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Deciphera Pharmaceuticals, LLC

STATISTICAL ANALYSIS PLAN
Protocol DCC-2618-03-002 (INTRIGUE)

A Phase 3, Interventional, Randomized, Multicenter, Open--label Study of DCC-2618 vs Sunitinib in Patients with Advanced Gastrointestinal Stromal Tumors after Treatment with Imatinib

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ACRONYMS

Below is the list of acronyms that will be used throughout this document.

Abbreviation	Definition
AE	Adverse Event
AP	All Patients
ATC-3	Anatomical Therapeutic Chemical 3rd level
ATC-4	Anatomical Therapeutic Chemical 4rd level
BOR	Best Overall Response
CI	Confidence Interval
CR	Complete Response
CSR	Clinical Study Report
CTCAE	Common Terminology Criteria for Adverse Events
DCR	Disease Control Rate
DLQI	Dermatology Life Quality Index
DOR	Duration of Response
ECOG	Eastern Cooperative Oncology Group
eCRF	Electronic Case Report Form
EDC	Electronic Data Capture
EORTC-QLQ-C30	European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire for Cancer 30 Item
EOT	End of Treatment
EQ-5D-5L	EuroQol 5 Dimension 5 Level
EQ-VAS	EuroQol Visual Analogue Scale
Ex11	KIT Exon 11
FACT-G	Functional Assessment of Cancer Therapy - General
GIST	Gastrointestinal Stromal Tumor
HR	Hazard Ratio
ICH	International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use
IDMC	Independent Data Monitoring Committee
INV	Investigator assessment
IRR	Independent Radiologic Review
IRT	Interactive Response Technology
ITT	Intent to Treat
KM	Kaplan-Meier
MAF	Mutation Allele Frequency
MedDRA	Medical Dictionary for Regulatory Activities
mPFS	Median Progression-Free Survival
mRECIST	Modified Response Evaluation Criteria in Solid Tumors

Abbreviation	Definition
NCI	National Cancer Institute
ORR	Objective Response Rate
OS	Overall Survival
PD	Progressive Disease
PFS	Progression-free Survival
PFS2	Progression-Free Survival on the Next Line of Therapy
PK	Pharmacokinetics
PP	Per Protocol
PR	Partial Response
PT	Preferred Term
QD	Once Daily
QOL	Quality of Life
SAP	Statistical Analysis Plan
SOC	System Organ Class
TEAE	Treatment Emergent Adverse Event
TKI	Tyrosine Kinase Inhibitor
TTP	Time to Progression
TTR	Time to Response
VAS	Visual Analogue Scale
WHO	World Health Organization

1. INTRODUCTION

This Statistical Analysis Plan (SAP) describes the detailed methodology for summary and statistical analyses of data from clinical protocol DCC-2618-03-002 (INTRIGUE) based on Amendment 6 of the study protocol, dated 23 October 2020. This document may modify the plans outlined in the protocol and supersedes the previous versions of the SAP and the statistical sections of the protocol.

Populations for analysis, statistical methods, data handling rules, and formats for data presentation are described within this document. The statistical analyses and summary tabulations described in this SAP will provide the basis for the results sections of the Clinical Study Report (CSR) for this trial. Analysis plan of population pharmacokinetics (PK) and exposure-response analysis, pharmacodynamics data, and quality-of-life (QOL) data collected for exploratory objectives will be separately documented.

Any changes to the data analysis methods after the SAP is finalized will be described in the CSR.

2. OVERALL STUDY DESIGN AND OBJECTIVES

2.1. Study Objectives

2.1.1. Primary Objective

To assess the efficacy (progression-free survival [PFS]) of DCC-2618 (ripretinib) by independent radiologic review (IRR) in patients with advanced gastrointestinal stromal tumors (GIST) who have previously received first-line therapy with imatinib

2.1.2. Key Secondary Objectives

- To assess objective response rate (ORR) by independent radiologic review using modified RECIST (mRECIST) criteria
- To assess Overall Survival (OS)

2.1.3. Other Secondary Objectives

- To assess the quality-of-life (QOL) during treatment as measured by:
  - EORTC QLQ-C30
  - Dermatology Life Quality Index (DLQI)
  - GP5 question from the FACT-G (burden of side-effects)
  - EuroQol Visual Analogue Scale (EQ-VAS)
- To assess Time to Tumor Progression (TTP) by independent radiologic review
- To assess efficacy parameters including, disease control rate (DCR), PFS based on Investigator assessment, duration of response (DOR) and time to response (TTR)
- To assess efficacy based on Choi criteria by independent radiologic review

- To assess the PK/PD relationship of ripretinib
- To compare the safety profile of ripretinib to the safety profile of sunitinib

2.1.4. Exploratory Objectives

- To assess QOL during treatment as measured by:
  - Memory and concentration items from the PRO-CTCAE library
  - EQ-5D-5L
- To assess PFS on next line therapy (PFS2) based on local assessments
- To evaluate potential biomarkers in blood or tumor tissue which might predict response to ripretinib
  - To understand potential resistance mechanisms to ripretinib in GIST
  - To characterize KIT and PDGFRA mutations at baseline and ripretinib-driven longitudinal mutant allele frequency changes in plasma.
- To assess healthcare utilization

2.2. Study Design and Study Procedures

2.2.1. Study Design

This is a 2-arm, randomized, open-label, international, multicenter study comparing the efficacy of ripretinib to sunitinib in GIST patients who progressed on or were intolerant to first-line anticancer treatment with imatinib.

Approximately 426 patients will be randomized in a 1:1 ratio to ripretinib 150 mg once daily (QD) or sunitinib 50 mg QD, 4 weeks on, 2 weeks off (6 weeks cycle). [redacted] Randomization will be stratified by:

- Mutational Status: KIT exon 9 mutation; KIT exon 11 mutation; KIT/PDGFRA WT; or other KIT (absence of exon 9 or 11)/PDGFRA mutations
  Note: if a patient has a KIT exon 11 mutation, along with mutation(s)
  - in KIT exon 9 and/or PDGFRA, the patient will be randomized as having a KIT exon 11 mutation, unless the mutation allele frequency (MAF) data is available then the mutation with the higher MAF will be used to categorize the patient for the purposes of randomization;
  - in KIT other exon, the patient will be randomized as having a KIT exon 11 mutation.
- Intolerance to imatinib (Yes or No)

The primary endpoint for the study will be evaluated using the mRECIST Version 1.1 – GIST specific based on IRR.

Upon disease progression by mRECIST based on IRR, patients will discontinue their assigned treatment.

2.2.2. Treatments and Assignment to Treatments

Approximately 426 patients (213 randomized to ripretinib and 213 randomized to sunitinib) will be randomized in this study at approximately 125 centers globally. Patients will be randomized to receive 150 mg QD of ripretinib or 50 mg of sunitinib in repeated 42-day cycles. Ripretinib will be given continuously and sunitinib will be given continuously for 4 weeks with a 2 week break. Sunitinib dose modifications are allowed per approved package insert or institutional guidelines.

Patients will be treated until they develop progressive disease based on IRR as per mRECIST, experience unacceptable toxicity, or withdraw consent. If the Investigator wishes to end treatment due to local progression based on mRECIST, without confirmation of progression by IRR, or before the independent read results are available, the Investigator must reach out to the Sponsor Medical Monitor to discuss.

Patients will be eligible to receive study drug for up to 2 years. This will be extended by agreement between the Sponsor and Investigator for patients who exhibit evidence of clinical benefit and tolerability to the drug, and who adhere to the study procedures. The study will end following the last patient last visit.

2.3. Determination of Sample Size

The sample size selection of 426 patients (n=213 ripretinib, n=213 sunitinib) was based on considerations for powering of the primary endpoint, secondary endpoints, detection of rare safety events and overall exposure to ripretinib. Patients will be randomized in a 1:1 ratio of ripretinib versus sunitinib.

Under the assumptions that median progression-free survival (mPFS) is 9 months for ripretinib and 6 months for sunitinib, the HR is about 0.667 for All Patients (AP) PFS (ripretinib vs sunitinib). A total of 262 events will be required to achieve a statistical power of 90% to test the hypothesis of no difference between ripretinib and sunitinib in AP. Accrual of 426 patients (213 in ripretinib and 213 in sunitinib) within 21 months is expected to have 262 PFS events occurred after additional 8 months of follow up. This has accounted for 20% of dropout rate (discontinuation without progressive disease per IRR or death).

It is further assumed that the mPFS is 9 months for patients with a KIT Exon 11 primary mutation (Ex11) in ripretinib and 5 months for KIT Ex11 in sunitinib, the HR is 0.556 for the KIT Exon11 PFS. A minimum of 151 PFS events in KIT Ex11 population have at least 95% power to test the hypothesis of no difference between ripretinib and sunitinib in KIT Ex11 population.

No interim analysis is planned for PFS based on IRR. The final analysis of PFS based on IRR will be performed in the Ex11 ITT population and in the AP ITT population (as defined in Section 4) using the same data cutoff, following the hierarchical testing sequence specified in Section 8.5. This final analysis is planned to occur when at least 151 PFS events in Ex11 ITT population and approximately 262 PFS events in AP ITT population have occurred. The analysis of PFS in Ex11 ITT population and AP ITT population will be based on the actual number of events observed in Ex11 ITT population and AP ITT population, respectively, at the time of final analysis of PFS.

At the time of final analysis of PFS by IRR, ORR by IRR and OS in Ex11 ITT and AP ITT will be tested hierarchically as specified in Section 8.5. If all the testing preceding OS are statistically significant, OS in Ex11 ITT will be tested at 2-sided 0.05 significance level; if OS in Ex11 ITT is statistically significant, OS in AP ITT will be tested at 2-sided 0.05 significance level.

Assuming median OS is 40 months for sunitinib arm and 53.3 months for ripretinib arm (HR=0.75), 145 events in the Ex11 ITT population will have 40% power to detect the difference in OS between the two arms in the Ex11 ITT population with 2-sided significance level 0.05, and 200 events in the AP ITT population will have 52% power to detect the difference in OS between the two arms in the AP ITT population with 2-sided significance level 0.05.

There are two interim analyses (IA) of OS planned, both for early stopping for efficacy only, in each of the Ex11 ITT population and in the AP ITT population, respectively. The first IA for OS in each of the two populations will be performed at the same time as the final analysis for PFS based on IRR in the population. The second IA for OS will be performed with the data cutoff date approximately one year after the first IA. The final analysis of OS will be performed using the same data cutoff in both populations when at least 145 OS events in the Ex11 ITT population and approximately 200 OS events in the AP ITT population are observed. The overall two-sided nominal significance level for the efficacy analysis of OS will be preserved at 0.05. Formal efficacy boundary will be determined based on Lan-DeMets (O'Brien-Fleming) alpha spending function. Table 1 summarizes the operating characteristics and efficacy boundaries for the OS analyses based on projected number of OS events. The final analysis of OS in Ex11 ITT population and AP ITT population will be based on the actual number of events observed in Ex11 ITT population and AP ITT population, respectively, at the time of final analysis of OS. The exact boundary at each analysis will be calculated on the actual number of events at the time of data cutoff.

Table 1: Planned Stopping Boundaries for Overall Survival at Interim Analyses and Final Analysis

Analysis Population	Analysis	Number of Events (Info. Fraction)	Cumulative Alpha Spent	Efficacy Boundary p-value
Ex 11 ITT	First IA	63 (44%)	0.001	0.001
	Second IA	122 (84%)	0.029	0.029
	FA	145 (100%)	0.05	0.041
AP ITT	First IA	88 (44%)	0.001	0.001
	Second IA	169 (85%)	0.030	0.029
	FA	200 (100%)	0.05	0.041

Abbreviations: IA=interim analysis; FA=final analysis; ITT=intent-to-treat
The cumulative alpha spent and boundaries were calculated using software nQuery (version 8.7).

3. GENERAL ANALYSIS CONVENTIONS

3.1. Study Periods

The study will include screening, treatment, safety follow up (30 days post last dose of study treatment), and overall survival follow-up periods.

3.2. Study Visits

All study assessments will be performed according to the schedule of assessments in the protocol. In general, for by-visit summaries, data recorded at nominal visits will be presented. Unscheduled visits will be mapped to a scheduled visit if possible, using a window based on all the available actual visit dates for the scheduled visits.

3.3. Study Day

Reference start date will be defined as Cycle 1 Day 1. Study Day will be calculated from the reference start date and used to show start/stop day of the assessments and events as follows,

- For assessments/events on/after the reference start date, Study Day=(date of assessment/event – reference start date) +1
- For assessments/events before the reference start date, Study Day=(date of assessment/event – reference start date)

3.4. Baseline

Unless specified otherwise, baseline measurements will be the most recent (i.e., last non-missing) value prior to receiving the first dose of study medication.

3.5. Coding Dictionaries

Medical history and adverse events (AEs) will be coded using Medical Dictionary for Regulatory Activities (MedDRA), Version 24.0 or higher.

Prior and concomitant medications and procedures will be coded using the World Health Organization (WHO) Drug Dictionary (MAR 2021 or higher).

Clinical laboratory parameters will be graded for toxicity as defined by the National Cancer Institute Common Terminology Criteria for Adverse Events (NCI-CTCAE), Version 5.0.

3.6. General Analysis Conventions

Continuous data will be summarized using descriptive statistics (number of patients with assessment, mean, median, standard deviation, minimum, and maximum). Categorical data will be summarized using frequencies and proportions. Time-to-event data will be reported in months, and summarized via Kaplan-Meier (KM) methodology using the 25th, 50th (median), and 75th percentiles with associated 2-sided 95% confidence intervals (CIs), and time point survival probabilities with associated 2-sided 95% CIs.

4. ANALYSIS POPULATIONS

4.1. Intent to Treat Population

The KIT Exon 11 ITT (Ex11 ITT) Population is defined as all randomized patients who are designated as having a mutation in KIT Exon 11 per IRT. Patients in this population will be analyzed according to the treatment which they were scheduled to receive.

The all patients (AP) ITT Population is defined as all patients who are randomized. Patients in this population will be analyzed according to the treatment which they were scheduled to receive.

4.2. Safety Population

The Safety Population is defined as all patients who are randomized and receive at least one dose of study drug.

The KIT Exon 11 Safety (Ex11 Safety) Population is defined as all patients in the Safety population who are designated as having a mutation in KIT Exon 11 per IRT.

Safety Population and Ex11 Safety Population will be used for safety analyses and treatment assignment will be based on the actual study treatment initially received.

4.3. PK Population

The PK Population will include all randomized patients who received at least 1 dose of ripretinib and had at least 1 non-missing PK concentration in plasma reported for ripretinib or DP-5439.

4.4. Per Protocol Population

The KIT Exon 11 Per Protocol (Ex11 PP) Population is defined as all patients in the Ex11 ITT population who did not have any important protocol deviations which may affect efficacy analysis.

The All Patients Per Protocol (AP PP) population is defined as all patients in AP ITT population who did not have any important protocol deviations which may affect efficacy analysis.

The efficacy analysis based on the Ex11 PP and AP PP population will be supportive and treatment groups will be based on actual treatment received. Important protocol deviations and whether they affect efficacy will be identified and pre-specified in a separate document prior to final analysis of PFS based on IRR.

5. PATIENT DISPOSITION

Patient disposition will be summarized overall and by treatment arm. The number and proportion of patients will be displayed for each population (i.e., Ex11 ITT, AP ITT, Safety, Ex11 Safety, PK, Ex11 PP, and AP PP). The number and proportion of patients in the Safety Population and Ex11 Safety Population who have discontinued from treatment will be summarized by the primary reason for treatment discontinuation. The number and proportion of patients in the Ex11 ITT population and AP ITT population who have discontinued from the study will be summarized by the reason for study discontinuation as well.

6. PROTOCOL DEVIATIONS

A protocol deviation is any change, divergence, or departure from the study design or procedures defined in the clinical protocol. Protocol deviations will be classified by medical review prior to database snapshot for the primary analysis and important protocol deviations will be identified.

An important protocol deviation is a deviation that may significantly impact the completeness, accuracy, and/or reliability of the trial data; that may significantly affect a subject's rights, safety, or well-being. All important deviations related to trial inclusion or exclusion criteria, conduct of the trial, patient management or patient assessment will be summarized and described in the CSR.

7. DEMOGRAPHIC AND BASELINE CHARACTERISTICS

7.1. Demographic Characteristics

Demographic and baseline characteristics at study entry will be summarized in the Ex11 ITT, AP ITT, Safety population, and Ex11 Safety population.

Demographic and baseline variables to be summarized are:

- Continuous variables
  - Age (years) at time of consent
  - Height (cm)
  - Weight (kg)
  - BMI (kg/m^2)
- Categorical variables
  - Age Category at time of consent
    - 18 – 64 years
    - 65 – 74 years
    - 75 years or older
  - Gender
    - Female
    - Male
  - Race
    - Black or African American
    - American Indian or Alaska Native
    - Asian
    - Native Hawaiian or Other Pacific Islander
    - White
    - Not Reported
    - Other
  - Race Category
    - White
    - Non-white
    - Not Reported
  - Ethnicity

    - Not Hispanic or Latino
    - Hispanic or Latino
    - Not Reported
    - Unknown
- Region
    - North America
    - South America
    - Europe
    - Asia-Pacific
- ECOG Score at Screening
    - 0
    - 1
    - 2
- Mutation Type per EDC
    - KIT exon 9
    - KIT exon 11
    - KIT/PDGFRA WT
    - other KIT {absence of exon 9 or 11}/PDGFRA
- Intolerance to Imatinib per EDC
    - Yes
    - No
- Mutation Type per IRT
    - KIT exon 9
    - KIT exon 11
    - KIT/PDGFRA WT
    - other KIT {absence of exon 9 or 11}/PDGFRA
- Intolerance to Imatinib per IRT
    - Yes
    - No

7.2. Medical History

The number and percentage of patients with each medical history condition will be summarized for the Safety Population and Ex11 Safety Population by System Organ Class (SOC) and Preferred Term (PT) as coded using MedDRA in the Ex11 ITT, AP ITT, Safety Population, and Ex11 Safety Population.

7.3. Cancer History and Prior Cancer Therapy

Time since the initial diagnosis in years (calculated from initial diagnosis to the date of randomization), stage, site of primary tumor, histology of primary tumor, and baseline tumor burden by IRR and by INV, respectively, as measured by number of target lesions and sum of

longest diameters of the target lesions at baseline will be summarized for the Ex11 ITT, AP ITT, , Safety Population, and Ex11 Safety Population.

For prior imatinib therapies for GIST, the following data will be summarized overall and by treatment arm: number of patients who were treated with prior imatinib therapy, number of patients treated in a given clinical setting among any prior imatinib regimens, clinical setting of the most recent imatinib therapy (neoadjuvant, adjuvant, locally advanced, metastatic, unknown), best overall response to the most recent imatinib therapy, reason for discontinuation from the most recent imatinib therapy, time since the start of the first imatinib therapy, and time from the end date of the most recent imatinib therapy.

Prior surgery and radiation therapies for GIST will be summarized overall and by treatment arm.

Cancer history of GIST, prior imatinib therapies, prior surgeries for GIST, and prior radiation therapies for GIST will be summarized in the Ex11 ITT, AP ITT, Safety Population, and Ex11 Safety Population.

8. EFFICACY ANALYSIS

8.1. Primary Endpoint

8.1.1. Primary Analysis

The primary endpoint of PFS based on IRR is defined as the time interval between the date of randomization and the earliest documented evidence of the first disease progression based on IRR or death due to any cause, whichever occurs first.

Special rules of defining an event or censoring PFS are as follows:

- For patients who do not have adequate tumor assessment at baseline (adequate baseline is defined as having baseline assessment ≤31 days before the date of first dose or date of randomization if the patient did not receive study treatment) or do not have any adequate post-baseline assessments (defined as non-missing and evalulable assessment), PFS will be censored at randomization date (PFS=1 day) unless they die ≤14 weeks from the date of randomization, they will be considered to have a PFS event at death date.
- For patients who received a new anticancer therapy (including surgical resection on GIST lesions, radiotherapy of GIST lesions, or an anticancer treatment other than the study treatment) before event, PFS will be censored at the date of the latest evaluable progression-free tumor assessment prior to the start of new anticancer therapy. If date of progression occurs on the same date of as the start of new anti-cancer therapy, the progression will be counted as an event.
- For patients who did not have disease progression and did not die, PFS will be censored at the time of the latest date of evaluable progression-free tumor assessment.
- For patients who have first disease progression or die after two or more consecutive missed/non-evaluable assessments since the last evaluable tumor assessment, PFS will be censored at the time of the last evaluable progression-free tumor assessment.

PFS (months) = [(date of event or censoring – date of randomization) +1]/30.4375

The primary endpoint PFS will be analyzed in both Ex11 ITT Population and AP ITT Population.

Analysis for PFS in Ex11 ITT population will be stratified by intolerance to imatinib per IRT [yes vs. no]. Analysis for PFS in AP ITT population will be stratified by the randomization stratification factors per IRT (mutation status [KIT exon 9 vs. KIT exon 11 vs. KIT/PDGFRA WT vs. other KIT {absence of exon 9 or 11}/PDGFRA] and intolerance to imatinib [yes vs. no]).

The p-value from a 2-sided stratified log-rank test at 0.05 significance level will be used for evaluation of treatment difference. Point estimate of hazard ratio will be obtained from a Cox proportional-hazards regression model stratified by randomization stratification factors per IRT and the associated 95% CI will be obtained using Wald method. PFS time will be summarized via Kaplan-Meier (KM) methodology using the percentiles (25^{th}, 50^{th} [median], and 75^{th}), survival probabilities at pre-specified timepoints with associated 2-sided 95% confidence intervals, and KM plot of the estimated survival functions.

8.1.2. Supportive and Sensitivity Analyses

Supportive analysis of the primary endpoint PFS based on IRR in the PP populations and the sensitivity analyses of PFS will be performed in an analogous fashion as the primary analysis.

Supportive analysis of the primary endpoint PFS in the PP populations will include the following:

- PFS based on IRR using mRECIST criteria in Ex11 PP population
- PFS based on IRR using mRECIST in AP PP population

Sensitivity analyses will include the following:

- PFS based on IRR using mRECIST criteria stratified by intolerance to imatinib treatment per EDC in Ex11 ITT population based on mutation status per EDC (note: this analysis is performed only in the case that the mutations status per EDC and intolerance to Imatinib per EDC are not consistent with the randomization stratification factors per IRT)
- PFS based on IRR using mRECIST criteria stratified by mutation status per EDC and intolerance to imatinib treatment per EDC in AP ITT population (note: this analysis is performed only in the case that the mutations status per EDC and intolerance to Imatinib per EDC are not consistent with the randomization stratification factors per IRT)

8.2. Analysis of Key Secondary Efficacy Endpoints

The key secondary efficacy endpoints will be analyzed for Ex11 ITT and AP ITT populations.

8.2.1. Objective Response Rate

Best overall response (BOR) will be assessed based on reported overall tumor responses at different evaluation timepoints from the date of randomization until the first documentation of

disease progression, death, surgical resection on GIST lesions or radiotherapy of GIST lesions, or start of new anticancer therapy, whichever occurs first.

BOR Based on Confirmed Responses:

- Confirmed Complete Response (CR): at least two determinations of CR at least 4 weeks apart (allowing a minus 3-day window) and before first documentation of disease progression
- Confirmed Partial Response (PR): at least two determinations of PR or better (PR followed by PR or PR followed by CR) at least 4 weeks apart (allowing a minus 3-day window) and before first documentation of disease progression (and not qualifying for a CR)
- Stable Disease (SD): at least one SD assessment (or better) ≥ 6 weeks (allowing a minus 3-day window) after the date of randomization and before first documentation of PD (and not qualifying for confirmed CR or confirmed PR).
  - Non-CR/non-PD per IRR review will be reported together as SD (applicable only to patients without target lesions at baseline per IRR): at least one non-CR/non-PD assessment (or better) ≥ 6 weeks (allowing a minus 3-day window) after the date of randomization and before first documentation of PD (and not qualifying for confirmed CR or confirmed PR).
- Progressive Disease (PD): first documentation of PD ≤ 14 weeks after the date of randomization (and not qualifying for confirmed CR, confirmed PR, or SD).
- Not evaluable (NE): all other cases.
  - Undefined per IRR review will be reported together as NE (applicable only to patients with neither target lesions nor non-target lesions at baseline per IRR)

Objective response is defined as BOR of either a confirmed CR or a confirmed PR. ORR is defined as the proportion of patients with a confirmed CR or a confirmed PR as the BOR. Patients with non-evaluable or missing response will be treated as non-responders and will be included in the denominator during calculation.

For ORR based on IRR in each treatment arm, the 95% exact binomial confidence interval will be calculated with Clopper-Pearson method. Analysis for ORR based on IRR in AP ITT will be stratified by the randomization stratification factors (mutation status [KIT exon 9 vs. KIT exon 11 vs. KIT/PDGFRA WT vs. other KIT {absence of exon 9 or 11}/PDGFRA] and intolerance to imatinib [yes vs. no]). Analysis for ORR based on IRR in Ex11 ITT will be stratified by intolerance to imatinib [yes vs. no]. For each population, the p-value from a Cochran Mantel-Haenszel (CMH) chi-square test will be used to evaluate the association between the ORR and the study treatment at 2-sided 0.05 significance level; stratified Newcombe 95% Confidence Limits (Newcombe, 1998) will be calculated for the difference in ORR based on IRR between the treatment arms. The analysis will be performed in the Ex11 ITT Population and AP ITT Population as the main analysis and in the PP population as supportive analysis.

Sensitivity analysis of ORR based on IRR will be performed in an analogous manner and include the following:

- ORR based on IRR using mRECIST criteria stratified by intolerance to Imatinib treatment per EDC in Ex11 ITT population based on mutation status per EDC (note: this analysis is performed only in the case that the mutations status per EDC and intolerance to Imatinib per EDC are not consistent with the randomization strata per IRT)
- ORR based on IRR using mRECIST criteria stratified by mutation status per EDC and intolerance to Imatinib treatment per EDC in AP ITT population (note: this analysis is performed only in the case that the mutations status per EDC and intolerance to Imatinib per EDC are not consistent with the randomization strata)
- ORR based on INV using mRECIST criteria in Ex11 ITT population
- ORR based on INV using mRECIST criteria in AP ITT population

Supportive analysis of ORR in the PP populations will include the following:

- ORR based on IRR using mRECIST criteria in AP PP population
- ORR based on IRR using mRECIST criteria in Ex11 PP population
- ORR based on INV using mRECIST criteria in Ex11 PP population
- ORR based on INV using mRECIST criteria in AP PP population

8.2.2. Overall Survival

OS is defined as the time interval between the date of randomization and date of death from any cause. Patients who are still alive or are lost to follow-up will be censored at the date of last contact.

OS (months) = [date of death or censoring – date of randomization +1]/30.4375

Analysis for OS in AP ITT Population will be stratified by the randomization stratification factors per IRT (mutation status [KIT exon 9 vs. KIT exon 11 vs. KIT/PDGFRA WT vs. other KIT {absence of exon 9 or 11}/PDGFRA] and intolerance to imatinib [yes vs. no]). Analysis for OS in Ex11 ITT population will be stratified by intolerance to imatinib per IRT [yes vs. no]. The p-value will be from a 2-sided stratified Log-rank test at 0.05 significance level for evaluation of treatment difference. Point estimate of hazard ratio will be obtained from a Cox proportional-hazards regression model stratified by randomization stratification factors per IRT; the associated 95% CI will be obtained using Wald method. OS will be summarized via KM methodology using the 25^{th}, 50^{th} (median), and 75^{th} percentiles and survival probability at pre-specified timepoints, each with associated 2-sided 95% confidence intervals. The estimated survival functions will be displayed in a KM plot.

8.3. Analysis of Other Secondary Efficacy Endpoints

All other secondary efficacy endpoints will be analyzed for Ex11 ITT and AP ITT populations. The secondary endpoints of DOR, TTR, TTP will be analyzed based on both IRR and INV. PFS based on INV will be analyzed as other secondary efficacy endpoints.

8.3.1. Duration of Response

DOR is defined, for patients with objective response (confirmed CR or confirmed PR), as the time interval from the first assessment of CR or PR, which is subsequently confirmed, until the first assessment of disease progression or death, whichever occurs first. The censoring rules for DOR are the same as those for PFS.

DOR (months) = [date of event or censoring–first date of objective response +1]/30.4375

DOR will be analyzed with Kaplan-Meier method using the 25th, 50th (median), and 75th percentiles and survival probability at pre-specified timepoints, each with associated 2-sided 95% confidence intervals. Comparison of DOR between the two arms and estimation of HR will be done in a similar fashion as for PFS.

8.3.2. Time to Response

TTR is defined, for patients who achieved objective response, as the interval between the date of randomization and the first assessment date of CR or PR which is subsequently confirmed. Time to response will be summarized using descriptive statistics for confirmed responders only.

8.3.3. Quality of Life

Quality of life (QOL) will be based on European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire for Cancer 30-item (EORTC-QLQ-C30), Dermatology Life Quality Index (DLQI), Question GP5 from Functional Assessment of Cancer Therapy-General (FACT-G) questionnaires and EuroQol Visual Analogue Scale (EQ-VAS).

8.3.3.1. EORTC QLQ C30

The questionnaire of EORTC QLQ-C30 is composed of multi-item and single-item scales. These include 5 functional scales, 9 symptom scales, and a global health status/QOL scale. The multi-item scale is scored at four levels from “not at all” (1), “a little” (2), “quite a bit” (3) and “very much” (4). Two single items assess the patient's global health status over the past week using self-reported scales with “very poor” (1) to “excellent” (7). The focus of the analysis will be on the physical function and role function scales plus the two global health status items.

The EORTC QLQ C30 will be summarized by scales per the manual. In all scales, a high scale score represents a higher response level. The scoring for this questionnaire will be done in 2 steps:

- Calculate the average of the items that contribute to the scale. This will be used as the raw score for the scale, and
- Apply a linear transformation to standardize the raw score, so that scores range from 0 to 100.

For each scale at baseline, each post-baseline time point, and the last on-treatment assessment, the derived scores and change in scores from baseline will be summarized using descriptive statistics. The change from baseline for physical function (Q1-5) and role function (Q6-7) at specific timepoints (3 and 6 months) will be compared between the two arms. The function scale at 3 months will be calculated as the average of its score on C2D29 visit and C3D1 visit;

similarly, the function scale at 6 months will be calculated as the average of its score on C5D29 visit and C6D1 visit.

8.3.3.2. DLQI

DLQI measures the impact of skin symptoms on the QOL of an affected person. This questionnaire has 10 questions, covering the following topics: symptoms, embarrassment, shopping and home care, clothes, social and leisure, sport, work or study, close relationships, sex, and wider treatment consequences. Each question refers to the impact of the skin disease on the patient's life over the previous week. Each question is scored at four levels from "Not at all" (0), through "A little" (1), and "A lot" (2), to "very much"(3), giving a summary score range from 0 (meaning no impact of skin disease on QOL) to 30 (meaning maximum impact on QOL). A difference of four is considered to be clinically significant in inflammatory skin disease.

The total score for the DLQI will be calculated by summing the score of each question per the scoring manual (see http://sites.cardiff.ac.uk/dermatology/quality-of-life/dermatology-quality-of-life-index-dlqi/dlqi-instructions-for-use-and-scoring/). Higher scores are associated with a lower quality of life. The total score will be summarized descriptively using proportions who are moderately impacted (a total score of six to ten points) and severely impacted (a score of eleven or more) at baseline, each post-baseline time point, and the last on-treatment assessment.

8.3.3.3. GP5 Question From FACT-G

FACT-G includes a question referred to as GP5 which asks, "I am bothered by side effects of treatment". The answer is provided by the patient who selects one of the following five choices: Not at all (0), A little bit (1), Some-what (2), Quite a bit (3), or Very much (4). GP5 scores will be descriptively summarized at baseline, each post-baseline time point, and the last on-treatment assessment.

8.3.3.4. EQ-VAS

EQ-VAS is the sixth item of EQ-5D-5L. It records the patient's self-rated health on a vertical visual analogue scale with endpoints labeled "the best health you can imagine" and "the worst health you can imagine." A patient is asked to "mark an X on the scale to indicate how your health is TODAY" and "write the number you marked on the scale in the box below."

EQ-VAS at each post-baseline time point, and the last on-treatment assessment, and change in scores from baseline will be summarized using descriptive statistics. The change in EQ-VAS from baseline at specific timepoints (3 and 6 months) will be compared between the two arms. The EQ-VAS at 3 months will be calculated as the average of its score on C2D29 visit and C3D1 visit; similarly, the EQ-VAS at 6 months will be calculated as the average of its score on C5D29 visit and C6D1 visit.

8.3.4. Disease Control Rate

Disease control will be defined as having a BOR of confirmed CR, or confirmed PR, or BOR of SD lasting for 3 months or longer. Disease control rate (DCR) will be calculated as the proportion of patients with disease control. DCR will be also calculated at 6, 9, and 12 months.

Disease control rate based on IRR and INV will be summarized in the Ex11 ITT Population and AP ITT Population.

8.3.5. Time to Tumor Progression

TTP is defined as the interval between the date of randomization and the earliest documented evidence of disease progression.

Censoring rules for TTP will be same as those specified for PFS in Section 8.1.1. Additionally, patients who died without documented progression will be censored at the latest date of evaluable progression-free tumor assessment.

TTP (months) = [date of event or censoring – date of randomization +1]/30.4375

TTP will be analyzed in a similar fashion as PFS.

8.3.6. PFS Based on Investigator Assessment

As a sensitivity analysis to the primary efficacy analysis, PFS based on Investigator assessment (INV) is defined as the interval between the date of randomization and the earliest documented evidence of disease progression based on INV or death due to any cause, whichever occurs first. Special rules for defining a PFS event or censoring PFS based on Investigator assessment will be similar to those specified for the primary endpoint PFS in Section 8.1.

PFS based on INV will be analyzed in an analogous fashion to PFS based on IRR. As noted in Section 8.1, the following analyses will be performed based on the Investigator assessment and used as sensitivity analyses for the primary endpoint PFS based on IRR:

- PFS based on INV using mRECIST criteria in Ex11 ITT population
- PFS based on INV using mRECIST criteria in AP ITT population

In addition to the sensitivity analyses based on the investigator assessment, the discordance between the IRR and INV will be summarized.

8.3.7. Efficacy Based on Choi Criteria by Independent Radiologic Review

The analyses of the endpoints PFS, ORR, and TTP based on IRR will be repeated using the tumor assessments per Choi criteria among patients evaluable for Choi (CT scan present at least partially at baseline assessment and at at least one post-baseline assessment).

8.4. Handling of Missing Data

Algorithms for imputing partial or missing dates are shown below in Table 2. Adverse event end dates are imputed to facilitate calculation of AE duration. Missing or partial death dates will be imputed based on last contact date.

Table 2: Partial or Missing Date Imputation Rules

Variable	Missing Day	Missing Day, Month	Missing Day, Month, Year

Date of Prior Therapy/Date of Initial Diagnosis	Assign 1	Assign January 1 if prior to date of informed consent, otherwise use date of informed consent.	Missing (do not impute)
Adverse Event Start Date	Assign first day of month unless it is the month of first dose of study drug. Otherwise, assign date of first dose of study drug or AE end date (if not missing) whichever is earlier.	Assign January 1 unless the year is year of first dose of study drug. Otherwise, assign date of first dose of study drug or AE end date (if not missing) whichever is earlier.	Assign date first dose of study drug.
Adverse Event/Medication End Date	Assign the last day of the month or death date or data cut-off date (or end of study date), whichever is earliest.	Assign December 31 or death date or data cut-off date (or end of study date), whichever is earliest.	If ongoing, end date is missing. Otherwise, assign death date or data cut-off date (or end of study date), whichever is the earliest.
Medications Start Date	Assign 1 unless it is the month of first dose of study medication. Otherwise, assign date of first dose of study drug or imputed medication end date whichever is earlier.	Assign January 1 unless the year is year of first dose of study medication Otherwise, assign date of first dose of study drug or imputed medication end date whichever is earlier.	Assign date first dose of study.
Death date	Assign 1 unless before the last contact date. Otherwise, assign the day after the date of last contact.	Assign January 1 unless before the last contact date. Otherwise, assign the day after the date of last contact.	Assign the day after the date of last contact.

8.5. Multiple Comparisons/Multiplicity

To control familywise type-I error at 0.05 level, the hypothesis tests for treatment difference will be performed according to the hierarchical testing sequence below:

1. PFS by IRR in Ex11 ITT (two-sided 0.05 level)
2. PFS by IRR in AP ITT (two-sided 0.05 level)
3. ORR by IRR in Ex11 ITT (two-sided 0.05 level)
4. ORR by IRR in AP ITT (two-sided 0.05 level)
5. OS in Ex11 ITT (two-sided 0.05 level)

6. OS in AP ITT (two-sided 0.05 level)

The testing starts from PFS in Ex11 ITT and each subsequent endpoint will only be tested if all the testing preceding to it have been statistically significant. If the testing for any endpoint fails to meet statistical significance, the testing and p-value for all the subsequent endpoints will be nominal and statistical significance won't be claimed for all the subsequent endpoints.

8.6. Examination of Subgroups

Subgroup analysis will be performed for the primary and key secondary efficacy endpoints in subgroups of patients defined by the following variables:

- Age (<65 vs ≥65)
  - <65 years
  - ≥65 years
    - 65 – 74 years
    - ≥75 years
- Gender (Male vs. female)
- Race (White vs non-White vs Not-reported)
- Region (North America, South America, Europe, Asia-Pacific)
- Screening ECOG (0 vs. 1 vs. 2)
- Mutation type [KIT exon 9 vs. KIT exon 11 vs. KIT/PDGFRA WT vs. other KIT {absence of exon 9 or 11}/PDGFRA]
- Intolerance to Imatinib treatment (yes vs. no)
- Sum of longest diameters of target lesions at baseline (by tertiles)
- Time Since Initial Diagnosis (by tertiles)
- Best Overall Response to The Most Recent Imatinib Treatment (CR/PR, SD, PD, NE, Missing)

The efficacy endpoints in the patient subgroups will be tabulated by treatment arm and displayed in forest plots.

Subgroup analysis will be performed in the Ex11 ITT Population and AP ITT Population.

8.7. Interim Analysis

No interim analyses are planned for the primary endpoint of PFS based on IRR, or the key secondary endpoint of ORR. The interim analyses of OS will be performed as described in Section 2.3.

8.8. Data Monitoring

The Independent Data Monitoring Committee (IDMC) will consist of an experienced biostatistician and two qualified clinicians, who are not employees of the Sponsor, with

combined scientific expertise in general oncology and GIST and practical experience conducting clinical studies and monitoring safety and efficacy of clinical studies. The IDMC or Sponsor may request an ad hoc meeting for any reason, including significant unexpected safety event, follow-up of an observation during a planned IDMC meeting, or a report external to the study, such as publication of study results from a competing product. The IDMC objectives and operational details will be defined in the IDMC Charter.

9. SAFETY ANALYSIS

Exposure to study treatment and all safety assessments data will be analyzed in Safety Population and Ex11 Safety Population.

9.1. Study Drug Exposure

Treatment duration, total dose, and relative dose intensity will be summarized as continuous variables using descriptive statistics and categorized as appropriate. For each treatment arm, person year will be calculated. In addition, the number and percent of patients with at least one dose increase and reduction, will be summarized.

9.1.1. Study Drug Exposure in Ripretinib Arm

For ripretinib arm, treatment duration will be calculated as [(last dose date – first dose date) + 1 day]/30.4375 months. If last dose date is unknown, the earliest of the end of treatment date, data cut-off date (or end of study date), and death date will be used.

The cumulative dose (mg) of ripretinib in a cycle is the sum of the actual dose levels that the patient received within the cycle (ie, total dose administered). Total cumulative dose will be calculated as the total amount of doses received on study.

Relative dose intensity (RDI) for a cycle will be calculated as (cumulative dose in the cycle)/(number of days in the cycle×150mg) ×100%.

Overall RDI will be calculated as (total cumulative dose)/(treatment duration [days]×150 mg) ×100%.

Person year will be calculated as the sum of (last dose date before discontinuation treatment – first dose date + 1 day)/365.25 of all patients.

9.1.2. Study Drug Exposure in Sunitinib Arm

For sunitinib arm, treatment duration will be calculated as (last dose date – first dose date + 1 day)/30.4375 months.

The cumulative dose (mg) of sunitinib in a cycle is the sum of the actual dose levels that the patient received within the cycle (ie, total dose administered). Total cumulative dose of sunitinib will be calculated as the total amount of doses received on study.

RDI in a cycle will be calculated as (cumulative dose received in the cycle)/(50*7*4 mg)×100%.

Overall RDI will be calculated as (total cumulative dose received)/(Total number of cycles started*[50*7*4])×100%.

Person year will be calculated as the sum of (last dose date before discontinuation treatment – first dose date + 1 day)/365.25.

9.2. Adverse Events

Adverse events tables will summarize the number and proportion of patients with an event by SOC and PT for the Safety Population and Ex11 Safety Population. All tables will only include treatment emergent AEs (TEAEs), where TEAEs are defined as any AE which occurs after the administration of the first dose of study drug and through 30 days after the last dose of study drug or the day before the start of subsequent new anticancer drug therapy, whichever occurs first. Drug-related AEs reported after 30 days after the last dose of study drug will also be considered TEAEs. Listings will include all reported AEs, flagging events that were TEAEs. In the case of missing start and/or stop date, non-missing date parts will be used to determine if an AE is treatment-emergent or not. An AE will be categorized as TEAE if a determination cannot be made using the non-missing date parts as to when the event occurred relative to study drug administration. Adverse event toxicity grade will be classified using NCI-CTCAE Version 5.0 criteria. For incidence summaries, a missing toxicity grade of a TEAE will be conservatively imputed as severe; for a TEAE missing causal relationship to study treatment, a causality of "related" will be assigned. Listings will include all reported AEs, flagging events that were TEAEs and displaying missing start/stop dates, severity grades and causalities as they were entered in the clinical database.

An overall summary of the number of patients with TEAEs will be presented, including the number and percentage of patients with any TEAEs, serious TEAEs (TESAE), drug-related TEAEs and TEAEs leading to dose modification, treatment discontinuation, and death.

The number and percentage of patients reporting TEAEs in each treatment arm will be tabulated by SOC and PT; by PT; by SOC, PT, and maximum severity. If a patient has multiple occurrences of the same SOC and PT, then the patient will be counted only once for the SOC and PT using the most severe occurrence for the summarization by maximum severity. Presentation by SOC and PT will display SOC sorted alphabetically and PT by descending frequency based on frequencies observed in the ripretinib arm.

TEAEs and drug-related TEAEs will be summarized by SOC and PT, PT in descending frequency. TEAEs and drug-related TEAEs leading to dose modification, study treatment discontinuation, and TESAEs leading to death will be summarized by SOC, PT, and treatment arm.

Adverse events of special interest (AESI) are serious or nonserious AEs of scientific and medical concern specific to study drug, for which ongoing monitoring and immediate notification by the Investigator to the Sponsor is required. AESIs will be flagged on the eCRF by the investigator. The following AEs are considered AESIs: squamous cell carcinoma (SCC) of skin, actinic keratosis, and keratoacanthoma.

The number and percentage of patients by treatment arm with the following categories of TEAEs will be summarized in tables by SOC and preferred term:

- Any AE
- Any AE by maximum severity grade

- Any AE by maximum severity grade 1/2, 3/4, and 5
- Any drug-related AE
- Any SAE
- Any drug-related SAE
- Any AE leading to dose modification (dose reduction and dose interruption) or treatment discontinuation
- Any drug-related AE leading to dose modification or treatment discontinuation
- Any AESI
- Any AESI by maximum severity grade
- Any drug-related AESI
- Any fatal AE

9.3. Deaths

The number of patients with reported death and cause of death will be summarized by treatment arm for Ex11 ITT and AP ITT populations.

- Summary of all deaths by cause of death (Progressive disease, Adverse event, Other)
- Summary of all deaths ≤ 30 days of last dose by cause of death (Progressive disease, Adverse event, Other)
- Summary of all deaths > 30 days of last dose by cause of death (Progressive disease, Adverse event, Other)

A data listing of all deaths will be provided.

9.4. Eastern Cooperative Oncology Group Performance Status

The Eastern Cooperative Oncology Group (ECOG) Performance Status Assessments will be summarized as a categorical variable at each visit.

9.5. Clinical Laboratory Data

Clinical laboratory measurements will be collected from screening until the end of treatment visit (within 7 days of the last dose). Laboratory values will be graded for severity according to the National Cancer Institute Common Terminology Criteria for Adverse Events (NCI-CTCAE), Version 5.0.

Table 3: Safety Laboratory Tests

Serum Chemistry	Hematology	Urinalysis
Blood urea nitrogen Creatinine Sodium Potassium Calcium	Hemoglobin • Mean corpuscular hemoglobin • Mean corpuscular hemoglobin concentration • Mean corpuscular volume	Urine protein Urine blood Specific gravity Urine ketones Urine glucose

Magnesium Phosphorus Total and direct bilirubin Alkaline phosphatase Aspartate aminotransferase Alanine aminotransferase Lactate dehydrogenase Total protein Albumin Creatine Phosphokinase Globulin Triglycerides Lipase Amylase TSH T3 T4	Hematocrit Platelets Leukocytes Reticulocytes Differential (absolute): • Eosinophils • Basophils • Neutrophils • Lymphocytes • Monocytes **Coagulation Studies (for patients taking anticoagulants)** • Activated partial thromboplastin time • Prothrombin time • International Normalized Ratio	

Assessments will be summarized by time point utilizing continuous descriptive statistics as appropriate. In addition, the numeric changes from baseline will be summarized for continuous parameters. For categorical parameters, the number and percentage of patients with assessment will be displayed.

Changes in severity from baseline will be summarized by the maximum shift in CTCAE severity grade from baseline to post baseline.

9.6. Vital Signs

Temperature, heart rate, respiratory rate, and blood pressure will be summarized overall by time point utilizing continuous descriptive statistics. In addition, the change from baseline will be summarized for continuous parameters. For categorical parameters, the number and percentage of patients with assessment will be displayed.

9.7. Electrocardiograms

PR, QRS, QT, QTc (ie, QTcB and QTcF) and RR intervals and their change from baseline will be summarized for each treatment arm by scheduled visit. Patients will be categorized into >450, >480, or >500 ms per their maximum post-baseline absolute QTc interval and >30, or >60 ms per their maximum change from baseline QTc interval. Additionally, patients will be classified into the following categories: HR ≤50 bpm and/or decrease from baseline ≥20 bpm; HR ≥120 bpm and/or increase from baseline ≥20 bpm; PR ≥220 ms and/or increase from baseline ≥20 ms; QRS ≥120 ms. The number and percentage of patients in each category will be summarized for each treatment group.

9.8. Echocardiograms/Multigated Acquisition Scans

Left ventricle ejection fraction (LVEF) will be summarized at baseline and post-baseline time points utilizing descriptive statistics, including observed percent LVEF as a continuous variable and numeric change from baseline, number and percentage of patients with grade 3 decreased ejection fraction defined as an observed left ventricular ejection fraction (%) in 20% - 39% or a

percent reduction of 20% or more from baseline in left ventricular ejection fraction (%) among those patients who have baseline assessment and at least one post-baseline assessment.

9.9. Dermatologic Assessments

The number of patients with new suspicious skin lesions will be summarized overall and by location by number and percent of patients with assessment.

9.10. Prior and Concomitant Medications and Procedures

Prior medications and procedures taken or performed within 30 days prior to screening and prior to the first dose will be documented.

All concomitant medications and procedures (those taken or performed on or after the day of the first dose to 30 days after the last dose of study drug, including those started prior to first dose of study treatment and continued during on-treatment period) will be documented.

Prior and concomitant medications will be summarized by the WHO Drug Dictionary Anatomical Therapeutic Chemical 2nd level (ATC-2) and preferred name for the Safety Population and Ex11 Safety Population. If the ATC-2 level term is not available, the next available level (e.g., ATC-1) will be used.

The number and proportion of the patients who took each medication will be tabulated by the ATC-2 level and preferred name for concomitant medications. A patient will only be counted once within each ATC-2 code and within each preferred name.

All prior and concomitant medication data will be listed by patient.

10. ANALYSIS OF DISRUPTIONS DUE TO COVID-19 PANDEMIC

10.1. Changes in Data Collection due to COVID-19 Pandemic

Under the guidance of the FDA, a COVID-19 Pandemic Impact Form was created to capture the supplemental information regarding the impact of the COVID-19 pandemic on study conduct, including missed visit, out of window visit, televisit/remote visit, local tests, and the other scenarios.

10.2. Analysis of Data Captured due to COVID-19 Pandemic

Study assessments disrupted by COVID-19 pandemic will be listed by site, treatment arm, patient, and scheduled visit. The number of disrupted visits will be tabulated by site and treatment arm.

10.2.1. COVID-19 Adverse Events or COVID-19 Related Deaths

COVID-19 adverse events and COVID-19 related deaths will be presented under COVID-19 terms in the listings.

Analysis of concomitant medications/procedures specifically for COVID-19 related indications may be listed if needed.

10.2.2. Other Safety Data Captured due to COVID-19 Disruption

Data collected through a televisit will be analyzed together with those collected at on-site visits unless otherwise specified.

Local test data of vital signs, dermatologic exam, 12-Lead ECG, and Echocardigram/MUGA will be analyzed together with those collected at on-site visits unless otherwise specified.

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