

## **Appendix H.**

### **Additional Study Details:**

#### **Sample size**

- Sample size was determined by
  - ▶ A total of 584 male and female patients will be enrolled in the study. Therapeutic equivalence to Remicade in the all randomised population will be based on expected responder rates of 50% in the test and control groups [Maini et al 1999]. Specifying a 2-sided alpha level of 0.05, power of 80%, and a 2-sided equivalence margin of 15% would require 468 patients to be included in the per-protocol population for the final analysis. Assuming that 20% of patients will be excluded from the per-protocol population would require 584 patients in total to be randomised.

#### **Randomisation**

- The random allocation sequence was generated by PPD unblended biostatistics team.
- The random allocation sequence was implemented using
  - ▶ An interactive voice recognition system (IVRS) will be used for the randomisation. Biostatistics will generate the randomisation schedule for IVRS, which will link sequential patient randomisation numbers to treatment codes. The randomisation will be stratified by region (European and non-European) and CRP. The randomisation numbers will be blocked, and within each block the same number of patients will be allocated to each treatment group. The block size will not be revealed.
- Participants were enrolled by investigators in each institution, and participants were assigned to their interventions by each institution.

## Blinding

- ▶ As this is a double-blind study, the overall randomisation code will be broken only for reporting purposes, which will occur once all final clinical data up to Week 30 have been entered into the database and the database up to Week 30 is finalized for analysis. Final determination of the analysis sets will occur prior to finalizing the database. Once the overall randomisation code has been broken, the study can be considered open-label. While the study data are analysed at Week 30, the study will remain blinded to the investigators and patients until the end of the study to reduce bias.
  
- ▶ **Breaking the Blind**
  - The study blind should not be broken except in a medical emergency (where knowledge of the study treatment received would affect the treatment of the emergency) or regulatory requirement (e.g., for SAEs or death). Any unblinding by study centre personnel will be documented in the eCRF, and statistical analysis will examine the potential impact of the unblinding. The blind must only be broken following discussion on a case-by-case basis, at the discretion of the sponsor or medical monitor. If the blind is broken, the date, time, and reason must be recorded in the patient's eCRF and any associated AE report.
  
  - The investigator should notify the sponsor or medical monitor prior to contacting IVRS. All calls resulting in an unblinding event will be recorded and reported by the IVRS to the medical monitor and the sponsor.