



**ANTI-CD3 MAB (TEPLIZUMAB) FOR PREVENTION OF
DIABETES IN RELATIVES AT-RISK FOR TYPE 1
DIABETES MELLITUS**

(Protocol TN-10)

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PREFACE

The TrialNet Type 1 Diabetes Protocol TN-10, Anti-CD3 (teplizumab) for Prevention of Diabetes in Relatives at risk for Type 1 Diabetes Mellitus (T1DM), describes the background, design, and organization of the study. The protocol will be maintained by the TrialNet Coordinating Center (TNCC) over the course of the study through new releases of the entire protocol, or issuance of updates either in the form of revisions of complete chapters or pages thereof, or in the form of supplemental protocol memoranda.

Abbreviations

ADA	American Diabetes Association
AE	Adverse event
ALT	Alanine aminotransferase
AST	Aspartate aminotransferase
AUC	Area under the curve
CBC	Complete blood count
CFR	Code of Federal Regulations
CMV	Cytomegalovirus
CRF	Case report form
DCCT	Diabetes Control and Complications Trial
DPT-1	Diabetes Prevention Trial of Type I Diabetes
DSMB	Data and Safety Monitoring Board
EBV	Epstein-Barr virus
FDA	US Food and Drug Administration
GAD	Glutamate decarboxylase
GCP	Good clinical practice
HbA_{1c}	Hemoglobin A1C
HIV	Human immunodeficiency virus
ICH	International Conference on Harmonisation
IRB	Institutional Review Board
ITN	Immune Tolerance Network
NCI-CTCAE	National Cancer Institute <i>Common Terminology Criteria for Adverse Events</i>
PE	Physical exam
PPD	Purified protein derivative test
SAE	Serious adverse event
T1DM	Type 1 diabetes mellitus
TNCC	TrialNet Coordinating Center

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1. INTRODUCTION

1.1. Study Overview

Title	Anti-CD3 mAb (teplizumab) for prevention of diabetes in relatives at-risk for Type 1 diabetes mellitus
IND Sponsor	MacroGenics, Inc. Under IND 102,629
Study Supported by	National Institute of Diabetes, Digestive and Kidney Diseases
Conducted By	Type 1 Diabetes Trial Network (TrialNet)
Protocol Chair	Dr. Kevan Herold, Yale University
Accrual Objective	The study plans to enroll approximately 71 subjects over 6 years. The study is projected to last between 6-10 years, depending upon rate of enrollment and number of subjects who develop diabetes.
Study Design	The study is a 2-arm, multicenter, randomized, placebo controlled masked clinical trial. All subjects will receive close monitoring for development of T1DM.
Treatment Description	Subjects will receive teplizumab + close monitoring for development of T1DM or placebo + close monitoring for development of T1DM.
Objective	To assess the safety, efficacy, and mode of action of teplizumab for prevention of T1DM.
Primary Outcome	The primary objective is to determine whether intervention with teplizumab will prevent or delay the development of T1DM in high risk autoantibody positive non-diabetic relatives of patients with T1DM.
Secondary Outcome	Secondary outcomes are to include analyses of C-peptide and other measures from the OGTT; safety and tolerability; and mechanistic outcomes.
Major Inclusion Criteria	Autoantibody positive relatives of T1DM proband with abnormal glucose tolerance. Age 1-45 years at the time of enrollment in TN01 and age \geq 8 at time of randomization in this trial.

1.2. Statement of Purpose

This protocol describes the background, design, and organization of study of the anti-CD3 monoclonal antibody, teplizumab [hOKT3 γ 1(Ala-Ala)] for prevention of diabetes in relatives at very high risk for T1DM. The protocol was written by Dr. Kevan Herold, Chair of the TrialNet Anti-CD3 Protocol Committee, the TrialNet Chairman's Office at the University of Miami and the Benaroya Research Institute, and the TNCC. Significant changes that occur to this protocol during the course of the trial require the formal approval of the TrialNet Steering Committee. The study protocol, along with the required informed consent forms, will be approved by each participating institution's Institutional Review Board (IRB) or Ethics Committee/Research Ethics Board (EC/REB).

2. BACKGROUND AND SIGNIFICANCE

2.1. Type 1 Diabetes (T1DM)

2.1.1. Definition and metabolic characteristics of Type 1 diabetes mellitus

Type 1 diabetes mellitus (T1DM) is an immune-mediated disease in which insulin-producing beta cells are completely or near completely destroyed, resulting in life-long dependence on exogenous insulin. It is a chronic and potentially disabling disease that represents a major public health and clinical concern. The number of patients being diagnosed with type 1 diabetes is increasing each year and is approaching an epidemic level in some countries that track this information (1; 2).

Compared to individuals with the more common form of diabetes, Type 2 diabetes, (where individuals retain some endogenous insulin production which is inadequate to maintain normal glucose and lipid metabolism), the metabolic impairment in T1DM is much more severe and the loss of insulin production more complete. Continuous exogenous insulin therapy is needed to prevent ketoacidosis and allow assimilation of food and to maintain life. Most likely as a consequence of the absolute deficiency of insulin, glucose counterregulation (i.e. the hormonal response to insulin induced hypoglycemia) is impaired, and therefore, hypoglycemia is a frequent complication of the disease. The occurrence of hypoglycemia limits the ability to achieve near normal glucose control. The Diabetes Control and Complications study (DCCT) showed that the long term complications could be reduced with near normal control of glucose levels but at the cost of an increased frequency of severe hypoglycemia (3). While there have been significant improvements in insulin delivery systems, such as continuous subcutaneous insulin infusions with insulin pumps, normal glucose control, particularly in children, is rarely achieved. Therefore, individuals with Type 1 diabetes remain at risk for secondary end-organ complications including visual impairment and blindness, renal failure, vascular disease and limb amputation, peripheral neuropathy, stroke, acute risk for severe hypoglycemia, and others. Moreover, at the time of diagnosis, many individuals, and children in particular, suffer significant morbidity frequently requiring ICU admission. As described below, virtually all the individuals identified for enrollment into this prevention trial will develop diabetes. Clearly, prevention of the onset of the disease itself would represent a significant advancement.

2.1.2. Natural History of Type 1 Diabetes

Much is known about the natural history of the type 1 diabetes disease process (4). Although all people are susceptible, relatives of individuals with T1DM are at much greater risk for development of the disease. In the general population, approximately 0.3 % of individuals will develop T1DM. In contrast, those with a relative with T1DM have a 5% incidence of disease – a 15 fold increase (5). Further risk stratification among family members depends upon genetic, immune and metabolic data (6).

Beta cell destruction generally begins in genetically susceptible individuals years before clinical onset(7). The autoimmune process that causes beta cell destruction is clinically silent and can only be identified by the detection of autoantibodies such as Islet Cell Antibodies (ICA), anti-glutamic acid decarboxylase (GAD)65ab, anti-ICA512ab, anti-insulin autoantibodies (mIAA) (5), and the recently described antibodies to a zinc transporter (ZnT8) (8). Continued immune mediated beta cell

destruction occurs until physiologic insulin demand cannot be met by the remaining beta cells, resulting in hyperglycemia and clinical diagnosis of T1DM (9)(10).

Based on data from the Diabetes Prevention Trial, type 1 diabetes (DPT-1), the risk for developing diabetes in relatives without the disease can be defined by the presence of autoantibodies and the degree of metabolic impairment (11-13). The DPT-1 study was one of the first large-scale prevention trials of T1DM. The aim of this trial, which tested >100,000 relatives of individuals with T1DM, was to study whether either low dose parenteral insulin or oral insulin administration would prevent the development of T1DM. The results of the DPT-1 study showed that neither parenteral nor oral insulin prevented the development of T1DM, (although a secondary analysis of the data suggested some effect of oral insulin in delaying the onset of diabetes in a subgroup of subjects defined by high anti-insulin antibodies and normal glucose tolerance)(13).

Autoantibody positive subjects enrolled in the DPT-1 study who had impaired or indeterminate glucose tolerance (any glucose level after ingestion of oral glucose of > 200 mg/dL and/or a glucose level 2 hours after ingestion of oral glucose of 140-200 mg/dL and/or fasting glucose between 110 – 126 mg/dL during a standard oral glucose tolerance test were at very high risk (78% over 5 years) of developing T1DM over a 5 – 6 year follow up. The risk was particularly high for individuals under the age of 18 (Figure 1).

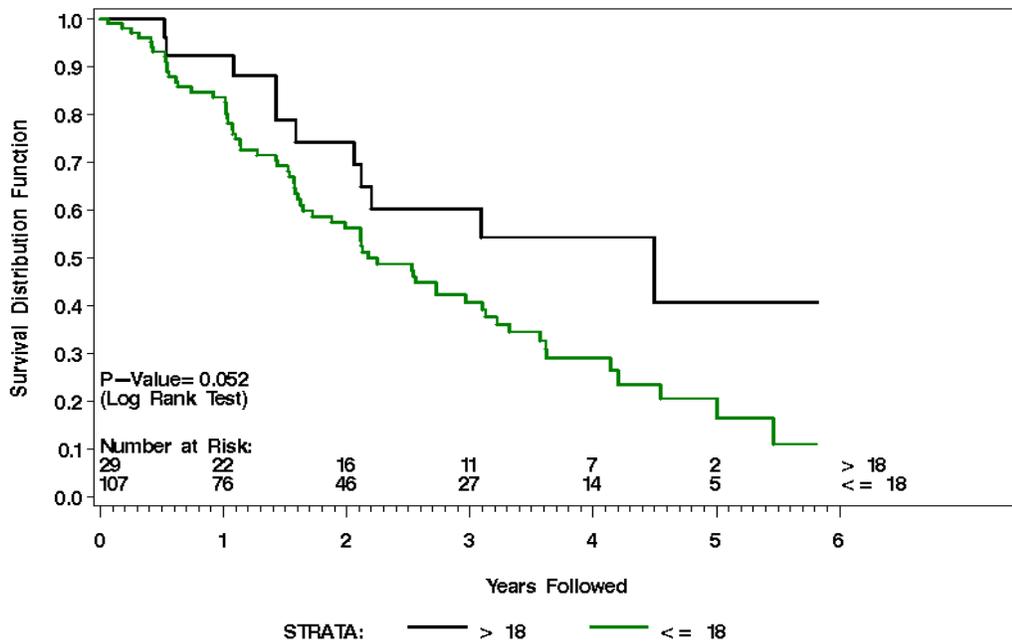


Figure 1: Risk of diabetes among individuals recruited for the DPT-1 study with abnormal glucose tolerance, stratified by age ≤ 18 or ≥ 18 yrs.

Similar results confirming the very high risk of those with abnormal glucose were found in the ENDIT (European Nicotinamide Diabetes Intervention Trial) study in which Nicotinamide failed to prevent the onset of diabetes in relatives at risk for the disease (14).

It is important to note that the diagnosis of diabetes is based on a glucose threshold that is associated with risk of secondary endorgan complications of the disease rather than the pathologic process that leads to hyperglycemia. Detailed analyses of metabolic function in individuals who do and do not progress to diabetes in the DPT-1 study have been published (10; 15; 16). These studies have identified the progressive loss of stimulated C-peptide responses to a mixed meal over time in high risk individuals. The differences between the responses in the prediabetic period and after the diagnosis of diabetes are modest but statistically significant. These studies describe a progressive predictable loss of beta cell function rather than a precipitous change. In addition, they also suggest that once metabolic impairment has occurred, the risk is extremely high. These combined immunologic and metabolic studies suggest to us that those individuals differ from those in whom the diagnosis of T1DM has been made only in the time of progression.

There have been no therapies tested to date which are aimed only at those at very high risk for development of T1DM (~80% as described above). The previous DPT-1 and ENDIT studies enrolled subjects with a broad range of risk – the overall 5-year risk in the target population was between 50-60%. However, in newly diagnosed subjects, there is reason to believe that individuals with more beta cell function may show a better response to interventions. Earlier studies with Cyclosporine A suggested that response to immune therapies is greatest in those with higher levels of insulin secretion at the time of diagnosis of T1DM (17). In a recently published study of another non-FcR binding anti-CD3 mAb, Keymeulen et al found that clinical responses to drug were greatest in those in the upper half of C-peptide responses at the time of study entry (18).

Therefore, the rationale for this study is that individuals with immunologic markers of T1DM and abnormal glucose tolerance are at very high risk for progression to overt disease. They have a condition that differs from overt diabetes only in the duration of the autoimmune process that results in beta cell destruction. Intervention at the “prediabetic” stage is likely to be more effective than intervention in those in whom frank hyperglycemia has developed and beta cell function has deteriorated further because insulin production is greater before compared to after the diagnosis.

2.2. Development of Teplizumab

The Fc-engineered teplizumab [hOKT3 γ 1 (Ala-Ala)] was developed as an approach to mitigate the adverse effects of OKT $^{\text{®}}$ 3 resulting from Fc/FcR engagement (19). OKT $^{\text{®}}$ 3 produces profound, transient T-cell depletion in vivo. It also activates T cells, is strongly mitogenic, and its use in vivo is associated with severe cytokine-release syndrome (incidence >90%). The cytokine-release syndrome induced by OKT $^{\text{®}}$ 3 is characterized by fever, chills, nausea, vomiting and other symptoms, and usually requires corticosteroid therapy to suppress. OKT $^{\text{®}}$ 3 also is associated with a small incidence of EBV lymphomas (~1%-2%). T-cell activation is strongly facilitated by the interaction of Fc component of OKT $^{\text{®}}$ 3 with Fc receptors on lymphocytes (Fc/FcR engagement).

Teplizumab is a 150-KD humanized mAb that binds the CD3-e epitope of the T cell receptor (TCR) complex with affinity equal to OKT $^{\text{®}}$ 3, but it differs from OKT $^{\text{®}}$ 3 in two properties:

1. The humanization process has resulted in the generation of a mAb that used less than 10% of the original murine amino acids in the antibody construction. The clinical consequence of this property is reduced immunogenicity or formation of anti-idiotypic antibodies.
2. Two amino acids have been changed (leucine₂₃₄ to an alanine and leucine₂₃₅ to an alanine) in the Fc portion of the immunoglobulin that disrupt Fc receptor and complement component C1q

binding. These two amino acid changes were aimed at eliminating the majority of cytokine-mediated toxicity observed during infusions of OKT[®]3.

The modified Fc component of teplizumab minimizes the activating capacity of the antibody compared with unmodified murine OKT[®]3. Although the primary mechanism of action of the antibody involves binding the CD3 antigen target on T cells, subsequent mechanisms involved in the therapeutic effects are incompletely understood. These mechanisms of action appear to involve weak agonistic activity on T cells as well as the generation of regulatory cytokines and regulatory T cells leading to the development of tolerance (20; 21).

2.3. Clinical Studies

As of March 2009, over 500 subjects have been treated with teplizumab including over 450 individuals with T1DM. Other subjects who have received teplizumab include subjects undergoing renal allograft rejection, individuals receiving islet transplantation, and patients with psoriatic arthritis.

Two clinical trials testing safety and efficacy have been completed using teplizumab in participants with recent onset T1DM; Study 1 (a phase I/II trial); Study 2 (protocol ITN007AI [NDB01]), as well as one PK/safety study (protocol ITN017AI). In addition, four clinical studies to preserve beta cell function in those with T1DM are underway. These studies are described below. Further information about these studies and other clinical experience with teplizumab are in the Investigator's Brochure.

2.3.1. Study 1: A Phase I/II Trial

Study 1 was a randomized, controlled, phase I/II, three-center trial that enrolled a total of 43 participants and tested two dosing regimens with hOKT3 γ 1(Ala-Ala)(23; 30). The clinical efficacy outcome tested was change in C-peptide response to MMTT in treated as compared to control groups.

The results of these studies suggest that treatment with the anti-CD3 mAb hOKT3 γ 1 (Ala-Ala) reduces the loss of insulin production over the first year in individuals with T1DM (Table 1)(23; 30).

Table 1. Changes in C-peptide response to an MMTT among participants in study 1

Patient Group	Change at 6 months			Change at 1 year		
		No change			No change	
Drug treated	9	6	6	7	8	6
Control*	2	2	15	1	3	15

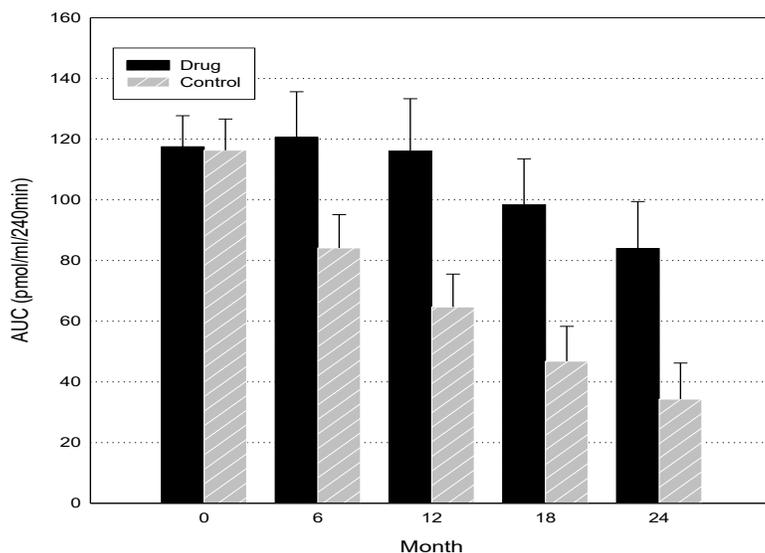
p<0.01; * Two control participants withdrew from the study.

At 1 year, the mean area under the curve (AUC) of the C-peptide response was 97 \pm 9.6% of the response at baseline in the drug-treated group (vs. 53 \pm 7.6% in the control group, p=0.001).

Follow-up was extended for 2 years after study entry. There continued to be a significant drug treatment effect at 2 years (p=0.002), although the meal stimulated C-peptide responses were falling

in both the drug treated and control groups. The differences between the two groups were 44% at both year 1 and year 2 (31).

Figure 2. C-peptide response to an MMTT over 2-year period in study 1. There was a significant effect of drug treatment on the C-peptide responses over the 2 year period ($p=0.002$). (The data represent mean \pm SEM of the study groups.)



In the patients with diabetes, the drug treatment was associated with improvement in the hemoglobin A_{1c} (HbA_{1c}) levels ($p=0.004$) and reduced use of insulin ($p=0.001$) over the 2-year period.

2.3.2. Study 2: A Phase II Multiple-Dose Trial, NCT00806572

Protocol ITN007AI [NDB01] started in June 2002 to assess the ability of the regimen to prolong the duration of the clinical response and to increase the number of responders (31). In study 2, the drug was to be administered soon after clinical diagnosis and at 6 and 12 months after diagnosis. Between June and August 2002, 10 patients were enrolled in study 2 (6 were randomized to the drug treatment group and 4 to the control group) and those assigned to the drug treatment group received one course of hOKT3 γ 1 (Ala-Ala) treatment. Further enrollment and hOKT3 γ 1 (Ala-Ala) treatments were stopped based on adverse event findings. Further investigation into the potential differences of the drug products and their preparations indicated that the absolute amount of drug that was administered to the six experimental patients in study 2 was greater than had been used in study 1.

2.3.3. ITN 017: A Phase I dosing study

Following discontinuation of Protocol ITN007, protocol ITN017 was conducted to determine a safe dose to be used for studies of teplizumab in subjects with Type 1 diabetes. Six subjects were enrolled in this open label trial. There were no serious adverse events in the first dosing cohort of 4 subjects. The study was discontinued when the first subject in the higher dosing cohort developed hyperbilirubinemia. The current dosing regimen is based on the findings from ITN017.

2.3.4. “ABATE Trial” ITN027 NCT00129259

This Phase II randomized open label study will test whether two courses of treatment (each for 14 days) within 8 weeks of diagnosis and at 1 year will improve C-peptide responses 2 years after diagnosis. There have been 6 serious adverse events in this trial. Three of these were judged to be study drug related. Two of the 3 were lymphopenia that was not unexpected, and one was cytokine release syndrome. This study showed reduced decline in C-peptide in the drug-treated vs control group ($p=0.001$, manuscript in preparation).

2.3.5. “Delay Trial” NCT00378508

This randomized, double blind, placebo controlled trial will test the ability of a single 14 day course of treatment with teplizumab to prevent the loss of C-peptide 1 year after study enrollment. The “Delay Trial” offers optional retreatment for all subjects who retain detectable levels of insulin production, 1 year after study entry. The inclusion criteria for the Delay Trial differs from other studies in its enrollment of individuals with Type 1 diabetes of duration of 4 – 12 months. There have been two serious adverse events in this trial, neither of which was judged to be study drug related. The analysis of the primary endpoint (difference in C-peptide responses to a mixed meal test at 12 mos adjusted for baseline C-peptide response and duration stratum) showed significantly greater responses in the teplizumab treated group ($p=0.03$, manuscript submitted). However, because of an imbalance in HgbA1c levels at baseline, an additional analysis was performed correcting for the baseline HgbA1c level, C-peptide AUC, and duration stratum, and difference in the primary endpoint was 17.7% ($p=0.09$). Nonetheless, the drug treated group lost significantly less of the baseline C-peptide AUC level (20.6%) compared to placebo treated subjects (37%) ($p=0.04$) after correction for baseline C-peptide AUC, baseline HgbA1c, and duration stratum, and a greater proportion of subjects lost detectable C-peptide in the placebo group ($p=0.02$). In a post-hoc analysis subjects with HgbA1c levels $< 6.5\%$ and younger ($< \text{age } 15 \text{ yrs}$) subjects showed significant responses to teplizumab after correction for duration strata and baseline C-peptide and baseline HgbA1c levels (as a covariate in the analysis of age strata).

2.3.6. “Protégé Trial” NCT00385697

This is a Phase II/III multicenter study to compare efficacy, safety, and tolerability of 3 dose levels of teplizumab relative to placebo, in subjects within 12 weeks of T1DM diagnosis. Segment 1 was an open label study of 30 subjects which has completed enrollment.

The results from the analysis of the primary endpoint were announced in October 2010 and published in 2011. The primary endpoint (a comparison of the proportion of subjects with hemoglobin A1C $< 6.5\%$ who were using $< 0.5 \text{U/kg/d}$ of exogenous) was not met. However, a posthoc analysis of the effects of full dose of drug treatment showed that the C-peptide levels in the teplizumab treatment group were significantly greater than in placebo treated control subjects 12 months after enrollment (Sherry et al, 2011).

2.3.7. “Protégé Encore Trial” NCT00385697

This is a Phase II/III multicenter study to compare efficacy, safety, and tolerability of 3 dose levels of teplizumab relative to placebo, in subjects within 12 weeks of T1DM diagnosis. Enrollment into this double-masked, placebo controlled, four arm trial was ended in October 2010, prior to completing enrollment. A follow up study of subjects is underway.

2.4 Evaluations of Safety Experience with Teplizumab and the Basis for the Proposed Clinical Protocol

Safety reviews of the use of teplizumab in patients with type 1 diabetes were carried out in 2004, 2006, and continue on an ongoing basis by Data Safety and Monitoring Boards. These evaluations identified the occurrence of mild cytokine release, during the first 6 days of drug treatment, in about 10% of subjects. The 2006 safety evaluation noted that study drug was discontinued in 6/60 individuals due to adverse events characterized by laboratory abnormalities of consumptive coagulopathy and were thought to be due to the release of cytokines that occurred with the initial doses of drug. Specifically, the signs that identified this complex included any of the following: a) fever (of grade 3), b) an increase in the PT and/or PTT and an increase in the level of D-dimers, c) an increase in the total bilirubin level, d) hypotension, and e) an increase in liver enzymes. In each case, the abnormal findings began within the first 6 days of drug administration, and frequently with the first dose of drug. In all 6 cases, drug administration was stopped prior to administration to a complete course of protocol-defined treatment. The laboratory abnormalities were self-limited, did not progress, and completely resolved without sequelae.

Based on these analyses, additional laboratory studies to evaluate the presence of cytokine release were recommended, and more stringent criteria for withholding drug were developed. With the modified criteria, all subjects who discontinued drug administration because of adverse events were identified by the second dose of drug. These new evaluations are incorporated into this and other ongoing protocols. More information is available in the Investigator’s Brochure.

2.5. Use of Teplizumab in Children

The majority of new cases of T1DM occur in children under the age of 18. Moreover, given that the duration of diabetes is a significant risk factor for the development of diabetes complications and the clearly recognized difficulty in attaining excellent metabolic control of diabetes during adolescence (3; 32), it is critical that children are included in studies of the prevention of type 1 diabetes. The experience gained from DPT-1 and other studies demonstrates that children are more likely to have risk factors associated with rapid progression of the disease, suggesting a difference in the natural history of the disease from that in adults, and again demonstrating the need to include children in prevention studies.

600 subjects have participated in clinical trials of teplizumab: 100 in open-label studies (all treated with teplizumab) and approximately 500 in randomized, blinded studies (approximately 80% treated with teplizumab). See **Table 2** shown below which displays enrollment by age group.

Table 2: Age Distribution of Subjects by Study in Previous and Ongoing T1DM Studies (Data Available as of July 2009)

Age Range (years)	Open-label (Treated with Teplizumab)					Total	Blinded		Open-Label & Blinded Total
	Herold Study 1	ITN 007 (NDB01)	ITN017	ITN027 (Abate)	Protégé Segment 1		Delay	Protégé Segment 2	
8-11	9	2	2	24	11	48	7	73	128
12-17	8	1	4	23	16	52	9	189	250
>18	5	3	0	4	11	23	2	230	255
Total	22	6	6	51	38	123	18	492	633

Notes: Protégé is Protocol CP-MGA031-01. The Herold studies are investigator-initiated studies. For further information regarding these studies, please refer to the Investigator's Brochure

Dr. Herold and colleagues reviewed the adverse event experience of the completed trials and concluded that although the number of subjects was small, there was no apparent relationship of age to the number or severity of adverse events.

In addition to the possibility of delaying or preventing the onset of T1DM, which is unproven, there are other prospects for direct benefit to children by their participation in the study. These include the recognized benefits of being in a clinical study, and of close monitoring for development of diabetes which significantly prevents morbidity associated with onset of the disease in the community including ICU admissions. The intervention has the prospect of direct benefit to the individual subject and in addition, is likely to yield general knowledge about T1DM which is of importance for the understanding and amelioration of T1DM in children.

The study procedures, while greater than minimal risk, offers the possibility of benefit due to the close monitoring for all participants, including children. Assent of children along with consent of the parents will be obtained prior to any study procedures. This research proposal in children is therefore consistent with United States Department of Health and Human Services, Protection of Human Subjects, 45CFR46.405 (research involving greater than minimal risk but presenting the prospect of direct benefit to individual subjects) and with 21CFR50.52 (Clinical investigations involving greater than minimal risk but presenting the prospect of direct benefit to individual subjects).

2.6. Additional information

Please refer to the Teplizumab Investigator's Brochure for further non-clinical and clinical information on the antibody.

3. STUDY DESIGN

3.1. Overview

This is a multicenter, double masked, randomized, placebo- controlled study to determine whether treatment of subjects at high risk for diabetes with teplizumab results in delay or prevention of clinical T1DM.

3.2. Objectives

3.2.1. Primary Objective

The primary objective of the study is to determine whether treatment of at-risk subjects with teplizumab results in a delay or prevention of T1DM.

3.2.2. Secondary Objectives

- to determine whether treatment with teplizumab is superior to placebo with respect to C-peptide responses to oral glucose, as obtained from timed collections during longitudinal tests
- to compare the safety and tolerability of teplizumab to placebo
- to assess the effects of treatment on mechanistic outcomes

3.3. Summary of Inclusion/Exclusion Criteria

Participants must meet all entry criteria for the protocol as outlined below.

3.3.1. Inclusion Criteria:

Study subjects must be or have:

1. Participant in TrialNet Natural History Study (TN01) and thus a relative of a proband** with T1DM.
2. Between the ages of 1-45 years at the time of enrollment in TN01 and age ≥ 8 at time of randomization in this trial
3. Subject (or parent or legal guardian if the subject is a minor) is willing to provide Informed Consent.
4. Individuals <18 years of age at time of randomization must have had a TrialNet conducted OGTT demonstrating abnormal glucose tolerance* within 7 weeks (52 days) of the baseline visit (visit 0).
5. Individuals ≥ 18 years of age at time of randomization must have had two consecutive TrialNet conducted OGTT's demonstrating abnormal glucose tolerance, the most recent of which must have been within 7 weeks (52 days) of the baseline visit (visit 0).
6. The participant must be positive for two or more diabetes-related autoantibodies on two occasions.

The second occasion must occur within the six months prior to study drug administration, but does not need to involve the same two autoantibodies as were found on the first occasion. The autoantibodies that are to be confirmed are anti-GAD65, anti-ICA512, anti-insulin (MIAA), ZnT8 and/or ICA.

7. Weigh at least 26 kg at randomization.
8. If participant is female with reproductive potential, she must have a negative pregnancy test on Day 0 and be willing to avoid pregnancy for at least one year from randomization.
9. If participant is male, he must be willing to avoid pregnancy in any partners for at least one year from randomization.
10. Willing and medically acceptable to postpone live vaccine immunizations for one year after treatment.
11. Willing to forego other forms of experimental treatment during the study.

* a. Fasting plasma glucose ≥ 110 mg/dL, and <126 mg/dL

or

b. 2 hour plasma glucose ≥ 140 mg/dL, and <200 mg/dL

or

c. 30, 60, or 90 minute value on OGTT ≥ 200 mg/dL

Fasting glucose levels of 110-125 mg/dL qualify subjects as having abnormal glucose tolerance in this protocol as it reflects the criteria used for entry into the DPT-1 (33) study and the DPT-1 data was used for the calculation of diabetes risk for this trial. Using data for individuals with Type 2 diabetes, the ADA uses a different glucose range to define impaired fasting glucose(34).

** A proband is an individual diagnosed with diabetes before age 40 and started on insulin therapy within one year of diagnosis, or if subjects with probands considered to have type 1 diabetes by their physician who do not meet this definition, the TrialNet Eligibility Committee for the TrialNet Natural History/Pathway to Prevention Study (TN01) must have approved enrollment in TN01.

3.3.2. Exclusion Criteria:

Study subjects cannot be randomized if they have:

1. If ≥18yo: Diabetes, or have a screening OGTT with:
 - a. Fasting plasma glucose ≥ 126 mg/dL, or
 - b. 2 hour plasma glucose ≥ 200 mg/dL
2. If <18yo: Diabetes, or have a screening random glucose ≥ 200 mg/dL
3. Lymphopenia (< 1000 lymphocytes/ μ L).
4. Neutropenia (< 1500 PMN/ μ L).
5. Thrombocytopenia (< 150,000 platelets/ μ L).
6. Anemia (Hgb < 10 grams/deciliter [g/dL]).
7. AST or ALT >1.5 x ULN.
8. Total bilirubin >1.5 x upper limit of normal (ULN) with the exception of subjects with the diagnosis of Gilbert's syndrome who may be eligible provided they have no other causes leading to hyperbilirubinemia.
9. INR > 0.1 above the upper limit of normal at the participating center's laboratory.
10. Chronic active infection other than localized skin infections.
11. A positive PPD test.
12. Vaccination with a live virus within 8 weeks of randomization
13. Vaccination with a killed virus within 4 weeks of randomization.
14. A history of infectious mononucleosis within the 3 months prior to enrollment.
15. Laboratory or clinical evidence of acute infection with EBV or CMV.
16. Serological evidence of current or past HIV, Hepatitis B or Hepatitis C infection.
17. Be currently pregnant or lactating, or anticipate getting pregnant.
18. Chronic use of steroids or other immunosuppressive agents.
19. A history of asthma or atopic disease requiring chronic treatment.
20. Untreated hypothyroidism or active Graves' disease at randomization.
21. Current use of non-insulin pharmaceuticals that affect glycemic control.
22. Prior OKT®3 or other anti-CD3 treatment.
23. Administration of a monoclonal antibody within the year before randomization.
24. Participation in any type of therapeutic drug or vaccine clinical trial within the 12 weeks before randomization.
25. Any condition that, in the opinion of the investigator, would interfere with the study conduct or the safety of the subject.

3.4. Enrollment

Potential study subjects will be identified through the ongoing TrialNet Natural History/Pathway to Prevention study. In this study, first and second degree relatives of patients with T1DM are screened for biochemical autoantibodies and ICA. Those individuals who test positive are then further staged with the performance of an OGTT. The results of this OGTT performed in a TrialNet study will be used to determine eligibility for this protocol.

The TrialNet Natural History/Pathway to Prevention study screens participants at over 200 clinical sites. The infusion of teplizumab or placebo will occur at a limited number of designated TrialNet infusion sites, whereas the initial screening visit and follow-up testing, as described in the Schedule of Assessments, may occur at other (non-infusion) TrialNet sites.

3.5. Double-Masking and Description of Treatment Groups

The intervention will be conducted only amongst those who consent to participate. Subjects will be randomized to receive either teplizumab or placebo. All subjects will undergo close monitoring for the development of diabetes. Subjects and clinical investigators will be masked as to treatment assignment. The intervention protocol will be conducted at approved TrialNet clinical sites with appropriate facilities. All blood and serum samples for the primary and secondary outcome determinations will be sent to the TrialNet Core Laboratories for analysis. Clinical laboratory studies that will be used for determining eligibility for study drug infusion will be performed at the local sites.

Participants will be randomly assigned in a 1:1 ratio (within the two strata defined by age at enrollment: <18 and 18 or older) to the following 2 groups:

- to receive teplizumab (14 day IV infusion) followed by close monitoring for T1DM development
- to receive placebo (14 day IV infusion) followed by close monitoring for T1DM development

3.6. Treatment Assignment

After participants provide informed consent, complete the screening visit(s), and meets all of the inclusion criteria and none of the exclusion criteria, participants will be randomized to receive either teplizumab or placebo.

Participants will be randomized in equal allocations to each group. The randomization method will be stratified by TrialNet study site and whether the participant is less than 18 years of age or 18 years and older. This approach ensures that study site will not be a potential confounder. The TNCC will generate the randomization numbers and tables.

3.6.1. Procedures for Unmasking

Emergency unmasking will occur upon notification of the TrialNet Central Pharmacy and TNCC via the 24 hour emergency number and approval by TrialNet Chair, NIDDK TrialNet program officer, or TrialNet Medical Monitor. Non-emergent unmasking will occur upon notification of the TNCC and approval by TrialNet Chair or NIDDK TrialNet program officer. If unmasking is approved, the study sponsor and appropriate TrialNet committees (e.g. Safety Monitoring) will be notified of the event as soon as reasonably possible; however, they will not be unmasked.

3.7. Study Assessments

During the course of the study, participants will frequently undergo assessments of their glucose tolerance status, insulin production, immunologic status, and overall health and well-being (see Schedule of Assessments).

Samples will be drawn for storage in the National Institute for Diabetes and Digestive and Kidney Disease (NIDDK) Repository and at TrialNet Laboratory Sites for future analysis.

3.8. Quality Assurance

During the study, duplicate collections of blood samples for assays will be obtained in a small sample of subjects for the purpose of external quality surveillance of the performance of the TrialNet Central Laboratories.

3.9. Study Timeline

3.9.1. Study Duration

The study is designed to provide 80% statistical power to detect a 60% risk reduction with a one-sided test at the 0.025 significance level. This risk reduction is expected to result in a delay in the median time to onset of diabetes of 7.52, 8.93, and 10.6 yrs. for the age cohorts < 18 and ≥18 within strata 1, 2, and 3, respectively. To attain these design parameters will require the observation of 40 participants that are diagnosed on-study with T1DM. Consequently, the total sample size and study duration can only be approximated. The study plans to enroll approximately 71 subjects over approximately 6 years, and is projected to last between 6 and 10 years. As the study progresses, projections of the study end will be computed and updated based on the rate of enrollment, the observed hazard rate and the rate of loss-to-follow-up.

3.9.2. Follow-up Studies

Although subjects who develop diabetes will have reached the study endpoint, these individuals will be offered annual follow up for a minimum of two years. Those individuals who have not developed diabetes by study end will continued to be followed as part of the TrialNet Natural History/Pathway to Prevention study protocol.

Individuals who develop T1DM may be eligible for interventional studies sponsored by TrialNet or other organizations under separate INDs. In the event that a subject wishes to participate in another investigational study that has, as an exclusion, treatment with experimental or immune modulatory drugs, the subject may request and be told of their treatment group assignment for the anti-CD3 prevention study. Every attempt will be made to minimize potential bias that this may introduce. The TNCC will make treatment assignment information available to the site investigator of the new study after the subject is determined to be willing to participate and not otherwise excluded from the new study. Other study group members will not be informed of the treatment assignment information. Mitigation of bias issues must be balanced against safety and interests of participants.

4. PATIENT MANAGEMENT

4.1. Screening Visit and Eligibility Assessment

This study will draw participants from the TrialNet Natural History/Pathway to Prevention Study.

The initial testing for autoantibodies, HLA type, and Oral Glucose Tolerance Test (OGTT) will be done as part of Natural History/Pathway to Prevention. Those individuals with two confirmed diabetes-related autoantibodies and abnormal glucose tolerance on the OGTT, will then be eligible for additional tests and possible enrollment into this study.

Appendices 1 and 2 summarize the flow of subjects from the Natural History/Pathway to Prevention Study into this study.

4.2. Anti-CD3 mAb Trial for At-risk Subjects Initial Visit

Prior to the initial visit, this study will be described to the potential participant. The participant/parent/guardian will be asked to sign an informed consent document describing the purpose, risks, and benefits of screening for the trial. A participant's signature indicates that he/she understands the potential risks and benefits of study participation. Subjects less than age 18, qualify for the study with a single OGTT with abnormal glucose tolerance. Those age 18 or older, require two consecutive OGTTs with abnormal glucose tolerance. Qualifying OGTTs may occur under the auspice of another TrialNet study or as a part of this visit if needed. During these visits, other clinical tests will also be performed to determine eligibility.

Any participant either not eligible or not willing to be randomized into this study is eligible for continued follow-up as part of the TrialNet Natural History/Pathway to Prevention Study.

4.3. Randomization and Baseline Visits

Review will be made to be certain the subject meets study eligibility criteria. Prior to randomization, the intervention and follow-up phases of the study will be described to the participant. The participant/parent/guardian will be asked to sign an informed consent document indicating that he/she understands the study as well as the potential risks and benefits of study participation.

Participants will be randomized to either the treatment arm or the control arm. The randomization and the baseline visit must occur within 7 weeks of the qualifying OGTT in order to ensure that participants have abnormal glucose tolerance at time of randomization and study drug administration. Note, subjects who are febrile at the time of baseline visit, may have the visit postponed up to five days outside the 7 week window if needed because of intercurrent illness. At or prior to the baseline visit (visit 0), subjects < age 18 will undergo an OGTT.

4.4. Close Monitoring

During the study period, all participants will receive close monitoring for development of diabetes. OGTT tests will be performed at 3 and 6 months and every 6 months thereafter. In addition, at three

month intervals (where there is no OGTT scheduled), a random (non-fasting) glucose level will be measured. At each visit and via routine contact in between visits, participants will be asked directed questions about the presence or absence of symptoms associated with diabetes such as blurry vision, unintended weight loss of more than 3 kg, polyuria, and polydypsia. If subjects respond affirmatively to any of these questions or if any of the post-prandial glucose values are greater than 200 mg/dL, further evaluation, including fasting glucose or an OGTT, will be performed. Individuals in both of the study arms will have laboratory and mechanistic studies performed as detailed in the Schedule of Assessments.

4.5. Administration of Teplizumab

4.5.1. Drug Administration

Teplizumab or saline will be administered via IV infusion over 14 days. The 14 day course must commence within 7 weeks of the qualifying OGTT, except in the case of interim illness as noted above (Section 4.3).

Subjects will be randomized to 1 of 2 treatment arms and will receive a 14-day course of teplizumab and/or placebo. The treatment course will be administered on Study Days 0–13. The 2 treatment arms are described below.

- **Arm #1:** Subjects will receive a 14-day course of teplizumab consisting of daily IV doses of 51 micrograms/meter squared ($\mu\text{g}/\text{m}^2$), 103 $\mu\text{g}/\text{m}^2$, 207 $\mu\text{g}/\text{m}^2$, and 413 $\mu\text{g}/\text{m}^2$ on Study Days 0–3, respectively, and one dose of 826 $\mu\text{g}/\text{m}^2$ on each of Study Days 4–13. The total dose for a 14-day course is approximately 9034 $\mu\text{g}/\text{m}^2$. For subjects weighing 70 kg and having a body surface area (BSA) of 1.92 m^2 , this dosing schedule delivers ~18 milligrams (mg) of teplizumab.
- **Arm #2:** Subjects will receive a 14-day course of IV placebo only.

The subject's BSA will be calculated by the pharmacist using the Mosteller formula. The BSA will be calculated on Study Day 0, and will be based on the subject's height and weight on that day. This calculation will be used for dosing over the entire 14 days. For dosing purposes the participant's BSA should be rounded up to the nearest tenth place regardless of the number in the hundredth position. For example, if the BSA is 1.61, it will be rounded up to 1.7 and if the BSA is 1.67, it will also be rounded up to 1.7. The dose should be rounded to the nearest whole number. For example if the participant's BSA is 1.722, on Day 0 the participant would receive 92 μg .

The Mosteller formula

$$\text{BSA (m}^2\text{)} = ([\text{Height(cm)} \times \text{Weight(kg)}] / 3600)^{1/2}$$

Teplizumab or saline is administered via an IV infusion over a minimum of 30 minutes in the research or hospital setting. This infusion should be given at the same time each day +/- 4 hours. Vital signs will be monitored for 2 hours after each infusion. Subjects are permitted to leave the research or hospital setting each day upon completion of the 2 hours of post-infusion monitoring if they remain within approximately one hour (driving time) of the treatment center.

The formulation of teplizumab will consist of:

- 10 mM sodium phosphate
- 150 mM sodium chloride
- 0.05 mg/mL Tween 80
- pH 6.1

Final drug product will be provided at a concentration of 1 mg/mL for a total of 2 mg of recoverable drug product per vial.

The vials should be stored upright at 2°–8° C and must not be frozen. Because there is no preservative and drug loss occurs over time, administration of study drug should begin as soon as possible and no later than 2 hours after preparation. The infusion must be complete within 6 hours of preparation. The drug may be prepared into a bag for infusion or into a syringe for delivery by infusion pump. Intravenous drug delivery devices, including IV bags and tubing, must be composed of PVC.

Laboratory studies that will be obtained prior to each dose are described in the Schedule of Assessments. The results of chemistries including liver function tests, WBC, Hgb, Hct, platelets, and INRs must be reviewed each day they are drawn prior to commencement of the drug infusion.

4.5.2. Drug Withholding in an Individual Subject During the 14 Day Treatment Period

Chemistries, liver function studies, CBC and differentials, and INR studies will be evaluated before drug is administered on each day that these studies are drawn as described in the attached Schedule of Assessments.

The following situations, laboratory abnormalities, or adverse events will lead to withholding of drug treatment *during the treatment course*: (Note: Day 0 is the first day of infusion)

1. Withdrawal of consent
2. Pregnancy for a female subject
3. Anaphylaxis requiring hemodynamic support (i.e., epinephrine and/or blood pressure medications) or mechanical ventilation.
4. Hepatic abnormalities*:
 - a. Defined as total bilirubin >1.3 mg/dL on Day 1, ≥2.0 mg/dL on other days.
 - i. The exception will be for subjects diagnosed prior to randomization with Gilbert's syndrome. These subjects will be monitored with GGT levels. They may receive drug if the total bilirubin exceeds these levels provided the GGT is ≤ 3 times the ULN. Otherwise, drug will be withheld.
 - b. AST level >2 times ULN on Day 1. AST, ALT or LDH ≥3.0 times ULN on other days
5. Thrombocytopenia*: Defined as a platelet count < 140,000 on Day 1 and < 100,000 on other days.
6. Neutropenia*: Defined as <1000 cells/mm³ (grade 3).
7. Anemia*: Defined as hemoglobin ≤ 8.5 g/dL or a drop in ≥2g/dL compared with prior to infusion to a value < 10.0 g/dL.
8. Coagulopathy*: INR > 0.1 above the upper limit of normal at the laboratory.
9. Fever: Grade 3 pyrexia on Day 0 or 1.
10. Other adverse events: Defined as a grade 3 or higher adverse event, regardless of relatedness to study drug, except for: lymphopenia, hypoglycemia, hyperglycemia,

fatigue/malaise, insomnia, cheilitis, dry skin, nail changes, hot flushes/flushes, headache, myalgia, flu-like symptoms.

11. Any medically important event such as a concurrent illness, complications or abnormal laboratory test result that, in the opinion of the investigator, contraindicates continued dosing of study drug.

A laboratory test result meeting any of the above abnormalities noted by (*) should be confirmed on the same day as the initial test. Drug dosing will not occur while awaiting confirmation of the laboratory abnormality. If laboratory abnormalities are confirmed, or if any of the other situations listed above occur, the drug infusions will be discontinued in that participant and the procedures listed below will be followed. The drug infusions may not be resumed. Depending on the severity of the event, further reporting may be required as outlined below.

If the laboratory test is not confirmed when tested on the same day, drug dosing may be continued at the discretion of the site investigator.

The Study Chair, TNCC, and Medical Monitor will be notified within 24 hours of any subject who is discontinued from study drug dosing. Participants who are discontinued from teplizumab dosing will continue to receive follow-up care and evaluation as scheduled.

4.5.3. Further Evaluation after Withholding Infusions

The following are minimal assessments to be performed for those participants in whom an infusion is withheld (as described above):

1. LIVER TESTS: Total and direct bilirubin, AST, ALT, alkaline phosphatase the day the adverse event occurs and followed with frequent laboratory studies in order to establish the day that the event resolves. Additional studies may include an abdominal ultrasound to assess liver status and GI consult when necessary. If GGT, AST or ALT is $> 3 \times \text{ULN}$ and bilirubin $> 2 \times \text{ULN}$, evaluation should be done to determine if there is a cause other than study drug for these abnormalities (e.g., acute viral hepatitis, alcoholic and autoimmune hepatitis, biliary tract disorders, cardiovascular causes such as right heart failure or concomitant medications).
2. HEMATOLOGIC TESTS: CBC, differential, INR, D-dimer, and fibrinogen the day the adverse event occurs. The peripheral blood smear will be studied for evidence of RBC fragmentation. The CBC and differential and INR, will be frequently repeated in order to establish the day that the event resolves.
3. DRUG LEVELS: Teplizumab levels
4. ADDITIONAL SAMPLES: Serum samples for storage and potential future analysis.

4.6. Interruption of Enrollment/Trial Cessation

Sections 4.5.2 and 4.5.3 describe monitoring and procedures for withholding drug treatment in individual patients. This section lists clinical and laboratory adverse events that will necessitate interruption of enrollment in the trial as a whole. As part of their ongoing safety review, the DSMB will make independent judgments regarding other adverse events requiring trial interruption.

1. Any drug related death*

2. Occurrence of anaphylaxis during study treatment in any participant. Anaphylaxis is defined in this protocol as a requirement of hemodynamic support or mechanical ventilation.
3. Stopping of drug infusions for criteria listed in section 4.5.2 in more than 2 of the first 10 enrolled subjects or in more than 20% of the total number of teplizumab treated subjects.
4. Grade 3 cytokine release syndrome (according to CTCAE criteria) at any time in more than 2 of the first 10 or more than 20% of the total number of teplizumab treated subjects.
5. The occurrence of ALT or AST ≥ 3 x ULN and bilirubin > 2 x ULN at any time in any one subject, with the exception of those who have been diagnosed with Gilbert's syndrome prior to randomization and have met the criteria listed in section 4.5.2 for this occurrence.
6. Grade 3 hypotension at any time in more than 2 of the first 10 or more than 20% of the total number of teplizumab treated subjects.
7. Grade 3 thrombocytopenia at any time in more than 2 of the first 10 or more than 20% of the total number of teplizumab treated subjects.
8. Clinical mononucleosis syndrome which may include: Grade 2 or above fever, pharyngitis, lymphadenopathy, splenomegaly, or rash, with detectable EBV viral load more than one week after the last dose of drug in any 3 of the first 10 or more than 25% of the total number of teplizumab treated subjects.
9. Severe adverse event: defined by CTCAE criteria of grade 3 or greater in any 2 of the first 3 patients or 3 of the first 7 drug treated patients at any time with the exception of Grade 3 lymphopenia within the first 30 days of drug treatment . In addition, severe adverse event of grade 3 or greater in more than 20% of the total number of teplizumab treated subjects.
10. Failure of the absolute number of lymphocytes to recover to 80% of the pretreatment level 2 months after the final dose of drug in 2 of the first 10 or 20% of the total number of teplizumab treated subjects.

In the event that these criteria are met, study enrollment will be suspended and the Institutional Review Boards/Ethics Committees/Research Ethics Board (IRB/EC/REB), and FDA and other applicable regulatory authorities will be notified that enrollment has been interrupted in order to perform a safety review of the enrolled subjects. The safety review will include a comprehensive evaluation of the safety experience from this trial as well as data from other ongoing studies with teplizumab in other disease settings. Before enrollment will resume, a satisfactory report of the safety review will be provided to the FDA, other applicable regulatory authorities, Institutional Review Boards/Ethics Committees/Research Ethics Boards (IRB/EC/REB), and the DSMB.

*During this trial, any death event will be temporarily considered unexpected and potentially drug-related until the event is adjudicated by the DSMB. In this event, the trial will be interrupted, including dosing of subjects already enrolled and enrollment of new subjects, until the death event is adjudicated by the DSMB and deemed "unlikely to be related to study drug."

4.7. Prophylactic Medications

Ibuprofen and antihistamine will be administered prophylactically prior to teplizumab/placebo infusion on the first 5 days of treatment. Further dosing of Ibuprofen, antihistamines, and/or acetaminophen can be used as needed for fever, malaise, headache, arthralgia, or rash.

5. STUDY VISIT ASSESSMENTS

The schedule of evaluations and laboratory studies is presented in Appendix 3, Schedule of Assessments. A summary of assessments for the Protocol is given below.

5.1. General Assessments

General assessments for this Protocol will include:

- Informed consent
- Inclusion/exclusion criteria
- Medical history including lifestyle and participant experience assessment
- Physical examination including height/weight, abdominal circumference
- Concomitant medications
- Adverse events

5.2. Laboratory Assessments

The following clinical laboratory assessments will be performed during the study as described in the Schedule of Assessments (SOA):

- Chemistry (sodium, potassium, chloride, CO₂, glucose, BUN, creatinine)
- Liver function tests (ALT, AST, LDH, alkaline phosphatase, total protein, albumin, total and direct bilirubin). Prior to each infusion, GGT will be run locally in subjects with Gilbert's syndrome.
- Hematology (complete blood count with differential and platelets)
- INR
- Purified protein derivative (PPD) test
- Urine pregnancy test
- Antibodies to HIV, hepatitis B (antiHBcAb, HBsAg), hepatitis C (HCV)
- Cytomegalovirus antibodies (CMV IgG and IgM) and viral load
- Epstein-Barr virus antibodies (EBV IgG, IgM and EBNA) and viral load as indicated
- Samples for virology and other immunization titers
- ECG

5.3. Mechanistic Outcome Assessments

TrialNet will perform immune and genetic assays to further understand mechanisms that may be underlying the type 1 diabetes disease process and response to therapy. For this purpose, samples for PBMC, DNA, RNA, plasma, and serum will be obtained. HLA testing may be done either under the auspices of TrialNet Natural History/Pathway to Prevention or this protocol.

5.4. Metabolic Outcome Assessments

Metabolic assessments will consist of:

1. OGTT
 - Primary study outcome - Glucose tolerance status. The diagnostic criteria for diabetes from the 2003 Report of the Expert Committee on the diagnosis and classification of diabetes will be used (34). This study will be performed every 6 months or more frequently if clinically indicated based on a random glucose level of ≥ 200 mg/dL.
 - The C-peptide and insulin data from the OGTT will be used to measure insulin secretion.
 - The insulin, glucose and C-peptide data from the OGTT will be used to measure insulin sensitivity.
2. HbA1c
 - Measure of glycemic control.

5.5. Laboratory Measures Related to Teplizumab Administration

Laboratory tests to measure drug level and immune response to the drug:

- Trough drug levels of teplizumab will be measured during the last 4 days of mAb administration in 12 subjects of each of the age strata: ≥ 16 yrs, 12-15 yrs, and 8-11 yrs.
- Antibodies against teplizumab will be measured at month 3 in 12 subjects from each age strata: ≥ 16 yrs, 12-15 yrs, and 8-11 yrs.

5.6. Visit Windows

The baseline visit must occur within 7 weeks after qualifying OGTT (with the exception that individuals who are febrile at the time of the scheduled baseline visit, may have up to an additional 5 days). Visit 14 must be +/- 2 days. Visit 15 is to be +/- 4 days. All other visits described in the Schedule of Assessments can be ± 3 weeks.

6. ADVERSE EVENT REPORTING AND SAFETY MONITORING

6.1. Adverse Event Definition

6.1.1. Adverse Event

In this clinical trial, an adverse event is any occurrence or worsening of an undesirable or unintended sign, symptom or disease whether or not associated with the treatment and study procedures.

Throughout the study, the investigator must record all adverse events on source documents. Events not related to diabetes onset, hypoglycemia, or hyperglycemia which are Grade 2 or greater per the NCI CTCAE (see Section 6.1.4. Grading Event Severity below) must be reported to TNCC. The investigator should treat participants with adverse events appropriately and observe them at suitable intervals until the events resolve or stabilize.

Adverse events may be discovered through:

- observation of the participant;
- questioning the participant;
- unsolicited complaint by the participant

Questioning of the participant should be conducted in an objective manner.

6.1.2. Serious Adverse Event

A serious adverse event (SAE) or reaction is defined as “any adverse event occurring at any dose that suggests a significant hazard, contraindication, side effect, or precaution.” This includes but is not limited to any of the following events:

1. Death. A death that occurs during the study or that comes to the attention of the investigator during the protocol-defined follow-up after the completion of therapy must be reported whether it is considered to be treatment related or not.
2. A life-threatening event. A life-threatening event is any adverse therapy experience that, in the view of the investigator, places the participant at immediate risk of death from the reaction as it occurred.
3. Inpatient hospitalization or prolongation of existing hospitalization.
4. Persistent or significant disability.
5. An event that required intervention to prevent permanent impairment or damage. An important medical event that may not result in death, be life threatening, or require hospitalization may be considered an SAE when, based on appropriate medical judgment, it may jeopardize the participant and may require medical or surgical intervention to prevent one of the outcomes listed above.
6. Congenital anomaly or birth defect.
7. Grade 4 or higher lymphopenia for 7 or more days occurring in the first 30 days after the start of the teplizumab/placebo infusion.
8. Grade 3 or higher lymphopenia occurring anytime later than the first 30 days after the start of the teplizumab/placebo infusion.

Regardless of the relationship of the adverse event to study drug, the event must be reported as a serious adverse event if it meets any of the above definitions.

6.1.3. Unexpected Adverse Event

An adverse event is considered unexpected when the nature (specificity) or severity of the event is not consistent with the risks described in the Investigator's Brochure or the informed consent document.

6.1.4. Grading Event Severity and Causality

TrialNet has adopted usage of the National Cancer Institute (NCI) Common Technology Criteria for Adverse Events (CTCAE) and/or study-specific criteria for classification to describe the severity of adverse events. Hypoglycemia and hyperglycemia will be reported as adverse events only in the case of requiring the assistance of others due to loss of consciousness or DKA. TN Investigators will also provide an assessment of relationship of AE to study drug as not, unlikely, possibly, probably, or definitely related.

6.2. Adverse Event Reporting and Monitoring

Adverse events will be reported to the TrialNet Coordinating Center. The investigator will grade their severity according to common toxicity criteria or study-specific criteria and will make a determination of their relation to therapy. Events will be assessed and reported consistent with the ICH Guideline for Good Clinical Practice and per the guidance of the DHHS Office for Human Research Protections (OHRP).

The adverse event case report form for the protocol must be completed for all reportable adverse events (AE). For reporting serious adverse events (SAE), the TrialNet MedWatch Form should also be completed and faxed to the TNCC *within 24 hours of when the site was notified of the event*. This will be reviewed by the TrialNet Medical Monitor, the TrialNet Safety Committee, and the DSMB as appropriate. Deaths must be reported immediately. Event outcome and other follow-up information regarding the treatment and resolution of the event will be obtained and reported when available, if not known at the time the event is initially reported. The follow-up information should contain sufficient detail to allow for a complete medical assessment of the case and an independent determination of possible causality.

Adverse events will be assessed by the TrialNet Medical Monitor. The DSMB will conduct regular safety reviews approximately every three to six months (and otherwise as needed) of adverse events by treatment group assignment. Serious adverse events as well as adverse events leading to study discontinuation will be reviewed by the DSMB. All adverse events will also be reported to MacroGenics by the TNCC.

7. PARTICIPANT SAFETY

7.1. Protecting Against or Minimizing Potential Treatment Risks

Subjects will not be enrolled who have other active serious medical problems. Frequent monitoring of patients with history, physical examination, and laboratory studies will allow for early identification of adverse events. All participants will be required to have adequate hemoglobin to allow safe frequent venipuncture. Every attempt will be made to minimize the number of venipunctures.

All infusions will take place in a facility that has resuscitation capabilities.

Participants will be counseled by study personnel and requested to avoid pregnancy for 1 year following drug administration for safety purposes. This applies to females on study and female sexual partners of males.

7.1.1. Prohibited Medications

Participants will be instructed not to use Prednisone, other immunosuppressive agents, or chronic inhaled or nasal corticosteroids during this trial in order to reduce infectious risks and to prevent possible impact on progression to diabetes. However, as an intention to treat study, no individual will be withdrawn from analysis if this occurs.

Participants who receive teplizumab/placebo will be instructed not to receive live vaccinations for 1 year after dosing. In addition, participants should not receive vaccination with a killed virus vaccine less than 4 weeks after treatment with study drug unless approved by the study chair or the study ID team.

7.2. Expected Side Effects and Adverse Events

A full description of the adverse events experienced by subjects in trials using teplizumab is in the Investigator's Brochure. The descriptions below highlight the most common drug related events and potential adverse events.

7.2.1. Hematologic

The drug causes a reduction in the number of circulating lymphocytes. Grade 3 or higher lymphopenia has been seen during drug administration in 15% of subjects. However, in more than 85% of individuals, circulating lymphocytes return to $\geq 80\%$ of baseline values by 2 months after initiation of treatment. A single SAE (i.e., prolonged CD4 cytopenia) has occurred in a subject who was given 2 times the proposed dose of drug. This subject did not develop infections and the CD4 cytopenia resolved spontaneously after two years.

Neutropenia, eosinophilia, and thrombocytopenia have also been seen during drug administration. Overall these adverse events have occurred in $< 5\%$ of subjects but have been up to grade 3 in $< 2\%$ of individuals. They have resolved spontaneously or with withholding of drug in all cases. This risk will be mitigated by having platelet and neutrophil count reviewed before administration of

teplizumab/placebo as indicated in the SOE. No specific therapy for the eosinophilia is planned. Specific treatment stopping rules are described in Section 4.5.2.

Mild anemia has been seen in 21.9% of subjects. This risk will be mitigated by having the hemoglobin reviewed before administration of teplizumab/placebo as indicated in the SOA.

7.2.2. Cytokine Release Syndrome

Cytokine release syndrome (CRS) has been described in 5.7% of drug treated subjects – the syndrome was mild or moderate in 5/6 reported subjects. Compared to FcR binding anti-CD3 antibodies like OKT3, the CRS that has occurred with Teplizumab is reduced in frequency and severity. The clinical experience to date suggests that the occurrence of CRS may be seen with the initial doses of the drug and is dose related. The single reported case of moderate disseminated intravascular coagulation was related to the occurrence of cytokine release syndrome. In a previous phase II trial (using a drug dose that is 2 times higher than the proposed dose), symptoms of CRS—including headache, nausea, vomiting, fever, myalgias, arthralgias, and shaking—occurred over the first 3 days of drug treatment, but subsequently resolved. The potential for occurrence of cytokine release syndrome has led to the drug withholding rules listed in Section 4.5.2.

Manifestations of CRS have also included hyperbilirubinemia and increased liver function tests. In the PK/safety trial (ITN017AI), a grade 4 direct hyperbilirubinemia, which may have been a manifestation of a cytokine release syndrome, was observed.

Transient increases in the alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST) up to 5 times normal (grades 1 and 2) levels have been seen in all trials. These abnormalities have been transient. Grade 1 hypoalbuminemia has been seen in patients receiving the anti-CD3 mAb with other immunosuppressive agents for prevention of transplant rejection.

This risk will be mitigated by having INR and liver function tests, including bilirubin, reviewed before administration of teplizumab/placebo as described in the SOE and the specific drug withholding rules listed in Section 4.5.2.

7.2.3. Lymphoproliferative Disease

Although not raised as an issue in the single-dose studies of hOKT3γ1 (Ala-Ala), immunosuppression of any sort may predispose participants to additional risks such as infection or lymphoproliferative disease. On a theoretical basis, this risk is minimal since the total duration of immunosuppression is short. Clinical experience in transplant recipients, treated with other biologic agents, suggests that the risk of lymphoproliferative disease is highest in participants who develop infections with EBV around the time of immunosuppression. Nonetheless, the lymphoproliferative syndrome associated with reactivation of EBV infection that was seen in an islet transplant patient treated with teplizumab and other immunosuppressive drugs occurred in a subject who was EBV IgG+ before study entry. Therefore, a careful history will be taken regarding development of mononucleosis-like illnesses during the period preceding and after study enrollment. Subjects will be screened for CMV viral load. Subjects will be screened for EBV infection with serology (VCA IgG, VCA IgM, and EBNA) and EBV viral loads as indicated. The finding of a positive viral load will preclude enrollment for at least 90 days after the viral load becomes undetectable. In this situation, the subject will need to repeat OGTT assessments to ensure continued eligibility for the trial. Samples for EBV and CMV viral will be obtained after drug treatment as described in the SOE. These will be routinely measured in symptomatic subjects. This aggressive monitoring scheme will allow us to determine whether changes in lymphocyte subsets are associated with reactivation of latent viruses.

7.2.4. Anti-idiotypic Responses

Anti-idiotypic antibodies have been detected in up to 50% of patients administered teplizumab. The presence of these antibodies may diminish efficacy of future cycles of study drug and/or lead to manifestations of antigen-antibody complexes such as serum-sickness illness or hypersensitivity reactions. The titer of these anti-idiotypic antibodies has been < 1:1000 and patients with anti-idiotypic antibodies have been retreated with Teplizumab without adverse effects or detectable changes in the efficacy of the drug. To date, no adverse effects have been reported as a result of these antibodies.

7.2.5. Infection

As with any therapy that suppresses the immune system, there is a risk of developing infections. On a theoretical basis, this risk is minimal, as the total duration of immunosuppression is short. Overall, in open labeled trials with teplizumab, 49.5% of subjects have experienced infections of any kind. Of these, 48.6% were classified as mild or moderate. There have been two cases of TB reported in Protégé trial participants in India and Ukraine respectively. However, trial remains blinded so relatedness is not known at this time.

An increase in herpes virus infections has occurred with teplizumab administration. Specifically, up to 10% of subjects have had a transient increase in EBV viral load, but this was not necessarily associated with an increase in mononucleosis like syndrome. There have been case reports of herpes zoster in the Protégé study. Some occurred during dosing and others were over 270 days after commencing dosing. All subjects recovered and none of the cases were serious.

This risk will be mitigated by having subjects report even mild illness between study visits. They will be specifically asked about infectious adverse events during the study visit, and they will be monitored regularly for infections and appropriate anti-infective therapy will be instituted if indicated. Consultation with TrialNet infectious disease team will be available. All infectious adverse events will be reviewed by the TrialNet ID team, Medical Monitor and DSMB if serious.

7.2.6. Rash

Rash has been seen in 42-62% of subjects treated with drug. The rashes that have been observed include a macular rash on the face, neck, and trunk, as well as a maculopapular rash on the extremities. The latter rash has occurred on the hands and feet and has resolved spontaneously but with peeling of the skin. Biopsies of the rash performed in two subjects showed histologic findings of spongiosis consistent with eczematous dermatitis. A severe rash occurred in one subject, receiving hOKT3 γ 1(Ala-Ala) for prevention of islet allograft rejection on the 3rd day of drug administration. It was classified as severe and the patient was hospitalized. A biopsy of the rash showed a moderate mixed perivascular dermal infiltrate consistent with a drug reaction. Supportive care was given, the drug dosage was reduced, and the rash resolved.

7.3 Pregnancy

Pregnant and lactating women will not be included in the study. Females must have a negative pregnancy test prior to enrolling in the study and will be required to use a reliable and effective form of birth control during the study. Male participants will also be required to prevent pregnancy in their partners. At every study visit the sexual activity of participants of reproductive age will be re-assessed. If a subject who was previously sexually inactive becomes sexually active, s/he will be counseled about the need to use a reliable and effective form of birth control. Female subjects of

childbearing potential will also be required to undergo urine pregnancy tests at regular intervals including prior to teplizumab/placebo administration. A positive pregnancy test will result in holding of scheduled drug infusion.

All pregnancies that are identified during the study must be followed to conclusion and the outcome of each must be reported. The investigator should be informed immediately of any pregnancy whether occurring in a female participant or the female partner of a male participant. The investigator should report all pregnancies to TrialNet within the same timeframe (24 hours) as SAEs, using the SAE report form. Monitoring of the participant should continue until the conclusion of the pregnancy, and a follow-up SAE report form detailing the outcome of the pregnancy should be submitted to TrialNet.

8. STATISTICAL CONSIDERATIONS AND ANALYSIS PLAN

Analyses of study data will be conducted to address all objectives of the trial and other interrelationships among data elements of interest to the investigators and of relevance to the objectives of the study. Analyses by gender and race/ethnicity, as appropriate, are also planned.

Primary analysis of treatment effect will be conducted under the intention-to-treat principle whereby outcome data from all subjects randomized will be included regardless of treatment compliance.

8.1 Primary Outcome

The primary outcome is the elapsed time from random treatment assignment to the development of diabetes or time of last contact among those randomized.

Criteria for diabetes onset (T1DM) are, based on glucose testing, or the presence of unequivocal hyperglycemia with acute metabolic decompensation (diabetic ketoacidosis). One of the following criteria must be met on two occasions as soon as possible but no less than one day apart for diabetes to be defined:

1. Symptoms of diabetes plus casual plasma glucose concentration ≥ 200 mg/dL (11.1 mmol/l). Casual is defined as any time of day without regard to time since last meal. The classic symptoms of diabetes include polyuria, polydipsia, and unexplained weight loss.
2. Fasting plasma glucose ≥ 126 mg/dL (7 mmol/l). Fasting is defined as no caloric intake for at least 8 hours.
3. 2 hour plasma glucose ≥ 200 mg/dL (11.1 mmol/l). The test should be performed using a glucose load containing the equivalent of 1.75g/kg body weight to a maximum of 75 g anhydrous glucose dissolved in water.

It is preferred that at least one of the two testing occasions involve an OGTT.

Cases identified will be confirmed as having diabetes if the glucose values to make these determinations were obtained in a TrialNet laboratory as part of an OGTT. Cases diagnosed with diabetes by symptoms and casual glucose >200 mg/dL or by other criteria than the above will be adjudicated by the TrialNet Diabetes Adjudication committee.

8.2 Primary Analysis

The study design is a randomized double-blind placebo controlled trial. The primary objective of the TrialNet Anti-CD3 Trial is to assess the effect of teplizumab versus control on the risk of diabetes onset in the target population as defined by the eligibility criteria.

The cumulative incidence of diabetes onset over time since randomization within each treatment group will be estimated using the Kaplan-Meier method (proportion surviving diabetes-free as a function of time). The difference between groups in the cumulative incidence functions, and the

associated hazard functions, will be tested at the 0.025 level, one-sided, using the Cox Proportional Hazards (PH) model, stratified by age and the OGTT status (confirmed abnormal or not) at prior to randomization (35, 36). The estimates of cumulative incidence of diabetes and the test will be adjusted for age at enrollment. The relative risk of diabetes onset between groups will be estimated from the PH model. The critical values will be determined by the group-sequential procedure outlined in the section entitled Interim Monitoring Plan below.

8.3 Secondary Outcomes and Analyses

A variety of secondary analyses are planned, some of which will include the following.

1. Subgroup analyses will be conducted comparing the effects of teplizumab versus control on the risk of diabetes within subsets of the study cohort. Subgroups of the population will be classified by age (stratum) gender, race/ethnicity, specific antibody status at baseline, and presence or absence of HLA DQB1*0602. Differences in the treatment effect between subgroups will be tested using a covariate by treatment group interaction term in a PH model.

Similar analyses will be conducted using the values of quantitative baseline factors including weight, BMI, and the immunologic and metabolic factors described in Section 5 that include the autoantibody titers, basal C-peptide, OGTT stimulated C-peptide (peak and AUC mean), and measures of insulin resistance modeled from the OGTT. The treatment effect within the quantitative levels of each factor will be assessed through a covariate by treatment group interaction in a PH model. Such an analysis will also be conducted to assess the effects of age as quantitative covariate.

Additional covariates may be defined during the conduct of the study. The reporting of the analyses will distinguish between factors specified prior to primary analysis and those identified post-hoc during analysis.

2. Longitudinal analyses will assess the effects of teplizumab versus control treatment on immunologic and metabolic markers over time up to the onset of diabetes. Differences between groups in the mean levels of quantitative factors over time will be assessed using a normal errors linear model for repeated measures. Differences between groups in the prevalence of qualitative factors over time will be assessed using generalized estimating equations for categorical measures. Generalized estimating equations may also be employed for the analysis of quantitative factors when the normal errors assumptions are violated (37).

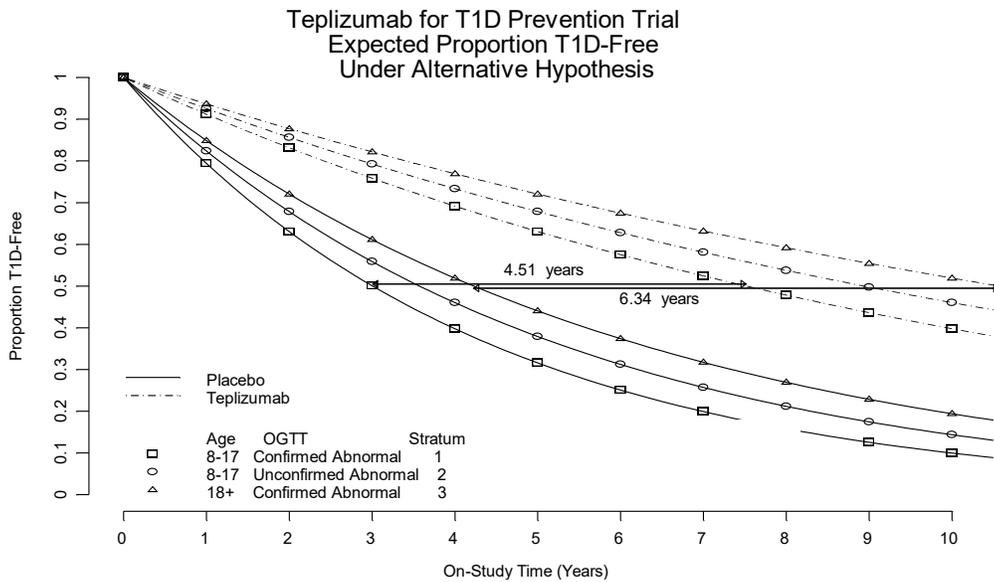
Once a subject develops diabetes, the subject will have reached the primary outcome of the study. However, the subject may still be followed for assessment of other outcomes that will permit continued longitudinal assessment of metabolic and immunologic parameters. This requirement may be satisfied through participation in another study in TrialNet.

3. The association of demographic, genetic, immunologic, metabolic, and lifestyle factors, among others, both at baseline and over time, with the risk of diabetes onset will be assessed in Cox PH Models over time. The effects of changes in longitudinal factors on diabetes risk will be assessed using time-dependent covariates for these factors. Analyses will be conducted separately within the treatment and control groups, and differences between groups in covariate effects (group by covariate interactions) will be assessed.

8.4 Study Power and Sample Size

Applying the eligibility criteria for this study to the data from the Natural History Study (TN-01), hazard and accrual rates were estimated from the TrialNet Natural History/Pathway to Prevention Study (PTP; TN-01) for the three eligible strata: 1) ages 8-17 with a confirmed abnormal OGTT, 2) ages 8-17 with an abnormal OGTT that is not confirmed, (expanded eligibility criteria), and 3) 18 or older with a confirmed abnormal OGTT. Assumptions included a constant risk over time and 25% probability of agreeing to participate. For those subjects that never received a confirmatory OGTT in the PTP study we presumed they are divided by stratum size between stratum 1 and stratum 2 in the same proportions as these groups are in the PTP Study. Likewise, hazard rates for T1DM of these grouped strata were determined by weighted average of the hazard rates from the PTP data. That is, for the 8-17 age groups the 3 strata: a) Abnormal OGTT confirmed: HR=0.1771 and accrual rate: 14.6 (35% by size) b) Abnormal but no confirmatory test: HR=0.3370 and accrual rate: 14.1 (33% by size) c) Abnormal OGTT followed by normal OGTT: HR=0.1222 and accrual rate: 13.5 (32% by size) were weighted to derive the hazard rates for strata 1 and 2. In a similar manner the accrual for 8-17 age groups was determined yielding: 22.0 and 20.3 (multiplied by 0.25, probability of agreeing to participate) for strata 1 and 2, respectively.

The estimated hazard rate is 0.231, 0.194 and 0.164 per year for strata 1, 2, and 3, respectively. The median time to T1DM onset for the control group based on a constant hazard rate is 3.01, 3.57, and 4.23 years for strata 1, 2, and 3, respectively. The effect size for this trial is a 60% reduction in the risk of T1DM (i.e., hazard ratio of experimental to control equals 0.4). This reduction in risk translates into a median time to T1DM of 7.52, 8.93, and 10.6 years for the teplizumab group for strata 1, 2, and 3, respectively (the increase is 4.51, 5.36, and 6.34 years, respectively). These design characteristics are displayed in the graph below.



The primary hypothesis test will be the Wald test of the treatment assignment variable when modeling the time to T1DM using the Cox model adjusting for baseline age and OGTT status (expanded eligibility criteria). To achieve statistical power of 80% for a one-sided Wald test at the 0.025 significance level and the effect size described above, will require enrollment and follow-up of enough participants to observe 40 subjects with T1DM onset (38) (this is the “event” sample size in contrast to the study sample size). This event sample size reflects the combination of the study sample size

and the amount of follow-up at which the fixed-sample primary hypothesis test may be conducted. Although group sequential testing will be employed, the method of Lan and DeMets maintains the power while controlling the type I error used in determining the fixed sample size.

Participants <18yo will undergo an OGTT prior to the first infusion. The results of this study will be incorporated into the analysis of the primary outcome variable but will not be used to determine eligibility for the study. The study sample size and duration are variable when fixing the “event” sample size. In the absence of any safety concerns and evoking any stopping rules, closing accrual should not occur until sufficient participants are accrued so that projections (based on the observed T1DM rates and the actual accrual pattern) indicate that within a reasonable follow-up period the event sample size will be achieved. The constant hazard rate assumption is retained to compute the initial projection. The projected annual accrual is 5.5, 5.1 and 1.6 for strata 1, 2 and 3, respectively. Allowing for a 5% per year drop-out rate and the approximately 3 dozen subjects already enrolled, the study will need to accrue a total of 71 subjects in 3 years and follow all those enrolled for another 4 years beyond the last enrolled subject to achieve a statistical power of 80% (39).

Note the accrual period and the study sample size are only projections since the actual accrual rate, the control hazard rate and the loss to follow-up rate are estimates from the PTP Study or other similar trials. Furthermore, the over-all hazard rate is sensitive to the age distribution of the enrolled study population which is also an approximation. As the study progresses, projections of the study duration will be computed based on the observed data (noncomparative treatment analysis) and if in conflict, will be brought to the attention of the DSMB and the TrialNet governing body to determine the best course of action.

8.5 Interim Monitoring Plan

Interim analyses will be conducted when 50% of the expected number of cases of T1DM have been observed and will be reviewed by the TrialNet Data and Safety Monitoring Board (DSMB) for assessment of effectiveness and safety. The same primary endpoint analysis described above will be used to evaluate the evidence of a treatment group effect during interim analyses. The Wald test from the PH model will be transformed to a z-score (with negative values indicating a reduction in risk in the teplizumab treated group). If a group sequential stopping boundary is crossed, the DSMB may terminate the trial early. The Lan and DeMets (40) spending function with an O’Brien-Fleming boundary will be used to protect the type I error probability for the primary outcome analyses, and to assess the significance of the interim results periodically during the trial. The spending function (α_1) that approximates the O’Brien-Fleming boundaries is:

$$\alpha_1(t^*) = 2 - 2\Phi \left[\frac{Z_{\alpha/2}}{\sqrt{t^*}} \right]$$

where t^* is the information fraction ($0 < t^* \leq 1$) and α is the fixed-sample type I error (i.e., 0.025).

The DSMB will also be informed if there is a serious lack of evidence of a treatment effect (i.e. futility analysis). The boundaries are based on the paper by Lachin (41). The study should be stopped based on the futility of rejecting the null hypothesis at the completion of the trial if: $Z_{HR}(t^*) \geq 0$ when $0.5 \leq t^* < 0.8$ or if $Z_{HR}(t^*) \geq -0.8$ when $t^* \geq 0.8$.

Using Lachin's formulas a onetime use of either boundary for the design parameters above ($\theta \equiv Z_{1-\alpha} + Z_{1-\beta} = 2.8$) raises the type II error to approximately 0.204 and 0.202, respectively. For larger values of t^* the increase to the error probability is even less. Furthermore, by the laws of probability a single use of each rule will increase the type II error no more than the sum of the increase (i.e., $0.15+0.004+0.002 = 0.156$).

Additional analysis will assess potential adverse outcomes of treatment and will assess the incidence of all severe adverse events.

8.6. Withdrawal Criteria- Individual Subjects

An intent-to-treat approach will be used. Subjects will not be replaced. All data acquired prior to termination for the reasons outlined below will be included in the primary analysis unless patient withdraws consent. Every effort will be made to conduct a final study visit with the participant and participants will be followed clinically until, if applicable, all adverse events resolve.

- Withdrawal of consent
- Withdrawal by the participant
- Withdrawal by the investigator
- Intercurrent illness or event that precludes further visits to the study site or ability to evaluate disease

9. ETHICAL CONSIDERATIONS AND COMPLIANCE WITH GOOD CLINICAL PRACTICE

9.1. Statement of Compliance

This study will be conducted in compliance with the protocol and consistent with current Good Clinical Practices (GCP), adopting the principles of the Declaration of Helsinki, and all applicable regulatory requirements (*ICH E6, 45CFR46, and FDA 21CFR sections 11, 50, 56, 312*).

Prior to study initiation, the protocol and the informed consent documents will be reviewed and approved by an appropriate Independent Ethics Committee/Research Ethics Board (IEC/REB) or Institutional Review Board (IRB). Any amendments to the protocol or consent materials must also be approved before they are implemented.

9.2. Participating Centers

Participating TrialNet clinical sites must have an appropriate assurance, such as a Federal-wide Assurance (FWA) or an Unaffiliated Investigators Agreement (UIA), with the Office for Human Research Protections (OHRP), since they are actively engaged in research and provide informed consent. The protocol and consent forms will be approved by Institutional Review Boards or Ethics Committees/Research Ethics Boards at each of the participating clinical sites. HIPAA and applicable local regulations will be followed by each participating institution in accordance with each institution's requirements. The participating international sites will obtain approval from their corresponding review boards in accordance with their local procedures and institutional requirements.

The investigator is required to keep accurate records to ensure the conduct of the study is fully documented. The investigator is required to ensure that all source documentation is legibly completed for every participant entered in the trial.

The investigational sites participating in this study will maintain the highest degree of confidentiality permitted for the clinical and research information obtained from participants participating in this study. When a subject participates in this study at more than one TrialNet site, sharing of this information is required. Medical and research records will be maintained at each site in the strictest confidence. However, as a part of the quality assurance and legal responsibilities of an investigation, the investigational site must permit authorized representatives of the sponsor(s) and regulatory agencies to examine (and when required by applicable law, to copy) records for the purposes of quality assurance reviews, audits and evaluation of the study safety and progress. Unless required by the laws permitting copying of records, only the coded identity associated with documents or other participant data may be copied (obscuring any personally identifying information). Authorized representatives, as noted above, are bound to maintain the strict confidentiality of medical and research information that may be linked to identify individuals. The investigational site will normally be notified in advance of auditing visits.

9.3. Informed Consent

The process of assuring that individuals (and parent/guardian if less than 18 years of age) are making an informed decision about participating in this study includes both verbal and written communication. Written materials include a Participant Handbook and written consent forms. There are several consent forms for this study. One is a Screening consent form that describes the procedures, risks, and benefits, and eligibility requirements for the study. The second is the Intervention consent form, which describes the procedures, risks, and benefits for the remainder of the study. A third consent form is for use at clinical sites that will be performing the post-treatment visits, but not the treatment visits. The consent forms will be reviewed with participants (and their guardian in the case of participants under 18 years of age) and the participant will be given time to review the written consent form and ask questions. An assent form has also been developed for participants less than 18 years of age (unless local IRB requirements differ in procedure).

As part of the informed consent process, the participant and/or parent or guardian (if the participant is less than 18 years of age) will also be required to complete a short, written Volunteer Understanding Quiz that is designed to ensure that the subject understands the study, as well as what is being asked of him/her. The participant will be given a copy of their signed consent/assent forms.

The consent process will be conducted by qualified study personnel (the Trial or Study Coordinator and/or Investigator or other designee). All participants (or their legally acceptable representative) must read, sign and date a consent form prior to participation in the study, and/or undergoing any study-specific procedures.

The informed consent form must be updated or revised whenever there is new, clinically significant information applicable to the safety of the participants, when indicated for a protocol amendment, and/or whenever any new information becomes available that may affect a patient's participation in the study.

Subjects will be re-consented if they reach the age of 18 years while enrolled in the study.

9.4. Study Subject Confidentiality

Study records with the study subject's information for internal use at the clinical sites will be secured at the study site during the study. Identifying study subject information may be shared between TrialNet clinical sites that are involved in study procedures and/or oversight of the participant. At the end of the study, all records will continue to be kept in a secure location. There are no plans to destroy the records.

Study subject data, which is for reporting purposes, will be stored at The TrialNet Coordinating Center. Data sent to the Coordinating Center will identify participants by the unique TrialNet Identification Number. The data entry system at the Coordinating Center is a secured, password protected computer system. At the end of the study, all study databases will be archived at the Coordinating Center for long-term storage. De-identified safety data will be shared with MacroGenics during the course of the study so the company may meet its regulatory reporting requirements as the drug manufacturer and IND sponsor. Additional de-identified data will be shared with MacroGenics at the end of the study.

Stored samples including genetic samples could be utilized to learn more about causes of type 1 diabetes, its complications (such as eye, nerve, and kidney damage) and other conditions for which individuals with diabetes are at increased risk, and how to improve treatment. The results of these future analyses, and any mechanistic studies will not be made known to the participant.

9.5. Risks and Benefits

The risks of this study are presented in this protocol, the Investigator's Brochure and informed consent form. There is no guaranteed benefit to subjects for their participation in the study. This study will examine whether intervention with teplizumab will delay or prevent the onset of diabetes, but there is no guarantee that this will occur. However, all subjects will benefit from close monitoring for the development of diabetes. This close monitoring significantly reduces the morbidity typically associated with clinical onset of disease.

Special consideration regarding risks and benefits for children is described in section 2.5.

9.6. Ethics

The study protocol, along with the required informed consent forms, will be approved by each participating institution's Institutional Review Board (IRB) or Ethics Committee/Research Ethics Board (EC/REB) at international sites prior to the initiation of any research procedures (at the site). In addition to details described in the sections above (informed consent, confidentiality, and risks and benefits) the investigators have reviewed and considered ethical ramifications in the design and development of this protocol. The investigators have made every effort to minimize and monitor risks and discomforts to participants throughout the course of the study.

10. STUDY ADMINISTRATION

10.1. Organizational Structure

This study is part of Type 1 Diabetes TrialNet, which is funded by the National Institutes of Health. Funding will cover the costs of administration and laboratory tests associated with this study during the participant's period of follow-up.

10.2. Role of Industry

The IND holder is MacroGenics, Inc. MacroGenics will provide teplizumab and placebo for the study and financial support for clinical trial monitoring supplemental to standard TrialNet procedures. Eli Lilly and Company holds an exclusive license from MacroGenics to develop and commercialize teplizumab. Under TrialNet's direction, MacroGenics will perform measurements such as PK and anti-teplizumab antibodies as indicated on coded samples. Data and data analysis will be conducted by TrialNet investigators.

10.3. Groups and Committees

10.3.1. Anti-CD3 Prevention Study Chair

The Study Chair and TrialNet executive committee will receive periodic reports from the TNCC on the progress of the study. These will include accrual rates and baseline demographic characteristics. Interim data summaries provided to others (except those that could lead to unmasking of the treatment arms) will first be supplied to the Study Chair for review. Criteria and results of ongoing monitoring of the TrialNet labs in terms of reproducibility will also be provided on a routine basis and reported on during Anti-CD3 Prevention Study Committee meetings, as scheduled. As appropriate, abstracts and manuscripts dealing with the progress of the trial shall be directed by the Study Committee.

10.3.2. TrialNet Chairman's Office and TrialNet Coordinating Center

The TrialNet Chairman's Office and TNCC will work together in providing leadership to the TrialNet study group to include protocol and manual preparation, training for clinical sites, development of statistical design for each study, and analysis of study results. The TNCC will also coordinate interactions among the participating TrialNet clinical centers, test laboratories including TrialNet core laboratories and other subcontract laboratories, NIDDK, and other sponsoring agencies.

10.3.3. Clinical Sites

Each Principal Investigator at the participating TrialNet clinical site will oversee all operations at that site. The clinical sites will forward all laboratory and data collection form information to the TNCC for analysis. Conference calls and site visits, as needed, will facilitate evaluation of the trial management. Certain TrialNet sites will be involved in recruitment and follow up of subjects and some sites will also administer study drug.

10.3.4. Diabetes Adjudication Committee

A TrialNet Diabetes Onset Adjudication Committee will review all relevant information for each subject who does not meet the criteria stated in section 8.1 but has been otherwise diagnosed as having developed diabetes. The Committee will determine whether the diagnosis of diabetes in each of these subjects is sufficiently sound so as to include that subject among the cases who have reached the primary outcome in the statistical analysis. The Committee will be masked to treatment assignment as it reviews each case masked to treatment assignment.

10.3.5. Clinical Site Monitoring

In order to conduct this study with established research principles, site visits will be conducted during the study to evaluate study conduct. All sites will be monitored by the Coordinating Center and appropriate TrialNet committees for patient enrollment, compliance with protocol procedures, completeness and accuracy of data entered on the case report forms (CRFs), and the occurrence and reporting of adverse events (AEs) and serious adverse events (SAEs).

10.4. Medical Monitor and Data Safety and Monitoring Board (DSMB)

All adverse events will be recorded on the adverse event forms, which will be sent to the local IRBs, per their reporting requirements, and to the TNCC according to reporting guidelines.

An independent physician will be designated to serve as the medical monitor for this study who will maintain regular contact with the study and the study chair. (S)he will review all adverse event reports, masked to treatment assignment, and will file event reports with regulatory authorities as appropriate.

The DSMB will meet approximately every 3 months and as needed to review indicators of safety. In addition, they will meet every 6 months to review the interim effectiveness and potential toxicity of the study treatments based on interim analyses of indicators of effectiveness and safety prepared by the TNCC separately by treatment group. The DSMB will independently evaluate whether there are grounds to modify or discontinue the study.

10.5. Sample and Data Storage

Samples to be stored for research purposes will be located at the NIDDK Repository and at TrialNet Sites. While TrialNet is active, the use of the samples will be restricted to TrialNet researchers unless researchers from outside of TrialNet obtain approval from the TrialNet Steering Committee and the NIDDK to utilize the samples. Samples that are obtained for pharmacokinetics and measurement of anti-teplizumab antibodies may be made available to MacroGenics for analysis. All samples will be coded with unique study numbers, but TrialNet researchers will be able to identify samples if it is necessary to contact participants for reasons of health or for notification to them about future studies. Approval from the TrialNet Steering Committee and the NIDDK would be required before such linkage could occur. Researchers from outside of TrialNet will not be permitted to identify samples.

Data collected for this study will be sent to the TNCC. After the study is completed, the safety study data will be sent to MacroGenics by the TNCC to allow integration of all safety data on teplizumab.

De-identified data will be stored at the NIDDK Repository, under the supervision of the NIDDK/NIH, for use by researchers including those outside of TrialNet.

When TrialNet is completed, samples will continue to be stored at the NIDDK Repository Sites. Since the stored data will be fully de-identified upon the completion of TrialNet, it will no longer be possible to identify samples. Thus, whereas a sample can be destroyed upon a participant's request during the existence of the TrialNet, it can no longer be destroyed once TrialNet is completed. However, there will still be the potential to link data derived from the samples with data that had been derived from TrialNet studies. Once TrialNet is completed, researchers will only obtain access to samples through grant proposals approved by the NIDDK. The NIDDK will convene an external panel of experts to review requests for access to samples.

10.6. Preservation of the Integrity of the Study

The scientific integrity of the trial dictates that results be reported on a study-wide basis; thus, an individual Center will not report the data collected from its site alone. All presentations and publications using TrialNet trial data must protect the main objectives of the trial. Data that could be perceived as threatening the study outcome will not be presented prior to release of the primary study outcomes. Approval as to the timing of presentations of data and the meetings at which they might be presented will be granted by the TrialNet Steering Committee. Study results should be discussed with the news media only upon authorization of the Steering Committee, and never before the results are presented. Any written statements about this study that are shared with national media must be approved by TrialNet before release.

10.7. Participant Reimbursement and Compensation

Participants will be compensated for each visit attended in the study.

APPENDIX 1: Natural History/Pathway to Prevention to Teplizumab in At-Risk Relatives Study Flow Chart for Subjects ≥18yo

Natural History

Screening

Procedures First or second degree relative
Initial AutoAntibody draw

Results to move on **AutoAntibodies (AA)**
At least one autoantibody confirmed positive, or two autoantibodies present



Natural History

Risk

Assessment

Procedures Confirmation of autoantibody status, OGTT, HLA

Results to move onto teplizumab **AutoAntibodies (AA)¹**
At least two confirmed diabetes related autoantibodies confirmed to be present on two occasions. Confirmation of 2 positive autoantibodies must occur within six months prior to randomization, but the confirmation does not have to involve the same 2 autoantibodies.

OGTT

Fasting Plasma Glucose ≥ 110 mg/dL and < 126 mg/dL OR
2-hr Plasma Glucose ≥140 mg/dL and < 200 mg/dL OR
30, 60, or 90 minute glucose ≥ 200 mg/dL



Teplizumab eligibility visit

Procedures Screening consent is signed. OGTT² (unless abnormal glucose tolerance has been previously confirmed from a test in TrialNet within 7 weeks (52 days) of randomization), laboratory assessments, PPD, History, PE, Volunteer Quiz, Education.

Results to move on OGTT with abnormal glucose tolerance (if applicable)
Does not meet any exclusion criteria³



Teplizumab Baseline and Randomization visit

Procedures Intervention consent signed. Baseline laboratory assessments, dosing of teplizumab/placebo

¹*If autoantibodies are not confirmed positive on the second test a tiebreaker draw will be required.*

²*If the OGTT confirms abnormal glucose tolerance, the subject is eligible to proceed with randomization. If the OGTT is consistent with diabetes, the subject is not eligible for enrollment. He/She may be eligible for enrollment in the future if subsequent studies do not confirm the diagnosis of diabetes and the above entry criteria are met. If neither abnormal glucose tolerance or diabetes is confirmed, the subjects may have repeat studies as outlined above to meet the entry criteria.*

³*If subject not eligible or unwilling to participate in teplizumab in at-risk, subject may be followed in TN Natural History/Pathway to Prevention Study.*

APPENDIX 2: Natural History/Pathway to Prevention to Teplizumab in At-Risk Relatives Study Flow Chart for Subjects <18yo

Natural History

Screening

Procedures First or second degree relative
Initial AutoAntibody draw

Results to move on **AutoAntibodies (AA)**
At least one autoantibody confirmed positive, or two autoantibodies present



Natural History

Risk

Assessment

Procedures Confirmation of autoantibody status, OGTT, HLA

Results to move onto teplizumab **AutoAntibodies (AA)¹**
At least two confirmed diabetes related autoantibodies confirmed to be present on two occasions. Confirmation of 2 positive autoantibodies must occur within six months prior to randomization, but the confirmation does not have to involve the same 2 autoantibodies.

OGTT

Fasting Plasma Glucose ≥ 110 mg/dL and < 126 mg/dL OR
2-hr Plasma Glucose ≥ 140 mg/dL and < 200 mg/dL OR
30, 60, or 90 minute glucose ≥ 200 mg/dL



Teplizumab eligibility visit

Procedures Screening consent is signed. Random Glucose² or OGTT if not previously performed, laboratory assessments, PPD, History, PE, Volunteer Quiz, Education.

Results to move on Non-Fasting Random Glucose < 200 mg/dL, or OGTT with abnormal glucose tolerance
Does not meet any exclusion criteria³



Teplizumab Baseline and Randomization visit

Procedures Intervention consent signed. Baseline laboratory assessments, OGTT, dosing of teplizumab/placebo

¹*If autoantibodies are not confirmed positive on the second test a tiebreaker draw will be required.*

²*If the Random Glucose is consistent with diabetes, the subject is not eligible for enrollment. He/She may be eligible for enrollment in the future if subsequent studies do not confirm the diagnosis of diabetes and the above entry criteria are met. If neither abnormal glucose tolerance or diabetes is confirmed, the subjects may have repeat studies as outlined above to meet the entry criteria.*

³*If subject not eligible or unwilling to participate in teplizumab in at-risk, subject may be followed in TN Natural History/Pathway to Prevention Study.*

10= The assessments at month 72 will be repeated every 6 months.

11. REFERENCES

1. Harris MI, Cowie C, Stern MP, Boyko EJ, Reiber GE, Bennett PH: *Diabetes in America*, National Diabetes Information Clearinghouse 2007
2. Variation and trends in incidence of childhood diabetes in Europe. EURODIAB ACE Study Group. *Lancet* 355:873-876, 2000
3. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. The Diabetes Control and Complications Trial Research Group. *N Engl J Med* 329:977-986, 1993
4. Atkinson MA: ADA Outstanding Scientific Achievement Lecture 2004. Thirty years of investigating the autoimmune basis for type 1 diabetes: why can't we prevent or reverse this disease? *Diabetes* 54:1253-1263, 2005
5. Riley WJ, Maclaren NK, Krischer J, Spillar RP, Silverstein JH, Schatz DA, Schwartz S, Malone J, Shah S, Vadheim C, et al.: A prospective study of the development of diabetes in relatives of patients with insulin-dependent diabetes. *N Engl J Med* 323:1167-1172., 1990
6. Sherr J, Sosenko J, Skyler JS, Herold KC: Prevention of type 1 diabetes: the time has come. *Nat Clin Pract Endocrinol Metab* 4:334-343, 2008
7. Eisenbarth GS: Type I diabetes mellitus. A chronic autoimmune disease. *N Engl J Med* 314:1360-1368, 1986
8. Wenzlau JM, Juhl K, Yu L, Moua O, Sarkar SA, Gottlieb P, Rewers M, Eisenbarth GS, Jensen J, Davidson HW, Hutton JC: The cation efflux transporter ZnT8 (Slc30A8) is a major autoantigen in human type 1 diabetes. *Proc Natl Acad Sci U S A* 104:17040-17045, 2007
9. Sosenko JM, Palmer JP, Greenbaum CJ, Mahon J, Cowie C, Krischer JP, Chase HP, White NH, Buckingham B, Herold KC, Cuthbertson D, Skyler JS: Patterns of metabolic progression to type 1 diabetes in the Diabetes Prevention Trial-Type 1. *Diabetes Care* 29:643-649, 2006
10. Tsai EB, Sherry NA, Palmer JP, Herold KC: The rise and fall of insulin secretion in type 1 diabetes mellitus. *Diabetologia* 49:261-270, 2006
11. Effects of insulin in relatives of patients with type 1 diabetes mellitus. *N Engl J Med* 346:1685-1691., 2002
12. Effect of intensive therapy on residual beta-cell function in patients with type 1 diabetes in the diabetes control and complications trial. A randomized, controlled trial. The Diabetes Control and Complications Trial Research Group. *Ann Intern Med* 128:517-523, 1998
13. Skyler JS, Krischer JP, Wolfsdorf J, Cowie C, Palmer JP, Greenbaum C, Cuthbertson D, Rafkin-Mervis LE, Chase HP, Leschek E: Effects of oral insulin in relatives of patients with type 1 diabetes: The Diabetes Prevention Trial--Type 1. *Diabetes Care* 28:1068-1076, 2005
14. Gale EA, Bingley PJ, Emmett CL, Collier T: European Nicotinamide Diabetes Intervention Trial (ENDIT): a randomised controlled trial of intervention before the onset of type 1 diabetes. *Lancet* 363:925-931, 2004
15. Sosenko JM, Krischer JP, Palmer JP, Mahon J, Cowie C, Greenbaum CJ, Cuthbertson D, Lachin JM, Skyler JS: A Risk Score for Type 1 Diabetes Derived from Autoantibody Positive Participants in The Diabetes Prevention Trial- Type 1. *Diabetes Care*, 2007
16. Sosenko JM, Palmer JP, Rafkin-Mervis L, Krischer JP, Cuthbertson D, Matheson D, Skyler JS: Glucose and C-peptide changes in the perionset period of type 1 diabetes in the Diabetes Prevention Trial-Type 1. *Diabetes Care* 31:2188-2192, 2008
17. Bougneres PF, Carel JC, Castano L, Boitard C, Gardin JP, Landais P, Hors J, Mihatsch MJ, Paillard M, Chaussain JL, et al.: Factors associated with early remission of type I diabetes in children treated with cyclosporine. *N Engl J Med* 318:663-670., 1988
18. Keymeulen B, Vandemeulebroucke E, Ziegler AG, Mathieu C, Kaufman L, Hale G, Gorus F, Goldman M, Walter M, Candon S, Schandene L, Crenier L, De Block C, Seigneurin JM, De Pauw P, Pierard D, Weets I, Rebello P, Bird P, Berrie E, Frewin M, Waldmann H, Bach JF, Pipeleers D,

- Chatenoud L: Insulin needs after CD3-antibody therapy in new-onset type 1 diabetes. *N Engl J Med* 352:2598-2608, 2005
19. Xu D, Alegre ML, Varga SS, Rothermel AL, Collins AM, Pulito VL, Hanna LS, Dolan KP, Parren PW, Bluestone JA, Jolliffe LK, Zivin RA: In vitro characterization of five humanized OKT3 effector function variant antibodies. *Cell Immunol* 200:16-26., 2000
 20. Bisikirska B, Colgan J, Luban J, Bluestone JA, Herold KC: TCR stimulation with modified anti-CD3 mAb expands CD8 T cell population and induces CD8CD25 Tregs. *J Clin Invest* 115:2904-2913, 2005
 21. Herold KC, Burton JB, Francois F, Poumian-Ruiz E, Glandt M, Bluestone JA: Activation of human T cells by FcR nonbinding anti-CD3 mAb, hOKT3gamma1(Ala-Ala). *J Clin Invest* 111:409-418, 2003
 22. Mach H, Middaugh CR, Lewis RV: Statistical determination of the average values of the extinction coefficients of tryptophan and tyrosine in native proteins. *Anal Biochem* 200:74-80, 1992
 23. Herold KC, Hagopian W, Auger JA, Poumian-Ruiz E, Taylor L, Donaldson D, Gitelman SE, Harlan DM, Xu D, Zivin RA, Bluestone JA: Anti-CD3 monoclonal antibody in new-onset type 1 diabetes mellitus. *N Engl J Med* 346:1692-1698., 2002
 24. Chatenoud L, Primo J, Bach JF: CD3 antibody-induced dominant self tolerance in overtly diabetic NOD mice. *J Immunol* 158:2947-2954., 1997
 25. Chatenoud L, Thervet E, Primo J, Bach JF: Anti-CD3 antibody induces long-term remission of overt autoimmunity in nonobese diabetic mice. *Proc Natl Acad Sci U S A* 91:123-127., 1994
 26. Herold KC, Bluestone JA, Montag AG, Parihar A, Wiegner A, Gress RE, Hirsch R: Prevention of autoimmune diabetes with nonactivating anti-CD3 monoclonal antibody. *Diabetes* 41:385-391., 1992
 27. Fife BT, Guleria I, Gubbels Bupp M, Eagar TN, Tang Q, Bour-Jordan H, Yagita H, Azuma M, Sayegh MH, Bluestone JA: Insulin-induced remission in new-onset NOD mice is maintained by the PD-1-PD-L1 pathway. *J Exp Med* 203:2737-2747, 2006
 28. Sherry N, Chen W, Kushner JA, Glandt M, Tang Q, Tsai S, Santamaria P, Bluestone J, Brillantes AM, Herold K: Exendin-4 improves reversal of diabetes in NOD mice treated with anti-CD3 mAb by enhancing recovery of β cells. *Endocrinology*, 2007
 29. Belghith M, Bluestone JA, Barriot S, Megret J, Bach JF, Chatenoud L: TGF-beta-dependent mechanisms mediate restoration of self-tolerance induced by antibodies to CD3 in overt autoimmune diabetes. *Nat Med* 9:1202-1208, 2003
 30. Herold KC, Gitelman SE, Masharani U, Hagopian W, Bisikirska B, Donaldson D, Rother K, Diamond B, Harlan DM, Bluestone JA: A Single Course of Anti-CD3 Monoclonal Antibody hOKT3{gamma}1(Ala-Ala) Results in Improvement in C-Peptide Responses and Clinical Parameters for at Least 2 Years after Onset of Type 1 Diabetes. *Diabetes* 54:1763-1769, 2005
 31. Herold KC, Gitelman S, Greenbaum C, Puck J, Hagopian W, Gottlieb P, Sayre P, Bianchine P, Wong E, Seyfert-Margolis V, Bourcier K, Bluestone JA: Treatment of patients with new onset Type 1 diabetes with a single course of anti-CD3 mAb teplizumab preserves insulin production for up to 5 years. *Clin Immunol*, 2009
 32. Tamborlane WV, Beck RW, Bode BW, Buckingham B, Chase HP, Clemons R, Fiallo-Scharer R, Fox LA, Gilliam LK, Hirsch IB, Huang ES, Kollman C, Kowalski AJ, Laffel L, Lawrence JM, Lee J, Mauras N, O'Grady M, Ruedy KJ, Tansey M, Tsalikian E, Weinzimer S, Wilson DM, Wolpert H, Wysocki T, Xing D: Continuous glucose monitoring and intensive treatment of type 1 diabetes. *N Engl J Med* 359:1464-1476, 2008
 33. Classification and diagnosis of diabetes mellitus and other categories of glucose intolerance. National Diabetes Data Group. *Diabetes* 28:1039-1057, 1979
 34. Report of the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. *Diabetes Care* 26:3160-3167, 2003
 35. Cox DR: Regression model and Life Tables *J R Stat Soc* 34B:187-220, 1972
 36. Kalbfleisch JD, Prentice RL: The statistical analysis of failure time data., 1980
 37. Diggle PJ, Heagerty PJ, Liang K-Y, Zeger SL: *Analysis of longitudinal data*. Oxford, UK, Oxford Clarendon Press, 1994

38. Schoenfeld D. *Sample-sizes for the Proportional Hazards Regression Model*. Biometrics 1983;39:499-503 1983
39. Lachin JM, Foulkes MA. Evaluation of sample size and power for analyses of survival with allowance for nonuniform patient entry, losses to follow-up, noncompliance, and stratification. Biometrics 1986; 42(3):507-519.
40. Lan KKG, DeMets DL. Discrete sequential boundaries for clinical trials. Biometrika 1983; 70:659-663
41. JM Lachin. Futility interim monitoring with control of type I and II error probabilities using the interim Z-value or confidence limit. Clinical Trials 2009; 6 (6) 565-573