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DOI:

[10.1053/j.gastro.2020.02.030](https://doi.org/10.1053/j.gastro.2020.02.030)

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### Document Version

Peer reviewed version

### Citation for published version (Harvard):

Sandborn , WJ, Ghosh, S, Panes, J, Schreiber, S, D'Haens, G, Tanida, S, Siffledeen, J, Enejosa, J, Zhou, W, Ahmed, O, Huang, B & Higgins, PDR 2020, 'Efficacy of upadacitinib in a randomized trial of patients with active ulcerative colitis', *Gastroenterology*, vol. 158, no. 8, pp. 2139-2149.e14. <https://doi.org/10.1053/j.gastro.2020.02.030>

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Efficacy of Upadacitinib in a Randomized Trial of Patients With Active Ulcerative Colitis

William J. Sandborn, M.D., Subrata Ghosh, M.D., Julian Panes, M.D., PhD., Stefan Schreiber, M.D., Geert D'Haens, M.D., Ph.D., Satoshi Tanida, M.D., Ph.D., Jesse Siffledeen, M.D., Jeffrey Enejosa, M.D., Wen Zhou, M.D., Ph.D., Ahmed A. Othman, Ph.D., Bidan Huang, Ph.D., Peter D.R. Higgins, M.D., Ph. D

PII: S0016-5085(20)30241-9  
DOI: <https://doi.org/10.1053/j.gastro.2020.02.030>  
Reference: YGAST 63229

To appear in: *Gastroenterology*  
Accepted Date: 16 February 2020

Please cite this article as: Sandborn WJ, Ghosh S, Panes J, Schreiber S, D'Haens G, Tanida S, Siffledeen J, Enejosa J, Zhou W, Othman AA, Huang B, Higgins PDR, Efficacy of Upadacitinib in a Randomized Trial of Patients With Active Ulcerative Colitis, *Gastroenterology* (2020), doi: <https://doi.org/10.1053/j.gastro.2020.02.030>.

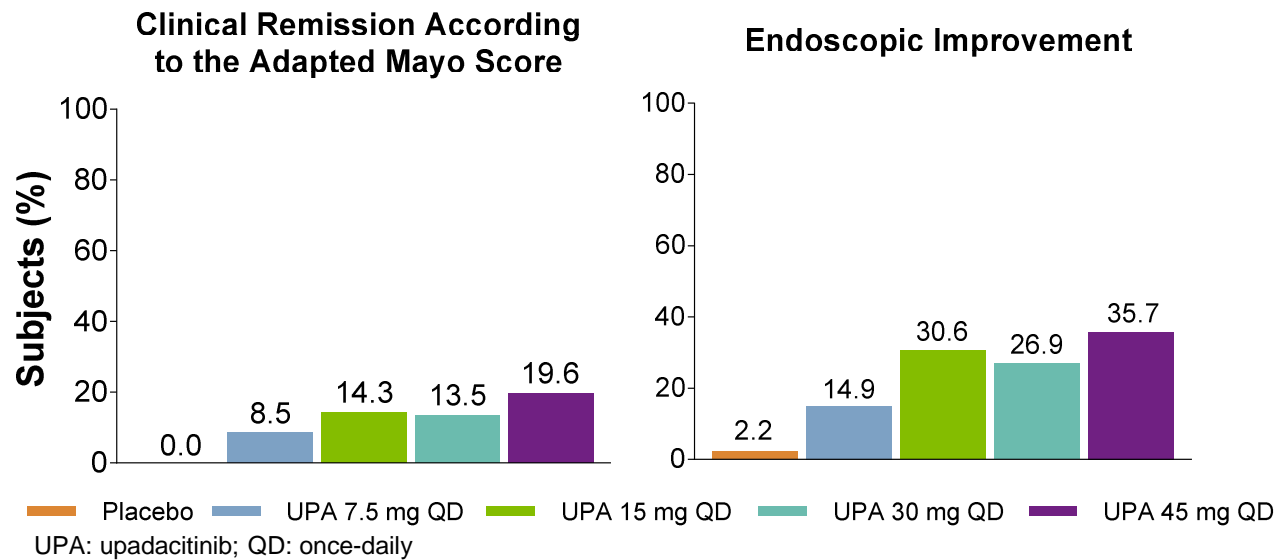
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250 adults with median disease duration of 5.92 years: 54% of the patients had pancolitis and 36.1% of the patients had Adapted Mayo score > 7, and 73.2% of patients had been previously exposed to a TNF antagonist.

### Upadacitinib was more effective than placebo as an induction therapy in patients with ulcerative colitis at Week 8



Upadacitinib was well tolerated. The frequency of adverse events of special interest was generally low (<5%) in the upadacitinib groups with the exception of anemia, hepatic disorder and creatine phosphokinase elevation.

Gastroenterology

**Title:** Efficacy of Upadacitinib in a Randomized Trial of Patients With Active Ulcerative Colitis

**Authors:** William J. Sandborn, M.D.,<sup>1</sup> Subrata Ghosh, M.D.,<sup>2</sup> Julian Panes, M.D.,PhD.,<sup>3</sup> Stefan Schreiber, M.D.,<sup>4</sup> Geert D'Haens, M.D., Ph.D.,<sup>5</sup> Satoshi Tanida, M.D., Ph.D.,<sup>6</sup> Jesse Siffledeen, M.D.,<sup>7</sup> Jeffrey Enejosa, M.D.,<sup>8</sup> Wen Zhou, M.D., Ph.D.,<sup>8</sup> Ahmed A. Othman, Ph.D.,<sup>8</sup> Bidan Huang, Ph.D.,<sup>8</sup> Peter D. R. Higgins, M.D., Ph. D.<sup>9</sup>

**Affiliations:**

<sup>1</sup>University of California San Diego, La Jolla, United States

<sup>2</sup>NIHR Biomedical Research Centre Birmingham, University of Birmingham and University Hospitals Birmingham NHS Trust, UK

<sup>3</sup>Hospital Clínic Barcelona, IDIBAPS, CIBERehd, Barcelona, Spain

<sup>4</sup>University Hospital Schleswig-Holstein, Kiel, Germany

<sup>5</sup>Amsterdam University Medical Centers, Amsterdam, Netherlands

<sup>6</sup>Nagoya City University, Nagoya, Japan

<sup>7</sup>University of Alberta, Edmonton, Canada

<sup>8</sup>AbbVie Inc., North Chicago, United States

<sup>9</sup>University of Michigan, Ann Arbor, United States

**Funding:** AbbVie Inc.

**Abbreviations used in this manuscript:** AE, adverse event; CMH, Cochran-Mantel-Haenszel; CPK, creatine phosphokinase; DVT, deep venous thrombosis; ES, endoscopic subscore; ICH, International Conference on Harmonization; ITT, intention-to-treat; JAK, Janus kinase; MCP-Mod, multiple comparison procedure and modelling; PE, pulmonary embolism; QD, once daily; RBS, rectal bleeding subscore; SFS, stool frequency subscore; STATs, signal transducers and activators of transcription; TK, tyrosine kinase;

**Corresponding authors:**

**Dr. William Sandborn**

Professor of Medicine and Adjunct Professor of Surgery  
Chief, Division of Gastroenterology  
Vice Chair for Clinical Operations, Department of Medicine  
Director, UCSD IBD Center, UC San Diego Health System  
Mail: 9500 Gilman Drive, MC 0956, La Jolla, CA 92093  
Email: [wsandborn@ucsd.edu](mailto:wsandborn@ucsd.edu)  
Telephone: 858-657-5331  
Fax: 858-657-5022

**Dr. Peter D. R. Higgins**

Professor of Gastroenterology and Internal Medicine  
Director of IBD program at the University of Michigan  
Mail: 1500 E Medical Center Dr # 391, Ann Arbor, MI 48109  
Email: [phiggins@med.umich.edu](mailto:phiggins@med.umich.edu)  
Telephone: 734-647-2964

**Disclosures**

**W.J. Sandborn:** research grants from Atlantic Healthcare Limited, Amgen, Genentech, Gilead Sciences, Abbvie, Janssen, Takeda, Lilly, Celgene/Receptos, Pfizer, Prometheus Laboratories (now Prometheus Biosciences); consulting fees from Abbvie, Allergan, Amgen, Arena Pharmaceuticals, Avexegen Therapeutics, BeiGene, Boehringer Ingelheim, Celgene, Celltrion, Conatus, Cosmo, Escalier Biosciences, Ferring, Forbion, Genentech, Gilead Sciences, Gossamer Bio, Incyte, Janssen, Kyowa Kirin Pharmaceutical Research, Landos Biopharma, Lilly, Oppilan Pharma, Otsuka, Pfizer, Progenity, Prometheus Biosciences (merger of Precision IBD and Prometheus Laboratories), Reistone, Ritter Pharmaceuticals, Robarts Clinical Trials (owned by Health Academic Research Trust, HART), Series Therapeutics, Shire, Sienna Biopharmaceuticals, Sigmoid Biotechnologies, Sterna Biologicals, Sublimity Therapeutics, Takeda, Theravance Biopharma, Tigenix, Tillotts Pharma, UCB Pharma, Ventyx Biosciences, Vimalan Biosciences, Vivelix Pharmaceuticals; and stock or stock options from BeiGene,

Escalier Biosciences, Gossamer Bio, Oppilan Pharma, Prometheus Biosciences (merger of Precision IBD and Prometheus Laboratories), Progenity, Ritter Pharmaceuticals, Ventyx Biosciences, Vimalan Biosciences. Spouse: Opthotech - consultant, stock options; Progenity - consultant, stock; Oppilan Pharma - employee, stock options; Escalier Biosciences - employee, stock options; Prometheus Biosciences (merger of Precision IBD and Prometheus Laboratories) - employee, stock options; Ventyx Biosciences – employee, stock options; Vimalan Biosciences – employee, stock options.

**S. Ghosh:** consulting fees from Boehringer-Ingelheim, Gilead, Pfizer, Janssen, AbbVie, BMS, Celgene and speaker's fees from AbbVie, Ferring, Janssen, Takeda, Shield, Pfizer and Falk Pharma.

**J. Panés:** consulting fees from AbbVie, Arena Pharmaceuticals, Boehringer Ingelheim, Celgene, Celltrion, Ferring, Genentech, Janssen, MSD, Oppilan, Pfizer, Progenity, Robarts, Roche, Takeda, Theravance, and TiGenix, a, speaker's fees from AbbVie, Ferring, Janssen, MSD, Shire Pharmaceuticals, and Takeda; and research funding from AbbVie and MSD.

**S. Schreiber:** consultancy and lecture fees from AbbVie, Boehringer Ingelheim, Celltrion, Falk Pharma, Ferring, Genentech, Gilead, Janssen, Novartis, MSD, Pfizer, Genenech/Roche, Shire, Takeda.

**G. D'Haens:** consulting and/or lecture fees from AbbVie, ActoGeniX, AIM, Boehringer Ingelheim GmbH, Centocor, Chemo Centryx, Cosmo Technologies, Elan Pharmaceuticals, enGene, Dr Falk Pharma, Ferring, Galapagos, Giuliani SpA, Given Imaging, GlaxoSmithKline, Janssen Biologics, MSD, Neovacs, Novo Nordisk, Otsuka, PDL BioPharma, Pfizer, Receptos, Salix, SetPoint, Shire Pharmaceuticals, Schering-Plough, Takeda, Tillotts Pharma, UCB Pharma, Versant, and Vifor Pharma; research grants from AbbVie, Janssen, Given Imaging, MSD, Dr

Falk Pharma, and PhotoPill; and speaking honoraria from AbbVie, Tillotts, Tramedico, Ferring, MSD, UCB Pharma, Norgine, and Shire.

**S. Tanida:** Consulting fee from Kissei pharmaceutical Co., Ltd and research funding from EA Pharma Co., Ltd.

**J. Siffledeen:** consultancy and/or speaking honoraria fees from Abbvie Inc, Janssen Pharmaceuticals, Allergan, Takeda, Ferring Pharmaceuticals, Shire, Pfizer. Educational grants from Abbvie Inc.

**P.D.R. Higgins:** consultancy fees from AbbVie, PRIME Medical Education, UCB, Takeda, Amgen, Lilly, Lycera, research funding from Janssen, Abbvie, Pfizer, Lilly, UCB, Takeda, Janssen, Arena, NIH, and CCF.

**W. Zhou, B. Huang, J. Enejosa** are Abbvie employees; may own AbbVie stock and/or options.

**A. Othman** is a former Abbvie employee; may own AbbVie stock and/or options.

#### **Writing assistance**

Ramona Vladea, PhD of AbbVie Inc. provided medical writing support in the development of this manuscript. The writing of this manuscript was funded by AbbVie Inc.

#### **Authors' contributions to the manuscript**

W. J. Sandborn, S. Ghosh, J. Panes, S. Schreiber, G. D'Haens, S. Tanida, J. Siffledeen, J. Enejosa, W. Zhou, A. A. Othman, B. Huang, and P. D. R. Higgins contributed to the study concept and design, acquisition of data, and analysis and interpretation of the data. W. J. Sandborn, S. Ghosh, J. Panes, S. Schreiber, G. D'Haens, S. Tanida, J. Siffledeen, J. Enejosa, W. Zhou, A. A. Othman, B. Huang, and P. D. R. Higgins provided critical revision of the manuscript for important intellectual content. Statistical analysis was provided by B. Huang. Administrative,

technical, or material support was provided by W. Zhou and B. Huang, and study supervision was provided W. Zhou and J. Enejosa.

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**ABSTRACT**

**Background & Aims:** We evaluated the efficacy and safety of upadacitinib, an oral selective inhibitor of Janus kinase 1, as induction therapy for ulcerative colitis (UC).

**Methods:** We performed a multicenter, double-blind, phase 2b study of 250 adults with moderately to severely active UC and an inadequate response, loss of response, or intolerance to corticosteroids, immunosuppressive agents, and/or biologic therapies. Patients were randomly assigned to groups that received placebo or induction therapy with upadacitinib (7.5 mg, 15 mg, 30 mg, or 45 mg, extended release), once daily for 8 weeks. The primary endpoint was the proportion of subjects who achieve clinical remission according to the Adapted Mayo score at week 8. No multiplicity adjustments were applied.

**Results:** At week 8, 8.5%, 14.3%, 13.5%, and 19.6% of patients receiving 7.5 mg, 15 mg, 30 mg, or 45 mg upadacitinib, respectively, achieved clinical remission compared with none of the patients receiving placebo ( $P = .052$ ,  $P = .013$ ,  $P = .011$ , and  $P = .002$ , compared with placebo, respectively). Endoscopic improvement at week 8, defined as endoscopic subscore  $\leq 1$ , was achieved in 14.9%, 30.6%, 26.9%, and 35.7% of patients receiving upadacitinib 7.5 mg, 15 mg, 30 mg, or 45 mg, respectively compared with 2.2% receiving placebo ( $P = .033$ ,  $P < .001$ ,  $P < .001$ ,  $P < .001$ , compared with placebo, respectively). One event of herpes zoster and 1 subject with pulmonary embolism and deep venous thrombosis (diagnosed 26 days after treatment discontinuation) were reported in the group that received upadacitinib 45 mg once daily.

Increases in serum lipid levels and creatine phosphokinase with upadacitinib were observed.

**Conclusion:** In a phase 2b trial, 8 weeks treatment with upadacitinib was more effective than placebo for inducing remission in patients with moderately to severely active UC.

ClinicalTrials.gov no: NCT02819635

**Keywords:** U-ACHIEVE, inflammatory bowel disease; IBD treatment; selective JAK1 inhibitor

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## **Introduction**

Ulcerative colitis is a chronic, relapsing inflammatory disease of the colon, leading to a significant burden and disability for patients.(1-4) Current therapeutic options include mesalamine, glucocorticoids, immunosuppressives, and biologics. However, these available treatments are not effective in more than one third of patients and can be associated with side effects that limit their use.(5-8) New treatments are needed to provide sustained improvements in symptomatic and endoscopic outcomes in a higher proportion of patients with ulcerative colitis.(9)

Janus kinases (JAK1, JAK2, JAK3, and tyrosine kinase 2) are intracellular tyrosine kinases (TK). They are activated by binding of a cytokine ligand, leading to recruitment, phosphorylation, and activation of signal transducers and activators of transcription (STATs).(10, 11) STATs control many functions of innate and adaptive immunity, haematopoiesis, and cellular processes, including cell growth, survival, differentiation, and migration.(11) Increasingly, JAK inhibition has been evaluated as a target for management of many immune-mediated diseases, including ulcerative colitis. Tofacitinib, a pan-JAK inhibitor, has demonstrated efficacy in three phase 3 placebo-controlled studies in patients with moderately to severely ulcerative colitis and has been approved for the treatment of ulcerative colitis.(12) Upadacitinib is a once daily, oral, small-molecule therapy that was engineered to have increased selectivity for JAK1 over JAK2, JAK3 and TK2.(13) We report the results of a phase 2b trial, investigating the dose-response, efficacy, and safety of upadacitinib, in patients with moderately-to-severely active ulcerative colitis.

## **Methods**

### **Trial design and oversight**

The overarching U-ACHIEVE program comprises 3 studies: a phase 2b dose-ranging induction study (study 1), a phase 3 dose-confirming induction study (study 2), and a phase 3 maintenance study (study 3). Here we report the results of the primary and secondary efficacy endpoints and safety from study 1. This was a multicenter, randomized, double-blind, placebo-controlled trial, conducted from October 2016 through April 2018, at 142 sites in 28 countries. A total of 250 patients were randomized in study 1 part 1; after the enrollment in this study part was completed, an additional 132 patients were enrolled in study 1 part 2 and randomized into upadacitinib groups 30 mg and 45 mg once daily (QD) to avoid interrupting the study activities and to provide a sufficient number of clinical responders for the maintenance portion of the study. An exploratory analysis for the combined results of study 1 part 1 and part 2 is provided in the **Supplementary Appendix (Table S8-Table S11)**. The complete study design of study 1 is shown in **Figure S1**.

This study was conducted per the International Conference on Harmonization (ICH) guidelines, applicable regulations, and the Declaration of Helsinki. The trial was registered at ClinicalTrials.gov (NCT02819635). The protocol was approved by institutional ethics committees and is available with the full text of this article at [gastrojournal.org](http://gastrojournal.org). Safety data were regularly assessed by an independent data monitoring committee. Cardiovascular and embolic and thrombotic events were reviewed and adjudicated by an independent Cardiovascular Adjudication Committee in a blinded manner. Written informed consent was provided by all subjects. AbbVie sponsored the study and the academic authors collaborated with AbbVie on the study design, data analysis, interpretation of results, and the preparation, review, and approval of the final version of the manuscript. AbbVie provided writing support. The first and last authors wrote the first draft of the manuscript, and all the authors contributed to subsequent drafts. All

the authors had access to the data, reviewed and approved the final manuscript, and vouch for its accuracy.

### **Patients**

Eligible patients were aged 18-75 years, with a confirmed diagnosis of ulcerative colitis for at least 90 days. Patients had moderately-to-severely active disease, defined as an Adapted Mayo score (Mayo score excluding physician's global assessment) of 5 to 9 points with a centrally read endoscopy subscore of 2 or 3. The Mayo score is a composite of the stool frequency subscore, rectal bleeding subscore, endoscopy subscore, and Physician's Global Assessment subscore, which ranges from 0 to 12, with each of the four subscores ranging from 0 to 3. Exclusion criteria were a diagnosis of Crohn's disease or indeterminate colitis, ulcerative colitis limited to the rectum, clinical signs of fulminant colitis, toxic megacolon, or patients with a history of colectomy. Patients were required to have had an inadequate response, loss of response or intolerance to corticosteroids, immunosuppressives, and/or biologics. Permitted concomitant medications for ulcerative colitis included oral aminosalicylates, methotrexate, and oral corticosteroids ( $\leq 30$  mg/day of prednisone or equivalent) at stable doses and kept unchanged during the study. Prohibited concomitant therapies included biologics, cyclosporine, tacrolimus, live vaccines, intravenous corticosteroids, azathioprine, and 6-mercaptopurine.

### **Randomization and masking**

In part 1 of study 1, eligible patients were randomized at baseline to receive double-blind 8-week induction therapy with placebo or upadacitinib at 7.5 mg, 15 mg, 30 mg, 45 mg extended-release QD in a 1:1:1:1:1 ratio. In part 2 of study 1, eligible patients were randomized to receive double-blind 8-week induction therapy with upadacitinib 30 mg or 45 mg extended-release QD in a 1:1 ratio. Randomization was performed centrally using a web based Interactive Response

Technology and was stratified by previous biologic use, baseline corticosteroid use, and baseline Adapted Mayo score ( $\leq 7$  and  $> 7$ ). Patients, investigators, and the sponsor were masked to treatment assignment.

### **Efficacy, safety and pharmacokinetic evaluations**

The Adapted Mayo score and the Mayo score were determined at weeks 0 and 8. The Partial Mayo score (Mayo score excluding the endoscopic subscore) was determined at weeks 0, 2, 4, and 8. Adapted Mayo scores were calculated based on the data collected from the patient diaries and centrally read endoscopic score. Endoscopy and biopsy for histologic assessment were performed at screening and week 8. Endoscopies were reviewed by a primary central reader who was blinded to the subject's clinical data, the site's endoscopy assessment and the subject's therapy. Biopsies for evaluation of the histologic endpoints were obtained from the area of most severe inflammation in rectosigmoid colon. The samples were then sent for histologic evaluation to central readers who are board certified gastrointestinal pathologists with expertise in inflammatory bowel diseases (IBD). One of the central readers performed the reading and determined the histologic score. The patient reported outcomes were measured at baseline and weeks 2, 4, 6 and 8. Treatment emergent adverse events were monitored in all patients from the time of study drug administration until 30 days following discontinuation of study drug. Adverse events were tabulated by system organ class and preferred term using the Medical Dictionary for Regulatory Activities. Blood samples for pharmacokinetic analysis were collected at weeks 2, 4, 6, and 8 to determine upadacitinib plasma concentrations.

### **Endpoints**

The primary efficacy endpoint of study 1 part 1 was clinical remission according to the Adapted Mayo score, defined as stool frequency subscore (SFS)  $\leq 1$ , rectal bleeding subscore (RBS) = 0,

and endoscopic subscore (ES)  $\leq 1$  by central reading at week 8. Ranked secondary endpoints were endoscopic improvement (defined as ES  $\leq 1$ ) at week 8; clinical remission according to the Mayo score (defined as a Mayo score  $\leq 2$  with no subscore  $> 1$ ) at week 8; clinical response according to the Adapted Mayo score (defined as decrease from baseline in the Adapted Mayo score  $\geq 2$  points and  $\geq 30\%$  from baseline, plus a decrease in RBS  $\geq 1$  or an absolute RBS  $\leq 1$ ) at week 8; clinical response according to the Partial Mayo score (defined as decrease from baseline in the Partial Mayo score  $\geq 2$  points and  $\geq 30\%$  from baseline, plus a decrease in RBS  $\geq 1$  or an absolute RBS  $\leq 1$ ) at week 2; endoscopic remission (defined as ES of 0) at week 8; histologic improvement (defined as any decrease from baseline in Geboes score) at week 8; and change in the Mayo score from Baseline to week 8. A complete list of additional secondary efficacy endpoints is provided in **Table S3** of the **Supplementary Appendix**.

### **Statistical analysis**

The sample size was based on the expected proportion of subjects who would achieve clinical remission according to the Adapted Mayo score at week 8. A total sample size of 250 subjects (50 subjects per treatment group) was deemed sufficient to test for the presence of a dose-response signal, to select the best dose-response model for the observed data out of a pre-specified set of candidate models, and to estimate target doses of interest via modeling using the Multiple comparison procedure and modelling (MCP-Mod) approach. This approach provides an average power of 68% to detect a dose effect at 5% level of significance (two-sided) with the log linear,  $E_{\max}$ , exponential, logistic, and  $\text{sig}E_{\max}$  models pre-specified as likely candidates to characterize the dose-response for upadacitinib for the primary endpoint of clinical remission. Efficacy endpoints were analysed in the intention-to-treat (ITT) population, defined as all randomly assigned patients who received at least one dose of study drug. For selected endpoints

(clinical remission according to the Adapted Mayo score and endoscopic improvement), the overall dose-response relationships between multiple upadacitinib doses and placebo were modelled using the MCP-Mod approach (**Supplementary Appendix, Table S2**).

The pairwise comparisons for the difference in proportions of subjects between the treatment groups and placebo group were performed using the Cochran-Mantel-Haenszel (CMH) test. The CMH-based two-sided 95% CIs for the difference in proportions between groups were calculated. All statistical tests were two-sided with the significance level of .05.

The non-responder imputation method was used to impute missing values at week 8. The last observation carried forward method was used in sensitivity analyses of all the efficacy endpoints. A closed testing procedure was not used, and no multiplicity adjustments were applied for the pairwise comparisons, so reported *P* values should be considered nominal.

The safety analysis set consists of all subjects who received at least one dose of study medication in the study. For the safety analysis, subjects were assigned to a treatment group based on the treatment actually received, regardless of the randomly selected treatment group. Safety analyses were summarized by study group and presented as proportions of patients. Comparisons of the percent of subjects experiencing an adverse event between treatment groups and placebo were performed using Fisher's exact tests.

## **Results**

### **Patient characteristics**

In study 1 part 1, 250 subjects were randomly allocated to placebo ( $n = 46$ ), and upadacitinib 7.5 mg ( $n = 47$ ), 15 mg ( $n = 49$ ), 30 mg ( $n = 52$ ), and 45 mg QD ( $n = 56$ ; **Figure 1**). The number of patients in the 30 and 45mg groups is slightly larger due to a randomization error in which 12 subjects were randomized with only two options, the upadacitinib 30 mg or 45 mg QD doses.



Overall, 227 subjects (90.8%) completed the study; the most common reasons for discontinuation of study drug were adverse events (14/250; 5.6%) and lack of efficacy (7/250; 2.8%).

Patient demographics and baseline clinical characteristics were similar between the placebo and upadacitinib groups (**Table 1**). The median disease duration was 5.92 years, 54% of the patients had pancolitis, 36.1% of the patients had Adapted Mayo score > 7; the median fecal calprotectin at baseline was 1703.0 mcg/gram of stool. Of the 250 randomized patients, 77.6% (194/250) of patients have been previously exposed to biologic treatment (19.2% to one biologic, 30.8% to 2 biologics, and 23.2% to 3 biologics); 73.2% (183/250) of patients had been previously exposed to a TNF antagonist, 46.8% (117/250) of patients have been previously exposed to vedolizumab, 44.0% (110/250) have been exposed to both a TNF antagonist and vedolizumab, and none were exposed to tofacitinib or other JAK inhibitors.

## **Efficacy**

### **Primary endpoint**

An overall positive dose-response relationship between multiple upadacitinib doses and placebo was detected by MCP-Mod for clinical remission according to the Adapted Mayo score in the log-linear and  $E_{\max}$  pre-specified candidate models (**Table S2**). Clinical remission was reported in 8.5% ( $P = .052$ ), 14.3% ( $P = .013$ ), 13.5% ( $P = .011$ ), and 19.6% ( $P = .002$ ) of patients receiving upadacitinib 7.5 mg, 15 mg, 30 mg, and 45 mg QD, respectively compared with 0% of patients receiving placebo (**Figure 2A and Table 2**). After adjustment for prior biologic use, baseline corticosteroid use, and baseline Adapted Mayo score, CMH-adjusted risk differences (95% CI) for the upadacitinib 7.5 mg, 15 mg, 30 mg, and 45 mg QD groups versus placebo were 8.1 (-0.1 to 16.3), 12.7 (2.7 to 22.6), 12.7 (3.0 to 22.5), and 19.4 (7.4 to 31.4) percent,

respectively. Subgroup analyses are shown in **Figure S2** in the **Supplementary Appendix**. In general, the treatment effect of all upadacitinib doses was lower in patients who had received previous treatment with biologics compared with those who had not. The efficacy results excluding the 12 patients who were only randomized to upadacitinib 30 mg or 45 mg in part 1 are reported in the **Supplementary Appendix Table S7**. The results of this sensitivity analysis were consistent with the ITT analysis. Combined results for the study 1 part 1 and part 2 are shown in **Table S10** in the **Supplementary Appendix**.

### Secondary endpoints

The key secondary endpoint, endoscopic improvement at week 8, occurred in more patients receiving upadacitinib 7.5 mg (14.9%;  $P = .033$ ), 15 mg (30.6%;  $P < .001$ ), 30 mg (26.9%;  $P < .001$ ), and 45 mg QD (35.7%;  $P < .001$ ) compared with placebo (2.2%; **Figure 2C and Table 2**).

The overall dose-response relationship across the range of upadacitinib doses was confirmed by MCP-Mod in four of the five pre-specified candidate models (except for the less pharmacologically plausible exponential model; **Supplementary Appendix, Table S2**).

Clinical remission according to the full Mayo score at week 8 occurred in a higher proportion of patients receiving upadacitinib 15 mg (10.2%;  $P = .027$ ), 30 mg (11.5%;  $P = .016$ ), and 45 mg QD (19.6%;  $P = .001$ ) compared with 0% of patients receiving placebo. More patients achieved clinical response according to the Adapted Mayo score at week 8 with upadacitinib 7.5 mg (29.8%;  $P = .046$ ), 15 mg (44.9%;  $P < .001$ ), 30 mg (44.2%;  $P < .001$ ), and 45 mg QD (50.0%;  $P < .001$ ) compared with placebo (13.0%; **Figure 2B and Table 2**). At week 8, histologic improvement was reported more in patients receiving upadacitinib 7.5 mg (31.9%;  $P = .003$ ), 15 mg (51.0%;  $P < .001$ ), 30 mg (44.2%;  $P < .001$ ), and 45 mg QD (48.2%;  $P < .001$ ) compared with placebo (6.5%; **Figure 2D and Table 2**). Endoscopic remission at week 8 occurred in a

higher proportion of patients receiving upadacitinib 30 mg (9.6%;  $P = .015$ ) and 45 mg QD (17.9%;  $P = .004$ ; **Table 2**). Other ranked secondary endpoints also showed consistent efficacy (results provided in **Table 2**).

The change from baseline in high-sensitivity C-reactive protein (hs-CRP) to week 2, 4, and 8 was greater for all upadacitinib groups compared with placebo (**Figure 3A and Table S5**). At week 8, the changes from baseline in fecal calprotectin were numerically greater in all upadacitinib groups than in the placebo group (**Figure 3B and Table S6**).

### Safety

Incidences of adverse events (AEs) and AEs leading to discontinuation were similar across upadacitinib groups, and numerically higher in the placebo group (**Table 3**). Rates of serious AEs were 10.9%, 0%, 4.1%, 5.8%, and 5.4%, for placebo, upadacitinib 7.5 mg, 15 mg, 30 mg, and 45 mg QD, respectively. Serious infections occurred in patients receiving placebo (4.3%,  $n = 2$ ), 15 mg QD (2.0%,  $n = 1$ ), and 45 mg QD (3.6%,  $n = 2$ ). Adverse events of special interest were generally low (<5%) except for hepatic disorders and creatine phosphokinase (CPK) elevation in the upadacitinib 45 mg QD group and anemia in upadacitinib 15 mg QD and placebo treatment groups. The hepatic disorders were mainly due to transaminase elevations and were mostly transient. One event of herpes zoster with 45 mg QD was reported, the case was disseminated and cutaneous only, moderate in severity. The study drug was not discontinued. No malignancy was reported in study 1; one case of change in appearance of a mole was reported in the upadacitinib 7.5 mg QD treatment group; the case was later diagnosed as melanoma after the patient entered the maintenance study 3. One subject with adjudicated severe AE of pulmonary embolism (PE) and mild AE of deep venous thrombosis (DVT) was reported with upadacitinib 45 mg QD. These concurrent events were reported 26 days after the study drug discontinuation

due to ulcerative colitis worsening. The risk factors include age of 65 years old, former smoker, hospitalization, fluid loss and bed rest during ulcerative colitis worsening, with concomitant use of corticosteroids. There were no reports of lymphoma, death, gastrointestinal perforation, active/latent tuberculosis, or renal dysfunction.

Rates of AE Grade 3 or 4 laboratory values were generally less than 5% in the upadacitinib groups. At week 8, significant increases from baseline in average cholesterol, high-density lipoprotein, and low-density lipoprotein were observed in all upadacitinib treatment groups. Grade 3 or higher of increased CPK level was reported more frequently in upadacitinib treatment groups.

### **Pharmacokinetics**

Upadacitinib exposures were approximately dose-proportional over the evaluated 7.5 mg to 45 mg QD dose range, consistent with previous pharmacokinetic evaluations of upadacitinib.(14, 15) Within 24 hours of dosing, upadacitinib mean plasma concentrations ranged (around peak time to around trough time) from 13 ng/mL to 1.6 ng/mL for the 7.5 mg dose, from 33 ng/mL to 3.6 ng/mL for 15 mg, from 59 ng/mL to 8.1 ng/mL for 30 mg, and from 75 ng/mL to 11 ng/mL for the 45 mg.

### **Discussion**

Upadacitinib is a selective JAK1 inhibitor engineered to address the hypothesis that JAK1 selectivity will have a more favorable benefit-risk profile over the pan-JAK inhibitors. Studies in cellular assays demonstrated that upadacitinib is up to 60-fold selective for JAK1 over JAK2, and > 100 fold selective over JAK3.(16) The efficacy and safety of selective JAK1 inhibitors filgotinib and upadacitinib have been studied in phase 2 trials in Crohn's disease with positive

results.(17, 18) This is the first phase 2 study evaluating the efficacy and safety of a selective JAK1 inhibitor in ulcerative colitis patients.

The U-ACHIEVE study 1 evaluated the safety and efficacy of multiple doses of upadacitinib extended-release formulation in patients with moderately-to-severely active ulcerative colitis, with most patients having pancolitis and being refractory to biologic therapy. The study evaluated a broad range of upadacitinib doses as an induction treatment for ulcerative colitis and showed efficacy with doses of 7.5 mg QD to 45mg QD. The study incorporated a new definition for the primary endpoint of clinical remission using the Adapted Mayo score with a more stringent criteria than previous studies. A consistent dose-response relationship with upadacitinib for this primary endpoint was observed. The definition of endoscopic improvement (ES = 0 or 1) in this study was used to define the mucosal healing in previous studies.(12) A stringent definition for endoscopic remission (ES = 0) was used in the study and was achieved at 30 mg QD and 45 mg QD treatment groups. Histologic change was evaluated using Geboes score by central reading.(19) Histologic improvement was demonstrated in all treatment arms. Geboes score generates a score between 0 and 5.4, with higher scores indicating greater level of inflammation and has been widely used in ulcerative colitis trials.(20) The onset of action was rapid, demonstrated by improvement in the Partial Mayo score at week 2. Treatment effect was greater with all upadacitinib doses compared with placebo for the primary and all secondary endpoints.

The type of AEs reported in this study were similar to those previously observed in clinical trials with JAK inhibitors in patients with moderately-to-severely active IBD (12, 21, 22) and rheumatoid arthritis (RA).(23-29) Serious infections were observed in patients receiving upadacitinib or placebo.

One subject who received upadacitinib 45 mg QD had adjudicated cardiovascular events of DVT and PE. These events were reported 26 days after treatment discontinuation, risk factors including former smoker, hospitalization, fluid loss and bed rest during ulcerative colitis worsening, with concomitant use of corticosteroids. No other cardiovascular events were reported. In this study, the reports of embolic and thrombotic events and cardiovascular events were adjudicated by an independent adjudication committee. Patients with IBD have an increased risk of thrombosis, which has been reported to be 2- to 3-fold higher than that of patients without IBD and is exacerbated during times of disease flare.(30-32) In upadacitinib studies for RA, venous thromboembolism events (VTEs) were reported in all treatment groups, including placebo, upadacitinib and active comparator (e.g. methotrexate and adalimumab).(33) With long-term exposure, the rates of VTEs occurred at comparable frequency on upadacitinib versus active comparators. The rate of VTEs in subjects with upadacitinib was not dose related. All subjects with VTE had at least one risk factor present at baseline of the studies.

One non-serious event of herpes zoster was reported with upadacitinib 45 mg QD treatment. An increased risk of herpes zoster infection has been reported with the use of tofacitinib and baricitinib in RA.(34, 35) Data from the upadacitinib clinical trials in RA also showed that the rates of herpes zoster were higher with upadacitinib versus placebo.(33). In tofacitinib phase 2/3 UC program, an increased risk of herpes zoster was also identified.(36) Overall, 5.6% of the patients developed herpes zoster. The data suggests that herpes zoster may be a risk for the JAK inhibitor class.

A rigorous estimation of the risk and incidence of herpes zoster and pulmonary embolus with upadacitinib exposure is warranted and requires additional evaluation in larger and long-term studies.

This study has some limitations. The study was a phase 2 dose ranging study with limited sample size and exposure time and not sufficient to fully characterize the safety of upadacitinib in the treatment of ulcerative colitis. These limitations will be addressed with the phase 3 program.

There was no adjustment for multiple testing or secondary endpoints.

In conclusion, upadacitinib was more effective than placebo for inducing remission in patients with moderately to severely active ulcerative colitis. The benefit-risk profile supports further development of upadacitinib as a novel treatment for ulcerative colitis.

**Role of authors and sponsor**

The authors and AbbVie scientists designed the study and analyzed and interpreted the data. AbbVie funded the research and provided writing support. All authors contributed to the development of the content. The authors and AbbVie reviewed and approved the manuscript; the authors maintained control over the final content.

**Acknowledgments**

AbbVie and the authors thank the patients who participated in the study and all study investigators for their contributions. Ramona Vladea, PhD of AbbVie Inc. provided medical writing support and Wangang Xie, PhD of AbbVie Inc., provided statistical support in the development of this manuscript.

**Data Sharing Statement**

AbbVie is committed to responsible data sharing regarding the clinical trials we sponsor. This includes access to anonymized, individual and trial-level data (analysis data sets), as well as other information (e.g. protocols and Clinical Study Reports), as long as the trials are not part of an ongoing or planned regulatory submission. This includes requests for clinical trial data for unlicensed products and indications.

This clinical trial data can be requested by any qualified researchers who engage in rigorous, independent scientific research, and will be provided following review and approval of a research proposal and Statistical Analysis Plan (SAP) and execution of a Data Sharing Agreement (DSA). Data requests can be submitted at any time and the data will be accessible for 12 months, with possible extensions considered. For more information on the process, or to submit a request, visit the following link: <https://www.abbvie.com/our-science/clinical->



[trials/clinical-trials-data-and-information-sharing/data-and-information-sharing-with-qualified-researchers.html](#).

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## References

1. Burisch J, Weimers P, Pedersen N, et al. Health-related quality of life improves during one year of medical and surgical treatment in a European population-based inception cohort of patients with inflammatory bowel disease--an ECCO-EpiCom study. *J Crohns Colitis*. 2014;8(9):1030-42.
2. Farrell D, McCarthy G, Savage E. Self-reported Symptom Burden in Individuals with Inflammatory Bowel Disease. *J Crohns Colitis*. 2016;10(3):315-22.
3. Ghosh S, Peyrin-Biroulet L, Sensky T, et al. Correlation between physician and patient disease assessments in ulcerative colitis: baseline data from the ICONIC study of 1816 patients in 33 countries. *Journal of Crohns & Colitis*. 2017;11:S259-S60.
4. Lonnfors S, Vermeire S, Greco M, et al. IBD and health-related quality of life -- discovering the true impact. *J Crohns Colitis*. 2014;8(10):1281-6.
5. Ordas I, Eckmann L, Talamini M, et al. Ulcerative colitis. *Lancet*. 2012;380(9853):1606-19.
6. Kornbluth A, Sachar DB, Practice Parameters Committee of the American College of G. Ulcerative colitis practice guidelines in adults: American College Of Gastroenterology, Practice Parameters Committee. *Am J Gastroenterol*. 2010;105(3):501-23; quiz 24.
7. Feagan BG, Rutgeerts P, Sands BE, et al. Vedolizumab as induction and maintenance therapy for ulcerative colitis. *N Engl J Med*. 2013;369(8):699-710.
8. Dignass A, Eliakim R, Magro F, et al. [Second European evidence-based Consensus on the diagnosis and management of ulcerative colitis Part 1: Definitions and diagnosis (Spanish version)]. *Rev Gastroenterol Mex*. 2014;79(4):263-89.
9. Vavricka SR, Brun L, Ballabeni P, Pittet V, et al. Frequency and risk factors for extraintestinal manifestations in the Swiss inflammatory bowel disease cohort. *Am J Gastroenterol*. 2011;106(1):110-9.
10. De Vries LCS, Wildenberg ME, De Jonge WJ, et al. The future of Janus kinase inhibitors in inflammatory bowel disease. *J Crohns Colitis*. 2017;11(7):885-93.
11. Olivera P, Danese S, Peyrin-Biroulet L. JAK inhibition in inflammatory bowel disease. *Expert Rev Clin Immunol*. 2017;13(7):693-703.

12. Sandborn WJ, Su C, Sands BE, et al. Tofacitinib as Induction and Maintenance Therapy for Ulcerative Colitis. *N Engl J Med*. 2017;376(18):1723-36.
13. Voss J, Graff C, Schwartz A, et al. Pharmacodynamics of a Novel Jak1 Selective Inhibitor in Rat Arthritis and Anemia Models and in Healthy Human Subjects. *Annals of the Rheumatic Diseases*. 2014;73:222-.
14. Mohamed MF, Zeng J, Marroum PJ, et al. Pharmacokinetics of Upadacitinib With the Clinical Regimens of the Extended-Release Formulation Utilized in Rheumatoid Arthritis Phase 3 Trials. *Clin Pharmacol Drug Dev*. 2019;8(2):208-16.
15. Klunder B MR, Mohamed M, Friedel A, et al. Population Pharmacokinetics of Upadacitinib with the Immediate Release and Extended Release Formulations in Healthy Subjects and Subjects with Rheumatoid Arthritis: Analyses of Phase 1 to 3 Clinical Trials. *Clinical pharmacokinetics*. 2019.
16. Parmentier JM, Voss J, Graff C, et al. In vitro and in vivo characterization of the JAK1 selectivity of upadacitinib (ABT-494). *BMC Rheumatol*. 2018;2:23.
17. Vermeire S, Schreiber S, Petryka R, et al. Clinical remission in patients with moderate-to-severe Crohn's disease treated with filgotinib (the FITZROY study): results from a phase 2, double-blind, randomised, placebo-controlled trial. *Lancet*. 2017;389(10066):266-75.
18. Sandborn WJ, Feagan BG, Panes J, et al. Safety and Efficacy of Abt-494 (Upadacitinib), an Oral Jak1 Inhibitor, as Induction Therapy in Patients with Crohn's Disease: Results from Celest. *Gastroenterology*. 2017;152(5):S1308-S9.
19. Walsh AJ, Bryant RV, Travis SP. Current best practice for disease activity assessment in IBD. *Nat Rev Gastroenterol Hepatol*. 2016;13(10):567-79.
20. Mosli MH, Feagan BG, Zou G, et al. Development and validation of a histological index for UC. *Gut*. 2017;66(1):50-8.
21. Sandborn WJ, Ghosh S, Panes J, et al. A phase 2 study of tofacitinib, an oral Janus kinase inhibitor, in patients with Crohn's disease. *Clin Gastroenterol Hepatol*. 2014;12(9):1485-93 e2.

22. Panes J, Sandborn WJ, Schreiber S, et al. Tofacitinib for induction and maintenance therapy of Crohn's disease: results of two phase IIb randomised placebo-controlled trials. *Gut*. 2017;66(6):1049-59.
23. Genovese MC, Smolen JS, Weinblatt ME, et al. Efficacy and Safety of ABT-494, a Selective JAK-1 Inhibitor, in a Phase IIb Study in Patients With Rheumatoid Arthritis and an Inadequate Response to Methotrexate. *Arthritis Rheumatol*. 2016;68(12):2857-66.
24. Kremer JM, Emery P, Camp HS, et al. A Phase IIb Study of ABT-494, a Selective JAK-1 Inhibitor, in Patients With Rheumatoid Arthritis and an Inadequate Response to Anti-Tumor Necrosis Factor Therapy. *Arthritis Rheumatol*. 2016;68(12):2867-77.
25. Westhovens R, Taylor PC, Alten R, et al. Filgotinib (GLPG0634/GS-6034), an oral JAK1 selective inhibitor, is effective in combination with methotrexate (MTX) in patients with active rheumatoid arthritis and insufficient response to MTX: results from a randomised, dose-finding study (DARWIN 1). *Ann Rheum Dis*. 2017;76(6):998-1008.
26. Kavanaugh A, Kremer J, Ponce L, et al. Filgotinib (GLPG0634/GS-6034), an oral selective JAK1 inhibitor, is effective as monotherapy in patients with active rheumatoid arthritis: results from a randomised, dose-finding study (DARWIN 2). *Ann Rheum Dis*. 2017;76(6):1009-19.
27. Wollenhaupt J, Silverfield J, Lee EB, et al. Safety and efficacy of tofacitinib, an oral janus kinase inhibitor, for the treatment of rheumatoid arthritis in open-label, longterm extension studies. *J Rheumatol*. 2014;41(5):837-52.
28. Burmester GR, Kremer J, van Den Bosch F, et al. A Phase 3 Randomized, Placebo-Controlled, Double-Blind Study of Upadacitinib (ABT-494), a Selective JAK-1 Inhibitor, in Patients with Active Rheumatoid Arthritis with Inadequate Response to Conventional Synthetic Dmards. *Arthritis & Rheumatology*. 2017;69.
29. Genovese MC, Kremer J, Zhong S, et al. Long-Term Safety and Efficacy of Upadacitinib (ABT-494), an Oral JAK-1 Inhibitor in Patients with Rheumatoid Arthritis in an Open Label Extension Study. *Arthritis & Rheumatology*. 2017;69.

30. Papa A, Gerardi V, Marzo M, et al. Venous thromboembolism in patients with inflammatory bowel disease: focus on prevention and treatment. *World J Gastroenterol*. 2014;20(12):3173-9.
31. Grainge MJ, West J, Card TR. Venous thromboembolism during active disease and remission in inflammatory bowel disease: a cohort study. *Lancet*. 2010;375(9715):657-63.
32. Desai RJ, Gagne JJ, Lii J, et al. Comparative risk of incident venous thromboembolism in patients with inflammatory bowel disease initiating tumour necrosis factor-alpha inhibitors or nonbiologic agents: a cohort study. *CMAJ*. 2017;189(47):E1438-E47.
33. Cohen SB, Vollenhoven Rv, Winthrop K, et al. Thu0167 Safety Profile Of Upadacitinib In Rheumatoid Arthritis: Integrated Analysis From The Select Phase 3 Clinical Program. *Annals of the Rheumatic Diseases*. 2019;78(Suppl 2):357-.
34. Winthrop KL, Lindsey S, Weinblatt M, et al. Herpes Zoster in Patients with Moderate to Severe Rheumatoid Arthritis Treated with Baricitinib. *Arthritis & Rheumatology*. 2016;68.
35. Winthrop KL, Yamanaka H, Valdez H, et al. Herpes Zoster and Tofacitinib Therapy in Patients With Rheumatoid Arthritis. *Arthritis & Rheumatology*. 2014;66(10):2675-84.
36. Winthrop KL, Melmed GY, Vermeire S, et al. Herpes Zoster Infection in Patients With Ulcerative Colitis Receiving Tofacitinib. *Inflamm Bowel Dis*. 2018;24(10):2258-65.

**Table Legend**

**Table 1: Patient demographics and baseline disease characteristics.** QD=once daily;

UC=ulcerative colitis; hs-CRP=high sensitivity C-reactive protein; TNF=tumor necrosis factor.

**Table 2: Efficacy Outcomes in the U-ACHIEVE Study 1 part 1 trial.** QD=once daily;

CI=confidence interval.

**Table 3: Safety Outcomes at week 8 in the U-ACHIEVE Study 1 part 1 trial.** AE=adverse

event; QD=once daily.

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**Figure Legend**

**Figure 1: CONSORT flow chart Study 1 Part 1.** QD: once daily

**Figure 2. Proportion of patients with clinical remission according to the Adapted Mayo score (A), clinical response according to the Adapted Mayo score (B), endoscopic improvement (C), and histologic improvement (D).** UPA: upadacitinib; QD: once daily

**Figure 3. Change from baseline in hs-CRP (A) and FC (B) in the U-ACHIEVE Study 1 part 1.** QD: once daily; hs-CRP: high sensitivity C-reactive protein; FC: fecal calprotectin.

\*\*\*, \*\*, \* statistically significant versus placebo at 0.001, 0.01, and 0.05 levels, respectively.

p-value is for comparing the mean change from baseline.



**Table 1:**

Characteristic	Upadacitinib				
	Placebo n=46	7.5 mg QD n=47	15 mg QD n=49	30 mg QD n=52	45 mg QD n=56
Female, n (%)	17 (37.0)	24 (51.1)	19 (38.8)	21 (40.4)	19 (33.9)
Age, years, median (range)	40 (21-67)	41 (18-75)	47 (22-71)	42 (20-72)	37 (19-74)
UC duration, years, median (range)	5.19 (0.4-30.8)	6.59 (0.8-43.7)	4.58 (0.2-43.0)	6.06 (0.3-27.5)	6.46 (0.4-23.9)
Disease extent, n (%)					
Rectosigmoid	0	1 (2.1)	0	0	0
Left-sided colitis	19 (41.3)	21 (44.7)	25 (51.0)	23 (44.2)	26 (46.4)
Extensive colitis or pancolitis	27 (58.7)	25 (53.2)	24 (49.0)	29 (55.8)	30 (53.6)
Mayo score, median (range)	9.3 (7-12)	9.0 (7-12)	9.7 (7-12)	9.0 (6-12)	9.0 (7-12)
Adapted Mayo score					
≤ 7	27 (58.7)	30 (63.8)	31 (63.3)	33 (63.5)	38 (67.9)
7 - 9	19 (41.3)	17 (36.2)	18 (36.7)	19 (36.5)	17 (30.4)
Median (range)	6.9 (5-9)	7.0 (5-9)	7.0 (4-9)	7.0 (4-9)	6.7 (5-9)
hs-CRP, mg/L, median (range)	5.4	4.9	8.7	6.7	6.3

	(0.35-41.2)	(0.2-29.1)	(1.27-117)	(0.2-82.9)	(0.2-67)
Fecal calprotectin, µg/g, median (range)	2100.5 (93-28800)	1576.0 (91-17690)	1843.0 (48-18865)	1648.0 (30-18053)	1666.0 (30-17259)
Baseline corticosteroid use, n (%)	25 (54.3)	25 (53.2)	27 (55.1)	25 (48.1)	28 (50.0)
Prior immunosuppressant use, n (%)	36 (78.3)	31 (66.0)	38 (77.6)	39 (75.0)	41 (73.2)
Prior all biologics use, n (%)	35 (76.1)	36 (76.6)	38 (77.6)	42 (80.8)	43 (76.8)
Prior TNF antagonist use	33 (71.7)	33 (70.2)	37 (75.5)	41 (78.8)	39 (69.6)
Prior vedolizumab use	23 (50.0)	25 (53.2)	24 (50.0)	22 (42.3)	23 (41.1)
Prior TNF antagonist and vedolizumab use	22 (47.8)	23 (48.9)	23 (46.9)	22 (42.3)	20 (35.7)
Previous inadequate response/loss of response, n (%)					
Corticosteroid	30 (65.2)	29 (61.7)	22 (44.9)	29 (55.8)	29 (51.8)
Immunosuppressant	22 (47.8)	24 (51.1)	27 (49.0)	22 (42.3)	20 (35.7)
TNF antagonist	30 (65.2)	26 (55.3)	34 (69.4)	38 (73.1)	34 (60.7)
Biologics other than TNF antagonist	24 (52.2)	23 (48.9)	22 (44.9)	24 (46.2)	24 (42.9)

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**Table 2:**

End Point	Placebo N=46	Upadacitinib			
		7.5 mg QD N=47	15 mg QD N=49	30 mg QD N=52	45 mg QD N=56
Clinical remission according to the Adapted Mayo score at week 8					
n (%)	0	4 (8.5)	7 (14.3)	7 (13.5)	11 (19.6)
Adjusted risk difference (95% CI)		8.1 (-0.1 to 16.3)	12.7 (2.7 to 22.6)	12.7 (3.0 to 22.5)	19.4 (7.4 to 31.4)
<i>P</i> value		.052	.013	.011	.002
Endoscopic improvement at week 8					
n (%)	1 (2.2)	7 (14.9)	15 (30.6)	14 (26.9)	20 (35.7)
Adjusted risk difference (95% CI)		12.9 (1.1 to 24.7)	26.9 (12.6 to 41.2)	26.5 (12.2 to 40.7)	36.0 (19.6 to 52.3)
<i>P</i> value		.033	< .001	< .001	< .001
Clinical remission according to the full Mayo score at week 8					
n (%)	0	4 (8.5)	5 (10.2)	6 (11.5)	11 (19.6)
Adjusted risk difference (95% CI)		8.1 (-0.1 to 16.3)	9.0 (1.0 to 17.0)	12.0 (2.2 to 21.7)	20.3 (8.2 to 32.4)
<i>P</i> value		.052	.027	.016	.001

Clinical response according to the Adapted Mayo					
score at week 8					
n (%)	6 (13.0)	14 (29.8)	22 (44.9)	23 (44.2)	28 (50.0)
Adjusted risk difference (95% CI)		16.0 (0.3 to 31.7)	30.2 (12.5 to 47.8)	31.2 (13.9 to 48.6)	38.4 (20.1 to 56.8)
<i>P</i> value		.046	< .001	< .001	< .001
Clinical response according to the Partial Mayo score					
at week 2					
n (%)	7 (15.2)	11 (23.4)	18 (36.7)	19 (36.5)	31 (55.4)
Adjusted risk difference (95% CI)		8.8 (-8.0 to 25.6)	20.2 (2.4 to 38.1)	22.0 (4.4 to 39.6)	43.0 (23.8 to 62.1)
<i>P</i> value		.305	.027	.014	< .001
Change in Mayo score from Baseline to week 8,					
median (range)	-0.350 (-5.30, 4.00)	-2.000 (-10.70, 3.30)	-3.300 (-8.70, 1.30)	-3.700 (-11.00, 2.00)	-5.000 (-10.00, 3.00)
<i>P</i> value		< .001	< .001	< .001	< .001
Endoscopic remission at week 8					
n (%)	0	3 (6.4)	2 (4.1)	5 (9.6)	10 (17.9)
Adjusted risk difference (95% CI)		5.9 (-1.2 to 13.0)	3.5 (-2.0 to 9.0)	10.9 (2.1 to 19.7)	17.8 (5.8 to 29.8)
<i>P</i> value		.101	.212	.015	.004
Histologic improvement at week 8					

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n (%)	3 (6.5)	15 (31.9)	25 (51.0)	23 (44.2)	27 (48.2)
Adjusted risk difference (95% CI)		24.8 (8.2 to 41.5)	43.0 (24.9 to 61.2)	39.4 (21.3 to 57.6)	43.4 (24.6 to 62.2)
<i>P</i> value		.003	< .001	< .001	< .001

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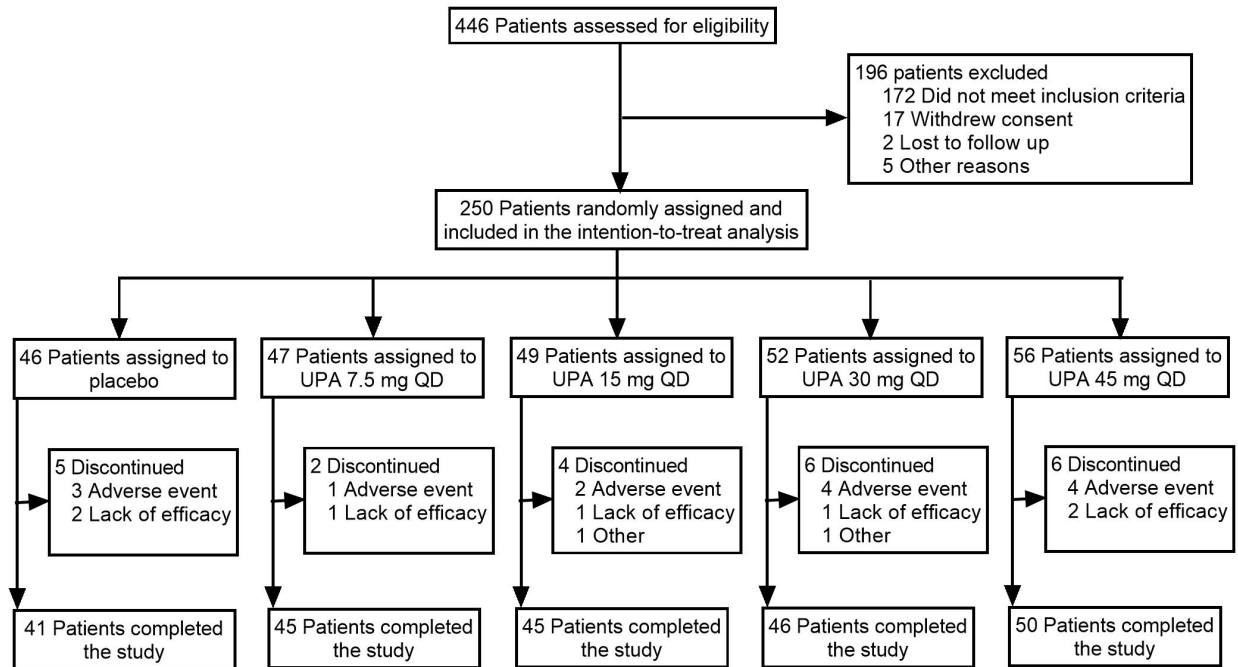
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**Table 3:**

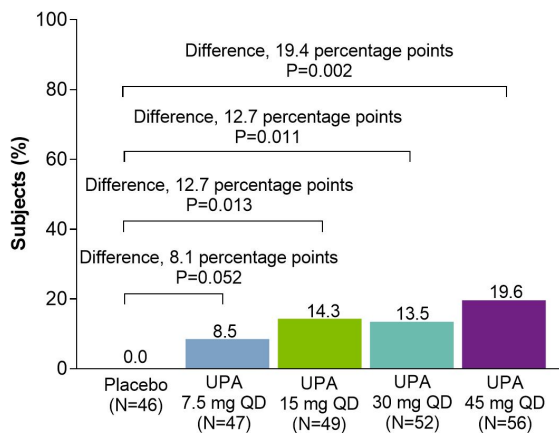
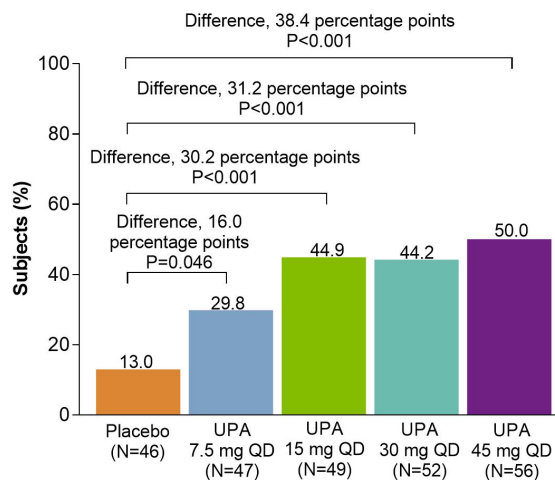
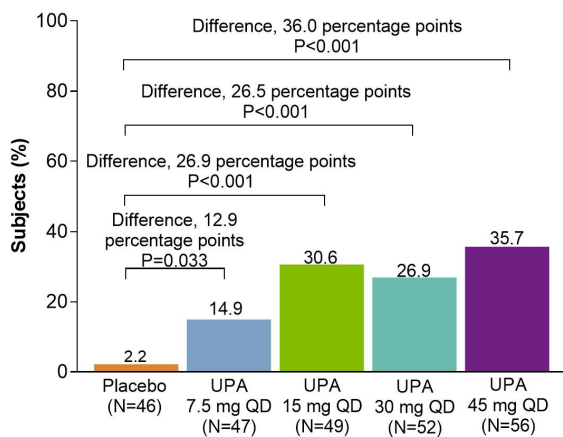
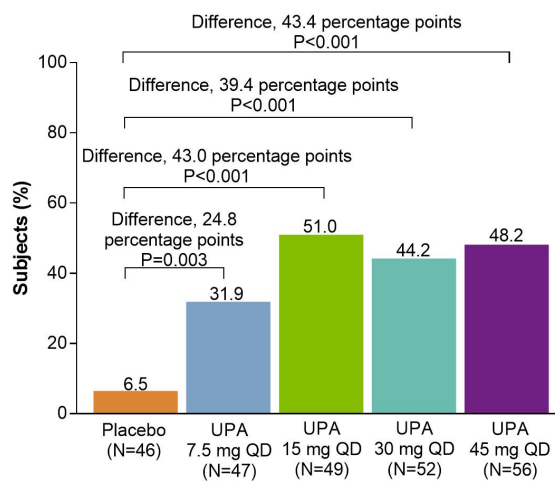
Adverse event	Upadacitinib				
	Placebo	7.5 mg QD	15 mg QD	30 mg QD	45 mg QD
	n=46	n=47	n=49	n=52	n=56
Any AE, n (%)	33 (71.7)	30 (63.8)	30 (61.2)	36 (69.2)	35 (62.5)
Colitis ulcerative, n (%)	6 (13.0)	1 (2.1)	3 (6.1)	6 (11.5)	4 (7.1)
Any serious AE, n (%)	5 (10.9)	0	2 (4.1)	3 (5.8)	3 (5.4)
Any AE leading to discontinuation, n (%)	4 (8.7)	1 (2.1)	2 (4.1)	4 (7.7)	4 (7.1)
Infections and infestations, n (%)	16 (34.8)	9 (19.1)	10 (20.4)	6 (11.5)	13 (23.2)
Serious infections	2 (4.3)	0	1 (2.0)	0	2 (3.6)
Opportunistic infection	1 (2.2)	0	0	0	1 (1.8)
Herpes zoster	0	0	0	0	1 (1.8)
Any hepatic disorder, n (%)	1 (2.2)	2 (4.3)	0	0	6 (10.7)
Anemia, n (%)	3 (6.5)	1 (2.1)	4 (8.2)	2 (3.8)	0
Any creatine phosphokinase elevation, n (%)	0	0	3 (6.1)	2 (3.8)	5 (8.9)
Adjudicated cardiovascular events, n (%)	0	0	0	0	1 (1.8)
<b>Abnormal laboratory test results</b>					
Hemoglobin (g/L)					
Grade 3 (< 80)	1/46 (2.2)	2/47 (4.3)	2/49 (4.1)	2/50 (4.0)	0/56
Lymphocytes (x10 <sup>9</sup> /L)					
Grade 3 (0.5-0.2)	0/46	2/47 (4.3)	1/49 (2.0)	2/50 (4.0)	2/56 (3.6)
Grade 4 (< 0.2)	0/46	0/47	0/49	0/50	0/56
Neutrophils (x10 <sup>9</sup> /L)					

Grade 3 (0.5 - < 1.0)	0/46	0/47	1/49 (2.0)	0/50	2/56 (3.6)
Grade 4 (< 0.5)	0/46	0/47	0/49	0/50	0/56
Alanine Aminotransferase (U/L)					
Grade 3 (5.0 - < 20.0*ULN)	0/46	0/47	0/49	0/52	0/56
Grade 4 (> 20.0*ULN)	0/46	0/47	0/49	0/52	0/56
Aspartate Aminotransferase (U/L)					
Grade 3 (5.0 - < 20.0*ULN)	0/46	0/47	0/49	0/52	1/56 (1.8)
Grade 4 (> 20.0*ULN)	0/46	0/47	0/49	0/52	0/56
Creatine phosphokinase (U/L)					
Grade 3 (> 5.0 - 10.0 x ULN)	0/46	0/47	1/49 (2.0)	1/52 (1.9)	2/55 (3.6)
Grade 4 (> 10.0 x ULN)	0/46	0/47	1/49 (2.0)	0/52	2/55 (3.6)

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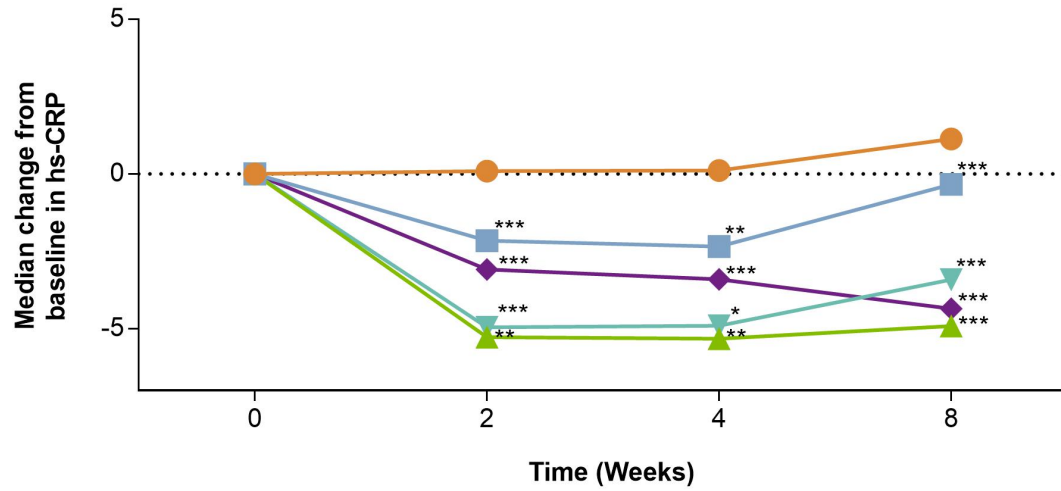




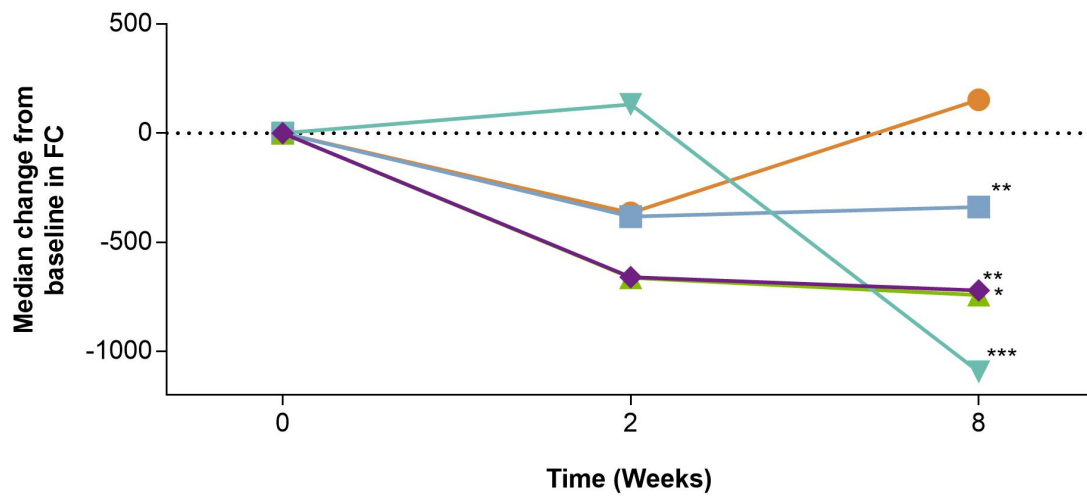
**A.****B.****C.****D.**

—○— PBO —■— 7.5 mg QD —▲— 15 mg QD —▼— 30 mg QD —◆— 45 mg QD

**A.**



**B.**



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**Section 1. Study investigators and sites**

The Principal Investigators at each of the study sites that randomized patients in U-ACHIEVE Substudy 1 are listed below.

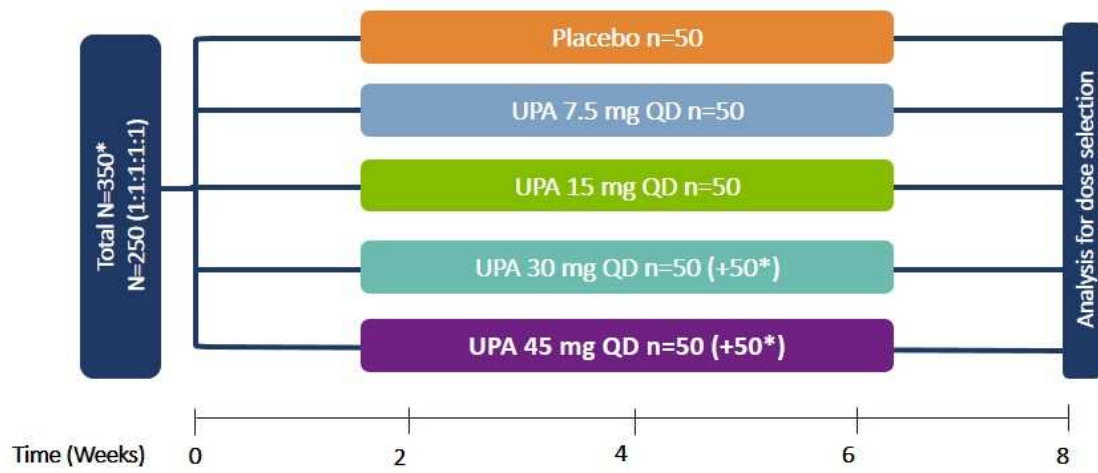
**Africa:** Dr. John Wright, South Africa.

**Asia:** Dr. Doron Schwartz, Israel; Dr. Matti Waterman, Israel; Dr. Satoshi Motoya, Japan; Dr. Katsuyoshi Matsuoka, Japan; Dr. Takayuki Shirai, Japan; Dr. Yuichiro Kojima, Japan; Dr. Satoshi Tanida, Japan; Dr. Makoto Sasaki, Japan; Dr. Yusuke Okuyama, Japan; Dr. Shiro Nakamura, Japan; Dr. Nobuo Aoyama, Japan; Dr. Osamu Watanabe, Japan; Dr. Shinji Tanaka, Japan; Dr. Keiichi Mitsuyama, Japan; Dr. Satoki Tokito, Japan; Dr. Taku Kobayashi, Japan; Dr. Yoh Ishiguro, Japan; Dr. Akira Chikuba, Japan; Dr. Hirokazu Yamagami, Japan; Dr. Motohiro Esaki, Japan; Prof. Byung Ik Jang, South Korea; Dr. Dong Il Park, South Korea; Dr. Young-Ho Kim, South Korea; Dr. ByongDuk Ye, South Korea; Dr. Abu Hassan Muhammad Radzi, Malaysia; Prof. Ida Normiha Hilmi, Malaysia; Dr. Jen-Wei Chou, Taiwan; Dr. Shu Chen Wei, Taiwan.

**Europe:** Dr. Harry Fuchssteiner, Austria; Prof. Harald Vogelsang, Austria; Prof. Gert Van Assche, Belgium; Dr. Filip Baert, Belgium; Dr. Tomas Vanasek, Czech Republic; Dr. Vit Smajstrla, Czech Republic; Dr. Kulliki Suurmaa, Estonia; Dr. Airi Jussila, Finland; Dr. Martti Farkkila, Finland; Dr. Inka Koskinen, Finland; Dr. Mika Puhto, Finland; Prof. Xavier Hebuterne, France; Dr. Stefan Schubert, Germany; Dr. Sebastian Haag, Germany; Dr. Wolfgang Reindl, Germany; Dr. Arpad Patai, Hungary; Dr. Guido Basilisco, Italy; Dr. Sandro Ardizzone, Italy; Dr. Aldis Pukitis, Latvia; Dr. Geert D'Haens, Netherlands; Dr. Pieter Wolter Maljaars, Netherlands; Dr. Frank Hoentjen, Netherlands; Prof. Janneke van der Woude, Netherlands; Dr. Henrica Fidler, Netherlands; Dr. Jorgen Jahnsen, Norway; Dr. Jaroslaw Kierkus, Poland; Dr. Susana

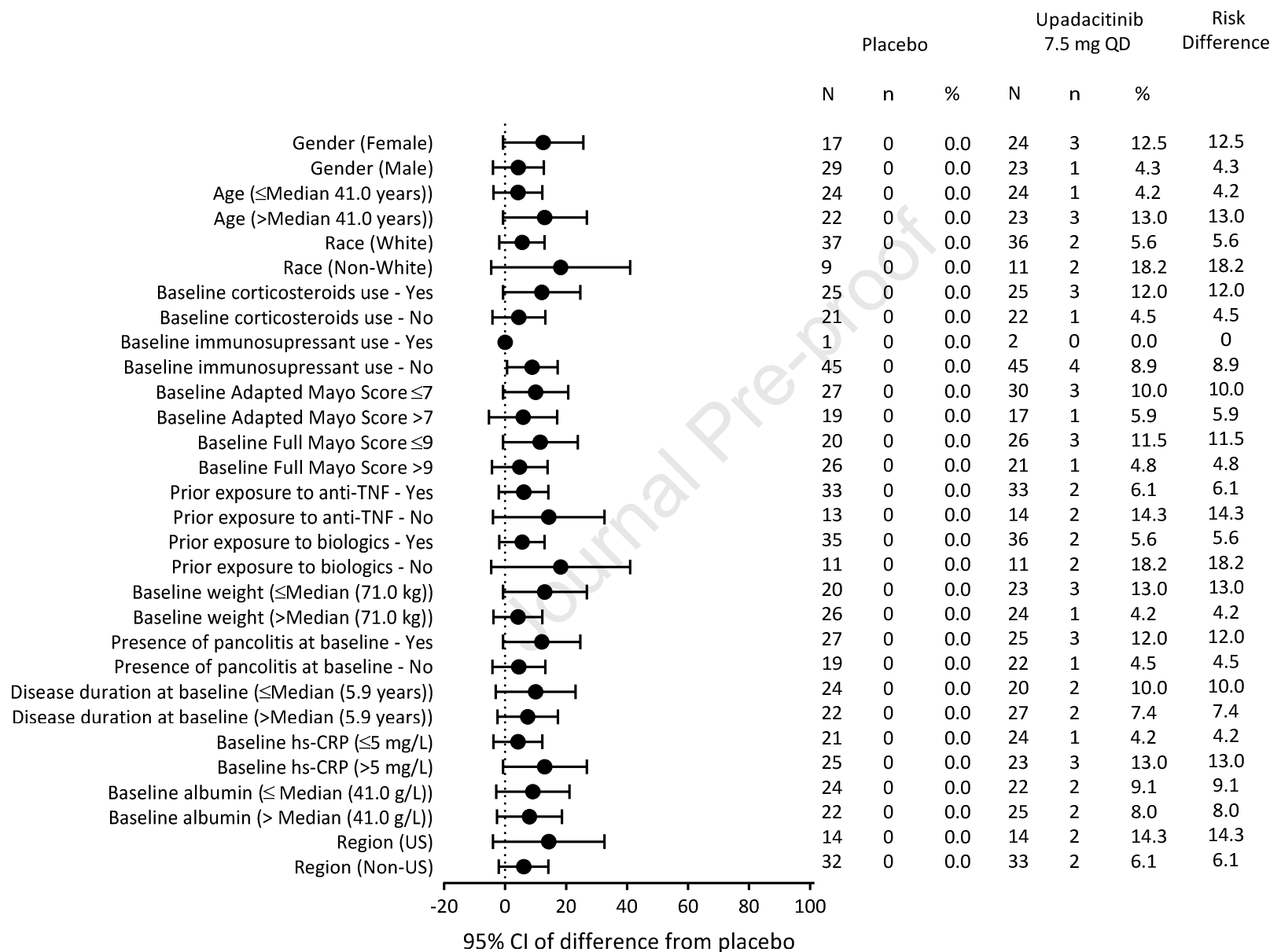
Lopes, Portugal; Dr. Jozef Balaz, Slovakia; Dr. Ivan Bunganic, Slovakia; Dr. Petr Hruz, Switzerland; Dr. Pascal Juillerat, Switzerland; Dr. Michael Sulz, Switzerland; Prof. Gerhard Rogler, Switzerland; Dr. Matthew Brown, United Kingdom; Dr. Tariq Ahmad, United Kingdom; Dr. James Lindsay, United Kingdom.

**North America:** Dr. Etienne Desilets, Canada; Dr. Jesse Siffledeen, Canada; Dr. Joannie Ruel, Canada; Dr. John Marshall, Canada; Dr. Susan Greenbloom, Canada; Dr. M. Tarek Al-Assi, Unites States; Dr. Philip Ginsburg, Unites States; Dr. Sanjib Mohanty, Unites States; Dr. Harry Sarles, Jr., Unites States; Dr. Ziad Younes, Unites States; Dr. Humberto Aguilar, Unites States; Dr. Sartaj Arora, Unites States; Dr. Richard Bloomfeld, Unites States; Dr. Raymond Cross, Jr., Unites States; Dr. Michael Georgetson, Unites States; Dr. Jonathan Goldstein, Unites States; Dr. Peter Higgins, Unites States; Dr. Suzy Kim, Unites States; Dr. Alexander Veloso, Unites States; Dr. Michael Kreines, Unites States; Dr. Bruce Salzberg, Unites States; Dr. Corey Siegel, Unites States; Dr. Dana Lukin, United States; Dr. Daniel Greenen, United States; Dr. Nathaniel Winstead, Unites States; Dr. Edward Loftus, Unites States; Dr. Sunil Khurana, Unites States; Dr. Barry Kaufman, Unites States; Dr. Zahid Rashid, Unites States; Dr. Igor Grosman, Unites States; Dr. Naresh Gunaratnam, Unites States; Dr. Paul Hellstern Jr., Unites States; Dr. John Weber, Unites States; Dr. Rajesh Jain, Unites States; Dr. Sara Horst, Unites States; Dr. John Lowe, Unites States; Dr. Michael Chiorean, Unites States; Dr. Christian Stone, Unites States; Dr. Charles Johnson, Unites States.

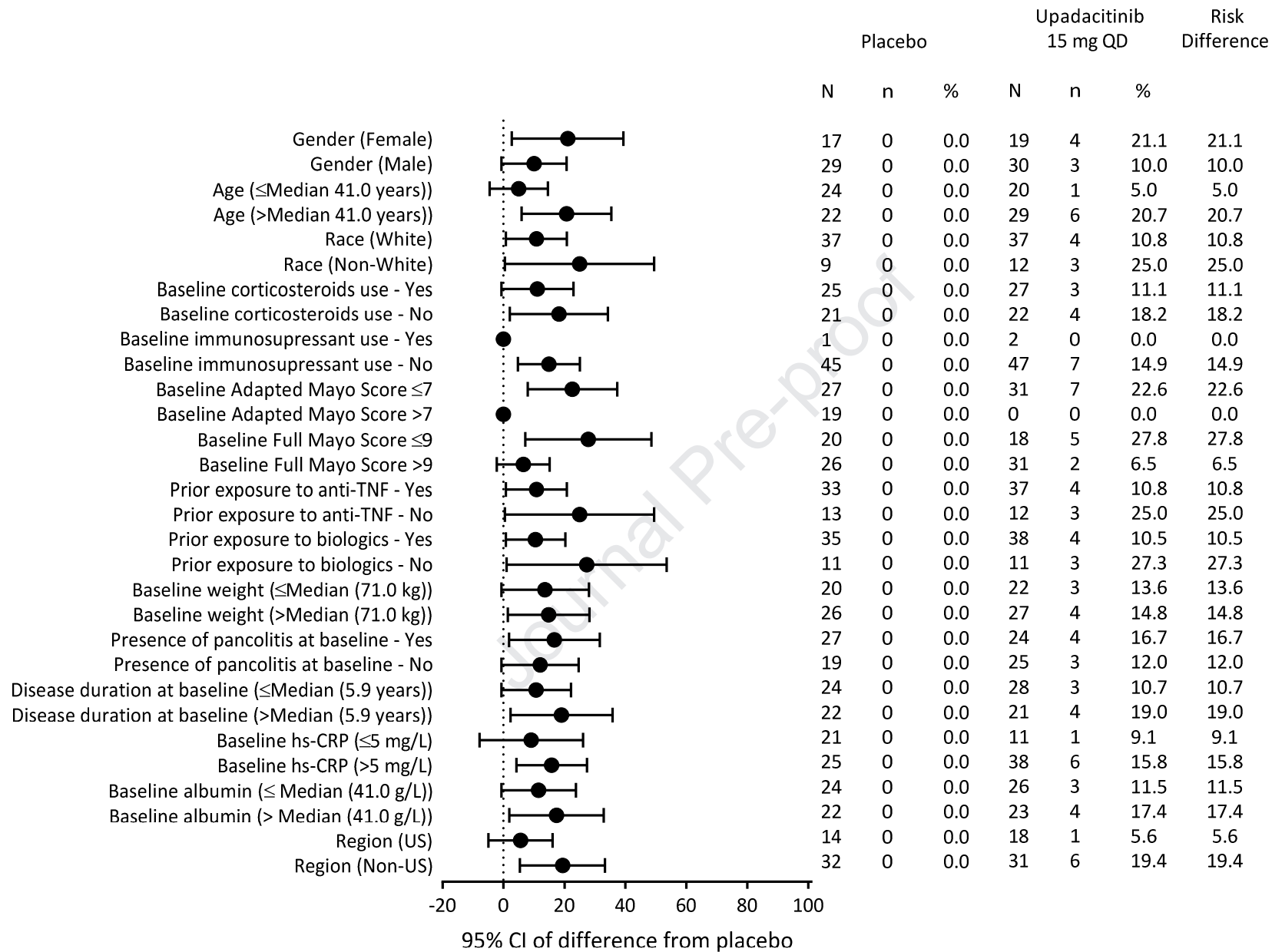
**Figure S1. U-ACHIEVE study 1 design.** QD=once daily; UPA=upadacitinib

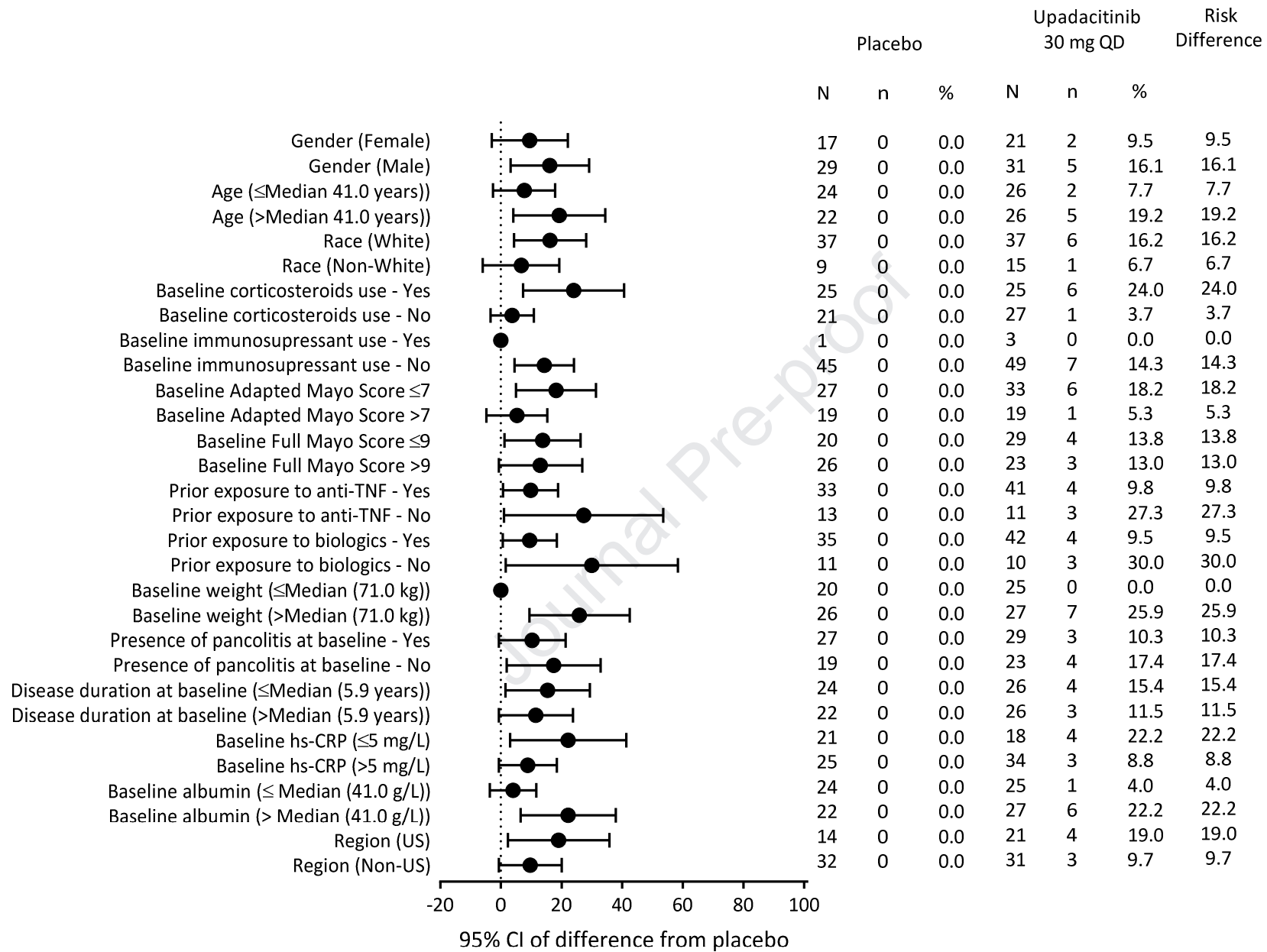
\* During the analysis period for part 1, 132 additional subjects were enrolled in the 30 mg QD and 45 mg QD treatment groups.

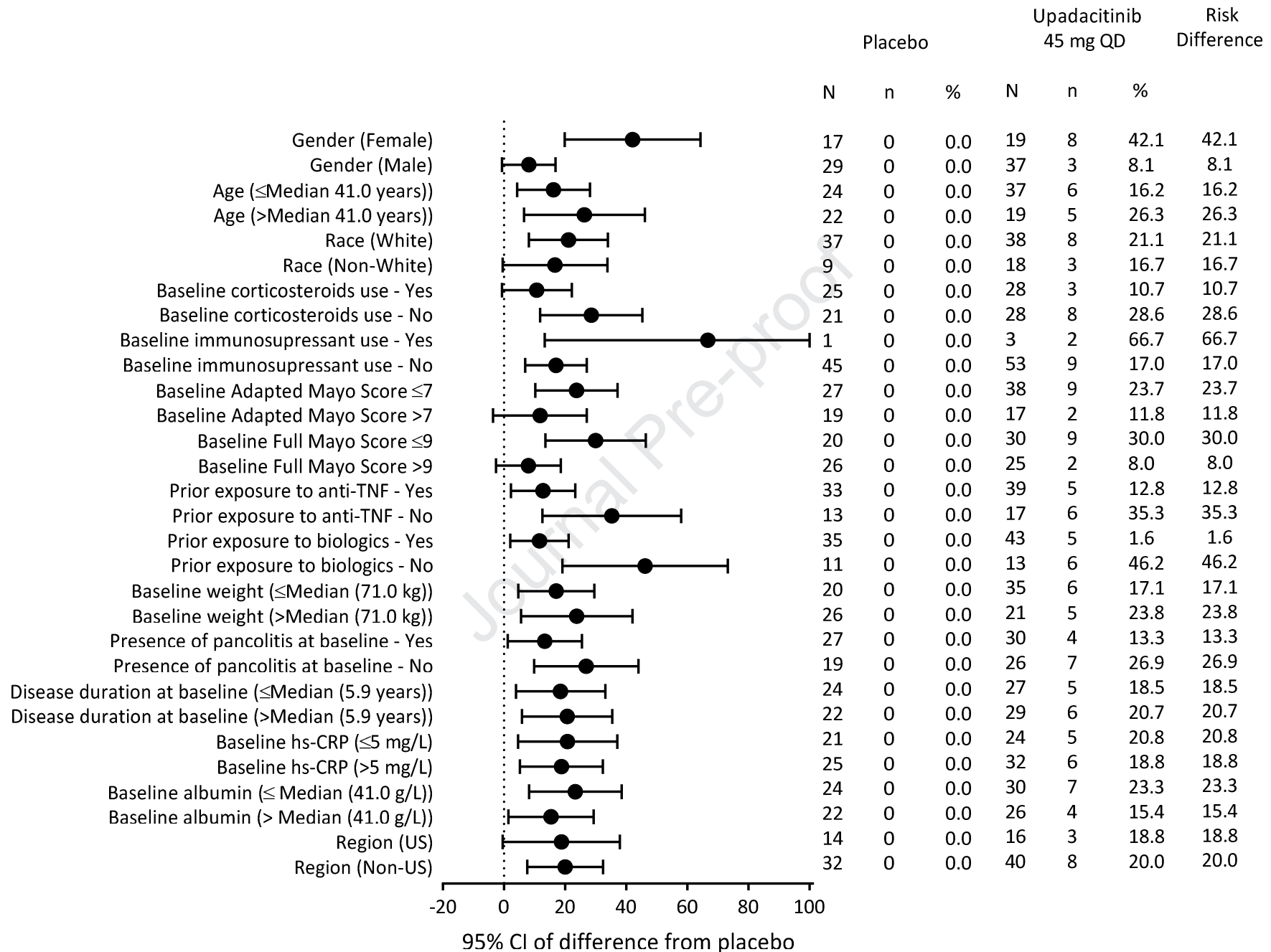
**Figure S2. Proportion of patients with clinical remission according to the Adapted Mayo score at Week 8 in the pre-specified subgroup analyses in the U-ACHIEVE study 1 part 1**











**Table S1. Stool frequency subscore and Rectal bleeding subscore at Week 8 in the U-ACHIEVE study 1 part 1**

	Placebo	Upadacitinib			
		7.5 mg QD	15 mg QD	30 mg QD	45 mg QD
<b>Adapted Mayo Score Component at week 8, n (%)</b>	<b>N=46</b>	<b>N=47</b>	<b>N=49</b>	<b>N=52</b>	<b>N=56</b>
Stool Frequency Subscore $\leq 1$	6 (13.0)	16 (34.0)	13 (26.5)	19 (36.5)	26 (46.4)
Rectal Bleeding Subscore =0	12 (26.1)	17 (36.2)	20 (40.8)	27 (51.9)	33 (58.9)

**Table S2. MCP-Mod dose-response modeling in the U-ACHIEVE study 1 part 1**

<b>Outcome</b>	<b>Rate</b>	<b>Models, p-value</b>
<b>Clinical remission according to the Adapted Mayo score</b>	Placebo: 0%	Exponential: 0.147
	7.5 mg QD: 8.5%	$E_{\max}$ : 0.0404
	15 mg QD: 14.3%	$\text{Sig}E_{\max}$ : 0.0642
	30 mg QD: 13.5%	Log-Linear: 0.0328
	45 mg QD: 19.6%	Logistic: 0.107
<b>Endoscopic improvement</b>	Placebo: 2.2%	Exponential: 0.0765
	7.5 mg QD: 14.9%	$E_{\max}$ : 0.0037
	15 mg QD: 30.6%	$\text{Sig}E_{\max}$ : 0.0094
	30 mg QD: 26.9%	Log-Linear: 0.0023
	45 mg QD: 35.7%	Logistic: 0.0222
<p>QD= once daily. MCP-Mod= Multiple Comparison Procedure and Modeling.</p> <p>In addition to estimating the relative treatment effect of upadacitinib to placebo, an important goal of this phase 2b study was to establish dose-response relationships to facilitate the dose selection for future phase 3 trials. Multiple Comparison Procedure and dose-response Modeling (MCP-Mod) with a pre-defined group of candidate dose-response curves will be tested against flat dose-response curve to best characterize the dose-response relationship.</p> <p>Steps of MCP-Mod:</p> <ol style="list-style-type: none"> <li>1. Choose a candidate set of S models.</li> <li>2. Compute the optimum contrast for each model.</li> <li>3. Use contrast test to find the significant Tmodels while preserving FWER.</li> <li>4. Use AIC criteria to find the most significant model from the significant Tmodels found from Step 3.</li> <li>5. Use the model found from Step 4 to fit observed data from the study and make inference (e.g., to find Minimum Effective Dose (MED) or the dose achieving certain amount of maximum effect), or use all significant models to make inference about the weighted target dose of interest.</li> </ol> <p>ADDPLAN or R will be used to evaluate different dose-response models and to make dose recommendation.</p>		

**Table S3. Additional efficacy endpoints in the U-ACHIEVE Study 1 part 1 Protocol**

<b>Efficacy endpoints</b>	<b>Reported in this manuscript or supplement</b>	<b>Nor reported in this manuscript or supplement</b>
Proportion of subjects who are taking corticosteroids at Baseline and are steroid-free over time		<b>X</b>
Proportion of subjects who achieve clinical remission according to the Adapted Mayo score over time		<b>X</b>
Proportion of subjects achieving clinical remission according to the Partial Mayo score over time		<b>X</b>
Proportion of subjects achieving clinical remission defined as stool frequency subscore $\leq 1$ , rectal bleeding subscore of 0, and endoscopic subscore $\leq 1$ with absence of friability over time		<b>X</b>
Proportion of subjects achieving clinical remission defined as stool frequency subscore of 0, rectal bleeding subscore of 0, and endoscopic subscore of 0 over time		<b>X</b>
Proportion of subjects achieving clinical response according to the Partial Mayo score over time		<b>X</b>
Proportion of subjects with stool frequency subscore $\leq 1$ over time		<b>X</b>
Proportion of subjects with rectal bleeding subscore of 0 over time		<b>X</b>
Proportion of subjects with fecal calprotectin below 150 mg/kg over time		<b>X</b>
Proportion of subjects with IBDQ response (increase of IBDQ $\geq 16$ from Baseline) over time		<b>X</b>
Change from Baseline in hs-CRP over time	<b>X</b>	

Change from Baseline in fecal calprotectin over time	<b>X</b>	
Change from Baseline in corticosteroid dose over time		<b>X</b>
Change from Baseline in Adapted Mayo score, Mayo score, Partial Mayo score and Mayo subscores over time		<b>X</b>
Change from Baseline in UCEIS score over time		<b>X</b>
Change from Baseline in histologic score over time		<b>X</b>
Change from Baseline in laboratory and nutritional parameters (e.g. hemoglobin, hematocrit, albumin, total protein concentration, and weight)		<b>X</b>
Change from Baseline in subject-reported stool frequency (absolute values)		<b>X</b>
Change from Baseline in IBDQ score over time		<b>X</b>
Change from Baseline in EQ-5D-5L score over time		<b>X</b>
Change from Baseline in WPAI scores over time		<b>X</b>
Change from Baseline in SF-36 PCS, MCS components and domain scores over time		<b>X</b>
Change in PGIC score over time		<b>X</b>
Change from Baseline in FACIT-F score over time		<b>X</b>
Change from Baseline in UC-SQ score over time		<b>X</b>
Health care resource utilization (UC-related hospitalizations and surgeries) during the study		<b>X</b>

**Table S4. Efficacy outcomes by prior biologic exposure in the U-ACHIEVE study 1 part 1**

End Point	Placebo N=46	Upadacitinib			
		7.5 mg QD N=47	15 mg QD N=49	30 mg QD N=52	45 mg QD N=56
Clinical remission according to the Adapted Mayo					
score at week 8					
Bio-IR, N	34	34	36	40	42
n (%)	0	2 (5.9)	3 (8.3)	4 (10.0)	5 (11.9)
Risk difference (95% CI)		5.9 (-2.0 to 13.8)	8.3 (-0.7 to 17.4)	10.0 (0.7 to 19.3)	11.9 (2.1 to 21.7)
P value		0.493	0.120	0.120	0.061
Non Bio-IR, N	12	13	13	12	14
n (%)	0	2 (15.4)	4 (30.8)	3 (25.0)	6 (42.9)
Risk difference (95% CI)		15.4 (-4.2 to 35.0)	30.8 (5.7 to 55.9)	25.0 (0.5 to 49.5)	42.9 (16.9 to 68.8)
P value		0.480	0.096	0.217	0.017
Endoscopic improvement at week 8					
Bio-IR, N	34	34	36	40	42
n (%)	0	3 (8.8)	9 (25.0)	8 (20.0)	11 (26.2)
Risk difference (95% CI)		8.8 (-0.7 to 18.4)	25.0 (10.9 to 39.1)	20.0 (7.6 to 32.4)	26.2 (12.9 to 39.5)



P value		0.239	0.002	0.006	<0.001
Non Bio-IR	12	13	13	12	14
n (%)	1 (8.3)	4 (30.8)	6 (46.2)	6 (50.0)	9 (64.3)
Risk difference (95% CI)		22.4 (-7.1 to 52.0)	37.8 (6.5 to 69.1)	41.7 (9.3 to 74.0)	56.0 (26.4 to 85.5)
P value		0.322	0.073	0.069	0.005
Clinical remission according to the full Mayo score at					
week 8					
Bio-IR, N	34	34	36	40	42
n (%)	0	2 (5.9)	1 (2.8)	3 (7.5)	4 (9.5)
Risk difference (95% CI)		5.9 (-2.0 to 13.8)	2.8 (-2.6 to 8.1)	7.5 (-0.7 to 15.7)	9.5 (0.6 to 18.4)
P value		0.493	1.000	0.245	0.123
Non Bio-IR, N	12	13	13	12	14
n (%)	0	2 (15.4)	4 (30.8)	3 (25.0)	7 (50.0)
Risk difference (95% CI)		15.4 (-4.2 to 35.0)	30.8 (5.7 to 55.9)	25.0 (0.5 to 49.5)	50.0 (23.8 to 76.2)
P value		0.480	0.096	0.217	0.006
Clinical response according to the Adapted Mayo					
score at week 8					
Bio-IR, N	34	34	36	40	42

n (%)	2 (5.9)	8 (23.5)	13 (36.1)	13 (32.5)	17 (40.5)
Risk difference (95% CI)		17.6 (1.3 to 34.0)	30.2 (12.7 to 47.8)	26.6 (10.1 to 43.1)	34.6 (17.8 to 51.4)
P value		0.040	0.002	0.005	<0.001
Non Bio-IR, N	12	13	13	12	14
n (%)	4 (33.3)	6 (46.2)	9 (69.2)	10 (83.3)	11 (78.6)
Risk difference (95% CI)		12.8 (-25.2 to 50.8)	35.9 (-0.7 to 72.5)	50.0 (16.0 to 84.0)	45.2 (11.0 to 79.5)
P value		0.688	0.073	0.013	0.020
Clinical response according to the Partial Mayo score					
at week 2					
Bio-IR, N	34	34	36	40	42
n (%)	5 (14.7)	6 (17.6)	11 (30.6)	14 (35.0)	20.3 (1.3 to 52.4)
Risk difference (95% CI)		2.9 (-14.5 to 20.4)	15.8 (-3.3 to 35.0)	to 39.3)	37.7 (18.4 to 56.9)
P value		0.742	0.114	0.046	<0.001
Non Bio-IR, N	12	13	13	12	14
n (%)	2 (16.7)	5 (38.5)	7 (53.8)	5 (41.7)	9 (64.3)
Risk difference (95% CI)		21.8 (-12.0 to 55.6)	37.2 (2.8 to 71.5)	25.0 (-10.0 to 60.0)	47.6 (14.8 to 80.4)
P value		0.378	0.097	0.371	0.014
Change in the full Mayo score from Baseline to week					

8, median (range)					
Bio-IR, N	30	33	34	36	37
	-0.300	-2.000	-2.500	-2.550	-4.300
	(-5.30 to 4.00)	(-8.00 to 1.00)	(-8.30 to 1.30)	(-8.70 to 2.00)	(-10.00 to 3.00)
Non Bio-IR, N	12	13	13	11	14
	-2.150	-3.700	-5.400	-6.300	-5.850
	(-5.30 to 1.60)	(-10.70 to 3.30)	(-8.70 to 1.30)	(-11.00 to -2.70)	(-9.00 to 1.00)
Endoscopic remission at week 8					
Bio-IR, N	34	34	36	40	42
n (%)	0	1 (2.9)	0	1 (2.5)	5 (11.9)
Risk difference (95% CI)		2.9 (-2.7 to 8.6)		2.5 (-2.3 to 7.3)	11.9 (2.1 to 21.7)
P value		1.000		1.000	0.061
Non Bio-IR, N	12	13	13	12	14
n (%)	0	2 (15.4)	2 (15.4)	4 (33.3)	5 (35.7)
Risk difference (95% CI)		15.4 (-4.2 to 35.0)	15.4 (-4.2 to 35.0)	33.3 (6.7 to 60.0)	35.7 (10.6 to 60.8)
P value		0.480	0.480	0.093	0.042
Histologic improvement at week 8					
Bio-IR, N	34	34	36	40	42

n (%)	3 (8.8)	7 (20.6)	15 (41.7)	15 (37.5)	20 (47.6)
Risk difference (95% CI)		11.8 (-4.8 to 28.4)	32.8 (14.1 to 51.6)	28.7 (10.9 to 46.5)	38.8 (20.9 to 56.7)
P value		0.171	0.002	0.004	<0.001
Non Bio-IR, N	12	13	13		
n (%)	0	8 (61.5)	10 (76.9)	8 (66.7)	7 (50.0)
Risk difference (95% CI)		61.5 (35.1 to 88.0)	76.9 (54.0 to 99.8)	66.7 (40.0 to 93.3)	50.0 (23.8 to 76.2)
P value		0.002	<0.001	0.001	0.006

Biologic inadequate response (Bio-IR)=patients who had inadequate response, loss of response or intolerance to an TNF antagonist or other biologic agent; Non

biologic inadequate response (Non Bio-IR)= patients who had no inadequate response, loss of response or intolerance to an TNF antagonist or other biologic agent

**Table S5. Change from baseline in hs-CRP in the U-ACHIEVE study 1 part 1**

Visit Treatment,	Placebo	Upadacitinib			
		7.5 mg QD	15 mg QD	30 mg QD	45 mg QD
Median (range)	<b>N=46</b>	<b>N=47</b>	<b>N=49</b>	<b>N=52</b>	<b>N=56</b>
<b>Week 2</b>	0.095 (-15.98, 30.10)	-2.150 (-20.58, 4.30)	-5.275 (-115.37, 36.84)	-4.950 (-45.00, 2.93)	-3.090 (-61.73, 19.69)
<b>Week 4</b>	0.115 (-20.70, 86.43)	-2.350 (-20.44, 18.86)	-5.330 (-115.27, 32.53)	-4.900 (-49.38, 115.59)	-3.405 (-60.69, 28.50)
<b>Week 8</b>	1.135 (-21.27, 168.76)	-0.340 (-16.20, 10.00)	-4.920 (-115.34, 20.94)	-3.420 (-45.00, 24.12)	-4.355 (-64.81, 41.00)

QD=once daily

**Table S6. Change from baseline in fecal calprotectin in the U-ACHIEVE study 1 part 1**

Visit Treatment,	Placebo	Upadacitinib			
		7.5 mg QD	15 mg QD	30 mg QD	45 mg QD
Median (range)	<b>N=46</b>	<b>N=47</b>	<b>N=49</b>	<b>N=52</b>	<b>N=56</b>
<b>Week 2</b>	-365.0 (-11820, 8522)	-382.5 (-6593, 13402)	-662.0 (-15174, 25639)	132.0 (-17838, 5341)	-659.0 (-16528, 11610)
<b>Week 8</b>	154.0 (-5896, 16680)	-338.0 (-17313, 3521)	-742.0 (-18475, 18063)	-1093.0 (-18018, 4059)	-720.0 (-16830, 24916)

QD=once daily

**Table S7: Efficacy outcomes in the U-ACHIEVE Study 1 part 1 trial excluding the 12 patients with randomization error**

End Point	Placebo N=46	Upadacitinib			
		7.5 mg QD N=47	15 mg QD N=49	30 mg QD N=46	45 mg QD N=50
Clinical remission according to the Adapted Mayo					
score at Week 8					
Overall					
n (%)	0	4 (8.5)	7 (14.3)	7 (15.2)	9 (18.0)
Adjusted risk difference (95% CI)		8.1 (-0.1 to 16.3)	12.7 (2.7 to 22.6)	13.5 (3.1 to 23.8)	17.7 (5.9 to 29.5)
P value		0.052	0.013	0.011	0.003
Bio-IR					
n (%)	0	2 (5.9)	3 (8.3)	4 (11.4)	4 (10.5)
Risk difference (95% CI)		5.9 (-2.0 to 13.8)	8.3 (-0.7 to 17.4)	11.4 (0.9 to 22.0)	10.5 (0.8 to 20.3)
P value		0.493	0.240	0.114	0.117
Non Bio-IR					
n (%)	0	2 (15.4)	4 (30.8)	3 (27.3)	5 (41.7)
Risk difference (95% CI)		15.4 (-4.2 to 35.0)	30.8 (5.7 to 55.9)	27.3 (1.0 to 53.6)	41.7 (13.8 to 69.6)
P value		0.480	0.096	0.093	0.037

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 Endoscopic improvement at Week 8

## Overall

n (%)	1 (2.2)	7 (14.9)	15 (30.6)	13 (28.3)	18 (36.0)
Adjusted risk difference (95% CI)		12.9 (1.1 to 24.7)	26.9 (12.6 to 41.2)	26.1 (11.7 to 40.6)	36.3 (19.6 to 52.9)
P value		0.033	<0.001	<0.001	<0.001

## Bio-IR

n (%)	0	3 (8.8)	9 (25.0)	7 (20.0)	10 (26.3)
Risk difference (95% CI)		8.8 (-0.7 to 18.4)	25.0 (10.9 to 39.1)	20.0 (6.7 to 33.3)	26.3 (12.3 to 40.3)
P value		0.239	0.002	0.011	0.001

## Non Bio-IR

n (%)	1 (8.3)	4 (30.8)	6 (46.2)	6 (54.5)	8 (66.7)
Risk difference (95% CI)		22.4 (-7.1 to 52.0)	37.8 (6.5 to 69.1)	46.2 (12.9 to 79.5)	58.3 (27.4 to 89.3)
P value		0.322	0.073	0.027	0.009

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 Clinical remission according to the full Mayo score

## at Week 8

## Overall

n (%)	0	4 (8.5)	5 (10.2)	6 (13.0)	9 (18.0)
Adjusted risk difference (95% CI)		8.1 (-0.1 to 16.3)	9.0 (1.0 to 17.0)	12.7 (2.4 to 23.0)	18.6 (6.8 to 30.5)

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P value		0.052	0.027	0.016	0.002
Bio-IR					
n (%)	0	2 (5.9)	1 (2.8)	3 (8.6)	3 (7.9)
Risk difference (95% CI)		5.9 (-2.0 to 13.8)	2.8 (-2.6 to 8.1)	8.6 (-0.7 to 17.8)	7.9 (-0.7 to 16.5)
P value		0.493	1.000	0.239	0.242
Non Bio-IR					
n (%)	0	2 (15.4)	4 (30.8)	3 (27.3)	6 (50.0)
Risk difference (95% CI)		15.4 (-4.2 to 35.0)	30.8 (5.7 to 55.9)	27.3 (1.0 to 53.6)	50.0 (21.7 to 78.3)
P value		0.480	0.096	0.093	0.014
Clinical response according to the Adapted Mayo					
score at Week 8					
Overall					
n (%)	6 (13.0)	14 (29.8)	22 (44.9)	21 (45.7)	22 (44.0)
Adjusted risk difference (95% CI)		16.0 (0.3 to 31.7)	30.2 (12.5 to 47.8)	31.7 (13.9 to 49.5)	33.6 (15.2 to 52.0)
P value		0.046	<0.001	<0.001	<0.001
Bio-IR					
n (%)	2 (5.9)	8 (23.5)	13 (36.1)	12 (34.3)	13 (34.2)
Risk difference (95% CI)		17.6 (1.3 to 34.0)	30.2 (12.7 to 47.8)	28.4 (10.8 to 46.0)	28.3 (11.3 to 45.4)

P value		0.040	0.002	0.003	0.003
Non Bio-IR					
n (%)	4 (33.3)	6 (46.2)	9 (69.2)	9 (81.8)	9 (75.0)
Risk difference (95% CI)		12.8 (-25.2 to 50.8)	35.9 (-0.7 to 72.5)	48.5 (13.4 to 83.6)	41.7 (5.5 to 77.9)
P value		0.688	0.073	0.036	0.041

Biologic inadequate response (Bio-IR)=patients who had inadequate response, loss of response or intolerance to an TNF antagonist or other

biologic agent; Non biologic inadequate response (Non Bio-IR)= patients who had no inadequate response, loss of response or intolerance to an

TNF antagonist or other biologic agent. QD=once daily; CI=confidence interval

The confidence intervals have not been adjusted for multiplicity and inferences drawn from the intervals may not be reproducible.

**Table S8. Patient demographics and baseline disease characteristics in patients from U-ACHIEVE study 1 part 1 and part 2**

Characteristic	Placebo n=46	Upadacitinib			
		7.5 mg QD n=47	15 mg QD n=49	30 mg QD n=117	45 mg QD n=123
Female, n (%)	17 (37.0)	24 (51.1)	19 (38.8)	47 (40.2)	44 (35.8)
Age, years, median (range)	40.0 (21- 67)	41.0 (18- 75)	47.0 (22-71)	41.0 (19.0-75)	39.0 (19-74)
UC duration, years, median (range)	5.86 (0.4-30.8)	6.59 (0.8-43.7)	4.58 (0.2-43.0)	7.03 (0.3-28.0)	5.99 (0.2-35.3)
Disease extent, n (%)					
Rectosigmoid	0	1 (2.1)	0	0	0
Left-sided colitis	18 (39.1)	20 (42.6)	25 (51.0)	53 (45.3)	54 (43.9)
Extensive colitis or pancolitis	28 (60.9)	26 (55.3)	24 (49.0)	64 (54.7)	69 (56.1)
Total Mayo score, median (range)	9.3 (7-12)	9.0 (7-12)	9.7 (7-12)	9.0 (5-12)	9.0 (6-12)
Adapted Mayo score, median (range)	6.9 (5-9)	7.0 (5-9)	7.0 (4-9)	6.7 (3-9)	6.9 (4-9)
Baseline corticosteroid use, n (%)	26 (56.5)	25 (53.2)	27 (55.1)	50 (42.7)	53 (43.1)
Baseline immunosuppressant use, n (%)	1 (2.2)	2 (4.3)	2 (4.1)	3 (2.6)	5 (4.1)
Baseline aminosalicylates use, n (%)	26 (56.5)	27 (57.4)	25 (51.0)	64 (54.7)	67 (54.5)

**Table S9. Stool frequency subscore and Rectal bleeding subscore at Week 8 in the U-ACHIEVE study 1 part 1 and part 2**

	Placebo	Upadacitinib			
		7.5 mg QD	15 mg QD	30 mg QD	45 mg QD
<b>Adapted Mayo Score Component at Week 8, n (%)</b>	<b>N=46</b>	<b>N=47</b>	<b>N=49</b>	<b>N=52</b>	<b>N=56</b>
Stool Frequency Subscore $\leq 1$	6 (13.0)	15 (31.9)	13 (26.5)	46 (39.3)	54 (43.9)
Rectal Bleeding Subscore =0	12 (26.1)	18 (38.3)	20 (40.8)	73 (62.4)	69 (56.1)

**Table S10: Efficacy outcomes in the U-ACHIEVE study 1 part 1 and part 2**

End Point	Placebo N=46	Upadacitinib			
		7.5 mg QD N=47	15 mg QD N=49	30 mg QD N=117	45 mg QD N=123
Clinical remission according to the Adapted Mayo					
score at week 8					
n (%)	0	4 (8.5)	7 (14.3)	25 (21.4)	22 (17.9)
Adjusted risk difference (95% CI)		8.2 (-0.1 to 16.6)	13.5 (3.3 to 23.8)	21.2 (8.9 to 33.4)	17.8 (6.9 to 28.8)
P value		0.054	0.010	<0.001	0.001
Endoscopic improvement at week 8					
n (%)	1 (2.2)	7 (14.9)	15 (30.6)	40 (34.2)	42 (34.1)
Adjusted risk difference (95% CI)		12.9 (1.1 to 24.8)	27.6 (13.1 to 42.1)	31.1 (16.8 to 45.3)	33.0 (18.2 to 47.8)
P value		0.033	<0.001	<0.001	<0.001
Clinical response according to the Adapted Mayo					
score at week 8					
n (%)	6 (13.0)	13 (27.7)	22 (44.9)	63 (53.8)	65 (52.8)
Adjusted risk difference (95% CI)		13.8 (-1.4 to 29.0)	31.1 (13.8 to 48.4)	38.2 (22.4 to 54.0)	40.1 (23.5 to 56.7)
P value		0.074	<0.001	<0.001	<0.001

Clinical response according to the Partial Mayo score					
at week 2					
n (%)	7 (15.2)	11 (23.4)	18 (36.7)	52 (44.4)	63 (51.2)
Adjusted risk difference (95% CI)		8.0 (-8.6 to 24.7)	20.3 (2.7 to 37.8)	29.2 (12.8 to 45.6)	39.6 (22.7 to 56.5)
P value		0.345	0.024	<0.001	<0.001
Endoscopic remission at week 8					
n (%)	0	3 (6.4)	2 (4.1)	19 (16.2)	20 (16.3)
Adjusted risk difference (95% CI)		6.5 (-0.8 to 13.7)	3.8 (-2.0 to 9.6)	16.0 (5.8 to 26.1)	15.3 (4.6 to 25.9)
P value		0.079	0.199	0.002	0.005
Histologic improvement at week 8					
n (%)	3 (6.5)	16 (34.0)	25 (51.0)	55 (47.0)	62 (50.4)
Adjusted risk difference (95% CI)		27.4 (10.3 to 44.5)	43.6 (25.4 to 61.8)	39.1 (23.3 to 54.9)	45.1 (28.1 to 62.2)
P value		0.002	<0.001	<0.001	<0.001

QD=once daily; CI=confidence interval

The confidence intervals have not been adjusted for multiplicity and inferences drawn from the intervals may not be reproducible

**Table S11: Safety outcomes at Week 8 in patients from U-ACHIEVE study 1 part 1 and part 2**

Adverse event	Upadacitinib				
	Placebo n=46	7.5 mg QD n=47	15 mg QD n=49	30 mg QD n=117	45 mg QD n=123
Any AE, n (%)	33 (71.7)	30 (63.8)	30 (61.2)	81 (69.2)	79 (64.2)
Colitis ulcerative, n (%)	6 (13.0)	1 (2.1)	3 (6.1)	8 (6.8)	6 (4.9)
Any serious AE, n (%)	5 (10.9)	0	2 (4.1)	5 (4.3)	6 (4.9)
Any AE leading to discontinuation, n (%)	4 (8.7)	1 (2.1)	2 (4.1)	5 (4.3)	7 (5.7)
Infections and infestations, n (%)	16 (34.8)	9 (19.1)	10 (20.4)	24 (20.5)	28 (22.8)
Serious infections	2 (4.3)	0	1 (2.0)	1 (0.9)	2 (1.6)
Opportunistic infection	1 (2.2)	0	0	0	1 (0.8)
Herpes zoster	0	0	0	0	1 (0.8)
Any hepatic disorder, n (%)	1 (2.2)	2 (4.3)	0	0	6 (4.9)
Anemia, n (%)	3 (6.5)	1 (2.1)	4 (8.2)	5 (4.3)	5 (4.1)
Any creatine phosphokinase elevation, n (%)	0	0	3 (6.1)	4 (3.4)	8 (6.5)
Adjudicated cardiovascular events, n (%)	0	0	0	0	1 (0.8)
<b>Abnormal laboratory test results</b>					
Hemoglobin (g/L)					
Grade 3 (<80)	1/46 (2.2)	2/47 (4.3)	2/49 (4.1)	3/115 (2.6)	1/122 (0.8)
Lymphocytes (x10 <sup>9</sup> /L)					
Grade 3 (<0.5-0.2)	0/46	2/47 (4.3)	1/49 (2.0)	4/115 (3.5)	4/122 (3.3)
Grade 4 (<0.2)	0/46	0/47	0/49	0/115	0/122

Neutrophils ( $\times 10^9/L$ )					
Grade 3 (0.5-<1.0)	0/46	0/47	1/49 (2.0)	1/115 (0.9)	4/122 (3.3)
Grade 4 (<0.5)	0/46	0/47	0/49	0/115	0/122
Alanine aminotransferase (U/L)					
Grade 3 (5.0-<20.0*ULN)	0/46	0/47	0/49	0/117	0/122
Grade 4 (>20.0*ULN)	0/46	0/47	0/49	0/117	0/122
Aspartate aminotransferase (U/L)					
Grade 3 (5.0-<20.0*ULN)	0/46	0/47	0/49	0/117	1/122 (0.8)
Grade 4 (>20.0*ULN)	0/46	0/47	0/49	0/117	0/122
Creatine Kinase (U/L)					
Grade 3 (>5.0-10.0 x ULN)	0/46	0/47	1/49 (2.0)	1/117 (0.9)	4/121 (3.3)
Grade 4 (>10.0 x ULN)	0/46	0/47	1/49 (2.0)	1/117 (0.9)	3/121 (2.5)

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AE=adverse event. QD=once daily.



**What you need to know:**

**BACKGROUND AND CONTEXT:** Studies are needed to evaluate the efficacy and safety of upadacitinib, an oral selective inhibitor of Janus kinase 1, for treatment of ulcerative colitis (UC).

**NEW FINDINGS:** In a phase 2b trial, 8 weeks treatment with upadacitinib was more effective than placebo for induction of remission in patients with moderately to severely active UC.

**LIMITATIONS:** This study comprised 250 patients with UC; further studies are needed.

**IMPACT:** Upadacitinib might be used as a new therapy in patients with moderate to severe UC.

**Lay Summary:** In a clinical trial, the drug upadacitinib was effective in inducing remission in patients with moderate to severe UC.