3 or 4 toxicities except mucositis	75% of previous dose	75% of previous dose
Any diarrhea requiring hospitalization (irrespective of Grade) or Grade 3 or 4	75% of previous dose	75% of previous dose

diarrhea		
Grade 3 or 4 mucositis	50% of previous dose	100% of previous dose

<sup>a</sup> NCI Common Toxicity Criteria (CTC)

<sup>b</sup> excluding neurotoxicity (see Table below).

In the event of neurotoxicity, the recommended dose adjustments for Pemetrexed and cisplatin are described in below Table. Patients should discontinue therapy if Grade 3 or 4 neurotoxicity is experienced.

**Dose Reduction for Pemetrexed (single-agent or in combination) and Cisplatin – Neurotoxicity:**

CTC Grade	Dose of Pemetrexed (mg/m <sup>2</sup> )	Dose of Cisplatin (mg/m <sup>2</sup> )
0-1	100% of previous dose	100% of previous dose
2	100% of previous dose	50% of previous dose

**Discontinuation Recommendation:** Pemetrexed therapy should be discontinued if patient experiences any hematologic or nonhematologic Grade 3 or 4 toxicity after two dose reductions or immediately if Grade 3 or 4 neurotoxicity is observed.

**Renally Impaired Patients:** In clinical studies, patients with creatinine clearance  $\geq 45$  mL/min required no dose adjustments other than those recommended for all patients. Insufficient numbers of patients with creatinine clearance below 45 mL/min have been treated to make dosage recommendations for this group of patients. Therefore, Pemetrexed should not be administered to patients whose creatinine clearance is  $< 45$  mL/min using the standard Cockcroft and Gault formula (below) or GFR measured by Tc99m-DTPA serum clearance method:

<b>Males:</b>	$\frac{[140 - \text{Age in years}] \times \text{Actual Body Weight (kg)}}{72 \times \text{Serum Creatinine (mg/dL)}} = \text{mL/min}$
<b>Females:</b>	Estimated creatinine clearance for males $\times 0.85$

Caution should be exercised when administering Pemetrexed concurrently with NSAIDs to patients whose creatinine clearance is  $< 80$  mL/min.

## 6.9 Study governance and oversight

### 6.9.1 Steering Committee

A Steering Committee comprising of the principal investigators for study D5160C00003, in addition to principal investigators from the other AZD9291 pivotal studies will provide advice



on any aspect of the study design or conduct based on requests from the sponsor and assure consistency across the entire AZD9291 pivotal programme.

No Data Monitoring Committee (DMC) is planned, as the safety profile of AZD9291 from the ongoing phase I trial in a similar NSCLC patient population is modest, predictable with no reported life-threatening adverse events. There is therefore no requirement for pre-planned specified expert independent safety reviews in this study.

## 7. INVESTIGATIONAL PRODUCT AND OTHER TREATMENTS

### 7.1 Identity and Dose of investigational product – AZD9291

Investigational product	Dosage form and strength
AZD9291	40mg Tablets 80mg Tablets

AstraZeneca will supply AZD9291 as tablets for oral administration as a single daily dose of 80 mg. Tablets can be taken whole with approximately 240 mL water, with or without regard to food. Subjects will be required to fast (water only) for at least 8 hours prior to the collection of a fasting glucose sample as per the study plan ([Table 1](#)) and Section [5.2.1](#).

At each dispensing visit, sufficient AZD9291 for 21 days treatment, plus overage, will be distributed. Individual bottles will be dispensed in accordance with the medication identification numbers provided by the IVRS/IWRS.

Subjects should swallow one AZD9291 80 mg tablets once daily, commencing on Cycle 1 Day 1. Tablets should be taken whole with water, with or without food.

The initial dose of 80 mg AZD9291 can be reduced to 40 mg AZD9291 once daily under circumstances described in Section [6.7](#)

On clinic days on which PK samples are scheduled, the dosing should be delayed until arrival at the clinic. Subjects should not take their dose until instructed to do so by site personnel.

Doses should be taken approximately 24 hours apart at the same time point each day. Doses should not be missed. If a subject misses taking a scheduled dose, within a window of 12 hours, it is acceptable to take the dose. If it is more than 12 hours after the dose time, the missed dose should not be taken, and subjects should be instructed to take the next dose at the next scheduled time. If a subject vomits after taking their AZD9291, they should not make up for this dose, but should take the next scheduled dose.

Any change from dosing schedule, dose interruptions, dose reductions should be recorded in the eCRF.

Tablets will be packed in high-density polyethylene (HDPE) bottles with child-resistant closures. Bottles will be dispensed to subjects in the AstraZeneca packing provided. The packaging includes bottles, caps and a label. Bottle tampers should not be broken prior to dispensing investigational product to a subject.

Additional information about the Investigational product may be found in the Investigators' Brochure.

## 7.2 Identity and Dose of Comparator Product – Platinum-based Doublet-Chemotherapy

Comparator product	Dosing
pemetrexed + carboplatin	500mg/m <sup>2</sup> AUC5 on Day 1 of every 21d cycle
pemetrexed + cisplatin	500mg/m <sup>2</sup> 75mg/m <sup>2</sup> on Day 1 of every 21d cycle

Platinum-based Doublet-chemotherapy is available in a range of strengths and will be sourced locally or centrally and should be administered according to local prescribing information, including any treatment restrictions.

To reduce the incidence and severity of skin reactions, a corticosteroid should be given the day prior to, on the day of, and the day after pemetrexed administration. The corticosteroid should be equivalent to 4mg of dexamethasone administered orally twice a day.

To reduce toxicity, subjects treated with pemetrexed must also receive vitamin supplementation. Subjects must take oral folic acid or a multivitamin containing folic acid (350 to 1000 micrograms) on a daily basis. At least five doses of folic acid must be taken during the approximately 7 days preceding the first dose of pemetrexed, and dosing must continue during the full course of therapy and for 21 days after the last dose of pemetrexed. Subjects must also receive vitamin B12 (e.g. i.m. 1000 micrograms or equivalent) in the week preceding the first dose of pemetrexed and once every three cycles thereafter. Subsequent vitamin B12 doses may be given on the same day as pemetrexed. Subjects may also receive other pre-treatment / concomitant treatment as recommended by approved label for pemetrexed, carboplatin or cisplatin as clinically indicated by the investigator.

Anticipated treatment duration is approximately six months.

## 7.3 Labelling

Labels for IP (if required also for chemotherapy) will be prepared in accordance with Good Manufacturing Practice (GMP) and local regulatory guidelines. Label text will be translated into local language.

The label will include the Name of the Sponsor, Study Code, For Clinical trial use only and/or any other market specific requirements.

#### **7.4 Storage**

All investigational products should be kept in a secure place under appropriate storage conditions. The investigational product label on the IP specifies the appropriate storage.

#### **7.5 Compliance**

The administration of all study treatments (including investigational products) should be recorded in the appropriate sections of the Case Report Form.

Subjects should return all unused investigational product and empty containers to the investigator.

#### **7.6 Accountability**

The investigational product provided for this study will be used only as directed in the study protocol.

The study personnel will account for all investigational products dispensed to and returned from the subject.

The study personnel at the investigational site will account for all treatments dispensed and for appropriate destruction. Certificates of delivery and destruction should be signed.

#### **7.7 Concomitant and other treatments**

Information on any treatment in the 4 weeks prior to starting study treatment and all concomitant treatments given during the study, with reasons for the treatment, will be recorded in the CRF. After permanent discontinuation of study treatment and 28 day follow up, only subsequent regimens of anti-cancer therapy will be recorded in CRF. If medically feasible, subjects taking regular medication, with the exception of potent inducers of CYP3A4 (see Appendix F), should be maintained on it throughout the study period. Subjects taking concomitant medications whose disposition is dependent upon BCRP and which have a narrow therapeutic index should be closely monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst receiving AZD9291. Guidance on medications that require close monitoring is given in Appendix F.

Patients taking rosuvastatin (due to BCRP mediated increase in exposure) should have CPK levels monitored. If the subject experiences any potentially relevant adverse events suggestive of muscle toxicity including unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever, rosuvastatin should be stopped, creatine kinase (CK) levels should be checked, and any appropriate further management should be taken.

Subjects taking warfarin should be monitored regularly for changes in prothrombin time or INR.

Other anticancer agents, investigational agents and radiotherapy should not be given while the subject is on study treatment.

Pre-medication will be allowed for subjects randomized to the doublet chemotherapy arm. It is also allowed for subjects randomized to AZD9291, but not before the first dose of AZD9291. This includes management of diarrhoea, nausea and vomiting.

Leukocyte-depleted blood transfusions are allowed at any time during the study.

Granulocyte colony stimulating factors should not be used prophylactically during Cycle 1. Use of prophylactic colony stimulating factors may be considered after Cycle 1 following discussion with the AstraZeneca Study Team Physician.

Subjects may receive treatment with corticosteroids and/or bisphosphonates for the treatment of bone metastases. Subjects may also receive radiotherapy or medication (e.g. denosumab) for painful bony metastases. For questions related to specific mediations, please contact the Study Physician.

Supportive care and other medications that are considered necessary for the subject's well-being, may be given at the discretion of the investigator.

**Study Treatment (Subjects randomized to AZD9291)**

Tablets should be taken whole with approximately 240 mL water, with or without regard to food.

**Study Treatment (Subjects randomized to platinum-based doublet chemotherapy)**

Platinum-based doublet chemotherapy should be administered according to local prescribing information, including any treatment restrictions.

<b>Prohibited Medication/Class of drug:</b>	<b>Usage:</b>
Other anticancer agents, investigational agents and radiotherapy	Should not be given while the subject is on study treatment.

<b>Rescue/Supportive Medication/Class of drug:</b>	<b>Usage:</b>
Pre-medication will be allowed for subjects randomized to the doublet chemotherapy arm. It is also allowed for subjects randomized to AZD9291, but not before the first dose of AZD9291.	To be administered as directed by the investigator. This includes management of diarrhoea, nausea and vomiting.
Blood transfusions	Allowed at any time during the study.

Granulocyte colony stimulating factors	Should not be used prophylactically during Cycle 1. Use of prophylactic colony stimulating factors may be considered after Cycle 1 following discussion with the AstraZeneca Study Team Physician.
Corticosteroids and/or bisphosphonates	Subjects may receive treatment with corticosteroids and/or bisphosphonates for the treatment of bone metastases. Subjects may also receive radiotherapy for painful bony metastases.
Palliative radiation	Subjects may receive radiotherapy for painful bony metastases.
Supportive care and other medications that are considered necessary for the subject's well-being	To be administered as directed by the investigator (e.g. denosumab for painful bony metastases).

### 7.7.1 Other concomitant treatment

Other medication other than that described above, which is considered necessary for the subject's safety and well-being, may be given at the discretion of the Investigator and recorded in the appropriate sections of the Case Report Form. Some medications may be limited due to their QT potential, please refer to Appendix F.

## 7.8 Post Study Access to Study Treatment

Subjects receiving AZD9291 at the time of study completion (ie, after final data cut-off date) may continue to receive AZD9291, if in the opinion of their treating physician they are continuing to derive clinical benefit from continued treatment. Such subjects will continue to be monitored and all safety assessments will be performed until AZD9291 is discontinued. These subjects will then be followed up for a period of 28 days after the last AZD9291 dose is administered for any new treatment-related serious adverse events. A CSR addendum will be prepared to summarise any additional safety data collected.

## 7.9 Cross-over to AZD9291

Subjects who are eligible and choose to enter cross-over AZD9291 treatment will be dispensed bottles of AZD9291 80mg, once daily, tablets. For details on AZD9291, please refer to Section 7.1.

## 8. STATISTICAL ANALYSES BY ASTRAZENECA

### 8.1 Statistical considerations

A comprehensive Statistical Analysis Plan (SAP) will be prepared and finalised prior to first subject in (FSI). The aim of the study is to compare the efficacy and safety of AZD9291 versus platinum-based doublet chemotherapy. All analyses will be performed by AstraZeneca or its representatives.

The primary analysis will be performed when at least 221 PFS events have occurred, so that the PFS data are approximately 54% mature. Three analyses of OS are planned; two interim analyses and final analysis. The data cut-off for the first analysis of overall survival will be conducted approximately 4 months after data cut-off for the primary analysis of PFS and the second analysis will be conducted when the OS data are approximately 50% mature (approximately 205 death events). A final analysis of overall survival will be performed when the OS data are approximately 70% mature (approximately 287 death events).

### **Multiple Testing Strategy**

In order to describe the benefits of AZD9291 treatment, the primary and secondary endpoints will be tested at a 2-sided significance level of 5%.

However, in order to provide strong control of the type I error rate (2-sided 5%), the primary endpoint of PFS and key efficacy secondary endpoints, ORR and OS will be tested in this sequential order. If any previous analysis in the sequence is not statistically significant, the alpha spending cannot be transferred to subsequent analyses. A 2-sided 5% alpha will be used in all testing, with the exception of overall survival endpoint. Since three analyses of OS are planned, the Lan DeMets approach that approximates the O'Brien and Fleming spending function will be used to maintain an overall 2-sided 5% type I error across the three planned analyses of OS. Note, any non-statistically significant analyses at the interims will not preclude further testing of OS.

For PRO symptoms and health related quality of life endpoints, the overall type I error (5% 2 sided) will be controlled across the five primary PRO measures of cough, dyspnoea and pain as assessed by the EORTC QLQ-LC13 and fatigue and appetite loss as assessed by the EORTC QLQ-C30 using the Bonferroni-Holm procedure.

The physical functioning and overall health status domains of the EORTC CT30 are furthermore pre-specified endpoints of interest.

## **8.2 Sample size estimate**

PFS is the primary endpoint for this study. Approximately 410 subjects will be randomized in a 2:1 ratio (AZD9291: chemotherapy) to this study.

The primary analysis of PFS will occur when at least 221 progression events have been observed out of the 410 globally randomized subjects. With 221 progression events, the study will have at least 80% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were HR 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed. The smallest treatment difference that would be statistically significant is a PFS HR of 0.76 (this translates into an approximate 2 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed). Assuming 15 months non-linear recruitment, 221 PFS events are expected to occur approximately 20 months after the first subject is randomized in the study.

In order to randomize 410 subjects assuming a 10% screen failure rate, 455 T790M+ subjects will need to be enrolled. In order to enrol 455 T790M+ subjects, 1034 subjects will need to be screened [assuming 827 (55%) of subjects are T790+ and allowing for a 20% attrition rate].

### **8.3 Definitions of analysis sets**

#### **8.3.1 Full analysis set**

The full analysis set will include all randomized subjects prior to the end of global recruitment. Any subjects randomized in China, after global recruitment has ended, will not be included in the FAS (see Section 8.6). The full analysis set will be used for all efficacy analyses and treatment groups will be compared on the basis of randomized treatment, regardless of the treatment actually received.

#### **8.3.2 Safety analysis set**

The safety analysis set will consist of all subjects randomized prior to the end of global recruitment who received at least one dose of randomized treatment and for whom post dose data are available. Any subjects randomized in China only, after global recruitment has ended, will not be included in the safety analysis set (see Section 8.6). Safety data will not be formally analysed but summarised using the safety analysis set, according to the treatment received, i.e. erroneously treated subjects (e.g., those randomized to treatment A but actually given treatment B) will be summarised according to the treatment they actually received.

#### **8.3.3 PK analysis set**

Subjects in the Full Analysis Set who have at least one measurable PK concentration, supported by the relevant date and time of this sample and for each time a PK sample was taken the dosing data for that day and for samples taken after multiple dosing the dosing data for the 2 days prior to the sample day as well as the sample day. For any individual sample to be included in the PK analysis set the full sample data and dosing data needs to be present for that sample.

### **8.4 Outcome measures for analyses**

#### **8.4.1 Calculation or derivation of efficacy variables**

##### **Investigator RECIST based assessments**

From the investigators review of the imaging scans, the RECIST tumour response data will be used to determine each subject's visit response according to RECIST version 1.1. It will also be used to determine the endpoints ORR, DoR, DCR and PFS from the overall visit response and scan dates.

At each visit, subjects will be programmatically assigned a RECIST 1.1 visit response of CR, PR, SD or PD depending on the status of their disease compared with baseline and previous assessments. If a subject has had a tumour assessment, which cannot be evaluated, then the subject will be assigned a visit response of not evaluable (NE) (unless there is evidence of progression in which case the response will be assigned as PD).

Please refer to Appendix H for the definitions of Complete Response, Partial Response, Stable Disease and Progressive Disease.

### **Blinded Independent Central Review of RECIST based assessments**

The Blinded Independent Central Review of radiological imaging data will be carried out using RECIST version 1.1. All radiological scans for all subjects (including those at unscheduled visits, or outside visit windows) will be provided to the BICR. The imaging scans will be reviewed by two independent radiologists using RECIST 1.1 criteria and will be adjudicated if required. The independent reviewers will be blinded to treatment. For each subject, the BICR will define the overall visit response data (CR, PR, SD, PD or NE) and the relevant scan dates for each time point (ie, for visits where response or progression is/is not identified). If a subject has had a tumour assessment, which cannot be evaluated, then the subject will be assigned a visit response of not evaluable (NE) (unless there is evidence of progression in which case the response will be assigned as PD

Further details of the Blinded Independent Central Review will be documented in the Blinded Independent Review Charter.

### **Progression Free Survival (PFS)**

PFS is defined as the time from randomization until the date of objective disease progression or death (by any cause in the absence of progression) regardless of whether the subject withdraws from randomized therapy or receives another anti-cancer therapy prior to progression. Subjects who have not progressed or died at the time of analysis will be censored at the time of the latest date of assessment from their last evaluable RECIST assessment.

However, if the subject progresses or dies after two or more missed visits, the subject will be censored at the time of the latest evaluable RECIST assessment. If the subject has no evaluable visits or does not have baseline data they will be censored at 0 days unless they die within two visits of baseline.

The PFS time will always be derived based on scan/assessment dates not visit dates.

RECIST assessments/scans contributing towards a particular visit may be performed on different dates. The following rules will be applied:

- Date of progression will be determined based on the earliest of the dates of the component that triggered the progression
- When censoring a subject for PFS the subject will be censored at the latest of the dates contributing to a particular overall visit assessment

### **Objective Response Rate (ORR)**

ORR rate is defined as the number (%) of subjects with measurable disease with at least one visit response of CR or PR that is confirmed at least 4 weeks later. Data obtained up until progression, or last evaluable assessment in the absence of progression, will be included in the assessment of ORR. However, any complete response or partial response, which occurred after a further anticancer therapy was received, will not be included in the numerator for the ORR calculation.



In the case where a subject has two non-consecutive visit responses of PR, then, as long as the time between the 2 visits of PR is greater than 4 weeks and there is no PD between the PR visits, the subject will be defined as a responder. Similarly, if a subject has visit responses of CR, NE, CR, then, as long as the time between the 2 visits of CR is greater than 4 weeks, then a best response of CR will be assigned.

### **Duration of Response (DoR)**

Duration of response will be defined as the time from the date of first documented response, (that is subsequently confirmed) until date of documented progression or death in the absence of disease progression, the end of response should coincide with the date of progression or death from any cause used for the PFS endpoint. The time of the initial response will be defined as the latest of the dates contributing towards the first visit response of PR or CR. If the response is not confirmed, it will not be included.

If a subject does not progress following a response, then their duration of response will use the PFS censoring time.

### **Disease control rate (DCR)**

Disease control rate is defined as the percentage of subjects who have a best overall response of CR or PR or SD.

### **Tumour shrinkage**

Tumour shrinkage will be assessed using RECIST tumour response. The absolute change and percentage change from baseline in sum of tumour size at each assessment will be calculated. The best change in tumour size will include all assessments prior to progression or start of subsequent anticancer therapy.

### **Overall Survival (OS)**

Overall survival is defined as the time from the date of randomization until death due to any cause. Any subject not known to have died at the time of analysis will be censored based on the last recorded date on which the subject was known to be alive.

Note: Survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis, and if subjects are confirmed to be alive, or if the death date is post the final data cut-off date, these subjects will be censored at the date of the final data cut off. Death dates may be found by checking publicly available death registries.

### **HRQoL & Symptoms**

Patient reported outcomes will be assessed using the EORTC QLQ-C30 and QLQ-LC13 questionnaires. The QLQ-C30 consists of 30 questions, which can be combined to produce 5 functional scales (Physical, Role, Cognitive, Emotional, Social), 3 symptom scales (Fatigue, Pain, Nausea/vomiting), 5 individual items (dyspnoea, insomnia, appetite loss, constipation, diarrhoea) and a global measure of health status. The QLQ-LC13 is a lung cancer specific module comprising 13 questions to assess lung cancer symptoms (cough, haemoptysis, dyspnoea and site-specific pain), treatment related side-effects (sore mouth, dysphagia,

peripheral neuropathy and alopecia) and pain medication. With the exception of a multi-item scale for dyspnoea, all are single items.

An outcome variable consisting of a score from 0 to 100 will be derived for each of the symptom scales/symptom items, the functional scales and the global health status scale in the QLQ-C30 and for each of the symptom scales/items in the QLQ-LC13 according to the EORTC QLQ-C30 Scoring Manual and EORTC QLQ-LC13 instructions.

Higher scores on the global health status and functioning scales indicate better health status/function. Higher scores on the symptoms scales indicate greater symptom burden.

The primary PRO outcome measures will be patient-reported lung cancer symptoms assessed using the EORTC QLQ-LC13, namely

- dyspnoea (multi-item scale based on three questions: “Were you short of breath when you rested; walked; climbed stairs”),
- cough: one item (“How much did you cough?”),
- pain: one item (“Have you had pain in your chest”).
- fatigue (a composite score of three items: “Did you need rest; Have you felt weak; Were you tired”)
- appetite loss: one individual item (“Have you lacked appetite”)

#### ***Definition of clinically meaningful changes***

Changes in score compared to baseline will be evaluated. A minimum clinically meaningful change is defined as a change in the score from baseline of  $\geq 10$  for scales/items from the QLQ-LC13 and the QLQ-C30 (Obosa et al 1998).

For example, a clinically meaningful deterioration or worsening in chest pain (as assessed by QLQ-LC13) is defined as an increase in the score from baseline of  $\geq 10$ . A clinically meaningful improvement in fatigue (as assessed by QLQ-C30) is defined as a decrease in the score from baseline of  $\geq 10$ .

At each post-baseline assessment, change in symptoms/functioning from baseline will be categorised as improved, stable or worsening as shown in Table 11.

**Table 11 Visit Response for HRQoL and disease-related symptoms**

<b>Score</b>	<b>Change from baseline</b>	<b>Visit Response</b>
LC13 symptom scales/items	$\geq +10$	Worsened
	$\leq -10$	Improved
	Otherwise	Stable
C30 symptom scales/items	$\geq +10$	Worsened
	$\leq -10$	Improved

	Otherwise	Stable
C30 functional scales and	$\geq +10$	Improved
Global health status	$\leq -10$	Worsened
	Otherwise	Stable

---

### ***Time to symptom deterioration***

For each of the symptoms scales/items in QLQ-LC13, time to symptom deterioration will be defined as the time from randomization until the date of first clinically meaningful symptom deterioration (an increase in the score from baseline of  $\geq 10$ ) or death (by any cause) in the absence of a clinically meaningful symptom deterioration, regardless of whether the subject withdraws from randomized therapy or receives another anticancer therapy prior to symptom deterioration. Death will be included as an event only if the death occurs within two visits of the last PRO assessment where the symptom change could be evaluated.

Subjects whose symptoms (as measured by QLQ-LC13) have not shown a clinically meaningful deterioration and who are alive at the time of the analysis will be censored at the time of their last PRO assessment where the symptom could be evaluated. Also, if symptoms progress after two or more missed PRO assessment visits or the subject dies after two or more missed PRO assessment visits, the subject will be censored at the time of the last PRO assessment where the symptom could be evaluated. If a subject has no evaluable visits or does not have baseline data they will be censored at day 1. The population for analysis of time to symptom deterioration will include a subset of the ITT population who have baseline scores  $\leq 90$ .

### ***Symptom Improvement Rate***

The symptom improvement rate will be defined as the number (%) of subjects with two consecutive assessments at least 18 days apart (ie, 21 days allowing a visit window of 3 days), which showed a clinically meaningful improvement (a decrease from baseline score  $\geq 10$  for LC13 scales/items or C30 scales/items) in that symptom from baseline. The denominator will consist of a subset of the ITT population who have a baseline symptom score  $\geq 10$ .

### ***Mixed Models Repeated Measures (MMRM) Analysis***

Change from baseline in cough, dyspnoea and pain scores as assessed by the EORTC QLQ-LC13 and fatigue and appetite loss as assessed by the EORTC QLQ-C30 will be the primary analysis and assessment of PRO outcome measures. The analysis will be performed using a linear mixed model for repeated measures (MMRM) analysis of change from baseline in the scores for each visit.

Symptom improvement rate and Time to symptom deterioration analyses will be considered as supportive analyses.

***Time from randomization to second progression (PFS2) (exploratory)***

Time from randomization to second progression (PFS2) is defined as the time from the date of randomization to the earliest of the progression event subsequent to that used for the primary variable PFS or death. Subjects alive and for whom a second disease progression has not been observed should be censored at the last time known to be alive and without a second disease progression, ie, censored at the last progression assessment date if the subject has not had a second progression or death.

***Time to first subsequent therapy or death (TFST)***

Time to first subsequent therapy or death is defined as the time from the date of randomization to the earlier of the date of anticancer therapy start date following study treatment discontinuation, or death. Any subject not known to have had a subsequent therapy or not known to have died at the time of the analysis will be censored at the last known time to have not received subsequent therapy, ie, the last follow-up visit where this was confirmed.

***Time to second subsequent therapy or death (TSST)***

Time to second subsequent therapy or death is defined as the time from the date of randomization to the earlier of the date of second subsequent anticancer therapy start date following study treatment discontinuation, or death. Any subject not known to have died at the time of the analysis and not known to have had a second further intervention of this type will be censored at the last known time to have not received second subsequent therapy, ie, the last follow-up visit where this was confirmed.

**Patient reporting of CTCAE symptoms**

The PRO-CTCAE questionnaire will be used to derive subject reporting of CTCAE symptoms.

**Health State Utility**

The EQ-5D-5L index comprises 5 dimensions of health (mobility, self-care, usual activities, pain/discomfort and anxiety/depression). For each dimension, respondents select which statement best describes their health on that day from a possible 5 options of increasing levels of severity (no problems, slight problems, moderate problems, severe problems and unable to/extreme problems). A unique EQ-5D health state is referred to by a 5-digit code allowing for a total of 3125 health states. For example, state 11111 indicates no problems on any of the 5 dimensions. These data will be converted into a weighted health state index by applying scores from EQ5D value sets elicited from general population samples (the base case will be the United Kingdom valuation set, with other country value sets applied in scenario analyses). Where values sets are not available, the EQ-5D-5L to EQ-5D-3L crosswalk will be applied. In addition to the descriptive system, respondents also assess their health on the day of assessment on a visual analogue scale, ranging from 0 (worst imaginable health) to 100 (best imaginable health). This score is reported separately.

**Health Resource Utilisation**

Health resource utilisation will be assessed in terms of hospitalization, outpatient visits and emergency department visits

#### **8.4.2 Calculation or derivation of safety variable(s)**

Safety and tolerability will be assessed in terms of AEs, deaths, laboratory data, vital signs (pulse and BP) and ECG. These will be collected for all subjects.

##### **Adverse events**

AEs (both in terms of MedDRA preferred terms and CTCAE grade) will be listed individually by subject.

Any AE occurring before treatment with AZD9291 will be included in the data listings but will not be included in the summary tables of AEs.

Any AE occurring within 28 days of discontinuation of investigational product (ie, the last dose of AZD9291/chemotherapy) will be included in the AE summaries. Any events in this period that occur after a subject has received further therapy for cancer (following discontinuation of AZD9291) will be flagged in the data listings. Please refer to Section 6.3.1

##### **Other significant adverse events (OAEs)**

During the evaluation of the AE data, an AstraZeneca medically qualified expert will review the list of AEs that were not reported as SAEs and AEs leading to discontinuation. Based on the expert's judgement, significant AEs of particular clinical importance may, after consultation with the Global Patient Safety Physician, be considered OAEs and reported as such in the CSR. A similar review of laboratory/vital signs (pulse and BP)/ECG data will be performed for identification of OAEs.

Examples of these could be marked haematological and other laboratory abnormalities, and certain events that lead to intervention (other than those already classified as serious), dose reduction or significant additional treatment.

#### **8.4.3 Calculation or derivation of pharmacokinetic variables**

Pharmacokinetic analysis of the plasma concentration data for AZD9291 and AZ5104 and AZ7550 will be performed by Quantitative Clinical Pharmacology, AZ or delegate on behalf of Quantitative Clinical Pharmacology. Plasma concentration will be summarized by normal time window. The ratio of metabolite to AZD9291 will be calculated.

The plasma concentration data for AZD9291 and metabolites will also be analysed using a population pharmacokinetic approach, which may include exploring the influence of covariates on PK, if the data allows. A pharmacokinetic-pharmacodynamic approach will be used to investigate the relationship between PK and selected primary, secondary and/or exploratory endpoints, where deemed appropriate. Results may be reported separately from the Clinical Study Report for the main study.

The data collected in this study may also be combined with similar data from other studies and explored using population pharmacokinetic and/or pharmacokinetic-pharmacodynamic method. The results of any such analyses will be reported separately from the Clinical Study Report.

## 8.5 Methods for statistical analyses

All efficacy analyses will be performed on the FAS population. Results of all statistical analyses will be presented using a 95% confidence interval and 2-sided p-value.

### 8.5.1 Analysis of the primary variable(s)

PFS will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian) for generation of the p-value and using the Breslow approach for handling ties. The hazard ratio (HR) and confidence interval will be obtained directly from the U and V statistics as follows (Berry G et al 1991, Selke & Siegmund 1982):

$$\text{HR} = \exp(U/V)$$

$$95\% \text{ CI for HR} = (\exp\{U/V - 1.96/\sqrt{V}\}, \exp\{U/V + 1.96\sqrt{V}\})$$

Where  $U = \sum_i(d_{1i} - e_{1i})$  is the log-rank test statistic (with  $d_{1i}$  and  $e_{1i}$  the observed and expected events in group 1) and  $\sqrt{V}$  the standard deviation of the log-rank test statistic obtained from the LIFETEST procedure with a STRATA term for the stratification variable.

A Kaplan-Meier (KM) plot of PFS will be presented by treatment group.

### Subgroup analysis

Subgroup analyses will be conducted by comparing PFS between treatments in the following groups:

- Ethnicity (Asian versus Non-Asian)
- Gender (Male versus Female)
- Age at randomisation (<65 versus ≥65)
- Mutation status prior to start of study (ex19 versus L858R)
- Duration of prior EGFR TKI (<6 months, ≥6 months)
- Brain metastases at entry
- Smoking history

The HR (AZD9291: chemotherapy) and associated CI will be calculated from a Cox proportional hazards model (ties=Efron) that contains the treatment term, factor and treatment-by-factor interaction term. The treatment effect HRs for each treatment comparison along with their confidence intervals will be obtained for each level of the subgroup from this single model. The HRs and 95% CIs will be presented on a forest plot including the HR and 95% CI from the overall population (using the primary analysis).

The assumption of proportionality will be assessed. In the event on non-proportionality, the HR will be interpreted as an average HR over the observed extent of follow-up.

Proportionality will be tested firstly by examining the plots of complementary log-log (event times) versus log (time) and, if necessary, a time dependent covariate will be fitted to assess the extent to which this represents random variation.

No adjustment to the significance level for testing will be made since the subgroup analysis will be considered exploratory and may only be supportive of the primary analysis of PFS.

The presence of quantitative interactions will be assessed by means of an overall global interaction test. This will be performed in the overall population by comparing the fit of a Cox proportional hazards model including treatment, all covariates, and all covariate-by-treatment interaction terms, with one that excludes the interaction terms and will be assessed at the 2-sided 10% significance level. If the fit of the model is not significantly improved then it will be concluded that overall the treatment effect is consistent across the subgroups.

If the global interaction test is found to be statistically significant, an attempt to determine the cause and type of interaction will be made. Stepwise backwards selection will be performed on the saturated model, whereby (using a 10% level throughout) the least significant interaction terms are removed one-by-one and any newly significant interactions re-included until a final model is reached where all included interactions are significant and all excluded interactions are non-significant. Throughout this process all main effects will be included in the model regardless of whether the corresponding interaction term is still present. This approach will identify the factors that independently alter the treatment effect and prevent identification of multiple correlated interactions.

Any quantitative interactions identified using this procedure will then be tested to rule out any qualitative interaction using the approach of [Gail and Simon 1985](#).

### **Sensitivity analyses**

#### **(a) Ascertainment bias**

The possibility of bias in assessment and measurement of PFS by investigators will be assessed by comparing the hazard ratios derived from investigator review with the hazard ratio derived using the blinded independent central review assessment of disease progression by RECIST.

#### **(b) Evaluation-time bias**

In order to assess possible evaluation-time bias, that could occur if scans are not performed at the protocol-scheduled time points, the midpoint between the time of progression and the previous evaluable RECIST assessment will be analyzed using a stratified log rank test, as described for the primary analysis of PFS. For patients who die in the absence of progression, the date of death will be used to derive the PFS time used in the analysis.

#### **(c) Attrition bias**

Possible attrition bias will be assessed by repeating the primary PFS analysis, except that the actual PFS event times, rather than the censored times, of subjects who progressed or died in the absence of progression immediately following two, or more, non-evaluable tumour assessments will be included. In addition, subjects who take subsequent therapy prior to progression or death will be censored at their last evaluable assessment prior to taking the subsequent therapy. A Kaplan-Meier plot of the time to censoring, where the censoring indicator of the primary PFS analysis is reversed, will be presented.

#### (d) Exploratory Analysis

Recently, it has been suggested that, in order to assess the potential for bias amongst investigators, a BICR amongst only a sample of subjects could be performed; if evidence of bias is detected, according to a pre-defined threshold, the BICR is then assessed in all subjects, otherwise it is concluded the sample was sufficient to rule-out meaningful levels of bias. A proposed sample BICR method has been submitted to a peer reviewed statistical journal for publication as of August 2014 and in order to demonstrate that this is a valid methodology for use in future trials, an exploratory analysis will be carried out using this methodology. Further details will be provided in the SAP.

### **8.5.2 Analysis of the secondary variable(s)**

#### **8.5.2.1 Analysis of ORR**

ORR will be analyzed using a logistic regression with a covariate for ethnicity (Asian, Non-Asian). The results of the analysis will be presented in terms of an odds ratio together with its associated 95% profile likelihood confidence interval and 2-sided p-value. The p-value will be based on twice the change in log-likelihood resulting from the addition of a treatment factor to a model that contains the covariates defined above.

#### **8.5.2.2 Analysis of DoR**

In order to analyze the secondary outcome variable of Duration of Response between arms the Expected Duration of Response (EDoR) will be derived for each treatment arm (Ellis S et al 2008). The EDoR is the product of the proportion of subjects responding to treatment and the mean DoR in responding subjects, and provides an estimate based on all randomized subjects. Treatments will be compared by calculating the ratio of EDoRs using an appropriate probability distribution for duration of response in responding subjects. The choice of probability distribution will be detailed in the SAP. The analysis of DoR will be stratified by the same covariates as the primary analysis, weighting each stratum inversely proportional to the within stratum variance of the log of the ratio of EDoRs. Additionally, descriptive data will be provided for the duration of response in responding subjects, including associated Kaplan-Meier curves (without any formal comparison of or p-value attached).

#### **8.5.2.3 Analysis of DCR**

DCR will be analyzed using a logistic regression with a covariate for ethnicity (Asian, Non-Asian). The results of the analysis will be presented in terms of an odds ratio together with its associated 95% profile likelihood confidence interval and 2-sided p-value. The p-value will be



based on twice the change in log-likelihood resulting from the addition of a treatment factor to a model that contains the covariates defined above.

#### **8.5.2.4 Analysis of Tumour Shrinkage**

The best absolute change in target lesion tumour size from baseline and percentage change in target lesion tumour size from baseline will be summarized using descriptive statistics and presented at each timepoint and by randomized treatment group. The effect of AZD9291 on percentage change in tumour size will be estimated from an analysis of covariance (ANCOVA) model with a covariate for ethnicity (Asian, Non-Asian). The number of subjects, unadjusted mean and lsmeans for each treatment group will be presented, together with the difference in lsmeans, 95% confidence interval and corresponding p-value.

#### **8.5.2.5 Analysis of OS**

OS data will be analyzed using the same methodology and model as for the analysis of PFS (provided there are sufficient events available for a meaningful analysis [ $>20$  deaths], if not descriptive summaries will be provided). Two interim analyses of OS will be performed and a final, optional analysis of OS may be performed. The first interim analysis of OS will be performed at the time of the primary analysis of PFS. The second interim analysis of OS will be performed when the OS data are approximately 50% mature.

#### **8.5.2.6 Analysis of Time to PRO Symptom Deterioration**

Time to PRO symptom deterioration will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian) for generation of the p-value and using the Breslow approach for handling ties. The hazard ratio (HR) and confidence interval will be estimated using the same methods as for the primary endpoint of PFS, as described in Section 8.5.1.

#### **8.5.2.7 Analysis of PRO Symptom Improvement Rate**

Symptom Improvement Rate will be analyzed using a logistic regression with a covariate for ethnicity (Asian, Non-Asian). The results of the analysis will be presented in terms of an odds ratio together with its associated 95% profile likelihood confidence interval and 2-sided p-value. The p-value will be based on twice the change in log-likelihood resulting from the addition of a treatment factor to a model that contains the covariates defined above.

#### **8.5.2.8 Pharmacokinetics**

Pharmacokinetic concentration data will be summarised using appropriate summary statistics and further details will be provided in the SAP.

#### **8.5.2.9 Patients with EGFR T790M mutation status detected in baseline plasma sample (ctDNA)**

The efficacy of AZD9291 versus chemotherapy will be evaluated for the subgroups of patients with T790M detected in their baseline plasma sample and patients that are T790M negative by the plasma test. For PFS, the HR and associated 95% CI will be calculated and KM plots

presented for each group. For ORR, the odds ratio and associated 95% CI will be presented for each group.

### **8.5.3 Exploratory analysis**

#### **PRO-CTCAE**

PRO-CTCAE data will be presented using summaries and descriptive statistics based on the Full Analysis Set and further details will be provided in the SAP.

#### **Healthcare Resource Use**

Healthcare Resource Use data will be presented using summaries and descriptive statistics, based on the Full Analysis Set and further details will be provided in the SAP.

#### **Exploratory analysis of post progression outcomes**

PFS2 will be analysed using the same method as the analysis of PFS. Time to first subsequent therapy, time to second subsequent therapy and time to change in symptoms (measured by PRO HRQoL questionnaires) will be summarised as appropriate and further details will be provided in the SAP.

#### **Exploratory analysis of characterising survival**

All further analysis of overall survival will be exploratory. The effect of baseline characteristics on overall survival in each randomized treatment arm will be summarised. As appropriate, time-varying outcomes measured during the study treatment and post progression phases will also be summarised. All subsequent treatments in each treatment arm will be summarised, including duration of treatments. For summaries, anti-cancer treatments will be grouped by mode of action (e.g. 1<sup>st</sup>/2<sup>nd</sup> generation EGFR TKIs, 3<sup>rd</sup> generation EGFR TKIs with T790M activity (e.g. AZD9291, others), platinum-based doublet chemotherapy, single agent chemotherapy).

Additional analysis of overall survival adjusting for the impact of subjects randomized to chemotherapy, who subsequently receive a 3rd generation EGFR TKI with T790M activity (ie, those who “switch” treatment) may be completed if this treatment sequence occurs in a significant proportion of subjects. Methods such as Rank Preserving Structural Failure Time (RPSFT) ([Robins et al 1991](#)), Inverse Probability of Censoring Weighting (IPCW) ([Robins et al 1993](#)) and other methods in development may be explored. The decision to adjust and final choice of methods will be based on a blinded review of the data and the plausibility of the underlying assumptions.

Further detail will be provided in the SAP and Payer Analysis Plan.

Summaries and analyses for other exploratory objectives will be documented in a separate analysis plan and will be reported outside the CSR in a separate report.

## **8.6 China Cohort**

In order to adequately compare the efficacy and safety of AZD9291 versus placebo in Chinese patients to fulfil China FDA requirements, subjects recruited in China after global recruitment has ended will be combined with any subjects recruited from China prior to the end of the global recruitment. This China-only cohort will be analysed and reported separately from the Clinical Study Report.

### **8.6.1 Definition of China analysis sets**

#### **8.6.1.1 China-only Full Analysis Set**

The China-only Full analysis set will include all subjects randomized in China. This includes all subjects randomized in China prior to the end of global recruitment and all additional subjects recruited in mainland China after global recruitment is completed.

The China-only Full analysis set will be used for all China-only efficacy analyses and treatment groups will be compared on the basis of randomized study treatment, regardless of the treatment actually received.

#### **8.6.1.2 China-only Safety Analysis Set**

The China-only safety analysis set will consist of all subjects randomized in China who received at least one dose of study treatment and for whom post-dose data are available.

#### **8.6.1.3 China-only Pharmacokinetic Analysis Set**

The China-only Pharmacokinetic Analysis Set is defined as subjects in the China-only FAS who have at least one evaluable PK concentration.

### **8.6.2 China-only analyses**

All efficacy, safety, PRO and PK variables will be derived in the same way as detailed in Section 8.4.

All analyses detailed in Section 8.5 will be repeated for the China-only cohort using the analysis sets described in Section 8.6.1.

All statistical analyses will be considered exploratory and only performed if sufficient numbers of events or subjects are available (e.g. > 20 PFS or OS events), otherwise descriptive statistics only will be presented. No adjustment for multiplicity will be made and so the procedure for hierarchical testing detailed in Section 8.5.2.1 will not be followed. Statistical analyses will not be stratified by ethnicity (Asian versus Non-Asian).

The analyses be performed at the time of the primary PFS analysis if at least 20 PFS events have been observed out of approximately 50 Chinese subjects, otherwise summaries of efficacy will be provided only. Additional follow-up of Chinese subjects if deemed appropriate may be performed when the PFS data are more mature (for example, 70% maturity, as consistent with the primary global PFS analysis).

## **9. STUDY AND DATA MANAGEMENT BY ASTRAZENECA**

### **9.1 Training of study site personnel**

Before the first subject is entered into the study, an AstraZeneca representative will review and discuss the requirements of the Clinical Study Protocol and related documents with the investigational staff and also train them in any study specific procedures and the WBDC and ePRO system(s) utilised.

The Principal Investigator will ensure that appropriate training relevant to the study is given to all of these staff, and that any new information relevant to the performance of this study is forwarded to the staff involved.

The Principal Investigator will maintain a record of all individuals involved in the study (medical, nursing and other staff).

### **9.2 Monitoring of the study**

During the study, an AstraZeneca representative will have regular contacts with the study site, including visits to:

- Provide information and support to the Investigator(s)
- Confirm that facilities remain acceptable
- Confirm that the investigational team is adhering to the protocol, that data are being accurately and timely recorded in the CRFs, that biological samples are handled in accordance with the Laboratory Manual and that investigational product accountability checks are being performed
- This study plans to follow the principles of targeted monitoring and perform 100% Source Data Verification (SDV) on critical variables (including eligibility criteria) only. The expected overall SDV will be at least 50%
- Perform source data verification (a comparison of the data in the CRFs with the subject's medical records at the hospital or practice, and other records relevant to the study) including verification of informed consent of participating subjects. This will require direct access to all original records for each subject (e.g., clinic charts)
- Ensure withdrawal of informed consent to the use of the subject's biological samples is reported and biological samples are identified and disposed of/destroyed accordingly, and the action is documented, and reported to the subject.

The AstraZeneca representative will be available between visits if the Investigator(s) or other staff at the centre needs information and advice about the study conduct.

#### **9.2.1 Source data**

Refer to the Clinical Study Agreement for location of source data.

### **9.2.2 Study agreements**

The Principal Investigator at each/the centre should comply with all the terms, conditions, and obligations of the Clinical Study Agreement, or equivalent, for this study. In the event of any inconsistency between this Clinical Study Protocol and the Clinical Study Agreement, the terms of Clinical Study Protocol shall prevail with respect to the conduct of the study and the treatment of subjects and in all other respects, not relating to study conduct or treatment of subjects, the terms of the Clinical Study Agreement shall prevail.

Agreements between AstraZeneca and the Principal Investigator should be in place before any study-related procedures can take place, or subjects are screened.

### **9.2.3 Archiving of study documents**

The Investigator follows the principles outlined in the Clinical Study Agreement (CSA).

## **9.3 Study timetable and end of study**

The end of the study is defined as ‘the last visit of the last subject undergoing the study’.

The study is expected to start in Q3 2014 and to end by Q1 2018.

The study may be terminated at individual centres if the study procedures are not being performed according to GCP, or if recruitment is slow. AstraZeneca may also terminate the entire study prematurely if concerns for safety arise within this study or in any other study with AZD9291.

## **9.4 Data management by AstraZeneca**

Data management will be performed by \_\_\_\_\_ staff, according to the Data Management Plan. Adverse events and medical/surgical history will be classified according to the terminology of the latest version the Medical Dictionary for Regulatory Activities (MedDRA). Medications will be classified according to the AstraZeneca Drug Dictionary. Classification coding will be performed by the Medical Coding Team at the

The data collected through third party sources will be obtained and reconciled against study data.

Data queries will be raised for inconsistent, impossible or missing data. All entries to the study database will be available in an audit trail.

The data will be validated as defined in the Data Management Plan. Quality control procedures will be applied to each stage of data handling to ensure that all data are reliable and have been processed correctly. The Data Management Plan will also clarify the roles and responsibilities of the various functions and personnel involved in the data management process.

When all data have been coded, validated, signed and locked, clean file will be declared. Any treatment revealing data may thereafter be added and the final database will be locked.

### **Serious Adverse Event (SAE) Reconciliation**

SAE reconciliation reports are produced and reconciled with the Patient Safety database and/or the investigational site.

### **Data Management of Genotype Data**

Any genotype data generated in this study will be stored in the AstraZeneca genotyping Laboratory Information Management System (LIMS) database, or other appropriate secure System within AstraZeneca and/or third party contracted to work with AstraZeneca to analyse samples.

### **Data Associated with Human Biological Samples**

Data associated with biological samples will be transferred from laboratory(ies) internal or external to AstraZeneca.

### **Management of External Data**

Data associated with ePRO will be transferred from vendor to Cognizant Data Management Centre.

## **10. ETHICAL AND REGULATORY REQUIREMENTS**

### **10.1 Ethical conduct of the study**

The study will be performed in accordance with ethical principles that have their origin in the Declaration of Helsinki and are consistent with ICH/Good Clinical Practice, applicable regulatory requirements and the AstraZeneca policy on Bioethics and Human Biological Samples.

### **10.2 Subject data protection**

The Informed Consent Form will incorporate (or, in some cases, be accompanied by a separate document incorporating) wording that complies with relevant data protection and privacy legislation.

AstraZeneca will not provide individual genotype results to subjects, any insurance company, any employer, their family members, general physician or any other third party, unless required to do so by law.

Precautions are taken to preserve confidentiality and prevent genetic data being linked to the identity of the subject. In exceptional circumstances, however, certain individuals might see both the genetic data and the personal identifiers of a subject. For example, in the case of a medical emergency, an AstraZeneca Physician or an Investigator might know a subject's identity and also have access to his or her genetic data. Also Regulatory authorities may

require access to the relevant files, though the subject's medical information and the genetic files would remain physically separate.

### **10.3 Ethics and regulatory review**

An Ethics Committee should approve the final study protocol, including the final version of the Informed Consent Form and any other written information and/or materials to be provided to the subjects. The Investigator will ensure the distribution of these documents to the applicable Ethics Committee, and to the study site staff.

The opinion of the Ethics Committee should be given in writing. The Investigator should submit the written approval to AstraZeneca before enrolment of any subject into the study.

The Ethics Committee should approve all advertising used to recruit subjects for the study.

AstraZeneca should approve any modifications to the Informed Consent Form that are needed to meet local requirements.

If required by local regulations, the protocol should be re-approved by the Ethics Committee annually.

Before enrolment of any subject into the study, the final study protocol, including the final version of the Informed Consent Form are to be approved by the national regulatory authority or a notification to the national regulatory authority is done, according to local regulations.

AstraZeneca will handle the distribution of any of these documents to the national regulatory authorities.

AstraZeneca will provide Regulatory Authorities, Ethics Committees and Principal Investigators with safety updates/reports according to local requirements.

Each Principal Investigator is responsible for providing the Ethics Committees/IRB with reports of any serious and unexpected adverse drug reactions from any other study conducted with the investigational product. AstraZeneca will provide this information to the Principal Investigator so that he/she can meet these reporting requirements.

### **10.4 Informed consent**

The Principal Investigator(s) at each centre will:

- Ensure each subject is given full and adequate oral and written information about the nature, purpose, possible risk and benefit of the study
- Ensure each subject is notified that they are free to discontinue from the study at any time
- Ensure that each subject is given the opportunity to ask questions and allowed time to consider the information provided

- Ensure each subject provides signed and dated informed consent before conducting any procedure specifically for the study
- Ensure the original, signed Informed Consent Form(s) is/are stored in the Investigator's Study File
- Ensure a copy of the signed Informed Consent Form is given to the subject
- Ensure that any incentives for subjects who participate in the study as well as any provisions for subjects harmed as a consequence of study participation are described in the informed consent form that is approved by an Ethics Committee.

## **10.5 Changes to the protocol and informed consent form**

Study procedures will not be changed without the mutual agreement of the International coordinating Investigators and AstraZeneca.

If there are any substantial changes to the study protocol, then these changes will be documented in a study protocol amendment and where required in a new version of the study protocol (Revised Clinical Study Protocol).

The amendment is to be approved by the relevant Ethics Committee and if applicable, also the national regulatory authority approval, before implementation. Local requirements are to be followed for revised protocols.

AstraZeneca will distribute any subsequent amendments and new versions of the protocol to each Principal Investigator(s). For distribution to Ethics Committee see Section 10.3.

If a protocol amendment requires a change to a centre's Informed Consent Form, AstraZeneca and the centre's Ethics Committee are to approve the revised Informed Consent Form before the revised form is used.

If local regulations require, any administrative change will be communicated to or approved by each Ethics Committee.

## **10.6 Audits and inspections**

Authorised representatives of AstraZeneca, a regulatory authority, or an Ethics Committee may perform audits or inspections at the centre, including source data verification. The purpose of an audit or inspection is to systematically and independently examine all study-related activities and documents, to determine whether these activities were conducted, and data were recorded, analysed, and accurately reported according to the protocol, Good Clinical Practice (GCP), guidelines of the International Conference on Harmonisation (ICH), and any applicable regulatory requirements. The Investigator will contact AstraZeneca immediately if contacted by a regulatory agency about an inspection at the centre.



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**Clinical Study Protocol Amendment**

Amendment Number	1
Drug Substance	AZD9291
Study Code	D5160C00003
Date	
Protocol Dated	

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**A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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This submission /document contains trade secrets and confidential commercial information, disclosure of which is prohibited without providing advance notice to AstraZeneca and opportunity to object.

**Sponsor: AstraZeneca AB,**

**Centres affected by the Amendment:**

This amendment affects all participating sites in the study.

**The protocol for the study is to be amended as follows:**

Original text

~~Removed text~~

**Added text**

## **Change 1**

### **Section of protocol affected:**

PROTOCOL SYNOPSIS

### **Previous text:**

#### **Study site(s) and number of subjects planned**

Approximately 610 subjects will be recruited from approximately 17 countries across approximately 140 centres in North America, Asia and Europe.

### **Revised text:**

#### **Study site(s) and number of subjects planned**

Approximately 610 subjects will be recruited from approximately **20** countries across approximately **160** centres in North America, Asia and Europe.

### **Reason for Amendment:**

A third International Coordinating Principal Investigator for North America has been added. Update on the approximate number of countries and sites participating in the study.

## **Change 2**

### **Section of protocol affected:**

PROTOCOL SYNOPSIS

### **Previous text:**

Subjects must be followed until evidence on RECIST 1.1 defined progression (regardless of reason for treatment discontinuation). It is important that subjects are assessed according to the intended scanning schedule to prevent the bias in analysis that can occur if one treatment group is assessed more or less often than the other.

Note: Throughout this document the term “platinum-based doublet chemotherapy” refers to “platinum” as both carboplatin and cisplatin.

**Revised text:**

Subjects must be followed until evidence on RECIST 1.1 defined progression (regardless of reason for treatment discontinuation). It is important that subjects are assessed according to the intended scanning schedule to prevent the bias in analysis that can occur if one treatment group is assessed more or less often ~~that~~ **than** the other.

**Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be given the opportunity to begin treatment with AZD9291 80mg, once daily. These subjects may continue treatment with AZD9291 even after disease progression, as long as they are continuing to show clinical benefit, as judged by the investigator.**

**Subjects who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be eligible to cross-over to AZD9291. They will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.**

Note: Throughout this document the term “platinum-based doublet chemotherapy” refers to “platinum” as both carboplatin and cisplatin

**Reason for Amendment:**

Subjects on platinum-based doublet chemotherapy arm with objective radiological progression will be allowed to cross-over to receive AZD9291, giving the opportunity to patients on standard of care chemotherapy to be treated with AZD9291 after progression.

**Change 3**

**Section of protocol affected:**

PROTOCOL SYNOPSIS

**Duration of treatment**

**Previous text:**

Treatment with AZD9291 80 mg (once daily) will commence following randomization. Subjects may continue to receive treatment with AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria (see Section 3.7).

**Revised text:**

Treatment with AZD9291 **80mg, once daily**, will commence following randomization. Subjects may continue to receive treatment with AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria (see Section 3.7).

**Subjects on the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291 80mg, once daily.**

**Reason for Amendment:**

Subjects on platinum-based doublet chemotherapy arm with objective radiological progression will be allowed to cross-over to receive AZD9291, giving the opportunity to subjects on standard of care chemotherapy to be treated with AZD9291 after progression.

**Change 4**

**Section of protocol affected:**

PROTOCOL SYNOPSIS

**Comparator product, dosage and mode of administration**

**Previous text:**

NA

**Revised text:**

**The wash out period between stopping the doublet chemotherapy and starting AZD9291 80mg, once daily, in subjects eligible for cross-over is 14 days. Any unresolved toxicities from prior therapy should be controlled, and be no greater than CTCAE grade 1 (with the exception of alopecia which may be grade 2) at the time of starting AZD9291 treatment.**

**Reason for Amendment:**

To avoid confounding potential toxicities carry-over effects from the previous treatment and to guarantee these are not related to the AZD9291 treatment.



## Change 5

### Section of protocol affected:

PROTOCOL SYNOPSIS

### Previous text:

PFS will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian). The primary analysis will be based on investigator-recorded assessment of disease progression by RECIST; a sensitivity analysis will also be performed using a blinded independent central review (BICR) from a random sample of scans from approximately 200 patients.

### Revised text:

PFS will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian). The primary analysis will be based on investigator-recorded assessment of disease progression by RECIST; a sensitivity analysis will also be performed using a blinded independent central review (BICR) ~~from a random sample of scans from approximately 200 patients.~~

### Reason for Amendment:

Following regulatory feedback, the sensitivity analysis of the primary PFS endpoint will be performed using blinded independent central review on all patients rather than a subset of patients.

## Change 6

### Section of protocol affected:

List of Abbreviations and Definition of Terms

### Previous text:

NA

### Revised text:

Abbreviation or special term	Explanation
Pre-treatment:	Medication used before chemotherapy, e.g., folic acid, corticosteroid and vitamin B12 or anti-emetic drugs according to the respective chemotherapy local labels (cisplatin, carboplatin and pemetrexed).
Pre-medication:	Medication used to prevent study drug side effects, for example, to treat diarrhoea once it is detected, and used as long as needed. It can also be used prophylactically in case subjects are prone to develop a particular adverse event.
<del>ctDNA</del>	<del>Circulating tumour Deoxyribonucleic acid</del>

**Reason for Amendment:**

Clarification. Also, ctDNA repeated twice in the list.

**Change 7**

**Section of protocol affected:**

1.3. Rationale for study design, doses and control groups

**Previous text:**

A commonly used platinum doublet is pemetrexed in combination with cisplatin or carboplatin. Pemetrexed in combination with cisplatin demonstrated superior OS compared to Gemcitabine in combination with cisplatin in previously untreated advanced NSCLC patients with non-squamous histology (adenocarcinoma and large cell carcinoma) in a randomised phase III trial: 10.4 vs 6.7 months respectively (Scagliotti et al 2008). Pemetrexed in combination with either Cisplatin or Carboplatin is therefore an appropriate control arm treatment in this phase III trial.

**Revised text:**

A commonly used platinum doublet is pemetrexed in combination with cisplatin or carboplatin. Pemetrexed in combination with cisplatin demonstrated superior OS compared to Gemcitabine in combination with cisplatin in previously untreated advanced NSCLC patients with non-squamous histology (adenocarcinoma and large cell carcinoma) in a randomised phase III trial: **12.6 vs. 10.9 (with adenocarcinoma) and 10.4 vs 6.7 months (with large-cell carcinoma) respectively** (Scagliotti et al 2008). **Pemetrexed in combination with cisplatin reported lower rates of grades 3 or 4 neutropenia, anaemia, thrombocytopenia, febrile neutropenia and alopecia, and higher rates of grades 3 or 4 nausea, compared to Gemcitabine in combination with cisplatin.** Pemetrexed in combination with either Cisplatin or Carboplatin is therefore an appropriate control arm treatment in this phase III trial.

**Reason for Amendment:**

To align data with the publication.

**Change 8**

**Section of protocol affected:**

1.3. Rationale for study design, doses and control groups

**Previous text:**

NA

**Revised text:**

**Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be given the opportunity to begin treatment with AZD9291 80mg, once daily. These subjects may continue treatment with AZD9291 even after disease progression, as long as they are continuing to show clinical benefit, as judged by the investigator.**

**Subjects who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be eligible to cross-over to AZD9291. They will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.**

**Reason for Amendment:**

Subjects on platinum-based doublet chemotherapy arm with objective radiological progression will be allowed to cross-over to receive AZD9291, giving the opportunity to subjects on standard of care chemotherapy to be treated with AZD9291 after progression.

**Change 9**

**Section of protocol affected:**

1.5. Study Design

**Previous text:**

NA

**Revised text:**

**Subjects on the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291 80mg, once daily.**

**Reason for Amendment:**

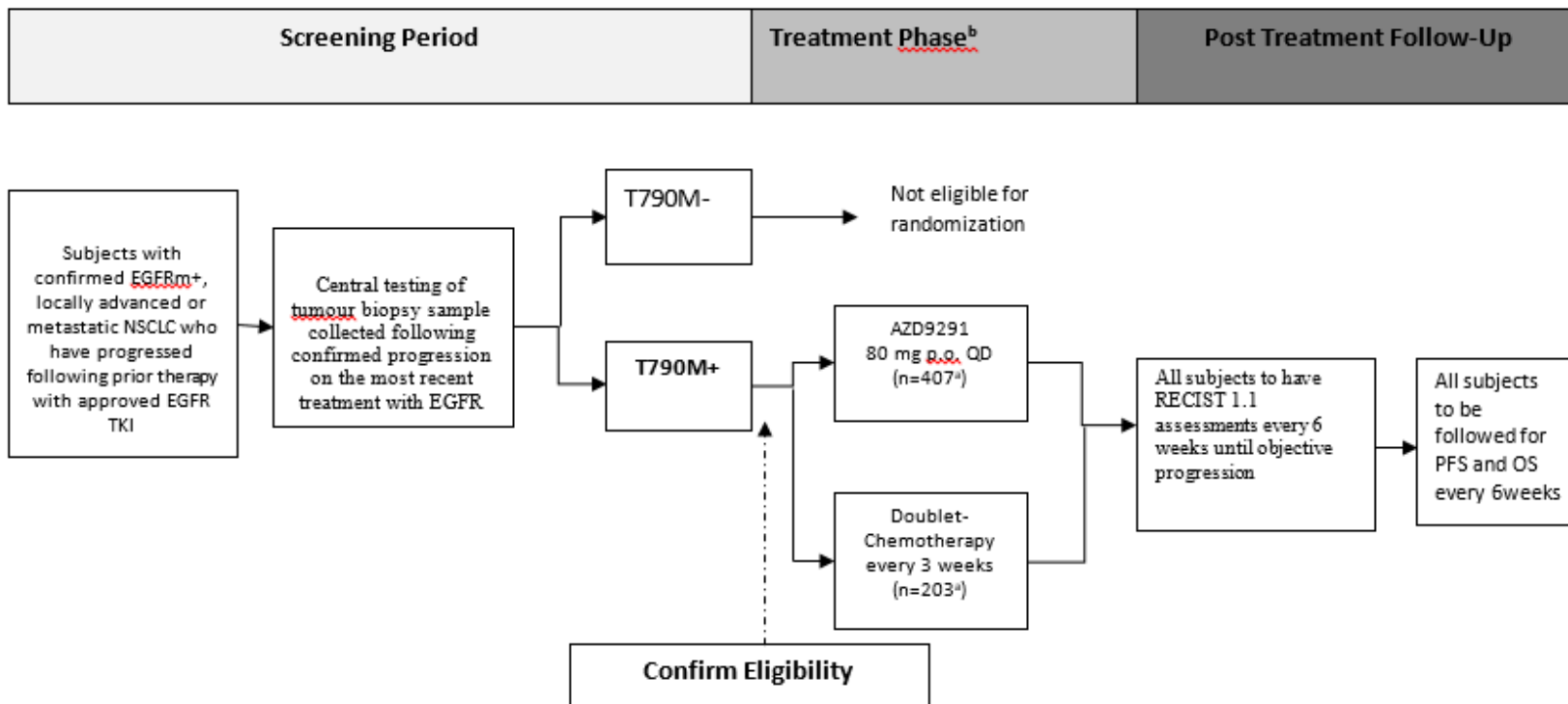
To allow subjects on platinum-based doublet chemotherapy arm to receive AZD9291 after progression and clarify that thereafter independent central review will be no longer required.

**Change 10**

**Section of protocol affected:**

Figure 1

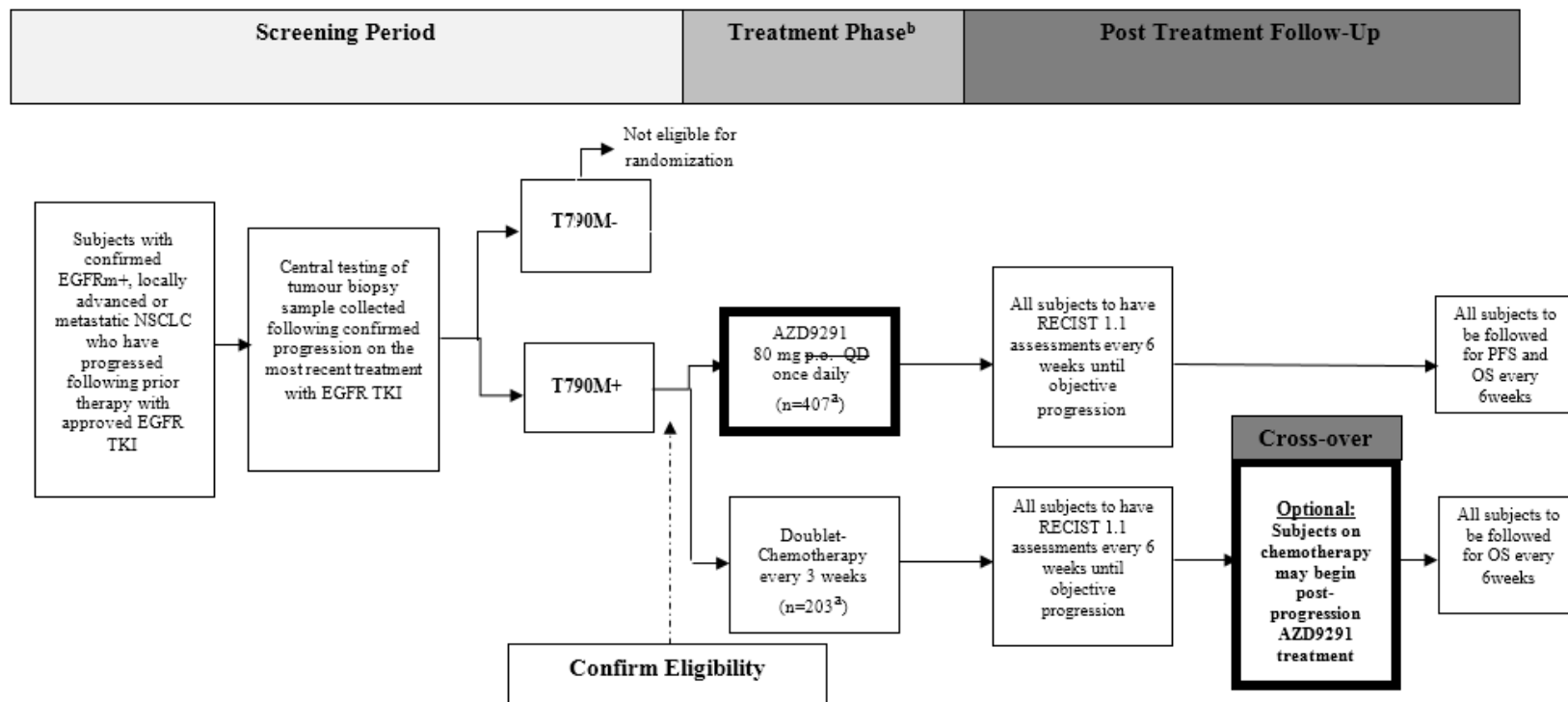
**Previous text:**



(a) Approximately 610 subjects will be randomized into the trial; from these approximately 407 subjects will be treated with AZD9291 and approximately 203 subjects will be treated with a platinum-based doublet-chemotherapy.

(b) Subjects will be considered in “Treatment phase” at the time AZD9291/Doublet-Chemotherapy (study treatment) is started. Subjects will continue to receive study treatment until objective disease progression (according to RECIST 1.1). Subjects randomized to AZD9291 may continue to receive AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria

**Revised text:**



(a) Approximately 610 subjects will be randomized into the trial; from these approximately 407 subjects will be treated with AZD9291 and approximately 203 subjects will be treated with a platinum-based doublet-chemotherapy.

(b) Subjects will be considered in “Treatment phase” at the time AZD9291/Doublet-Chemotherapy (study treatment) is started. Subjects will continue to receive study treatment until objective disease progression (according to RECIST 1.1). Subjects randomized to AZD9291 may continue to receive AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria. **Subjects on the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291, 80 mg once daily.**

**Reason for Amendment:**

Update the study flow to reflect the new protocol amendment

## Change 11

### Section of protocol affected:

#### 3.2 Exclusion criteria

#### Previous text:

Subjects should not enter the study if any of the following exclusion criteria are fulfilled:

1. Treatment with any of the following:

- Treatment with more than one prior line of treatment for advanced NSCLC
- Treatment with an EGFR-TKI (e.g., erlotinib, gefitinib or afatinib) within 8 days or approximately 5x half-life, whichever is the longer, of the first dose of study treatment. (If sufficient washout time has not occurred due to schedule or PK properties, an alternative appropriate washout time based on known duration and time to reversibility of drug related adverse events could be agreed upon by AstraZeneca and the Investigator)
- Any cytotoxic chemotherapy, investigational agents or other anticancer drugs from a previous treatment regimen or clinical study within 14 days of randomization
- Previous treatment with AZD9291, or a 3<sup>rd</sup> generation EGFR TKI

#### Revised text:

Subjects should not enter the study if any of the following exclusion criteria are fulfilled:

1. Treatment with any of the following:

- Treatment with more than one prior line of treatment for advanced NSCLC
- Treatment with an EGFR-TKI (e.g., erlotinib, gefitinib or afatinib) within 8 days or approximately 5x half-life, whichever is the longer, of the first dose of study treatment. (If sufficient washout time has not occurred due to schedule or PK properties, an alternative appropriate washout time based on known duration and time to reversibility of drug related adverse events could be agreed upon by AstraZeneca and the Investigator)
- Any ~~cytotoxic chemotherapy~~ investigational agents or anticancer drugs from a previous treatment regimen or clinical study within 14 days of randomization
- Previous treatment with AZD9291, or a 3<sup>rd</sup> generation EGFR TKI
- **Prior neo-adjuvant or adjuvant chemotherapy treatment within 6 months of starting 1<sup>st</sup> EGFR TKI treatment**

**Reason for Amendment:**

Clarification. While neo-adjuvant and adjuvant chemotherapy more than 6 months ago is allowed, if the recurrence post adjuvant is less than 6 months, the subsequent treatment would be considered second line, rather than first line.

**Change 12**

**Section of protocol affected:**

Section 3.3

**Previous text:**

If a subject is re-screened, a new E-code will always be assigned.

**Revised text:**

If a subject is re-screened, a new E-code will always be assigned. **Any repeated tests and/or procedures will be performed as per documented local standards. Subjects will reconfirm their consent to participate in the study by resigning and dating their original consent form(s), next to their initial signature and date. A subject with a valid negative T790M result cannot be re-screened.**

**A subject randomized to platinum-based doublet chemotherapy who crosses over to AZD9291 will be managed via IVRS/IWRS.**

**Reason for Amendment:**

To make it clearer that if subject is re-screened, some of the enrolment procedures may or may not have to be repeated. Subjects do not need to sign a new consent form; they are allowed to reconfirm their participation on the previously signed consent, by signing and dating next to their initial signature.

To point out that subject will be assigned open label AZD9291 via IVRS/IWRS.

**Change 13**

**Section of protocol affected:**

3.5 Methods for assigning treatment groups

**Previous text:**

NA

**Revised text:**

**Investigators will have the option to provide AZD9291 80mg, once daily, to subjects randomized to platinum-based doublet chemotherapy, who are determined by them to**

**have objective radiological progression according to RECIST 1.1, and who have objective disease progression confirmed by the independent central imaging review.**

**Reason for Amendment:**

To allow subjects on platinum-based doublet chemotherapy arm to receive AZD9291 after objective disease progression.

**Change 14**

**Section of protocol affected:**

STUDY PLAN AND TIMING OF PROCEDURES

Table 1 Study Plan for AZD9291 Subjects

Clinical chemistry/ Haematology/Urinalysis <sup>m</sup>	X <sup>f</sup>	X
---------------------------------------------------------	----------------	---

footnotes

<sup>c</sup> Consent can be taken prior to 28-day window if required. Screening period will then start with first study-related assessment

and

<sup>d</sup> Taken following progression on the latest line of therapy

and

<sup>f</sup> If screening assessments have been performed within 14 days prior to starting study treatment they do not have to be repeated on Visit 2 if subject's condition has not changed.

and

<sup>l</sup> At least one lesion, not previously irradiated and not chosen for biopsy during the study-screening period, that can be accurately measured. If only one lesion exists, the visit window may be extended beyond 28 days based on clinical judgement.

**Revised text:**

Clinical chemistry/ Haematology/Urinalysis <sup>m</sup>	X <sup>f</sup>	X <sup>f</sup>
---------------------------------------------------------	----------------	----------------

<sup>c</sup> Consent can be taken prior to 28-day window if required. Screening period will then start with first study-related assessment, **excluding the collection of the tumour tissue sample for central mutation analysis.**



and

<sup>d</sup> Taken following progression on the latest line of therapy. **The collection of this tumour tissue sample for central mutation analysis is not included in the 28-day screening period.**

and

<sup>f</sup> ~~If screening assessments are not done at Visit 2, but have been done at Visit 1 and have been performed~~ within 14 days **window** prior to starting study treatment, **with no change in condition and no clinical indication to do so**, they do not have to be repeated on Visit 2 ~~if subject's condition has not changed.~~ **(except for fasting glucose).**

and

<sup>l</sup> At least one lesion, not previously irradiated and not chosen for biopsy during the study-screening period, that can be accurately measured. If only one lesion exists, the visit window may be extended beyond 28 days based on clinical judgement, **for the screening biopsy, however the RECIST assessment must be performed within 28 days of the start of randomized treatment.**

**Reason for Amendment:**

Clarification.

**Change 15**

**Section of protocol affected:**

4. STUDY PLAN AND TIMING OF PROCEDURES

**Table 2:**

**Previous text:**

Cycle <sup>a</sup> / Day			C1 DI
Day	-28	-7	1
Window (days)	NA		±7
Platinum-based Doublet Chemotherapy			X <sup>f</sup>
EORTC QLQ-C30 and EQ-5D-5L (by e-device)			X <sup>m</sup>
EORTC QLQ LC13 (by e-device)			X <sup>m</sup>
PRO-CTCAE (by e-device) <sup>p</sup>			X <sup>m</sup>

and

<sup>f</sup> Chemotherapy may start within 1 week after randomization to allow Vitamin B12, Folic acid and corticosteroid treatment

and

<sup>g</sup> If screening assessments have been performed within 14 days prior to starting study treatment they do not have to be repeated on Visit 2 if subject's condition has not changed.

and

<sup>l</sup> At least one lesion, not previously irradiated and not chosen for biopsy during the study-screening period, that can be accurately measured. If only one lesion exists, the visit window may be extended beyond 28 days based on clinical judgement.

and

<sup>M</sup> To be completed pre-dose

**Revised text:**

Cycle <sup>a</sup> / Day			C1 DI
Day	-28	-7	1
Window (days)	NA		±7
Platinum-based Doublet Chemotherapy			X <sup>f</sup>
EORTC QLQ-C30 and EQ-5D-5L (by e-device) <sup>m</sup>		X	X <sup>m</sup>
EORTC QLQ LC13 (by e-device) <sup>m</sup>		X	X <sup>m</sup>
PRO-CTCAE (by e-device) <sup>p,m</sup>		X	X <sup>m</sup>

**and**

<sup>f</sup> Chemotherapy may start within 1 week after randomization to allow Vitamin B12, Folic acid and corticosteroid treatment, **as well as any other assessments for this visit, with the exception of the ePROs, which must be assigned to the patient on the date of randomization**

**and**

<sup>g</sup> If ~~screening~~ assessments **are not done at Visit 2, but have been done at Visit 1 and have been performed** within 14 days ~~window~~ prior to starting study treatment, **with no change in**

**condition and no clinical indication to do so, they do not have to be repeated on Visit 2 if subject's condition has not changed. (except for fasting glucose).**

<sup>l</sup> At least one lesion, not previously irradiated and not chosen for biopsy during the study-screening period, that can be accurately measured. If only one lesion exists, the visit window may be extended beyond 28 days based on clinical judgement **for the screening biopsy, however the RECIST assessment must be performed within 28 days of the start of randomized treatment. Subjects on the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 confirmed by the Investigator and by independent central imaging review will be given the opportunity to cross-over and begin treatment with AZD9291.**

**and**

<sup>m</sup> To be completed pre-dose **for all cycles, baseline ePROs to be completed as close to randomization date as possible.**

**Reason for Amendment:**

Clarification.

**Change 16**

**Section of protocol affected:**

4. STUDY PLAN AND TIMING OF PROCEDURES

**Table 1. Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

**Previous text:**

NA

**Revised text:**

**Table 3 Cross-over to AZD9291**



**Reason for Amendment:**

Addition of Table #3 that outlines study assessments for subjects on platinum-based doublet chemotherapy arm to receive AZD9291 after central imaging review confirms objective disease progression as per RECSIT 1.1.

**Change 17**

**Section of protocol affected:**

4.1 Screening period

**Previous text:**

**Mandatory screening tumour biopsy sample for mutation analysis:**

Tumour sample must be formalin fixed and paraffin embedded (FFPE) and must be biopsied following progression on the latest line of therapy. Samples may be collected from primary or metastatic tumour deposits. Sites should ship the FFPE tumour sample to the testing laboratory as soon as it is available. Blocks must be provided wherever possible. If this is not possible, 10-20 slides of freshly prepared unstained 5-micron sections from this screening tumour block may be provided. See Section 5.6.

The mandatory screening tumour biopsy must not be taken from a previously irradiated lesion or the lesion(s) selected for Inclusion criterion # 10. This biopsy sample is not subject to the 28-day screening window; if tissue is already available from a biopsy taken since documentation of disease progression on the most recent treatment regimen then there is no need for a further biopsy as this sample can be submitted for T790M mutation status. If the first biopsy is not confirmed as T790M mutation positive (due to test failure or if test is negative for the T790M mutation) a further biopsy sample may be submitted for central testing.

**Revised text:**

**Mandatory screening tumour biopsy sample for mutation analysis:**

Tumour sample must be formalin fixed and paraffin embedded (FFPE) and must be biopsied following progression on the latest line of therapy. Samples may be collected from primary or metastatic tumour deposits. **Bone samples (including soft tissue tumoural masses emerging from the bone) cannot be accepted for testing.** Sites should ship the FFPE tumour sample to the testing laboratory as soon as it is available. **Tissue should be less than 60 days old from date of sectioning to date of testing.** Blocks must be provided wherever possible. If this is not possible, a minimum of 6 slides of freshly prepared unstained 5-micron sections from this screening tumour block may must be provided. See Section 5.6.

The mandatory screening tumour biopsy must not be taken from a previously irradiated lesion or the lesion(s) selected for Inclusion criterion # 10. This biopsy sample is not subject to the 28-day screening window; if tissue is already available from a biopsy taken since documentation of disease progression on the most recent treatment regimen then there is no need for a further biopsy as this sample can be submitted for T790M mutation status. **If the first biopsy is not confirmed as T790M mutation positive due to test failure (i.e. an invalid result or invalid run occurred), testing will be repeated and an additional biopsy sample may be requested. If the T790M mutation is not detected in the first biopsy (and the cobas® EGFR Mutation Test indicates a valid result), no additional testing for the subject will be performed for this study and an additional biopsy sample WILL NOT be accepted.**

**Reason for Amendment:**

Reduction in number of required slides from 12-20 to 6 slides, which is sufficient for T790M mutation status testing. Clarification on acceptable samples and retesting.

**Change 18**

**Section of protocol affected:**

4.2 Treatment period

**Previous text:**

**For subjects receiving AZD9291:**

A cycle of treatment is defined as 21 days of once daily AZD9291 treatment. After Cycle 7 Day 1, the duration between study visits will change from every 21 days (3 weeks) to every 42 days (6 weeks).

If a subject continues to receive treatment with AZD9291 beyond RECIST 1.1 defined progression they must continue to follow the treatment visit schedule and assessments excluding study specific RECIST 1.1 assessments.

For subjects receiving AZD9291, please follow the study schedule described in Error! Reference source not found..

**For subjects receiving platinum-based doublet-chemotherapy:**

In order to adequately assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy on overall survival, cross-over (switching treatment) will not be allowed.

**Revised text:**

**For subjects receiving AZD9291:**

A cycle of treatment is defined as 21 days of once daily AZD9291 treatment. After Cycle 7 Day 1, the duration between study visits will change from every 21 days (3 weeks) to every 42 days (6 weeks).

If a subject continues to receive treatment with AZD9291 beyond RECIST 1.1 defined progression they must continue to follow the treatment visit schedule and assessments excluding study specific RECIST 1.1 assessments.

For subjects **randomized to receiving** AZD9291, please follow the study schedule described in Error! Reference source not found..

**For subjects receiving platinum-based doublet-chemotherapy:**

~~In order to adequately assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy on overall survival, cross-over (switching treatment) will not be allowed.~~

**For subjects who cross-over to AZD9291:**

**Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will receive AZD9291 80mg, once daily and will follow the assessments as per Table 3. These subjects may continue treatment with AZD9291 even after disease progression, as long as they are continuing to show clinical benefit, as judged by the investigator.**

**Subjects who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be eligible to cross-over to AZD9291. They will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.**

**Reason for Amendment:**

Clarification and to allow subjects on platinum-based doublet chemotherapy arm to receive AZD9291 after progression.

**Change 19**

**Section of protocol affected:**

4.2 Treatment period

**Previous text:**

Platinum-based doublet chemotherapy will be administrated every 21 days from previous cycle Day 1. Subjects can continue to receive platinum-based doublet-chemotherapy until matching discontinuation criteria (see section 3.9) or up to a total of 6 cycles or until

progression (whichever occurs first). Each cycle treatment can be interrupted maximum 14 days for safety reasons. If appropriate, and according to the approved label use or local practice guidelines, pemetrexed may be continued as maintenance treatment.

**Revised text:**

Platinum-based doublet chemotherapy will be administrated every 21 days from previous cycle Day 1. Subjects can continue to receive platinum-based doublet-chemotherapy until matching discontinuation criteria (see section 3.9) or up to a total of 6 cycles or until progression (whichever occurs first). Each cycle treatment can be **interrupted for a maximum of 21 days for safety reasons. If cycle treatment is delayed by more than 21 days, subject will be permanently discontinued from doublet-chemotherapy.** If appropriate, and according to the approved label use or local practice guidelines, pemetrexed may be continued as maintenance treatment.

**Reason for Amendment:**

To be in accordance of standard clinical care of subjects on chemotherapy within a clinical trial setting.

**Change 20**

**Section of protocol affected:**

4.2 Treatment period

**Previous text:**

**Optional second tissue sample for diagnostic development:**

The optional second tissue sample (FFPE) may be provided to facilitate diagnostic development and pre-market approval of the diagnostic test. This should be obtained at the same time and as part of the same procedure as the mandatory screening biopsy.

**Revised text:**

~~**Optional second tissue sample for diagnostic development:**~~

~~The optional second tissue sample (FFPE) may be provided to facilitate diagnostic development and pre-market approval of the diagnostic test. This should be obtained at the same time and as part of the same procedure as the mandatory screening biopsy.~~

**Reason for Amendment:**

Deleted. This statement is already mentioned in section 4.1.



## Change 21

### Section of protocol affected:

#### 4.3.3 Progression follow-up

#### Previous text:

Subjects who discontinue study medication for reasons other than objective disease progression will continue RECIST 1.1 assessments every 6 weeks (relative to date of randomization) for objective progression. In addition to RECIST 1.1 assessments, the following assessments are also required during this follow-up period as detailed in the Study Plan Table 1 and Table 2.

- EORTC QLQ-C30 and EQ-5D-5L every 6 weeks and at the time of progression.
- EORTC QLQ LC13 and PRO-CTCAE every 3 weeks and at the time of progression.
- Plasma for ctDNA collected every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation if this is in absence of progression)
- Adverse event collection detailed in 6.3
- Anti-cancer therapy and surgery collected every 6 weeks
- WHO performance status should also be collected at other site visits that the subject attends, if appropriate site staff are available to collect such information. In addition, where possible, please provide WHO performance status when information on subsequent anticancer therapy is provided

#### Revised text:

Subjects who discontinue study medication for reasons other than objective disease progression will continue RECIST 1.1 assessments every 6 weeks (relative to date of randomization) for objective progression. In addition to RECIST 1.1 assessments, the following assessments are also required during this follow-up period as detailed in the Study Plan Table 1 and Table 2.

- EORTC QLQ-C30 and EQ-5D-5L every 6 weeks and at the time of progression.
- EORTC QLQ LC13 and PRO-CTCAE every 3 weeks and at the time of progression.
- Plasma for ctDNA collected every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation if this is in absence of progression)
- Adverse event collection detailed in **section 6.3**

- Anti-cancer therapy and surgery collected every 6 weeks
- WHO performance status should also be collected at other site visits that the subject attends, if appropriate site staff are available to collect such information. In addition, where possible, please provide WHO performance status when information on subsequent anticancer therapy is provided
- **Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will receive AZD9291 80mg, once daily and will follow the assessments as per Table 3. These subjects may continue treatment with AZD9291 even after disease progression, as long as they are continuing to show clinical benefit, as judged by the investigator.**

**Subjects who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be eligible to cross-over to AZD9291. They will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.**

**Reason for Amendment:**

Clarification for subjects who discontinue study medication for reasons other than objective disease progression

**Change 22**

**Section of protocol affected:**

5.1.1 RECIST 1.1

**Previous text:**

The methods used at baseline for assessment of tumour burden [CT or MRI scans of chest and abdomen (including liver and adrenal glands)] must be used at each subsequent follow-up assessment. Any other areas of disease involvement should be additionally investigated based on the signs and symptoms of individual subjects. The baseline assessment should be performed within 28 days of treatment start. Subsequent assessments are to be performed every 6 weeks relative to randomization until objective disease progression. It is important to follow the assessment schedule as closely as possible. If scans are performed outside of the scheduled visit ( $\pm$  1 week window interval) and the subject has not progressed, every attempt should be made to perform the subsequent scans at their scheduled time points. Any other sites at which new disease is suspected should also be appropriately imaged.

**Revised text:**

The methods used at baseline for assessment of tumour burden [CT or MRI scans of chest and abdomen (including liver and adrenal glands)] must be used at each subsequent follow-up assessment. Any other areas of disease involvement should be additionally investigated based on the signs and symptoms of individual subjects. The baseline assessment should be performed within 28 days of ~~treatment start~~ **the start of randomized treatment**. Subsequent assessments are to be performed every 6 weeks relative to randomization until objective disease progression. It is important to follow the assessment schedule as closely as possible. If scans are performed outside of the scheduled visit ( $\pm 1$  week window interval) and the subject has not progressed, every attempt should be made to perform the subsequent scans at their scheduled time points. Any other sites at which new disease is suspected should also be appropriately imaged.

**Reason for Amendment:**

The term “treatment start” is incorrect. The term “randomization” is correct.

**Change 23**

**Section of protocol affected:**

5.1.2 RECIST 1.1 – Blinded Independent Central Review (BICR) Assessment

**Previous text:**

A planned BICR of a subset of scans, from approximately 200 evaluable subjects (with both progressive and non-progressive disease by investigator assessment), used in the assessment of tumours using RECIST 1.1 will be conducted. However, imaging assessments for all subjects will be collected in case BICR of additional subjects is required at a later date. All imaging assessments including unscheduled visit scans will be collected on an ongoing basis and sent to an AstraZeneca appointed CRO to enable central analysis. Results of this independent review will not be communicated to Investigators and the management of subjects will be based solely upon the results of the RECIST 1.1 assessment conducted by the Investigator. A sensitivity analysis will be conducted to identify any potential biases in the investigator assessments compared with BICR according to RECIST 1.1 (see Section 8.5.1). If any potential biases are identified, a BICR of additional subject scans may be performed.

In order to ensure 200 evaluable subjects have BICR data available, 220 subjects will be identified to be reviewed by BICR. This has been chosen to allow a 10% overage for any selected subjects who may not be evaluable by central review, for example because of poor imaging quality. The method of generating the random sample of subjects will be detailed in the Statistical Analysis Plan (SAP). Subject selection for BICR will be performed once all subjects have been randomized and BICR of subjects will be completed before database lock for the primary analysis of PFS.

### Revised text:

~~A planned BICR of a subset of scans, from approximately 200 evaluable subjects (with both progressive and non-progressive disease by investigator assessment), used in the assessment of tumours using RECIST 1.1 will be conducted. However, imaging assessments for all subjects will be collected in case BICR of additional subjects is required at a later date. All imaging assessments including unscheduled visit scans will be collected on an ongoing basis and sent to an AstraZeneca appointed CRO to enable central analysis. Results of this independent review will not be communicated to Investigators and the management of subjects will be based solely upon the results of the RECIST 1.1 assessment conducted by the Investigator. The central review will provide confirmation of progression for patients on platinum-based doublet chemotherapy who have progressed, as assessed by the investigator, at the request of the investigational site for confirmation of progression prior to starting AZD9291. Otherwise, the results of this independent central review will not be communicated to the investigational site, and the management of subjects will be based on the result of RECIST 1.1 assessments conducted by the investigator. Since confirmation by central imaging review is required for subjects to cross-over to AZD9291, no subjects will be permitted to cross-over without the aforementioned confirmation. A sensitivity analysis will be conducted to identify any potential biases in the investigator assessments compared with BICR according to RECIST 1.1 (see Section 8.5.1). If any potential biases are identified, a BICR of additional subject scans may be performed.~~

~~In order to ensure 200 evaluable subjects have BICR data available, 220 subjects will be identified to be reviewed by BICR. This has been chosen to allow a 10% overage for any selected subjects who may not be evaluable by central review, for example because of poor imaging quality. The method of generating the random sample of subjects will be detailed in the Statistical Analysis Plan (SAP). Subject selection for BICR will be performed once all subjects have been randomized and BICR of subjects will be completed before database lock for the primary analysis of PFS.~~

### Reason for Amendment:

Following regulatory feedback, the sensitivity analysis of the primary PFS endpoint will be performed using blinded independent central review on all subjects rather than a subset of subjects.

### Change 24

#### Section of protocol affected:

5.1.3 Laboratory safety assessments

#### Previous text:

**NB.** In case a subject shows an AST **or** ALT  $\geq 3 \times \text{ULN}$  **or** total bilirubin  $\geq 2 \times \text{ULN}$  please refer to Appendix E 'Actions required in cases of combined increase of Aminotransferase and Total Bilirubin – Hy's Law', for further instructions (section 6.3.7 and Appendix E).

**Revised text:**

**NB.** In case a subject shows an AST **or** ALT  $\geq 3 \times \text{ULN}$  **and** total bilirubin  $\geq 2 \times \text{ULN}$  please refer to Appendix E ‘Actions required in cases of combined increase of Aminotransferase and Total Bilirubin – Hy’s Law’, for further instructions (section 6.3.7 and Appendix E).

**Reason for Amendment:**

Typo error. For consistency with Appendix E

**Change 25**

**Section of protocol affected:**

5.4.4 Collection of cerebrospinal fluid - optional

**Previous text:**

For subjects on AZD9291: If the subject agrees, and upon signature of optional ICF, a sample of CSF will be obtained at one time point taken at any time from Cycle 2 Day 1 onwards. Samples will be collected, labelled and stored and shipped as detailed in the laboratory manual.

**Revised text:**

For subjects **randomized to** ~~on~~ AZD9291: If the subject agrees, and upon signature of optional ICF, a sample of CSF will be obtained at one time point taken at any time from Cycle 2 Day 1 onwards. Samples will be collected, labelled and stored and shipped as detailed in the laboratory manual.

**Reason for Amendment:**

Clarification.

**Change 26**

**Section of protocol affected:**

5.5.2. Collection of exploratory samples - blood-borne biomarkers and ctDNA

**Previous text:**

All subjects will be requested to provide a series of blood samples to generate plasma samples. These samples will be used for the extraction and analysis of ctDNA. The ctDNA may be used to further investigate the relationship between PK and blood-borne biomarkers

and/or develop a blood-based companion diagnostic for detection of EGFR mutations (including T790M).

**Revised text:**

All subjects will be requested to provide a series of blood samples to generate plasma samples. These samples will be used for the extraction and analysis of ctDNA. The ctDNA may be used to further investigate the relationship between PK and blood-borne biomarkers. **The ctDNA samples will be used to further explore EGFR (and other gene) mutation status and may be used to develop a plasma-based diagnostic test.**

**Reason for Amendment:**

To be in line with other AURA studies.

**Change 27**

**Section of protocol affected:**

5.6.1.3 Discontinuation Biopsy

**Previous text:**

**Table 2 Tumour biopsy samples**

<b>Time relative to dose</b>	<b>Requirement</b>
Archival	M*
Screening	M + O
Discontinuation or progression <sup>1</sup>	O

<sup>1</sup> To be taken at discontinuation or progression, whichever occurs first

**Revised text:**

**Table 8 Tumour biopsy samples**

<b>Time relative to dose</b>	<b>Requirement</b>
Archival	M*
Screening	M + O <sup>2</sup>
Discontinuation or progression <sup>1</sup>	O

<sup>1</sup> To be taken at discontinuation or progression, whichever occurs first

<sup>2</sup> Only block tissue sample will accepted.

**Reason for Amendment:**

For consistency with Pathology Manual on requirement for optional tissue sample.

**Change 28**

**Section of protocol affected:**

6.3.7 Hy's Law

**Previous text:**

Cases where a subject shows an AST or ALT  $\geq 3xULN$  **or** total bilirubin  $\geq 2xULN$  may need to be reported as SAEs. Prompt reporting of cases meeting Hy's law criteria (via the SAE expedited reporting system) is required for compliance with regulatory guidelines. The investigator is responsible for, without delay, determining whether a subject meets potential Hy's law (PHL) criteria.

**Revised text:**

Cases where a subject shows an AST or ALT  $\geq 3xULN$  **and** total bilirubin  $\geq 2xULN$  may need to be reported as SAEs. Prompt reporting of cases meeting Hy's law criteria (via the SAE expedited reporting system) is required for compliance with regulatory guidelines. The investigator is responsible for, without delay, determining whether a subject meets potential Hy's law (PHL) criteria.

**Reason for Amendment:**

Typo error. For consistency with Appendix E

**Change 29**

**Section of protocol affected:**

6.7.1 Skin reactions

**Previous text:**

Recommendations for appropriate management of skin reactions, including guidance on dose-adjustments for clinically significant and/or intolerable skin reactions that are considered by the investigator to be causally related to AZD9291 will be provided to investigators.

Skin reactions are to be reported as AEs in the CRF, with additional details captured in the "SKNREAC" CRF:

Changes in the characteristics of skin reactions will be collected in the "SKNREAC" CRF.

Changes in the CTCAE grade of skin reactions will be collected in the AE CRF.

Photographs of skin reactions may be collected and these photographs should be available for central review by AstraZeneca and for external expert dermatological review if required.

Skin biopsies of skin reactions may be taken.

**Revised text:**

Recommendations for appropriate management of skin reactions, including guidance on dose-adjustments for clinically significant and/or intolerable skin reactions that are considered by the investigator to be causally related to AZD9291 will be provided to investigators.

Skin reactions are to be reported as AEs in the CRF, with additional details captured in the "SKNREAC" CRF:

Changes in the characteristics of skin reactions will be collected in the "SKNREAC" CRF.

Changes in the CTCAE grade of skin reactions will be collected in the AE CRF.

Photographs of skin reactions may be collected and these photographs should be available for central review by AstraZeneca and for external expert dermatological review if required.

Skin biopsies of skin reactions may be taken **as per investigator discretion, as per the standard local medical practice. Skin biopsies should ideally be taken in subjects with clinically significant or grade  $\geq 3$  skin reaction.**

**Reason for Amendment:**

More specific instructions on when to take skin biopsies.

**Change 30**

**Section of protocol affected:**

7.2 Identity and Dose of Comparator Product – Platinum-based Doublet-Chemotherapy

**Previous text:**

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<b>Investigational product</b>	<b>Dosage form and strength</b>
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**Revised text:**

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<b>Investigational-Comparator products</b>	<b><del>Dosage form and strength</del> Dosing</b>
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**Reason for Amendment:**

Clarification.

**Change 31**

**Section of protocol affected: Section 7**

**Previous text:**

NA

**Revised text:**

**7.9 Cross-over to AZD9291**

**Subjects who are eligible and choose to enter cross-over AZD9291 treatment will be dispensed bottles of AZD9291 80mg, once daily, tablets. For details on AZD9291, please refer to section 7.1.**

**Reason for Amendment:**

To add in cross-over drug information.

**Change 32**

**Section of protocol affected:**

8.4.1 Calculation or derivation of efficacy variables

**Previous text:**

**Investigator RECIST based assessments**

From the investigators review of the imagining scans, the RECIST tumour response data will be used to determine each subject's visit response according to RECIST version 1.1.

At each visit, subjects will be programmatically assigned a RECIST 1.1 visit response of CR, PR, SD or PD depending on the status of their disease compared with baseline and previous assessments. If a subject has had a tumour assessment, which cannot be evaluated, then the subject will be assigned a visit response of not evaluable (NE) (unless there is evidence of progression in which case the response will be assigned as PD).

Please refer to Appendix H for the definitions of Complete Response, Partial Response, Stable Disease and Progressive Disease.

**Blinded Independent Central Review of RECIST based assessments**

The Blinded Independent Central Review of radiological imagining data will be carried out using RECIST version 1.1. All radiological scans for all subjects (including those at unscheduled visits, or outside visit windows) will be provided to the BICR. Prior radiotherapy

reports for subjects (at baseline) and information on biopsied lesions will also be provided to the BICR to allow the selection of appropriate target lesions. However, only a subset of scans will be reviewed by the BICR. The method of generating the random sample of subjects will be detailed in the Statistical Analysis Plan (SAP). The subset of imaging scans will be reviewed by two independent radiologists using RECIST 1.1 criteria and will be adjudicated if required. The independent reviewers will be blinded to treatment. For each subject, the BICR will define the overall visit response data (CR, PR, SD, PD or NE) and the relevant scan dates for each time point (i.e., for visits where response or progression is/is not identified). If a subject has had a tumour assessment, which cannot be evaluated, then the subject will be assigned a visit response of not evaluable (NE) (unless there is evidence of progression in which case the response will be assigned as PD). Endpoints (ORR, DoR, DCR, PFS) will be derived from the overall visit response date and the scan dates. ORR will only include subjects whose response has been confirmed by a second scan at least 4 weeks after the initial response. The endpoint of tumour shrinkage will be assessed from tumour size measurements based on the primary independent radiologist assessment.

Note, all imaging assessments for all subjects will be collected and stored in case a full BICR of all subjects is required at a later date.

#### **Revised text:**

#### **Investigator RECIST based assessments**

From the investigators review of the imaging scans, the RECIST tumour response data will be used to determine each subject's visit response according to RECIST version 1.1. **It will also be used to determine the endpoints ORR, DoR, DCR and PFS from the overall visit response and scan dates.**

At each visit, subjects will be programmatically assigned a RECIST 1.1 visit response of CR, PR, SD or PD depending on the status of their disease compared with baseline and previous assessments. If a subject has had a tumour assessment, which cannot be evaluated, then the subject will be assigned a visit response of not evaluable (NE) (unless there is evidence of progression in which case the response will be assigned as PD).

Please refer to Appendix H for the definitions of Complete Response, Partial Response, Stable Disease and Progressive Disease.

#### **Blinded Independent Central Review of RECIST based assessments**

The Blinded Independent Central Review of radiological imaging data will be carried out using RECIST version 1.1. All radiological scans for all subjects (including those at unscheduled visits, or outside visit windows) will be provided to the BICR. Prior radiotherapy reports for subjects (at baseline) and information on biopsied lesions will also be provided to the BICR to allow the selection of appropriate target lesions. ~~However, only a subset of scans will be reviewed by the BICR. The method of generating the random sample of subjects will be detailed in the Statistical Analysis Plan (SAP).~~ The subset of imaging scans will be reviewed by two independent radiologists using RECIST 1.1 criteria and will be adjudicated if required. The independent reviewers will be blinded to treatment. For each subject, the BICR

will define the overall visit response data (CR, PR, SD, PD or NE) and the relevant scan dates for each time point (, for visits where response or progression is/is not identified). If a subject has had a tumour assessment, which cannot be evaluated, then the subject will be assigned a visit response of not evaluable (NE) (unless there is evidence of progression in which case the response will be assigned as PD). ~~Endpoints (ORR, DoR, DCR, PFS) will be derived from the overall visit response date and the scan dates. ORR will only include subjects whose response has been confirmed by a second scan at least 4 weeks after the initial response. The endpoint of tumour shrinkage will be assessed from tumour size measurements based on the primary independent radiologist assessment.~~

~~Note, all imaging assessments for all subjects will be collected and stored in case a full BICR of all subjects is required at a later date.~~

**Reason for Amendment:**

Following regulatory feedback, the sensitivity analysis of the primary PFS endpoint will be performed using blinded independent central review on all subjects rather than a subset of subjects.

Correction of previous statements, as the endpoints ORR, DoR, DCR and PFS will be based on investigator assessment, not blinded independent central review.

**Change 33**

**Section of protocol affected:**

8.5.1 Analysis of the primary variable(s)

**Previous text:**

(a) Ascertainment bias

The possibility of bias in assessment and measurement of PFS by investigators will be assessed using the blinded independent central review assessment of disease progression by RECIST. The hazard ratios from investigator assessment and BICR assessment of PFS will be assessed. If they are sufficiently close, no more scans will be reviewed. If they are not sufficiently close, all scans will be reviewed and a HR calculated from the BICR of all patients. Further details will be provided in the SAP.

**Revised text:**

**Sensitivity analyses**

(a) Ascertainment bias

The possibility of bias in assessment and measurement of PFS by investigators will be assessed ~~using the blinded independent central review assessment of disease progression by~~

~~RECIST. The by comparing the hazard ratios derived from investigator assessment and BICR assessment of PFS will be assessed review with the hazard ratio derived using the blinded independent central review assessment of disease progression by RECIST. If they are sufficiently close, no more scans will be reviewed. If they are not sufficiently close, all scans will be reviewed and a HR calculated from the BICR of all patients. Further details will be provided in the SAP.~~

**Reason for Amendment:**

Following regulatory feedback, the sensitivity analysis of the primary PFS endpoint will be performed using blinded independent central review on all patients rather than a subset of patients.

**Change 34**

**Section of protocol affected:**

8.5.1 Analysis of the primary variable(s)

**Previous text:**

NA

**Revised text:**

**(d) Exploratory Analysis**

**Recently, it has been suggested that, in order to assess the potential for bias amongst investigators, a BICR amongst only a sample of subjects could be performed; if evidence of bias is detected, according to a pre-defined threshold, the BICR is then assessed in all subjects, otherwise it is concluded the sample was sufficient to rule-out meaningful levels of bias. A proposed sample BICR method has been submitted to a peer reviewed statistical journal for publication as of August 2014 and in order to demonstrate that this is a valid methodology for use in future trials, an exploratory analysis will be carried out using this methodology. Further details will be provided in the SAP.**

**Persons who initiated the Amendment:**

AstraZeneca Project Team

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**Clinical Study Protocol Amendment**

Amendment Number 2  
Drug Substance AZD9291  
Study Code D5160C00003

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**A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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This submission /document contains trade secrets and confidential commercial information, disclosure of which is prohibited without providing advance notice to AstraZeneca and opportunity to object.

**Sponsor: AstraZeneca**

**Centres affected by the Amendment:**

This amendment affects all participating sites in the study.

**The protocol for the study is to be amended as follows:**

Original text

Removed text

Added text

**The protocol for the study is to be amended as follows:**

**Change 1**

**Section of protocol affected:**

Title page

**Previous text:**

Clinical Study Protocol

Drug Substance AZD9291

Study Code D5160C00003

Edition Number 3

**Revised text:**

**Revised** Clinical Study Protocol

Drug Substance AZD9291

Study Code D5160C00003

Edition Number **2**

**Reason for Amendment:**

The term “Revised” is missing from the header information prior to “Clinical Study Protocol”. This will also change the version from 3 to 2 as this is the second revised Clinical Study Protocol.

When this error was noticed, it was documented in External “Note To File”, dated 10 February 2015.

**Change 2**

**Section of protocol affected:**

PROTOCOL SYNOPSIS

**Previous text:**

**Study site(s) and number of subjects planned**

Approximately 610 subjects will be recruited from approximately 20 countries across approximately 160 centres in North America, Asia and Europe.

Study period		Phase of development
Estimated date of first subject enrolled	Q3 2014	III
Estimated date of last subject completed	Q1 2018	

**Revised text:**

**Study site(s) and number of subjects planned**

Approximately **410** subjects will be ~~recruited~~ **randomized** from approximately **19** countries across approximately 160 centres in North America, Asia and Europe. **Once 410 subjects have been randomized globally, recruitment will continue only in mainland China until approximately 50 Chinese subjects have been randomized.**

Study period		Phase of development
Estimated date of first subject enrolled <b>globally</b>	Q3 2014	III
Estimated date of last subject completed	Q1 2018	
<b>Estimated date of last subject completed in China</b>	<b>Q4 2018</b>	

**Reason for Amendment:**

Although the primary endpoint is Progression Free Survival (PFS), the study had been sized to characterize the secondary endpoint of overall survival (OS) and was over-powered for PFS (>95% power to detect a difference in PFS assuming the true hazard ratio is 0.67). Due to the introduction of crossover, the interpretation of OS will be compromised and therefore, the study has been re-sized to characterise PFS, which has resulted in a sample size reduction. The study now has 90% power to detect the original hypothesised treatment effect of PFS hazard ratio of 0.67.

A China extension cohort has been introduced to ensure adequate Chinese subject participation to fulfil China Regulatory Authority requirements; it is possible that this target may not be met before the global recruitment of 410 subjects is achieved.

**Change 3**

**Section of protocol affected:**

PROTOCOL SYNOPSIS

**Previous text:**

In order to randomize approximately 610 subjects it is expected that an estimated 1540 subjects will be screened.

**Revised text:**

In order to randomize approximately ~~610~~**410** subjects it is expected that an estimated ~~1540~~**1034** subjects will be screened. **Once 410 subjects have been randomized globally, recruitment will continue only in mainland China until approximately 50 Chinese subjects have been randomized.**

**Reason for Amendment:**

Although the primary endpoint is Progression Free Survival (PFS), the study had been sized to characterize the secondary endpoint of overall survival (OS) and was over-powered for PFS (>95% power to detect a difference in PFS assuming the true hazard ratio is 0.67). Due to the introduction of crossover, the interpretation of OS will be compromised and therefore, the study has been re-sized to characterise PFS, which has resulted in a sample size reduction. The study now has 90% power to detect the original hypothesised treatment effect of PFS hazard ratio of 0.67.

A China extension cohort has been introduced to ensure adequate Chinese subject participation to fulfil China Regulatory Authority requirements; it is possible that this target may not be met before the global recruitment of 410 subjects is achieved.

**Change 4**

**Section of protocol affected:**

PROTOCOL SYNOPSIS

**Previous text:**

Subjects can receive up to 6 cycles of pemetrexed + carboplatin/cisplatin as initial treatment. Subjects whose disease has not progressed after four cycles of platinum-based first-line chemotherapy may receive pemetrexed maintenance therapy.

Subjects must be followed until evidence of RECIST 1.1 defined progression (regardless of reason for treatment discontinuation). It is important that subjects are assessed according to the intended scanning schedule to prevent the bias in analysis that can occur if one treatment group is assessed more or less often than the other.

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed



by independent central imaging review, they will be given the opportunity to begin treatment with AZD9291 80mg, once daily. These subjects may continue treatment with AZD9291 even after disease progression, as long as they are continuing to show clinical benefit, as judged by the investigator.

Subjects who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be eligible to cross-over to AZD9291, They will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.

**Revised text:**

Subjects can receive up to 6 cycles of pemetrexed + carboplatin/cisplatin as initial treatment. Subjects whose disease has not progressed after four cycles of platinum-based first-line chemotherapy may receive pemetrexed maintenance therapy. **Subjects who progress according to RECIST 1.1 criteria prior to completion of initial doublet chemotherapy treatment or during pemetrexed maintenance monotherapy, may continue with chemotherapy treatment as long as they are continuing to show clinical benefit, as judged by the investigator.**

Subjects must be followed until evidence of RECIST 1.1 defined progression (regardless of reason for treatment discontinuation). It is important that subjects are assessed according to the intended scanning schedule to prevent the bias in analysis that can occur if one treatment group is assessed more or less often than the other.

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be given the opportunity to begin treatment with AZD9291 80mg, once daily. **These subjects may continue treatment with AZD9291 as long as they show clinical benefit, as judged by the investigator.**

**If a subject has been deemed to have objective disease progression according to Investigator tumour assessment according to RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subjects' best interests, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy, sites are to submit the next scheduled tumour assessment for central imaging review according to Table 2.**

~~If Ssubjects who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be~~ **are not eligible to cross-over to AZD9291, ¶they will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.**

**Reason for Amendment:**

Clarification that subjects with objective disease progression that is not initially confirmed by independent central imaging review can continue with scheduled RECIST assessments until disease is confirmed by independent central imaging review. Also, subjects may continue on randomized chemotherapy if the investigator deems that they are showing clinical benefit.

**Change 5**

**Section of protocol affected:**

PROTOCOL SYNOPSIS

**Previous text:**

The wash out period between stopping the doublet chemotherapy and starting AZD9291 80mg, once daily, in subjects eligible for cross-over is 14 days. Any unresolved toxicities from prior therapy should be controlled, and be no greater than CTCAE grade 1 (with the exception of alopecia which may be grade 2) at the time of starting AZD9291 treatment.

**Revised text:**

The wash out period between stopping the ~~doublet~~ **randomized** chemotherapy **and/or associated supportive treatments (i.e. corticosteroids, radiation)**, and starting AZD9291 80mg, once daily, in subjects eligible for cross-over is **at least** 14 days. Any unresolved toxicities from prior therapy should be controlled, and be no greater than CTCAE grade 1 (with the exception of alopecia which may be grade 2) at the time of starting AZD9291 treatment.

**Reason for Amendment:**

Clarification

**Change 6**

**Section of protocol affected:**

PROTOCOL SYNOPSIS

**Previous text:**

PFS is the primary endpoint for this study. The study has been sized to also characterise the overall survival (OS). Approximately 610 subjects will be randomized globally in a 2:1 ratio (AZD9291: platinum-based doublet chemotherapy) in this study.

The primary analysis of PFS will occur when approximately 400 progression events have been observed. With 400 progression events, the study will have >95% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were HR 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed.

If the true OS hazard ratio for the comparison of AZD9291 versus doublet chemotherapy is 0.75, 427 death events will provide approximately 80% power to demonstrate a statistically significant difference in OS at 5% 2-sided significance level. For example, this translates to an approximate 5-6 month improvement in median OS over an assumed 16-19 month median OS on chemotherapy, assuming OS is exponentially distributed.

Two interim analyses of overall survival will be conducted, one at the time of the primary analysis of PFS, and one when the OS data are approximately 50% mature (approximately 305 death events). A final optional analysis of overall survival may be performed when the OS data are approximately 70% mature (approximately 430 death events).

**Revised text:**

PFS is the primary endpoint for this study. ~~The study has been sized to also characterise the overall survival (OS).~~ Approximately ~~610~~ **410** subjects will be randomized globally in a 2:1 ratio (AZD9291: platinum-based doublet chemotherapy) in this study.

The primary analysis of PFS will occur when approximately ~~400-295~~ progression events have been observed **out of the 410 globally randomized subjects**. With ~~400-295~~ progression events, the study will have ~~>95%~~ **90%** power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were HR 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed. **The smallest treatment difference that would be statistically significant is a PFS HR of 0.78. Assuming 12 months non-linear recruitment, 295 PFS events are expected to occur approximately 23 months after the first subject is enrolled in the study.**

If the true OS hazard ratio for the comparison of AZD9291 versus doublet chemotherapy is 0.75~~2~~, ~~427~~ **287** death events will provide approximately 80% power to demonstrate a statistically significant difference in OS at 5% 2-sided significance level. ~~For example, this translates to an approximate 5-6 month improvement in median OS over an assumed 16-19 month median OS on chemotherapy, assuming OS is exponentially distributed.~~ **Assuming 12 months non-linear recruitment, 16-19 month median on chemotherapy, 287 OS events are expected to occur approximately 42-48 months after the first subject is enrolled in the study.**

Two interim analyses of overall survival will be conducted, one at the time of the primary analysis of PFS, and one when the OS data are approximately 50% mature (approximately ~~305~~ **205** death events). A final optional analysis of overall survival may be performed when the OS data are approximately 70% mature (approximately ~~430~~ **287** death events).

**Reason for Amendment:**

Although the primary endpoint is Progression Free Survival (PFS), the study had been sized to characterize the secondary endpoint of overall survival (OS) and was over-powered for PFS (>95% power to detect a difference in PFS assuming the true hazard ratio is 0.67). Due to the introduction of crossover, the interpretation of OS will be compromised and therefore, the study has been re-sized to characterise PFS, which has resulted in a sample size reduction. The study now has 90% power to detect the original hypothesised treatment effect of PFS hazard ratio of 0.67.

**Change 7**

**Section of protocol affected:**

PROTOCOL SYNOPSIS

**Previous text:**

Treatment with AZD9291 80 mg, once daily, will commence following randomization. Subjects may continue to receive treatment with AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria (see Section 3.7).

Subjects on the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291 80mg, once daily.

Treatment with intravenous platinum-based doublet chemotherapy (on Day 1 of every 21 day cycle) will commence following randomization up to a total of 6 cycles or until progression (whichever occurs first). Patients whose disease has not progressed after four cycles of platinum-based first-line chemotherapy may receive pemetrexed maintenance therapy.

**Revised text:**

Treatment with AZD9291 80 mg, once daily, will commence following randomization. Subjects may continue to receive treatment with AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria (see Section 3.7).

Treatment with intravenous platinum-based doublet chemotherapy (on Day 1 of every 21 day cycle) will commence following randomization up to a total of 6 cycles ~~or until progression (whichever occurs first)~~. Patients whose disease has not progressed after four cycles of platinum-based first-line chemotherapy may receive pemetrexed maintenance therapy.

**Subjects who progress according to RECIST 1.1 criteria prior to completion of initial doublet chemotherapy treatment or during pemetrexed maintenance monotherapy, may continue with treatment as long as they show clinical benefit, as judged by the investigator.**

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be given the opportunity to begin treatment with AZD9291 80mg, once daily.

**If a subject has been deemed to have objective disease progression according to Investigator tumour assessment according to RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subjects' best interests, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy, sites are to submit the next scheduled tumour assessment for central imaging review according to Table 2.**

**Reason for Amendment:**

Clarification that subjects with objective disease progression that is not initially confirmed by independent central imaging review can continue with scheduled RECIST assessments until disease is confirmed by independent central review. Also, subjects may continue on randomized chemotherapy if the investigator deems that they are showing clinical benefit.

**Change 8**

**Section of protocol affected:**

PROTOCOL SYNOPSIS

**Previous text:**

NA

**Revised text:**

**The safety and efficacy data collected for Chinese subjects after global recruitment has closed will be combined with data from the Chinese subjects recruited prior to the end of**

**global recruitment, and summarised and analysed separately. This China cohort will provide standalone safety and efficacy analyses of subjects from China and will be reported separately from the Clinical Study Report. These analyses may be performed at the time of the primary PFS analysis if at least 20 PFS events have been observed out of approximately 50 Chinese subjects, otherwise summaries of efficacy will be provided only. Additional follow-up of Chinese subjects if deemed appropriate may be performed when the PFS data are more mature (for example, 70% maturity, as consistent with the primary global PFS analysis).**

**Reason for Amendment:**

A China extension cohort has been introduced to ensure adequate Chinese subject participation to fulfil China Regulatory Authority requirements; it is possible that this target may not be met before the global recruitment of 410 subjects is achieved.

**Change 9**

**Section of protocol affected:**

1.3 Rationale for study design, doses and control groups

**Previous text:**

Given the unmet medical need that exists in the aforementioned subject population alongside the lack of well-proven treatment options, and given the good evidence of efficacy with AZD9291 (>50% RR in T790M+ population) and well tolerated profile reported in ongoing phase I study in T790M+ subject population (Ranson et al WCLC 2013), it is considered appropriate to assess efficacy and safety of AZD9291 in a randomised open-label phase III study in 2<sup>nd</sup> line NSCLC versus pemetrexed in combination with cisplatin or carboplatin.

**Revised text:**

Given the unmet medical need that exists in the aforementioned subject population alongside the lack of well-proven treatment options, and given the good evidence of efficacy with AZD9291 (>50% RR in T790M+ population) and well tolerated profile reported in ongoing phase I study in T790M+ subject population (Ranson et al WCLC 2013), it is considered appropriate to assess efficacy and safety of AZD9291 in a randomised open-label phase III study in 2<sup>nd</sup> line NSCLC versus pemetrexed in combination with cisplatin or carboplatin.

**Once 410 subjects have been randomized globally, recruitment will continue only in mainland China until approximately 50 Chinese subjects have been randomized. This is to ensure adequate Chinese subject participation to satisfy China Regulatory Authority requirements; it is anticipated that this target may not be met before the global recruitment of 410 is achieved.**

### **Reason for Amendment:**

A China extension cohort has been introduced to ensure adequate Chinese subject participation to fulfil China Regulatory Authority requirements; it is possible that this target may not be met before the global recruitment of 410 subjects is achieved.

### **Change 10**

#### **Section of protocol affected:**

1.3 Rationale for study design, doses and control groups

#### **Previous text:**

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be given the opportunity to begin treatment with AZD9291 80mg, once daily. These subjects may continue treatment with AZD9291 even after disease progression, as long as they are continuing to show clinical benefit, as judged by the investigator.

Subjects who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be eligible to cross-over to AZD9291. They will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.

#### **Revised text:**

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be given the opportunity to begin treatment with AZD9291 80mg, once daily.

**If a subject has been deemed to have objective disease progression according to Investigator tumour assessment according to RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subjects' best interests, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy, sites are to submit the next scheduled tumour assessment for central imaging review according to Table 2.**

~~If Ssubjects who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be~~ **are not** eligible to cross-over to AZD9291, ~~they~~ **they** will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.

### **Reason for Amendment:**

Clarification that subjects with objective disease progression that is not initially confirmed by independent central imaging review can continue with scheduled RECIST assessments until disease is confirmed by independent central imaging review.

### **Change 11**

#### **Section of protocol affected:**

1.5 Study Design

#### **Previous text:**

Subjects should continue on study treatment until Response Evaluation Criteria in Solid Tumors version 1.1 (RECIST 1.1) defined progression or until a treatment discontinuation criterion is met. There is no maximum duration of treatment as subjects may continue to receive investigational product beyond RECIST 1.1 defined progression as long as they are continuing to show clinical benefit, as judged by the investigator.

Subjects on the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291 80mg, once daily.

#### **Revised text:**

Subjects should continue on study treatment until Response Evaluation Criteria in Solid Tumors version 1.1 (RECIST 1.1) defined progression or until a treatment discontinuation criterion is met. There is no maximum duration of treatment as subjects may continue to receive ~~investigational product~~ **randomized treatment** beyond RECIST 1.1 defined progression as long as they are continuing to show clinical benefit, as judged by the investigator.

Subjects on the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291 80mg, once daily.

**If a subject has been deemed to have objective disease progression according to Investigator tumour assessment according to RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subjects' best interests, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or**



**Pemetrexed maintenance monotherapy, sites are to submit the next scheduled tumour assessment for central imaging review according to Table 2.**

**Reason for Amendment:**

Clarification that subjects with objective disease progression that is not initially confirmed by independent central imaging review can continue with scheduled RECIST assessments until disease is confirmed by independent central imaging review.

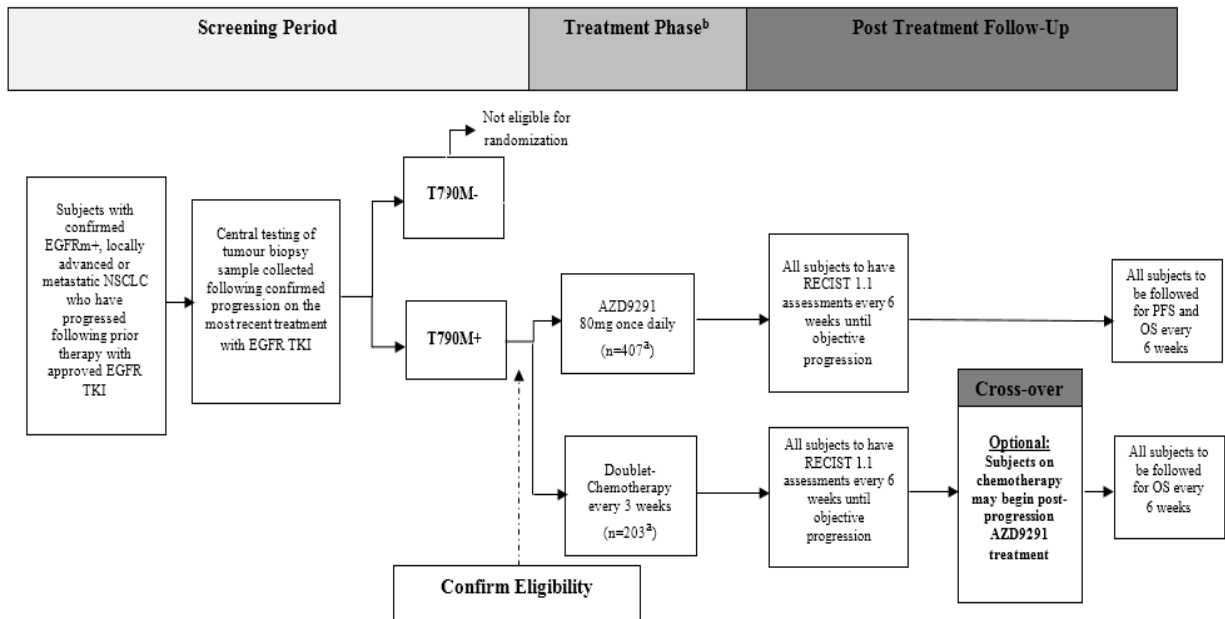
**Change 12**

**Section of protocol affected:**

1.5 Study Design

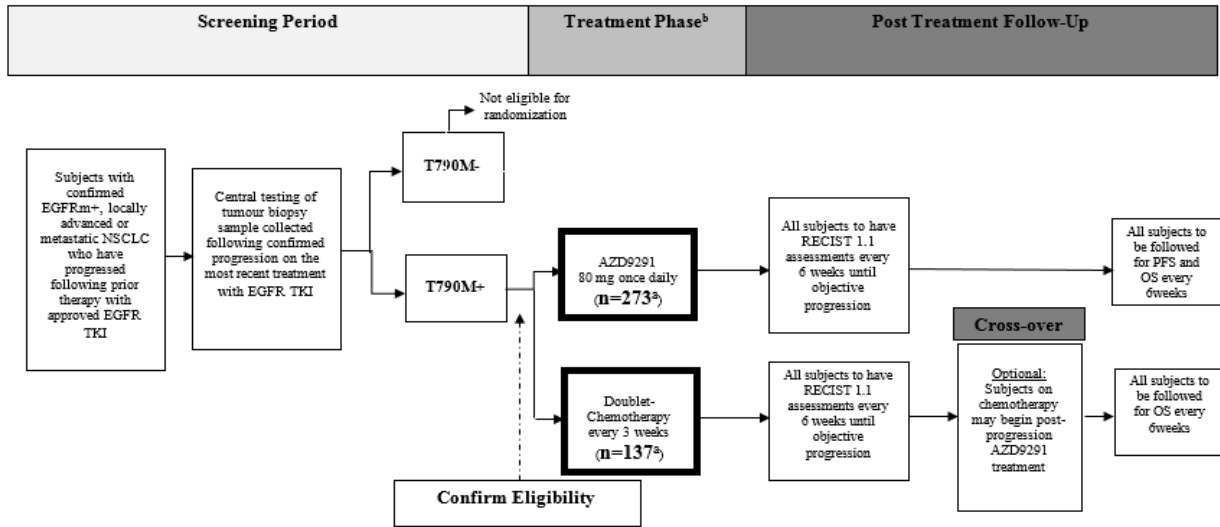
Figure 1

**Previous text:**



- (a) Approximately 610 subjects will be randomized into the trial; from these approximately 407 subjects will be treated with AZD9291 and approximately 203 subjects will be treated with a platinum based doublet-chemotherapy.
- (b) Subjects will be considered in "Treatment phase" at the time AZD9291/Doublet-Chemotherapy (study treatment) is started. Subjects will continue to receive study treatment until objective disease progression (according to RECIST 1.1). Subjects randomized to AZD9291 may continue to receive AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria. Subjects on the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291, 80 mg once daily.

**Revised text:**



- (a) Approximately 610 subjects will be randomized into the trial; from these approximately 407 subjects will be treated with AZD9291 and approximately 203 subjects will be treated with a platinum based doublet-chemotherapy.
- (b) Subjects will be considered in "Treatment phase" at the time AZD9291/Doublet-Chemotherapy (study treatment) is started. Subjects will continue to receive study treatment until objective disease progression (according to RECIST 1.1). Subjects randomized to AZD9291 may continue to receive AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria. Subjects **randomized to on** the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291, 80 mg once daily.

**Reason for Amendment:**

Although the primary endpoint is Progression Free Survival (PFS), the study had been sized to characterize the secondary endpoint of overall survival (OS) and was over-powered for PFS (>95% power to detect a difference in PFS assuming the true hazard ratio is 0.67). Due to the introduction of crossover, the interpretation of OS will be compromised and therefore, the study has been re-sized to characterise PFS, which has resulted in a sample size reduction. The study now has 90% power to detect the original hypothesised treatment effect of PFS hazard ratio of 0.67.

**Change 13**

**Section of protocol affected:**

Section 3.1 Inclusion criteria # 10

**Previous text:**

10. At least one lesion, not previously irradiated and not chosen for biopsy during the study screening period, that can be accurately measured at baseline as  $\geq 10$ mm in the longest diameter (except lymph nodes which must have short axis  $\geq 15$ mm) with computerised

tomography (CT) or magnetic resonance imaging (MRI) which is suitable for accurate repeated measurements.

**Revised text:**

10. At least one lesion not previously irradiated and not chosen for biopsy during the study screening period, that can be accurately measured at baseline as  $\geq 10\text{mm}$  in the longest diameter (except lymph nodes which must have short axis  $\geq 15\text{mm}$ ) with computerised tomography (CT) or magnetic resonance imaging (MRI) which is suitable for accurate repeated measurements. **If only one measurable lesion exists, it is acceptable to be used as long as it has not been previously irradiated, and baseline tumour assessment scans are done at least 14 days after the screening biopsy is performed.**

**Reason for Amendment:**

Clarification on the situation of one lesion being used as site of biopsy and as a target lesion for RECIST 1.1 assessments.

**Change 14**

**Section of protocol affected:**

Section 3.3 Subject screening and randomization

**Previous text:**

If a subject is re-screened, a new E-code will always be assigned. Any repeated tests and/or procedures will be performed as per documented local standards. Subjects will reconfirm their consent to participate in the study by resigning and dating their original consent form(s), next to their initial signature and date. A subject with a valid negative T790M result cannot be re-screened.

**Revised text:**

If a subject is re-screened, a new E-code will always be assigned. Any repeated tests and/or procedures will be performed as per documented local standards. Subjects will reconfirm their consent to participate in the study by resigning and dating their original consent form(s), next to their initial signature and date. A subject with a valid negative T790M result cannot be re-screened.

**The following assessments need to be repeated for subjects who are re-screened and where > 28 days will have lapsed since their last screening period to the date of proposed randomization:**

- **Demography & baseline characteristics**
- **Medical/surgical history**
- **Inclusion/exclusion criteria**

- **Physical examination, including weight**
- **WHO performance status**
- **Pregnancy test (if applicable)**
- **Vital signs (pulse and BP)**
- **Clinical chemistry/haematology/urinalysis**
- **Digital ECG**
- **Echocardiogram/MUGA (if clinically needed)**
- **Tumour assessments (RECIST 1.1)**
- **Concomitant medications & procedures**
- **Adverse events**
- **Anti-cancer treatment**

**Reason for Amendment:**

Providing clear guidance to investigational sites on which assessments are required for rescreening.

### Change 15

#### Sections of protocol affected:

#### 4. STUDY PLAN AND TIMING OF PROCEDURES

#### Previous text:

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> + D1	NA	NA	NA	NA	
Day	-28	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days)	NA	0	±2	±2	±7	±7	±7	±7	NA	+7	±7	±7	<b>SECTION:</b>
Informed consent <sup>c</sup>	X												3.3, 0, 4.2, 4.3
Submit tumour tissue sample for mutation analysis <sup>d</sup>	X												0 & 5.6
Collect/submit optional tumour biopsy for exploratory research & diagnostic development	X								X <sup>u</sup>		X <sup>u</sup>		0 & 5.6
Archival tumour tissue <sup>e</sup>	X												5.6
Demography & baseline characteristics	X												0
Medical/surgical history	X												0
Inclusion/exclusion criteria	X												3

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section	
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> + D1	NA	NA	NA	NA		
Day	-28	1	8	15	22	43	64-106	127+	NA	NA	NA	NA		
Window (days)	NA	0	±2	±2	±7	±7	±7	±7	NA	+7	±7	±7	SECTION:	
Physical examination, including weight	X	X <sup>f</sup>			X	X	X	X	X	(X) <sup>w</sup>			5.2.3, 5.2.6.1	
Height	X												5.2.6.1	
WHO Performance status	X	X			X	X	X	X	X		X	X	0	
Pregnancy test (pre-menaopausal females only)	X												5.2.1	
Ophthalmologic assessment	X	← as clinically indicated →											5.2.7.1	
Plasma sample for ctDNA <sup>m</sup> and blood borne biomarkers	X <sup>h</sup>	X	X	X	X	X	X	X	← every 6 weeks in line with RECIST assessments <sup>i</sup> →				5.6.2	
Vital signs (pulse and BP) <sup>m</sup>	X	X	X	X	X	X	X	X	X	(X) <sup>w</sup>			5.2.6	
Clinical chemistry/ Haematology/Urinalysis <sup>m</sup>	X	X <sup>f</sup>	X	X	X	X	X	X	X	(X) <sup>w</sup>			5.2.1	
PK blood sample (including metabolites)		X				X	X C5 only	X <sup>v</sup>					5.4	
Digital ECG <sup>g</sup>	X	X	X	X	X	X	X	X	X	(X) <sup>w</sup>			5.2.4	
Echocardiogram/MUGA (for LVEF)	X		← every 12 weeks (± 1 week) relative to randomization →								(X) <sup>w</sup>			5.2.5

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> + D1	NA	NA	NA	NA	
Day	-28	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days)	NA	0	±2	±2	±7	±7	±7	±7	NA	+7	±7	±7	SECTION:
Optional genetic consent and sample	X <sup>j</sup>												5.5
Optional CSF sample					X (once only) <sup>k</sup>								5.4.4
Tumour assessments <sup>l</sup> (RECIST v1.1)	X	← every 6 weeks (± 1 week) relative to randomization until disease progression →										0, 4.2, 4.3.3, 5.1.1	
EORTC QLQ-C30 and EQ-5D-5L (by e-device)		X <sup>m</sup>	← every 6 weeks (± 1 week) relative to randomization →					X		X <sup>n</sup>	X <sup>n</sup>	5.3.2	
EORTC QLQ LC13 (by e-device)		X <sup>m</sup>	← weekly (± 2 days) relative to randomization →		← every 3 weeks (± 3 days) relative to randomization →			X		X <sup>o</sup>	X <sup>o</sup>	5.3.2	
PRO-CTCAE (by e-device) <sup>p</sup>		X <sup>m</sup>	← weekly (± 2 days) for first 18 weeks of treatment →				X <sup>q</sup>	X		X <sup>o</sup>	X <sup>o</sup>	5.3.2	
Healthcare Resource Use		← asked for at every visit →										5.3.2.5	
IVRS/TWRS	X	X			X	X	X	X <sup>b</sup>	X				3.3, 3.5
Dispense study medication		X			X	X	X	X <sup>b</sup>					3.3
Dose with AZD9291		← Daily dosing →											7.1
Concomitant medication & procedures		← →										7.7	
Adverse events		← →										X <sup>r</sup>	6.3 & 6.4

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b</sup> + D1	NA	NA	NA	NA	
Day	-28	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days)	NA	0	±2	±2	±7	±7	±7	±7	NA	+7	± 7	± 7	<b>SECTION:</b>
Survival Status												X <sup>s</sup>	4.3.4
Anti-cancer treatment	X										X	X <sup>s</sup>	4.3
Subsequent response / progression data												X <sup>t</sup>	<b>Error! Reference source not found.</b>

- a A cycle is defined as 21-day treatment period
- b Visit schedule changes after Cycle 7 Day 1 from every 21 days (3 weeks) to every 42 days (6 weeks)
- c Consent may be taken prior to 28-day window if required. Screening period will then start with first study-related assessment, excluding the collection of the tumour tissue sample for central mutation analysis.
- d Taken following progression on the latest line of therapy. The collection of this tumour tissue sample for central mutation analysis is not included in the 28-day screening period.
- e Archival tumour sample only to be submitted after T790M positive status confirmed by central testing. Not required for T790M negative patients
- f If assessments are not done at Visit 2, but have been done at Visit 1 and within 14 day window prior to starting study treatment, with no change in condition and no clinical indication to do so, they do not have to be repeated on Visit 2 (except for fasting glucose).
- g There is a potential to move from centrally reviewed to locally reviewed ECGs upon review of QT data of approximately 100 subjects
- h To be taken at the same time as the screening biopsy is taken or prior to mutation screening. All screening plasma samples required by AstraZeneca, regardless of the outcome of the mutation screening
- i Collect every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation in absence of disease progression). If patient discontinues from study, please collect a sample at treatment discontinuation and at Progression follow-up
- j If for any reason the sample is not drawn prior to randomization it may be taken at any visit until the last study visit
- k To be obtained at one time point at any time from Cycle 2 Day 1 onwards



- l At least one lesion, not previously irradiated and not chosen for biopsy during the study-screening period, that can be accurately measured. If only one lesion exists, the visit window may be extended beyond 28 days based on clinical judgement, for the screening biopsy, however the REIST assessment must be performed within 28 days of the start of randomized treatment.
- m To be completed pre-dose
- n Assess every 6 weeks ( $\pm$  1 week) relative to randomization until end of study (including survival follow-up period) and at the time of progression
- o Assess every 3 weeks ( $\pm$  3 days) relative to randomization until end of study (including survival follow-up period) and at the time of progression
- p PRO-CTCAE will only be administered in those countries where a linguistically validated version exists
- q Assessed at Cycle 7 Day 1 then every 3 weeks ( $\pm$  3 days) relative to randomization thereafter until end of study (including survival follow-up period) and at the time of progression
- r Following AZD9291 discontinuation, SAEs considered related to study procedures should continue to be collected until disease progression
- s Survival status including anti-cancer treatment to be performed every 6 weeks (relative to randomization) following disease progression or withdrawal from treatment. [Note: Additional survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis.]
- t Record subsequent response/progression data every 6 weeks until first confirmed disease progression on a subsequent treatment
- u Discontinuation biopsy can be taken at discontinuation or progression, whichever comes first
- v After Cycle 7, every other cycle up to and including Cycle 13
- w A 28-day follow-up assessment will be required if on treatment assessment was abnormal at treatment discontinuation.

**Revised Text:**

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b+</sup> D1	NA	NA	NA	NA	
Day	-28 to 1	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	0	±2	±2	±7	±7	±7	±7	NA 0	+7	±7	±7	SECTION:
Informed consent <sup>c</sup>	X												3.3, 0, 4.1, 4.2, 4.3
Submit tumour tissue sample for mutation analysis <sup>d</sup>	X												0 4.1 & 5.6
Collect/submit optional tumour biopsy for exploratory research & diagnostic development	X								X <sup>u</sup>		X <sup>u</sup>		0 4.1 & 5.6
Archival tumour tissue <sup>e</sup>	X												5.6
Demography & baseline characteristics	X												0 4.1
Medical/surgical history	X												0 4.1
Inclusion/exclusion criteria	X												3
Physical examination, including weight <sup>m</sup>	X	X <sup>f</sup>			X	X	X	X	X	{X} <sup>w</sup>			5.2.3, 5.2.6.1

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrolment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section	
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b+</sup> D1	NA	NA	NA	NA		
Day	-28 to 1	1	8	15	22	43	64-106	127+	NA	NA	NA	NA		
Window (days) <sup>y</sup>	NA	0	±2	±2	±7	±7	±7	±7	NA 0	+7	±7	±7	SECTION:	
Height	X												5.2.6.1	
WHO Performance status <sup>m</sup>	X	X			X	X	X	X	X		X	X	0 4.1	
Pregnancy test (pre-menopausal females only)	X												5.2.1	
Ophthalmologic assessment	X	← as clinically indicated →											5.2.7.1	
Plasma sample for ctDNA <sup>m</sup> and blood borne biomarkers	X <sup>h</sup>	X	X	X	X	X	X	X	← every 6 weeks in line with RECIST assessments <sup>i</sup> →				5.6.2	
Vital signs (pulse and BP) <sup>m</sup>	X	X	X	X	X	X	X	X	X	(X) <sup>w</sup>			<del>6.2.6</del> 5.2.6	
Clinical chemistry/ Haematology/Urinalysis <sup>m</sup>	X	X <sup>f</sup>	X	X	X	X	X	X	X	(X) <sup>w</sup>			5.2.1	
PK blood sample (including metabolites)		X				X	X C5 only	X <sup>v</sup>					5.4	
Digital ECG <sup>g</sup>	X	X	X	X	X	X	X	X	X	(X) <sup>w</sup>			5.2.4	
Echocardiogram/MUGA (for LVEF)	X		← every 12 weeks (± 1 week) relative to randomization →								(X) <sup>w</sup>			5.2.5

**Table 1 Study Plan for AZD9291 Subjects**

Visit	Screening/ Enrollment	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+		28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day		C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b+</sup> D1	NA	NA	NA	NA	
Day	-28 to 1	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	0	±2	±2	±7	±7	±7	±7	NA 0	+7	±7	±7	SECTION:
Optional genetic consent and sample	X <sup>j</sup>												5.5
Optional CSF sample					X (once only) <sup>k</sup>								5.4.4
Tumour assessments <sup>l</sup> (RECIST v1.1)	X	← every 6 weeks (± 1 week) relative to randomization until disease progression →											0 4.1, 4.2, 4.3.3, 5.1.1, 5.1.2
EORTC QLQ-C30 and EQ-5D-5L (by e-device) <sup>x</sup>		X <sup>m</sup>	← every 6 weeks (± 1 week) relative to randomization →					X			X <sup>n</sup>	X <sup>n</sup>	5.3.2
EORTC QLQ LC13 (by e-device) <sup>x</sup>		X <sup>m</sup>	← weekly (± 2 days) relative to randomization →		← every 3 weeks (± 3 days) relative to randomization →				X		X <sup>o</sup>	X <sup>o</sup>	5.3.2
PRO-CTCAE (by e-device) <sup>p, x</sup>		X <sup>m</sup>	← weekly (± 2 days) for first 18 weeks of treatment →					X <sup>q</sup>	X		X <sup>o</sup>	X <sup>o</sup>	5.3.2
Healthcare Resource Use		← asked for at every visit →											5.3.2.5
IVRS/IWRS	X	X			X	X	X	X <sup>b</sup>	X				3.3, 3.5
Dispense study medication		X			X	X	X	X <sup>b</sup>					3.3
Dose with AZD9291		← Daily dosing →											7.1



- g There is a potential to move from centrally reviewed to locally reviewed ECGs upon review of QT data of approximately 100 subjects
- h To be taken **prior to receiving the central T790M mutation result. at the same time as the screening biopsy is taken or prior to mutation screening.** All screening plasma samples **are** required by AstraZeneca, regardless of the outcome of the mutation screening.
- i Collect every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation in absence of disease progression). If patient discontinues from study, please collect a sample at treatment discontinuation and at Progression follow-up
- j If for any reason the sample is not drawn prior to randomization it may be taken at any visit until the last study visit
- k To be obtained at one time point at any time from Cycle 2 Day 1 onwards
- l At least one lesion, not previously irradiated ~~and not chosen for biopsy during the study screening period,~~ that can be accurately measured. ~~If only one lesion exists, the visit window may be extended beyond 28 days based on clinical judgement for the screening biopsy, however the REIST assessment must be performed within 28 days of the start of randomized treatment.~~
- m To be completed pre-dose
- n Assess every 6 weeks ( $\pm 1$  week) relative to **the date of** randomization until end of study (including survival follow-up period) and at the time of progression.
- o Assess every 3 weeks ( $\pm 3$  days) relative to **the date of** randomization until end of study (including survival follow-up period) and at the time of progression.
- p PRO-CTCAE will only be administered in those ~~countries~~ **languages** where a linguistically validated version exists.
- q Assessed at Cycle 7 Day 1 then every 3 weeks ( $\pm 3$  days) relative to **the date of** randomization thereafter until end of study (including survival follow-up period) and at the time of progression.
- r Following AZD9291 discontinuation, SAEs considered related to study procedures should continue to be collected until disease progression.
- s Survival status including anti-cancer treatment to be performed every 6 weeks (relative to randomization) following disease progression or withdrawal from treatment. [Note: Additional survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis.]
- t Record subsequent response/progression data every 6 weeks until first confirmed disease progression on a subsequent treatment.
- u Discontinuation biopsy can be taken at discontinuation or progression, whichever comes first.
- v After Cycle 7, every other cycle up to and including Cycle 13.
- w A 28-day follow-up assessment will be required if on treatment assessment was abnormal at treatment discontinuation.
- x **ePRO LogPads must be assigned to subjects only on the day of randomization; baseline ePROs should be completed by subjects prior to dosing, when they are still in the clinic on the day of randomization, to ensure these are done properly.**
- y **Visit windows are always calculated in relation to Cycle 1, Day 1.**

### **Reason for Amendment:**

To provide clarification of study plan, especially in regards to processes around patient visits and assessments.

### Change 16

#### Sections of protocol affected:

#### 4. STUDY PLAN AND TIMING OF PROCEDURES

#### Previous text:

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrolment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)							Treatment Discontinuation	Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	28-day follow-up		Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day			C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b+</sup> D1	NA	NA	NA	NA	
Day	-28	-7	1	8	15	22	43	64-	127+	NA	NA	NA	NA	
Window (days)	NA		±7	±2	±2	±7	±7	±7	±7	NA	+7	±7	±7	<b>SECTION:</b>
Informed consent <sup>c</sup>	X													3.3, 0, 4.2, 4.3
Submit tumour tissue sample for mutation analysis <sup>d</sup>	X													0 & 5.6
Collect and submit optional tumour biopsy for exploratory research and diagnostic development	X									X <sup>u</sup>		X <sup>u</sup>		0 & 5.6
Archival tumour tissue <sup>e</sup>	X													5.6

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrollment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section
	1		2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up	
Cycle <sup>a</sup> / Day			C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b+</sup> D1	NA	NA	NA	NA	
Day	-28	-7	1	8	15	22	43	64-	127+	NA	NA	NA	NA	
Window (days)	NA		±7	±2	±2	±7	±7	±7	±7	NA	+7	±7	±7	<b>SECTION:</b>
Demography & baseline characteristics	X													0
Medical/surgical history	X													0
Inclusion/exclusion criteria	X													3
Physical examination, including weight	X		X <sup>g</sup>			X	X	X	X <sup>v</sup>	X	(X) <sup>v</sup>			5.2.3, 5.2.6.1
Height	X													5.2.6.1
WHO Performance status	X		X			X	X	X	X	X		X	X	0
Pregnancy test (pre-menopausal females only)	X													5.2.1
Ophthalmologic assessment	X		← as clinically indicated →											5.2.7.1
Vital signs (pulse and BP) <sup>g</sup>	X		X	X	X	X	X	X	X	X	(X) <sup>v</sup>			5.2.6



**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrollment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day			C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b+</sup> D1	NA	NA	NA	NA	
Day	-28	-7	1	8	15	22	43	64-	127+	NA	NA	NA	NA	
Window (days)	NA		±7	±2	±2	±7	±7	±7	±7	NA	+7	±7	±7	<b>SECTION:</b>
Clinical chemistry/ Haematology/Urinalysis <sup>g</sup>	X <sup>m</sup>		X	X	X	X	X	X	X <sup>v</sup>	X	(X) <sup>v</sup>			5.2.1
Plasma sample for ctDNA <sup>m</sup> and blood borne biomarkers	X <sup>h</sup>		X	X	X	X	X	X	← every 6 weeks in line with RECIST assessments →				5.6.2	
Digital ECG <sup>k</sup>	X		X	X	X	X	X	X	X <sup>v</sup>	X	(X) <sup>v</sup>			5.2.4
Echocardiogram/MUGA (for LVEF)	X		← every 12 weeks (± 1 week) relative to randomization →									(X) <sup>v</sup>		5.2.5
Optional genetic consent and sample	X <sup>j</sup>													5.5
Tumour assessments (RECIST v1.1) <sup>l</sup>	X		← every 6 weeks (± 1 week) relative to randomization until disease progression →										0, 4.2, 4.3.3, 5.1.1, 5.1.2	
EORTC QLQ-C30 and EQ-5D-5L (by e-device)		X	← every 6 weeks (± 1 week) relative to randomization →							X		X <sup>n</sup>	X <sup>n</sup>	5.3.2
EORTC QLQ LC13 (by e-device)		X	← weekly (± 2 days) relative to randomization →			← every 3 weeks (± 3 days) relative to randomization →				X		X <sup>o</sup>	X <sup>o</sup>	5.3.2

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrollment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section	
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up			
Cycle <sup>a</sup> / Day			C1 D1	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b+</sup> D1	NA	NA	NA	NA		
Day	-28	-7	1	8	15	22	43	64-	127+	NA	NA	NA	NA		
Window (days)	NA		±7	±2	±2	±7	±7	±7	±7	NA	+7	±7	±7	<b>SECTION:</b>	
PRO-CTCAE (by e-device) <sup>p</sup>		X		← weekly (± 2 days) for first 18 weeks of treatment →					X <sup>q</sup>	X		X <sup>o</sup>	X <sup>o</sup>	5.3.2	
Healthcare Resource Use			← asked for at every visit →											5.3.2.5	
IVRS/IWRS	X	X								X				3.3, 3.5, 7.2	
Folic Acid administration (pre-treatment)			5-7d prior to 1 <sup>st</sup> infusion	← Daily during treatment period →											4.2
Vitamin B12 (pre-treatment)			Within 7d prior to 1 <sup>st</sup> infusion	← Every 9 weeks during treatment period →											4.2
Corticosteroid administration (pre-treatment)			← On the day prior to, on the day, and on the day after infusion →											4.2	
Platinum-based Doublet Chemotherapy			X <sup>f</sup>			X	X	X						3.3, 7.2	



- e Archival tumour sample only to be submitted after T790M positive status confirmed by central testing. Not required for T790M negative patients
- f Chemotherapy may start within 1 week after randomization to allow Vitamin B12, Folic acid and corticosteroid treatment, as well as any other assessments for this visit, with the exception of the ePROs, which must be assigned to the patient on the date of randomization
- g If assessments are not done at Visit 2, but have been done at Visit 1 and within 14 day window prior to starting study treatment, with no change in condition and no clinical indication to do so, they do not have to be repeated on Visit 2 (Except for fasting glucose).
- h To be taken at the same time as the screening biopsy is taken or prior to mutation screening. All screening plasma samples required by AZ, regardless of the outcome of the mutation screening
- i Collect every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation in absence of disease progression). If patient discontinues from study, please collect a sample at treatment discontinuation and at Progression follow-up
- j If for any reason the sample is not drawn prior to randomization it may be taken at any visit until the last study visit
- k There is a potential to move from centrally reviewed to locally reviewed ECGs upon review of QT data of approximately 100 subjects
- l At least one lesion, not previously irradiated and not chosen for biopsy during the study-screening period, that can be accurately measured. If only one lesion exists, the visit window may be extended beyond 28 days based on clinical judgement for the screening biopsy, however the RECIST assessment must be performed within 28 days of the start of randomized treatment. Subjects on the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 confirmed by the Investigator and by independent central imaging review will be given the opportunity to cross-over and begin treatment with AZD9291.
- m To be completed pre-dose for all cycles, baseline ePROs to be completed as close to randomization date as possible.
- n Assess every 6 weeks ( $\pm$  1 week) relative to randomization until end of study (including survival follow-up period) and at the time of progression.
- o Assess every 3 weeks ( $\pm$  3 days) relative to randomization until end of study (including survival follow-up period) and at the time of progression.
- p PRO-CTCAE will only be administered in those countries where a linguistically validated version exists
- q Assessed at Cycle 7 Day 1 then every 3 weeks ( $\pm$  3 days) relative to randomization thereafter until end of study (including survival follow-up period) and at the time of progression
- r Following chemotherapy discontinuation, SAEs considered related to study procedures should continue to be collected until disease progression
- s Survival status including anti-cancer treatment to be performed every 6 weeks (relative to randomization) following disease progression or withdrawal from treatment. Additional survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis
- t Record subsequent response/progression data every 6 weeks until first confirmed disease progression on a subsequent treatment
- u Discontinuation biopsy can be taken at discontinuation or progression, whichever comes first
- v A 28-day follow-up assessment will be required if on treatment assessment was abnormal at treatment discontinuation.

Revised text:

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrolment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day			C1 D1 <sup>f</sup>	C1 D8	C1 D15	C2 D1	C3 D1	C4-6 D1	C7 <sup>b+</sup> D1	NA	NA	NA	NA	
Day	-28 to 1	-7 to 1	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	-7	±70	±2	±2	±7	±7	±7	±7	NA 0	+7	±7	±7	SECTION:
Informed consent <sup>c</sup>	X													3.3, 4.10, 4.2, 4.3
Submit tumour tissue sample for mutation analysis <sup>d</sup>	X													4.10 & 5.6
Collect and submit optional tumour biopsy for exploratory research and diagnostic development	X									X <sup>u</sup>		X <sup>u</sup>		4.10 & 5.6
Archival tumour tissue <sup>e</sup>	X													5.6
Demography & baseline characteristics	X													4.10

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrollment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 <i>DI</i> <sup>f</sup>	C1 <i>D8</i>	C1 <i>D15</i>	C2 <i>D1</i>	C3 <i>D1</i>	C4-6 <i>D1</i>	C7 <sup>b+</sup> <i>D1</i>	NA	NA	NA	NA		
Day	-28 to 1	-7 to 1	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	-7	±70	±2	±2	±7	±7	±7	±7	<del>NA</del> 0	+7	±7	±7	SECTION:
Medical/surgical history	X													4.10
Inclusion/exclusion criteria	X													3
Physical examination, including weight <sup>m</sup>	X	X <sup>g</sup>				X	X	X	X <sup>v</sup>	X	{X} <sup>v</sup>			5.2.3, 5.2.6.1
Height	X													5.2.6.1
WHO Performance status <sup>m</sup>	X	X				X	X	X	X	X		X	X	4.10
Pregnancy test (pre-menopausal females only)	X													5.2.1

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrollment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 <i>D1</i> <sup>f</sup>	C1 <i>D8</i>	C1 <i>D15</i>	C2 <i>D1</i>	C3 <i>D1</i>	C4-6 <i>D1</i>	C7 <sup>b+</sup> <i>D1</i>	NA	NA	NA	NA		
Day	-28 to 1	-7 to 1	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	-7	±70	±2	±2	±7	±7	±7	±7	<b>NA 0</b>	+7	±7	±7	<b>SECTION:</b>
Ophthalmologic assessment	X		← as clinically indicated →											5.2.7.1
Vital signs (pulse and BP) <sup>gm</sup>	X		X	X	X	X	X	X	X	X	{X} <sup>v</sup>			5.2.6
Clinical chemistry/ Haematology/ Urinalysis <sup>gm</sup>	X <sup>m</sup>		X <sup>g</sup>	X	X	X	X	X	X <sup>v</sup>	X	{X} <sup>v</sup>			5.2.1
Plasma sample for ctDNA <sup>m</sup> and blood borne biomarkers	X <sup>h</sup>		X	X	X	X	X	X	← every 6 weeks in line with RECIST assessments <sup>†</sup> →					5.6.2
Digital ECG <sup>k</sup>	X		X	X	X	X	X	X <sup>v</sup>	X	{X} <sup>v</sup>			5.2.4	
Echocardiogram/ MUGA (for LVEF)	X			← every 12 weeks (± 1 week) relative to randomization →							{X} <sup>v</sup>			5.2.4-5.2.5
Optional genetic consent and sample	X <sup>j</sup>													5.5

**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrollment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 <i>DI</i> <sup>f</sup>	C1 <i>D8</i>	C1 <i>D15</i>	C2 <i>D1</i>	C3 <i>D1</i>	C4-6 <i>D1</i>	C7 <sup>b+</sup> <i>D1</i>	NA	NA	NA	NA		
Day	-28 to 1	-7 to 1	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	-7	±70	±2	±2	±7	±7	±7	±7	<b>NA 0</b>	+7	±7	±7	<b>SECTION:</b>
Tumour assessments (RECIST v1.1) <sup>1</sup>	X		← every 6 weeks (± 1 week) relative to randomization until disease progression →											4.10, 4.2, 4.3.3, 5.1.1, 5.1.2
EORTC QLQ-C30 and EQ-5D-5L (by e-device) <sup>w</sup>		X	← every 6 weeks (± 1 week) relative to randomization →					X			X <sup>n</sup>	X <sup>n</sup>	5.3.2	
EORTC QLQ LC13 (by e-device) <sup>w</sup>		X	← weekly (± 2 days) relative to randomization →		← every 3 weeks (± 3 days) relative to randomization →			X			X <sup>o</sup>	X <sup>o</sup>	5.3.2	
PRO-CTCAE (by e-device) <sup>p, w</sup>		X	← weekly (± 2 days) for first 18 weeks of treatment →				X <sup>q</sup>	X			X <sup>o</sup>	X <sup>o</sup>	5.3.2	
Healthcare Resource Use			← asked for at every visit →											5.3.2.5
IVRS/TWRS	X	X								X				3.3, 3.5, 7.2





**Table 2 Study Plan for Platinum-based Doublet-Chemotherapy Subjects**

Visit	Screening/ Enrolment	Randomization	Treatment Period (further treatment cycles as per Cycle 7)								Follow-up Period			For details see Protocol Section
	1	2	3	4	5	6	7-9	10+	Treatment Discontinuation	28-day follow-up	Progression follow-up	Survival follow-up		
Cycle <sup>a</sup> / Day		C1 <i>D1<sup>f</sup></i>	C1 <i>D8</i>	C1 <i>D15</i>	C2 <i>D1</i>	C3 <i>D1</i>	C4-6 <i>D1</i>	C7 <sup>b+</sup> <i>D1</i>	NA	NA	NA	NA		
Day	-28 to 1	-7 to 1	1	8	15	22	43	64-106	127+	NA	NA	NA	NA	
Window (days) <sup>y</sup>	NA	-7	±70	±2	±2	±7	±7	±7	±7	NA 0	+7	±7	±7	SECTION:
Survival Status													X <sup>s</sup>	4.3.4
Anti-cancer treatment	X											X	X <sup>s</sup>	4.2, 4.3
Subsequent response/ progression data													X <sup>t</sup>	<b>5.8Error! Reference source not found.</b>

- a A cycle is defined as 21-day treatment period
- b Visit schedule changes after Cycle 7 Day 1 from every 21 days (3 weeks) to every 42 days (6 weeks). Platinum-based doublet chemotherapy will be administered every 21 days from previous cycle’s day 1. Subjects can continue to receive platinum-based doublet-chemotherapy until ~~matching meeting~~ discontinuation criteria (see section 3.9) or up to a total of 6 cycles or until progression (whichever occurs first). Each cycle treatment may be interrupted for a maximum of 14 days for safety reasons. In case of treatment interruption, other assessments are to be done as originally planned. Subjects whose disease has not progressed after four cycles of platinum-based ~~doublet first-line~~ chemotherapy may receive pemetrexed maintenance therapy.
- c Consent may be taken prior to the 28-day window, if required. ~~The S~~ Screening period will then start with first study-related assessment, **excluding the collection of the tumour tissue sample for central mutation analysis.**
- d Taken following progression on the latest line of therapy. **The collection of this tumour tissue sample for central mutation analysis is not included in the 28-day**

**screening period.**

- e Archival tumour sample only to be submitted after T790M positive status confirmed by central testing. Not required for T790M negative patients.
- f Chemotherapy may start within 1 week after randomization to allow Vitamin B12, Folic acid and corticosteroid treatment, as well as any other assessments for this visit, with the exception of the ePROs, which must be assigned to the **subject patient** on the date of randomization
- g If assessments are not done at Visit 2, but have been done at Visit 1 and within 14 day window prior to starting study treatment, with no change in condition and no clinical indication to do so, they do not have to be repeated on Visit 2 (Except for fasting glucose).
- h To be taken **prior to receiving the central T790M mutation result. at the same time as the screening biopsy is taken or prior to mutation screening.** All screening plasma samples **are** required by AstraZeneca, regardless of the outcome of the mutation screening.
- i Collect every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation in absence of disease progression). If patient discontinues from study, please collect a sample at treatment discontinuation and at Progression follow-up.
- j If for any reason the sample is not drawn prior to randomization, it may be taken at any visit until the last study visit.
- k There is a potential to move from centrally reviewed to locally reviewed ECGs upon review of QT data of approximately 100 subjects.
- l At least one lesion, not previously irradiated ~~and not chosen for biopsy during the study screening period~~, that can be accurately measured. ~~If only one lesion exists, the visit window may be extended beyond 28 days based on clinical judgement for the screening biopsy, however the RECIST assessment must be performed within 28 days of the start of randomized treatment.~~ Subjects on the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 confirmed by the Investigator and by independent central imaging review will be given the opportunity to cross-over and begin treatment with AZD9291 **80mg, once daily. For subjects under consideration for cross-over to AZD9291, scheduled tumour assessments will continue until confirmation of objective radiological disease progression by independent central imaging review.**
- m To be completed pre-dose for all cycles, ~~baseline ePROs to be completed as close to randomization date as possible.~~
- n Assess every 6 weeks ( $\pm$  1 week) relative to **the date of** randomization until end of study (including **Cross-over (if applicable), and/or** survival follow-up period) and at the time of progression.
- o Assess every 3 weeks ( $\pm$  3 days) relative to **the date of** randomization until end of study (including **Cross-over (if applicable), and/or** survival follow-up period) and at the time of progression.
- p PRO-CTCAE will only be administered in those ~~countries~~ **languages** where a linguistically validated version exists.
- q Assessed at Cycle 7 Day 1 then every 3 weeks ( $\pm$  3 days) relative to **the date of** randomization thereafter until end of study (including survival follow-up period) and at the time of progression.
- r Following chemotherapy discontinuation, SAEs considered related to study procedures should continue to be collected until disease progression.
- s Survival status including anti-cancer treatment to be performed every 6 weeks (relative to randomization) following disease progression or withdrawal from treatment. Additional survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis.
- t Record subsequent response/progression data every 6 weeks until first confirmed disease progression on a subsequent treatment.
- u Discontinuation biopsy can be taken at discontinuation or progression, whichever comes first.
- v A 28-day follow-up assessment will be required if ~~an~~ treatment assessment was abnormal at treatment discontinuation.
- w **ePRO LogPads must be assigned to subjects only on the day of randomization; baseline ePROs should be completed prior to dosing, by subjects when they are still in the clinic on the day of randomization, to ensure these are done properly.**
- x **Platinum-based doublet chemotherapy must be administered no less than every 21 days from previous cycle day 1.**
- y **Visit windows are always calculated in relation to cycle 1 Day 1.**

**Reason for Amendment:**

To provide clarification of study plan, especially in regards to processes around patient visits and assessments.



disease progression or withdrawal from treatment. [Note: Additional survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis.]

- i To be completed pre-dose on visit day
- j AZD9291 will be dispensed every 42 days.

**Revised text:**

**Table 3 Study Plan for Subjects Crossing-over to AZD9291**

Visit	Cross-over AZD9291 Treatment Visit	AZD9291 Treatment Discontinuation	Survival follow-up	For details see Protocol Section
Cycle <sup>a</sup> / Day	Each cycle	NA	NA	
Day	NA 1	NA	NA	
Window (days) <sup>j</sup>	± 7	NA-0	± 7	SECTION:
<del>Optional</del> Cross-over Informed Consent <sup>b</sup>	X			3.3, 4.1, 4.2, 4.3
<del>Collect/submit optional tumour biopsy for exploratory research &amp; diagnostic development</del>	<del>X<sup>e</sup></del>	<del>X<sup>e</sup></del>		4.1 & 5.6
Physical examination, including weight <sup>h</sup>	X	X		5.2.3, 5.2.6.1
WHO Performance status <sup>h</sup>	X	X	X	4.1
Vital signs (pulse and BP) <sup>ih</sup>	X	X		5.2.6
Clinical chemistry/ Haematology/Urinalysis <sup>ih</sup>	X	X		5.2.1
Digital ECG <sup>h</sup>	X	X		5.2.4
EORTC QLQ-C30 and EQ-5D-5L (by e-device)	X <sup>dc</sup>	X	X <sup>dc</sup>	5.3.2
EORTC QLQ LC13 (by e-device)	X <sup>ed</sup>	X	X <sup>ed</sup>	5.3.2
PRO-CTCAE (by e-device) <sup>fe</sup>	X <sup>ed</sup>	X	X <sup>ed</sup>	5.3.2
IVRS/IWRS	X	X		3.3, 3.5
Dose with AZD9291 <sup>ji</sup>	X (daily)			7.1
Concomitant medication & procedures	X			7.7
Adverse events	X <sup>gf</sup>			6.3 & 6.4
Survival Status			X <sup>hg</sup>	4.3.4
Anti-cancer treatment	X		X <sup>hg</sup>	4.3

- <sup>a</sup> A cycle **for subjects crossing over to AZD9291** is defined as 42-day treatment period
- <sup>b</sup> ~~Optional~~ Cross-over consent must be given prior to cross-over from platinum doublet-chemotherapy to AZD9291 **treatment**.
- <sup>e</sup> ~~Discontinuation biopsy can be taken at discontinuation or progression, whichever comes first.~~
- <sup>dc</sup> Assess every 6 weeks (± 1 week) relative to **the date of** randomization until end of study (including **post cross-over** survival follow-up period) ~~and at the time of progression.~~
- <sup>ed</sup> Assess every 3 weeks (± 3 days) relative to **the date of** randomization until end of study (including **post cross-over** survival follow-up period) ~~and at the time of progression.~~
- <sup>fe</sup> PRO-CTCAE will only be administered in those ~~countries~~ **languages** where a linguistically validated version exists.

- gf Following AZD9291 ~~platinum-based doublet chemotherapy~~ discontinuation, SAEs considered related to study procedures should continue to be collected until ~~further disease progression~~ **resolution**.
- hg Survival status including anti-cancer treatment to be performed every 6 weeks (relative to **date of** randomization) following **subsequent** disease progression **with cross-over AZD9291 treatment** or withdrawal from treatment. [Note: Additional survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis.]
- ih To be completed pre-dose on **each cross-over AZD9291 treatment** visit day.
- ji AZD9291 will be dispensed every 42 days.
- j **Cross-over visit windows are always calculated in relation to Cycle 1 Day 1 of cross-over AZD9291 treatment.**

### Reason for Amendment:

To provide clarification of study plan, especially in regards to processes around patient visits and assessments.

### Change 18

#### Section of protocol affected:

#### 4.1 Screening period

#### Previous text:

It is recommended the screening assessments be performed in a stepwise process beginning with the confirmation of T790M mutation status as determined by the designated central laboratory. However, screening assessments may be done in parallel to the T790M mutation assessment, as appropriate. Procedures will be performed according to the Study Plan (Table 1 and Table 2). Tumour assessments and other clinical data obtained as standard of care prior to consent may be used for the study, provided the assessments fall within the protocol specified period prior to randomization.

#### Revised text:

It is recommended the screening assessments be performed in a stepwise process beginning with the confirmation of T790M mutation status as determined by the designated central laboratory. However, **certain** screening assessments ~~may~~ **must** be done in parallel to the T790M mutation assessment, as appropriate (**e.g. Baseline ctDNA and blood borne biomarkers plasma samples must be taken before central T790M status result is known**). Procedures will be performed according to the Study Plan (Table 1 or Table 2). Tumour assessments and other clinical data obtained as standard of care prior to consent may be used for the study, provided the assessments fall within the protocol specified period prior to randomization.

### Reason for Amendment:

Clarification

## Change 19

### Section of protocol affected:

#### 4.1 Screening period

### Previous text:

#### **Mandatory screening tumour biopsy sample for mutation analysis:**

Tumour sample must be formalin fixed and paraffin embedded (FFPE) and must be biopsied following progression on the latest line of therapy. Samples may be collected from primary or metastatic tumour deposits. Bone samples (including soft tissue tumoral masses emerging from the bone) cannot be accepted for testing. Sites should ship the FFPE tumour sample to the testing laboratory as soon as it is available. Tissue should be less than 60 days old from date of sectioning to date of testing. Blocks must be provided wherever possible. If this is not possible, a minimum of 6 slides of freshly prepared unstained 5-micron sections from this screening tumour block may be provided. See Section 5.6.

The mandatory screening tumour biopsy must not be taken from a previously irradiated lesion or the lesion(s) selected for Inclusion criterion #10. This biopsy sample is not subject to the 28-day screening window; if tissue is already available from a biopsy taken since documentation of disease progression on the most recent treatment regimen then there is no need for a further biopsy as this sample can be submitted for T790M mutation status. If the first biopsy is not confirmed as T790M mutation positive due to test failure (i.e. an invalid result or invalid run occurred), testing will be repeated and an additional biopsy sample may be requested. If the T790M mutation is not detected in the first biopsy (and the cobas® EGFR Mutation Test indicates a valid result), no additional testing for the subject will be performed for this study and an additional biopsy sample WILL NOT be accepted.

### Revised text:

#### **Mandatory screening tumour biopsy sample for mutation analysis:**

Tumour sample must be formalin fixed and paraffin embedded (FFPE) and must be biopsied following progression on the latest line of therapy. Samples may be collected from primary or metastatic tumour deposits. Bone samples (including soft tissue tumoral masses emerging from the bone) cannot be accepted for testing. Sites should ship the FFPE tumour sample to the testing laboratory as soon as it is available. Tissue should be less than 60 days old from date of sectioning to date of testing. Blocks must be provided wherever possible. If this is not possible, a minimum of 6 slides of freshly prepared unstained 5-micron sections from this screening tumour block may be provided. See Section 5.6.

The mandatory screening tumour biopsy must not be taken from a previously irradiated lesion ~~or the lesion(s) selected for~~ **(please refer to Inclusion criterion #10 for details)**. This biopsy

sample is not subject to the 28-day screening window; if tissue is already available from a biopsy taken since documentation of disease progression on the most recent treatment regimen then there is no need for a further biopsy as this sample can be submitted for T790M mutation status. If the first biopsy is not confirmed as T790M mutation positive due to test failure (i.e. an invalid result or invalid run occurred), testing will be repeated and an additional biopsy sample may be requested. If the T790M mutation is not detected in the first biopsy (and the **cobas® EGFR Mutation Test** indicates a valid result), no additional testing for the subject will be performed for this study and an additional biopsy sample WILL NOT be accepted.

**Reason for Amendment:**

Clarification.

**Change 20**

**Section of protocol affected:**

4.1 Screening period

**Previous text:**

**Plasma for ctDNA and blood borne biomarkers:**

All subjects will be requested to provide two plasma samples at screening regardless of their T790M mutation status. All screening plasma samples should be sent to the AstraZeneca (AZ) appointed Clinical Research Organisation (CRO) for retrospective analysis. See Section 5.6.2.

**Revised text:**

**Plasma for ctDNA and blood borne biomarkers:**

All subjects ~~will be requested~~ **are required** to provide two **baseline** plasma samples **prior to receiving the result of at screening regardless of their T790M mutation status result. These baseline samples are not required to be taken again, if the subject is re-screened.** All screening plasma samples should be sent to the AstraZeneca (AZ) appointed Clinical Research Organisation (CRO) for retrospective analysis. See Section 5.6.2.

**Reason for Amendment:**

Clarification



## **Change 21**

### **Section of protocol affected:**

4.2 Treatment period

### **Previous text:**

#### **For subjects receiving platinum-based doublet-chemotherapy:**

Folic acid will be administered 5-7 days prior to the 1<sup>st</sup> dose, then daily during the treatment period until 21 days post the last dose. Vitamin B12 will be administered within 7 days of first infusion and every 9 weeks during the treatment period. Corticosteroid will be administered on the day prior to, on the day, and on the day after infusion. Subjects may also receive other pre-treatment/ concomitant treatment as recommended by approved label for pemetrexed, carboplatin or cisplatin as clinically indicated by the investigator.

Platinum-based doublet chemotherapy will be administered every 21 days from previous cycle Day 1. Subjects can continue to receive platinum-based doublet-chemotherapy until matching discontinuation criteria (see section 3.9) or up to a total of 6 cycles or until progression (whichever occurs first). Each cycle treatment can be interrupted maximum of 21 days. If cycle treatment is delayed by more than 21 days, subject will be permanently discontinued from doublet-chemotherapy. If appropriate, and according to the approved label use or local practice guidelines, pemetrexed may be continued as maintenance treatment.

For subjects receiving platinum-based doublet-chemotherapy, please follow the study schedule in Table 2.

#### **For subjects who cross-over to AZD9291:**

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will receive AZD9291 80mg, once daily and will follow the assessments as per Table 3. These subjects may continue treatment with AZD9291 even after disease progression, as long as they are continuing to show clinical benefit, as judged by the investigator.

Subjects who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be eligible to cross-over to AZD9291. They will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.

### **Revised text:**

#### **For subjects receiving platinum-based doublet-chemotherapy:**

Folic acid will be administered 5-7 days prior to the 1<sup>st</sup> dose, then daily during the treatment period until 21 days post the last dose. Vitamin B12 will be administered within 7 days of first

infusion and every 9 weeks during the treatment period. Corticosteroid will be administered on the day prior to, on the day, and on the day after infusion. Subjects may also receive other pre-treatment/ concomitant treatment as recommended by approved label for pemetrexed, carboplatin or cisplatin as clinically indicated by the investigator.

Platinum-based doublet chemotherapy will be administered every 21 days from previous cycle Day 1. Subjects can continue to receive platinum-based doublet-chemotherapy until matching discontinuation criteria (see section 3.9) or up to a total of 6 cycles ~~or until progression (whichever occurs first)~~. Each cycle treatment can be interrupted maximum of 21 days. If cycle treatment is delayed by more than 21 days, subject will be permanently discontinued from doublet-chemotherapy. If appropriate, and according to the approved label use or local practice guidelines, pemetrexed may be continued as maintenance treatment.

**Subjects who progress according to RECIST 1.1 criteria prior to completion of initial doublet chemotherapy treatment or during pemetrexed maintenance monotherapy may continue with chemotherapy treatment as long as they ~~are continuing to show clinical benefit, as judged by the investigator.~~**

For subjects receiving platinum-based doublet-chemotherapy, please follow the study schedule in Table 2.

**For subjects who cross-over to AZD9291:**

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will **be eligible to** receive AZD9291 80mg, once daily, and will follow the assessments as per Table 3.

**If a subject has been deemed to have objective disease progression according to Investigator tumour assessment according to RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subjects' best interests, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy, sites are to submit the next scheduled tumour assessment for central imaging review according to Table 2.**

**In addition, the following criteria must be met for a subject to cross-over to AZD9291:**

- **No intervening systemic anti-cancer therapy following discontinuation of randomized chemotherapy treatment**
- **At least a 14 day washout period between last dose of randomized chemotherapy and/or associated supportive treatments (i.e. corticosteroids, radiation), and starting cross-over AZD9291 treatment.**

- **Any unresolved toxicities from prior therapy should be controlled, and be no greater than CTCAE grade 1 (with the exception of alopecia which may be grade 2) at the time of starting AZD9291 treatment.**

**These subjects may continue treatment with AZD9291 as long as they ~~are continuing to~~ show clinical benefit, as judged by the investigator.**

~~If sSubjects are who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be eligible to cross-over to AZD9291, they will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.~~

**Reason for Amendment:**

Clarification

**Change 22**

**Section of protocol affected:**

**4.3.1 Discontinuation visit**

**Previous text:**

A Discontinuation Visit will be performed at the time investigational product is permanently stopped. Refer to Table 1, Table 2 or Table 3 for details.

**Revised text:**

A Discontinuation Visit will be performed at the time **randomized treatment** ~~investigational product~~ is permanently stopped. **A second Discontinuation Visit will be performed for those subjects that stop AZD9291 in the Cross-over Treatment Phase.**

Refer to Table 1, Table 2 or Table 3 for details.

**Reason for Amendment:**

Clarification.

## Change 23

### Section of protocol affected:

#### 4.3.3 Progression follow-up

##### Previous text:

Subjects who discontinue study medication for reasons other than objective disease progression will continue RECIST 1.1 assessments every 6 weeks (relative to date of randomization) for objective progression. In addition to RECIST 1.1 assessments, the following assessments are also required during this follow-up period as detailed in the Study Plan Table 1, Table 2 or Table 3.

- EORTC QLQ-C30 and EQ-5D-5L every 6 weeks and at the time of progression.
- EORTC QLQ LC13 and PRO-CTCAE every 3 weeks and at the time of progression.
- Plasma for ctDNA collected every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation if this is in absence of progression)
- Adverse event collection detailed in Section 6.3
- Anti-cancer therapy and surgery collected every 6 weeks
- WHO performance status should also be collected at other site visits that the subject attends, if appropriate site staff are available to collect such information. In addition, where possible, please provide WHO performance status when information on subsequent anticancer therapy is provided.
- Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will receive AZD9291 80mg, once daily and will follow the assessments as per Table 3. These subjects may continue treatment with AZD9291 even after disease progression, as long as they are continuing to show clinical benefit, as judged by the investigator.
- Subjects who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be eligible to cross-over to AZD9291. They will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.

##### Revised text:

Subjects who discontinue study medication for reasons other than objective disease progression will continue RECIST 1.1 assessments every 6 weeks (relative to date of randomization) for objective progression.

**If a subject has been deemed to have objective disease progression according to Investigator tumour assessment according to RECIST 1.1, but is not confirmed by**

**independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subjects' best interests, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy, sites are to submit the next scheduled tumour assessment for central imaging review according to Table 2.**

In addition to RECIST 1.1 assessments, the following assessments are also required during this follow-up period as detailed in the Study Plan Table 1, Table 2 or Table 3.

- EORTC QLQ-C30 and EQ-5D-5L every 6 weeks and at the time of progression.
- EORTC QLQ LC13 and PRO-CTCAE every 3 weeks and at the time of progression.
- Plasma for ctDNA collected every 6 weeks up to and including progression (corresponding with the RECIST assessments – and continuing after treatment discontinuation if this is in absence of progression)
- Adverse event collection detailed in Section 6.3
- Anti-cancer therapy and surgery collected every 6 weeks
- WHO performance status should also be collected at other site visits that the subject attends, if appropriate site staff are available to collect such information. In addition, where possible, please provide WHO performance status when information on subsequent anticancer therapy is provided.
- Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will receive AZD9291 80mg, once daily and will follow the assessments as per Table 3. These subjects may continue treatment with AZD9291 ~~even after disease progression~~, as long as they ~~are continuing to~~ show clinical benefit, as judged by the investigator.
- ~~Subjects who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be~~ **who are not** eligible to cross-over to AZD9291, ~~They~~ will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.

**Reason for Amendment:**

Clarification.

## **Change 24**

### **Section of protocol affected:**

#### **5.1.1 RECIST 1.1**

##### **Previous text:**

The methods used at baseline for assessment of tumour burden [CT or MRI scans of chest and abdomen (including liver and adrenal glands)] must be used at each subsequent follow-up assessment. Any other areas of disease involvement should be additionally investigated based on the signs and symptoms of individual subjects. The baseline assessment should be performed within 28 days of the start of randomized treatment. Subsequent assessments are to be performed every 6 weeks relative to randomization until objective disease progression. It is important to follow the assessment schedule as closely as possible. If scans are performed outside of the scheduled visit ( $\pm 1$  week window interval) and the subject has not progressed, every attempt should be made to perform the subsequent scans at their scheduled time points. Any other sites at which new disease is suspected should also be appropriately imaged.

##### **Revised text:**

The methods used at baseline for assessment of tumour burden [CT or MRI scans of chest and abdomen (including liver and adrenal glands)] must be used at each subsequent follow-up assessment. Any other areas of disease involvement should be additionally investigated based on the signs and symptoms of individual subjects. The baseline assessment should be performed within 28 days of the start of randomized treatment. Subsequent assessments are to be performed every 6 weeks relative to randomization until objective disease progression. It is important to follow the assessment schedule as closely as possible. If scans are performed outside of the scheduled visit ( $\pm 1$  week window interval) and the subject has not progressed, every attempt should be made to perform the subsequent scans at their scheduled time points. Any other sites at which new disease is suspected should also be appropriately imaged.

**For subjects under consideration for cross-over to AZD9291, scheduled tumour assessments will continue until confirmation of objective radiological disease progression by independent central imaging review according to RECIST 1.1, if even after investigator has deemed objective disease progression.**

##### **Reason for Amendment:**

Clarification that tumour assessment may continue after investigator confirmed objective disease progression according to RECIST 1.1

## Change 25

### Section of protocol affected:

#### 7.7 Concomitant and other treatments

#### Previous text:

Pre-medication will be allowed after, but not before the first dose of study treatment. This includes management of diarrhoea, nausea and vomiting.

#### Revised text:

Pre-medication will be allowed **for subjects randomized to the doublet chemotherapy arm. It is also be allowed for subjects randomized to AZD9291**, after, but not before the first dose of **AZD9291** study treatment. This includes management of diarrhoea, nausea and vomiting.

#### Reason for Amendment:

Clarification that pre-medication is allowed prior to C1D1 for subjects randomized to the doublet chemotherapy arm.

## Change 26

### Section of protocol affected:

#### 7.7 Concomitant and other treatments

#### Previous text:

Rescue/Supportive Medication/Class of drug:	Usage:
Pre-medication will be allowed after, but not before the first dose of study treatment.	To be administered as directed by the investigator. This includes management of diarrhoea, nausea and vomiting.

#### Revised text:

Rescue/Supportive Medication/Class of drug:	Usage:
Pre-medication will be allowed <b>for subjects randomized to the doublet chemotherapy arm. It is also be allowed for subjects randomized to AZD9291</b> , after, but not before the first dose of <b>AZD9291</b> study treatment.	To be administered as directed by the investigator. This includes management of diarrhoea, nausea and vomiting.

**Reason for Amendment:**

Clarification that pre-medication is allowed at any time for subjects randomized to the chemotherapy arm.

**Change 27**

**Section of protocol affected:**

8.1 Statistical considerations

**Previous text:**

The primary analysis will be performed when approximately 400 PFS events have occurred, so that the PFS data are approximately 65% mature. Three analyses of OS are planned; two interim analyses and an optional final analysis. The first interim analysis of overall survival will be conducted at the time of the primary analysis of PFS and the second interim analysis will be conducted when the OS data are approximately 50% mature (approximately 305 death events). A final analysis of overall survival may be performed when the OS data are approximately 70% mature (approximately 430 death events).

**Revised text:**

The primary analysis will be performed when approximately ~~400~~ **295** PFS events have occurred, so that the PFS data are approximately ~~65-70%~~ mature. Three analyses of OS are planned; two interim analyses and an optional final analysis. The first interim analysis of overall survival will be conducted at the time of the primary analysis of PFS and the second interim analysis will be conducted when the OS data are approximately 50% mature (approximately ~~305~~ **205** death events). A final analysis of overall survival may be performed when the OS data are approximately 70% mature (approximately ~~430~~ **287** death events).

**Reason for Amendment:**

Although the primary endpoint is Progression Free Survival (PFS), the study had been sized to characterize the secondary endpoint of overall survival (OS) and was over-powered for PFS (>95% power to detect a difference in PFS assuming the true hazard ratio is 0.67). Due to the introduction of crossover, the interpretation of OS will be compromised and therefore, the study has been re-sized to characterise PFS, which has resulted in a sample size reduction. The study now has 90% power to detect the original hypothesised treatment effect of PFS hazard ratio of 0.67.



## Change 28

### Section of protocol affected:

#### 8.2 Sample size estimate

#### Previous text:

PFS is the primary endpoint for this study. The study has been sized to also characterize the overall survival benefit of AZD9291. Approximately 610 subjects will be randomized in a 2:1 ratio (AZD9291: chemotherapy) to this study.

The primary analysis of PFS will occur when approximately 400 progression events have been observed. With 400 progression events, the study will provide >95% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were HR 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed.

Assuming 12 months non-linear recruitment, 400 PFS events are expected to occur approximately 20 months after the first subject is enrolled in the study.

If the true OS hazard ratio for the comparison of AZD9291 versus chemotherapy is 0.75, 427 death events will provide approximately 80% power to demonstrate a statistically significant difference in OS at 5% 2-sided significance level. For example, this translates to an approximate 5-6 month improvement in median OS over an assumed 16-19 month median OS on chemotherapy, assuming OS is exponentially distributed.

In order to randomize 610 subjects (assuming a 10% screen failure rate), 678 (55%) (T790M+) subjects will need to be enrolled. With a 20% attrition rate, and 1232 subjects with known T790M status, approximately 1540 subjects will need to be screened.

#### Revised text:

PFS is the primary endpoint for this study. ~~The study has been sized to also characterise the overall survival (OS).~~ Approximately ~~610~~ **410** subjects will be randomized globally in a 2:1 ratio (AZD9291: platinum-based doublet chemotherapy) in this study.

The primary analysis of PFS will occur when approximately ~~400~~ **295** progression events have been observed **out of the 410 globally randomized subjects**. With ~~400~~ **295** progression events, the study will have ~~>95%~~ **90%** power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were HR 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed. **The smallest treatment difference that would be statistically significant is a PFS HR of 0.78. Assuming 12 months non-linear recruitment, 295 PFS events are expected to occur approximately 23 months after the first subject is enrolled in the study.**

If the true OS hazard ratio for the comparison of AZD9291 versus doublet chemotherapy is 0.752, ~~427~~ **287** death events will provide approximately 80% power to demonstrate a statistically significant difference in OS at 5% 2-sided significance level. ~~For example, this translates to an approximate 5-6 month improvement in median OS over an assumed 16-19 month median OS on chemotherapy, assuming OS is exponentially distributed.~~ **Assuming 12 months non-linear recruitment, 16-19 month median on chemotherapy, 287 OS events are expected to occur approximately 42-48 months after the first subject is enrolled in the study.**

Assuming 12 months non-linear recruitment, ~~400~~ **295** PFS events are expected to occur approximately ~~20~~ **23** months after the first subject is enrolled in the study.

In order to randomize ~~610~~ **410** subjects (assuming a 10% screen failure rate), ~~678 (55%)~~ **455 (T790M+)** subjects will need to be enrolled. **In order to enrol 455 T790M+ subjects, 1034 subjects will need to be screened [assuming 827 (55%) of subjects are T790+ and allowing for a 20% attrition rate].**

~~With a 20% attrition rate, and 1232 subjects with known T790M status, approximately 1540 subjects will need to be screened.~~

### **Reason for Amendment:**

Although the primary endpoint is Progression Free Survival (PFS), the study had been sized to characterize the secondary endpoint of overall survival (OS) and was over-powered for PFS (>95% power to detect a difference in PFS assuming the true hazard ratio is 0.67). Due to the introduction of crossover, the interpretation of OS will be compromised and therefore, the study has been re-sized to characterise PFS, which has resulted in a sample size reduction. The study now has 90% power to detect the original hypothesised treatment effect of PFS hazard ratio of 0.67.

### **Change 29**

#### **Section of protocol affected:**

8.3.1 Full analysis set

#### **Previous text:**

The full analysis set will include all randomized subjects. The full analysis set will be used for all efficacy analyses and treatment groups will be compared on the basis of randomized treatment, regardless of the treatment actually received.

**Revised text:**

The full analysis set will include all randomized subjects **prior to the end of global recruitment. Any subjects randomized in China, after global recruitment has ended, will not be included in the FAS (see Section 8.6).** The full analysis set will be used for all efficacy analyses and treatment groups will be compared on the basis of randomized treatment, regardless of the treatment actually received.

**Reason for Amendment:**

A China extension cohort has been introduced to ensure adequate Chinese subject participation to fulfil China Regulatory Authority requirements: it is possible that this target may not be met before the global recruitment of 410 subjects is achieved.

**Change 30**

**Section of protocol affected:**

8.3.2 Safety analysis set

**Previous text:**

The safety analysis set will consist of all subjects who received at least one dose of randomized treatment and for whom post dose data are available. Safety data will not be formally analysed but summarised using the safety analysis set, according to the treatment received, i.e. erroneously treated subjects (e.g. those randomized to treatment A but actually given treatment B) will be summarised according to the treatment they actually received.

**Revised text:**

The safety analysis set will consist of all subjects **randomized prior to the end of global recruitment** who received at least one dose of randomized treatment and for whom post dose data are available. **Any subjects randomized in China only, after global recruitment has ended, will not be included in the safety analysis set (see Section 8.6).** Safety data will not be formally analysed but summarised using the safety analysis set, according to the treatment received, i.e. erroneously treated subjects (e.g. those randomized to treatment A but actually given treatment B) will be summarised according to the treatment they actually received.

**Reason for Amendment:**

A China extension cohort has been introduced to ensure adequate Chinese subject participation to fulfil China Regulatory Authority requirements; it is possible that this target may not be met before the global recruitment of 410 subjects is achieved.

**Change 31**

**Section of protocol affected:**

**8.4.1 Calculation or derivation of efficacy variables**

**Previous text:**

**Blinded Independent Central Review of RECIST based assessments**

The Blinded Independent Central Review of radiological imaging data will be carried out using RECIST version 1.1. All radiological scans for all subjects (including those at unscheduled visits, or outside visit windows) will be provided to the BICR. Prior radiotherapy reports for subjects (at baseline) and information on biopsied lesions will also be provided to the BICR to allow the selection of appropriate target lesions.

**Revised text:**

**Blinded Independent Central Review of RECIST based assessments**

The Blinded Independent Central Review of radiological imaging data will be carried out using RECIST version 1.1. All radiological scans for all subjects (including those at unscheduled visits, or outside visit windows) will be provided to the BICR. ~~Prior radiotherapy reports for subjects (at baseline) and information on biopsied lesions will also be provided to the BICR to allow the selection of appropriate target lesions.~~

**Reason for Amendment:**

Prior radiotherapy reports will not be collected at central review. Reviewing radiologist will not select target lesions with signs of intervention including radiotherapy unless there is no other target lesion available.

**Change 32**

**Section of protocol affected:**

**8. STATISTICAL ANALYSES BY ASTRAZENECA**

**8.5 Methods for statistical analyses**

**Previous text:**

NA

**Revised text:**

**8.6 China extension**

**In order to adequately compare the efficacy and safety of AZD9291 versus placebo in Chinese patients to fulfil China FDA requirements, subjects recruited in China after global recruitment has ended will be combined with any subjects recruited from China prior to the end of the global recruitment. This China-only cohort will be analysed and reported separately from the Clinical Study Report.**

**8.6.1 Definition of China analysis sets**

**8.6.1.1 China-only Full Analysis Set**

**The China-only Full analysis set will include all subjects randomized in China. This includes all subjects randomized in China prior to the end of global recruitment and all additional subjects recruited in mainland China after global recruitment is completed.**

**The China-only Full analysis set will be used for all China-only efficacy analyses and treatment groups will be compared on the basis of randomized study treatment, regardless of the treatment actually received.**

**8.6.1.2 China-only Safety Analysis Set**

**The China-only safety analysis set will consist of all subjects randomized in China who received at least one dose of study treatment and for whom post-dose data are available.**

**8.6.1.3 China-only Pharmacokinetic Analysis Set**

**The China-only Pharmacokinetic Analysis Set is defined as subjects in the China-only FAS who have at least one evaluable PK concentration.**

**8.6.2 China-only analyses**

**All efficacy, safety, PRO and PK variables will be derived in the same way as detailed in Section 8.4.**

**All analyses detailed in Section 8.5 will be repeated for the China-only cohort using the analysis sets described in Section 8.6.1.**

**All statistical analyses will be considered exploratory and only performed if sufficient numbers of events or subjects are available (e.g. > 20 PFS or OS events), otherwise descriptive statistics only will be presented. No adjustment for multiplicity will be made and so the procedure for hierarchical testing detailed in Section 8.5.2.1 will not be followed. Statistical analyses will not be stratified by ethnicity (Asian versus Non-Asian).**

**The analyses be performed at the time of the primary PFS analysis if at least 20 PFS events have been observed out of approximately 50 Chinese subjects, otherwise summaries of efficacy will be provided only. Additional follow-up of Chinese subjects if deemed appropriate may be performed when the PFS data are more mature (for example, 70% maturity, as consistent with the primary global PFS analysis).**

**Reason for Amendment:**

A China extension cohort has been introduced to ensure adequate Chinese subject participation to fulfil China Regulatory Authority requirements; it is possible that this target may not be met before the global recruitment of 410 subjects is achieved.

**Change 33**

**Section of protocol affected:**

Appendix H            Guidelines for Evaluation of Objective Tumour Response Using RECIST 1.1 (Response Evaluation Criteria in Solid Tumours)

**Previous text:**

Only patients with at least one measurable lesion at baseline that can be accurately assessed by computerised tomography (CT), magnetic resonance imaging (MRI) or plain X-ray should be included in this study.

**Measurable lesions:**

1. At least one lesion, not previously irradiated that can be accurately measured and not chosen for biopsy during the study screening period, at baseline as  $\geq 10$ mm in the longest diameter (except lymph nodes which must have short axis  $\geq 15$ mm) with CT or MRI which is suitable for accurate repeated measurements.

**Non-measurable lesions:**

- All other lesions, including small lesions (longest diameter  $< 10$  mm or pathological lymph nodes with  $\geq 10$  mm to  $< 15$  mm short axis at baseline. Nodes with  $< 10$  mm short axis are considered non-pathological and should not be recorded as non-target lesions (NTLs)
- Truly non-measurable lesions include the following: bone lesions, leptomeningeal disease, ascites, pleural / pericardial effusion, inflammatory breast disease, lymphangitic involvement of skin or lung, abdominal masses/abdominal organomegaly identified by physical examination that are not measurable by CT or MRI
- Previously irradiated lesions as localised post-radiation changes, which affect lesion sizes, may occur. Therefore, lesions that have been previously irradiated will not be considered measurable and should be selected as NTLs at baseline and followed up as part of the NTL assessment

- Lesions chosen for biopsy during the study screening period if still present should be selected as NTL at baseline and follow up as part of the NTL assessment
- Skin lesions assessed by clinical examination
- Brain metastasis

**Revised text:**

Only patients with at least one measurable lesion at baseline that can be accurately assessed by computerised tomography (CT), magnetic resonance imaging (MRI) or plain X-ray should be included in this study.

**Measurable lesions:**

1. At least one lesion, not previously irradiated **and not biopsied during the screening period**, that can be accurately measured ~~and not chosen for biopsy during the study screening period~~, at baseline as  $\geq 10$ mm in the longest diameter (except lymph nodes which must have short axis  $\geq 15$ mm) with CT or MRI which is suitable for accurate repeated measurements. **If only one measurable lesion exists, it is acceptable to be used as long as it has not been previously irradiated and baseline tumour assessment scans are done at least 14 days after the screening biopsy is performed.**

**Non-measurable lesions:**

- All other lesions, including small lesions (longest diameter  $< 10$  mm or pathological lymph nodes with  $\geq 10$  mm to  $< 15$  mm short axis at baseline. Nodes with  $< 10$  mm short axis are considered non-pathological and should not be recorded as non-target lesions (NTLs)
- Truly non-measurable lesions include the following: bone lesions, leptomenigeal disease, ascites, pleural / pericardial effusion, inflammatory breast disease, lymphangitic involvement of skin or lung, abdominal masses/abdominal organomegaly identified by physical examination that are not measurable by CT or MRI
- Previously irradiated lesions as localised post-radiation changes, which affect lesion sizes, may occur. Therefore, lesions that have been previously irradiated will not be considered measurable and should be selected as NTLs at baseline and followed up as part of the NTL assessment
- Lesions chosen for biopsy during the study screening period if still present should be selected as NTL at baseline and follow up as part of the NTL assessment **unless they fulfil the criteria for measurability, when there is only one measurable lesion.**
- Skin lesions assessed by clinical examination
- Brain metastasis

**Reason for Amendment:**

Clarification of situation when only one measurable target lesion exists.

**Change 34**

**Section of protocol affected:**

Appendix H Guidelines for Evaluation of Objective Tumour Response Using RECIST  
1.1 (Response Evaluation Criteria in Solid Tumours)

**Previous text:**

**5. SPECIFICATIONS FOR RADIOLOGICAL IMAGING**

These notes are recommendations for use in clinical studies. The use of standardised protocols for CT and MRI allows comparability both within and between different studies, irrespective of where the examination has been undertaken.

**5.1 CT Scan**

CT scans of chest and abdomen (including liver and adrenal glands) should be contiguous throughout all the anatomical regions of interest.

The most critical CT image acquisition parameters for optimal tumour evaluation using RECIST 1.1 are anatomic coverage, contrast administration, slice thickness, and reconstruction interval.

**Anatomic coverage**

Optimal anatomic coverage for most solid tumours is the chest, abdomen and pelvis. Coverage should encompass all areas of known predilection for metastases in the disease under evaluation and should additionally investigate areas that may be involved based on signs and symptoms of individual patients. Because a lesion later identified in a body part not scanned at baseline would be considered as a new lesion representing disease progression, careful consideration should be given to the extent of imaging coverage at baseline and at subsequent follow-up time points. This will enable better consistency not only of tumour measurements but also identification of new disease.

**Intravenous contrast administration**

Optimal visualisation and measurement of metastases in solid tumours requires consistent administration (dose and rate) of intravenous contrast as well as timing of scanning. Typically, most abdominal imaging is performed during the portal venous phase and (optimally) about the same time frame after injection on each examination. An adequate volume of a suitable contrast agent should be given so that the metastases are demonstrated to



best effect and a consistent method is used on subsequent examinations for any given patient. It is very important that the same technique be used at baseline and on follow-up examinations for a given patient. For subjects who develop contraindications to contrast after baseline contrast CT is done, the decision as to whether non-contrast CT or MRI (enhanced or non-enhanced) should be performed should also be based on the tumour type, anatomic location of the disease and should be optimised to allow for comparison to the prior studies if possible. Each case should be discussed with the radiologist to determine if substitution of these other approaches is possible and, if not, the patient should be considered not evaluable from that point forward. Care must be taken in measurement of TLs on a different modality and interpretation of non-target disease or new lesions, since the same lesion may appear to have a different size using a new modality. Oral contrast is recommended to help visualise and differentiate structures in the abdomen.

If iodine contrast media is medically contraindicated at baseline or at any time during the course of the study then the recommended methods are: CT thoracic examination without contrast and abdominal and pelvic MRI with contrast. If MRI cannot be performed then CT without intravenous contrast is an option for the thorax, abdomen and pelvic examinations. For assessment of brain lesions MRI is the preferred method.

### **Slice thickness and reconstruction material**

It is recommended that CT scans be performed at 5mm contiguous slice thickness and this guideline presumes a minimum 5 mm thickness in recommendations for the measurable lesion definition. Exceptionally, particular institutions may perform medically acceptable scans at slice thicknesses greater than 5 mm. If this occurs, the minimum size of measurable lesions at baseline should be twice the slice thickness of the baseline scans.

All window settings should be included in the assessment, particularly in the thorax where lung and soft tissue windows should be considered. When measuring lesions, the TLs should be measured on the same window setting for repeated examinations throughout the study. All images from each examination should be included in the assessment and not “selected” images of the apparent lesion.

## **5.2 MRI Scan**

MRI has excellent contrast, spatial and temporal resolution; however, there are many image acquisition variables involved in MRI, which greatly impact image quality, lesion conspicuity and measurement. Furthermore, the availability of MRI is variable globally. The modality used at follow-up should be the same as was used at baseline and the lesions should be measured/assessed on the same pulse sequence. Generally, axial imaging of the abdomen and pelvis with T1 and T2 weighted imaging along with gadolinium-enhanced imaging should be performed. The field of view, matrix, number of excitations, phase encode steps, use of fat suppression and fast sequences should be optimised for the specific body part being imaged as well as the scanner utilised. It is beyond the scope of this appendix to prescribe specific MRI pulse sequence parameters for all scanners, body parts and diseases. Ideally, the same type of scanner should be used and the image acquisition protocol should be followed as closely as

possible to prior scans. Body scans should be performed with breath-hold scanning techniques if possible.

For these reasons, CT is the imaging modality of choice.

### **5.3 FDG-PET scans**

FDG-PET has gained acceptance as a valuable tool for detecting, staging and restaging several malignancies. If FDG-PET scans are included in a protocol, an FDG uptake period of 60 min prior to imaging has been decided as the most appropriate for imaging of subjects with malignancy. Whole-body acquisition is important since this allows for sampling of all areas of interest and can assess if new lesions have appeared thus determining the possibility of interval progression of disease. Images from the base of the skull to the level of the mid-thigh should be obtained 60 min post injection. PET camera specifications are variable and manufacturer specific, so every attempt should be made to use the same scanner, or the same model scanner, for serial scans on the same patient. Whole-body acquisitions can be performed in either 2- or 3-dimensional mode with attenuation correction, but the method chosen should be consistent across all subjects and serial scans in the clinical trial.

#### **5.3.1 PET/CT scans**

At present, low dose or attenuation correction CT portions of a combined PET–CT are of limited use in anatomically based efficacy assessments and it is therefore suggested that they should not be substituted for dedicated diagnostic contrast enhanced CT scans for tumour measurements by RECIST 1.1. In exceptional situations, if a site can document that the CT performed as part of a PET–CT is of identical diagnostic quality to a diagnostic CT (with IV and oral contrast) then the CT portion of the PET–CT can be used for RECIST measurements. However, this is not recommended because the PET portion of the CT introduces additional data that may bias an investigator if it is not routinely or serially performed.

## **6. REFERENCES**

### **Eisenhauer et al 2009**

Eisenhauer EA, Therasse P, Bogaerts J, Schwartz LH, Sargent D, Ford R, Dancey J, Arbuck S, Gwyther S, Mooney M, Rubinstein L, Shankar L, Dodd L, Kaplan R, Lacombe D, Verweij J. New response evaluation criteria in solid tumours: Revised RECIST guideline (version 1.1). *European Journal of Cancer*. 45 (2009) 228-247.

### **Revised text:**

#### **~~5. SPECIFICATIONS FOR RADIOLOGICAL IMAGING~~**

~~These notes are recommendations for use in clinical studies. The use of standardised protocols for CT and MRI allows comparability both within and between different studies, irrespective of where the examination has been undertaken.~~

## 5.1 — CT Scan

~~CT scans of chest and abdomen (including liver and adrenal glands) should be contiguous throughout all the anatomical regions of interest.~~

~~The most critical CT image acquisition parameters for optimal tumour evaluation using RECIST 1.1 are anatomic coverage, contrast administration, slice thickness, and reconstruction interval.~~

### ~~Anatomic coverage~~

~~Optimal anatomic coverage for most solid tumours is the chest, abdomen and pelvis. Coverage should encompass all areas of known predilection for metastases in the disease under evaluation and should additionally investigate areas that may be involved based on signs and symptoms of individual patients. Because a lesion later identified in a body part not scanned at baseline would be considered as a new lesion representing disease progression, careful consideration should be given to the extent of imaging coverage at baseline and at subsequent follow-up time points. This will enable better consistency not only of tumour measurements but also identification of new disease.~~

### ~~Intravenous contrast administration~~

~~Optimal visualisation and measurement of metastases in solid tumours requires consistent administration (dose and rate) of intravenous contrast as well as timing of scanning. Typically, most abdominal imaging is performed during the portal venous phase and (optimally) about the same time frame after injection on each examination. An adequate volume of a suitable contrast agent should be given so that the metastases are demonstrated to best effect and a consistent method is used on subsequent examinations for any given patient. It is very important that the same technique be used at baseline and on follow-up examinations for a given patient. For subjects who develop contraindications to contrast after baseline contrast CT is done, the decision as to whether non-contrast CT or MRI (enhanced or non-enhanced) should be performed should also be based on the tumour type, anatomic location of the disease and should be optimised to allow for comparison to the prior studies if possible. Each case should be discussed with the radiologist to determine if substitution of these other approaches is possible and, if not, the patient should be considered not evaluable from that point forward. Care must be taken in measurement of TLs on a different modality and interpretation of non-target disease or new lesions, since the same lesion may appear to have a different size using a new modality. Oral contrast is recommended to help visualise and differentiate structures in the abdomen.~~

~~If iodine contrast media is medically contraindicated at baseline or at any time during the course of the study then the recommended methods are: CT thoracic examination without contrast and abdominal and pelvic MRI with contrast. If MRI cannot be performed then CT without intravenous contrast is an option for the thorax, abdomen and pelvic examinations. For assessment of brain lesions MRI is the preferred method.~~

## Slice thickness and reconstruction material

It is recommended that CT scans be performed at 5mm contiguous slice thickness and this guideline presumes a minimum 5 mm thickness in recommendations for the measurable lesion definition. Exceptionally, particular institutions may perform medically acceptable scans at slice thicknesses greater than 5 mm. If this occurs, the minimum size of measurable lesions at baseline should be twice the slice thickness of the baseline scans.

All window settings should be included in the assessment, particularly in the thorax where lung and soft tissue windows should be considered. When measuring lesions, the TLs should be measured on the same window setting for repeated examinations throughout the study. All images from each examination should be included in the assessment and not “selected” images of the apparent lesion.

## 5.2—MRI Scan

MRI has excellent contrast, spatial and temporal resolution; however, there are many image acquisition variables involved in MRI, which greatly impact image quality, lesion conspicuity and measurement. Furthermore, the availability of MRI is variable globally. The modality used at follow up should be the same as was used at baseline and the lesions should be measured/assessed on the same pulse sequence. Generally, axial imaging of the abdomen and pelvis with T1 and T2 weighted imaging along with gadolinium enhanced imaging should be performed. The field of view, matrix, number of excitations, phase encode steps, use of fat suppression and fast sequences should be optimised for the specific body part being imaged as well as the scanner utilised. It is beyond the scope of this appendix to prescribe specific MRI pulse sequence parameters for all scanners, body parts and diseases. Ideally, the same type of scanner should be used and the image acquisition protocol should be followed as closely as possible to prior scans. Body scans should be performed with breath-hold scanning techniques if possible.

For these reasons, CT is the imaging modality of choice.

## 5.3—FDG-PET scans

FDG-PET has gained acceptance as a valuable tool for detecting, staging and restaging several malignancies. If FDG-PET scans are included in a protocol, an FDG uptake period of 60 min prior to imaging has been decided as the most appropriate for imaging of subjects with malignancy. Whole-body acquisition is important since this allows for sampling of all areas of interest and can assess if new lesions have appeared thus determining the possibility of interval progression of disease. Images from the base of the skull to the level of the mid thigh should be obtained 60 min post injection. PET camera specifications are variable and manufacturer specific, so every attempt should be made to use the same scanner, or the same model scanner, for serial scans on the same patient. Whole-body acquisitions can be performed in either 2- or 3-dimensional mode with attenuation correction, but the method chosen should be consistent across all subjects and serial scans in the clinical trial.

### ~~5.3.1 PET/CT scans~~

~~At present, low dose or attenuation correction CT portions of a combined PET-CT are of limited use in anatomically based efficacy assessments and it is therefore suggested that they should not be substituted for dedicated diagnostic contrast enhanced CT scans for tumour measurements by RECIST 1.1. In exceptional situations, if a site can document that the CT performed as part of a PET-CT is of identical diagnostic quality to a diagnostic CT (with IV and oral contrast) then the CT portion of the PET-CT can be used for RECIST measurements. However, this is not recommended because the PET portion of the CT introduces additional data that may bias an investigator if it is not routinely or serially performed.~~

## **5. CONFIRMATION OF RESPONSE**

**In this study, imaging for confirmation of response (CR or PR) should be performed at the next scheduled RECIST assessment.**

## **6. CENTRAL REVIEW**

**The Contract Research Organisation appointed by AstraZeneca to perform the independent central review for this study will provide specification for radiological imaging protocols in standard acquisition guidelines documentation.**

## **7. ~~6.~~ REFERENCES**

### **Eisenhauer et al 2009**

Eisenhauer EA, Therasse P, Bogaerts J, Schwartz LH, Sargent D, Ford R, Dancey J, Arbuck S, Gwyther S, Mooney M, Rubinstein L, Shankar L, Dodd L, Kaplan R, Lacombe D, Verweij J. New response evaluation criteria in solid tumours: Revised RECIST guideline (version 1.1). *European Journal of Cancer*. 45 (2009) 228-247.

### **Wolchok et al 2009**

**Wolchok JD, Hoos A, Bohnsack O, Weber JS, O'Day S, Hamid O, et.al., Guidelines for the Evaluation of Immune Therapy Activity in Solid Tumors: Immune-Related Response Criteria, *Clin Cancer Res* 2009;15(23): 7412-20**

### **Reason for Amendment:**

To provide clarification of imaging for confirmation of response, and to delete the site information on imaging method requirements as these will be provided via PXL informatics in the IAG.

**Persons who initiated the Amendment:**

AstraZeneca Project Team

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**Clinical Study Protocol Amendment**

Amendment Number 3  
Drug Substance AZD9291  
Study Code D5160C00003  
Date  
Protocol Dated

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**A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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This submission /document contains trade secrets and confidential commercial information, disclosure of which is prohibited without providing advance notice to AstraZeneca and opportunity to object.

**Sponsor: AstraZeneca**

**Centres affected by the Amendment:**

This amendment affects all participating sites in the study.

**The protocol for the study is to be amended as follows:**

Original text

Removed text

Added text

**The protocol for the study is to be amended as follows:**

## Change 1

### Section of protocol affected:

Title page

### Previous text:

AstraZeneca Research and Development  
site representative

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Date

### Revised text:

AstraZeneca Research and Development  
site representative

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Date

### Reason for Amendment:

Change in Clinical Development Manager.

## Change 2

### Section of protocol affected:

PROTOCOL SYNOPSIS

### Previous text:

#### Study site(s) and number of subjects planned

Approximately 410 subjects will be randomized from 19 countries across approximately 160 centres in North America, Asia and Europe. Once 410 subjects have been randomized globally, recruitment will continue only in mainland China until approximately 50 Chinese subjects have been randomized.

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Study period	Phase of development	
Estimated date of first subject enrolled globally	Q3 2014	III
Estimated date of last subject completed	Q1 2018	

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<b>Study period</b>	<b>Phase of development</b>
Estimated date of last subject completed in China	Q4 2018

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**Revised text:**

**Study site(s) and number of subjects planned**

Approximately 410 subjects will be randomized from 19 countries across approximately 160 centres in North America, Asia and Europe. Once 410 subjects have been randomized globally, recruitment will continue only in mainland China until approximately 50 Chinese subjects have been randomized.

---

<b>Study period</b>	<b>Phase of development</b>	
Estimated date of first subject enrolled globally	Q3 2014	III
Estimated date of last subject completed	Q1 2018	

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<del>Estimated date of last subject completed in China</del>	<del>Q4 2018</del>
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**Reason for Amendment:**

Since China completed their full recruitment within the regular global study timelines, the same estimated last subject completed has followed the study planned date.

**Change 3**

**Section of protocol affected:**

PROTOCOL SYNOPSIS

**Previous text:**

The primary analysis of PFS will occur when approximately 295 progression events have been observed out of the 410 globally randomized subjects. With 295 progression events, the study will have 90% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were HR 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed. The smallest treatment difference that would be statistically significant is a PFS HR of 0.78. Assuming 12 months non-linear recruitment, 295 PFS events are expected to occur approximately 23 months after the first subject is enrolled in the study.

If the true OS hazard ratio for the comparison of AZD9291 versus doublet chemotherapy is 0.72, 287 death events will provide approximately 80% power to demonstrate a statistically

significant difference in OS at 5% 2-sided significance level. Assuming 12 months non-linear recruitment, 16-19 month median on chemotherapy, 287 OS events are expected to occur approximately 42-48 months after the first subject is enrolled in the study.

Two interim analyses of overall survival will be conducted, one at the time of the primary analysis of PFS, and one when the OS data are approximately 50% mature (approximately 205 death events). A final optional analysis of overall survival may be performed when the OS data are approximately 70% mature (approximately 287 death events).

PFS will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian). The primary analysis will be based on investigator-recorded assessment of disease progression by RECIST; a sensitivity analysis will also be performed using a blinded independent central review (BICR).

All secondary endpoints of ORR, DoR, DCR and Tumour Shrinkage will be analyzed at the time of the primary analysis.

In order to provide strong control of the type I error rate, the primary endpoint (PFS) and key secondary endpoints (ORR and OS) will be tested in a sequential order. If any previous analysis in the sequence is not statistically significant, the alpha spending cannot be transferred to subsequent analyses. Since three analyses of OS are planned, the alpha will be split between the two interim and final analyses of overall survival to maintain a 2-sided 5% type I error.

#### **Revised text:**

The primary analysis of PFS will occur when **at least approximately 221** ~~295~~-progression events have been observed out of the 410 globally randomized subjects. With **221** ~~295~~ progression events, the study will have **at least 80** ~~>90~~% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were HR 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed. The smallest treatment difference that would be statistically significant is a PFS HR of **0.78** ~~0.76~~ **(this translates into an approximate 2 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed)**. Assuming **15** ~~42~~ months non-linear recruitment, **221** ~~295~~ PFS events are expected to occur approximately **20** ~~23~~ months after the first subject is ~~randomized~~**enrolled** in the study.

~~If the true OS hazard ratio for the comparison of AZD9291 versus doublet chemotherapy is 0.72, 287 death events will provide > approximately 80% power to demonstrate a statistically significant difference in OS at 5% 2-sided significance level. Assuming 12 months non-linear recruitment, 16-19 month median on chemotherapy, 287 OS events are expected to occur approximately 42-48 months, after the first subject is enrolled in the study.~~

~~Three~~ **Two** interim analyses of overall survival will be conducted.; **The data cut-off for the first analysis will be performed approximately 4 months after data cut-off for one at the**

~~time of~~ the primary analysis of PFS, and ~~one~~ **the second analysis will be performed** when the OS data are approximately 50% mature (approximately 205 death events). ~~The A-final (third) optional~~ analysis of overall survival ~~will may~~ be performed when the OS data are approximately 70% mature (approximately 287 death events).

PFS will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian). The primary analysis will be based on investigator-recorded assessment of disease progression by RECIST; a sensitivity analysis will also be performed using a blinded independent central review (BICR).

~~All~~ Secondary endpoints of ORR, DoR, DCR and Tumour Shrinkage will be analyzed at the time of the primary PFS analysis. **OS will be summarised only at the time of the primary analysis (a summary of the frequency of deaths and primary cause of death will be provided for safety purposes); the analysis of OS will be performed approximately 4 months after the data cut-off for the primary analysis of PFS.**

In order to provide strong control of the type I error rate (**2-sided 5%**), the primary endpoint (PFS) and key secondary endpoints (ORR and OS) will be tested in a sequential order. If any previous analysis in the sequence is not statistically significant, the alpha spending cannot be transferred to subsequent analyses. **Since three OS analyses are planned, the Lan DeMets approach that approximates the O'Brien and Fleming spending function will be used to maintain an overall 2-sided 5% type I error across the testing of three planned analyses of OS.** ~~Since three analyses of OS are planned, the alpha will be split between the two interim and final analyses of overall survival to maintain a 2-sided 5% type I error.~~

#### **Reason for Amendment:**

AstraZeneca proposes to change the power to detect a statistically significant difference for the primary analysis of progression-free survival [PFS] from 90% to 80% (assuming a Hazard Ratio [HR] = 0.67). This change is based on the compelling results from the most recent PFS data from the Phase II osimertinib monotherapy studies (AURA extension and AURA2). If the assumed the treatment effect were still a HR of 0.67 (which translates to approximate 3-month improvement on an estimated median PFS of 6 months on the control arm assuming proportional hazards), then 221 progression events provides 80% power to demonstrate a statistically significant difference in PFS at the 5% 2- sided significance level (as compared with the 295 progression events required for assuring the currently planned 90% power).

Additionally, in order to maximise the maturity of the overall survival (OS) data at the time of the first analysis, the data cut for the first OS analysis will be performed approximately 4 months after data cut-off (DCO) for the primary PFS analysis. At the time of the primary PFS analysis, OS will be summarised and not analysed. A summary of the frequency of deaths and primary cause of death will be provided for safety purposes, no additional summaries will be performed in order to protect the integrity of the first interim OS analyses.

Following FDA feedback, the approach to control the overall type I error at 5% (2 sided) for OS has been modified to the Lan DeMets approach that approximates the O'Brien and Fleming spending function.

## Change 4

### Section of protocol affected:

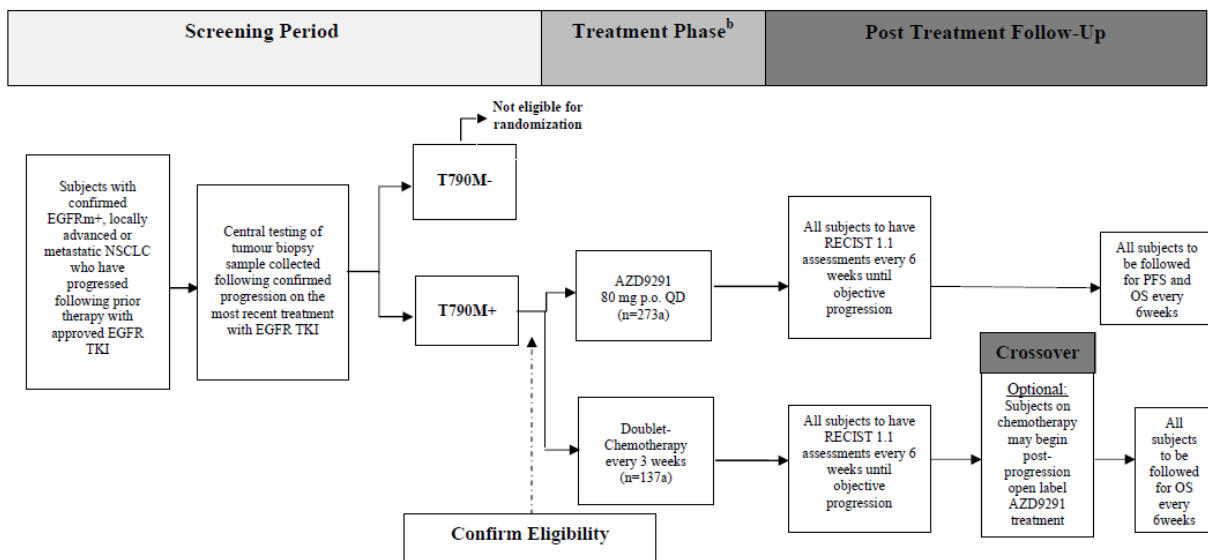
#### 1.5 Study Design

#### Previous text:

Subjects on the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291 80mg, once daily.

If a subject has been deemed to have objective disease progression according to Investigator tumour assessment by RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subject's best interest, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy. Sites are to submit the next scheduled tumour assessment for central imaging review according to Table 2.

Figure 1 Study flow chart



(a) Approximately 610 subjects will be randomized into the trial; from these approximately 407 subjects will be treated with AZD9291 and approximately 203 subjects will be treated with a platinum based doublet-chemotherapy.

(b) Subjects will be considered in "Treatment phase" at the time AZD9291/Doublet-Chemotherapy (study treatment) is started. Subjects will continue to receive study treatment until objective disease progression (according to RECIST 1.1). Subjects randomized to AZD9291 may continue to receive AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria. Subjects on the platinum-based doublet chemotherapy arm with objective radiological progression

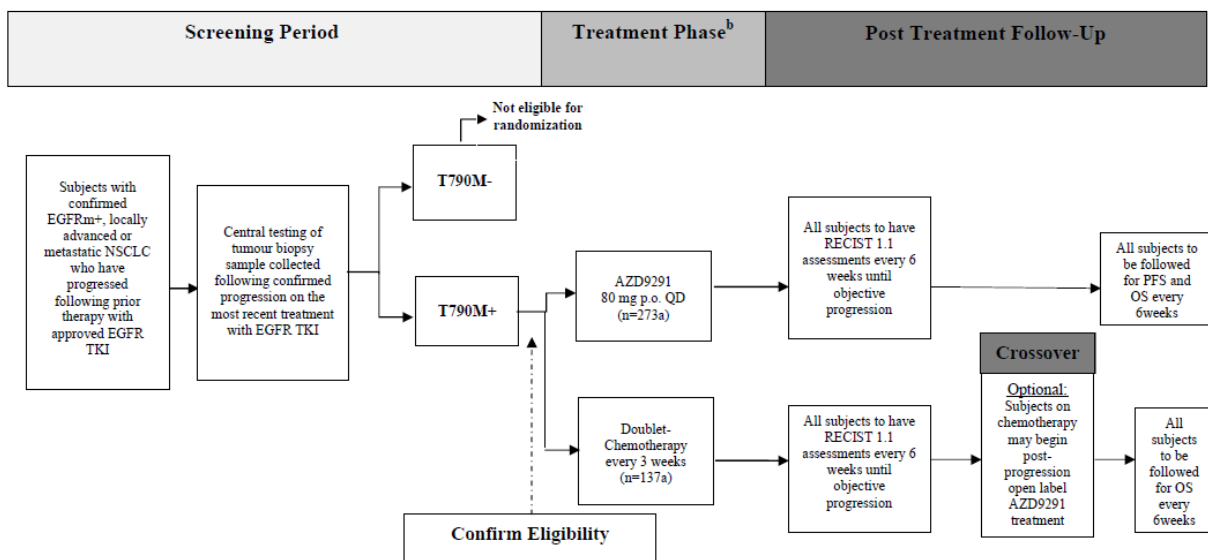
according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291, 80 mg once daily.

**Revised text:**

**Once subjects** ~~Subjects~~ on the platinum-based doublet chemotherapy arm **are determined to have with** objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, **they** will be given the opportunity to begin treatment with AZD9291 80mg, once daily. **These subjects may continue treatment with AZD9291 as long as they show clinical benefit, as judged by the investigator.**

If a subject has been deemed to have objective disease progression according to Investigator tumour assessment by RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subject’s best interest, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy. Sites are to submit the next scheduled tumour assessment for central imaging review according to Table 2.

Figure 1 Study flow chart



- (a) Approximately 410 640 subjects will be randomized into the trial; from these approximately 273 407 subjects will be treated with AZD9291 and approximately 137 203 subjects will be treated with a platinum based doublet-chemotherapy.
- (b) Subjects will be considered in “Treatment phase” at the time AZD9291/Doublet-Chemotherapy (study treatment) is started. Subjects will continue to receive study treatment until objective disease progression (according to RECIST 1.1). Subjects randomized to AZD9291 may continue to receive AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria. Subjects randomized to the platinum-based doublet chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291, 80 mg once daily.

**Reason for Amendment:**

Footnote A changes to the number of subjects was a update that should have been included in Protocol Amendment #2 that incorporated the addition of crossover and the change to sample size. Oversight in this footnote when creating Amendment #2 is being corrected now. Also,

confirmation provided that subjects on the platinum-based doublet chemotherapy arm who were determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review may continue to receive AZD9291 after the next subsequent disease progression.

## **Change 5**

### **Section of protocol affected:**

#### 3.6 Restrictions

#### **Previous text:**

1. Females of child-bearing potential should use reliable methods of contraception from the time of screening until 3 months after discontinuing study treatment. Acceptable methods of contraception include total and true sexual abstinence, tubal ligation, hormonal contraceptives that are not prone to drug-drug interactions (IUS Levonorgestrel Intra Uterine System (Mirena), Medroxyprogesterone injections (Depo-Provera)), copper-banded intra-uterine devices and vasectomised partner. All hormonal methods of contraception should be used in combination with the use of a condom by their male sexual partner for intercourse. For subjects receiving platinum-based doublet-chemotherapy, the reliable methods of contraception chosen should be in accordance with the local prescribing label.
2. Male subjects should be asked to use barrier contraceptives (ie, by use of condoms) during sex with all partners during the trial and for a washout period of 3 months. Subjects should not father a child for 6 months after completion of study treatment. Subjects should refrain from donating sperm from the start of dosing until 6 months after discontinuing study treatment. If male subjects wish to father children they should be advised to arrange for freezing of sperm samples prior to the start of study treatment. For subjects receiving platinum-based doublet chemotherapy, above recommendations should be in accordance with the local prescribing label.
3. All subjects must try to avoid concomitant use of medications, herbal supplements and/or ingestion of foods with known potent inhibitors or inducers of CYP3A4 whenever feasible. Subjects may receive any medication that is clinically indicated for treatment of adverse events. Such drugs must have been discontinued for an appropriate period before they enter screening and for a period of 3 months after the last dose of AZD9291. All concomitant medications should be captured on the eCRF. Guidance on medicines to avoid, medications that require close monitoring and on washout periods is provided (see Appendix F).
4. If medically feasible, subjects taking regular medication, with the exception of potent inhibitors or inducers of CYP3A4 (see above), should be maintained on it throughout the study period. Subjects randomized to AZD9291 taking concomitant medications whose disposition is dependent upon CYP3A4, CYP2C8 or Breast cancer resistance protein (BCRP) and which have a narrow therapeutic index should be closely

monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst receiving AZD9291. Subjects taking concomitant medications whose disposition is dependent upon CYP3A4, CYP1A2, CYP2C or p-glycoprotein and which have a narrow therapeutic index should be closely monitored for reduction in therapeutic activity as a result of the reduced exposure of the concomitant medication whilst receiving AZD9291. Guidance on medications to avoid, medications that require close monitoring and on washout periods should be provided (see Appendix F).

Up to 3 fold increase in exposure may occur in statin exposure when coadministered with AZD9291. It is recommended that the starting and maintenance dose of statins should be as low as possible and should be guided by the statin label. Monitoring of low-density lipoprotein (LDL) cholesterol levels is advised. If the subject experiences any potentially relevant adverse events suggestive of muscle toxicity including unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever, the statin should be stopped, creatine kinase (CK) levels should be checked, and any appropriate further management should be taken.

Subjects taking warfarin should be monitored regularly for changes in prothrombin time or international normalized ratio (INR).

5. Subjects who wear contact lenses must discontinue wearing their lenses if they have any mild to moderate eye symptoms (CTCAE grade  $\leq 2$ ) while receiving treatment with AZD9291 until at least one week after symptoms have resolved. If a subject has a recurrence of eye symptoms or experiences any severe (CTCAE grade  $\geq 3$ ) ocular events they must discontinue wearing their contact lenses until at least one week after treatment with AZD9291 is permanently discontinued. Subjects must not use any eye drops or ointment for treatment of eye symptoms, unless agreed by a study doctor, at any time during the study until 1 week after AZD9291 has been permanently discontinued. Subject should consult the clinic promptly if they have any concerns.

**Revised text:**

1. Females of child-bearing potential should use reliable methods of contraception from the time of screening until ~~3 months~~ **6 weeks** after discontinuing study treatment. Acceptable methods of contraception include total and true sexual abstinence, tubal ligation, hormonal contraceptives that are not prone to drug-drug interactions (IUS Levonorgestrel Intra Uterine System (Mirena), Medroxyprogesterone injections (Depo-Provera)), copper-banded intra-uterine devices and vasectomised partner. All hormonal methods of contraception should be used in combination with the use of a condom by their male sexual partner for intercourse. For subjects receiving platinum-based doublet-chemotherapy, the reliable methods of contraception chosen should be in accordance with the local prescribing label.
2. Male subjects should be asked to use barrier contraceptives (ie, by use of condoms) during sex with all partners during the trial and for a washout period of ~~3~~ **4** months.

Subjects should not father a child for 6 months after completion of study treatment. Subjects should refrain from donating sperm from the start of dosing until 6 months after discontinuing study treatment. If male subjects wish to father children they should be advised to arrange for freezing of sperm samples prior to the start of study treatment. For subjects receiving platinum-based doublet chemotherapy, above recommendations should be in accordance with the local prescribing label.

3. All subjects must try to avoid concomitant use of medications, herbal supplements and/or ingestion of foods ~~with that are~~ known potent ~~inhibitors or~~ inducers of CYP3A4 whenever feasible. Subjects may receive any medication that is clinically indicated for treatment of adverse events. Such drugs must have been discontinued for an appropriate period before they enter screening and for a period of 3 months after the last dose of AZD9291. All concomitant medications should be captured on the eCRF. Guidance on medicines to avoid, medications that require close monitoring and on washout periods is provided (see Appendix F).
4. If medically feasible, subjects taking regular medication, with the exception of potent ~~inhibitors or~~ inducers of CYP3A4 (see above), should be maintained on it throughout the study period. Subjects randomized to AZD9291 taking concomitant medications whose disposition is dependent upon ~~CYP3A4, CYP2C8 or~~ Breast cancer resistance protein (BCRP) and which have a narrow therapeutic index should be closely monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst receiving AZD9291. ~~Subjects taking concomitant medications whose disposition is dependent upon CYP3A4, CYP1A2, CYP2C or p-glycoprotein and which have a narrow therapeutic index should be closely monitored for reduction in therapeutic activity as a result of the reduced exposure of the concomitant medication whilst receiving AZD9291.~~ Guidance on medications to avoid, medications that require close monitoring and on washout periods ~~should be~~ is provided (see Appendix F).

~~Up to 3 fold increase in exposure may occur in statin exposure when coadministered with AZD9291. It is recommended that the starting and maintenance dose of statins should be as low as possible and should be guided by the statin label. Monitoring of low density lipoprotein (LDL) cholesterol levels is advised.~~ **Patients taking rosuvastatin should have creatine phosphokinase levels monitored (due to BCRP-mediated increase in exposure).** If the subject experiences any potentially relevant adverse events suggestive of muscle toxicity including unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever, ~~the statin~~ **rosuvastatin** should be stopped, creatine kinase (CK) levels should be checked, and any appropriate further management should be taken.

Subjects taking warfarin should be monitored regularly for changes in prothrombin time or international normalized ratio (INR).

5. Subjects who wear contact lenses must discontinue wearing their lenses if they have any mild to moderate eye symptoms (CTCAE grade  $\leq 2$ ) while receiving treatment



with AZD9291 until at least one week after symptoms have resolved. If a subject has a recurrence of eye symptoms or experiences any severe (CTCAE grade  $\geq 3$ ) ocular events they must discontinue wearing their contact lenses until at least one week after treatment with AZD9291 is permanently discontinued. Subjects must not use any eye drops or ointment for treatment of eye symptoms, unless agreed by a study doctor, at any time during the study until 1 week after AZD9291 has been permanently discontinued. Subject should consult the clinic promptly if they have any concerns.

**Reason for Amendment:**

The recommended duration of contraceptive use following cessation of treatment with AZD9291 includes two elements: the 15 day PK washout period and an additional period to allow recovery of any adverse effects on the male or female reproductive tracts as follows. In females, the 6 week period is comprised of the 15 day PK washout plus approximately 4 weeks for completion of one menstrual cycle. In males, the 4 month period encompasses the 15 day PK washout plus 90 days for completion of one spermatogenic cycle.

Updated guidance for drug-drug interactions is based on the results from Study D5160C00012 which evaluated the effect of itraconazole (a strong CYP3A4 inhibitor) on the exposure of AZD9291. In that clinical pharmacokinetic study in patients, AZD9291 co-administered with 200 mg itraconazole twice daily had no clinically significant effect on the exposure of AZD9291 (AUC increased by 24% (90%CI 15, 35) and Cmax decreased by 20% (90% CI -27, -13)). Therefore, CYP3A4 inhibitors are not likely to affect the exposure of AZD9291 and hence, the restrictions on CYP3A4 inhibitors are removed.

In a clinical PK study, co-administration of AZD9291 with rosuvastatin (sensitive BCRP substrate) increased the AUC and Cmax of rosuvastatin by 35% (90%CI 15, 57) and 72% (90% CI 46, 103), respectively. Patients taking concomitant medications where the disposition is dependent upon BCRP and with narrow therapeutic index should be closely monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst receiving AZD9291.

**Change 6**

**Section of protocol affected:**

4.0 STUDY PLAN AND TIMING OF PROCEDURES

**Table 1 Study Plan for AZD9291 Subjects**

**Previous text:**

Clinical chemistry/ Haematology/Urinalysis <sup>m</sup>	X	X <sup>f</sup>	X	X	X	X	X	X	X	X <sup>w</sup>			5.2.1
------------------------------------------------------------	---	----------------	---	---	---	---	---	---	---	----------------	--	--	-------

**Revised text:**

Clinical chemistry/ Haematology/Urinalysis <sup>m</sup>	X	X <sup>f</sup>	X	X	X	X	X	X	X	X <sup>w</sup>			5.2.1
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**Reason for Amendment:**

Removal of footnote f due to typographical error.

**Change 7**

**Section of protocol affected:**

4.0 STUDY PLAN AND TIMING OF PROCEDURES

**Table 1 Study Plan for AZD9291 Subjects**

**Previous text:**

PRO-CTCAE (by e- device) <sup>p, x</sup>		X <sup>m</sup>	← weekly (± 2 days) for first 18 weeks of treatment →		X <sup>q</sup>	X		X <sup>o</sup>	X <sup>o</sup>	5.3.2
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**Revised text:**

PRO-CTCAE (by e- device) <sup>p, x</sup>		X <sup>m</sup>	← weekly (± 2 days) for first 18 weeks from randomization to treatment →		X <sup>q</sup>	X		X <sup>o</sup>	X <sup>o</sup>	5.3.2
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**Reason for Amendment:**

PRO CTAE (by e-device) assessment was corrected to read “weekly (± 2 days) for the first 18 weeks from randomization” to provide better clarification on the time period the ePRO is collected.

**Change 8**

**Section of protocol affected:**

4.0 STUDY PLAN AND TIMING OF PROCEDURES

**Table 2 Study Plan for Platinum-based Doublet Chemotherapy Subjects**

**Previous text:**

PRO-CTCAE (by e-device) <sup>p, w</sup>		X	← weekly (± 2 days) for first 18 weeks of treatment →		X <sup>q</sup>	X		X <sup>o</sup>	X <sup>o</sup>	5.3.2
--------------------------------------------	--	---	-------------------------------------------------------	--	----------------	---	--	----------------	----------------	-------

**Revised text:**

PRO-CTCAE (by e-device) <sup>p, w</sup>		X	← weekly (± 2 days) for first 18 weeks of from randomization to treatment →		X <sup>q</sup>	X		X <sup>o</sup>	X <sup>o</sup>	5.3.2
--------------------------------------------	--	---	--------------------------------------------------------------------------------	--	----------------	---	--	----------------	----------------	-------

**Reason for Amendment:**

PRO CTAE (by e-device) assessment was corrected to read “weekly ( $\pm$  2 days) for the first 18 weeks from randomization” to provide better clarification on the time period the ePRO is collected.

**Change 9**

**Sections of protocol affected:**

4.0 STUDY PLAN AND TIMING OF PROCEDURES

**Table 2 Study Plan for Platinum-based Doublet Chemotherapy Subjects**

Footnote b:

- b Visit schedule changes after Cycle 7 Day 1 from every 21 days (3 weeks) to every 42 days (6 weeks). Platinum-based doublet chemotherapy will be administered every 21 days from previous cycle’s day 1. Subjects can continue to receive platinum-based doublet-chemotherapy until meeting discontinuation criteria (see section 3.9) or up to a total of 6 cycles or until progression (whichever occurs first). Each cycle treatment may be interrupted maximum 14 days for safety reasons. In case of treatment interruption, other assessments are to be done as originally planned. Subjects whose disease has not progressed after four cycles of platinum-based doublet chemotherapy may receive pemetrexed maintenance therapy.

**Revised Text:**

- b Visit schedule changes after Cycle 7 Day 1 from every 21 days (3 weeks) to every 42 days (6 weeks). Platinum-based doublet chemotherapy will be administered every 21 days from previous cycle’s day 1. Subjects can continue to receive platinum-based doublet-chemotherapy until meeting discontinuation criteria (see Section 3.9) or up to a total of 6 cycles or until progression (whichever occurs first). Each cycle treatment may be interrupted **for a maximum of 14-21 days for safety reasons. If cycle treatment is delayed by more than 21 days, subject will be permanently discontinued from doublet-chemotherapy. If appropriate, and according to the approved label use or local practice guidelines, pemetrexed may be continued as maintenance treatment.** In case of treatment interruption, other assessments are to be done as originally planned. Subjects whose disease has not progressed after four cycles of platinum-based doublet chemotherapy may receive pemetrexed maintenance therapy.

**Reason for Amendment:**

To provide additional clarification to the study plan in regards to treatment options given to investigators for patients having treatment delays of more than 21 days.

## Change 10

### Sections of protocol affected:

## 4. STUDY PLAN AND TIMING OF PROCEDURES

### Previous text:

**Table 3 Cross-over to AZD9291**

Visit	Cross-over AZD9291 Treatment Visit	AZD9291 Treatment Discontinuation	Survival follow-up	For details see Protocol Section
Cycle <sup>a</sup> / Day	Each cycle	NA	NA	
Day	NA	NA	NA	
Window (days) <sup>j</sup>	± 7	0	± 7	<b>SECTION:</b>
Cross-over Informed Consent	X			3.3, 4.1, 4.2, 4.3
Physical examination, including weight <sup>h</sup>	X	X		5.2.3, 5.2.6.1
WHO Performance status <sup>h</sup>	X	X	X	4.1
Vital signs (pulse and BP) <sup>hh</sup>	X	X		5.2.6
Clinical chemistry/ Haematology/Urinalysis <sup>h</sup>	X	X		5.2.1
Digital ECG <sup>h</sup>	X	X		5.2.4
EORTC QLQ-C30 and EQ-5D-5L (by e-device)	X <sup>c</sup>	X	X <sup>c</sup>	5.3.2
EORTC QLQ LC13 (by e-device)	X <sup>d</sup>	X	X <sup>d</sup>	5.3.2
PRO-CTCAE (by e-device) <sup>e</sup>	X <sup>d</sup>	X	X <sup>d</sup>	5.3.2
IVRS/IWRS	X	X		3.3, 3.5
Dose with AZD9291 <sup>i</sup>	X (daily)			7.1

**Revised text:**

**Table 3 Study Plan for Subjects Crossing-over to AZD9291**

Visit	Cross-over AZD9291 Treatment Visit	AZD9291 Treatment Discontinuation	Survival follow-up	For details see Protocol Section
Cycle <sup>a</sup> / Day	Each cycle	NA	NA	
Day	NA	NA	NA	
Window (days) <sup>i</sup>	± 7	0	± 7	SECTION:
Cross-over Informed Consent	X			3.3, 4.1, 4.2, 4.3
Physical examination, including weight <sup>h</sup>	X	X		5.2.3, 5.2.6.1
WHO Performance status <sup>h</sup>	X	X	X	4.1
Vital signs (pulse and BP) <sup>hh</sup>	X	X		5.2.6
Clinical chemistry/ Haematology/Urinalysis <sup>h</sup>	X	X		5.2.1
Digital ECG <sup>h</sup>	X	X		5.2.4
EORTC QLQ-C30 and EQ-5D-5L (by e-device)	X <sup>c</sup>	X	X <sup>c</sup>	5.3.2
EORTC QLQ LC13 (by e-device)	X <sup>d</sup>	X	X <sup>d</sup>	5.3.2
PRO-CTCAE (by e-device) <sup>e</sup>	X <sup>d</sup>	X	X <sup>d</sup>	5.3.2
IVRS/IWRS	X	X		3.3, 3.5
Dose with AZD9291 <sup>i</sup>	X <del>(with)</del>			7.1

**Reason for Amendment:**

Typographical error.

**Change 11**

**Section of protocol affected:**

4.2 Treatment period

For subjects who cross-over to AZD9291

**Previous text:**

In addition, the following criteria must be met for a subject to cross-over to AZD9291:

- No intervening systemic anti-cancer therapy following discontinuation of randomized chemotherapy treatment.
- At least a 14 day washout period between last dose of randomized chemotherapy and/or associated supportive treatments (i.e. corticosteroids, radiation), and starting cross-over AZD9291 treatment.

- Any unresolved toxicities from prior therapy should be controlled, and be no greater than CTCAE grade 1 (with the exception of alopecia which may be grade 2) at the time of starting AZD9291 treatment.

These subjects may continue treatment with AZD9291 as long as they show clinical benefit, as judged by the investigator.

**Revised text:**

**The ~~In addition,~~ the following criteria must be met for a subject to cross-over to AZD9291:**

- No intervening systemic anti-cancer therapy following discontinuation of randomized chemotherapy treatment.
- At least a 14 day washout period between last dose of randomized chemotherapy and/or associated supportive treatments (i.e. corticosteroids, radiation), and starting cross-over AZD9291 treatment.
- Any unresolved toxicities from prior therapy should be controlled, and be no greater than CTCAE grade 1 (with the exception of alopecia which may be grade 2) at the time of starting AZD9291 treatment.

These subjects may continue treatment with AZD9291 as long as they show clinical benefit, as judged by the investigator.

**While RECIST 1.1 assessments are not required to be reported in the RAVE eCRF following confirmation of progression by Independent Central Review, tumour assessments should be done in accordance to local clinical practices.**

**Reason for Amendment:**

Clarification that RECIST data is not required to be entered into the RAVE eCRF following confirmation of progression for subjects on the platinum-based doublet chemotherapy arm who are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review.

**Change 12**

**Section of protocol affected:**

4.3.1 Discontinuation visit

**Previous text:**

A Discontinuation Visit will be performed at the time randomized treatment is permanently stopped. A second Discontinuation Visit will be performed for those subjects that stop AZD9291 in the Cross-over Treatment Phase.

**Revised text:**

A Discontinuation Visit will be performed at the time randomized treatment is permanently stopped. A second Discontinuation Visit will be performed for those subjects that stop AZD9291 in the Cross-over Treatment Phase.

**For subjects randomized to the Platinum-based Doublet-Chemotherapy, the discontinuation visit should be done after central confirmation of disease progression. The Chemotherapy discontinuation visit and Cross-Over visit can be done on the same day, as long as all other parameters are met.**

**Reason for Amendment:**

Clarification on when the discontinuation visit should be done for subjects on the platinum-based doublet chemotherapy arm who are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review.

**Change 13**

**Section of protocol affected:**

5.1.1 RECIST 1.1

**Previous text:**

NA

**Revised text:**

**For subjects not or no longer under consideration, or ineligible to cross-over to AZD9291 (e.g. subjects randomized to the chemotherapy arm, but not meeting criteria to cross-over to AZD9291; subjects originally randomized to the AZD9291 arm; or subjects who already crossed-over to AZD9291), no subsequent tumour assessments are expected to be sent for independent central imaging analysis after the investigator confirms objective disease progression.**

**Reason for Amendment:**

Clarification that tumour assessments are not required to be sent for independent central imaging review after disease progression to platinum-based doublet chemotherapy.

**Change 14**

**Section of protocol affected:**

5.2.4 ECG

**Previous text:**

All subjects will have three 12-lead ECG performed at the time points indicated in Study Plan

(Table 1, Table 2, or Table 3). A twelve-lead ECG will be obtained after the subject has been resting semi-supine for at least 10 minutes prior to times indicated and should be recorded at 25 mm/sec. All ECGs should be recorded with the subject in the same physical position. The three ECG recordings should be taken within an approximate 5 minute period. Digital ECG recordings will be collected, analyzed and stored by a central ECG vendor. A 28-day followup assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

**Revised text:**

All subjects will have three 12-lead ECG performed at the time points indicated in Study Plan (Table 1, Table 2, or Table 3). A twelve-lead ECG will be obtained after the subject has been resting semi-supine for at least 10 minutes prior to times indicated and should be recorded at 25 mm/sec. All ECGs should be recorded with the subject in the same physical position. The three ECG recordings should be taken within an approximate 5 minute period. **A standardised ECG machine should be used and the patient should be examined using the same machine throughout the study if possible.**

**After paper ECGs have been recorded, the investigator or designated physician will review each of the ECGs and may refer to a local cardiologist if appropriate. A paper copy should be filed in the patient's medical records. If an abnormal ECG finding at screening or baseline is considered to be clinically significant by the investigator, it should be reported as a concurrent condition. For all ECGs details of rhythm, ECG intervals and an overall evaluation will be recorded.**

~~Digital ECG recordings will be collected, analyzed and stored by a central ECG vendor.~~

**ECG data will be collected digitally and will be transferred electronically for central analysis as described in the study specific ECG manual.**

**Heart rate, PR, R-R, QRS and QT intervals will be determined and reviewed by an external cardiologist.**

**If there is a clinically significant abnormal ECG finding during the Treatment period, this should be recorded on the AE eCRF, according to standard adverse events collection and reporting processes.** A 28-day followup assessment will be required if an on treatment assessment was abnormal at the time of discontinuation of study therapy, to confirm reversibility of the abnormality.

**Patients who experience a QTc interval greater than 500 msec on at least 2 separate ECGs must have AZD9291 treatment interrupted until the QTc interval is less than 481 msec or recovery to baseline if baseline QTc is greater than or equal to 481 msec, then restart at a reduced dose (40 mg).**

**Patients experiencing QTc interval prolongation with signs/symptoms of serious arrhythmia will not be permitted to restart study treatment.**

**Reason for Amendment:**



To provide additional clarification on the collection of ECG data and to reflect the current management of patients who experience a QTc interval greater than 500 msec or a QTc interval prolongation with sign/symptoms of serious arrhythmia.

## **Change 15**

### **Section of protocol affected:**

5.4.1 Collection of samples for subjects randomized to AZD9291

### **Previous text:**

The date and time of collection of each sample and the date and time of dose will be recorded.

### **Revised text:**

The date and time of collection of each sample and the date and time of dose (**on PK sampling day and for previous dose**) will be recorded.

### **Reason for Amendment:**

Clarification on what information needs to be recorded for PK samples.

## **Change 16**

### **Section of protocol affected:**

5.4.3 Storage and destruction of pharmacokinetic samples

### **Previous text:**

Any residual back-up PK samples may be used for future exploratory biomarker research (in this case, residual back-up PK samples will be shipped to AZ Biobank; see details in the Laboratory Manual).

### **Revised text:**

Any residual back-up PK samples may be used for future exploratory biomarker research (in this case, residual back-up PK samples will be shipped to **the AZ Biobank or its designee**; see details in the Laboratory Manual).

### **Reason for Amendment:**

Clarification, due to change in Biobank facility.

## **Change 17**

### **Section of protocol affected:**

5.7.1 Storage, re-use and destruction of biological samples

#### **Previous text:**

Samples will be stored for a maximum of 15 years from the date of the Last Subject's Last Visit, after which they will be destroyed. The results of this biomarker research will be reported either in the Clinical Study Report itself or as an addendum, or separately in a scientific report or publication. The results of this biomarker research may be pooled with biomarker data from other studies with the investigational product to generate hypotheses to be tested in future research.

#### **Revised text:**

~~Samples will be stored for a maximum of 15 years from the date of the Last Subject's Last Visit,~~ **Biological samples for future research will be retained at AstraZeneca or its designee for a maximum of 15 years following the finalisation of the Clinical Study Report,** after which they will be destroyed. The results of this biomarker research will be reported either in the Clinical Study Report itself or as an addendum, or separately in a scientific report or publication. The results of this biomarker research may be pooled with biomarker data from other studies with the investigational product to generate hypotheses to be tested in future research.

#### **Reason for Amendment:**

Improved clarification on the time period and storage location of biological samples for this protocol.

## **Change 18**

### **Section of protocol affected:**

5.7.3 Chain of custody of biological samples

#### **Previous text:**

Samples retained for further use are registered in the AstraZeneca Biobank during the entire life cycle.

#### **Revised text:**

Samples retained for further use are registered in the AstraZeneca Biobank **system** during the entire life cycle.

#### **Reason for Amendment:**

Clarification, due to change in Biobank facility.

## **Change 19**

### **Section of protocol affected:**

#### **6.5 Overdose**

##### **Previous text:**

Investigators are advised that any subject, who receives a higher dose than intended should be monitored closely, managed with appropriate supportive care and followed up expectantly.

##### **Revised text:**

~~Investigators are advised that any subject, who receives a higher dose than intended should be monitored closely, managed with appropriate supportive care and followed up expectantly.~~  
**There is no definition of what constitutes an overdose. In the Phase I study, 355 patients with advanced NSCLC were administered AZD9291 at single and multiple oral doses ranging from 20 mg to 240 mg daily (as of data cut-off date 02 December 2014). All doses were well tolerated. Experiences of excessive doses (i.e. in excess of the optimal 80 mg indicated dose) in this study did not show any DLTs or acute toxicities.**

**There is no known antidote. Investigators will be advised that any patient who receives a higher dose than that intended should be monitored closely, managed with appropriate supportive care and followed up expectantly.**

##### **Reason for Amendment:**

Revision due to the availability of Phase I data where patients routinely received in excess of the optimal 80 mg daily dose.

## **Change 20**

### **Section of protocol affected:**

#### **6.7 Management of toxicities related to AZD9291**

##### **Previous text:**

If new or worsening pulmonary symptoms (e.g., dyspnoea) or radiological abnormality suggestive of interstitial lung disease is observed, an interruption in study treatment dosing is recommended, and the AstraZeneca study team should be informed. A questionnaire regarding the results of the full diagnostic workup (including high-resolution computed tomography (HRCT), blood and sputum culture, haematological parameters) will be sent to Investigators. It is strongly recommended to perform a full diagnostic workup, to exclude alternative causes such as lymphangitic carcinomatosis, infection, allergy, cardiogenic edema, or pulmonary hemorrhage. In the presence of confirmatory HRCT scans where other causes of respiratory symptoms have been excluded, a diagnosis of interstitial lung disease should be considered and study treatment permanently discontinued.

In the absence of a diagnosis of interstitial lung disease study treatment may be restarted following consultation with the AstraZeneca Study Team Physician.

Subjects with QTcF prolongation fulfilling the following criteria (ie, confirmed QTcF prolongation to > 500 msec absolute or a > 60 msec increase from baseline) should have study treatment interrupted and regular ECGs performed until resolution to baseline. If the toxicity does not resolve to < grade 1 within 3 weeks the subject will be permanently withdrawn from study treatment.

Subjects experiencing corneal ulceration or Interstitial Lung Disease will not be permitted to restart study treatment.

**Revised text:**

If new or worsening pulmonary symptoms (e.g., dyspnoea) or radiological abnormality suggestive of interstitial lung disease is observed, an interruption in study treatment dosing is recommended, and the AstraZeneca study team should be informed. ~~The A-questionnaire regarding the results of the full diagnostic workup (including high-resolution computed tomography (HRCT), blood and sputum culture, haematological parameters) will be sent to investigators~~ **captured in the RAVE eCRF. All image data should also be provided to AstraZeneca.** It is strongly recommended to perform a full diagnostic workup, to exclude alternative causes such as lymphangitic carcinomatosis, infection, allergy, cardiogenic edema, or pulmonary hemorrhage. In the presence of confirmatory HRCT scans where other causes of respiratory symptoms have been excluded, a diagnosis of interstitial lung disease should be considered and study treatment permanently discontinued.

In the absence of a diagnosis of interstitial lung disease study treatment may be restarted following consultation with the AstraZeneca Study Team Physician.

~~Subjects with QTcF prolongation fulfilling the following criteria (ie, confirmed QTcF prolongation to > 500 msec absolute or a > 60 msec increase from baseline) should have study treatment interrupted and regular ECGs performed until resolution to baseline. If the toxicity does not resolve to < grade 1 within 3 weeks the subject will be permanently withdrawn from study treatment.~~

**Subjects who experience a QTc interval greater than 500 msec on at least 2 separate ECGs must have AZD9291 treatment interrupted until the QTc interval is less than 481 msec or recovery to baseline if baseline QTc is greater than or equal to 481 msec, then restart at a reduced dose (40 mg). Subjects experiencing QTc interval prolongation with signs/symptoms of serious arrhythmia will not be permitted to restart study treatment.**

~~Subjects experiencing corneal ulceration or Interstitial Lung Disease~~ **any of the following** will not be permitted to restart study treatment:-

- **Corneal ulceration**
- **Interstitial Lung Disease (ILD)**
- **QTc interval prolongation with signs/symptoms of serious arrhythmia**

**Reason for Amendment:**

Revision to reflect that the ILD paper questionnaire is now replaced by a separate ILD module within the RAVE eCRF system. Also to reflect the current management of patients who experience a QTc interval greater than 500 msec or a QTc interval prolongation with sign/symptoms of serious arrhythmia.

**Change 21**

**Section of protocol affected:**

7.1 Identity and Dose of investigational product – AZD9291

**Previous text:**

Investigational product	Dosage form and strength	Manufacturer
AZD9291	40mg Tablets 80mg Tablets	AstraZeneca

AstraZeneca will supply AZD9291 as tablets for oral administration as a single daily dose of 80 mg. Subjects (with the exception of subjects with insulin dependent diabetes) must fast for  $\geq 1$  hours prior to taking a dose to  $\geq 2$  hour post dose. Water is permitted during this fasting period. Subjects will be required to fast (water only) for at least 8 hours prior to the collection of a fasting glucose sample as per the study plan (Table 1) and Section 5.2.1.

If data is generated that demonstrates that it is not necessary to maintain the fasting restriction, this will be communicated to Investigational Sites.

At each dispensing visit, sufficient AZD9291 for 21 days treatment, plus overage, will be distributed. Individual bottles will be dispensed in accordance with the medication identification numbers provided by the IVRS/IWRS.

Subjects should swallow one AZD9291 80 mg tablets once daily, commencing on Cycle 1 Day 1. Tablets should be taken whole with water.

**Revised text:**

Investigational product	Dosage form and strength	Manufacturer
AZD9291	40mg Tablets 80mg Tablets	AstraZeneca

AstraZeneca will supply AZD9291 as tablets for oral administration as a single daily dose of 80 mg. **Tablets can be taken whole with approximately 240 mL water, with or without regard to food.** ~~Subjects (with the exception of subjects with insulin dependent diabetes) must fast for  $\geq 1$  hours prior to taking a dose to  $\geq 2$  hour post dose. Water is permitted during~~

~~this fasting period.~~ Subjects will be required to fast (water only) for at least 8 hours prior to the collection of a fasting glucose sample as per the study plan (Table 1) and Section 5.2.1.

~~If data is generated that demonstrates that it is not necessary to maintain the fasting restriction, this will be communicated to Investigational Sites.~~

At each dispensing visit, sufficient AZD9291 for 21 days treatment, plus overage, will be distributed. Individual bottles will be dispensed in accordance with the medication identification numbers provided by the IVRS/IWRS.

Subjects should swallow one AZD9291 80 mg tablets once daily, commencing on Cycle 1 Day 1. Tablets should be taken whole with water, **with or without food**.

#### **Reason for Amendment:**

Removal of manufacturer to mitigate the risk of future protocol amendments if any manufacturer changes occur. For the food restriction changes, based on a clinical pharmacokinetic study in patients at 80 mg, exposure to AZD9291 is not altered by food (90% CI for exposure ratio contained within the 80-125% limit).

#### **Change 22**

##### **Section of protocol affected:**

7.7 Concomitant and other treatments

##### **Previous text:**

Information on any treatment in the 4 weeks prior to starting study treatment and all concomitant treatments given during the study, with reasons for the treatment, will be recorded in the CRF. After permanent discontinuation of study treatment and 28 day follow up, only subsequent regimens of anti-cancer therapy will be recored in CRF. If medically feasible, subjects taking regular medication, with the exception of potent inhibitors or inducers of CYP3A4 (see Appendix F), should be maintained on it throughout the study period. Subjects taking concomitant medications whose disposition is dependent upon CYP3A4, CYP2C8 or BCRP and which have a narrow therapeutic index should be closely monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst receiving AZD9291. Subjects taking concomitant medications whose disposition is dependent upon CYP3A4, CYP1A2, CYP2C or p-glycoprotein and which have a narrow therapeutic index should be closely monitored for reduction in therapeutic activity as a result of the reduced exposure of the concomitant medication whilst receiving AZD9291. Guidance on medications that require close monitoring is given in Appendix F.

Up to 3 fold increase in exposure may occur in statin exposure when coadministered with AZD9291. It is recommended that the starting and maintenance dose of statins should be as low as possible and should be guided by the statin label. Monitoring of low-density lipoprotein (LDL) cholesterol levels is advised. If the subject experiences any potentially relevant adverse events suggestive of muscle toxicity including unexplained muscle pain,

tenderness, or weakness, particularly if accompanied by malaise or fever, the statin should be stopped, creatine kinase (CK) levels should be checked, and any appropriate further management should be taken.

#### **Revised text:**

Information on any treatment in the 4 weeks prior to starting study treatment and all concomitant treatments given during the study, with reasons for the treatment, will be recorded in the CRF. After permanent discontinuation of study treatment and 28 day follow up, only subsequent regimens of anti-cancer therapy will be recored in CRF. If medically feasible, subjects taking regular medication, with the exception of potent ~~inhibitors or~~ inducers of CYP3A4 (see Appendix F), should be maintained on it throughout the study period. Subjects randomized to AZD9291 taking concomitant medications whose disposition is dependent upon ~~CYP3A4, CYP2C8 or~~ Breast cancer resistance protein (BCRP) and which have a narrow therapeutic index should be closely monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst receiving AZD9291. ~~Subjects taking concomitant medications whose disposition is dependent upon CYP3A4, CYP1A2, CYP2C or p-glycoprotein and which have a narrow therapeutic index should be closely monitored for reduction in therapeutic activity as a result of the reduced exposure of the concomitant medication whilst receiving AZD9291.~~ Guidance on medications that require close monitoring is given in Appendix F.

**Patients taking rosuvastatin (due to BCRP mediated increase in exposure) should have CPK levels monitored.** ~~Up to 3 fold increase in exposure may occur in statin exposure when coadministered with AZD9291. It is recommended that the starting and maintenance dose of statins should be as low as possible and should be guided by the statin label. Monitoring of low density lipoprotein (LDL) cholesterol levels is advised.~~ If the subject experiences any potentially relevant adverse events suggestive of muscle toxicity including unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever, ~~the~~ **statin rosuvastatin** should be stopped, creatine kinase (CK) levels should be checked, and any appropriate further management should be taken.

#### **Reason for Amendment:**

This is based on the results from Study D5160C00012 which evaluated the effect of itraconazole (a strong CYP3A4 inhibitor) on the exposure of AZD9291. In that clinical pharmacokinetic study in patients, AZD9291 co-administered with 200 mg itraconazole twice daily had no clinically significant effect on the exposure of AZD9291 (AUC increased by 24% (90%CI 15, 35) and Cmax decreased by 20% (90% CI -27, -13)). Therefore, CYP3A4 inhibitors are not likely to affect the exposure of AZD9291 and hence, the restrictions on CYP3A4 inhibitors are removed.

In a clinical PK study, co-administration of AZD9291 with rosuvastatin (sensitive BCRP substrate) increased the AUC and Cmax of rosuvastatin by 35% (90%CI 15, 57) and 72% (90% CI 46, 103), respectively. Patients taking concomitant medications where the disposition is dependent upon BCRP and with narrow therapeutic index should be closely

monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst receiving AZD9291.

### **Change 23**

#### **Section of protocol affected:**

7.7 Concomitant and other treatments

#### **Previous text:**

##### **Study Treatment (Subjects randomized to AZD9291)**

Subjects (with the exception of subjects with insulin dependent diabetes) must fast for  $\geq 1$  hours prior to taking a dose to  $\geq 2$  hour post dose. Water is permitted during this fasting period.

#### **Revised text:**

##### **Study Treatment (Subjects randomized to AZD9291)**

**Tablets should be taken whole with approximately 240 mL water, with or without regard to food.**

~~Subjects (with the exception of subjects with insulin dependent diabetes) must fast for  $\geq 1$  hours prior to taking a dose to  $\geq 2$  hour post dose. Water is permitted during this fasting period.~~

#### **Reason for Amendment:**

Based on a clinical pharmacokinetic study in patients at 80 mg, exposure to AZD9291 is not altered by food (90% CI for exposure ratio contained within the 80-125% limit).

### **Change 24**

#### **Section of protocol affected:**

8.1 Statistical considerations

#### **Previous text:**

A comprehensive Statistical Analysis Plan (SAP) will be prepared and finalised prior to first subject in (FSI). The aim of the study is to compare the efficacy and safety of AZD9291 versus platinum-based doublet chemotherapy. All analyses will be performed by AstraZeneca or its representatives.

The primary analysis will be performed when approximately 295 PFS events have occurred, so that the PFS data are approximately 70% mature. Three analyses of OS are planned; two interim analyses and an optional final analysis. The first interim analysis of overall survival will be conducted at the time of the primary analysis of PFS and the second interim analysis will be conducted when the OS data are approximately 50% mature (approximately 205 death



events). A final analysis of overall survival may be performed when the OS data are approximately 70% mature (approximately 287 death events).

### Multiple Testing Strategy

In order to describe the benefits of AZD9291 treatment, the primary and secondary endpoints will be tested at a 2-sided significance level of 5%.

However, in order to provide strong control of the type I error rate, the primary endpoint of PFS and key secondary endpoints, ORR and OS will be tested in this sequential order. If any previous analysis in the sequence is not statistically significant, the alpha spending cannot be transferred to subsequent analyses. The analyses of primary and all secondary endpoints will all occur at the time of primary analysis of PFS. A 2-sided 5% alpha will be used in all testing, with the exception of overall survival endpoint. Since three analyses of OS are planned, the alpha will be split between the three analyses, in order to control the overall type I error, as follows: 2% will be allocated to the first interim analysis, 2.5% will be allocated to the second interim analysis and the remaining alpha will be allocated to the final analysis. Therefore, any non-statistically significant analyses at the interims will not preclude further testing of OS.

However, if, at the 2nd interim analysis, when the OS data are expected to be 50% mature, a statistically significant improvement in OS is not observed, AstraZeneca may decide not to perform the final OS analysis.

#### Revised text:

A comprehensive Statistical Analysis Plan (SAP) will be prepared and finalised prior to first subject in (FSI). The aim of the study is to compare the efficacy and safety of AZD9291 versus platinum-based doublet chemotherapy. All analyses will be performed by AstraZeneca or its representatives.

The primary analysis will be performed when **at least approximately 221** ~~approximately 221~~ ~~295~~ PFS events have occurred, so that the PFS data are approximately **54** ~~70~~ % mature. Three analyses of OS are planned; two interim analyses and an ~~optional~~ final analysis. The **data cut-off for the first interim analysis of overall survival will be conducted at the time of approximately 4 months after data cut-off for the primary analysis of PFS and the second interim analysis will be conducted when the OS data are approximately 50% mature (approximately 205 death events). A final analysis of overall survival will may be performed when the OS data are approximately 70% mature (approximately 287 death events).**

### Multiple Testing Strategy

In order to describe the benefits of AZD9291 treatment, the primary and secondary endpoints will be tested at a 2-sided significance level of 5%.

However, in order to provide strong control of the type I error rate (**2-sided 5%**), the primary endpoint of PFS and key **efficacy** secondary endpoints, ORR and OS will be tested in this sequential order. If any previous analysis in the sequence is not statistically significant, the

~~alpha spending cannot be transferred to subsequent analyses. The analyses of primary and all secondary endpoints will all occur at the time of primary analysis of PFS. A 2-sided 5% alpha will be used in all testing, with the exception of overall survival endpoint. Since three analyses of OS are planned, the Lan DeMets approach that approximates the O'Brien and Fleming spending function will be used to maintain an overall 2-sided 5% type I error across the three planned analyses of OS alpha will be split between the three analyses, in order to control the overall type I error, as follows: 2% will be allocated to the first interim analysis; 2.5% will be allocated to the second interim analysis and the remaining alpha will be allocated to the final analysis. Note, Therefore, any non-statistically significant analyses at the interims will not preclude further testing of OS.~~

~~However, if, at the 2nd interim analysis, when the OS data are expected to be 50% mature, a statistically significant improvement in OS is not observed, AstraZeneca may decide not to perform the final OS analysis.~~

**For PRO symptoms and health related quality of life endpoints, the overall type I error (5% 2 sided) will be controlled across the five primary PRO measures of cough, dyspnoea and pain as assessed by the EORTC QLQ-LC13 and fatigue and appetite loss as assessed by the EORTC QLQ-C30 using the Bonferroni-Holm procedure.**

**The physical functioning and overall health status domains of the EORTC CT30 are furthermore pre-specified endpoints of interest.**

#### **Reason for Amendment:**

AstraZeneca proposes to change the power to detect a statistically significant difference for the primary analysis of progression-free survival [PFS] from 90% to 80% (assuming a Hazard Ratio [HR] = 0.67). This change is based on the compelling results from the most recent PFS data from the Phase II osimertinib monotherapy studies (AURA extension and AURA2). If the assumed the treatment effect were still a HR of 0.67 (which translates to approximate 3-month improvement on an estimated median PFS of 6 months on the control arm assuming proportional hazards), then 221 progression events provides 80% power to demonstrate a statistically significant difference in PFS at the 5% 2 sided significance level (as compared with the 295 progression events required for assuring the currently planned 90% power).

Additionally, in order to maximise the maturity of the overall survival (OS) data at the time of the first analysis, the data cut for the first OS analysis will be performed approximately 4 months after data cut-off (DCO) for the primary PFS analysis. At the time of the primary PFS analysis, OS will be summarised only.

Following FDA feedback, the approach to control the overall type I error at 5% (2 sided) for OS has been modified to the Lan DeMets approach that approximates the O'Brien and Fleming spending function.

For PRO health related quality of life endpoints, the procedure for controlling overall type I error at 5% (2 sided) across the five primary PRO measures has been specified.

## Change 25

### Section of protocol affected:

#### 8.2 Sample size estimate

#### Previous text:

PFS is the primary endpoint for this study. Approximately 410 subjects will be randomized in a 2:1 ratio (AZD9291: chemotherapy) to this study.

The primary analysis of PFS will occur when approximately 295 progression events have been observed in the 410 globally randomized subjects. With 295 progression events, the study will provide 90% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were HR 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed. The smallest treatment difference that would be statistically significant is a PFS HR of 0.78. Assuming 12 months non-linear recruitment, 295 PFS events are expected to occur approximately 23 months after the first subject is enrolled in the study.

Assuming 12 months non-linear recruitment, 295 PFS events are expected to occur approximately 23 months after the first subject is enrolled in the study.

If the true OS hazard ratio for the comparison of AZD9291 versus chemotherapy is 0.72, 287 death events will provide approximately 80% power to demonstrate a statistically significant difference in OS at 5% 2-sided significance level. Assuming 12 months non-linear recruitment, 16-19 month median on chemotherapy, 287 OS events are expected to occur approximately 42-48 months after the first subject is enrolled in the study. Assuming 12 months non-linear recruitment, 295 PFS events are expected to occur approximately 23 months after the first subject is enrolled in the study.

In order to randomize 410 subjects assuming a 10% screen failure rate, 455 T790M+ subjects will need to be enrolled. In order to enrol 455 T790M+ subjects, 1034 subjects will need to be screened [assuming 827 (55%) of subjects are T790+ and allowing for a 20% attrition rate].

#### Revised text:

#### 8.2 Sample size estimate

PFS is the primary endpoint for this study. Approximately 410 subjects will be randomized in a 2:1 ratio (AZD9291: chemotherapy) to this study.

The primary analysis of PFS will occur when **at least approximately 221** ~~295~~ progression events have been observed out of the 410 globally randomized subjects. With **221** ~~295~~ progression events, the study will have **at least 80** ~~>90~~% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were HR 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed. The smallest treatment difference that would be statistically significant is a PFS HR of ~~0.78~~ **0.76 (this translates into an**

**approximate 2 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed).** Assuming ~~15~~ 12 months non-linear recruitment, ~~221~~ 295 PFS events are expected to occur approximately ~~20~~ 23 months after the first subject is ~~randomized~~enrolled in the study.

~~Assuming 12 months non-linear recruitment, 295 PFS events are expected to occur approximately 23 months after the first subject is enrolled in the study.~~

~~If the true OS hazard ratio for the comparison of AZD9291 versus chemotherapy is 0.72, 287 death events will provide > approximately 80% power to demonstrate a statistically significant difference in OS at 5% 2-sided significance level. Assuming 12 months non-linear recruitment, 16-19 month median on chemotherapy, 287 OS events are expected to occur approximately 42-48 months after the first subject is enrolled in the study.~~

~~Assuming 12 months non-linear recruitment, 295 PFS events are expected to occur approximately 23 months after the first subject is enrolled in the study.~~

In order to randomize 410 subjects assuming a 10% screen failure rate, 455 T790M+ subjects will need to be enrolled. In order to enrol 455 T790M+ subjects, 1034 subjects will need to be screened [assuming 827 (55%) of subjects are T790+ and allowing for a 20% attrition rate].

#### **Reason for Amendment:**

AstraZeneca proposes to change the power to detect a statistically significant difference for the primary analysis of progression-free survival [PFS] from 90% to 80% (assuming a Hazard Ratio [HR] = 0.67). This change is based on the compelling results from the most recent PFS data from the Phase II osimertinib monotherapy studies (AURA extension and AURA2). If the assumed the treatment effect were still a HR of 0.67 (which translates to approximate 3-month improvement on an estimated median PFS of 6 months on the control arm assuming proportional hazards), then 221 progression events provides 80% power to demonstrate a statistically significant difference in PFS at the 5% 2- sided significance level (as compared with the 295 progression events required for assuring the currently planned 90% power).

Additionally, in order to maximise the maturity of the overall survival (OS) data at the time of the first analysis, the data cut for the first OS analysis will be performed approximately 4 months after data cut-off (DCO) for the primary PFS analysis. At the time of the primary PFS analysis, OS will be summarised only and not analysed. A summary of the frequency of deaths and primary cause of death will be provided for safety purposes, no additional summaries will be performed in order to protect the integrity of the OS analyses.

## **Change 26**

### **Section of protocol affected:**

8.4.1 Calculation or derivation of efficacy variables

### **Previous text:**

#### **Overall Survival (OS)**

Overall survival is defined as the time from the date of first dose until death due to any cause. Any subject not known to have died at the time of analysis will be censored based on the last recorded date on which the subject was known to be alive.

### **Revised text:**

#### **Overall Survival (OS)**

Overall survival is defined as the time from the date of **randomization** ~~first dose~~ until death due to any cause. Any subject not known to have died at the time of analysis will be censored based on the last recorded date on which the subject was known to be alive.

### **Reason for Amendment:**

Clarification to define OS as this is a randomised study and therefore the time to death variable should be derived from the date of randomised and not first dose. This was a typographical error carried forward from the definition of overall survival included in a non-randomised study.

## **Change 27**

### **Section of protocol affected:**

8.4.1 Calculation or derivation of efficacy variables

### **Previous text:**

#### **HRQoL & Symptoms**

Patient reported outcomes will be assessed using the EORTC QLQ-C30 and QLQ-LC13 questionnaires. The QLQ-C30 consists of 30 questions, which can be combined to produce 5 functional scales (Physical, Role, Cognitive, Emotional, Social), 3 symptom scales (Fatigue, Pain, Nausea/vomiting), 5 individual items (dyspnoea, insomnia, appetite loss, constipation, diarrhoea) and a global measure of health status. The QLQ-LC13 is a lung cancer specific module comprising 13 questions to assess lung cancer symptoms (cough, haemoptysis, dyspnoea and site-specific pain), treatment related side-effects (sore mouth, dysphagia, peripheral neuropathy and alopecia) and pain medication. With the exception of a multi-item scale for dyspnoea, all are single items.

An outcome variable consisting of a score from 0 to 100 will be derived for each of the symptom scales/symptom items, the functional scales and the global health status scale in the

QLQ-C30 and for each of the symptom scales/items in the QLQ-LC13 according to the EORTC QLQ-C30 Scoring Manual and EORTC QLQ-LC13 instructions.

Higher scores on the global health status and functioning scales indicate better health status/function. Higher scores on the symptoms scales indicate greater symptom burden.

The primary PRO outcome measures will be patient-reported lung cancer symptoms assessed using the EORTC QLQ-LC13, namely

- dyspnoea (multi-item scale based on three questions: “Were you short of breath when you rested; walked; climbed stairs”),
- cough: one item (“How much did you cough?”),
- haemoptysis: one item (“Did you cough up blood?”),
- pain: three individual items (“Have you had pain in your chest; your arm or shoulder; other parts of your body?”).

***Definition of clinically meaningful changes***

Changes in score compared to baseline will be evaluated. A minimum clinically meaningful change is defined as a change in the score from baseline of  $\geq 5$  for scales/items from the QLQ-LC13 and  $\geq 10$  for scales/items from the QLQ-C30 (Obosa et al 1998).

For example, a clinically meaningful deterioration or worsening in chest pain (as assessed by QLQ-LC13) is defined as an increase in the score from baseline of  $\geq 5$ . A clinically meaningful improvement in fatigue (as assessed by QLQ-C30) is defined as a decrease in the score from baseline of  $\geq 10$ .

At each post-baseline assessment, change in symptoms/functioning from baseline will be categorised as improved, stable or worsening as shown in Table 11.

**Table 11 Visit response for HRQoL and disease-related symptoms**

Score	Change from baseline	Visit Response
LC13 symptom scales/items	$\geq +5$	Worsened
	$\leq -5$	Improved
	Otherwise	Stable
C30 symptom scales/items	$\geq +10$	Worsened
	$\leq -10$	Improved
	Otherwise	Stable

C30 functional scales and Global health status	$\geq +10$	Worsened
	$\leq -10$	Improved
	Otherwise	Stable

### ***Time to symptom deterioration***

For each of the symptoms scales/items in QLQ-LC13, time to symptom deterioration will be defined as the time from randomization until the date of first clinically meaningful symptom deterioration (an increase in the score from baseline of  $\geq 5$ ) or death (by any cause) in the absence of a clinically meaningful symptom deterioration, regardless of whether the subject withdraws from randomized therapy or receives another anticancer therapy prior to symptom deterioration. Death will be included as an event only if the death occurs within two visits of the last PRO assessment where the symptom change could be evaluated.

Subjects whose symptoms (as measured by QLQ-LC13) have not shown a clinically meaningful deterioration and who are alive at the time of the analysis will be censored at the time of their last PRO assessment where the symptom could be evaluated. Also, if symptoms progress after two or more missed PRO assessment visits or the subject dies after two or more missed PRO assessment visits, the subject will be censored at the time of the last PRO assessment where the symptom could be evaluated. If a subject has no evaluable visits or does not have baseline data they will be censored at day 1. The population for analysis of time to symptom deterioration will include a subset of the ITT population who have baseline scores  $\leq 95$ .

### ***Symptom Improvement Rate***

The symptom improvement rate will be defined as the number (%) of subjects with two consecutive assessments at least 18 days apart (ie, 21 days allowing a visit window of 3 days), which showed a clinically meaningful improvement (a decrease from baseline score  $\geq 5$  for LC13 scales/items or  $>10$  for C30 scales/items) in that symptom from baseline. The denominator will consist of a subset of the ITT population who have a baseline symptom score  $\geq 5$  (LC13 scales/items) or  $\geq 10$  (C30 scales/items).

### **Revised text:**

#### **Symptoms & HRQoL**

Patient reported outcomes will be assessed using the EORTC QLQ-C30 and QLQ-LC13 questionnaires. The QLQ-C30 consists of 30 questions, which can be combined to produce 5 functional scales (Physical, Role, Cognitive, Emotional, Social), 3 symptom scales (Fatigue, Pain, Nausea/vomiting), 5 individual items (dyspnoea, insomnia, appetite loss, constipation, diarrhoea) and a global measure of health status. The QLQ-LC13 is a lung cancer specific module comprising 13 questions to assess lung cancer symptoms (cough, haemoptysis,

dyspnoea and site-specific pain), treatment related side-effects (sore mouth, dysphagia, peripheral neuropathy and alopecia) and pain medication. With the exception of a multi-item scale for dyspnoea, all are single items.

An outcome variable consisting of a score from 0 to 100 will be derived for each of the symptom scales/symptom items, the functional scales and the global health status scale in the QLQ-C30 and for each of the symptom scales/items in the QLQ-LC13 according to the EORTC QLQ-C30 Scoring Manual and EORTC QLQ-LC13 instructions.

Higher scores on the global health status and functioning scales indicate better health status/function. Higher scores on the symptoms scales indicate greater symptom burden.

The primary PRO outcome measures will be patient-reported lung cancer symptoms assessed using the EORTC QLQ-LC13 and QLQ-C30, namely

- dyspnoea (multi-item scale based on three questions: “Were you short of breath when you rested; walked; climbed stairs”),
- cough: one item (“How much did you cough”),
- ~~haemoptysis: one item (“Did you cough up blood?”),~~
- pain: ~~three~~ **one** individual items (“Have you had pain in your chest; ~~your arm or shoulder; other parts of your body~~”).
- fatigue (a composite score of three items: “Did you need rest; Have you felt weak; Were you tired”)
- appetite loss: one individual item (“Have you lacked appetite”)

***Definition of clinically meaningful changes***

Changes in score compared to baseline will be evaluated. A minimum clinically meaningful change is defined as a change in the score from baseline of  $\geq 5$ ~~10~~ for scales/items from the QLQ-LC13 and  $\geq 10$  ~~for scales/items from~~ the QLQ-C30 (Obosa et al 1998).

For example, a clinically meaningful deterioration or worsening in chest pain (as assessed by QLQ-LC13) is defined as an increase in the score from baseline of  $\geq 5$ ~~10~~. A clinically meaningful improvement in fatigue (as assessed by QLQ-C30) is defined as a decrease in the score from baseline of  $\geq 10$ .

At each post-baseline assessment, change in symptoms/functioning from baseline will be categorised as improved, stable or worsening as shown in Table 11.

**Table 11 Visit response for HRQoL and disease-related symptoms**

Score	Change from baseline	Visit Response
LC13 symptom scales/items	$\geq +5$ <del>10</del>	Worsened



	$\leq -510$	Improved
	Otherwise	Stable
C30 symptom scales/items	$\geq +10$	Worsened
	$\leq -10$	Improved
	Otherwise	Stable
C30 functional scales and Global health status	$\geq +10$	Worsened
	$\leq -10$	Improved
	Otherwise	Stable

### ***Time to symptom deterioration***

For each of the symptoms scales/items in QLQ-LC13, time to symptom deterioration will be defined as the time from randomization until the date of first clinically meaningful symptom deterioration (an increase in the score from baseline of  $\geq 510$ ) or death (by any cause) in the absence of a clinically meaningful symptom deterioration, regardless of whether the subject withdraws from randomized therapy or receives another anticancer therapy prior to symptom deterioration. Death will be included as an event only if the death occurs within two visits of the last PRO assessment where the symptom change could be evaluated.

Subjects whose symptoms (as measured by QLQ-LC13) have not shown a clinically meaningful deterioration and who are alive at the time of the analysis will be censored at the time of their last PRO assessment where the symptom could be evaluated. Also, if symptoms progress after two or more missed PRO assessment visits or the subject dies after two or more missed PRO assessment visits, the subject will be censored at the time of the last PRO assessment where the symptom could be evaluated. If a subject has no evaluable visits or does not have baseline data they will be censored at day 1. The population for analysis of time to symptom deterioration will include a subset of the ITT population who have baseline scores  $\leq 9590$ .

### ***Symptom Improvement Rate***

The symptom improvement rate will be defined as the number (%) of subjects with two consecutive assessments at least 18 days apart (ie, 21 days allowing a visit window of 3 days), which showed a clinically meaningful improvement (a decrease from baseline score  $\geq 510$  for LC13 scales/items or  $\geq 40$  for C30 scales/items) in that symptom from baseline. The denominator will consist of a subset of the ITT population who have a baseline symptom score  $\geq 510$  (LC13 scales/items) or  $\geq 10$  (C30 scales/items).

***Mixed Models Repeated Measures (MMRM) Analysis***

**Change from baseline in cough, dyspnoea and pain scores as assessed by the EORTC QLQ-LC13 and fatigue and appetite loss as assessed by the EORTC QLQ-C30 will be the primary analysis and assessment of PRO outcome measures. The analysis will be performed using a linear mixed model for repeated measures (MMRM) analysis of change from baseline in the scores for each visit.**

**Symptom improvement rate and Time to symptom deterioration analyses will be considered as supportive analyses.**

**Reason for Amendment:**

The clinically meaningful threshold for the EORTC-QLQ-LC13 has been increased from 5 to 10 to be consistent with the EORTC-QLQ-Q30 questionnaire.

The primary PRO outcome measures have been updated to reflect those identified by the external NSCLC working group at the PRO Consortium at the Critical Path Institute as important lung cancer specific symptoms.

A mixed models repeated measures analysis of the primary PRO outcome measures has been added in order to provide an estimate of the treatment effect over time within and between treatment groups. Clarification has been provided that this is the primary method of analysis with Symptom improvement rate and Time to symptom worsening as supportive analyses.

**Change 28**

**Section of protocol affected:**

8.4.2 Calculation or derivation of safety variable(s)

**Previous text:**

Any AE occurring within 90 days of discontinuation of investigational product (ie, the last dose of AZD9291/chemotherapy) will be included in the AE summaries. Any events in this period that occur after a subject has received further therapy for cancer (following discontinuation of AZD9291) will be flagged in the data listings. Please refer to Section 6.3.1.

**Revised text:**

Any AE occurring within ~~90~~ 28 days of discontinuation of investigational product (ie, the last dose of AZD9291/chemotherapy) will be included in the AE summaries. Any events in this period that occur after a subject has received further therapy for cancer (following discontinuation of AZD9291) will be flagged in the data listings. Please refer to Section 6.3.1.

**Reason for Amendment:**

Typographical error.

## Change 29

### Section of protocol affected:

#### 8.5.1 Analysis of the primary variable(s)

##### Previous text:

PFS will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian) for generation of the p-value and using the Breslow approach for handling ties. The hazard ratio (HR) and confidence interval will be obtained directly from the U and V statistics as follows (Berry G et al 1991, Selke & Siegmund 1982):

$$\text{HR} = \exp(U/V)$$

$$95\% \text{ CI for HR} = (\exp\{U/V - 1.96/\sqrt{V}\}, \exp\{U/V + 1.96\sqrt{V}\})$$

Where  $U = \sum_i(d_{1i} - e_{1i})$  is the log-rank test statistic (with  $d_{1i}$  and  $e_{1i}$  the observed and expected events in group 1) and  $\sqrt{V}$  the standard deviation of the log-rank test statistic obtained from the LIFETEST procedure with a STRATA term for the stratification variable.

The assumption of proportionality will be assessed. In the event on non-proportionality, the HR will be interpreted as an average HR over the observed extent of follow-up. Proportionality will be tested firstly by examining the plots of complementary log-log (event times) versus log (time) and, if necessary, a time dependent covariate will be fitted to assess the extent to which this represents random variation.

A Kaplan-Meier (KM) plot of PFS will be presented by treatment group.

##### Subgroup analysis

Subgroup analyses will be conducted by comparing PFS between treatments in the following groups:

- Ethnicity (Asian versus Non-Asian)
- Gender (Male versus Female)
- Age at randomisation (<65 versus ≥65)
- Mutation status prior to start of study (ex19 versus L858R)
- Duration of prior EGFR TKI (<6 months, ≥6 months)
- Brain metastases at entry
- Smoking history

The HR (AZD9291: chemotherapy) and associated CI will be calculated from a Cox proportional hazards model (ties=Efron) that contains the treatment term, factor and treatment-by-factor interaction term. The treatment effect HRs for each treatment comparison along with their confidence intervals will be obtained for each level of the subgroup from this single model. The HRs and 95% CIs will be presented on a forest plot including the HR and 95% CI from the overall population (using the primary analysis).

**Revised text:**

PFS will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian) for generation of the p-value and using the Breslow approach for handling ties. The hazard ratio (HR) and confidence interval will be obtained directly from the U and V statistics as follows (Berry G et al 1991, Selke & Siegmund 1982):

$$HR = \exp(U/V)$$

$$95\% \text{ CI for HR} = (\exp\{U/V - 1.96/\sqrt{V}\}, \exp\{U/V + 1.96/\sqrt{V}\})$$

Where  $U = \sum_i(d_{1i} - e_{1i})$  is the log-rank test statistic (with  $d_{1i}$  and  $e_{1i}$  the observed and expected events in group 1) and  $\sqrt{V}$  the standard deviation of the log-rank test statistic obtained from the LIFETEST procedure with a STRATA term for the stratification variable.

~~The assumption of proportionality will be assessed. In the event on non-proportionality, the HR will be interpreted as an average HR over the observed extent of follow-up. Proportionality will be tested firstly by examining the plots of complementary log-log (event times) versus log (time) and, if necessary, a time dependent covariate will be fitted to assess the extent to which this represents random variation.~~

A Kaplan-Meier (KM) plot of PFS will be presented by treatment group.

**Subgroup analysis**

Subgroup analyses will be conducted by comparing PFS between treatments in the following groups:

- Ethnicity (Asian versus Non-Asian)
- Gender (Male versus Female)
- Age at randomisation (<65 versus ≥65)
- Mutation status prior to start of study (ex19 versus L858R)
- Duration of prior EGFR TKI (<6 months, ≥6 months)
- Brain metastases at entry
- Smoking history

The HR (AZD9291: chemotherapy) and associated CI will be calculated from a Cox proportional hazards model (ties=Efron) that contains the treatment term, factor and treatment-by-factor interaction term. The treatment effect HRs for each treatment comparison along with their confidence intervals will be obtained for each level of the subgroup from this single model. The HRs and 95% CIs will be presented on a forest plot including the HR and 95% CI from the overall population (using the primary analysis).

**The assumption of proportionality will be assessed. In the event on non-proportionality, the HR will be interpreted as an average HR over the observed extent of follow-up. Proportionality will be tested firstly by examining the plots of complementary log-log**

**(event times) versus log (time) and, if necessary, a time dependent covariate will be fitted to assess the extent to which this represents random variation.**

**Reason for Amendment:**

Evaluating the assumption of proportionality is associated with Cox proportional hazards model. Moved to appropriate section.

**Change 30**

**Section of protocol affected:**

8.6 China extension

**Previous text:**

8.6 China extension

**Revised text:**

8.6 China **cohort** ~~extension~~

**Reason for Amendment:**

Changed section title to reflect true situation, as no extension was needed for China.

**Change 31**

**Section of protocol affected:**

8.6.2 China only analysis

**Previous text:**

All efficacy, safety, PRO and PK variables will be derived in the same way as detailed in Section 8.4.

All analyses detailed in Section 8.4 will be repeated for the China-only cohort using the analysis sets described in Section 8.5.1.

**Revised text:**

All efficacy, safety, PRO and PK variables will be derived in the same way as detailed in Section 8.4.

All analyses detailed in Section ~~8.5~~ 8.4 will be repeated for the China-only cohort using the analysis sets described in Section ~~8.6.1~~ 8.5.1.

**Reason for Amendment:**

Typographical error.

## Change 32

### Section of protocol affected:

Appendix F Guidance Regarding Potential Interactions With Concomitant Medications

### Previous text:

## **GUIDANCE REGARDING POTENTIAL INTERACTIONS WITH CONCOMITANT MEDICATIONS**

The use of any natural/herbal products or other “folk remedies” should be discouraged, but use of these products, as well as use of all vitamins, nutritional supplements, and all other concomitant medications must be recorded in the eCRF.

AZD9291 is an investigational drug for which no data on in vivo interactions are currently available. Based on in vitro data and predicted clinical exposure data, AZD9291 is considered unlikely to cause clinically significant drug interactions through inhibition or induction of cytochrome P450 enzyme activity. In vitro data have shown that the principal CYP enzyme responsible for the Phase I metabolism of AZD9291 is CYP3A4.

### **1. DRUGS INHIBITING CYP3A4 METABOLISM THAT ATRAZENECA STRONGLY RECOMMEND ARE NOT COMBINED WITH AZD9291**

The contribution of Phase I metabolism to the total clearance of AZD9291 is currently unknown but, to ensure patient safety, the following potent inhibitors of CYP3A4 must not be used during this study for any patient receiving AZD9291.

**Table 1 Drugs inhibiting CYP3A4**

<b>Contraindicated drugs</b>	<b>Withdrawal period prior to AZD9291 start</b>
Clarithromycin, telithromycin, troleandomycin	
Conivaptan	
Indinavir, lopinavir, nelfinavir, ritonavir, saquinavir, tipranavir, telaprevir, boceprevir, elvitegravir	<b>1 week</b>
Itraconazole, ketoconazole, posaconazole, voriconazole	
Mibefradil	
Nefadozone	

This list is not intended to be exhaustive, and a similar restriction will apply to other agents that are known to strongly modulate CYP3A4 activity. Appropriate medical judgment is required. Please contact AstraZeneca with any queries you have on this issue.

## **2. DRUGS INDUCING CYP3A4 METABOLISM THAT ASTRAZENECA STRONGLY RECOMMEND ARE NOT COMBINED WITH AZD9291**

**Table 2 Drugs inducing CYP3A4**

<b>Contraindicated drugs</b>	<b>Withdrawal period prior to AZD9291 start</b>
Carbamazepine, phenobarbital, phenytoin	
Rifampicin, rifabutin, rifapentin	<b>3 weeks</b>
St John's Wort	
Phenobarbitone	<b>5 weeks</b>

This list is not intended to be exhaustive, and a similar restriction will apply to other agents that are known to strongly modulate CYP3A4 activity. Appropriate medical judgment is required. Please contact AstraZeneca with any queries you have on this issue.

## **3. MEDICINES WHOSE EXPOSURES MAY BE AFFECTED BY AZD9291 THAT ASTRAZENECA CONSIDERS MAY BE ALLOWED WITH CAUTION**

**Table 3 Exposure, pharmacological action and toxicity may be increased or decreased by AZD9291**

<b>Warning of possible interaction</b>	<b>Advice</b>
Alfentanil	
Amodiaquine	
Repaglinide	
Sirolimus	
Tacrolimus	
Torsemide	
Fentanyl	
Dihydroergotamine	
Ergotamine	
Simvastatin	
Lovastatin	
	Drugs are permitted but caution should be exercised and subjects monitored closely for possible drug interactions. Please refer to full prescribing information for all drugs prior to co-administration with AZD9291.

**Table 3 Exposure, pharmacological action and toxicity may be increased or decreased by AZD9291**

<b>Warning of possible interaction</b>	<b>Advice</b>
Atorvastatin	
Rosuvastatin	
Fluvastatin	
Sulfasalazine	
Warfarin	
Phenytoin (also see Table 2)	
s-Mephenytoin	
Cyclosporine	
Theophylline	
Tizanidine	
Aliskiren	
Ambrisentan	
Colchicine	
Dabigatran etexilate	
Digoxin	
Fexofenadine	
Maraviroc	
Ranolazine	
Talinolol	
Tolvaptan	

There are currently no data confirming that there is a pharmacokinetic (PK) interaction between these agents and AZD9291; *in vitro* data suggests AZD9291 has the potential to cause drug interactions at the intestinal level through CYP3A4 and BCRP, it has also been shown to be an inhibitor of CYP2C8 and inducer of CYP3A4, CYP1A2 and CYP2C and p-glycoprotein. This list is not intended to be exhaustive, and a similar restriction will apply to other agents that are known to depend on CYP3A4, CYP2C8, CYP1A2 and CYP2C for metabolism or BCRP and p-glycoprotein for deposition. Appropriate medical judgement is required. Please contact AstraZeneca with any queries you have on this issue.



## 4. DRUGS THAT MAY PROLONG QT INTERVAL

The drugs listed in this section are taken from information provided by The Arizona Center for Education and Research on Therapeutics and The Critical Path Institute, Tucson, Arizona and Rockville, Maryland. Ref: <http://www.arizonacert.org/medical-pros/drug-lists/drug-lists.htm>.

### 4.1. Drugs known to prolong QT interval

The following drugs are known to prolong QT interval or induce Torsades de Pointes and should not be combined with AZD9291. Recommended withdrawal periods following cessation of treatment with these agents are provided in the table.

**Table 4 Drugs prolonging QT interval**

<b>Contraindicated drug</b>	<b>Withdrawal period prior to AZD9291 start</b>
Clarithromycin, droperidol, erythromycin, procainamide	<b>2 days</b>
Cisapride, disopyramide, dofetilide, domperidone, ibutilide, quinidine, sotalol, sparfloxacin, thioridazine	<b>7 days</b>
Bepridil, chlorpromazine, halofantrine, haloperidol, mesoridazine	<b>14 days</b>
Levomethadyl, methadone, pimozone	<b>4 weeks</b>
Arsenic trioxide	<b>6 weeks*</b>
Pentamidine	<b>8 weeks</b>
Amiodarone, chloroquine	<b>1 year</b>

\* Estimated value as pharmacokinetics of arsenic trioxide has not been studied

### 4.2. Drugs that may possibly prolong QT interval

The use of the following drugs is permitted (notwithstanding other exclusions and restrictions) provided the patient has been stable on therapy for the periods indicated.

**Table 5 Drugs that may prolong QT interval**

<b>Drug</b>	<b>Minimum treatment period on medication prior to AZD9291 start</b>
Alfuzosin, chloral hydrate, ciprofloxacin, dolasetron, foscarnet, galantamine, gemifloxacin, isradipine, ketoconazole, levofloxacin, mexiletine, nicardipine, octreotide, ofloxacin, ondansetron, quetiapine, ranolazine, telithromycin, tizanidine, vardenafil, venlafaxine, ziprasidone	<b>2 days</b>
Amantadine, amitriptyline, amoxapine, clozapine, doxepin, felbamate, flecainide, fluconazole, fosphenytoin, gatifloxacin, granisetron, imipramine, indapamide, lithium, moexipril/HCTZ, moxifloxacin, risperidone, roxithromycin, sertraline, trimethoprim-sulfa, trimipramine, voriconazole	<b>7 days</b>
Azithromycin, citalopram, clomipramine, itraconazole, nortriptyline, paroxetine, solifenacin, tacrolimus	<b>14 days</b>
Fluoxetine	<b>5 weeks</b>
Protriptyline	<b>6 weeks</b>
Tamoxifen	<b>8 weeks</b>

**Revised text:**

**GUIDANCE REGARDING POTENTIAL INTERACTIONS WITH CONCOMITANT MEDICATIONS**

The use of any natural/herbal products or other “folk remedies” should be discouraged, but use of these products, as well as use of all vitamins, nutritional supplements, and all other concomitant medications must be recorded in the eCRF.

~~AZD9291 is an investigational drug for which no data on in vivo interactions are currently available. Based on in vitro data and predicted clinical exposure data, AZD9291 is considered unlikely to cause clinically significant drug interactions through inhibition or induction of cytochrome P450 enzyme activity. In vitro data have shown that the principal CYP enzyme responsible for the Phase I metabolism of AZD9291 is CYP3A4.~~

## **~~1. DRUGS INHIBITING CYP3A4 METABOLISM THAT ASTRAZENECA STRONGLY RECOMMEND ARE NOT COMBINED WITH AZD9291~~**

The contribution of Phase I metabolism to the total clearance of AZD9291 is currently unknown but, to ensure patient safety, the following potent inhibitors of CYP3A4 must not be used during this study for any patient receiving AZD9291.

**Table 6 — Drugs inhibiting CYP3A4**

<b>Contraindicated drugs</b>	<b>Withdrawal period prior to AZD9291 start</b>
Clarithromycin, telithromycin, troleandomycin	
Conivaptan	
Indinavir, lopinavir, nelfinavir, ritonavir, saquinavir, tipranavir, telaprevir, boceprevir, elvitegravir	<b>1 week</b>
Itraconazole, ketoconazole, posaconazole, voriconazole	
Mibefradil	
Nefadozone	

This list is not intended to be exhaustive, and a similar restriction will apply to other agents that are known to strongly modulate CYP3A4 activity. Appropriate medical judgment is required. Please contact AstraZeneca with any queries you have on this issue.

## **~~2. 1. DRUGS INDUCING CYP3A4 METABOLISM THAT ASTRAZENECA STRONGLY RECOMMEND ARE NOT COMBINED WITH AZD9291~~**

AZD9291 is metabolised by CYP3A4 and CYP3A5 enzymes.

A drug-drug interaction study of AZD9291 evaluated in patients showed that there is potential for AZD9291 being a victim when co-administered with strong inducers of CYP3A4 (AZD9291 concentrations are decreased when co-dosed with rifampicin).

The following potent inducers of CYP3A4 must not be used during this study for any patient receiving AZD9291.

**Table 2 1 Drugs inducing CYP3A4**

<b>Contraindicated drugs</b>	<b>Withdrawal period prior to AZD9291 start</b>
Carbamazepine, phenobarbital, phenytoin Rifampicin, rifabutin, rifapentin St John’s Wort	<b>3 weeks</b>
Phenobarbitone	<b>5 weeks</b>

This list is not intended to be exhaustive, and a similar restriction will apply to other agents that are known to strongly modulate CYP3A4 activity. Appropriate medical judgment is required. Please contact AstraZeneca with any queries you have on this issue.

**3. 2. MEDICINES WHOSE EXPOSURES MAY BE AFFECTED BY AZD9291 THAT ASTRAZENECA CONSIDERS MAY BE ALLOWED WITH CAUTION**

**AZD9291 may increase the concentration of sensitive BCRP substrates (concentration of the sensitive BCRP substrate, rosuvastatin, is increased).**

**Table 3 2 Exposure, pharmacological action and toxicity may be increased or decreased by AZD9291**

<b>Warning of possible interaction</b>	<b>Advice</b>
Alfentanil Amodiaquine Repaglinide Sirolimus Tacrolimus Torsemide Fentanyl Dihydroergotamine Ergotamine Simvastatin Lovastatin Atorvastatin Rosuvastatin Fluvastatin	Drugs are permitted but caution should be exercised and <del>subjects</del> <b>patients</b> monitored closely for possible drug interactions. Please refer to full prescribing information for all drugs prior to co-administration with AZD9291.

**Table 3 2 Exposure, pharmacological action and toxicity may be increased or decreased by AZD9291**

Warning of possible interaction	Advice
<b>Doxorubicin</b>	
<b>Daunorubicin</b>	
<b>Topotecan</b>	
Phenytoin (also see Table 2)	
Sulfasalazine	
Warfarin	
s-Mephenytoin	
Cyclosporine	
Theophylline	
Tizanidine	
Aliskiren	
Ambrisentan	
Colchicine	
Dabigatran etexilate	
Digoxin	
Fexofenadine	
Maraviroc	
Ranolazine	
Talinolol	
Tolvaptan	

There are currently no data confirming that there is a pharmacokinetic (PK) interaction between these agents and AZD9291; *in vitro* data suggests AZD9291 has the potential to cause drug interactions at the intestinal level through CYP3A4 and BCRP, it has also been shown to be an inhibitor of CYP2C8 and inducer of CYP3A4, CYP1A2 and CYP2C and p-glycoprotein. This list is not intended to be exhaustive, and a similar restriction will apply to other agents that are known to depend on CYP3A4, CYP2C8, CYP1A2 and CYP2C for metabolism or BCRP and p-glycoprotein for deposition. Appropriate medical judgement is required. Please contact AstraZeneca with any queries you have on this issue.

### **4. 3. DRUGS THAT MAY PROLONG QT INTERVAL**

The drugs listed in this section are taken from information provided by The Arizona Center for Education and Research on Therapeutics and The Critical Path Institute, Tucson, Arizona and Rockville, Maryland. Ref: <http://www.arizonacert.org/medical-pros/drug-lists/drug-lists.htm>.

#### **4.1. 3.1 Drugs known to prolong QT interval**

The following drugs are known to prolong QT interval or induce Torsades de Pointes and should not be combined with AZD9291. Recommended withdrawal periods following cessation of treatment with these agents are provided in the table.

**Table-4 3 Drugs prolonging QT interval**

<b>Contraindicated drug</b>	<b>Withdrawal period prior to AZD9291 start</b>
Clarithromycin, droperidol, erythromycin, procainamide	<b>2 days</b>
Cisapride, disopyramide, dofetilide, domperidone, ibutilide, quinidine, sotalol, sparfloxacin, thioridazine	<b>7 days</b>
Bepridil, chlorpromazine, halofantrine, haloperidol, mesoridazine	<b>14 days</b>
Levomethadyl, methadone, pimozone	<b>4 weeks</b>
Arsenic trioxide	<b>6 weeks*</b>
Pentamidine	<b>8 weeks</b>
Amiodarone, chloroquine	<b>1 year</b>

\* Estimated value as pharmacokinetics of arsenic trioxide has not been studied

#### **4.2. 3.2 Drugs that may possibly prolong QT interval**

The use of the following drugs is permitted (notwithstanding other exclusions and restrictions) provided the patient has been stable on therapy for the periods indicated.

**Table 7 Drugs that may prolong QT interval**

<b>Drug</b>	<b>Minimum treatment period on medication prior to AZD9291 start</b>
Alfuzosin, chloral hydrate, ciprofloxacin, dolasetron, foscarnet, galantamine, gemifloxacin, isradipine, ketoconazole, levofloxacin, mexiletine, nicardipine, octreotide, ofloxacin, ondansetron, quetiapine, ranolazine, telithromycin, tizanidine, vardenafil, venlafaxine, ziprasidone	<b>2 days</b>
Amantadine, amitriptyline, amoxapine, clozapine, doxepin, felbamate, flecainide, fluconazole, fosphenytoin, gatifloxacin, granisetron, imipramine, indapamide, lithium, moexipril/HCTZ, moxifloxacin, risperidone, roxithromycin, sertraline, trimethoprim-sulfa, trimipramine, voriconazole	<b>7 days</b>
Azithromycin, citalopram, clomipramine, itraconazole, nortriptyline, paroxetine, solifenacin, tacrolimus	<b>14 days</b>
Fluoxetine	<b>5 weeks</b>
Protriptyline	<b>6 weeks</b>
Tamoxifen	<b>8 weeks</b>

**Reason for Amendment:**

This is based on the results from Study D5160C00012 which evaluated the effect of itraconazole (a strong CYP3A4 inhibitor) on the exposure of AZD9291. In that clinical pharmacokinetic study in patients, AZD9291 co-administered with 200 mg itraconazole twice daily had no clinically significant effect on the exposure of AZD9291 (AUC increased by 24% (90%CI 15, 35) and Cmax decreased by 20% (90% CI -27, -13)). Therefore, CYP3A4 inhibitors are not likely to affect the exposure of AZD9291 and hence, the restrictions on CYP3A4 inhibitors are removed.

In a clinical PK study, co-administration of AZD9291 with rosuvastatin (sensitive BCRP substrate) increased the AUC and Cmax of rosuvastatin by 35% (90%CI 15, 57) and 72% (90% CI 46, 103), respectively. Patients taking concomitant medications where the disposition is dependent upon BCRP and with narrow therapeutic index should be closely monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst receiving AZD9291.

Clinical Study Protocol Amendment 3  
Drug Substance AZD9291  
Study Code D5160C00003  
Date

**Persons who initiated the Amendment:**

AstraZeneca Project Team





Drug substance: Osimertinib (AZD9291)

Study Code: D5160C00003 (AURA3)

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### **Summary of rationale for Protocol Amendment #3**

**Study title:** A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene

## INTRODUCTION

AstraZeneca is submitting a clinical information amendment for the clinical trial D5160C00003 (AURA3), entitled “A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)”.

This clinical information amendment contains the key changes proposed and rationale for making these changes in the protocol amendment (Version 1.0, dated \_\_\_\_\_).

As of October 28<sup>th</sup>, 2015, AstraZeneca has completed enrollment of clinical trial AURA3. First subject was enrolled into the trial in August 2014, and last subject was enrolled in September 2015. A total of 419 subjects have been randomised by October 2015.

AstraZeneca propose to change the power to detect a statistically significant difference for the primary analysis of progression-free survival [PFS] from 90% to 80% (assuming a Hazard Ratio [HR] = 0.67). This change is based on the compelling results from the most recent PFS data available from the Phase II osimertinib monotherapy studies (AURA extension and AURA2). If the assumed treatment effect were still a HR of 0.67 (which translates to approximate 3-month improvement on an estimated median PFS of 6 months on the control arm assuming proportional hazards), then 221 progression events provides 80% power to demonstrate a statistically significant difference in PFS at the 5% 2-sided significance level (as compared with the 295 progression events required for assuring the currently planned 90% power).

Additionally, in order to maximise the maturity of the overall survival (OS) data at the time of the first analysis, the data cut for the first OS analysis will be performed approximately 4 months after the primary PFS analysis. Therefore, at the time of the primary PFS analysis, OS will not be analysed. A summary of the frequency of deaths and primary cause of death will be provided for safety purposes, no additional summaries will be performed in order to protect the integrity of the OS analyses.

There are three planned analyses of OS; two interim analyses and a final analysis. The first analysis of OS will be conducted approximately 4 months after the primary analysis of PFS and the second analysis will be conducted when the OS data are approximately 50% mature (approximately 205 death events). A final analysis of OS will be performed when the OS data are approximately 70% mature (approximately 287 death events). Following feedback received from FDA, the approach to maintain an overall 2-sided 5% type I error across the three analyses of OS has been modified. Since three OS analyses are planned, the Lan DeMets approach that approximates the O’Brien and Fleming spending function will be used to maintain an overall 2-sided 5% type I error across the testing of the three planned analyses of OS.

These changes will maintain the study and methodological integrity and also aim for expeditious delivery of critical confirmatory and comparative evidence that have the potential to enrich the practice of care for patients with relapsed T790M positive mutation NSCLC.

The AURA3 trial was designed as a confirmatory study, to provide a definitive answer to the superiority of osimertinib vs. platinum doublet-based chemotherapy in a randomised prospective and controlled setting, and has two main scientific objectives:

- First, robustly establish the magnitude of treatment effect of osimertinib vs. platinum doublet-based chemotherapy with a precision of the PFS estimate which is clinically relevant.
- Second, define and characterize the safety and tolerability profile of osimertinib, enabling the evaluation of disease and control treatment related events compared to those attributable to osimertinib.

In the light of recent osimertinib data presented below, from the AURA extension and AURA2 Phase II studies (DCO: 1<sup>st</sup> November 2015), which is based upon a more mature PFS analysis as well as an indirect comparison with historical data from the IMPRESS study (for platinum-based doublet chemotherapy), it is considered that the updated planned analysis with 25% fewer PFS events and a predefined first analysis of OS approximately 4 months after the primary PFS analysis will still meet the main scientific objectives of the AURA3 study. Furthermore, if the study results are positive, subjects currently randomised to the platinum-based doublet chemotherapy arm may crossover earlier to osimertinib therapy. This will reduce the side effects related to chemotherapy and improve efficacy and tolerability of the anticancer therapy for this group of patients with high unmet medical need. Most importantly, it will also contribute to establish the definitive benefit:risk profiles of osimertinib and platinum-based doublet chemotherapy in a comparative setting, which will inform the scientific community about the new clinical practice.

### **Supportive clinical information for the proposed AURA3 progression-free survival amendment**

AURA3 is a Phase III trial in which patients must have shown disease progression on an approved first-line EGFR-TKI and only patients with T790M positive NSCLC will be recruited. Patients were randomised to receive either osimertinib (80 mg orally, once daily) or platinum-based doublet chemotherapy (pemetrexed 500 mg/m<sup>2</sup>+ carboplatin area under the plasma concentration-time curve AUC 5 or pemetrexed 500 mg/m<sup>2</sup>+ cisplatin 75 mg/m<sup>2</sup>) on Day 1 of every 21-day cycle in a 2:1 (osimertinib: platinum-based doublet chemotherapy) ratio. Progression-free survival by Investigator assessment is the primary endpoint for this study. AURA3 study completed enrolment in September 2015. A total of 1,037 patients were enrolled in order to randomise approximately 410 patients. As of 28 October 2015, randomisation was complete and 419 NSCLC patients with EGFR T790M mutation positive

tumours who had progressed following prior treatment with an approved EGFR TKI had been randomised.

The primary endpoint of the study is PFS. The trial was also originally sized to characterize overall survival (OS) as a key secondary endpoint. The primary analysis of PFS was planned to occur when approximately 400 progression events had been observed in 610 patients. With 400 progression events, the study would have >95% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were hazard ratio (HR) of 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed.

In May 2015, as requested by the investigators and supported by the emerging safety and efficacy data for osimertinib in patients with T790M positive advanced NSCLC, the study was amended to allow for introduction of crossover, to osimertinib treatment, at the time of disease progression for patients on the control arm; in such circumstances, it was considered that the interpretation of OS would be compromised and therefore, the study was re-sized as it was no longer aimed to characterise OS. This resulted in a reduction of the sample size (from 610 to 410 patients) and the number of PFS events required for the planned primary analysis of PFS (from 400 to 295 progression events). With 295 progression events (including deaths), the study was fully powered for a PFS assessment, having 90% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were a HR of 0.67.

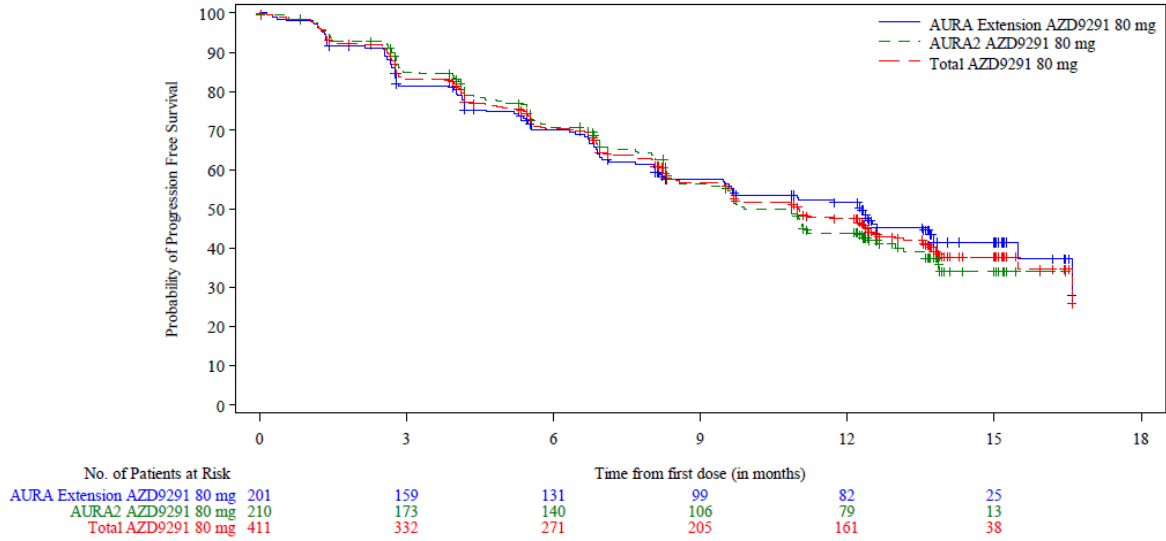
AstraZeneca is proposing to further amend the current protocol (Version 02, dated 06 May 2015), so that the primary PFS analysis would take place when approximately 221 progression events have been observed (instead of the currently planned 295 events). With 221 progression events (including deaths), the study will have approximately 80% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were a HR of 0.67.

The rationale for conducting the primary PFS analysis at approximately 221 progression events are as follows:

- The latest PFS data from the AURA extension and AURA2 (DCO: 1 November 2015) studies suggests that the median PFS for osimertinib is longer than the assumption of 9 months stated in the current protocol. Based on blinded independent central review (BICR) with 55.2% maturity, 227/411  $\geq$ second-line patients had progressed or died at the time of the updated DCO (1 November 2015); 70.4% (95% CI: 65.7 to 74.7) of patients were estimated to be alive and progression free for >6 months, 56.9% (95% CI: 51.8 to 61.6) for >9 months, and 47.5% (95% CI: 42.4 to 52.5) for >12 months. At the time of analysis, the median PFS in  $\geq$ second-line patients is estimated to be 11 months (95% CI: 9.6 months to 12.4 months) ([Figure 1](#)) and in second-line patients (71 events in 129 patients) is estimated to be 11 months (95% CI: 8.3 months to 13.1 months). This data suggests that the osimertinib PFS is likely to be longer than the estimated 9 month

PFS value used for the current statistical assumptions in the AURA3 study; implicitly, it is likely the treatment effect, compared with platinum-based doublet chemotherapy, will be larger than the assumed HR value of 0.67.

**Figure 1 Progression-free survival by central review by study and total, Kaplan-Meier plot (Full analysis set)**

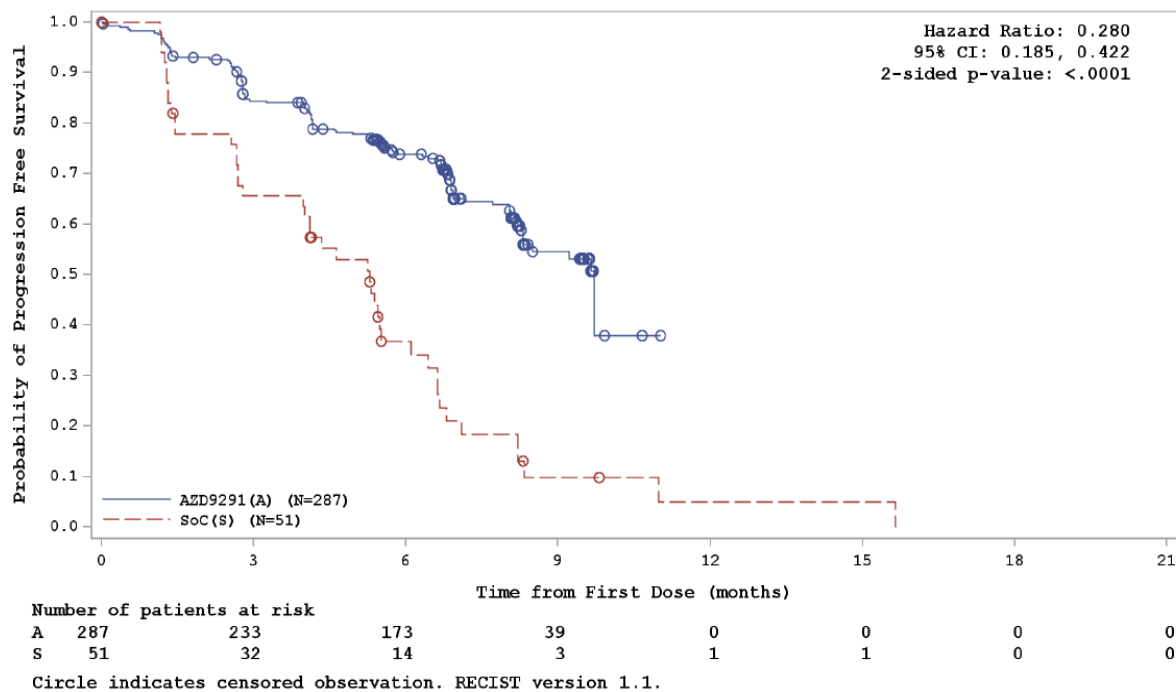


Progression events that do not occur at the time of analysis are censored.  
RECIST version 1.1.

AstraZeneca has conducted a non-randomised, adjusted comparison of efficacy and safety outcomes from the two pooled osimertinib Phase II single arm trials (AURA extension and AURA2) with the control arm (Standard of Care (SoC) chemotherapy treatment) from the Iressa IMPRESS study in the subset of patients who have EGFR T790M mutation positive locally advanced or metastatic NSCLC. The analysis was conducted following the concept outlined in [Blumenthal et al, 2015](#) to perform a formal comparison of osimertinib single arm trial data to historical controls on a patient level. The SoC treatment group includes patients randomised to receive platinum-based doublet chemotherapy (pemetrexed 500 mg/m<sup>2</sup> + cisplatin 75 mg/m<sup>2</sup>) plus placebo for patients who have EGFR T790M mutation positive (similar to those randomised to the comparator arm in AURA3 study). Propensity score applications ([D'agostino, 1998](#)) were used in an attempt to balance the non-randomised cohorts on common observable baseline characteristics and reduce bias. As a result of applying the propensity score applications, subgroups of the osimertinib (n=297) and IMPRESS SoC arm (n=51) were used for the analyses, summary results are outlined here. The analysis results included a comparison of PFS, OS, ORR and key safety variables. Based on Blinded independent Central Review Data (BICR), the ORR was significantly greater in the osimertinib group compared with the SoC group (64.6% versus 34.8%, respectively) odds ratio (OR) 4.76; 95% CI: 2.21, 10.26; p<0.001. Based on BICR, PFS was significantly longer in the osimertinib group compared with the SoC group. The HR was 0.28 (95% CI:

0.18, 0.42;  $p < 0.0001$ ), indicating a 72% reduction in risk of disease progression or death in the osimertinib group compared with the SoC group. Median PFS was 9.7 months in the osimertinib group compared with 5.3 months in the SoC group; a 4.4 month longer median PFS in the osimertinib group compared with the SoC. For OS, median OS for osimertinib was not calculable; SoC was 21.7 months. The Kaplan-Meier plots were overlapping for the two groups; HR was 1.022 (95% CI: 0.387, 2.696;  $p < 0.9654$ ). Data was immature for both osimertinib and SoC; 11.5% and 29.4%, respectively, so meaningful conclusions on OS data could not be drawn.

**Figure 2** Kaplan-Meier plot of PFS by independent central review (T790M + set)



### Re-evaluation of power for progression-free survival assessment

The newly emerging data led AstraZeneca to consider a blinded re-evaluation of power for the primary PFS analysis for AURA3. In turn, AstraZeneca is proposing to modify the number of PFS events required from 295 to 221 for the statistical comparison of PFS between osimertinib vs. the control arm.

The re-calculation shows that, if the assumed treatment effect were still a HR of 0.67 (assuming a median PFS of 6 months on the control arm), then 221 progression events provides 80% power to demonstrate a statistically significant difference in PFS at the 5% 2-sided significance level.

AstraZeneca consider the planned changes maintain the integrity of the AURA3 study and implicitly continue to support the ability of this trial to provide a definitive answer to the comparison of osimertinib with platinum-based double chemotherapy, whilst enabling an expeditious delivery of critical data that have the potential to enrich the practice of care for patients with relapsed T790M positive mutation NSCLC.

### **Supportive clinical information for the proposed AURA3 overall survival amendment**

AstraZeneca is proposing to amend the current protocol (Version 02, ) to change the timing of the data cut-off for the first OS analysis and the alpha spend allocation across the three analyses of OS.

The reason for the proposed amendment to change the data cut-off for the first OS analysis is to maximise the maturity of the OS data at the time of the first analysis. The proposal is to change the first OS analysis from being performed at the time of the primary PFS analysis to be conducted approximately 4 months after the primary analysis of PFS. Therefore, at the time of the primary PFS analysis, OS will not be analysed. A summary of the frequency of deaths and primary cause of death will be provided for safety purposes, no additional summaries will be performed in order to protect the integrity of the OS analyses.

There are three planned analyses of OS; two interim analyses and a final analysis. The first analysis of OS will be conducted approximately 4 months after the primary analysis of PFS and the second analysis will be conducted when the OS data are approximately 50% mature (approximately 205 death events). A final analysis of OS will be performed when the OS data are approximately 70% mature (approximately 287 death events).

Following feedback received from FDA, the approach to maintain an overall 2-sided 5% type I error across the three analyses of OS has been modified. The Lan DeMets approach that approximates the O'Brien and Fleming spending function will be used to maintain an overall 2-sided 5% type I error across the testing of the three planned analyses of OS.

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**Statistical Analysis Plan**

Study Code        D5160C00003

Edition Number    1.0

Date

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**A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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**A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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Study Statistician

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**A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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Global Product Statistician

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## LIST OF ABBREVIATIONS

<b>Abbreviation or special term</b>	<b>Explanation</b>
ANCOVA	Analysis of covariance
AT	Acceptance threshold
ATC	Anatomical Therapeutic Chemical
AUC 5	Area under the plasma concentration-time curve 5 mg/ml per minute
AUC <sub>(0-24)</sub>	Area under the plasma concentration-time curve (plasma concentration/time curve from zero to 24 hours)
AUC <sub>ss</sub>	Area under the plasma concentration-time curve at steady state
BICR	Blinded Independent Central Review
BP	Blood pressure
CFS	Cerebrospinal fluid
CI	Confidence interval
Cl <sub>ss</sub> /F	Plasma clearance at steady state
C <sub>max</sub>	Maximum plasma concentration
CMET	Proto-oncogene encoding Hepatocyte Growth Factor Receptor
CR	Complete response
CSP	Clinical study protocol
CSR	Clinical study report
C <sub>ss</sub>	Concentration at study state
CT	Computerized tomography scan
CTCAE	Common Terminology Criteria for Adverse Event
ctDNA	Circulating tumor DNA
DCR	Disease control rate
dECG	Digital electrocardiogram
DNA	Deoxyribonucleic acid
DoR	Duration of response
ECG	Electrocardiogram
eCRF	Electronic case report form
EDoR	Expected duration of response
EGFR	Epidermal growth factor receptor



<b>Abbreviation or special term</b>	<b>Explanation</b>
EGFRm+	EGFR mutation positive
EORTC QLQ-C30	European Organization for Research and Treatment of Cancer Quality of Life Questionnaire - Core 30 items
EORTC QLQ-LC13	European Organization for Research and Treatment of Cancer Quality of Life Questionnaire - Lung Cancer 13 items
EQ-5D-5L	European Quality of Life - 5 Dimensions - 5 Levels
EuroQoL	European Quality of Life
FAS	Full analysis set
HER2	Human epidermal growth factor receptor 2
HP	Haybittle-Peto
HR	Hazard ratio
HRR	Hazard ratio ratio
HRQoL	Health Related Quality of Life
IP	Investigational product
IPCW	Time Inverse Probability of Censoring Weighting
IVRS	Interactive Voice Response System
IWRS	Interactive Web Response System
KM	Kaplan-Meier
L858R	An amino acid substitution at position 858 in EGFR, from a Leucine (L) to an Arginine (R)
LD	Longest diameter
LDH	Lactate dehydrogenase
LE	Local evaluation
LLoQ	Lower limit of quantification
LVEF	Left ventricular ejection fraction
MedDRA	Medical Dictionary for Regulatory Activities
MRI	Magnetic resonance imaging
MUGA	Multi-gated acquisition scan
N/A	Not applicable
NE	Not evaluable
NSCLC	Non-small cell lung cancer
NTL	Non-target lesion
OAE	Other significant adverse event

<b>Abbreviation or special term</b>	<b>Explanation</b>
ORR	Objective response rate
OS	Overall survival
p.o.	Per os, by mouth, orally
PD	Progression of disease
PFS	Progression Free Survival
PID	Percentage intended dose
PFS2	Time from randomization to second progression
PK	Pharmacokinetics
PR	Partial response
PRO	Patient reported outcome
PT	Preferred term
QD	Once daily
RAC	Ratio of AUCss after multiple dosing to AUC(0-24) after single dose
RDI	Relative dose intensity
RECIST	Response Evaluation Criteria in Solid Tumors
RPSFT	Rank Preserving Structural Failure
SAE	Serious adverse event
SD	Stable disease
SLD	Sum of longest diameter
SOC	System organ class
T790M	An amino acid substitution at position 790 in EGFR, from a Threonine (T) to a Methionine (M)
T790M-	T790M mutation negative
T790M+	T790M mutation positive
TFST	Time to first subsequent therapy or death
TKI	Tyrosine kinase inhibitor
TL	Target lesion
$t_{\max}$	Time to $C_{\max}$
$t_{ss \max}$	Time to $C_{ss \max}$
TSST	Time to second subsequent therapy or death
ULoQ	Upper limit of quantification
WHO	World Health Organization

## AMENDMENT HISTORY

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<b>Date</b>	<b>Brief description of change</b>

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## 1. STUDY DETAILS

### 1.1 Study objectives

#### Primary objective

<b>Objective:</b>	<b>Outcome Measure:</b>
To assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy by assessment of Progression Free Survival (PFS).	PFS using investigator assessments according to Response Evaluation Criteria in Solid Tumors (RECIST) 1.1.  Sensitivity analysis of PFS using Blinded Independent Central Review (BICR).

#### Secondary objectives

<b>Objective:</b>	<b>Outcome Measure:</b>
To further assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy in terms of:  - Objective Response Rate (ORR) - Duration of Response (DoR)  - Disease Control Rate (DCR)  - Overall Survival (OS)  - Tumor shrinkage	ORR, DoR, DCR and tumor shrinkage using investigator assessments according to RECIST 1.1.  Analysis of OS.
To assess the effect of AZD9291 compared to platinum-based doublet chemotherapy on subjects' disease-related symptoms and health related quality of life (HRQoL).	EORTC QLQ-C30: Questionnaire consisting of 30 items measuring subjects general cancer symptoms and functioning.  EORTC QLQ-LC13: A complementary questionnaire measuring lung cancer symptoms and side effects from conventional chemo- and radiotherapy.
To characterize the pharmacokinetics (PK) of AZD9291, AZ5104 and AZ7550 in subjects receiving AZD9291.	PK exposure parameters derived from plasma concentrations of AZD9291, and metabolites AZ5104 and AZ7550.  PK parameters (such as $Cl_{ss}/F$ , $C_{ss\ min}$ and $C_{ss\ max}$ $AUC_{ss}$ ) will be derived using population PK analysis and reported separately to the Clinical Study Report (CSR). Data from this study may form part of a pooled analysis with data from other studies.

## Safety objective

<b>Objective:</b>	<b>Outcome Measure:</b>
To assess the safety and tolerability profile of AZD9291 compared with platinum-based doublet chemotherapy.	<ul style="list-style-type: none"> <li>- Adverse events, graded by Common Terminology Criteria for Adverse Event (CTCAE v4)</li> <li>- Clinical chemistry, hematology and urinalysis</li> <li>- Vital signs (pulse and blood pressure), physical examination, weight</li> <li>- Centrally reviewed digital electrocardiogram (dECG)</li> <li>- Multi-gated acquisition scan (MUGA) for left ventricular ejection fraction (LVEF)</li> <li>- World Health Organization (WHO) performance status</li> </ul>

## Exploratory objectives

<b>Objective:</b>	<b>Outcome Measure:</b>
To explore the relationship between PK and selected endpoints (which may include efficacy, safety and/or Patient Reported Outcome [PRO]), where deemed appropriate.	<p>Correlation of PK with other primary/secondary/exploratory endpoints in subjects treated with AZD9291.</p> <p>Results from such analyses will be reported separately from the CSR.</p> <p>Data from this study may also form part of a pooled analysis with other AZD9291 studies.</p>
To compare the effects of AZD9291 compared with chemotherapy on post-progression outcomes	<p>Time from randomization to second progression (PFS2)</p> <p>Time to subsequent therapy</p> <p>Time to change in symptoms (including post-progression assessments)</p>
To further characterize the effects of AZD9291 on survival outcomes.	<p>Assess the impact on OS of baseline potentially prognostic factors (e.g., tumor stage, performance status, sex, baseline lactate dehydrogenase [LDH]).</p> <p>Assess the impact on OS of subsequent treatments and other potential covariates (e.g., changes in performance status).</p>
To compare adverse events by subject self-reporting of specific CTCAE symptoms (where applicable) between AZD9291 and chemotherapy.	<p>Collection of approximately 28 PRO-CTCAE symptoms via an electronic device solution (in countries where language is available).</p>

<b>Objective:</b>	<b>Outcome Measure:</b>
To compare AZD9291 treatment with chemotherapy treatment on health state utility.	The European Quality of Life - 5 Dimensions - 5 Levels (EQ-5D-5L) health state utility index will be used to derive health state utility based on subject reported data.
To compare health resource use associated with AZD9291 treatment with chemotherapy treatment.	Health resource utilization measures including hospitalization, outpatient visits, or emergency department visits.
To characterize the PK of AZD9291, AZ5104 and AZ7550 in cerebrospinal fluid (CSF).	Concentration of AZD9291, AZ5104 and AZ7550. Ratio of metabolites to AZD9291. Ratio of CSF to plasma concentration. Summaries of PK concentration data.
To collect and store deoxyribonucleic acid (DNA) for future exploratory research into genes/genetic variation that may influence PK or response to AZD9291, platinum-based doublet chemotherapy (i.e., absorption, distribution, metabolism, excretion, safety and efficacy) and/or susceptibility to/development of cancers.	Correlation of polymorphisms with variation in PK, pharmacodynamics, safety or response observed in subjects treated with AZD9291 or comparator. Data generated may be reported separately and may also form part of a pooled analysis with other AZD9291 studies.
To collect and store tumor samples and blood-based samples for potential for exploratory research into factors that may influence susceptibility to/development of non-small cell lung cancer (NSCLC)/cancer and/or response to AZD9291 (where response is defined broadly to include efficacy, tolerability or safety).	Analysis of key genetic and proteomic markers to include, but not limited to, epidermal growth factor receptor (EGFR) mutations, human epidermal growth factor receptor 2 (HER2) and proto-oncogene encoding hepatocyte growth factor receptor (CMET) expression and/or amplification. Collection of plasma samples to include, but not be limited to, extraction of circulating tumor DNA (ctDNA) for investigation of blood-borne biomarkers. The sample may be used to investigate the relationship between PK and blood-borne biomarkers. Samples may be analyzed retrospectively. Any biomarker data generated may be reported separately and may also form part of a pooled analysis with other AZD9291 studies.
To collect and store plasma for isolation of ctDNA. Extracted ctDNA will be assessed for the presence of genetic aberrations including, but not limited to, EGFR mutations (T790M, L858R, etc). These samples may be shared with a diagnostic partner for development of a ctDNA test for T790M detection.	Retrospective/real-time analysis of EGFR (and other) mutations in ctDNA from all study subjects (mandatory).

<b>Objective:</b>	<b>Outcome Measure:</b>
To collect and store residual CSF for potential exploratory research of factors that may influence development of NSCLC and/or response to AZD9291 (where response is defined broadly to include efficacy, tolerability or safety).	Collection of CSF for the investigation of PK and/or biomarkers. Samples may be analyzed retrospectively.

Results from such analyses outlined above may be reported separately from the CSR.

## **1.2 Study design**

This is a phase III, open-label, randomized study assessing the safety and efficacy of AZD9291 (80 mg, orally [p.o.], once daily [QD]) versus platinum-based doublet chemotherapy in second-line subjects with EGFR mutation and T790M mutation positive (EGFRm+/T790M+), locally advanced or metastatic NSCLC who have progressed following treatment with an approved EGFR Tyrosine Kinase Inhibitor (EGFR-TKI) agent.

A biopsy will be needed for central testing of T790M mutation status following confirmed disease progression on first-line treatment with an EGFR-TKI.

Approximately 610 subjects, stratified by ethnicity (Asian/non-Asian) will be centrally randomized to receive either AZD9291 (80mg QD p.o.) or platinum-based doublet chemotherapy (pemetrexed 500 mg/m<sup>2</sup> + carboplatin area under the plasma concentration-time curve AUC 5 or pemetrexed 500 mg/m<sup>2</sup> + cisplatin 75 mg/m<sup>2</sup>) on Day 1 of every 21-day cycle in a 2:1 (AZD9291: platinum-based doublet chemotherapy) ratio using the Interactive Voice Response (IVRS) or Interactive Web Response System (IWRS). The investigational site must declare (in IVRS/IWRS), prior to randomization, their choice of chemotherapy for that subject.

Subjects should continue on investigational product (IP) AZD9291 until a treatment discontinuation criterion is met. Subjects may continue to receive AZD9291 beyond RECIST 1.1 defined progression as long as they are continuing to show clinical benefit, as judged by the investigator.

Subjects can receive up to 6 cycles of pemetrexed + carboplatin/cisplatin as initial treatment.

Subjects whose disease has not progressed after four cycles of platinum-based first-line chemotherapy may receive pemetrexed maintenance therapy.

Subjects must be followed until evidence of RECIST 1.1 defined progression (regardless of reason for treatment discontinuation). It is important that subjects are assessed according to the intended scanning schedule to prevent the bias in analysis that can occur if one treatment group is assessed more or less often than the other.

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be given the opportunity to begin treatment

with AZD9291 80mg, once daily. These subjects may continue treatment with AZD9291, as long as they are continuing to show clinical benefit, as judged by the investigator.

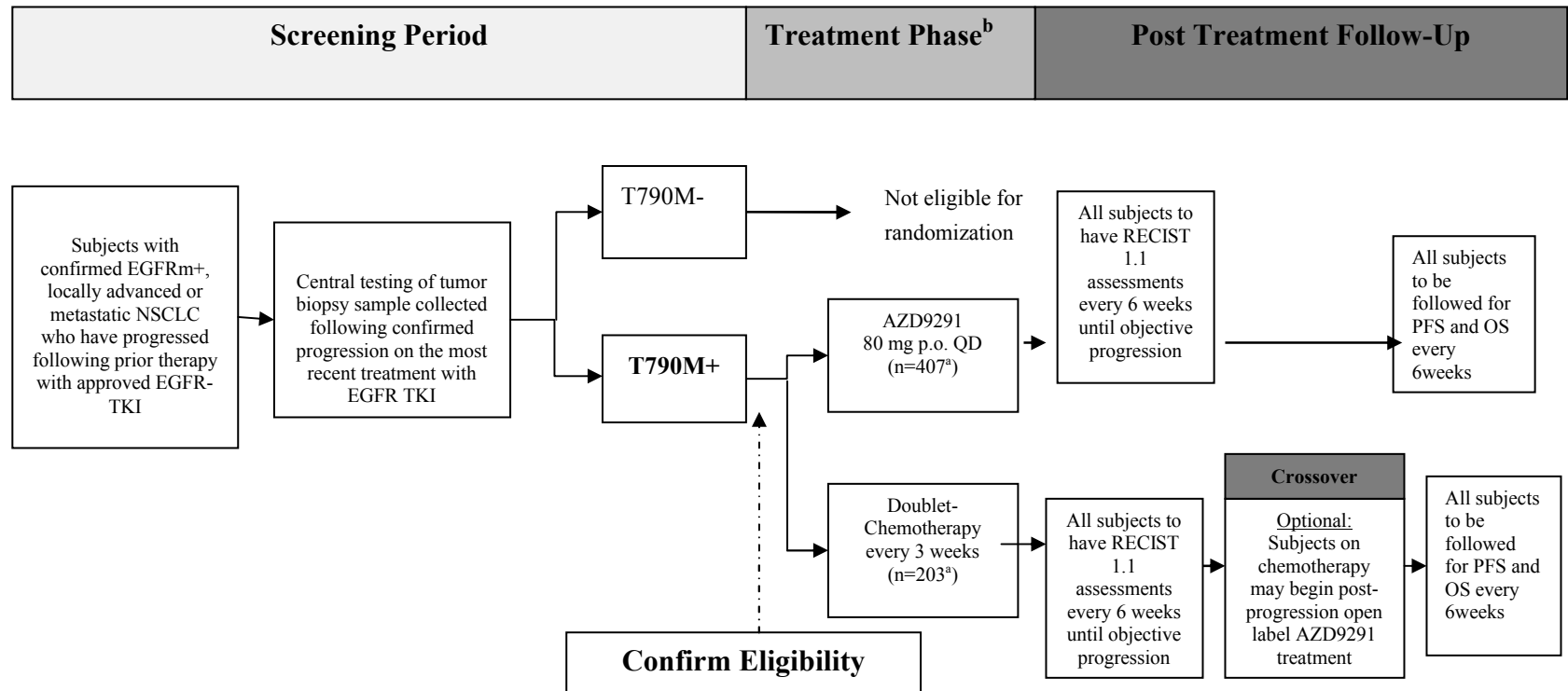
Subjects who stop platinum-based doublet chemotherapy for reasons other than objective disease progression according to RECIST 1.1 will not be eligible to cross-over to AZD9291. They will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.

Note: Throughout this document the term “platinum-based doublet chemotherapy”, refers to “platinum” as both carboplatin and cisplatin.

The overall study design is shown in Figure 1 of the clinical study protocol (CSP) and the study flow chart in Figure 1 below. The study schedule for AZD9291 subjects and for platinum-based doublet chemotherapy subjects is detailed in Tables 1 and 2 of the CSP, respectively.



**Figure 1 Study flow chart**



(a) Approximately 610 subjects will be randomized into the trial; from these approximately 407 subjects will be treated with AZD9291 and approximately 203 subjects will be treated with a platinum based doublet-chemotherapy.

(b) Subjects will be considered in "Treatment phase" at the time AZD9291/Doublet-Chemotherapy (study treatment) is started. Subjects will continue to receive study treatment until objective disease progression (according to RECIST 1.1). Subjects randomized to AZD9291 may continue to receive AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria. Subjects on the platinum-based double chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291, 80 mg once daily.



### **1.3 Number of subjects**

PFS is the primary endpoint for this study. The study has been sized to also characterize the OS benefit of AZD9291. Approximately 610 subjects, stratified by ethnicity (Asian/non-Asian) will be randomized in a 2:1 ratio to the treatments as specified below:

- AZD9291 80mg QD p.o.
- Platinum-based doublet chemotherapy (pemetrexed 500mg/m<sup>2</sup> + carboplatin AUC5 or pemetrexed 500mg/m<sup>2</sup> + cisplatin 75mg/m<sup>2</sup>)

The primary analysis of PFS will occur when approximately 400 progression events have been observed. With 400 progression events, the study will provide >95% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were hazard ratio (HR) 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed.

Assuming 12 months non-linear recruitment, 400 PFS events are expected to occur approximately 20 months after the first subject is enrolled in the study.

If the true OS HR for the comparison of AZD9291 versus chemotherapy is 0.75, 427 death events will provide approximately 80% power to demonstrate a statistically significant difference in OS at 5% 2-sided significance level. For example, this translates to an approximate 5-6 month improvement in median OS over an assumed 16-19 month median OS on chemotherapy, assuming OS is exponentially distributed.

In order to randomize 610 subjects (assuming a 10% screen failure rate), 678 (55%) (T790M+) subjects will need to be enrolled. With a 20% attrition rate, and 1232 subjects with known T790M status, approximately 1540 subjects will need to be screened.

## **2. ANALYSIS SETS**

### **2.1 Definition of analysis sets**

#### **2.1.1 Full analysis set**

The full analysis set (FAS) will include all randomized subjects.

The FAS will be used for all efficacy and exploratory analyses and treatment groups will be compared on the basis of randomized treatment, regardless of the treatment actually received.

#### **2.1.1.1 FAS subset for analysis of time to symptom deterioration**

For analysis of time to symptom deterioration, the FAS will be subset to include subjects who have EORTC QLQ-LC13 baseline scores  $\leq 95$  or EORTC QLQ-C30 baseline scores  $\leq 90$ .

### 2.1.1.2 FAS subset for analysis of symptom improvement rate

For analysis of symptom improvement rate, the FAS will be subset to include subjects who have a baseline score  $\geq 5$  for EORTC QLQ-LC13 scales/items or a baseline score  $\geq 10$  for EORTC QLQ-C30 scales/items.

### 2.1.2 Safety analysis set

The safety analysis set will consist of all subjects who received at least one dose of randomized treatment and for whom post-dose data are available.

Safety data will not be formally analyzed but summarized using the safety analysis set, according to the treatment received (i.e., erroneously treated subjects [e.g., those randomized to treatment A but actually given treatment B] will be summarized according to the treatment they actually received).

### 2.1.3 PK analysis set

The PK analysis set includes subjects in the FAS who have at least one measurable PK concentration and who have the relevant date, time and dosing data for this sample. The dosing data must include the dosing data for the 2 days prior to the sample day as well as the sample day.

**Table 1 Summary of outcome variables and analysis populations**

<b>Outcome variable</b>	<b>Populations</b>
Efficacy Data: PFS, ORR, DoR, DCR, Tumor shrinkage, OS, symptoms/HRQoL	FAS
Demography	FAS
PK data	PK (subset of FAS)
Safety Data	Safety
Exploratory Data	FAS

Data on the number of patients and duration of treatment for subjects who begin treatment with AZD9291 following centrally confirmed objective progression will also be summarized separately, as described in Section 4.2.6.

## 2.2 Violations and deviations

All important deviations related to the study inclusion or exclusion criteria and study conduct will be listed and summarized by randomized treatment group. None of the deviations will lead to any subjects being excluded from any of the analysis sets described in Section 2.1 (with the exception of the PK analysis set, if the deviation is considered to impact upon PK). If the deviations are serious enough to have the potential to impact the primary analysis, sensitivity analyses may be performed.

The following general categories will be considered important deviations. This list is not exhaustive and additional important deviations may be added prior to database lock.

- Informed consent procedure deviation (e.g., no informed consent signed prior to any screening procedure)
- Eligibility criteria deviation (e.g., any inclusion criteria not met or exclusion criteria met)
- Prohibited medication deviation (e.g., subject received other anticancer agents, investigational agents, or radiotherapy while on study treatment)

The categorization of these as important deviations is not automatic and will depend on duration and the perceived effect on efficacy.

In addition to the programmatic determination of the deviations above, monitoring notes or summaries will be reviewed to determine any important post-entry deviations that are not identifiable via programming, and to check that those identified via programming are correctly classified. The final classification will be made prior to database lock.

Misrandomizations in terms of errors in treatment dispensing, in addition to incorrect stratifications, will also be summarized and listed, separately to the important protocol deviations. A misrandomization is when a subject is not randomized or treated according to the randomization schedule. It includes subjects who receive no treatment whatsoever for a period of time due to errors in dispensing of medication. Note, this is not due to tolerability issues where subjects may stop taking drug.

The summary will include all subjects with a dispensing error and will also include information on how many of those subjects received at least one dose of the wrong treatment (AZD9291/platinum-based doublet chemotherapy) at any time. Subjects who receive the wrong treatment at any time will be included in the safety analysis set as described in Section 2.1. During the study, decisions on how to handle misrandomizations will be made on an individual basis with written instruction from the study team leader and/or statistician.

### **3. PRIMARY AND SECONDARY VARIABLES**

#### **3.1 Efficacy assessments**

##### **Investigator's RECIST-based assessments**

From the investigator's review of the imaging scans, the RECIST tumor response data will be used to determine each subject's visit response according to RECIST 1.1. It will also be used to determine the endpoints ORR, DoR, DCR and PFS from the overall visit response and scan dates. ORR will only include subjects whose response has been confirmed by a second scan at

least 4 weeks after the initial response. The endpoint of tumor shrinkage will be assessed from tumor size measurements based on investigator assessment.

Baseline radiological tumor assessments are to be performed no more than 28 days before the start of randomized treatment. Tumor assessments are then performed every 6 weeks relative to randomization until disease progression. Baseline values recorded after treatment start should not be used as the baseline assessment; although such assessments can be used in the calculation of PD. At each visit, subjects will be programmatically assigned an overall visit response of complete (CR), partial (PR), stable disease (SD) or progressive disease (PD) depending on the status of their disease compared with baseline and previous assessments. If a subject has had a tumor assessment, which cannot be evaluated, then the subject will be assigned a visit response of not evaluable (NE) (unless there is evidence of progression in which case the response will be assigned as PD).

Please refer to CSP Appendix H for the definitions of CR, PR, SD and PD and the derivations of overall visit response using the information from target lesions (TL), non-target lesions (NTL) and new lesions.

### **Rounding of TL data**

For calculation of PD and PR for TLs percentage changes from baseline and previous minimum should be rounded to 1 decimal place before assigning a TL response. For example, 19.95% should be rounded to 20.0% but 19.94% should be rounded to 19.9%.

### **Missing TL data**

For a visit to be evaluable, all TL measurements should be recorded. However, a visit response of PD should be assigned if any of the following occurred:

- A new lesion is recorded;
- A NTL visit response of PD is recorded;
- The sum of TLs is sufficiently increased to result in a 20% increase, and an absolute increase of  $\geq 5$  mm from nadir even assuming the non-recorded TLs have disappeared.

The nadir can only be taken from assessments where all the TLs had a longest diameter (LD) recorded.

### **Lymph nodes**

For lymph nodes, if the size reduces to  $< 10$  mm, these are considered non-pathological.

However a size will still be given and this size should still be used to determine the TL visit response as normal. In the special case where all lymph nodes are  $< 10$  mm and all other TLs are 0 mm, although the sum may be  $> 0$  mm, the calculation of TL response should be overwritten as a CR.

### **TL visit responses subsequent to CR**

A CR response can only be followed by CR, PD or NE. If a CR has occurred, the following rules at the subsequent visits must be applied:

- Step 1: If all lesions meet the CR criteria (i.e., 0 mm or <10 mm for lymph nodes), the response will be set to CR irrespective of whether the criteria for PD of TL is also met (i.e., if a lymph node LD increases by 20% but remains <10 mm).
- Step 2: If some lesion measurements are missing but all other lesions meet the CR criteria (i.e., 0 mm or <10 mm for lymph nodes), the response will be set to NE irrespective of whether when referencing the sum of TL diameters the criteria for PD is also met.
- Step 3: If not all lesions meet the CR criteria, and the sum of lesions meets the criteria for PD, the response will be set to PD.
- Step 4: If, after steps 1 through 3, a response cannot be determined, the response will be set to remain as CR.

### **TL too big to measure**

If a TL becomes too big to measure, this should be indicated in the database and a size ('x') above which it cannot be accurately measured should be recorded. If using a value of  $x$  in the calculation of TL response would not give an overall visit response of PD, then this will be flagged and reviewed by the study team blinded to treatment assignment. It is expected that a visit response of PD will remain in the vast majority of cases.

### **TL too small to measure**

If a TL becomes too small to measure a value of 5 mm will be entered into the database and used in TL calculations, unless the radiologist has indicated and entered a smaller value that can be measured reliably. If a TL response of PD results then this will be reviewed by the study team blinded to treatment assignment.

### **Irradiated lesions/lesion intervention**

Previously irradiated lesions (i.e., lesion irradiated prior to entry into the study) should be recorded as NTLs and should not form part of the TL assessment.

Any TL (including lymph nodes), which has had intervention during the study (for example, irradiation/palliative surgery/embolization), should be handled in the following way:

- Step 1: the diameters of the TLs (including the lesions that have had intervention) will be summed and the calculation will be performed in the usual manner. If the visit response is PD this will remain as a valid response category.

- Step 2: If there was no evidence of progression after step 1, the lesion diameter (for those lesions with intervention) will be treated as missing and scaled up as described previously as long as there remain  $\leq 1/3$  of the TLs with missing measurements. If the scaling results in a visit response of PD then the subject will be assigned a TL response of PD.
- Step 3: If after both steps PD has not been assigned, then a scaled sum of diameters will be calculated, treating the lesion with intervention as missing, and PR or SD then assigned as the visit response. Subjects with intervention are evaluable for CR as long as all non-intervened lesions are 0 (or  $< 10$  mm for lymph nodes) and the lesions that have been subject to intervention also have a value of 0 recorded.

At subsequent visits the above steps will be repeated to determine the TL and overall visit response. When calculating the previous minimum, lesions with intervention should be treated as missing and scaled up (as per step 2 above).

Once a lesion has had intervention then it should be treated as having intervention for the remainder of the study noting that an intervention will most likely shrink the size of tumors.

### **Lesions that split in two**

If a TL splits in two, then the LDs of the split lesions should be summed and reported as the LD for the lesion that split.

### **Lesions that merge**

If two TLs merge, then the LD of the merged lesion should be recorded for one of the TL sizes and the other TL size should be recorded as 0mm.

### **Change in method of assessment of TLs**

Computerized tomography (CT) scan and magnetic resonance imaging (MRI) are the only methods of assessment that can be used within this trial. If a change in method of assessment occurs between CT scan and MRI this will be considered acceptable and no adjustment within the programming is needed.

### **BICR of RECIST based assessments**

BICR of radiological imaging data will be carried out using RECIST 1.1. All radiological scans for all subjects (including those at unscheduled visits, or outside visit windows) will be provided to the BICR. Prior radiotherapy reports for subjects (at baseline) and information on biopsied lesions will also be provided to the BICR to allow the selection of appropriate TLs. The imaging scans will be reviewed by two independent radiologists using RECIST 1.1 criteria and will be adjudicated if required.

Up to three qualified radiologists will independently review the imaging scans in the following way. First a primary review will be performed by two independent radiologists for each patient on a timepoint by timepoint basis to give an overall tumour assessment at each

timepoint using RECIST 1.1. Then a global radiology review will be performed whereby the same independent radiologists will globally assess all timepoints for a patient in the review period and adjust an overall assessment if necessary. Finally, if the overall assessment for at least one timepoint for a patient does not agree between the two independent radiologists, a third independent radiologist will adjudicate and identify which radiologist's assessments they agree with and should be used (for the whole patient). These visit responses (either from the adjudicator selected reviewer, or the primary reviewer in the absence of adjudication) will be used to report BICR visit responses, BICR best overall response, BICR time to response, BICR censoring of response, BICR progression date and BICR progression censoring.

If no adjudication has taken place but the dates for response or progression are different for the two reviewers, the following approaches will be used. For scan dates to be used for progression, the progression date that is the earlier of the two reviewers should be taken as the progression date. For target lesion diameters, data from the reviewer who read the baseline scan first for the patient should be used.

All independent reviewers will be blinded to treatment. For each subject, the BICR will define the overall visit response data (CR, PR, SD, PD or NE) and the relevant scan dates for each time point (i.e., for visits where response or progression is/is not identified).

Further details of the BICR will be documented in the Blinded Independent Review Charter.

### **3.1.1 PFS**

PFS is defined as the time from randomization until the date of objective disease progression or death (by any cause in the absence of progression) regardless of whether the subject withdraws from randomized therapy or receives another anti-cancer therapy prior to progression. Subjects who have not had PD or died at the time of analysis will be censored at the time of the latest date of assessment from their last evaluable RECIST assessment.

However, if the subject has PD or dies after two or more missed visits, the subject will be censored at the time of the latest evaluable RECIST assessment. If the subject has no evaluable visits or does not have baseline data they will be censored at 0 days unless they die within two visits of baseline.

The PFS time will always be derived based on scan/assessment dates not visit dates.

RECIST assessments/scans contributing towards a particular visit may be performed on different dates. The following rules will be applied:

- Date of progression will be determined based on the earliest of the dates of the component that triggered the progression
- When censoring a subject for PFS the subject will be censored at the latest of the dates contributing to a particular overall visit assessment



### **3.1.2 ORR**

ORR rate is defined as the percentage of subjects with measurable disease with at least one visit response of CR or PR that is confirmed at least 4 weeks later. Data obtained up until progression, or last evaluable assessment in the absence of progression, will be included in the assessment of ORR. However, any complete response or partial response, which occurred after a further anti-cancer therapy was received, will not be included in the numerator for the ORR calculation.

In the case where a subject has two non-consecutive visit responses of PR, then, as long as the time between the 2 visits of PR is greater than 4 weeks and there is no PD between the PR visits, the subject will be defined as a responder. Similarly, if a subject has visit responses of CR, NE, CR, then, as long as the time between the 2 visits of CR is greater than 4 weeks, then a best response of CR will be assigned.

### **3.1.3 DoR**

DoR will be defined as the time from the date of first documented response (that is subsequently confirmed) until the date of documented PD or death in the absence of PD, the end of response should coincide with the date of PD or death from any cause used for the PFS endpoint. The time of the initial response will be defined as the latest of the dates contributing towards the first visit response of PR or CR. If the response is not confirmed, it will not be included.

If a subject does not progress following a response, then the subject's duration of response will use the PFS censoring time.

### **3.1.4 DCR**

DCR is defined as the percentage of subjects who have a best overall response of CR or PR or SD at  $\geq 4$  weeks, prior to any PD event.

### **3.1.5 Tumor shrinkage**

Tumor shrinkage will be assessed using RECIST 1.1 tumor response. The absolute change and percentage change from baseline in sum of tumor size at each assessment will be calculated.

Tumor size is the sum of the longest diameters (SLD) of the TLes. The percentage change in SLD at each week for which data are available will be obtained for each subject taking the difference between the SLD at each week and the SLD at baseline divided by the SLD at baseline multiplied by 100 [i.e.,  $(\text{week } n - \text{baseline}) / \text{baseline} \times 100$ ]. The change from baseline will be obtained for each subject taking the difference between the SLD at each week and the SLD at baseline (i.e.,  $\text{week } n - \text{baseline}$ ).

The best percentage change in SLD from baseline or the minimum increase from baseline in the absence of a reduction from baseline based on all post-baseline assessments prior to progression or start of subsequent anti-cancer therapy.

If best percentage change cannot be calculated due to missing data, a value of +20% will be imputed as the best percentage change from baseline in the following situations (otherwise best percentage change will be left as missing):

- If a subject has no post-baseline assessment and has died;
- If a subject has new lesions or progression of NTLs;
- If a subject has withdrawn due to PD and has no evaluable TL data before or at PD.

### **3.1.6 OS**

OS is defined as the time from the date of first dose until death due to any cause. Any subject not known to have died at the time of analysis will be censored based on the last recorded date on which the subject was known to be alive.

Note: Survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis, and if subjects are confirmed to be alive, or if the death date is post the final data cut-off date, these subjects will be censored at the date of the final data cut off. Death dates may be found by checking publicly available death registries.

### **3.1.7 HRQoL and symptoms**

PROs will be assessed using the EORTC QLQ-C30 and EORTC QLQ-LC13 questionnaires. The EORTC QLQ-C30 consists of 30 questions, which can be combined to produce 5 functional scales (Physical, Role, Cognitive, Emotional, Social), 3 symptom scales (Fatigue, Pain, Nausea/vomiting), 5 individual items (dyspnea, insomnia, appetite loss, constipation, diarrhea) and a global measure of health status. The EORTC QLQ-LC13 is a lung cancer specific module comprising 13 questions to assess lung cancer symptoms (cough, hemoptysis, dyspnea and site-specific pain), treatment related side-effects (sore mouth, dysphagia, peripheral neuropathy and alopecia) and pain medication. With the exception of a multi-item scale for dyspnea, all are single items.

An outcome variable consisting of a score from 0 to 100 will be derived for each of the symptom scales/symptom items, the functional scales and the global health status scale in the EORTC QLQ-C30 and for each of the symptom scales/items in the EORTC QLQ-LC13 according to the EORTC QLQ-C30 Scoring Manual and EORTC QLQ-LC13 instructions, respectively.

Higher scores on the global health status and functioning scales indicate better health status/function. Higher scores on the symptoms scales indicate greater symptom burden.

The primary PRO measures will be subject-reported lung cancer symptoms assessed using the EORTC QLQ-LC13, namely:

- dyspnea (multi-item scale based on three questions: “Were you short of breath when you rested; walked; climbed stairs”),

- cough: one item (“How much did you cough?”),
- hemoptysis: one item (“Did you cough up blood?”),
- pain: three individual items (“Have you had pain in your chest; your arm or shoulder; other parts of your body?”).

***Definition of clinically meaningful changes***

Changes in score compared to baseline will be evaluated. A minimum clinically meaningful change is defined as a change in the score from baseline of  $\geq 5$  for scales/items from the EORTC QLQ-LC13 and  $\geq 10$  for scales/items from the EORTC QLQ-C30 (Obosa et al 1998).

For example, a clinically meaningful deterioration or worsening in chest pain (as assessed by EORTC QLQ-LC13) is defined as an increase in the score from baseline of  $\geq 5$ . A clinically meaningful improvement in fatigue (as assessed by EORTC QLQ-C30) is defined as a decrease in the score from baseline of  $\geq 10$ .

At each post-baseline assessment, change in symptoms/functioning from baseline will be categorized as improved, stable or worsening as shown in Table 2.

**Table 2 Visit response for HRQoL and disease-related symptoms**

Score	Change from baseline	Visit response
EORTC QLQ-LC13 symptom scales/items	$\geq +5$	Worsened
	$\leq -5$	Improved
	Otherwise	Stable
EORTC QLQ-C30 symptoms scales/items	$\geq +10$	Worsened
	$\leq -10$	Improved
	Otherwise	Stable
EORTC QLQ-C30 functional scales and Global health status	$\geq +10$	Improved
	$\leq -10$	Worsened
	Otherwise	Stable

**3.1.7.1 Time to symptom deterioration**

For each of the symptoms scales/items in EORTC QLQ-LC13, time to symptom deterioration will be defined as the time from randomization until the date of first clinically meaningful symptom deterioration (an increase in the score from baseline of  $\geq 5$ ) or death (by any cause)

in the absence of a clinically meaningful symptom deterioration, regardless of whether the subject withdraws from randomized therapy or receives another anti-cancer therapy prior to symptom deterioration. Death will be included as an event only if the death occurs within two visits of the last PRO assessment where the symptom change could be evaluated.

Subjects whose symptoms (as measured by EORTC QLQ-LC13) have not shown a clinically meaningful deterioration and who are alive at the time of the analysis will be censored at the time of their last PRO assessment where the symptom could be evaluated. Also, if symptoms progress after two or more missed PRO assessment visits or the subject dies after two or more missed PRO assessment visits, the subject will be censored at the time of the last PRO assessment where the symptom could be evaluated. If a subject has no evaluable visits or does not have baseline data they will be censored at Day 1. The population for analysis of time to symptom deterioration will include a subset of the FAS who have EORTC QLQ-LC13 baseline scores  $\leq 95$  or EORTC QLQ-C30 baseline scores  $\leq 90$ .

### **3.1.7.2 Symptom improvement rate**

The symptom improvement rate will be defined as the number (%) of subjects with two consecutive assessments at least 18 days apart (i.e., 21 days allowing a visit window of 3 days), which showed a clinically meaningful improvement (a decrease from baseline score  $\geq 5$  for EORTC QLQ-LC13 scales/items or  $\geq 10$  for EORTC QLQ-C30 scales/items) in that symptom from baseline. The denominator will consist of a subset of the FAS who have a baseline symptom score  $\geq 5$  (EORTC QLQ-LC13 scales/items) or  $\geq 10$  (EORTC QLQ-C30 scales/items).

### **3.1.7.3 PFS2**

PFS2 is defined as the time from the date of randomization to the earliest of the progression event subsequent to that used for the primary variable PFS or death. Subjects who are alive and for whom a second PD has not been observed will be censored at their last assessment where the subject has not had a second progression or death. If a subject dies without a progression event, the subject's PFS and PFS2 events would be the equivalent.

For subjects with no PFS and no PFS2, the PFS2 censor date will be same as PFS censor date, with the following exceptions:

- If there is no PFS event but a PFS2 event has been recorded, the PFS2 event should be used in the PFS2 analysis even though the subject will be censored in PFS analysis.
- If there is no PFS event but the PFS2 form has been completed as no event with a date, then use this date as the censor date (rather than PFS censor date).

### **3.1.7.4 TFST**

TFST is defined as the time from the date of randomization to the earlier of the date of anti-cancer therapy start date following study treatment discontinuation, or death. Any subject not known to have had a subsequent therapy or not known to have died at the time of the analysis

will be censored at the last known time to have not received subsequent therapy (i.e., the last follow-up visit where this was confirmed). If a subject terminates the study for a reason other than death before first subsequent anti-cancer therapy, the subject will be censored at the termination date.

### **3.1.7.5 TSST**

TSST is defined as the time from the date of randomization to the earlier of the date of second subsequent anti-cancer therapy start date following study treatment discontinuation, or death. Any subject not known to have died at the time of the analysis and not known to have had a second further intervention of this type will be censored at the last known time to have not received second subsequent therapy (i.e., the last follow-up visit where this was confirmed). If a subject terminates the study for a reason other than death before the second subsequent anti-cancer therapy, the subject will be censored at the termination date.

### **3.1.8 PRO-CTCAE symptoms**

The PRO-CTCAE questionnaire will be used to derive subject reporting of CTCAE symptoms.

The PRO-CTCAE will only be administered in those countries where a linguistically validated version exists (languages available are English, German, Japanese and Spanish). PRO-CTCAE is an item-bank of symptoms of the CTCAE experienced by subjects while undergoing treatment of their cancer that has been converted to subject terms (i.e., CTCAE term “myalgia” converted to “aching muscles”). Twenty-eight items from the PRO-CTCAE item-bank have been selected as being relevant for this study.

### **3.1.9 Health state utility**

The EQ-5D-5L index comprises 5 dimensions of health (mobility, self-care, usual activities, pain/discomfort and anxiety/depression). For each dimension, subjects select which statement best describes their health on that day from a possible 5 options of increasing levels of severity (no problems, slight problems, moderate problems, severe problems and unable to/extreme problems). A unique EQ-5D health state is referred to by a 5-digit code allowing for a total of 3125 health states. For example, state 11111 indicates no problems on any of the 5 dimensions. These data will be converted into a weighted health state index by applying scores from EQ-5D value sets elicited from general population samples (the base case will be the United Kingdom valuation set, with other country value sets applied in scenario analyses). Where values sets are not available, the EQ-5D-5L to EQ-5D-3L crosswalk will be applied.

In addition to the descriptive system, subjects also assess their health on the day of assessment on a visual analogue scale, ranging from 0 (worst imaginable health) to 100 (best imaginable health). This score is reported separately.

### **3.1.10 Health resource utilization**

Health resource utilization will be assessed in terms of hospitalization, outpatient visits and emergency department visits.

## **3.2 Safety variables**

Safety and tolerability will be assessed in terms of AEs, deaths, laboratory data, vital signs (pulse, BP and weight), ECG, physical examinations, and WHO performance status. These will be collected for all subjects.

### **3.2.1 AEs**

All AEs will be coded using the latest version of the Medical Dictionary for Regulatory Activities (MedDRA) and graded according to the National Cancer Institute Common Terminology Criteria for Adverse Event (CTCAE) (version 4.0.3 or later).

Preferred terms used to identify adverse events of special interest will be listed before database lock and documented in the Study Master File. Groupings of certain MedDRA preferred terms will be based on preferred terms provided by the medical team and a listing of the preferred terms in each grouping will be produced. The grouped terms are as follows: ocular surface effects, dry eye/conjunctivitis, interstitial lung disease and acute interstitial pneumonitis, nail and nail bed conditions, skin disorders, upper GI tract inflammatory events, cardiotoxicity, and diarrhoea.

Any AE occurring before treatment with AZD9291/chemotherapy will be included in the data listings but will not be included in the summary tables of AEs.

Any AE occurring within 90 days of discontinuation of IP (i.e., the last dose of AZD9291/chemotherapy) will be included in the AE summaries. Any events in this period that occur after a subject has received further therapy for cancer (following discontinuation of AZD9291) will be flagged in the data listings. Please refer to CSP Section 6.3.1

### **3.2.2 Other significant adverse events (OAEs)**

During the evaluation of the AE data, an AstraZeneca medically qualified expert will review the list of AEs that were not reported as SAEs and AEs leading to treatment discontinuation. Based on the expert's judgment, significant AEs of particular clinical importance may, after consultation with the Global Patient Safety Physician, be considered OAEs and reported as such in the CSR. A similar review of laboratory, vital signs (pulse, BP and weight), and/or ECG data will be performed for identification of OAEs.

Examples of these could be marked hematological and other laboratory abnormalities, and certain events that lead to intervention (other than those already classified as serious), dose reduction or significant additional treatment.

### **3.2.3 dECG**

Baseline is the pre-dose time point on the first dosing day (Day 1 Cycle 1). For each time point three dECG recordings should be taken within an approximate 5 minute period. The variables to be reported from the continuous dECG measurements are RR, PQ, QRS, and QT intervals. The QT interval will be corrected for RR (the duration of a heart beat) to obtain corrected (QTc) variables.

QTcF will be calculated using the formula:

$$QTcF = QT / RR_b$$

Where  $b = 1/3$ .

To obtain a single value of QTcF, RR, PR, QRS and QT at each specified time point, the mean of the triplicate values at that time point will be used. For each patient, the change-from-baseline in a dECG variable at each time point will be calculated as the difference between the mean of the replicate value at each post-dose time point and the mean of pre-dose baseline replicate value. All ECG data will be obtained from the vendor, eRT, and there will be no site interpretation.

### **3.2.4 Duration of exposure**

#### **Exposure to AZD9291**

Total exposure to AZD9291 will be time (days) from the first dose to the last dose:

$$\text{Total exposure} = (\text{last dose date where dose} > 0 \text{ mg} - \text{first dose date}) + 1$$

Actual exposure to AZD9291 will be time (days) from first dose to the last dose, taking account of dose interruptions.

$$\text{Actual exposure} = ((\text{last dose date where dose} > 0 \text{ mg} - \text{first dose date}) + 1) - \text{total duration of dose interruption (i.e., number of days with dose} = 0 \text{ mg)}.$$

#### **Exposure to chemotherapy**

Duration of treatment on chemotherapy will be in terms of the number of cycles. A cycle will be counted if chemotherapy is started, even if the full dose is not delivered.

If a new cycle is delayed, the day when chemotherapy dosing occurs will be deemed to be day 1 of the next cycle.

### **3.2.5 Dose intensity**

Relative dose intensity (RDI) and percentage intended dose (PID) will be defined as follows:

- $RDI = 100\% \times d / D$ , where  $d$  is the actual cumulative dose delivered up to the earlier of progression (or a censoring event) or the actual last day of dosing, and  $D$  is the intended cumulative dose up to the earlier of progression (or a censoring event) or the actual last day of dosing plus the protocol-defined post-dose rest period. Protocol-defined post-dose rest period is 0 days for AZD9291 and 20 days for chemotherapy.
- $PID = 100\% \times d_1 / D_1$ , where  $d_1$  is the actual cumulative dose delivered up to progression (or a censoring event), and  $D_1$  is the intended cumulative dose up to

progression (or a censoring event).  $D_1$  is the total dose that would be delivered, if there were no modifications to dose or schedule.

RDI and PID for AZD9291 and chemotherapy will be calculated for the entire intended treatment period (censored at data cut-off). RDI and PID for chemotherapy will also be calculated for the 6 planned cycles (censored at the earliest of data cut-off or end of the planned number of cycles).

### **3.3 PK variables**

PK analysis of the plasma concentration data for AZD9291, AZ5104 and AZ7550 will be performed by Quantitative Clinical Pharmacology, AstraZeneca or delegate on behalf of Quantitative Clinical Pharmacology. The actual sampling times will be used in the parameter calculations.

The ratio of metabolite to AZD9291 will be calculated. The plasma concentration data for AZD9291 and metabolites will also be analyzed using a population PK approach, which may include exploring the influence of covariates on PK, if the data allows.

The data collected in this study may also be combined with similar data from other studies and explored using population PK and/or PK-pharmacodynamic methods. A separate analysis plan will be written to describe these analyses. The results of any such analyses will be reported separately from the CSR.

Where possible the appropriate PK parameters will also be determined for the metabolites of AZD9291.

The concentration in CSF will be summarized and metabolite to AZD9291 ratio calculated. If the CSF was taken on a PK day then the CSF to pre-dose plasma concentration for AZD9291 will be calculated.

## **4. ANALYSIS METHODS**

### **4.1 General principles**

Continuous data will be summarized using descriptive statistics (number of observations, mean, standard deviation, median, 25th and 75th percentiles, minimum, and maximum). Frequencies and percentages will be used for summarizing categorical (discrete) data.

Confidence intervals (CIs), when presented, will generally be constructed at the 95% level. For binomial variables, the normal approximation methods will be employed unless otherwise specified.



A month is operationally defined to be 30.4375 days. Six months is operationally defined to be 183 days.

Data will be presented in data listings by treatment group and subject number.

All summaries will be presented by treatment group unless otherwise specified.

#### **4.1.1 Baseline measurements and change from baseline variables**

In general, for efficacy endpoints and PROs the last observed measurement prior to randomization will be considered the baseline measurement. For safety endpoints the last observation before the first dose of study treatment will be considered the baseline measurement unless otherwise specified.

For assessments on the day of first dose where time is not captured, a nominal pre-dose indicator, if available, will serve as sufficient evidence that the assessment occurred prior to first dose.

Assessments on the day of the first dose where neither time nor a nominal pre-dose indicator are captured will be considered prior to the first dose if such procedures are required by the protocol to be conducted before the first dose.

In all summaries change from baseline variables will be calculated as the post-treatment value minus the value at baseline. The % change from baseline will be calculated as  $(\text{post-baseline value} - \text{baseline value}) / \text{baseline value} \times 100$ .

#### **4.1.2 Multiple testing strategy**

In order to provide strong control of the type I error rate, the primary endpoint of PFS and key secondary endpoints, ORR and OS will be tested in this sequential order. If any previous analysis in the sequence is not statistically significant, the alpha spending cannot be transferred to subsequent analyses.

The analyses of primary and all secondary endpoints will all occur at the time of primary analysis of PFS. A 2-sided 5% alpha will be used in all testing, with the exception of overall survival endpoint.

Since three analyses of OS are planned, the alpha will be split between the three analyses using a bespoke spending function where fixed significance levels will be assigned at the first two interims and the remaining significance level assigned to the final analysis, taking account of correlation ([Stone 2010](#)). Therefore:

- 2% will be allocated to the first interim analysis,
- 2.5% will be allocated to the second interim analysis and
- The significance level for the final analysis will be calculated using the software package EAST by selecting: boundary family, p-value, Haybittle-Peto (HP) and

specifying the fixed significance levels used at the interim analyses as well as the information fraction for each analysis. The information fraction is calculated as the number of events at the analysis time-point divided by the total number of events at the final analysis time-point.

For example, assuming that 214 events were observed at the first interim analysis, 320 events were observed at the second interim analysis and 427 events at the final analysis, the information fraction would be entered as 0.5 for the first analysis (214/427 events) and 0.75 for the second analysis (320/427 events). This would result in a significance level for the final analysis of 2.85%.

Any non-statistically significant analyses at the interims will not preclude further testing of OS. However, if, at the 2nd interim analysis, when the OS data are expected to be 50% mature, a statistically significant improvement in OS is not observed, AstraZeneca may decide not to perform the final OS analysis.

#### **4.1.3 Study day definitions**

For the purpose of efficacy data summary, Study Day 1 is defined as the date of randomization to study treatment. For visits (or events) that occur on or after randomization, study day is defined as (date of visit [event] - date of randomization + 1). For visits (or events) that occur prior to randomization, study day is defined as (date of visit [event] - date of randomization). There is no Study Day 0.

For the purpose of safety data summary, Dose Day 1 is defined as the date of first dose of study treatment (referred to in the protocol as Week 1 Day 1). For visits (or events) that occur on or after first dose, dose day is defined as (date of visit [event] - date of first dose of study treatment + 1). For visits (or events) that occur prior to first dose, dose day is defined as (date of visit [event] - date of first dose of study treatment). There is no Dose Day 0.

For listings (such as for AEs) that include the derivation of “days since last dose,” this is defined as (event date - date of last dose). Events that occur on the same day as the last dose of study drug will therefore be described as occurring zero days from the last dose of study drug.

#### **4.1.4 Visit windows**

For summaries of vital signs, laboratory data, ECG, HRQoL, and PROs etc., assessments will be assigned to calculated visit windows (using study day).

The time windows should be exhaustive so that data recorded at any time point have the potential to be summarized. Inclusion within the visit window should be based on the actual date and not the intended date of the visit. For summaries at a subject level, all values should be included, regardless of whether they appear in a corresponding visit-based summary, when deriving a subject level statistic such as a maximum.

The window for the visits following baseline (including unscheduled visits) will be constructed in such a way that the upper limit of the interval falls half way between the two visits.

For summaries showing the maximum or minimum values, the maximum/minimum value recorded on treatment will be used (regardless of where it falls in an interval). Listings should display all values contributing to a time point for a subject; they should also highlight the value for that subject that was used in the summary table, wherever feasible.

For visit based summaries:

- If there is more than one value per subject within a visit window then the closest to the planned study day value should be summarized, or the earlier in the event the values are equidistant from the planned study day. The visit will be missing if no assessment was reported within the specified visit window around the planned study day.
- To prevent very large tables or plots being produced that contain many cells with meaningless data, summary statistics will be presented where at least 10 subjects in either treatment group have data recorded at a particular visit.

#### **4.1.5 Handling missing data**

In general, other than for partial dates, missing data will not be imputed and will be treated as missing.

##### **Imputation of partial dates**

###### ***Initial diagnosis date:***

- If year is missing (or completely missing), do not impute.
- If only day is missing, impute day as 15th of the month.
- If day and month are missing, impute as July 1st.

###### ***Concomitant medication start date***

- If year is missing (or completely missing), do not impute.
- If (year is present and month and day are missing) or (year and day are present and month is missing), impute as January 1st.
- If year and month are present and day is missing, impute day as first day of the month.

###### ***Concomitant medication end date***

- If year is missing (or completely missing), do not impute.

- If (year is present and month and day are missing) or (year and day are present and month is missing, impute as December 31st.
- If year and month are present and day is missing, impute day as last day of the month.

#### **4.1.6 Imputation rules for lab values outside of quantification range**

Lab values below the lower limit of quantification (LLOQ) that are reported as “<LLOQ” or “≤LLOQ” in the database will be imputed by LLOQ x 0.99 for analysis purposes. The original value will be listed.

Lab values above the upper level of quantification (ULOQ) that are reported as “>ULOQ” or “≥ULOQ” in the database will be imputed by ULOQ x 1.01 for analysis purposes. The original value will be listed.

#### **4.1.7 Rounding rules for reported percentages**

For percentages  $\geq 10\%$ :

- Values  $\geq X.5$  or above round to  $X+1$ .
- Values  $>X$  but  $<X.5$  round to  $X$ .

For percentages  $< 10\%$ :

- Values  $\geq X.Y5$  or above round to  $X.Y+0.1$ .
- Values  $>X.Y$  but  $<X.Y5$  round to  $X.Y$ .

## **4.2 Analysis methods**

### **4.2.1 Subject disposition and data sets analyzed**

Subject disposition will be listed and summarized for the FAS. Summaries will include the number and percentage of subjects:

- Randomized
- Treated
- Subjects ongoing study treatment at the data cut-off
- Included in each analysis set (FAS, Safety, and PK).

In addition, the number and percentage of subjects who discontinued treatment and who discontinued the study, including a breakdown of the main reason for discontinuation will be presented for all subjects.

#### **4.2.2 Protocol deviations**

All important protocol deviations will be listed and summarized for the FAS. All protocol deviations will be defined by the study team and identified before database lock.

#### **4.2.3 Demographic and other baseline characteristics**

Demographic and baseline subject characteristics will be listed and summarized for the FAS. Standard descriptive statistics will be presented for the continuous variables of:

- Age (years).
- Weight (kg).
- Height (cm).
- Body mass index ( $\text{kg}/\text{m}^2$ ) [calculated as  $(\text{weight}/\text{height}^2)$  where weight is in kg and height is in m].
- Nicotine consumption (cigarettes/cigars per day and pipe tobacco packs per week)

The total counts and percentages of subjects will be presented for the categorical variables of:

- Age group (years) (grouped as  $<50$ ,  $\geq 50$ - $<65$ ,  $\geq 65$ )
- Sex
- Race
- Ethnic group
- EGFR mutation type (Exon 20 T790M, G719X, S768I, Exon 19 deletion, L858R, and other) (as reported prior to study screening)
- Overall disease classification (metastatic, locally advanced, both)
- Site of disease
- Baseline TL size (mean and categories:  $<40$ , 40-79, 80-119,  $\geq 120$ mm)
- Histology
- Smoking status.
- WHO performance status (0/1)

The number of subjects with all types of EGFR mutations identified by the cobas EGFR central test (by biopsy taken after confirmation of disease progression on the most recent

treatment regime) will be summarized (i.e., T790M only, T790M and exon 19 deletion, T790M and L858R, and T790M with all other mutations with >5 subjects). Examples of other EGFR mutations which may be detected are G719X, S768I, and Exon 20 insertion). A listing of all subjects showing all the EGFR mutations reported prior to study screening and the EGFR mutations identified by the cobas central test after confirmation of disease progression will be presented.

#### **4.2.4 Medical history**

Disease related medical history and relevant surgical history will be coded using MedDRA. All disease related medical history will be listed and the number and percentage of subjects with any disease related medical history will be summarized for the FAS by system organ class (SOC) and preferred term (PT).

All relevant surgical history will be listed and summarized similarly.

#### **4.2.5 Anti-cancer medications and radiotherapy (prior, during, post-treatment with IP)**

Medications received prior to, concomitantly, or post-treatment will be coded using the AstraZeneca Drug Dictionary Anatomical Therapeutic Chemical (ATC) Classification codes. Concomitant medications/radiotherapy will be listed and summarized for the FAS by ATC classification codes.

For the purpose of inclusion in prior and/or concomitant medication or therapy summaries, incomplete medication or radiotherapy start and stop dates will be imputed as detailed in Section [4.1.5](#).

Prior medications, concomitant and post-treatment medications are defined based on imputed start and stop dates as follows:

- Prior medications are those taken prior to screening with a stop date prior to the first dose of study treatment.
- Concomitant medications are those with a stop date on or after the first dose date of study treatment (and could have started prior to or during treatment).
- Post-treatment medications are those with a start date after the last dose date of study treatment.

EGFR-TKI therapies will be defined as approved EGFR-TKI therapies and will include gefitinib, erlotinib and afatinib only.

##### **4.2.5.1 Anti-cancer therapy**

All anti-cancer therapies will be summarized for the FAS. They will be summarized separately for prior, current, and post-withdrawal of IP anti-cancer therapies.

The number of anti-cancer therapy regimens and number of cycles will be summarized using descriptive statistics. The anti-cancer therapy agent, therapy class, best response, and treatment status will be summarized using frequencies and percentages. Any anti-cancer therapies will also be listed.

#### **4.2.5.2 Radiotherapy**

All radiotherapies will be summarized for the FAS. They will be summarized separately for prior, current, and post-withdrawal of IP radiotherapies.

The number of fraction doses and fraction dose (Gy) will be summarized using descriptive statistics. The radiotherapy site/region and treatment status will be summarized using frequencies and percentages.

Any radiotherapy will also be listed.

#### **4.2.6 Exposure**

Exposure will be listed and summarized for safety analysis set. The following summaries will be produced:

- Summary of duration of exposure of AZD9291
- Summary of total number of cycles of chemotherapy received
- RDI and PID of AZD9291
- RDI and PID of chemotherapy
- Summary of interruptions and reductions of AZD9291
- Summary of interruptions and reductions of chemotherapy

A table of the number of subjects on the chemotherapy arm who begin treatment with AZD9291 following centrally confirmed objective progression will be presented together with a patient journey (swimmer) plot displaying the duration of chemotherapy and duration of AZD9291 treatments for these patients.

#### **4.2.7 Brain metastases**

The proportion of subjects who develop brain metastases during the trial will be summarized by treatment group.

#### **4.2.8 Efficacy**

All efficacy analyses will be performed on the FAS. Results of all statistical analyses will be presented using a 95% CI and 2-sided p-value.

#### 4.2.8.1 Primary outcome: PFS

PFS will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian) for generation of the p-value and using the Breslow approach for handling ties. The HR and CI will be obtained directly from the U and V statistics as follows (Berry G et al 1991, Selke & Siegmund 1982):

$$\text{HR} = \exp(U/V)$$

$$95\% \text{ CI for HR} = (\exp\{U/V - 1.96/\sqrt{V}\}, \exp\{U/V + 1.96/\sqrt{V}\})$$

Where  $U = \sum_i(d_{1i} - e_{1i})$  is the log-rank test statistic (with  $d_{1i}$  and  $e_{1i}$  the observed and expected events in group 1) and  $\sqrt{V}$  the standard deviation of the log-rank test statistic obtained from the LIFETEST procedure with a STRATA term for the stratification variable.

The assumption of proportionality will be assessed. In the event of non-proportionality, the HR will be interpreted as an average HR over the observed extent of follow-up.

Proportionality will be tested firstly by examining the plots of complementary log-log (event times) versus log (time) and, if necessary, a time dependent covariate will be fitted to assess the extent to which this represents random variation.

A Kaplan-Meier (KM) plot of PFS will be presented by treatment group.

#### *Subgroup analysis*

Subgroup analyses will be conducted by comparing PFS between treatments in the following groups:

- Ethnicity (Asian versus Non-Asian)
- Gender (Male versus Female)
- Age at randomization (<65 versus ≥65)
- Mutation status prior to start of study (ex19 versus L858R)
- Duration of prior EGFR-TKI (<6 months, ≥6 months)
- Brain metastases at entry
- Smoking history

The HR (AZD9291: chemotherapy) and associated CI will be calculated from a Cox proportional hazards model (ties=Efron) that contains the treatment term, factor and treatment-by-factor interaction term. The treatment effect HRs for each treatment comparison along with their CIs will be obtained for each level of the subgroup from this single model. The HRs and 95% CIs will be presented on a forest plot including the HR and 95% CI from the overall population (using the primary analysis).



If there are too few events available for a meaningful analysis of a particular subgroup (it is not considered appropriate to present analyses where there are less than 20 events in a subgroup), the relationship between that subgroup and PFS will not be formally analyzed. In this case, only descriptive summaries will be provided.

No adjustment to the significance level for testing will be made since the subgroup analysis will be considered exploratory and may only be supportive of the primary analysis of PFS.

The presence of quantitative interactions will be assessed by means of an overall global interaction test. This will be performed in the overall population by comparing the fit of a Cox proportional hazards model including treatment, all covariates, and all covariate-by-treatment interaction terms, with one that excludes the interaction terms and will be assessed at the 2-sided 10% significance level. If the fit of the model is not significantly improved then it will be concluded that overall the treatment effect is consistent across the subgroups.

If the global interaction test is found to be statistically significant, an attempt to determine the cause and type of interaction will be made. Stepwise backwards selection will be performed on the saturated model, whereby (using a 10% level throughout) the least significant interaction terms are removed one-by-one and any newly significant interactions re-included until a final model is reached where all included interactions are significant and all excluded interactions are non-significant. Throughout this process all main effects will be included in the model regardless of whether the corresponding interaction term is still present. This approach will identify the factors that independently alter the treatment effect and prevent identification of multiple correlated interactions.

Any quantitative interactions identified using this procedure will then be tested to rule out any qualitative interaction using the approach of [Gail and Simon 1985](#).

### ***Sensitivity analysis***

(a) Ascertainment bias

The possibility of bias in assessment and measurement of PFS by investigators will be assessed by comparing the hazard ratio derived from investigator review with the hazard ratio derived using the BICR assessment of disease progression by RECIST 1.1.

(b) Evaluation-time bias

In order to assess possible evaluation-time bias, which could occur if scans are not performed at the protocol-scheduled time points, the midpoint between the time of progression and the previous evaluable RECIST 1.1 assessment will be analyzed using a stratified log rank test, as described for the primary analysis of PFS. For subjects who die in the absence of progression, the date of death will be used to derive the PFS time used in the analysis. Subjects with no events (i.e., subjects censored for PFS) will be censored at Day 1 for this sensitivity analysis.

(c) Attrition bias

Possible attrition bias will be assessed by:

- (i) Repeating the primary PFS analysis, except that the actual PFS event times, rather than the censored times, of subjects who progressed or died in the absence of progression immediately following two, or more, non-evaluable tumor assessments will be included.
- (ii) Subjects who take subsequent therapy prior to progression or death will be censored at their last evaluable assessment prior to taking the subsequent therapy.
- (iii) A reversed KM plot of the time to censoring, where the censoring indicator of the primary PFS analysis is reversed, will be presented to assess the number of subjects being followed over time.

***Post-hoc exploratory analysis of the use of a novel sample BICR methodology to assess bias in assessment of PFS by investigators***

Recently, it has been suggested that, in order to assess the potential for bias amongst investigators, a BICR amongst only a sample of patients could be performed; if evidence of bias is detected, according to a pre-defined threshold, the BICR is then assessed in all patients, otherwise it is concluded the sample was sufficient to rule-out meaningful levels of bias. A proposed sample BICR method has been submitted to a peer reviewed statistical journal for publication as of August 2014 and in order to demonstrate that this is a valid methodology for use in future trials, a post hoc exploratory analysis will be carried out using this methodology. The results of this exploratory analysis will be reported separately from the CSR. A random sample of subjects from the full study population will be selected and the results of the BICR review of these subjects will be used to rule out a concerning level of bias in the full study local evaluation (LE) estimate of the treatment effect (Hazard Ratio) for PFS. The hazard ratio ratio (HRR), the ratio of the hazard ratio (HR) for the treatment effect estimated from the sample BICR to the corresponding HR for the investigator assessments, will be used as the metric to assess bias. Lack of evidence of meaningful bias will be concluded if there is a low conditional probability that the HRR seen in the random sample would have been observed, if in fact, the point estimate in the full trial were unacceptably high (i.e., 1.25).

The subjects forming the sample BICR will be randomly selected from within each treatment group with separate sampling within subjects who have a LE progression event and from those censored for PFS by the LE. This is so that the BICR sample is representative of the study as a whole.

A sample BICR would be deemed to be acceptable if there was a low (conditional) probability (10%), given the sample, that the null hypothesis of concerning bias in the overall study ( $HRR \geq 1.25$ ) was really true. This protects the sensitivity of the procedure at 90% (i.e., correctly failing to reject the hypothesis of concerning bias when this is really true).

#### **4.2.8.2 Secondary outcomes**

##### ***ORR***

ORR will be analyzed using a logistic regression with a covariate for ethnicity (Asian/non-Asian). The results of the analysis will be presented in terms of an odds ratio together with its associated 95% profile likelihood CI and 2-sided p-value. The p-value will be based on a test statistics that is calculated as twice the change in log-likelihood resulting from the addition of a treatment factor to a model that contains the covariates defined above. The test statistics is chi-squared distributed with 1 degree of freedom.

A summary of all responses (both confirmed and unconfirmed) will also be presented by treatment group. Subject level responses will be listed.

##### ***DoR***

In order to analyze the secondary outcome variable of DoR between arms the Expected Duration of Response (EDoR) will be derived for each treatment group ([Ellis S et al 2008](#)). The EDoR is the product of the proportion of subjects responding to treatment and the mean DoR in responding subjects, and provides an estimate based on all randomized subjects.

Treatments will be compared by calculating the ratio of EDoRs. Probability distributions for the duration of response for each treatment group will be determined prior to database lock by fitting blinded DoR data for responding subjects to the best fitting distribution of the generalized gamma family of distributions. Duration of response data from other AURA studies available at this time may also be used to help determine the most appropriate distribution. The mean DoR will be estimated, and the null hypothesis that the distribution of the ratio of EDoRs is 1 will be tested and a p-value and 95% CI provided according to the formula provided in [Ellis S et al 2008](#).

The analysis of DoR will be stratified by the same covariates as the primary analysis, weighting each stratum inversely proportional to the within stratum variance of the log of the ratio of EDoRs. Additionally, listings and descriptive data will be provided for the duration of response in responding subjects, including associated KM curves (without any formal comparison of or p-value attached).

##### ***DCR***

DCR will be analyzed using a logistic regression with a covariate for ethnicity (Asian/non-Asian). The results of the analysis will be presented in terms of an odds ratio together with its associated 95% profile likelihood CI and 2-sided p-value. The p-value will be based on twice the change in log-likelihood resulting from the addition of a treatment factor to a model that contains the covariates defined above.

##### ***Tumor shrinkage***

The effect of AZD9291 on best percentage change in tumor size will be estimated from an analysis of covariance (ANCOVA) model with a covariate for ethnicity (Asian/non-Asian).

The number of subjects, unadjusted mean and lsmeans for each treatment group will be presented, together with the difference in lsmeans, 95% CI and corresponding p-value.

## ***OS***

OS data will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian) for generation of the p-value and using the Breslow approach for handling ties. The HR and CI will be obtained directly from the U and V statistics as described in Section 4.2.8.1 (provided there are sufficient events available for a meaningful analysis [ $>20$  deaths], if not descriptive summaries will be provided). For the interim analysis, see Section 5.

### ***Time to PRO symptom deterioration***

Time to PRO symptom deterioration will be analyzed using a log rank test stratified by ethnicity (Asian/non-Asian) for generation of the p-value and using the Breslow approach for handling ties. The HR and CI will be estimated using the same methods as for the primary endpoint of PFS, as described in Section 4.1.

### ***PRO symptom improvement rate***

Symptom Improvement Rate at each visit will be analyzed using a logistic regression with a covariate for ethnicity (Asian/non-Asian). The results of the analysis will be presented in terms of an odds ratio together with its associated 95% profile likelihood CI and 2-sided p-value. The p-value will be based on twice the change in log-likelihood resulting from the addition of a treatment factor to a model that contains the covariates defined above.

### ***Subjects with EGFR T790M mutation status detected in baseline plasma sample (ctDNA)***

The efficacy of AZD9291 versus chemotherapy will be evaluated for the subgroups of subjects with T790M+ in their baseline plasma sample and subjects that are T790M- by the plasma test. For PFS, the HR and associated 95% CI will be calculated and KM plots presented. For ORR, the odds ratio and associated 95% CI will be presented.

## **4.2.8.3 Exploratory outcomes**

### ***PRO-CTCAE***

PRO-CTCAE data will be presented using summaries and descriptive statistics based on the FAS.

### ***Healthcare resource use***

Healthcare Resource Use data (i.e., the hospital admission details including type of attendance and primary symptom for admission) will be presented using frequencies and percentages the duration of admission/attendance and duration of ICU/HDU stay will be summarized using descriptive statistics, based on the FAS.

### ***Post-progression outcomes***

PFS2 will be analyzed using the same method as the analysis of PFS. TFST, TSST and time to change in symptoms (measured by PRO HRQoL questionnaires) will be summarized as appropriate.

### ***Further analysis of OS***

The effect of baseline characteristics on OS in each randomized treatment group will be summarized.

All subsequent treatments in each treatment group will be summarized, including duration of treatments. The duration of ongoing treatment will be calculated up to the analysis data cut-off date.

For summaries, anti-cancer treatments will be grouped by mode of action (e.g., 1<sup>st</sup>/2<sup>nd</sup> generation EGFR-TKIs, 3<sup>rd</sup> generation EGFR-TKIs with T790M activity [e.g., AZD9291, others], platinum-based doublet chemotherapy, single agent chemotherapy).

Additional analysis of OS adjusting for the impact of subjects randomized to chemotherapy, who subsequently receive AZD9291 may be completed if this treatment sequence occurs in a significant proportion of subjects. Methods such as Rank Preserving Structural Failure Time (RPSFT) (Robins et al 1991) Inverse Probability of Censoring Weighting (IPCW) (Robins 1993) and other methods in development may be explored. The decision to adjust and final choice of methods will be based on a review of the data and the plausibility of the underlying assumptions. Further detail will be provided in a Payer Analysis Plan.

#### **4.2.9 PK and CSF concentration data**

All plasma concentrations of AZD9291, AZ5104 and AZ7550 will be listed.

Secondary outcomes include summaries of the following PK parameters: plasma concentrations, plasma metabolite, and AZD9291 ratio.

Exploratory outcomes include summaries of CSF concentrations, CSF metabolite: AZD9291 ratio, and CFS: plasma ratio.

The following summary statistics by nominal sample time will be presented for the PK analysis set:

- The geometric mean (gmean, calculated as  $\exp[\mu]$ , where  $\mu$  is the mean of the data on a logarithmic scale).
- Coefficient of variation (CV, calculated as  $100 \sqrt{\exp(s^2)-1}$ , where  $s$  is the standard deviation of the data on a logarithmic scale).
- Gmean  $\pm$  standard deviation (calculated as  $\exp[\mu \pm s]$ ).

- Arithmetic mean calculated using untransformed data.
- Standard Deviation (SD) calculated using untransformed data.
- Minimum.
- Median.
- Maximum.
- Number of observations (n).

Non-quantifiable (NQ) values of plasma concentrations will be handled as follows:

- If, at a given time point, 50% or less of the plasma concentrations are NQ, the gmean, CV, gmean  $\pm$  SD, arithmetic mean and standard deviation will be calculated by substituting the limit of quantification (LOQ) for values which are NQ.
- If more than 50%, but not all, of the concentrations are NQ, the gmean, CV, gmean  $\pm$  SD, arithmetic mean and SD will be reported as not calculable (NC).
- If all the concentrations are NQ, the gmean and arithmetic mean will be reported as NQ and the CV, gmean  $\pm$  SD and SD as NC.
- The number of values above LLOQ will be reported for each time point along with the total number of collected values.

If data are available for fewer than 3 subjects, no summary statistics other than minimum, maximum and n will be presented.

The PK data for Cycle 1 Day 1 and Cycle 3 Day 1 will also be displayed graphically for the PK analysis set. Displays will include plasma concentration subject profiles versus time and gmean concentrations ( $\pm$  SD) both on the linear and on the log-scale versus time by cohort.

#### **4.2.10 Safety and tolerability**

The safety analysis set will be used for all safety and tolerability tables, figures and listings except where expressly noted.

##### **4.2.10.1 AEs**

All AEs, both in terms of MedDRA PT and CTCAE grade, will be listed and summarized descriptively by count (n) and percentage (%) for each treatment group. MedDRA will be used for coding. Any AE occurring before AZD9291/chemotherapy treatment (i.e., before Study Day 1) will be included in the AE listings, but will not be included in the summary tables (unless otherwise stated). These will be referred to as 'pre-treatment'. The summary tables will include all AEs that occurred after the start of treatment up until the end of the 90

day follow-up period. The 90 day follow-up period will be defined as 90 days following discontinuation of AZD9291/chemotherapy treatment.

All reported AEs will be listed along with the date of onset, date of resolution (if AE is resolved), investigator's assessment of severity and relationship to study drug. Frequencies and percentages of subjects reporting each preferred term will be presented (i.e., multiple events per subject will not be accounted for apart from on the episode level summaries).

Summary information (the number and percent of subjects by treatment) will be tabulated for:

- All AEs
- All AEs causally related to study medication
- AEs with CTCAE grade 3 or higher
- AEs with CTCAE grade 3 or higher, causally related to study medication
- AEs with outcome of death
- AEs with outcome of death causally related to study medication
- All SAEs
- All SAEs causally related to study medication
- AEs leading to dose modification of AZD9291/chemotherapy
- AEs leading to discontinuation of AZD9291/chemotherapy
- AEs leading to discontinuation of AZD9291/chemotherapy, causally related to AZD9291/chemotherapy
- OAEs
- OAEs causally related to AZD9291/chemotherapy

An overall summary of the number and percentage of subjects in each category will be presented, as will an overall summary of the number of episodes in each category. In addition, a truncated AE table of the most common AEs, showing all events that occur in at least 5% of subjects overall will be summarized by preferred term, by decreasing frequency. This cut-off may be modified after review of the data.

AEs will be assigned CTCAE grades and summaries of the number and percentage of subjects will be provided by maximum reported CTCAE grade, SOC, PT and actual treatment group. Fluctuations observed in CTCAE grades during the study will be listed.

Summaries of the number and percentage of subjects with AEs leading to a dose change of AZD9291/chemotherapy and also dose interruptions of AZD9291/chemotherapy will be presented by PT.

In addition, AEs with an outcome of death, SAEs, AEs leading to discontinuation of treatment, AEs causally related to AZD9291/chemotherapy and OAEs will be listed.

A separate summary will be produced that presents any events that occur prior to dosing or starting more than 90 days after discontinuing therapy.

#### **4.2.10.2 AEs of Special Interest**

Summary tables of AEs of special interest will be produced. The number (%) of patients experiencing any of the specified terms will be presented by maximum CTCAE grade. Additional listings and/or summaries may be produced, as appropriate, including time to onset of first AE for each grouped term and each preferred term within it, time to onset of first CTCAE grade 3 or higher, fluctuations in CTCAE grade, duration of AEs of special interest and number (%) of patients treated for AEs of special interest. In addition, the summary tables in the AEs section listed above will be repeated for grouped AEs of special interest.

Data collected on the specific eCRF for skin reactions will also be listed and summarized to further assess tolerability of specific events.

#### **4.2.10.3 Deaths**

A summary of deaths will be provided with the number and percentage of subjects, categorized as:

- Related to disease under investigation,
- AE outcome=death,
- Both related to disease under investigation and with AE outcome=death,
- AE with outcome=death >90 days after last treatment dose,
- Deaths >90 days after last treatment dose, unrelated to AE or disease under investigation, and
- Subjects with unknown reason for death.

A corresponding listing will also be produced.

#### **4.2.10.4 Laboratory evaluations**

All laboratory data recorded in the electronic case report form (eCRF) will be listed. If any additional analytes to those in [Table 3](#) are also recorded then these will be listed only.



All values will be classified as low (below range), normal (within range) and high (above range) based on reference ranges provided by the local or central laboratory. As applicable, values will be graded using CTCAE v4.0.

For clinical chemistry and hematology, shift tables will present movements in and out of the reference range or, if applicable, CTCAE grade changes from baseline to the maximum/minimum value on treatment will be provided. Corresponding shift tables (“Negative”, “Trace”, “Positive”, “0”, “+”, “++”, “+++”) will be produced for urinalysis.

Plots of both the maximum post-baseline ALT and AST versus the maximum post-baseline total bilirubin, expressed as multiples of their upper limit of reference range will be produced.

A pregnancy test performed at screening for women of child-bearing potential will be listed.

The following laboratory variables will be summarized:

**Table 3 Laboratory safety variables**

<b>Clinical chemistry (Serum/Plasma)</b>	<b>Hematology (Blood)</b>	<b>Urinalysis (Urine)</b>
Albumin	Hemoglobin	Glucose
ALT	Leukocyte	Protein
AST	Hematocrit	Blood
Alkaline phosphatase	Red blood cell (RBC) count	
Bilirubin, total	Absolute leukocyte differential count:	
Calcium, total	Neutrophils	
Creatinine	Lymphocytes	
Glucose (fasting, on PK days only) <sup>1</sup>	Monocytes	
LDH <sup>2</sup>	Basophils	
HbA1C	Eosinophils	
Magnesium	Platelet count	
Potassium	Reticulocytes	
Sodium		
Urea nitrogen/Blood urea nitrogen (BUN)		

<sup>1</sup> Subjects will be required to fast (water only) for at least 8 hours prior to the collection of a fasting glucose sample required on PK days. Random glucose sample will be collected on non-PK days.

<sup>2</sup> LDH is an additional variable collected at Visit 1 only.

#### **4.2.10.5 Vital signs (pulse and BP) and weight**

All vital signs data will be listed. Absolute and percentage change from baseline for pulse, BP and weight will be summarized by treatment group, overall and visit.

#### **4.2.10.6 Physical examination**

Abnormalities identified from physical examination will be listed. For each physical examination body system, the number and percentage of subjects with abnormalities at baseline and post-baseline will be summarized.

#### **4.2.10.7 ECG**

##### ***dECG***

All dECG data received will be presented in data listings. QTc summaries will be presented for subjects in the FAS.

The dECG parameters that will be summarized (absolute values and change from baseline) are: QTcF, RR, PR, QRS and QT.

The observed values and change from baseline in QTcF will be summarized by visit using summary statistics. Plots of mean observed QTc parameters and change from baseline in QTc parameters versus time will be presented. Shift plots of the maximum change from baseline versus the baseline value for QTcF, with reference lines for 450 ms, 480 ms, 500 ms,  $\pm 30$  ms and  $\pm 60$  ms change will be presented.

QTc outliers are defined as QTcF values following dosing that are greater than 450 ms or are increases from baseline greater than 30 ms. QTcF outliers will be highlighted in the data listings and summarized using the following categories:

- Values  $>450$  ms,  $>480$  ms,  $>500$  ms
- Increase from baseline of  $>30$  ms, Increase from baseline of  $>60$  ms, Increase from baseline of  $>90$  ms,
- Values  $>450$  ms and increases of  $>30$  ms. Values  $>500$  ms and increases of  $>60$  ms.

The number and percentage of subjects who meet the ECG outlier criteria at any assessment post-date of first dose will be summarized.

##### ***LVEF***

LVEF outliers are defined as LVEF values following dosing that are

- $\geq 10$  percentage points decrease from baseline and  $< 50\%$  LVEF, or
- $\geq 15$  percentage points decrease from baseline and  $\geq 50\%$  LVEF.

Abnormal LVEF are defined as values less than the lower limit of normal. LVEF outliers and abnormal values will be highlighted in the data listings and summarized.

Further, subjects with outliers that are associated with an AE (related or unrelated to AZD9291) will be listed and summarized as appropriate, along with the duration of the abnormality.

#### **4.2.10.8 WHO performance status**

WHO performance status will be listed and summarized by treatment and visit.

## **5. INTERIM ANALYSES**

Three analyses of OS are planned

- First analysis of OS will be conducted at the time of the primary analysis of PFS.
- Second analysis will be conducted when the OS data are approximately 50% mature (approximately 305 death events).

An optional analysis of OS may be performed when the OS data are approximately 70% mature (approximately 430 death events).

## **6. CHANGES OF ANALYSIS FROM PROTOCOL**

N/A

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**8. APPENDIX**

N/A



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**Statistical Analysis Plan**

Study Code        D5160C00003

Edition Number    4

Date

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**A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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**A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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**Study Statistician**

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**A Phase III, Open Label, Randomized Study of AZD9291 versus Platinum-Based Doublet Chemotherapy for Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer whose Disease has Progressed with Previous Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy and whose Tumours harbour a T790M mutation within the Epidermal Growth Factor Receptor Gene (AURA3)**

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**Global Product Statistician**

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## LIST OF ABBREVIATIONS

Abbreviation or special term	Explanation
ANCOVA	Analysis of covariance
ATC	Anatomical Therapeutic Chemical
AUC 5	Area under the plasma concentration-time curve 5 mg/ml per minute
AUC <sub>(0-24)</sub>	Area under the curve (plasma concentration / time curve from zero to 24 hours)
AUC <sub>ss</sub>	Area under the plasma concentration-time curve at steady state
BICR	Blinded Independent Central Review
BP	Blood pressure
CSF	Cerebrospinal fluid
CI	Confidence interval
Cl <sub>ss</sub> /F	Plasma clearance at steady state
C <sub>max</sub>	Maximum plasma concentration
CMET	Proto-oncogene encoding Hepatocyte Growth Factor Receptor
CR	Complete response
CSP	Clinical study protocol
CSR	Clinical study report
C <sub>ss</sub>	Concentration at study state
CT	Computerized tomography scan
CTCAE	Common Terminology Criteria for Adverse Event
ctDNA	Circulating tumor DNA
DCR	Disease control rate
dECG	Digital electrocardiogram
DNA	Deoxyribonucleic acid
DoR	Duration of response
ECG	Electrocardiogram
eCRF	Electronic case report form
EDoR	Expected duration of response
EGFR	Epidermal growth factor receptor
EGFRm+	EGFR mutation positive

<b>Abbreviation or special term</b>	<b>Explanation</b>
EORTC QLQ-C30	European Organization for Research and Treatment of Cancer Quality of Life Questionnaire - Core 30 items
EORTC QLQ-LC13	European Organization for Research and Treatment of Cancer Quality of Life Questionnaire - Lung Cancer 13 items
EQ-5D-5L	European Quality of Life - 5 Dimensions - 5 Levels
EuroQoL	European Quality of Life
FAS	Full analysis set
FDA	Food and Drug Administration
HER2	Human epidermal growth factor receptor 2
HP	Haybittle-Peto
HR	Hazard ratio
HRR	Hazard ratio ratio
HRQoL	Health Related Quality of Life
IP	Investigational product
IPCW	Time Inverse Probability of Censoring Weighting
IVRS	Interactive Voice Response System
IWRS	Interactive Web Response System
KM	Kaplan-Meier
L858R	An amino acid substitution at position 858 in EGFR, from a Leucine (L) to an Arginine (R)
LD	Longest diameter
LDH	Lactate dehydrogenase
LE	Local evaluation
LLoQ	Lower limit of quantification
LVEF	Left ventricular ejection fraction
MedDRA	Medical Dictionary for Regulatory Activities
MRI	Magnetic resonance imaging
MUGA	Multi-gated acquisition scan
NE	Not evaluable
NSCLC	Non-small cell lung cancer
NTL	Non-target lesion
OAE	Other significant adverse event
ORR	Objective response rate

<b>Abbreviation or special term</b>	<b>Explanation</b>
OS	Overall survival
p.o.	Per os, by mouth, orally
PD	Progression of disease
PFS	Progression Free Survival
PID	Percentage intended dose
PFS2	Time from randomization to second progression
PK	Pharmacokinetics
PR	Partial response
PRO	Patient reported outcome
PT	Preferred term
QD	Once daily
RAC	Ratio of AUCss after multiple dosing to AUC(0-24) after single dose
RDI	Relative dose intensity
RECIST	Response Evaluation Criteria in Solid Tumors
RPSFT	Rank Preserving Structural Failure
SAE	Serious adverse event
SD	Stable disease
SLD	Sum of longest diameter
SOC	System organ class
T790M	An amino acid substitution at position 790 in EGFR, from a Threonine (T) to a Methionine (M)
T790M-	T790M mutation negative
T790M+	T790M mutation positive
TFST	Time to first subsequent therapy or death
TKI	Tyrosine kinase inhibitor
TL	Target lesion
$t_{\max}$	Time to $C_{\max}$
$t_{ss \max}$	Time to $C_{ss \max}$
TSST	Time to second subsequent therapy or death
ULoQ	Upper limit of quantification
WHO	World Health Organization

## AMENDMENT HISTORY

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<b>Date</b>	<b>Brief description of change</b>
	SAP updated based on protocol amendment 2
	SA updated based on protocol amendment 3

---

## 1. STUDY DETAILS

### 1.1 Study objectives

#### Primary objective

<b>Objective:</b>	<b>Outcome Measure:</b>
To assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy by assessment of Progression Free Survival (PFS).	PFS using investigator assessments according to Response Evaluation Criteria in Solid Tumors (RECIST) 1.1.  Sensitivity analysis of PFS using Blinded Independent Central Review (BICR).

#### Secondary objectives

<b>Objective:</b>	<b>Outcome Measure:</b>
To further assess the efficacy of AZD9291 compared with platinum-based doublet chemotherapy in terms of: <ul style="list-style-type: none"><li>- Objective Response Rate (ORR)</li><li>- Duration of Response (DoR)</li><li>- Disease Control Rate (DCR)</li><li>- Overall Survival (OS)</li><li>- Tumor shrinkage</li></ul>	ORR, DoR, DCR and tumor shrinkage using investigator assessments according to RECIST 1.1.  Analysis of OS.
To assess the effect of AZD9291 compared to platinum-based doublet chemotherapy on subjects' disease-related symptoms and health related quality of life (HRQoL).	EORTC QLQ-C30: Questionnaire consisting of 30 items measuring subjects general cancer symptoms and functioning.  EORTC QLQ-LC13: A complementary questionnaire measuring lung cancer symptoms
To characterize the pharmacokinetics (PK) of AZD9291, AZ5104 and AZ7550 in subjects receiving AZD9291.	Plasma concentrations of AZD9291, and metabolites AZ5104 and AZ7550.  PK parameters (such as $Cl_{ss}/F$ , $C_{ss\ min}$ and $C_{ss\ max}$ $AUC_{ss}$ ) will be derived using population PK analysis and reported separately to the Clinical Study Report (CSR). Data from this study may form part of a pooled analysis with data from other studies.



## Safety objective

<b>Objective:</b>	<b>Outcome Measure:</b>
To assess the safety and tolerability profile of AZD9291 compared with platinum-based doublet chemotherapy.	<ul style="list-style-type: none"> <li>- Adverse events, graded by Common Terminology Criteria for Adverse Event (CTCAE v4)</li> <li>- Clinical chemistry, hematology and urinalysis</li> <li>- Vital signs (pulse and blood pressure), physical examination, weight</li> <li>- Centrally reviewed digital electrocardiogram (dECG)</li> <li>- Multi-gated acquisition scan (MUGA) for left ventricular ejection fraction (LVEF)</li> <li>- World Health Organization (WHO) performance status</li> </ul>

## Exploratory objectives

<b>Objective:</b>	<b>Outcome Measure:</b>
To explore the relationship between PK and selected endpoints (which may include efficacy, safety and/or Patient Reported Outcome [PRO]), where deemed appropriate.	<p>Correlation of PK with other primary/secondary/exploratory endpoints in subjects treated with AZD9291.</p> <p>Results from such analyses will be reported separately from the CSR.</p> <p>Data from this study may also form part of a pooled analysis with other AZD9291 studies.</p>
To compare the effects of AZD9291 compared with chemotherapy on post-progression outcomes	<p>Time from randomization to second progression (PFS2)</p> <p>Time to subsequent therapy</p> <p>Time to change in symptoms (including post-progression assessments)</p>
To further characterize the effects of AZD9291 on survival outcomes.	<p>Assess the impact on OS of baseline potentially prognostic factors (e.g., tumor stage, performance status, sex, baseline lactate dehydrogenase [LDH]).</p> <p>Assess the impact on OS of subsequent treatments and other potential covariates (e.g., changes in performance status).</p>
To compare adverse events by subject self-reporting of specific CTCAE symptoms (where applicable) between AZD9291 and chemotherapy.	Collection of approximately 28 PRO-CTCAE symptoms via an electronic device solution (in countries where language is available).

<b>Objective:</b>	<b>Outcome Measure:</b>
To compare AZD9291 treatment with chemotherapy treatment on health state utility.	The European Quality of Life - 5 Dimensions - 5 Levels (EQ-5D-5L) health state utility index will be used to derive health state utility based on subject reported data.
To compare health resource use associated with AZD9291 treatment with chemotherapy treatment.	Health resource utilization measures including hospitalization, outpatient visits, or emergency department visits.
To characterize the PK of AZD9291, AZ5104 and AZ7550 in cerebrospinal fluid (CSF).	Concentration of AZD9291, AZ5104 and AZ7550. Ratio of metabolites to AZD9291. Ratio of CSF to plasma concentration. Summaries of PK concentration data.
To collect and store deoxyribonucleic acid (DNA) for future exploratory research into genes/genetic variation that may influence PK or response to AZD9291, platinum-based doublet chemotherapy (i.e., absorption, distribution, metabolism, excretion, safety and efficacy) and/or susceptibility to/development of cancers.	Correlation of polymorphisms with variation in PK, pharmacodynamics, safety or response observed in subjects treated with AZD9291 or comparator. Data generated may be reported separately and may also form part of a pooled analysis with other AZD9291 studies.
To collect and store tumor samples and blood-based samples for potential for exploratory research into factors that may influence susceptibility to/development of non-small cell lung cancer (NSCLC)/cancer and/or response to AZD9291 (where response is defined broadly to include efficacy, tolerability or safety).	Analysis of key genetic and proteomic markers to include, but not limited to, epidermal growth factor receptor (EGFR) mutations, human epidermal growth factor receptor 2 (HER2) and proto-oncogene encoding hepatocyte growth factor receptor (CMET) expression and/or amplification. Collection of plasma samples to include, but not be limited to, extraction of circulating tumor DNA (ctDNA) for investigation of blood-borne biomarkers. The sample may be used to investigate the relationship between PK and blood-borne biomarkers. Samples may be analyzed retrospectively. Any biomarker data generated may be reported separately and may also form part of a pooled analysis with other AZD9291 studies.
To collect and store plasma for isolation of ctDNA. Extracted ctDNA will be assessed for the presence of genetic aberrations including, but not limited to, EGFR mutations (T790M, L858R, etc). These samples may be shared with a diagnostic partner for development of a ctDNA test for T790M detection.	Retrospective/real-time analysis of EGFR (and other) mutations in ctDNA from all study subjects (mandatory).

<b>Objective:</b>	<b>Outcome Measure:</b>
To collect and store residual CSF for potential exploratory research of factors that may influence development of NSCLC and/or response to AZD9291 (where response is defined broadly to include efficacy, tolerability or safety).	Collection of CSF for the investigation of PK and/or biomarkers. Samples may be analyzed retrospectively.

Results from such analyses outlined above may be reported separately from the CSR.

## **1.2 Study design**

This is a phase III, open-label, randomized study assessing the safety and efficacy of AZD9291 (80 mg, orally [p.o.], once daily [QD]) versus platinum-based doublet chemotherapy in second-line subjects with EGFR mutation and T790M mutation positive (EGFRm+/T790M+), locally advanced or metastatic NSCLC who have progressed following treatment with an approved EGFR Tyrosine Kinase Inhibitor (EGFR-TKI) agent.

A biopsy will be needed for central testing of T790M mutation status following confirmed disease progression on first-line treatment with an EGFR-TKI.

Approximately 410 subjects, stratified by ethnicity (Asian/non-Asian) will be centrally randomized to receive either AZD9291 (80mg QD p.o.) or platinum-based doublet chemotherapy (pemetrexed 500 mg/m<sup>2</sup> + carboplatin area under the plasma concentration-time curve AUC 5 or pemetrexed 500 mg/m<sup>2</sup> + cisplatin 75 mg/m<sup>2</sup>) on Day 1 of every 21-day cycle in a 2:1 (AZD9291: platinum-based doublet chemotherapy) ratio using the Interactive Voice Response (IVRS) or Interactive Web Response System (IWRS). The investigational site must declare (in IVRS/IWRS), prior to randomization, their choice of chemotherapy for that subject. Once 410 subjects have been randomized globally, recruitment will continue only in mainland China until approximately 50 Chinese subjects have been randomized.

Subjects should continue on investigational product (IP) AZD9291 until a treatment discontinuation criterion is met. Subjects may continue to receive AZD9291 beyond RECIST 1.1 defined progression as long as they show clinical benefit, as judged by the investigator.

Subjects can receive up to 6 cycles of pemetrexed + carboplatin/cisplatin as initial treatment.

Subjects whose disease has not progressed after four cycles of platinum-based first-line chemotherapy may receive pemetrexed maintenance therapy. Subjects who progress according to RECIST 1.1 criteria prior to completion of initial doublet chemotherapy treatment or during pemetrexed maintenance monotherapy, may continue with chemotherapy treatment as long as they are continuing to show clinical benefit, as judged by the investigator.

Subjects must be followed until evidence of RECIST 1.1 defined progression (regardless of reason for treatment discontinuation). It is important that subjects are assessed according to the intended scanning schedule to prevent the bias in analysis that can occur if one treatment group is assessed more or less often than the other.

Once subjects on the platinum-based doublet chemotherapy arm are determined to have objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review, they will be given the opportunity to begin treatment with AZD9291 80mg, once daily. These subjects may continue treatment with AZD9291, as long as they are continuing to show clinical benefit, as judged by the investigator.

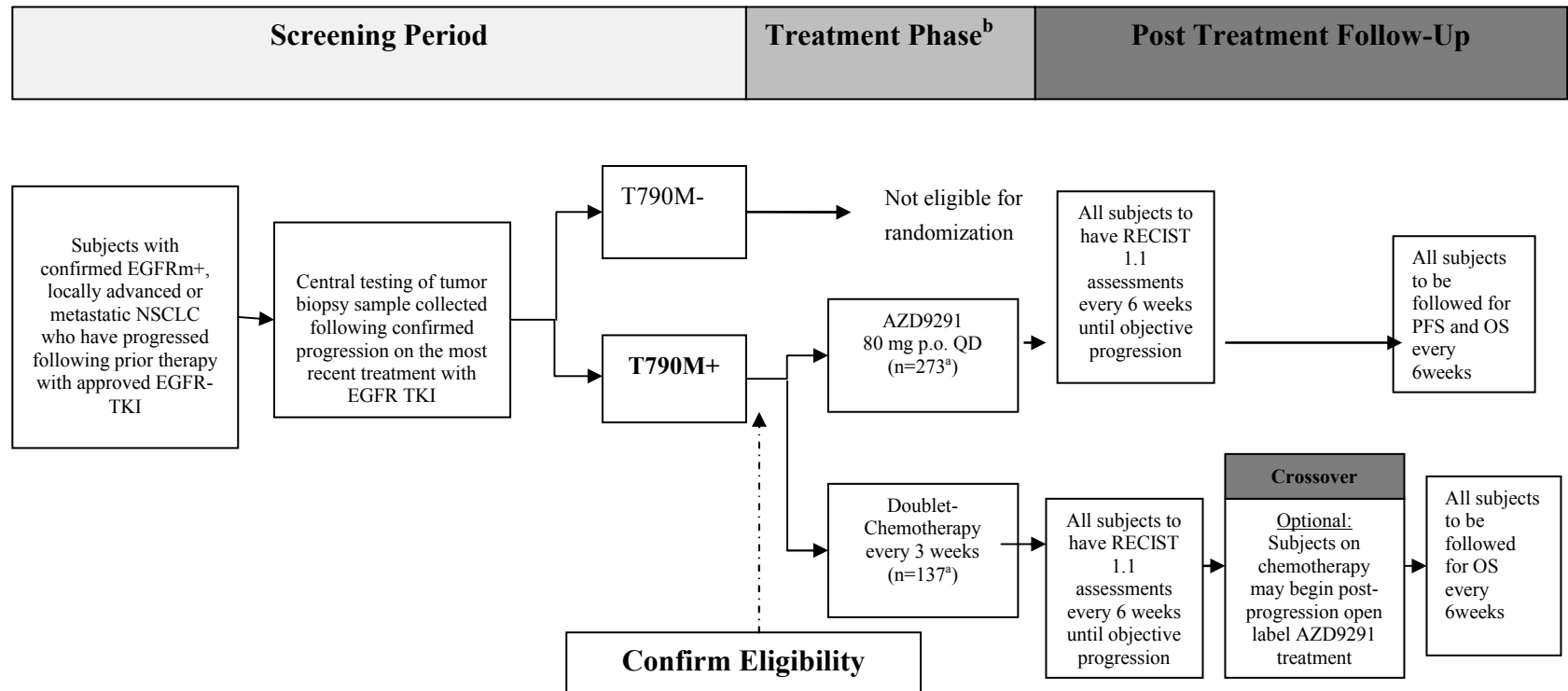
If a subject has been deemed to have objective disease progression according to Investigator tumour assessment according to RECIST 1.1, but is not confirmed by independent central imaging review, he/she is not eligible to cross-over to AZD9291 at that time. Should it be in the subjects' best interests, and only if further randomized chemotherapy is warranted, he/she may continue to receive randomized doublet chemotherapy (if initial doublet chemotherapy treatment has not yet been completed) or Pemetrexed maintenance monotherapy, sites are to submit the next scheduled tumour assessment for central imaging review according to Table 2 of the CSP.

If subjects are not eligible to cross-over to AZD9291, they will enter into the follow-up phase of the study, and other treatment options should be discussed by the investigator.

Note: Throughout this document the term “platinum-based doublet chemotherapy”, refers to “platinum” as both carboplatin and cisplatin.

The overall study design is shown in Figure 1 of the clinical study protocol (CSP) and the study flow chart in [Figure 1](#) below. The study schedule for AZD9291 subjects and for platinum-based doublet chemotherapy subjects is detailed in Tables 1 and 2 of the CSP, respectively.

**Figure 1 Study flow chart**



(a) Approximately 410 subjects will be randomized into the trial; from these approximately 273 subjects will be treated with AZD9291 and approximately 137 subjects will be treated with a platinum based doublet-chemotherapy.

(b) Subjects will be considered in “Treatment phase” at the time AZD9291/Doublet-Chemotherapy (study treatment) is started. Subjects will continue to receive study treatment until objective disease progression (according to RECIST 1.1). Subjects randomized to AZD9291 may continue to receive AZD9291 as long as they are continuing to show clinical benefit, as judged by the investigator, and in the absence of discontinuation criteria. Subjects randomized to the platinum-based double chemotherapy arm with objective radiological progression according to RECIST 1.1 by the investigator and confirmed by independent central imaging review will be given the opportunity to begin treatment with AZD9291, 80 mg once daily.



### **1.3 Number of subjects**

PFS is the primary endpoint for this study. Approximately 410 subjects, stratified by ethnicity (Asian/non-Asian) will be randomized in a 2:1 ratio to the treatments as specified below:

- AZD9291 80mg QD p.o.
- Platinum-based doublet chemotherapy (pemetrexed 500mg/m<sup>2</sup> + carboplatin AUC5 or pemetrexed 500mg/m<sup>2</sup> + cisplatin 75mg/m<sup>2</sup>)

The primary analysis of PFS will occur when at least 221 progression events have been observed out of the 410 globally randomized subjects. With 221 progression events, the study will have at least 80% power to show a statistically significant PFS at the 5% 2-sided significance level if the assumed treatment effect were hazard ratio (HR) 0.67; this translates to a 3 month improvement on an estimated median PFS of 6 months on the control arm, assuming PFS is exponentially distributed. The smallest treatment difference that would be statistically significant is a PFS HR of 0.76. Assuming 15 months non-linear recruitment, 221 PFS events are expected to occur approximately 20 months after the first subject is randomized to the study.

Three analyses of OS are planned; two interim analyses and a final analysis. The data cut-off for the first analysis of overall survival will be conducted approximately 4 months after data cut-off for the primary analysis of PFS and the second analysis will be conducted when the OS data are approximately 50% mature (approximately 205 death events). A final analysis of overall survival will be performed when the OS data are approximately 70% mature (approximately 287 death events).

In order to randomize 410 subjects (assuming a 10% screen failure rate), 455 T790M+ subjects will need to be enrolled. In order to enroll 455 T790M+ subjects, 1034 subjects will need to be screened (allowing for a 20% attrition rate and assuming 55% of subjects are T790M+).

## **2. ANALYSIS SETS**

### **2.1 Definition of analysis sets**

#### **2.1.1 Full analysis set**

The full analysis set (FAS) will include all randomized subjects prior to the end of global recruitment. Any subjects randomized in China, after global recruitment has ended, will not be included in the FAS.

The FAS, or subsets thereof as per 2.1.1-2, will be used for all efficacy and exploratory analyses and treatment groups will be compared on the basis of randomized treatment, regardless of the treatment actually received.

### 2.1.2 Safety analysis set

The safety analysis set will consist of all subjects randomized prior to the end of global recruitment who received at least one dose of randomized treatment and for whom post-dose data are available. Any subjects randomized in China only, after global recruitment has ended, will not be included in the safety analysis set.

Safety data will not be formally analyzed but summarized using the safety analysis set, according to the treatment received (i.e., erroneously treated subjects [e.g., those randomized to treatment A but actually given treatment B] will be summarized according to the treatment they actually received).

### 2.1.3 PK analysis set

The PK analysis set includes subjects in the FAS who have at least one measurable PK concentration and who have the relevant date, time and dosing data for this sample. The dosing data must include the dosing data for the calendar day prior to the sample day as well as the sample day.

**Table 1 Summary of outcome variables and analysis sets**

<b>Outcome variable</b>	<b>Analysis Set</b>
Efficacy Data: PFS, ORR, DoR, DCR, Tumor shrinkage, OS, symptoms/HRQoL	FAS
Demography	FAS
PK data	PK (subset of FAS)
Safety Data	Safety
Exploratory Data	FAS

Data on the number of subjects and duration of treatment for subjects who begin treatment with AZD9291 following centrally confirmed objective progression will also be summarized separately, as described in Section 4.2.6.

### 2.1.4 China extension

In order to adequately compare the efficacy and safety of AZD9291 versus chemotherapy in Chinese patients to fulfill China Food and Drug Administration (FDA) requirements, subjects recruited in China after global recruitment has ended will be combined with any subjects recruited from China prior to the end of the global recruitment. This China-only cohort will be analysed and reported separately from the CSR. These analyses will be performed when approximately 27 PFS events have been observed out of approximately 50 Chinese subjects (54% maturity, as consistent with the primary global PFS analysis).

All efficacy, safety, PRO and PK variables will be derived in the same way as detailed in Section 4. All analyses detailed in Section 4 will be repeated for the China-only cohort using the analysis sets described in this section.

All statistical analyses will be considered exploratory and only performed if sufficient numbers of events or subjects are available (e.g. > 20 PFS or OS events), otherwise descriptive statistics only will be presented. No adjustment for multiplicity will be made and so the procedure for hierarchical testing detailed in protocol Section 8.5.2.1 will not be followed. Statistical analyses will not be stratified by ethnicity (Asian versus Non-Asian).

#### **2.1.4.1 China-only Full Analysis Set**

The China-only FAS will include all subjects randomized in China. This includes all subjects randomized in China prior to the end of global recruitment and all additional subjects recruited in mainland China after global recruitment is completed.

The China-only FAS will be used for all China-only efficacy analyses and treatment groups will be compared on the basis of randomized study treatment, regardless of the treatment actually received.

#### **2.1.4.2 China-only Safety Analysis Set**

The China-only safety analysis set will consist of all subjects randomized in China who received at least one dose of study treatment and for whom post-dose data are available.

#### **2.1.4.3 China-only Pharmacokinetic Analysis Set**

The China-only PK analysis set is defined as subjects in the China-only FAS who have at least one evaluable PK concentration without any violation or deviation that impacts the PK analysis.

## **2.2 Violations and deviations**

All important deviations related to the study inclusion or exclusion criteria and study conduct will be listed and summarized by randomized treatment group. None of the deviations will lead to any subjects being excluded from any of the analysis sets described in Section 2.1 (with the exception of the PK analysis set, if the deviation is considered to impact upon PK). If the deviations are serious enough to have the potential to impact the primary analysis, sensitivity analyses may be performed.

The following general categories will be considered important deviations. This list is not exhaustive and additional important deviations may be added prior to database lock.

- Informed consent procedure deviation (e.g., no informed consent signed prior to any screening procedure)
- Eligibility criteria deviation (e.g., any inclusion criteria not met or exclusion criteria met)



- Prohibited medication deviation (e.g., subject received other anticancer agents, investigational agents, or radiotherapy while on study treatment)

The categorization of these as important deviations is not automatic and will depend on duration and the perceived effect on efficacy.

In addition to the programmatic determination of the deviations above, monitoring notes or summaries will be reviewed to determine any important post-entry deviations that are not identifiable via programming, and to check that those identified via programming are correctly classified. The final classification will be made prior to database lock.

Misrandomizations in terms of errors in treatment dispensing, in addition to incorrect stratifications, will also be summarized and listed, separately to the important protocol deviations. A misrandomization is when a subject is not randomized or treated according to the randomization schedule. It includes subjects who receive no treatment whatsoever for a period of time due to errors in dispensing of medication. Note, this is not due to tolerability issues where subjects may stop taking drug.

The summary will include all subjects with a dispensing error and will also include information on how many of those subjects received at least one dose of the wrong treatment (AZD9291/platinum-based doublet chemotherapy) at any time. Subjects who receive the wrong treatment at any time will be included in the safety analysis set as described in Section 2.1. During the study, decisions on how to handle misrandomizations will be made on an individual basis with written instruction from the study team leader and/or statistician.

### **3. PRIMARY AND SECONDARY VARIABLES**

#### **3.1 Efficacy assessments**

##### **Investigator's RECIST-based assessments**

From the investigator's review of the imaging scans, the RECIST tumor response data will be used to determine each subject's visit response according to RECIST 1.1. It will also be used to determine the endpoints ORR, DoR, DCR and PFS from the overall visit response and scan dates. The endpoint of tumor shrinkage will be assessed from tumor size measurements based on investigator assessment.

Baseline radiological tumor assessments are to be performed no more than 28 days before the start of randomized treatment. If a baseline radiological tumor assessment is performed more than 28 days before the start of randomized treatment, then the scan will still be included as baseline but will be recorded as an important protocol deviation. Tumor assessments are then performed every 6 weeks relative to randomization until disease progression. Baseline values recorded after treatment start should not be used as the baseline assessment; although such assessments can be used in the calculation of PD. At each visit, subjects will be programmatically assigned an overall visit response of complete (CR), partial (PR), stable

disease (SD) or progressive disease (PD) depending on the status of their disease compared with baseline and previous assessments. If a subject has had a tumor assessment which cannot be evaluated, then the subject will be assigned a visit response of not evaluable (NE) (unless there is evidence of progression in which case the response will be assigned as PD).

Please refer to CSP Appendix H for the definitions of CR, PR, SD and PD and the derivations of overall visit response using the information from target lesions (TL), non-target lesions (NTL) and new lesions.

### **Rounding of TL data**

For calculation of PD and PR for TLs percentage changes from baseline and previous minimum should be rounded to 1 decimal place before assigning a TL response. For example, 19.95% should be rounded to 20.0% but 19.94% should be rounded to 19.9%.

### **Missing TL data**

For a visit to be evaluable, all TL measurements should be recorded. However, a visit response of PD should be assigned if any of the following occurred:

- A new lesion is recorded;
- A NTL visit response of PD is recorded;
- The sum of TLs is sufficiently increased to result in a 20% increase, and an absolute increase of  $\geq 5$  mm from nadir even assuming the non-recorded TLs have disappeared.

The nadir can only be taken from assessments where all the TLs had a longest diameter (LD) recorded.

### **Lymph nodes**

For lymph nodes, if the size reduces to  $< 10$  mm, these are considered non-pathological.

However a size will still be given and this size should still be used to determine the TL visit response as normal. In the special case where all lymph nodes are  $< 10$  mm and all other TLs are 0 mm, although the sum may be  $> 0$  mm, the calculation of TL response should be overwritten as a CR.

### **TL visit responses subsequent to CR**

A CR response can only be followed by CR, PD or NE. If a CR has occurred, the following rules at the subsequent visits must be applied:

- Step 1: If all lesions meet the CR criteria (i.e., 0 mm or  $< 10$  mm for lymph nodes), the response will be set to CR irrespective of whether the criteria for PD of TL is also met (i.e., if a lymph node LD increases by 20% but remains  $< 10$  mm).

- Step 2: If some lesion measurements are missing but all other lesions meet the CR criteria (i.e., 0 mm or <10 mm for lymph nodes), the response will be set to NE irrespective of whether when referencing the sum of TL diameters the criteria for PD is also met.
- Step 3: If not all lesions meet the CR criteria, and the sum of lesions meets the criteria for PD, the response will be set to PD.
- Step 4: If, after steps 1 through 3, a response cannot be determined, the response will be set to remain as CR.

### **TL too big to measure**

If a TL becomes too big to measure, this should be indicated in the database and a size ('x') above which it cannot be accurately measured should be recorded. If using a value of x in the calculation of TL response would not give an overall visit response of PD, then this will be flagged and reviewed by the study team blinded to treatment assignment. It is expected that a visit response of PD will remain in the vast majority of cases.

### **TL too small to measure**

If a TL becomes too small to measure a value of 5 mm will be entered into the database and used in TL calculations, unless the radiologist has indicated and entered a smaller value that can be measured reliably. If a TL response of PD results then this will be reviewed by the study team blinded to treatment assignment.

### **Irradiated lesions/lesion intervention**

Previously irradiated lesions (i.e., lesion irradiated prior to entry into the study) should be recorded as NTLs and should not form part of the TL assessment.

Any TL (including lymph nodes), which has had intervention during the study (for example, irradiation/palliative surgery/embolization), should be handled in the following way:

- Step 1: the diameters of the TLs (including the lesions that have had intervention) will be summed and the calculation will be performed in the usual manner. If the visit response is PD this will remain as a valid response category.
- Step 2: If there was no evidence of progression after step 1, the lesion diameter (for those lesions with intervention) will be treated as missing and scaled up as described below as long as there remain  $\leq 1/3$  of the TLs with missing measurements. If the scaling results in a visit response of PD then the subject will be assigned a TL response of PD.
- Step 3: If after both steps PD has not been assigned, then if  $\leq 1/3$  of the TLs have missing measurements), the scaled sum of diameters will be calculated, and PR or SD then assigned as the visit response. Subjects with intervention are evaluable for

CR as long as all non-intervened lesions are 0 (or <10 mm for lymph nodes) and the lesions that have been subject to intervention also have a value of 0 recorded.

- If scaling up is not appropriate due to > 1/3 missing measurements then the visit response will be set as NE.

At subsequent visits the above steps will be repeated to determine the TL and overall visit response. When calculating the previous minimum, lesions with intervention should be treated as missing and scaled up (as per step 2 above).

Once a lesion has had intervention then it should be treated as having intervention for the remainder of the study noting that an intervention will most likely shrink the size of tumors.

**Scaling (applicable only for irradiated lesions/lesion intervention)**

If > 1/3 of TL measurements are missing (because of intervention) then the TL response will be NE, unless the sum of diameters of non-missing TL would result in PD (i.e. if using a value of 0 for missing lesions, the sum of diameters has still increased by 20% or more compared to nadir and the sum of TLs has increased by ≥5mm from nadir).

If ≤ 1/3 of the TL measurements are missing (because of intervention) then the results will be scaled up (based on the sizes at the nadir visit to give an estimated sum of diameters and this will be used in calculations; this is equivalent to comparing the visit sum of diameters of the non-missing lesions to the nadir sum of diameters excluding the lesions with missing measurements).

***Example of scaling***

Lesion	Longest diameter at nadir visit	Longest diameter at follow-up visit
1	7.2	7.1
2	6.7	6.4
3	4.3	4.0
4	8.6	8.5
5	2.5	Missing
Sum	29.3	26

Lesion 5 is missing at the follow-up visit.

The sum of lesions 1-4 at the follow-up is 26 cm. The sum of the corresponding lesions at the nadir visit is 26.8 cm.

Scale up as follows to give an estimated TL sum of 28.4cm:

$$\frac{26}{26.8} \times 29.3 = 28.4\text{cm}$$

CR will not be allowed as a TL response for visits where there is missing data. Only PR, SD or PD (or NE) could be assigned as the TL visit response in these cases. However, for visits with  $\leq 1/3$  lesion assessments not recorded, the scaled up sum of TLs diameters will be included when defining the nadir value for the assessment of progression.

### **Lesions that split in two**

If a TL splits in two, then the LDs of the split lesions should be summed and reported as the LD for the lesion that split.

### **Lesions that merge**

If two TLs merge, then the LD of the merged lesion should be recorded for one of the TL sizes and the other TL size should be recorded as 0mm.

### **Change in method of assessment of TLs**

Computerized tomography (CT) scan and magnetic resonance imaging (MRI) are the only methods of assessment that can be used within this trial. If a change in method of assessment occurs between CT scan and MRI this will be considered acceptable and no adjustment within the programming is needed.

### **BICR of RECIST based assessments**

BICR of radiological imaging data will be carried out using RECIST 1.1. All radiological scans for all subjects (including those at unscheduled visits, or outside visit windows) will be provided to the BICR. The imaging scans will be reviewed by at least two independent radiologists using RECIST 1.1 criteria and will be adjudicated if required.

Up to three qualified radiologists will independently review the imaging scans in the following way. First a primary review will be performed by two independent radiologists for each patient on a timepoint by timepoint basis to give an overall tumour assessment at each timepoint using RECIST 1.1. Then a global radiology review will be performed whereby the same independent radiologists will globally assess all timepoints for a patient in the review period and adjust an overall assessment if necessary. Finally, if the overall assessment for at least one timepoint for a patient does not agree between the two independent radiologists, a third independent radiologist will adjudicate and identify which radiologist's assessments they agree with and should be used (for the whole patient). These visit responses (either from the adjudicator selected reviewer, or the primary reviewer in the absence of adjudication) will be used to report BICR visit responses, BICR best overall response, BICR time to response, BICR censoring of response, BICR progression date and BICR progression censoring.

If adjudication is performed, the reviewer that the adjudicator agreed with will be selected as a single reviewer. In the absence of adjudication, the records for all visits for a single reviewer will be used. The reviewer selected in the absence of adjudication will be the reviewer who read the baseline scan first. The records from the single selected reviewer will be used to all BICR RECIST endpoints including dates of progression, response, visit response, censoring and changes in target lesion dimensions.

All independent reviewers will be blinded to treatment. For each subject, the BICR will define the overall visit response data (CR, PR, SD, PD or NE) and the relevant scan dates for each time point (i.e., for visits where response or progression is/is not identified).

Further details of the BICR will be documented in the Blinded Independent Review Charter.

### **3.1.1 PFS**

PFS is defined as the time from randomization until the date of objective disease progression or death (by any cause in the absence of progression) regardless of whether the subject withdraws from randomized therapy or receives another anti-cancer therapy prior to progression. Subjects who have not had PD or died at the time of analysis will be censored at the time of the latest date of assessment from their last evaluable RECIST assessment.

However, if the subject has PD or dies after two or more missed visits, the subject will be censored at the time of the latest evaluable RECIST assessment. If the subject has no evaluable visits or does not have baseline data they will be censored at 0 days unless they die within two visits of baseline.

The PFS time will always be derived based on scan/assessment dates not visit dates.

RECIST assessments/scans contributing towards a particular visit may be performed on different dates. The following rules will be applied:

- Date of progression will be determined based on the earliest of the dates of the component that triggered the progression
- When censoring a subject for PFS the subject will be censored at the latest of the dates contributing to a particular overall visit assessment

### **3.1.2 ORR**

ORR rate is defined as the number and percentage of randomized subjects with at least one visit response of CR or PR. Data obtained up until progression, or last evaluable assessment in the absence of progression, will be included in the assessment of ORR. However, any complete response or partial response, which occurred after a further anti-cancer therapy was received, will not be included in the numerator for the ORR calculation.

### **3.1.3 DoR**

DoR will be defined as the time from the date of first documented response until the date of documented PD or death in the absence of PD, the end of response should coincide with the date of PD or death from any cause used for the PFS endpoint. The time of the initial response will be defined as the latest of the dates contributing towards the first visit response of PR or CR.

If a subject does not progress following a response, then the subject's duration of response will use the PFS censoring time.

### **3.1.4 DCR**

DCR is defined as the percentage of subjects who have a best overall response of CR or PR or SD at  $\geq 6$  weeks ( $\pm 7$  day visit window), prior to any PD event.

### **3.1.5 Tumor shrinkage**

Tumor shrinkage will be assessed using RECIST 1.1 tumor response. The absolute change and percentage change from baseline in sum of tumor size at each assessment will be calculated.

Tumor size is the sum of the longest diameters (SLD) of the TLs. The percentage change in SLD at each week for which data are available will be obtained for each subject taking the difference between the SLD at each week and the SLD at baseline divided by the SLD at baseline multiplied by 100 [i.e.,  $(\text{week } n - \text{baseline}) / \text{baseline} \times 100$ ]. The change from baseline will be obtained for each subject taking the difference between the SLD at each week and the SLD at baseline (i.e.,  $\text{week } n - \text{baseline}$ ).

The best percentage change in SLD from baseline or the minimum increase from baseline in the absence of a reduction from baseline based on all post-baseline assessments prior to the visit when progression is detected or start of subsequent anti-cancer therapy.

If best percentage change cannot be calculated due to missing data, a value of +20% will be imputed as the best percentage change from baseline in the following situations (otherwise best percentage change will be left as missing):

- If a subject has no post-baseline assessment and has died;
- If a subject has new lesions or progression of NTLs;
- If a subject has withdrawn due to PD and has no evaluable TL data before or at PD.

### **3.1.6 OS**

OS is defined as the time from the date of randomisation until death due to any cause. Any subject not known to have died at the time of analysis will be censored based on the last recorded date on which the subject was known to be alive.

Note: Survival calls will be made in the 2 weeks following the date of the data cut-off for each OS analysis, and if subjects are confirmed to be alive, or if the death date is post the final data cut-off date, these subjects will be censored at the date of the final data cut off. Death dates may be found by checking publicly available death registries.

### 3.1.7 HRQoL and symptoms

PROs will be assessed using the EORTC QLQ-C30 and EORTC QLQ-LC13 questionnaires. The EORTC QLQ-C30 consists of 30 questions, which can be combined to produce 5 functional scales (Physical, Role, Cognitive, Emotional, Social), 3 symptom scales (Fatigue, Pain, Nausea/vomiting), 5 individual items (dyspnea, insomnia, appetite loss, constipation, diarrhea) and a global measure of health status. The EORTC QLQ-LC13 is a lung cancer specific module comprising 13 questions to assess lung cancer symptoms (cough, hemoptysis, dyspnea and site-specific pain), treatment related side-effects (sore mouth, dysphagia, peripheral neuropathy and alopecia) and pain medication. With the exception of a multi-item scale for dyspnea, all are single items.

An outcome variable consisting of a score from 0 to 100 will be derived for each of the symptom scales/symptom items, the functional scales and the global health status scale in the EORTC QLQ-C30 and for each of the symptom scales/items in the EORTC QLQ-LC13 according to the EORTC QLQ-C30 Scoring Manual and EORTC QLQ-LC13 instructions, respectively.

Higher scores on the global health status and functioning scales indicate better health status/function. Higher scores on the symptoms scales indicate greater symptom burden.

For each symptom/scale, if less than 50% of the subscale items are missing, the subscale score will be divided by the number of non-missing items and multiplied by the total number of items on the subscale. If at least 50% of the items are missing, that subscale also will be treated as missing.

For analysis of time to symptom deterioration, the FAS will be subset to include subjects who have EORTC QLQ-LC13 baseline scores  $\leq 90$ .

For analysis of symptom improvement rate, the FAS will be subset to include subjects who have a baseline score  $\geq 10$  for EORTC QLQ-C30 scales/items or EORTC QLQ-LC13 scales/items.

The primary PRO measures will be subject-reported lung cancer symptoms assessed using the EORTC QLQ-LC13 and EORTC QLQ-C30, namely:

- dyspnea (multi-item scale based on three questions: “Were you short of breath when you rested; walked; climbed stairs?”),
- cough: one item (“How much did you cough?”),
- pain: one item (“Have you had pain in your chest?”)



- fatigue (multi-item scale based on three questions: “Did you need rest; Have you felt weak; Were you tired?”)
- appetite loss: one item (“Have you lacked appetite?”).

***Definition of clinically meaningful changes***

Changes in score compared to baseline will be evaluated. A minimum clinically meaningful change is defined as a change in the score from baseline of  $\geq 10$  for scales/items (Obosa et al 1998).

For example, a clinically meaningful deterioration or worsening in chest pain (as assessed by EORTC QLQ-LC13) is defined as an increase in the score from baseline of  $\geq 10$ . A clinically meaningful improvement in fatigue (as assessed by EORTC QLQ-C30) is defined as a decrease in the score from baseline of  $\geq 10$ .

At each post-baseline assessment, change in symptoms/functioning from baseline will be categorized as improved, stable or worsening as shown in Table 2.

**Table 2 Visit response for HRQoL and disease-related symptoms**

Score	Change from baseline	Visit response
EORTC QLQ-LC13 symptom scales/items	$\geq +10$	Worsened
	$\leq -10$	Improved
	Otherwise	Stable
EORTC QLQ-C30 symptoms scales/items	$\geq +10$	Worsened
	$\leq -10$	Improved
	Otherwise	Stable
EORTC QLQ-C30 functional scales and Global health status	$\geq +10$	Improved
	$\leq -10$	Worsened
	Otherwise	Stable

***Compliance***

Summary measures of compliance at each scheduled assessment will be derived for the EORTC QLQ-C13 and QLQ-C30 score. These will be based upon:

- Received questionnaire = a questionnaire that has been received and has a completion date and at least one individual item completed

- Expected questionnaire = a questionnaire that is expected to be completed at a scheduled assessment time, i.e. a questionnaire from a patient who has not withdrawn from the study at the scheduled assessment time but excluding patients in countries with no available translation.
- Evaluable questionnaire = a questionnaire with a completion date and at least one subscale that is non-missing.

### **3.1.7.1 Time to symptom deterioration**

For each of the symptoms scales/items in EORTC QLQ-LC13, time to symptom deterioration will be defined as the time from randomization until the date of first clinically meaningful symptom deterioration (an increase in the score from baseline of  $\geq 10$ ) or death (by any cause) in the absence of a clinically meaningful symptom deterioration, regardless of whether the subject withdraws from randomized therapy or receives another anti-cancer therapy prior to symptom deterioration. Death will be included as an event only if the death occurs within two visits of the last PRO assessment where the symptom change could be evaluated.

Subjects whose symptoms (as measured by EORTC QLQ-LC13) have not shown a clinically meaningful deterioration and who are alive at the time of the analysis will be censored at the time of their last PRO assessment where the symptom could be evaluated. Also, if symptoms progress after two or more missed PRO assessment visits or the subject dies after two or more missed PRO assessment visits, the subject will be censored at the time of the last PRO assessment where the symptom could be evaluated. If a subject has no evaluable visits or does not have baseline data they will be censored at Day 1. The population for analysis of time to symptom deterioration will include a subset of the FAS who have EORTC QLQ-LC13 or EORTC QLQ-C30 baseline scores  $\leq 90$ .

### **3.1.7.2 Symptom improvement rate**

The symptom improvement rate will be defined as the number (%) of subjects with two consecutive assessments at least 18 days apart (i.e., 21 days allowing a visit window of 3 days), which showed a clinically meaningful improvement (a decrease from baseline score  $\geq 10$  for EORTC QLQ-LC13 scales/items and EORTC QLQ-C30 scales/items) in that symptom from baseline. The denominator will consist of a subset of the FAS who have a baseline symptom score  $\geq 10$ .

### **3.1.7.3 PFS2**

PFS2 is defined as the time from the date of randomization to the earliest of the progression event subsequent to that used for the primary variable PFS or death. Subjects who are alive and for whom a second PD has not been observed will be censored at their last assessment where the subject has not had a second progression or death. If a subject dies without a progression event, the subject's PFS and PFS2 events would be equivalent.

For subjects with no PFS and no PFS2, the PFS2 censor date will be same as PFS censor date, with the following exceptions:

- If there is no PFS event but a PFS2 event has been recorded, the PFS2 event should be used in the PFS2 analysis even though the subject will be censored in PFS analysis.
- If there is no PFS event but the PFS2 form has been completed as no event with a date, then use this date as the censor date (rather than PFS censor date).

#### **3.1.7.4 TFST**

TFST is defined as the time from the date of randomization to the earlier of the date of anti-cancer therapy start date following study treatment discontinuation, or death. Any subject not known to have had a subsequent therapy or not known to have died at the time of the analysis will be censored at the last known time to have not received subsequent therapy (i.e., the last follow-up visit where this was confirmed). If a subject terminates the study for a reason other than death before first subsequent anti-cancer therapy, the subject will be censored at the termination date.

#### **3.1.7.5 TSST**

TSST is defined as the time from the date of randomization to the earlier of the date of second subsequent anti-cancer therapy start date following study treatment discontinuation, or death. Any subject not known to have died at the time of the analysis and not known to have had a second further intervention of this type will be censored at the last known time to have not received second subsequent therapy (i.e., the last follow-up visit where this was confirmed). If a subject terminates the study for a reason other than death before the second subsequent anti-cancer therapy, the subject will be censored at the termination date.

#### **3.1.8 PRO-CTCAE symptoms**

The PRO-CTCAE questionnaire will be used to derive subject reporting of CTCAE symptoms.

The PRO-CTCAE will only be administered in those countries where a linguistically validated version exists (languages available are English, German, Japanese and Spanish). PRO-CTCAE is an item-bank of symptoms of the CTCAE experienced by subjects while undergoing treatment of their cancer that has been converted to subject terms (i.e., CTCAE term “myalgia” converted to “aching muscles”). Twenty-eight items from the PRO-CTCAE item-bank have been selected as being relevant for this study.

#### **3.1.9 Health state utility**

The EQ-5D-5L index comprises 5 dimensions of health (mobility, self-care, usual activities, pain/discomfort and anxiety/depression). For each dimension, subjects select which statement best describes their health on that day from a possible 5 options of increasing levels of severity (no problems, slight problems, moderate problems, severe problems and unable to/extreme problems). A unique EQ-5D health state is referred to by a 5-digit code allowing for a total of 3125 health states. For example, state 11111 indicates no problems on any of the 5 dimensions. These data will be converted into a weighted health state index by applying

scores from EQ-5D value sets elicited from general population samples (the base case will be the United Kingdom valuation set, with other country value sets applied in scenario analyses). Where values sets are not available, the EQ-5D-5L to EQ-5D-3L crosswalk will be applied.

In addition to the descriptive system, subjects also assess their health on the day of assessment on a visual analogue scale, ranging from 0 (worst imaginable health) to 100 (best imaginable health). This score is reported separately.

### **3.1.10 Health resource utilization**

Health resource utilization will be assessed in terms of hospitalization, outpatient visits and emergency department visits.

## **3.2 Safety variables**

Safety and tolerability will be assessed in terms of AEs, deaths, laboratory data, vital signs (pulse, BP and weight), ECG, physical examinations, and WHO performance status. These will be collected for all subjects.

### **3.2.1 AEs**

All AEs will be coded using the latest version of the Medical Dictionary for Regulatory Activities (MedDRA) and graded according to the National Cancer Institute Common Terminology Criteria for Adverse Event (CTCAE) (version 4.0.3 or later).

Preferred terms used to identify adverse events of special interest will be listed before database lock and documented in the Study Master File. Groupings of certain MedDRA preferred terms will be based on preferred terms provided by the medical team and a listing of the preferred terms in each grouping will be produced. The grouped terms are as follows: ocular surface effects, dry eye/conjunctivitis, interstitial lung disease and acute interstitial pneumonitis, nail and nail bed conditions, skin disorders, upper GI tract inflammatory events, cardiotoxicity, and diarrhoea.

Any AE occurring before treatment with AZD9291/chemotherapy will be included in the data listings but will not be included in the summary tables of AEs.

Any AE occurring within 28 days of discontinuation of IP (i.e., the last dose of AZD9291/chemotherapy) will be included in the AE summaries. Any events in this period that occur after a subject has received further therapy for cancer (following discontinuation of AZD9291) will be flagged in the data listings. Please refer to CSP Section 6.3.1

### **3.2.2 Other significant adverse events (OAEs)**

During the evaluation of the AE data, an AstraZeneca medically qualified expert will review the list of AEs that were not reported as SAEs and AEs leading to treatment discontinuation. Based on the expert's judgment, significant AEs of particular clinical importance may, after consultation with the Global Patient Safety Physician, be considered OAEs and reported as

such in the CSR. A similar review of laboratory, vital signs (pulse, BP and weight), and/or ECG data will be performed for identification of OAEs.

Examples of these could be marked hematological and other laboratory abnormalities, and certain events that lead to intervention (other than those already classified as serious), dose reduction or significant additional treatment.

### **3.2.3 dECG**

Baseline is the pre-dose time point on the first dosing day (Day 1 Cycle 1). For each time point three dECG recordings should be taken within an approximate 5 minute period. The variables to be reported from the continuous dECG measurements are RR, PQ, QRS, and QT intervals. The QT interval will be corrected for RR (the duration of a heart beat) to obtain corrected (QTc) variables.

QTcF will be calculated using the formula:

$$QTcF = QT / RR_b$$

Where  $b = 1/3$ .

To obtain a single value of QTcF, RR, PR, QRS and QT at each specified time point, the mean of the triplicate values at that time point will be used. If there are more than three values for a single time point, the mean of all the recorded values will be taken. For each patient, the change-from-baseline in a dECG variable at each time point will be calculated as the difference between the mean of the replicate value at each post-dose time point and the mean of pre-dose baseline replicate value. All ECG data will be obtained from the vendor, eRT, and there will be no site interpretation.

### **3.2.4 Duration of exposure**

#### **Exposure to AZD9291**

Total exposure to AZD9291 will be time (days) from the first dose to the last dose:

$$\text{Total exposure} = (\text{last dose date where dose} > 0 \text{ mg} - \text{first dose date}) + 1$$

Actual exposure to AZD9291 will be time (days) from first dose to the last dose, taking account of dose interruptions.

$$\text{Actual exposure} = ((\text{last dose date where dose} > 0 \text{ mg} - \text{first dose date}) + 1) - \text{total duration of dose interruption (i.e., number of days with dose} = 0 \text{ mg)}$$

#### **Exposure to chemotherapy**

Duration of treatment on chemotherapy will be in terms of the number of cycles. A cycle will be counted if chemotherapy is started, even if the full dose is not delivered.

If a new cycle is delayed, the day when chemotherapy dosing occurs will be deemed to be day 1 of the next cycle.

### 3.2.5 Dose intensity

Relative dose intensity (RDI) and percentage intended dose (PID) will be defined as follows:

- $RDI = 100\% \times d / D$ , where  $d$  is the actual cumulative dose delivered up to the earlier of progression (or a censoring event) or the actual last day of dosing, and  $D$  is the intended cumulative dose up to the earlier of progression (or a censoring event) or the actual last day of dosing plus the protocol-defined post-dose rest period. Protocol-defined post-dose rest period is 0 days for AZD9291.
- $PID = 100\% \times d_1 / D_1$ , where  $d_1$  is the actual cumulative dose delivered up to progression (or a censoring event), and  $D_1$  is the intended cumulative dose up to progression (or a censoring event).  $D_1$  is the total dose that would be delivered, if there were no modifications to dose or schedule.

### 3.3 PK variables

PK analysis of the plasma concentration data for AZD9291, AZ5104 and AZ7550 will be performed by Quantitative Clinical Pharmacology, AstraZeneca or delegate on behalf of Quantitative Clinical Pharmacology. Plasma concentration will be listed and summarized according to the time ranges.

The ratio of metabolite to AZD9291 will be calculated at the time-points. The plasma concentration data for AZD9291 and metabolites will also be analyzed using a population PK approach, which may include exploring the influence of covariates on PK, if the data allows.

The data collected in this study may also be combined with similar data from other studies and explored using population PK and/or PK-pharmacodynamic methods. A separate analysis plan will be written to describe these analyses. The results of any such analyses will be reported separately from the CSR.

The concentration in CSF will be summarized and metabolite to AZD9291 ratio calculated. If the CSF was taken on a PK day then the CSF to pre-dose plasma concentration for AZD9291 will be calculated. If there are no CSF samples collected in the study, CSF data will not be presented or summarized.

## **4. ANALYSIS METHODS**

### **4.1 General principles**

Continuous data will be summarized using descriptive statistics (number of observations, mean, standard deviation, median, 25th and 75th percentiles, minimum, and maximum). Frequencies and percentages will be used for summarizing categorical (discrete) data.

Confidence intervals (CIs), when presented, will generally be constructed at the 95% level. For binomial variables, the normal approximation methods will be employed unless otherwise specified.

A month is operationally defined to be 30.4375 days. Six months is operationally defined to be 183 days.

Data will be presented in data listings by treatment group and subject number.

All summaries will be presented by treatment group unless otherwise specified.

Additional summaries of efficacy and other variables may be produced as a separate report(s) for specific regions (e.g. Japan), as required by local health authorities.

#### **4.1.1 Baseline measurements and change from baseline variables**

In general, for efficacy endpoints and PROs the last observed measurement prior to randomization will be considered the baseline measurement. However, if an evaluable assessment is only available after randomization but before the first dose of randomized treatment then this assessment will be used as baseline. For safety endpoints the last observation before the first dose of study treatment will be considered the baseline measurement unless otherwise specified.

For assessments on the day of first dose where time is not captured, a nominal pre-dose indicator, if available, will serve as sufficient evidence that the assessment occurred prior to first dose.

Assessments on the day of the first dose where neither time nor a nominal pre-dose indicator are captured will be considered prior to the first dose if such procedures are required by the protocol to be conducted before the first dose.

In all summaries change from baseline variables will be calculated as the post-treatment value minus the value at baseline. The % change from baseline will be calculated as  $(\text{post-baseline value} - \text{baseline value}) / \text{baseline value} \times 100$ .

#### **4.1.2 Multiple testing strategy**

In order to provide strong control of the type I error rate, the primary endpoint of PFS and key secondary endpoints, ORR and OS will be tested in this sequential order. If any previous

analysis in the sequence is not statistically significant, the alpha cannot be transferred to subsequent analyses.

The analyses of primary and all secondary endpoints will all occur at the time of primary analysis of PFS with the exception of OS. Three analyses of OS are planned; two interim analyses and a final analysis. The data cut-off for the first analysis of overall survival will be conducted approximately 4 months after data cut-off for the primary analysis of PFS and the second analysis will be conducted when the OS data are approximately 50% mature (approximately 205 death events). A final analysis of overall survival will be performed when the OS data are approximately 70% mature (approximately 287 death events).

The analyses of PFS2, time to first subsequent therapy and time to second subsequent therapy will be performed at the time of the OS analyses since these endpoints are considered important to the interpretation of OS.

A 2-sided 5% alpha will be used in all testing, with the exception of overall survival endpoint. Since three analyses of OS are planned, the Lan DeMets approach that approximates the O'Brien and Fleming spending function will be used to maintain an overall 2-sided 5% type I error across the three planned analyses of OS.

The significance level for the OS analyses will be calculated using the statistical software package EAST by specifying the information fraction for each analysis. The information fraction is calculated as the number of OS events at the analysis time-point divided by the total number of events at the final analysis time-point. For example, assuming a median OS on the chemotherapy arm of 16 months and a median OS of 22 months on the AZD9291 arm, that 119 OS events were observed at the first analysis, the information fraction would be entered as 0.41 (119/287 events) for the first analysis and 0.71 (205/287 events) for the second analysis, since 205 and 287 events are expected at the second and final analysis, respectively. This would result in a significance level for the first analysis of 0.001 (2-sided), a significance level for the second analysis of 0.016 (2-sided) and a significance level for the final analysis of 0.045 (2-sided).

Note, any non-statistically significant analyses at the interims will not preclude further testing of OS.

For PRO symptoms, the overall type I error (5% 2 sided) will be controlled across the five primary PRO measures of cough, dyspnoea and pain as assessed by the EORTC QLQ-LC13 and fatigue and appetite loss as assessed by the EORTC QLQ-C30 using the Bonferroni-Holm procedure.

#### **4.1.3 Study day definitions**

For the purpose of efficacy data summary, Study Day 1 is defined as the date of randomization to study treatment. For visits (or events) that occur on or after randomization, study day is defined as (date of visit [event] - date of randomization + 1). For visits (or events)



that occur prior to randomization, study day is defined as (date of visit [event] - date of randomization). There is no Study Day 0.

For the purpose of safety data summary, Dose Day 1 is defined as the date of first dose of study treatment (referred to in the protocol as Week 1 Day 1). For visits (or events) that occur on or after first dose, dose day is defined as (date of visit [event] - date of first dose of study treatment + 1). For visits (or events) that occur prior to first dose, dose day is defined as (date of visit [event] - date of first dose of study treatment). There is no Dose Day 0.

For listings (such as for AEs) that include the derivation of “days since last dose,” this is defined as (event date - date of last dose). Events that occur on the same day as the last dose of study drug will therefore be described as occurring zero days from the last dose of study drug.

#### **4.1.4 Visit windows**

For summaries of vital signs, laboratory data, ECG, HRQoL, and PROs etc., assessments will be assigned to calculated visit windows (using study day).

The time windows should be exhaustive so that data recorded at any time point have the potential to be summarized. Inclusion within the visit window should be based on the actual date and not the intended date of the visit. For summaries at a subject level, all values should be included, regardless of whether they appear in a corresponding visit-based summary, when deriving a subject level statistic such as a maximum.

The window for the visits following baseline (including unscheduled visits) will be constructed in such a way that the upper limit of the interval falls half way between the two visits.

For summaries showing the maximum or minimum values, the maximum/minimum value recorded on treatment will be used (regardless of where it falls in an interval). Listings should display all values contributing to a time point for a subject; they should also highlight the value for that subject that was used in the summary table, wherever feasible.

For visit based summaries:

- If there is more than one value per subject within a visit window then the closest to the planned study day value should be summarized, or the earlier in the event the values are equidistant from the planned study day. The visit will be missing if no assessment was reported within the specified visit window around the planned study day.
- To prevent very large tables or plots being produced that contain many cells with meaningless data, summary statistics will be presented where at least 10 subjects in either treatment group have data recorded at a particular visit.

#### **4.1.5 Handling missing data**

In general, other than for partial dates, missing data will not be imputed and will be treated as missing.

##### **Imputation of partial dates**

###### ***Initial diagnosis date:***

- If year is missing (or completely missing), do not impute.
- If only day is missing, impute day as 15th of the month.
- If day and month are missing, impute as July 1st.

###### ***Concomitant medication start date***

- If year is missing (or completely missing), do not impute.
- If (year is present and month and day are missing) or (year and day are present and month is missing), impute as January 1st.
- If year and month are present and day is missing, impute day as first day of the month.

###### ***Concomitant medication end date***

- If year is missing (or completely missing), do not impute.
- If (year is present and month and day are missing) or (year and day are present and month is missing), impute as December 31st.
- If year and month are present and day is missing, impute day as last day of the month.

#### **4.1.6 Imputation rules for lab values outside of quantification range**

Lab values below the lower limit of quantification (LLoQ) that are reported as “<LLoQ” or “≤LLoQ” in the database will be imputed by LLoQ x 0.99 for analysis purposes. The original value will be listed.

Lab values above the upper level of quantification (ULoQ) that are reported as “>ULoQ” or “≥ULoQ” in the database will be imputed by ULoQ x 1.01 for analysis purposes. The original value will be listed.

#### **4.1.7 Rounding rules for reported percentages**

For percentages  $\geq 10\%$ :

- Values  $\geq X.5$  or above round to  $X+1$ .

- Values  $>X$  but  $<X.5$  round to  $X$ .

For percentages  $<10\%$ :

- Values  $\geq X.Y5$  or above round to  $X.Y+0.1$ .
- Values  $>X.Y$  but  $<X.Y5$  round to  $X.Y$ .

## **4.2 Analysis methods**

### **4.2.1 Subject disposition and data sets analyzed**

Subject disposition will be listed and summarized for the FAS. Summaries will include the number and percentage of subjects:

- Randomized
- Treated
- Subjects ongoing study treatment at the data cut-off
- Included in each analysis set (FAS, Safety, and PK).

In addition, the number and percentage of subjects who discontinued treatment and who discontinued the study, including a breakdown of the main reason for discontinuation will be presented for all subjects.

### **4.2.2 Protocol deviations**

All important protocol deviations will be listed and summarized for the FAS. All protocol deviations will be defined by the study team and identified before database lock.

### **4.2.3 Demographic and other baseline characteristics**

Demographic and baseline subject characteristics will be listed and summarized for the FAS. Standard descriptive statistics will be presented for the continuous variables of:

- Age (years).
- Weight (kg).
- Height (cm).
- Body mass index ( $\text{kg}/\text{m}^2$ ) [calculated as  $(\text{weight}/\text{height}^2)$  where weight is in kg and height is in m].
- Nicotine consumption (cigarettes/cigars per day and pipe tobacco packs per week)

The total counts and percentages of subjects will be presented for the categorical variables of:

- Age group (years) (grouped as <50, ≥50-<65, ≥65)
- Sex
- Race
- Ethnic group
- EGFR mutation type (Exon 20 T790M, G719X, S768I, Exon 19 deletion, L858R, and other) (as reported prior to study screening)
- Overall disease classification (metastatic, locally advanced, both)
- Site of disease
- Baseline TL size (mean and categories: <40, 40-79, 80-119, ≥120mm)
- Histology
- Smoking status.
- WHO performance status (0/1)

The number of subjects with all types of EGFR mutations identified by the cobas EGFR central test (by biopsy taken after confirmation of disease progression on the most recent treatment regime) will be summarized (i.e., T790M only, T790M and exon 19 deletion, T790M and L858R, and T790M with all other mutations with >5 subjects). Examples of other EGFR mutations which may be detected are G719X, S768I, and Exon 20 insertion). A listing of all subjects showing all the EGFR mutations reported prior to study screening and the EGFR mutations identified by the cobas central test after confirmation of disease progression will be presented.

#### **4.2.4 Medical history**

Disease related medical history and relevant surgical history will be coded using MedDRA. All disease related medical history will be listed and the number and percentage of subjects with any disease related medical history will be summarized for the FAS by system organ class (SOC) and preferred term (PT).

All relevant surgical history will be listed and summarized similarly.

#### **4.2.5 Anti-cancer medications and radiotherapy (prior, during, post-treatment with IP)**

Medications received prior to, concomitantly, or post-treatment will be coded using the AstraZeneca Drug Dictionary Anatomical Therapeutic Chemical (ATC) Classification codes.

Concomitant medications/radiotherapy will be listed and summarized for the FAS by ATC classification codes.

For the purpose of inclusion in prior and/or concomitant medication or therapy summaries, incomplete medication or radiotherapy start and stop dates will be imputed as detailed in Section 4.1.5.

Prior medications, concomitant and post-treatment medications are defined based on imputed start and stop dates as follows:

- Prior medications are those taken prior to screening with a stop date prior to the first dose of study treatment.
- Concomitant medications are those with a stop date on or after the first dose date of study treatment (and could have started prior to or during treatment).
- Post-treatment medications are those with a start date after the last dose date of study treatment.

EGFR-TKI therapies will be defined as approved EGFR-TKI therapies and will include gefitinib, erlotinib and afatinib only.

#### **4.2.5.1 Anti-cancer therapy**

All anti-cancer therapies will be summarized for the FAS. They will be summarized separately for prior, current, and post-withdrawal of IP anti-cancer therapies.

The number of anti-cancer therapy regimens and number of cycles will be summarized using descriptive statistics. The anti-cancer therapy agent, therapy class, best response, and treatment status will be summarized using frequencies and percentages. Any anti-cancer therapies will also be listed.

#### **4.2.5.2 Radiotherapy**

All radiotherapies will be summarized for the FAS. They will be summarized separately for prior, current, and post-withdrawal of IP radiotherapies.

The number of fraction doses and fraction dose (Gy) will be summarized using descriptive statistics. The radiotherapy site/region and treatment status will be summarized using frequencies and percentages.

Any radiotherapy will also be listed.

#### **4.2.6 Exposure**

Exposure will be listed and summarized for safety analysis set. The following summaries will be produced:

- Summary of duration of exposure of AZD9291
- Summary of total number of cycles of chemotherapy received
- RDI and PID of AZD9291
- Summary of interruptions and reductions of AZD9291
- Summary of delays and reductions of chemotherapy

#### **4.2.7 Brain metastases**

The proportion of subjects who develop brain metastases during the trial will be summarized by treatment group.

The proportion of RECIST progression events by medical history of brain metastases will be summarized.

#### **4.2.8 Efficacy**

All efficacy analyses will be performed on the FAS. Results of all statistical analyses will be presented using a 95% CI and 2-sided p-value.

The stratification factor for the efficacy analyses will be based on the values entered into the IVRS.

##### **4.2.8.1 Primary outcome: PFS**

PFS will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian) for generation of the p-value and using the Breslow approach for handling ties. The HR and CI will be obtained directly from the U and V statistics as follows ([Berry G et al 1991](#), [Selke & Siegmund 1982](#)):

$$\text{HR} = \exp(U/V)$$

$$95\% \text{ CI for HR} = (\exp\{U/V - 1.96/\sqrt{V}\}, \exp\{U/V + 1.96/\sqrt{V}\})$$

Where  $U = \sum_i(d_{1i} - e_{1i})$  is the log-rank test statistic (with  $d_{1i}$  and  $e_{1i}$  the observed and expected events in group 1) and  $\sqrt{V}$  the standard deviation of the log-rank test statistic obtained from the LIFETEST procedure with a STRATA term for the stratification variable.

A Kaplan-Meier (KM) plot of PFS will be presented by treatment group.

#### ***Subgroup analysis***

Subgroup analyses will be conducted by comparing PFS between treatments in the following groups:

- Ethnicity (Asian versus Non-Asian)

- Gender (Male versus Female)
- Age at screening (<65 versus ≥65)
- Mutation status prior to start of study (ex19 versus L858R)
- Duration of prior EGFR-TKI (<6 months, ≥6 months)
- Brain metastases at entry
- Smoking history

The HR (AZD9291: chemotherapy) and associated CI will be calculated from a Cox proportional hazards model (ties=Efron) that contains the treatment term, factor and treatment-by-factor interaction term. The treatment effect HRs for each treatment comparison along with their CIs will be obtained for each level of the subgroup from this single model. The HRs and 95% CIs will be presented on a forest plot including the HR and 95% CI from the overall population (using the primary analysis).

If there are too few events available for a meaningful analysis of a particular subgroup (it is not considered appropriate to present analyses where there are less than 20 events per level in a subgroup), the relationship between that subgroup and PFS will not be formally analyzed. In this case, only descriptive summaries will be provided.

The assumption of proportionality will be assessed. Proportionality will be tested firstly by examining the plots of complementary log-log (event times) versus log (time) and, if necessary, a time dependent covariate will be fitted to assess the extent to which this represents random variation.

No adjustment to the significance level for testing will be made since the subgroup analysis will be considered exploratory and may only be supportive of the primary analysis of PFS.

The presence of quantitative interactions will be assessed by means of an overall global interaction test. This will be performed in the overall population by comparing the fit of a Cox proportional hazards model including treatment, all covariates, and all covariate-by-treatment interaction terms, with one that excludes the interaction terms and will be assessed at the 2-sided 10% significance level. If the fit of the model is not significantly improved as assessed by twice the change in log-likelihood then it will be concluded that overall the treatment effect is consistent across the subgroups.

If the global interaction test is found to be statistically significant, an attempt to determine the cause and type of interaction will be made. Stepwise backwards selection will be performed on the saturated model, whereby (using a 10% level throughout) the least significant interaction terms are removed one-by-one and any newly significant interactions re-included until a final model is reached where all included interactions are significant and all excluded interactions are non-significant. Throughout this process all main effects will be included in

the model regardless of whether the corresponding interaction term is still present. This approach will identify the factors that independently alter the treatment effect and prevent identification of multiple correlated interactions.

Any quantitative interactions identified using this procedure will then be tested to rule out any qualitative interaction using the approach of [Gail and Simon 1985](#).

### ***Sensitivity analysis***

(a) Ascertainment bias

The possibility of bias in assessment and measurement of PFS by investigators will be assessed by comparing the hazard ratio derived from investigator review with the hazard ratio derived using the BICR assessment of disease progression by RECIST 1.1.

(b) Evaluation-time bias

In order to assess possible evaluation-time bias, which could occur if scans are not performed at the protocol-scheduled time points, the midpoint between the time of progression and the previous evaluable RECIST 1.1 assessment will be analyzed using a stratified log rank test, as described for the primary analysis of PFS. For subjects who die in the absence of progression, the date of death will be used to derive the PFS time used in the analysis.

(c) Attrition bias

Possible attrition bias will be assessed by:

- (i) Repeating the primary PFS analysis, except that the actual PFS event times, rather than the censored times, of subjects who progressed or died in the absence of progression immediately following two, or more, non-evaluable tumor assessments will be included.
- (ii) Subjects who take subsequent therapy prior to progression or death will be censored at their last evaluable assessment prior to taking the subsequent therapy.
- (iii) A reversed KM plot of the time to censoring, where the censoring indicator of the primary PFS analysis is reversed, will be presented to assess the number of subjects being followed over time.

### ***Post-hoc exploratory analysis of the use of a novel sample BICR methodology to assess bias in assessment of PFS by investigators***

Recently, it has been suggested that, in order to assess the potential for bias amongst investigators, a BICR amongst only a sample of patients could be performed; if evidence of



bias is detected, according to a pre-defined threshold, the BICR is then assessed in all patients, otherwise it is concluded the sample was sufficient to rule-out meaningful levels of bias. A proposed sample BICR method has been submitted to a peer reviewed statistical journal for publication as of August 2014 and in order to demonstrate that this is a valid methodology for use in future trials, a post hoc exploratory analysis will be carried out using this methodology. The results of this exploratory analysis will be reported separately from the CSR. A random sample of subjects from the full study population will be selected and the results of the BICR review of these subjects will be used to rule out a concerning level of bias in the full study local evaluation (LE) estimate of the treatment effect (Hazard Ratio) for PFS. The hazard ratio ratio (HRR), the ratio of the hazard ratio (HR) for the treatment effect estimated from the sample BICR to the corresponding HR for the investigator assessments, will be used as the metric to assess bias. Lack of evidence of meaningful bias will be concluded if there is a low conditional probability that the HRR seen in the random sample would have been observed, if in fact, the point estimate in the full trial were unacceptably high (i.e., 1.25).

The subjects forming the sample BICR will be randomly selected from within each treatment group with separate sampling within subjects who have a LE progression event and from those censored for PFS by the LE. This is so that the BICR sample is representative of the study as a whole.

A sample BICR would be deemed to be acceptable if there was a low (conditional) probability (10%), given the sample, that the null hypothesis of concerning bias in the overall study (HRR  $\geq 1.25$ ) was really true. This protects the sensitivity of the procedure at 90% (i.e., correctly failing to reject the hypothesis of concerning bias when this is really true).

#### **4.2.8.2 Secondary outcomes**

##### ***ORR***

The ORR will be compared between treatment using logistic regression models adjusting for the covariate ethnicity (Asian/non-Asian). The results of the analysis will be presented in terms of an odds ratio together with its associated 95% profile likelihood CI. The p-value will be based on a test statistic that is calculated as twice the change in log-likelihood resulting from the addition of a treatment factor to a model that contains the covariate defined above. The test statistics is chi-squared distributed with 1 degree of freedom.

A summary of best objective response will also be presented by treatment group.

##### ***DoR***

In order to analyze the secondary outcome variable of DoR between arms the Expected Duration of Response (EDoR) will be derived for each treatment group (Ellis S et al 2008). The EDoR is the product of the proportion of subjects responding to treatment and the mean DoR in responding subjects, and provides an estimate based on all randomized subjects.

Treatments will be compared by calculating the ratio of EDoRs using the log Normal probability distribution for duration of response in responding subjects. The log Normal

distribution has been chosen based on a review of the fit of this distribution, the Exponential distribution, the Weibull distribution and the log logistic distribution to duration of response data from pooled data from the two Phase II AZD9291 single-arm monotherapy studies: D5160C0001C (AURA extension) and D5160C00002 (AURA2), using the data cut-off date of 1st November 2015. The log Normal distribution had the lowest value Akaike information criterion and Bayesian Information Criterion and the fitted line for the model overlaid with the KM plot indicated visually that the distribution was a reasonable fit.

The analysis of DoR will be stratified by the same covariates as the primary analysis, weighting each stratum inversely proportional to the within stratum variance of the log of the ratio of EDoRs. The mean DoR will also be estimated, and the null hypothesis that the distribution of the ratio of EDoRs is 1 will be tested and a p-value and 95% CI provided. Additionally, descriptive data will be provided for the duration of response in responding subjects, including associated KM curves (without any formal comparison of or p-value attached).

### ***DCR***

DCR will be analyzed using a logistic regression with a covariate for ethnicity (Asian/non-Asian). The results of the analysis will be presented in terms of an odds ratio together with its associated 95% profile likelihood CI and 2-sided p-value. The p-value will be based on twice the change in log-likelihood resulting from the addition of a treatment factor to a model that contains the covariates defined above.

### ***Tumor shrinkage***

The effect of AZD9291 on best percentage change in tumor size will be estimated from an analysis of covariance (ANCOVA) model with a covariate for ethnicity (Asian/non-Asian). The number of subjects, unadjusted mean and lsmeans for each treatment group will be presented, together with the difference in lsmeans, 95% CI and corresponding p-value.

### ***OS***

OS data will be analyzed using a log rank test stratified by ethnicity (Asian, Non-Asian) for generation of the p-value and using the Breslow approach for handling ties. The HR and CI will be obtained directly from the U and V statistics as described in Section 4.2.8.1 (provided there are sufficient events available for a meaningful analysis [ $>20$  deaths], if not descriptive summaries will be provided). For the interim analysis, see Section 5.

### ***Mixed models repeated measures of change from baseline in primary PRO symptoms***

Change from baseline in the primary PRO symptom scores of dyspnea, cough, pain, fatigue and appetite loss (described in Section 3.1.7) will be analysed using a mixed model for repeated measures (MMRM) analysis. The analysis will be to compare the average treatment effect from the point of randomisation for the first 6 months unless there is excessive missing data (defined as  $>75\%$  missing data). Following confirmed disease progression, patients on the chemotherapy arm are eligible to crossover to AZD9291 treatment, therefore only data up to 6 months is included in this analysis to limit any confounding caused by treatment

switching. However, if the time to first AZD9291 dose when approximately 50% of chemotherapy patients receive AZD9291 occurs prior to 6 months post-randomisation then only data until this earlier time-point will be used in the analysis.

It is acknowledged that patients will discontinue treatment at different timepoints during the study and that this is an important time with regards to symptoms and HRQoL data collection. To account for this, and in order to include the discontinuation and follow up visits, a generic visit variable will be derived for each subject in order that the average treatment effect can be analyzed using the above method. Each visit will be assigned a sequential number. The time from randomization to each of these will be derived in order to select only those visits occurring within the first 6 months of randomization.

As an example, say a patient X attends the first 4 scheduled visits of a 6-weekly schedule and then discontinues treatment, whilst patient Y discontinues treatment after the first scheduled visit, the first 5 generic visits would be as follows:

Generic visit	Days since randomization	
	Patient X	Patient Y
Baseline	Baseline	Baseline
1	42	42
2	84	50 (discontinuation)
3	126	84
4	168	126
5	189 (discontinuation)	168

Thus, the first 5 generic visits could be used in the analysis of deriving the average treatment effect.

The MMRM model will include patient, treatment, and visit) and treatment by visit interaction as explanatory variables, and the baseline symptom score as a covariate along with the baseline symptom score by visit interaction. Treatment, visit and treatment by visit interaction will be fixed effects in the model; patient will be included as a random effect. Restricted maximum likelihood (REML) estimation will be used. An overall adjusted mean estimate will be derived that will estimate the average treatment effect over visits giving each visit equal weight. For this overall treatment comparison, adjusted mean estimates per treatment group and corresponding 95% CIs will be presented along with an estimate of the treatment

difference, 95% CI and p-value. The treatment by visit interaction will remain in the model regardless of significance.

An unstructured covariance matrix will be used to model the within-subject error and the Kenward-Roger approximation will be used to estimate the degrees of freedom.

If the fit of the unstructured covariance structure fails to converge, the following covariance structures will be tried in order until convergence is reached: toeplitz with heterogeneity, autoregressive with heterogeneity, toeplitz, and autoregressive. If there are still issues with the fit of the model or estimation of the treatment effects, SUBJECT will be treated as a fixed effect.

#### ***Time to PRO symptom deterioration***

Time to PRO symptom deterioration will be analyzed using a log rank test stratified by ethnicity (Asian/non-Asian) for generation of the p-value and using the Breslow approach for handling ties. The HR and CI will be estimated using the same methods as for the primary endpoint of PFS, as described in Section 4.1.

#### ***PRO symptom improvement rate***

Symptom Improvement Rate at each visit will be analyzed using a logistic regression with a covariate for ethnicity (Asian/non-Asian). The results of the analysis will be presented in terms of an odds ratio together with its associated 95% profile likelihood CI and 2-sided p-value. The p-value will be based on twice the change in log-likelihood resulting from the addition of a treatment factor to a model that contains the covariates defined above.

#### ***Subjects with EGFR T790M mutation status detected in baseline plasma sample (ctDNA)***

The efficacy of AZD9291 versus chemotherapy will be evaluated in patients with baseline plasma T790M mutation status (positive, negative and unknown). For PFS, the HR and associated 95% CI will be calculated for each group. For ORR, the odds ratio and associated 95% CI will be presented for each group.

Note, plasma testing will not be performed on China patients due to sample export limitations, therefore the denominator for this analysis will exclude patients from China.

### **4.2.8.3 Exploratory outcomes**

#### ***PRO-CTCAE***

PRO-CTCAE data will be presented using summaries and descriptive statistics based on the FAS.

#### ***Healthcare resource use***

Healthcare Resource Use data (i.e., the hospital admission details including type of attendance and primary symptom for admission) will be presented using frequencies and percentages the duration of admission/attendance and duration of ICU/HDU stay will be summarized using descriptive statistics, based on the FAS.

### ***Post-progression outcomes***

PFS2, TFST and TSST will be analyzed using the same method as the analysis of PFS.

### ***Further analysis of OS***

Additional analysis of OS adjusting for the impact of subjects randomized to chemotherapy, who subsequently receive AZD9291 may be completed if this treatment sequence occurs in a significant proportion of subjects. Methods such as Rank Preserving Structural Failure Time (RPSFT) (Robins et al 1991) Inverse Probability of Censoring Weighting (IPCW) (Robins 1993) and other methods in development may be explored. The decision to adjust and final choice of methods will be based on a review of the data and the plausibility of the underlying assumptions. Further detail will be provided in a Payer Analysis Plan.

All further analyses of OS will be reported separately from the CSR.

#### **4.2.9 PK and CSF concentration data**

All plasma concentrations of AZD9291, AZ5104 and AZ7550 will be listed.

Secondary outcomes include summaries of plasma concentrations of AZD9292 and plasma metabolite (AZ5104 and AZ7550).

Exploratory outcomes include summaries of CSF concentrations, CSF metabolite: AZD9291 ratio, and CFS: plasma ratio, if any CSF data is obtained. If no CSF data is obtained, then this exploratory outcome will not be listed or summarized.

The following summary statistics by nominal sample time will be presented for the PK analysis set:

- The geometric mean (gmean, calculated as  $\exp[\mu]$ , where  $\mu$  is the mean of the data on a logarithmic scale).
- Coefficient of variation (CV, calculated as  $100 \sqrt{[\exp(s^2)-1]}$ , where  $s$  is the standard deviation of the data on a logarithmic scale).
- Gmean  $\pm$  standard deviation (calculated as  $\exp[\mu \pm s]$ ).
- Arithmetic mean calculated using untransformed data.
- Standard Deviation (SD) calculated using untransformed data.
- Minimum.
- Median.
- Maximum.

- Number of observations (n).

Non-quantifiable (NQ) values of plasma concentrations will be handled as follows:

- If, at a given time point, 50% or less of the plasma concentrations are NQ, the gmean, CV, gmean  $\pm$  SD, arithmetic mean and standard deviation will be calculated by substituting the limit of quantification (LOQ) for values which are NQ.
- If more than 50%, but not all, of the concentrations are NQ, the gmean, CV, gmean  $\pm$  SD, arithmetic mean and SD will be reported as not calculable (NC).
- If all the concentrations are NQ, the gmean and arithmetic mean will be reported as NQ and the CV, gmean  $\pm$  SD and SD as NC.
- The number of values above LLOQ will be reported for each time point along with the total number of collected values.

If data are available for fewer than 3 subjects, no summary statistics other than minimum, maximum and n will be presented.

The PK data for Cycle 1 Day 1 and Cycle 3 Day 1 will also be displayed graphically for the PK analysis set. Displays will include plasma concentration subject profiles versus time and gmean concentrations ( $\pm$  SD) both on the linear and on the log-scale versus time by cohort.

#### **4.2.10 Safety and tolerability**

The safety analysis set will be used for all safety and tolerability tables, figures and listings except where expressly noted.

##### **4.2.10.1 AEs**

All AEs, both in terms of MedDRA PT and CTCAE grade, will be listed and summarized descriptively by count (n) and percentage (%) for each treatment group. MedDRA will be used for coding. Any AE occurring before AZD9291/chemotherapy treatment (i.e., before Study Day 1) will be included in the AE listings, but will not be included in the summary tables (unless otherwise stated). These will be referred to as 'pre-treatment'. The summary tables will include all AEs that occurred after the start of treatment up until the end of the 28 day follow-up period. The 28 day follow-up period will be defined as 28 days following discontinuation of AZD9291/chemotherapy treatment.

All reported AEs will be listed along with the date of onset, date of resolution (if AE is resolved), investigator's assessment of severity and relationship to study drug. Frequencies and percentages of subjects reporting each preferred term will be presented (i.e., multiple events per subject will not be accounted for apart from on the episode level summaries).

Summary information (the number and percent of subjects by treatment) will be tabulated for:

- All AEs
- All AEs causally related to study medication
- AEs with CTCAE grade 3 or higher
- AEs with CTCAE grade 3 or higher, causally related to study medication
- AEs with outcome of death
- AEs with outcome of death causally related to study medication
- All SAEs
- All SAEs causally related to study medication
- AEs leading to discontinuation of AZD9291/chemotherapy
- AEs leading to discontinuation of AZD9291/chemotherapy, causally related to AZD9291/chemotherapy
- OAEs
- OAEs causally related to AZD9291/chemotherapy

An overall summary of the number and percentage of subjects in each category will be presented, as will an overall summary of the number of episodes in each category. In addition, a truncated AE table of the most common AEs, showing all events that occur in at least 5% of subjects overall will be summarized by preferred term, by decreasing frequency. This cut-off may be modified after review of the data.

AEs will be assigned CTCAE grades and summaries of the number and percentage of subjects will be provided by maximum reported CTCAE grade, SOC, PT and actual treatment group. Fluctuations observed in CTCAE grades during the study will be listed.

Summaries of the number and percentage of subjects with AEs leading to dose interruptions of AZD9291/chemotherapy will be presented by PT.

In addition, AEs with an outcome of death, SAEs, AEs leading to discontinuation of treatment, AEs causally related to AZD9291/chemotherapy and OAEs will be listed.

A separate summary will be produced that presents any events that occur prior to dosing or starting more than 28 days after discontinuing therapy.

#### **4.2.10.2 AEs of Special Interest**

Summary tables of AEs of special interest will be produced including the number (%) of patients experiencing any of the specified terms presented by maximum CTCAE grade, time to onset of first AE for each grouped term and each preferred term within it, time to onset of first CTCAE grade 3 or higher, fluctuations in CTCAE grade, duration of AEs of special interest and number (%) of patients treated for AEs of special interest.

Life table and prevalence plots for rash (rashes and acnes), diarrhoea and fatigue will be produced.

#### **4.2.10.3 Deaths**

A summary of deaths will be provided with the number and percentage of subjects, categorized as:

- Related to disease under investigation,
- AE outcome=death,
- Both related to disease under investigation and with AE outcome=death,
- AE with outcome=death >28 days after last treatment dose,
- Deaths >28 days after last treatment dose, unrelated to AE or disease under investigation, and
- Subjects with unknown reason for death.

A corresponding listing will also be produced.

#### **4.2.10.4 Laboratory evaluations**

All laboratory data recorded in the electronic case report form (eCRF) will be listed. If any additional analytes to those in [Table 3](#) are also recorded then these will be listed only.

All values will be classified as low (below range), normal (within range) and high (above range) based on reference ranges provided by the local or central laboratory. As applicable, values will be graded using CTCAE v4.0.

For clinical chemistry and hematology, shift tables of the number of CTCAE grade changes from baseline will be provided. Corresponding shift tables (“Negative”, “Trace”, “Positive”, “0”, “+”, “++”, “+++”) will be produced for urinalysis.

Plots of both the maximum post-baseline ALT and AST versus the maximum post-baseline total bilirubin, expressed as multiples of their upper limit of reference range will be produced.



A pregnancy test performed at screening for women of child-bearing potential will be listed.

The following laboratory variables will be summarized:

**Table 3 Laboratory safety variables**

<b>Clinical chemistry (Serum/Plasma)</b>	<b>Hematology (Blood)</b>	<b>Urinalysis (Urine)</b>
Albumin	Hemoglobin	Glucose
ALT	Leukocyte	Protein
AST	Hematocrit	Blood
Alkaline phosphatase	Red blood cell (RBC) count	
Bilirubin, total	Absolute leukocyte differential count:	
Calcium, total	Neutrophils	
Creatinine	Lymphocytes	
Calculated creatinine clearance	Monocytes	
Glucose (fasting, on PK days only) <sup>1</sup>	Basophils	
LDH <sup>2</sup>	Eosinophils	
HbA1C	Platelet count	
Magnesium	Reticulocytes	
Potassium		
Sodium		
Urea nitrogen/Blood urea nitrogen (BUN)		

<sup>1</sup> Subjects will be required to fast (water only) for at least 8 hours prior to the collection of a fasting glucose sample required on PK days.

Random glucose sample will be collected on non-PK days.

<sup>2</sup> LDH is an additional variable collected at Visit 1 only.

#### **4.2.10.5 Vital signs (pulse and BP) and weight**

All vital signs data will be listed. Absolute and percentage change from baseline for pulse, BP and weight will be summarized by treatment group and visit.

#### **4.2.10.6 Physical examination**

Abnormalities identified from physical examination will be listed. For each physical examination body system, the number and percentage of subjects with abnormalities at baseline and post-baseline will be summarized.

#### 4.2.10.7 ECG

##### *dECG*

All dECG data received will be presented in data listings. QTc summaries will be presented for subjects in the safety analysis set.

The dECG parameters that will be summarized (absolute values and change from baseline) are: QTcF, RR, PR, QRS and QT.

The observed values and change from baseline in QTcF will be summarized by visit using summary statistics. Plots of mean observed QTc parameters and change from baseline in QTc parameters versus time will be presented. Shift plots of the maximum change from baseline versus the baseline value for QTcF, with reference lines for 450 ms, 480 ms, 500 ms,  $\pm 30$  ms and  $\pm 60$  ms change will be presented.

QTc outliers are defined as QTcF values following dosing that are greater than 450 ms or are increases from baseline greater than 30 ms. QTcF outliers will be highlighted in the data listings and summarized using the following categories:

- Values  $>450$  ms,  $>480$  ms,  $>500$  ms
- Increase from baseline of  $>30$  ms, Increase from baseline of  $>60$  ms, Increase from baseline of  $>90$  ms,
- Values  $>450$  ms and increases of  $>30$  ms. Values  $>500$  ms and increases of  $>60$  ms.

The number and percentage of subjects who meet the ECG outlier criteria at any assessment post-date of first dose will be summarized.

##### *LVEF*

LVEF outliers are defined as LVEF values following dosing that are

- $\geq 10$  percentage points decrease from baseline and  $<50\%$  LVEF, or
- $\geq 15$  percentage points decrease from baseline and  $\geq 50\%$  LVEF.

LVEF outliers will be highlighted in the data listings and summarized.

#### 4.2.10.8 WHO performance status

WHO performance status will be listed and summarized by treatment and visit.

#### 4.2.11 Crossover

Summaries for subjects randomized to the chemotherapy arm that crossover to receive treatment with AZD9291 will be provided and will include patient disposition, duration of

exposure to AZD9291, treatment interruptions and dose reductions, and adverse events summaries.

## **5. INTERIM ANALYSES**

Three analyses of OS are planned:

- First analysis of OS will be conducted approximately 4 months after data cut-off for the primary analysis of PFS.
- Second analysis will be conducted when the OS data are approximately 50% mature (approximately 205 death events).
- A third analysis of OS will be performed when the OS data are approximately 70% mature (approximately 287 death events).

## **6. ADDITIONAL BRAIN METASTASES ANALYSIS**

An additional exploratory analysis will be conducted to explore efficacy in 2 subgroups of patients.

- a) The first set of analysis will be conducted to explore the efficacy in patients who undertook a brain scan in the screening/baseline period, had their scan sent for independent radiology review and were identified by that review as having non-measurable and/or measurable brain disease at baseline at the time of randomization.
- b) The second set of analysis will be conducted to explore the efficacy in patients with and without a prior history of brain metastases and/or current brain lesion at baseline.

The analysis sets, definition of required variables and description of analysis will be pre-specified in a separate SAP.

## **7. CHANGES OF ANALYSIS FROM PROTOCOL**

The China-cohort analyses will be performed when approximately 27 PFS events have occurred in approximately 50 Chinese patients so that the maturity of the PFS analysis is consistent with that of the global analysis. This update was not included in protocol amendment 3 in error.

The definitions of ORR and DoR have been amended so that visit responses of CR or PR do not need to be confirmed. This is in line with New response evaluation criteria in solid

tumours: Revised RECIST guideline (version 1.1) that, in randomised Phase III studies where progression is the primary endpoint, confirmation of response is not required.

The PK analysis set includes subjects in the FAS who have at least one measurable PK concentration and who have the relevant date, time and dosing data for this sample. The definition that the dosing data must include the dosing data for the 2 days prior to the sample day as well as the sample day has been changed to include the dosing data 1 calendar day prior to the sample day as there were very few samples for the 2 days prior to the sample day.

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## **9. APPENDIX**

N/A