

STUDY PROTOCOL

StereoTactic radiotherapy for wet Age-Related macular degeneration (STAR): A randomized, double-masked, sham-controlled, clinical trial comparing low-voltage X-ray irradiation with as needed ranibizumab, to as needed ranibizumab monotherapy.

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SYNOPSIS

Protocol Version (Date)	STAR Trial Protocol Version 1.9 (25 January 2019)
ClinicalTrials.gov Identifier	NCT02243878
ISRCTN	12884465
Full Title	StereoTactic radiotherapy for wet Age-Related macular degeneration (STAR): A randomized, double-masked, sham-controlled, clinical trial comparing low-voltage X-ray irradiation with as needed ranibizumab, to as needed ranibizumab monotherapy.
Short Title	STAR.
Sponsor	King's College London and King's College Hospital.
Funder	NIHR Efficacy and Mechanism Evaluation (EME) Programme
Objectives	To study the safety and efficacy of stereotactic radiotherapy for the treatment of pre-existing neovascular (wet) age-related macular degeneration (AMD).
Study Design	Randomized, double-masked, sham-controlled, multicenter, clinical trial.
Study Population	Patients receiving anti-VEGF treatment for neovascular AMD.
Number of Participants	411
Number of Groups/Arms	One treatment arm (16 Gy stereotactic radiotherapy - SRT), One control arm (sham treatment).
Gender/Age	Males and females aged at least 50 years old.
Number of Centers	Approximately 25 recruiting sites and 3 treatment centers.
Key Eligibility Criteria	Males and females with wet AMD requiring anti-VEGF treatment at the time of entry to the study.
Treatment Modality	0 (Sham) or 16 Gray SRT delivered in a single session at baseline, using the IRay® device (Carl Zeiss Meditec AG). Participants will receive a single intravitreal injection of 0.5 mg ranibizumab given on the same day, shortly after SRT. Thereafter they will be assessed every 28 days, and if predefined retreatment criteria are met they will receive an intravitreal injection of ranibizumab.
Study Duration	Participants will be treated at baseline and followed every 28 days for 24 months, with safety visits at month 36 and month 48.
Safety Measures	Incidence of adverse events (AEs) Incidence of serious adverse events (SAEs)
Primary Efficacy Measure	Primary efficacy measure: Mean number of ranibizumab injections over 24 months. Secondary efficacy measure: Mean change in ETDRS visual acuity at 24 months.

1. TABLE OF CONTENTS

2.	INVESTIGATOR SIGNATURE PAGE	6
3.	BACKGROUND.....	7
3.1.	AGE-RELATED MACULAR DEGENERATION	7
3.2.	IONIZING RADIATION	9
3.3.	RATIONALE FOR IONIZING RADIATION THERAPY IN AMD.....	11
3.4.	EARLY STUDIES OF RADIATION FOR NEOVASCULAR AMD.....	11
3.5.	EPIMACULAR BRACHYTHERAPY	12
3.6.	OVERVIEW OF IRAY STEREOTACTIC RADIOTHERAPY (SRT) SYSTEM.....	13
3.7.	STEREOTACTIC RADIOTHERAPY CLINICAL TRIALS	13
4.	STUDY DESIGN	16
4.1.	OBJECTIVE	16
4.2.	DESCRIPTION OF THE STUDY	16
5.	OUTCOME MEASURES	18
5.1.	EFFICACY	18
5.1.1.	PRIMARY MEASURE	18
5.1.2.	SECONDARY MEASURE	18
5.1.3.	OTHER SECONDARY MEASURES (AT 2 YEARS).....	18
5.2.	SAFETY OUTCOME MEASURES.....	18
6.	SELECTION OF STUDY PARTICIPANTS AND STUDY EYE	19
1.	INCLUSION CRITERIA	19
2.	EXCLUSION CRITERIA	19
7.	COMPLIANCE WITH LAWS AND REGULATIONS	21
8.	STUDY TREATMENTS	21
8.1.	STEREOTACTIC RADIOTHERAPY (SRT) AND RANDOMIZATION	21
8.2.	SHAM TREATMENT.....	22
8.3.	RANIBIZUMAB TREATMENT	22
8.3.1.	INITIAL RANIBIZUMAB TREATMENT.....	22
8.3.2.	RANIBIZUMAB RETREATMENT CRITERIA	22
8.3.3.	INJECTION TECHNIQUE	23
8.3.4.	RANIBIZUMAB SUPPLY AND STORAGE	23
8.4.	PARTICIPANT TREATMENT AT STUDY END	24
9.	CONCOMITANT AND EXCLUDED THERAPIES	24
10.	CATARACT SURGERY	24
11.	STUDY ASSESSMENTS	24
11.1.	ASSIGNMENT OF PATIENT IDENTIFICATION	25
11.2.	DAY -14 TO DAY 0: SCREENING	25
11.3.	DAY 0 TO DAY 21: STEREOTACTIC RADIOTHERAPY	26

11.4. DAY 0 TO DAY 21: RANIBIZUMAB TREATMENT	26
11.5. MONTHLY REVIEW	26
11.6. Month 12, 24, 36 and 48	27
11.7. Withdrawal of Participants and Treatment Stopping Rules.....	27
12. CLINICAL PARAMETERS.....	28
12.1 ETDRS BEST-CORRECTED VISUAL ACUITY	28
12.2 FLUORESCEIN AND INDOCYANINE GREEN ANGIOGRAPHY	29
12.3 OPTICAL COHERENCE TOMOGRAPHY (OCT)	29
12.4 AREDS LENS GRADING PROTOCOL	29
12.5 BIOMETRY OF THE GLOBE.....	30
13. HEALTH ECONOMIC AND QUALITY OF LIFE EVALUATION	30
14. ADVERSE EVENT REPORTING	31
14.1 ADVERSE EVENTS (AE)	31
14.2 SERIOUS ADVERSE EVENTS (SAE).....	31
14.3 SIGHT-THREATENING EVENTS	32
14.4 ADVERSE EVENT ASSESSMENT	32
14.5 ADVERSE EVENT TERMS	33
14.6 ADVERSE EVENT INTENSITY/SEVERITY	33
14.7 TREATMENT OR ACTION TAKEN	34
14.8 ADVERSE EVENT OUTCOME.....	34
14.9 ADVERSE EVENT FOLLOW UP.....	34
14.10 REPORTING ADVERSE EVENTS	35
14.11 REPORTING DEVICE MALFUNCTIONS.....	36
14.12 REPORTS TO RESEARCH ETHICS COMMITTEES (RECs)	36
14.13 PREFERRED TERMINOLOGY	37
14.14 EXPECTEDNESS	39
14.15 RELATEDNESS	41
14.16 RETINOPATHY EVALUATION	42
14.17 KERATOPATHY, KERATITIS AND DRY EYE.....	42
15. STUDY DISCONTINUATION	42
16. STATISTICAL PLAN	42
16.1 EFFICACY OUTCOMES AND HYPOTHESES.....	42
16.1.1 PRIMARY OUTCOME.....	43
16.1.2 SECONDARY OUTCOME.....	43
16.1.3 OTHER SECONDARY OUTCOMES (AT 24 MONTHS).....	43
16.2 SAFETY MEASURES	43
16.3 SAMPLE SIZE JUSTIFICATION.....	43
16.3.1 SUMMARY	43
16.3.2 JUSTIFICATION FOR PARAMETERS USED IN THE SAMPLE SIZE CALCULATIONS.....	44
16.4 RANDOMIZATION	45
16.5 ANALYSIS POPULATION	45
16.6 STATISTICAL METHODOLOGY	45

16.6.1 EFFICACY	45
16.6.1.1 ANALYSIS OF PRIMARY OUTCOME	45
16.6.1.2 ANALYSIS OF SECONDARY OUTCOMES	46
16.6.2 SAFETY	46
16.7 INTERIM ANALYSIS	46
17. RECORDKEEPING	46
18. STUDY MONITORING REQUIREMENTS	47
19. PROTOCOL DEVIATIONS AND AMENDMENTS	48
20. PARTICIPANT IDENTIFICATION NUMBER	48
21. ETHICAL AND REGULATORY PRECEPTS	48
21.1 PRINCIPAL INVESTIGATOR'S RESPONSIBILITY	49
21.1.1 MEDIA AND PUBLIC RELATIONS	49
21.1.2 AUTHORIZATION OF TREATMENT COSTS	49
21.2 RADIATION LICENSING/CERTIFICATION	49
21.3 REGULATORY AUTHORITY AND RESEARCH ETHICS COMMITTEE APPROVAL	50
21.4 INDEMNITY AND INSURANCE	50
22. MANAGEMENT AND ORGANIZATION	50
22.1 DATA MONITORING AND ETHICS COMMITTEE	51
22.2 TRIAL STEERING COMMITTEE	52
23. INFORMED CONSENT	52
24. DATA MANAGEMENT AND DATA PROTECTION	53
25. DIRECT ACCESS TO SOURCE DATA AND DOCUMENTS	54
26. PUBLICATION POLICY, INTELLECTUAL PROPERTY AND FINANCES	54
27. REFERENCES	55
28. APPENDIX 1: SCHEDULE OF ASSESSMENTS	59
29. APPENDIX 2: ASSESSMENT OF CENTRAL SUBFIELD THICKNESS AND MACULAR VOLUME	61
30. APPENDIX 3: ASSESSMENT OF VISUAL ACUITY	67
31. APPENDIX 4: AREDS Clinical Lens Opacity Grading Procedures	76
32. APPENDIX 5: DATA MONITORING AND ETHICS COMMITTEE CHARTER	78
33. APPENDIX 6: TRIAL STEERING COMMITTEE TERMS OF REFERENCE	83
34. APPENDIX 7: DRY EYE GRADING	86
35. APPENDIX 8: IRay User Manual	88
36. APPENDIX 9: ASSESSMENT OF GREATEST LINEAR DIMENSION AND LESION DISTANCE FROM THE FOVEA	89

2. INVESTIGATOR SIGNATURE PAGE

STAR protocol: StereoTactic radiotherapy for wet Age-Related macular degeneration (STAR): A randomized, sham-controlled, double-masked, clinical trial.

My signature confirms that I have carefully read, and that I understand this protocol. I agree to follow the study procedures as outlined in this protocol in compliance with Good Clinical Practice and all other regulatory requirements.

This protocol contains confidential information with respect to products and clinical trials. I agree to hold this information in confidence and not to disclose it to any third parties for a period of three years from the date of this agreement, or until this information becomes a matter of public knowledge, or until a formal agreement for that purpose has been entered into by the parties.

Print Name of Investigator Site

Print Name of Principal Investigator

Principal Investigator's Signature

Date

3. BACKGROUND

3.1. Age-Related Macular Degeneration

Age-related macular degeneration (AMD) accounts for more UK blind registrations than all other eye diseases combined.¹ There are two forms of AMD: the dry atrophic form and the wet neovascular form. Wet AMD is associated with the formation of choroidal neovascularization (CNV) in the macula. The incompetent new vessels leak blood and fluid into and under the macula, which in turn causes macular scarring and loss of central vision. The overall prevalence of wet AMD is estimated to be 1.2%, increasing to 2.5% in those aged 65 or older, and 6.3% in those aged 80 years or older.² There are thought to be 263,000 affected individuals in the UK, and 39,700 new cases each year.² As the population ages the prevalence is projected to increase by one-third over 8 years.²

Over the past decade, a number of therapies have been introduced to treat the neovascular form of AMD (nAMD), with generally increasing levels of efficacy. The Macular Photocoagulation Study found that focal laser photocoagulation to CNV lesions was beneficial to visual outcomes.^{3, 4} However, a large proportion of CNV lesions are subfoveal, and direct laser ablation led to a permanent and immediate loss of central vision.

Photodynamic therapy (PDT) using verteporfin (Visudyne[®], Novartis, Frimley, UK) for selective photochemical angio-occlusion of neovascular vessels showed better results in both the TAP and VIP trials.^{5, 6} In these studies PDT treatment reduced moderate visual loss, but only a few patients demonstrated improved vision.

A variety of drugs have subsequently been introduced that target vascular endothelial growth factor (VEGF), delivered via intraocular injection. Pegaptanib (Macugen[®], Pfizer, Sandwich, UK) was the first anti-VEGF agent approved by the Food and Drug Administration (FDA) for the treatment of nAMD, in December 2004. The VISION trial found that 70% of patients receiving a 0.3 mg intravitreal injection every 6 weeks lost <3 lines of vision versus 55% of control patients receiving sham injection, across all lesion types, at 12 months.⁷

Ranibizumab (Lucentis[®], Novartis), a monoclonal fragment derived from the anti-VEGF antibody bevacizumab, was approved by the FDA in June 2006 for the treatment of wet AMD. Approximately 95% of ranibizumab treated patients maintained or improved vision compared with approximately 64% of patients treated with PDT. The MARINA study subsequently demonstrated that 95% of ranibizumab treated patients experienced visual improvement or stabilization compared with 62% of sham-treated patients after 12 months. Moreover, 34% of patients experienced 15 letter increases in vision. In both the MARINA and ANCHOR studies, patients received monthly ranibizumab injections.^{8, 9}

Bevacizumab (Avastin[®], Novartis) is a full-length, recombinant, humanized, monoclonal anti-VEGF antibody that is licensed for the treatment of colorectal cancer. Although it does not have marketing authorization for the treatment of nAMD, it has been widely adopted as an off-label nAMD treatment since its first use in 2005.^{10, 11} There is no commercial incentive for the

manufacturer of bevacizumab to seek marketing authorization for nAMD, as the parent company produces ranibizumab.

The CATT trial, a large, US government-sponsored, randomized controlled study of nAMD, compared four intravitreal treatment arms: ranibizumab administered monthly; ranibizumab administered on a monthly 'as required' (*prn*) basis; bevacizumab administered monthly; and bevacizumab administered monthly *prn*.¹² The *prn* arms involved monthly review, and treatment was mandated at any of these visits if there was evidence of disease activity, such as reduced visual acuity (VA) or fluid leakage on retinal imaging. For both drugs, treatment administered monthly was found to be non-inferior to *prn* dosing. Also, bevacizumab was non-inferior to ranibizumab when given using the same dosing regimen. The mean number of *prn* treatments over 12 months was 6.9 for ranibizumab and 7.7 for bevacizumab. All treatments had favourable safety profiles. More serious adverse events occurred in the bevacizumab group, but the events did not fall into any particular category; specifically, they did not point to an increased risk of arteriothromboembolism, or the types of events that were associated with treatment using much higher systemic doses for cancer.

The results of the CATT study are important given that the effect of bevacizumab on vision was non-inferior to the results for ranibizumab, but the drug costs differed considerably. The per patient drug cost in the monthly ranibizumab arm was US\$23,400 compared to US\$595 for monthly bevacizumab (US\$13,800 versus US\$385 for the *prn* arms).¹ The American Academy of Ophthalmologists issued a statement following publication of the CATT results, noting that: "The initial results of the CATT study affirm the position of the American Academy of Ophthalmology that both Lucentis and Avastin should be available for the treatment of AMD". A survey by the American Society of Retinal Specialists in 2012 indicated that bevacizumab was the most commonly used treatment for nAMD in the USA, accounting for more anti-VEGF injections than all other agents combined.¹³

IVAN is a large, UK, multicentre, National Institute of Health Research (NIHR)-backed, randomized controlled trial (RCT) making a head-to-head comparison of ranibizumab and bevacizumab given monthly and on a *prn* basis.¹⁴ The comparison of ranibizumab and bevacizumab was statistically inconclusive, but a meta-analysis that included the IVAN and CATT data showed equivalence in terms of visual outcome.¹⁴ IVAN found that continuous and discontinuous treatment were equivalent in terms of vision. There was no difference in the proportion of participants experiencing a serious systemic adverse event, but significantly fewer participants in the bevacizumab arm had arteriothrombotic events or heart failure. Bevacizumab treatment was significantly less expensive; continuous and discontinuous ranibizumab cost £9,656 and £6,398 per patient per year respectively, versus £1,654 and £1,509 for bevacizumab.¹⁴ At the end of year two the median number of injections that patients required was similar comparing bevacizumab and ranibizumab groups, at 19 versus 18 injections (with the continuous and discontinuous arms combined, as per the trial's factorial design).¹⁵ Aflibercept (Eylea®, Regeneron, Tarrytown, NY, and Bayer HealthCare, Berlin, Germany) is a soluble decoy receptor fusion protein targeting VEGF and is designed for intraocular injection. In a prespecified combined analysis of the VIEW 1 and VIEW 2 studies, aflibercept given monthly or two monthly (following induction with three, monthly injections) was found to be non-inferior

to monthly ranibizumab with respect to vision, with a similar safety profile and anatomic outcomes.¹⁶

In the UK there are two National Institute for Health and Care Excellence (NICE)-approved treatments for nAMD: ranibizumab and, more recently, aflibercept. NICE recommends that ranibizumab treatment commences with monthly injections for three months. Thereafter patients are reviewed monthly, and treated with ranibizumab on a *prn* basis if there is evidence of disease activity. NICE guidance on aflibercept states that it should be administered in accordance with its summary of product characteristics, namely monthly for three months then two-monthly, over the first year. Thereafter NICE advises that the treatment interval may be extended based on visual and anatomic outcomes, as determined by the treating doctor.

Despite the impressive results with anti-VEGF therapy and the possibility of reduced drug costs with bevacizumab, intravitreal monotherapy for nAMD still has significant drawbacks. In the SUSTAIN trial,¹⁷ a large study investigating monthly *prn* dosing with ranibizumab, the mean visual gain of the group as a whole was 3.9 letters, but almost 50% of patients failed to maintain their initial vision gain by Month 12, or lost vision from the outset.

The total cost of nAMD treatment is likely to increase in the UK over time, as every year 40,000 new cases of nAMD emerge,² adding to those already on treatment. The incidence of nAMD is also expected to increase as the population ages. Most importantly, anti-VEGF monotherapy entails an enormous burden of care for patients, with regular hospital review for the remainder of their life, and regular intraocular injections. There is therefore a large unmet need for a more durable treatment that reduces the economic cost nAMD treatment, and the considerable burden faced by patients who require chronic anti-VEGF monotherapy.

The STAR trial investigates a new CE marked device that uses radiation to treat nAMD, so called stereotactic radiotherapy (SRT). The feasibility studies detailed below indicate that SRT has the potential to produce a more durable and cost-effective treatment than anti-VEGF monotherapy.

SRT is not designed to replace anti-VEGF therapy in all patients, but to reduce the frequency of anti-VEGF therapy. STAR will use ranibizumab as the anti-VEGF agent in both the treatment and control arms. Ranibizumab was chosen over bevacizumab as it is licensed for use in the eye, and at present bevacizumab is used in only a small minority of NHS hospitals, such that the results with bevacizumab may be less generalisable. Bevacizumab may slow recruitment if prospective participants are anxious about swapping to an off label treatment, and preliminary discussions with prospective sites indicated some investigators would prefer to use ranibizumab. Further, ranibizumab was used in the phase II INTREPID study (detailed below), which helps inform the STAR statistical analysis. Aflibercept's mandated dosing in year 1 means it is not possible to determine if radiation reduces the need for anti-VEGF treatment, the primary outcome measure.

3.2. Ionizing Radiation

X-rays produce high-energy photons that generate hydroxyl (OH^\cdot) ions when they collide with water molecules. This is used clinically to target DNA. Although X-rays can directly affect DNA, the main effect is mediated by the hydroxyl ions, which cause fragmentation of DNA. Ionizing radiation has been used extensively for both malignant and benign disease, although its use in cancer treatment is particularly well established. Radiation affects all cells in its path, but it preferentially damages proliferating cells that, unlikely non-dividing cells, are unable to repair cleaved DNA. Consequently they cannot continue the division cycle and undergo apoptosis.

Ionizing radiation can be categorized by the means through which it is generated, or by its mode of delivery. In brachytherapy, where the ionization energy is generated by short acting electrons, the ionizing radiation source is delivered directly to the lesion via surgery or other intervention. The source used in brachytherapy is traditionally an isotope, which produces ionizing radiation as it decays. Because the isotope is always decaying and emitting energy, storage is an issue, and dosing is difficult to control. Recently, an electronic brachytherapy source has been developed which can deliver X-rays on command, but the source needs to be proximate to the lesion. Electronic brachytherapy utilizes very low energy photons (<50 keV) with a very short range of action, emulating the electron-emitting brachytherapies.

Teletherapy is the term given to radiation formed into a beam (of photons typically), which can be projected at an internal body target from an external source. External beam radiotherapy (EBRT) is the more modern term given to this type of therapy. The generation of the beam can be accomplished with certain decaying isotopes such as Cobalt-60, but most modern EBRT equipment delivers ionizing radiation electronically.

Stereotactic radiosurgery or stereotactic radiotherapy (SRT) is the term given to teletherapy devices which direct beams from different angles to overlap at the target area, so as to minimize exposure to surrounding healthy tissues, and precisely localize energy delivery.

The energy level generated by EBRT X-ray devices is important. Most EBRT devices in clinical use today are linear accelerators which generate photons with X-ray energies over one million electron volts (MeV), enabling the X-Rays to penetrate skin and bone. Consequently, with such high energy emission, linear accelerators are highly regulated, and need to be placed in rooms with very thick walls. Linear accelerators require large power supplies and cooling measures. X-ray sources which generate thousands of electron volts (keV) are called orthovoltage (if >100keV) or low voltage (if <100keV), and do not require extensive shielding, power supplies, or cooling. For example, a portable chest X-ray machine can be placed in any room in a hospital.

The treatment system used in this study (IRay®, , Newark, NJ, USA) utilizes a low voltage X-ray source, and therefore can be placed in most clinical settings, including an ophthalmology outpatient clinic. Energy is absorbed as low voltage X-rays pass through tissue. Consequently, when a beam is targeted at the retina, the sclera receives a higher dose than the retina. To compensate for this phenomenon, the dose is divided into three separate beams in different locations along the sclera, but all three beams overlap on the retinal target.

The gray (Gy), a common measure of deposited ionizing energy, is equal to the absorption of one joule of energy by one kilogram of matter. The biological effects of radiation vary based upon the type of delivered energy and the tissues involved. A whole-body exposure of $\geq 10\text{Gy}$ of high-

energy radiation, delivered at one time, can be fatal to humans.¹⁸ Clinically, radiation is typically measured in milligray (mGy). The radiation exposure from a typical chest X-ray is 0.4 mGy,¹⁹ and that from an head computed tomography (CT) scan is 40 mGy.²⁰

3.3. Rationale for Ionizing Radiation Therapy in AMD

Significant theoretical, experimental and clinical evidence suggests that low dose external beam radiation is a useful therapy in nAMD. Ionizing beam radiation is the standard of care in oncology, where radiation is used to destroy dividing cells, while leaving normal cells intact. The purpose of radiotherapy in AMD would be multifold. First, radiation is known to attenuate the inflammatory response, and is therefore likely to attenuate the acute and delayed inflammatory response that is thought to play a role in CNV reactivation. Second, radiation would inhibit the rapid formation of fibroblasts after treatment and thus lead to less scar formation, as it does in the treatment of dermal keloids.²¹ Third, it would lead to the death of rapidly dividing endothelial cells - the main pathological component of the CNV.²²

Theoretically, precise radiation delivery to the macula can selectively inhibit proliferating endothelial cells with limited destruction of retinal tissue and no systemic side effects. Takahasi and colleagues found that new capillaries or vessels are more radiosensitive than larger vessels or fibroblasts.²³ Vascular endothelial cells in particular are more susceptible to radiation than other mesenchymal cells types such as fibroblasts and smooth muscle cells.²⁴ Further work has demonstrated that macrophages and inflammatory cells are notably radiosensitive. This is a particularly useful finding, since inflammatory cells and macrophages are found in choroidal neovascular complexes.²⁵ Since macrophages are known to release proangiogenic cytokines and growth factors, shutting down these cell lines would theoretically lead to less CNV recurrence and reduced need for retreatment.

Miyamoto and colleagues demonstrated the beneficial effect of focal radiation in a rabbit model of CNV, where leakage from the CNV lesions was significantly reduced in the eyes irradiated with 20 Gy compared to controls.²⁶ Histologic and immunohistochemical studies following irradiation demonstrated decreased vascular formation and number of vascular endothelial cells in the subretinal membrane of the treated eyes.

3.4. Early Studies of Radiation for Neovascular AMD

Chakravarthy was the first to describe the use of radiotherapy as a treatment for nAMD, in 1993.²⁷ Patients received a total of 10 to 15 Gray that was delivered via an external beam directed from the temporal area and aimed at the macula. The total dose was divided into five fractions of 2 to 3 Gray each, given in different treatment sessions. Nineteen treated patients were compared to seven patients who declined treatment. Vision was stable or improved in 63% of the treated patients whereas 86% of the controls lost vision. The treated group had angiographic lesion regression in 77% of cases, but all lesions in the control group enlarged. Several RCTs followed but these generally failed to establish that radiation offered visual benefit over the natural history of wet

AMD.²⁸⁻³⁶ The largest RCT, the RAD study, randomized 205 patients to 8 fractions of 2 Gy external beam radiation or to sham radiation treatment. The mean VA reduced 3.5 lines in the treatment arm and 3.7 lines in the sham arm, a non-significant difference.

However, the devices used to deliver radiation produced a wide beam across ipsilateral and contralateral critical structures. Marcus *et al* reported that 63% of the dose was delivered to the contralateral brain, 1.5% to the ipsilateral optic nerve, and 1.2% to the ipsilateral lens.³⁵ As a result of this imprecision only a small amount of radiation could be applied to the macula at each setting, without risking collateral damage. Furthermore, the patients' eyes were neither tracked nor immobilized, so it was not possible to confirm that the dose of radiation was delivered to the macula.

Although the early studies did not collectively establish that external beam radiotherapy improved visual outcomes, many found less scarring compared to the natural history of nAMD. Hart *et al* reported 35 patients with bilateral disease who received radiotherapy for subfoveal CNV lesions up to 40 months previously, and noted improved vision and asymmetric scarring favoring the radiation treated eye.³⁷

Support for larger doses in smaller fractions comes from studies using brachytherapy, which has the advantage of being able to deliver high energy to focused regions. In a prospective controlled study of 86 patients, Jaakkola *et al* reported the use of external Sr⁹⁰ plaque with single doses of 15 Gy and 12.6 Gy.³⁸ The 15 Gy group demonstrated significantly better preserved VA compared to controls. The control eyes lost an average of 3.02, 3.95, and 4.90 lines at 6, 12, and 24 months, respectively, while the treated group lost 0.24, 0.82, and 2.41 lines. The 12.6 Gy group did not show a significant difference compared to the control, suggesting improved effectiveness for the higher dose.

3.5. Epimacular Brachytherapy

Subsequently, researchers reported the use of epimacular brachytherapy (EMB) as a means of delivering targeted radiation to the macula of patients with wet AMD. The EMB device (NeoVista Inc., Fremont, California, USA) delivers radiation to the fovea via an endoscopic probe containing a strontium-90 source. The patient first undergoes pars plana vitrectomy and then the probe is held over the macula for 3-4 minutes to deliver 24 Gray. Following positive results from initial uncontrolled studies³⁹⁻⁴¹ two pivotal trials were undertaken, the first (CABERNET) in treatment naïve patients, and the second (MERLOT) in previously treated patients. The CABERNET study (ClinicalTrials.gov identifier, NCT00454389) failed to show non-inferiority of visual acuity at the pre-specified 10% non-inferiority margin.⁴² EMB did however demonstrate a favorable safety profile. The most significant adverse event, other than the expected post-vitrectomy cataract, was a 3% rate of non-proliferative radiation retinopathy. Interestingly, the 10 participants with suspected radiation retinopathy all met the primary endpoint (losing fewer than 10 ETDRS letters), and they gained, on average, 4.4 Early Treatment of Diabetic Retinopathy (ETDRS) letters over 2 years – better than the other EMB cases without radiation retinopathy. MERLOT (NCT01006538) recently reported its top line 12 month results (Jackson TL, Retina Day, Royal College of

Ophthalmologists' Annual Congress, Liverpool, 20th May 2013) and, like CABERNET, failed to meet its co-primary endpoints. MERLOT safety outcomes have yet to be reported.

3.6. Overview of IRay Stereotactic Radiotherapy (SRT) System

The IRay system is an outpatient-based radiotherapy platform that provides stereotactic application of low energy X-ray to the retina. The system uses three highly collimated beams of radiation that pass through the inferior sclera to overlap at the macula, administered in a single treatment session. Unlike EMB, SRT does not require vitrectomy. This may be advantageous as vitrectomy reduces the half-life of intravitreal drugs,⁴³ so that any remaining disease activity may be hard to control with anti-VEGF agents.⁴⁴ Further, with IRay, the entire 4mm treatment zone receives 90% of the intended dose, whereas with EMB the dose declines exponentially with increasing distance from the radioactive source,⁴⁵ so that larger lesions receive a reduced dose at their outer margin.

The IRay system is described in detail in the User Manual, but the key components of the device are summarized below:

1. Low energy X-ray tube, generator, and cooling unit. The system produces a highly collimated, narrow beam, designed to treat only the target lesion, and minimize scatter to surrounding healthy tissues.
2. Self-contained robotic tube positioning system.
3. Treatment planning model, which inputs standard eye parameters, such as axial length, to calculate the required beam positioning. The diameter of each beam on the sclera is 3.5 mm, diverging slightly to 4 mm at the retina.
4. I-Guide™ scleral interface, designed to stabilize the eye along its central axis in relation to the IRay system. The I-Guide incorporates a contact lens, based upon a standard Haag-Streit model, which holds the eye in the appropriate treatment location, and a reflector, which “communicates” with the X-ray tube positioning robot. The I-Guide is attached to the head restraint component of the device.

The SRT device will be used to deliver 16 Gray of radiation to the macula. The total body dose is low (< 0.5 mSv), equivalent to a dental X-ray or the radiation absorbed during normal life over a 3 month interval.

3.7. Stereotactic Radiotherapy Clinical Trials

Oraya's external beam radiation treatment was studied in a single center, open-label, non-randomized, Phase I clinical trial (CLH001MEX; ClinicalTrials.gov identifier: NCT01217762) designed to evaluate the safety and tolerability of SRT in participants with active subfoveal CNV

secondary to AMD. Ranibizumab was injected at days 0 and 30. Patients were then assessed monthly and re-injected as needed, if one of the following findings were observed:

- An increase of >100 microns in central subfield on optical coherence tomography (OCT) compared to the recorded thickness from the previously scheduled study visit.
- Evidence of new macular haemorrhage on examination.
- New area of classic CNV.
- A ≥ 10 -letter decrease in best corrected visual acuity (BCVA) compared to the recorded VA score from the previously scheduled study visit, associated with any OCT evidence of fluid in the macula.

Patients were required to have VAs in the range of 20/40 to 20/320 (69 to 24 ETDRS letters) and lesion sizes less than 11 disc areas, although some protocol violations were permitted, as the study was designed primarily to assess safety.

Sixty-two participants were enrolled and treated. Of these, two participants received treatment at 11 Gy, 28 received treatment at 16 Gy, administered between two injections of ranibizumab, 13 received 16 Gy without prior baseline ranibizumab treatment (the “Radiation First” cohort), and 19 received treatment at 24 Gy, administered between two injections of ranizumab. Enrolment in the radiation-first regimen was discontinued as a result of initial loss in vision seen in some of these participants, that was not typically observed in eyes treated with ranibizumab prior to radiation. One participant in the 16 Gy with ranibizumab group was subsequently found to have had a retinal vein occlusion, and was excluded from the efficacy evaluation.

Thirteen participants in the radiation-first 16 Gray arm completed 12 months follow up. All except one were treatment naïve at enrolment. Eleven eyes (85%) lost <15 ETDRS letters, seven (54%) gained ≥ 0 ETDRS letters and 0 gained ≥ 15 ETDRS letters. There were no radiation related safety events.⁴⁶

Of the 47 participants who received SRT between two anti-VEGF injections, 28 received 16 Gy and 19 received 24 Gy. The mean VA improved by 8.4 letters in the 16 Gy group and by 7.8 letters in the 24 Gy group at month 12.⁴⁷ All participants lost <15 letters. Participants received a mean of only 1.0 additional injection over 12 months. The mean change in OCT central subfield thickness from baseline to month 12 was -107 and -87 μm for the 16 Gy and 24 Gy groups, respectively. There was no reported radiation retinopathy at 12 months, but it is important to note that experience with EMB suggests radiation retinopathy is more likely to occur in year 2 than year 1.⁴⁸

Based on these positive phase I data the INTREPID (IRay Plus Anti-VEGF Treatment For Patients With Wet AMD) study was initiated to further investigate SRT. INTREPID is a randomized, double-masked, sham controlled, dose-ranging, phase II commercial clinical trial (ClinicalTrials.gov identifier: NCT01016873). A total of 230 participants were randomized to 16 Gy, 24 Gy or sham SRT. Full eligibility criteria are as published,⁴⁹ but the key inclusion criteria were:

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1. Participants must have neovascular AMD diagnosed within the previous 3 years, have received at least three injections with Lucentis or Avastin within the previous year, and have the need for treatment with anti-VEGF therapy due to increased fluid or persistent cysts on OCT, or leakage on FA.
 2. Total lesion size of <12 disc areas and a CNV lesion with a greatest linear dimension (GLD) of <6 mm, but not greater than 3 mm from the center of the fovea to the furthest point on the lesion perimeter.
 3. Corrected visual acuity of 75 to 25 letters in the study eye.

All participants had a baseline ranibizumab injection alongside their SRT, and were retreated with ranibizumab on a monthly *prn* basis out to Month 12. Retreatment criteria were less aggressive than current treat-until-dry regimens¹² but reflected standard trial design at that time:

- A 100-micron increase in central subfield thickness from lowest previous OCT measurement.
- New or increased macular haemorrhage documented by fundus photographs.
- A >5 letter decrease in BCVA since the last visit or the baseline BCVA, with disease activity, for example, persistent or increased fluid on OCT or leakage on fluorescein angiography (FA).

The primary outcome was the number of *prn* ranibizumab injections over 12 month.

INTREPID met its primary endpoint. Both the 16 Gy and 24 Gy SRT arms received significantly fewer ranibizumab treatments compared with the sham arm. The mean of the 16 and 24 Gy arms were 2.64 (median, 2) and 2.43 (median, 2) respectively versus 3.74 (median, 3.5) in the control arm ($P = 0.013$ and $P = 0.004$, respectively, versus sham).⁴⁹

In terms of vision, the sham arm lost 1.3 letters more than the 16 Gy arm, and 2.0 letters more than the 24 Gy arm (−1.57 versus −0.28 and +0.40 letters, respectively). The 16 Gy, 24 Gy, and sham arms lost <15 letters in 93%, 89%, and 91% of eyes, respectively.⁴⁹

The structural changes appeared to favour the SRT arm. Total mean angiographic lesion area changed by −1.15 mm², +0.49 mm², and +0.75 mm², in the 16 Gy, 24 Gy and sham arms respectively. The mean CNV lesion area decreased by 0.16 mm², 0.18 mm², and 0.10 mm², respectively. OCT central subfield thickness decreased by 85.9 µm, 70.4 µm, and 33.5 µm, respectively.⁴⁹

The safety profile was favorable at 12 months. The number of adverse events (AEs) and the serious AEs (SAEs) were similar across arms. No AEs were attributed to the delivery of radiation with no radiation retinopathy reported. No SAEs were observed in the study eye.⁴⁹ As noted previously though, radiation retinopathy may occur beyond a 1 year window.

A post-hoc subgroup analysis was undertaken to determine which baseline characteristics best predict the response to SRT (TL Jackson *et al*, In press, Retina). This found that the following features were associated with a positive response to SRT:

- Significant macular leakage, defined as a macular fluid volume greater than the median.
- Lesion size ≤ 4 mm in greatest linear dimension (GLD), corresponding to the 4mm treatment zone at the macula.

For eyes with a GLD ≤ 4 mm and significant macular leakage (26% of the trial population, the so-called, ‘best-responders’) there was a highly significant, 54% reduction in injection frequency versus comparable sham patients, and also better visual acuity (6.83 letters superior to sham; $P=0.0037$). There was also a 71 micron greater reduction in OCT central subfield thickness ($P=0.027$). There was no apparent difference when considering 16 or 24 Gray.

Other features that helped predict a positive response to SRT included an absence of fibrosis, classic lesions, age > 75 years, and the presence of a pigment epithelial detachment (PED).

INTREPID was not designed to assess the effect of SRT on VA, nor the durability of treatment beyond 12 months. After month 12, participants reverted to standard care, but there were annual safety visits out to 3 years. Thus, the efficacy results beyond year 1 need to be interpreted with caution, however, at year 2 there was a continued significant reduction in injection frequency. In the best-responder group this reduction was 45% ($p = 0.001$), with VA 4.4 letters better than the control group ($P 0.24$). Year 3 INTREPID results are not yet published.

These encouraging results support the conduct of a prospective, multicenter, randomized, sham-controlled, double-masked study of SRT, with refined case selection, longer efficacy and safety review, and sufficient patient numbers to make reliable conclusions on the effect of SRT on VA in the ‘best-responder’ population.

4. STUDY DESIGN

4.1. Objective

The key objective of the STAR study is to evaluate the safety and efficacy of low voltage external beam radiotherapy, in combination with anti-VEGF therapy, for the treatment of neovascular AMD. Specifically, this study will evaluate whether SRT reduces the need for ranibizumab injections, compared with ranibizumab monotherapy. STAR will also determine if SRT produces a non-inferior visual outcome compared with anti-VEGF monotherapy.

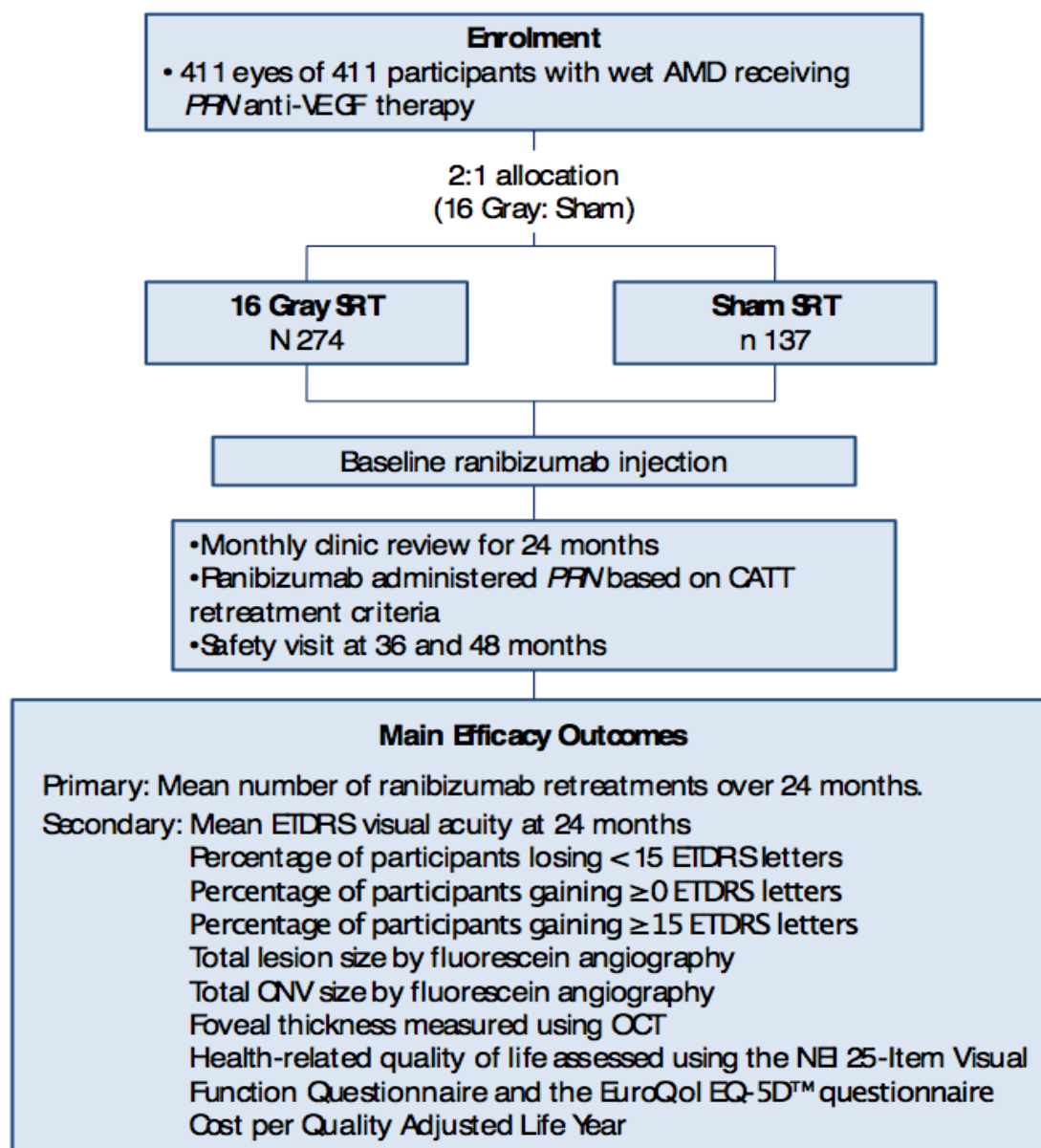
4.2. Description of the Study

This study aims to enroll 411 participants in a double-masked, multicentre, sham-controlled clinical trial.

Participants will receive a single treatment of SRT using the IRay system (sham or 16 gray) with a concomitant baseline intravitreal injection of 0.5 mg ranibizumab. Thereafter, participants will attend clinic for a review every month (28 days) for 24 months, and ranibizumab will be

administered at the visit if defined retreatment criteria are met (termed ranibizumab monthly *prn*). Two safety visits occur subsequently, one at 36 months and the other at 48 months.

The trial is summarized in the following diagram:



Abbreviations: AMD, age-related macular degeneration; CATT, comparison of AMD treatments trial; ETDRS, early treatment of diabetic retinopathy study; PRN, 'as required' dosing; SRT, stereotactic radiotherapy; VEGF, vascular endothelial growth factor; CNV, choroidal neovascularization; OCT, optical coherence tomography; NEI, National Eye Institute.

5. OUTCOME MEASURES

5.1. Efficacy

The following outcomes will be reported at Month 24.

5.1.1. Primary Measure

Number of as required (*prn*) ranibizumab injections during the first 24 months.

5.1.2. Secondary Measure

Mean ETDRS VA.

5.1.3. Other Secondary Measures (at 2 years)

- Percentage of participants losing < 15 ETDRS letters
- Percentage of participants gaining ≥ 0 ETDRS letters
- Percentage of participants gaining ≥ 15 ETDRS letters
- Total lesion size by fluorescein angiography
- Total CNV size by fluorescein angiography
- Foveal thickness measured using OCT
- Health-related quality of life assessed using the National Eye Institute 25-Item Visual Function Questionnaire and the EuroQol EQ-5D™ questionnaire
- Cost per Quality Adjusted Life Year (QALY)

5.2. Safety Outcome Measures

Safety will be evaluated by assessing adverse events (AEs) and serious adverse events (SAEs). The trial will specifically report the incidence of radiation retinopathy or radiation-related microvascular changes, and arteriothrombotic events.

6. SELECTION OF STUDY PARTICIPANTS AND STUDY EYE

The trial will randomize 411 patients with previously treated, wet AMD. After giving fully informed written consent, patients with wet AMD will be screened for participation in the study. For patients with two eligible eyes, the patient may select which eye they wish to allocate as the study eye. Patients should fulfill the following criteria to be eligible for enrolment:

1. Inclusion Criteria

1. Participants must have neovascular AMD in the study eye, for which they have received at least 3 prior intravitreal injections of either bevacizumab (Avastin), aflibercept (Eylea), ranibizumab (Lucentis), or pegaptanib (Macugen).
2. Participants must have received an anti-VEGF injection in the study eye within 4 months prior to enrolment.
3. Participants must require treatment with anti-VEGF therapy at the time of enrolment, due to OCT evidence of subretinal fluid and/or cystoid macular oedema, **and** have a macular volume that is greater than a **pre-defined threshold** that varies for each different make of SD-OCT machine. The threshold for each approved machine is shown in Appendix 2.
4. Participants must be at least 50 years of age.

2. Exclusion Criteria

1. Disciform scarring that involves the fovea, in the study eye.
2. Visual acuity worse than 6/96 (24 ETDRS letters) in the study eye.
3. Lesion size greater than 4 mm in greatest linear dimension, or greater than 2 mm from the centre of the fovea to the furthest point on the lesion perimeter, to include active choroidal neovascular leakage, pigment epithelial detachment and haemorrhage, as determined by fluorescein angiography.[†]
4. An axial length of less than 20 mm, or greater than 26 mm, in the study eye.
5. Contraindication or sensitivity to contact lens application, including recurrent corneal erosions, in the study eye.
6. Type 1 or Type 2 diabetes mellitus.
7. Retinopathy in the study eye.

-
8. Prior, current or anticipated treatment in the study eye for age-related macular degeneration, other than anti-VEGF agents, including submacular surgery, subfoveal thermal laser photocoagulation, photodynamic therapy (PDT), or transpupillary thermotherapy (TTT).
 9. Presence of an intravitreal device in the study eye.
 10. Previous radiation therapy to the study eye, head, or neck with the exception of radio-iodine treatment for hyperthyroidism, epimacular brachytherapy to the non-study eye, or IRay SRT to the non-study eye.
 11. Inadequate pupillary dilation or significant media opacities in the study eye, including cataract, which may interfere with visual acuity testing, the clinical evaluation of the posterior segment, or fundus imaging.
 12. Study eyes with CNV due to causes other than AMD, including presumed ocular histoplasmosis syndrome (POH), angioid streaks, multifocal choroiditis, choroidal rupture, and pathological myopia (greater than 8 Dioptres spherical equivalent). Participants with retinal angiomatous proliferation (RAP) or idiopathic polypoidal choroidal vasculopathy (PCV) are *not* excluded.
 13. Known allergy to intravenous fluorescein, ICG or intravitreal ranibizumab.
 14. Intraocular surgery or laser-assisted in situ keratomileusis (LASIK) in the study eye within 12 weeks prior to enrolment.
 15. Prior pars plana vitrectomy in the study eye.
 16. Current participation in another interventional clinical trial, or participation in such a clinical trial within the last six months.
 17. Unwilling, unable, or unlikely to return for scheduled follow-up for the duration of the trial.
 18. Women who are pregnant at the time of radiotherapy.
 19. Participants with an implantable cardioverter defibrillator (ICD) or pacemaker implant (or any implanted device) where the device labelling specifically contraindicates patients undergoing X-ray.
 20. Any other condition, which in the judgment of the investigator, would prevent the participant from granting informed consent or completing the study, such as dementia, and mental illness (including generalized anxiety disorder and claustrophobia).

[†] See Appendix 9 for details.

7. COMPLIANCE WITH LAWS AND REGULATIONS

The conduct of this study will conform to all applicable national, European, and international standards. Principal Investigators working at the national SRT treatment sites (those providing SRT) will liaise with a Consultant Clinical Radiation Expert and Senior Medical Physicist to ensure that treatment is compliant with local and national regulations governing the use of radiation therapy.

All national SRT treatment sites participating in this study will attain the appropriate local licensing requirements permitting the utilization of X-ray systems with energy levels of 100 keV.

8. STUDY TREATMENTS

Participants meeting the inclusion and exclusion criteria will be randomized to 16 Gy SRT or Sham SRT in a 2:1 ratio. Treatment allocation will be double masked. Both groups will also be treated with a baseline intravitreal injection of 0.5 mg ranibizumab, and then ranibizumab administered using defined retreatment criteria.

8.1. Stereotactic Radiotherapy (SRT) and Randomization

SRT will be provided in two or more UK national treatment centres (NTCs). Participants will travel from their recruiting site to the NTC for SRT, and then return to their recruiting site for study follow-up. Recruiting centres will supply the NTCs with their patients' axial length (usually via biometry), which is needed to target the radiation beam correctly.

Zeiss will deliver the SRT system with an operating manual to the NTCs. During this study, Zeiss support personnel will be available as needed to support the NTC investigators administering SRT. In addition, NTC investigators will undergo training on the use of the IRay system prior to study initiation.

The NTCs will be responsible for randomizing patients when they attend for treatment. Treatment assignment will be made via a secure password-protected website, which will provide a four letter/number alphanumeric code that, once entered into the IRay device, will dictate whether active or sham treatment is given. Patients and all study personnel, including the operator, will be masked to whether active or sham treatment is delivered.

The randomization service is available at the King's College London Clinical Trials Unit's online secure randomization service, available under Useful Links via 'Randomisation Service – Advanced' at the CTU website (www.ctu.co.uk) or directly at:

<https://cturandomisation.iop.kcl.ac.uk/ProjectIndex/Default.aspx>.

<https://cturandomisation.iop.kcl.ac.uk/STAR/Login.aspx?ReturnUrl=%2fSTAR%2f>

Participants will receive a 16 Gy dose of radiation (or sham treatment) delivered to the macula. The radiotherapy will be delivered in a single session with the IRay SRT device, utilizing three sequential beams, each depositing 5.3 Gy at the macula through calculated scleral entry points and crossing the pars plana region of the eye. If it is not possible to obtain clear access for all three beams then it may, on occasion, be necessary to deliver radiation through two beams. The dose of radiation will therefore be 8 Gy per beam, identical to the dose delivered in each of the three beams used in the 24 Gy arm of the INTREPID study.⁴⁹

The IRay User Manual, provided in Appendix 8, details the technique for using the device. An ophthalmologist will administer the treatment in accordance with the instructions given in the User Manual.

The IRay device provides a printout showing the details of the treatment delivered to a given participant. This includes information such as the time needed to deliver treatment and a topographic isodose colour map. Two copies should be printed. One should return with the patient to the recruiting site, to be filed in the source documents. The other should be filed in the NTC. Both copies should include the participant study ID and the randomization code entered into the IRay device.

8.2. Sham Treatment

Control participants will undergo a procedure that is identical to active treatment (as detailed above), but the device will not deliver radiation.

8.3. Ranibizumab Treatment

8.3.1. Initial ranibizumab treatment

All participants will receive a 0.5 mg baseline, intravitreal injection of ranibizumab (Lucentis) alongside SRT. The timing of the ranibizumab injection is important, as studies indicate that SRT is more effective if given alongside anti-VEGF therapy.^{46, 47} To ensure that this occurs the baseline ranibizumab will be administered in the SRT national treatment centres, immediately after SRT. The injection is given after SRT rather than before, in order to avoid possible discomfort from the application of the I-Guide during SRT.

8.3.2. Ranibizumab retreatment criteria

After the initial ranibizumab treatment participants will be reviewed every 28 days in the recruiting site, and 0.5 mg intravitreal ranibizumab (Lucentis) will be administered at that visit if the CATT retreatment criteria apply,ⁱⁱ as provided below:

CATT: “Treatment is warranted if there are signs of active CNV. It is anticipated that most retreatment decisions will be driven by the presence or absence of fluid (subretinal, intraretinal fluid, or sub-RPE) on the OCT. Eyes with fluid on OCT should be treated, with the exception of eyes in which there has been no decrease in fluid after three consecutive monthly injections. For such eyes, it is possible that continued treatment may be futile and the ophthalmologist and patient may choose to suspend treatment. Treatment may be reinstituted in these eyes at a later visit if there is increased fluid (relative to the visit when treatment was stopped) on OCT.

If there is no fluid on OCT, but there are other signs of active CNV, the eye should be treated. These signs include new subretinal or intraretinal haemorrhage, persistent subretinal or intraretinal haemorrhage, decreased visual acuity relative to the last visit without another explanation, increased lesion size on fluorescein angiography relative to the last angiogram, or leakage on fluorescein angiography.

Fluorescein angiography is required at specific visits and may be used in deciding whether treatment is warranted. Fluorescein angiography may be obtained at other visits to aid in the decision on whether treatment should be applied. Fluorescein angiography may also be obtained when there is no fluid on OCT and the decision to treat is based on new subretinal or intraretinal haemorrhage or decreased visual acuity relative to the last visit without another explanation.

Patients who present for a “non-scheduled” study examination may be retreated if they meet the above criteria for retreatment and at least four weeks have elapsed since the last study treatment. If the patient is retreated, no additional intravitreal study treatment may be administered for the next 23 days.”

8.3.3. Injection technique

Ranibizumab must be administered by a qualified ophthalmologist or specialist nurse experienced in intravitreal injections. The drug should be inspected for particulate matter and discoloration prior to injection. The injection should be undertaken using aseptic conditions, including the use of surgical hand disinfection, sterile gloves, a sterile drape, and a sterile eyelid speculum, and with the availability of sterile paracentesis if needed.

The periorcular skin, eyelid and ocular surface should be disinfected with povidone iodine 5%, following topical anaesthesia.

The injection needle should be inserted 3.5-4.0 mm posterior to the limbus into the vitreous cavity, avoiding the horizontal meridian and aiming towards the centre of the globe. The injection volume of 0.05 ml should be delivered and then the needle should be held in position for at least 5 seconds to minimize reflux. A different scleral site should be used for subsequent injections.

8.3.4. Ranibizumab supply and storage

It is anticipated that all sites will already have a regular supply of ranibizumab (Lucentis), given that it is a commonly administered intravitreal injection. The MHRA have determined that STAR is not a Clinical Trial of an Investigational Medicinal Product (CTIMP) and as such routine NHS ranibizumab stock may be used, without specific trial labeling. Ranibizumab must be stored in accordance with the manufacturer's instructions and also in accordance with local policy. The safety and supply of ranibizumab will be overseen by the site's non-trial pharmacy, but if any issues of concern arise, the Chief Investigator or Trial Manager should be informed.

8.4. Participant treatment at study end

Participants randomized to the sham treatment may be offered active treatment at the end of the study, if the study shows that the benefits of the SRT outweigh the risks, treatment is clinically indicated for a given patient in their study eye, the patient wishes to undergo treatment with SRT, and the treatment device remains serviceable and available to the Sponsor.. SRT will be provided free of charge at at least one national treatment centre.

9. CONCOMITANT AND EXCLUDED THERAPIES

Concomitant medications are any prescription drugs used by a patient during the study, until conclusion of study participation (Month 48) or early termination. The paper source documents and electronic case report forms will record administration of these medications. Use of concomitant treatment with a clinical device should also be recorded.

No other experimental or investigational treatments are allowed during this study, including ocular experimental and investigational treatments in the study eye.

10. CATARACT SURGERY

If cataract surgery is required, it should be performed at least 90 days after radiation is delivered, and at least 30 days prior to the Month 12 or Month 24 visit. Cataracts that require surgery should be recorded as an SAE.

11. STUDY ASSESSMENTS

A table of the procedures by visit is given in Appendix 1, and summarized below. Written informed consent must be obtained prior to all screening events. Investigators must undertake the necessary tests and examinations at each visit and complete the paper source documents in full.

These data must then be uploaded onto the central, web-based electronic case report form (eCRF).

11.1.ASSIGNMENT OF PATIENT IDENTIFICATION

A patient identification (ID) number, which will be assigned at screening, should be used on all study-related documents. To maintain confidentiality, the participant's name should not be recorded on any study document other than the informed consent form. The participant ID will have six digits. The first two digits will identify the site. The following four digits will be assigned to patient undergoing screening, sequentially across all sites, regardless of whether screening was successful or not. The assignment of an ID number to screen failures will facilitate preparation of the CONSORT flow diagram when analyzing the data.

11.2. DAY -14 TO DAY 0: SCREENING

The following assessments will be performed at the screening visit. If necessary, the assessments may occur over a maximum of fourteen days, although it is preferred that they are completed over a much shorter time span, ideally one or two days. The patient is enrolled after screening is complete (Day 0). All treatment administered following successful enrolment will be recorded as part of the study.

All ocular assessments will be undertaken **on both eyes** at the screening visit:

- Demographic information
- Medical history
- Blood pressure
- Ophthalmic history, including medication use
- Best corrected visual acuity using ETDRS (VA) at 4 meters (performed prior to dilating eyes)
- Ophthalmic examination including slit lamp and indirect ophthalmoscopy (Ophthalmic Exam)
- Intraocular pressure (IOP)
- Cataract Assessment (AREDS 2008 criteria)
- Optical coherence tomography (OCT)^a
- Fluorescein and indocyanine green angiography (FA and ICG)*
- Fundus photography (photos)*
- Biometry of the globe †
- Health-related quality of life and visual function questionnaires

^aThe OCT scan at screening is used to determine whether the macular volume is greater than the pre-defined threshold in order to satisfy the inclusion criteria. See Appendix 2 for details.

* The OCT, FA and fundus photographs are sent to the reading centre at baseline, month 12, 24, 36, and 48 but not at other visits unless retinopathy is identified at such other visits. ICG is only undertaken at baseline, and in centres that have the facility to undertake ICG.

† Biometry is undertaken as part of the screening process but the axial length is used by the SRT device to calculate the delivery of radiation to the macula. Therefore, the biometry results should accompany participants to the national SRT treatment centres. If biometry results are already available at the time of enrolment, these retrospective results can be used instead of repeating biometry.

Day 0 is defined as the day the patient successfully enrolls in the study. The measurements recorded during screening will constitute the baseline values for subsequent comparison.

All screen failures and the reasons for non-eligibility will be entered onto the source document and uploaded onto the eCRF. Randomization occurs at the national treatment centres.

Only successfully screened patients should proceed with the following tests.

11.3. DAY 0 TO DAY 21: STEREOTACTIC RADIOTHERAPY

Once screening is complete and the patient is deemed eligible to enrol then SRT should be administered within 21 days (Day 0 to 21). SRT will be delivered using the IRay system at dedicated national treatment centres. The technique is described further in Section 8. The baseline ranibizumab will be injected on the same day, as detailed below.

11.4. DAY 0 TO DAY 21: RANIBIZUMAB TREATMENT

Studies suggest that SRT is more effectively when given alongside anti-VEGF therapy, and so the timing of the baseline ranibizumab is important.^{46, 47, 50, 51} Therefore the first ranibizumab injection will be administered at the national treatment centres shortly after SRT, ensuring that ranibizumab and SRT are both given on the same day. The injection technique is described in Section 8.

11.5. MONTHLY REVIEW

Participants will return every 28 days for measurement of ETDRS VA, slit lamp examination of the anterior segment and fundus, and OCT, in the study eye. Fluorescein angiography will be undertaken only if clinically indicated. The first monthly review should be 28 days after the initial ranibizumab.

Ranibizumab will be administered at any of the monthly visits if the CATT retreatment criteria apply,ⁱⁱⁱ as provided in Section 8.3.2. Best-corrected ETDRS VA and OCT examination will be undertaken by trial-certified staff, as detailed in the appendices and as advised by the reading centre. Full refraction will be undertaken at every third monthly visit over the first 24 months, and yearly thereafter, namely at baseline and months 3, 6, 9, 12, 15, 18, 21, 24, 36 and 48. The monthly OCTs are not sent to the reading centre except at Baseline, Month 12, 24, 36, and 48. The OCT central subfield thickness should be recorded in the source documents and eCRF for all OCTs (including those at Month 12, 24, 36, and 48). Examination of the non-study eye should be undertaken as clinically indicated.

Monthly assessment is mandated by the study protocol for the first 24 months. Following the Month 24 visit there are two mandated safety visits at Month 36 and Month 48. The Month 36 and 48 visits are designed to ensure that participants remain in a study setting, with the infrastructure to report any adverse effects occurring in that period, including radiation retinopathy, and to facilitate detection of delayed radiation retinopathy by clinical examination and angiography. The interval of follow-up and treatment regimen between Month 24 and Month 48 is as clinically indicated, and study data will not be routinely collected during this interval. However, please remember to record all their anti-VEGF injections, in the study eye and non-study eye, either as they occur or at the month 36 or month 48 visits.

Any adverse events should, however, be recorded and clinicians are encouraged to examine the retina on a regular basis, looking specifically for retinopathy.

11.6. MONTH 12, 24, 36 AND 48

At the one year assessment, the following will be performed **on both eyes**:

- BCVA and full refraction
- Ophthalmic examination
- IOP
- Cataract Assessment (AREDS 2008 criteria)
- OCT
- Fluorescein angiogram and fundus photographs
- Health-related quality of life and visual function questionnaires

At the end of the trial participants in the SRT Arm will be provided with a card noting that they were treated with radiation, to pass to their treating retinal specialist. The card will detail the clinical features of radiation retinopathy, and a request that if there is any evidence of radiation retinopathy then the specialist should contact the Chief Investigator.

11.7. WITHDRAWAL OF PARTICIPANTS AND TREATMENT STOPPING RULES

Participants have the right to withdraw from the study at any time, for any reason, without jeopardizing their medical care. Participants who withdraw from the study must be made aware that the detection of radiation damage may be less likely outside of the clinical trial, and they should be encouraged to seek regular retinal examination for at least four years after SRT.

Patients who wish to withdraw from the study will be asked to complete procedures outlined in the next annual visit (Month 12, 24, 36 or 48). The fluorescein angiogram that is undertaken at the annual visits is important in excluding radiation retinopathy. If a fluorescein angiogram was obtained in the 3 months prior to exiting the study it does not need to be repeated, but all other procedures in the annual visit should be completed.

Because SRT is administered as a single treatment at the start of the study, there are no defined treatment stopping rules for SRT. Treatment with ranibizumab may be discontinued if clinically indicated, as detailed in the CATT study¹² and as reproduced below:

“If in the best medical judgment of the treating ophthalmologist it is believed that there is no chance of any benefit to the patient from additional intravitreal injections in terms of preserving vision or retinal anatomy, intravitreal injections of the study drug may be suspended. Examples of this scenario would include patients with very large areas of central atrophy or subretinal fibrosis who have no evidence of residual macular function.”

Suspension of ranibizumab therapy does not exclude participants from the trial, and follow up is clinically important to detect radiation retinopathy.

Treatment complications (for example, endophthalmitis, retinal detachment, and traumatic cataract) will not normally be considered absolute contraindications to continue with anti-VEGF treatment, or reasons to exit the trial.

12.CLINICAL PARAMETERS

Ophthalmic assessments will include ETDRS best corrected VA, fluorescein angiography, ICG angiography (in centres with ICG capability), optical coherence tomography and colour fundus photographs. The number of anti-VEGF injections will also be recorded. Whenever possible, the same person should perform the evaluations specified by the protocol at each study visit. Except where otherwise indicated, ocular assessments should be performed on the study eye only.

12.1 ETDRS Best-Corrected Visual Acuity

Manifest refraction and VA measurement must be performed according to the standard procedure originally developed for ETDRS and adapted for the Age Related Eye Disease Study (AREDS) protocol. The trial frame spectacle correction used to test VA should be updated every three months during the first 24 months, but the previous month's refraction can be used for intervening monthly visits. Full refraction is also required at baseline and all annual visits out to month 48.

VA testing by the ETDRS protocol is detailed in Appendix 3. VA will be tested by trial certified examiners, in trial certified examination rooms, at each visit.

12.2 Fluorescein and Indocyanine Green Angiography

Fluorescein angiograms (FAs) will be undertaken at screening and then yearly thereafter. In addition, indocyanine green angiography (ICG) will be undertaken at baseline, in centres with ICG capability. All angiograms will be performed using digital photography equipment certified by the central reading center (CARF, Queen's University of Belfast). All photographers must be certified by the reading centre prior to undertaking any angiograms on trial participants. The reading center will provide a protocol for image acquisition and transfer. This protocol must be strictly adhered to. Images must be transferred to the reading centre within 7 days of obtaining them. Additional FAs will be undertaken when required by clinical need or because retinopathy has been observed; these should be acquired using the same protocol, and using certified equipment and photographers.

12.3 Optical Coherence Tomography (OCT)

Spectral domain OCT will be utilised to assess subretinal fluid, intraretinal thickening, and neovascular lesions at each visit. At each of monthly visit the Investigator will review the participant's OCT. At set visits (Baseline and Month 12, 24, 36 and 48) the OCT will also be sent to the reading centre for masked assessment. The OCT machine and technician will be certified by the reading centre prior to study commencement. OCTs will be acquired and transferred in a timely manner, using the protocol specified by the reading centre. Extra OCTs may be taken when retinopathy has been observed or at unscheduled visits, using the same protocol, equipment and staff, as specified by the reading centre.

Monthly OCT images that are not sent for central reading should be captured using the same approved device, technician, and technique of image acquisition. The OCT scan should be centered on the fovea, in the same position each month. The OCT software will provide an objective thickness reading in the **central 1 mm subfield**. This reading is recorded each month as part of the study. It may also be used, alongside other criteria, to determine if retreatment is required. This automated reading should be checked for errors as it is possible that the OCT software fails to correctly identify the inner and outer neural retina limits correctly. To check for errors it is best to review a higher magnification radial line scan. If there are segmentation errors then a manual adjustment should be made, by repositioning all the central segmentation lines and re-reading the central 1mm subfield value. This corrected value should be recorded in the source documents and eCRF, and it should also be recorded that a manual adjustment was made.

OCTs that require central reading should be sent to the reading centre within 7 days of their acquisition, and in accordance with the protocol supplied by the reading centre.

12.4 AREDS Lens Grading Protocol

Radiation can cause cataract in phakic eyes. The IRay device is designed to minimize lens exposure, and the INTREPID study did not find an increased rate of cataract in treated eyes.⁴⁹ Nonetheless, in phakic eyes the AREDS Lens Grading Protocol will be used to assess any lens opacity (See Appendix 4).

12.5 Biometry of the Globe

The axial length of the globe may be determined via any commercially available A-Scan immersion ultrasonography system, or an IOLMaster[®]/equivalent machine. The axial length, must be recorded in the eCRF. The axial length is used in the computer algorithm that ensures that the IRay device correctly targets radiation on the macula. The patient's axial length should be measured by the recruiting site and then provided to the SRT national treatment centres. Biometry is also used to exclude patients with an axial length of less than 20 mm, or greater than 26 mm, in the study eye. If suitable biometry is already available at the time of enrolment this can be used, instead of repeating biometry on-study. Retrospective biometry should be filed in the study documents and forwarded to the National Treatment Centre, as per on-study biometry.

13. HEALTH ECONOMIC AND QUALITY OF LIFE EVALUATION

The health economic component of STAR will estimate the relative cost-effectiveness of SRT compared to no SRT and help determine whether SRT provides value for money for the NHS. The main outcome measure will be quality of life which will be used to calculate a cost per quality-adjusted life year (QALY) gained for SRT plus ranibizumab versus ranibizumab alone.

Participants will complete the National Eye Institute 25 Item Visual Function Questionnaire (VFQ-25)⁵² and the EuroQoL EQ-5D⁵³ at enrolment and then yearly until the study ends at month 48. The questionnaires, with instructions, are provided in the source documents. While there is overlap between the EQ-5D and VFQ-25 questionnaires, using both allows comparison of VFQ-25 results for this trial population to those reported for other eye trials. This provides some indication of the baseline quality of life (in terms of visual function) and a change in response to treatment of the population compared on a common scale with other trial populations. The EQ-5D, a generic quality of life questionnaire will allow comparison of the study results against other (non-vision) health care interventions.

The base case analysis will take an NHS and personal and social services perspective in accordance with NICE guidance.^{54, 55} Since there is no Health Research Group (HRG) code specific to intravitreal injection or AMD monitoring, we will use microcosting estimates of the cost of ranibizumab injections and associated monitoring that were collected previously within the IVAN trial.¹⁴ This costing work will be replicated to estimate the cost of administering SRT alongside ranibizumab in routine clinical practice. The number of ranibizumab injections, monitoring consultations and ocular imaging procedures (angiography and OCT) will be collected on standard trial forms. At each study visit, participants will be asked to provide data on all hospital admissions and contacts with medical professionals or eye clinic liaison officers

and the reasons for such admissions and contacts in addition to any residential care, low vision aids and personal care received.

The base case analysis will include all resource use accrued by trial participants, although a sensitivity analysis including only those costs associated with the study eye or expected adverse events will also be conducted. Data on all hospital admissions and outpatient consultations between randomization and the end of the efficacy study will also be collected from Hospital Episode Statistics to ensure that costs are not underestimated by participant's recall, missed appointments and/or withdrawal from the study. Analysis of costs and cost-effectiveness will follow standard NICE guidelines.⁵⁴ We anticipate using bootstrapping to estimate the uncertainty around incremental costs and QALYs, which will be presented as cost-effectiveness acceptability curves.

14. ADVERSE EVENT REPORTING

This section describes the protocol requirements for recording and reporting adverse events. In this section, the term “study treatment” means both SRT using the IRay device (16 Gy or sham) and injection of ranibizumab.

14.1 Adverse Events (AE)

An adverse event (AE) includes any untoward sign, symptom, disease, or condition associated with the use of the study treatment (SRT or ranibizumab) regardless of the suspected cause. Conditions or diseases that are chronic but stable should not be recorded on AE pages of the eCRF.

14.2 Serious Adverse Events (SAE)

An AE should be classified as a serious adverse event (SAE) and reported as such, if it meets one or more of the following criteria:

- It results in death (i.e., the AE actually causes or leads to death)
- It is life threatening (i.e., the AE places the participant at immediate risk of death)
- It results in hospitalization or prolongation of hospitalization
- It results in persistent or significant disability/incapacity (i.e., the AE results in substantial disruption of the participant's ability to conduct normal life functions)
- It results in a congenital anomaly/birth defect in a neonate/infant born to a mother exposed to study treatment
- The investigator considers it an important medical event because, based on medical judgment, it may jeopardize the participant or require medical or surgical intervention to prevent one of the outcomes listed above

-
- It is considered sight-threatening by the investigator.

Hospitalizations for the following reasons will not be recorded as SAEs:

- Hospitalization or prolongation of hospitalization for diagnostic, medical or surgical procedures for preexisting conditions;
- Hospitalization or prolongation of hospitalization required to allow outcome measurement for the study;
- Hospitalization or prolongation of hospitalization for treatment of the target disease of the study.

14.3 Sight-Threatening Events

An event is considered sight-threatening and should be reported as an SAE if it meets one or more of the following criteria:

- It is associated with a decrease in visual acuity of >30 ETDRS letters (compared with the assessment of visual acuity at the last visit)
- It is associated with a decrease in visual acuity to the level of Light Perception or worse
- It required surgical intervention (e.g., conventional surgery, vitreous tap or biopsy with intravitreal injection of antibiotics, or laser or retinal cryopexy with gas) to prevent permanent loss of sight
- It is associated with severe intraocular inflammation (i.e., 4+ anterior chamber cell/flare or 4+ vitritis)
- In the opinion of the investigator it may require medical or surgical intervention to prevent permanent loss of sight.

14.4 Adverse Event Assessment

All participants who have been exposed to the study treatment will be evaluated for AEs at each visit. All AEs, regardless of severity or seriousness and whether or not they are ascribed to the study treatment, will be recorded in the source documents and eCRF using standard medical terminology.

All AEs will be evaluated beginning with onset, and evaluation will continue until resolution is noted, or until the investigator determines that the participant's condition is stable. The investigator will take appropriate and necessary therapeutic measures required for resolution of the AE. Any medication or other intervention necessary for the treatment of an AE must be recorded on the concomitant medication section of the source documents and eCRF.

All AEs will be characterized by the following criteria:

- Event term
- Intensity or severity
- Expectedness
- Outcome
- Treatment or action taken.

14.5 Adverse Event Terms

Whenever possible, recognized medical terms should be used when recording AEs. Colloquialisms and/or abbreviations should not be used. Only one medical concept, preferably a diagnosis instead of individual symptoms, should be recorded as the event.

If more than one distinct AE occurs, each event should be recorded separately.

However, if known at the time of reporting, a diagnosis (i.e., disease or syndrome) should be recorded on the eCRF rather than individual signs and symptoms (e.g., record congestive heart failure rather than dyspnoea, rales, and cyanosis). If a constellation of signs and/or symptoms cannot be medically characterized as a single diagnosis or syndrome at the time of reporting, each individual event should be recorded as a separate AE. If a diagnosis is subsequently established, this information should be reported on the source documents and eCRF as follow-up information.

Signs and symptoms that are considered unrelated to an encountered syndrome or disease should be recorded as individual AEs (e.g., if congestive heart failure and severe headache are observed at the same time, each event should be recorded as a separate AE).

AEs occurring secondary to other events (e.g., sequelae) should be identified by the primary cause; a "primary" event, if clearly identifiable, should represent the most accurate clinical term to record as the AE event term. For example:

Orthostatic hypotension ⇒ fainting and fall to floor ⇒ head trauma ⇒ neck pain

The primary event is orthostatic hypotension and the sequelae are head trauma and neck pain.

If a participant is hospitalized to undergo a medical or surgical procedure as a result of an AE, the event responsible for the procedure, not the procedure itself, should be recorded as the event. For example, if a participant is hospitalized to undergo coronary bypass surgery, record the heart condition that necessitated the bypass.

14.6 Adverse Event Intensity/Severity

All AEs should be graded on a three-point scale (mild, moderate, severe) for intensity/severity. Unless otherwise defined in the protocol, these definitions are as follows:

- Mild:** Transient; no medical intervention/therapy required and does not interfere with daily activities.
- Moderate:** Low level of concern and only mild to moderate limitation in daily activities; some assistance may be needed; minimal or no medical intervention/therapy required.
- Severe:** Severe limitation in daily activities, significant assistance required; significant medical intervention/therapy required.

There is a distinction between the severity and the seriousness of an AE. Severity is a measurement of intensity; thus, a severe reaction is not necessarily a serious adverse event (SAE). For example, a headache may be severe in intensity, but would not be serious unless it met one of the criteria for SAEs listed in the section Serious Adverse Events, above.

14.7 Treatment or Action Taken

The intervention taken to treat an AE is defined as:

- None
- Medical intervention
- Surgical intervention
- Other (specify).

14.8 Adverse Event Outcome

The clinical outcome of an AE will be characterized as follows:

- Resolved without sequelae
- Resolved with sequelae (specify)
- Ongoing (i.e. continuing at time of study discontinuation)
- Death.
-

14.9 Adverse Event Follow up

All AEs and SAEs will be followed through to resolution or 30 days after the participant terminates from the study, whichever occurs first.

The Sponsor or its designee may follow-up with the site by telephone, fax, email, and/or a monitoring visit to obtain additional case details deemed necessary to appropriately evaluate the SAE report (e.g., hospital discharge summary, consultant report, or autopsy report).

14.10 Reporting Adverse Events

Two kinds of events must be reported to the Chief Investigator/Trial Manager within 24 hours of learning of their occurrence.

- a. Serious adverse events
- b. Important Medical Event (IME)

Please complete the paper SAE Form and mark as an IME or SAE and submit.

IMEs which require reporting via the SAE form

- Retinopathy or signs of retinopathy
- Cataracts requiring surgery
- Microvascular abnormalities in the study eye
- Diabetes

Immediately after the trial personnel become aware of any of these two types of events, the Principal Investigator with responsibility at each research site must report them to the Chief Investigator or the organizing research team on the form specified. The Principal Investigator or his/her research team must also follow all through to outcome, and report to the Chief Investigator, or to the organizing research team on the form specified.

In addition, the Investigator should expeditiously notify the Chief Investigator of any of these two kinds of adverse events that occurs after a participant has completed or discontinued from study participation.

Contact details for submission to:

Chief Investigator (Tim Jackson) or Trial Manager (Riti Desai)

The initial report can be made by completing the SAE form, emailing or faxing to:

King's Clinical Trials Unit (KCTU)

Email: ctu@kcl.ac.uk

Fax: 0207 848 5229

A record of this notification (including the date of notification) must be clearly documented to provide an audit trail. In the case of incomplete information at the time of initial reporting, a follow up report should be provided as soon as the information becomes available.

14.11 Reporting Device Malfunctions

The IRay device that delivers SRT is CE marked. All device malfunctions must be reported to the device manufacturer, Carl Zeiss Meditec AG with a copy to the Chief Investigator. When a device malfunction is associated with an AE or SAE, the AE or SAE should be reported separately to the Sponsor, as noted in the section above.

The address for reporting a device malfunction is given below, but to expedite reporting the device manufacturer should be contacted by email or telephone, as detailed below:

Igor Koruga
Director, Engineering
Carl Zeiss Meditec AG
ZEISS Group
5160 Hacienda Drive
Dublin, CA 94568, USA

Office: +1 925 557 4167
Mobile: +1 925 413 1052
Home Mobile: +1 650 207 3203
igor.koruga@zeiss.com
www.zeiss.com/med

14.12 Reports to Research Ethics Committees (RECs)

The Chief Investigator will report to the relevant Research Ethics Committee (REC).

Reporting timelines are as follows:

- SAEs which are fatal or life-threatening must be reported not later than 7 days after the Sponsor is first aware of the reaction. Any additional relevant information must be reported within a further 8 days.
- SAEs that are not fatal or life-threatening must be reported within 15 days of the Sponsor first becoming aware of the reaction.

The Chief Investigator will provide an annual report of all SAEs which will be distributed to the Data Monitoring and Ethics Committee (DMEC) or the REC, as appropriate.

14.13 Preferred Terminology

The following list details the preferred terminology for a range of potential ocular adverse events. The list also includes some non-ocular events that may be relevant to the trial population, and adverse reactions reported in clinical trials of ranibizumab. The list is not intended to be exhaustive but, where possible, these terms should be used to describe adverse events. If an event does not fit one of the following diagnoses it should nonetheless be recorded. The expected AEs are given in the next section. Where possible it is better to record a diagnosis rather than a symptom.

Age-related macular degeneration, dry; Age-related macular degeneration, neovascular (wet); Anaphylaxis; Anaemia; Angina; Anisocoria; Anterior chamber flare; Anterior uveitis; Anxiety; Aphakia; Arcus senilis; Arthralgia; Astigmatism; Atrial fibrillation.

Bacterial keratitis; Blepharitis; Blepharospasm; Blurred vision (specify diagnosis if possible); Branch retinal artery occlusion; Branch retinal vein occlusion (BRVO); Bronchitis.

Capillary dilation (see also retinal telangiectasia)*, Capillary closure (see also Retinal Ischaemia)*; Cardiac arrest; Cataract; Cellulitis; Central retinal artery occlusion; Central retinal vein occlusion (CRVO) ; Central serous retinopathy (CSR); Chalazion; Chemosis; Choroidal effusion; Choroidal folds; Choroidal ischaemia; Choroidal naevus; Choroidal neovascularization (CNV); Chronic obstructive pulmonary disease; Conjunctival abrasion; Conjunctival bleb; Conjunctival haemorrhage (see also sub-conjunctival haemorrhage); Conjunctival hyperaemia; Conjunctivitis, allergic; Conjunctivitis, bacterial; Conjunctivitis, other; Conjunctivitis, viral; Contact lens intolerance; Corneal abrasion; Corneal infection (see also bacterial keratitis); Corneal oedema; Corneal opacity; Corneal staining; Cotton wool spots*; Cough (specify diagnosis if possible).

Deep vein thrombosis; Diabetic maculopathy; Diabetic retinopathy; Diabetes (specify type); Diplopia, monocular; Diplopia, binocular; Disciform scarring of macula; Drusen; Dry eye syndrome (please classify as described in Appendix 7); Dyspnoea.

Ectropion; Endophthalmitis, culture negative; Endophthalmitis, culture positive; Endophthalmitis, suspected (no culture obtained); Entropion; Epiphora; Epiretinal membrane (ERM); Episcleritis; Esophoria; Esotropia; Eye drop hypersensitivity; Eye irritation; Eye pain; Eye pruritus; Eyelid bruising; Eyelid cyst; Eyelid swelling; Eyelid pain; Exophoria; Exotropia

Facial pain; Flare (see anterior chamber flare); Foreign body sensation, of eye.

Gastroenteritis; Gastrointestinal haemorrhage (specify site); Gastrointestinal perforation (specify site); Geographic atrophy; Glaucoma, angle closure; Glaucoma, open angle; Glaucoma, other.

Haemorrhage of eye, unspecified (see also choroidal haemorrhage, conjunctival haemorrhage, subconjunctival haemorrhage, optic disc haemorrhage, retinal haemorrhage, subretinal haemorrhage, and retrobulbar haemorrhage); Headache; Hyperaemia of eye (specify diagnosis if

possible); Hypercholestromia; Hypermetropia; Hypertension; Hypertensive retinopathy; Hypotony (IOP <5mmHg).

Idiopathic polypoidal choroidal vasculopathy (IPCV); Increased intraocular pressure (>30 mmHg or >10 from screening); Influenza; Insomnia; Intraretinal microvascular abnormality (IRMA); Iris atrophy; Iris ischaemia; Iridocyclitis; Iritis (refer to anterior uveitis, posterior uveitis, uveitis, iridocyclitis, pars planitis, or vitritis).

Keratitis (see also punctate keratitis); Keratopathy; Keratoconjunctivitis.

Lacrimation, increased; Lattice degeneration of the retina; Limb pain.

Macular atrophy; Macular depigmentation; Macular fibrosis (see also disciform scar of macula, and macular scarring); Macular hole, full thickness; Macular hole, partial thickness; Macular oedema; Macular pucker; Macular scarring (see also macular fibrosis and disciform scar of macula); Metamorphopsia; Microvascular abnormality of retina (see retinal microvascular abnormality); Myocardial infarction (MI); Myopia.

Nausea; nystagmus.

Ocular hypertension; Optic disc atrophy; Optic disc cupping; Optic disc haemorrhage; Optic disc neovascularization*; Optic disc palor; Optic disc swelling; Optic neuritis; Optic neuropathy, other; Optic neuropathy, radiation induced.

Pars planitis; perforation of globe; Perivascular sheathing*; Photopsia; Pigment epithelial detachment (PED); Posterior capsular opacification (PCO); Posterior uveitis; Posterior vitreous detachment (PVD); Ptoxis; Pulmonary embolus; Punctate keratitis; Pupillary deformity. Radiation retinopathy*; Relative afferent papillary defect (RAPD); Retinal angiomatous proliferation (RAP); Retinal atrophic hole; Retinal degeneration; Retinal detachment, rhegmatogenous; Retinal detachment, serous; Retinal detachment, tractional; Retinal exudates; Retinal haemorrhage; Retinal ischaemia*; Retinal macroaneurysm; Retinal microaneurysm*; Retinal microvascular change*; Retinal neovascularization (not associated with neovascular age-related macular degeneration); Retinal oedema; Retinal tear; Retinal telangiectasia*; Retinal vascular tortuosity*; Retinopathy* (see also diabetic retinopathy, hypertensive retinopathy, radiation retinopathy, and sickle retinopathy); Retrobulbar haemorrhage; RPE atrophy; RPE depigmentation; RPE hyperpigmentation; RPE tear.

Scleritis; Scotoma; Sickle retinopathy; Sinusitis; Stroke; Subconjunctival haemorrhage (see also conjunctival haemorrhage); Subretinal (or submacular) haemorrhage; Subretinal (or submacular) fibrosis.

Telangiectasia (see retinal telangiectasia)*; Transient ischaemic attack (TIA).

Upper respiratory tract infection; Urinary tract infection; Uveitis (see also anterior uveitis, posterior uveitis, iridocyclitis, pars planitis, or vitritis).

Venous Thrombosis (specify site); Visual field defect; Vitreomacular traction (VMT); Vitreous haemorrhage; Vitreous opacity; Vitritis.

Wound healing complications (delayed or non healing wounds)

*these changes may be associated with radiation retinopathy – see section below.

14.14 Expectedness

All AEs will be evaluated as to whether they are expected or unexpected.

- **Expected (anticipated):** An AE is expected if it is identified in the list of expected adverse events below, or in the latest ranibizumab Summary of Product Characteristics, or the latest User Manual of the IRay SRT device, or the Patient Information Sheet.
- **Unexpected (unanticipated):** An adverse event is unexpected if it is not identified in the list of adverse events below or in the latest ranibizumab Summary of Product Characteristics, or the latest User Manual of the IRay SRT device, or the Patient Information Sheet.

Expected (Anticipated) AE:

- **Dry Eye Syndrome (DES):** A worsening of 2 grades or a finding of Grade 4 (marked) or Grade 5 (severe) on the Oxford Grading Scheme (see Appendix 7) will be considered an AE.
- **Keratitis:** Inflammation of the cornea and/or conjunctiva due to infectious or other etiologies (e.g. autoimmune). A worsening of 2 grades or a finding of Grade 4 (marked) or Grade 5 (severe) on the Oxford Grading Scheme will be considered an adverse event).
- **Keratopathy:** (Also known as superficial punctate, or epithelial, keratopathy): Spots or lesions on the epithelium which may be caused by drying of the cornea or by trauma. A worsening of 2 grades or a finding of Grade 4 (marked) or Grade 5 (severe) on the Oxford Grading Scheme will be considered an AE.
- **Anterior uveitis:** Presence of inflammatory cells in the anterior chamber. The presence of aqueous flare alone is not considered to constitute iritis and should be documented as anterior chamber flare.
- **Iridocyclitis:** Presence of inflammatory cells in both the aqueous and vitreous.
- **Posterior Uveitis:** Inflammation in the uveal tract (iris, ciliary body, and choroid), either primary or secondary to keratitis or systemic diseases.
- **Vitritis:** Presence of active inflammation in the vitreous, as demonstrated by the presence of inflammatory cells (trace or greater). Active inflammation in the vitreous should be clinically differentiated from cellular debris from prior episodes of inflammation, haemorrhage, or other causes.

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- **Endophthalmitis:** Diffuse intraocular inflammation predominantly involving the vitreous cavity but also involving the anterior chamber, implying a suspected underlying infectious cause (trace benign, aqueous pigmented cells visible by slit lamp that are caused by dilation and are not red or white blood cells or the result of any ocular disorder should not be recorded as an AE). Endophthalmitis should be classified as culture positive, culture negative, or suspected (no culture obtained).
 - **Cataract:** Lens changes consisting of an increase (worsening) >2 categories from baseline (using the AREDS Lens Grading Protocol) in nuclear opalescence, cortical cataract, or posterior subcapsular evaluation observed at two consecutive visits.
 - **Vitreous Haze:** Vitreous haze that obscures or partially obscures the view of the fundus.
 - **Vitreous Haemorrhage:** Haemorrhage within the vitreous cavity.
 - **Increased IOP:** IOP ≥ 30 mmHg or an increase in IOP of ≥ 10 mm from baseline recorded on two separate occasions or an increase in IOP that requires intervention.
 - **Significant Decrease in Visual Acuity:** >30 ETDRS letters (compared with the last assessment of visual acuity, or from baseline).
 - **Rhegmatogenous retinal detachment:** Macular on or macular off detachment of the neurosensory retina.
 - **Retinal haemorrhage:** Subhyaloid, intraretinal, or subretinal haemorrhage. See also the section of retinopathy below.
 - **Cystoid macular oedema:** Cystoid, intraretinal fluid within the macular area visible by examination, angiography, or OCT.
 - **Macular fibrosis:** Fibrosis of the macula, including disciform scarring and macular scarring.
 - **Macular atrophy:** Atrophy of the macular neurosensory retina, macular retinal pigment epithelium, or both.
 - **IGuide™ & Eyelid Retractor-associated Adverse Events:**
 - Sensitivity or allergic reaction to the coupling gel
 - Corneal abrasion
 - Conjunctival haemorrhage
 - Conjunctival abrasion
 - Eye irritation (including foreign body sensation)
 - Eyelid bruising
 - Eyelid pain.
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- **Retinopathy (also called microvascular abnormalities, MVAs):** Occlusive microangiopathy secondary to endothelial cell loss and capillary closure. Any cases of retinopathy, regardless of the suspected cause, and regardless of seriousness, must be recorded as an AE and reported to the Chief Investigator. Investigators are not required to determine whether or not **radiation retinopathy** is present, but they must report any cases of retinopathy or signs of **retinopathy**, to the Chief Investigator and for review by an expert panel. The following clinical features of **retinopathy** may occur secondary to a range of disorders or to radiation. Each should be treated as a sign of retinopathy if it occurs in the study eye.
 - **Retinal microaneurysms**
 - **Telangiectasia**
 - **Retinal haemorrhage (except that attributed to the AMD lesion itself)**
 - **Cotton-wool spots (nerve fiber layer infarcts)**
 - **Capillary dilation**
 - **Capillary closure (non-perfusion)**
 - **Perivascular sheathing**
 - **Retinal neovascularization**
 - **Optic disc neovascularization.**

If **retinopathy**, or a sign of **retinopathy**, is observed by a study Investigator, the Investigator should obtain fundus photographs and perform fluorescein angiography and OCT. The Investigator should inform the Chief Investigator and then send the photographs, FA, and OCT to the central Reading Centre(s) for evaluation.

14.15 Relatedness

Serious adverse events should be assessed in terms of the causality or relatedness to the following events:

- Ranibizumab drug
- Ranibizumab injection procedure
- Stereotactic radiotherapy

This relationship should be classified as follows:

- Not related
- Remote
- Possible
- Probable
- Definite

14.16 Retinopathy Evaluation

As noted in the preceding section, an Investigator who detects retinopathy or signs of retinopathy will forward fundus photographs, angiography, and OCT scans to the Reading Centre(s). If the Reading Centre confirms retinopathy, or detects a case of retinopathy during routine image review, it will forward the fundus photographs, angiography, and OCT for that case to a **Retinopathy Evaluation Committee**. The Retinopathy Evaluation Committee will consist of experts in reading FAs, and experts in the clinical characteristics of radiation retinopathy. The Chief Investigator will forward the Retinopathy Evaluation Committee the full CRF, including baseline and on-study medical history. The Retinopathy Evaluation Committee may request other information and, if it is available, it will be provided to them. The Retinopathy Evaluation Committee will decide by majority vote whether or not radiation retinopathy is present. The committee will be the final arbiter as to whether or not radiation retinopathy is present, but it may review its decision if new, relevant, clinical information emerges for a particular case.

14.17 Keratopathy, Keratitis and Dry Eye

Radiation may cause keratopathy, keratitis and dry eye, although the IRay system is designed to minimize this risk by using three separate beams. If any of these conditions occur the Oxford Grading System, as given in Appendix 7, should be used to grade the severity of disease. If keratopathy, keratitis or dry eye occur they should be recorded as an AEs in the eCRF.

15. STUDY DISCONTINUATION

The Sponsor has the right to terminate this study at any time. Reasons for terminating the study may include, but are not limited to, the following:

1. The incidence or severity of adverse events in this or other studies indicates an unacceptable potential health hazard to participants.
2. Patient enrollment is unsatisfactory.
3. Data recording is inaccurate or incomplete.
4. The Trial Steering Committee recommends that the trial should be discontinued.

16. STATISTICAL PLAN

16.1 Efficacy Outcomes and Hypotheses

The study's primary hypothesis is that the mean number of ranibizumab injections during the first 24 months after randomization will be less in the SRT group than in the sham group. The secondary hypothesis is that participants who undergo SRT will have a non-inferior visual outcome compared with those in the sham group.

16.1.1 Primary Outcome

The primary outcome is the number of as required (*prn*) ranibizumab injections during the first 24 months after randomization. SRT will be considered superior to sham if the mean number of injections in the SRT group is statistically less than the mean in the sham group.

16.1.2 Secondary Outcome

SRT will be considered non-inferior to sham treatment if the lower bound of the 95% confidence interval for the difference in mean change in ETDRS VA at 24 months, between the SRT and sham groups, is no greater than 5 letters.

16.1.3 Other secondary outcomes (at 24 months)

- Percentage of participants losing < 15 ETDRS letters
- Percentage of participants gaining ≥ 0 ETDRS letters
- Percentage of participants gaining ≥ 15 ETDRS letters
- Total lesion size by fluorescein angiography
- Total CNV size by fluorescein angiography
- Foveal thickness measured using OCT
- Health-related quality of life assessed using the National Eye Institute 25-Item Visual Function Questionnaire and the EuroQol EQ-5D™ questionnaire
- Cost per Quality Adjusted Life Year (QALY)

16.2 Safety Measures

Safety will be evaluated by assessing adverse events (AEs) and serious adverse events (SAEs). The trial will specifically report the incidence of radiation retinopathy or radiation-related microvascular changes, and arteriothrombotic events.

16.3 Sample Size Justification

16.3.1 Summary

If SRT produces a 25% reduction, group sample sizes of 248 and 124 (ratio: 2:1) achieve 90% power to detect a difference of 2.5 injections between the null hypothesis that both group means are 10 injections and the alternative hypothesis that the mean of the active treatment group is 7.5 injections, with a standard deviation (SD) of 7 for both, and a significance level (α) of 0.05

(two-sided) using a two-sample t-test. A 2:1 ratio adds only 42 patients but boosts recruitment and safety data.

We expect VA in the SRT group to be non-inferior compared to the control group. The SD of the mean change in VA was estimated as 12 letters from INTREPID. Group sample sizes of 248 and 124 achieve 97% power to detect non-inferiority in the mean changes in VA using a one-sided, two-sample t-test assuming a SD of 12 for both groups. The margin of equivalence is 5 letters. The true difference between the means is assumed to be 0. The significance level (alpha) of the test is 0.025.

In the INTREPID study, 2.2% of the randomized population were lost to follow up by year 1. Year 2 data are not representative as INTREPID had minimal review in year 2. The CABERNET study had 93% of data available for analysis at the end of year 2. We anticipate a 10% loss to follow-up over two years for STAR, so we aim to recruit 274 participants in the active arm and 137 in the control arm (total 411). Sample size calculations were performed using PASS software.

16.3.2 Justification for parameters used in the sample size calculations.

The INTREPID study (ClinicalTrials.gov identifier: NCT01016873) compared patients treated with low-voltage x-ray, external-beam, SRT plus ranibizumab *prn* to patients treated with sham SRT plus ranibizumab *prn*. Since INTREPID studied anti-VEGF-experienced patients the results of that study are more relevant to the STAR population than the results of CATT, which studied anti-VEGF-naïve participants. Participants in INTREPID were randomized to 16 Gy plus ranibizumab *prn*, 24 Gy plus ranibizumab *prn*, or sham radiotherapy (either 16 Gy or 24 Gy) plus ranibizumab *prn*. The mean changes in ETDRS VA at 12 months (\pm SD) were 0.28 ± 8.77 , 0.40 ± 10.33 , and 1.57 ± 11.90 , respectively. The pooled SD across all groups is therefore 10.4, with approximate 95% confidence limits of 9.6 and 11.5. For power calculations for STAR, the assumed SD of the mean change in VA is 12 letters.

The treatment arm of the present study (STAR) will receive 16 Gy SRT, as used in the INTREPID study. Both arms will receive ranibizumab *prn*, as used in the CATT trial. The primary outcome is the ranibizumab re-injection rate over 2 years. CATT reported a mean (\pm SD) of 6.9 ± 3.0 ranibizumab retreatments to the end of year 1 and 12.6 ± 6.6 to the end of year 2. The year 2 retreatment rate is most relevant to the STAR control group, which recruits patients with previously treated disease (CATT participants were treatment-naïve at enrolment). The year 2 CATT retreatment was calculated to be 5.7 injections ($12.6 - 6.9$), so we might expect our control group to receive twice this (11.4) over two years. As CATT was undertaken in the US, to allow more conservative assumptions in case the injection rate is lower in the UK, we assume the injection rate to be 10 injections over 2 years in our control group, with a SD of 7 (based on INTREPID data which showed the SD was 69% of the mean). A 25% reduction in the number of injections is thought to be clinically and economically meaningful. Notwithstanding the fact that the second year of INTREPID was primarily designed to assess safety and not efficacy, this figure also matches the 25% reduction in the injection rate in the 2 year results of INTREPID, comparing the combined radiotherapy arms to the sham arm (Jackson et al, 2015).

16.4 Randomization

Once baseline assessments are complete, participants will be randomized to SRT and sham in a 2:1 ratio. Randomization is at the patient level and is performed using an online randomization system set up by the King's Clinical Trials Unit (KCTU) at King's College London, available at:

<https://cturandomisation.iop.kcl.ac.uk/ProjectIndex/Default.aspx>.

Randomization is stratified by national treatment centre with variable block sizes to ensure that patients are allocated to the two arms within each treatment centre in a 2:1 ratio.

16.5 Analysis Population

The primary analysis population for efficacy will be the Intent-to-Treat population, consisting of all randomized patients. All efficacy analyses will be performed by randomized group assignment. The primary and secondary outcome will be at Month 24.

The analysis population for safety will consist of all participants treated. All safety analyses will be performed by actual treatment received.

16.6 Statistical Methodology

The primary analysis of this trial will occur after all data from the first 24 months are available. At this time, the data from the first 24 months will be locked and the Sponsor will be unmasked. This section briefly describes the methods to be used to analyze the data. A Statistical Analysis Plan (SAP), to be written prior to unmasking the data, will describe the statistical analysis of the primary and secondary outcomes in detail. Should the methods in the SAP differ from the description in this protocol, the methods in the SAP shall prevail.

16.6.1 Efficacy

16.6.1.1 Analysis of primary outcome

The principal analyses of primary outcome will be performed according to an "intent-to-treat" principle. All randomized patients in these analyses will be classified according to their assigned treatment at randomization, regardless of the patient's adherence. The primary analysis is to test the mean difference in number of ranibizumab retreatments up to and including Month 24 between the SRT and sham group (ranibizumab monotherapy). Previous research (CATT and INTREPID) has suggested that the number of injections is approximately normally distributed. In this case, a multiple linear regression analysis will be used to assess the treatment effect with adjustment for the baseline stratification factor – National Treatment Centre. The analysis will not include the initial mandated ranibizumab treatment as it is administered to all participants, and does not reflect the effect of SRT or sham treatment. The treatment effect is evaluated at the two-sided 0.05 significance level.

16.6.1.2 Analysis of secondary outcomes

The change in visual acuity (VA) will be formally tested statistically for non-inferiority. The change in VA in the SRT arm compared to the change in VA in the control arm from baseline to Month 24 will be analysed by using a multiple linear regression model with adjustment for the baseline stratification factor (treatment centre) and the baseline VA score. Multiple linear regression will be used rather than repeated measure analysis because although there will be 24 monthly visits for patients in the trial, the focus of interest is the mean changes in VA from baseline to Month 24.

Data from the other secondary outcomes (listed in Section 15.1.3) will be summarized. Statistical analysis of these outcomes will be descriptive, with differences and 95% confidence intervals where possible. There will be no correction for multiple testing. Mean vision change and mean OCT thickness will be plotted against time (24 monthly visits over two years) as summary measures showing vision change over time and OCT thickness over time.

16.6.2 Safety

Safety will be evaluated by assessing the incidence of adverse events (AEs), the incidence of serious adverse events (SAEs).

The trial will specifically report the incidence of radiation retinopathy/microvascular abnormalities, and arteriothrombotic events.

AEs, SAEs, and other findings will be summarized by presenting the percentages of participants with each event for each treatment group. When relevant, the time course of AEs will be presented.

16.7 Interim analysis

The usual rationale for an interim analysis is to consider stopping the treatment (or the trial) however as this treatment is given at baseline, it is not possible to subsequently stop treatment. As such we elected not to include an interim analysis. The DMC will examine the recruitment rate, data completeness and monitor safety, and will recommend whether the study should continue, stop, be suspended, or be modified, based on their findings.

17. RECORDKEEPING

The investigator must maintain the following accurate, current, and complete records relating to his/her participation in the study:

- All correspondence with another investigator, REC, Sponsor, monitor, including required reports

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- Records of each participant's source documents and exposure to the device, including signed and dated consent forms and medical records, progress notes, hospital or clinical charts and nurses' notes
 - All relevant observations, including records concerning adverse device or drug effects, information and data on the condition of the participant upon entering and during the course of the study, including information about relevant previous medical history and the results of all diagnostic tests
 - The protocol, with documents showing the dates of and reasons for each deviation from the protocol
 - Source documents
 - Fundus fluorescein and ICG angiography and OCT images

All study records should be maintained in a locked, limited-access area.

The Investigator will act as custodian for the trial data at each site. The following guidelines will be strictly adhered to:

- Patient data will be anonymised
- All anonymised data will be stored on a password protected computer
- All trial data will be stored and archived in line with the Medicines for Human Use (Clinical Trials) Amended Regulations 2006.

The local Principal Investigator shall maintain all study records until notified by the Chief Investigator that retention is no longer required. If the Investigator moves from the site at which he/she conducted the study and/or maintained the study records, the Investigator shall notify the Chief Investigator in writing whether the records will remain at the site at which the study was conducted or be moved to another location, and if another location, where and under whose custody. The Investigator shall notify the Sponsor as soon as possible in the event of destruction or loss of any study records

18. STUDY MONITORING REQUIREMENTS

The Sponsor, or its designees, will monitor the trial in a manner consistent with the regulatory requirements and Good Clinical Practice (GCP). Study monitoring involves the following elements:

- The Sponsor's personnel may meet with investigators prior to the initiation of the study in order to review the adequacy of the patient population, facilities, and equipment with respect to the needs of the study, and to familiarize the investigator with the study protocol.
- The Sponsor's personnel may meet with the investigators at the time enrollment is initiated in order to ensure that patients are being properly selected, that the methods described in the study

protocol are thoroughly understood by the investigator, that study data are being correctly recorded, and that the protocol is being correctly implemented.

- The Sponsor's personnel, or designee, may visit the clinical site at any time during the course of the study to review source documents, study data, clinical data, and all other documents, and to interview study personnel.
- Telephone consultations between the Sponsor's personnel and site staff will occur as necessary during the course of the study to ensure the proper progress and documentation of the study findings.

19. PROTOCOL DEVIATIONS AND AMENDMENTS

Investigators should make every attempt to not deviate from the protocol. Deviations can ultimately affect the scientific soundness of the protocol, as well as the rights, safety and welfare of the participants. An Investigator who feels that a deviation from the protocol is necessary must submit a request to the Chief Investigator or Trial Manager by email. A form will be supplied to document all protocol deviations and these will be summarized in the final study report. Prior approval of a protocol deviation is not required for clinically urgent actions that are undertaken to protect participants, if the delay needed for prior approval would increase the risk to the participant. A protocol deviation form must be sent to the Chief Investigator for all deviations that occur.

The Sponsor will make all changes to the protocol as an amendment to the protocol and approved by the REC prior to implementation.

20. PARTICIPANT IDENTIFICATION NUMBER

Once a participant has provided informed consent, including signing the informed consent form, a Participant Identification (ID) Number will be assigned. The first two digits of the ID number will be the site number followed by a three-digit number in sequential order (i.e. 01001, 01002, etc.). This ID number will be retained throughout the study.

The ID number and participant initials are to be recorded on all study documents and will link the study treatment and the study documents to the participant's name and medical record. To maintain confidentiality, the participant's name should not be recorded on any study document other than the informed consent form and the Participant ID log. Participants who withdraw from the study will not be replaced.

21. ETHICAL AND REGULATORY PRECEPTS

21.1 Principal Investigator's Responsibility

The Principal Investigators (PI) at each site must comply with the signed Sponsor-Site Agreement. The PI must have and maintain current good clinical practice (GCP) training, and ensure that all trial staff do likewise. He or she may delegate tasks to appropriately trained staff, but he or she maintains responsibility for their conduct. The PI shall ensure that there is a delegation log detailing all staff involved in the conduct of the trial at his or her site.

21.1.1 Media and Public Relations

If the PI intends to advertise for participants, whether in a professional or consumer publication, radio, television or community notices, all advertising must receive prior approval of the Sponsor and the Chief Investigator. The PI must also involve his or her Communications team prior to issuing any press releases, or dealing with the media.

21.1.2 Authorization of Treatment Costs

The PI will ensure that local healthcare commissioning bodies, such as Clinical Commissioning Groups or equivalent, are informed of and agree to the trial treatment costs, or that the treatment costs are covered by existing commissioning arrangements. Note that there is no cost for SRT, which is provided free of charge, and most sites are anticipated to already have funding for ranibizumab treatment, consistent with NICE guidance. The PI will not pass on research costs to commissioning bodies, only agreed treatment costs.

21.2 Radiation Licensing/Certification

The following requirements apply only to sites that are acting as the national treatment centres providing SRT.

All SRT treatment centers will have attained the appropriate national and local licensing requirements to allow for the utilization of the IRay system at the participating institution. All SRT treatment sites will have obtained licenses to administer SRT, in accordance with the requirements of the Administration of Radioactive Substances Advisory Committee (ARSAC). Each SRT treatment site will provide proof of documentation of the licensure to the Sponsor prior to treating any participants in this study.

A Radiation Safety Officer (RSO) or Medical Physicist will be involved in the oversight of the radiation use at each SRT treatment site, and a named individual will be identified to the Sponsor.

A named clinical radiation expert, such as a Radiation Oncologist or Nuclear Medicine Consultant, will oversee the delivery of radiation treatment at each SRT treatment site. A named individual taking overall responsibility for the delivery of SRT will be identified to the Sponsor.

21.3 Regulatory Authority and Research Ethics Committee Approval

The trial will be conducted in compliance with the principles of the Declaration of Helsinki (1996), the principles of GCP and in accordance with all applicable regulatory requirements including but not limited to the Research Governance Framework and the Medicines for Human Use (Clinical Trial) Regulations 2004, as amended in 2006 and any subsequent amendments.

The Medicines and Healthcare products Regulatory Agency (MHRA) has reviewed the STAR protocol. They have determined that the trial is not a Clinical Trial of an Investigational Medicinal Product (CTIMP) as defined by the EU Directive 2001/20/EC and that no submission to the Clinical Trials Unit at the MHRA is required.

The protocol and related documents will be submitted for review to a UK Research Ethics Committee (REC) prior to trial commencement. The details of the REC will be provided to participants and study sites by the Sponsor.

Annual progress and safety reports and a final report at the conclusion of the trial will be submitted to the REC within the timelines defined in the Regulations.

Prior to recruitment of any participants into the study at each participating site, Site Specific Approval (SSA) and NHS Research and Development approval must also be obtained.

Any changes to the protocol must be discussed and approved by Sponsor in writing unless the change is made to assure the safety of the participant.

Signed consent forms must remain in each participant's study file and must be available for verification by study monitors at any time.

21.4 Indemnity and Insurance

Clinical Negligence Scheme for Trusts (CNST) provides indemnity that covers clinical negligence and harm caused.

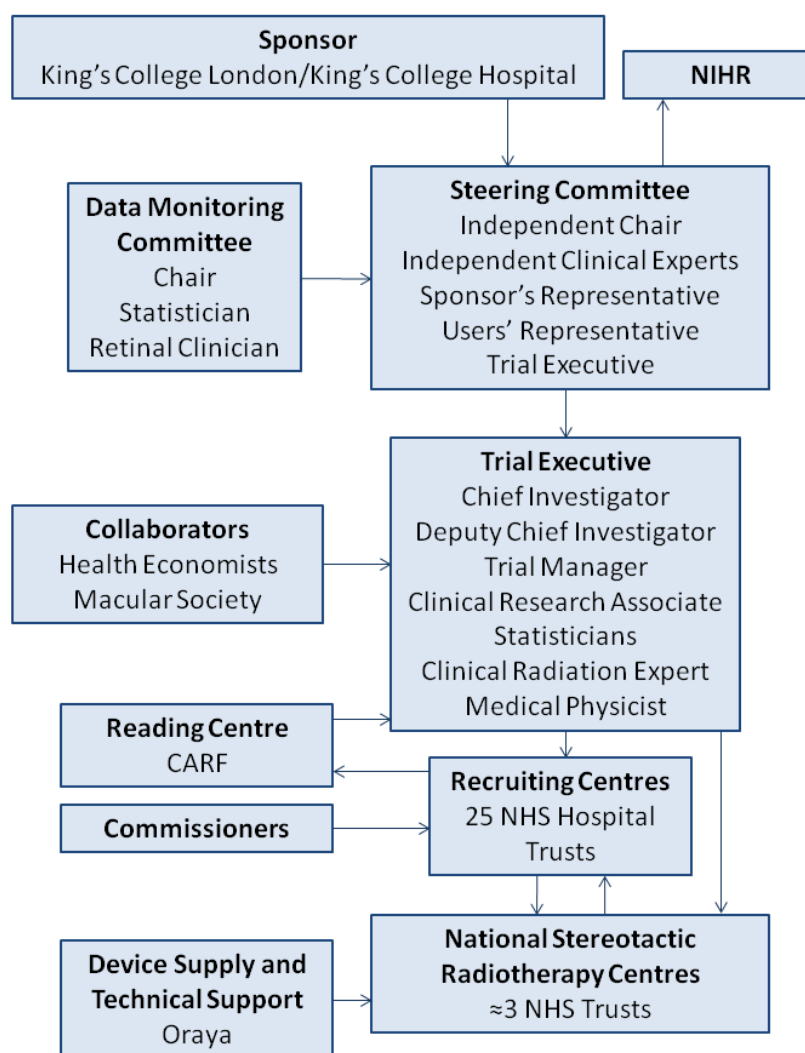
22.MANAGEMENT AND ORGANIZATION

The chart on the next page shows the organizational structure of the STAR trial. In summary, a trial Executive will run the study, under the oversight of a Trial Steering Committee (TSC) that will meet approximately every six months. A Data Monitoring and Ethics Committee (DMEC) will have access to unmasked data, as needed, and will report to the TSC. King's College London (KCL) and King's College Hospital will co-sponsor the trial, and they will collectively take ultimate responsibility for the conduct of the trial.

The Sponsor will contract with recruiting sites to undertake the research through a Site-Sponsor agreement. Recruiting Centres will enrol participants and manage all their clinical care within

the trial, with the exception a single treatment with SRT, which will be undertaken at national SRT treatment centres. The Sponsor will contract with the Central Angiographic Reading Centre (CARF) at Queen's University of Belfast to read the angiograms and OCTs, supplied to CARF by the Recruiting Centres. Recruiting Centres will have contracts with their usual healthcare commissioners, such as local Clinical Commissioning Groups (CCGs), to cover the treatment costs within the trial. The National Institute of Health Research funds the research costs through its Efficacy and Mechanism Evaluation programme and representatives will be invited to attend TSC meetings.

Trial Organisation



22.1 Data Monitoring and Ethics Committee

The Data Monitoring and Ethics Committee (DMEC) will have access to unblinded data to monitor safety and will make recommendations to the Trial Steering Committee. The DMEC will adhere to the terms of the DMEC Charter shown in Appendix 5.

22.2 Trial Steering Committee

The Trial Steering Committee (TSC) will provide general oversight of the trial. The Terms of Reference are provided in Appendix 6.

23. INFORMED CONSENT

The Investigator is responsible for obtaining the legally effective informed consent of the participant. In carrying out this responsibility, the investigator (and other involved team members) should recognise that informed consent is not just a signature on an informed consent form, but a process during which the participant and those with whom the participant wishes to consult (such as family members, friends, and personal physicians) are provided with sufficient information about the study under circumstances that allow the participant to consider whether or not to participate and to minimize the possibility of undue influence or coercion.

Once the REC has approved the Patients Information Sheet and Informed Consent Form, the form should be used as the basis of the information presented to the participant during the informed consent process. The form should be provided to the participant early in the process, so that he/she has ample time to read it and discuss it with others if he or she wishes to do so.

Each of the following key elements must be discussed with the participant:

- A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the participant's participation, a description of the procedures to be followed, and identification of any procedures which are experimental.
- A description of any reasonably foreseeable risks or discomforts to the participant.
- A description of any benefits to the participant or to others which may reasonably be expected from the research.
- A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the participant.
- A statement describing the extent, if any, to which confidentiality of records identifying the participant will be maintained and that notes the possibility that regulatory authorities and external monitors may inspect the records.
- For research involving more than minimal risk, an explanation as to whether any compensation and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained.
- An explanation of whom to contact for answers to pertinent questions about the research and research participants' rights, and whom to contact in the event of a research-related injury to the participant.

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- A statement that participation is voluntary, that refusal to participate will involve no penalty or loss of benefits to which the participant is otherwise entitled, and that the participant may discontinue participation at any time without penalty or loss of benefits to which the participant is otherwise entitled.
 - A statement that the particular treatment or procedure may involve risks to the participant (or to the embryo or foetus, if the participant is or may become pregnant) which are currently unforeseeable.
 - Anticipated circumstances under which the participant's participation may be terminated by the investigator without regard to the participant's consent.
 - Any additional costs to the participant that may result from participation in the research.
 - The consequences of a participant's decision to withdraw from the research and procedures for orderly termination of participation by the participant.

Once the informed consent process is complete and the participant has reached a decision as to whether to participate, the investigator should record the decision in the case history form. A participant who decides to participate should be asked to sign the Informed Consent Form. A copy of the signed form should be given to the participant, and the signed form should be included with the participant's study records.

If there is any new information which may affect a participant's willingness to continue participating in the trial, he or she will be re-consented with an amended or supplementary Patient Information Sheet and Consent Form.

24. DATA MANAGEMENT AND DATA PROTECTION

All study data will be initially entered onto paper source documents and then transferred into the online eCRF. All requested information must be entered on the eCRF. If an item is not available or not applicable this fact should be indicated. Data management must comply with the Data Protection Act 1998. The data management team and study monitors may raise queries using the electronic system, and the study site Investigator must provide a response in a timely manner.

To ensure the quality of clinical data across all participants and sites, data will be checked for consistency, omissions, and any apparent discrepancies. In addition, the data will be reviewed for adherence to the protocol. To resolve any questions arising from the clinical data, data queries and/or site notifications will be created in the database for resolution.

The IRay device logs a number of parameters that are used to assess system performance, such as X-ray output, motion metrics, alignment assessments, high voltage power supply stability, and I-Guide motion. These data are stored in log-files ("runtime logs") that contain no patient-identifying information. As such, self-test logs and runtime logs can be extracted without revealing patient data. The device manufacturer will be given permission to extract these log-files to monitor and improve device functionality, subject to approval from the Caldicott guardian at the Sponsor's site.

25. DIRECT ACCESS TO SOURCE DATA AND DOCUMENTS

The Investigator(s) shall permit trial-related monitoring, audits, REC review, and regulatory inspections (where appropriate) by providing direct access to source data and other documents (e.g., patients' case sheets, ocular images). Where necessary, inspection may also take place at a site's facilities.

26. PUBLICATION POLICY, INTELLECTUAL PROPERTY AND FINANCES

It is intended that the results from this study be published in high quality, peer-reviewed, medical journals. The main paper will report the safety and efficacy outcomes at the 24 month endpoint, with supplementary reports covering the month 36 and month 48 safety outcomes. The named authors will comprise researchers who have made a significant contribution to study design, clinical or statistical analysis, and manuscript preparation. These authors will present data on behalf of the STAR study group which will include, amongst others, Principal Investigators who have made a substantial contribution to the trial, such as high levels of recruitment. The format for acknowledging the STAR study group will depend on the target journal. Principal Investigators or other researchers may approach or be invited by the Chief Investigator to prepare and submit other manuscripts in their own right, or on behalf of the STAR study group. The authorship lists will be determined by the Chief Investigator. The Trial Steering Committee and Data Monitoring and Ethics Committee will be invited to review and approve the key outcome papers.

Researchers involved in this study will submit all data for pooled analysis by the Chief Investigator. Researchers will not present, publish or disseminate any study data, including case reports and case series, without the prior permission of the Chief Investigator.

This investigator-initiated trial is co-sponsored King's College London (KCL) and King's College Hospital, who own any intellectual property arising from the trial. The device manufacturer (Oraya Therapeutic, Inc, Newark, USA) provided material that was used in the INTREPID study protocol that was then adapted for use in the STAR protocol. Oraya also provided peer review of the protocol using a panel of external experts, but the STAR Chief Investigator retained final editorial control. The protocol was also modified in response to the peer review process that formed part of the application to the National Institute for Health Research (NIHR) for trial funding.

Zeiss will provide free SRT device use for the duration of the trial, and technical and training staff to support SRT at the National Treatment Centres. Zeiss will not have ownership of any of the clinical data obtained in this study, and will not be represented on the Trial Steering Committee. Zeiss will be invited to critique key publications prior to submission, but the

Sponsor will retain exclusive editorial control. Zeiss will not have access to trial data during the trial.

Research costs will be covered by a grant from the NIHR via the Efficacy and Mechanism Evaluation (EME) programme. The Sponsor will make a site payment to Recruiting Centres for each participant that they recruit, to cover local research costs. Treatment costs will be funded by local healthcare commissioning groups. The Principal Investigators at each site must ensure that their healthcare commissioners have agreed to fund participants' treatment costs for the 48 month trial duration, prior to site initiation. The STAR trial is part of the UK Clinical Research Network Study Portfolio and so Recruiting Centres will be eligible to apply for service support from their Comprehensive Local Research Network (CLRN).

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28. APPENDIX 1: SCHEDULE OF ASSESSMENTS

Assessment	Screening	SRT with baseline ranibizumab [†]	Monthly review* (Month 1-11)	Month 12	Monthly review* (Month 13-23)	Month 24	Month 36	Month 48
Visit Window: <i>Day 0 = Day of successful enrolment</i>	Day -14 to 0	Day 0 to 21	±7 days	±7 days	±7 days	±7 days	±14 days	±14 days
Informed Consent	X							
Demographics	X							
Ophthalmic History	X							
Med History/Con Meds	X							
Blood Pressure	X							
EDTRS Visual Acuity [†]	X		X	X	X	X	X	X
Intraocular Pressure	X			X		X	X	X
Cataract Assessment	X			X		X	X	X
Biometry [§]	X							
OCT (sent to reading centre)	X			X		X	X	X
OCT (not sent to reading centre)	X		X		X			
Fundus Photographs (sent to reading centre)	X			X		X	X	X
Fluorescein Angiography (sent to reading centre)	X			X		X	X	X
Indocyanine Green Angiography** (sent to reading centre)	X							
Stereotactic Radiotherapy with mandated baseline Ranibizumab [‡]		X						
Ranibizumab injection if required (<i>prn</i>)			X	X	X	X	X	X
Health Economics questionnaires			X	X	X	X	X	X
EQ-5D and VFQ-25 patient questionnaires	X			X		X	X	X
AEs/ConMed changes			X	X	X	X	X	X

* Monthly review entails review every 28 days rather than by calendar month. The first monthly review should be scheduled 28 ± 7 days after stereotactic radiotherapy/baseline ranibizumab. It is preferable to allow at least 23 days between visits as this is the minimum time between ranibizumab injections.

** Indocyanine green may be omitted in centres that do not have ICG capability, if pre-agreed by Sponsor.

† Trial certified best-corrected visual acuity is required at each visit. Full refraction is undertaken at screening and then updated at months 3, 6, 9, 12, 15, 18, 21, 24, 36 and 48.

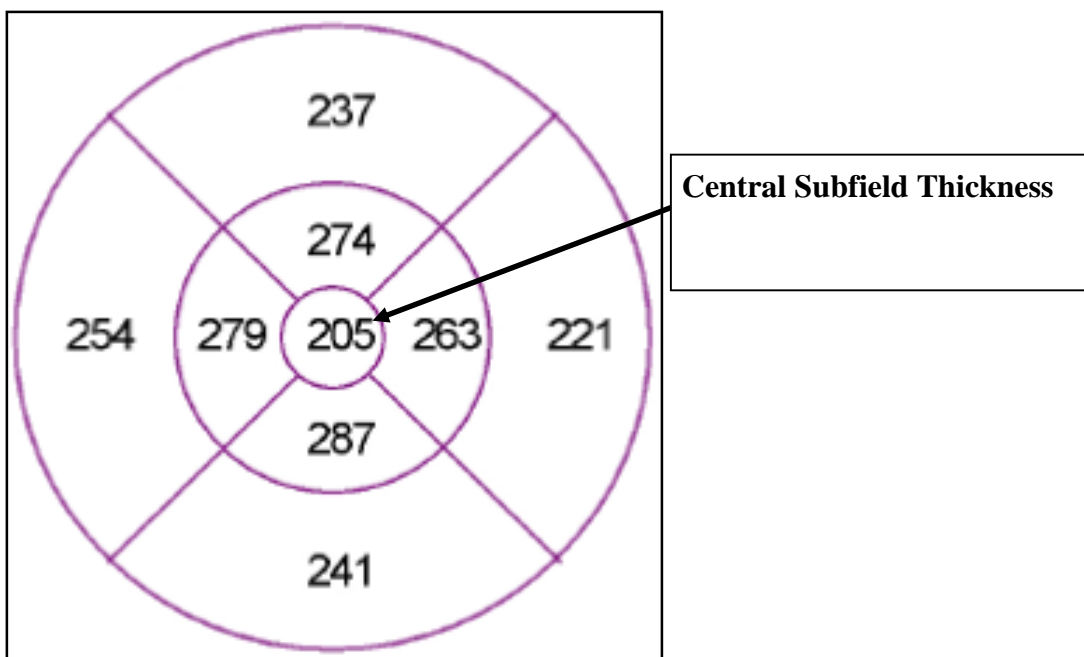
‡ The baseline mandated ranibizumab injection should be given at the National Treatment Centres following stereotactic radiotherapy

§ Retrospective biometry can be used, if available.

29. APPENDIX 2: ASSESSMENT OF CENTRAL SUBFIELD THICKNESS AND MACULAR VOLUME

1. Central Subfield Thickness

On the OCT result page, the following ETDRS grid is displayed for all machines. The central subfield thickness measurement is the value at the centre of the circle (arrow). Before recording the central subfield thickness please make sure that the grid is centred at the fovea and the segmentations errors are corrected as described for each of the OCT machines (see below).



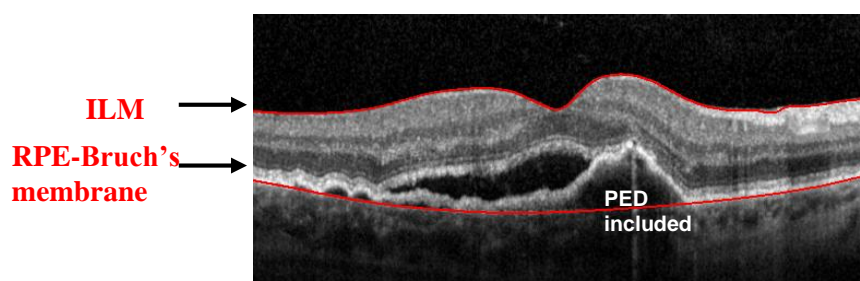
2. Macular Volume

In order to be eligible for inclusion on the STAR study, the macular volume for the study eye needs to be calculated during screening. This measurement, generated by the SD-OCT machines, must then be compared with the pre-defined threshold for each of the OCT machines. It is important to note that variation occurs between different machines, and therefore this check must be performed against the correct SD-OCT machine values (see below). Before recording the

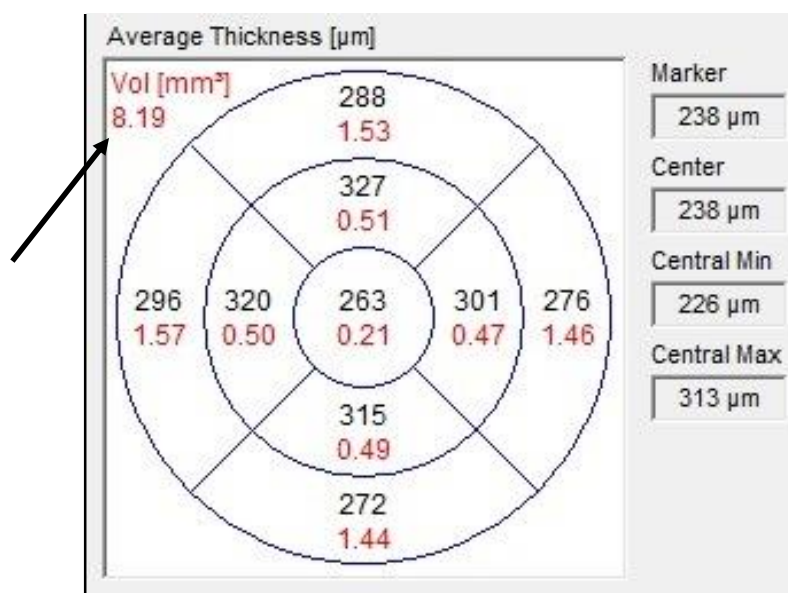
macular volume please make sure that the grid is centered at the fovea and the segmentations errors are corrected as described for each of the OCT machines.

Spectralis

A 30° x 25° macular cube with 31 line scans should be used (see imaging protocol). Once the scan has been completed, either the machine operator or clinician should check and manually adjust (if needed) each line scan to ensure no segmentation errors have occurred. The segmentation lines should be positioned on the internal limiting membrane (ILM) anteriorly, and the RPE-Bruch's membrane complex posteriorly, **to include pigment epithelial detachments (PEDs)** (see figure below and details in the imaging protocol).



Once the scan has been centered at the fovea and any segmentation errors have been corrected, the thickness map tab can be clicked, which will load the following diagram;

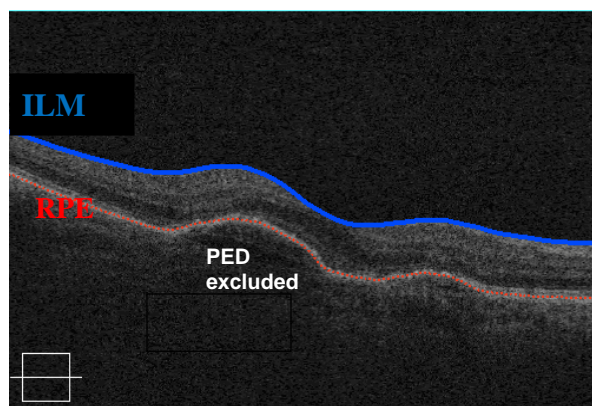


The macular volume is displayed in **red** at the top left corner (arrowed).

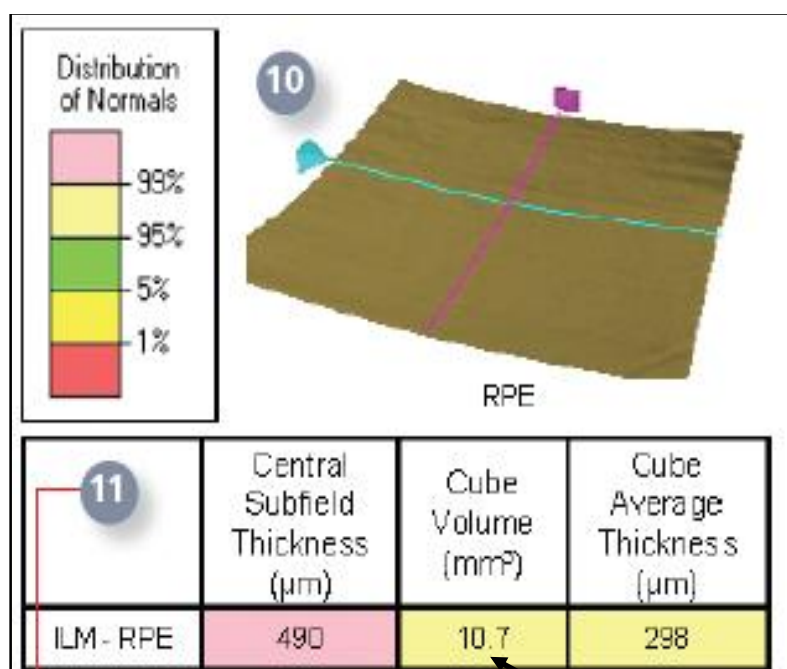
To meet the inclusion criteria, the macular volume must exceed **8.15 mm³**.

Cirrus

A Macular Cube 512 x 128 should be used (see imaging protocol). Once the scan has been completed, either the machine operator or clinician should check and manually adjust (if needed) each line scan to ensure no segmentation errors have occurred. Segmentation lines should be placed on the ILM anteriorly, and the RPE posteriorly, **to exclude pigment epithelial detachments (PEDs)** (see figure below).



Once the scan has been centred at the fovea and any segmentation errors have been corrected, the data analysis information can be displayed, which will load the following information:

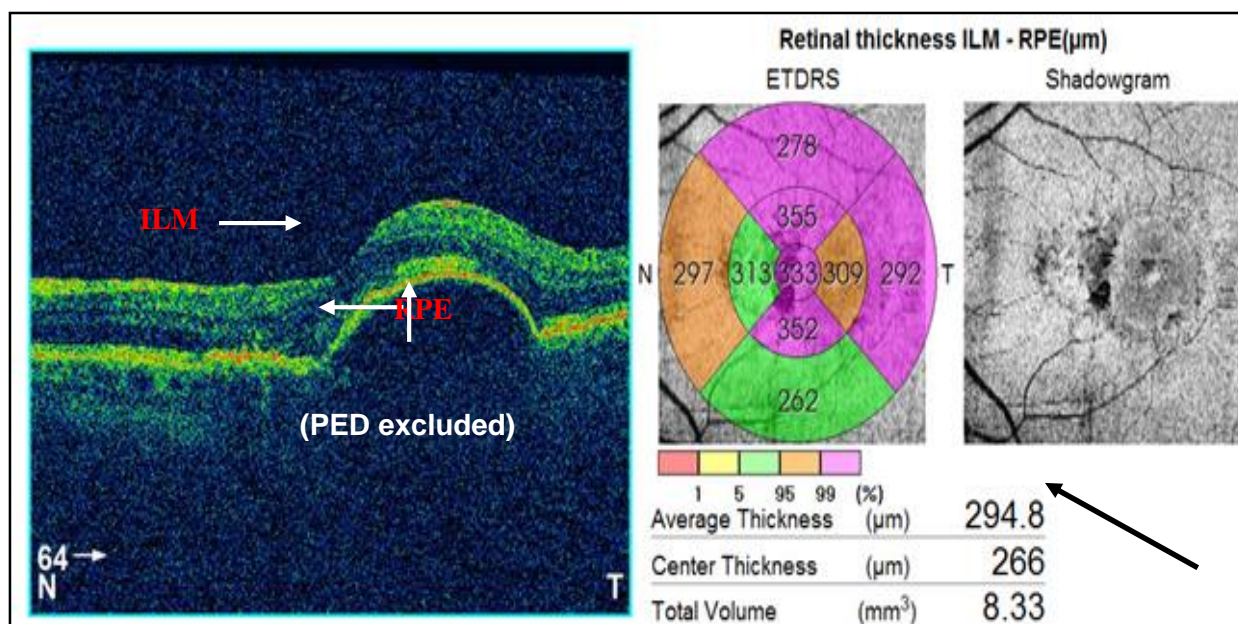


To meet the inclusion criteria, the macular volume must exceed **9.57 mm³**.

Topcon

A 3D Scan, 6x6mm, 512x128 should be used (see imaging protocol). Once the scan has been completed, either the machine operator or clinician should check and manually adjust (if needed) each line scan to ensure no segmentation errors have occurred. Segmentation lines should be placed on the ILM anteriorly, and the RPE posteriorly, **to exclude pigment epithelial detachments (PEDs) (see figure below - left).**

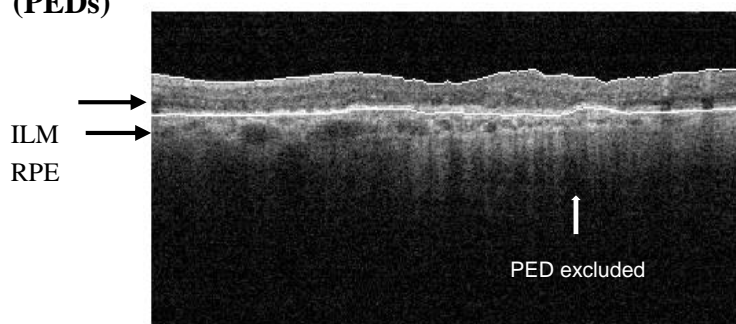
Once the scan has been centered at the fovea and any segmentation errors have been corrected, the “Report” button should be clicked, and the option “show volume” clicked. This will display the ETDRS grid with volumes for each individual segment:



To meet the inclusion criteria, the macular volume must exceed **6.94 mm³**.

Optovue

A Retina Map scan should be used. Once the scan has been completed, either the machine operator or clinician should check and manually adjust (if needed) each line scan to ensure no segmentation errors have occurred. Segmentation lines should be placed on the ILM anteriorly, and the RPE posteriorly, **to exclude pigment epithelial detachments (PEDs)** (see figure below).



After saving the segmentation adjustments, the macular volume will be recalculated. In the Retina Map Report the total macular volume is displayed at the bottom of the thickness and volume parameter table (arrow).

Section	Thick (μm)	Vol(mm ³)
Fovea	270	0.212
ParaFovea	324	2.038
S. Hemisphere	328	1.031
I. Hemisphere	321	1.008
Tempo	315	0.495
Superior	332	0.521
Nasal	330	0.519
Inferior	320	0.503
Perifovea	296	3.718
S. Hemisphere	303	1.906
I. Hemisphere	288	1.813
Tempo	281	0.884
Superior	307	0.963
Nasal	313	0.983
Inferior	283	0.888
Vol within: 0.212(1mm) 2.250(3mm) 5.968(5mm)		

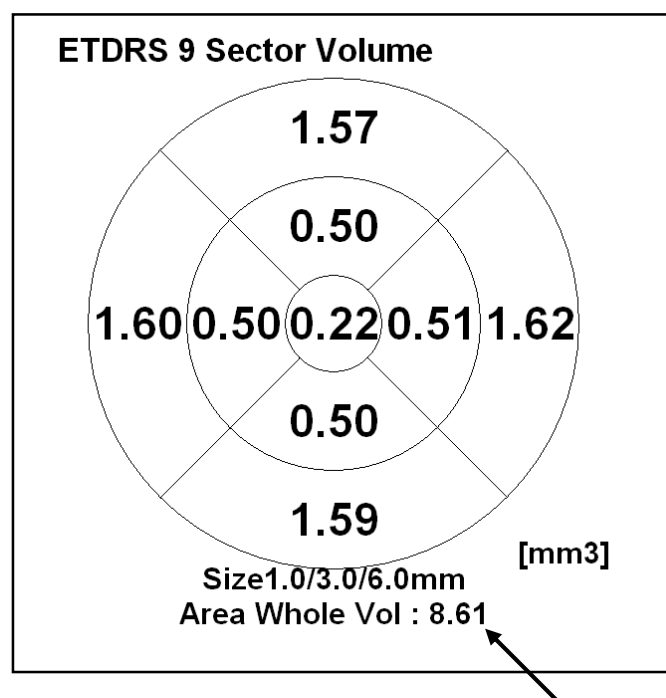
To meet the inclusion criteria, the macular volume must exceed **5.47 mm³**.

Nidek

A Macula Map scan should be used (see imaging protocol). Once the scan has been completed, either the machine operator or clinician should check and manually adjust (if needed) each line scan to ensure no segmentation errors have occurred. The segmentation lines should be positioned on the internal limiting membrane (ILM) anteriorly, and the RPE-Bruch's membrane complex posteriorly **to include pigment epithelial detachments (PEDs)**, as illustrated in the Spectralis section above (details in the imaging protocol).

Once the scan has been centred at the fovea and any segmentation errors have been corrected, the Analysis Chart should be used to record the macular volume.

The macular volume is displayed on the bottom right of the ETDRS sector grid (arrowed).



To meet the inclusion criteria, the macular volume must exceed **8.20 mm³**.

30. APPENDIX 3: ASSESSMENT OF VISUAL ACUITY

Visual acuity (VA) is measured at **baseline and monthly** for 24 months, and then at the **annual** visits thereafter (months 36 and 48). Full refraction will be undertaken at every third of the monthly visits over the first 24 months, and at the annual visits thereafter, namely at baseline (screening) and months 3, 6, 9, 12, 15, 18, 21, 24, 36 and 48.

For the intervening visits up to month 24, where full refraction is not mandated, the trial certified VA examiner should use the previous full refraction.

Refraction and VA measurements will be performed for all patients by trained vision examiners only. The **name** of the vision examiner should be documented in the patient's **source document** at each visit. VA examiners are "masked" to trial assignment and previous VA testing results. Therefore VA examiners should not have access to the patient's chart or previous VA testing results. Only the previous refraction should be made available. Refraction should be conducted prior to VA testing to obtain best-corrected vision as described below. Visual acuity is measured at all trial visits using standard charts, lighting, and procedures, including the visits that do not mandate a full refraction.

Equipment

Refraction equipment required includes:

1. Retroilluminated Light box and ETDRS 4 meter distance acuity chart set
2. Trial lens frames
3. Trial lens set with plus or minus cylinder lenses
4. Jackson cross-cylinders of 0.25, 0.50, and 1.00 diopters
5. Pinhole occluder
6. Tissues or eye pads and tape
7. A 1 meter rigid measuring stick

Visual Acuity Charts

Chart 1 is used for testing the VA of the RIGHT eye; Chart 2 for testing the LEFT eye; and Chart R (or 3) for refraction only. Patients should not be allowed to see any of the charts before the examination.

Visual Acuity Lane and Visual Acuity Box

A distance of **4 meters** is required between the patient's eyes and the VA chart. With the box light off, not more than **15 foot-candles of light** (161.4 Lux) should fall on the center of the chart. To measure the amount of light, the room is set up for VA testing, but with the box light off. The light meter is placed at the fourth line from the top of the chart, with its back against the chart and the reading is taken. If more than one lane is available for testing VA, the VA of an individual patient should be measured in the same lane at each visit, if possible. If different lanes are used to test VA, they must each meet the same standards.

Retro illuminated ETDRS charts are used in this trial. The illuminator box will be either wall-mounted or mounted on a stand. . The light box should be mounted at a height such that top of third row letter is 49 ± 2 inches from floor.

The VA light box is equipped with two General Electric 20-watt fluorescent tubes (or equivalent lightbox housing 24 Watt Fluorescent tubes) and ballast. Each tube is partly covered by a 12 or 14-inch fenestrated sleeve, which is centered on the tube and open in the back. This serves as a “baffle” to produce even illumination over the testing chart. Because the illumination of fluorescent tubes diminishes by 5 percent during the first 100 hours and by another 5 percent during the next 2000 hours, new tubes should be kept on for a total time period of 4 days (96 hours) before use in the study, and should be replaced once a year. Luminance will be confirmed with a use of a light meter (Sekonik L-398A) at the outset of the trial to confirm a minimum luminance of 85 cd/m² (80-160 cd/m²).

A **sticker** should be placed on the back of the light box, indicating the date on which the present tubes were installed. A spare set of burned in bulbs should be available on site.

Beginning Approximate Refraction

At the Baseline visit, the patient’s beginning refraction is determined by one of the following ways:

If the patient’s VA is 6/30 (20/100) or better and the patient does not require glasses for distance vision, then the beginning approximate refraction should be no lens correction or plano.

If the patient’s VA is 6/30 (20/100) or better and the patient requires glasses for distance viewing, the glasses should be measured using a focimeter, and these measurements are used for the beginning refraction.

If the patient’s VA is less than 6/30 (20/100) with or without correction, then retinoscopy or autorefractometry should be performed to determine the beginning approximate refraction.

If the patient wears contact lenses for refraction, a notation should be made that the refraction was over contact lenses. It is suggested that the patient wear the contact lenses for future examinations. If the patient is not a regular contact lens wearer and wore the lenses by mistake, they should be removed and you should wait at least 30 minutes before beginning the refraction. The patient should be reminded not to wear contact lenses at subsequent visits.

Refractions are performed with either plus or minus cylinder power. Whichever cylinder type is used at baseline (minus or plus) must be used for all subsequent visits. Best correction results should be recorded on the sponsor provided worksheet which will be included in the source documents. At each **follow-up visit, the results of the protocol refraction from the previous visit are used as the beginning approximate refraction.** If the previous refraction is not available for some reason, the procedure described immediately above should be used. Whilst previous refraction results are made available at subsequent visits, **previous VA results should not be**

visible to the examiners at subsequent testing, so that assessment of VA is masked to prior visual function.

The charts used for measuring distance VA must NOT be used for refraction. Refraction for each eye should be performed at **4 meters** unless the patient's VA measured at 4 meters on the refraction chart (Chart R or Chart 3) is **worse than 6/48 (20/160)**. **If VA is worse than 6/48 (20/160) the eye is refracted at 1.0 meter**. If during the refraction process at one meter, the patient is reading letters on the eighth line or lower line of the chart, the refraction should continue at 4 meters. Whenever a patient cannot read any letters on the top line of Chart R or Chart 3 at 1.0 meter the vision should be checked with a pinhole to see whether reduced vision is due, at least in part, to a larger refractive error. If there is no improvement with the pinhole, then the eye is exempt from refraction.

Patient Refraction

Patient refraction allows one to determine the best correction for a patient to perform the VA tests. The “**push plus**” approach is used. Add minus diopter spherical corrections **only when the patient is able to read at least one more letter** on a line or a letter on a smaller line.

Procedure

1. Measure and record the distance vision of the eye being tested using Chart R while occluding the fellow eye. The fellow eye should be lightly patched with an eye pad or tissue and tape. Patients should be reminded to blink and encouraged to use eccentric fixation, or their side vision, when necessary.
2. All refraction and vision testing must be done at 4 meters or 1 meter. Distance for 4 meters is 13 feet and 1.5 inches or 157.5 inches. The one meter distance is 39 and 3/8 inches.
3. All patients should be seated for testing. A **rigid measuring device** should be used to measure the distance from the patient to the chart if testing is done at **1 meter**. The distance is measured from the outer canthus to the center of the second letter (left eye) or fourth letter (right eye) of the third line of the chart. For **4 meter** testing, **clear and permanent floor markings** should be used to mark the distance for consistency.
4. Place and adjust the trial frame on the patient's face so that the lens cells are parallel to the anterior plane of the orbits and centered in front of the pupils. Adjust the lens cells for the proper distance from the cornea. Be sure the trial frame is comfortable on the patient's face.
5. Occlude the left eye by lightly patching with an eye pad or tissue and tape. Place the spherical lens correction in the compartment closest to the eye. The cylindrical lens correction, if present, is placed in the compartment in front of the spherical correction. Adjust the axis.
6. **Spherical Correction:** To determine the highest plus or least minus sphere, refract the right eye. The following refraction steps are recommended for VAs of 6/3 (20/10) to 6/24 (20/80) with the beginning approximate refraction. For VAs less than 6/24 (20/80), refer to the refraction table for the appropriate sphere and cylinder powers and testing distance (See summary below) and follow a similar procedure. *Note: Whenever VA is improved to a higher range, refraction should be performed with the smaller sphere and cylinder powers given for the better VA level (See table at end of appendix).*

-
- a) Hold a **+0.50 sphere** in front of the patient's right eye. The patient should be looking at the smallest legible line on the VA chart. In these exact words, ask the patient, "**Is this better, worse, or no change?**"
 - b) If the patient responds that the vision is **worse or blurred**, remove the +0.50 sphere from in front of the trial frame and **go to Step 6d**.
 - c) If the patient responds **better or no change**, remove the +0.50 sphere from in front of the trial frame and replace the spherical lens in the trial frame with a spherical lens that is one-half diopter more positive. Continue this procedure by returning to Step 6a and repeating this process **until a +0.50 makes the vision worse** or blurred and then go to Step 6d.
 - d) Hold a **-0.50 sphere** in front of the patient's right eye. In these exact words, ask the patient, "Is this better, worse or no change?" If the patient replies "worse" or "no change", go to Step 6f. If they reply "better" go to step 6e.
 - e) Hold the -0.50 sphere in front of the eye. If the patient responds that the vision is better, ask the patient to read the VA chart. **Only when the VA is improved, by at least one letter, may you increase the minus** by 0.50 (or decrease the plus) and repeat Step 6d. Whenever VA is not improved, go to Step 6f.
 - f) Remove the -0.50 sphere from in front of the eye and hold a +0.50 sphere in front of the right eye. In these exact words, ask the patient, "Is this better, worse, or no change?" If the patient responds that vision is better or unchanged, then return to Step 6c. Otherwise, go to Step 7. **Spherical testing should always end with a plus lens.**
7. **Cylinder Axis:** To determine and refine the cylinder axis for **PLUS** cylinder, proceed as follows; (*If minus cylinders are used, the appropriate technique using minus cylinders must be employed and minus cylinder must be used throughout the trial.*)
- a) Have the patient look at a line which is either **one or two lines larger** than the smallest line the patient is able to read. Ask the patient to focus on a rounded letter such as "C", "D", or "O". The patient should focus on this same letter throughout this procedure.
 - b) If a cylinder is present in the beginning approximate refraction, then go to Step 7c. Otherwise, follow the option listed below to determine if cylinder may be needed.
Testing for cylinder when there is none in the beginning approximate refraction:
 Place a **+0.50 diopter** cylinder with the positive axis first at 90°, then compare this to no cylinder; repeat this procedure for 180°, then 45°, and 135° always comparing to no cylinder after each axis position. If the patient says that vision is improved at any one of the four axis positions, place a +0.50 cylindrical lens in the trial frame at the preferred axis and go to step 7c. If the patient prefers no cylinder at all four axis positions, then go to Step 9.
 - c) Place the +0.25 diopter hand held cross-cylinder (for VA 6/3 – 6/24; 20/10-20/80) first with the positive axis 45° to the right of the preferred cylinder axis (as determined above), and second with the positive axis 45° to the left of the preferred cylinder axis. Ask the patient, "Which do you like better, position one or position two?" Also, tell the patient that both positions may blur their vision. The patient must choose the least blurred position, either one or two. "Neither" is allowed only if both positions are equally blurred or equally good.
 - d) If "neither" position is better and this was the first test of axis position, move the axis of the cylinder in the trial frame 15° to the right or left and return to Step 7c. Otherwise,
-

proceed to Step 7e.

- e) When one position is preferred over another, move the cylinder to the preferred positive axis position in the step sizes noted below and return to Step 7c. If no single position is better than another then go to Step 8.

Cylinder Refinement suggested axis step sizes

Cylinder Power	Axis Step Sizes
<1.00D	15°
1.00 to <2.00D	10°
2.00 to <3.00D	5°
3.00 to <5.00D	3°
5.00 to <8.00D	2°

8. Cylinder Power: Cylinder power is refined by following the steps:

- Ask the patient to look at the **smallest line** that can be read on the VA chart.
- Test the cylinder power by placing the 0.25 diopter cross-cylinder (for vision of 6/3 - 6/24; 20/10-20/80) first with the positive axis and second with the negative axis coincident with the cylinder axis. Ask the patient, “Which is better, position one or position two?” Do not give the patient the choice of neither.
- If the patient prefers the minus axis coincident with the cylinder axis, the total power of the correcting plus cylinder is reduced by 0.25 diopter. Repeat the process until the patient cannot choose one of the cross cylinder positions over the other. If the patient indicates a change that would introduce negative cylinder power, remove all cylinder power and continue testing for positive cylinder power at an axis 90° away from the previous axis. Otherwise go to Step 8d.
- If the patient prefers the plus axis coincident with the cylinder axis, increase the power of the cylinder by 0.25 diopters and return to Step 8b. Otherwise proceed to Step 8e.
- When the patient feels that both positions are equally bad or good, and the cylinder power in the trial frame has changed by more than 0.50 diopter, return to Step 7c and re-check the axis if necessary. Otherwise, proceed to Step 9.

*Note: If the cylinder is changed by more than 0.50 diopter, the **spherical equivalent** should be maintained. (For each 0.50 **plus** CX increase, add -0.25 to the sphere, for each 0.50 **minus** CX increase, add +0.25 to the sphere).*

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9. **Spherical Correction Refinement:** Recheck, or “*refine*” the power of the sphere by adding **+0.25 and -0.25** spheres and changing the spherical power by 0.25 diopter increments of the appropriate sign until the patient cannot detect any improvement in vision. As a reminder, **minus sphere should only be added if the patient can read additional letters** and spherical testing should always begin and end with a plus lens.
 10. Record the lens corrections obtained by patient refraction for the right eye on the examination form in the section for VA measurements as the corrections obtained by protocol refraction for the right eye.
 11. Repeat the entire process (Steps 1-10) for the left eye and record the refraction result on the VAE worksheet.

Best Corrected Visual Acuity Measures

As a reminder, Charts 1, 2, and R (or 3) are used for testing the right eye, left eye, and refraction, respectively. Patients should not see the charts until the test begins. The lens correction from the patient refraction should be in the trial frame worn by the patient. All eyes must be tested at 4 meters first, even if the refraction was performed at 1 meter.

The patient should be seated comfortably directly in front of the chart so that the eyes remain at the 4 meter distance. Testing always begins with the right eye. The fellow should be occluded with a folded tissue or eye pad lightly taped over the eye behind the trial frame serves as an effective occluder that allows eccentric fixation without inadvertent use of the covered eye. After testing the right eye, occlusion of the right eye should be done **BEFORE** Chart 2 is put up for testing the left eye.

The patient is asked to read the letters slowly, approximately one letter per second. The patient should be told that only one chance is given to read each letter, but they may change their mind before moving to the next letter. If the patient is unsure about the identity of the letter, then the patient should be encouraged to guess.

The patient should begin by reading the top line of the chart and continue reading every letter on each smaller line, from left to right on each line. *The patient should be encouraged to continue reading even if making mistakes. Each letter read is counted.* The examiner circles every correct letter read and totals each line and the whole column (0 if no letters are correct) on the data collection form. An X is put through letters read incorrectly. Letters, for which no guess was attempted, are not marked. When a patient reaches a level where he/she cannot guess, the examiner may stop the test provided that the patient has made errors on previous guesses, which is a clear indication that the best VA has been obtained.

When a patient cannot read at least 20 letters on the chart at 4.0 meters, the patient is tested at 1.0 meter. The distance from the patient to the chart should be measured again using the rigid one meter stick. The distance is measured from the outer canthus to the center of the fourth letter (right eye) or the second letter (left eye) of the third line of the chart. The spherical correction in the trial frame should be changed by adding **+0.75** to correct for the closer test distance. The patient may fixate eccentrically or turn or shake his/her head to

improve VA. Particular care should be taken to make sure the patient does not move forward when testing at 1 meter. The patient should be reminded to blink.

The examiner should not tell the patient if a letter was identified correctly. The patient may be encouraged by neutral comments, such as “good”, “next”, and “OK”. The examiner should not stand close to the chart during testing. Attention should be focused on the patient and the data collection form. If the patient has difficulty locating the next line to read, the examiner may go up to the chart and point briefly to the next line to be read, but then must move away from the chart.

When 20 or more letters are read at 4 meters the VA score for that eye is recorded as the number of letters correct plus 30 (refer to the VA worksheet) The patient gets credit for the 30 1M letters even though they did not have to read them. Otherwise, the VA score is the number of letters read correctly at 1.0 meter plus the number, if any, read at 4M. If no letters are read correctly at either 4.0 meters or 1 meter, then the VA score is recorded as 0.

Testing for Count Fingers Vision, Hand Motion Vision and Light Perception/No Light Perception (NLP) Vision

If the patient’s VA is so poor that he/she cannot read any chart letters when tested at one meter then the patient’s ability to count fingers, detect hand motion, or have light perception should be evaluated.

Testing for Count Fingers Vision

In testing for count fingers vision, the examiner’s hand holding 1, 2, or 5 fingers is held steady at a distance of two feet directly in front of the eye being examined. The fellow eye is completely occluded with a patch on the face. A light should be shown directly on the hand from behind the patient. The examiner’s fingers should be presented in random order and repeated 5 times. Eccentric fixation, if present, should be encouraged. If the patient correctly identifies three of the five presentations, then count fingers vision is noted. If not, then the patient must be tested for hand motion vision.

Testing for Hand Motion Vision

The examiner’s hand with all fingers spread out should be extended two feet directly in front of the eye being examined. The fellow eye should be occluded with a patch on the patient’s face. A light should be shone directly on the examiner’s hand from behind the patient. The examiner’s hand should be moved in an up-and-down direction (vertically) or in a side-to-side direction (horizontally) at a constant speed of approximately one back and forth presentation per second. The patient is instructed that the examiner’s hand will be presented and they will have to respond to the question: “What am I doing with my hand?” This should be repeated five times. Three out of five correct responses indicate that hand motion vision is present. If the patient does not correctly identify three of five presentations, then you must test for light perception.

Testing for Light Perception/No Light Perception Vision

Light perception should be tested with an indirect ophthalmoscope in a darkened room. The fellow eye should be completely patched and also covered by the patient’s hand. The indirect

ophthalmoscope light should be in focus at 1 meter with the rheostat set at maximum voltage. From that distance the beam should be directed in and out of the patient's eye at least four times, and the patient should be asked to respond when he or she sees the light. If the examiner is convinced that the patient perceives the light, vision should be recorded as "light perception", if not, vision should be recorded as "no light perception".

4M Refraction Protocol Summary							
Refraction Distance	Check Sphere First		Check Cylinder Axis then Power			Sphere "Refinement"	
If VA on "R" chart is between:	Power (a)	Increment	Axis (b)	Power (c)	Increment	Power (d)	Increment
6/3 - 6/24	+1.50	+1.50	.25	.25	+1.25	+1.25	+1.25
20/10 - 20/80	-1.50	-1.50	JCC	JCC	-1.25	-1.25	-1.25
(4 meters)							
6/30 - 6/48	+1.00	+1.00	.50JC	.50	+1.50	+1.50	+1.50
20/100 - 20/160	-1.00	-1.00	C	JCC	-1.50	-1.50	-1.50
(4 meters)							
6/60 - 6/120	+2.00	+2.00	1.00	1.00	+1.00	+1.00	+1.00
20/200 - 20/400	-2.00	-2.00	JCC	JCC	-1.00	-1.00	-1.00
(1 meter)							
<6/120	+2.00	+2.00	No cylinder test required			No refinement required	
<20/400	-2.00	-2.00					
(1.0 meters) sequence refraction a-d							

31. APPENDIX 4: AREDS CLINICAL LENS OPACITY GRADING PROCEDURES

Despite the fact that the IRay device is designed to minimise lens exposure to radiation and the INTREPID study did not find that stereotactic radiotherapy caused cataract, it is possible that radiotherapy will produce lens opacity and clinically significant cataract. For this reason, the trial mandates regular assessment of lens opacity using a validated clinical system and standardized photographs. This study uses the ARED lens opacity grading procedure (2008). The standard photograph is provided on the next page. To grade the lens opacity, proceed as follows:

- Dilate pupils to at least 5 mm diameter
- Use slit lamp with ~10X magnification
- Use brightest beam intensity
- Nuclear opacity

Orient beam at 45° to viewing axis

Adjust slit beam to standard parameters: 8 mm height and 0.3 mm width

Compare opalescence of nucleus with that in standard photos

- Cortical and PSC opacities

Select wide slit beam setting optimum for retro-illumination of lens

Visualize lens opacities against red fundus reflex background

Count only opacities definitely visible against red reflex

Mentally combine all cortical opacities into one contiguous area

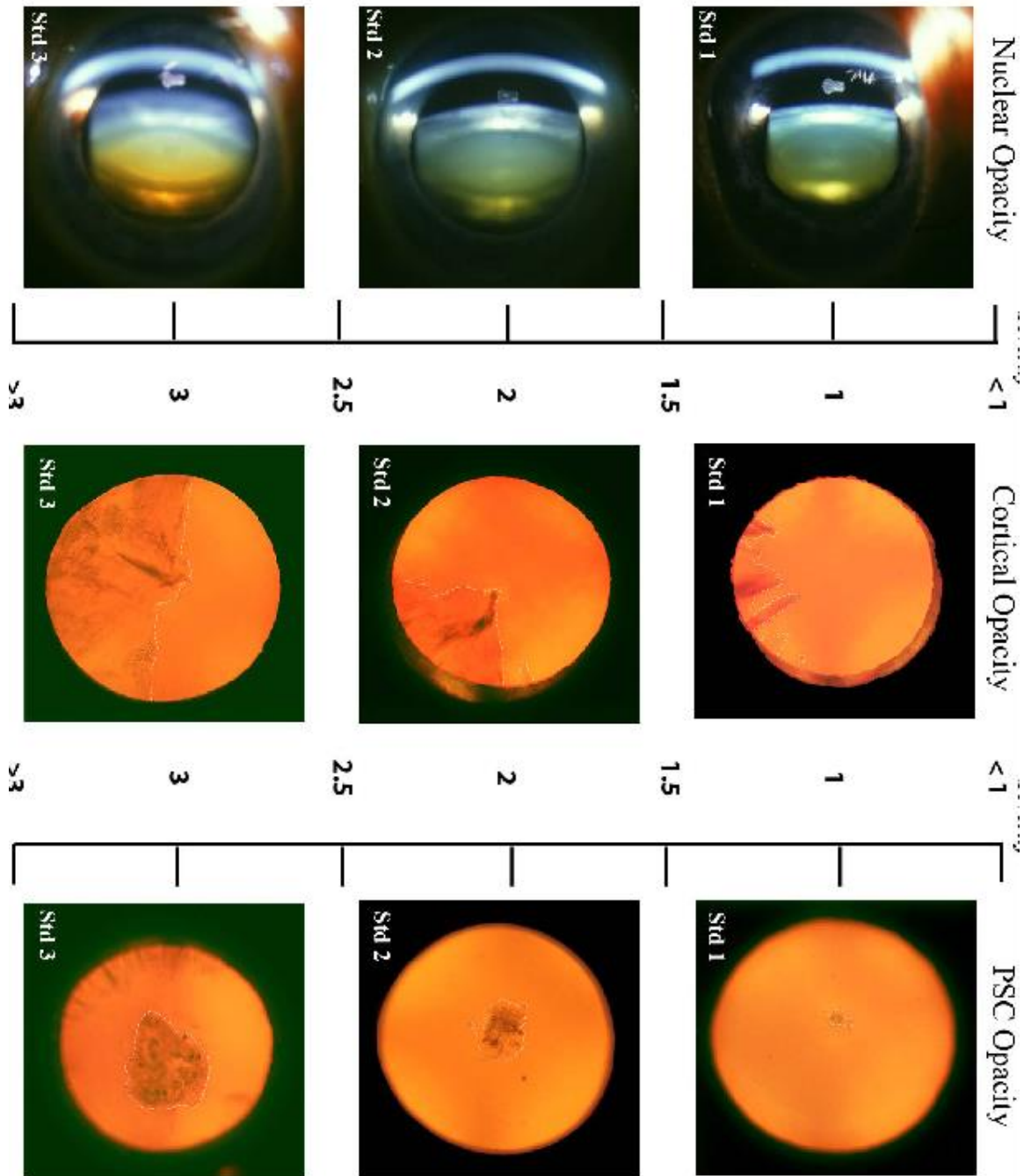
Compare total opacity area with that in standard photos

- Classify each opacity with scale defined by 3 standard photos
- Select nearest half-step which is

Similar to standard or between two standards

Obviously less than mildest standard or greater than most severe

AREDS 2008 Clinical Lens Opacity Standard Photographs



32. APPENDIX 5: DATA MONITORING AND ETHICS COMMITTEE CHARTER

1. INTRODUCTION

This charter was developed for the Data Monitoring and Ethics Committee (DMEC) for the clinical study, StereoTactic radiotherapy for wet Age-Related macular degeneration (STAR). The STAR trial is co-sponsored by King's College London and King's College Hospital (the Sponsor). This charter describes the roles and responsibilities of the DMEC. By accepting a position on the DMEC, members are indicating that they agree to the following terms of reference.

2. ROLES AND RESPONSIBILITIES OF THE DMEC

The primary role of the DMEC will be to ensure the safety of participants in the STAR trial. The STAR trial recruits patients with neovascular (wet) age-related macular degeneration (AMD). It investigates the safety and efficacy of stereotactic radiotherapy (SRT) delivered using a device developed by Carl Zeiss Meditec AG. Participants in the trial will also receive 'as required' (prn) anti-VEGF treatment with ranibizumab. Details of the trial are provided in the Protocol. All members of the DMEC agree to carefully read and consider the protocol in its entirety.

The DMEC will periodically evaluate safety data, and make consequent recommendations to the Trial Steering Committee (TSC). The TSC may accept, reject, or modify DMEC recommendations.

The Sponsor will ensure that all Adverse Events (AEs) and Serious Adverse Events (SAEs) are reported to the DMEC. The primary emphasis of the DMEC member's review of these events will be on safety, so as to inform the TSC of any specific safety concerns in a timely manner.

The recommendations of the DMEC to the TSC may include:

- Discontinuation of the study if it is concluded by majority vote that the study participants are exposed to an unacceptable risk.
- Permanently or temporarily halt enrollment into the study.
- Modification of the study protocol.
- Continue the study according to the protocol and any related amendments.

3. DMEC MEMBERSHIP

1. Members

The names and contact information for the DMEC members is provided by the Sponsor on the study website. A copy of each DMEC member's curriculum vitae will be collected at the outset of their involvement, and retained by the Sponsor. This may be provided to any regulatory agency that requires a copy. A DMEC member may not participate in the STAR trial as a principal or co-investigator, or as a personal physician to any study participant.

2. Confidentiality

All members will treat as confidential the reports, meetings, discussions, emails and minutes pertaining to the STAR trial.

3. Conflict of Interest Guidelines

A declaration of interests form will be provided by the Sponsor. Each DMEC member must disclose any financial interests which create a potential conflict with respect to their role on the DMEC. Members of the DMEC will not buy, sell, or hold stock or stock options in Carl Zeiss Meditec AG, or competing companies, until the trial is concluded and the final outcomes have been reported in the scientific literature. Each member agrees not to serve as a paid consultant to Carl Zeiss Meditec AG, or a competing company, for the duration of the study. This guideline also applies to the member's spouse and dependents. Members of the DMEC will be responsible for advising the DMEC Chair, the TSC, and Sponsor of any changes in relation to their financial interests, or any other matter that creates a potential conflict of interest. The Sponsor will collect and retain the declarations of interest and if any potential conflict of interest arises, the Sponsor will inform the TSC. The TSC will be responsible for deciding whether a financial or other interest impacts on a member's objectivity, and may require a member to resign from the DMEC. Members of the DMEC will not be paid for their role, but reasonable expenses will be reimbursed by the Sponsor.

4. Duration of DMEC Membership

The Chief Investigator, on behalf of the Sponsor, will propose members for the DMEC to the National Institute of Health Research (NIHR), who will approve or amend as appropriate. The DMEC membership will serve for the duration of the STAR trial, including long-term follow-up of participants. If a member cannot continue to serve on the DMEC, the reason must be indicated in writing to the DMEC Chair. If a member, including the Chair, leaves the DMEC, a replacement will be sought. If the TSC has concerns that a member of the DMEC is not fulfilling his or her role, they may, by majority vote, require that the member resigns.

4. DMEC MEETINGS

1. Initial Organizational Meeting

The initial meeting of the DMEC will be organizational in nature. The meeting will formally establish and thoroughly acquaint the DMEC members with the STAR trial protocol and other pertinent information. The meeting will allow DMEC members to provide input on future interactions between the DMEC, the Sponsor, and the TSC. Invited attendees will include the DMEC members, the Chief Investigator, Trial Statistician, and the Sponsor's representatives. The format of data reports will be agreed between the DMEC and the Trial Statistician.

2. Interim Analysis

The STAR trial administers SRT at baseline. Although the INTREPID study reported favourable safety data,⁴⁹ the main risk of SRT is likely to be radiation retinopathy, and that may not emerge in patients until the second or possibly subsequent years. For this reason the trial has extended follow up out to 4 years. Because radiation retinopathy has delayed onset the trial may be fully recruited by the time most cases emerge. Therefore, stopping the trial due to radiation retinopathy may only serve to reduce the chance of its detection. For this reason an interim safety analysis may not be as useful as it might be for trials with ongoing treatment. Nonetheless, the DMEC will be at liberty to request an interim analysis and if requested they will work with the Trial Statistician to determine the nature of the analysis.

3. Scheduled Meetings

Meetings may occur in-person or by teleconference. Meetings will occur approximately every six months in the first year, and then every six to 12 months thereafter. The frequency of scheduled meetings may change depending on participant enrollment and safety event rates. The Sponsor, TSC and the DMEC may each request an unscheduled DMEC teleconference or in-person meeting.

4. Quorum and Voting

A quorum of three DMEC members, including the Chair, is required to hold any meeting that requires voting, such as a recommendation to halt, suspend, and substantially alter the trial. A majority vote of members in attendance at the meeting passes a recommendation to the TSC or Sponsor. Non-quorate meetings may proceed if required, but minutes should be made as per quorate meetings and substantial recommendations may not be voted on.

5. Meeting Format

The meeting will begin with an open session to review the enrollment data and the status of the STAR trial. The Trial Statistician and the Chief Investigator (or their deputies), will be available to present the information and answer any questions from the DMEC.

A closed session will immediately follow the open session to discuss trial safety. In the event that efficacy data need to be reviewed in order to put risk/benefit in perspective, efficacy data may also be considered. This session will be attended by the DMEC members and the Trial Statistician who is unmasked to study treatment groups. The Trial Statistician and his or her team will be non-voting attendees of the closed DMEC sessions. Once the Trial Statistician has presented the data reports, the DMEC will usually request that he or she leaves the meeting prior to a private discussion and, if required, voting by DMEC members. Upon completion of the DMEC meeting, the Chair will convey the committee's recommendations to the Sponsor, Chief Investigator and TSC within 14 days.

5. COMMUNICATION

1. Data Reports and Trial Statistician

The Trial Statistician will be appointed by the Sponsor. The Trial Statistician will prepare reports for the DMEC meetings, at least seven days prior to each meeting. The format and content of these reports will be as requested by the DMEC, and will be agreed at the initial organizational meeting. The DMEC and Trial Statistician must ensure that masked data are not disclosed to the Sponsor, Investigators, Trial Manager and other members of the research team, prior to data lock. The Trial Statistician may however unmask a Data Manager and junior statistician, if they are required to assist with data handling. These members of the data management team must also ensure that they do not unmask data to other trial staff. Whilst the Trial Statistician may be required to present unmasked data to the DMEC, he or she will not have access to the closed reports prepared by the DMEC.

2. Protocol Amendments

The Sponsor will be responsible for informing the DMEC of all substantial amendments to the protocol. The DMEC are not required to approve amendments, but the DMEC may submit recommendations to the Sponsor and TSC.

3. Data Access

If the DMEC requests additional information concerning the study data, the DMEC Chair will contact the Trial Statistician who will provide the data. Only the DMEC will have access to the closed DMEC reports, until the study dataset is locked.

If the DMEC recommends stopping or suspending the trial, the TSC may request some or all of the data from the DMEC reports, and may seek independent statistical or other analysis prior to making a decision to stop or suspend the trial.

4. DMEC Minutes

The Chair of the DMEC will prepare, with administrative assistance from someone unaffiliated with the Sponsor, two sets of minutes following each meeting. The first set of minutes will cover the open session, and the second set of minutes will cover the closed session. The DMEC Chair will distribute the open minutes to all who attended the meeting, but the closed minutes will only be sent to DMEC members. The minutes will be circulated within 1 month of the meeting. The open and closed minutes will be approved at the subsequent meeting, in their respective sessions. The DMEC will forward the closed minutes to the Chief Investigator and Sponsor at the conclusion of the trial.

5. DMEC Recommendations

At each DMEC meeting, the DMEC will recommend whether the study should continue, stop, or be modified based on their findings. The DMEC will provide written recommendations about the trial to the TSC Chair, Chief Investigator and Sponsor within 14 days of the meeting. A shorter timeline may be required if there are urgent findings.

Upon receipt of the DMEC recommendations, the TSC will consider the DMEC recommendations, review the status of the trials, and determine a timely course of action. The TSC may identify expert individuals to review the DMEC Reports. These individuals will have the clinical, statistical, regulatory or other expertise needed to assist the TSC. The TSC may seek input from regulatory agencies and then make a decision to accept or disregard the recommendation of the DMEC. The Sponsor, Chief Investigator, TSC and DMEC will assure that confidentiality of the data, and DMEC recommendations, are maintained.

If the DMEC recommends stopping the trial and the TSC agrees by majority vote, then the Sponsor will inform all regulatory agencies of the decision and notify all investigational centers.

33. APPENDIX 6: TRIAL STEERING COMMITTEE TERMS OF REFERENCE

The following are the terms of reference for the Trial Steering Committee (TSC) of the STAR trial. By accepting a position on the TSC, members are indicating that they agree to the following terms of reference, and that they have read and considered the entire contents of the STAR protocol.

The role of the TSC is to provide general oversight of the trial.

1. Membership of TSC

TSC membership will include members of the trial team, and independent TSC members. Independent TSC members may not participate in the STAR trial other than as members of the TSC. Independent members should comprise a voting majority.

1.1. Confidentiality

TSC members will treat as confidential the reports, meetings, discussions, emails and minutes pertaining to the STAR trial.

1.2. Appointment to the TSC

The Chief Investigator, on behalf of the Sponsor, will propose members for the TSC to the National Institute of Health Research (NIHR), who will approve or amend as appropriate.

1.3. Conflict of Interest

Each TSC member must disclose any financial interests on a Declaration of Interests form provided by the Sponsor. This must record any potential conflict with respect to their role on the TSC. Members of the TSC will be responsible for advising the TSC Chair, and Sponsor, of any relevant changes in their financial interests, or any other matter that creates a potential conflict of interest, such as a family relationship with members of the trial executive. The TSC, Sponsor and NIHR will be jointly responsible for deciding whether a financial or other interest impacts on a member's objectivity, and may require a member to resign from the TSC. Members of the TSC will not be paid for their role, but reasonable expenses will be reimbursed by the Sponsor.

1.4. Duration of TSC Membership

The TSC membership will serve for the duration of the STAR trial, including long-term follow-up of participants. If a member leaves the TSC the NIHR, in discussion with the Sponsor, may appoint a replacement. If the TSC has concerns that a member of the committee is not fulfilling his or her role, they may, by majority vote, require that the

member resigns.

2. TSC Meetings

Meetings may occur in-person or by teleconference. Meetings will occur at the start of the trial and then approximately every six to 12 months. The frequency of scheduled meetings may change depending on participant enrolment and safety event rates. The Sponsor, NIHR, TSC or Data Monitoring and Ethics Committee (DMEC) may each request an unscheduled TSC teleconference or in-person meeting.

2.1 Quorum and Voting

A quorum consists of five TSC members, including the Chair. The TSC may hold non-quorate meetings, but a quorum is required for any meeting at which a vote will be taken. Once a quorum is established, a majority of those present is needed for a vote to pass.

For a meeting at which early termination or suspension of the study is under consideration, a quorum consists of at least eight members (more than half of whom are independent members) and the Chair and Chief Investigator (or their deputies) must be present. Once this quorum is established, a majority of those present is needed for a vote to pass to terminate or suspend the study.

2.2 Protocol Amendments

The Sponsor retains the right to make amendments as it sees fit, but protocol amendments, other than administrative amendments, will be presented to the TSC for its approval at the next scheduled TSC meeting. If a proposed amendment affects the safety of trial participants, or the overall integrity of the trial, then the Chief Investigator will seek approval of the TSC Chair before implementing change, unless urgent amendments are needed to safeguard patient safety. The Chair may request a special meeting of the TSC to review proposed amendment.

2.3 Data Access

The Chief Investigator or Trial Manager will provide the TSC with key study data during the course of the trial, such as recruitment figures, adverse events, and serious adverse events. The TSC will however remain masked with respect to treatment assignments and treatment outcomes, until the trial is formally unmasked.

2.4 Minutes

An independent scribe, provided by the Sponsor, will minute each meeting of the TSC. The minutes will be circulated by the Trial Manager or Chief Investigator within 6 weeks of the meeting. The minutes will be amended as necessary and approved at the next TSC meeting. The Sponsor will maintain a record of all minutes. If required, the TSC will

provide any reports requested by the Research Ethics Committee and, if applicable, the MHRA

3 Data Monitoring Committee Recommendations

At each DMEC meeting, the DMEC will recommend whether the study should continue, stop, be suspended, or be modified, based on their findings. The DMEC will provide written recommendations about the trial to the TSC Chair, Chief Investigator and Sponsor within six weeks of the meeting. A shorter timeline is required if there are urgent findings, including a DMEC recommendation to stop or suspend the trial.
















The recommendations of the DMEC to the TSC may include:

- Discontinuation of the study.
- Permanently or temporarily halt enrollment into the study.
- Modification of the study protocol.
- Continue the study according to the protocol and any related amendments.

Upon receipt of the DMEC recommendations, the TSC will consider the DMEC recommendations, review the status of the trials, and determine a course of action. The TSC may accept, reject, or modify DMEC recommendations. If the DMEC recommends discontinuation of the study or halting enrolment, the TSC Chair will convene an urgent meeting of the TSC.

The TSC may identify expert individuals to review the DMEC reports. These individuals will not have the clinical, statistical, regulatory or other expertise needed to assist the TSC. The Sponsor, Chief Investigator, TSC and DMEC will assure that confidentiality of the data, and DMEC recommendations, are maintained.

34. APPENDIX 7: DRY EYE GRADING

APPENDIX 6																							
DEWS	DRY EYE: DIAGNOSTIC TEST TEMPLATE																						
RAPPORTEUR	A.J.Bron	21st Oct 04																					
TEST	GRADING STAINING: Oxford Schema																						
TO DIAGNOSE	The scheme is used to estimate surface damage in dry eye.	REFERENCES																					
VERSION of TEST	[V 1]																						
DESCRIPTION	Surface damage to the exposed eye, assessed by staining, is graded against standard charts.																						
CONDUCT of TEST	<p>Grading Schema: Staining is represented by punctate dots on a series of panels (A-E). Staining ranges from 0-5 for each panel and 0-15 for the total exposed inter-palpebral conjunctiva and cornea. The dots are ordered on a log scale</p> <table border="1"> <thead> <tr> <th>PANEL</th><th>Grade</th><th>Criteria</th></tr> </thead> <tbody> <tr> <td>A </td><td>0</td><td>Equal to or less than panel A</td></tr> <tr> <td>B </td><td>I</td><td>Equal to or less than panel B, greater than A</td></tr> <tr> <td>C </td><td>II</td><td>Equal to or less than panel C, greater than B</td></tr> <tr> <td>D </td><td>III</td><td>Equal to or less than panel D, greater than C</td></tr> <tr> <td>E </td><td>IV</td><td>Equal to or less than panel E, greater than D</td></tr> <tr> <td>>E</td><td>V</td><td>Greater than panel E</td></tr> </tbody> </table> <p>Conduct of Test:</p> <ul style="list-style-type: none"> Dye is instilled. Slit-lamp is set (eg, 16 magnification with x1.0 oculars with Haag-Streit). Cornea: The upper eyelid is lifted slightly to grade the whole corneal surface, Conjunctiva: To grade the temporal zone, the subject looks nasally; to grade the nasal zone the subject looks temporally. (The upper and lower conjunctiva can also be graded). <p>Selection of dyes: A list dyes and filters can be found in the original paper. With fluorescein, staining must be graded as quickly as possible after instillation, since the dye then diffuses rapidly into the tissue and its high luminosity blurring the stain margin. Staining after rose bengal or lissamine green, persists at high contrast and may therefore be observed for a considerable period. This is convenient for both grading and photography.</p> <p>Fluorescein sodium 1. Quantified drop instillation eg 2 µl of 2% sterile fluorescein instilled into each conjunctival sac with a micro-pipette (using a sterile tip). In very dry eye, larger volumes risk the possibility of inadequate dilution into the fluorescent range.</p> <p>2. Unquantified instillation — impregnated paper strips This is a convenient approach in the clinic using the following method of application:</p> <ul style="list-style-type: none"> A single drop of unit dose saline is instilled onto a fluorescein-impregnated strip. When the drop has saturated the impregnated tip, the excess is shaken into a waste bin with a sharp flick. The right lower lid is then pulled down and the strip is tapped onto the lower tarsal conjunctiva. A similar procedure is carried out on the left. <p>If too large a volume is delivered then the concentration in the tear film will be too high, and the tear film and staining pattern will be non-fluorescent.</p>	PANEL	Grade	Criteria	A 	0	Equal to or less than panel A	B 	I	Equal to or less than panel B, greater than A	C 	II	Equal to or less than panel C, greater than B	D 	III	Equal to or less than panel D, greater than C	E 	IV	Equal to or less than panel E, greater than D	>E	V	Greater than panel E	Bron Evans Smith 2003
PANEL	Grade	Criteria																					
A 	0	Equal to or less than panel A																					
B 	I	Equal to or less than panel B, greater than A																					
C 	II	Equal to or less than panel C, greater than B																					
D 	III	Equal to or less than panel D, greater than C																					
E 	IV	Equal to or less than panel E, greater than D																					
>E	V	Greater than panel E																					

continued

APPENDIX 6 continued

	<p>3. Timing The fluorescein break-up time (FBUT) is usually performed prior to grading staining. Since fluorescein diffuses rapidly into tissues, punctate staining blurs after a short period. It is therefore essential to assess staining rapidly, in sequence, in the right and then the left eye, so that the staining patterns observed are equally crisp. If it is intended to photograph the staining pattern for grading, then photography should follow immediately after each instillation.</p> <p>Exciter and Barrier Filters The absorption peak of fluorescein sodium occurs between 465 - 490 nm and the emission peak between 520 - 530 nm. A suggested filter pair for detection of fluorescein staining is a yellow, Kodak Wratten 12 barrier filter (transmitting above 495 nm) or an orange Wratten 15 filter (transmitting above 510 nm) in combination with a blue Wratten 47 or 47A exciter filter. The 47A shows greater transmittance than the Wratten 47 over the absorption range. The 'cobalt' filter of many slit-lamps is suitable to use with a Wratten 12 or 15 barrier.</p> <p>Where more light is required for photographic purposes, narrow band-pass, interference filters can be used.</p> <p>The use of both exciter and barrier filters allows both the cornea and conjunctiva to be assessed using a single stain. This is a major advantage in clinical trials where it is otherwise customary to employ fluorescein to grade corneal staining and rose bengal or lissamine green to grade conjunctival staining.</p> <p>Disadvantages of Fluorescein Staining Blurred pattern if reading is delayed. Delay in photographing fluorescein staining results in blurred images of the staining pattern.</p> <p>Rose Bengal The intensity of rose bengal staining is dose dependent. If drop size or concentration is reduced to minimize stinging, the amount of staining is also reduced. Use of impregnated strips will give weaker staining than use of a full drop of 1% solution. Best results are achieved with, eg. 25 µl 1%, instilled into the conjunctival sac. Because rose bengal stings, instillation is best preceded by a topical anesthetic.</p> <p>Instillation Technique 1) eg. a drop of Proxymetacaine is instilled into the conjunctival sac followed, after recovery, by; 2) A drop of rose bengal 1.0%. This is instilled onto the upper bulbar conjunctiva with the upper lid retracted and the patient looking down. 3) Since both anaesthetic and drop may stimulate reflex tearing, the test should follow measurement of the FBUT and of the Schirmer test. (Conjunctival staining due to insertion of the Schirmer paper can usually be distinguished from that due to dry eye disease). Both eyes may be stained prior to grading, since there is no risk of the staining pattern in the first eye being obscured by the time the second eye is graded. The cited paper gives advice about avoidance of overspill.</p> <p>Visibility Rose bengal staining on the conjunctiva shows up well against the sclera and may be enhanced using a red-free (green) light source. Corneal staining may show up well against a blue iris, but is difficult to see against a dark brown iris.</p> <p>Phototoxicity Photo-activation of rose bengal by sunlight increases post-instillation symptoms, especially in severe dry eye with heavy staining. This post-instillation pain can be minimized by liberal irrigation with normal saline at the end of the test.</p> <p>Lissamine green stains the eye in a similar manner to rose bengal but is as well tolerated as fluorescein. Visibility and dose-dependency are the same as rose bengal and staining is persistent so that photography need not be performed immediately after instillation. Lissamine green is available as impregnated strips or may be ordered as a pre-prepared solution. A 25 µl 1% drop will give more intense staining. Because the drop is well tolerated, no anaesthetic is required.</p>	
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continued

35.APPENDIX 8: IRAY USER MANUAL

CARL ZEISS MEDITEC, INC.

**IRAY® RADIOTHERAPY SYSTEM, MODEL 5000
USER MANUAL**



Foreign patents pending.

©Copyright 2016, Carl Zeiss Meditec, Inc. All rights reserved. Oraya Therapy and I-Guide are trademarks and IRay System is a registered trademark of Carl Zeiss Meditec, Inc.

The IRay System is an investigational device and is not available for sale in the U.S.A.

0400-0102 Rev A 2016-06

36. APPENDIX 9: ASSESSMENT OF GREATEST LINEAR DIMENSION AND LESION DISTANCE FROM THE FOVEA

One of the key exclusion criteria is the lesion size and distance from the centre of the fovea to the furthest point on the lesion perimeter. This assessment is done for the study eye on the fluorescein angiogram, at screening.

The measurement relates to the area of active leakage on fluorescein angiography. The measurement should be taken on an early phase of angiography. The measurement includes active CNV leakage, pigment epithelial detachment and haemorrhage that is contiguous with the active leakage. Atrophy, inactive fibrosis, RPE tears and haemorrhages that are not related to the area of active leakage are not included in the measurement.

Two separate measurement must be performed:

- greatest linear dimension (GLD) - the maximum diameter of the area of active leakage defined as above; in order for the patient to be eligible for the study, this must not exceed 4 mm; the GLD must be recorded in the source documents.
- distance from the centre of the fovea to the furthest point on lesion perimeter (same lesion as above) - in order for the patient to be eligible for the study this must be less than 2 mm.

If the area of the lesion is uncertain on fluorescein angiography, OCT can be used to help determine the active leakage, but the final measurement must be taken on fluorescein angiography.

The greatest linear dimension is also measured and recorded in the source documents at month 12 and month 24 visits.

Signed:  Tim Jackson (Chief Investigator) 25 January 2019