**SUPPLEMENT:**

# Phase 2 trial to assess lebrikizumab in patients with idiopathic pulmonary fibrosis

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This supplement contains:

- Supplemental methods
- 3 supplemental figures
- 10 supplemental tables

## Supplemental Methods

### *Ethics approvals*

All participants provided informed, written consent. Approval of the study protocol was obtained from the institutional review board or independent ethics committee at each study site prior to study initiation. (See Supplemental table S9 for a full list of investigators and ethics approvals.)

### *Determination of sample size*

The study was initially designed as a time-to-event trial to assess the benefit of lebrikizumab as monotherapy on progression-free survival (PFS). PFS was defined as time from randomisation to the first occurrence of: death from any cause, non-elective hospitalization for any cause, relative decline in FVC (L) ≥10%. After the approval of antifibrotic therapy to treat IPF in October 2014, the protocol was amended in January 2015 to add Cohort B to assess lebrikizumab vs. placebo with background pirfenidone. When the protocol was amended, the primary endpoint for both cohorts was changed from PFS to annualised rate of decline in % predicted forced vital capacity (FVC) through Week 52.

In Cohort A, it was estimated that a sample size of 75 patients in each treatment group would be needed to achieve ≈80% power to detect a 3.7% difference in the annualised rate of decline in % predicted FVC over 52 weeks. This is assuming a common SD of 8% (as reported in the placebo group of ASCEND) using a 2-group *t* test with a 0.05 two-sided significance level.

In Cohort B, it was estimated that a sample size of 165 patients in each treatment group would be needed to achieve ≈80% power to detect a 2.5% difference in the annualised rate of decline in % predicted FVC over 52 weeks. A similar assumption for the SD applied here.

### *Exclusion criteria*

Key exclusion criteria included:

- History of severe allergic reaction or anaphylactic reaction to a biologic agent or known hypersensitivity
- Evidence of other known causes of interstitial lung disease or clinically significant lung disease other than IPF
- Lung transplant expected within 12 months of screening
- Post-bronchodilator forced expiratory volume in 1 second ($FEV_1$)/FVC ratio <0.7
- Positive bronchodilator response indicated by an increase of ≥12% predicted and 200 mL increase in either $FEV_1$ or FVC
- Hospitalisation due to IPF exacerbation ≤4 weeks prior to or during screening
- Cardiac or liver disease, known current malignancy, infections or immunodeficiency
- Chronic oral corticosteroid therapy

***Randomisation and blinding***

Patients were randomised via an interactive voice/Web-based response system (IxRS). Within each cohort, dynamic hierarchical randomisation was performed centrally and stratified by the following:

- Region: United States, Europe/Canada, other
- Lung function: % predicted FVC <50%, 50% to 75%, <75%
- Serum periostin concentration: <50 ng/mL, ≥50 ng/mL

Patients, all study site personnel and the Sponsor were blinded to the treatment assignment throughout the placebo-controlled period. Treatment for each cohort was unblinded at the time of the primary analysis.

***Dosing and administration***

*Lebrikizumab*

All patients in Cohorts A and B received lebrikizumab 250 mg or placebo every 4 weeks for the 52-week placebo-controlled period. All patients received a total of 2 injections per dosing visit for a minimum of 13 doses of study treatment during the placebo-controlled, blinded, study treatment period. Patients in Cohort A who experienced confirmed disease progression, defined as ≥10% decline in FVC (mL/year, relative change) or non-elective hospitalisation, during the placebo-controlled period could initiate rescue therapy, including use of pirfenidone or nintedanib, at the investigator's discretion if approved by local regulatory authorities (see Supplemental table S10). During the open-label period, patients in Cohort A could add treatment with pirfenidone, nintedanib or other regionally approved IPF therapies at the investigator's discretion.

*Pirfenidone*

The recommended dose of pirfenidone is 2403 mg/day (or 1800 mg/day for patients in Japan) administered in divided doses 3 times per day (TID) with food. Patients in Cohort B who entered screening receiving stable pirfenidone were randomised to receive lebrikizumab or placebo. Patients in Cohort B who were treatment-naive to pirfenidone initiated titration during the run-in period over 14 days, as tolerated, to the full dose of 9 capsules per day (3 capsules TID) as follows:

- Days 1–7: 1 capsule TID
- Days 8–14: 2 capsules TID
- Day 15 and onward: 3 capsules TID

Combination treatment with pirfenidone and nintedanib was not permitted.

***Biomarker assessments***

CCL13 was measured using the R&D Systems Quantikine human CCL13-MCP-4 immunoassay (DCC130) with lower limit of quantification (LLOQ) of 31.2 pg/mL. CCL18 was measured using the IMPACTD R-CID10.01 chip with LLOQ of 6 ng/mL. Periostin was measured using the Elecys assay on a Cobas e601 instrument with LLOQ of 10 ng/mL.

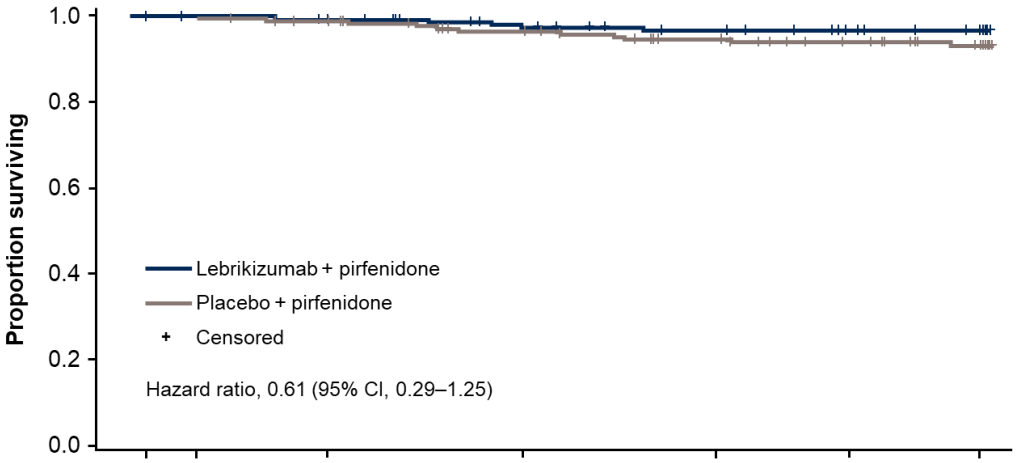
***Immunogenicity***

Lebrikizumab ADAs and PLBL2 antibodies were tested using a validated immunoassay by Covance Laboratories, Inc. (Chantilly, VA). The assay had a relative sensitivity 64 ng/mL of a surrogate positive control, a monoclonal anti-idiotypic antibody against lebrikizumab and 133 ng/mL of a surrogate positive control for monoclonal antibody against PLBL2. The assay could detect 500 ng/mL of this surrogate positive control in the presence of 50 µg/mL lebrikizumab or 250 ng/mL of this surrogate positive control in the presence of 200 ng/mL PLBL2.

A positive ADA sample was defined as one in which the presence of detectable ADAs could be confirmed by competitive binding with lebrikizumab. Treatment-induced ADA patients were those with negative or missing baseline ADA results and ≥1 positive post-baseline ADA result. Treatment-enhanced ADA patients were those with positive ADA results at baseline who then had ≥1 post-baseline titre result that were ≥0.6 more titre units than the baseline titre units. The baseline prevalence and post-baseline incidence of ADAs were calculated from the number of patients who tested ADA positive at baseline or post-baseline divided by either the total number of patients with evaluable samples at the baseline timepoint or post-baseline, respectively. Similar rules were used to define PLBL2 antibodies.

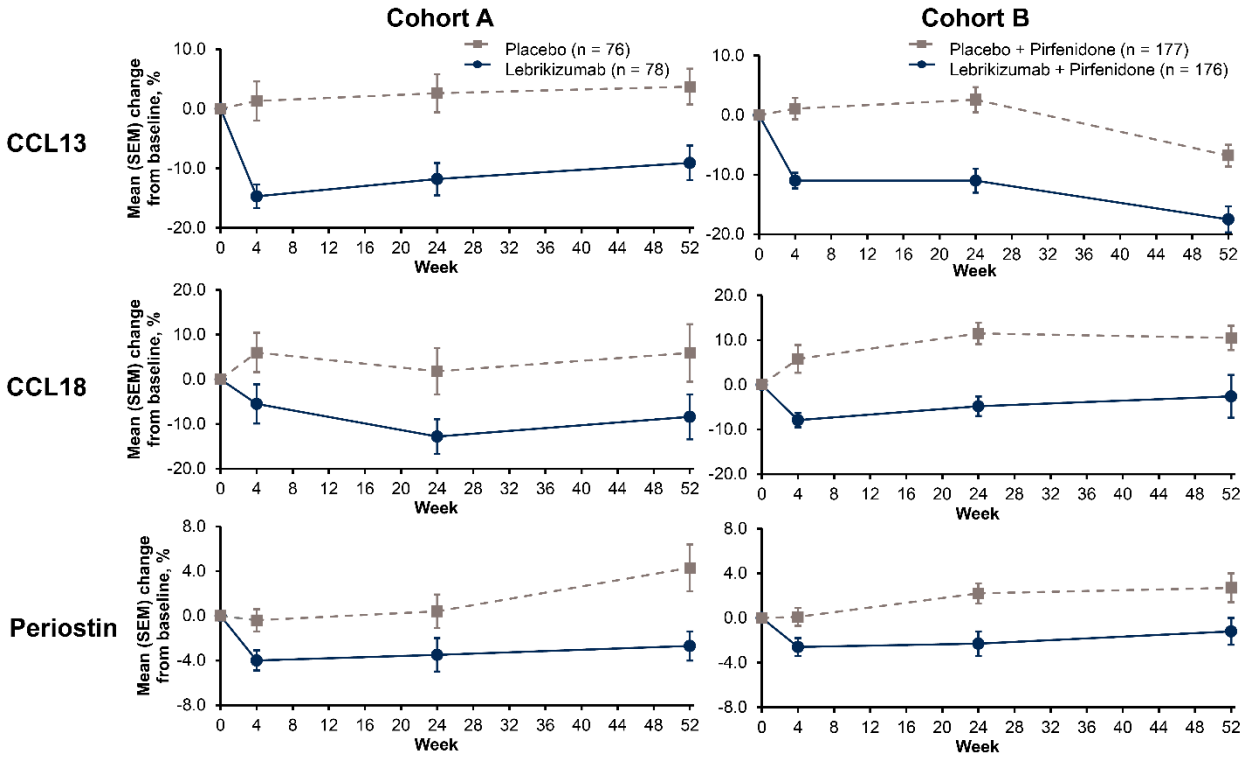
## Supplemental Figures

**SUPPLEMENTAL FIGURE S1.** Time from randomisation to first acute exacerbation or death in Cohort B



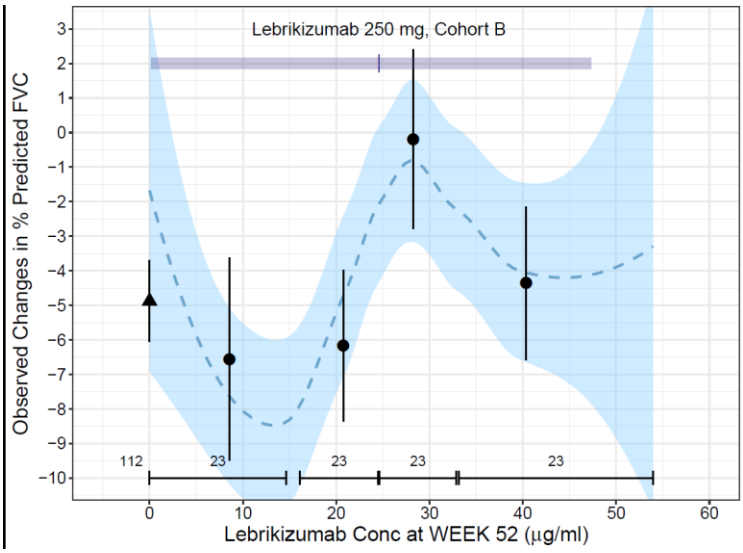

| No. of patients at risk | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lebrikizumab + pirfenidone | 172 | 170 | 168 | 159 | 152 | 144 | 125 |
| Placebo + pirfenidone | 175 | 174 | 170 | 159 | 148 | 140 | 113 |
| **Cumulative no. of events by visit** | | | | | | | |
| Lebrikizumab + pirfenidone | 0 | 0 | 3 | 6 | 9 | 12 | 12 (6.9%) |
| Placebo + pirfenidone | 0 | 2 | 7 | 12 | 16 | 17 | 19 (10.9%) |

**SUPPLEMENTAL FIGURE S2.** Pharmacodynamics of biomarkers for lebrikizumab target engagement




CCL: chemokine C-C motif ligand.

**SUPPLEMENTAL FIGURE S3.** Relationship between lebrikizumab exposure and FVC change at Week 52




FVC: forced vital capacity.

**Supplemental Tables**

**SUPPLEMENTAL TABLE S1.** Baseline 6MWD data

| Characteristic[#] | Cohort A | | | Cohort B | | |
|---|---|---|---|---|---|---|
| | **Lebrikizumab (n=78)** | **Placebo (n=76)** | **All patients (N=154)** | **Lebrikizumab + pirfenidone (n=174)** | **Placebo + pirfenidone (n=177)** | **All patients (N=351)** |
| 6MWD, m | 436.5 (150.0–926.0) | 455.5 (190.0–975.0) | 450.0(150.0–975.0) | 455 (156.0–996.3) | 510 (118.0–9900) | 480 (118.0–996.3) |
| Difference in Borg scale[+] | 1.5 (−2.0–9.5) | 2.0 (−1.0–10.0) | 2.0 (−2.0–10.0) | 2.0 (−2.7–9.5) | 2.0 (−2.5–9.5) | 2.0 (−2.7–9.5) |

6MWD, 6-minute walk distance.

[#] Values are median (range) unless otherwise noted. All values are from measurements at baseline visit (day of randomisation); eligibility was based on measurements at screening visit.

[¶] Results may not be reliable due to inconsistency with reporting and measurement between study sites.

[+] Baseline difference in Borg scale represents change in dyspnoea after the 6MWD test compared with before the test. The Borg scale range is 0–10.

**SUPPLEMENTAL TABLE S2.** Concomitant medications reported during the placebo-controlled period

| Patients reporting concomitant medication use, n (%)[#] | Cohort A | | | Cohort B | | |
|---|---|---|---|---|---|---|
| | Lebrikizumab (n=78) | Placebo (n=76) | All patients (n=154) | Lebrikizumab + pirfenidone (n=174) | Placebo + pirfenidone (n=177) | All patients (n=351) |
| ≥ 1 concomitant medication | 77 (98.7) | 76 (100.0) | 153 (99.4) | 174 (100.0) | 174 (98.3) | 348 (99.1) |
| Medication use by class[¶] | | | | | | |
| Proton pump inhibitors | 52 (66.7) | 44 (57.9) | 96 (62.3) | 125 (71.8) | 122 (68.9) | 247 (70.4) |
| Statins | 41 (52.6) | 35 (46.1) | 76 (49.4) | 86 (49.4) | 85 (48.0) | 171 (48.7) |
| Steroids | 27 (34.6) | 28 (36.8) | 55 (35.7) | 93 (53.4) | 98 (55.4) | 191 (54.4) |
| Salicylates | 36 (46.2) | 34 (44.7) | 70 (45.5) | 78 (44.8) | 88 (49.7) | 166 (47.3) |
| Antihistamines | 21 (26.9) | 20 (26.3) | 41 (26.6) | 59 (33.9) | 73 (41.2) | 132 (37.6) |
| Analgesics | 26 (33.3) | 28 (36.8) | 54 (35.1) | 50 (28.7) | 66 (37.3) | 116 (33.0) |
| Herbal, homeopathic and dietary supplements | 32 (41.0) | 24 (31.6) | 56 (36.4) | 51 (29.3) | 60 (33.9) | 111 (31.6) |
| Non-steroidal anti-inflammatory drugs | 26 (33.3) | 30 (39.5) | 56 (36.4) | 52 (29.9) | 54 (30.5) | 106 (30.2) |
| Cough preparations | 23 (29.5) | 15 (19.7) | 38 (24.7) | 48 (27.6) | 63 (35.6) | 111 (31.6) |
| Vaccines, toxoids and serologic agents | 25 (32.1) | 25 (32.9) | 50 (32.5) | 41 (23.6) | 52 (29.4) | 93 (26.5) |
| Macrolide antibiotics | 17 (21.8) | 15 (19.7) | 32 (20.8) | 50 (28.7) | 46 (26.0) | 96 (27.4) |
| β-adrenoceptor blocking agents | 23 (29.5) | 15 (19.7) | 38 (24.7) | 43 (24.7) | 47 (26.6) | 90 (25.6) |
| Bronchodilators and anti-asthmatic drugs | 13 (16.7) | 15 (19.7) | 28 (18.2) | 38 (21.8) | 56 (31.6) | 94 (26.8) |
| Angiotensin II receptor antagonists | 22 (28.2) | 19 (25.0) | 41 (26.6) | 37 (21.3) | 38 (21.5) | 75 (21.4) |
| Penicillins | 17 (21.8) | 10 (13.2) | 27 (17.5) | 27 (15.5) | 54 (30.5) | 81 (23.1) |
| Quinolone antibiotics | 17 (21.8) | 14 (18.4) | 31 (20.1) | 37 (21.3) | 32 (18.1) | 69 (19.7) |

[#] Concomitant medication use occurred at any time from first dose of study treatment through the end of the placebo-controlled period.

[¶] Concomitant medication classes reported in ≥ 20% of patients in either Cohort A or Cohort B are shown. When pirfenidone was excluded as a concomitant medication, < 1% and 2% of patients in Cohort A and Cohort B, respectively, received immunosuppressants. Medications were coded using Medical Dictionary for Regulatory Activities (MedDRA) version 20.1.

**SUPPLEMENTAL TABLE S3.** Baseline biomarker levels

| Biomarker[#] | Cohort A | | | Cohort B | | |
|---|---|---|---|---|---|---|
| | **Lebrikizumab (n=78)** | **Placebo (n=76)** | **All patients (N=154)** | **Lebrikizumab + pirfenidone (n=174)** | **Placebo + pirfenidone (n=177)** | **All patients (N=351)** |
| CCL13, pg/mL | 264.0 (215.2–324.7) | 270.9 (222.4–339.4) | 270.5 (219.8–333.9) | 302.0 (225.6, 381.7) | 295.2 (244.2–383.7) | 296.9 (229.3–382.1) |
| CCL18, ng/mL | 628.6 (399.7–873.8) | 659.9 (341.5–900.6) | 657.5 (360.5–882.3) | 269.8 (205.0–357.7) | 275.0 (217.5–374.6) | 273.5 (211.3–363.2) |
| Periostin, ng/mL | 64.4 (54.7–81.0) | 66.9 (57.2–80.7) | 65.6 (56.1–80.9) | 62.2 (54.9–74.1) | 64.8 (53.0–79.0) | 63.5 (53.4–75.4) |

CCL: chemokine C-C motif ligand.

[#] Values are median (interquartile range).

**SUPPLEMENTAL TABLE S4.** Summary of pharmacokinetics following lebrikizumab administration

| Cohort | Treatment | Summary | Mean (SD) | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Week 4 $C_{min,}$ µg/mL | Week 12 $C_{min,}$ µg/mL | Week 24 $C_{min,}$ µg/mL | Week 36 $C_{min,}$ µg/mL | Week 52 $C_{min,}$ µg/mL | $t_{1/2}$, days |
| A | Lebrikizumab 250 mg | N | 74 | 68 | 65 | 2 | 61 | 35 |
| | | Mean (SD) | 14.0 (4.86) | 24.4 (9.86) | 28.5 (12.5) | 29.6 (14.1) | 28.5 (14.0) | 23.5 (5.36) |
| B | Lebrikizumab 250 mg + pirfenidone | N | 170 | 165 | 153 | 146 | 137 | 125 |
| | | Mean (SD) | 14.9 (5.75 | 25.1 (11.0) | 25.7 (12.4) | 25.6(13.8) | 25.2(12.7 | 21.9 (4.79) |

$C_{min}$: observed minimum serum concentration; $t_{1/2}$: elimination half-life.

**SUPPLEMENTAL TABLE S5.** Treatment exposure

| | Cohort A | | | Cohort B | | |
|---|---|---|---|---|---|---|
| | **Lebrikizumab (n=78)** | **Placebo (n=76)** | **All patients (N=154)** | **Lebrikizumab + pirfenidone (n=174)** | **Placebo + pirfenidone (n=177)** | **All patients (N=351)** |
| **Lebrikizumab or placebo exposure during the placebo-controlled period** | | | | | | |
| Treatment duration, mean (SD), weeks | 44.7 (18.3) | 44.9 (18.0) | 44.8 (18.1) | 42.4 (13.1) | 41.3 (13.1) | 41.8 (13.1) |
| No. of doses, mean (SD) | 12.0 (4.5) | 12.1 (4.4) | 12.0 (4.5) | 11.4 (3.3) | 11.2 (3.3) | 11.3 (3.3) |
| **Lebrikizumab exposure period**[#] | | | | | | |
| | **Lebrikizumab to lebrikizumab (n=78)** | **Placebo to lebrikizumab (n=52)** | **All patients (N=130)** | | | |
| Treatment duration, mean (SD), weeks | 79.1 (38.6) | 39.3(15.0) | 63.2 (36.9) | – | – | – |
| No. of doses, mean (SD) | 20.5 (9.6) | 10.8 (3.8) | 16.6 (9.1) | – | – | – |
| **Pirfenidone exposure during the placebo-controlled period** | | | | | | |
| Treatment duration, mean (SD), weeks | – | – | – | 46.7 (12.7) | 44.9 (13.4) | 45.8 (13.1) |
| Daily dose, mean (SD), mg | – | – | – | 2088.6 (470.6) | 2053.4 (504.2) | 2070.9 (487.5) |

[#] The lebrikizumab exposure period included all adverse events reported from the first dose of study drug until the end of safety follow-up. This included patients who were randomised to receive lebrikizumab and all patients who received lebrikizumab during the open-label treatment period (including patients who were randomised to receive placebo).

**SUPPLEMENTAL TABLE S6.** Summary of AEs by preferred terms in ≥10% of patients in any treatment arm during the placebo-controlled period

| AE | Cohort A | | Cohort B | |
|---|---|---|---|---|
| | **Lebrikizumab (n=78)** | **Placebo (n=76)** | **Lebrikizumab + pirfenidone (n=174)** | **Placebo + pirfenidone (n=177)** |
| Cough | 17 (21.8) | 13 (17.1) | 28 (16.1) | 43 (24.3) |
| IPF | 15 (19.2) | 16 (21.1) | 24 (13.8) | 29 (16.4) |
| Dyspnoea | 12 (15.4) | 8 (10.5) | 13 (7.5) | 17 (9.6) |
| Fatigue | 11 (14.1) | 8 (10.5) | 26 (14.9) | 19 (10.7) |
| Nasopharyngitis | 11 (14.1) | 15 (19.7) | 29 (16.7) | 24 (13.6) |
| Upper respiratory tract infection | 11 (14.1) | 10 (13.2) | 29 (16.7) | 36 (20.3) |
| Bronchitis | 10 (12.8) | 7 (9.2) | 17 (9.8) | 11 (6.2) |
| Diarrhoea | 8 (10.3) | 10 (13.2) | 17 (9.8) | 19 (10.7) |
| Dizziness | 8 (10.3) | 9 (11.8) | 7 (4.0) | 11 (6.2) |
| Headache | 7 (9.0) | 9 (11.8) | 10 (5.7) | 15 (8.5) |
| Arthralgia | 5 (6.4) | 8 (10.5) | 10 (5.7) | 7 (4.0) |
| Nausea | 7 (9.0) | 4 (5.3) | 22 (12.6) | 18 (10.2) |
| Vascular disorders | 4 (5.1) | 7 (9.2) | 19 (10.9) | 13 (7.3) |
| Photosensitivity reaction | 2 (2.6) | 1 (1.3) | 6 (3.4) | 22 (12.4) |
| Rash | 6 (7.7) | 4 (5.3) | 16 (9.2) | 20 (11.3) |
| Decreased appetite | 3 (3.8) | 3 (3.9) | 15 (8.6) | 18 (10.2) |
| | | | | |

AE: adverse event; IPF: idiopathic pulmonary fibrosis.

**SUPPLEMENTAL TABLE S7.** Summary of AEs by preferred terms in ≥10% of patients in either arm of Cohort A during the lebrikizumab exposure period[#]

| AE | Lebrikizumab (N=130) |
|---|---|
| Any | 126 (96.9) |
| IPF | 31 (23.8) |
| Cough | 28 (21.5) |
| Nasopharyngitis | 27 (20.8) |
| Diarrhoea | 24 (18.5) |
| Bronchitis | 22 (16.9) |
| Upper respiratory tract infection | 21 (16.2) |
| Dyspnoea | 20 (15.4) |
| Fatigue | 19 (14.6) |
| Constipation | 17 (13.1) |
| Dizziness | 17 (13.1) |
| Back pain | 15 (11.5) |
| Nausea | 15 (11.5) |
| Urinary tract infection | 15 (11.5) |
| Lower respiratory tract infection | 14 (10.8) |

AE: adverse event; IPF: idiopathic pulmonary fibrosis.

[#] The lebrikizumab exposure period included all adverse events reported from the first dose of study drug until the end of safety follow-up. This included patients who were randomised to receive lebrikizumab and all patients who received lebrikizumab during the open-label treatment period (including patients who were randomised to receive placebo).

**SUPPLEMENTAL TABLE S8.** Summary of causes of death

| Deaths, n (%) | Cohort A | | | Cohort B | | |
|---|---|---|---|---|---|---|
| | **Lebrikizumab** | **Placebo** | **All patients** | **Lebrikizumab + pirfenidone** | **Placebo + pirfenidone** | **All patients** |
| Total, at any time | 15 | 4 | 19 | 11 | 18 | 29 |
| Placebo-controlled period | **(n=78)** | **(n=76)** | **(N=154)** | **(n=174)** | **(n=177)** | **(N=351)** |
| All causes[#] | 3 (3.8) | 3 (3.9) | 6 (3.9) | 9 (5.2) | 13 (7.3) | 22 (6.3) |
| IPF | 2 | 1 | 3 | 5 | 8[¶] | 13 |
| Pneumonia | 0 | 0 | 0 | 1 | 1 | 2 |
| Pulmonary embolism | 1[¶] | 0 | 1 | 0 | 0 | 0 |
| Acute respiratory failure | 0 | 1 | 1 | 0 | 1 | 1 |
| Sudden death | 0 | 1 | 1 | 0 | 0 | 0 |
| Graft vs. host disease | 0 | 0 | 0 | 1 | 0 | 1 |
| Septic shock | 0 | 0 | 0 | 1 | 0 | 1 |
| Cardiovascular accident | 0 | 0 | 0 | 1 | 0 | 1 |
| Dyspnoea | 0 | 0 | 0 | 0 | 1 | 1 |
| Pulmonary fibrosis | 0 | 0 | 0 | 0 | 1 | 1 |
| Respiratory failure | 0 | 0 | 0 | 0 | 1 | 1 |
| Lebrikizumab exposure period[+] | **(N=130)** | | | | | |
| All causes, at any time | 15 (11.5) | – | – | – | – | – |
| During placebo-controlled period (above) | 3[§] | – | – | – | – | – |
| During open-label lebrikizumab | 9 | – | 9 | – | – | – |
| IPF | 4 | – | 4 | – | – | – |
| IPF and hypoxia | 1 | – | 1 | – | – | – |
| Acute myocardial infarction | 1 | – | 1 | – | – | – |

| | | | | | | |
|---|---|---|---|---|---|---|
| Malignant lung neoplasm | 1 | – | 1 | – | – | – |
| Lower respiratory tract infection | 1 | – | 1 | – | – | – |
| Acute respiratory failure | 1[¶] | – | 1[¶] | – | – | – |
| During safety follow-up (below) | 3[§] | – | – | – | – | – |
| Safety follow-up | | | | | | |
| All causes | 3[f] | 1 | 4 | 2 | 5 | 7 |
| IPF | 2 | 1[¶] | 3 | 0 | 4 | 4 |
| Pleural effusion | 1 | 0 | 1 | 0 | 1 | 1 |
| Cardiac failure | 0 | 0 | 0 | 2 | 0 | 2 |

[#] Including deaths that occurred ≤30 days after last dose of lebrikizumab; this count does not match the count of deaths for the efficacy analysis, which excluded deaths after lung transplant or after the 52-week placebo-controlled period.

[¶] Included 1 death that was assessed by the investigator to be treatment related.

[+] The lebrikizumab exposure period included all AEs reported from the first dose of study drug until the end of safety follow-up. This included patients who were randomised to receive lebrikizumab and all patients who received lebrikizumab during the open-label treatment period (including patients who were randomised to receive placebo).

[§] Of 15 deaths that occurred during the lebrikizumab exposure period, 3 were also counted during the placebo-controlled period (lebrikizumab arm) and 3 were also counted during safety follow-up.

[f] Included 2 patients in safety follow-up after double-blind lebrikizumab treatment and 1 after open-label lebrikizumab treatment after having received placebo.

**SUPPLEMENTAL TABLE S9.** List of investigators and ethics review approvals for each study site by country

| Country | Investigator | Institutional review board/independent ethics committee name and address (if available) | Approval date |
|---|---|---|---|
| Australia | A. Glanville | SSWAHS Ethics Review Committee (RPAH Zone), c/- Research Development Office Level 3, Building 92, Missenden Road, 2050, Camperdown, NSW, Australia | 08 Sep 2015 |
| Australia | I. Glaspole | The Alfred Hospital Research Ethics Committee, The Alfred Hospital, 55 Commercial Road, 3004, Melbourne, VIC, Australia | 17 Feb 2014 |
| Australia | M. Phillips | Bellberry Human Research Ethics Committee, Bellberry Limited, 229 Greenhill Road, 5065, Dulwich, SA, Australia | 16 Oct 2013 |
| Australia | F. Thien | Northern Sydney Local Health District Human Research Ethics Committee, Level 13, Kolling Building, 2065, St. Leonards, NSW, Australia | 28 Mar 2014 |
| Australia | L. Troy | SSWAHS Ethics Review Committee (RPAH Zone), c/- Research Development Office Level 3, Building 92, Missenden Road, 2050, Camperdown, NSW, Australia | 10 Apr 2014 |
| Belgium | B. Bondue | Central EC, Commissie Medische Ethiek UZ KU Leuven, Campus Gasthuisberg E330 Herestraat 49, 3000 Leuven | 28 Apr 2014 |
| Belgium | C. Dahlqvist | Central EC, Commissie Medische Ethiek UZ KU Leuven, Campus Gasthuisberg E330 Herestraat 49, 3000 Leuven | 28 Apr 2014 |
| Belgium | T. Pieters | Central EC, Commissie Medische Ethiek UZ KU Leuven, Campus Gasthuisberg E330 Herestraat 49, 3000 Leuven | 28 Apr 2014 |
| Belgium | W. Wuyts | Central EC, Commissie Medische Ethiek UZ KU Leuven, Campus Gasthuisberg E330 Herestraat 49, 3000 Leuven | 28 Apr 2014 |
| Canada | N. Khalil | University of British Columbia Office of Research Services, 102-6190 Agronomy Road, Vancouver, BC Canada V6T 1Z3 | 25 Nov 2013 |
| Canada | M. Mura | Western University Research Support Services Bldg., Rm. 5150, London, ON, Canada N6G 1G9 | 1 Nov 2013 |
| Canada | S. Provencher | Institut Universitaire de Cardiologie et de Pneumologie de Quebec 2725 chemin Sainte-Foy, Local 2614, QC, Canada G1V 4G5 | 28 Jan 2014 |
| France | B. Crestani | CPP Ile de France I, Hotel Dieu, 1 Place du Parvis de Notre-Dame, 75181, Paris, France | 17 Sep 2013 |
| France | S. Jouneau | CPP Ile de France I, Hotel Dieu, 1 Place du Parvis de Notre-Dame, 75181, Paris, France | 17 Sep 2013 |
| France | H. Nunes | CPP Ile de France I, Hotel Dieu, 1 Place du Parvis de Notre-Dame, 75181, Paris, France | 17 Sep 2013 |
| France | B. Wallaert | CPP Ile de France I, Hotel Dieu, 1 Place du Parvis de Notre-Dame, 75181, Paris, France | 17 Sep 2013 |
| Germany | J. Behr | EK Essen Ethik-Kommission der Medizinischen Fakultät der Universität Duisburg-Essen, Robert-Koch-Str. 9-11, 45147 Essen, Germany | 4 Nov 2013 |
| Germany | U. Costabel | EK Essen Ethik-Kommission der Medizinischen Fakultät der Universität Duisburg-Essen, Robert-Koch-Str. 9-11, 45147 Essen, Germany | 4 Nov 2013 |
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**SUPPLEMENTAL TABLE S10.** Patients receiving antifibrotics as rescue therapy in Cohort A during the placebo-controlled period

| Patients Receiving Antifibrotic Therapy, n (%) | Cohort A | | |
|---|---|---|---|
| | Lebrikizumab (n=78) | Placebo (n=76) | All patients (N=154) |
| Pirfenidone | 13 (16.7) | 8 (10.5) | 21 (13.6) |
| Nintedanib | 1 (1.3) | 3 (3.9) | 4 (2.6) |