

Ph 2/3 Trial for Selepressin in the Treatment of Vasopressor- Dependent Septic Shock

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Trial Basics

- Selepressin:
 - selective vasopressin V1a agonist for treatment of vasopressor-dependent septic shock
- Arms created by level of concentration – allowing multiple “doses” to be blinded and infusion rates can vary:

Treatment Arm	Starting Dose (ng/kg/min)	Maximum Dose (ng/kg/min)
0	0	0
1	1.7	2.5
2	2.5	3.75
3	3.5	5.25
4	5.0	7.5

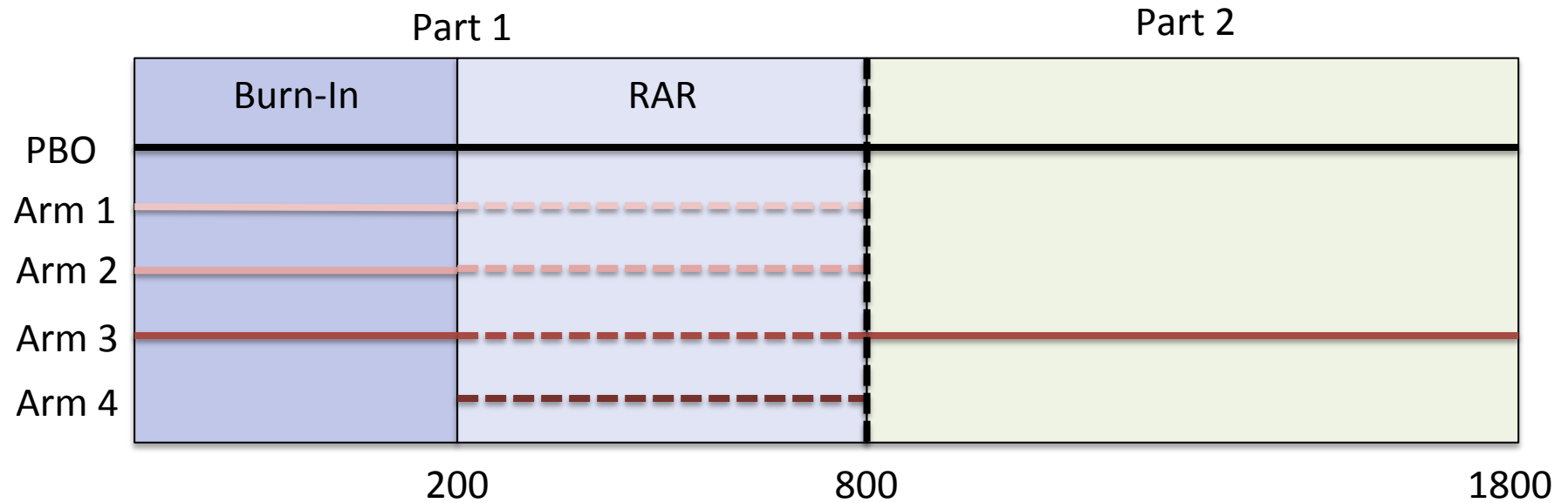
Trial Basics

- Double-blind, placebo-controlled
- “Pivotal Trial” Endpoint
 - Composite mortality/morbidity endpoint

Possible Phase 2?

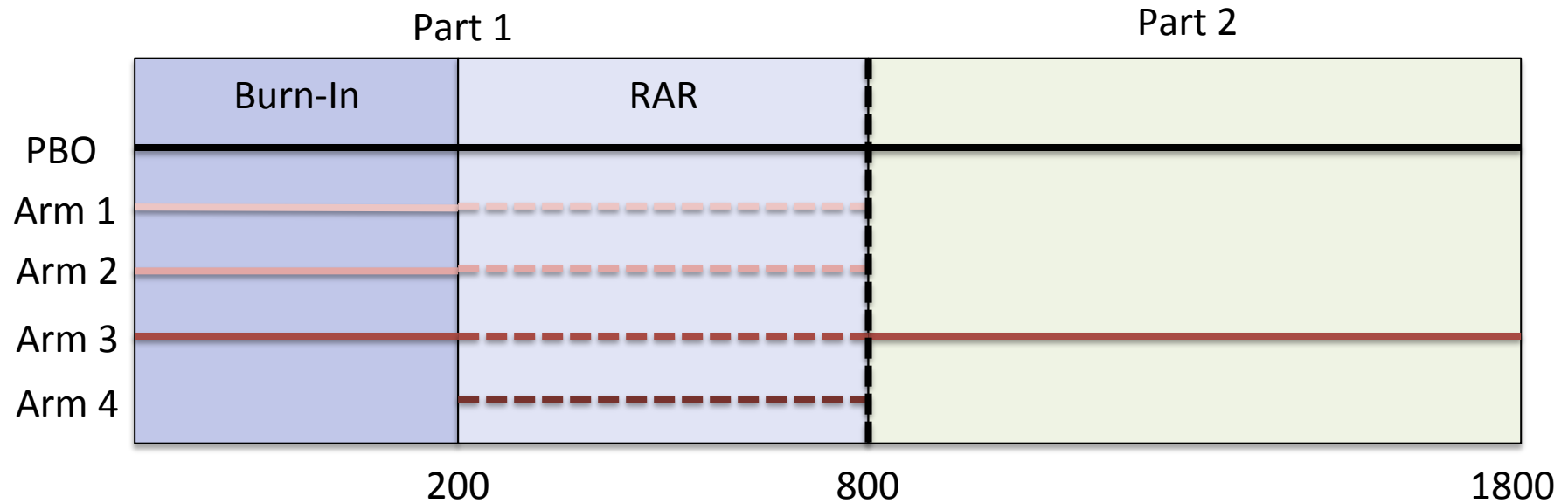
- 200 patient study of a “biomarker” for dose selection (2 arms given fixed nature?)
 - Then phase III
- 400 patient trial of doses on primary endpoint to select dose and make phase 3 go/no-go
 - Then phase III
- 800 patient trial of doses on primary endpoint to select dose and make phase 3 go/no-go
 - Then phase III

Adaptive Phase 2



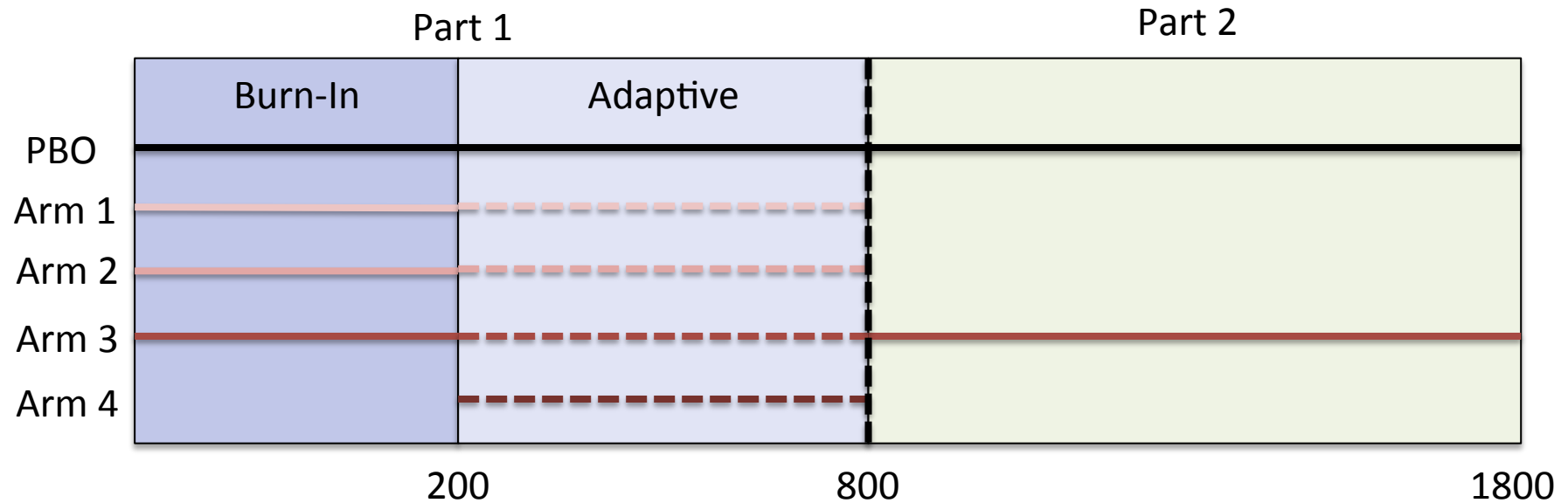
Phase 2-like

Part 1: Burn-In



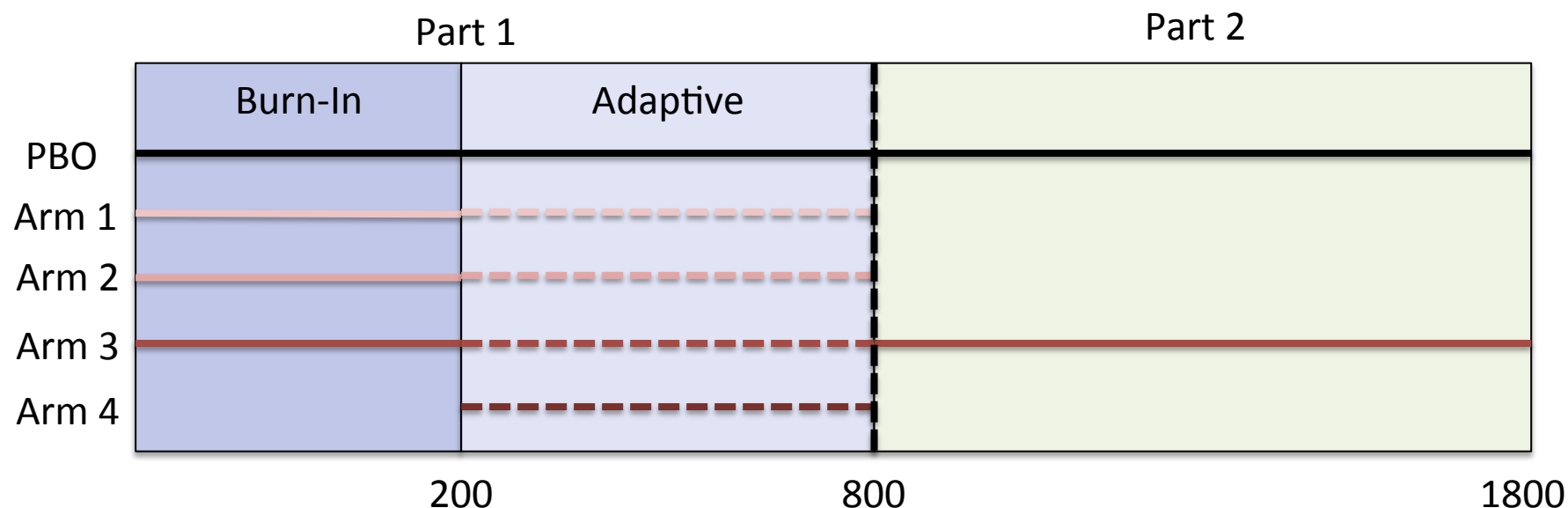
- Start with 3 doses + PBO during 200 patient burn-in
 - 3:2:2:2:0 (Arms 0:1:2:3:4)

Part 1: Adaptive



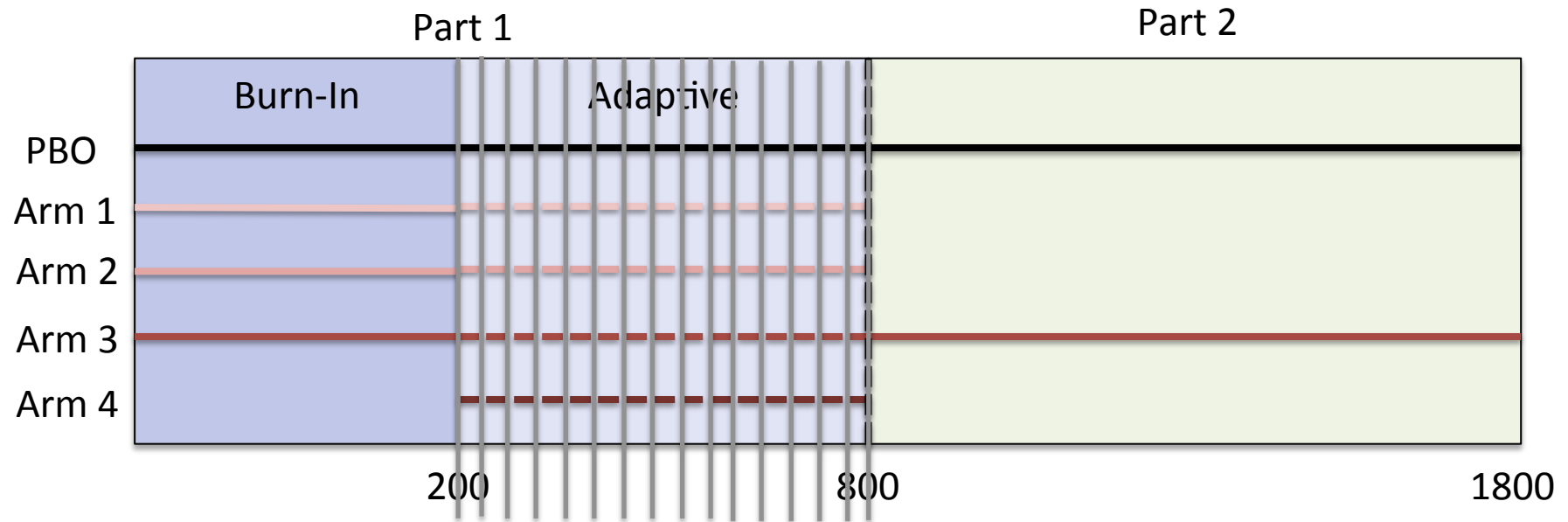
- Interims occur from 200-800 continue monthly for Part 1
 - Create response adaptive randomization over active arms ($1/3 : ? : ? : ? : ?$) for next month
 - Futility / Go to Part 2 decisions

Part 2: Confirm



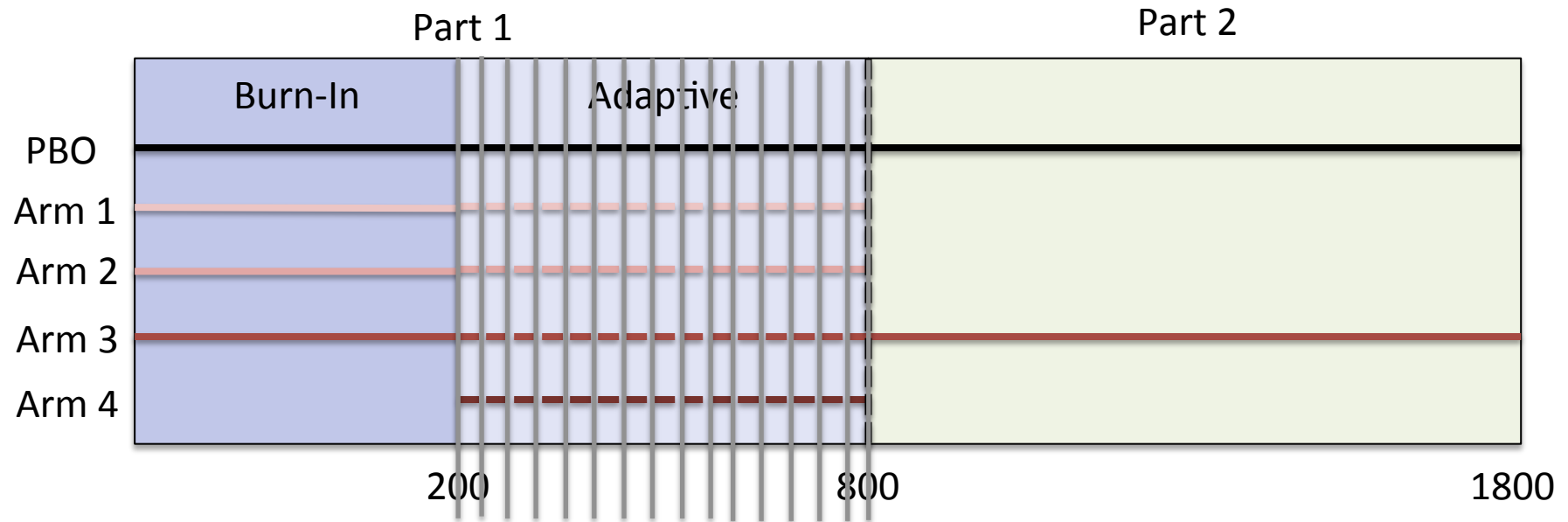
- Enroll 1:1 to PBO and selected 'target' dose to make the final sample size 1800
 - Part 2 minimum is 1000 patients
 - Futility analyses every month

Part 1: RAR



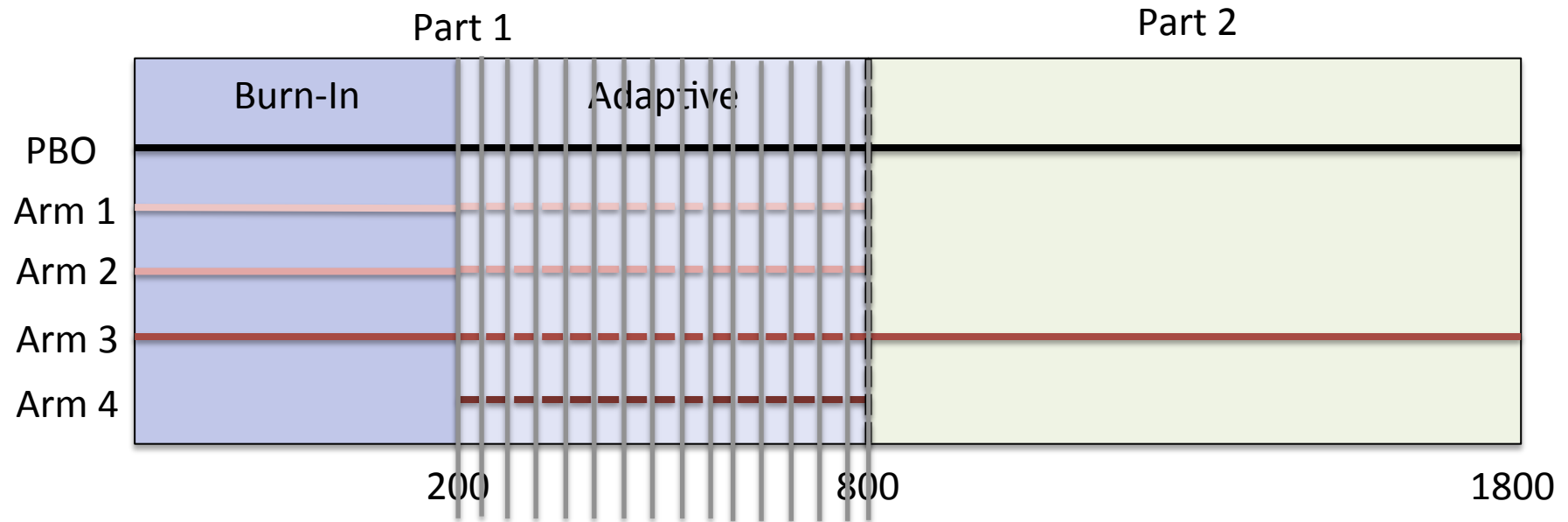
- Randomization probability proportional to the probability the arm maximizes the effect on the primary endpoint
 - Open “Arm 4” if $\geq 50\%$ probability Arm 3 has better effect on the primary endpoint than Arm 2.

Part 1: Decisions



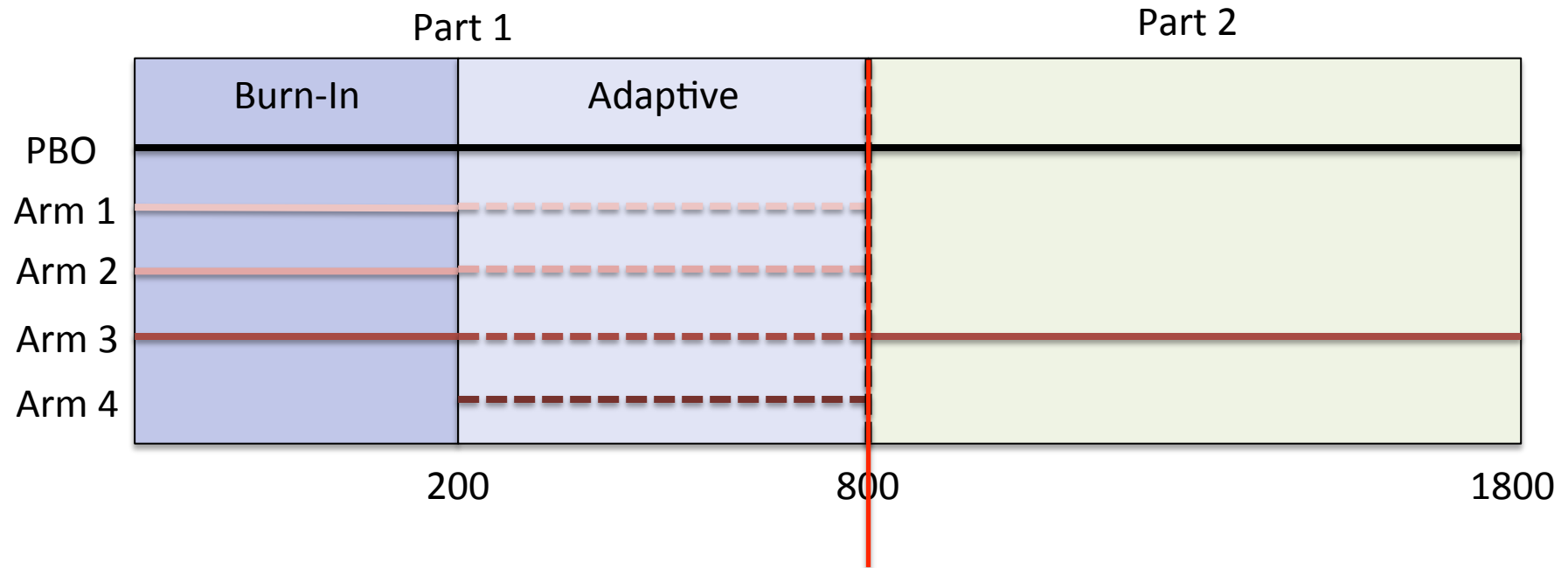
- Go to Part 2 if ($n \geq 300$)
 - Predictive probability of superiority @ 1800 with most likely maximum dose $\geq 90\%$

Part 1: Decisions



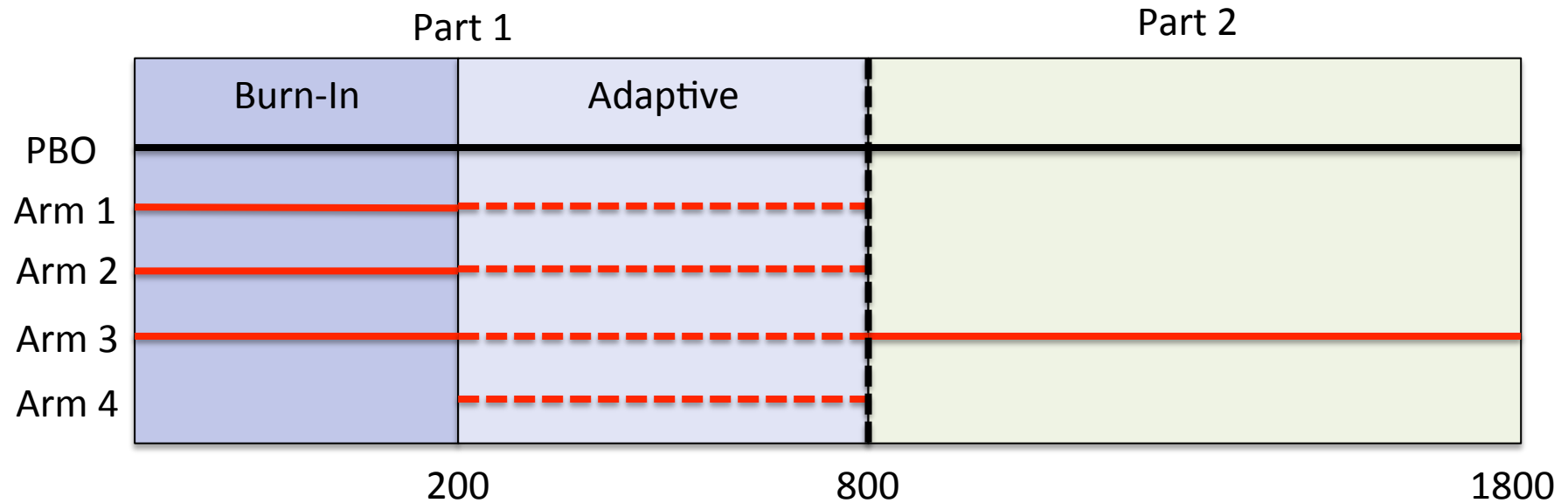
- Stop for futility if
 - Predictive probability of superiority @ 1800 with most likely maximum dose $< 5\%$

Part 1: n=800 Decision



- Go to Part 2 if (n=800)
 - Predictive probability of superiority @ 1800 with most likely maximum dose $\geq 25\%$
 - If not stop the trial

Final Analysis



- Pool all selepressin arms (Part 1 & Part 2) in final analysis vs. PBO with Wilcoxon Test (Van Elteren's) at the 0.025 level
- Type I error controlled analysis of superiority

Bayesian Statistical Model

- Statistical model to drive all adaptations
- Model mixture of death and morbidity outcome for survivors
 - Proportional effect for selepressin treatment arms ($\alpha_1, \dots, \alpha_4$)
- Model for morbidity for survivors
 - Proportional effect for selepressin treatment arms ($\theta_1, \dots, \theta_4$)
- Inverted U-Dose-Response models

Operating Characteristics

Scenario (Effect)	Prop. Of Trials			Mean Sample Size			
	Success	Part 2	1800	Total	Part 1	Part 2	Target Dose
0	.016	.148	.043	770.5	638.6	131.9	709.5
A	.127	.370	.187	1069.4	694.6	374.8	712.2
B	.497	.680	.569	1442.2	665.6	776.6	741
C	.854	.895	.875	1690.3	582.4	1107.9	756.5
D	.983	.986	.985	1785.2	501.6	1283.6	776.5
E	1	1	1	1800	441	1359	796.1
F	1	1	1	1800	438.3	1361.7	806.1

Individual Scenarios

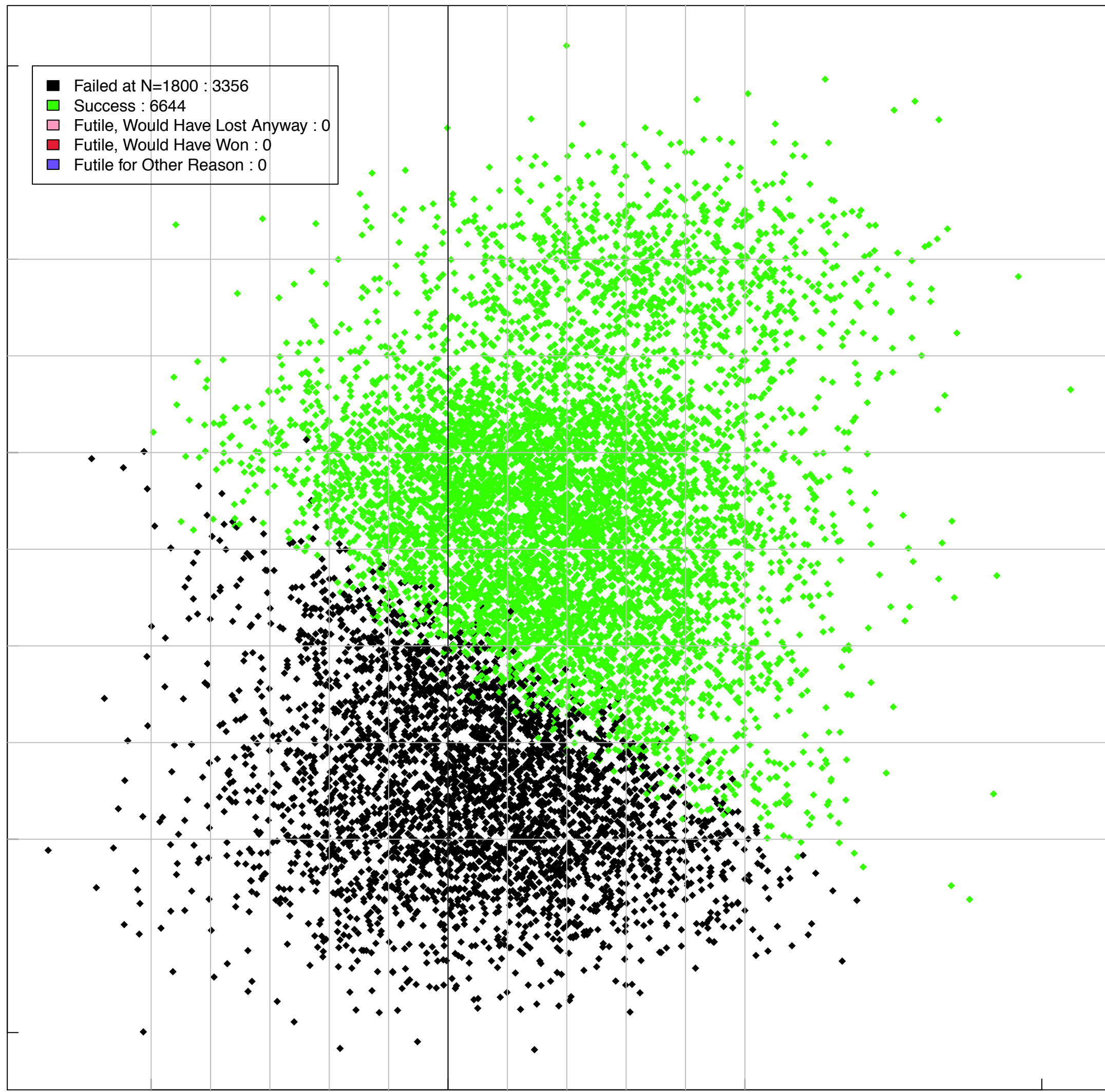
Arm	True Effect	Prop of Trials		Mean Sample Size		
		Target	Target & Win	Total	Part 1	Part 2
PBO	0	0	0	638.6	131.9	709.5
Dose 1	C	.194	.181	694.6	374.8	712.2
Dose 2	C	.456	.440	665.6	776.6	741
Dose 3	C	.234	.225	582.4	1107.9	756.5
Dose 4	C	.011	.008	501.6	1283.6	776.5
PBO	0	0	0	618.8	178.9	439.9
Dose 1	A	.021	.011	185.2	173.2	12.0
Dose 2	B	.206	.155	266.9	142.6	124.3
Dose 3	C	.432	.390	362.0	109.7	252.3
Dose 4	C	.093	.085	96.8	45.8	51.0
PBO	0	0	0	701.8	164.3	537.5
Dose 1	C	.317	.292	402.6	215.2	187.4
Dose 2	C	.489	.468	427.2	123.6	303.6
Dose 3	B	.077	.053	124.6	78.1	46.5
Dose 4	A	0	0	13.4	13.4	0

Simulation

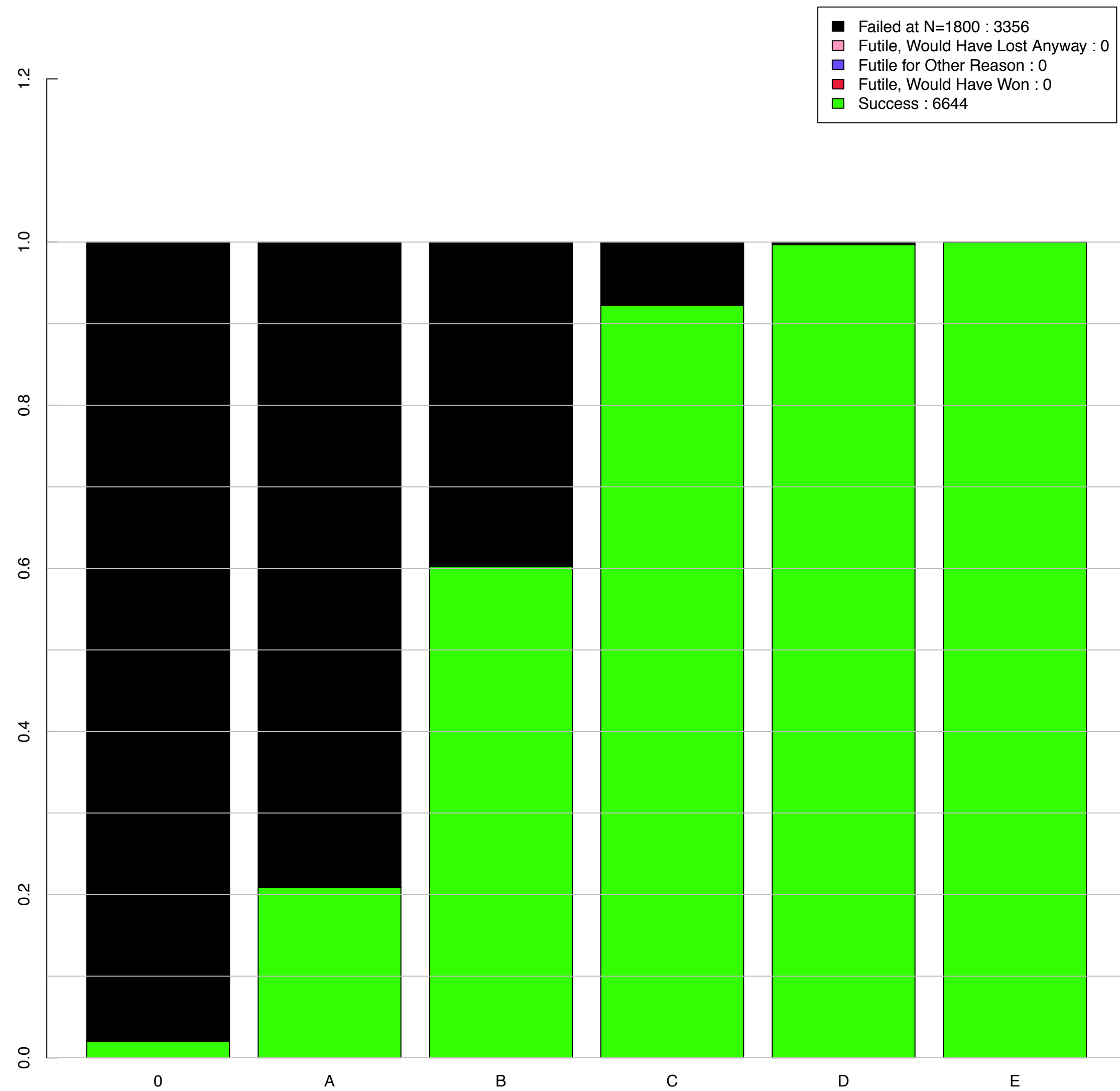
- Trial conducted through extensive simulations
 - Example trials, cut-offs, modeling, sample sizes, power, dose selection, etc... *type I error*
- Example of value of simulations for futility thresholds prospectively...

Primary Endpoint Part 1 Futility = 0

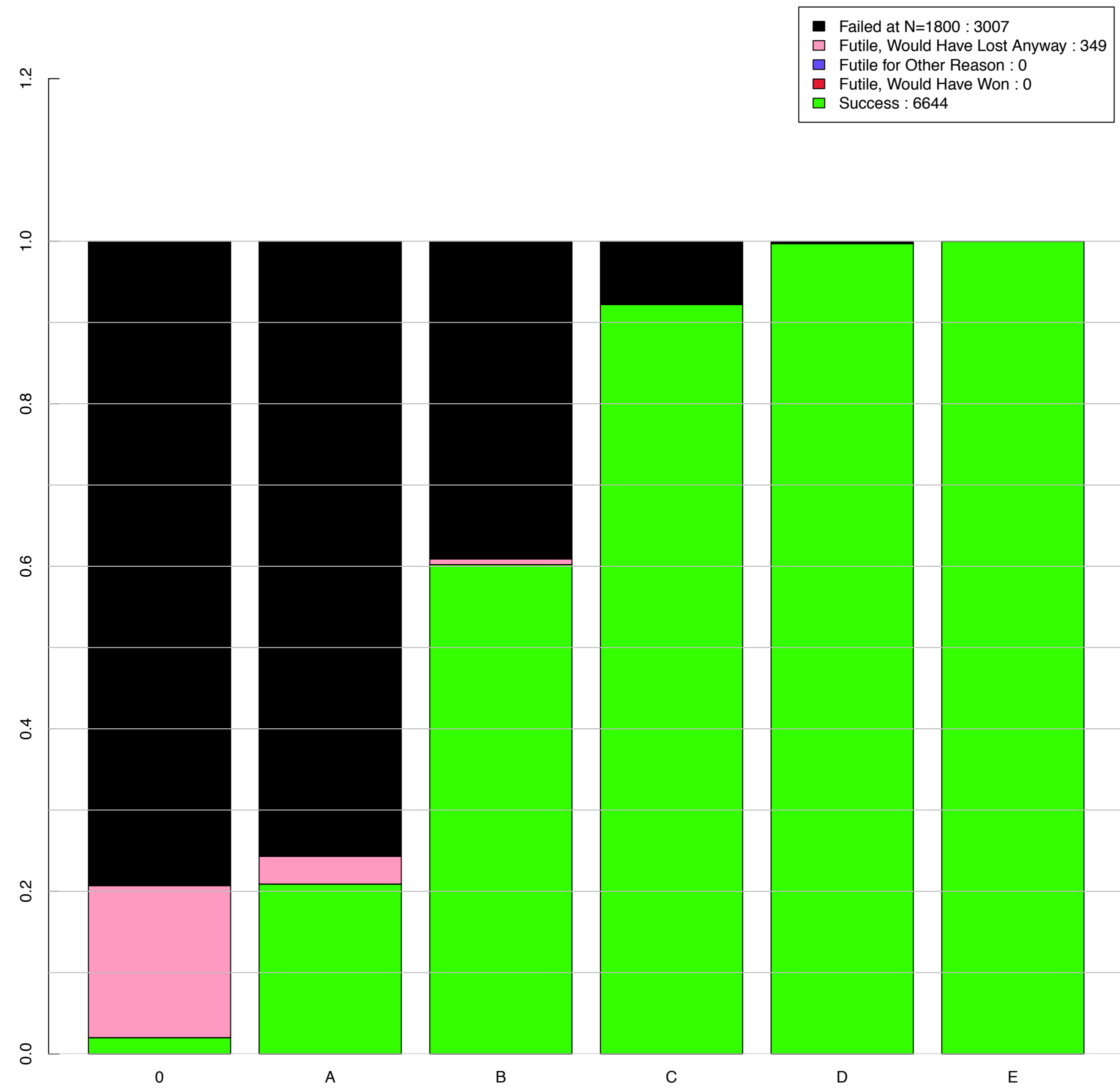
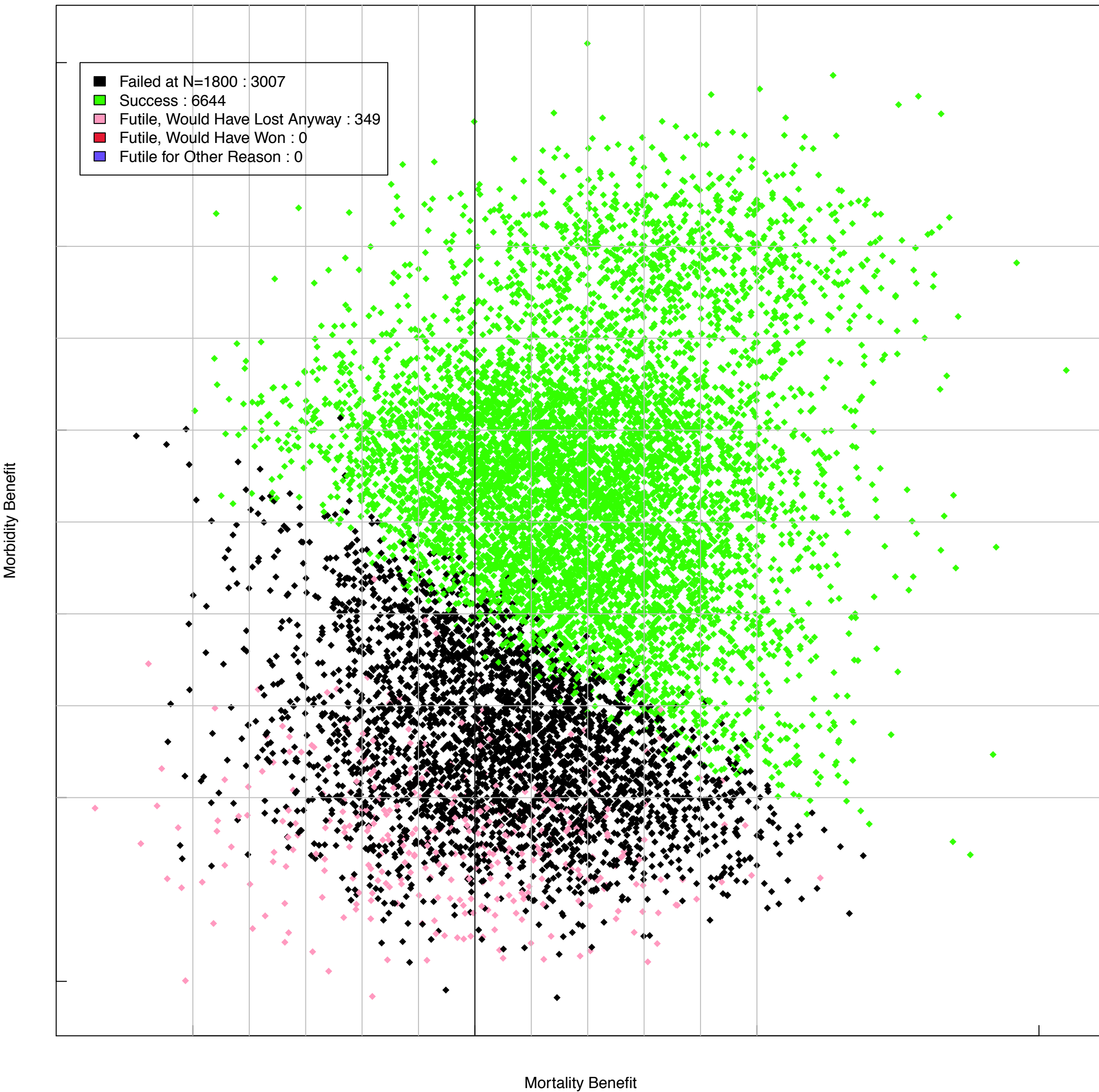
Morbidity Benefit



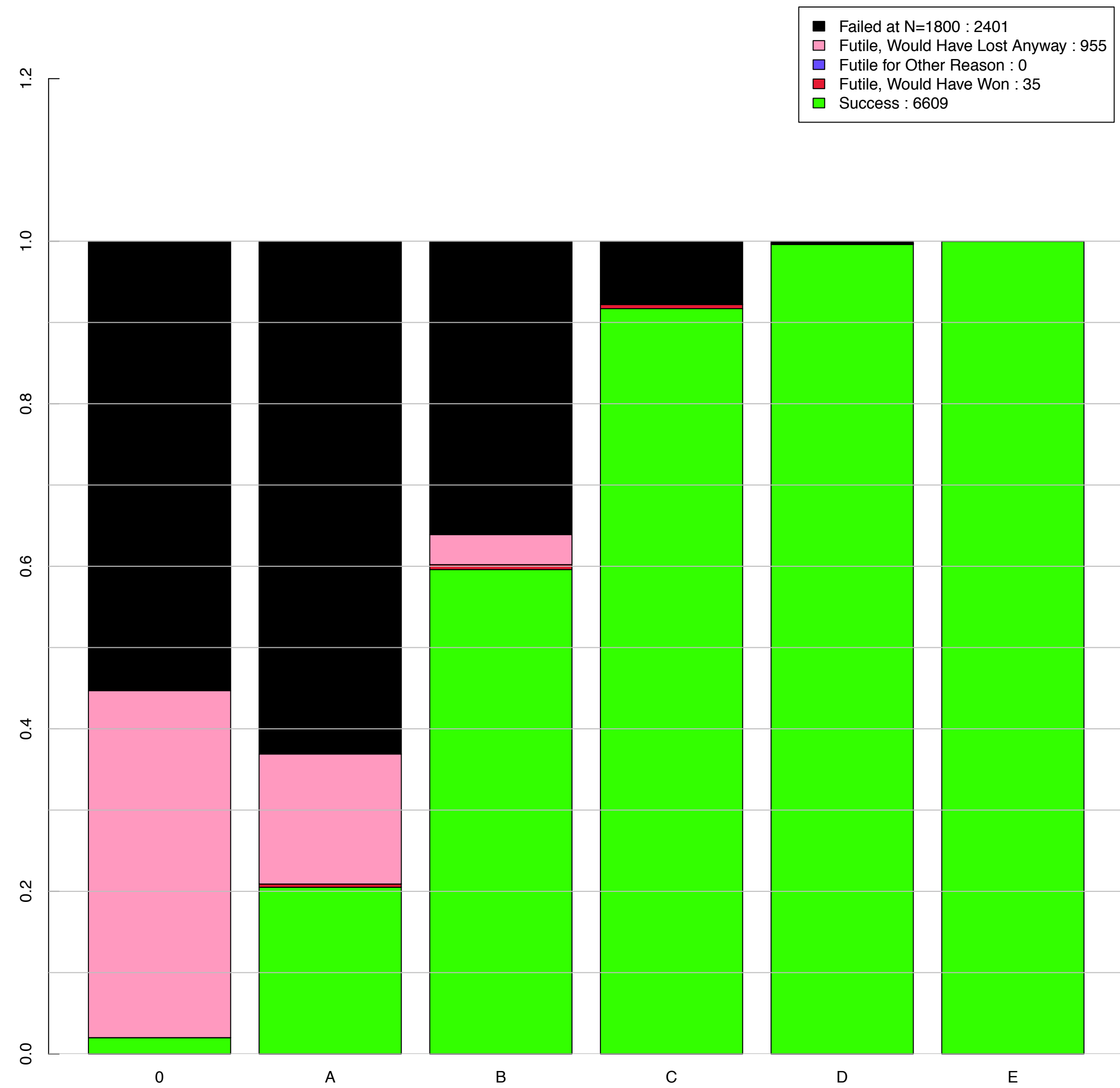
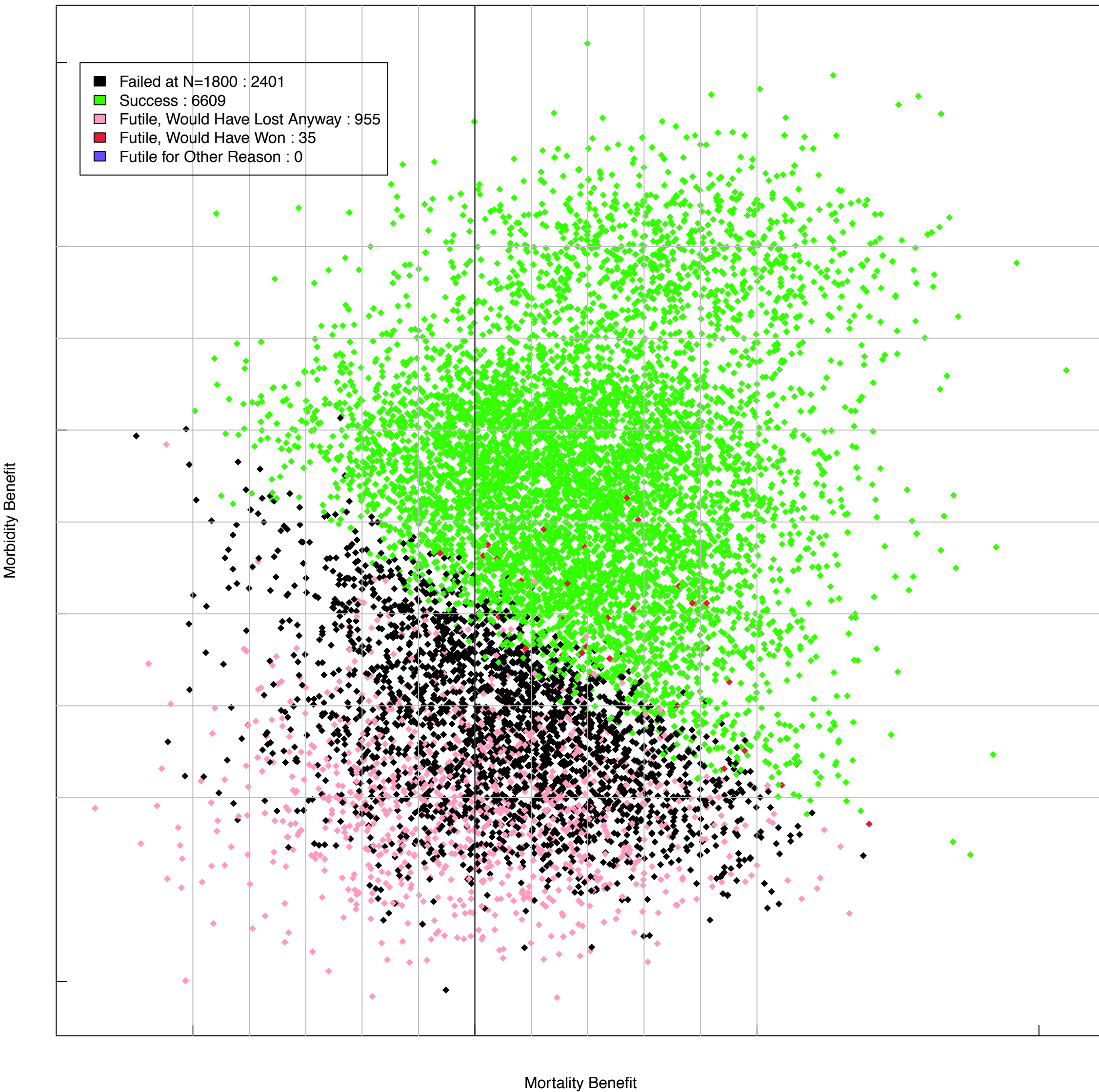
Mortality Benefit



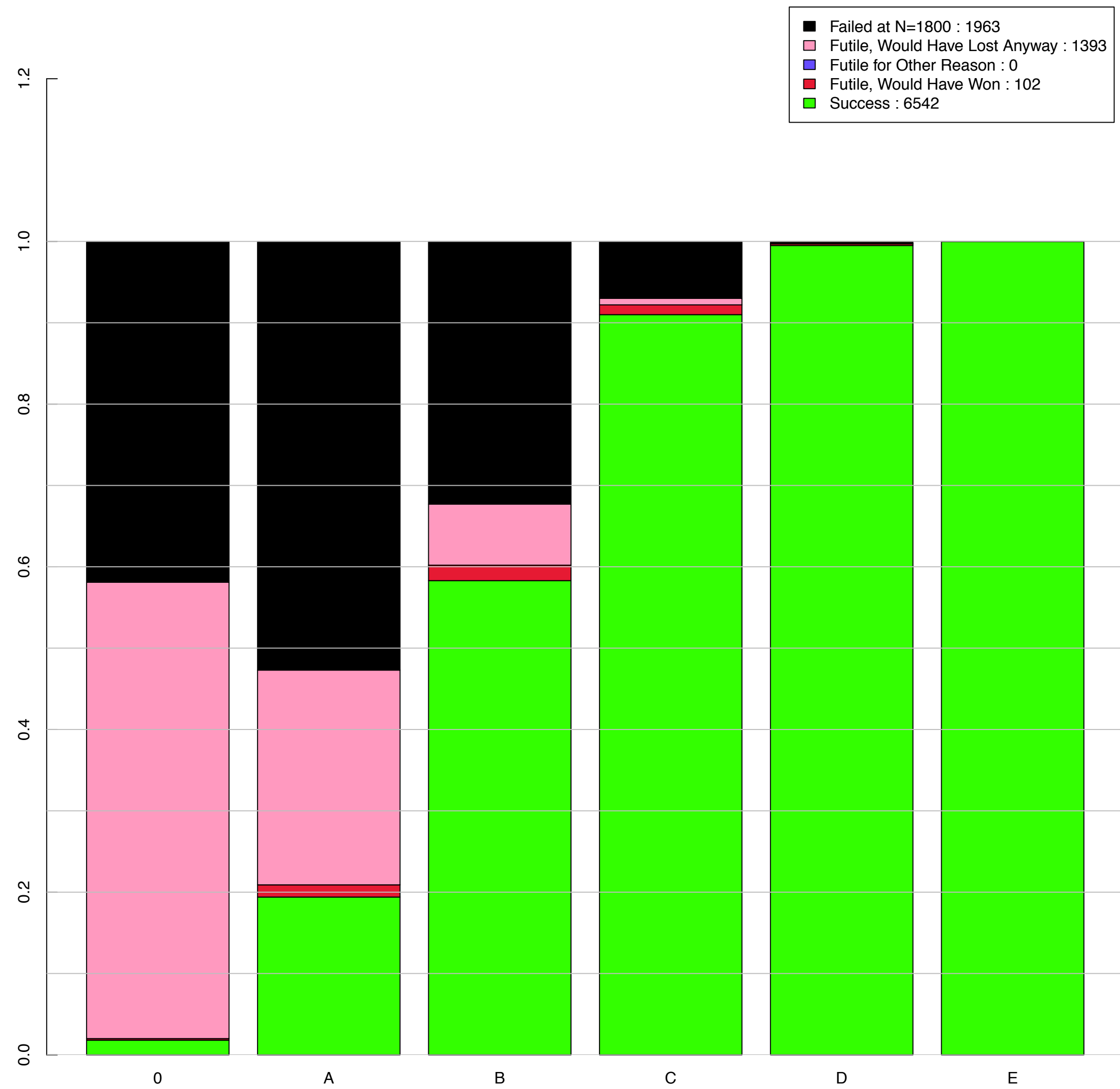
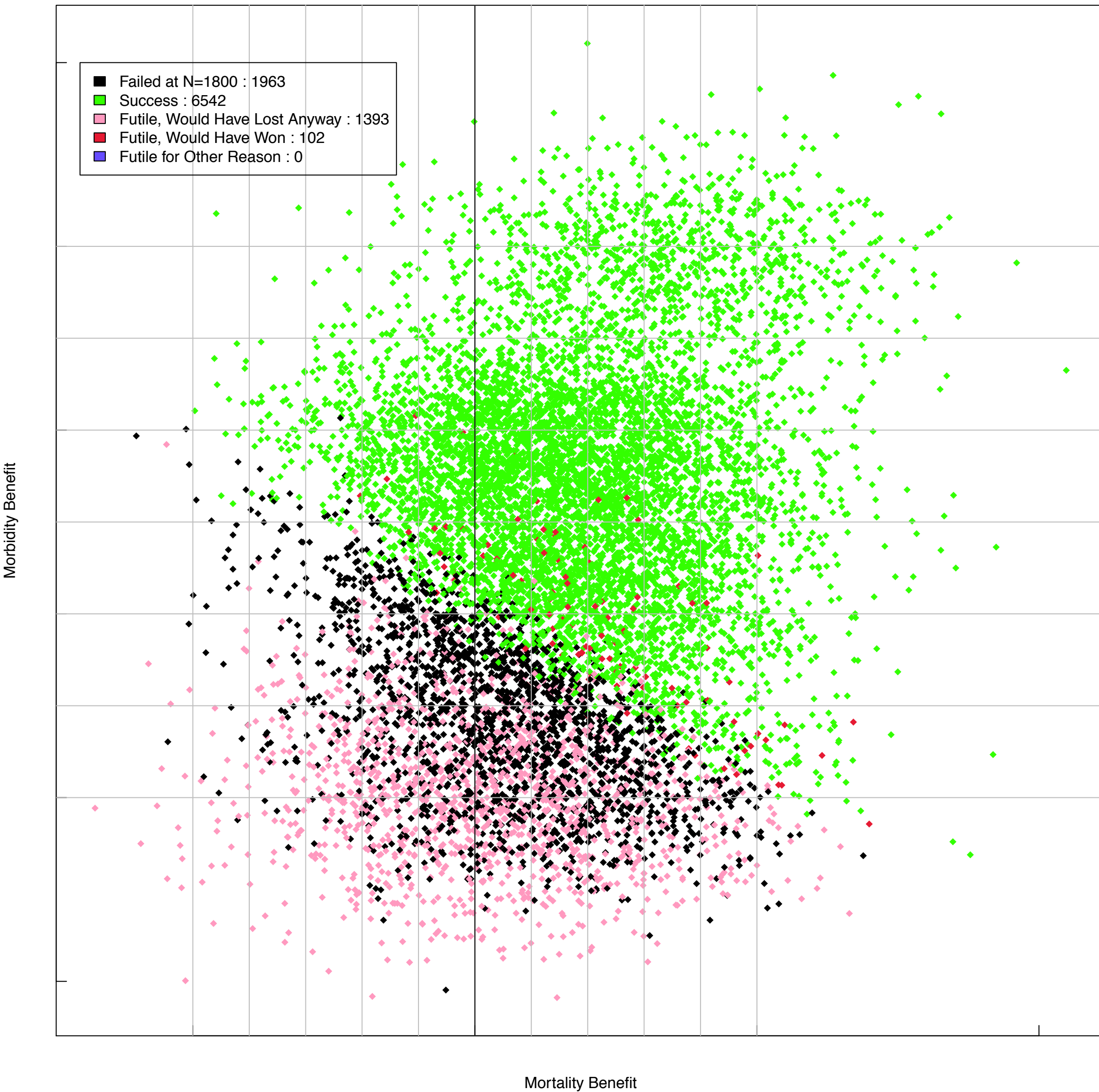
Primary Endpoint Part 1 Futility = 0.01



Primary Endpoint Part 1 Futility = 0.05

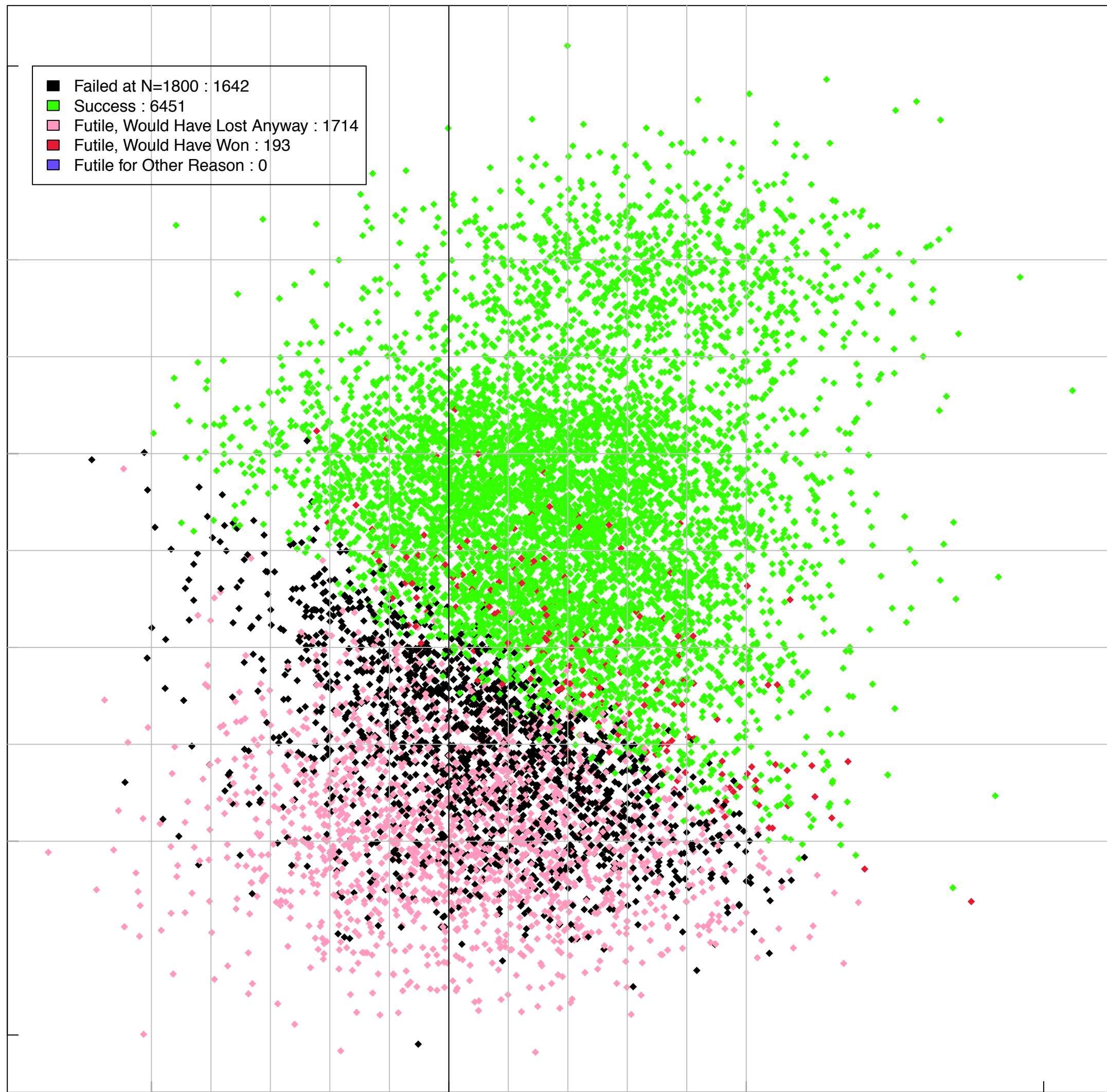


Primary Endpoint Part 1 Futility = 0.1

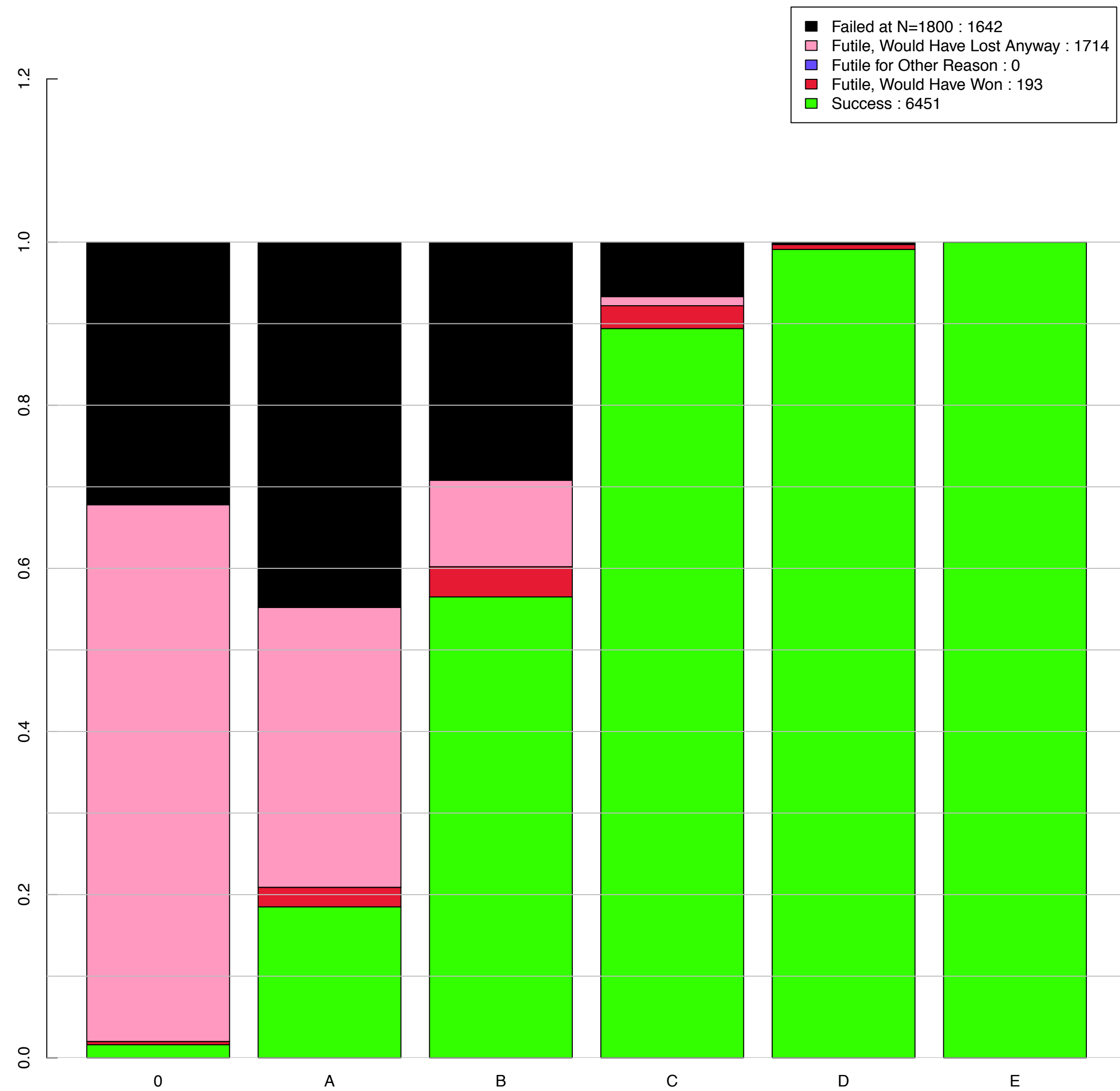


Primary Endpoint Part 1 Futility = 0.15

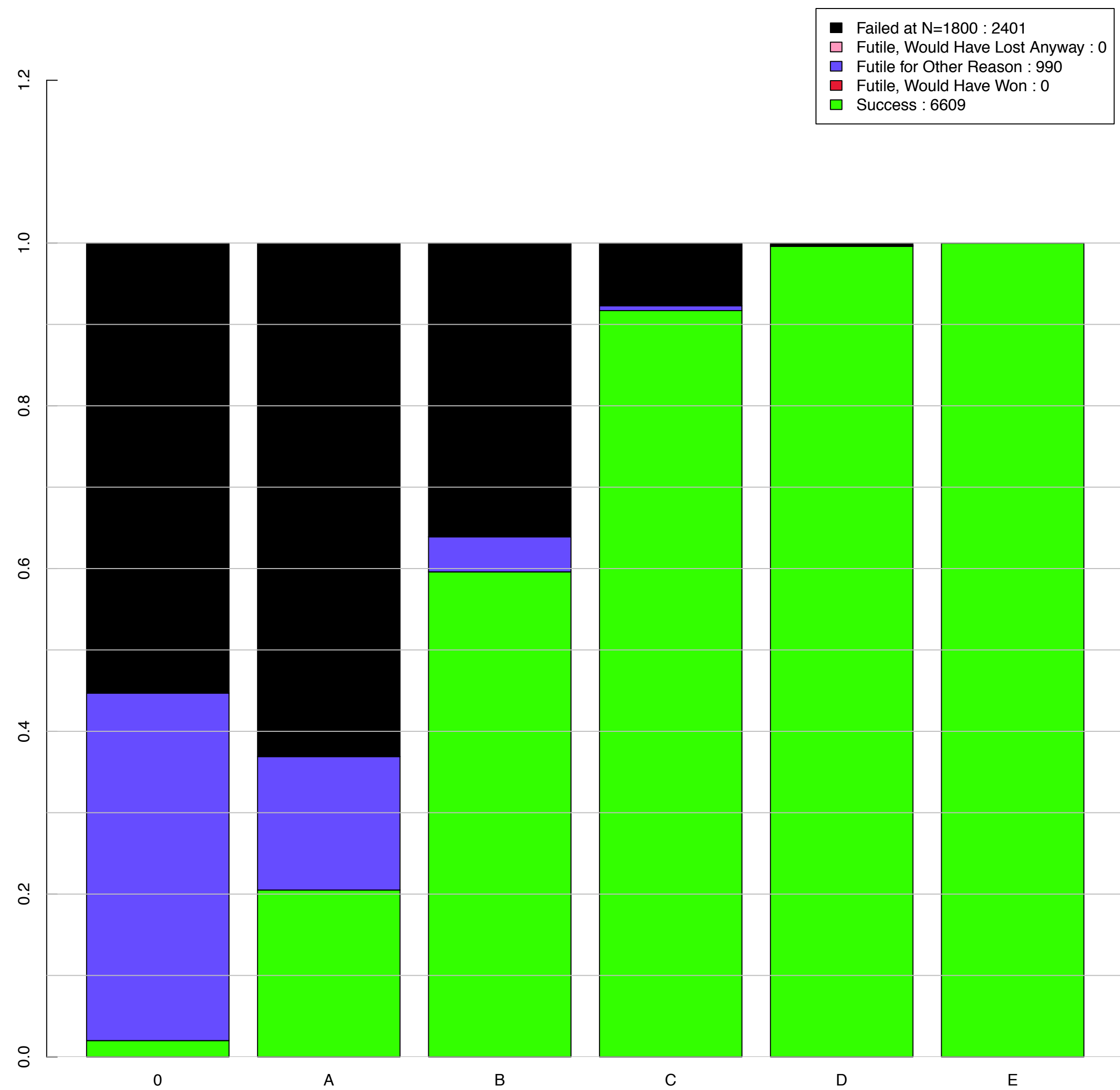
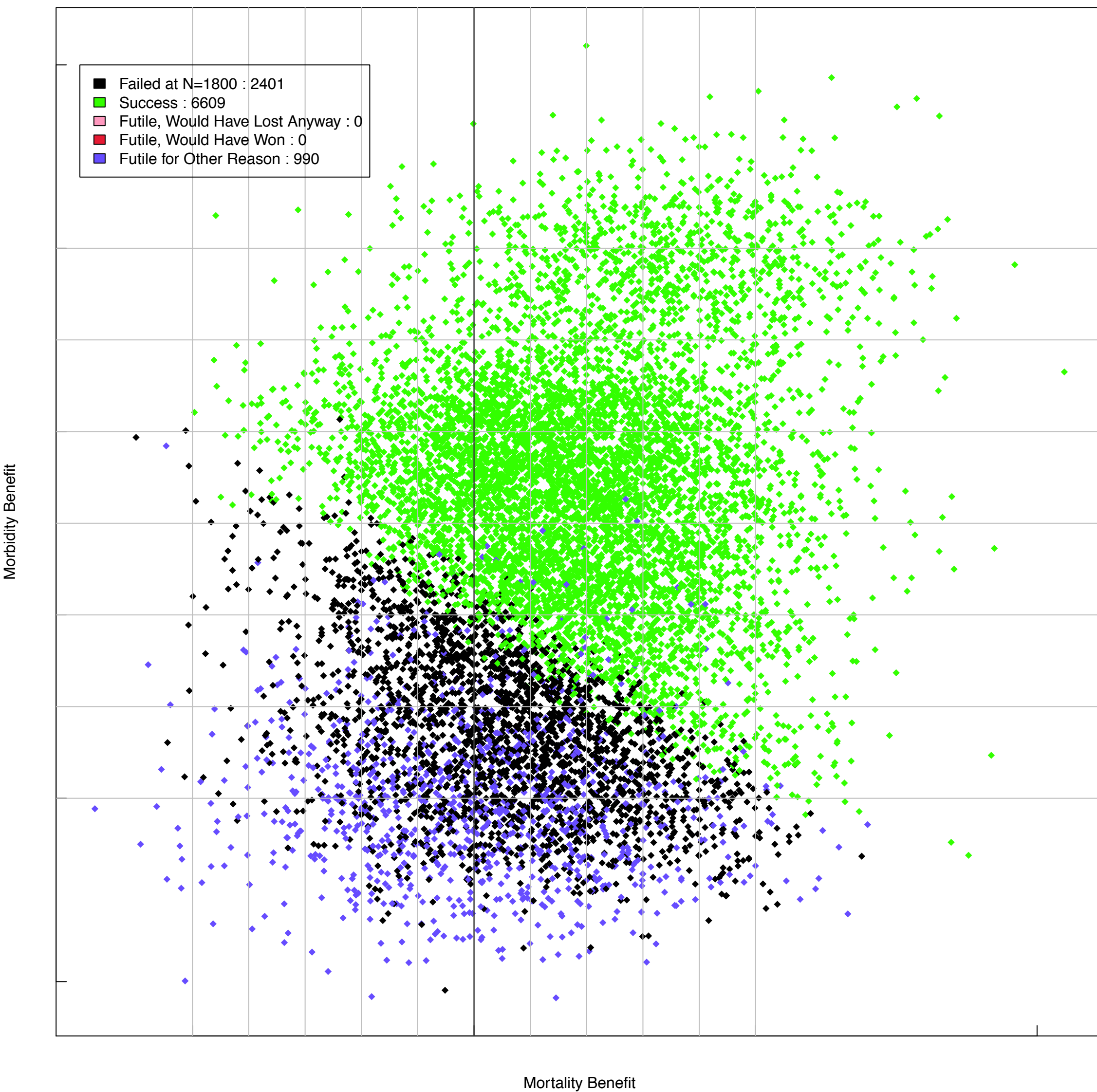
Morbidity Benefit



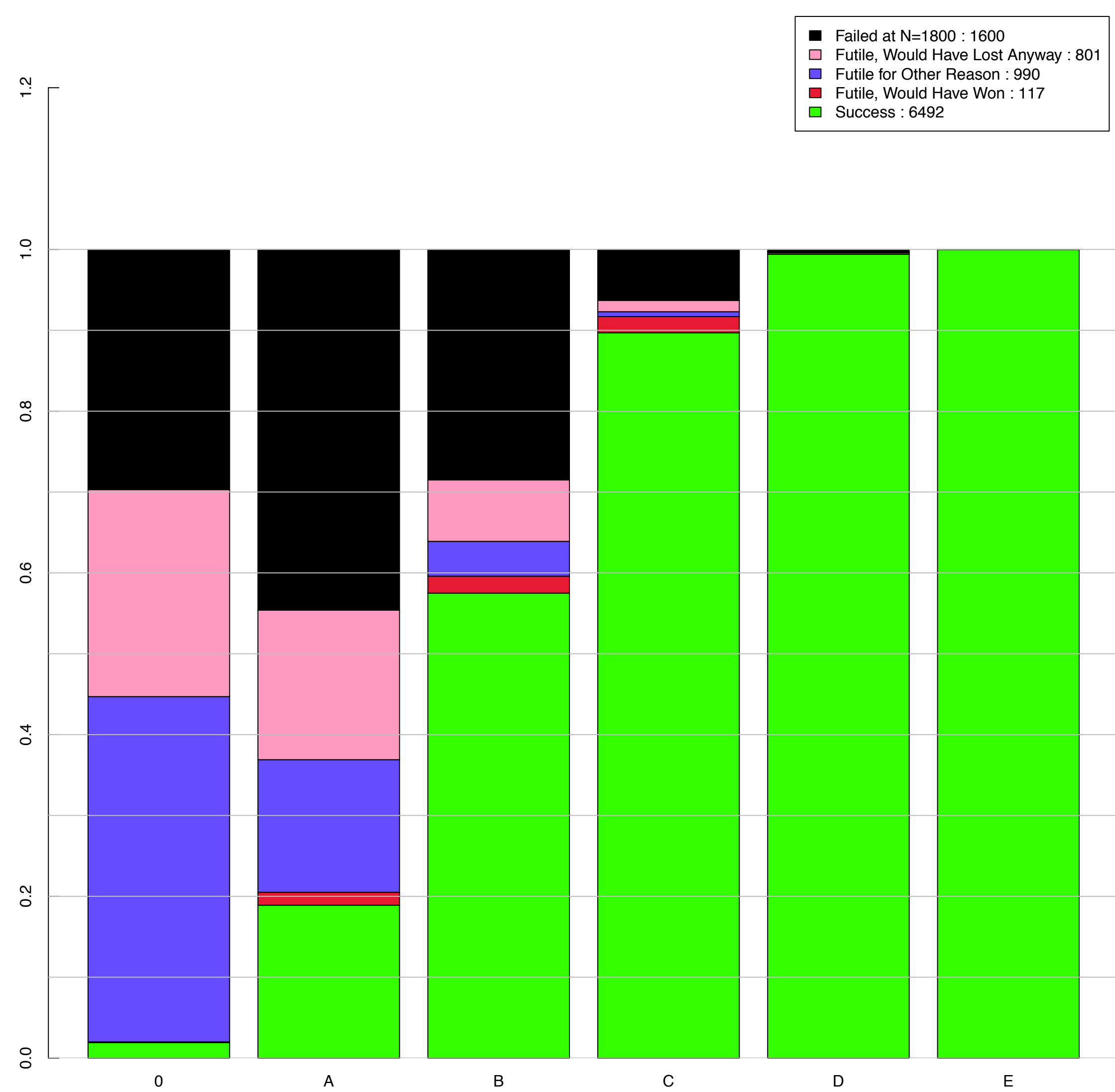
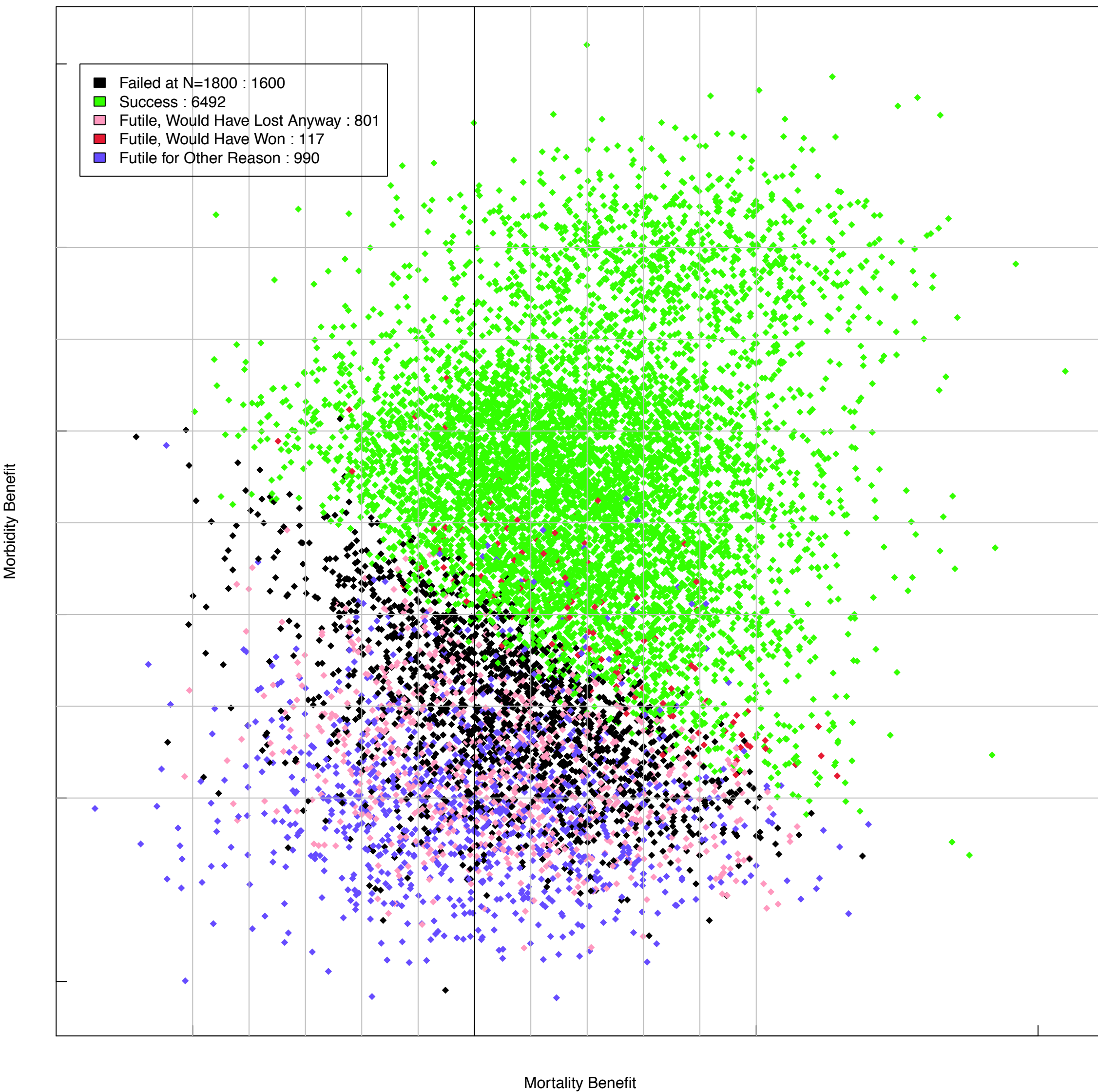
Mortality Benefit



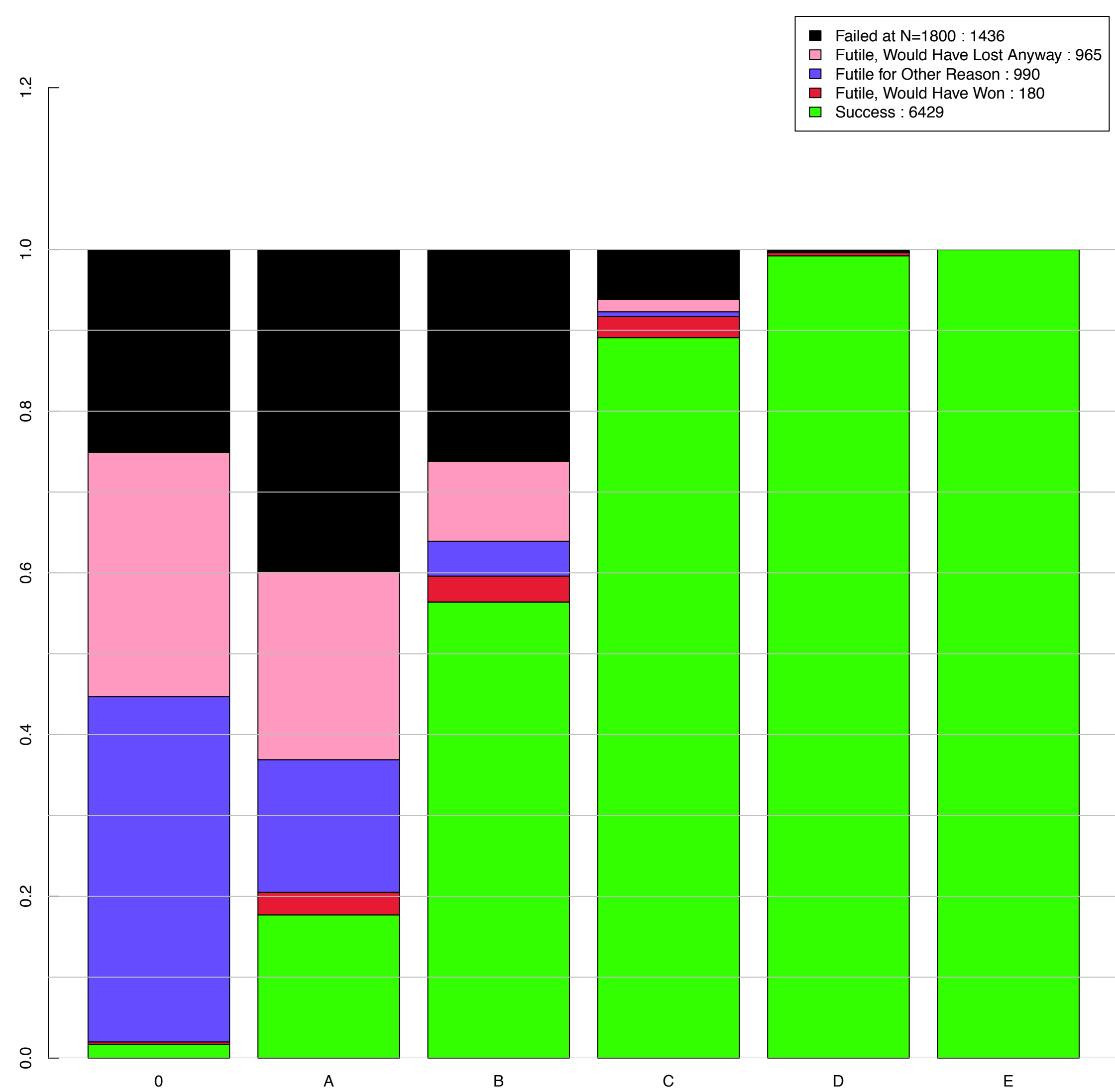
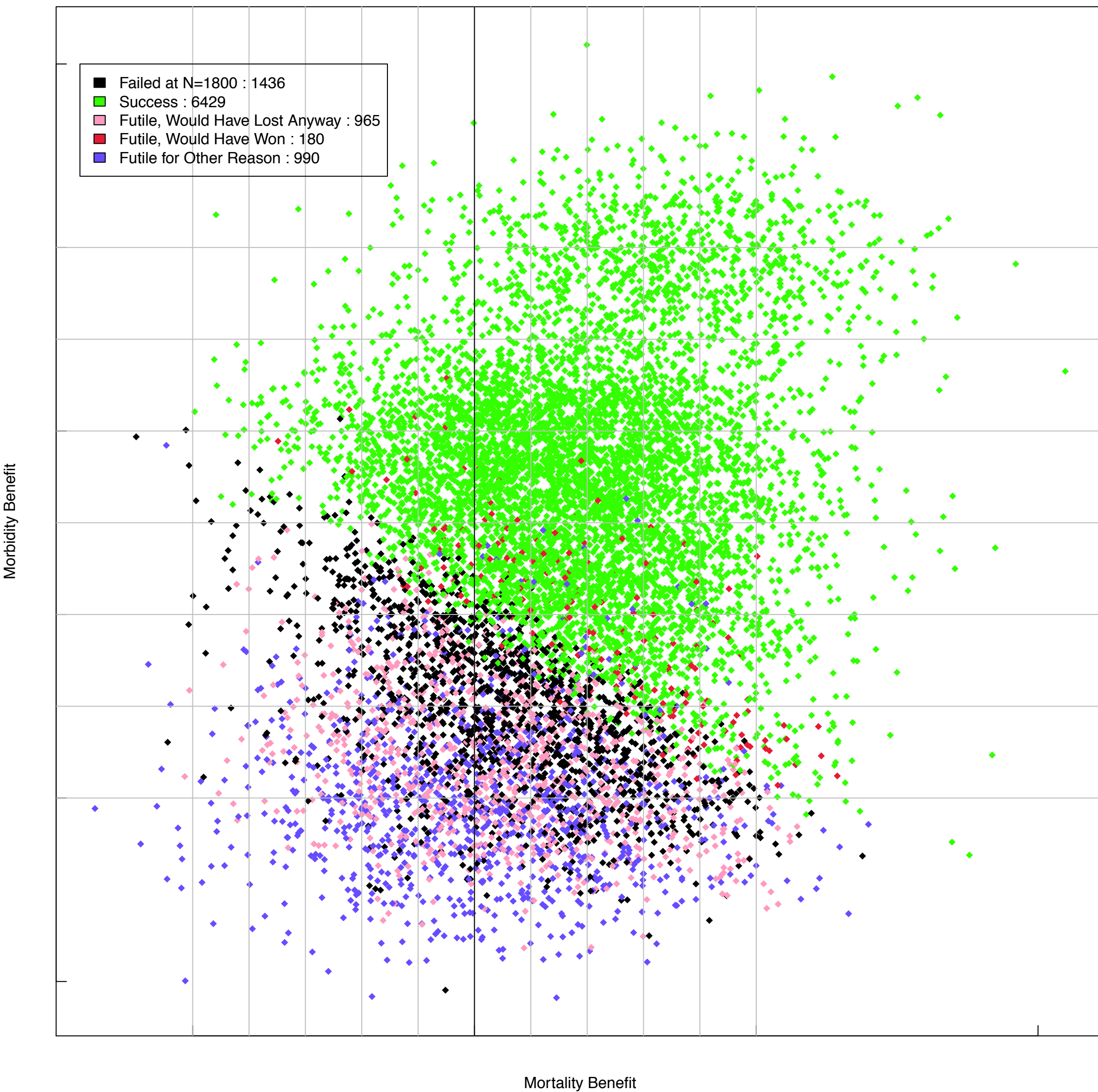
(Part 1 Rule = 0.05) Primary Endpoint, N=800 Futility = 0



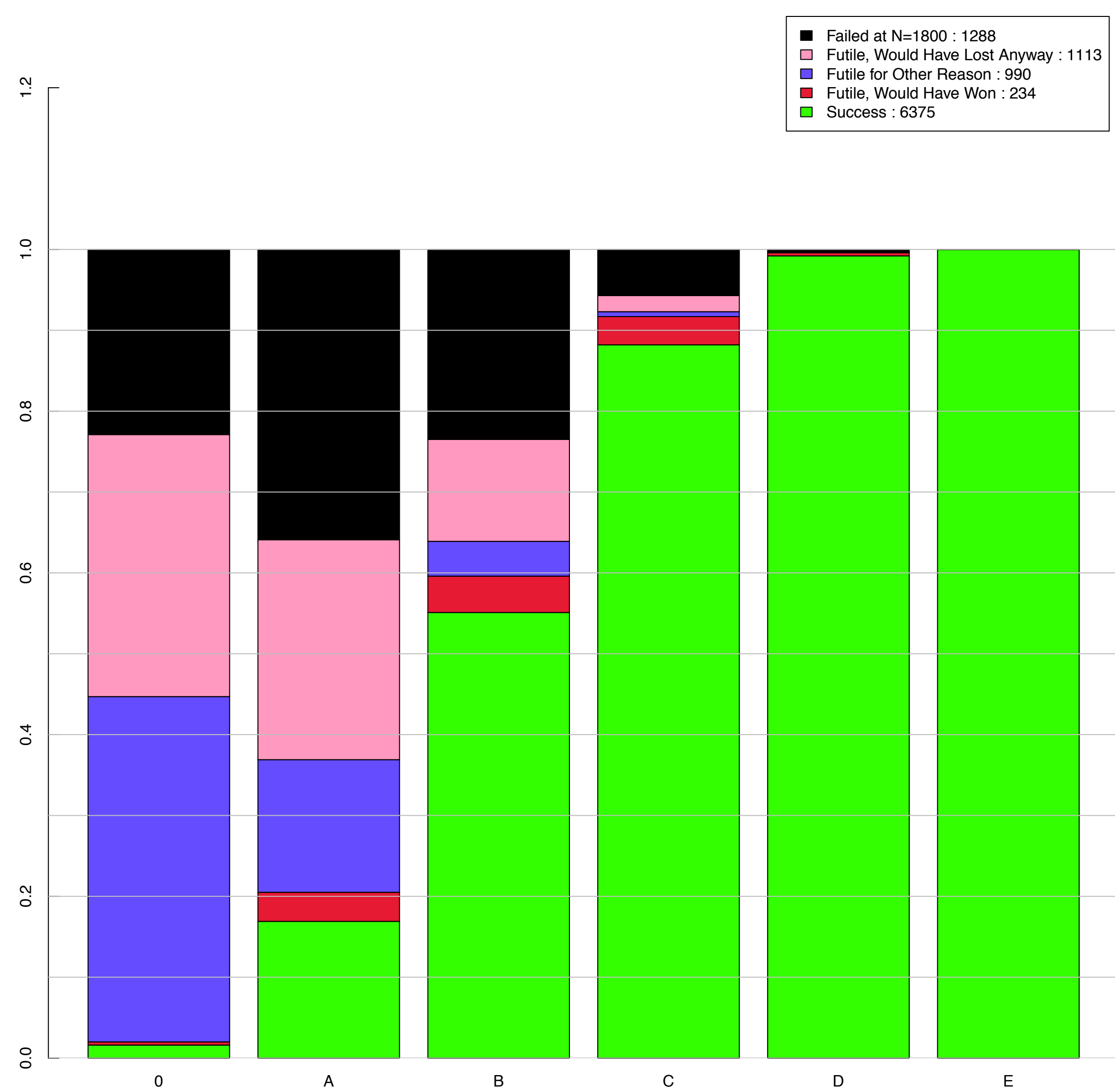
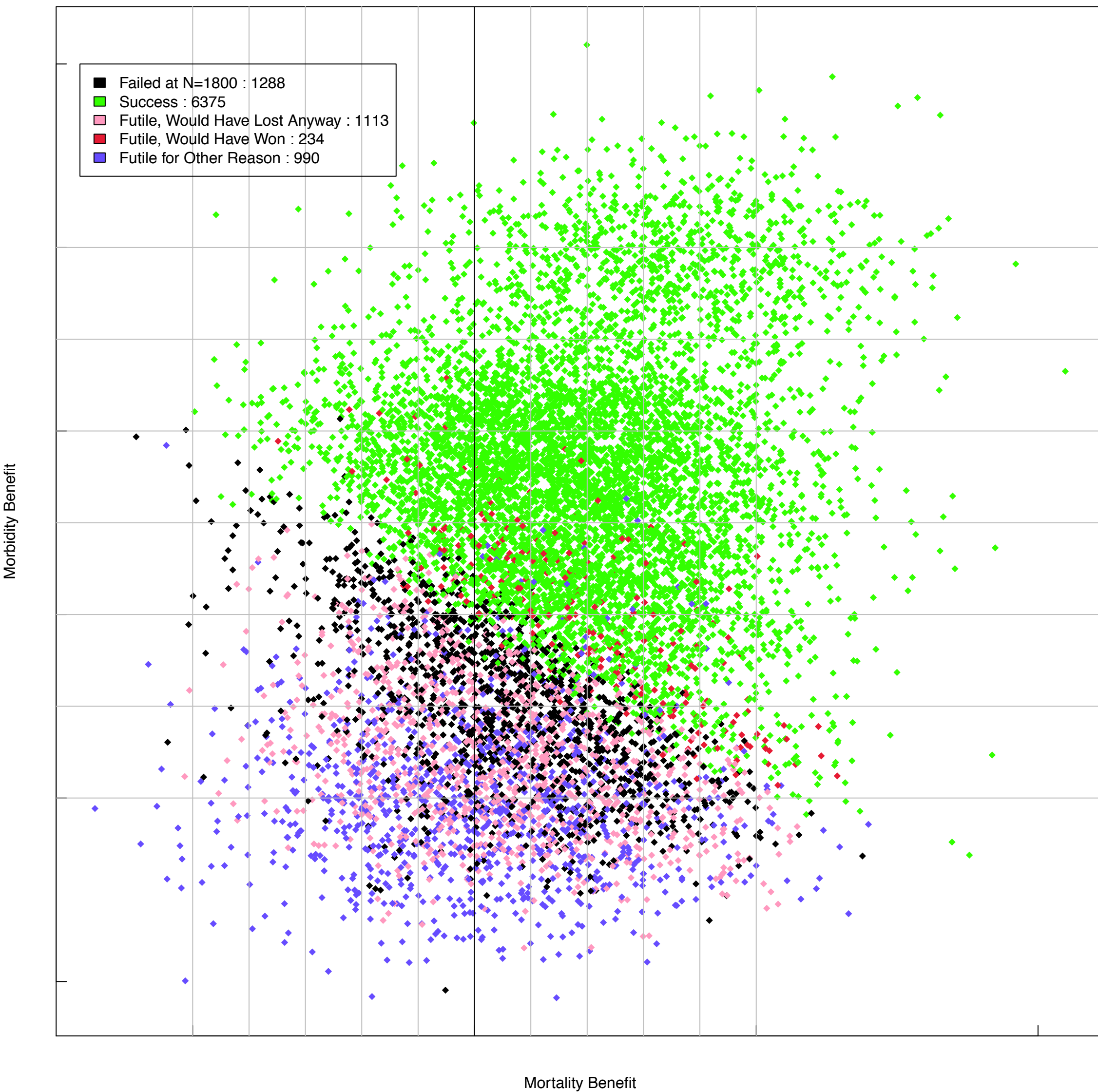
(Part 1 Rule = 0.05) Primary Endpoint, N=800 Futility = 0.25



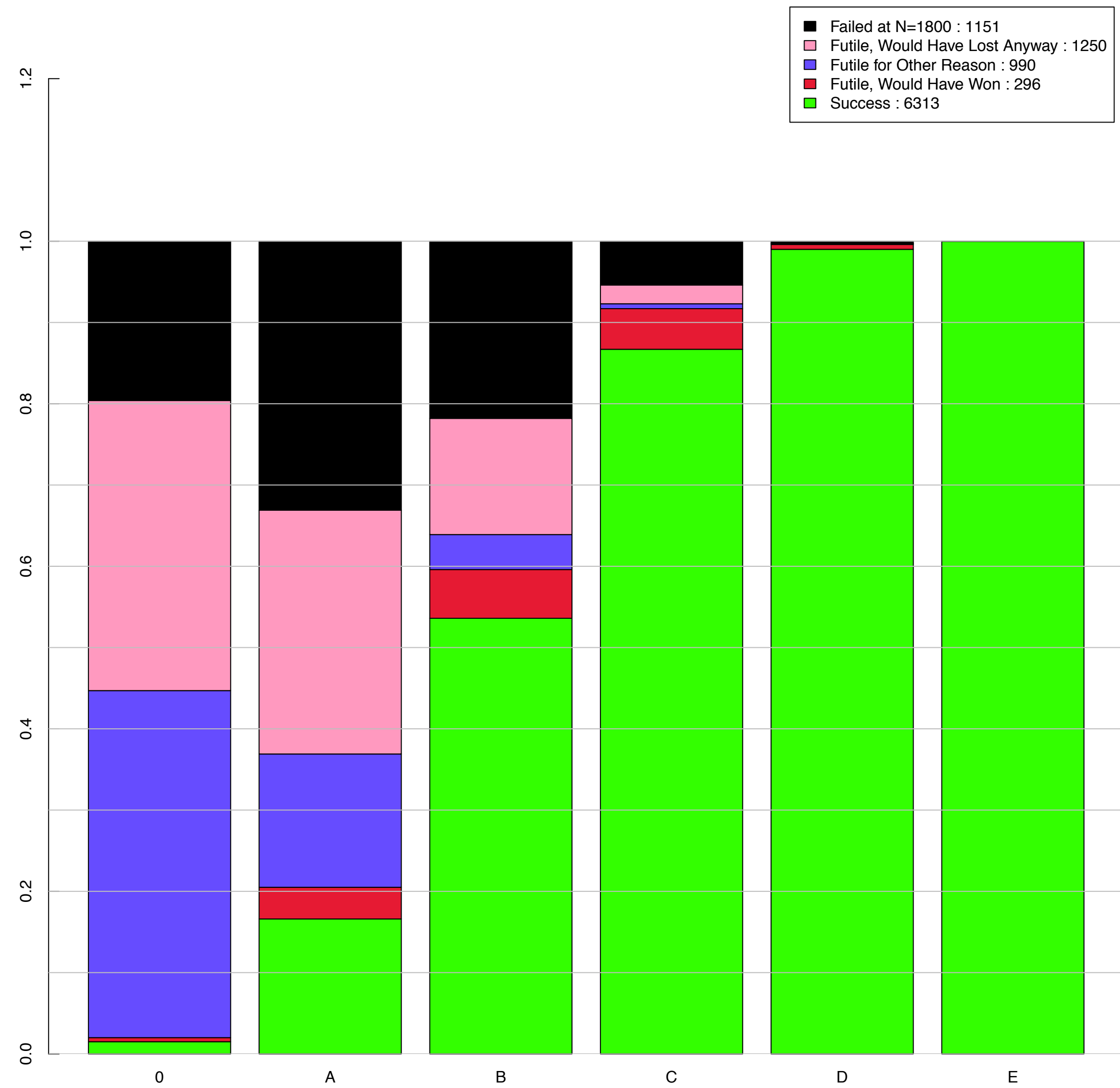
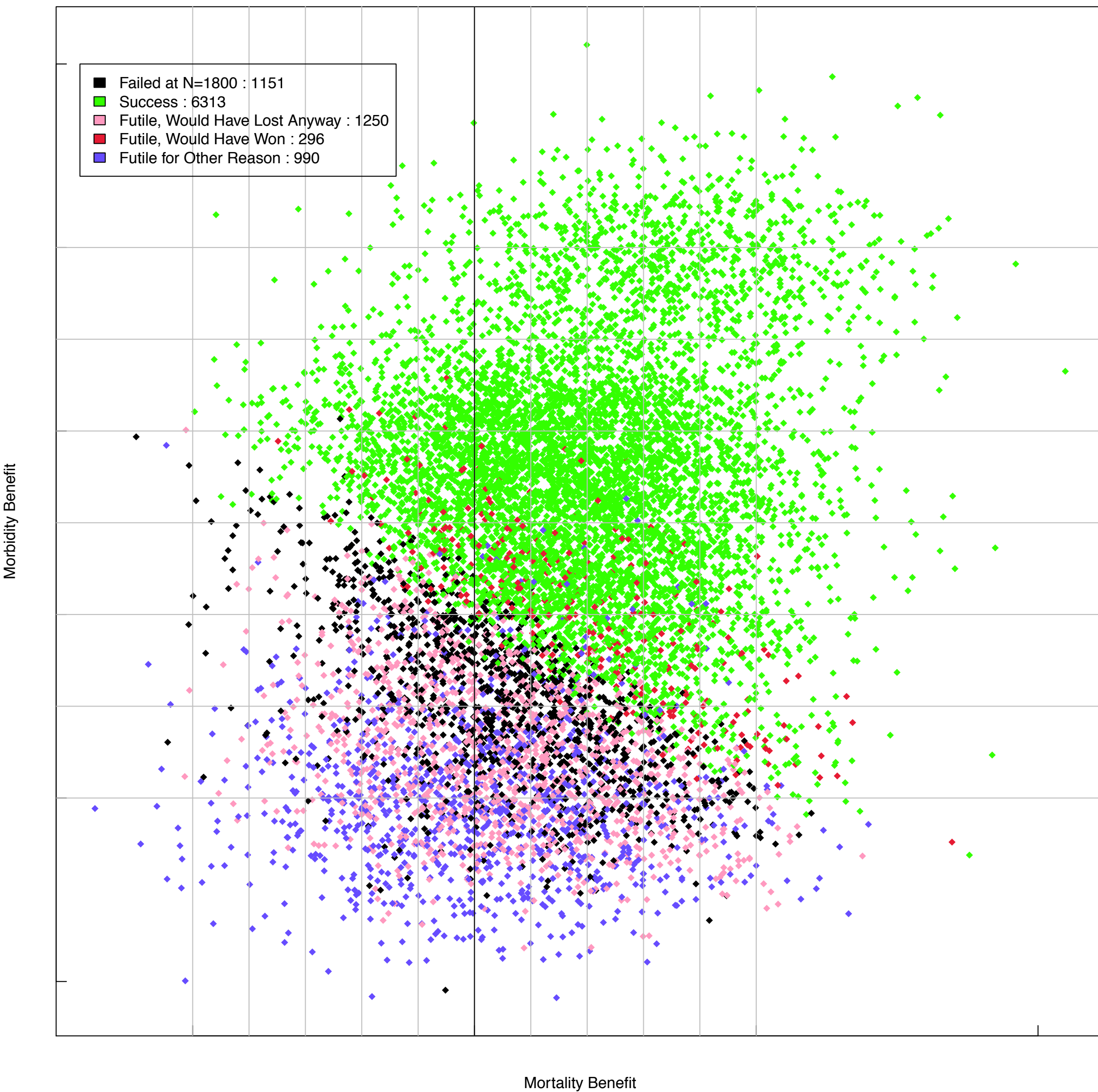
(Part 1 Rule = 0.05) Primary Endpoint, N=800 Futility = 0.3



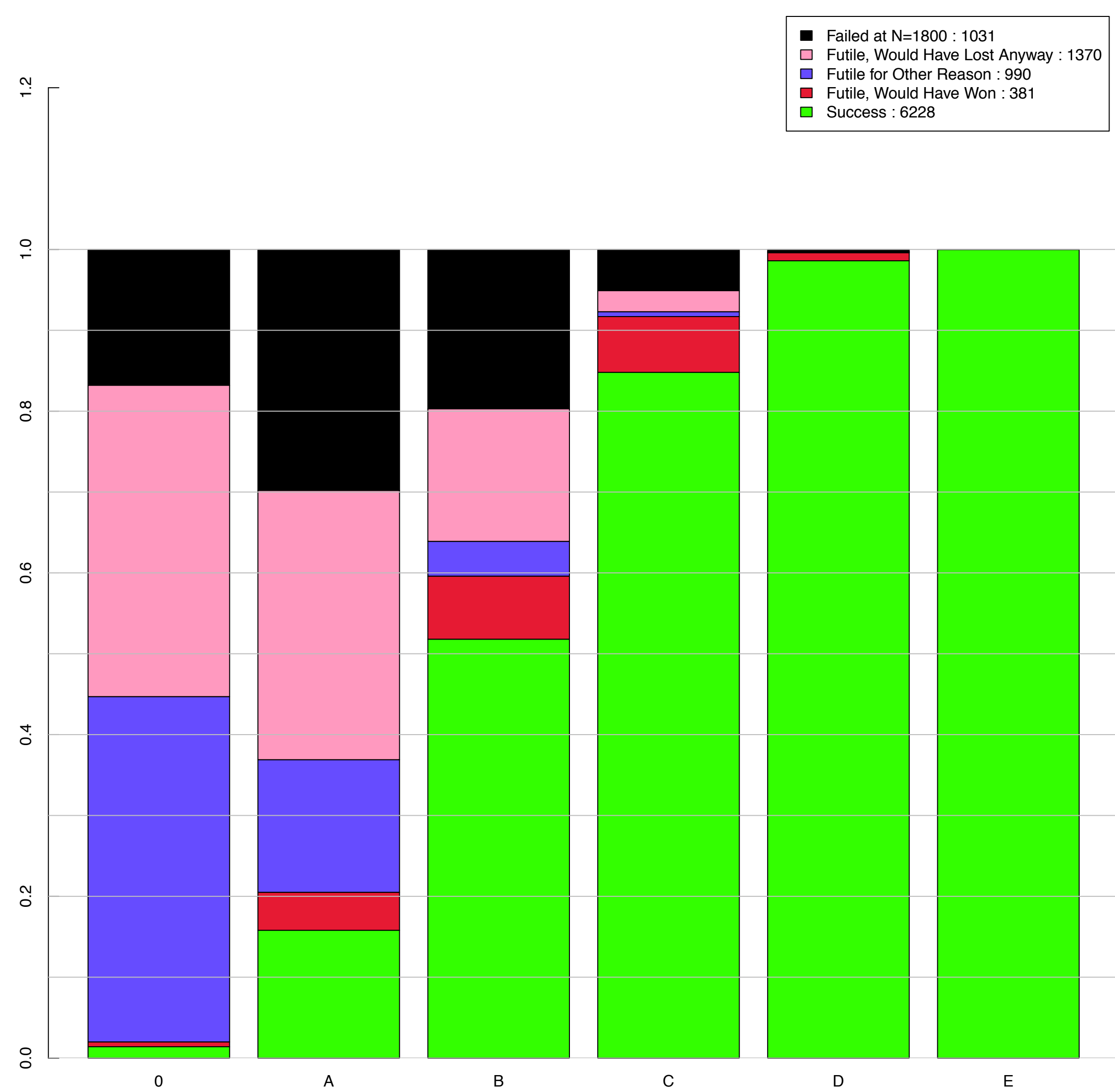
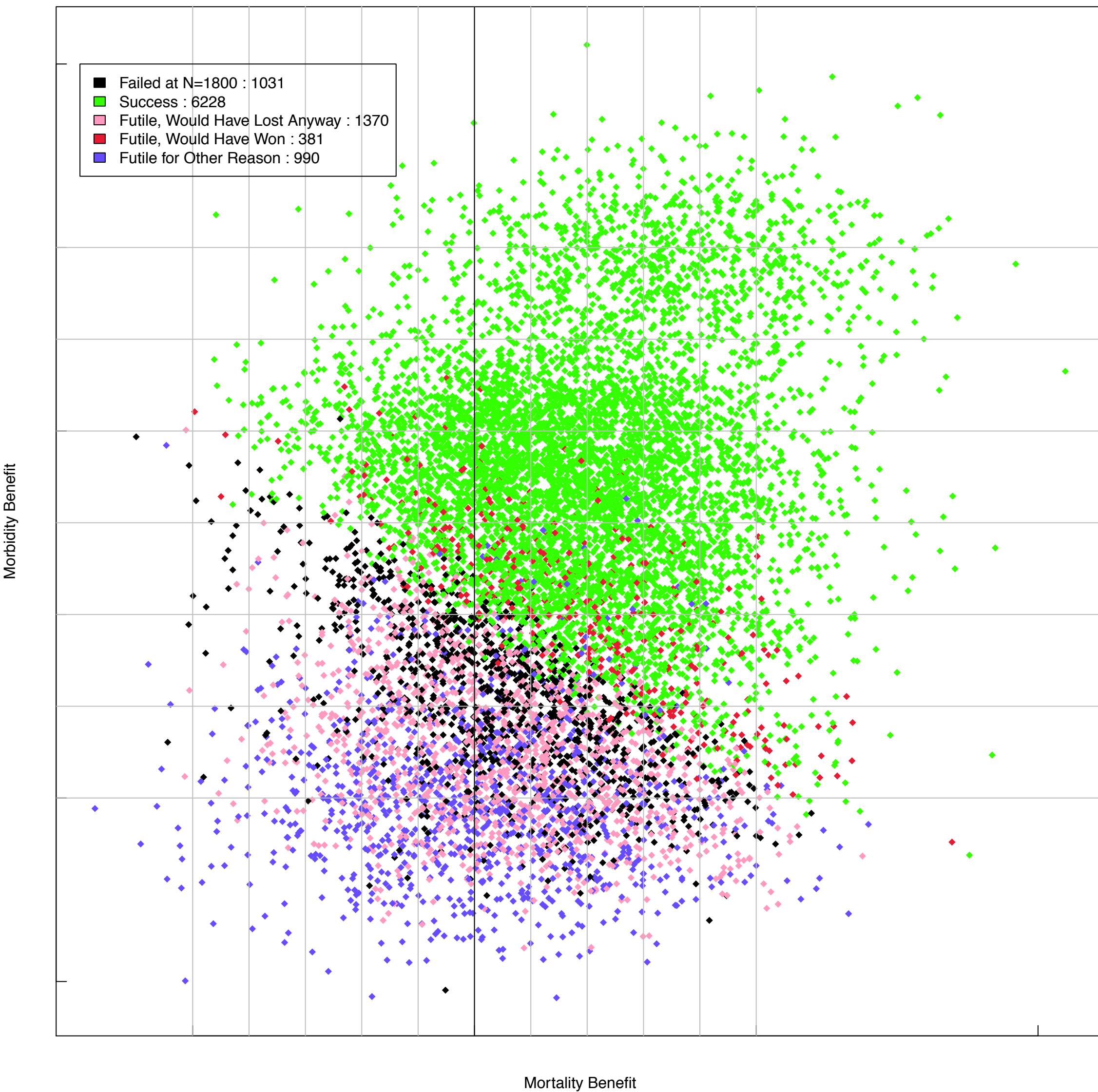
(Part 1 Rule = 0.05) Primary Endpoint, N=800 Futility = 0.35



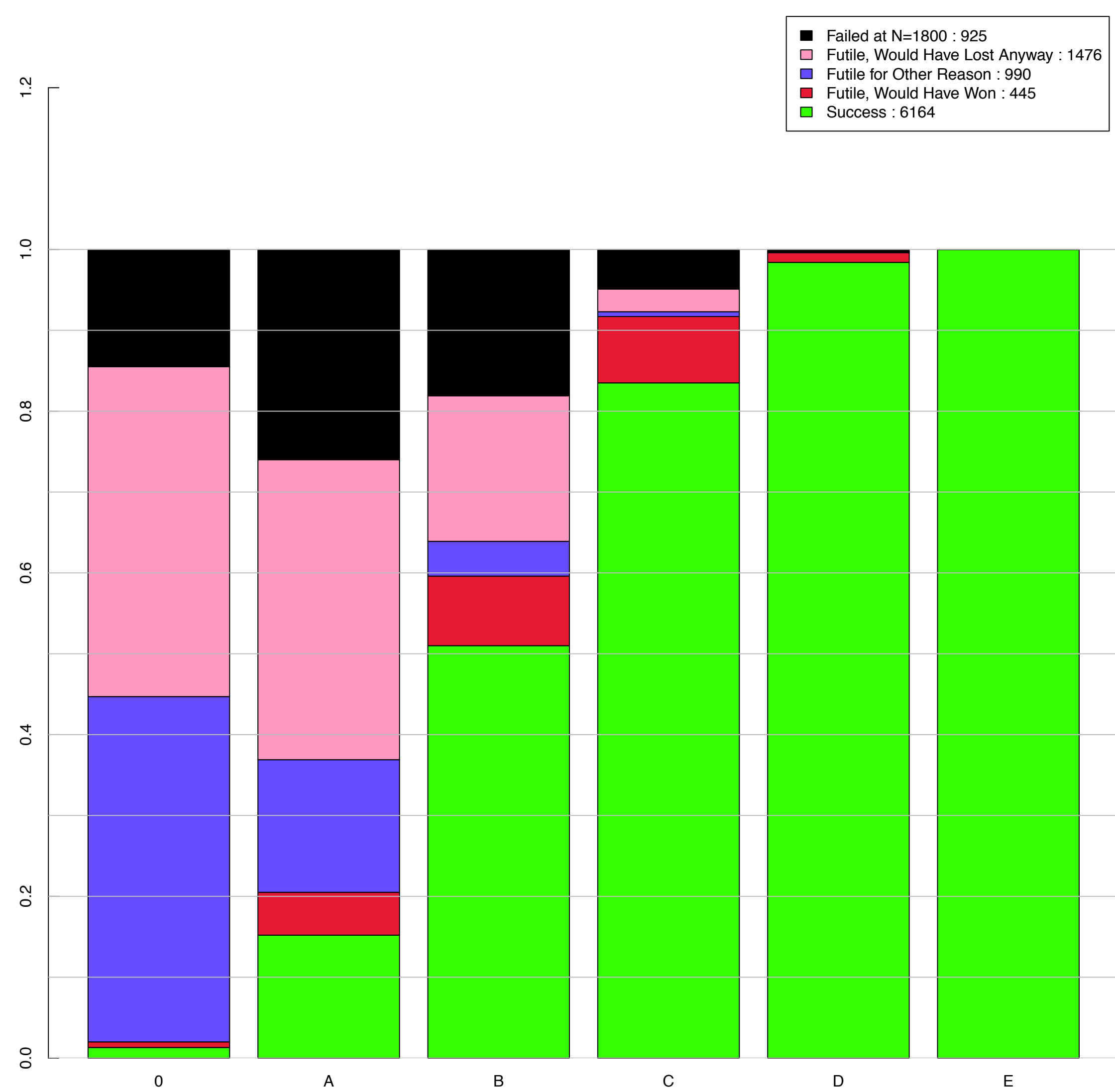
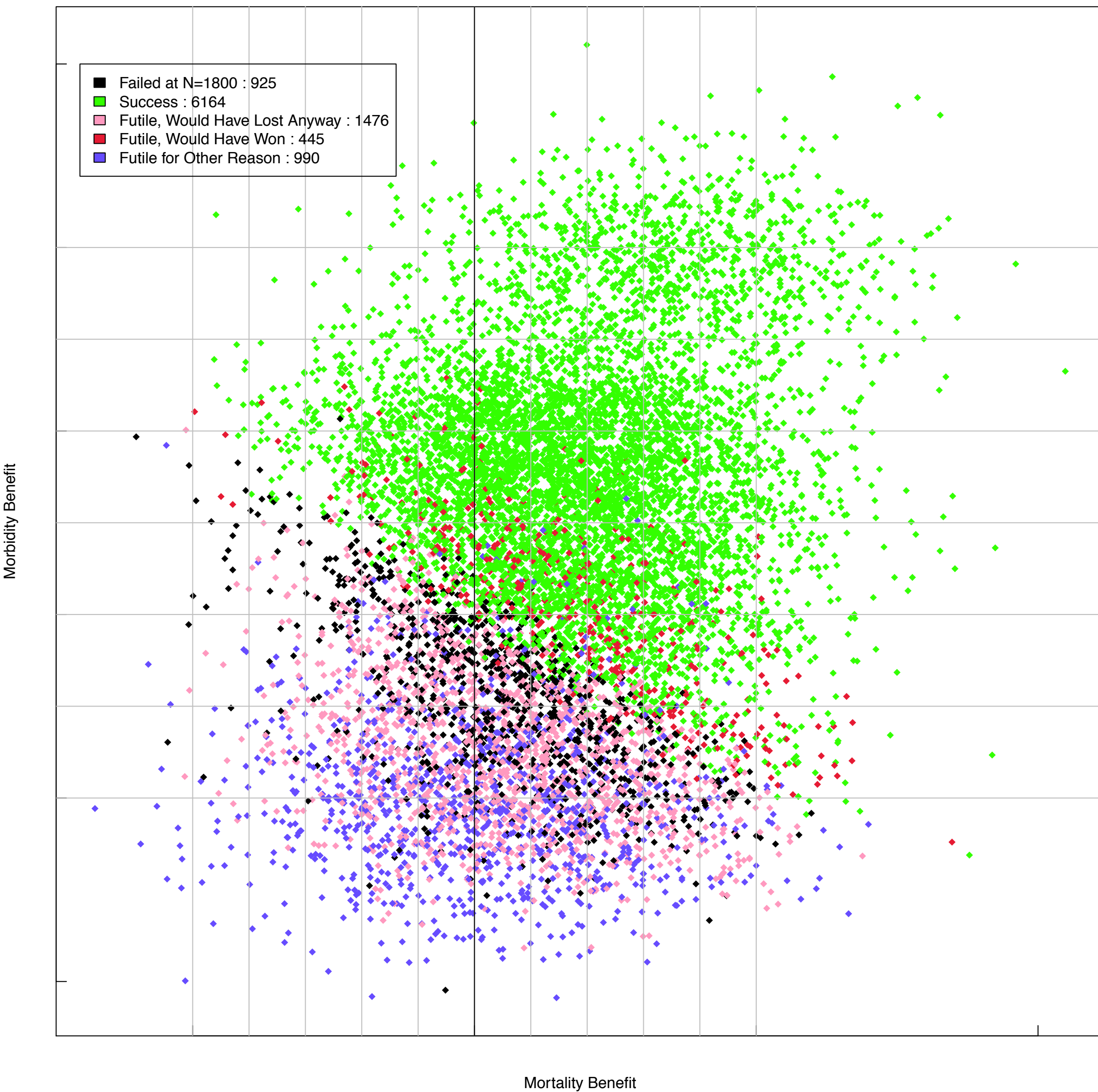
(Part 1 Rule = 0.05) Primary Endpoint, N=800 Futility = 0.4



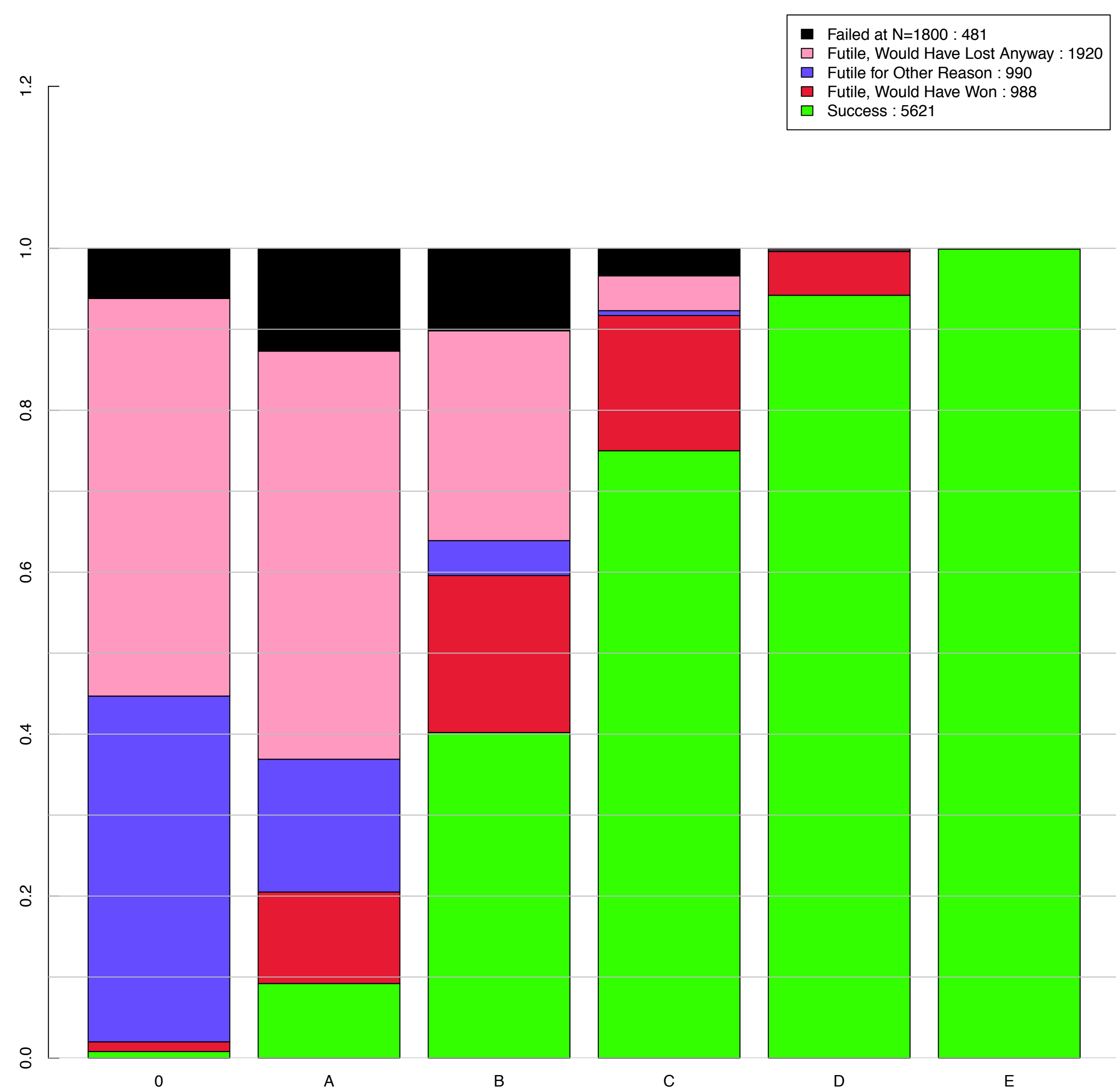
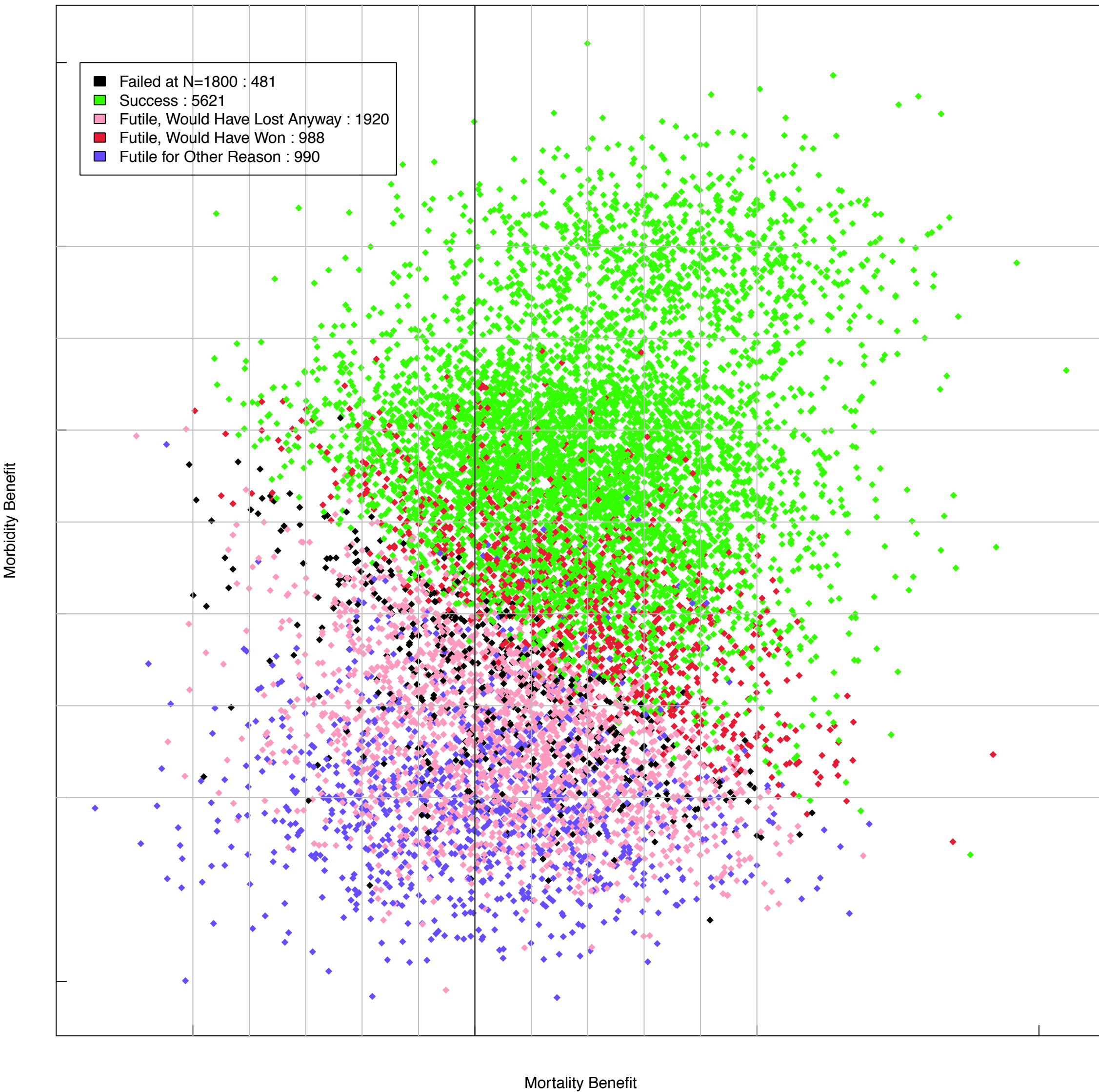
(Part 1 Rule = 0.05) Primary Endpoint, N=800 Futility = 0.45



(Part 1 Rule = 0.05) Primary Endpoint, N=800 Futility = 0.5



(Part 1 Rule = 0.05) Primary Endpoint, N=800 Futility = 0.75



Summary

- Adaptations allow more thorough exploration of dose range
 - RAR, Adaptive Decisions, Modeling
- Allow “dose-finding” to be larger if needed
- Able to use the subjects for dose-finding and confirmation
 - No need to take shot-in-the-dark for dose and go/no-go