

11. STATISTICS

11.1. Sample Size and Accrual

Based on a two-sided t-test with the 5% significance level, the planned sample size of 100 subjects per arm (a total of 200 subjects) provides approximately 98% power to detect a mean difference of 0.65 point in the average of nausea severity score assuming the standard deviation of 1.15 in each treatment group. Assuming an equal enrollment for each of diabetic and idiopathic etiology groups, a total of 100 subjects (50 per arm) per etiology will also provide approximately 80% power for each of these groups.

11.2. Statistical Methods and Analysis Plan

This section describes the planned statistical analyses in general terms. A complete description of the methodology will be specified in a statistical analysis plan (SAP). Any changes in the statistical methods described in this protocol that occur prior to database lock will be documented in the SAP and will not require a protocol amendment.

11.2.1. General

Statistical analyses will be performed using two-sided tests.

Data will be summarized by treatment group (and by visit when applicable), with respect to demographic and baseline characteristics, efficacy variables, and safety variables.

Summary statistics will include the mean, N, standard deviation, median, minimum, and maximum values for continuous variables, and frequencies and percentages for categorical variables.

Continuous efficacy variables will be analyzed using a mixed-effect model for repeated measures (MMRM) and/or an analysis of covariance (ANCOVA) model. The models will be described in the SAP.

For the analyses of change from baseline, only subjects with a baseline and at least one (1) post-baseline measure will be included in the analysis. Unless otherwise specified, baseline is defined as the latest non-missing observation across all the visits in the screening phase, before the active study drug begins. Endpoint will be the latest non-missing observation across all the post-baseline visits in the evaluation phase.

Low enrolling sites will be pooled for analysis and the pooling algorithm will be determined prior to breaking the blind. The goal of pooling low enrolling sites is to have a sufficient number of subjects per treatment group within a site for the analysis models and for the evaluation of the treatment-by-site interaction for the primary endpoint. Unless otherwise specified, the pooled sites will only be used in the analyses where site is included. The actual sites rather than the pooled sites will be specified in data listings.

Categorical variables will be analyzed using the Cochran-Mantel-Haenszel (CMH) test blocking on sites, and Fisher's exact test will be used when site is not adjusted (mainly for safety assessment).

Details of the model and the analyses will be specified in the SAP. All statistical analyses will be performed using SAS®, Version 9.1.3 or higher.

11.2.2. Subject Populations for Analysis

The following analysis populations will be defined for this study:

Intent-to-Treat: will include any subject randomized into the study that receives a dose of study drug and that has completed at least one post-baseline efficacy measurement while on study medication;

Safety: Any subject randomized into the study that receives a dose of study drug;

Per-Protocol: Any subject who is randomized and receives the protocol required study drug exposure and required protocol processing.

Efficacy analyses will be performed on the Intent-to-Treat population and the Per-Protocol population. Safety summaries will be based on Safety set. Subject characteristics will be presented for all subjects randomized.

11.2.3. Subject Disposition

Study completion and reasons for discontinuation for all randomized subjects in the double-blind phase will be summarized for each treatment group. Discontinuations by reason will be tabulated by visit for each treatment group.

Time to discontinuation due to adverse events, lack of efficacy and for any reason will be analyzed using Kaplan-Meier survival techniques; the log-rank test will be used for group comparison.

11.2.4. Demography and Other Baseline Data

Demographic data and subject characteristics at screening/baseline will be listed and summarized by treatment group for all randomized subjects using descriptive statistics.

Past and current medical history will be summarized by treatment group using the system organ class (SOC) as coded using the Medical Dictionary for Regulatory Activities (MedDRA) coding dictionary.

Past medical conditions will be defined as an onset date prior to randomization (Visit 2) and resolved (not on-going) as of Visit 2. Current medical conditions, defined as an onset date on or after the date of randomization (Visit 2) or an onset date prior to randomization (Visit 2) and

unresolved (on-going) as of Visit 2, will be reported separately, but similarly to the past medical conditions. If both a past and a current (on-going) medical condition record are indicated for a condition, the condition will be presented under current medical conditions only.

11.2.5. Study Medication

The number of subjects at each visit will be summarized by treatment group.

The compliance to study medication, as recorded in the CRF, will also be summarized by treatment group. The proportion of subjects who are significantly noncompliant in the double-blind phase will be summarized by treatment groups.

11.2.6. Prior/Concomitant Therapy

Any medications or therapy present before the first dose of study medication (Visit 2) will be considered as prior medications. Concomitant medications (medications present while on study medication) will be recorded throughout the study and at early discontinuation. These medications will be coded using the WHO-drug dictionary. The number of subjects from the Safety Population using prior or concomitant medications will be categorized by the WHO-drug category and preferred term, and presented for each treatment group. In any given category (e.g., drug category) a subject will be counted only once.

11.3. Efficacy Data Analysis

11.3.1. Primary Outcome and Methodology

The primary efficacy outcome measure will be change from baseline to Week 12 (Visit 8) in daily nausea severity score. A repeated measures analysis employing a restricted maximum likelihood (REML)-based, mixed-effects model approach (MMRM) will be used to analyze the primary efficacy outcome. The MMRM model will include the fixed, categorical effects of treatment group assignment, visit, treatment group-by-visit interaction and pooled site as well as the fixed, continuous covariates of baseline symptom score and the baseline symptom score-by-visit interaction. A detailed description of the MMRM model will be included in the SAP.

In addition to the MMRM model, an analysis of covariance (ANCOVA) model will also be applied. The last-observation-carried-forward (LOCF) will be used to impute any subsequent missing data. The model will have baseline as a covariate, and the fixed, categorical effects of treatment group assignment, pooled site. An observed cases (OC) analysis will also be performed.

As stated previously, any changes in the statistical methods that occur prior to database lock will be documented in the SAP and will not require a protocol amendment.

11.3.2. Secondary Efficacy Analysis

The secondary efficacy outcomes include:

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- Other Gastroparesis Core Symptoms: vomiting, early satiety, post-prandial fullness, and upper abdominal pain;
- Gastroparesis Cardinal Symptom Index (GCSI, calculated out of PAGA-SYM)
- PAGA-SYM
- Global Assessment of Gastroparesis
- Patient Rated Change in Gastroparesis Symptoms
- PGI-C
- PAGA-QOL
- GTBS
- CGI-S

Continuous endpoints will be summarized and analyzed in a manner similar to the primary endpoint. Details of the analysis will be described in the SAP.

Categorical variables will be evaluated as described in the SAP. Time to event data will be analyzed using the Kaplan-Meier method, and the treatment group differences will be tested by the log-rank test. Details of the analysis will be described in the SAP.

11.4. Safety Data Analysis

The primary assessment of safety will be based on the frequency of treatment-emergent adverse events (TEAEs), serious adverse events (SAEs) and on the frequency of clinically notable abnormal vital signs, electrocardiograms (ECGs) and laboratory values. Other safety evaluations include changes in vital signs, changes in clinical laboratory evaluations, and changes in ECGs, physical exam findings during treatment, and suicide ideation and behavior events.

11.4.1. Adverse Events

Adverse events will be recorded throughout the study and at early discontinuation. Adverse events and medical conditions will be coded using the Medical Dictionary for Regulatory Activities (MedDRA) coding dictionary. Treatment-emergent adverse events will be defined as those events, which are newly occurring or worsening from baseline. In all cases only treatment emergent adverse events will be summarized.

Treatment-emergent adverse events will be summarized within each treatment group by primary system organ class (SOC) and preferred term. (***NOTE***: In any given category [e.g. body system] a subject will only be counted once.) The incidence rates of TEAEs will be analyzed as described in the SAP. Similar displays will be provided for SAE and prior (conditions ending prior to the first dose of study medication and current (conditions present while on study medication) medical conditions.

Adverse events will further be categorized by severity, relationship to study medication, and action taken. Other information collected will be listed, as appropriate. Any event starting more than 3 days after the final dose of study medication will be excluded from the above tables and only listed, unless the event caused discontinuation.

The proportions of subjects experiencing SAEs and AEs resulting in discontinuation from the study will be summarized by treatment groups.

11.4.2. Laboratory Data

Clinical Laboratory Data

The summary statistics of raw data (hematology and chemistry) and change from baseline values will be presented, as well as shift tables from baseline to post-baseline values using normal ranges. For urinalysis parameters, the number and percentage of subjects falling under each category of the test will be presented.

Clinical laboratory data will be summarized for each treatment group by presenting the proportions of subjects with clinically notable abnormalities ([Appendix 18](#)).

Clinically notable values will be identified according to the criteria identified in the FDA's "Supplementary Suggestions for Preparing an Integrated Summary of Safety Information in an Original NDA Submission and for Organizing Information in Periodic Safety Updates" (Revised 2-APR-87) provided by the FDA Division of Neuropharmacological Drug Products (DNDP). Differences in incidence rates between the treatment groups will be tested as described in the SAP.

11.4.3. Vital Signs and Body Measurements

Data from vital signs and body measurements will be listed, clinically notable values ([Appendix 18.2](#)) will be flagged, and any other information collected will be listed. Data will also be summarized by treatment group using mean change from baseline and proportions of subjects with values outside the normal range, and values that were clinically notable.

11.4.4. Electrocardiogram (ECG)

Results from the ECG will be listed for each subject. These data will also be summarized for each treatment group by presenting subjects with newly occurring or worsening ECG abnormalities.

11.4.5. C-SSRS

Results from the C-SSRS will be listed for each subject. These data will also be summarized by treatment group and for suicidal ideation events, suicidal behaviors and completed suicides. In particular, for each of the following suicide related events, the number and percent of subjects with the event will be enumerated by treatment group: completed suicide, nonfatal suicide attempt, interrupted attempt, aborted attempt, preparatory acts or behavior, active suicidal ideation with specific plan and intent, active suicidal ideation with some intent to act without specific plan, active suicidal ideation with any methods (no plan) without intent to act, non-specific active suicidal thoughts, and wish to be dead. Details of the analysis will be provided in the SAP.

11.5. Subgroup Analysis

The subgroup analysis (such as, gender, age, etiology, baseline illness severity etc.) for efficacy variables and safety variables may be conducted as described in the SAP.

11.6. Interim Analysis

No interim analyses are planned.

11.7. Deviations in Analysis from Statistical Plan and Other Issues

During the analysis and reporting process, any deviations from the statistical plan designed for this protocol will be described and justified in the final report.