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## Molidustat for the treatment of renal anaemia in patients with dialysis-dependent chronic kidney disease: design and rationale of three phase 3 studies

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## Molidustat for the treatment of renal anaemia in patients with dialysis-dependent chronic kidney disease: design and rationale of three phase 3 studies

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**ABSTRACT**

**Introduction:** New medications for anaemia associated with chronic kidney disease (CKD) are desirable, owing to the limitations of erythropoiesis-stimulating agents (ESAs), the current standard of care. Molidustat is a novel hypoxia-inducible factor prolyl-hydroxylase inhibitor that stimulates erythropoietin production, predominately in the kidney. We report methodological details of three phase 3 trials, named **Molidustat Improves sYmptoms of renal Anemia By Increasing endogenous erythropoietin (MIYABI)**, designed primarily to investigate the efficacy of molidustat therapy in adults with renal anaemia and dialysis-dependent CKD.

**Methods and analysis:** MIYABI Haemodialysis-Correction (HD-C) is a single-arm trial (24-week treatment duration) in approximately 25 patients on haemodialysis, currently untreated with ESAs. MIYABI Peritoneal Dialysis (PD) is a single-arm trial (36-week treatment duration) in approximately 50 patients on peritoneal dialysis, treated or untreated with ESAs. MIYABI Haemodialysis-Maintenance (HD-M) is a randomised, active-controlled, double-blinded, double-dummy trial (52-week treatment duration) comparing molidustat with darbepoetin alfa in approximately 225 patients on haemodialysis, treated with ESAs. Molidustat (starting dose 75 mg/day) will be titrated 4-weekly to maintain haemoglobin in pre-determined target ranges. The primary objective is to evaluate the efficacy of molidustat, using the following measures: the rate of rise in haemoglobin (g/dL/week) at the first dose change up to week 8 (MIYABI HD-C); responder rate (MIYABI HD-C and MIYABI PD); non-inferiority to darbepoetin alfa with respect to mean haemoglobin level and change from baseline during weeks 33–36 (MIYABI HD-M). The secondary objectives are to assess safety, pharmacokinetics and pharmacodynamics. These trials will provide the first evaluations of molidustat therapy in patients receiving either peritoneal dialysis or currently untreated with ESAs on haemodialysis, and provide further evidence in patients treated with ESAs on haemodialysis.

**Ethics and dissemination:** The trials will be conducted in accordance with the Declaration of Helsinki and Good Clinical Practice.

**Trial registration numbers:** NCT03351166, NCT03418168, NCT03543657

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**Keywords:** Chronic kidney disease; dialysis; molidustat; renal anaemia**STRENGTHS AND LIMITATIONS OF THESE STUDIES**

- The three phase 3 MIYABI trials in patients with renal anaemia on dialysis will comprise two open-label, single-arm studies (due to feasibility of recruitment) and one randomised, active-controlled, double-blinded, double-dummy, parallel-group study.
- In MIYABI HD-M, molidustat treatment will be compared with an ESA (darbepoetin alfa), the current standard of care for renal anaemia, in a double-blinded manner; the only other study that has investigated the effects of molidustat therapy in patients with renal anaemia on haemodialysis was an open-label phase 2b trial using epoetin as a comparator.
- The MIYABI HD-M trial will involve a larger patient population (n=150) receiving a 75 mg starting dose than in the phase 2b trial (n=44 of the 157 patients treated with molidustat received a 75 mg starting dose).
- Treatment durations will be longer (eg, 52 weeks in MIYABI HD-M) than in the phase 2b trial (16 weeks), although approximately one-third of the molidustat-treated patients in the phase 2b trial (n=57) continued treatment in an extension study for up to 36 months.
- The efficacy of molidustat therapy will be investigated for the first time in patients on peritoneal dialysis in MIYABI PD and in patients currently untreated with ESAs on haemodialysis in MIYABI HD-C.

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## INTRODUCTION

Anaemia is a common and serious complication of chronic kidney disease (CKD),<sup>1</sup> which worsens as CKD progresses.<sup>2-4</sup> The main cause of anaemia associated with CKD (also known as renal anaemia) is erythropoietin (EPO) deficiency.<sup>5</sup>

Treatment with erythropoiesis-stimulating agents (ESAs) is the current standard of care for renal anaemia.<sup>6</sup> However, this approach has limitations. In 10–20% of patients, irrespective of dialysis status, ESAs are ineffective at raising haemoglobin (Hb) to prespecified levels.<sup>7-9</sup> ESAs may also cause several adverse events (AEs), including pure red cell aplasia,<sup>10</sup> development or worsening of hypertension,<sup>11-13</sup> thrombosis,<sup>14</sup> tumour progression in patients with various malignancies,<sup>15 16</sup> poor cardiovascular outcomes and death.<sup>17 18</sup> These AEs may be related to injecting high doses of ESAs to achieve Hb targets<sup>14 17 19 20</sup> and excessive increases in Hb levels.<sup>21</sup>

A new approach under investigation involves using small molecules to inhibit hypoxia-inducible factor prolyl-hydroxylases (HIF-PH), thereby inducing EPO production. In addition to addressing EPO deficiency, the main cause of renal anaemia, the therapeutic effect of HIF-PH inhibition may also be mediated by increasing the availability of iron for erythropoiesis, as indicated by reductions in hepcidin levels.<sup>22-27</sup> These findings are particularly notable, given that functional iron deficiency may contribute to the inadequate responses that 10–20% of patients experience during treatment with ESAs, even though these patients often receive intravenous iron supplementation.<sup>5-9</sup> HIF-PH inhibition may theoretically also have a downside, because HIF transcriptionally upregulates a large number of genes; although EPO gene upregulation is helpful in treating anaemia associated with CKD, vascular endothelial growth factor (VEGF) upregulation could potentially exacerbate undesirable conditions.<sup>23</sup> However, in clinical trials of HIF-PH inhibitors, no safety signals or changes in VEGF levels were reported.<sup>25-27</sup>

Molidustat, a novel, orally administered inhibitor of HIF-PH, induces circulating levels of EPO close to the normal physiological range, with high relative selectivity for the induction of EPO gene expression, predominately in the kidney.<sup>22</sup> Results from preclinical<sup>22</sup> and clinical studies<sup>28</sup> suggest that molidustat is a promising option for the treatment of EPO-sensitive

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anaemia in patients with CKD. In preclinical studies, molidustat restored renal EPO production with minor induction of hepatic EPO. Molidustat increased plasma EPO and EPO mRNA in the kidney and prevented decline in haematocrit and corrected decreases in Hb level.<sup>22</sup> In a randomised, placebo-controlled, phase 1 study involving 59 healthy participants, single doses of molidustat (5–50 mg) elicited a dose-dependent increase in EPO and were well tolerated.<sup>28</sup> In three 16-week, randomised, phase 2b, dose-ranging studies, comprising one study with patients on haemodialysis and two studies with patients not on dialysis, more than 400 patients with CKD were enrolled. These studies demonstrated that, during treatment with flexible-dose molidustat, Hb levels could be corrected relative to placebo or maintained at levels comparable to those in patients who continued treatment with ESAs, with manageable side effects. Comparable results and no significant safety concerns were observed in extension studies up to 36 months (manuscripts for phase 2 studies of molidustat are currently under consideration for publication).

Based on the positive findings of the preclinical and phase 2b clinical studies, the **Molidustat Improves symptoms of renal Anemia By Increasing endogenous EPO (MIYABI)** programme of five phase 3 trials has been designed to investigate the efficacy, safety, pharmacokinetics (PK) and pharmacodynamics (PD) of molidustat further in patients with renal anaemia in Japan. Here, we report the methodological details of the three MIYABI trials in which molidustat therapy will be investigated in patients receiving dialysis. These trials will provide the first evaluations of molidustat therapy in patients on peritoneal dialysis and in patients currently untreated with ESAs on haemodialysis, as well as extending the evidence in patients treated with ESAs on haemodialysis.

**METHODS AND PLANNED ANALYSES****Study designs, objectives and populations**

Each of the three phase 3 trials is a multicentre study conducted in adults with renal anaemia and dialysis-dependent CKD in Japan. In each trial, the primary objective is to evaluate the efficacy of molidustat in the respective patient populations and, in the MIYABI Haemodialysis Maintenance (HD-M) trial, to show non-inferiority to darbepoetin alfa. The secondary objectives of each trial are to evaluate the safety, tolerability, PK and PD of molidustat during the treatment periods.

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Trial designs are shown in figure 1 and table 1, and key inclusion criteria are also summarised in table 1. All inclusion and exclusion criteria are shown in table 2.

MIYABI Haemodialysis Correction (HD-C) is a single-arm study in patients on haemodialysis who are not currently treated with ESAs, with a 24-week treatment duration. Japanese guidelines for the clinical evaluation of medications for renal anaemia recommend demonstrating efficacy in the correction and maintenance of renal anaemia in patients on dialysis, as well as in patients not on dialysis.<sup>29</sup> However, the number of patients with renal anaemia on dialysis who do not receive ESAs is limited in Japan. A single-arm study design was chosen owing to the feasibility of patient recruitment.<sup>30</sup>

MIYABI Peritoneal Dialysis (PD) is a single-arm study in patients on peritoneal dialysis who are treated or not treated with ESAs, with a 36-week treatment duration. A single-arm study design was chosen owing to the limited number of peritoneal dialysis patients with renal anaemia in Japan.

MIYABI HD-M is a randomised, active-controlled, double-blinded, double-dummy, parallel-group study comparing molidustat with darbepoetin alfa in patients on haemodialysis who are treated with ESAs. The study will have a treatment duration of 52 weeks. As most patients with renal anaemia on dialysis in Japan are treated with ESAs, it is feasible to recruit sufficient patients to perform a confirmatory, randomised, double-blinded trial of molidustat in this patient population. In MIYABI HD-M, eligible patients will be randomised in a ratio of 2:1 to the molidustat group or darbepoetin alfa group. Randomisation will be stratified by previous ESA dose group (low or high) and by medical history of thromboembolic events (yes or no for myocardial infarction, pulmonary thromboembolism, stroke [excluding haemorrhagic stroke] or acute limb ischaemia). Unblinding will be permitted in cases of emergency, such as occurrence of a suspected, unexpected, serious AE, when the investigator needs to know which drug has been allocated.

Each study will be overseen by a data monitoring committee consisting of independent clinical experts and an independent biostatistician supported by an independent statistical analysis centre, whose main responsibility will be to recommend a change, interruption or termination of the study (or all phase 3 studies) based on safety findings.



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**Treatments**

Study treatments are summarised in table 1. In each study, a starting dose of 75 mg molidustat once daily (OD) will be titrated every 4 weeks using an interactive voice/web response system (IxRS), based on the patient's Hb response to the previous dose. Planned doses for the titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD. The dose of molidustat will be adjusted to correct and maintain Hb levels in the target ranges ( $\geq 10.0$  to  $< 12.0$  g/dL in MIYABI HD-C and MIYABI HD-M;  $\geq 11.0$  to  $< 13.0$  g/dL in MIYABI PD).

For patients untreated with ESAs (all patients in MIYABI HD-C and some patients in MIYABI PD), a dose adaptation visit will occur at week 4 to avoid excessive elevation of Hb levels after the initiation of molidustat treatment. In both studies, dose titration at week 4 will be based on both the magnitude of the rise in Hb and the Hb level (supplementary table 1) and from week 8 according to the Hb level alone (supplementary table 2). For patients treated with ESAs (all patients in MIYABI HD-M and some patients in MIYABI PD), the dose will be titrated from week 4 according to Hb level (supplementary table 2).

In MIYABI HD-M, patients will receive molidustat or molidustat placebo orally and darbepoetin alfa or darbepoetin alfa placebo intravenously. Patients in the molidustat group will receive molidustat plus darbepoetin alfa placebo, while patients in the darbepoetin alfa group will receive darbepoetin alfa plus molidustat placebo. The starting dose of darbepoetin alfa or darbepoetin alfa placebo will be selected for each patient based on their previous ESA dosage. Patients treated with darbepoetin alfa at screening will continue this treatment or start treatment with darbepoetin alfa placebo at the previous dose and interval (ie, weekly or biweekly). Patients treated with an epoetin therapy at screening will be treated with darbepoetin alfa or darbepoetin alfa placebo at a starting dose and interval determined by their epoetin dosage at screening. Then, depending on the Hb level (supplementary table 2), doses of darbepoetin alfa and darbepoetin alfa placebo will be titrated at biweekly intervals from week 2, and doses of molidustat and molidustat placebo will be titrated from week 4 at 4-weekly intervals.

Iron, vitamin B12 and folate supplementation is permitted if required and will be administered according to Japanese guideline recommendations.<sup>31</sup>

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**Variables**

All efficacy and safety variables, and associated definitions, are shown in table 3. The primary efficacy variables in MIYABI HD-C are the rate of rise in Hb level (g/dL/week) at the first dose change up to week 8 and responder rate. In all three studies, a responder is defined as a patient who meets all of the following criteria: (i) mean of the Hb levels during the evaluation period is in the target range; (ii)  $\geq 50\%$  of the Hb levels during the evaluation period are in the target range; (iii) no rescue treatment received up to the end of the evaluation period. In MIYABI PD, the primary efficacy variable will be the responder rate. In MIYABI HD-M, the primary efficacy variables will be mean Hb level during the evaluation period and its change from baseline. Secondary variables are shown in table 3. Exploratory variables will include measures of iron metabolism, VEGF levels and health-related quality of life assessments.

To investigate systemic exposure to molidustat and the relationship between molidustat exposure and response, sparse sampling for PK and EPO will be conducted. If possible, molidustat exposure parameters (eg,  $C_{max}$ , AUC) and the relationship between molidustat exposure and treatment effects will be evaluated using population approaches (eg, non-linear mixed effect modelling), including potential influence of relevant patient covariables.

**Statistical analysis**

All variables (including demographic and other baseline characteristics) will be analysed descriptively with appropriate statistical methods: categorical variables by frequency tables and continuous variables by summary statistics (mean, standard deviation, minimum, median and maximum). Summary statistics will be presented for the original data as well as for the difference from baseline.

The primary analysis set for efficacy will be the full analysis set, which includes all patients assigned to treatment who have at least one baseline Hb level (ie, at least one Hb level before the first dose of the study drug).

In MIYABI HD-C, the primary efficacy variables (rate of rise in Hb and responder rate) and their two-sided 95% confidence intervals (CI) will be estimated using one-sample *t*-statistics and the Clopper–Pearson method, respectively. In MIYABI PD, the primary efficacy variable

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(responder rate) and its two-sided 95% CI will be estimated using the Clopper–Pearson method. In MIYABI HD-M, the primary efficacy variables (mean Hb level and change in mean Hb level) will be analysed by sequentially testing two hypotheses. The primary objective of showing non-inferiority to darbepoetin alfa will be achieved if the following two hypotheses are confirmed. (i) In the molidustat treatment group, the mean Hb level during the evaluation period (weeks 30–36) remains within the target range ( $\geq 10.0$  to  $< 12.0$  g/dL). The mean Hb level in the molidustat treatment group will be calculated using the mean Hb level per patient. If the lower limit of the two-sided 95% CI of the mean of the mean Hb level is greater than or equal to the lower limit of the target Hb level (ie,  $\geq 10.0$  g/dL) and if the upper limit of the two-sided 95% CI is less than the upper limit of the target Hb level (ie,  $< 12.0$  g/dL), it will be established that the mean Hb level is within the target range. Two-sided 95% CI will be estimated using one sample *t*-statistics. (ii) Molidustat is not inferior to darbepoetin alfa. The non-inferiority of molidustat to darbepoetin alfa will be established if the lower limit of the two-sided 95% CI for the difference (molidustat minus darbepoetin alfa) is above  $-1.0$  g/dL with non-inferiority margin of  $1.0$  g/dL. This margin was chosen because a variation of approximately  $1.0$  g/dL is considered acceptable in Japanese clinical practice.<sup>31</sup> The difference in change between the treatment groups and its two-sided 95% CI will be estimated using an analysis of covariance (ANCOVA) model, including treatment group, previous ESA dose group (low/high) and previous thromboembolic events (yes/no) as fixed effects and baseline Hb level as a covariate.

**Determination of sample size**

In MIYABI HD-C and MIYABI PD, the respective sample sizes of approximately 25 and 50 patients are determined based on feasibility.

In MIYABI HD-M, if 150 patients are randomised to the molidustat group and 75 patients to the darbepoetin alfa group, the power to establish that mean Hb levels are within target levels during the evaluation period is  $\geq 98\%$ . This sample size has  $>90\%$  power to reject the null hypothesis that molidustat is inferior to darbepoetin alfa with a non-inferiority margin of  $1.0$  g/dL at a one-sided 2.5% significance level, assuming the expected difference between molidustat and darbepoetin alfa to be  $0$  g/dL and with a common standard deviation of  $1.3$ – $1.5$  g/dL. In addition, assuming a dropout rate of approximately 30%, this

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sample size should result in sufficient data to assess the long-term safety of molidustat therapy.

**DISCUSSION**

Renal anaemia due to EPO deficiency is a common and serious complication of CKD.<sup>1</sup> However, new approaches to the treatment of renal anaemia are needed, owing to safety issues and limitations with current treatments. Results from previous studies, including three phase 2b dose-ranging trials, suggest that molidustat is a promising option for the treatment of EPO-sensitive anaemia in patients with CKD.

At present, only one phase 2b trial assessing molidustat has been conducted in patients with renal anaemia who are on dialysis. It is anticipated that the three phase 3 trials described here will demonstrate the efficacy and safety of molidustat in patients with renal anaemia on dialysis, and that the trials will have the following strengths, relative to the one phase 2b trial conducted in patients on dialysis: (i) in MIYABI HD-M, molidustat treatment will be compared with an ESA (darbepoetin alfa), the current standard of care for renal anaemia, in a double-blinded manner, whereas an open-label design was used in the phase 2b trial, in which molidustat treatment was compared with another ESA (epoetin); (ii) a larger patient population in the MIYABI HD-M trial (n=150) receiving a starting dose of 75 mg molidustat OD than in the phase 2b trial (n=44 of the 157 patients treated with molidustat received a 75 mg starting dose); (iii) the treatment periods will be longer (eg, 52 weeks in MIYABI HD-M) than in the phase 2b trial (16 weeks), although about one-third of the molidustat-treated patients in the phase 2b trial (n=57) continued treatment in an extension study, with a duration of up to 36 months; (iv) molidustat therapy will be investigated for the first time in patients who are not treated with ESAs on haemodialysis in the MIYABI HD-C trial, and MIYABI HD-M will provide further evaluations of molidustat in patients treated with ESAs, whereas the phase 2b trial only included patients who switched from epoetin; (v) the efficacy of molidustat therapy will be investigated for the first time in patients on peritoneal dialysis in MIYABI PD, whereas only patients undergoing haemodialysis were included in the phase 2b trial.

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In the three MIYABI trials in patients on dialysis, the efficacy of molidustat will primarily be assessed by investigating Hb levels, including changes from baseline and maintenance of prespecified Hb targets. However, several exploratory variables will be also investigated. These include assessments of VEGF levels and ophthalmological examinations, conducted to evaluate the theoretical risk of VEGF-mediated diabetic retinopathy,<sup>23</sup> and biomarkers of iron metabolism as, in addition to increasing renal EPO production, molidustat may increase the availability of iron for erythropoiesis.<sup>22-24</sup>

In summary, the three trials in patients on dialysis described here, together with two other trials in patients who are not receiving dialysis (the MIYABI ND-C and MIYABI ND-M randomised, open-label, active-controlled, parallel-group, multicentre trials), comprise the MIYABI phase 3 programme. This programme will investigate the efficacy and safety of molidustat in a broad clinical spectrum spanning approximately 600 patients with renal anaemia and CKD in Japan.

**ETHICS AND DISSEMINATION**

The studies will be conducted in accordance with the principles of the Declaration of Helsinki and the International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use (ICH) Guidelines for Good Clinical Practice (GCP). Documented approval from appropriate independent ethics committees and institutional review boards has been obtained, according to GCP and local laws, regulations and organisations. Informed consent will be obtained from patients before entering the studies and may be withdrawn at any time. The studies have been registered on ClinicalTrials.gov (NCT03351166 [MIYABI HD-C], NCT03418168 [MIYABI PD], NCT03543657 [MIYABI HD-M]). Results will be disseminated through peer-reviewed publications and presentation(s).

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**AUTHOR CONTRIBUTORS**

TA, HY and TY contributed to designing these studies. TY contributed to developing the original study protocols. MT contributed to drafting the article and revising it. TA, HY, MT and KI critical revised the article for important intellectual content. YM contributed to developing the statistical analysis plan and assisted in the preparation of the manuscript. All authors approved the final version of the manuscript and agree to be accountable for all aspects of the work, ensuring that questions related to the accuracy or integrity of any part of the work are appropriately resolved.

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**FIGURE LEGEND**

**Figure 1** Trial designs for (A) MIYABI HD-C, (B) MIYABI PD and (C) MIYABI HD-M. MIYABI HD-C and MIYABI PD are single-arm, multicentre trials. MIYABI HD-M is a randomised, active-controlled, double-blinded, double-dummy, parallel-group, multicentre trial. Haemoglobin levels and safety will be assessed at each study visit, conducted at the time points shown.

BL, baseline; EOF, end of follow-up; EOT, end of treatment; ESA, erythropoiesis-stimulating agent.

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**TABLES****Table 1** Trial designs, patient populations and treatments

	<b>MIYABI HD-C [NCT03351166]</b>	<b>MIYABI PD [NCT03418168]</b>	<b>MIYABI HD-M [NCT03543657]</b>
Trial design	Single-arm, multicentre	Single-arm, multicentre	Randomised, active-controlled, double-blinded, double-dummy, parallel-group, multicentre
Patient population	Men and women (aged $\geq 20$ years, body weight $>40$ and $\leq 160$ kg) with a diagnosis of renal anaemia		
Key inclusion criteria	Patients with ESKD on haemodialysis at least weekly for $\geq 2$ weeks	Patients with ESKD on peritoneal dialysis	Patients with ESKD on haemodialysis at least weekly for $\geq 12$ weeks
	Not treated with HIF-PH inhibitors during the 8 weeks before study drug assignment	Not treated with HIF-PH inhibitors during the 8 weeks before study drug assignment	
	Not treated with ESAs during the 8 weeks before study drug assignment	Not treated or treated with ESAs during the 8 weeks before study drug assignment	Treated with the same ESA for $\geq 8$ weeks before screening
	Mean of the last two Hb levels between $\geq 8.0$ and $<10.0$ g/dL	Mean of the last two Hb levels between $\geq 8.0$ and $<11.0$ g/dL for ESA untreated and $\geq 10.0$ and $<13.0$ g/dL for ESA treated	Mean of all Hb levels (at least two measurements) between $\geq 9.5$ and $<12.0$ g/dL
Study treatments	A starting dose of 75 mg molidustat OD, titrated based on Hb response of the previous dose. Planned doses for	A starting dose of 75 mg molidustat OD, titrated based on Hb response of the previous dose. Planned doses for	Two groups: molidustat + darbepoetin alfa placebo, or molidustat placebo + darbepoetin alfa

Page 16 of 24

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	titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD	titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD	A starting dose of 75 mg molidustat or molidustat placebo OD, titrated based on Hb response of the previous dose Planned doses for titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD.
	Hb target range $\geq 10.0$ to $< 12.0$ g/dL	Hb target range $\geq 11.0$ to $< 13.0$ g/dL	Hb target range $\geq 10.0$ to $< 12.0$ g/dL
			A starting dose of darbepoetin alfa or darbepoetin alfa placebo will be decided in accordance with the previous ESA dosages and schedule of once a week or every 2 weeks per Japanese label
Treatment duration, weeks	24	36	52

ESA, erythropoiesis-stimulating agent; ESKD, end-stage kidney disease; Hb, haemoglobin; HIF-PH, hypoxia-inducible factor prolyl-hydroxylase; OD, once daily.

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**Table 2** An overview of all inclusion and exclusion criteria**Inclusion criteria***All three trials had the following inclusion criteria*

- Written informed consent before performing any study-specific tests or procedures
  - Body weight (after dialysis) >40 and ≤160 kg at screening
  - Male or female ≥20 years of age at screening
  - At least one kidney
  - Serum folate level and serum vitamin B12 level above LLN at screening
  - Women of reproductive potential must agree to use adequate contraception when sexually active. This applies for the time period between signing of the informed consent form until 12 weeks after the last administration of the study drug.
    - Acceptable methods of contraception may include, but are not limited to, condoms (male or female) with or without a spermicidal agent; diaphragm or cervical cap with spermicide; intra-uterine device; hormone-based contraception.
    - Patients must agree to utilise two reliable and acceptable methods of contraception simultaneously.
- Women are considered postmenopausal and not of childbearing potential if they have had 12 months of natural (spontaneous) amenorrhoea with an appropriate clinical profile (eg, age-appropriate, history of vasomotor symptoms) or 6 months of spontaneous amenorrhoea with serum FSH levels >40 mIU/mL or have had surgical treatment such as bilateral tubal ligation, bilateral ovariectomy or hysterectomy.
- Ability to understand and follow study-related instructions.

*MIYABI HD-C had four additional inclusion criteria*

- Patients with ESKD on dialysis (including haemodiafiltration, haemodialysis and other modalities except for peritoneal dialysis) weekly or more than weekly for ≥2 weeks before study drug assignment
- Mean screening Hb level ≥8.0 and <10.0 g/dL (at least two measurements must be taken ≥2 days apart, assessed by the central laboratory, and the difference between the two measurements must be <1.2 g/dL) with the last screening Hb measurement during the 14 days before study drug assignment
- Not treated with any ESAs or HIF-PH inhibitors during the 8 weeks before study drug assignment. For patients washed out from ESAs, the mean Hb level before dialysis (at least two measurements taken ≥2 days apart, assessed by the central laboratory) must have decreased by ≥0.5 g/dL

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after the last ESA administration, AND the interval from the last ESA administration to study drug assignment should be >1 week for epoetin alfa, >2 weeks for darbepoetin alfa or >4 weeks for epoetin beta pegol

- Ferritin  $\geq 50$  ng/mL at screening

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*MIYABI PD had five additional inclusion criteria*

- Patients with ESKD on peritoneal dialysis before study drug assignment and not expected to start maintenance dialysis (eg, haemodialysis, haemodiafiltration) other than peritoneal dialysis during the study period
- Not treated with HIF-PH inhibitors during the 8 weeks before study drug assignment
- Patients who meet one of the following criteria

*A: Untreated with ESA at study drug assignment*

Mean screening Hb level  $\geq 8.0$  and  $< 11.0$  g/dL (based on the last two measurements taken  $\geq 2$  days apart, assessed by the central laboratory; the difference between the two measurements must be  $< 1.2$  g/dL), with the last screening Hb measurement during the 14 days before study drug assignment

*B: Pre-treated with ESA at study drug assignment*

Mean screening Hb level  $\geq 10.0$  and  $< 13.0$  g/dL (based on the last two measurements taken  $\geq 2$  days apart, assessed by the central laboratory; the difference between the two measurements must be  $< 1.2$  g/dL), with the last screening Hb measurement during the 14 days before study drug assignment

- Patients who meet one of the following criteria

*A: Untreated with ESA at study drug assignment*

- Patient with ESKD on peritoneal dialysis for  $\geq 2$  weeks before study drug assignment

and

- Not treated with ESA for the 8 weeks before study drug assignment

or

- Washed out from ESAs, when the mean Hb level (based on at least two measurements taken  $\geq 2$  days apart, assessed by the central laboratory) has decreased by  $\geq 0.5$  g/dL after the last ESA administration, AND the interval from the last ESA administration to study drug assignment should be >2 weeks for epoetin alfa/beta and >4 weeks for darbepoetin alfa or epoetin beta pegol

*B: Pre-treated with ESA at study drug assignment*

- Patient with ESKD on peritoneal dialysis for  $\geq 12$  weeks before study drug assignment
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- Treated with IV or SC ESA during the 8 weeks before study drug assignment
- Treated with 2- or 4-weekly dose of darbepoetin alfa, 4-weekly dose of epoetin beta pegol, OR 3 times per week, twice per week, weekly or biweekly dose of epoetin alfa/beta, and having had no more than one dose change during the 8 weeks before study drug assignment
- Patients who meet one of the following criteria
  - A: Untreated with ESA at study drug assignment*
  - Ferritin  $\geq 50$  ng/mL at screening
  - B: Pre-treated with ESA at study drug assignment*
  - Ferritin  $\geq 100$  ng/mL or transferrin saturation  $\geq 20\%$

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*MIYABI HD-M had five additional inclusion criteria*

- Patients with ESKD on dialysis (including haemodiafiltration, haemofiltration, haemodialysis and other modalities except for peritoneal dialysis) weekly or more than weekly for  $\geq 12$  weeks before randomisation
- Treated with the same ESA for  $\geq 8$  weeks before screening
- Treated with weekly or biweekly dose of darbepoetin alfa, monthly or biweekly dose of epoetin beta pegol, OR weekly, biweekly, twice or three times per week dose of epoetin alfa/beta, and having had no more than one dose change during the 8 weeks before randomisation
- Mean screening Hb level  $\geq 9.5$  and  $< 12.0$  g/dL before dialysis (based on at least two measurements taken  $\geq 2$  days apart, assessed by the central laboratory, AND the difference between the lowest level and highest level  $< 1.2$  g/dL), with the last screening Hb level measurement during the 14 days before randomisation
- Ferritin  $\geq 100$  ng/mL or transferrin saturation  $\geq 20\%$  at screening

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**Exclusion criteria**

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*All three trials had the following exclusion criteria*

- Any current condition leading to significant blood loss
  - Active haemolysis or diagnosis of haemolytic syndrome
  - Previous or concurrent myelodysplastic syndrome, multiple myeloma, marrow fibrosis or PRCA
  - Previous or concurrent haemosiderosis or haemochromatosis
  - Previous or concurrent hereditary haemoglobinopathies (eg, sickle-cell disease, beta thalassaemia, thalassaemia major)
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- Previous or concurrent aplastic anaemia
  - Previous or concurrent chronic lymphoproliferative diseases
  - Proliferative choroidal or retinal disease, such as neovascular age-related macular degeneration or proliferative diabetic retinopathy requiring invasive treatment (eg, intraocular injections or laser photocoagulation) at screening
  - Chronic inflammatory disease, such as rheumatoid arthritis, systemic lupus erythematosus, ankylosing spondylitis, psoriatic arthritis or inflammatory bowel disease, which is determined to be the principal cause of the anaemia
  - Known hypersensitivity to the study drugs (active substances or excipients of the preparations)
  - Uncontrolled and symptomatic hyperparathyroidism
  - Uncontrolled active infection at study drug assignment
  - Previous or concurrent cancer except cervical carcinoma *in situ*, treated basal cell carcinoma, superficial bladder tumours (Ta, Tis and T1) or any cancer curatively treated >3 years before study drug assignment
  - Previous or scheduled organ transplantation (being on a transplant waiting list does not exclude a patient)
  - History of alcohol or drug abuse during the 2 years before study drug assignment
  - RBC-containing transfusion for treatment of anaemia during the 8 weeks before study drug assignment
  - Treatment with uridine-diphosphate-glucuronosyltransferase 1 family, polypeptide A1 inhibitors during the 7 days before study drug assignment:
    - antiretroviral drugs (eg, ritonavir, saquinavir, atazanavir, indinavir, lopinavir, nelfinavir)
    - tyrosine kinase inhibitors (eg, erlotinib, pazopanib, nilotinib, sorafenib, regorafenib)
    - tranilast
  - Patients treated with immune- or myelosuppressive therapy during the 8 weeks before study drug assignment (eg, everolimus, sirolimus, rituximab, azathioprine, mycophenolate mofetil, mycophenolic acid, cyclosporine, methotrexate, tacrolimus, chemotherapeutic agents and other anticancer agents, and systemic steroids treatment [except inhaled steroids] for 7 days or more)
  - Treated with the following therapies during the 8 weeks before study drug assignment: anabolic hormone, testosterone enanthate or mepitiostane
  - History of cardiovascular or cerebrovascular events (eg, unstable angina, myocardial infarction, stroke, pulmonary thromboembolism and ALI) during the 6 months before study drug assignment
  - Sustained, poorly controlled arterial hypertension (defined as systolic BP  $\geq$ 180mmHg or diastolic BP  $\geq$ 110mmHg) or hypotension (defined as
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systolic BP <90mmHg) at study drug assignment

- NYHA class III or IV congestive heart failure
  - Severe hepatic disorder (defined as ALT or AST >3 x the upper limit of normal, total bilirubin >2 mg/dL, or Child-Pugh B or C) at screening
  - Previous use of molidustat
  - A patient in need of surgery that may be expected to lead to significant blood loss
  - Expected need for rescue treatment during the next 7 days after study drug assignment
  - Active hepatitis, as assessed by the investigator
  - Any medical condition that in the opinion of the investigator may pose a safety risk to a patient in this study, may confound safety or efficacy assessment or may interfere with study participation
  - Previous assignment to study treatment during this study
  - Previous (during the 30 days before study drug assignment) or concomitant participation in another clinical study with investigational medicinal product(s)
  - Close affiliation with the investigational site, for example, a close relative of the investigator, dependent person (eg, employee or student at the investigational site)
  - Pregnant or breastfeeding women
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*MIYABI PD had two additional exclusion criteria*

- Previous or concurrent indications for removal of peritoneal dialysis catheter (eg, recurrent peritoneum inflammation, refractory tunnel infection)
  - Concomitant use of maintenance dialysis (eg, haemodialysis, haemodiafiltration) other than peritoneal dialysis
- 

ALI, acute limb ischaemia; ALT, alanine aminotransferase; AST, aspartate aminotransferase; BP, blood pressure; ESA, erythropoiesis-stimulating agent; ESKD, end-stage kidney disease; FSH, follicle-stimulating hormone; Hb, haemoglobin; HIF-PH, hypoxia-inducible factor propyl hydroxylase; IV, intravenous; LLN, lower limit of normal; NYHA, New York Heart Association; PRCA, pure red cell aplasia; RBC, red blood cell; SC, subcutaneous.



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**Table 3** Efficacy and safety variables

	MIYABI HD-C	MIYABI PD	MIYABI HD-M
Primary efficacy variables specific to each trial	<ul style="list-style-type: none"> <li>Rate of rise in Hb level (g/dL/week) at the first dose change up to week 8*</li> <li>Responder rate during the evaluation period (weeks 21–24)†</li> </ul>	<ul style="list-style-type: none"> <li>Responder rate during the evaluation period (weeks 30–36)†</li> </ul>	<ul style="list-style-type: none"> <li>Mean Hb level during the evaluation period (weeks 33–36)</li> <li>Change in mean Hb level from baseline during the evaluation period</li> </ul>
Secondary efficacy variables in all three trials	<ul style="list-style-type: none"> <li>Proportions of patients who meet the three response criteria during the evaluation period†</li> <li>Hb level and change from baseline (measurement at each visit and mean during the evaluation period)</li> <li>Proportion of patients whose mean Hb level is in, above or below the target range during the evaluation period</li> <li>Proportion of patients whose Hb level is in, above or below the target range, respectively, at each visit</li> <li>Proportion of patients whose maximum rise in Hb between each consecutive visit is &gt;0.5 g/dL/week (defined as change in Hb level/duration between two visits [weeks])</li> </ul>		
Secondary efficacy variables specific to each trial	<ul style="list-style-type: none"> <li>Rate of rise in Hb (g/dL/week) at the dose change up to week 4</li> <li>Cumulative proportion of patients who achieve the lower limit of the target Hb range at least once at each visit</li> </ul>	<ul style="list-style-type: none"> <li>Rate of rise in Hb level (g/dL/week) at the dose changes up to weeks 4 and 8*</li> <li>Change in mean Hb level from baseline during the evaluation period</li> <li>Mean Hb level during the evaluation period</li> </ul>	<ul style="list-style-type: none"> <li>Responder rate during the evaluation period†</li> </ul>
Other efficacy variables in MIYABI HD-C and MIYABI HD-M (secondary variables)	<ul style="list-style-type: none"> <li>Rate of rise in Hb level (g/dL/week) during each visit interval</li> <li>Percentage of days in the target Hb range during the evaluation period and treatment period, respectively (defined as the number of days in the target range/number of days during the period × 100 [%])</li> </ul>		

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in MIYABI PD)	<ul style="list-style-type: none"> <li>Percentage of Hb levels in target range during the evaluation period and treatment period, respectively (defined as the number of measurements in the target range/number of measurements × 100 [%])</li> <li>Proportion of patients who received at least one rescue treatment (RBC transfusion, ESA treatment)</li> </ul>
Safety variables in all three trials	<ul style="list-style-type: none"> <li>Adjudicated AEs†</li> <li>AEs including serious AEs</li> <li>Change in vital signs (pulse rate and blood pressure)</li> <li>12-lead electrocardiogram parameters</li> <li>Observations of ophthalmological examination (fundus and anterior ocular segment examination and intraocular pressure measurement)</li> <li>Laboratory examinations (including haematology, coagulation, clinical chemistry, electrolyte, HbA<sub>1c</sub>, PTH and TSH levels)</li> </ul>
Exploratory variables in all three trials	<ul style="list-style-type: none"> <li>Parameters of iron metabolism</li> <li>EQ-5D-5L</li> <li>Vascular endothelial growth factor</li> </ul>

AEs, adverse events; EQ-5D-5L, EuroQol 5-dimension 5-level questionnaire; ESA, erythropoiesis-stimulating agents; Hb, haemoglobin; HbA<sub>1c</sub>, glycated haemoglobin; PTH, parathyroid hormone; TSH, thyroid-stimulating hormone; RBC, red blood cell.

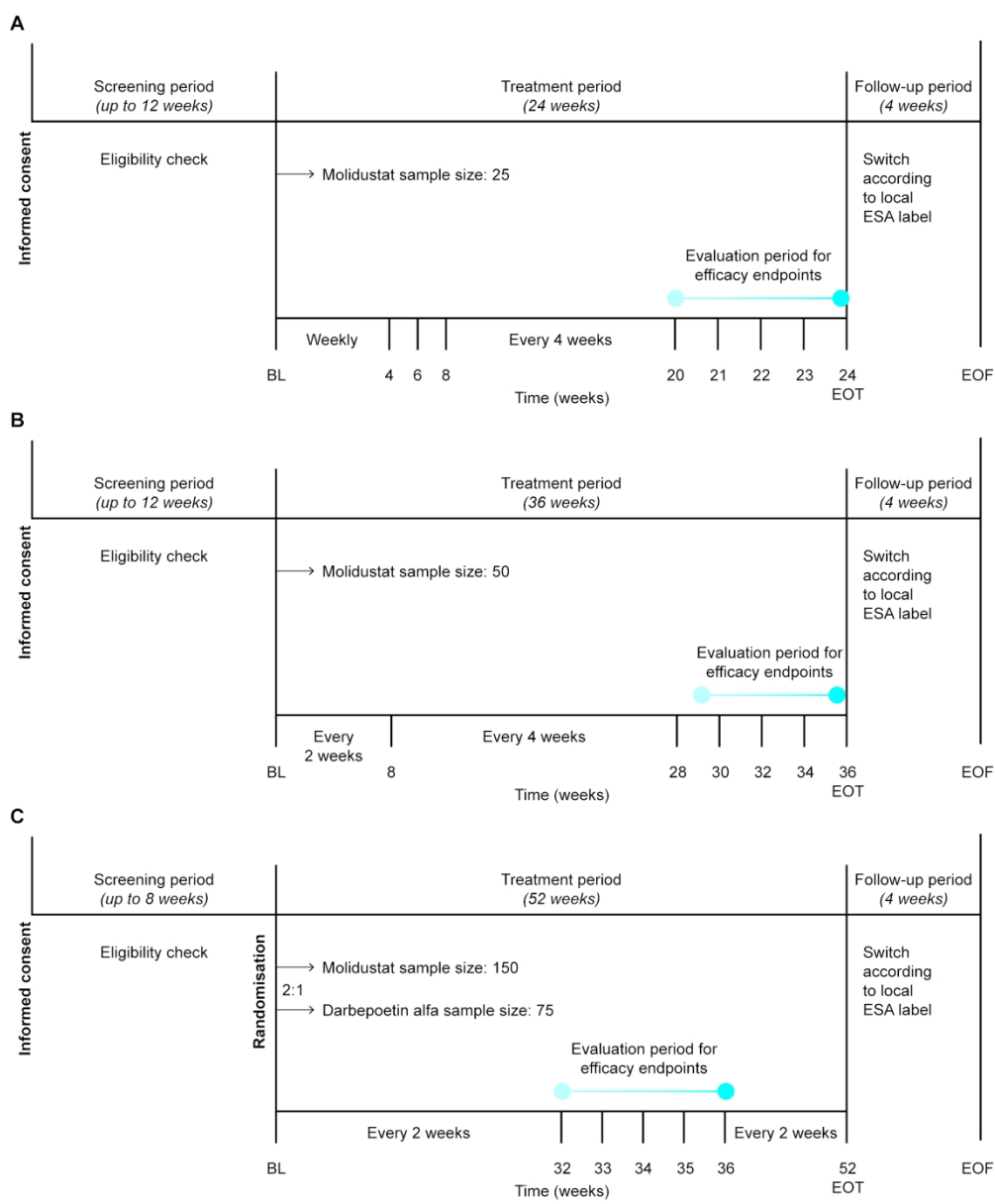
\*Rate of rise in Hb (g/dL/week) at the first dose change up to week 8 is defined as the change in Hb level from baseline to the first dose change of study drug up to week 8 divided by the duration of the starting dose (in weeks). If no dose change is performed up to week 8, then an Hb level at week 8 and the date of the week 8 visit will be used to calculate the change in Hb level and duration.

†A responder is defined as a patient who meets all of the following criteria:

- (i) mean of the Hb levels during the evaluation period is in the target range
- (ii) ≥50% of the Hb levels during the evaluation period are in the target range
- (iii) no rescue treatment up to the end of the evaluation period.

‡Adjudicated AEs include death, myocardial infarction, unstable angina pectoris, stroke or transient ischaemic attack, pulmonary thromboembolism or acute limb ischaemia.

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**SUPPLEMENTARY TABLES**

**Supplementary table 1** Dose titration for molidustat at week 4 for all patients in the MIYABI HD-C trial\* and for patients not treated with ESA at study drug assignment in the MIYABI PD trial

Rise in Hb in the first 4 weeks (g/dL)	Hb level (g/dL) in MIYABI HD-C	Hb level (g/dL) in MIYABI PD	Titration step
<0.5	<9.5	<10.5	Increase to the next higher dose
	≥9.5	≥10.5	
≥0.5 and <1.0	Any value	Any value	Maintain the same dose
≥1.0 and ≤2.0	≤10.0	≤11.0	
>2.0	>10.0	>11.0	Decrease to the next lower dose
	Any value	Any value	

\*All patients in MIYABI HD-C will not be treated with ESAs at study drug assignment or during the trial.

ESA, erythropoiesis-stimulating agent; Hb, haemoglobin.

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Supplementary table 2 Dose titration from week 8 in MIYABI HD-C, from week 4 or 8 in MIYABI PD\*, and from week 2 or 4 in MIYABI HD-M†

Hb level (g/dL) in MIYABI HD-C and MIYABI HD-M	Hb level (g/dL) in MIYABI PD	Titration step
<10.0	<11.0	Increase to the next higher dose
≥10.0 and <12.0	≥11.0 and <12.5	Maintain the same dose
≥12.0 and <13.0	≥12.5 and <13.0	Decrease to the next dose
≥13.0	≥13.0	Suspend a dose until the next scheduled visit

\*In MIYABI PD, patients treated with ESAs at study drug assignment will start this dose-titration schedule for molidustat at week 4, whereas patients not treated with ESAs at study drug assignment will start this dose titration schedule for molidustat at week 8.

†In MIYABI HD-M, doses of darbepoetin alfa or darbepoetin alfa placebo will be titrated from week 2, whereas doses of molidustat will be titrated from week 4.

ESA, erythropoiesis-stimulating agent; Hb, haemoglobin.

# BMJ Open

## Molidustat for the treatment of renal anaemia in patients with dialysis-dependent chronic kidney disease: design and rationale of three phase 3 studies

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**20 ABSTRACT**

21 **Introduction:** New medications for anaemia associated with chronic kidney disease (CKD)  
22 are desirable, owing to the limitations of erythropoiesis-stimulating agents (ESAs), the  
23 current standard of care. Molidustat is a novel hypoxia-inducible factor prolyl-hydroxylase  
24 inhibitor that stimulates erythropoietin production, predominately in the kidney. We report  
25 methodological details of three phase 3 trials, named **Molidustat Improves sYmptoms of**  
26 **renal Anemia By Increasing endogenous erythropoietin (MIYABI)**, designed primarily to  
27 investigate the efficacy of molidustat therapy in adults with renal anaemia and dialysis-  
28 dependent CKD.

29 **Methods and analysis:** MIYABI Haemodialysis-Correction (HD-C) is a single-arm trial (24-  
30 week treatment duration) in approximately 25 patients on haemodialysis, currently  
31 untreated with ESAs. MIYABI Peritoneal Dialysis (PD) is a single-arm trial (36-week treatment  
32 duration) in approximately 50 patients on peritoneal dialysis, treated or untreated with  
33 ESAs. MIYABI Haemodialysis-Maintenance (HD-M) is a randomised, active-controlled,  
34 double-blinded, double-dummy trial (52-week treatment duration) comparing molidustat  
35 with darbepoetin alfa in approximately 225 patients on haemodialysis, treated with ESAs.  
36 Molidustat (starting dose 75 mg/day) will be titrated 4-weekly to maintain haemoglobin in  
37 pre-determined target ranges. The primary objective is to evaluate the efficacy of  
38 molidustat, using the following measures: the rate of rise in haemoglobin (g/dL/week) at the  
39 first dose change up to week 8 (MIYABI HD-C); responder rate (MIYABI HD-C and MIYABI  
40 PD); mean haemoglobin level during weeks 33–36 and non-inferiority to darbepoetin alfa  
41 shown by change in mean haemoglobin level from baseline (MIYABI HD-M). The secondary  
42 objectives are to assess safety, pharmacokinetics and pharmacodynamics. These trials will  
43 provide the first evaluations of molidustat therapy in patients receiving either peritoneal  
44 dialysis or currently untreated with ESAs on haemodialysis, and provide further evidence in  
45 patients treated with ESAs on haemodialysis.

46 **Ethics and dissemination:** The trials will be conducted in accordance with the Declaration of  
47 Helsinki and Good Clinical Practice.

48 **Trial registration numbers:** NCT03351166, NCT03418168, NCT03543657



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50 **Keywords:** Chronic kidney disease; dialysis; molidustat; renal anaemia

## 51 **STRENGTHS AND LIMITATIONS OF THESE STUDIES**

- 52 • The three phase 3 MIYABI trials in patients with renal anaemia on dialysis will  
53 comprise two open-label, single-arm studies (due to feasibility of recruitment) and  
54 one randomised, active-controlled, double-blinded, double-dummy, parallel-group  
55 study.
- 56 • In MIYABI HD-M, molidustat treatment will be compared with an ESA (darbepoetin  
57 alfa), the current standard of care for renal anaemia, in a double-blinded manner;  
58 the only other study that has investigated the effects of molidustat therapy in  
59 patients with renal anaemia on haemodialysis was an open-label phase 2b trial using  
60 epoetin as a comparator.
- 61 • The MIYABI HD-M trial will involve a larger patient population (n=150) receiving a 75  
62 mg starting dose than in the phase 2b trial (n=44 of the 157 patients treated with  
63 molidustat received a 75 mg starting dose).
- 64 • Treatment durations will be longer (eg, 52 weeks in MIYABI HD-M) than in the phase  
65 2b trial (16 weeks), although approximately one-third of the molidustat-treated  
66 patients in the phase 2b trial (n=57) continued treatment in an extension study for  
67 up to 36 months.
- 68 • The efficacy of molidustat therapy will be investigated for the first time in patients  
69 on peritoneal dialysis in MIYABI PD and in patients currently untreated with ESAs on  
70 haemodialysis in MIYABI HD-C.

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## 72 INTRODUCTION

73 Anaemia is a common and serious complication of chronic kidney disease (CKD),<sup>1</sup> which  
74 worsens as CKD progresses.<sup>2-4</sup> The main cause of anaemia associated with CKD (also known  
75 as renal anaemia) is erythropoietin (EPO) deficiency.<sup>5</sup>

76 Treatment with erythropoiesis-stimulating agents (ESAs) is the current standard of care for  
77 renal anaemia.<sup>6</sup> However, this approach has limitations. In 10–20% of patients, irrespective  
78 of dialysis status, ESAs are ineffective at raising haemoglobin (Hb) to prespecified levels.<sup>7-9</sup>  
79 ESAs may also cause several adverse events (AEs), including development or worsening of  
80 hypertension,<sup>10-12</sup> rare cases of antibody-mediated pure red cell aplasia,<sup>13</sup> poor  
81 cardiovascular outcomes and death.<sup>14-16</sup> In patients with cancer and anaemia, ESA use is  
82 associated with increased risk of thrombosis.<sup>17</sup> These AEs may be related to injecting high  
83 doses of ESAs to achieve Hb targets<sup>15 17-19</sup> and excessive increases in Hb levels.<sup>20</sup>

84 A new approach under investigation involves using small molecules to inhibit hypoxia-  
85 inducible factor prolyl-hydroxylases (HIF-PH), thereby inducing EPO production. In addition  
86 to addressing EPO deficiency, the main cause of renal anaemia, the therapeutic effect of  
87 HIF-PH inhibition may also be mediated by increasing the availability of iron for  
88 erythropoiesis, as indicated by reductions in hepcidin levels.<sup>21-26</sup> These findings are  
89 particularly notable, given that functional iron deficiency may contribute to the inadequate  
90 responses that 10–20% of patients experience during treatment with ESAs, even though  
91 these patients often receive intravenous iron supplementation.<sup>5-9</sup> HIF-PH inhibition may  
92 theoretically also have a downside, because HIF transcriptionally upregulates a large  
93 number of genes; although EPO gene upregulation is helpful in treating anaemia associated  
94 with CKD, vascular endothelial growth factor (VEGF) upregulation could result in neoplasia  
95 and diabetic retinopathy.<sup>22</sup> However, in clinical trials of HIF-PH inhibitors, no safety signals  
96 or changes in VEGF levels were reported.<sup>24-26</sup>

97 Molidustat, a novel, orally administered inhibitor of HIF-PH, induces circulating levels of EPO  
98 close to the normal physiological range, with high relative selectivity for the induction of  
99 EPO gene expression, predominately in the kidney.<sup>21</sup> Results from preclinical<sup>21</sup> and clinical  
100 studies<sup>27</sup> suggest that molidustat is a promising option for the treatment of EPO-sensitive  
101 anaemia in patients with CKD. In preclinical studies, molidustat restored renal EPO

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102 production with minor induction of hepatic EPO. Molidustat increased plasma EPO and EPO  
103 mRNA in the kidney and prevented decline in haematocrit and corrected decreases in Hb  
104 level.<sup>21</sup> In a randomised, placebo-controlled, phase 1 study involving 59 healthy participants,  
105 single doses of molidustat (5–50 mg) elicited a dose-dependent increase in EPO and were  
106 well tolerated.<sup>27</sup> In three 16-week, randomised, phase 2b, dose-ranging studies, comprising  
107 one study with patients on haemodialysis and two studies with patients not on dialysis,  
108 more than 400 patients with CKD were enrolled. These studies demonstrated that, during  
109 treatment with flexible-dose molidustat, Hb levels could be corrected relative to placebo or  
110 maintained at levels comparable to those in patients who continued treatment with ESAs,  
111 with manageable side effects.<sup>28</sup> Comparable results and no significant safety concerns were  
112 observed in extension studies up to 36 months (unpublished data).

113 Based on the positive findings of the preclinical and phase 2b clinical studies, the **Molidustat**  
114 **Improves sYmptoms of renal Anemia By Increasing endogenous EPO (MIYABI)** programme  
115 of five phase 3 trials has been designed to investigate molidustat therapy further in patients  
116 with renal anaemia in Japan. Here, we report the methodological details of the three  
117 MIYABI trials in which the efficacy (up to 36 weeks), safety, pharmacokinetics and  
118 pharmacodynamics (up to 52 weeks) of molidustat therapy will be investigated in patients  
119 receiving dialysis. These three trials will provide the first evaluations of molidustat therapy  
120 in patients on peritoneal dialysis and in patients currently untreated with ESAs on  
121 haemodialysis, as well as extending the evidence in patients treated with ESAs on  
122 haemodialysis.

**METHODS AND PLANNED ANALYSES****Study designs, objectives and populations**

125 Each of the three phase 3 trials is a multicentre study conducted in adults aged 20 years or  
126 older with renal anaemia and dialysis-dependent CKD in Japan. In each trial, the primary  
127 objective is to evaluate the efficacy of molidustat in the respective patient populations and,  
128 in the MIYABI Haemodialysis Maintenance (HD-M) trial, to show non-inferiority to  
129 darbepoetin alfa. The secondary objectives of each trial are to evaluate the safety,  
130 tolerability, pharmacokinetics and pharmacodynamics of molidustat during the treatment  
131 periods. The three trials commenced in the first half of 2018 and have finished recruiting.

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132 Patient eligibility was assessed during screening periods lasting up to 12 weeks in the  
133 MIYABI Haemodialysis Correction (HD-C) and MIYABI Peritoneal Dialysis (PD) studies and up  
134 to 8 weeks in MIYABI HD-M. To be eligible, the mean of at least two Hb measurements (both  
135 taken before dialysis, at least 2 days apart, with the last measurement taken within 14 days  
136 before study drug assignment, and with a difference of less than 1.2 g/dL between the  
137 lowest and highest values) was required to lie within pre-specified levels (table 1). The main  
138 inclusion criteria are summarised in table 1. All inclusion and exclusion criteria are shown in  
139 supplementary table 1.

140 MIYABI HD-C is a single-arm study in patients on haemodialysis who are not currently  
141 treated with ESAs, with a 24-week treatment duration (figure 1 and table 1). Japanese  
142 guidelines for the clinical evaluation of medications for renal anaemia recommend  
143 demonstrating efficacy in the correction and maintenance of renal anaemia in patients on  
144 dialysis, as well as in patients not on dialysis.<sup>29</sup> However, the number of patients with renal  
145 anaemia on dialysis who do not receive ESAs is limited in Japan. A single-arm study design  
146 was chosen for MIYABI HD-C owing to the feasibility of patient recruitment.<sup>30</sup>

147 MIYABI PD is a single-arm study in patients on peritoneal dialysis who are treated or not  
148 treated with ESAs, with a 36-week treatment duration (figure 1 and table 1). A single-arm  
149 study design was chosen for MIYABI PD owing to the limited number of peritoneal dialysis  
150 patients with renal anaemia in Japan.

151 MIYABI HD-M is a randomised, active-controlled, double-blinded, double-dummy, parallel-  
152 group study comparing molidustat with darbepoetin alfa in patients on haemodialysis who  
153 are treated with ESAs (figure 1 and table 1). The study has a treatment duration of 52  
154 weeks. As most patients with renal anaemia on dialysis in Japan are treated with ESAs, it is  
155 feasible to recruit sufficient patients to perform a confirmatory, randomised, double-blinded  
156 trial of molidustat in this patient population. Therefore, in MIYABI HD-M, eligible patients  
157 will be randomised in a ratio of 2:1 to the molidustat group or darbepoetin alfa group.  
158 Allocation to treatment arms will be achieved using an interactive voice/web response  
159 system (IxRS) at the first (baseline) visit. Randomisation will be stratified by previous ESA  
160 dose group (low or high) and by medical history of thromboembolic events (yes or no for  
161 myocardial infarction, pulmonary thromboembolism, stroke [excluding haemorrhagic

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stroke] or acute limb ischaemia). All investigators and patients in MIYABI HD-M will be blinded to treatment allocation. In cases of emergency, such as occurrence of a suspected, unexpected, serious AE, when the investigator needs to know which drug has been allocated, unblinding will occur by entering the emergency key code for the relevant patient into the IxRS.

Each study is being overseen by a data monitoring committee consisting of independent clinical experts and an independent biostatistician supported by an independent statistical analysis centre, whose main responsibility is to recommend a change, interruption or termination of the study (or all phase 3 studies) based on safety findings.

**Treatments**

Study treatments are summarised in table 1. In each study, a starting dose of 75 mg molidustat once daily (OD) will be titrated every 4 weeks using the IxRS, based on the patient's Hb response to the previous dose. In each study, planned doses for the titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD. The dose of molidustat will be adjusted to correct and maintain Hb levels in the target ranges of  $\geq 10.0$  to  $< 12.0$  g/dL in MIYABI HD-C and MIYABI HD-M and  $\geq 11.0$  to  $< 13.0$  g/dL in MIYABI PD.

For patients untreated with ESAs (all patients in MIYABI HD-C and some patients in MIYABI PD, but no patients in MIYABI HD-M), a dose adaptation visit will occur at week 4 to avoid excessive elevation of Hb levels after the initiation of molidustat treatment. In MIYABI HD-C and MIYABI PD, dose titration at week 4 will be based on both the magnitude of the rise in Hb and the Hb level (supplementary table 2) and from week 8 according to the Hb level alone (supplementary table 3). For patients treated with ESAs (all patients in MIYABI HD-M and some patients in MIYABI PD, but no patients in MIYABI HD-C), the dose will be titrated from week 4 according to Hb level (supplementary table 3).

In MIYABI HD-M, patients will receive molidustat or molidustat placebo orally and darbepoetin alfa or darbepoetin alfa placebo intravenously. Patients in the molidustat group will receive molidustat plus darbepoetin alfa placebo, while patients in the darbepoetin alfa group will receive darbepoetin alfa plus molidustat placebo. The starting dose of darbepoetin alfa or darbepoetin alfa placebo will be selected for each patient based on their

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191 previous ESA dosage. Patients treated with darbepoetin alfa at screening will continue this  
192 treatment or start treatment with darbepoetin alfa placebo at the previous dose and  
193 interval (ie, weekly or biweekly). Patients treated with an epoetin therapy at screening will  
194 be treated with darbepoetin alfa or darbepoetin alfa placebo at a starting dose and interval  
195 determined by their epoetin dosage at screening. Then, depending on the Hb level  
196 (supplementary table 3), doses of darbepoetin alfa and darbepoetin alfa placebo will be  
197 titrated at biweekly intervals from week 2, and doses of molidustat and molidustat placebo  
198 will be titrated from week 4 at 4-weekly intervals.

199 In each study, iron, vitamin B12 and folate supplementation is permitted if required and will  
200 be administered according to Japanese guideline recommendations.<sup>31</sup> Iron supplementation  
201 will be administered to reach a target serum ferritin level of at least 100 ng/mL or  
202 transferrin saturation of at least 20%.

**203 Variables**

204 All efficacy and safety variables, and associated definitions, are shown in table 2. The  
205 primary efficacy variables in MIYABI HD-C are the rate of rise in Hb level (g/dL/week) at the  
206 first dose change up to week 8 and responder rate. In MIYABI PD, the primary efficacy  
207 variable will be the responder rate. In MIYABI HD-M, the primary efficacy variables will be  
208 mean Hb level during the evaluation period and its change from baseline. In all three  
209 studies, a responder is defined as a patient who meets all of the following criteria: (i) mean  
210 of the Hb levels during the evaluation period is in the target range; (ii)  $\geq 50\%$  of the Hb levels  
211 during the evaluation period are in the target range; (iii) no rescue treatment received up to  
212 the end of the evaluation period. Secondary variables for the three trials are shown in table  
213 2. In each study, exploratory variables will include measures of iron metabolism, VEGF levels  
214 and health-related quality of life assessments.

215 In each study, to investigate systemic exposure to molidustat and the relationship between  
216 molidustat exposure and response, sparse sampling from all patients will be conducted for  
217 pharmacokinetics and pharmacodynamics. If possible, molidustat exposure parameters (eg,  
218  $C_{max}$ , AUC) and the relationship between molidustat exposure and treatment effects will be  
219 evaluated using population approaches (eg, non-linear mixed effect modelling), including  
220 potential influence of relevant patient covariables.

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**221 Statistical analysis**

222 All variables (including demographic and other baseline characteristics) will be analysed  
223 descriptively with appropriate statistical methods: categorical variables by frequency tables  
224 and continuous variables by summary statistics (mean, standard deviation, minimum,  
225 median and maximum). Summary statistics will be presented for the original data as well as  
226 for the difference from baseline.

227 In each study, the primary analysis set for efficacy will be the full analysis set, which includes  
228 all patients assigned to treatment who have at least one baseline Hb level (ie, at least one  
229 Hb level before the first dose of the study drug).

230 In MIYABI HD-C, the primary efficacy variables (rate of rise in Hb and responder rate) and  
231 their two-sided 95% confidence intervals (CI) will be estimated using one-sample *t*-statistics  
232 and the Clopper–Pearson method, respectively. In MIYABI PD, the primary efficacy variable  
233 (responder rate) and its two-sided 95% CI will be estimated using the Clopper–Pearson  
234 method. In MIYABI HD-M, the primary efficacy variables (mean Hb level and change in mean  
235 Hb level) will be analysed by sequentially testing two hypotheses. In MIYABI HD-M, the  
236 primary objective will be achieved if the following two hypotheses are confirmed. (i) In the  
237 molidustat treatment group, the mean Hb level during the evaluation period (weeks 33–36)  
238 remains within the target range ( $\geq 10.0$  to  $< 12.0$  g/dL). The mean Hb level in the molidustat  
239 treatment group will be calculated using the mean Hb level per patient. If the lower limit of  
240 the two-sided 95% CI of the mean of the mean Hb level is greater than or equal to the lower  
241 limit of the target Hb level (ie,  $\geq 10.0$  g/dL) and if the upper limit of the two-sided 95% CI is  
242 less than the upper limit of the target Hb level (ie,  $< 12.0$  g/dL), it will be established that the  
243 mean Hb level is within the target range. Two-sided 95% CI will be estimated using one  
244 sample *t*-statistics. (ii) Molidustat is not inferior to darbepoetin alfa. The non-inferiority of  
245 molidustat to darbepoetin alfa will be established if the lower limit of the two-sided 95% CI  
246 for the difference (molidustat minus darbepoetin alfa) is above  $-1.0$  g/dL with non-  
247 inferiority margin of 1.0 g/dL. This margin was chosen because a variation of approximately  
248 1.0 g/dL is considered acceptable in Japanese clinical practice.<sup>31</sup> In MIYABI HD-M, the  
249 difference in change between the treatment groups and its two-sided 95% CI will be  
250 estimated using an analysis of covariance (ANCOVA) model, including treatment group,

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251 previous ESA dose group (low/high) and previous thromboembolic events (yes/no) as fixed  
252 effects and baseline Hb level as a covariate.

**253 Determination of sample size**

254 In MIYABI HD-C and MIYABI PD, the respective sample sizes of approximately 25 and 50  
255 patients are determined based on feasibility.

256 In MIYABI HD-M, the sample size of 150 patients in the molidustat group and 75 patients in  
257 the darbepoetin alfa group should result in sufficient data to assess the long-term safety of  
258 molidustat therapy, assuming a dropout rate of approximately 30%. If 150 patients are  
259 randomised to the molidustat group, the power to establish that mean Hb levels are within  
260 target levels during the evaluation period is  $\geq 98\%$ , assuming a standard deviation of 1.3–  
261 1.5g/dL from the previous phase 2b studies. This sample size has  $>90\%$  power to reject the  
262 null hypothesis that molidustat is inferior to darbepoetin alfa with a non-inferiority margin  
263 of 1.0 g/dL at a one-sided 2.5% significance level, assuming the expected difference  
264 between molidustat and darbepoetin alfa to be 0 g/dL and with a common standard  
265 deviation of 1.3–1.5 g/dL.

**266 Patient and public involvement**

267 Patients are not involved in the design and conduct of the studies.

**268 DISCUSSION**

269 Renal anaemia due to EPO deficiency is a common and serious complication of CKD.<sup>1</sup>  
270 However, new approaches to the treatment of renal anaemia are needed, owing to safety  
271 issues and limitations with current treatments. Results from previous studies, including  
272 three phase 2b dose-ranging trials, suggest that molidustat is a promising option for the  
273 treatment of EPO-sensitive anaemia in patients with CKD.

274 At present, only one phase 2b trial assessing molidustat has been conducted in patients with  
275 renal anaemia who are on dialysis. It is anticipated that the three phase 3 trials described  
276 here will demonstrate the efficacy and safety of molidustat in patients with renal anaemia  
277 on dialysis, and that the trials will have the following strengths, relative to the one phase 2b  
278 trial conducted in patients on dialysis: (i) in MIYABI HD-M, molidustat treatment will be  
279 compared with an ESA (darbepoetin alfa), the current standard of care for renal anaemia, in



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280 a double-blinded manner, whereas an open-label design was used in the phase 2b trial, in  
281 which molidustat treatment was compared with another ESA (epoetin); (ii) a larger patient  
282 population in the MIYABI HD-M trial (n=150) receiving a starting dose of 75 mg molidustat  
283 OD than in the phase 2b trial (n=44 of the 157 patients treated with molidustat received a  
284 75 mg starting dose); (iii) the treatment periods will be longer (eg, 52 weeks in MIYABI HD-  
285 M) than in the phase 2b trial (16 weeks), although about one-third of the molidustat-treated  
286 patients in the phase 2b trial (n=57) continued treatment in an extension study, with a  
287 duration of up to 36 months; (iv) molidustat therapy will be investigated for the first time in  
288 patients who are not treated with ESAs on haemodialysis in the MIYABI HD-C trial, and  
289 MIYABI HD-M will provide further evaluations of molidustat in patients treated with ESAs,  
290 whereas the phase 2b trial only included patients who switched from epoetin; (v) the  
291 efficacy of molidustat therapy will be investigated for the first time in patients on peritoneal  
292 dialysis in MIYABI PD, whereas only patients undergoing haemodialysis were included in the  
293 phase 2b trial.

294 Approximately 600 patients are planned to be involved in the five studies in the phase 3  
295 MIYABI programme; three studies in patients on dialysis and two studies in patients not on  
296 dialysis. While safety assessments will be conducted for all patients in the MIYABI  
297 programme, including assessments of vital signs and 12-lead electrocardiogram parameters,  
298 the sample size is insufficient to determine the risk of cardiovascular events. The MIYABI  
299 HD-C and MIYABI PD studies will also be limited to investigating molidustat therapy in the  
300 absence of a comparator and with small sample sizes (approximately 25 and 50,  
301 respectively), owing to the feasibility of patient recruitment (in Japan, limited numbers of  
302 patients with renal anaemia are on dialysis while not receiving ESAs or are on peritoneal  
303 dialysis), although molidustat will be compared with the current standard of care  
304 (darbepoetin alfa) as a maintenance treatment in a study powered to assess efficacy and  
305 safety in 150 patients on dialysis.

306 In the three MIYABI trials in patients on dialysis, the efficacy of molidustat will primarily be  
307 assessed by investigating Hb levels, including changes from baseline and maintenance of  
308 prespecified Hb targets. However, several exploratory variables will be also investigated.  
309 These include assessments of VEGF levels and ophthalmological examinations, conducted to

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310 evaluate the theoretical risk of VEGF-mediated diabetic retinopathy,<sup>22</sup> and biomarkers of  
311 iron metabolism as, in addition to increasing EPO production predominately in the kidney,  
312 molidustat may increase the availability of iron for erythropoiesis.<sup>21-23</sup>

313 In summary, the three trials in patients on dialysis described here, together with two other  
314 trials in patients who are not receiving dialysis (the MIYABI ND-C and MIYABI ND-M  
315 randomised, open-label, active-controlled, parallel-group, multicentre trials), comprise the  
316 MIYABI phase 3 programme. This programme will investigate the efficacy and safety of  
317 molidustat in a broad clinical spectrum spanning approximately 600 patients with renal  
318 anaemia and CKD in Japan.

**ETHICS AND DISSEMINATION**

320 The studies are being conducted in accordance with the principles of the Declaration of  
321 Helsinki and the International Council for Harmonisation of Technical Requirements for  
322 Pharmaceuticals for Human Use (ICH) Guidelines for Good Clinical Practice (GCP).  
323 Documented approval from appropriate independent ethics committees and institutional  
324 review boards has been obtained, according to GCP and local laws, regulations and  
325 organisations. Informed consent was obtained from patients before entering the studies  
326 and may be withdrawn at any time.

327 The studies have been registered on ClinicalTrials.gov (NCT03351166 [MIYABI HD-C],  
328 NCT03418168 [MIYABI PD], NCT03543657 [MIYABI HD-M]). Results will be disseminated  
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**AUTHOR CONTRIBUTORS**

335 TA, HY and TY contributed to designing these studies. TY contributed to developing the  
336 original study protocols. MT contributed to drafting the article and revising it. TA, HY, MT  
337 and KI critical revised the article for important intellectual content. YM contributed to  
338 developing the statistical analysis plan and assisted in the preparation of the manuscript. All

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339 authors approved the final version of the manuscript and agree to be accountable for all  
340 aspects of the work, ensuring that questions related to the accuracy or integrity of any part  
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351 Torii Pharmaceutical Co. Ltd. HY received consulting fees from Bayer Yakuhin Ltd during the  
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## FIGURE LEGEND

**Figure 1** Trial designs for (A) MIYABI HD-C, (B) MIYABI PD and (C) MIYABI HD-M. MIYABI HD-C and MIYABI PD are single-arm, multicentre trials. MIYABI HD-M is a randomised, active-controlled, double-blinded, double-dummy, parallel-group, multicentre trial. Haemoglobin levels and safety will be assessed at each study visit, conducted at the time points shown.

BL, baseline; EOF, end of follow-up; EOT, end of treatment; ESA, erythropoiesis-stimulating agent.

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## TABLES

**Table 1** Trial designs, patient populations and treatments

	<b>MIYABI HD-C [NCT03351166]</b>	<b>MIYABI PD [NCT03418168]</b>	<b>MIYABI HD-M [NCT03543657]</b>
Trial design	Single-arm, multicentre	Single-arm, multicentre	Randomised, active-controlled, double-blinded, double-dummy, parallel-group, multicentre
Patient population	Men and women (aged $\geq 20$ years, body weight $> 40$ and $\leq 160$ kg) with a diagnosis of renal anaemia		
Key inclusion criteria	<p>Patients with ESKD on haemodialysis at least weekly for <math>\geq 2</math> weeks</p> <p>Mean of the last two Hb levels between <math>\geq 8.0</math> and <math>&lt; 10.0</math> g/dL</p> <p>Not treated with ESAs during the 8 weeks before study drug assignment</p>	<p>Patients with ESKD on peritoneal dialysis</p> <p>Mean of the last two Hb levels between <math>\geq 8.0</math> and <math>&lt; 11.0</math> g/dL for ESA untreated and <math>\geq 10.0</math> and <math>&lt; 13.0</math> g/dL for ESA treated</p> <p>Not treated or treated with ESAs during the 8 weeks before study drug assignment*</p>	<p>Patients with ESKD on haemodialysis at least weekly for <math>\geq 12</math> weeks</p> <p>Mean of all Hb levels (at least two measurements) between <math>\geq 9.5</math> and <math>&lt; 12.0</math> g/dL</p> <p>Treated with the same ESA for <math>\geq 8</math> weeks before randomisation (weekly or biweekly dose of darbepoetin alfa, monthly or biweekly dose of epoetin beta pegol, OR weekly, biweekly, twice or three times per week dose of epoetin alfa/beta, and having had no more than one dose change during the 8 weeks before randomisation)*</p>

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Not treated with HIF-PH inhibitors during the 8 weeks before study drug assignment	Not treated with HIF-PH inhibitors during the 8 weeks before study drug assignment
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Study treatments	A starting dose of 75 mg molidustat OD, titrated based on Hb response of the previous dose. Planned doses for titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD  Hb target range $\geq 10.0$ to $< 12.0$ g/dL	A starting dose of 75 mg molidustat OD, titrated based on Hb response of the previous dose. Planned doses for titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD  Hb target range $\geq 11.0$ to $< 13.0$ g/dL	Two groups: molidustat + darbepoetin alfa placebo, or molidustat placebo + darbepoetin alfa  A starting dose of 75 mg molidustat or molidustat placebo OD, titrated based on Hb response of the previous dose Planned doses for titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD.  Hb target range $\geq 10.0$ to $< 12.0$ g/dL  A starting dose of darbepoetin alfa or darbepoetin alfa placebo will be decided in accordance with the previous ESA dosages and schedule of once a week or every 2 weeks per Japanese label
Treatment duration, weeks	24	36	52

ESA, erythropoiesis-stimulating agent; ESKD, end-stage kidney disease; Hb, haemoglobin; HIF-PH, hypoxia-inducible factor prolyl-hydroxylase; OD, once daily.

\*For patients washed out from ESAs, the mean Hb level before dialysis (at least two measurements taken  $\geq 2$  days apart, assessed by the central laboratory) must have decreased by  $\geq 0.5$  g/dL after the last ESA administration, AND the interval from the last ESA administration to study drug assignment should be  $> 1$  week for epoetin alfa,  $> 2$  weeks for darbepoetin alfa or  $> 4$  weeks for epoetin beta pegol.

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**Table 2** Efficacy and safety variables

	MIYABI HD-C	MIYABI PD	MIYABI HD-M
Primary efficacy variables specific to each trial	<ul style="list-style-type: none"> <li>Rate of rise in Hb level (g/dL/week) at the first dose change up to week 8*</li> <li>Responder rate during the evaluation period (weeks 21–24)†</li> </ul>	<ul style="list-style-type: none"> <li>Responder rate during the evaluation period (weeks 30–36)†</li> </ul>	<ul style="list-style-type: none"> <li>Mean Hb level during the evaluation period (weeks 33–36)</li> <li>Change in mean Hb level from baseline during the evaluation period</li> </ul>
Secondary efficacy variables in all three trials	<ul style="list-style-type: none"> <li>Proportions of patients who meet the three response criteria during the evaluation period†</li> <li>Hb level and change from baseline (measurement at each visit and mean during the evaluation period)</li> <li>Proportion of patients whose mean Hb level is in, above or below the target range during the evaluation period</li> <li>Proportion of patients whose Hb level is in, above or below the target range, respectively, at each visit</li> <li>Proportion of patients whose maximum rise in Hb between each consecutive visit is &gt;0.5 g/dL/week (defined as change in Hb level/duration between two visits [weeks])</li> </ul>		
Secondary efficacy variables specific to each trial	<ul style="list-style-type: none"> <li>Rate of rise in Hb (g/dL/week) at the dose change up to week 4</li> <li>Cumulative proportion of patients who achieve the lower limit of the target Hb range at least once at each visit</li> </ul>	<ul style="list-style-type: none"> <li>Rate of rise in Hb level (g/dL/week) at the dose changes up to weeks 4 and 8*</li> <li>Change in mean Hb level from baseline during the evaluation period</li> <li>Mean Hb level during the evaluation period</li> </ul>	<ul style="list-style-type: none"> <li>Responder rate during the evaluation period†</li> </ul>
Other efficacy variables in MIYABI HD-C and MIYABI HD-M (secondary variables in MIYABI PD)	<ul style="list-style-type: none"> <li>Rate of rise in Hb level (g/dL/week) during each visit interval</li> <li>Percentage of days in the target Hb range during the evaluation period and treatment period, respectively (defined as the number of days in the target range/number of days during the period × 100 [%])</li> <li>Percentage of Hb levels in target range during the evaluation period and treatment period, respectively (defined as the</li> </ul>		

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	number of measurements in the target range/number of measurements × 100 [%])
	<ul style="list-style-type: none"> <li>• Proportion of patients who received at least one rescue treatment (RBC transfusion, ESA treatment)</li> </ul>
Safety variables in all three trials	<ul style="list-style-type: none"> <li>• Adjudicated AEs†</li> <li>• AEs including serious AEs</li> <li>• Change in vital signs (pulse rate and blood pressure)</li> <li>• 12-lead electrocardiogram parameters</li> <li>• Observations of ophthalmological examination (fundus and anterior ocular segment examination and intraocular pressure measurement)</li> <li>• Laboratory examinations (including haematology, coagulation, clinical chemistry, electrolyte, HbA<sub>1c</sub>, PTH and TSH levels)</li> </ul>
Exploratory variables in all three trials	<ul style="list-style-type: none"> <li>• Parameters of iron metabolism</li> <li>• EQ-5D-5L</li> <li>• Vascular endothelial growth factor</li> </ul>

AEs, adverse events; EQ-5D-5L, EuroQol 5-dimension 5-level questionnaire; ESA, erythropoiesis-stimulating agents; Hb, haemoglobin; HbA<sub>1c</sub>, glycated haemoglobin; PTH, parathyroid hormone; TSH, thyroid-stimulating hormone; RBC, red blood cell.

\*Rate of rise in Hb (g/dL/week) at the first dose change up to week 8 is defined as the change in Hb level from baseline to the first dose change of study drug up to week 8 divided by the duration of the starting dose (in weeks). If no dose change is performed up to week 8, then an Hb level at week 8 and the date of the week 8 visit will be used to calculate the change in Hb level and duration.

†A responder is defined as a patient who meets all of the following criteria:

- (i) mean of the Hb levels during the evaluation period is in the target range
- (ii) ≥50% of the Hb levels during the evaluation period are in the target range
- (iii) no rescue treatment up to the end of the evaluation period.

‡Adjudicated AEs include death, myocardial infarction, unstable angina pectoris, stroke or transient ischaemic attack, pulmonary thromboembolism or acute limb ischaemia.

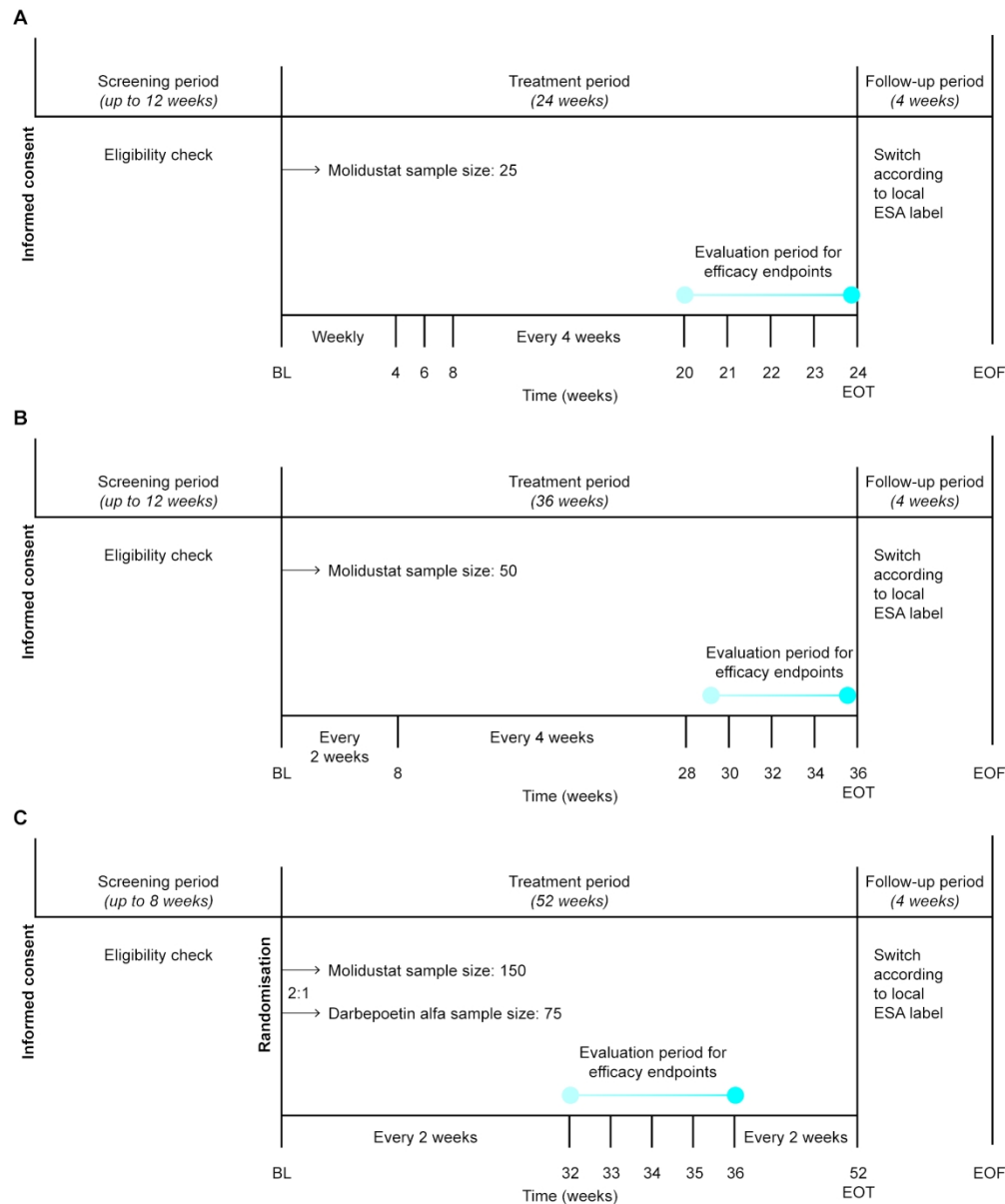


Figure 1 Trial designs for (A) MIYABI HD-C, (B) MIYABI PD and (C) MIYABI HD-M. MIYABI HD-C and MIYABI PD are single-arm, multicentre trials. MIYABI HD-M is a randomised, active-controlled, double-blinded, double-dummy, parallel-group, multicentre trial. Haemoglobin levels and safety will be assessed at each study visit, conducted at the time points shown.

BL, baseline; EOF, end of follow-up; EOT, end of treatment; ESA, erythropoiesis-stimulating agent.

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## SUPPLEMENTARY TABLES

Supplementary table 1 An overview of all inclusion and exclusion criteria

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**Inclusion criteria**

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*All three trials had the following inclusion criteria*

- Written informed consent before performing any study-specific tests or procedures
  - Body weight (after dialysis) >40 and ≤160 kg at screening
  - Male or female ≥20 years of age at screening
  - At least one kidney
  - Serum folate level and serum vitamin B12 level above LLN at screening
  - Women of reproductive potential must agree to use adequate contraception when sexually active. This applies for the time period between signing of the informed consent form until 12 weeks after the last administration of the study drug.
    - Acceptable methods of contraception may include, but are not limited to, condoms (male or female) with or without a spermicidal agent; diaphragm or cervical cap with spermicide; intra-uterine device; hormone-based contraception
    - Patients must agree to utilise two reliable and acceptable methods of contraception simultaneously.
- Women are considered postmenopausal and not of childbearing potential if they have had 12 months of natural (spontaneous) amenorrhoea with an appropriate clinical profile (eg, age-appropriate, history of vasomotor symptoms) or 6 months of spontaneous amenorrhoea with serum FSH levels >40 mIU/mL or have had surgical treatment such as bilateral tubal ligation, bilateral ovariectomy or hysterectomy.
- Ability to understand and follow study-related instructions.

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*MIYABI HD-C had four additional inclusion criteria*

- Patients with ESKD on dialysis (including haemodiafiltration, haemodialysis and other modalities except for peritoneal dialysis) weekly or more than weekly for ≥2 weeks before study drug assignment
  - Mean screening Hb level ≥8.0 and <10.0 g/dL (at least two measurements must be taken ≥2 days apart, assessed by the central laboratory; the
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difference between the two measurements must be  $<1.2$  g/dL), with the last screening Hb measurement during the 14 days before study drug assignment

- Not treated with any ESAs or HIF-PH inhibitors during the 8 weeks before study drug assignment. For patients washed out from ESAs, the mean Hb level before dialysis (at least two measurements taken  $\geq 2$  days apart, assessed by the central laboratory) must have decreased by  $\geq 0.5$  g/dL after the last ESA administration, AND the interval from the last ESA administration to study drug assignment should be  $>1$  week for epoetin alfa,  $>2$  weeks for darbepoetin alfa or  $>4$  weeks for epoetin beta pegol
- Ferritin  $\geq 50$  ng/mL at screening

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*MIYABI PD had five additional inclusion criteria*

- Patients with ESKD on peritoneal dialysis before study drug assignment and not expected to start maintenance dialysis (eg, haemodialysis, haemodiafiltration) other than peritoneal dialysis during the study period
  - Not treated with HIF-PH inhibitors during the 8 weeks before study drug assignment
  - Patients who meet one of the following criteria
    - A: Untreated with ESA at study drug assignment*  
Mean screening Hb level  $\geq 8.0$  and  $<11.0$  g/dL (based on the last two measurements taken  $\geq 2$  days apart, assessed by the central laboratory; the difference between the two measurements must be  $<1.2$  g/dL), with the last screening Hb measurement during the 14 days before study drug assignment
    - B: Pre-treated with ESA at study drug assignment*  
Mean screening Hb level  $\geq 10.0$  and  $<13.0$  g/dL (based on the last two measurements taken  $\geq 2$  days apart, assessed by the central laboratory; the difference between the two measurements must be  $<1.2$  g/dL), with the last screening Hb measurement during the 14 days before study drug assignment
  - Patients who meet one of the following criteria
    - A: Untreated with ESA at study drug assignment*
      - Patient with ESKD on peritoneal dialysis for  $\geq 2$  weeks before study drug assignment
    - and
    - Not treated with ESA for the 8 weeks before study drug assignment
    - or
    - Washed out from ESAs, when the mean Hb level (based on at least two measurements taken  $\geq 2$  days apart, assessed by the central
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laboratory) has decreased by  $\geq 0.5$  g/dL after the last ESA administration, AND the interval from the last ESA administration to study drug assignment should be  $> 2$  weeks for epoetin alfa/beta and  $> 4$  weeks for darbepoetin alfa or epoetin beta pegol

*B: Pre-treated with ESA at study drug assignment*

- Patient with ESKD on peritoneal dialysis for  $\geq 12$  weeks before study drug assignment
- Treated with IV or SC ESA during the 8 weeks before study drug assignment
- Treated with 2- or 4-weekly dose of darbepoetin alfa, 4-weekly dose of epoetin beta pegol, OR 3 times per week, twice per week, weekly or biweekly dose of epoetin alfa/beta, and having had no more than one dose change during the 8 weeks before study drug assignment
- Patients who meet one of the following criteria
  - A: Untreated with ESA at study drug assignment*
  - Ferritin  $\geq 50$  ng/mL at screening
  - B: Pre-treated with ESA at study drug assignment*
  - Ferritin  $\geq 100$  ng/mL or transferrin saturation  $\geq 20\%$

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*MIYABI HD-M had five additional inclusion criteria*

- Patients with ESKD on dialysis (including haemodiafiltration, haemofiltration, haemodialysis and other modalities except for peritoneal dialysis) weekly or more than weekly for  $\geq 12$  weeks before randomisation
  - Treated with the same ESA for  $\geq 8$  weeks before screening
  - Treated with weekly or biweekly dose of darbepoetin alfa, monthly or biweekly dose of epoetin beta pegol, OR weekly, biweekly, twice or three times per week dose of epoetin alfa/beta, and having had no more than one dose change during the 8 weeks before randomisation
  - Mean screening Hb level  $\geq 9.5$  and  $< 12.0$  g/dL before dialysis (based on at least two measurements taken  $\geq 2$  days apart, assessed by the central laboratory; the difference between the lowest level and highest level  $< 1.2$  g/dL), with the last screening Hb level measurement during the 14 days before randomisation
  - Ferritin  $\geq 100$  ng/mL or transferrin saturation  $\geq 20\%$  at screening
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**Exclusion criteria**

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*All three trials had the following exclusion criteria*

- Any current condition leading to significant blood loss
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- Active haemolysis or diagnosis of haemolytic syndrome
  - Previous or concurrent myelodysplastic syndrome, multiple myeloma, marrow fibrosis or PRCA
  - Previous or concurrent haemosiderosis or haemochromatosis
  - Previous or concurrent hereditary haemoglobinopathies (eg, sickle-cell disease, beta thalassaemia, thalassaemia major)
  - Previous or concurrent aplastic anaemia
  - Previous or concurrent chronic lymphoproliferative diseases
  - Proliferative choroidal or retinal disease, such as neovascular age-related macular degeneration or proliferative diabetic retinopathy requiring invasive treatment (eg, intraocular injections or laser photocoagulation) at screening
  - Chronic inflammatory disease, such as rheumatoid arthritis, systemic lupus erythematosus, ankylosing spondylitis, psoriatic arthritis or inflammatory bowel disease, which is determined to be the principal cause of the anaemia
  - Known hypersensitivity to the study drugs (active substances or excipients of the preparations)
  - Uncontrolled and symptomatic hyperparathyroidism
  - Uncontrolled active infection at study drug assignment
  - Previous or concurrent cancer except cervical carcinoma *in situ*, treated basal cell carcinoma, superficial bladder tumours (Ta, Tis and T1) or any cancer curatively treated >3 years before study drug assignment
  - Previous or scheduled organ transplantation (being on a transplant waiting list does not exclude a patient)
  - History of alcohol or drug abuse during the 2 years before study drug assignment
  - RBC-containing transfusion for treatment of anaemia during the 8 weeks before study drug assignment
  - Treatment with uridine-diphosphate-glucuronosyltransferase 1 family, polypeptide A1 inhibitors during the 7 days before study drug assignment:
    - antiretroviral drugs (eg, ritonavir, saquinavir, atazanavir, indinavir, lopinavir, nelfinavir)
    - tyrosine kinase inhibitors (eg, erlotinib, pazopanib, nilotinib, sorafenib, regorafenib)
    - tranilast
  - Patients treated with immune- or myelosuppressive therapy during the 8 weeks before study drug assignment (eg, everolimus, sirolimus, rituximab, azathioprine, mycophenolate mofetil, mycophenolic acid, cyclosporine, methotrexate, tacrolimus, chemotherapeutic agents and other anticancer agents, and systemic steroids treatment [except inhaled steroids] for 7 days or more)
  - Treated with the following therapies during the 8 weeks before study drug assignment: anabolic hormone, testosterone enanthate or
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- History of cardiovascular or cerebrovascular events (eg, unstable angina, myocardial infarction, stroke, pulmonary thromboembolism and ALI) during the 6 months before study drug assignment
- Sustained, poorly controlled arterial hypertension (defined as systolic BP  $\geq 180$ mmHg or diastolic BP  $\geq 110$ mmHg) or hypotension (defined as systolic BP  $< 90$ mmHg) at study drug assignment
- NYHA class III or IV congestive heart failure
- Severe hepatic disorder (defined as ALT or AST  $> 3$  x the upper limit of normal, total bilirubin  $> 2$  mg/dL, or Child-Pugh B or C) at screening
- Previous use of molidustat
- A patient in need of surgery that may be expected to lead to significant blood loss
- Expected need for rescue treatment during the next 7 days after study drug assignment
- Active hepatitis, as assessed by the investigator
- Any medical condition that in the opinion of the investigator may pose a safety risk to a patient in this study, may confound safety or efficacy assessment or may interfere with study participation
- Previous assignment to study treatment during this study
- Previous (during the 30 days before study drug assignment) or concomitant participation in another clinical study with investigational medicinal product(s)
- Close affiliation with the investigational site, for example, a close relative of the investigator, dependent person (eg, employee or student at the investigational site)
- Pregnant or breastfeeding women

*MIYABI PD had two additional exclusion criteria*

- Previous or concurrent indications for removal of peritoneal dialysis catheter (eg, recurrent peritoneum inflammation, refractory tunnel infection)
- Concomitant use of maintenance dialysis (eg, haemodialysis, haemodiafiltration) other than peritoneal dialysis

ALI, acute limb ischaemia; ALT, alanine aminotransferase; AST, aspartate aminotransferase; BP, blood pressure; ESA, erythropoiesis-stimulating agent; ESKD, end-stage kidney disease; FSH, follicle-stimulating hormone; Hb, haemoglobin; HIF-PH, hypoxia-inducible factor-1 prolyl hydroxylase; IV, intravenous; LLN, lower limit of normal; NYHA, New York Heart Association; PRCA, pure red cell aplasia; RBC, red blood cell; SC, subcutaneous.



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**Supplementary table 2** Dose titration for molidustat at week 4 for all patients in the MIYABI HD-C trial\* and for patients not treated with ESA at study drug assignment in the MIYABI PD trial

Rise in Hb in the first 4 weeks (g/dL)	Hb level (g/dL) in MIYABI HD-C	Hb level (g/dL) in MIYABI PD	Titration step
<0.5	<9.5	<10.5	Increase to the next higher dose
	≥9.5	≥10.5	
≥0.5 and <1.0	Any value	Any value	Maintain the same dose
≥1.0 and ≤2.0	≤10.0	≤11.0	
>2.0	>10.0	>11.0	Decrease to the next lower dose
	Any value	Any value	

\*All patients in MIYABI HD-C will not be treated with ESAs at study drug assignment or during the trial.

ESA, erythropoiesis-stimulating agent; Hb, haemoglobin.

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**Supplementary table 3** Dose titration from week 8 in MIYABI HD-C, from week 4 or 8 in MIYABI PD\*, and from week 2 or 4 in MIYABI HD-M†

Hb level (g/dL) in MIYABI HD-C and MIYABI HD-M	Hb level (g/dL) in MIYABI PD	Titration step
<10.0	<11.0	Increase to the next higher dose
≥10.0 and <12.0	≥11.0 and <12.5	Maintain the same dose
≥12.0 and <13.0	≥12.5 and <13.0	Decrease to the next dose
≥13.0	≥13.0	Suspend a dose until the next scheduled visit

\*In MIYABI PD, patients treated with ESAs at study drug assignment will start this dose-titration schedule for molidustat at week 4, whereas patients not treated with ESAs at study drug assignment will start this dose titration schedule for molidustat at week 8.

†In MIYABI HD-M, doses of darbepoetin alfa or darbepoetin alfa placebo will be titrated from week 2, whereas doses of molidustat will be titrated from week 4.

ESA, erythropoiesis-stimulating agent; Hb, haemoglobin.




# SPIRIT

STANDARD PROTOCOL ITEMS: RECOMMENDATIONS FOR INTERVENTIONAL TRIALS

SPIRIT 2013 Checklist: Recommended items to address in a clinical trial protocol and related documents\*

Section/item	Item No	Description
<b>Administrative information</b>		
Title	1	Descriptive title identifying the study design, population, interventions, and, if applicable, trial acronym
Trial registration	2a	Trial identifier and registry name. If not yet registered, name of intended registry
	2b	All items from the World Health Organization Trial Registration Data Set
Protocol version	3	Date and version identifier
Funding	4	Sources and types of financial, material, and other support
Roles and responsibilities	5a	Names, affiliations, and roles of protocol contributors
	5b	Name and contact information for the trial sponsor
	5c	Role of study sponsor and funders, if any, in study design; collection, management, analysis, and interpretation of data; writing of the report; and the decision to submit the report for publication, including whether they will have ultimate authority over any of these activities
	5d	Composition, roles, and responsibilities of the coordinating centre, steering committee, endpoint adjudication committee, data management team, and other individuals or groups overseeing the trial, if applicable (see Item 21a for data monitoring committee)
<b>Introduction</b>		
Background and rationale	6a	Description of research question and justification for undertaking the trial, including summary of relevant studies (published and unpublished) examining benefits and harms for each intervention
	6b	Explanation for choice of comparators
Objectives	7	Specific objectives or hypotheses
Trial design	8	Description of trial design including type of trial (eg, parallel group, crossover, factorial, single group), allocation ratio, and framework (eg, superiority, equivalence, noninferiority, exploratory)

## Methods: Participants, interventions, and outcomes

1			
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4	Study setting	9	Description of study settings (eg, community clinic, academic hospital) and list of countries where data will be collected. Reference to where list of study sites can be obtained
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8	Eligibility criteria	10	Inclusion and exclusion criteria for participants. If applicable, eligibility criteria for study centres and individuals who will perform the interventions (eg, surgeons, psychotherapists)
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13	Interventions	11a	Interventions for each group with sufficient detail to allow replication, including how and when they will be administered
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16		11b	Criteria for discontinuing or modifying allocated interventions for a given trial participant (eg, drug dose change in response to harms, participant request, or improving/worsening disease)
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21		11c	Strategies to improve adherence to intervention protocols, and any procedures for monitoring adherence (eg, drug tablet return, laboratory tests)
22			
23			
24			
25		11d	Relevant concomitant care and interventions that are permitted or prohibited during the trial
26			
27			
28	Outcomes	12	Primary, secondary, and other outcomes, including the specific measurement variable (eg, systolic blood pressure), analysis metric (eg, change from baseline, final value, time to event), method of aggregation (eg, median, proportion), and time point for each outcome. Explanation of the clinical relevance of chosen efficacy and harm outcomes is strongly recommended
29			
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36	Participant timeline	13	Time schedule of enrolment, interventions (including any run-ins and washouts), assessments, and visits for participants. A schematic diagram is highly recommended (see Figure)
37			
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41	Sample size	14	Estimated number of participants needed to achieve study objectives and how it was determined, including clinical and statistical assumptions supporting any sample size calculations
42			
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45	Recruitment	15	Strategies for achieving adequate participant enrolment to reach target sample size 
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## Methods: Assignment of interventions (for controlled trials)

### Allocation:

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53	Sequence generation	16a	Method of generating the allocation sequence (eg, computer-generated random numbers), and list of any factors for stratification. To reduce predictability of a random sequence, details of any planned restriction (eg, blocking) should be provided in a separate document that is unavailable to those who enrol participants or assign interventions
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2	Allocation	16b	Mechanism of implementing the allocation sequence (eg, central
3	concealment		telephone; sequentially numbered, opaque, sealed envelopes),
4	mechanism		describing any steps to conceal the sequence until interventions are
5			assigned
6			
7	Implementation	16c	Who will generate the allocation sequence, who will enrol participants,
8			and who will assign participants to interventions
9			
10	Blinding	17a	Who will be blinded after assignment to interventions (eg, trial
11	(masking)		participants, care providers, outcome assessors, data analysts), and
12			how
13		17b	If blinded, circumstances under which unblinding is permissible, and
14			procedure for revealing a participant's allocated intervention during
15			the trial
16			
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19			

### Methods: Data collection, management, and analysis


20			
21	Data collection	18a	Plans for assessment and collection of outcome, baseline, and other
22	methods		trial data, including any related processes to promote data quality (eg,
23			duplicate measurements, training of assessors) and a description of
24			study instruments (eg, questionnaires, laboratory tests) along with
25			their reliability and validity, if known. Reference to where data
26			collection forms can be found, if not in the protocol
27		18b	Plans to promote participant retention and complete follow-up,
28			including list of any outcome data to be collected for participants who
29			discontinue or deviate from intervention protocols
30			
31	Data	19	Plans for data entry, coding, security, and storage, including any
32	management		related processes to promote data quality (eg, double data entry;
33			range checks for data values). Reference to where details of data
34			management procedures can be found, if not in the protocol
35			
36	Statistical	20a	Statistical methods for analysing primary and secondary outcomes.
37	methods		Reference to where other details of the statistical analysis plan can be
38			found, if not in the protocol
39		20b	Methods for any additional analyses (eg, subgroup and adjusted
40			analyses)
41		20c	Definition of analysis population relating to protocol non-adherence
42			(eg, as randomised analysis), and any statistical methods to handle
43			missing data (eg, multiple imputation)
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### Methods: Monitoring

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53	Data monitoring	21a	Composition of data monitoring committee (DMC); summary of its role
54			and reporting structure; statement of whether it is independent from
55			the sponsor and competing interests; and reference to where further
56			details about its charter can be found, if not in the protocol.
57			Alternatively, an explanation of why a DMC is not needed
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1		21b	Description of any interim analyses and stopping guidelines, including
2			who will have access to these interim results and make the final
3			decision to terminate the trial
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6	Harms	22	Plans for collecting, assessing, reporting, and managing solicited and
7			spontaneously reported adverse events and other unintended effects
8			of trial interventions or trial conduct
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11	Auditing	23	Frequency and procedures for auditing trial conduct, if any, and
12			whether the process will be independent from investigators and the
13			sponsor
14			

## Ethics and dissemination

15			
16			
17	Research ethics	24	Plans for seeking research ethics committee/institutional review board
18	approval		(REC/IRB) approval
19			
20			
21	Protocol	25	Plans for communicating important protocol modifications (eg,
22	amendments		changes to eligibility criteria, outcomes, analyses) to relevant parties
23			(eg, investigators, REC/IRBs, trial participants, trial registries, journals,
24			regulators)
25			
26	Consent or assent	26a	Who will obtain informed consent or assent from potential trial
27			participants or authorised surrogates, and how (see Item 32)
28			
29			
30		26b	Additional consent provisions for collection and use of participant data
31			and biological specimens in ancillary studies, if applicable
32			
33	Confidentiality	27	How personal information about potential and enrolled participants will
34			be collected, shared, and maintained in order to protect confidentiality
35			before, during, and after the trial
36			
37	Declaration of	28	Financial and other competing interests for principal investigators for
38	interests		the overall trial and each study site
39			
40			
41	Access to data	29	Statement of who will have access to the final trial dataset, and
42			disclosure of contractual agreements that limit such access for
43			investigators
44			
45	Ancillary and	30	Provisions, if any, for ancillary and post-trial care, and for
46	post-trial care		compensation to those who suffer harm from trial participation
47			
48	Dissemination	31a	Plans for investigators and sponsor to communicate trial results to
49	policy		participants, healthcare professionals, the public, and other relevant
50			groups (eg, via publication, reporting in results databases, or other
51			data sharing arrangements), including any publication restrictions
52			
53			
54		31b	Authorship eligibility guidelines and any intended use of professional
55			writers 
56			
57		31c	Plans, if any, for granting public access to the full protocol, participant-
58			level dataset, and statistical code
59			
60			

## Appendices

Informed consent materials	32	Model consent form and other related documentation given to participants and authorised surrogates
Biological specimens	33	Plans for collection, laboratory evaluation, and storage of biological specimens for genetic or molecular analysis in the current trial and for future use in ancillary studies, if applicable

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\*It is strongly recommended that this checklist be read in conjunction with the SPIRIT 2013 Explanation & Elaboration for important clarification on the items. Amendments to the protocol should be tracked and dated. The SPIRIT checklist is copyrighted by the SPIRIT Group under the Creative Commons "[Attribution-NonCommercial-NoDerivs 3.0 Unported](#)" license.

For peer review only

# BMJ Open

## Molidustat for the treatment of renal anaemia in patients with dialysis-dependent chronic kidney disease: design and rationale of three phase 3 studies

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<b>Primary Subject Heading</b>:	Renal medicine
Secondary Subject Heading:	Renal medicine
Keywords:	Chronic kidney disease, Dialysis < NEPHROLOGY, Molidustat, Renal anaemia

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5 1 **Molidustat for the treatment of renal anaemia in patients with**  
6 2 **dialysis-dependent chronic kidney disease: design and rationale of**  
7 3 **three phase 3 studies**  
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**20 ABSTRACT**

21 **Introduction:** New medications for anaemia associated with chronic kidney disease (CKD)  
22 are desirable, owing to the limitations of erythropoiesis-stimulating agents (ESAs), the  
23 current standard of care. Molidustat is a novel hypoxia-inducible factor prolyl-hydroxylase  
24 inhibitor that stimulates erythropoietin production, predominately in the kidney. We report  
25 methodological details of three phase 3 trials, named **Molidustat once daily improves renal**  
26 **Anemia By Inducing erythropoietin (MIYABI)**, designed primarily to investigate the efficacy  
27 of molidustat therapy in adults with renal anaemia and dialysis-dependent CKD.

28 **Methods and analysis:** MIYABI Haemodialysis-Correction (HD-C) is a single-arm trial (24-  
29 week treatment duration) in approximately 25 patients on haemodialysis, currently  
30 untreated with ESAs. MIYABI Peritoneal Dialysis (PD) is a single-arm trial (36-week treatment  
31 duration) in approximately 50 patients on peritoneal dialysis, treated or untreated with  
32 ESAs. MIYABI Haemodialysis-Maintenance (HD-M) is a randomised, active-controlled,  
33 double-blinded, double-dummy trial (52-week treatment duration) comparing molidustat  
34 with darbepoetin alfa in approximately 225 patients on haemodialysis, treated with ESAs.  
35 Molidustat (starting dose 75 mg/day) will be titrated 4-weekly to maintain haemoglobin in  
36 pre-determined target ranges. The primary objective is to evaluate the efficacy of  
37 molidustat, using the following measures: the rate of rise in haemoglobin (g/dL/week) at the  
38 first dose change up to week 8 (MIYABI HD-C); responder rate (MIYABI HD-C and MIYABI  
39 PD); mean haemoglobin level during weeks 33–36 and non-inferiority to darbepoetin alfa  
40 shown by change in mean haemoglobin level from baseline (MIYABI HD-M). The secondary  
41 objectives are to assess safety, pharmacokinetics and pharmacodynamics. These trials will  
42 provide the first evaluations of molidustat therapy in patients receiving either peritoneal  
43 dialysis or currently untreated with ESAs on haemodialysis, and provide further evidence in  
44 patients treated with ESAs on haemodialysis.

45 **Ethics and dissemination:** The protocols were approved by ethics committees at all  
46 participating sites. The trials will be conducted in accordance with the Declaration of  
47 Helsinki and Good Clinical Practice.

48 **Trial registration numbers:** NCT03351166, NCT03418168, NCT03543657

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49

50 **Keywords:** Chronic kidney disease; dialysis; molidustat; renal anaemia

## 51 **STRENGTHS AND LIMITATIONS OF THESE STUDIES**

- 52 • Due to recruitment feasibility limitations, MIYABI HD-C and MIYABI-PD are single  
53 arm, open-label studies.
- 54 • In MIYABI HD-M, a randomised, double-blind study, molidustat treatment will be  
55 directly compared with an ESA (darbepoetin alfa), the current standard of care for  
56 renal anaemia, and will build on the results of a previous open-label phase 2b trial in  
57 patients on haemodialysis.
- 58 • The MIYABI HD-M trial will involve a larger patient population (n=150) receiving a  
59 75 mg starting dose than in the phase 2b trial.
- 60 • Treatment durations will be longer (eg, 52 weeks in MIYABI HD-M) than in the phase  
61 2b trial (16 weeks), although some molidustat-treated patients in the phase 2b trial  
62 (n=57) continued treatment in an extension study for up to 36 months.
- 63 • These are the first studies to directly investigate the efficacy of molidustat therapy in  
64 patients on peritoneal dialysis and in patients currently untreated with ESAs on  
65 haemodialysis.

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## INTRODUCTION

Anaemia is a common and serious complication of chronic kidney disease (CKD),<sup>1</sup> which worsens as CKD progresses.<sup>2-4</sup> The main cause of anaemia associated with CKD (also known as renal anaemia) is erythropoietin (EPO) deficiency.<sup>5</sup>

Treatment with erythropoiesis-stimulating agents (ESAs) is the current standard of care for renal anaemia.<sup>6</sup> However, this approach has limitations. In 10–20% of patients, irrespective of dialysis status, ESAs are ineffective at raising haemoglobin (Hb) to prespecified levels.<sup>7-9</sup> ESAs may also cause several adverse events (AEs), including development or worsening of hypertension,<sup>10-12</sup> rare cases of antibody-mediated pure red cell aplasia,<sup>13</sup> poor cardiovascular outcomes and death.<sup>14-16</sup> In patients with cancer and anaemia, ESA use is associated with increased risk of thrombosis.<sup>17</sup> These AEs may be related to injecting high doses of ESAs to achieve Hb targets<sup>15 17-19</sup> and excessive increases in Hb levels.<sup>20</sup>

A new approach under investigation involves using small molecules to inhibit hypoxia-inducible factor prolyl-hydroxylases (HIF-PH), thereby inducing EPO production. In addition to addressing EPO deficiency, the main cause of renal anaemia, the therapeutic effect of HIF-PH inhibition may also be mediated by increasing the availability of iron for erythropoiesis, as indicated by reductions in hepcidin levels.<sup>21-26</sup> These findings are particularly notable, given that functional iron deficiency may contribute to the inadequate responses that 10–20% of patients experience during treatment with ESAs, even though these patients often receive intravenous iron supplementation.<sup>5-9</sup> HIF-PH inhibition may theoretically also have a downside, because HIF transcriptionally upregulates a large number of genes; although EPO gene upregulation is helpful in treating anaemia associated with CKD, vascular endothelial growth factor (VEGF) upregulation could result in neoplasia and diabetic retinopathy.<sup>22</sup> However, in clinical trials of HIF-PH inhibitors, no safety signals or changes in VEGF levels were reported.<sup>24-26</sup>

Molidustat, a novel, orally administered inhibitor of HIF-PH, induces circulating levels of EPO close to the normal physiological range, with high relative selectivity for the induction of EPO gene expression, predominately in the kidney.<sup>21</sup> Results from preclinical<sup>21</sup> and clinical studies<sup>27</sup> suggest that molidustat is a promising option for the treatment of EPO-sensitive anaemia in patients with CKD. In preclinical studies, molidustat restored renal EPO

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5 97 production with minor induction of hepatic EPO. Molidustat increased plasma EPO and EPO  
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7 98 mRNA in the kidney and prevented decline in haematocrit and corrected decreases in Hb  
8  
9 99 level.<sup>21</sup> In a randomised, placebo-controlled, phase 1 study involving 59 healthy participants,  
10  
11 100 single doses of molidustat (5–50 mg) elicited a dose-dependent increase in EPO and were  
12  
13 101 well tolerated.<sup>27</sup> In three 16-week, randomised, phase 2b, dose-ranging studies, comprising  
14  
15 102 one study with patients on haemodialysis and two studies with patients not on dialysis,  
16  
17 103 more than 400 patients with CKD were enrolled. These studies demonstrated that, during  
18  
19 104 treatment with flexible-dose molidustat, Hb levels could be corrected relative to placebo or  
20  
21 105 maintained at levels comparable to those in patients who continued treatment with ESAs,  
22  
23 106 with manageable side effects.<sup>28</sup> Comparable results and no significant safety concerns were  
24  
25 107 observed in extension studies up to 36 months (unpublished data).

26  
27 108 Based on the positive findings of the preclinical and phase 2b clinical studies, the Molidustat  
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29 109 once daily improves renal Anemia By Inducing EPO (MIYABI) programme of five phase 3  
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31 110 trials has been designed to investigate molidustat therapy further in patients with renal  
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33 111 anaemia in Japan. Here, we report the methodological details of the three MIYABI trials in  
34  
35 112 which the efficacy (up to 36 weeks), safety, pharmacokinetics and pharmacodynamics (up to  
36  
37 113 52 weeks) of molidustat therapy will be investigated in patients receiving dialysis. These  
38  
39 114 three trials will provide the first evaluations of molidustat therapy in patients on peritoneal  
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41 115 dialysis and in patients currently untreated with ESAs on haemodialysis, as well as extending  
42  
43 116 the evidence in patients treated with ESAs on haemodialysis.

**METHODS AND PLANNED ANALYSES****Study designs, objectives and populations**

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45 118  
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47 119 Each of the three phase 3 trials is a multicentre study conducted in adults aged 20 years or  
48  
49 120 older with renal anaemia and dialysis-dependent CKD in Japan. In each trial, the primary  
50  
51 121 objective is to evaluate the efficacy of molidustat in the respective patient populations and,  
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53 122 in the MIYABI Haemodialysis Maintenance (HD-M) trial, to show non-inferiority to  
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55 123 darbepoetin alfa. The secondary objectives of each trial are to evaluate the safety,  
56  
57 124 tolerability, pharmacokinetics and pharmacodynamics of molidustat during the treatment  
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59 125 periods. The three trials commenced in the first half of 2018 and have finished recruiting.  
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126 The planned end dates for MIYABI HD-C, MIYABI PD, and MIYABI HD-M are November 2018,

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5 127 August 2019 and December 2019, respectively. Patient eligibility was assessed during  
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7 128 screening periods lasting up to 12 weeks in the MIYABI Haemodialysis Correction (HD-C) and  
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9 129 MIYABI Peritoneal Dialysis (PD) studies and up to 8 weeks in MIYABI HD-M. To be eligible,  
10  
11 130 the mean of at least two Hb measurements (both taken before dialysis, at least 2 days apart,  
12  
13 131 with the last measurement taken within 14 days before study drug assignment, and with a  
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15 132 difference of less than 1.2 g/dL between the lowest and highest values) was required to lie  
16  
17 133 within pre-specified levels (table 1). The main inclusion criteria are summarised in table 1.  
18  
19 134 All inclusion and exclusion criteria are shown in supplementary table 1.

20  
21 135 MIYABI HD-C is a single-arm study in patients on haemodialysis who are not currently  
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23 136 treated with ESAs, with a 24-week treatment duration (figure 1 and table 1). Japanese  
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25 137 guidelines for the clinical evaluation of medications for renal anaemia recommend  
26  
27 138 demonstrating efficacy in the correction and maintenance of renal anaemia in patients on  
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29 139 dialysis, as well as in patients not on dialysis.<sup>29</sup> However, the number of patients with renal  
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31 140 anaemia on dialysis who do not receive ESAs is limited in Japan. A single-arm study design  
32  
33 141 was chosen for MIYABI HD-C owing to the feasibility of patient recruitment.<sup>30</sup>

34  
35 142 MIYABI PD is a single-arm study in patients on peritoneal dialysis who are treated or not  
36  
37 143 treated with ESAs, with a 36-week treatment duration (figure 1 and table 1). A single-arm  
38  
39 144 study design was chosen for MIYABI PD owing to the limited number of peritoneal dialysis  
40  
41 145 patients with renal anaemia in Japan.

42  
43 146 MIYABI HD-M is a randomised, active-controlled, double-blinded, double-dummy, parallel-  
44  
45 147 group study comparing molidustat with darbepoetin alfa in patients on haemodialysis who  
46  
47 148 are treated with ESAs (figure 1 and table 1). The study has a treatment duration of 52  
48  
49 149 weeks. As most patients with renal anaemia on dialysis in Japan are treated with ESAs, it is  
50  
51 150 feasible to recruit sufficient patients to perform a confirmatory, randomised, double-blinded  
52  
53 151 trial of molidustat in this patient population. Therefore, in MIYABI HD-M, eligible patients  
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55 152 will be randomised in a ratio of 2:1 to the molidustat group or darbepoetin alfa group.  
56  
57 153 Allocation to treatment arms will be achieved using an interactive voice/web response  
58  
59 154 system (IxRS) at the first (baseline) visit. Randomisation will be stratified by previous ESA  
60  
155 dose group (low or high) and by medical history of thromboembolic events (yes or no for  
156 myocardial infarction, pulmonary thromboembolism, stroke [excluding haemorrhagic

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stroke] or acute limb ischaemia). All investigators and patients in MIYABI HD-M will be blinded to treatment allocation. In cases of emergency, such as occurrence of a suspected, unexpected, serious AE, when the investigator needs to know which drug has been allocated, unblinding will occur by entering the emergency key code for the relevant patient into the IxRS.

Each study is being overseen by a data monitoring committee consisting of independent clinical experts and an independent biostatistician supported by an independent statistical analysis centre, whose main responsibility is to recommend a change, interruption or termination of the study (or all phase 3 studies) based on safety findings.

**Treatments**

Study treatments are summarised in table 1. In each study, a starting dose of 75 mg molidustat once daily (OD) will be titrated every 4 weeks using the IxRS, based on the patient's Hb response to the previous dose. In each study, planned doses for the titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD. The dose of molidustat will be adjusted to correct and maintain Hb levels in the target ranges of  $\geq 10.0$  to  $< 12.0$  g/dL in MIYABI HD-C and MIYABI HD-M and  $\geq 11.0$  to  $< 13.0$  g/dL in MIYABI PD, as per Japanese guideline recommendations.<sup>31</sup>

For patients untreated with ESAs (all patients in MIYABI HD-C and some patients in MIYABI PD, but no patients in MIYABI HD-M), a dose adaptation visit will occur at week 4 to avoid excessive elevation of Hb levels after the initiation of molidustat treatment. In MIYABI HD-C and MIYABI PD, dose titration at week 4 will be based on both the magnitude of the rise in Hb and the Hb level (supplementary table 2) and from week 8 according to the Hb level alone (supplementary table 3). For patients treated with ESAs (all patients in MIYABI HD-M and some patients in MIYABI PD, but no patients in MIYABI HD-C), the dose will be titrated from week 4 according to Hb level (supplementary table 3).

In MIYABI HD-M, patients will receive molidustat or molidustat placebo orally and darbepoetin alfa or darbepoetin alfa placebo intravenously. Patients in the molidustat group will receive molidustat plus darbepoetin alfa placebo, while patients in the darbepoetin alfa group will receive darbepoetin alfa plus molidustat placebo. The starting dose of

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186 darbepoetin alfa or darbepoetin alfa placebo will be selected for each patient based on their  
187 previous ESA dosage. Patients treated with darbepoetin alfa at screening will continue this  
188 treatment or start treatment with darbepoetin alfa placebo at the previous dose and  
189 interval (ie, weekly or biweekly). Patients treated with an epoetin therapy at screening will  
190 be treated with darbepoetin alfa or darbepoetin alfa placebo at a starting dose and interval  
191 determined by their epoetin dosage at screening. Then, depending on the Hb level  
192 (supplementary table 3), doses of darbepoetin alfa and darbepoetin alfa placebo will be  
193 titrated at biweekly intervals from week 2, and doses of molidustat and molidustat placebo  
194 will be titrated from week 4 at 4-weekly intervals.

195 In each study, iron, vitamin B12 and folate supplementation is permitted if required and will  
196 be administered according to Japanese guideline recommendations.<sup>31</sup> Iron supplementation  
197 will be administered to reach a target serum ferritin level of at least 100 ng/mL or  
198 transferrin saturation of at least 20%.

**Variables**

200 All efficacy and safety variables, and associated definitions, are shown in table 2. The  
201 primary efficacy variables in MIYABI HD-C are the rate of rise in Hb level (g/dL/week) at the  
202 first dose change up to week 8 and responder rate. In MIYABI PD, the primary efficacy  
203 variable will be the responder rate. In MIYABI HD-M, the primary efficacy variables will be  
204 mean Hb level during the evaluation period and its change from baseline. In all three  
205 studies, a responder is defined as a patient who meets all of the following criteria: (i) mean  
206 of the Hb levels during the evaluation period is in the target range; (ii)  $\geq 50\%$  of the Hb levels  
207 during the evaluation period are in the target range; (iii) no rescue treatment received up to  
208 the end of the evaluation period. Secondary variables for the three trials are shown in table  
209 2. In each study, exploratory variables will include measures of iron metabolism, VEGF levels  
210 and assessment of health-related quality of life using the EuroQol 5-dimension 5-level  
211 questionnaire.

212 In each study, to investigate systemic exposure to molidustat and the relationship between  
213 molidustat exposure and response, sparse sampling from all patients will be conducted for  
214 pharmacokinetics and pharmacodynamics. If possible, molidustat exposure parameters (eg,  
215  $C_{max}$ , AUC) and the relationship between molidustat exposure and treatment effects will be



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216 evaluated using population approaches (eg, non-linear mixed effect modelling), including  
217 potential influence of relevant patient covariables.

**218 Statistical analysis**

219 All variables (including demographic and other baseline characteristics) will be analysed  
220 descriptively with appropriate statistical methods: categorical variables by frequency tables  
221 and continuous variables by summary statistics (mean, standard deviation, minimum,  
222 median and maximum). Summary statistics will be presented for the original data as well as  
223 for the difference from baseline.

224 In each study, the primary analysis set for efficacy will be the full analysis set, which includes  
225 all patients assigned to treatment who have at least one baseline Hb level (ie, at least one  
226 Hb level before the first dose of the study drug).

227 In MIYABI HD-C, the primary efficacy variables (rate of rise in Hb and responder rate) and  
228 their two-sided 95% confidence intervals (CI) will be estimated using one-sample *t*-statistics  
229 and the Clopper–Pearson method, respectively. In MIYABI PD, the primary efficacy variable  
230 (responder rate) and its two-sided 95% CI will be estimated using the Clopper–Pearson  
231 method. In MIYABI HD-M, the primary efficacy variables (mean Hb level and change in mean  
232 Hb level) will be analysed by sequentially testing two hypotheses. In MIYABI HD-M, the  
233 primary objective will be achieved if the following two hypotheses are confirmed. (i) In the  
234 molidustat treatment group, the mean Hb level during the evaluation period (weeks 33–36)  
235 remains within the target range ( $\geq 10.0$  to  $< 12.0$  g/dL). The mean Hb level in the molidustat  
236 treatment group will be calculated using the mean Hb level per patient. If the lower limit of  
237 the two-sided 95% CI of the mean of the mean Hb level is greater than or equal to the lower  
238 limit of the target Hb level (ie,  $\geq 10.0$  g/dL) and if the upper limit of the two-sided 95% CI is  
239 less than the upper limit of the target Hb level (ie,  $< 12.0$  g/dL), it will be established that the  
240 mean Hb level is within the target range. Two-sided 95% CI will be estimated using one  
241 sample *t*-statistics. (ii) Molidustat is not inferior to darbepoetin alfa. The non-inferiority of  
242 molidustat to darbepoetin alfa will be established if the lower limit of the two-sided 95% CI  
243 for the difference (molidustat minus darbepoetin alfa) is above  $-1.0$  g/dL with non-  
244 inferiority margin of 1.0 g/dL. This margin was chosen because a variation of approximately  
245 1.0 g/dL is considered acceptable in Japanese clinical practice.<sup>31</sup> In MIYABI HD-M, the

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246 difference in change between the treatment groups and its two-sided 95% CI will be  
247 estimated using an analysis of covariance (ANCOVA) model, including treatment group,  
248 previous ESA dose group (low/high) and previous thromboembolic events (yes/no) as fixed  
249 effects and baseline Hb level as a covariate.

**Determination of sample size**

251 In MIYABI HD-C and MIYABI PD, the respective sample sizes of approximately 25 and 50  
252 patients are determined based on feasibility.

253 In MIYABI HD-M, the sample size of 150 patients in the molidustat group and 75 patients in  
254 the darbepoetin alfa group should result in sufficient data to assess the long-term safety of  
255 molidustat therapy, assuming a dropout rate of approximately 30%. If 150 patients are  
256 randomised to the molidustat group, the power to establish that mean Hb levels are within  
257 target levels during the evaluation period is  $\geq 98\%$ , assuming a standard deviation of 1.3–  
258 1.5g/dL from the previous phase 2b studies. This sample size has  $>90\%$  power to reject the  
259 null hypothesis that molidustat is inferior to darbepoetin alfa with a non-inferiority margin  
260 of 1.0 g/dL at a one-sided 2.5% significance level, assuming the expected difference  
261 between molidustat and darbepoetin alfa to be 0 g/dL and with a common standard  
262 deviation of 1.3–1.5 g/dL.

**Patient and public involvement**

264 Patients are not involved in the design and conduct of the studies.

**DISCUSSION**

266 Renal anaemia due to EPO deficiency is a common and serious complication of CKD.<sup>1</sup>  
267 However, new approaches to the treatment of renal anaemia are needed, owing to safety  
268 issues and limitations with current treatments. Results from previous studies, including  
269 three phase 2b dose-ranging trials, suggest that molidustat is a promising option for the  
270 treatment of EPO-sensitive anaemia in patients with CKD.

271 At present, only one phase 2b trial assessing molidustat has been conducted in patients with  
272 renal anaemia who are on dialysis. It is anticipated that the three phase 3 trials described  
273 here will demonstrate the efficacy and safety of molidustat in patients with renal anaemia  
274 on dialysis, and that the trials will have the following strengths, relative to the one phase 2b

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275 trial conducted in patients on dialysis: (i) in MIYABI HD-M, molidustat treatment will be  
276 compared with an ESA (darbepoetin alfa), the current standard of care for renal anaemia, in  
277 a double-blinded manner, whereas an open-label design was used in the phase 2b trial, in  
278 which molidustat treatment was compared with another ESA (epoetin); (ii) a larger patient  
279 population in the MIYABI HD-M trial (n=150) receiving a starting dose of 75 mg molidustat  
280 OD than in the phase 2b trial (n=44 of the 157 patients treated with molidustat received a  
281 75 mg starting dose); (iii) the treatment periods will be longer (eg, 52 weeks in MIYABI HD-  
282 M) than in the phase 2b trial (16 weeks), although about one-third of the molidustat-treated  
283 patients in the phase 2b trial (n=57) continued treatment in an extension study, with a  
284 duration of up to 36 months; (iv) molidustat therapy will be investigated for the first time in  
285 patients who are not treated with ESAs on haemodialysis in the MIYABI HD-C trial, and  
286 MIYABI HD-M will provide further evaluations of molidustat in patients treated with ESAs,  
287 whereas the phase 2b trial only included patients who switched from epoetin; (v) the  
288 efficacy of molidustat therapy will be investigated for the first time in patients on peritoneal  
289 dialysis in MIYABI PD, whereas only patients undergoing haemodialysis were included in the  
290 phase 2b trial.

291 Approximately 600 patients are planned to be involved in the five studies in the phase 3  
292 MIYABI programme; three studies in patients on dialysis and two studies in patients not on  
293 dialysis. While safety assessments will be conducted for all patients in the MIYABI  
294 programme, including assessments of vital signs and 12-lead electrocardiogram parameters,  
295 the sample size is insufficient to determine the risk of cardiovascular events. The MIYABI  
296 HD-C and MIYABI PD studies will also be limited to investigating molidustat therapy in the  
297 absence of a comparator and with small sample sizes (approximately 25 and 50,  
298 respectively), owing to the feasibility of patient recruitment (in Japan, limited numbers of  
299 patients with renal anaemia are on dialysis while not receiving ESAs or are on peritoneal  
300 dialysis), although molidustat will be compared with the current standard of care  
301 (darbepoetin alfa) as a maintenance treatment in a study powered to assess efficacy and  
302 safety in 150 patients on dialysis.

303 In the three MIYABI trials in patients on dialysis, the efficacy of molidustat will primarily be  
304 assessed by investigating Hb levels, including changes from baseline and maintenance of

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305 prespecified Hb targets. However, several exploratory variables will be also investigated.  
306 These include assessments of VEGF levels and ophthalmological examinations, conducted to  
307 evaluate the theoretical risk of VEGF-mediated diabetic retinopathy,<sup>22</sup> and biomarkers of  
308 iron metabolism as, in addition to increasing EPO production predominately in the kidney,  
309 molidustat may increase the availability of iron for erythropoiesis.<sup>21-23</sup>

310 In summary, the three trials in patients on dialysis described here, together with two other  
311 trials in patients who are not receiving dialysis (the MIYABI ND-C and MIYABI ND-M  
312 randomised, open-label, active-controlled, parallel-group, multicentre trials), comprise the  
313 MIYABI phase 3 programme. The design and rationale of MIYABI ND-C and MIYABI ND-M are  
314 published in a companion article.<sup>32</sup> This programme will investigate the efficacy and safety  
315 of molidustat in a broad clinical spectrum spanning approximately 600 patients with renal  
316 anaemia and CKD in Japan.

**ETHICS AND DISSEMINATION**

318 The studies are being conducted in accordance with the principles of the Declaration of  
319 Helsinki and the International Council for Harmonisation of Technical Requirements for  
320 Pharmaceuticals for Human Use (ICH) Guidelines for Good Clinical Practice (GCP).  
321 Documented approval from appropriate independent ethics committees and institutional  
322 review boards has been obtained, according to GCP and local laws, regulations and  
323 organisations. The MIYABI HD-C study has been approved by the institutional review board  
324 of All Tohoku Clinical Trial Review and Audit Organization (application number: 20171204)  
325 and another 20 sites. The MIYABI PD study has been approved by the institutional review  
326 board of Kyushu University Hospital (application number: 20180221) and another 26 sites.  
327 The MIYABI HD-M study has been approved by the institutional review board of Ibaraki  
328 Prefectural Central Hospital (application number: 20180524), Asahikawa-Kosei General  
329 Hospital (20180806) and another 51 sites. Informed consent was obtained from patients  
330 before entering the studies and may be withdrawn at any time.

331 The studies have been registered on ClinicalTrials.gov (NCT03351166 [MIYABI HD-C],  
332 NCT03418168 [MIYABI PD], NCT03543657 [MIYABI HD-M]). Results will be disseminated  
333 through peer-reviewed publication(s).

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**AUTHOR CONTRIBUTORS**

339 TA, HY and TY contributed to designing these studies. TY contributed to developing the  
340 original study protocols. MT contributed to drafting the article and revising it. TA, HY, MT  
341 and KI critical revised the article for important intellectual content. YM contributed to  
342 developing the statistical analysis plan and assisted in the preparation of the manuscript. All  
343 authors approved the final version of the manuscript and agree to be accountable for all  
344 aspects of the work, ensuring that questions related to the accuracy or integrity of any part  
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349 of these studies, including analysis, interpretation and dissemination of data.

350 **COMPETING INTERESTS** MT, YM, KI and TY are employees of Bayer Yakuhin Ltd. TA received  
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## FIGURE LEGEND

**Figure 1** Trial designs for (A) MIYABI HD-C, (B) MIYABI PD and (C) MIYABI HD-M. MIYABI HD-C and MIYABI PD are single-arm, multicentre trials. MIYABI HD-M is a randomised, active-controlled, double-blinded, double-dummy, parallel-group, multicentre trial. Haemoglobin levels and safety will be assessed at each study visit, conducted at the time points shown.

BL, baseline; EOF, end of follow-up; EOT, end of treatment; ESA, erythropoiesis-stimulating agent.



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## TABLES

**Table 1** Trial designs, patient populations and treatments

	MIYABI HD-C [NCT03351166]	MIYABI PD [NCT03418168]	MIYABI HD-M [NCT03543657]
Trial design	Single-arm, multicentre	Single-arm, multicentre	Randomised, active-controlled, double-blinded, double-dummy, parallel-group, multicentre
Patient population	Men and women (aged $\geq 20$ years, body weight $> 40$ and $\leq 160$ kg) with a diagnosis of renal anaemia		
Key inclusion criteria	<p>Patients with ESKD on haemodialysis at least weekly for <math>\geq 2</math> weeks</p> <p>Mean of the last two Hb levels between <math>\geq 8.0</math> and <math>&lt; 10.0</math> g/dL</p> <p>Not treated with ESAs during the 8 weeks before study drug assignment</p>	<p>Patients with ESKD on peritoneal dialysis</p> <p>Mean of the last two Hb levels between <math>\geq 8.0</math> and <math>&lt; 11.0</math> g/dL for ESA untreated and <math>\geq 10.0</math> and <math>&lt; 13.0</math> g/dL for ESA treated</p> <p>Not treated or treated with ESAs during the 8 weeks before study drug assignment*</p>	<p>Patients with ESKD on haemodialysis at least weekly for <math>\geq 12</math> weeks</p> <p>Mean of all Hb levels (at least two measurements) between <math>\geq 9.5</math> and <math>&lt; 12.0</math> g/dL</p> <p>Treated with the same ESA for <math>\geq 8</math> weeks before randomisation (weekly or biweekly dose of darbepoetin alfa, monthly or biweekly dose of epoetin beta pegol, OR weekly, biweekly, twice or three times per week dose of epoetin alfa/beta, and having had no more than one dose change during the 8 weeks before randomisation)*</p>

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	Not treated with HIF-PH inhibitors during the 8 weeks before study drug assignment	Not treated with HIF-PH inhibitors during the 8 weeks before study drug assignment	
Study treatments	A starting dose of 75 mg molidustat OD, titrated based on Hb response of the previous dose. Planned doses for titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD  Hb target range $\geq 10.0$ to $< 12.0$ g/dL	A starting dose of 75 mg molidustat OD, titrated based on Hb response of the previous dose. Planned doses for titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD  Hb target range $\geq 11.0$ to $< 13.0$ g/dL	Two groups: molidustat + darbepoetin alfa placebo, or molidustat placebo + darbepoetin alfa  A starting dose of 75 mg molidustat or molidustat placebo OD, titrated based on Hb response of the previous dose Planned doses for titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD.  Hb target range $\geq 10.0$ to $< 12.0$ g/dL  A starting dose of darbepoetin alfa or darbepoetin alfa placebo will be decided in accordance with the previous ESA dosages and schedule of once a week or every 2 weeks per Japanese label
Treatment duration, weeks	24	36	52

ESA, erythropoiesis-stimulating agent; ESKD, end-stage kidney disease; Hb, haemoglobin; HIF-PH, hypoxia-inducible factor prolyl-hydroxylase; OD, once daily.

\*For patients washed out from ESAs, the mean Hb level before dialysis (at least two measurements taken  $\geq 2$  days apart, assessed by the central laboratory) must have decreased by  $\geq 0.5$  g/dL after the last ESA administration, AND the interval from the last ESA administration to study drug assignment should be  $> 1$  week for epoetin alfa,  $> 2$  weeks for darbepoetin alfa or  $> 4$  weeks for epoetin beta pegol.

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**Table 2** Efficacy and safety variables

	MIYABI HD-C	MIYABI PD	MIYABI HD-M
Primary efficacy variables specific to each trial	<ul style="list-style-type: none"> <li>Rate of rise in Hb level (g/dL/week) at the first dose change up to week 8*</li> <li>Responder rate during the evaluation period (weeks 21–24)†</li> </ul>	<ul style="list-style-type: none"> <li>Responder rate during the evaluation period (weeks 30–36)†</li> </ul>	<ul style="list-style-type: none"> <li>Mean Hb level during the evaluation period (weeks 33–36)</li> <li>Change in mean Hb level from baseline during the evaluation period</li> </ul>
Secondary efficacy variables in all three trials	<ul style="list-style-type: none"> <li>Proportions of patients who meet the three response criteria during the evaluation period†</li> <li>Hb level and change from baseline (measurement at each visit and mean during the evaluation period)</li> <li>Proportion of patients whose mean Hb level is in, above or below the target range during the evaluation period</li> <li>Proportion of patients whose Hb level is in, above or below the target range, respectively, at each visit</li> <li>Proportion of patients whose maximum rise in Hb between each consecutive visit is &gt;0.5 g/dL/week (defined as change in Hb level/duration between two visits [weeks])</li> </ul>		
Secondary efficacy variables specific to each trial	<ul style="list-style-type: none"> <li>Rate of rise in Hb (g/dL/week) at the dose change up to week 4</li> <li>Cumulative proportion of patients who achieve the lower limit of the target Hb range at least once at each visit</li> </ul>	<ul style="list-style-type: none"> <li>Rate of rise in Hb level (g/dL/week) at the dose changes up to weeks 4 and 8*</li> <li>Change in mean Hb level from baseline during the evaluation period</li> <li>Mean Hb level during the evaluation period</li> </ul>	<ul style="list-style-type: none"> <li>Responder rate during the evaluation period†</li> </ul>
Other efficacy variables in MIYABI HD-C and MIYABI HD-M (secondary variables)	<ul style="list-style-type: none"> <li>Rate of rise in Hb level (g/dL/week) during each visit interval</li> <li>Percentage of days in the target Hb range during the evaluation period and treatment period, respectively (defined as the number of days in the target range/number of days during the period × 100 [%])</li> </ul>		

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in MIYABI PD)	<ul style="list-style-type: none"> <li>Percentage of Hb levels in target range during the evaluation period and treatment period, respectively (defined as the number of measurements in the target range/number of measurements × 100 [%])</li> <li>Proportion of patients who received at least one rescue treatment (RBC transfusion, ESA treatment)</li> </ul>
Safety variables in all three trials	<ul style="list-style-type: none"> <li>Adjudicated AEs†</li> <li>AEs including serious AEs</li> <li>Change in vital signs (pulse rate and blood pressure)</li> <li>12-lead electrocardiogram parameters</li> <li>Observations of ophthalmological examination (fundus and anterior ocular segment examination and intraocular pressure measurement)</li> <li>Laboratory examinations (including haematology, coagulation, clinical chemistry, electrolyte, HbA<sub>1c</sub>, PTH and TSH levels)</li> </ul>
Exploratory variables in all three trials	<ul style="list-style-type: none"> <li>Parameters of iron metabolism</li> <li>EQ-5D-5L</li> <li>Vascular endothelial growth factor</li> </ul>

AEs, adverse events; EQ-5D-5L, EuroQol 5-dimension 5-level questionnaire; ESA, erythropoiesis-stimulating agents; Hb, haemoglobin; HbA<sub>1c</sub>, glycated haemoglobin; PTH, parathyroid hormone; TSH, thyroid-stimulating hormone; RBC, red blood cell.

\*Rate of rise in Hb (g/dL/week) at the first dose change up to week 8 is defined as the change in Hb level from baseline to the first dose change of study drug up to week 8 divided by the duration of the starting dose (in weeks). If no dose change is performed up to week 8, then an Hb level at week 8 and the date of the week 8 visit will be used to calculate the change in Hb level and duration.

†A responder is defined as a patient who meets all of the following criteria:

- (i) mean of the Hb levels during the evaluation period is in the target range
- (ii) ≥50% of the Hb levels during the evaluation period are in the target range
- (iii) no rescue treatment up to the end of the evaluation period.

‡Adjudicated AEs include death, myocardial infarction, unstable angina pectoris, stroke or transient ischaemic attack, pulmonary thromboembolism or acute limb ischaemia.

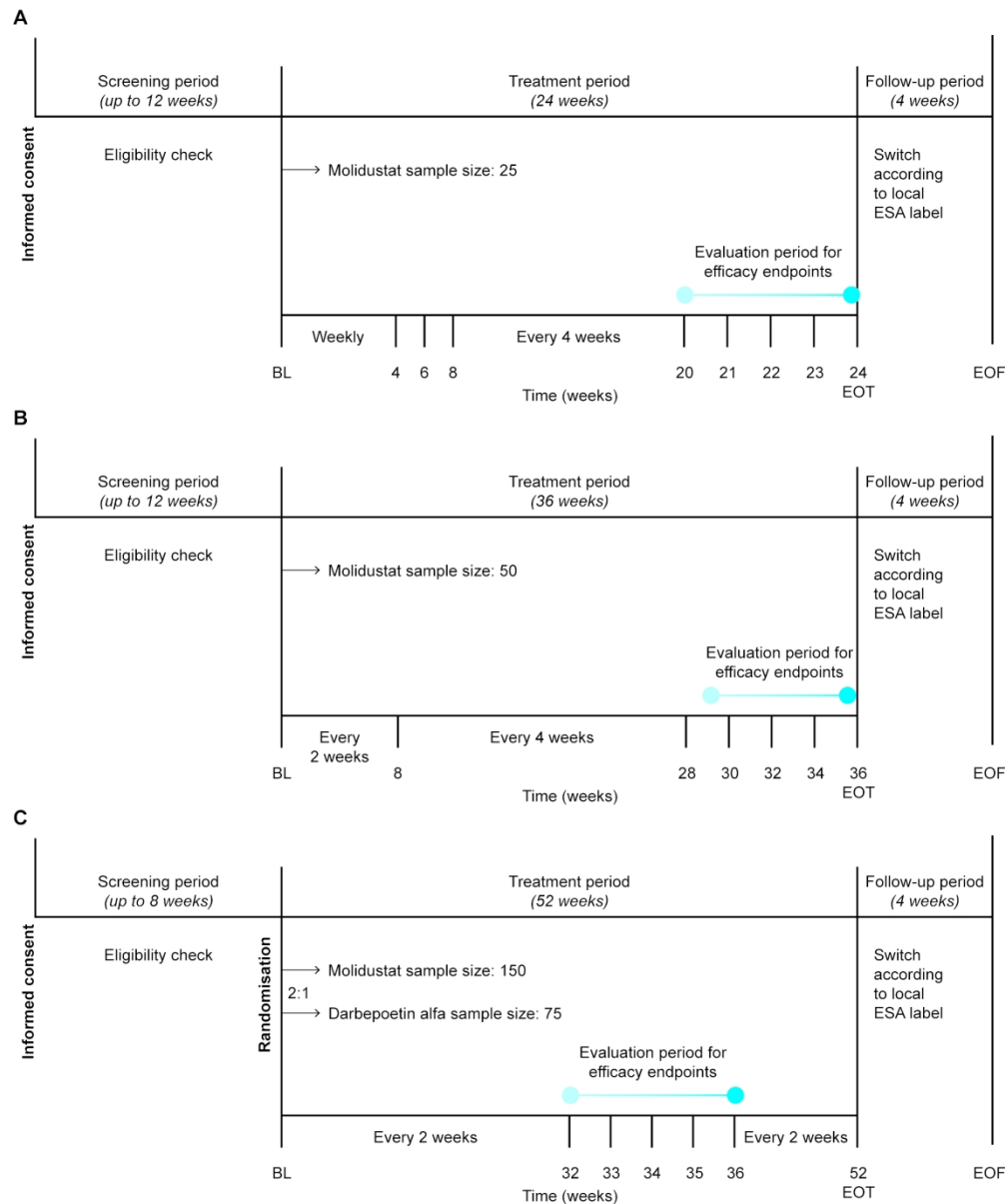


Figure 1 Trial designs for (A) MIYABI HD-C, (B) MIYABI PD and (C) MIYABI HD-M. MIYABI HD-C and MIYABI PD are single-arm, multicentre trials. MIYABI HD-M is a randomised, active-controlled, double-blinded, double-dummy, parallel-group, multicentre trial. Haemoglobin levels and safety will be assessed at each study visit, conducted at the time points shown.

BL, baseline; EOF, end of follow-up; EOT, end of treatment; ESA, erythropoiesis-stimulating agent.

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## SUPPLEMENTARY TABLES

Supplementary table 1 An overview of all inclusion and exclusion criteria

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**Inclusion criteria**

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*All three trials had the following inclusion criteria*

- Written informed consent before performing any study-specific tests or procedures
  - Body weight (after dialysis) >40 and ≤160 kg at screening
  - Male or female ≥20 years of age at screening
  - At least one kidney
  - Serum folate level and serum vitamin B12 level above LLN at screening
  - Women of reproductive potential must agree to use adequate contraception when sexually active. This applies for the time period between signing of the informed consent form until 12 weeks after the last administration of the study drug.
    - Acceptable methods of contraception may include, but are not limited to, condoms (male or female) with or without a spermicidal agent; diaphragm or cervical cap with spermicide; intra-uterine device; hormone-based contraception
    - Patients must agree to utilise two reliable and acceptable methods of contraception simultaneously.
- Women are considered postmenopausal and not of childbearing potential if they have had 12 months of natural (spontaneous) amenorrhoea with an appropriate clinical profile (eg, age-appropriate, history of vasomotor symptoms) or 6 months of spontaneous amenorrhoea with serum FSH levels >40 mIU/mL or have had surgical treatment such as bilateral tubal ligation, bilateral ovariectomy or hysterectomy.
- Ability to understand and follow study-related instructions.

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*MIYABI HD-C had four additional inclusion criteria*

- Patients with ESKD on dialysis (including haemodiafiltration, haemodialysis and other modalities except for peritoneal dialysis) weekly or more than weekly for ≥2 weeks before study drug assignment
  - Mean screening Hb level ≥8.0 and <10.0 g/dL (at least two measurements must be taken ≥2 days apart, assessed by the central laboratory; the
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difference between the two measurements must be  $<1.2$  g/dL), with the last screening Hb measurement during the 14 days before study drug assignment

- Not treated with any ESAs or HIF-PH inhibitors during the 8 weeks before study drug assignment. For patients washed out from ESAs, the mean Hb level before dialysis (at least two measurements taken  $\geq 2$  days apart, assessed by the central laboratory) must have decreased by  $\geq 0.5$  g/dL after the last ESA administration, AND the interval from the last ESA administration to study drug assignment should be  $>1$  week for epoetin alfa,  $>2$  weeks for darbepoetin alfa or  $>4$  weeks for epoetin beta pegol
- Ferritin  $\geq 50$  ng/mL at screening

---

*MIYABI PD had five additional inclusion criteria*

- Patients with ESKD on peritoneal dialysis before study drug assignment and not expected to start maintenance dialysis (eg, haemodialysis, haemodiafiltration) other than peritoneal dialysis during the study period
  - Not treated with HIF-PH inhibitors during the 8 weeks before study drug assignment
  - Patients who meet one of the following criteria
    - A: Untreated with ESA at study drug assignment*  
Mean screening Hb level  $\geq 8.0$  and  $<11.0$  g/dL (based on the last two measurements taken  $\geq 2$  days apart, assessed by the central laboratory; the difference between the two measurements must be  $<1.2$  g/dL), with the last screening Hb measurement during the 14 days before study drug assignment
    - B: Pre-treated with ESA at study drug assignment*  
Mean screening Hb level  $\geq 10.0$  and  $<13.0$  g/dL (based on the last two measurements taken  $\geq 2$  days apart, assessed by the central laboratory; the difference between the two measurements must be  $<1.2$  g/dL), with the last screening Hb measurement during the 14 days before study drug assignment
  - Patients who meet one of the following criteria
    - A: Untreated with ESA at study drug assignment*
      - Patient with ESKD on peritoneal dialysis for  $\geq 2$  weeks before study drug assignment
    - and
    - Not treated with ESA for the 8 weeks before study drug assignment
    - or
    - Washed out from ESAs, when the mean Hb level (based on at least two measurements taken  $\geq 2$  days apart, assessed by the central
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laboratory) has decreased by  $\geq 0.5$  g/dL after the last ESA administration, AND the interval from the last ESA administration to study drug assignment should be  $>2$  weeks for epoetin alfa/beta and  $>4$  weeks for darbepoetin alfa or epoetin beta pegol

*B: Pre-treated with ESA at study drug assignment*

- Patient with ESKD on peritoneal dialysis for  $\geq 12$  weeks before study drug assignment
- Treated with IV or SC ESA during the 8 weeks before study drug assignment
- Treated with 2- or 4-weekly dose of darbepoetin alfa, 4-weekly dose of epoetin beta pegol, OR 3 times per week, twice per week, weekly or biweekly dose of epoetin alfa/beta, and having had no more than one dose change during the 8 weeks before study drug assignment
- Patients who meet one of the following criteria
  - A: Untreated with ESA at study drug assignment*
  - Ferritin  $\geq 50$  ng/mL at screening
  - B: Pre-treated with ESA at study drug assignment*
  - Ferritin  $\geq 100$  ng/mL or transferrin saturation  $\geq 20\%$

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*MIYABI HD-M had five additional inclusion criteria*

- Patients with ESKD on dialysis (including haemodiafiltration, haemofiltration, haemodialysis and other modalities except for peritoneal dialysis) weekly or more than weekly for  $\geq 12$  weeks before randomisation
- Treated with the same ESA for  $\geq 8$  weeks before screening
- Treated with weekly or biweekly dose of darbepoetin alfa, monthly or biweekly dose of epoetin beta pegol, OR weekly, biweekly, twice or three times per week dose of epoetin alfa/beta, and having had no more than one dose change during the 8 weeks before randomisation
- Mean screening Hb level  $\geq 9.5$  and  $< 12.0$  g/dL before dialysis (based on at least two measurements taken  $\geq 2$  days apart, assessed by the central laboratory; the difference between the lowest level and highest level  $< 1.2$  g/dL), with the last screening Hb level measurement during the 14 days before randomisation
- Ferritin  $\geq 100$  ng/mL or transferrin saturation  $\geq 20\%$  at screening

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**Exclusion criteria**

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*All three trials had the following exclusion criteria*

- Any current condition leading to significant blood loss
-



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- Active haemolysis or diagnosis of haemolytic syndrome
  - Previous or concurrent myelodysplastic syndrome, multiple myeloma, marrow fibrosis or PRCA
  - Previous or concurrent haemosiderosis or haemochromatosis
  - Previous or concurrent hereditary haemoglobinopathies (eg, sickle-cell disease, beta thalassaemia, thalassaemia major)
  - Previous or concurrent aplastic anaemia
  - Previous or concurrent chronic lymphoproliferative diseases
  - Proliferative choroidal or retinal disease, such as neovascular age-related macular degeneration or proliferative diabetic retinopathy requiring invasive treatment (eg, intraocular injections or laser photocoagulation) at screening
  - Chronic inflammatory disease, such as rheumatoid arthritis, systemic lupus erythematosus, ankylosing spondylitis, psoriatic arthritis or inflammatory bowel disease, which is determined to be the principal cause of the anaemia
  - Known hypersensitivity to the study drugs (active substances or excipients of the preparations)
  - Uncontrolled and symptomatic hyperparathyroidism
  - Uncontrolled active infection at study drug assignment
  - Previous or concurrent cancer except cervical carcinoma *in situ*, treated basal cell carcinoma, superficial bladder tumours (Ta, Tis and T1) or any cancer curatively treated >3 years before study drug assignment
  - Previous or scheduled organ transplantation (being on a transplant waiting list does not exclude a patient)
  - History of alcohol or drug abuse during the 2 years before study drug assignment
  - RBC-containing transfusion for treatment of anaemia during the 8 weeks before study drug assignment
  - Treatment with uridine-diphosphate-glucuronosyltransferase 1 family, polypeptide A1 inhibitors during the 7 days before study drug assignment:
    - antiretroviral drugs (eg, ritonavir, saquinavir, atazanavir, indinavir, lopinavir, nelfinavir)
    - tyrosine kinase inhibitors (eg, erlotinib, pazopanib, nilotinib, sorafenib, regorafenib)
    - tranilast
  - Patients treated with immune- or myelosuppressive therapy during the 8 weeks before study drug assignment (eg, everolimus, sirolimus, rituximab, azathioprine, mycophenolate mofetil, mycophenolic acid, cyclosporine, methotrexate, tacrolimus, chemotherapeutic agents and other anticancer agents, and systemic steroids treatment [except inhaled steroids] for 7 days or more)
  - Treated with the following therapies during the 8 weeks before study drug assignment: anabolic hormone, testosterone enanthate or
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- History of cardiovascular or cerebrovascular events (eg, unstable angina, myocardial infarction, stroke, pulmonary thromboembolism and ALI) during the 6 months before study drug assignment
- Sustained, poorly controlled arterial hypertension (defined as systolic BP  $\geq 180$ mmHg or diastolic BP  $\geq 110$ mmHg) or hypotension (defined as systolic BP  $< 90$ mmHg) at study drug assignment
- NYHA class III or IV congestive heart failure
- Severe hepatic disorder (defined as ALT or AST  $> 3$  x the upper limit of normal, total bilirubin  $> 2$  mg/dL, or Child-Pugh B or C) at screening
- Previous use of molidustat
- A patient in need of surgery that may be expected to lead to significant blood loss
- Expected need for rescue treatment during the next 7 days after study drug assignment
- Active hepatitis, as assessed by the investigator
- Any medical condition that in the opinion of the investigator may pose a safety risk to a patient in this study, may confound safety or efficacy assessment or may interfere with study participation
- Previous assignment to study treatment during this study
- Previous (during the 30 days before study drug assignment) or concomitant participation in another clinical study with investigational medicinal product(s)
- Close affiliation with the investigational site, for example, a close relative of the investigator, dependent person (eg, employee or student at the investigational site)
- Pregnant or breastfeeding women

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 MIYABI PD had two additional exclusion criteria

- Previous or concurrent indications for removal of peritoneal dialysis catheter (eg, recurrent peritoneum inflammation, refractory tunnel infection)
- Concomitant use of maintenance dialysis (eg, haemodialysis, haemodiafiltration) other than peritoneal dialysis

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 ALI, acute limb ischaemia; ALT, alanine aminotransferase; AST, aspartate aminotransferase; BP, blood pressure; ESA, erythropoiesis-stimulating agent; ESKD, end-stage kidney disease; FSH, follicle-stimulating hormone; Hb, haemoglobin; HIF-PH, hypoxia-inducible factor-1 prolyl hydroxylase; IV, intravenous; LLN, lower limit of normal; NYHA, New York Heart Association; PRCA, pure red cell aplasia; RBC, red blood cell; SC, subcutaneous.

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**Supplementary table 2** Dose titration for molidustat at week 4 for all patients in the MIYABI HD-C trial\* and for patients not treated with ESA at study drug assignment in the MIYABI PD trial

Rise in Hb in the first 4 weeks (g/dL)	Hb level (g/dL) in MIYABI HD-C	Hb level (g/dL) in MIYABI PD	Titration step
<0.5	<9.5	<10.5	Increase to the next higher dose
	≥9.5	≥10.5	
≥0.5 and <1.0	Any value	Any value	Maintain the same dose
≥1.0 and ≤2.0	≤10.0	≤11.0	
>2.0	>10.0	>11.0	Decrease to the next lower dose
	Any value	Any value	

\*All patients in MIYABI HD-C will not be treated with ESAs at study drug assignment or during the trial.

ESA, erythropoiesis-stimulating agent; Hb, haemoglobin.

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**Supplementary table 3** Dose titration from week 8 in MIYABI HD-C, from week 4 or 8 in MIYABI PD\*, and from week 2 or 4 in MIYABI HD-M†

Hb level (g/dL) in MIYABI HD-C and MIYABI HD-M	Hb level (g/dL) in MIYABI PD	Titration step
<10.0	<11.0	Increase to the next higher dose
≥10.0 and <12.0	≥11.0 and <12.5	Maintain the same dose
≥12.0 and <13.0	≥12.5 and <13.0	Decrease to the next dose
≥13.0	≥13.0	Suspend a dose until the next scheduled visit

\*In MIYABI PD, patients treated with ESAs at study drug assignment will start this dose-titration schedule for molidustat at week 4, whereas patients not treated with ESAs at study drug assignment will start this dose titration schedule for molidustat at week 8.

†In MIYABI HD-M, doses of darbepoetin alfa or darbepoetin alfa placebo will be titrated from week 2, whereas doses of molidustat will be titrated from week 4.

ESA, erythropoiesis-stimulating agent; Hb, haemoglobin.




# SPIRIT

STANDARD PROTOCOL ITEMS: RECOMMENDATIONS FOR INTERVENTIONAL TRIALS

SPIRIT 2013 Checklist: Recommended items to address in a clinical trial protocol and related documents\*

Section/item	Item No	Description
<b>Administrative information</b>		
Title	1	Descriptive title identifying the study design, population, interventions, and, if applicable, trial acronym
Trial registration	2a	Trial identifier and registry name. If not yet registered, name of intended registry
	2b	All items from the World Health Organization Trial Registration Data Set
Protocol version	3	Date and version identifier
Funding	4	Sources and types of financial, material, and other support
Roles and responsibilities	5a	Names, affiliations, and roles of protocol contributors
	5b	Name and contact information for the trial sponsor
	5c	Role of study sponsor and funders, if any, in study design; collection, management, analysis, and interpretation of data; writing of the report; and the decision to submit the report for publication, including whether they will have ultimate authority over any of these activities
	5d	Composition, roles, and responsibilities of the coordinating centre, steering committee, endpoint adjudication committee, data management team, and other individuals or groups overseeing the trial, if applicable (see Item 21a for data monitoring committee)
<b>Introduction</b>		
Background and rationale	6a	Description of research question and justification for undertaking the trial, including summary of relevant studies (published and unpublished) examining benefits and harms for each intervention
	6b	Explanation for choice of comparators
Objectives	7	Specific objectives or hypotheses
Trial design	8	Description of trial design including type of trial (eg, parallel group, crossover, factorial, single group), allocation ratio, and framework (eg, superiority, equivalence, noninferiority, exploratory)

## Methods: Participants, interventions, and outcomes

Study setting	9	Description of study settings (eg, community clinic, academic hospital) and list of countries where data will be collected. Reference to where list of study sites can be obtained
Eligibility criteria	10	Inclusion and exclusion criteria for participants. If applicable, eligibility criteria for study centres and individuals who will perform the interventions (eg, surgeons, psychotherapists)
Interventions	11a	Interventions for each group with sufficient detail to allow replication, including how and when they will be administered
	11b	Criteria for discontinuing or modifying allocated interventions for a given trial participant (eg, drug dose change in response to harms, participant request, or improving/worsening disease)
	11c	Strategies to improve adherence to intervention protocols, and any procedures for monitoring adherence (eg, drug tablet return, laboratory tests)
	11d	Relevant concomitant care and interventions that are permitted or prohibited during the trial
Outcomes	12	Primary, secondary, and other outcomes, including the specific measurement variable (eg, systolic blood pressure), analysis metric (eg, change from baseline, final value, time to event), method of aggregation (eg, median, proportion), and time point for each outcome. Explanation of the clinical relevance of chosen efficacy and harm outcomes is strongly recommended
Participant timeline	13	Time schedule of enrolment, interventions (including any run-ins and washouts), assessments, and visits for participants. A schematic diagram is highly recommended (see Figure)
Sample size	14	Estimated number of participants needed to achieve study objectives and how it was determined, including clinical and statistical assumptions supporting any sample size calculations
Recruitment	15	Strategies for achieving adequate participant enrolment to reach target sample size 

## Methods: Assignment of interventions (for controlled trials)

### Allocation:

Sequence generation	16a	Method of generating the allocation sequence (eg, computer-generated random numbers), and list of any factors for stratification. To reduce predictability of a random sequence, details of any planned restriction (eg, blocking) should be provided in a separate document that is unavailable to those who enrol participants or assign interventions
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2	Allocation	16b	Mechanism of implementing the allocation sequence (eg, central
3	concealment		telephone; sequentially numbered, opaque, sealed envelopes),
4	mechanism		describing any steps to conceal the sequence until interventions are
5			assigned
6			
7	Implementation	16c	Who will generate the allocation sequence, who will enrol participants,
8			and who will assign participants to interventions
9			
10	Blinding	17a	Who will be blinded after assignment to interventions (eg, trial
11	(masking)		participants, care providers, outcome assessors, data analysts), and
12			how
13		17b	If blinded, circumstances under which unblinding is permissible, and
14			procedure for revealing a participant's allocated intervention during
15			the trial
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### Methods: Data collection, management, and analysis


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21	Data collection	18a	Plans for assessment and collection of outcome, baseline, and other
22	methods		trial data, including any related processes to promote data quality (eg,
23			duplicate measurements, training of assessors) and a description of
24			study instruments (eg, questionnaires, laboratory tests) along with
25			their reliability and validity, if known. Reference to where data
26			collection forms can be found, if not in the protocol
27		18b	Plans to promote participant retention and complete follow-up,
28			including list of any outcome data to be collected for participants who
29			discontinue or deviate from intervention protocols
30			
31	Data	19	Plans for data entry, coding, security, and storage, including any
32	management		related processes to promote data quality (eg, double data entry;
33			range checks for data values). Reference to where details of data
34			management procedures can be found, if not in the protocol
35			
36	Statistical	20a	Statistical methods for analysing primary and secondary outcomes.
37	methods		Reference to where other details of the statistical analysis plan can be
38			found, if not in the protocol
39		20b	Methods for any additional analyses (eg, subgroup and adjusted
40			analyses)
41		20c	Definition of analysis population relating to protocol non-adherence
42			(eg, as randomised analysis), and any statistical methods to handle
43			missing data (eg, multiple imputation)
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### Methods: Monitoring

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53	Data monitoring	21a	Composition of data monitoring committee (DMC); summary of its role
54			and reporting structure; statement of whether it is independent from
55			the sponsor and competing interests; and reference to where further
56			details about its charter can be found, if not in the protocol.
57			Alternatively, an explanation of why a DMC is not needed
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1		21b	Description of any interim analyses and stopping guidelines, including
2			who will have access to these interim results and make the final
3			decision to terminate the trial
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6	Harms	22	Plans for collecting, assessing, reporting, and managing solicited and
7			spontaneously reported adverse events and other unintended effects
8			of trial interventions or trial conduct
9			
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11	Auditing	23	Frequency and procedures for auditing trial conduct, if any, and
12			whether the process will be independent from investigators and the
13			sponsor
14			

## Ethics and dissemination

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17	Research ethics approval	24	Plans for seeking research ethics committee/institutional review board (REC/IRB) approval
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21	Protocol amendments	25	Plans for communicating important protocol modifications (eg, changes to eligibility criteria, outcomes, analyses) to relevant parties (eg, investigators, REC/IRBs, trial participants, trial registries, journals, regulators)
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26	Consent or assent	26a	Who will obtain informed consent or assent from potential trial participants or authorised surrogates, and how (see Item 32)
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30		26b	Additional consent provisions for collection and use of participant data and biological specimens in ancillary studies, if applicable
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33	Confidentiality	27	How personal information about potential and enrolled participants will be collected, shared, and maintained in order to protect confidentiality before, during, and after the trial
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37	Declaration of interests	28	Financial and other competing interests for principal investigators for the overall trial and each study site
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41	Access to data	29	Statement of who will have access to the final trial dataset, and disclosure of contractual agreements that limit such access for investigators
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45	Ancillary and post-trial care	30	Provisions, if any, for ancillary and post-trial care, and for compensation to those who suffer harm from trial participation
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48	Dissemination policy	31a	Plans for investigators and sponsor to communicate trial results to participants, healthcare professionals, the public, and other relevant groups (eg, via publication, reporting in results databases, or other data sharing arrangements), including any publication restrictions
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54		31b	Authorship eligibility guidelines and any intended use of professional writers 
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57		31c	Plans, if any, for granting public access to the full protocol, participant-level dataset, and statistical code
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## Appendices

Informed consent materials	32	Model consent form and other related documentation given to participants and authorised surrogates
Biological specimens	33	Plans for collection, laboratory evaluation, and storage of biological specimens for genetic or molecular analysis in the current trial and for future use in ancillary studies, if applicable

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\*It is strongly recommended that this checklist be read in conjunction with the SPIRIT 2013 Explanation & Elaboration for important clarification on the items. Amendments to the protocol should be tracked and dated. The SPIRIT checklist is copyrighted by the SPIRIT Group under the Creative Commons "[Attribution-NonCommercial-NoDerivs 3.0 Unported](#)" license.

For peer review only

# BMJ Open

## Molidustat for the treatment of renal anaemia in patients with dialysis-dependent chronic kidney disease: design and rationale of three phase 3 studies

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2018-026602.R3
Article Type:	Protocol
Date Submitted by the Author:	11-Apr-2019
Complete List of Authors:	Akizawa, Tadao; Showa University School of Medicine, Nephrology Taguchi, Megumi; Bayer Yakuhin Ltd, Medical Affairs, Pulmonology & Cardiology Matsuda, Yoshimi; Bayer Yakuhin Ltd, Medical Affairs, Pulmonology & Cardiology Iekushi, Kazuma; Bayer Yakuhin Ltd, Medical Affairs, Pulmonology & Cardiology Yamada, Takashi; Bayer Yakuhin Ltd, Medical Affairs, Pulmonology & Cardiology Yamamoto, Hiroyasu; The Jikei University School of Medicine, Division of Nephrology and Hypertension
<b>Primary Subject Heading</b>:	Renal medicine
Secondary Subject Heading:	Renal medicine
Keywords:	Chronic kidney disease, Dialysis < NEPHROLOGY, Molidustat, Renal anaemia

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5 1 **Molidustat for the treatment of renal anaemia in patients with**  
6 2 **dialysis-dependent chronic kidney disease: design and rationale of**  
7 3 **three phase 3 studies**  
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**20 ABSTRACT**

21 **Introduction:** New medications for anaemia associated with chronic kidney disease (CKD)  
22 are desirable, owing to the limitations of erythropoiesis-stimulating agents (ESAs), the  
23 current standard of care. Molidustat is a novel hypoxia-inducible factor prolyl-hydroxylase  
24 inhibitor that stimulates erythropoietin production, predominately in the kidney. We report  
25 methodological details of three phase 3 trials, named **Molidustat once daily improves renal**  
26 **Anemia By Inducing erythropoietin (MIYABI)**, designed primarily to investigate the efficacy  
27 of molidustat therapy in adults with renal anaemia and dialysis-dependent CKD.

28 **Methods and analysis:** MIYABI Haemodialysis-Correction (HD-C) is a single-arm trial (24-  
29 week treatment duration) in approximately 25 patients on haemodialysis, currently  
30 untreated with ESAs. MIYABI Peritoneal Dialysis (PD) is a single-arm trial (36-week treatment  
31 duration) in approximately 50 patients on peritoneal dialysis, treated or untreated with  
32 ESAs. MIYABI Haemodialysis-Maintenance (HD-M) is a randomised, active-controlled,  
33 double-blinded, double-dummy trial (52-week treatment duration) comparing molidustat  
34 with darbepoetin alfa in approximately 225 patients on haemodialysis, treated with ESAs.  
35 Molidustat (starting dose 75 mg/day) will be titrated 4-weekly to maintain haemoglobin in  
36 pre-determined target ranges. The primary objective is to evaluate the efficacy of  
37 molidustat, using the following measures: the rate of rise in haemoglobin (g/dL/week) at the  
38 first dose change up to week 8 (MIYABI HD-C); responder rate (MIYABI HD-C and MIYABI  
39 PD); mean haemoglobin level during weeks 33–36 and non-inferiority to darbepoetin alfa  
40 shown by change in mean haemoglobin level from baseline (MIYABI HD-M). The secondary  
41 objectives are to assess safety, pharmacokinetics and pharmacodynamics. These trials will  
42 provide the first evaluations of molidustat therapy in patients receiving either peritoneal  
43 dialysis or currently untreated with ESAs on haemodialysis, and provide further evidence in  
44 patients treated with ESAs on haemodialysis.

45 **Ethics and dissemination:** The protocols were approved by ethics committees at all  
46 participating sites. The trials will be conducted in accordance with the Declaration of  
47 Helsinki and Good Clinical Practice. Results arising from these studies will be published in  
48 peer-reviewed journal(s).

49 **Trial registration numbers:** NCT03351166, NCT03418168, NCT03543657

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51 **Keywords:** Chronic kidney disease; dialysis; molidustat; renal anaemia

## 52 **STRENGTHS AND LIMITATIONS OF THESE STUDIES**

- 53 • Due to recruitment feasibility limitations, MIYABI HD-C and MIYABI-PD are single  
54 arm, open-label studies.
- 55 • In MIYABI HD-M, a randomised, double-blind study, molidustat treatment will be  
56 directly compared with an ESA (darbepoetin alfa), the current standard of care for  
57 renal anaemia, and will build on the results of a previous open-label phase 2b trial in  
58 patients on haemodialysis.
- 59 • The MIYABI HD-M trial will involve a larger patient population (n=150) receiving a  
60 75 mg starting dose than in the phase 2b trial.
- 61 • Treatment durations will be longer (eg, 52 weeks in MIYABI HD-M) than in the phase  
62 2b trial (16 weeks), although some molidustat-treated patients in the phase 2b trial  
63 (n=57) continued treatment in an extension study for up to 36 months.
- 64 • These are the first studies to directly investigate the efficacy of molidustat therapy in  
65 patients on peritoneal dialysis and in patients currently untreated with ESAs on  
66 haemodialysis.

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## 68 INTRODUCTION

69 Anaemia is a common and serious complication of chronic kidney disease (CKD),<sup>1</sup> which  
70 worsens as CKD progresses.<sup>2-4</sup> The main cause of anaemia associated with CKD (also known  
71 as renal anaemia) is erythropoietin (EPO) deficiency.<sup>5</sup>

72 Treatment with erythropoiesis-stimulating agents (ESAs) is the current standard of care for  
73 renal anaemia.<sup>6</sup> However, this approach has limitations. In 10–20% of patients, irrespective  
74 of dialysis status, ESAs are ineffective at raising haemoglobin (Hb) to prespecified levels.<sup>7-9</sup>  
75 ESAs may also cause several adverse events (AEs), including development or worsening of  
76 hypertension,<sup>10-12</sup> rare cases of antibody-mediated pure red cell aplasia,<sup>13</sup> poor  
77 cardiovascular outcomes and death.<sup>14-16</sup> In patients with cancer and anaemia, ESA use is  
78 associated with increased risk of thrombosis.<sup>17</sup> These AEs may be related to injecting high  
79 doses of ESAs to achieve Hb targets<sup>15 17-19</sup> and excessive increases in Hb levels.<sup>20</sup>

80 A new approach under investigation involves using small molecules to inhibit hypoxia-  
81 inducible factor prolyl-hydroxylases (HIF-PH), thereby inducing EPO production. In addition  
82 to addressing EPO deficiency, the main cause of renal anaemia, the therapeutic effect of  
83 HIF-PH inhibition may also be mediated by increasing the availability of iron for  
84 erythropoiesis, as indicated by reductions in hepcidin levels.<sup>21-26</sup> These findings are  
85 particularly notable, given that functional iron deficiency may contribute to the inadequate  
86 responses that 10–20% of patients experience during treatment with ESAs, even though  
87 these patients often receive intravenous iron supplementation.<sup>5-9</sup> HIF-PH inhibition may  
88 theoretically also have a downside, because HIF transcriptionally upregulates a large  
89 number of genes; although EPO gene upregulation is helpful in treating anaemia associated  
90 with CKD, vascular endothelial growth factor (VEGF) upregulation could result in neoplasia  
91 and diabetic retinopathy.<sup>22</sup> However, in clinical trials of HIF-PH inhibitors, no safety signals  
92 or changes in VEGF levels were reported.<sup>24-26</sup>

93 Molidustat, a novel, orally administered inhibitor of HIF-PH, induces circulating levels of EPO  
94 close to the normal physiological range, with high relative selectivity for the induction of  
95 EPO gene expression, predominately in the kidney.<sup>21</sup> Results from preclinical<sup>21</sup> and clinical  
96 studies<sup>27</sup> suggest that molidustat is a promising option for the treatment of EPO-sensitive  
97 anaemia in patients with CKD. In preclinical studies, molidustat restored renal EPO

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5 98 production with minor induction of hepatic EPO. Molidustat increased plasma EPO and EPO  
6  
7 99 mRNA in the kidney and prevented decline in haematocrit and corrected decreases in Hb  
8  
9 100 level.<sup>21</sup> In a randomised, placebo-controlled, phase 1 study involving 59 healthy participants,  
10  
11 101 single doses of molidustat (5–50 mg) elicited a dose-dependent increase in EPO and were  
12  
13 102 well tolerated.<sup>27</sup> In three 16-week, randomised, phase 2b, dose-ranging studies, comprising  
14  
15 103 one study with patients on haemodialysis and two studies with patients not on dialysis,  
16  
17 104 more than 400 patients with CKD were enrolled. These studies demonstrated that, during  
18  
19 105 treatment with flexible-dose molidustat, Hb levels could be corrected relative to placebo or  
20  
21 106 maintained at levels comparable to those in patients who continued treatment with ESAs,  
22  
23 107 with manageable side effects.<sup>28</sup> Comparable results and no significant safety concerns were  
24  
25 108 observed in extension studies up to 36 months (unpublished data).

26  
27 109 Based on the positive findings of the preclinical and phase 2b clinical studies, the Molidustat  
28  
29 110 once daily improves renal Anemia By Inducing EPO (MIYABI) programme of five phase 3  
30  
31 111 trials has been designed to investigate molidustat therapy further in patients with renal  
32  
33 112 anaemia in Japan. Here, we report the methodological details of the three MIYABI trials in  
34  
35 113 which the efficacy (up to 36 weeks), safety, pharmacokinetics and pharmacodynamics (up to  
36  
37 114 52 weeks) of molidustat therapy will be investigated in patients receiving dialysis. These  
38  
39 115 three trials will provide the first evaluations of molidustat therapy in patients on peritoneal  
40  
41 116 dialysis and in patients currently untreated with ESAs on haemodialysis, as well as extending  
42  
43 117 the evidence in patients treated with ESAs on haemodialysis.

**METHODS AND PLANNED ANALYSES****Study designs, objectives and populations**

44  
45 119  
46  
47 120 Each of the three phase 3 trials is a multicentre study conducted in adults aged 20 years or  
48  
49 121 older with renal anaemia and dialysis-dependent CKD in Japan. In each trial, the primary  
50  
51 122 objective is to evaluate the efficacy of molidustat in the respective patient populations and,  
52  
53 123 in the MIYABI Haemodialysis Maintenance (HD-M) trial, to show non-inferiority to  
54  
55 124 darbepoetin alfa. The secondary objectives of each trial are to evaluate the safety,  
56  
57 125 tolerability, pharmacokinetics and pharmacodynamics of molidustat during the treatment  
58  
59 126 periods. The three trials commenced in the first half of 2018 and have finished recruiting.  
60  
127 The planned end dates for MIYABI HD-C, MIYABI PD, and MIYABI HD-M are November 2018,

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128 August 2019 and December 2019, respectively. Patient eligibility was assessed during  
129 screening periods lasting up to 12 weeks in the MIYABI Haemodialysis Correction (HD-C) and  
130 MIYABI Peritoneal Dialysis (PD) studies and up to 8 weeks in MIYABI HD-M. To be eligible,  
131 the mean of at least two Hb measurements (both taken before dialysis, at least 2 days apart,  
132 with the last measurement taken within 14 days before study drug assignment, and with a  
133 difference of less than 1.2 g/dL between the lowest and highest values) was required to lie  
134 within pre-specified levels (table 1). The main inclusion criteria are summarised in table 1.  
135 All inclusion and exclusion criteria are shown in supplementary table 1.

136 MIYABI HD-C is a single-arm study in patients on haemodialysis who are not currently  
137 treated with ESAs, with a 24-week treatment duration (figure 1 and table 1). Japanese  
138 guidelines for the clinical evaluation of medications for renal anaemia recommend  
139 demonstrating efficacy in the correction and maintenance of renal anaemia in patients on  
140 dialysis, as well as in patients not on dialysis.<sup>29</sup> However, the number of patients with renal  
141 anaemia on dialysis who do not receive ESAs is limited in Japan. A single-arm study design  
142 was chosen for MIYABI HD-C owing to the feasibility of patient recruitment.<sup>30</sup>

143 MIYABI PD is a single-arm study in patients on peritoneal dialysis who are treated or not  
144 treated with ESAs, with a 36-week treatment duration (figure 1 and table 1). A single-arm  
145 study design was chosen for MIYABI PD owing to the limited number of peritoneal dialysis  
146 patients with renal anaemia in Japan.

147 MIYABI HD-M is a randomised, active-controlled, double-blinded, double-dummy, parallel-  
148 group study comparing molidustat with darbepoetin alfa in patients on haemodialysis who  
149 are treated with ESAs (figure 1 and table 1). The study has a treatment duration of 52  
150 weeks. As most patients with renal anaemia on dialysis in Japan are treated with ESAs, it is  
151 feasible to recruit sufficient patients to perform a confirmatory, randomised, double-blinded  
152 trial of molidustat in this patient population. Therefore, in MIYABI HD-M, eligible patients  
153 will be randomised in a ratio of 2:1 to the molidustat group or darbepoetin alfa group.  
154 Allocation to treatment arms will be achieved using an interactive voice/web response  
155 system (IxRS) at the first (baseline) visit. Randomisation will be stratified by previous ESA  
156 dose group (low or high) and by medical history of thromboembolic events (yes or no for  
157 myocardial infarction, pulmonary thromboembolism, stroke [excluding haemorrhagic



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stroke] or acute limb ischaemia). All investigators and patients in MIYABI HD-M will be blinded to treatment allocation. In cases of emergency, such as occurrence of a suspected, unexpected, serious AE, when the investigator needs to know which drug has been allocated, unblinding will occur by entering the emergency key code for the relevant patient into the IxRS.

Each study is being overseen by a data monitoring committee consisting of independent clinical experts and an independent biostatistician supported by an independent statistical analysis centre, whose main responsibility is to recommend a change, interruption or termination of the study (or all phase 3 studies) based on safety findings. The data monitoring committee will be unblinded to treatment allocation in MIYABI HD-M.

**Treatments**

Study treatments are summarised in table 1. In each study, a starting dose of 75 mg molidustat once daily (OD) will be titrated every 4 weeks using the IxRS, based on the patient's Hb response to the previous dose. In each study, planned doses for the titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD. The dose of molidustat will be adjusted to correct and maintain Hb levels in the target ranges of  $\geq 10.0$  to  $< 12.0$  g/dL in MIYABI HD-C and MIYABI HD-M and  $\geq 11.0$  to  $< 13.0$  g/dL in MIYABI PD, as per Japanese guideline recommendations.<sup>31</sup>

For patients untreated with ESAs (all patients in MIYABI HD-C and some patients in MIYABI PD, but no patients in MIYABI HD-M), a dose adaptation visit will occur at week 4 to avoid excessive elevation of Hb levels after the initiation of molidustat treatment. In MIYABI HD-C and MIYABI PD, dose titration at week 4 will be based on both the magnitude of the rise in Hb and the Hb level (supplementary table 2) and from week 8 according to the Hb level alone (supplementary table 3). For patients treated with ESAs (all patients in MIYABI HD-M and some patients in MIYABI PD, but no patients in MIYABI HD-C), the dose will be titrated from week 4 according to Hb level (supplementary table 3).

In MIYABI HD-M, patients will receive molidustat or molidustat placebo orally and darbepoetin alfa or darbepoetin alfa placebo intravenously. Patients in the molidustat group will receive molidustat plus darbepoetin alfa placebo, while patients in the darbepoetin alfa

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187 group will receive darbepoetin alfa plus molidustat placebo. The starting dose of  
188 darbepoetin alfa or darbepoetin alfa placebo will be selected for each patient based on their  
189 previous ESA dosage. Patients treated with darbepoetin alfa at screening will continue this  
190 treatment or start treatment with darbepoetin alfa placebo at the previous dose and  
191 interval (ie, weekly or biweekly). Patients treated with an epoetin therapy at screening will  
192 be treated with darbepoetin alfa or darbepoetin alfa placebo at a starting dose and interval  
193 determined by their epoetin dosage at screening. Then, depending on the Hb level  
194 (supplementary table 3), doses of darbepoetin alfa and darbepoetin alfa placebo will be  
195 titrated at biweekly intervals from week 2, and doses of molidustat and molidustat placebo  
196 will be titrated from week 4 at 4-weekly intervals.

197 In all studies, in cases of excessive elevation of a patient's Hb level (rate of Hb rise >1.0 g/dL  
198 per 2 weeks or >2.0 g/dL per 4 weeks) during the treatment period, investigators may  
199 decrease the dose of molidustat (or darbepoetin alfa for MIYABI HD-M) at any time. If the  
200 administered dose is the minimum dose step, the dose may be suspended.

201 In each study, iron, vitamin B12 and folate supplementation is permitted if required and will  
202 be administered according to Japanese guideline recommendations.<sup>31</sup> Iron supplementation  
203 will be administered to reach a target serum ferritin level of at least 100 ng/mL or  
204 transferrin saturation of at least 20%.

205 For all studies, after the final administration of the study drug, further ESA treatment may  
206 be initiated at the discretion of the investigator. Details of the ESA treatment regimen will  
207 be recorded if treatment is initiated during the four week follow-up period.

**Variables**

209 All efficacy and safety variables, and associated definitions, are shown in table 2. The  
210 primary efficacy variables in MIYABI HD-C are the rate of rise in Hb level (g/dL/week) at the  
211 first dose change up to week 8 and responder rate. In MIYABI PD, the primary efficacy  
212 variable will be the responder rate. In MIYABI HD-M, the primary efficacy variables will be  
213 mean Hb level during the evaluation period and its change from baseline. In all three  
214 studies, a responder is defined as a patient who meets all of the following criteria: (i) mean  
215 of the Hb levels during the evaluation period is in the target range; (ii) ≥50% of the Hb levels  
216 during the evaluation period are in the target range; (iii) no rescue treatment received up to

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217 the end of the evaluation period. Secondary variables for the three trials are shown in table  
218 2. In each study, exploratory variables will include measures of iron metabolism, VEGF levels  
219 and assessment of health-related quality of life using the EuroQol 5-dimension 5-level  
220 questionnaire.

221 In each study, to investigate systemic exposure to molidustat and the relationship between  
222 molidustat exposure and response, sparse sampling from all patients will be conducted for  
223 pharmacokinetics and pharmacodynamics. If possible, molidustat exposure parameters (eg,  
224  $C_{max}$ , AUC) and the relationship between molidustat exposure and treatment effects will be  
225 evaluated using population approaches (eg, non-linear mixed effect modelling), including  
226 potential influence of relevant patient covariables.

**Quality assurance and data management**

228 For all studies, audits may be conducted by a member of the sponsor's quality assurance  
229 unit to assess the performance of the study at any of the study sites. In addition, sites may  
230 be inspected by regulatory health authority representatives, independent ethics committees  
231 and institutional review boards.

232 For all studies, data will be recorded by investigational site personnel onto the validated and  
233 password-protected electronic data capture system Rave (Medidata Solutions). All records  
234 identifying the patient will be kept confidential and will not be made available either to the  
235 public or the sponsor. All personal information made available for inspection will be handled  
236 in strictest confidence and in accordance with local data protection laws. Data will be  
237 pseudonymised for analysis. The sponsor will have access to the full trial dataset.

238 The sponsor maintains clinical trial insurance coverage for each of the studies to provide  
239 compensation in the unlikely event that a patient is harmed from participation in any of  
240 these clinical trials.

**Statistical analysis**

242 All variables (including demographic and other baseline characteristics) will be analysed  
243 descriptively with appropriate statistical methods: categorical variables by frequency tables  
244 and continuous variables by summary statistics (mean, standard deviation, minimum,

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245 median and maximum). Summary statistics will be presented for the original data as well as  
246 for the difference from baseline.

247 In each study, the primary analysis set for efficacy will be the full analysis set, which includes  
248 all patients assigned to treatment who have at least one baseline Hb level (ie, at least one  
249 Hb level before the first dose of the study drug).

250 In MIYABI HD-C, the primary efficacy variables (rate of rise in Hb and responder rate) and  
251 their two-sided 95% confidence intervals (CI) will be estimated using one-sample *t*-statistics  
252 and the Clopper–Pearson method, respectively. In MIYABI PD, the primary efficacy variable  
253 (responder rate) and its two-sided 95% CI will be estimated using the Clopper–Pearson  
254 method. In MIYABI HD-M, the primary efficacy variables (mean Hb level and change in mean  
255 Hb level) will be analysed by sequentially testing two hypotheses. In MIYABI HD-M, the  
256 primary objective will be achieved if the following two hypotheses are confirmed. (i) In the  
257 molidustat treatment group, the mean Hb level during the evaluation period (weeks 33–36)  
258 remains within the target range ( $\geq 10.0$  to  $< 12.0$  g/dL). The mean Hb level in the molidustat  
259 treatment group will be calculated using the mean Hb level per patient. If the lower limit of  
260 the two-sided 95% CI of the mean of the mean Hb level is greater than or equal to the lower  
261 limit of the target Hb level (ie,  $\geq 10.0$  g/dL) and if the upper limit of the two-sided 95% CI is  
262 less than the upper limit of the target Hb level (ie,  $< 12.0$  g/dL), it will be established that the  
263 mean Hb level is within the target range. Two-sided 95% CI will be estimated using one  
264 sample *t*-statistics. (ii) Molidustat is not inferior to darbepoetin alfa. The non-inferiority of  
265 molidustat to darbepoetin alfa will be established if the lower limit of the two-sided 95% CI  
266 for the difference (molidustat minus darbepoetin alfa) is above  $-1.0$  g/dL with non-  
267 inferiority margin of  $1.0$  g/dL. This margin was chosen because a variation of approximately  
268  $1.0$  g/dL is considered acceptable in Japanese clinical practice.<sup>31</sup> In MIYABI HD-M, the  
269 difference in change between the treatment groups and its two-sided 95% CI will be  
270 estimated using an analysis of covariance (ANCOVA) model, including treatment group,  
271 previous ESA dose group (low/high) and previous thromboembolic events (yes/no) as fixed  
272 effects and baseline Hb level as a covariate.

273 Several descriptive and exploratory subgroup analyses are planned for all studies, including  
274 age, sex, baseline weight, prior thromboembolic event and main cause of CKD. Subgroup

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analysis will also be conducted for previous ESA dose group for MIYABI HD-M, for baseline Hb level and duration of dialysis for MIYABI HD-C and for pre-treatment with ESAs at assignment and duration of dialysis for MIYABI PD.

**Determination of sample size**

In MIYABI HD-C and MIYABI PD, the respective sample sizes of approximately 25 and 50 patients are determined based on feasibility.

In MIYABI HD-M, the sample size of 150 patients in the molidustat group and 75 patients in the darbepoetin alfa group should result in sufficient data to assess the long-term safety of molidustat therapy, assuming a dropout rate of approximately 30%. If 150 patients are randomised to the molidustat group, the power to establish that mean Hb levels are within target levels during the evaluation period is  $\geq 98\%$ , assuming a standard deviation of 1.3–1.5 g/dL from the previous phase 2b studies. This sample size has  $>90\%$  power to reject the null hypothesis that molidustat is inferior to darbepoetin alfa with a non-inferiority margin of 1.0 g/dL at a one-sided 2.5% significance level, assuming the expected difference between molidustat and darbepoetin alfa to be 0 g/dL and with a common standard deviation of 1.3–1.5 g/dL.

**Patient and public involvement**

Patients are not involved in the design and conduct of the studies.

**DISCUSSION**

Renal anaemia due to EPO deficiency is a common and serious complication of CKD.<sup>1</sup> However, new approaches to the treatment of renal anaemia are needed, owing to safety issues and limitations with current treatments. Results from previous studies, including three phase 2b dose-ranging trials, suggest that molidustat is a promising option for the treatment of EPO-sensitive anaemia in patients with CKD.

At present, only one phase 2b trial assessing molidustat has been conducted in patients with renal anaemia who are on dialysis. It is anticipated that the three phase 3 trials described here will demonstrate the efficacy and safety of molidustat in patients with renal anaemia on dialysis, and that the trials will have the following strengths, relative to the one phase 2b trial conducted in patients on dialysis: (i) in MIYABI HD-M, molidustat treatment will be

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304 compared with an ESA (darbepoetin alfa), the current standard of care for renal anaemia, in  
305 a double-blinded manner, whereas an open-label design was used in the phase 2b trial, in  
306 which molidustat treatment was compared with another ESA (epoetin); (ii) a larger patient  
307 population in the MIYABI HD-M trial (n=150) receiving a starting dose of 75 mg molidustat  
308 OD than in the phase 2b trial (n=44 of the 157 patients treated with molidustat received a  
309 75 mg starting dose); (iii) the treatment periods will be longer (eg, 52 weeks in MIYABI HD-  
310 M) than in the phase 2b trial (16 weeks), although about one-third of the molidustat-treated  
311 patients in the phase 2b trial (n=57) continued treatment in an extension study, with a  
312 duration of up to 36 months; (iv) molidustat therapy will be investigated for the first time in  
313 patients who are not treated with ESAs on haemodialysis in the MIYABI HD-C trial, and  
314 MIYABI HD-M will provide further evaluations of molidustat in patients treated with ESAs,  
315 whereas the phase 2b trial only included patients who switched from epoetin; (v) the  
316 efficacy of molidustat therapy will be investigated for the first time in patients on peritoneal  
317 dialysis in MIYABI PD, whereas only patients undergoing haemodialysis were included in the  
318 phase 2b trial.

319 Approximately 600 patients are planned to be involved in the five studies in the phase 3  
320 MIYABI programme; three studies in patients on dialysis and two studies in patients not on  
321 dialysis. While safety assessments will be conducted for all patients in the MIYABI  
322 programme, including assessments of vital signs and 12-lead electrocardiogram parameters,  
323 the sample size is insufficient to determine the risk of cardiovascular events. The MIYABI  
324 HD-C and MIYABI PD studies will also be limited to investigating molidustat therapy in the  
325 absence of a comparator and with small sample sizes (approximately 25 and 50,  
326 respectively), owing to the feasibility of patient recruitment (in Japan, limited numbers of  
327 patients with renal anaemia are on dialysis while not receiving ESAs or are on peritoneal  
328 dialysis), although molidustat will be compared with the current standard of care  
329 (darbepoetin alfa) as a maintenance treatment in a study powered to assess efficacy and  
330 safety in 150 patients on dialysis.

331 In the three MIYABI trials in patients on dialysis, the efficacy of molidustat will primarily be  
332 assessed by investigating Hb levels, including changes from baseline and maintenance of  
333 prespecified Hb targets. However, several exploratory variables will be also investigated.

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334 These include assessments of VEGF levels and ophthalmological examinations, conducted to  
335 evaluate the theoretical risk of VEGF-mediated diabetic retinopathy,<sup>22</sup> and biomarkers of  
336 iron metabolism as, in addition to increasing EPO production predominately in the kidney,  
337 molidustat may increase the availability of iron for erythropoiesis.<sup>21-23</sup>

338 In summary, the three trials in patients on dialysis described here, together with two other  
339 trials in patients who are not receiving dialysis (the MIYABI ND-C and MIYABI ND-M  
340 randomised, open-label, active-controlled, parallel-group, multicentre trials), comprise the  
341 MIYABI phase 3 programme. The design and rationale of MIYABI ND-C and MIYABI ND-M are  
342 published in a companion article.<sup>32</sup> This programme will investigate the efficacy and safety  
343 of molidustat in a broad clinical spectrum spanning approximately 600 patients with renal  
344 anaemia and CKD in Japan.

**ETHICS AND DISSEMINATION**

346 The studies are being conducted in accordance with the principles of the Declaration of  
347 Helsinki and the International Council for Harmonisation of Technical Requirements for  
348 Pharmaceuticals for Human Use (ICH) Guidelines for Good Clinical Practice (GCP).

349 Documented approval from appropriate independent ethics committees and institutional  
350 review boards has been obtained, according to GCP and local laws, regulations and  
351 organisations. The MIYABI HD-C study has been approved by the institutional review board  
352 of All Tohoku Clinical Trial Review and Audit Organization (application number: 20171204)  
353 and another 20 sites. The MIYABI PD study has been approved by the institutional review  
354 board of Kyushu University Hospital (application number: 20180221) and another 26 sites.

355 The MIYABI HD-M study has been approved by the institutional review board of Ibaraki  
356 Prefectural Central Hospital (application number: 20180524), Asahikawa-Kosei General  
357 Hospital (20180806) and another 51 sites.

358 Informed consent was obtained from patients by the site investigator or a designated  
359 person before entering the studies and may be withdrawn at any time. Proposed protocol  
360 amendments must be agreed by the sponsor and investigators and approved by  
361 independent ethics committees and institutional review boards. Protocol amendments must  
362 be signed by the principal investigator and have received all external approvals before  
363 coming into effect at the respective centre. If there is a change in the protocol that

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364 necessitates a change in consent, the investigator will inform patients of the changes in a  
365 timely manner and ask each patient to reconfirm their participation in the study by signing a  
366 revised consent form.

367 The studies have been registered on ClinicalTrials.gov (NCT03351166 [MIYABI HD-C],  
368 NCT03418168 [MIYABI PD], NCT03543657 [MIYABI HD-M]). Results will be disseminated  
369 through peer-reviewed publication(s) but there are no plans to publicly release the full  
370 protocol, participant-level dataset or statistical code from any of the studies.

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374 scientific accuracy.

**AUTHOR CONTRIBUTORS**

375 TA, HY and TY contributed to designing these studies. TY contributed to developing the  
376 original study protocols. MT contributed to drafting the article and revising it. TA, HY, MT  
377 and KI critical revised the article for important intellectual content. YM contributed to  
378 developing the statistical analysis plan and assisted in the preparation of the manuscript. All  
379 authors approved the final version of the manuscript and agree to be accountable for all  
380 aspects of the work, ensuring that questions related to the accuracy or integrity of any part  
381 of the work are appropriately resolved.  
382



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383 **FUNDING** These trials are funded by Bayer Yakuhin Ltd. The trials were designed and are  
384 being conducted by employees of Bayer Yakuhin Ltd, in consultation with healthcare  
385 professionals including TA and HY. Bayer Yakuhin Ltd is responsible for the design of these  
386 studies and the analysis and interpretation of data collected by investigators. Bayer Yakuhin  
387 Ltd and participating contract research organisations are responsible for management of  
388 data and writing the report. Bayer Yakuhin Ltd will make the final decision regarding  
389 submission of a manuscript for publication.

390 **COMPETING INTERESTS** MT, YM, KI and TY are employees of Bayer Yakuhin Ltd. TA received  
391 consulting and lecture fees from Bayer Yakuhin Ltd during the conduct of the study. TA also  
392 received consulting, lecture or manuscript fees outside the submitted work from Astellas,  
393 GlaxoSmithKline, JT Pharmaceuticals, Kissei Pharmaceutical Co. Ltd, Kyowa Hakko Kirin,  
394 Nipro Corporation, Fuso Pharmaceutical Industries Ltd, and Ono Pharmaceutical Co. Ltd, and  
395 lecture fees from Bayer Yakuhin, Chugai Pharmaceutical Co. Ltd, Kyowa Hakko Kirin, and  
396 Torii Pharmaceutical Co. Ltd. HY received consulting fees from Bayer Yakuhin Ltd during the  
397 conduct of the study.

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## FIGURE LEGEND

**Figure 1** Trial designs for (A) MIYABI HD-C, (B) MIYABI PD and (C) MIYABI HD-M. MIYABI HD-C and MIYABI PD are single-arm, multicentre trials. MIYABI HD-M is a randomised, active-controlled, double-blinded, double-dummy, parallel-group, multicentre trial. Haemoglobin levels and safety will be assessed at each study visit, conducted at the time points shown.

BL, baseline; EOF, end of follow-up; EOT, end of treatment; ESA, erythropoiesis-stimulating agent.

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## TABLES

**Table 1** Trial designs, patient populations and treatments

	MIYABI HD-C [NCT03351166]	MIYABI PD [NCT03418168]	MIYABI HD-M [NCT03543657]
Trial design	Single-arm, multicentre	Single-arm, multicentre	Randomised, active-controlled, double-blinded, double-dummy, parallel-group, multicentre
Patient population	Men and women (aged ≥20 years, body weight >40 and ≤160 kg) with a diagnosis of renal anaemia		
Key inclusion criteria	<p>Patients with ESKD on haemodialysis at least weekly for ≥2 weeks</p> <p>Mean of the last two Hb levels between ≥8.0 and &lt;10.0 g/dL</p> <p>Not treated with ESAs during the 8 weeks before study drug assignment</p>	<p>Patients with ESKD on peritoneal dialysis</p> <p>Mean of the last two Hb levels between ≥8.0 and &lt;11.0 g/dL for ESA untreated and ≥10.0 and &lt;13.0 g/dL for ESA treated</p> <p>Not treated or treated with ESAs during the 8 weeks before study drug assignment*</p>	<p>Patients with ESKD on haemodialysis at least weekly for ≥12 weeks</p> <p>Mean of all Hb levels (at least two measurements) between ≥9.5 and &lt;12.0 g/dL</p> <p>Treated with the same ESA for ≥8 weeks before randomisation (weekly or biweekly dose of darbepoetin alfa, monthly or biweekly dose of epoetin beta pegol, OR weekly, biweekly, twice or three times per week dose of epoetin alfa/beta, and having had no more than one dose change during the 8 weeks before randomisation)*</p>

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	Not treated with HIF-PH inhibitors during the 8 weeks before study drug assignment	Not treated with HIF-PH inhibitors during the 8 weeks before study drug assignment	
Study treatments	A starting dose of 75 mg molidustat OD, titrated based on Hb response of the previous dose. Planned doses for titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD  Hb target range $\geq 10.0$ to $< 12.0$ g/dL	A starting dose of 75 mg molidustat OD, titrated based on Hb response of the previous dose. Planned doses for titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD  Hb target range $\geq 11.0$ to $< 13.0$ g/dL	Two groups: molidustat + darbepoetin alfa placebo, or molidustat placebo + darbepoetin alfa  A starting dose of 75 mg molidustat or molidustat placebo OD, titrated based on Hb response of the previous dose Planned doses for titration are 5, 12.5, 25, 50, 75, 100, 150 and 200 mg OD.  Hb target range $\geq 10.0$ to $< 12.0$ g/dL  A starting dose of darbepoetin alfa or darbepoetin alfa placebo will be decided in accordance with the previous ESA dosages and schedule of once a week or every 2 weeks per Japanese label
Treatment duration, weeks	24	36	52

ESA, erythropoiesis-stimulating agent; ESKD, end-stage kidney disease; Hb, haemoglobin; HIF-PH, hypoxia-inducible factor prolyl-hydroxylase; OD, once daily.

\*For patients washed out from ESAs, the mean Hb level before dialysis (at least two measurements taken  $\geq 2$  days apart, assessed by the central laboratory) must have decreased by  $\geq 0.5$  g/dL after the last ESA administration, AND the interval from the last ESA administration to study drug assignment should be  $> 1$  week for epoetin alfa,  $> 2$  weeks for darbepoetin alfa or  $> 4$  weeks for epoetin beta pegol.

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**Table 2** Efficacy and safety variables

	MIYABI HD-C	MIYABI PD	MIYABI HD-M
Primary efficacy variables specific to each trial	<ul style="list-style-type: none"> <li>• Rate of rise in Hb level (g/dL/week) at the first dose change up to week 8*</li> <li>• Responder rate during the evaluation period (weeks 21–24)†</li> </ul>	<ul style="list-style-type: none"> <li>• Responder rate during the evaluation period (weeks 30–36)†</li> </ul>	<ul style="list-style-type: none"> <li>• Mean Hb level during the evaluation period (weeks 33–36)</li> <li>• Change in mean Hb level from baseline during the evaluation period</li> </ul>
Secondary efficacy variables in all three trials	<ul style="list-style-type: none"> <li>• Proportions of patients who meet the three response criteria during the evaluation period†</li> <li>• Hb level and change from baseline (measurement at each visit and mean during the evaluation period)</li> <li>• Proportion of patients whose mean Hb level is in, above or below the target range during the evaluation period</li> <li>• Proportion of patients whose Hb level is in, above or below the target range, respectively, at each visit</li> <li>• Proportion of patients whose maximum rise in Hb between each consecutive visit is &gt;0.5 g/dL/week (defined as change in Hb level/duration between two visits [weeks])</li> </ul>		
Secondary efficacy variables specific to each trial	<ul style="list-style-type: none"> <li>• Rate of rise in Hb (g/dL/week) at the dose change up to week 4</li> <li>• Cumulative proportion of patients who achieve the lower limit of the target Hb range at least once at each visit</li> </ul>	<ul style="list-style-type: none"> <li>• Rate of rise in Hb level (g/dL/week) at the dose changes up to weeks 4 and 8*</li> <li>• Change in mean Hb level from baseline during the evaluation period</li> <li>• Mean Hb level during the evaluation period</li> </ul>	<ul style="list-style-type: none"> <li>• Responder rate during the evaluation period†</li> </ul>
Other efficacy variables in MIYABI HD-C and MIYABI HD-M (secondary variables)	<ul style="list-style-type: none"> <li>• Rate of rise in Hb level (g/dL/week) during each visit interval</li> <li>• Percentage of days in the target Hb range during the evaluation period and treatment period, respectively (defined as the number of days in the target range/number of days during the period × 100 [%])</li> </ul>		

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in MIYABI PD)	<ul style="list-style-type: none"> <li>Percentage of Hb levels in target range during the evaluation period and treatment period, respectively (defined as the number of measurements in the target range/number of measurements × 100 [%])</li> <li>Proportion of patients who received at least one rescue treatment (RBC transfusion, ESA treatment)</li> </ul>
Safety variables in all three trials	<ul style="list-style-type: none"> <li>Adjudicated AEs†</li> <li>AEs including serious AEs</li> <li>Change in vital signs (pulse rate and blood pressure)</li> <li>12-lead electrocardiogram parameters</li> <li>Observations of ophthalmological examination (fundus and anterior ocular segment examination and intraocular pressure measurement)</li> <li>Laboratory examinations (including haematology, coagulation, clinical chemistry, electrolyte, HbA<sub>1c</sub>, PTH and TSH levels)</li> </ul>
Exploratory variables in all three trials	<ul style="list-style-type: none"> <li>Parameters of iron metabolism</li> <li>EQ-5D-5L</li> <li>Vascular endothelial growth factor</li> </ul>

AEs, adverse events; EQ-5D-5L, EuroQol 5-dimension 5-level questionnaire; ESA, erythropoiesis-stimulating agents; Hb, haemoglobin; HbA<sub>1c</sub>, glycated haemoglobin; PTH, parathyroid hormone; TSH, thyroid-stimulating hormone; RBC, red blood cell.

\*Rate of rise in Hb (g/dL/week) at the first dose change up to week 8 is defined as the change in Hb level from baseline to the first dose change of study drug up to week 8 divided by the duration of the starting dose (in weeks). If no dose change is performed up to week 8, then an Hb level at week 8 and the date of the week 8 visit will be used to calculate the change in Hb level and duration.

†A responder is defined as a patient who meets all of the following criteria:

- (i) mean of the Hb levels during the evaluation period is in the target range
- (ii) ≥50% of the Hb levels during the evaluation period are in the target range
- (iii) no rescue treatment up to the end of the evaluation period.

‡Adjudicated AEs include death, myocardial infarction, unstable angina pectoris, stroke or transient ischaemic attack, pulmonary thromboembolism or acute limb ischaemia.



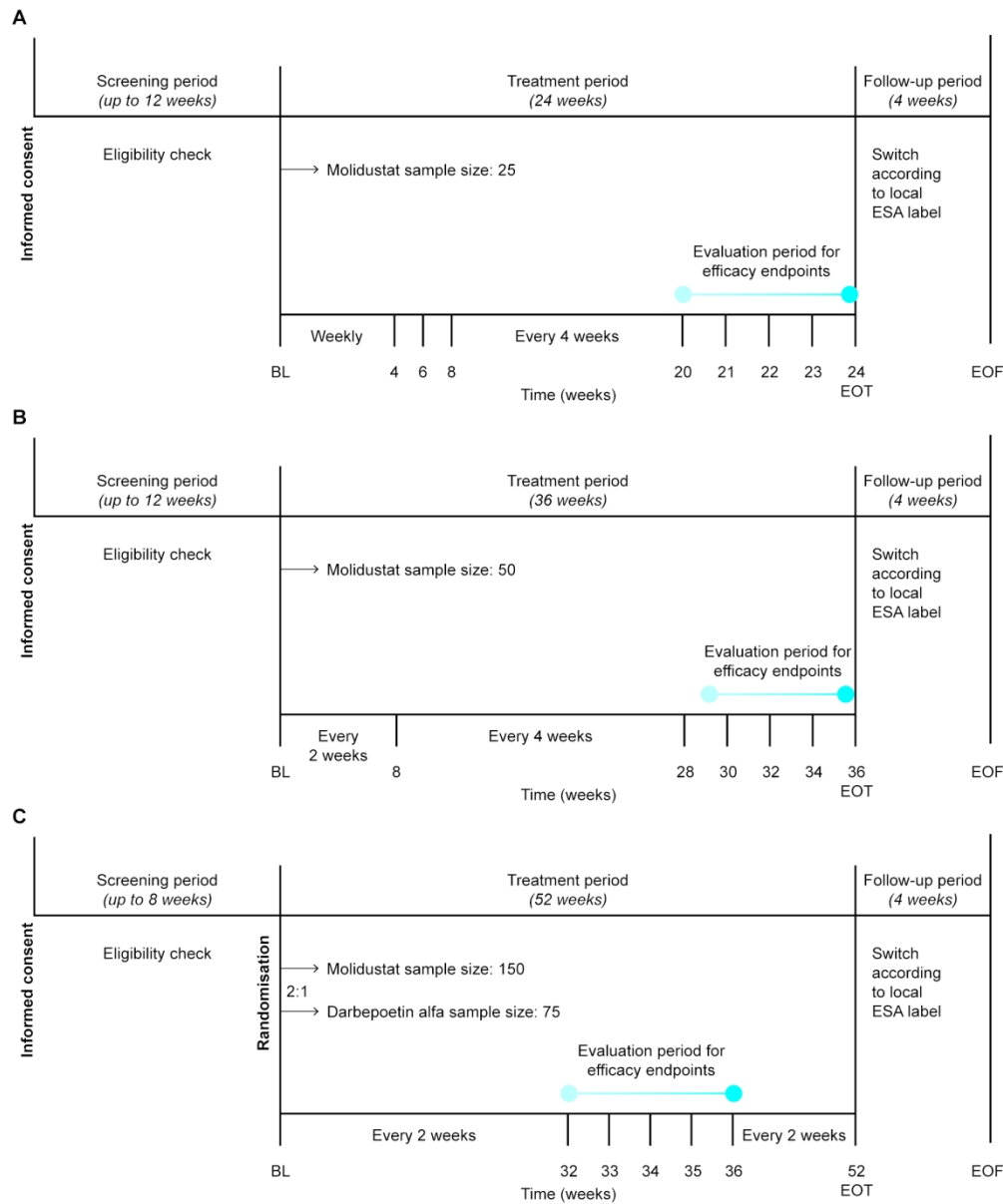


Figure 1 Trial designs for (A) MIYABI HD-C, (B) MIYABI PD and (C) MIYABI HD-M. MIYABI HD-C and MIYABI PD are single-arm, multicentre trials. MIYABI HD-M is a randomised, active-controlled, double-blinded, double-dummy, parallel-group, multicentre trial. Haemoglobin levels and safety will be assessed at each study visit, conducted at the time points shown.

BL, baseline; EOF, end of follow-up; EOT, end of treatment; ESA, erythropoiesis-stimulating agent.

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## SUPPLEMENTARY TABLES

### Supplementary table 1 An overview of all inclusion and exclusion criteria

#### Inclusion criteria

*All three trials had the following inclusion criteria*

- Written informed consent before performing any study-specific tests or procedures
  - Body weight (after dialysis) >40 and ≤160 kg at screening
  - Male or female ≥20 years of age at screening
  - At least one kidney
  - Serum folate level and serum vitamin B12 level above LLN at screening
  - Women of reproductive potential must agree to use adequate contraception when sexually active. This applies for the time period between signing of the informed consent form until 12 weeks after the last administration of the study drug.
    - Acceptable methods of contraception may include, but are not limited to, condoms (male or female) with or without a spermicidal agent; diaphragm or cervical cap with spermicide; intra-uterine device; hormone-based contraception
    - Patients must agree to utilise two reliable and acceptable methods of contraception simultaneously.
- Women are considered postmenopausal and not of childbearing potential if they have had 12 months of natural (spontaneous) amenorrhoea with an appropriate clinical profile (eg, age-appropriate, history of vasomotor symptoms) or 6 months of spontaneous amenorrhoea with serum FSH levels >40 mIU/mL or have had surgical treatment such as bilateral tubal ligation, bilateral ovariectomy or hysterectomy.
- Ability to understand and follow study-related instructions.

*MIYABI HD-C had four additional inclusion criteria*

- Patients with ESKD on dialysis (including haemodiafiltration, haemodialysis and other modalities except for peritoneal dialysis) weekly or more than weekly for ≥2 weeks before study drug assignment
- Mean screening Hb level ≥8.0 and <10.0 g/dL (at least two measurements must be taken ≥2 days apart, assessed by the central laboratory; the difference between the two measurements must be <1.2 g/dL), with the last screening Hb measurement during the 14 days before study drug

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- Not treated with any ESAs or HIF-PH inhibitors during the 8 weeks before study drug assignment. For patients washed out from ESAs, the mean Hb level before dialysis (at least two measurements taken  $\geq 2$  days apart, assessed by the central laboratory) must have decreased by  $\geq 0.5$  g/dL after the last ESA administration, AND the interval from the last ESA administration to study drug assignment should be  $>1$  week for epoetin alfa,  $>2$  weeks for darbepoetin alfa or  $>4$  weeks for epoetin beta pegol
- Ferritin  $\geq 50$  ng/mL at screening

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*MIYABI PD had five additional inclusion criteria*

- Patients with ESKD on peritoneal dialysis before study drug assignment and not expected to start maintenance dialysis (eg, haemodialysis, haemodiafiltration) other than peritoneal dialysis during the study period
  - Not treated with HIF-PH inhibitors during the 8 weeks before study drug assignment
  - Patients who meet one of the following criteria
    - A: Untreated with ESA at study drug assignment*  
Mean screening Hb level  $\geq 8.0$  and  $< 11.0$  g/dL (based on the last two measurements taken  $\geq 2$  days apart, assessed by the central laboratory; the difference between the two measurements must be  $< 1.2$  g/dL), with the last screening Hb measurement during the 14 days before study drug assignment
    - B: Pre-treated with ESA at study drug assignment*  
Mean screening Hb level  $\geq 10.0$  and  $< 13.0$  g/dL (based on the last two measurements taken  $\geq 2$  days apart, assessed by the central laboratory; the difference between the two measurements must be  $< 1.2$  g/dL), with the last screening Hb measurement during the 14 days before study drug assignment
  - Patients who meet one of the following criteria
    - A: Untreated with ESA at study drug assignment*
      - Patient with ESKD on peritoneal dialysis for  $\geq 2$  weeks before study drug assignment
    - and
    - Not treated with ESA for the 8 weeks before study drug assignment
    - or
    - Washed out from ESAs, when the mean Hb level (based on at least two measurements taken  $\geq 2$  days apart, assessed by the central laboratory) has decreased by  $\geq 0.5$  g/dL after the last ESA administration, AND the interval from the last ESA administration to study drug assignment should be  $>2$  weeks for epoetin alfa/beta and  $>4$  weeks for darbepoetin alfa or epoetin beta pegol
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**Confidential***B: Pre-treated with ESA at study drug assignment*

- Patient with ESKD on peritoneal dialysis for  $\geq 12$  weeks before study drug assignment
- Treated with IV or SC ESA during the 8 weeks before study drug assignment
- Treated with 2- or 4-weekly dose of darbepoetin alfa, 4-weekly dose of epoetin beta pegol, OR 3 times per week, twice per week, weekly or biweekly dose of epoetin alfa/beta, and having had no more than one dose change during the 8 weeks before study drug assignment

- Patients who meet one of the following criteria

*A: Untreated with ESA at study drug assignment*

Ferritin  $\geq 50$  ng/mL at screening

*B: Pre-treated with ESA at study drug assignment*

- Ferritin  $\geq 100$  ng/mL or transferrin saturation  $\geq 20\%$

*MIYABI HD-M had five additional inclusion criteria*

- Patients with ESKD on dialysis (including haemodiafiltration, haemofiltration, haemodialysis and other modalities except for peritoneal dialysis) weekly or more than weekly for  $\geq 12$  weeks before randomisation
- Treated with the same ESA for  $\geq 8$  weeks before screening
- Treated with weekly or biweekly dose of darbepoetin alfa, monthly or biweekly dose of epoetin beta pegol, OR weekly, biweekly, twice or three times per week dose of epoetin alfa/beta, and having had no more than one dose change during the 8 weeks before randomisation
- Mean screening Hb level  $\geq 9.5$  and  $< 12.0$  g/dL before dialysis (based on at least two measurements taken  $\geq 2$  days apart, assessed by the central laboratory; the difference between the lowest level and highest level  $< 1.2$  g/dL), with the last screening Hb level measurement during the 14 days before randomisation
- Ferritin  $\geq 100$  ng/mL or transferrin saturation  $\geq 20\%$  at screening

**Exclusion criteria***All three trials had the following exclusion criteria*

- Any current condition leading to significant blood loss
- Active haemolysis or diagnosis of haemolytic syndrome
- Previous or concurrent myelodysplastic syndrome, multiple myeloma, marrow fibrosis or PRCA
- Previous or concurrent haemosiderosis or haemochromatosis

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- Previous or concurrent hereditary haemoglobinopathies (eg, sickle-cell disease, beta thalassaemia, thalassaemia major)
  - Previous or concurrent aplastic anaemia
  - Previous or concurrent chronic lymphoproliferative diseases
  - Proliferative choroidal or retinal disease, such as neovascular age-related macular degeneration or proliferative diabetic retinopathy requiring invasive treatment (eg, intraocular injections or laser photocoagulation) at screening
  - Chronic inflammatory disease, such as rheumatoid arthritis, systemic lupus erythematosus, ankylosing spondylitis, psoriatic arthritis or inflammatory bowel disease, which is determined to be the principal cause of the anaemia
  - Known hypersensitivity to the study drugs (active substances or excipients of the preparations)
  - Uncontrolled and symptomatic hyperparathyroidism
  - Uncontrolled active infection at study drug assignment
  - Previous or concurrent cancer except cervical carcinoma *in situ*, treated basal cell carcinoma, superficial bladder tumours (Ta, Tis and T1) or any cancer curatively treated >3 years before study drug assignment
  - Previous or scheduled organ transplantation (being on a transplant waiting list does not exclude a patient)
  - History of alcohol or drug abuse during the 2 years before study drug assignment
  - RBC-containing transfusion for treatment of anaemia during the 8 weeks before study drug assignment
  - Treatment with uridine-diphosphate-glucuronosyltransferase 1 family, polypeptide A1 inhibitors during the 7 days before study drug assignment:
    - antiretroviral drugs (eg, ritonavir, saquinavir, atazanavir, indinavir, lopinavir, nelfinavir)
    - tyrosine kinase inhibitors (eg, erlotinib, pazopanib, nilotinib, sorafenib, regorafenib)
    - tranilast
  - Patients treated with immune- or myelosuppressive therapy during the 8 weeks before study drug assignment (eg, everolimus, sirolimus, rituximab, azathioprine, mycophenolate mofetil, mycophenolic acid, cyclosporine, methotrexate, tacrolimus, chemotherapeutic agents and other anticancer agents, and systemic steroids treatment [except inhaled steroids] for 7 days or more)
  - Treated with the following therapies during the 8 weeks before study drug assignment: anabolic hormone, testosterone enanthate or mepitiostane
  - History of cardiovascular or cerebrovascular events (eg, unstable angina, myocardial infarction, stroke, pulmonary thromboembolism and ALI) during the 6 months before study drug assignment
  - Sustained, poorly controlled arterial hypertension (defined as systolic BP  $\geq 180$ mmHg or diastolic BP  $\geq 110$ mmHg) or hypotension (defined as
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systolic BP <90mmHg) at study drug assignment

- NYHA class III or IV congestive heart failure
- Severe hepatic disorder (defined as ALT or AST >3 x the upper limit of normal, total bilirubin >2 mg/dL, or Child-Pugh B or C) at screening
- Previous use of molidustat
- A patient in need of surgery that may be expected to lead to significant blood loss
- Expected need for rescue treatment during the next 7 days after study drug assignment
- Active hepatitis, as assessed by the investigator
- Any medical condition that in the opinion of the investigator may pose a safety risk to a patient in this study, may confound safety or efficacy assessment or may interfere with study participation
- Previous assignment to study treatment during this study
- Previous (during the 30 days before study drug assignment) or concomitant participation in another clinical study with investigational medicinal product(s)
- Close affiliation with the investigational site, for example, a close relative of the investigator, dependent person (eg, employee or student at the investigational site)
- Pregnant or breastfeeding women

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*MIYABI PD had two additional exclusion criteria*

- Previous or concurrent indications for removal of peritoneal dialysis catheter (eg, recurrent peritoneum inflammation, refractory tunnel infection)
- Concomitant use of maintenance dialysis (eg, haemodialysis, haemodiafiltration) other than peritoneal dialysis

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ALI, acute limb ischaemia; ALT, alanine aminotransferase; AST, aspartate aminotransferase; BP, blood pressure; ESA, erythropoiesis-stimulating agent; ESKD, end-stage kidney disease; FSH, follicle-stimulating hormone; Hb, haemoglobin; HIF-PH, hypoxia-inducible factor-1; HIF-1, hypoxia-inducible factor-1; IV, intravenous; LLN, lower limit of normal; NYHA, New York Heart Association; PRCA, pure red cell aplasia; RBC, red blood cell; SC, subcutaneous.

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**Supplementary table 2** Dose titration for molidustat at week 4 for all patients in the MIYABI HD-C trial\* and for patients not treated with ESA at study drug assignment in the MIYABI PD trial

Rise in Hb in the first 4 weeks (g/dL)	Hb level (g/dL) in MIYABI HD-C	Hb level (g/dL) in MIYABI PD	Titration step
<0.5	<9.5	<10.5	Increase to the next higher dose
	≥9.5	≥10.5	
≥0.5 and <1.0	Any value	Any value	Maintain the same dose
≥1.0 and ≤2.0	≤10.0	≤11.0	
>2.0	>10.0	>11.0	Decrease to the next lower dose
	Any value	Any value	

\*All patients in MIYABI HD-C will not be treated with ESAs at study drug assignment or during the trial.

ESA, erythropoiesis-stimulating agent; Hb, haemoglobin.

## Confidential

**Supplementary table 3** Dose titration from week 8 in MIYABI HD-C, from week 4 or 8 in MIYABI PD\*, and from week 2 or 4 in MIYABI HD-M†

Hb level (g/dL) in MIYABI HD-C and MIYABI HD-M	Hb level (g/dL) in MIYABI PD	Titration step
<10.0	<11.0	Increase to the next higher dose
≥10.0 and <12.0	≥11.0 and <12.5	Maintain the same dose
≥12.0 and <13.0	≥12.5 and <13.0	Decrease to the next dose
≥13.0	≥13.0	Suspend a dose until the next scheduled visit

\*In MIYABI PD, patients treated with ESAs at study drug assignment will start this dose-titration schedule for molidustat at week 4, whereas patients not treated with ESAs at study drug assignment will start this dose titration schedule for molidustat at week 8.

†In MIYABI HD-M, doses of darbepoetin alfa or darbepoetin alfa placebo will be titrated from week 2, whereas doses of molidustat will be titrated from week 4.

ESA, erythropoiesis-stimulating agent; Hb, haemoglobin.