

Name of company: UCB Biopharma, SPRL	Individual study table referring to part of the dossier: Not applicable	<i>(For National Authority Use Only)</i>
Name of finished product: Cimzia	Volume: Not applicable	
Name of active ingredient: Certolizumab pegol	Page: Not applicable	
subject initially responded to therapy and then stopped treatment due to loss of response after Week 12) to no more than 1. Subjects with erythrodermic, guttate, or generalized pustular form of PSO were excluded.		
<p>Test product, dose(s) and mode of administration, batch number(s): Certolizumab pegol is an engineered humanized monoclonal antibody Fab' fragment with specificity for human tumor necrosis factor alpha (TNFα), manufactured in <i>Escherichia coli</i>. The antibody fragment is subsequently purified and conjugated with high molecular weight polyethylene glycol (40kDa).</p> <p>Certolizumab pegol was supplied as a sterile, clear, colorless to slightly yellow liquid solution with a pH of approximately 4.7 in 1mL single-use, glass prefilled syringe (PFS) with a 25G ½-inch thin-wall needle for sc injection. Each syringe contained an injectable volume of 1mL at a concentration of 200mg/mL of CZP in 10mM sodium acetate buffer and 125mM sodium chloride as a tonicity agent.</p> <p>Batch numbers: BX1012752, BX1012377, BX1012378, BX1012235, BX1012236, BX1012284, BX1012535, BX1012540, BX1012672, BX1012673, BX1012842, BX1012972, BX1012971, BX1013020, BX1013268, BX1013404, BX1013405, BX1013725, BX1013875, BX1014577, BX1014776, 229690, 233905</p>		
<p>Duration of treatment: The duration of the study for each subject was up to 157 weeks, consisting of:</p> <ul style="list-style-type: none"> • Screening Period of up to 5 weeks • Initial Treatment Period of 16 weeks (Week 0 to Week 16) • Maintenance Treatment Period of 32 weeks (Week 16 to Week 48) • Open-label Treatment Period of 96 weeks (Week 48 to Week 144) • SFU Period of 8 weeks (Week 144 to Week 152). Note: Ten (10) weeks since final dose. 		
<p>Reference therapy, doses and mode of administration, batch numbers: Placebo (0.9% saline) was supplied as a sterile solution in a single-use glass PFS with a 25G ½ inch thin-wall needle for sc injection, containing an injectable volume of 1mL.</p> <p>Batch numbers: BX1012377, BX1012752, BX1012235, BX1012284, BX1012540, BX1012672, BX1012842, BX1012971, BX1013020, BX1013404</p>		

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<p>Criteria for evaluation:</p> <p>Efficacy: The coprimary efficacy variables were:</p> <ul style="list-style-type: none"> • PASI75 at Week 16 • PGA Clear or Almost clear (with at least 2-category improvement) at Week 16 <p>The secondary efficacy variables were:</p> <ul style="list-style-type: none"> • At least 90% reduction from Baseline in PASI (PASI90) at Week 16 • PGA Clear or Almost clear (with at least 2-category improvement) at Week 48 • PASI75 at Week 48 • Change from Baseline in DLQI at Week 16 <p>The other efficacy variables are listed below and were evaluated at all scheduled visits. This excluded the primary and secondary variables.</p> <ul style="list-style-type: none"> • PASI50, PASI90, and 100% reduction from Baseline in PASI (PASI100) • PASI75 • PGA Clear or Almost clear (with at least 2-category improvement) • Absolute and percent change from Baseline in PASI score • PGA score distribution • Time to onset of action, defined as the time to PASI50 • Time to onset of action, defined as the time to PASI75 • Time to onset of action, defined as the time to PASI90 • Absolute and percent change from Baseline in the BSA affected by PSO • Change from Baseline in modified Nail Psoriasis Severity Index • Change from Baseline in SF-36 all domains, and Physical and Mental Component Summary (PCS and MCS, respectively) scores, and percent of subjects achieving the minimal clinically important difference (MCID) • Change from Baseline in DLQI, percent of subjects achieving MCID, and percent achieving DLQI Remission • Change from Baseline in Hospital Anxiety and Depression Scale for anxiety (HADS-A) and Hospital Anxiety and Depression Scale for depression (HADS-D) scores, percent of subjects with scores below 8 in HADS-A and HADS-D (subjects with normal scores) • Change from Baseline in Work Productivity and Activity Impairment Questionnaire–Specific Health Problem (WPAI-SHP) v2.0 adapted to PSO scores 		

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<ul style="list-style-type: none"> • Responses to the European Quality of Life 5 dimensions, 3 levels (EQ-5D-3L™) questionnaire, absolute and changes from Baseline in EQ-5D-3L visual analog scale (VAS) scores • Direct medical resource use: number of concomitant medical procedures, number of health care provider consultations not foreseen by the protocol, number of hospitalizations, number of emergency room visits, and length of hospital stay • Socio-professional status (educational level, professional status, and assistance in the usual activities) <p>The following variables were considered key efficacy variables for the open-label extension analysis:</p> <ul style="list-style-type: none"> • PASI75, PASI90, and PASI100 • PGA Clear or Almost Clear (with at least 2-category improvement) • Change from Baseline in DLQI and percent achieving DLQI remission <p>The 6 key efficacy variables listed above were summarized for the Open-label Treatment Period only and for the Combined Initial, Maintenance, and Open-label Treatment Period. Efficacy variables that were not defined as key were only summarized for the Open-label Treatment Period.</p>		
<p>Pharmacokinetics: All subjects provided samples for pharmacokinetic evaluation at Baseline; Weeks 2, 4, 16, 24, 32, 48, 72, 96, 120, and 144; the Early Withdrawal Visit; and the SFU Visit (10 weeks after final dose of CZP).</p> <p>Immunogenicity: Plasma samples for the measurement of anti-CZP antibodies were collected at Baseline; Weeks 2, 4, 16, 24, 32, 48, 72, 96, 120, and 144; the Early Withdrawal Visit; and the SFU Visit (10 weeks after final dose of CZP).</p> <p>Safety: Safety variables assessed were:</p> <ul style="list-style-type: none"> • Adverse events (AEs) • Blood pressure • Physical examination • Clinical laboratory values (hematology, biochemistry, and urinalysis) • Interferon-gamma release assay test for tuberculosis 		

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Statistical methods: This final clinical study report presents the complete analysis of results through the end of the study. Descriptive statistics were displayed to provide an overview of the study results. For categorical variables, the number and percentage of subjects in each category was presented. The denominator for percentages was based on the number of subjects appropriate for the purpose of analysis for the respective treatment group, subset, and period.

A Baseline value for a subject was defined as the latest measurement for that subject up to and including the day of administration of first study medication, unless otherwise stated. If a Baseline value was missing or not collected, and a Screening value was available, the Screening value was utilized as the Baseline value. Baseline values for composite scores were computed using components from the same visit when the relevant measurements were recorded prior to dosing. For example, if the Screening Visit had all of the components, but the Baseline Visit was missing one or more components, the Baseline value for the component score was calculated using the Screening Visit values.

All efficacy analyses were performed using the RS. The PPS was used for a sensitivity analysis on the primary endpoints only. For the final efficacy analyses of key and other efficacy endpoints, the RS and OLS were used for the Combined Initial, Maintenance, and Open-label Treatment Period and the OLS was used for the Open-label Treatment Period. Safety summaries were performed using the SS, TCS, TBCS, MSS, or OLS.

The statistical analysis of the coprimarily efficacy variables and secondary efficacy variables accounted for multiplicity and controlled the familywise type I error rate at a 2-sided alpha level of 0.05 by using a fixed-sequence testing procedure.

The hypotheses were mapped into 2 sets (H1, H3, H5, and H7) and (H2, H4, H6, and H8) such that the hypotheses within each set corresponded to the same CZP dose. The type I error was split equally between CZP 400mg Q2W and CZP 200mg Q2W, such that each dose was tested at a 2-sided alpha level of 0.025.

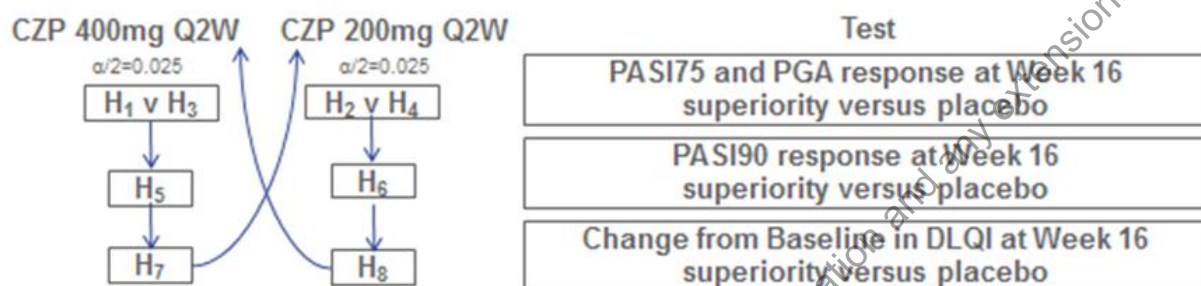
The first 2 hypotheses for each dose (H1 and H3 for CZP 400mg Q2W, and H2 and H4 for CZP 200mg Q2W) tested whether the given CZP dose was superior to placebo for PASI75 response and PGA response at Week 16. These were the hypothesis tests corresponding to the coprimarily endpoints. If both were rejected at a 2-sided alpha level of 0.025, that alpha was passed to the next test in the sequence, allowing the testing procedure to proceed.

The hypotheses associated with the subsequent tests were for the secondary efficacy endpoints and were based on testing for superiority relative to placebo. See [Figure 1](#) for details on this fixed-sequence testing procedure.

If all hypotheses within 1 set of hypotheses (either CZP 400mg Q2W or CZP 200mg Q2W) were rejected, the corresponding type I error probability was passed on to the other set of hypotheses and that set was retested, if necessary, at a 2-sided alpha level of 0.05.

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Figure 1: Fixed-sequence testing procedure



CZP=certolizumab pegol; DLQI=Dermatology Life Quality Index; H=hypothesis; PASI75=at least 75% reduction from Baseline in Psoriasis Area and Severity Index; PASI90=at least 90% reduction from Baseline in Psoriasis Area and Severity Index; PGA=Physician's Global Assessment; Q2W=every 2 weeks

Analysis of the coprimary efficacy variables. The first coprimary efficacy variable, PASI75 at Week 16, was based on the PASI score, which scores for each body part and the percentage of skin covered with PSO. The PASI75 response is based on at least 75% improvement (reduction) from Baseline in the PASI score. The second coprimary efficacy variable was a static PGA for PSO to assess disease activity during the study. The Investigator assessed the overall severity of PSO using a 5-point scale. Subjects were classified as responders at Week 16 if they achieved a PGA score of 0 or 1, and had at least a 2-category improvement from Baseline. The primary analyses for these variables were based on logistic regression for the RS. The odds ratio of the responder rate at Week 16 was estimated and tested between randomized treatment groups using a logistic regression model with factors of treatment group, geographic region, and prior biologic exposure (yes/no). The odds ratio, associated confidence interval (CI), and p-value were presented. The Markov Chain Monte Carlo (MCMC) method for multiple imputation was used to account for missing values in the primary analysis of PGA and PASI75 at Week 16. This is a commonly used method for handling intermittent or monotonic missing data under the assumption of a missing at random (MAR) pattern of missingness. The multiple imputation procedure for PGA response was based on the observed score on a scale from 0 to 4 (as opposed to the binary response). Similarly, for PASI75, the multiple imputation procedure was based on the actual PASI score.

Analysis of the secondary efficacy variables. The PASI90 response at Week 16 was calculated and analyzed in the same manner described for the primary analysis of PASI75 response at Week 16. The analysis of the DLQI was based on the change from Baseline at Week 16 for the RS. Randomized treatment group comparisons for each CZP treatment group vs placebo were performed using an analysis of covariance (ANCOVA) model with treatment group, geographic region, and prior biologic exposure as factors, and Baseline DLQI score as a covariate. The least squares (LS) means and standard errors (SE) derived from the model were presented for each treatment group. Additionally, adjusted mean treatment differences, corresponding CIs, and p-values were reported. Missing values were imputed using last observation carried forward (LOCF). The analysis of the PASI75 responder rate at Week 48 and PGA Clear or Almost clear (with at least 2-category improvement) at Week 48 was based on the RS and was

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summarized only for the CZP 200mg Q2W and CZP 400mg Q2W randomized treatment groups. Missing data were handled based on a combination of nonresponder imputation and multiple imputation.		
Summary and conclusions:		
<p>Subject disposition: A total of 227 randomized subjects started the Initial Treatment Period; 91 subjects randomized to the CZP 200mg Q2W group, 87 subjects randomized to the CZP 400mg Q2W group, and 49 subjects randomized to the placebo group. Overall, 212 subjects (93.4%) completed the Initial Treatment Period; the percentages of subjects who completed the Initial Treatment Period were similar across the CZP 200mg Q2W (92.3%), CZP 400mg Q2W (95.4%), and placebo (91.8%) groups. A total of 15 subjects (6.6%) discontinued during the Initial Treatment Period (prior to Week 16); overall, the most frequently reported primary reasons for discontinuation were consent withdrawn (6 subjects [2.6%]) and AE (4 subjects [1.8%]). Of the 212 subjects who completed the Initial Treatment Period, 2 subjects did not enter the Maintenance Treatment Period.</p> <p>A total of 210 subjects in the MS started the Maintenance Treatment Period, and 173 subjects (82.4%) completed Week 48. A total of 37 subjects (17.6%) discontinued during the Maintenance Treatment Period (prior to Week 48); overall, the most frequently reported primary reasons for discontinuation were AE (12 subjects [5.7%]) and consent withdrawn and other: mandatory withdrawal due to not achieving a PASI50 response (7 subjects each [3.3%]). Of the 173 subjects who completed the Maintenance Treatment Period, 2 subjects did not enter the Open-label Treatment Period.</p> <p>A total of 170 subjects in the OLS started the Open-label Treatment Period, and 132 subjects (77.6%) completed Week 144. A total of 38 subjects (22.4%) discontinued during the Open-label Treatment Period (prior to Week 144); overall, the most frequently reported primary reasons for discontinuation were as follows: AEs (14 subjects [8.2%]); other (9 subjects [5.3%]), including other: mandatory withdrawal due to not achieving a PASI50 response (7 subjects [5.3%]); lost to follow up (6 subjects [3.5%]); and consent withdrawn (6 subjects [3.5%]). Of the 2 subjects who discontinued the study due to “other” and not for mandatory withdrawal due to PASI50 nonresponse, 1 subject discontinued the study due to other: pregnancy and another subject discontinued the study due to other: loss of efficacy.</p>		
Efficacy results:		
<u>Efficacy during the Initial Treatment Period</u>		
<p>The statistical analysis of the coprimary efficacy variables (PASI75 and PGA responder rates) and selected secondary efficacy variables (PASI90 responder rate and change from Baseline in DLQI) at Week 16 were evaluated using a fixed-sequence testing procedure. Based on this procedure, data from PS0002 demonstrate that treatment with CZP 200mg Q2W and CZP 400mg Q2W resulted in clinically meaningful and statistically significant improvements in PSO area and severity (as assessed by PASI75 and PASI90 responder rates) as well as global physician-assessment of disease activity (via PGA responder rates of 0 or 1). In addition, CZP 200mg Q2W and CZP 400mg Q2W resulted in clinically meaningful and statistically significant improvements in patients’ HRQoL (as assessed by the mean change from Baseline at Week 16 in DLQI) compared with placebo.</p> <p>The results of the coprimary endpoints were supported and confirmed by similar findings from all</p>		

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<p>sensitivity analyses.</p> <p><i>Psoriasis area and severity</i></p> <ul style="list-style-type: none"> • A statistically significant and clinically meaningful difference in PSO area and severity, as measured by the PASI75 and PASI90 responder rates, was observed for CZP-treated subjects compared with placebo-treated subjects. At Week 16, the PASI75 responder rates were significantly greater in both the CZP 200mg Q2W group (81.4%) and the CZP 400mg Q2W group (82.6%) as compared to the placebo group (11.6%; $p < 0.0001$ for both comparisons). This analysis for the coprimary endpoint was supported by the predefined sensitivity analyses and the analysis using the PPS. Similarly, PASI90 responder rates were significantly greater in both the CZP 200mg Q2W group (52.6%) and CZP 400mg Q2W group (55.4%) compared with the placebo group (4.5%; $p < 0.0001$ for both comparisons). • During the Initial Treatment Period, PASI50, PASI75, PASI90, and PASI100 responder rates in both the CZP 200mg Q2W and CZP 400mg Q2W groups consistently increased over time through Week 16. • The improvements in PASI responder rates occurred rapidly following the initiation of treatment with CZP; clinically meaningful differences versus placebo were observed for both groups beginning at Week 2 for PASI50, Week 4 for PASI75, and Week 8 for PASI90 and PASI100. • Clinically meaningful differences in time to achieving a PASI50, PASI75, and PASI90 response were observed for CZP-treated subjects compared with placebo-treated subjects during the Initial Treatment Period. The median times to achieving PASI50 and PASI75 responses were 28.0 and 56.0 days, respectively, for both the CZP 200mg Q2W and CZP 400mg Q2W groups; the median times to PASI90 responses were 111.0 days and 87.0 days for the CZP 200mg Q2W and CZP 400mg Q2W groups, respectively. The differences versus placebo for the CZP 200mg Q2W and 400mg Q2W groups resulted in nominal p-values < 0.0001 for all comparisons. 		
<p><i>Physician's global assessment of disease activity</i></p> <ul style="list-style-type: none"> • At Week 16 (the coprimary endpoint), PGA responder rates were significantly higher in both the CZP 200mg Q2W group (66.8%) and the CZP 400mg Q2W group (71.6%) compared with the placebo group (2.0%; $p < 0.0001$ for both comparisons). • The improvements in PGA responder rates occurred rapidly following the initiation of treatment with CZP; clinically meaningful differences versus placebo were observed for both groups beginning at Week 4 and at all subsequent time points through Week 16. • PGA responder rates in both the CZP 200mg Q2W and CZP 400mg Q2W groups consistently increased through Week 12 and were subsequently maintained at Week 16. 		

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Subgroup analyses of the coprimary endpoints

- All subgroups had a clinically meaningful difference from placebo in PGA and PASI75 responder rates at Week 16 for both CZP groups. Subgroup analyses of the coprimary endpoints revealed that weight (ie, body mass index [BMI] and body weight), geographic region, and prior exposure to any biologic or any anti-TNF agent appeared to have the strongest and most consistent influences on PASI75 and PGA responder rates. For both the CZP 200mg Q2W and CZP 400mg Q2W groups, subjects in the highest 2 quintiles of BMI and body weight had lower responder rates compared with subjects in the lower quintiles; subjects in Europe had better responder rates than subjects in North America (especially on PGA responder rates); and, subjects with no prior history of any biologic or anti-TNF agent had better responder rates than subjects with a prior history of either of these agents. Across subgroups, there did not appear to be a dose effect on responder rates.
 - It should be noted that the results of the subgroup analyses should be interpreted with caution given that the sample sizes of many of the subgroup categories were relatively small. In addition, potential interactions between subgroup categories may have influenced the results and cannot be adequately explored in this individual study due to the small group sizes. Of note, with the exception of subjects positive for anti-CZP antibodies, in those subgroups in which PASI75 and PGA responder rates were comparatively lower, the responder rates in the CZP 200mg Q2W and 400mg Q2W groups were still clinically meaningfully greater than the responder rates observed in the corresponding placebo group.

Health-related quality of life

- At Week 16, the LS mean (SE) decrease (ie, improvement) from Baseline in DLQI using LOCF was -10.4 (0.62) points for the CZP 200mg Q2W group and -10.0 (0.64) for the CZP 400mg Q2W group compared with -3.8 (0.84) points for the placebo group (p<0.0001 for both comparisons).
- Subjects in the CZP 200mg Q2W and CZP 400mg Q2W groups had similar and clinically meaningful improvements in patients' HRQoL (as assessed by the mean change from Baseline in the DLQI) compared with the placebo group. Consistently larger mean decreases from Baseline in the DLQI score were observed over time from Weeks 2 through 12, and these decreases were subsequently maintained at Week 16.
- The percentages of subjects who were DLQI MCID responders (defined as a ≥ 4 -point change in the DLQI score) in both the CZP 200mg Q2W and CZP 400mg Q2W groups were generally similar and higher than placebo at each time point. At Week 16, 74.7% of subjects in the CZP 200mg Q2W group and 75.9% of subjects in the CZP 400mg Q2W group were DLQI MCID responders compared with 40.8% of subjects in the placebo group. Similar and increasingly larger percentages of subjects in both the CZP 200mg Q2W and CZP 400mg Q2W groups achieved DLQI remission (defined as a DLQI absolute score of 0 or 1) at Weeks 8, 12, and 16, and these percentages were larger than the percentages observed in the placebo group at each time point. By Week 16, 46.2% of subjects in the

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<p>CZP 200mg Q2W group and 50.6% of subjects in the CZP 400mg Q2W group had achieved DLQI remission compared with 8.2% of subjects in the placebo group.</p> <ul style="list-style-type: none"> Results of the DLQI were supported by clinically meaningful improvements versus placebo in overall health status (as assessed by the EQ-5D-3L VAS), physical functioning (as assessed by the SF-36 PCS), mental health (as assessed by the SF-36 MCS) as well as anxiety and depression (as assessed by the HADS-A and HADS-D) following treatment with CZP 200mg Q2W and CZP 400mg Q2W during the Initial Treatment Period. Impairment while working and in daily activities due to PSO (as assessed by the WPAI-SHP) was reduced in the CZP treatment groups over placebo as early as Week 4 (first assessment) and the reduction in impairment was sustained through the Initial Treatment Period. Improvements observed in these patient-reported outcome measures in the CZP 400mg Q2W group were comparable to and, in some cases, greater than those improvements seen in the CZP 200mg Q2W group. <p><u>Efficacy during the Maintenance Treatment Period</u></p> <ul style="list-style-type: none"> PASI75 responder rates at Week 16 were 81.4% for the CZP 200mg Q2W group and 82.6% for the CZP 400mg Q2W group and were maintained at Week 48 (78.7% for the CZP 200mg Q2W group and 81.3% for the CZP 400mg Q2W group) among subjects in the RS. Similarly, PGA responder rates at Week 16 were 66.8% for the CZP 200mg Q2W group and 71.6% for the CZP 400mg Q2W group and were maintained at Week 48 (72.6% for the CZP 200mg Q2W group and 66.6% for the CZP 400mg Q2W group) among subjects in the RS. During the Maintenance Treatment Period (based on either randomized treatment group or maintenance treatment group), the improvements observed across the collection of efficacy endpoints assessed during the Initial Treatment Period (based on PSO severity and/or area; PSO-specific HRQoL; and patient-reported outcome measurements) were, at a minimum, consistently maintained through 48 weeks of treatment. For the most stringent efficacy endpoints, treatment longer than the initial 16 weeks appeared to result in further improvements. For PASI90 responder rates, improvements continued through Week 24 and were maintained through Week 48; for PASI100 responder rates, improvements continued through Week 48. For those placebo-treated subjects who did not achieve a PASI50 response by Week 16, treatment with open-label CZP 400mg Q2W in the Maintenance Treatment Period resulted in improvements across the spectrum of efficacy endpoints assessed that resembled a pattern of improvement similar to those subjects who were originally randomized to blinded CZP treatment in the Initial Treatment Period. There were too few subjects in the CZP 200mg Q2W/Escaped CZP 400mg Q2W and CZP 400mg Q2W/Escaped CZP 400mg Q2W escape maintenance groups to allow for meaningful conclusions to be made. 		

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Efficacy during the Combined Initial, Maintenance, and Open-label Treatment Period

The focus of this summary is on the RS. The OLS is primarily used to summarize escapers (ie, subjects who received continuous open-label CZP 400mg Q2W for ~2.5 years) and nonadjusters (ie, subjects who entered the Open-label Treatment Period and did not subsequently have a dose adjustment).

Efficacy results for the CZP 200mg Q2W group

- Across the spectrum of efficacy endpoints assessed, CZP 200mg Q2W treatment up to 3 years demonstrated improvements that were generally maintained through Week 144.
 - PASI75, PGA, PASI90, and PASI100 responder rates (RS) increased consistently over time through Week 16, were maintained (PASI75, PGA, and PASI90) or generally increased (PASI100) through Week 48, and were maintained through Week 144.
 - Evaluation of the maintenance of PASI75, PGA, and PASI90 response in subjects who were PASI75, PGA, or PASI90 responders at Week 16 (RS) demonstrated PASI75, PGA, and PASI90 responder rates were maintained in >85%, >80%, and >80% of subjects, respectively, from Weeks 20 to 48 and in >85%, >75%, and >70% of subjects, respectively, from Weeks 60 to 144.
 - Similarly, improvements from Baseline in DLQI scores and DLQI remission rates (RS) increased from Week 16 and were generally maintained through Week 48 and through Week 144, with 42.9% of subjects achieving DLQI remission at Week 144.
 - For the subjects who entered the Open-label Treatment Period (OLS), trends were generally similar. For subjects who remained on CZP 200mg Q2W throughout the Open-label Treatment Period (ie, nonadjusters), PASI75, PGA, PASI90, and PASI100 responder rates were generally maintained through Week 144.

Efficacy results for the CZP 400mg Q2W group

- Across the spectrum of efficacy endpoints assessed, CZP 400mg Q2W treatment demonstrated improvements that were maintained through Week 48. Following the protocol-mandated dose down to CZP 200mg Q2W at Week 48, some loss of responses were generally observed during the Open-label Treatment Period, with a magnitude and time to decline that was endpoint-specific. Some regain in efficacy was observed during the Open-label Treatment Period, which could have been due to dose readjustments back to CZP 400mg Q2W.
 - PASI75, PGA, PASI90, and PASI100 responder rates (RS) increased consistently over time through Week 16 and were maintained (PASI75, PGA, and PASI90) or generally increased (PASI100) through Week 48. Some declines in PASI75, PGA, PASI90, and PASI100 responder rates were observed through Week 72 (PGA) and Week 84 (PASI75, PASI90, and PASI100), with some regain in responder rates (PASI75 and PASI90).
 - Evaluation of the maintenance of PASI75, PGA, and PASI90 response in subjects who were PASI75, PGA, and PASI90 responders at Week 16 (RS) demonstrated PASI75, PGA, and

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<p>PASI90 responder rates were maintained in $\geq 95\%$, $>80\%$, and $>85\%$ of subjects, respectively, from Weeks 20 through 48. Following the protocol-mandated dose down to CZP 200mg Q2W at Week 48, PASI75, PGA, and PASI90 responder rates were $>80\%$, $>65\%$, and $>50\%$, respectively, from Weeks 60 to 144.</p> <ul style="list-style-type: none"> - Improvements from Baseline in DLQI scores and DLQI remission rates (RS) increased from Week 16 and were maintained through Week 48. Following the protocol-mandated dose down to CZP 200mg Q2W at Week 48, improvements from Baseline in DLQI scores were maintained through Week 144. Some decline in the percentage of subjects who achieved DLQI remission was seen through Week 84; the percentage of subjects who achieved DLQI remission was maintained from Weeks 84 through 144, with 46.2% of subjects achieving DLQI remission at Week 144. - For the subjects who entered the Open-label Treatment Period (OLS), trends were generally similar. All subjects who dosed down at Week 48 and remained on CZP 200mg Q2W throughout the Open-label Treatment Period (ie, nonadjusters) were PASI75 responders at Week 48. For these subjects, PASI75, PGA, and PASI90 responder rates were generally maintained through Week 144. PASI100 responder rates generally declined through Week 60. <p><i>Efficacy results for the Escape CZP 400mg Q2W/CZP 400mg Q2W group</i></p> <ul style="list-style-type: none"> • Although the data in this section are for the results of open-label CZP treatment, this treatment group represents the longest continuous exposure to CZP 400mg Q2W for up to 128 weeks (~2.5 years). Improvements across the spectrum of efficacy endpoints assessed were observed up to Week 32 (ie, up to 16 weeks of CZP treatment) and maintained through Weeks 60 and 144 (ie, up to 44 and 128 weeks of CZP treatment, respectively). This pattern of improvement in efficacy was similar to those subjects who were originally randomized to blinded CZP 400mg Q2W treatment in the Initial and Maintenance Treatment Periods (Table 1). 		

Table 1: PGA, PASI75, PASI90, and PASI100 responder rates over time – Combined Initial, Maintenance, and Open-label Treatment Period

Parameter Statistic	OLS (MCMC) Escape CZP 400mg Q2W/CZP 400mg Q2W ^a N=40			RS (MCMC) CZP 400mg Q2W ^b N=87		
	Week 32 (ie, Week 16 of open-label CZP treatment)	Week 60 (ie, Week 44 of open-label CZP treatment)	Week 144 (ie, Week 128 of open-label CZP treatment)	Week 16	Week 48 ^b	Week 144
PGA responder rates over time						
Responder rate (%)	81.8	77.7	72.9	71.4	66.1	60.0
PASI75 responder rates over time						
Responder rate (%)	83.4	88.2	87.1	82.8	81.6	80.9
PASI90 responder rates over time						
Responder rate (%)	51.9	62.9	52.8	55.6	63.1	49.4
PASI100 responder rates over time						
Responder rate (%)	27.8	36.9	37.5	18.5	38.9	28.4

CZP=certolizumab pegol; MCMC=Markov Chain Monte Carlo; OLS=Open-label Extension Set; PASI50/75/90/100=at least 50%/75%/90%/100% reduction from Baseline in Psoriasis Area and Severity Index; PGA=Physician’s Global Assessment; Q2W=every 2 weeks; RS=Randomized Set

Note: PGA responders=Clear or Almost clear (with at least 2-category improvement from Baseline).

Note: Dose adjustments after Week 48 were not considered in this table.

Note: Estimates of the responder rate were based on using a logistic regression model with factors for treatment, region, and prior biologic exposure (yes/no) on the multiply imputed data sets where missing data were imputed using the MCMC method. The responder rates were the adjusted predicted probabilities from the logistic regression model. Subjects who should have been withdrawn at Week 32 or later due to lack of PASI50 response or subjects on CZP 400mg Q2W (for at least 12 weeks) during the Open-label Treatment Period who did not achieve a PASI50 response during the Open-label Treatment Period and should have been mandatorily withdrawn were treated as nonresponders for subsequent time points. All other missing data were imputed using multiple imputation based on MCMC methodology. In cases where no data were missing at a visit, the logistic regression was performed on the observed data.

^a In the Escape CZP 400mg Q2W/CZP 400mg Q2W group, subjects escaped from their randomized treatment (eg, CZP 200mg Q2W, CZP 400mg Q2W, or placebo) at Week 16.

^b Subjects in the CZP 400mg Q2W group had a protocol mandated dose down to CZP 200mg Q2W at Week 48.

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Pharmacokinetics results: <p>The observed plasma concentrations of CZP were consistent with the dosing regimens for the different treatment groups.</p> <p>The lower plasma concentrations of CZP observed in subjects who were anti-CZP antibody positive were as expected.</p>		
Immunogenicity results: <p>During the Combined Initial and Maintenance Treatment Period, as expected, the percentage of subjects who were anti-CZP antibody positive was higher in the CZP 200mg Q2W group than in the CZP 400mg Q2W group. In the CZP 200mg Q2W group, the percentages of subjects who were anti-CZP antibody positive at Weeks 16 and 48 were, respectively, 15.6% and 21.1% (14 and 19 of 90 subjects) while the corresponding percentages of subjects in the CZP 400mg Q2W group who were anti-CZP antibody positive at Weeks 16 and 48 were, respectively, 8.0% and 10.3% (7 and 9 of 87 subjects). Both groups included subjects who escaped from their initial treatment to 400mg Q2W at Week 16.</p> <p>The percentage of subjects who were anti-CZP antibody positive at any time during treatment was 17.5% (11 of 63 subjects) in the CZP 200mg Q2W to CZP 200mg Q2W at Week 16 to CZP 200mg Q2W at Week 48 group. The percentage of subjects who were anti-CZP antibody positive at any time during treatment was 10.2% (6 of 59 subjects) in the CZP 400mg Q2W to CZP 400mg Q2W at Week 16 to CZP 200mg Q2W at Week 48 group. In the placebo to Escape CZP 400mg Q2W at Week 16 to CZP 400mg Q2W at Week 48 group, the percentage of subjects who were anti-CZP antibody positive at any time during treatment was 13.0% (3 of 23 subjects).</p> <p>It was noted that the incidence of anti-CZP antibody positivity at Week 144 was sometimes higher or lower than the corresponding incidence at Week 48. The reason for this is that there were 2 sources for the change in the incidence of anti-CZP antibody positivity between Weeks 48 and 144. The first was that not all subjects included in the assessment at Week 48 continued into the Open-label Treatment Period, so anti CZP antibody-positive subjects could leave the study or enter the Open-label Treatment Period (randomly), thus either lowering or raising the proportion of anti-CZP antibody positive subjects remaining in the group of subjects who entered the Open-label Treatment Period. The second source was that of new first occurrences of anti-CZP antibody positivity in the subjects during the Open-label Treatment Period, which would increase the incidence of anti-CZP antibody positivity.</p> <p>While persistent high anti-CZP antibody responses with resulting falls in CZP concentration were observed in some subjects, in other subjects the anti-CZP antibody responses were transient and often associated with only transient falls in the CZP concentration.</p>		
Safety results: <ul style="list-style-type: none"> The safety profile was comparable between CZP treatment and placebo during the 16-week Initial Treatment Period with the exception of higher incidences with CZP treatment (particularly CZP 400mg Q2W) of Respiratory, thoracic, and mediastinal disorders (not driven by any particular preferred term), Infections and infestations (not driven by any particular preferred term), and injection site reactions, as would be expected for an anti-TNFα agent. Although the incidence was highest in 		

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<p>the CZP 400mg Q2W group for these 3 exceptions, there was not a consistent trend of a dose effect observed during the 16-week Initial Treatment Period and this was not further observed after long-term (up to 144 weeks) CZP exposure.</p> <ul style="list-style-type: none"> • Overall, the safety profile was comparable between the 200mg Q2W dose and the 400mg Q2W dose with no apparent dose effect with long-term CZP exposure. • The mean duration of exposure for the study in the All CZP group was 726.5 days. The duration of exposure was higher in the CZP 200mg Q2W group (mean: 553.5 days) compared with the CZP 400mg Q2W group (mean: 446.0 days), which is expected given that most subjects remained on or were switched to CZP 200mg Q2W at Week 48 (unless they were in the escape arm) per the dosing schedule. The total subject exposure years at risk was 471.09 years in the All CZP group, 274.52 years in the CZP 200mg Q2W group, and 196.58 years in the CZP 400mg Q2W group. • The exposure-adjusted incidence rate (IR) of any serious AE, including serious infections and other treatment-emergent AEs (TEAEs) of interest, during the entire study was low for both the CZP 200mg Q2W and CZP 400mg Q2W doses. Furthermore, the results suggest that there was no increase in the exposure-adjusted IR of any serious AE for the CZP 400mg Q2W group compared with the CZP 200mg Q2W group after long-term or higher CZP exposure. • Regarding TEAEs of interest, the incidence of serious infections (including opportunistic infections), malignancies, serious cardiovascular events, demyelinating-like disorders, hematopoietic cytopenias, and serious bleeding events was low in the All CZP group during the Combined Initial, Maintenance, and Open-label Treatment Period and similar in the CZP 200mg Q2W and CZP 400mg Q2W groups; there were no events of lupus, lupus-like illness, or serious skin reactions reported during the study (Table 2). • Maintaining CZP treatment at either dose (200mg Q2W or 400mg Q2W) for up to an additional 128 weeks beyond the Initial Treatment Period of 16 weeks was not associated with an increased safety risk compared with the Initial Treatment Period in the psoriasis population in this study. • The safety profile for up to 144 weeks of CZP treatment, including the type and incidence of TEAEs, was consistent with that expected in subjects with moderate to severe chronic plaque psoriasis receiving an anti-TNFα agent and with previous studies of CZP. No new safety signals were identified following a review of TEAEs, biochemistry values, hematology values, or vital signs at either the 200mg Q2W dose or the 400mg Q2W dose that have not been previously observed in other studies with CZP in subjects with psoriasis or other indications (ie, rheumatoid arthritis, Crohn's disease, axial spondyloarthritis, and psoriatic arthritis). • Overall, most TEAEs were mild or moderate in intensity and were not considered by the Investigator as related to study medication. 		

Table 2: Comparison of incidence and exposure-adjusted IRs across treatment periods for select safety parameters

Category Period	CZP 200mg Q2W			CZP 400mg Q2W			All CZP		
	N	n (%)	IR	N	n (%)	IR	N	n (%)	IR
TEAEs									
Initial (Weeks 0 to16) ^a	90	54 (60.0)	308.66	87	60 (69.0)	405.68	177	114 (64.4)	353.11
Combined Initial and Maintenance (Weeks 0 to 48) ^b	95	73 (76.8)	235.60	129	103 (79.8)	277.48	216	173 (80.1)	261.04
Open-label (Weeks 48 to 144) ^c	141	106 (75.2)	124.01	82	59 (72.0)	130.01	171	141 (82.5)	114.28
Combined Initial, Maintenance, and Open-label (Weeks 0 to 144) ^b	170	137 (80.6)	160.08	149	129 (86.6)	218.31	221	200 (90.5)	191.57
SAEs									
Initial (Weeks 0 to16) ^a	90	2 (2.2)	7.38	87	4 (4.6)	15.27	177	6 (3.4)	11.26
Combined Initial and Maintenance (Weeks 0 to 48) ^b	95	8 (8.4)	11.14	129	7 (5.4)	7.53	216	15 (6.9)	9.12
Open-label (Weeks 48 to 144) ^c	141	17 (12.1)	8.91	82	5 (6.1)	5.18	171	22 (12.9)	7.81
Combined Initial, Maintenance, and Open-label (Weeks 0 to 144) ^b	170	24 (14.1)	9.30	149	12 (8.1)	6.61	221	36 (16.3)	8.32
Serious infections									
Combined Initial, Maintenance, and Open-label (Weeks 0 to 144) ^b	170	6 (3.5)	2.23	149	3 (2.0)	1.55	221	9 (4.1)	1.96
Serious opportunistic infections									
Combined Initial, Maintenance, and Open-label (Weeks 0 to 144) ^b	170	0	--	149	1 (0.7)	0.51	221	1 (0.5)	0.21

Table 2: Comparison of incidence and exposure-adjusted IRs across treatment periods for select safety parameters

Category Period	CZP 200mg Q2W			CZP 400mg Q2W			All CZP		
	N	n (%)	IR	N	n (%)	IR	N	n (%)	IR
Malignancies									
Combined Initial, Maintenance, and Open-label (Weeks 0 to 144) ^b	170	3 (1.8)	1.10	149	2 (1.3)	1.03	221	5 (2.3)	1.07
Serious cardiovascular events									
Combined Initial, Maintenance, and Open-label (Weeks 0 to 144) ^b	170	0	--	149	1 (0.7)	0.51	221	1 (0.5)	0.21
Demyelinating-like disorders									
Combined Initial, Maintenance, and Open-label (Weeks 0 to 144) ^b	170	1 (0.6)	0.36	149	0	--	221	1 (0.5)	0.21
Hematopoietic cytopenias									
Combined Initial, Maintenance, and Open-label (Weeks 0 to 144) ^b	170	1 (0.6)	0.36	149	0	--	221	1 (0.5)	0.21
Serious bleeding events									
Combined Initial, Maintenance, and Open-label (Weeks 0 to 144) ^b	170	5 (2.9)	1.84	149	1 (0.7)	0.51	221	6 (2.7)	1.30

CZP=certolizumab pegol; IR=incidence rate; Q2W=every 2 weeks; SAE=serious adverse event; TEAE=treatment-emergent adverse event

^a Analyzed for the Safety Set.

^b Analyzed for the Treated with CZP Set.

^c Analyzed for the Open-label Extension Set.

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<p>Conclusions: Treatment with CZP 200mg Q2W and CZP 400mg Q2W resulted in clinically meaningful and statistically significant improvements in PSO area and severity, global physician-assessment of disease activity, and patients' HRQoL through 16 weeks of treatment, and these improvements were consistently maintained through Week 48 and continued to be maintained through Week 144.</p> <p>Overall, these results demonstrate that efficacy is maintained while receiving continuous CZP 200mg Q2W treatment for up to 3 years. Based on the dose-down study design, full 3-year exposure to CZP 400mg Q2W is not available in this study; however, maintenance of efficacy has been shown for continuous open-label CZP 400mg Q2W treatment for up to ~2.5 years (ie, based on CZP 400mg Q2W exposure in the Escape CZP 400mg Q2W/CZP 400mg Q2W group).</p> <p>For subjects receiving CZP 400mg Q2W who dosed down to CZP 200mg Q2W, a decline in the clinical response was observed over time for some subjects; however, the durability of efficacy response was observed in a subset of subjects who were PASI75 responders at Week 48 (ie, nonadjusters). Further exploration is needed to identify who may require continuous CZP 400mg Q2W treatment.</p> <p>The safety profile for CZP in subjects with moderate to severe chronic plaque PSO in PS0002 was similar to that observed in previous studies with CZP and was consistent with that expected in subjects receiving anti-TNFα therapy. No notable differences were observed in the safety profile between CZP 200mg Q2W and CZP 400mg Q2W with no apparent dose response over long-term CZP exposure. No new safety signals have been identified following CZP treatment for up to 144 weeks. Overall, considering both efficacy and safety results, this study demonstrated a positive benefit-risk balance of CZP treatment with CZP 200mg Q2W and CZP 400mg Q2W in subjects with moderate to severe PSO.</p>		
Report date: 09 May 2019		