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**Protocol Title: "Multicenter study on the efficacy and tolerability of tocilizumab in the treatment of patients with COVID-19 pneumonia"**

**Protocol Number: 1**

**Amendment Number: [amendment number]**

**Investigational Compound: tocilizumab**

**Short Title: Tocilizumab in COVID-19 pneumonia**

**Promoter Name and Legal Registered Address:** Istituto Nazionale Tumori, IRCCS, Fondazione G. Pascale – Via M. Semmola 80131 Napoli

**Scientific Committee**

Francesco Perrone<sup>1</sup> - Principal Investigator

Paolo Ascierto<sup>1</sup> - Co-Principal Investigator

Anna Maria Marata<sup>2</sup> - Co-Principal Investigator

Roberto Parrella<sup>3</sup> - Co-Principal Investigator

Patrizia Popoli<sup>4</sup> - Co-Principal Investigator

Carlo Salvarani<sup>5-6</sup> - Co-Principal Investigator

Maria Carmela Piccirillo<sup>1</sup> – Coordinating Physician

Luigi Atripaldi<sup>3</sup>, Marco Cascella<sup>1</sup>, Massimo Costantini<sup>5</sup>, Giovanni Dolci<sup>5-6</sup>, Nicola Facciolongo<sup>6</sup>, Fiorentino Fraganza<sup>3</sup>, Marco Massari<sup>5</sup>, Vincenzo Montesarchio<sup>3</sup>, Cristina Mussini<sup>5</sup>, Emanuele Alberto Negri<sup>6</sup>

<sup>1</sup> Istituto Nazionale Tumori, IRCCS, Fondazione G. Pascale, Napoli

<sup>2</sup> Regione Emilia Romagna e CTS AIFA

<sup>3</sup> AORN Ospedali dei Colli – Monaldi - Cotugno - CTO, Napoli

<sup>4</sup> Istituto Superiore di Sanità e CTS AIFA

<sup>5</sup> Università degli Studi di Modena e Reggio Emilia

<sup>6</sup> Azienda USL-IRCCS di Reggio Emilia

**Approval Date: Enter Approval Date**

**PROTOCOL AUTHORIZATION PAGE**

I have read this study protocol and agree that it contains all the information required to conduct the study. I agree to conduct the study as set out in this protocol. In particular, I agree to adhere to the moral, ethical and scientific principles governing clinical research as set out in the Declaration of Helsinki, the guidelines on Good Clinical Practice and the appropriate national laws.

**Local Investigator**

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Date

**Trial Promoter Coordinating Centre**

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Date

## Protocol Amendment Summary of Changes Table

<Start of common text>

DOCUMENT HISTORY	
Document	Date
[Amendment X]	[Day-Mon-Year]
[Amendment X]	[Day-Mon-Year]
[Amendment X]	[Day-Mon-Year]
Original Protocol	[Day-Mon-Year]

### Amendment [X] (Day-Month-Year)

#### Overall Rationale for the Amendment:

Section # and Name	Description of Change	Brief Rationale
[INSERT]	[INSERT]	[INSERT]
[INSERT]	[INSERT]	[INSERT]
[INSERT]	[INSERT]	[INSERT]

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## 1. Synopsis

**Protocol Title: " Multicenter study on the efficacy and tolerability of tocilizumab in the treatment of patients with COVID-19 pneumonia "**

**Short Title: Tocilizumab in COVID-19 pneumonia**

### Rationale

Pneumonia is the most frequent and serious complication of COVID-19, a disease that results from SARS-CoV-2 infection. In particular, SARS-CoV-2 infection induces an excessive and aberrant host immune response that is associated with an acute respiratory distress syndrome, with typical radiological findings and, in most critical patients, with a so-called "cytokine storm", characterized by the plasma increase of many cytokines that produce long-term damage and fibrosis of lung tissue.

Interleukin 6 (IL-6) is a pleiotropic proinflammatory multifunctional cytokine produced by a variety of cell types. IL-6 is involved in various physiological processes such as activation of T-cells, induction of acute phase proteins, stimulation of growth and differentiation of hematopoietic precursor cells, hepatic, cutaneous and neural cell proliferation, metabolism bone, lipid metabolism, and tissue fibrosis. Elevated tissue and serum levels of IL-6 are implicated in the pathogenesis of various inflammatory and autoimmune disorders including many forms of rheumatic diseases; they are also implicated in the cytokine release syndrome (CRS). Tocilizumab is a recombinant humanized monoclonal antibody, of the IgG1 class, directed against both the soluble IL-6 receptor (sIL-6R) and the receptor bound to the membrane (mIL-6R).

Tocilizumab is indicated for the treatment of severe rheumatoid arthritis, systemic juvenile idiopathic arthritis, juvenile idiopathic polyarthritis and for the treatment of the severe or life-threatening cytokine release syndrome (CRS) induced by the chimeric antigen receptor T-cell (CAR-T) in adults and pediatric patients 2 years of age or older. In an experience disclosed by Chinese researchers (Xiaoling Xu<sup>1</sup>, Mingfeng Han, Tiantian Li et al. Effective Treatment of Severe COVID-19 Patients with Tocilizumab. ChinaXiv: 202003.00026v1) 21 patients with severe or critical COVID-19 pneumonia were treated with tocilizumab 400 mg iv (i.e. the expected dose for the treatment of CRS) with reduction of oxygen requirement (15/20), resolution of CT lesions (19/21), normalization of lymphocyte count (10/19), reduction of C-reactive protein levels (16/19), hospital discharge (19/21) with an average hospitalization duration of 13.5 days. These results are considered by the Chinese authors to be very positive and led to the design of a randomized trial (tocilizumab vs control) which will include approximately 190 patients and is expected to reach the planned accrual by mid-May 2020.

## Objectives and Endpoints

Objectives	Endpoints
<b>Primary</b>	
<ul style="list-style-type: none"> <li>• To evaluate the efficacy of tocilizumab by describing:               <ul style="list-style-type: none"> <li>○ Mortality rate one month after registration</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Mortality rate one month after registration</li> </ul>
<b>Secondary</b>	
<ul style="list-style-type: none"> <li>• To describe:               <ul style="list-style-type: none"> <li>○ Whether IL-6 and CRP levels (at baseline and during treatment) are predictive of treatment efficacy</li> <li>○ Trend of the PaO<sub>2</sub>/FiO<sub>2</sub> ratio</li> <li>○ Trend of lymphocyte count</li> <li>○ Change of the “Sequential Organ Failure Assessment” (SOFA)</li> <li>○ Remission of respiratory symptoms in terms of :                   <ul style="list-style-type: none"> <li>▪ time to invasive mechanical ventilation (if not previously initiated)</li> <li>▪ time to definitive extubation (if previously intubated)</li> <li>▪ time to independence from non-invasive mechanical ventilation</li> <li>▪ time to independence from oxygen therapy</li> </ul> </li> <li>○ Duration of hospitalization</li> <li>○ Radiological response</li> </ul> </li> <li>• To describe the toxicity of tocilizumab</li> </ul>	<ul style="list-style-type: none"> <li>• IL-6 levels</li> <li>• CRP levels</li> <li>• PaO<sub>2</sub>/FiO<sub>2</sub> ratio</li> <li>• Lymphocyte count</li> <li>• SOFA score</li> <li>• date of intubation (if not previously intubated)</li> <li>• date of definitive extubation (if previously intubated)</li> <li>• date of independence from non-invasive mechanical ventilation</li> <li>• date of independence from oxygen therapy</li> <li>• Days of hospitalization</li> <li>• Radiological response</li> <li>• Rate of adverse events codified by Common Terminology Criteria for Adverse Events (CTCAE) v. 5.0</li> </ul>

## **Overall Design**

This study project includes a single-arm phase 2 study and a parallel observational cohort study, enrolling patients with COVID-19 pneumonia.

### **Phase 2 study**

This is a multicenter, single-arm, open-label, phase 2 study. All the patients enrolled are treated with tocilizumab. One-month mortality rate is the primary endpoint. From available data, it can be assumed that 1-month mortality for the population defined by the selection criteria is around 15% ( $P_0$ ). To verify the hypothesis that the experimental drug may produce a halving of the mortality rate (from 15% to 7.5%,  $P_1$ ), 330 patients are needed with a 99% power and a 5% bilateral alpha error.

### **Observational cohort study**

This prospective/retrospective observational cohort will include patients who are not eligible for the phase 2 study because:

- (a) emergency conditions or infrastructural or operational limits prevented registration before the administration of the experimental drug or
- (b) they had been intubated more than 24 hours before registration.

The same information planned for the phase 2 cohort is in principle required also for the observational cohort study. The sample size of the observational study is not defined a priori and the cohort will close at the end of the overall project. All the patients enrolled are treated with tocilizumab.

### **Treatment and Duration**

In both study groups (phase 2 and observational study), participants will receive one dose of Tocilizumab 8 mg/kg (up to a maximum of 800mg per dose). A second administration (same dose) can be given after 12 hours if respiratory function has not recovered, at discretion of the Investigator.



## 2. Schedule of assessments

Procedure	Baseline before first tocilizumab administration (possibly no more than 1 day before)	Treatment and hospitalization period		Discharge	Follow-up On day 30
		Before the eventual second administration of tocilizumab	Every day while hospitalized		
Informed consent	X				
Inclusion and exclusion criteria	X				
Demography	X				
Full physical examination including height and weight	X				
Medical history (includes past and current medical conditions, and substance usage)	X				
Arterial Blood Gas (ABG) Analysis <sup>1</sup>	X	X	X	X	
Respiratory assistance assessment	X	X	X	X	
Laboratory assessments <sup>2</sup>	X	X	X	X	
IL-6 (recommended but not mandatory) and CRP levels	X	X	X	X	
12-lead ECG	X	X	X	X	
Vital signs	X	X	X	X	
SOFA score <sup>3</sup>	X	X	X	X	
Thoracic CT scan or Chest XR <sup>4</sup>	X			X	

Procedure	Baseline before first tocilizumab administration (possibly no more than 1 day before)	Treatment and hospitalization period		Discharge	Follow-up On day 30
		Before the eventual second administration of tocilizumab	Every day while hospitalized		
AE review	X	X	X	X	X
Concomitant medication review	X	X	X	X	
Survival follow-up				X	X

<sup>1</sup>twice in a day

<sup>2</sup>At least blood count, bilirubin, AST, ALT, creatinine, PT, PTT, LDH, D-dimer

<sup>3</sup>SOFA score is calculated considering PaO<sub>2</sub>/FiO<sub>2</sub>, Glasgow coma scale, mean arterial pressure, and bilirubin, platelet and creatinine levels.

<sup>4</sup>Radiological evaluation is optional. If baseline evaluation (CT or XR) is available a re-evaluation is planned on day 7 and subsequently if clinically indicated. Anonymized CT or chest XR report will be uploaded in the web-based case report form.

### **3. Introduction**

Tocilizumab is a recombinant humanized monoclonal antibody, of the IgG1 class, directed against both the soluble IL-6 receptor (sIL-6R) and the receptor bound to the membrane (mIL-6R). Tocilizumab is indicated for the treatment of severe rheumatoid arthritis, systemic juvenile idiopathic arthritis, juvenile idiopathic polyarthritis and for the treatment of the severe or life-threatening cytokine release syndrome (CRS) induced by the chimeric antigen receptor T-cell (CAR-T) in adults and pediatric patients 2 years of age or older.

### **3.1. Background**

#### **3.1.1. SARS-CoV-2 induced Pneumonia**

Pneumonia is the most frequent and serious complication of COVID-19, a disease that results from SARS-CoV-2 infection. In particular, SARS-CoV-2 infection induces an excessive and aberrant host immune response that is associated with an acute respiratory distress syndrome, with typical radiological findings and, in most critical patients, with a so-called "cytokine storm", characterized by the plasma increase of many cytokines that produce long-term damage and fibrosis of lung tissue.

#### **3.1.2. Interleukin 6**

Interleukin 6 (IL-6) is a pleiotropic proinflammatory multifunctional cytokine produced by a variety of cell types. IL-6 is involved in various physiological processes such as activation of T-cells, induction of acute phase proteins, stimulation of growth and differentiation of hematopoietic precursor cells, hepatic, cutaneous and neural cell proliferation, metabolism bone, lipid metabolism, and tissue fibrosis. Elevated tissue and serum levels of IL-6 are implicated in the pathogenesis of various inflammatory and autoimmune disorders including many forms of rheumatic diseases; they are also implicated in the cytokine release syndrome (CRS).

#### **3.1.3. Tocilizumab experience in COVID-19 patients**

In an experience disclosed by Chinese researchers (Xiaoling Xu<sup>1</sup>, Mingfeng Han, Tiantian Li et al. Effective Treatment of Severe COVID-19 Patients with Tocilizumab. ChinaXiv: 202003.00026v1) 21 patients with severe or critical COVID-19 pneumonia were treated with tocilizumab 400 mg iv (i.e. the expected dose for the treatment of CRS) with reduction of oxygen requirement (15/20), resolution of CT lesions (19/21), normalization of lymphocyte count (10/19), reduction of C-reactive protein levels (16/19), hospital discharge (19/21) with an average hospitalization duration of 13.5 days. These results are considered by the Chinese authors to be very positive and raised to the design of a randomized trial (tocilizumab vs control) which will include approximately 190 patients and is expected to reach the planned accrual by mid-May 2020.

### **3.2. Study Rationale**

IL-6 might play a key role in the cytokine storm induced by SARS-CoV-2 and interfering of IL-6 might be a potentially therapeutic strategy for severe and critical COVID-19.

### **3.3. Benefit/Risk Assessment**

Detailed information about the known and expected benefits and risks and reasonably expected adverse events of tocilizumab may be found in the Investigator's Brochure of the drug.

However, most of the available information refer to chronic use of tocilizumab at different doses.

In the Chinese experience of tocilizumab 400 mg iv once in COVID-19 patients no toxic death and no adverse events were reported.

#### 4. Objectives and Endpoints

Objectives	Endpoints
Primary	
<ul style="list-style-type: none"> <li>• To evaluate the efficacy of tocilizumab by describing:               <ul style="list-style-type: none"> <li>○ Mortality rate one month after registration</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Mortality rate one month after registration</li> </ul>
Secondary	
<ul style="list-style-type: none"> <li>• To describe:               <ul style="list-style-type: none"> <li>○ Whether IL-6 and CRP levels (baseline and during treatment) are related to treatment efficacy indicators</li> <li>○ Trend of the PaO<sub>2</sub>/FiO<sub>2</sub> ratio</li> <li>○ Trend of lymphocyte count</li> <li>○ Change of the “Sequential Organ Failure Assessment” (SOFA)</li> <li>○ Remission of respiratory symptoms in terms of :                   <ul style="list-style-type: none"> <li>▪ time to invasive mechanical ventilation (if not previously initiated)</li> <li>▪ time to definitive extubation (if previously intubated)</li> <li>▪ time to independence from non-invasive mechanical ventilation</li> <li>▪ time to independence from oxygen therapy</li> </ul> </li> <li>○ Duration of hospitalization</li> <li>○ Radiological response</li> </ul> </li> <li>• To describe the toxicity of tocilizumab</li> </ul>	<ul style="list-style-type: none"> <li>• IL-6 levels</li> <li>• CRP levels</li> <li>• PaO<sub>2</sub>/FiO<sub>2</sub> ratio</li> <li>• Lymphocyte count</li> <li>• SOFA score</li> <li>• date of intubation (if not previously intubated)</li> <li>• date of definitive extubation (if previously intubated)</li> <li>• date of independence from non-invasive mechanical ventilation</li> <li>• date of independence from oxygen therapy</li> <li>• Days of hospitalization</li> <li>• Radiological response</li> <li>• Rate of adverse events codified by Common Terminology Criteria for Adverse Events (CTCAE) v. 5.0</li> </ul>

## **5. Study Design**

### **5.1. Preamble**

This project is written at the time of the coronavirus pandemic and while in Italy the number of people who get infected or is hospitalized for respiratory complication is dramatically increasing. Therefore, the clinical and operational scenario is extremely variable and it is expected that it will remain so for an unforeseeable time. In addition, very few solid evidence is available on the course of the disease and on the significance of intermediate end-points, before the use of the experimental drug.

Therefore, it is accepted in advance that the present protocol may need repeated amendments to comply with evolving knowledge on the pandemic, the rate of complications, and the therapeutic scenario for patients who develop pneumonia. A high degree of adaptivity is therefore planned, that will be strictly discussed with the Independent Data Monitoring Committee that will be nominated soon after the approval of the protocol.

### **5.2. Overall Design**

At its conception, the study project includes a single-arm phase 2 study and a parallel observational cohort study, enrolling patients with COVID-19 pneumonia.

#### **5.2.1. Phase 2 study**

This is a multicenter, single-arm, open-label, phase 2 study. All the patients enrolled are treated with tocilizumab. One-month mortality rate is the primary endpoint. From available data, it can be assumed that 1-month mortality for the population defined by the selection criteria in absence of the experimental treatment is around 15% ( $P_0$ ). To verify the hypothesis that the experimental drug may produce a halving of the mortality rate (from 15% to 7.5%,  $P_1$ ), 330 patients are needed to verify the hypothesis with a 99% power and a 5% bilateral alpha error.

#### **5.2.2. Observational cohort study**

This prospective/retrospective observational cohort will include patients who are not eligible for the phase 2 study because:

- (a) emergency conditions or infrastructural or operational limits prevented registration before the administration of the experimental drug or
- (b) they had been intubated more than 24 hours before registration.

The same information planned for the phase 2 cohort is in principle required also for the observational cohort study. The sample size of the observational study is not defined a priori and the cohort will close at the end of the overall project. Patients in the observational cohort will be treated with the same tocilizumab dose and schedule as in the phase 2.

### **5.3. End of Study Definition**

A participant is considered to have completed the study if he/she has completed the last scheduled procedure shown in the Schedule of assessments. The end of the study is defined as the date of the last scheduled procedure shown in the Schedule of assessments for the last participant in the trial globally.

## **6. Study Population**

### **6.1. Inclusion Criteria**

Participants are eligible to be included in the study if the following criteria apply:

1. Any gender
2. No age limit
3. Informed consent for participation in the study (consent can be oral if a written consent cannot be expressed. If the subject is incapable of giving an informed consent and an authorized representative is not available without a delay that would, in the opinion of the Investigator, compromise the potential life-saving effect of the treatment this can be administered without consent. Consent to remain in the research should be sought as soon the conditions of the patient will allow it)
4. Virological diagnosis of SARS-CoV-2 infection (real-time PCR)
5. Hospitalized due to clinical/instrumental diagnosis of pneumonia
6. Oxygen saturation at rest in ambient air  $\leq 93\%$  (valid for not intubated patients and for both phase 2 and observational cohort)
7. Intubated less than 24 hours before registration (eligible for phase 2 only – criterium #6 does not apply in this case)
8. Intubated more than 24 hours before registration (eligible for observational cohort only – criterium #6 does not apply in this case)
9. Patients already treated with tocilizumab before registration are eligible for observational cohort only if one criterium among #6, #7, #8 is valid

### **6.2. Exclusion Criteria**

Participants are excluded from the study if any of the following criteria apply:

1. Known hypersensitivity to tocilizumab or its excipients
2. Patient being treated with immunomodulators or anti-rejection drugs
3. Known active infections or other clinical condition that controindicate tocilizumab and cannot be treated or solved according to the judgement of the clinician
4. ALT / AST > 5 times the upper limit of the normality
5. Neutrophils < 500 / mmc
6. Platelets < 50.000 / mmc
7. Bowel diverticulitis or perforation

### 6.3. Observational cohort

Patients who fulfill inclusion/exclusion criteria reported above (paragraphs 6.1 bullets 1 to 6, paragraph 6.2) but (a) have been already treated with the experimental drug before registration due to emergency conditions or infrastructural or operational limits, or (b) have been intubated more than 24 hours before registration are eligible for being registered in the observational cohort.

## 7. Treatments

### 7.1. Treatments Administered

<b>Study Treatment Name:</b>	Tocilizumab
<b>Dosage formulation:</b>	Tocilizumab 20 mg/mL concentrate for solution for infusion
<b>Unit dose strength(s)/Dosage level(s):</b>	Tocilizumab 8 mg/kg (up to a maximum of 800mg per dose). Such dose is the same approved by FDA for the treatment of CRS following CAR-T therapy. A second administration (same dose) can be given after 12 hours if respiratory function has not recovered, at discretion of the Investigator.
<b>Route of Administration</b>	intravenously
<b>Dosing instructions:</b>	Withdraw a volume of sterile, non-pyrogenic sodium chloride 9 mg/mL (0.9%) solution for injection from a 100 mL infusion bag, equal to the volume of tocilizumab concentrate required for the patients dose, under aseptic conditions. The required amount of tocilizumab concentrate (0.4 mL/kg) should be withdrawn from the vial and placed in the 100 mL infusion bag. This should be a final volume of 100 mL.
<b>Packaging and Labeling</b>	Study treatment will be provided in vials. Each will be labeled as required per country requirement of use in clinical practice.
<b>Manufacturer</b>	Roche



## **7.2. Preparation/Handling/Storage/Accountability**

1. The investigator, institution, or the head of the medical institution (where applicable) is responsible for study treatment accountability, reconciliation, and record maintenance (ie, receipt, reconciliation, and final disposition records). Specific forms for drug accountability will be provided by the promoter.
2. The vial must be stored in a refrigerator (2°C–8°C). Do not freeze. Keep the vial(s) in the outer carton in order to protect from light.
3. Parenteral medicinal products should be inspected visually for particulate matter or discoloration prior to administration. Only solutions which are clear to opalescent, colorless to pale yellow and free of visible particles should be diluted
4. Withdraw a volume of sterile, non-pyrogenic sodium chloride 9 mg/mL (0.9%) solution for injection from a 100 mL infusion bag, equal to the volume of tocilizumab concentrate required for the patients dose, under aseptic conditions. The required amount of tocilizumab concentrate (0.4 mL/kg) should be withdrawn from the vial and placed in the 100 mL infusion bag. This should be a final volume of 100mL. To mix the solution, gently invert the infusion bag to avoid foaming.
5. After dilution, the prepared solution for infusion is physically and chemically stable in sodium chloride 9 mg/mL(0.9%) solution for injection at 30°C for 24 hours.
6. From a microbiological point of view, the prepared solution for infusion should be used immediately. If not used immediately, in use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2°C–8°C, unless dilution has taken place in controlled and validated aseptic conditions.

## **7.3. Treatment Compliance**

The effective doses of study drugs received by each participant during the study will be recorded.

## **7.4. Concomitant Therapy**

There is no contraindication to concomitant treatment (including antiviral drugs) that can be defined in advance given the severity of the disease and the availability of very few data on pharmacological interactions of the tocilizumab schedule planned in this study.

In case of suspected or demonstrated concomitant infections that can be successfully treated with antimicrobials in order to make the patient eligible, such treatments are allowed.

However, any medication that the participant is receiving at the time of enrollment or receives during the study will be recorded along with:

- Reason for use
- Dates of administration including start and end dates
- Dosage information including dose and frequency

## **8. Study Assessments and Procedures**

- Screening evaluations must be completed and reviewed to confirm that potential participants meet eligibility criteria. The investigator will maintain a screening log to record details of all participants screened and to confirm eligibility or record reasons for screening failure, as applicable.
- Procedures conducted as part of the participant's routine clinical management (eg, blood count) and obtained before informed consent may be used for screening or baseline purposes provided the procedures met the protocol-specified criteria.

### **8.1. Screening procedures**

- Informed Consent Form
- Demography (age, gender, ethnicity)
- Medical history (previous and current diseases, all medications started within 14 days prior to screening visit)
- Full physical examination including height and weight.
- Arterial Blood Gas (ABG) Analysis twice in a day
- Respiratory assistance assessment
- Laboratory assessments: At least blood count, bilirubin, AST, ALT, creatinine, PT, PTT, LDH, D-dimer
- IL-6 and CRP levels
- 12-lead ECG
- Vital signs (respiratory rate, pulse, blood pressure and temperature) will be obtained as appropriate
- SOFA score is calculated considering PaO<sub>2</sub>/FiO<sub>2</sub>, Glasgow coma scale, mean arterial pressure, and bilirubin, platelet and creatinine levels.
- Thoracic CT scan or Chest XR (if clinically indicated)
- AE review (including SAEs)
- Concomitant medication review

### **8.2. Treatment and procedures during hospitalization period**

- Arterial Blood Gas (ABG) Analysis twice in a day
- Respiratory assistance assessment
- Laboratory assessments: At least blood count, bilirubin, AST, ALT, creatinine, PT, PTT, LDH, D-dimer
- IL-6 and CRP levels
- 12-lead ECG

- Vital signs (respiratory rate, pulse, blood pressure and temperature) will be obtained as appropriate
- SOFA score is calculated considering PaO<sub>2</sub>/FiO<sub>2</sub>, Glasgow coma scale, mean arterial pressure, and bilirubin, platelet and creatinine levels
- Thoracic CT scan or Chest XR (if baseline evaluation (CT or XR) is available a re-evaluation is planned on day 7 and then if clinically indicated)
- Treatment with tocilizumab 8 mg/kg (up to a maximum of 800mg per dose) on day 1. A second administration (same dose) can be given after 12 hours if respiratory function has not recovered, at discretion of the Investigator.
- AE review (including SAEs)
- Concomitant medication review

### **8.3. Procedures before discharge**

- Arterial Blood Gas (ABG) Analysis
- Respiratory assistance assessment
- Laboratory assessments: At least blood count, bilirubin, AST, ALT, creatinine, PT, PTT, LDH, D-dimer
- IL-6 and CRP levels
- 12-lead ECG
- Vital signs (respiratory rate, pulse, blood pressure and temperature) will be obtained as appropriate
- SOFA score is calculated considering PaO<sub>2</sub>/FiO<sub>2</sub>, Glasgow coma scale, mean arterial pressure, and bilirubin, platelet and creatinine levels
- Thoracic CT scan or Chest XR if clinically indicated
- AE review (including SAEs)
- Concomitant medication review

### **8.4. Follow up (30 days) procedures**

- Follow-up information may be collected via telephone calls, patient medical records and/or clinical visits
- AE review (including SAEs)

## 8.5. Efficacy Assessments

### 8.5.1. PaO<sub>2</sub>/FiO<sub>2</sub> ratio

PaO<sub>2</sub>/FiO<sub>2</sub> ratio (or P/F ratio for brevity) represents the ratio between the arterial blood partial pressure of the oxygen (PaO<sub>2</sub>) and the percentage of oxygen supplied (fraction of inspired oxygen, FiO<sub>2</sub>). This parameter is calculated from arterial blood gas analysis and is commonly used for the definition of ARDS. A P/F ratio of 300 to 200, indeed, identifies Mild ARDS, 200 to 100 Moderate ARDS, and a respiratory failure featuring a P/F less than 100 is suggestive for Severe ARDS.

### 8.5.2. Laboratory assessment

Lymphocyte count, C-reactive protein (CRP) are assessed by routinely used determination of blood count and CRP.

IL-6 levels will be assessed using commercial ELISA method.

### 8.5.3. Sequential Organ Failure Assessment (SOFA) score

SOFA is a morbidity severity score and mortality estimation tool designed for evaluating organ dysfunction and morbidity. It evaluates 6 variables, each representing an organ system (one for the respiratory, cardiovascular, hepatic, coagulation, renal and neurological systems), and scored from 0 (normal) to 4 (high degree of dysfunction/failure). Thus, the maximum score may range from 0 to 24. The tool can be used for estimating mortality risk.

## 8.6. Adverse Events

### 8.6.1 Definitions

An **adverse event** (AE) is any untoward medical occurrence in a study participant administered the medicinal products and which does not necessarily have a causal relationship with this treatment. An AE can therefore be any unfavorable and unintended sign (including an abnormal laboratory finding), symptom, or disease temporally associated with the use of a medicinal product, whether or not considered related to the medicinal product.

An **adverse reaction** (AR) is an untoward and unintended response to the investigational medicinal products related to any dose administered, judged by either the investigator or the promoter.

An **unexpected adverse reaction** (UAR) is an adverse reaction, the nature or severity of which is not consistent with the applicable products information (investigator's brochure).

A **Serious Adverse Event** (SAE) is untoward medical occurrence or effect that at any dose results in death, risk of death, permanent disability/incapacity, hospitalisation or prolongation of existing hospitalization or need for urgent medical treatment, or another medically important serious event

as judged by the investigator. Further, any unexpected changes in relation to the toxicity profile of the drugs used of grade  $\geq 3$ , as well as adverse event(s) which, although not falling within this definition, are considered unexpected and serious by the Investigator should be reported.

The causality of SAEs (their relationship to all study treatment/procedures) will be assessed by the investigator(s) and communicated to the coordinating centre.

**A Suspected Unexpected Serious Adverse Reaction (SUSAR)** is an unexpected adverse reaction judged serious by the Investigator and/or Promoter, that is not consistent, either in nature or in severity, with the applicable product information.

**Adverse events of special interest (AESI)**- The following adverse events have been identified as AESI for this study and require prompt reporting to Safety desk for the study immediately and no more 24h of the Investigator becoming aware of the event (expedited reporting), even if the events can be considered non-serious according to the usual regulatory criteria as they may be subject to expedited submission to regulatory authorities:

- Cases of potential drug-induced liver injury (DILI) that include an elevated ALT or AST in combination with either an elevated bilirubin or clinical jaundice, as defined by Hy's law.
- Suspected transmission of an infectious agent by the study drug (STIAMP), defined as any organism, virus, or infectious particle (e.g., prion protein transmitting transmissible spongiform encephalopathy), pathogenic or non-pathogenic, that is considered an infectious agent. A transmission of an infectious agent may be suspected from clinical symptoms or laboratory findings that indicate an infection in a patient exposed to a medicinal product. This term applies only when a contamination of the study drug is suspected.

### 8.6.2. Collection and reporting of adverse events

All adverse events recorded from time of signature of informed consent, throughout the treatment and observation period up to 30 days following registration, have to be reported in the toxicity case report form, graded according to the corresponding CTCAE term (Version 5.0).

The Investigator must immediately report to the promoter all serious adverse events. The report should be made using the SAE report form online or by sending the paper copy by fax (+390817702938) to the coordinating office immediately and not exceeding 24 hours following knowledge of the event. All SAE must be also reported in the toxicity case report form within the corresponding CTCAE term.

During the course of the study all AEs and SAEs should be proactively followed up for each subject. Every effort should be made to obtain a resolution for all events, even if the events continue after discontinuation/study completion. The investigator is responsible for following all SAEs until resolution, until the subject returns to baseline status, or until the condition has stabilized with the expectation that it will remain chronic, even if this extends beyond study participation.

### 8.6.3. Causality assessment between treatment and event

The following criteria will be used for causality assessment:

Term	Description
CERTAIN	A clinical event, including laboratory test abnormality, occurring in a plausible time relationship to drug administration, and which cannot be explained by concurrent disease or other drugs or chemicals.
PROBABLE/ LIKELY	A clinical event, including laboratory test abnormality, with a reasonable time sequence to administration of the drug, unlikely to be attributed to the concurrent disease or other drugs or chemicals.
POSSIBLE	A clinical event, including laboratory test abnormality, with a reasonable time sequence to administration of the drug, but which could also be explained by concurrent disease or other drugs or chemicals.
UNLIKELY	A clinical event, including laboratory test abnormality, with a temporal relationship to drug administration which makes a causal relationship improbable, and in which other drugs, chemicals or underlying disease provide plausible explanations.
NOT RELATED	There is no causal relationship between the treatment and the event
CONDITIONAL/ UNCLASSIFIED	A clinical event, including laboratory test abnormality, reported as an adverse reaction, about which more data is essential for a proper assessment or the additional data are under examination.
UNASSESSIBLE/ UNCLASSIFIABLE	A report suggesting an adverse reaction which cannot be judged because information is insufficient or contradictory, and which cannot be supplemented or verified.

### 8.6.4. Regulatory Reporting Requirements for SAEs

- Prompt notification by the investigator to the promoter of a SAE is essential so that legal obligations and ethical responsibilities towards the safety of participants and the safety of a study treatment under clinical investigation are met.
- The promoter will review all adverse events and issue queries directly to the Investigator reporting the event. The promoter will determine if an event qualifies as a SUSAR.
- The Reference Safety Information (RSI) necessary to classify an adverse reaction as SUSAR, based on the nature and seriousness, including the frequency, is located in the specific section of the Investigator's Brochure of tocilizumab/RoActemra (section 6.4.1 as of the version 21 released in September 2019).
- The promoter has a legal responsibility to notify both the local regulatory authority and other regulatory agencies about the safety of a study treatment under clinical investigation.

The promoter will report all SUSARs to Eudravigilance through the EVCTM, to all participating Investigators, to all Ethical Committees of participating centres, and to the manufacturer (Roche), within the timelines of the article 17 of the European Directive 2001/20/EC.

- Investigator safety reports must be prepared for suspected unexpected serious adverse reactions (SUSAR) and forwarded to investigators as necessary.
- An investigator who receives an investigator safety report describing a SAE or other specific safety information (eg, summary or listing of SAEs) from the promoter will review and then file it along with the Investigator's Brochure.
- The promoter will provide an annual Development Safety Update Report, including all Serious Adverse Events occurring in the Study, to the Regulatory Agency, all participating Investigators, and to the Ethical Committees of participating centres.
- The Investigators are responsible for informing their Ethics Committee of the SAE reported in their centre, as per local requirements.

## **8.7. Safety Assessments**

Planned time points for all safety assessments are provided in the schedule of assessments table.

## **9. Statistical Considerations**

### **9.1. Sample Size Determination**

The study is designed as a single-arm single-stage phase 2 study with 1-month mortality rate as primary endpoint.

Expected 1-month mortality rate ( $P_0$ ): 15%

Auspicated 1-month mortality rate ( $P_1$ ): 7.5%

Statistical power: 99%

Bilateral alpha error: 5%

Sample size needed: 330 patients

### **9.2. Populations for Analyses**

For purposes of analysis, the following populations are defined:

<b>Population</b>	<b>Description</b>
Enrolled	All participants who sign the ICF and are registered
Evaluable	All participants enrolled (Intention-to-treat)
Safety	All participants who take at least 1 dose of study treatment.

### 9.3. Statistical Analyses

The statistical analysis plan will be developed and finalized before database lock and will describe the participant populations to be included in the analyses, and procedures for accounting for missing, unused, and spurious data. This section is a summary of the planned statistical analyses of the primary and secondary endpoints.

Primary and secondary analyses will be stratified by age categories, gender and eventually other clinically relevant factors (comorbidities, smoke habits etc.).

#### 9.3.1. Efficacy Analyses

<b>Endpoint</b>	<b>Statistical Analysis Methods</b>
Primary	<p><b>1-month mortality</b> is defined as the ratio of patients who will be alive after 1 month from study start out of those registered at baseline and will be described with its 95% confidence interval.</p> <p>In addition, since the mortality rate is certainly conditioned by the patient's age, the primary end point will be described separately by age group, and the possibility of comparing it with the mortality reported prior to the introduction of the off-label use of tocilizumab (obtained from the Civil Protection data) will be verified. Mortality estimates may also be standardized with respect to the reference population not affected by the pathology under examination.</p>
Secondary	All the analysis will be descriptive.

#### 9.3.2. Safety Analyses

All safety analyses will be performed on the Safety Population.

<b>Endpoint</b>	<b>Statistical Analysis Methods</b>
Primary	<p><b>Toxicity.</b> For each patient and for each type of toxicity described according to CTCAE, the worst degree ever suffered during treatment will be used for descriptive analysis.</p>



## **10. Ethics, Quality Assurance and Monitoring**

The procedures set out in this study protocol are designed to ensure that the promoter and the Investigators abide by the principles of the Good Clinical Practice guidelines of the International Conference on Harmonization (ICH) and the Declaration of Helsinki in the conduct, evaluation and documentation of this study. The study will be carried out adhering to local legal requirements and the applicable national law, whichever represents the greater protection for the individual.

Study protocol, patient information and informed consent will be submitted to the appropriate Ethical Committee for approval. The promoter will inform the appropriate Ethical Committee about any changes in the study protocol which could interfere with the patient's safety.

The monitoring activities during pandemia will be primarily or exclusively performed without peripheral visits. Remote monitoring will be performed through periodic, comprehensive connections through the web or the telephone with all participating centres by promoter personnel or representatives.

### **10.1. Informed Consent Process**

The physicians treating the hospitalized patient are responsible for information of the patient and obtaining of the Informed Consent.

The consent can be oral if a written consent cannot be expressed. If the subject is incapable of giving an informed consent and an authorized representative is not available without a delay that would, in the opinion of the Investigator, compromise the potential life-saving effect of the treatment this can be administered without consent. Consent to remain in the research should be sought as soon the conditions of the patient will allow it.

The same procedure apply to the information of the patient and providing of consent to the processing of personal data according to the European Regulation n. 679/2016 on the Protection of Personal Data, the Personal Data Protection Code (Legislative Decree 196/03) and subsequent amendments and additions, and to the provisions, guidelines and general authorizations of the National Guarantor for Personal Data Protection.

## **11. Data Monitoring Committee**

An Independent Data Monitoring committee (IDMC) will be nominated to warrant the quality of the study management and analysis. The IDMC will be made of 3 to 5 members, selected among statisticians, trialists and experts in Infectivology and Resuscitation; the IDMC will be nominated after the list of participating Institutions will be definitive, to select among experts not directly involved in the study. An IDMC charter will be produced after the nominations.

The IDMC will be responsible for:

- reviewing activity and safety data through progress reports produced by the promoter and recommending for example modifications in case of unexpected or unexpectedly severe toxicities for study treatment, or in case of preliminary data suggesting inactivity or surprisingly positive efficacy in specific subgroups of patients. These corrections may be modifications of the treatment, the inclusion criteria or conditions for retreatment, or the sample size, or the study procedures or early study termination.
- evaluating the effect on the study of possible changes in scientific evidence, such as results of other studies, and recommending modifications as above on the basis of such external data.

Considering the setting of the present study, which apply to a health emergency situation, progress report will be produced be-weekly and the IDMC will examine all the reports produced, in collaboration with the steering committee and/or within closed meetings, and will suggest possible modifications as described above.

## **12. Data collection procedures**

Patient registration and data collection are centralized at the Clinical Trials Unit of the National Cancer Institute of Naples and are web-based (<http://www.usc-intnapoli.net>).

Data collection is electronic through the above website (<http://www.usc-intnapoli.net>), or by paper CRF transmitted by fax to +39 081-7702938, as soon as possible after completion. For contacts for registration and data collection, see contacts page.

## **13. Administrative aspects**

This is a non-profit investigator initiated trial. In this trial, the experimental drug tocilizumab will be provided at no cost by the manufacturer (Roche).

Study protocol, patient information, and informed consent at beginning and at each required amendment will be submitted to the appropriate Ethical Committee for approval. After the first approval the study will be started at each Italian centre requiring to participate and such participation will be notified together with the approved protocol to the local Institutional Ethical Committee.

Coverage for any damage resulting from the participation of the subjects in the clinical trial is included in the general insurance of the individual participating clinical centers.

## **14. Coordinating centre contacts**

Clinical Trials Unit - National Cancer Institute, IRCCS, G.Pascale Foundation - Naples

Tel: +39 081 - 5903571

Fax: +39 081 - 7702938

<http://www.usc-intnapoli.net>

### **Medical contacts**

Francesco Perrone, MD, PhD

Maria Carmela Piccirillo, MD

Adriano Gravina, MD

Clorinda Schettino, MD

Piera Gargiulo, MD

Claudia Cardone, MD

E-mail: [f.perrone@istitutotumori.na.it](mailto:f.perrone@istitutotumori.na.it) ; [m.piccirillo@istitutotumori.na.it](mailto:m.piccirillo@istitutotumori.na.it) ;

[a.gravina@istitutotumori.na.it](mailto:a.gravina@istitutotumori.na.it) ; [c.schettino@istitutotumori.na.it](mailto:c.schettino@istitutotumori.na.it) ;

[piera.gargiulo@istitutotumori.na.it](mailto:piera.gargiulo@istitutotumori.na.it) ; [cardone.cla@gmail.com](mailto:cardone.cla@gmail.com)

### **Registration and data collection and management**

Manuela Florio, Valentina Barbato, Giovanni de Matteis, Fiorella Romano, Simona Bevilacqua, Anna Gimigliano

e-mail: [usc-datamanager@istitutotumori.na.it](mailto:usc-datamanager@istitutotumori.na.it)

### **Regulatory and authorization issues**

Giuliana Canzanella, Marilena Martino, Teresa Ribecco

e-mail: [usc-segreteria@istitutotumori.na.it](mailto:usc-segreteria@istitutotumori.na.it)

### **Pharmacovigilance**

Antonia Del Giudice

e-mail: [usc-farmacovigilanza@istitutotumori.na.it](mailto:usc-farmacovigilanza@istitutotumori.na.it); [a.delgiudice@istitutotumori.na.it](mailto:a.delgiudice@istitutotumori.na.it)

**Database and reporting**

Alfonso Savio, Laura Arenare

e-mail: [a.savio@istitutotumori.na.it](mailto:a.savio@istitutotumori.na.it); [l.arenare@istitutotumori.na.it](mailto:l.arenare@istitutotumori.na.it)

**Monitoring activities**

Gianfranco De Feo, Marcello Curvietto

Scientific Direction, National Cancer Institute Naples

e-mail: [g.defeo@istitutotumori.na.it](mailto:g.defeo@istitutotumori.na.it); [m.curvietto@istitutotumori.na.it](mailto:m.curvietto@istitutotumori.na.it)

## 15. References

- 1) Hui DSC, Zumla A. Severe acute respiratory syndrome: historical, epidemiologic, and clinical features. *Infect Dis Clin North Am* 2019; 33: 869–89.
- 2) Azhar EI, Hui DSC, Memish ZA, Drosten C, Zumla A. The Middle East respiratory syndrome (MERS). *Infect Dis Clin North Am* 2019; 33: 891–905.
- 3) Huang C, Wang Y, Li X. Clinical features of patients infected with 2019 coronavirus in Wuhan, China. *Lancet* 2020; published online Jan 24. [https://doi.org/10.1016/S0140-6736\(20\)30183-5](https://doi.org/10.1016/S0140-6736(20)30183-5).
- 4) Guan WJ, Ni ZY, Hu Y, et al. China Medical Treatment Expert Group for Covid-19 Clinical Characteristics of Coronavirus Disease 2019 in China. *N Engl J Med*. 2020 Feb 28. doi: 10.1056/NEJMoa2002032. [Epub ahead of print]
- 5) Li G, Fan Y, Lai Y, et al. Coronavirus infections and immune responses. *J Med Virol* 2020; published online Jan 25. DOI:10.1002/jmv.25685.
- 6) Channappanavar R, Perlman S. Pathogenic human coronavirus infections: causes and consequences of cytokine storm and immunopathology. *Semin Immunopathol* 2017; 39: 529–39.
- 7) Batawi S, Tarazan N, Al-Raddadi R, et al. Quality of life reported by survivors after hospitalization for Middle East respiratory syndrome (MERS). *Health Qual Life Outcomes* 2019; 17: 101.
- 8) Ngai JC, Ko FW, Ng SS, To KW, Tong M, Hui DS. The long-term impact of severe acute respiratory syndrome on pulmonary function, exercise capacity and health status. *Respirology* 2010; 15: 543–50.
- 9) Schirmer M, Muratore F, Salvarani C. Tocilizumab for the treatment of giant cell arteritis. *Expert Rev Clin Immunol*. 2018 May;14(5):339-349.
- 10) Stone JH, Tuckwell K, Dimonaco S, Klearman M, Aringer M, Blockmans D, Brouwer E, Cid MC, Dasgupta B, Rech J, Salvarani C, Schett G, Schulze-Koops H, Spiera R, Unizony SH, Collinson N. Trial of Tocilizumab in Giant-Cell Arteritis. *N Engl J Med*. 2017; 377:317-328.
- 11) Manfredi A, Cassone G, Furini F, Gremese E, Venerito V, Atzeni F, Arrigoni E, Della Casa G, Cerri S, Govoni M, Petricca L, Iannone F, Salvarani C, Sebastiani M. Tocilizumab therapy in rheumatoid arthritis with interstitial lung disease: a multicenter retrospective study. *Intern Med J*. 2019 Oct 29. doi:10.1111/imj.14670.
- 12) Ibrahim YF, Moussa RA, Bayoumi AMA, Ahmed AF. Tocilizumab attenuates acute lung and kidney injuries and improves survival in a rat model of sepsis via down-regulation of NF- $\kappa$ B/JNK: a possible role of P-glycoprotein. *Inflammopharmacology*. 2020 Feb;28(1):215-230. doi: 10.1007/s10787-019-00628-y. Epub 2019 Aug 22.
- 13) Ferreira FL, Bota DP, Bross A, Mélot C, Vincent JL. Serial evaluation of the SOFA score to predict outcome in critically ill patients. *JAMA* 2001; 286: 1754–8.