2024-12-09

Subject:	Posting study results to EudraCT
EudraCT number:	2021-001695-42
Protocol:	CAN04CLIN004
Study Sponsor:	Cantargia AB Scheelevägen 27 SE-223 63 Lund, Sweden
Study title:	A Phase 1/2 study of CAN04, a fully humanised monoclonal antibody against IL1RAP, in combination with different chemotherapy regimens in subjects with advanced solid tumours.

As communicated in October 2022 the recruitment to the above-mentioned trial was ended prematurely due to strategic reasons and not related to any safety or efficacy considerations. Business driven re-prioritization led to the reduction of the portfolio of clinical trials that were ongoing at that time.

All patients who were enrolled and received treatment at the time of the communication of the premature termination of recruitment continued their study participation according to protocol. Global end of the trial date was 23 June 2023.

Due to the premature termination of the trial, results are posted to EudraCT by means of a synopsis of the clinical study report.

Cantargia AB
Scheelevägen 27
223 63 LUND
Sweden

Tel. +46-46-275 62 60
www.cantargia.com
email: regulatory@cantargia.com
org nr. 556791-6019

SYNOPSIS

<table>
<tr><td>Name of Sponsor/Company:
Cantargia AB</td><td rowspan="3">Individual Study Table Referring to Part of the Dossier
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<tr><td>Name of Finished Product:
Nadunolimab (CAN04)</td></tr>
<tr><td>Name of Active Ingredient:
Nadunolimab</td></tr>
<tr><td colspan="3">Title of study: A Phase 1/2 study of CAN04, a fully humanised monoclonal antibody against IL1RAP, in combination with different chemotherapy regimens in subjects with advanced solid tumours</td></tr>
<tr><td colspan="3">Investigator(s):

Judith Raimbourg, MD
Institut de Cancerologie de l’Ouest ICO, Saint Herblain, France
Coordinating investigator, France

Rocio Garcia-Carbonero, MD
Hospital Universitario 12 Octubre, Madrid, Spain

Enriqueta Felip Font, MD
Hospital Universario Vall d’Hebron, Barcelona, Spain</td></tr>
<tr><td colspan="3">Study site(s): A total of 6 sites, in France (n=4) and Spain (n=2).</td></tr>
<tr><td colspan="3">Publication (reference): N/A</td></tr>
<tr><td colspan="2">Studied period:

First subject enrolled: 22 September 2021

Last subject last visit: 23 June 2023</td><td>Phase of development:

Phase 1 / 2</td></tr>
<tr><td colspan="3">Background and rationale:

Chronic inflammation is of major importance for tumour progression and the interleukin-1 (IL-1) system is an important component of the inflammatory microenvironment of tumours. The IL-1 receptor accessory protein (IL1RAP) is a coreceptor to the IL-1 receptor that is required for IL-1 signalling (IL-1α and IL-1β). Several malignancies have been found to</td></tr>
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overexpress IL1RAP and evidence indicates that many tumours depend on IL-1 signalling for tumour growth, as well as resistance to different chemotherapies and targeted therapies.

Nadunolimab is a monoclonal antibody with enhanced antibody-dependent cell cytotoxicity (ADCC) properties and high affinity to IL1RAP. In nonclinical models, nadunolimab demonstrated the ability to induce anti-tumour effects, either by blocking IL-1α and IL-1β signalling or through ADCC against IL1RAP expressing cells.

The aim of this Phase 1/2 study was to establish the safety, tolerability, and initial efficacy of nadunolimab in combination with 3 standard of care (SoC) chemotherapies (mFOLFOX, docetaxel [DTX], or gemcitabine/cisplatin [G/C]) in subjects with locally advanced or metastatic cancer. The dose escalation phase (Phase 1) of the study aimed to determine a maximum tolerated dose (MTD) and/or provisional recommended Phase 2 dose (RP2D) of nadunolimab in combination with the 3 different SoC chemotherapies. Phase 2 of the study aimed to further evaluate safety and initial efficacy of the provisional nadunolimab RP2D selected in combination with the SoC chemotherapies mFOLFOX, DTX, or G/C in subjects with colorectal cancer (CRC), non-small cell lung cancer (NSCLC), or biliary tract cancer (BTC) respectively.

The rationale for combining nadunolimab and SoC chemotherapies is based on preclinical evidence showing an upregulation of the IL-1 pathway in response to a chemotherapy insult which may constitute a survival signal; and promising clinical data from the first-in-human (FIH) clinical trial of nadunolimab (CAN04CLIN001; CANFOUR) supporting the safe administration of the investigational product to subjects with solid tumours as monotherapy and in combination with chemotherapy. Serum biomarker data confirmed target engagement and inhibition of IL-1 pathways.

Objectives:

<u>Dose escalation phase (Phase 1)</u>

Primary objective:

- To assess the safety and tolerability of CAN04 in combination with selected standard chemotherapy regimens and to establish MTD and/or RP2D.

Secondary objectives:

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- To assess preliminary anti-tumour activity of CAN04 in combination with selected standard chemotherapy regimens.
- To characterise the pharmacokinetic (PK) profiles of CAN04 after a single dose and at steady state after multiple doses in combination with chemotherapy using a population PK (PopPK) analysis approach.

Exploratory objectives:

- To evaluate the effect of CAN04 when administered in combination with chemotherapy on subject-reported cancer-related fatigue and health-related quality of life (Phase 2 only).
- To assess pharmacodynamic effects of CAN04 when administered in combination with SoC chemotherapy.
- To assess disease-related, genetic, inflammatory, immune, or microenvironment-related parameters related to CAN04, in the circulation and in tumour tissue.
- To assess anti-drug antibodies (ADA) formation against CAN04.

Methodology:

This Phase 1/2 open-label, multicentric, non-randomised, parallel-arm study aimed to establish the safety, tolerability, and initial efficacy of nadunolimab in combination with 3 SoC chemotherapies (mFOLFOX, DTX and G/C). The 3 arms in each phase of the study were run and analysed independently.

In the **dose escalation phase (Phase 1),** escalating repeat doses of nadunolimab in combination with 3 selected chemotherapy regimens belonging to different cytotoxic classes (mFOLFOX, DTX or G/C) were evaluated. This phase consisted of 3 non-randomised parallel treatment arms with the following dose levels:

- **mFOLFOX arm:** Subjects treated with escalating repeat doses of nadunolimab (0.5, 1.0, and 2.5 mg/kg dose levels) and mFOLFOX.
- **DTX arm:** Subjects treated with escalating repeat doses of nadunolimab (0.5, 1.0, and 2.5 mg/kg dose levels) and DTX.
- **G/C arm:** Subjects treated with escalating repeat doses of nadunolimab (1.0, 1.75, and 2.5 mg/kg dose levels) and G/C.

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In the initially used dosing schedule (Schedule A), nadunolimab in combination with chemotherapy was dosed in Cycle (C) 1 on Day (D) 1/D2 followed by administration of nadunolimab +/- chemotherapy on C1D8, depending on the treatment arm.

It was observed that, in a significant number of subjects receiving nadunolimab on D1 that there was an acute reduction in neutrophils on D2 before the administration of chemotherapy. Based on the collected data, the safety review committee (SRC) could recommend testing additional nadunolimab administration schedules with the same SoC cytotoxic treatments (Protocol Version 2.0, dated 21 February 2022):

- Schedule B (implementation of nadunolimab priming dose i.e., administration of nadunolimab 7 days prior to start of combination therapy on C1D1).
- Schedule C (nadunolimab priming dose with removal of nadunolimab dosing on C1D1), or to de-escalate nadunolimab initial dose to dose level -1 (0.5 mg/kg) for the G/C Arm.

Subject allocation was performed employing a modified toxicity probability interval (mTPI) design. The mTPI method relies upon a statistical toxicity probability algorithm (determined by dose limiting toxicity [DLT] rate: 25% [equivalence interval: 25% to 33%]) to support change in dose level. The output of mTPI at each dose escalation step can be escalation, no change, dose de-escalation, or stop enrolment. Intermediate dose levels (e.g., 0.75, 1.25, 1.5, 1.75, or 2.25 mg/kg) or other intermediate dose levels as per request of the SRC were evaluated. The final decision of dose escalation or de-escalation and identification of the MTD was made by the SRC, after assessing all safety data.

The MTD of nadunolimab was to be primarily determined by the number of subjects with DLTs and nature of the DLTs observed at each dose level, as well as safety data, PK, pharmacodynamic data, and anti-tumour activity. The MTD was to be used as provisional RP2D in Phase 2. If the MTD was not reached, the maximum administered dose (2.5 mg/kg) was to be chosen as provisional RP2D.

Phase 2 of the study aimed to further evaluate safety and initial efficacy of the provisional nadunolimab RP2D (dose selected at the end of Phase 1) in combination with SoC chemotherapy (mFOLFOX, DTX, and G/C) in 3 specific tumour indications (CRC, NSCLC and BTC, respectively).

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The Sponsor decided to terminate the study for strategic reasons before Phase 2 was initiated. Therefore Phase 2 is only briefly described in this clinical study report (CSR).

Number of subjects:

Number of subjects planned/dosed in Phase 1: 45-60/36 (11 in Spain and 25 in France)
Number of subjects planned/dosed in Phase 2: 120/0

Diagnosis and main criteria for inclusion:

The key selection criteria for this study were as follows:

Phase 1 Inclusion Criteria:

- Subject of ≥18 years of age, able to give a consent, with an Eastern Cooperative Oncology Group (ECOG) performance status (PS) score of 0 or 1.
- Subject with histologically or cytologically confirmed diagnosis of locally advanced cancer or metastatic cancer. Response Evaluation Criteria in Solid Tumours (RECIST) v1.1 measurable disease not required.
- Subject with a condition where all standard therapeutic options with proven survival benefit had been exhausted, refused by the subject, or were contraindicated.

OR

- Subject with a condition where 1 of the 3 study regimens (mFOLFOX, DTX, or G/C) was considered SoC for the next-line treatment.

Per treatment arm:

mFOLFOX arm: All subjects who were eligible for mFOLFOX. A maximum of 2 previous lines of cytotoxic chemotherapy treatment for metastatic disease was allowed (targeted agents without cytotoxic effect were not counted).

DTX arm: Subjects eligible to receive DTX as monotherapy for NSCLC enrolled in this treatment arm. No more than 2 lines of prior systemic anti-cancer therapies for the metastatic disease were allowed. Targeted therapy was not counted as prior therapy. Subjects who received DTX monotherapy in a prior line of therapy were not eligible.

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G/C arm: All subjects eligible for G/C enrolled (including first-line treatments). Subjects with BTC were prioritised.

Key exclusion criteria:

- Subject had another histologically confirmed cancer different from those described in inclusion criteria, except for cervical carcinoma in situ, superficial non-invasive bladder tumour, curatively treated stage I non-melanoma skin cancer, or prostate cancer subjects curatively treated with surgery or radiation and not receiving systemic or androgen deprivation therapy. Subjects with a history of another cancer, different from that described in the inclusion criteria, could be enrolled if the cancer was curatively treated ≥5 years ago and non-recurrence had been documented in the past 2 years.
- Subject to receive mFOLFOX or DTX: having peripheral sensory neuropathy Grade ≥2.
- Subject to receive DTX and nadunolimab: if they had liver metastases and aspartate aminotransferase and/or alanine aminotransferase >1.5 × upper limit of normal (ULN) concomitant with alkaline phosphatase >2.5 × ULN.
- Subject had uncontrolled brain metastases. Subjects were allowed to be enrolled if brain metastasis had been previously treated with surgery, and/or stereotactic radiosurgery and were considered controlled (controlled by the dose ≤10 mg/day of prednisone or equivalent) at the time of the first dose of nadunolimab. For asymptomatic subjects without known brain metastases, brain imaging during screening was not required. Subjects with known brain metastases should have undergone brain imaging in the frame of the imaging screening procedures.
- Subject had a history of a relevant autoimmune disease as per assessment of the Investigator or autoimmune disease requiring systemic immunosuppressive therapy (daily prednisone equivalent doses >10 mg/day).
- Subject was expected to require any other form of systemic or localised anti-neoplastic therapy while on the study (including maintenance therapy with another agent, radiation therapy, and/or surgical resection).
- Subject has had an allogeneic tissue/solid organ transplant.
- Subject received a live vaccination, etanercept, or other tumour necrosis factor-alpha inhibitors prior to (within 28 days of first study drug administration) participation in this study. For severe acute respiratory syndrome coronavirus 2 vaccines, a wash-out of 2 weeks before first administration of study drug was recommended.
- Subject had treatment with systemic anti-cancer treatments, or major surgery within 4 weeks before the first dose of study drug or 5 half-lives, whichever is shorter.

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Subjects should have recovered from previous treatment toxicity to Grade 1, baseline (except alopecia and peripheral neuropathy).

- Subject received radiotherapy ≤4 weeks before the start of treatment (≤2 weeks for palliative irradiation to peripheral tumour lesions) and has not recovered to Grade 1 or better from related toxicity of such therapy (except for alopecia).
- Subject had a history or current evidence of any condition, therapy, or laboratory abnormality that could confound the results of the study, interfere with the subject's participation for the full duration of the study, or was not in the best interest of the subject to participate, in the opinion of the treating Investigator.

mFOLFOX arm/CRC arm exclusion criteria:

- Subjects with clinical laboratory test values at screening below the lower limit of normal for any of the following electrolytes: potassium, magnesium, corrected or ionised calcium. **Note:** Subjects achieving normal values for these electrolytes with supplements during the screening period were allowed at the discretion of the Investigator. Serum chemistry documenting normal electrolyte values was required prior to each dose of oxaliplatin.
- Subjects with congenital long QT syndrome or a history of ventricular arrhythmias, including bradyarrhythmia (<50 beats per minute).
- Subjects with dihydropyrimidine dehydrogenase (DPD) deficiency or who had been treated within 4 weeks of first dose of study treatment with potent DPD inhibitors (e.g., brivudine, sorivudine). Subjects who previously received 5-fluorouracil (5-FU) without toxicity that could be correlated with DPD deficiency did not need to be tested.
- Subjects with pernicious anaemia or other anaemias due to vitamin B12 deficiency that could not be corrected before the first dose of mFOLFOX.

Test product, dose and mode of administration, batch number:

Nadunolimab was administered intravenously in the study.

The dose escalation phase (Phase 1) evaluated escalating repeat doses of nadunolimab in combination with 3 selected chemotherapy regimens (mFOLFOX, DTX, or G/C) in 3 parallel treatment arms with the following dose levels:

- 0.5, 1.0, and 2.5 mg/kg of nadunolimab in the mFOLFOX arm.
- 0.5, 1.0, and 2.5 mg/kg of nadunolimab in the DTX arm.

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- 1.0, 1.75, and 2.5 mg/kg of nadunolimab in the G/C arm.

In the Phase 2 study, provisional nadunolimab RP2D (dose selected at the end of the dose escalation phase [Phase 1]) was planned to be administered intravenously in combination with SoC chemotherapy (mFOLFOX, DTX, or G/C).

The nadunolimab batch used for the study was 1359.

Duration of treatment:

The planned duration of treatment was either:

- 12 treatment cycles (14 days per cycle) of nadunolimab/mFOLFOX, or
- 6 cycles for nadunolimab/DTX (every 3 weeks), or
- 8 cycles for nadunolimab/G/C (every 3 weeks)

The was an optional extension for all treatments options. The actual duration of treatment varied among subjects depending on the number of treatment cycles received.

Endpoints, Phase 1:

Primary safety endpoints:

- Nature, grade, and frequency of DLTs.
- Frequency, duration, and severity (according to National Cancer Institute – Common Terminology Criteria for Adverse Events [CTCAE] v5.0) of adverse events (AEs).
- Changes in vital signs, serum chemistry, and haematology.
- Treatment modifications measured as a percentage of relative dose intensity.
- Percentage of subjects discontinued from all or part of study treatment and reasons for discontinuations.

Secondary efficacy endpoints:

- Overall response rate (ORR) defined as the percentage of subjects with partial response (PR) or complete response (CR) based on RECIST v1.1.
- Immune overall response rate (iORR) defined as the percentage of subjects with immune partial response (iPR) or immune complete response (iCR) based on immune Response Evaluation Criteria in Solid Tumours (iRECIST).
- Progression-free survival (PFS) per RECIST v1.1, measured from the start of study treatment until disease progression or death from any cause.

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- Immune progression-free survival (iPFS) by iRECIST.
- Disease control rate (DCR) measured as a percentage of subjects with CR + PR + stable disease (SD) ≥16 weeks.
- Immune disease control rate (iDCR) measured as a percentage of subjects with iCR + iPR + immune unconfirmed progressive disease (iUPD)/immune stable disease (iSD) ≥16 weeks.
- Duration of response (DOR) defined as the time from response to progression/death.
- Change from baseline upon treatment in serum biomarkers: CEA and CA19-9 (CEA for subjects with CRC; CEA and CA19-9 for subjects with BTC).
- Changes from baseline upon treatment in ECOG PS and body weight.

Secondary PK endpoints:

- Serum PK parameters of CAN04 and potential covariates that impact the PK parameters.

Exploratory endpoints:

- Changes upon treatment in Functional Assessment of Chronic Illness Therapy (FACIT)-Fatigue Scores (Phase 2 only).
- Changes upon treatment in European Organisation for Research and Treatment of Cancer (EORTC) Quality of life questionnaire (QLQ)-C30 scores (Phase 2 only).
- Changes upon treatment in serum biomarkers including, but not limited to, IL-6, IL-8, C-reactive protein (CRP) and soluble IL1RAP, and in correlation with other biomarkers.
- Changes upon treatment in IL1RAP expression and other disease-related inflammatory, immune, or microenvironment-related emerging biomarkers (protein, RNA, genomic or other) in tumour tissue.
- Changes upon treatment in disease-related biomarkers (inflammatory, immune, or microenvironment-related emerging biomarkers) in circulation and changes associated with study treatment.
- ADA against CAN04.

Statistical methods:

Sample size: Approximately 45-60 subjects were to be dosed with nadunolimab in the dose escalation phase (Phase 1), approximately 15-20 subjects per treatment arm. If additional nadunolimab dosing schedules were to be tested in more arms, the number of subjects enrolled were to be increased correspondingly. No formal power calculation was performed for the dose escalation phase (Phase 1). The number of subjects to be evaluated was considered adequate to

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evaluate the initial safety of the combinations of nadunolimab with mFOLFOX, DTX or G/C, respectively, and to confirm the safety and efficacy of the nadunolimab dose selected at the end of the dose escalation phase (Phase 1) (proposed RP2D). This dose could be different for each arm.

For Phase 2, each of the treatment arms had a maximum sample size of 40 evaluable subjects (120 subjects), which was considered adequate to detect promising efficacy signals based on simulations of the chosen Bayesian design. The type I error was ≤ 4% for each of the treatment arms.

Safety analyses: Adverse event summaries included AEs, treatment-emergent adverse events (TEAEs), serious adverse events (SAEs), and adverse events of special interests (AESIs) (including DLTs and infusion-related reactions [IRRs]) by severity grade (according to CTCAE v5.0) and causality as well as deaths and discontinuations (of treatment) due to TEAEs. The number and percentage of subjects with at least 1 TEAE was summarised by system organ class and preferred term; further separate summaries were presented by severity and relationship as assessed by the Investigator and/or Sponsor. Other safety endpoints were summarised with descriptive statistics.

Efficacy analyses: Tumour response was determined by the Investigator according to radiological assessment (computerised tomography [CT]/magnetic resonance imaging [MRI] scan) following RECIST v1.1 and iRECIST. Efficacy assessments were derived from this assessment.

Serum CEA and CA19-9 responses were defined as >90% reduction in serum values from baseline to nadir. A 50% reduction cut-off was also evaluated. Changes in ECOG PS and in body weight from baseline were listed and summarised by time point.

Other analyses: Descriptive statistics were used for PK analysis, immunogenicity analysis, and exploratory endpoints. Additionally, exploratory analyses to assess correlations between biomarkers, and between biomarkers and response or other subject characteristics and response were performed, depending on the available data distribution.

Interim analyses: Three interim analyses for each treatment arm were performed to determine whether enrolment should stop earlier. At each interim analysis, the ORR of each treatment arm was calculated using accumulating subjects' data and then compared to the particular treatment arm's historical controls using the designated Bayesian enrichment design. Bayesian adaptive design allows informed and efficient decision making through ongoing analysis of

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existing study data. Final success or futility for each treatment arm was determined after the review of safety and efficacy endpoints.		

Summary of results and conclusions

CAN04CLIN004 is a Phase 1/2 open-label, multicentric, non-randomised, parallel-arm study aimed to establish the safety, tolerability, and initial efficacy of nadunolimab in combination with 3 SoC chemotherapies (mFOLFOX, DTX and G/C). The 3 arms in each phase of the study were run and analysed independently. The trial was prematurely terminated by the Sponsor for business reasons before Phase 1 determined the MTD of nadunolimab for each combination.

Safety summary

The Safety Population consisted of a total of 36 subjects:

- Eight subjects in the DTX arm. The 8 subjects received nadunolimab at 0.5 mg/kg: 5 with Schedule A and 3 with Schedule B.
- Fourteen subjects were treated in the G/C arm: 9 subjects received nadunolimab 1.0 mg/kg, 4 subjects at 1.75 mg/kg and 1 subject at 0.04 mg/kg in Cycles 1 and 2 due to a dosing error. All were dosed with Schedule A.
- Fourteen subjects were treated in the mFOLFOX arm: 7 subjects received nadunolimab at 0.5 mg/kg and 7 subjects at 1.0 mg/kg. All with Schedule A.

Dose Limiting toxicities were reported in the 3 arms:

- mFOLFOX arm: neutropenia delayed the start of Cycle 2 or 3 in 3 subjects. The 4th DLT was Grade 3 diarrhoea. The highest dose tested was 1.0 mg/kg.
- DTX arm: 1 subject had Grade 3 stomatitis. 0.5 mg/kg with both Schedule A and B was the highest dose tested.
- G/C arm: 1 subject had Grade 4 thrombocytopenia. The highest dose tested was 1.75 mg/kg.
- There were 11 non-evaluable subjects for DLT. The majority in DTX and G/C arms. The majority were non-evaluable because they could not receive full planned treatment in Cycle 1.

The most frequent PTs (% of subjects) were asthenia (75%), neutropenia (72%), thrombocytopenia (58%), anaemia (50%), diarrhoea (50%), nausea (47%), decreased appetite (44%), neuropathy peripheral (33%), constipation (31%) and pyrexia (31%). Haematological toxicity was greater in the G/C arm compared with the other arms. Whereas diarrhoea and neuropathy peripheral were greater in the mFOLFOX arm. Notably 19% of subjects were diagnosed with COVID19 infection. All COVID 19 cases were Grade 1/2.

Among CTCAE Grade 3 or 4 TEAEs related to nadunolimab, the most common SOC, with PTs reported at least once in ≥2 subjects (≥8%) was blood and lymphatic system disorders affecting a total of 18 subjects (50%). No CTCAE Grade 5 TEAEs related to nadunolimab was reported. The most common PTs (% of subjects) among CTCAE Grade 3 or 4 TEAEs were neutropenia (50%), thrombocytopenia (22%), anaemia (14%), diarrhoea (8%), and

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lymphopenia (8%). This aligned with the reported DLTs. 11 subjects (17%) were affected by at least one IRR. Only 1 was Grade 3 and serious.

The most common nadunolimab related TEAEs were neutropenia, thrombocytopenia, febrile neutropenia affecting 5 subjects, 2 subjects each in the DTX and G/C arms and 1 subject in the mFOLFOX arm.

A total of 6 TEAEs in 5 subjects led to discontinuation of nadunolimab, 3 TEAEs each in G/C arm and mFOLFOX arm. These TEAEs were neutropenia (2), thrombocytopenia (1), general physical health deterioration (1), asthenia (1) and stomatitis (1). None of the fatal TEAEs (n=3) were related to nadunolimab or chemotherapy.

Efficacy results summary

The trial enrolled in the Phase 1 dose escalation part a total of 36 subjects with metastatic cancer in 3 parallel arms with 3 different SoC chemotherapy drugs. The 36 subjects treated were considered evaluable for response. The DTX arm was the only one that enrolled only NSCLC subjects. The mFOLFOX arm enrolled 5 of 14 subjects with CRC and the G/C arm 8 of 14 subjects with BTC.

- In the DTX arm, no subjects showed PR. DCR was 38%. The median PFS was 1.5 months (95% CI:0.6, 6.2).
- In the G/C arm, 3 subjects showed PR; 2 subjects with NSCLC and 1 subject with BTC. DCR was 93%. Duration of response was 11.5 months. The median PFS was 6.2 months (95% CI: 5.7, 8.5).
- In the mFOLFOX arm, 3 subjects showed PR; one subject each with colorectal, gastric cardia and germ cell cancer. DCR was 43%. Duration of response was 7 months. The median PFS was 4.6 months (95% CI:1.4, 7.2).

Conclusion:

CAN04CLIN004 was prematurely closed by the Sponsor for strategic reasons before dose escalation was completed, therefore nadunolimab MTD was not identified. In general, the toxicity observed for the 3 combinations was aligned with what was previously described for other nadunolimab/cytotoxic combinations, mostly haematological. In the FOLFOX arm, higher doses of nadunolimab correlated with a later onset and reduced incidence of neuropathy, a major and serious side effect of several chemotherapies like taxanes and oxaliplatin.

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The evaluation of efficacy was limited. None the less, signals of efficacy were documented in subjects treated with G/C and mFOLFOX, achieving responses with prolonged duration for this pretreated population.		
Date of the report: 29 Nov 2024		