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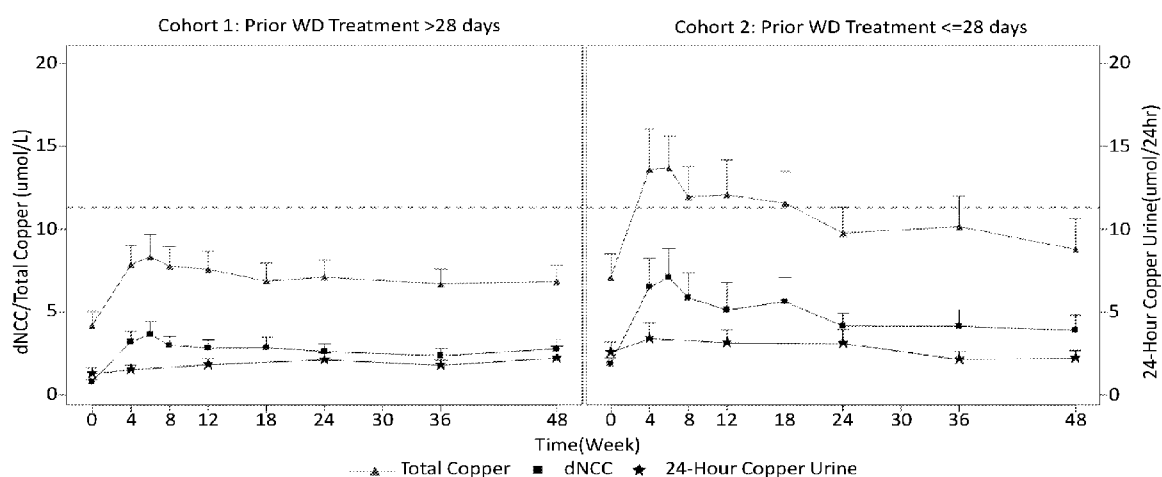


FIGURE 2

(57) Abstract: This disclosure relates to methods of treating a copper metabolism-associated disease or disorder, such as Wilson disease (WD). This disclosure also relates to methods of sequestering copper in a subject or of mobilizing copper into plasma in a subject.

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METHODS OF TREATING COPPER METABOLISM-ASSOCIATED DISEASES OR DISORDERS

CROSS-REFERENCE TO RELATED APPLICATIONS

[0001] This application claims the benefit of priority of U.S. Provisional Patent Applications No. 63/234,176, filed August 17, 2021, No. 63/235,098, filed August 19, 2021, No. 63/237,089, filed August 25, 2021, No. 63/237,120, filed August 25, 2021, No. 63/237,506, filed August 26, 2021, No. 63/270,421, filed October 21, 2021, No. 63/281,994, filed November 22, 2021, No. 63/290,599, filed December 16, 2021, No. 63/294,715, filed December 29, 2021, No. 63/322,155, filed March 21, 2022, No. 63/339,307, filed May 6, 2022, and No. 63/353,790, filed June 20, 2022, all of which are incorporated by reference in their entirety.

BACKGROUND OF THE DISCLOSURE

Field of the Disclosure

[0002] This disclosure relates to methods of treating a copper metabolism-associated disease or disorder, such as Wilson disease (WD). This disclosure also relates to methods of sequestering copper in a subject or of mobilizing copper into plasma in a subject.

Description of Related Art

[0003] Wilson disease (WD) is an autosomal recessive disorder of impaired copper transport. Mutations in the *ATP7B* gene result in deficient production of the copper-transporter ATPase2, leading to impaired incorporation of copper into ceruloplasmin (Cp), impaired biliary excretion of copper, increased exchangeable copper, and copper accumulation in liver, brain, and other tissues, with resulting organ damage and dysfunction. Ceruloplasmin is a serum ferroxidase, and in healthy humans, it contains greater than 95% of the copper found in plasma.

[0004] The prevalence of genetic markers associated with WD is approximately one per 30,000 population worldwide. Among people with an identified mutation, disease manifestation will be present in approximately 50%. The majority of patients are diagnosed before 30 years of age. A recent nationwide, population-based epidemiological study based in France found the diagnosed prevalence of WD to be 1.5 per 100,000 population.

[0005] Typical clinical presentation of WD is in adolescence to early adulthood. Genetic screening and genotype-phenotype correlation is complicated by a multitude (> 500) of associated *ATP7B* mutations; most individuals with WD are compound heterozygotes. Initial

signs and symptoms of WD are predominantly hepatic (~40%), neurologic (~40%), or psychiatric (~20%), but patients often develop combined hepatic and neuropsychiatric disease. Untreated or inadequately treated patients have progressive morbidity, and mortality is usually secondary to hepatic cirrhosis. Liver transplantation is the only effective therapy for WD-associated acute liver failure; other causes of death associated with WD include hepatic malignancy and neurologic deterioration with severe inanition.

[0006] The liver represents one of the main copper storage organs in humans. In healthy people, intracellular copper homeostasis is tightly regulated. Copper is transported into cells by copper transporter 1 (CTR1), and then transferred to copper chaperones such as the copper chaperones for antioxidant 1, cytochrome c oxidase, and superoxide dismutase. Copper accompanying the chaperone is delivered to a specific copper-requiring enzyme. If excess amounts of copper appear, the excess copper is bound to metallothionein (MT) as monovalent copper (Cu^+) via copper thiolate bridges by abundant cysteine residues in MT, thus leading to a detoxification of copper through a reduction of its redox potential.

[0007] In patients with WD, copper is not removed from the tissue compartments due to the deficient activity of ATPase2 due to its absence or reduced function. This results in an accumulation of copper, mainly in the liver where the protein is highly expressed in hepatocytes and then in the brain, but also in other organs. Within the capacity of MT biosynthesis, no apparent toxicity of copper exists because MT tightly binds copper. However, beyond the copper buffering capacity of MT, free copper ions appear and this excessive amount of free intracellular copper triggers pro-oxidant properties, leading to an increased risk of tissue/organ damages with clinical manifestations as a result. Historically, it has been assumed that the hepatic toxicity of copper in WD is mediated by copper that is not bound to ceruloplasmin or MT. Increased non-ceruloplasmin-bound copper (NCC) from the liver then enters the circulation in a form that is mostly bound to albumin, and is available for uptake into other organs where it may cause damage. Therefore, plasma NCC (NCC) concentration may serve as an important biomarker for tissue copper overload. However, achieving a normalized plasma NCC concentration does not necessarily reflect normalized tissue copper levels, particularly in organs with relatively slow copper exchange, such as the brain.

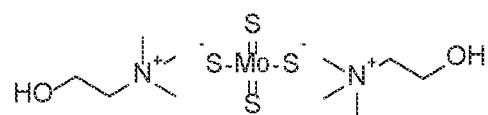
[0008] The optimal treatment goal of an effective therapy for WD has been to remove excessive copper from the tissues. The current treatments for WD are general chelator therapies D-penicillamine (Cuprimine, Depen) and trientine (Syprine), which non-specifically chelate copper and promote urinary copper excretion. In addition, zinc, which blocks dietary uptake of copper, is used mainly for maintenance treatment. Zinc impairs the absorption of copper by the induction of MT in the enterocytes of the gastrointestinal (GI) tract. As tissue

copper concentrations are not readily sampled, the adequacy of therapeutic copper control is currently monitored through periodic assessment of the 24-hour urinary copper excretion. The daily urinary copper excretion rate and plasma NCC concentration are both highly variable and neither is ideal for monitoring therapeutic copper control.

[0009] Disease control in patients with neurological symptoms at WD diagnosis is an area of particular concern. More than one-third of patients presenting with neurological symptoms show no improvement after 4 years of treatment with chelators. This failure to respond to chelation therapy with neurological presentation may reflect irreversible damage to the nervous system. Also, in a recent study, approximately 50% of patients had residual neurological symptoms despite years of therapy on a copper-modulating agent. Worsening of neurological symptoms on initiation of treatment has been reported in approximately 25% of patients initiated on penicillamine and trientine, and up to 50% of those patients never recover. The mechanism behind this worsening is believed to be a mobilization of copper from the liver leading to elevations in brain copper associated with neurological progression. This theory is supported by non-clinical data. Copper accumulation in the central nervous system is an evolutionary and long-term process. Excessive copper in the body as a whole (not just from the liver) may gradually accumulate in the central nervous system over time.

[0010] Currently available drugs have high rates of treatment discontinuation due to adverse events (AEs) and treatment failure. They also need to be dosed 2 to 5 times per day and must be taken in the fasted state. Their AE profiles and complicated dosing regimens lead to poor treatment compliance and high rates of treatment failure, a major concern in a disease that requires life-long treatment such as WD.

[0011] Bis-choline tetrathiomolybdate ("BC-TTM") (also known as ALXN1840, tiomolibdate choline, and tiomolibdic acid; formerly known as WTX101) is an investigational, oral, first-in-class copper-protein-binding molecule being developed for the treatment of WD. BC-TTM has the following structure:



[0012] BC-TTM improves control of Cu due to rapid and irreversible formation of Cu-tetrathiomolybdate-albumin tripartite complexes (TPCs) leading to rapid mobilization and sequestration of excess copper without releasing free Cu that could cause tissue toxicity including neurological deterioration. It is hoped that improved long-term compliance with BC-TTM treatment through improved tolerability and the convenience of a simplified once daily (QD) dosing regimen compared with current therapeutic options could be achieved.

[0013] Effective treatment of WD has been believed to involve establishing and maintaining net negative balance between dietary copper absorption and copper elimination. Monitoring the effectiveness of copper control relies on periodic measurement of biomarkers in blood and urine. While the “free” copper level can be a conceptual biomarker of disease burden in WD, copper present in blood and urine is believed to be chaperoned by carriers of varying affinity, including ceruloplasmin, metallothionein, albumin, transcuprein, and others. Copper control in patients with WD has been monitored through analysis of 24-hour copper excretion in urine. Stabilization or improvement of hepatic, neurologic and psychiatric manifestations is expected to follow copper control, and these factors contribute to the clinician’s interpretation of treatment response. In addition to monitoring of 24-hour urinary copper excretion, circulating copper in serum or plasma has been assessed through estimation of non-ceruloplasmin-bound copper (NCC), but such estimated (also referred to as calculated) NCC (cNCC) has limited value because it is an indirect estimate which may generate physiologically and numerically impossible negative NCC results.

[0014] Moreover, the results of recent studies with BC-TTM described herein suggest that effective treatment of WD can be achieved by mobilizing excess copper from tissues, sequestering it in the form of stable TPCs, and further blocking the absorption of additional copper, without necessarily the need for a net negative copper balance (or elimination of excess copper from the body). Without being bound by theory, it is believed that BC-TTM may achieve this effect in part by reducing excess Cu(II) ions to Cu(I) ions present in tissues or blood, and subsequently binding the Cu(I) ions to generate stable TPCs. BC-TTM having safely mobilized and sequestered the potentially toxic excess copper into stable TPCs, effective treatment of WD thus may be achieved in part by reducing the copper redox cycle, thereby reducing a potential toxic threat to tissues such as, as non-limiting examples, the liver and/or brain. Furthermore, the results of recent studies show that BC-TTM bolsters its sequestration effect by blocking the new absorption of additional copper into tissues, such as tissues of the liver and/or gastrointestinal tract.

[0015] Therefore, there remains a need for treatments of the underlying disease by mobilizing excess tissue copper, rapid formation copper-protein complexes with very high specificity for copper and blocking absorption of copper to reduce copper overload.

SUMMARY OF THE DISCLOSURE

[0016] The disclosure generally provides methods useful for treating a copper metabolism-associated disease or disorder, such as Wilson disease, in a subject.

[0017] One aspect of the disclosure provides a method for reducing copper concentration in tissues of a subject. Such method includes: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate.

[0018] The disclosure also provides a therapeutically effective amount of bis-choline tetrathiomolybdate for use in reducing copper concentration in tissues of a subject.

[0019] Another aspect of the disclosure provides a method for treating a copper metabolism-associated disease or disorder in a subject who is at least 12 years old. Such method includes: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate.

[0020] Another aspect of the disclosure provides a method for treating a copper metabolism-associated disease or disorder (such as Wilson Disease) in a subject. Such method includes:

- determining a concentration of total copper in plasma; and
- administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate.

[0021] Based on mechanism of action, BC-TTM forms stable TPCs (tetrathiomolybdate-albumin-copper tripartite complexes) with copper in the body, thereby sequestering and mobilizing excess copper for transportation and eventual elimination.

[0022] Thus, another aspect of the disclosure provides a method for sequestering copper in a subject who is at least 12 years old. Such method includes: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate. In certain embodiments, the bis-choline tetrathiomolybdate sequesters copper in the subject by at least about 3.3-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC and as compared to standard of care therapy. In certain embodiments, the subject is treatment-naïve or previously received standard of care therapy for ≤ 28 days, and the bis-choline tetrathiomolybdate sequesters copper in the subject by at least about 4.9-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC and as compared to standard of care therapy. In certain embodiments, the subject previously received standard of care therapy for > 28 days, and the bis-choline tetrathiomolybdate sequesters copper in the subject by at least about 2.9-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC and as compared to standard of care therapy.

[0023] Another aspect of the disclosure provides a method for mobilizing copper in a subject who is at least 12 years old. Such method includes: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate. In certain embodiments, the bis-choline tetrathiomolybdate mobilizes copper in the subject by at least about 3.3-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC and as compared to standard of care

therapy. In certain embodiments, the subject is treatment-naïve or previously received standard of care therapy for ≤ 28 days, and the bis-choline tetrathiomolybdate mobilizes copper in the subject by at least about 4.9-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC and as compared to standard of care therapy. In certain embodiments, the subject previously received standard of care therapy for > 28 days, and the bis-choline tetrathiomolybdate mobilizes copper in the subject by at least about 2.9-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC and as compared to standard of care therapy.

[0024] Another aspect of the disclosure provides a method for blocking absorption of copper in tissue of a subject who is at least 12 years old. Such method includes: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate, wherein the therapeutically effective amount of bis-choline tetrathiomolybdate is sufficient to block absorption of copper in tissue of the subject.

[0025] Another aspect of the disclosure provides a method treating a copper metabolism-associated disease or disorder in a subject who is at least 12 years old. Such method includes: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate for at least 48 weeks.

[0026] The disclosure also provides a therapeutically effective amount of bis-choline tetrathiomolybdate for use in treating a copper metabolism-associated disease or disorder in a subject who is at least 12 years old.

[0027] In certain embodiments of the methods or BC-TTM of the disclosure as described herein, the subject suffers from Wilson disease. In certain embodiments, the subject previously received no treatment for Wilson disease (i.e., a treatment-naïve subject). In certain embodiments, the subject has previously received a standard of care (SoC) treatment for Wilson disease. In certain embodiments of the methods or BC-TTM of the disclosure, the subject previously received no treatment for Wilson disease or the subject previously received a standard of care treatment for no more than 4 weeks for Wilson disease.

[0028] These and other features and advantages of the claimed invention will be more fully understood from the following detailed description taken together with the accompanying claims. It is noted that the scope of the claims is defined by the recitations therein and not by the specific discussion of features and advantages set forth in the present description.

BRIEF DESCRIPTION OF THE DRAWINGS

[0029] The accompanying drawings are included to provide a further understanding of the compositions and methods of the disclosure, and are incorporated in and constitute a part of

this specification. The drawings illustrate one or more embodiment(s) of the disclosure and, together with the description, serve to explain the principles and operation of the disclosure.

[0030] Figure 1A is a schematic representation of the study provided in the Example 1.

Abbreviation: SoC = standard of care.

[0031] Figure 1B is a schematic representation of the enrolment and study design of the study provided in the Example 1.

[0032] Figure 2 shows plasma total copper, directly measured non-ceruloplasmin-bound copper (dNCC) values and 24h-urine copper over time, by cohort in BC-TTM treated participants, mean and 95% CI (Full Analysis Set). Red dash line is the lower limit of the normal reference range for plasma total copper: 11.3 $\mu\text{mol/L}$.

[0033] Figure 3 shows plasma total copper, directly measured NCC and 24h-urine copper over time, by cohort in SoC treated participants, mean and 95% CI (Full Analysis Set). Red dash line is the lower limit of the normal reference range for plasma total copper: 11.3 $\mu\text{mol/L}$.

[0034] Figure 4 shows plasma total copper, directly measured NCC and 24h-urine copper over time, by cohort in zinc monotherapy treated participants, mean and 95% CI (Full Analysis Set). Red dash line is the lower limit of the normal reference range for plasma total copper: 11.3 $\mu\text{mol/L}$. No Cohort 2 participants were treated with zinc monotherapy.

[0035] Figure 5 shows plasma total copper, directly measured NCC and 24h-urine copper over time, by cohort in penicillamine (+/- zinc) treated participants, mean and 95% CI (Full Analysis Set). Red dash line is the lower limit of the normal reference range for plasma total copper: 11.3 $\mu\text{mol/L}$.

[0036] Figure 6 shows plasma total copper, directly measured NCC and 24h-urine copper over time, by cohort in trientine (+/- zinc) treated participants, mean and 95% CI (Full Analysis Set). Red dash line is the lower limit of the normal reference range for plasma total copper: 11.3 $\mu\text{mol/L}$.

[0037] Figure 7 shows boxplots of plasma CpC/Cp ratio by treatment (BC-TTM vs SoC) in Study 301.

[0038] Figure 8 shows box plots of the calculated daily mean $\text{AUC}_{(0-48 \text{ weeks})}$ values for plasma total and ultrafiltrate molybdenum by age group (adult vs adolescent) (PK Analysis Set).

[0039] Figure 9 shows box plots of calculated daily mean AUEC_(0-48 weeks) values for plasma total copper (PTC), dNCC, and LBC by age group (adult vs adolescent) (PD and Biomarker Analysis Set).

[0040] Figure 10 shows increase from baseline in directly measured NCC ($\mu\text{mol/L}$) in Plasma for each of 3 patients in Study 204.

[0041] Figure 11 shows increase from baseline in daily fecal copper excretion (mg) for each of 3 patients in Study 204.

[0042] Figure 12 shows decrease from baseline in average daily net copper balance (mg) for each of 3 patients in Study 204.

[0043] Figure 13 shows improvement in UWDRS Part II Score (range 0-40) least square means and standard errors over 5 years of BC-TTM from baseline (Pooling Full Analysis Set, Studies 301 and 201). X-axis legend: Red = Number of participants; Black = Weeks from BC-TTM treatment initiation.

[0044] Figure 14 shows improvement in UWDRS Part III Score (range 0-175) least square means and standard errors over 5 years of BC-TTM from baseline (Pooling Full Analysis Set, Studies 301 and 201). Note: X-axis legend: Red = Number of participants; Black = Weeks from BC-TTM treatment initiation.

[0045] Figure 15 shows improvement in UWDRS Part III functional subscale score (range 0-10) least square means and standard errors over 5 years of BC-TTM from baseline (Pooling Full Analysis Set, Studies 301 and 201). Note: X-axis legend: Red = Number of participants; Black = Weeks from BC-TTM treatment initiation.

[0046] Figure 16 shows ALT over time mean with 95% CI (Primary Evaluation Period - Safety Set).

[0047] Figure 17 shows GGT over time mean with 95% CI (Primary Evaluation Period - Safety Set).

[0048] Figure 18 shows total cholesterol over time: mean with 95% CI (Primary Evaluation Period - Safety Set). Note: Upper limit of normal: $5.17 \text{ mmol/L} = 200 \text{ mg/dL}$.

[0049] Figure 19 shows triglyceride over time: mean with 95% CI (Primary Evaluation Period - Safety Set). Note: Upper limit of normal: $1.69 \text{ mmol/L} = 150 \text{ mg/dL}$.

[0050] Figure 20 shows improvements in UWDRS Part II scores for most groups at week 24. ^aSymptomatic patients were those with UWDRS part II score > 0 at baseline; data for these subgroups are from a post-hoc analysis.

[0051] Figure 21 shows improvements in UWDRS Part III scores for most groups at week 24. ^aSymptomatic patients were those with UWDRS part III score > 0 at baseline; data for these subgroups are from a post-hoc analysis.

[0052] Figure 22 shows improvements in CGI-I scores with BC-TTM at week 48 versus SoC.

[0053] Figure 23 shows 24-hour urinary copper concentration ($\mu\text{mol/day}$, mean (SD)). P/T, penicillamine/trientine; Zn, zinc.

[0054] Figure 24 is a schematic representation of the study provided in Example 2.

[0055] Figure 25 shows reduction in hepatic ⁶⁴Cu uptake in a one-hour scan of a healthy subject treated with BC-TTM as provided in the study of Example 2.

[0056] Figure 26 shows the mean standard uptake value (SUV) ⁶⁴Cu in the liver. Legend: liver1 is a mean SUV after 1 hour pre-treatment; liver2 is a mean SUV after 15 hours pre-treatment; liver1t is a mean SUV after 1 hour post-treatment; liver2t is a mean SUV after 15 hours post-treatment; tetrathiomolybdate is BC-TTM.

[0057] Figure 27 is a schematic representation of the study provided in Example 3.

[0058] Figure 28 shows reduction in hepatic ⁶⁴Cu uptake of a subject treated with BC-TTM as provided in the study of Example 3.

[0059] Figure 29 shows reduction of hepatic copper uptake after treatment with BC-TTM in a gallbladder scan obtained 6 hours after intravenous administration of ⁶⁴Cu.

[0060] Figure 30 shows mean SUV for static PET-MR scans in four WD patients receiving BC-TTM for various organs.

[0061] Figure 31 shows the median percent of injected dose (ID) before and after treatment with BC-TTM for various organs.

[0062] Figure 32 shows the median percent of ID before and after treatment with BC-TTM in venous blood.

DETAILED DESCRIPTION OF THE DISCLOSURE

[0063] Before the disclosed processes and materials are described, it is to be understood that the aspects described herein are not limited to specific embodiments, and as such can, of course, vary. It is also to be understood that the terminology used herein is for the purpose of describing particular aspects only and, unless specifically defined herein, is not intended to be limiting.

[0064] In view of the present disclosure, the methods and compositions described herein can be configured by the person of ordinary skill in the art to meet the desired need. The present disclosure provides improvements in treating copper metabolism-associated diseases or disorders.

[0065] In certain embodiments of the methods or BC-TTM of the disclosure as described herein, the copper metabolism associated disease or disorder is Wilson disease.

[0066] In certain embodiments, the copper metabolism associated disease or disorder is copper toxicity (e.g., from high exposure to copper sulfate fungicides, ingesting drinking water high in copper, overuse of copper supplements, etc.). In certain embodiments, the copper metabolism associated disease or disorder is copper deficiency, Menkes disease, or aceruloplasminemia. In certain embodiments, the copper metabolism associated disease or disorder is at least one selected from academic underachievement, acne, attention-deficit/hyperactivity disorder, amyotrophic lateral sclerosis (ALS), atherosclerosis, autism, Alzheimer's disease, *Candida* overgrowth, chronic fatigue, cirrhosis, depression, elevated adrenaline activity, elevated cuproproteins, elevated norepinephrine activity, emotional meltdowns, fibromyalgia, frequent anger, geriatric-related impaired copper excretion, high anxiety, hair loss, hepatic disease, hyperactivity, hypothyroidism, intolerance to estrogen, intolerance to birth control pills, Kayser-Fleischer rings, learning disabilities, low dopamine activity, multiple sclerosis, neurological problems, oxidative stress, Parkinson's disease, poor concentration, poor focus, poor immune function, ringing in ears, allergies, sensitivity to food dyes, sensitivity to shellfish, skin metal intolerance, skin sensitivity, sleep problems, and white spots on fingernails.

[0067] As used herein, the terms "treatment" and "treating" mean (i) ameliorating the referenced disease state, condition, or disorder (or a symptom thereof), such as, for example, ameliorating a disease, condition or disorder in an individual who is experiencing or displaying the pathology or symptomatology of the disease, condition or disorder (*i.e.*, reversing or improving the pathology and/or symptomatology) such as decreasing the severity of disease or symptom thereof, or inhibiting the progression of disease; or (ii) eliciting the referenced biological effect.

[0068] As provided above, bis-choline tetrathiomolybdate (also known as ALXN1840, BC-TTM, tiomolibdate choline, tiomolibdic acid, and WTX101) is administered in the methods of the disclosure.

[0069] BC-TTM is a first-in-class, Cu-protein binding agent in development for the treatment of WD and has been described in detail in International Publication No. WO 2019/110619 (incorporated by reference herein in its entirety).

[0070] BC-TTM targets the following medical needs:

[0071] Rapid and sustained control of copper and clinical symptoms, with a low risk of neurological worsening – through the rapid formation of irreversible copper tetrathiomolybdate-protein complexes leading to a rapid copper mobilization and sequestration that could protect patients with WD from tissue toxicity including neurological deterioration. Results from previous studies support a proposed mechanism of action of BC-TTM whereby copper is mobilized to the bloodstream and sequestered through the formation of stable tripartite complexes (TPCs) comprising TTM, copper, and albumin.

[0072] A therapeutic option that is efficacious and well tolerated, and suitable for all naïve and pre-treated patients, including those with neurological symptoms who are at greatest risk of neurological deterioration during the initial phases of chelation therapy.

[0073] Improved compliance over long-term treatment through an improved tolerability and the convenience of a simplified dosing regimen (once daily [QD]) compared to current therapeutic options (multiple daily dosing in the fasted state).

[0074] BC-TTM has been evaluated in patients with WD in the Phase 2 Study 201 (registered with ClinicalTrials.gov, number NCT02273596; Weiss KH *et al.* Lancet Gastroenterol Hepatol. 2017 Dec;2(12):869-876, incorporated by reference in its entirety), which enrolled 28 patients with WD. Study 201 is described in Example 2 of U.S. Provisional Patent Application No. 63/339,307, filed May 6, 2022, and incorporated by reference herein. Final results from the main 24-week study showed that BC-TTM monotherapy reduced mean serum cNCC_{corrected} by 72% at Week 24 compared with baseline, a significant ($p < 0.0001$) reduction. The reduction in cNCC_{corrected} was sustained through Week 72 or longer. Initial increases in total plasma copper, exchangeable copper, and labile bound copper (LBC, mostly bound to albumin) were observed, followed by a gradual decline to baseline or even lower. These results suggest that BC-TTM mobilizes copper from tissues to blood, forming copper-albumin-tetrathiomolybdate complexes, thereby meeting the treatment goal of a therapy for WD that removes excessive copper from tissues such as the liver.

[0075] BC-TTM treatment also resulted in significant improvements in neurological status ($p < 0.0001$) and patient-reported disability ($p < 0.001$) measured as a change from baseline in Unified WD Rating Scale (UWDRS) Part III and Part II, respectively. In the Extension Period of Study 201, 48-week follow up data indicate maintained overall improvement in disability as shown by mean reduction in the UWDRS Part II score and maintained overall improvement in neurologic status as shown by mean reduction in UWDRS Part III.

[0076] In addition, liver status, as measured by the Modified Nazer Score, was stabilized or improved in the majority of patients. Treatment with BC-TTM was generally well-tolerated, with most reported AEs being mild (Grade 1) to moderate (Grade 2). The most frequently reported drug-related AEs were changes in hematological parameters, fatigue, sulphur eructations, and other gastrointestinal symptoms. Reversible liver function test elevations were observed in 39% of patients; these elevations were mild to moderate, asymptomatic, were associated with no notable increases in bilirubin, and normalized with dose reduction or treatment interruption. No paradoxical neurological worsening was observed upon treatment initiation with BC-TTM. All patients who completed the 24-week Study Period were enrolled in a 36-month Extension Period. Preliminary available follow-up data at 48 weeks from the ongoing 36-month Extension Period of the study were consistent with the 24-week Study Period results.

[0077] The main objective of effective WD treatment commonly has been to provide rapid copper control, i.e., mobilization and elimination of copper. The current goal of treatment for WD has been to establish and maintain negative or neutral whole-body copper balance. As such, current clinical recommendations suggest that copper control is essential for stabilization or improvement of hepatic, neurologic or psychiatric manifestations of WD. The concentration of circulating plasma total copper is expected to be low in WD due to decreased levels of Cp. In line with the efficacy assessments relied upon for approval of the copper chelators penicillamine and trientine, the measures of the primary endpoint for Study 201 and Study 203 (described in Example 3 of U.S. Provisional Patent Application No. 63/339,307, filed May 6, 2022, and incorporated by reference herein) were based on assessing the control of plasma exchangeable copper via $cNCC/NCC_{corrected}$ calculations.

[0078] As copper concentrations are consistently low at baseline in treatment-naïve patients with WD, it is difficult to justify using serial copper blood measures as an adequate monitoring tool for therapeutic efficacy. As plasma total copper concentrations are consistently low in WD, serial measurement of total copper has not previously been considered to be informative for monitoring treatment. However, the temporal patterns for both plasma total copper and molybdenum seen in Study 201 support the mobilizing and sequestering mechanism of action of BC-TTM. After the initial mobilizing and sequestering phase of approximately 24 weeks, participants with WD apparently entered a maintenance phase where tissue copper became less available and, thus, less TPC was formed, even though the BC-TTM dose was generally maintained. Overall, BC-TTM PK (plasma total molybdenum) and PD (plasma total copper) profiles changed coordinately and were highly correlated, with both PK and PD apparently dependent on formation of copper-albumin-TPC

complexes. These observations support the ability of BC-TTM to reduce copper overload in patients with WD.

[0079] Approximately half of newly-diagnosed patients with WD are younger than 18 years old. Standard treatments for WD are approved for use in children or adolescents, but significant unmet needs still exist with respect to efficacy, safety, and simplicity of dosing regimens. All currently available WD treatments are associated with adverse effects (such as neurological worsening) in a subset of patients, which can require adjustment, substitution, or even discontinuation of treatment. These adverse effects also reduce the patient's compliance with treatment, which by itself can lead to clinical deterioration and even death. All require multiple daily doses to achieve adequate copper control. The burden of multiple daily doses for standard treatments may negatively impact medical adherence and clinical outcomes, particularly among patients who discontinue treatment entirely. Once-daily dosing and the small tablet diameter of the 15 mg dose of BC-TTM (5 mm) may increase therapeutic adherence.

[0080] In patients with WD, the most commonly reported AEs associated with multiple BC-TTM dosing are reversible, dose-dependent, liver test elevations (transaminases) observed after treatment initiation with doses of 30 mg per day or higher. In the Phase 2 Study 201, reversible liver test elevations were observed in 39% of patients. These elevations were generally mild to moderate, asymptomatic and normalized with dose adjustments. No initial drug-induced neurological worsening was observed upon treatment initiation with BC-TTM. As tetrathiomolybdate is a copper modulating agent, there is the risk of producing copper deficiency with prolonged dosing with BC-TTM. Changes in hematological parameters (thrombocytopenia and leukopenia), attributed by the Investigators to overtreatment and resultant copper deficiency, have been observed. Multiple-dose WD studies, like Study 301, therefore, involve frequent monitoring for these potential adverse hematological and hepatic effects of BC-TTM.

[0081] Based on the efficacy results from Study 201 (lowering of free copper, stabilization or improvement of liver status and improvement in neurological symptoms) and the risk mitigation measures included in the protocol to account for the most common AEs reported in the study, BC-TTM is considered to have an acceptable benefit/risk in adults patients. The pathophysiology of copper overload does not differ substantially between adolescents and adults with WD, and the approved treatment options and therapeutic goal of copper control are also the same for adolescents and adults.

[0082] A therapeutically effective amount of BC-TTM has been previously established. For example, in certain embodiments, BC-TTM may be administered in the range of about 7.5 to

60 mg per day, such as 15 to 60 mg per day. In certain embodiments, BC-TTM is administered in an amount of about 15 mg every other day (or alternatively 7.5 mg daily). In certain embodiments, BC-TTM is administered in an amount of about 15 mg daily. In certain embodiments, BC-TTM is administered in an amount of about 30 mg daily (e.g., about 15 mg taken twice daily or two 15 mg tablets taken once daily). In certain embodiments, BC-TTM is administered in an amount of about 45 mg daily (e.g., about 15 mg taken three times daily or three 15 mg tablets taken once daily). In certain embodiments, BC-TTM is administered in an amount of about 60 mg daily (e.g., about 15 mg taken four times daily or four 15 mg tablets taken once daily).

[0083] In certain other embodiments, BC-TTM may be administered in the range of about 15 to 60 mg every other day. In certain embodiments, BC-TTM is administered in an amount of about 15 mg every other day. In certain embodiments, BC-TTM is administered in an amount of about 30 mg every other day. In certain embodiments, BC-TTM is administered in an amount of about 45 mg every other day. In certain embodiments, BC-TTM is administered in an amount of about 60 mg every other day.

[0084] In certain embodiments of the present disclosure increasing the therapeutically effective amount of BC-TTM during the treatment might provide additional benefits. Thus, in certain embodiments, the therapeutically effective amount of BC-TTM is increased after 6 weeks (*i.e.*, after 42 days) of treatment. For example, in certain embodiments, the initial therapeutically effective amount of BC-TTM (*i.e.*, days 1 to 42) is about 15 mg daily. The increased, subsequent therapeutically effective amount of BC-TTM (*i.e.*, after day 42, such as on day 43 and so on), in certain embodiments, is about 30 mg daily. In certain embodiments, the increased subsequent therapeutically effective amount of BC-TTM is about 45 mg daily. In certain embodiments, the increased subsequent therapeutically effective amount of BC-TTM is about 60 mg daily. For example, in certain other embodiments, the initial therapeutically effective amount of BC-TTM is about 30 mg daily. The increased, subsequent therapeutically effective amount of BC-TTM, in certain embodiments, is about 45 mg daily. In certain embodiments, the increased subsequent therapeutically effective amount of BC-TTM is about 60 mg daily. For example, in certain embodiments, the initial therapeutically effective amount of BC-TTM is about 15 mg every other day. The increased, subsequent therapeutically effective amount of BC-TTM, in certain embodiments, is about 15 mg daily.

[0085] In certain embodiments of the present disclosure decreasing the therapeutically effective amount of BC-TTM during the treatment might provide additional benefits. Thus, in certain embodiments, the therapeutically effective amount of BC-TTM is decreased after 6 weeks (*i.e.*, after 42 days) of treatment. For example, in certain embodiments, the initial

therapeutically effective amount of BC-TTM (*i.e.*, days 1 to 42) is about 60 mg daily. The decreased, subsequent therapeutically effective amount of BC-TTM (*i.e.*, after day 42, such as on day 43 and so on), in certain embodiments, is about 45 mg daily. In certain embodiments, the decreased subsequent therapeutically effective amount of BC-TTM is about 30 mg daily. In certain embodiments, the decreased subsequent therapeutically effective amount of BC-TTM is about 15 mg daily. For example, in certain other embodiments, the initial therapeutically effective amount of BC-TTM is about 30 mg daily. The decreased, subsequent therapeutically effective amount of BC-TTM, in certain embodiments, is about 15 mg daily. For example, in certain other embodiments, the initial therapeutically effective amount of BC-TTM is about 15 mg daily. The decreased, subsequent therapeutically effective amount of BC-TTM, in certain embodiments, is about 15 mg every other day.

[0086] As used herein, the terms “individual,” “patient,” or “subject” are used interchangeably, and refer to any animal, including mammals, and, in at least one embodiment, humans. In certain embodiments, the subject is a healthy subject. In certain embodiments, the subject suffers from WD. In certain embodiments of the methods or BC-TTM of the disclosure as described herein, the subject has cirrhosis. In certain other embodiments, the subject does not have cirrhosis.

[0087] The methods or BC-TTM of the disclosure are useful as a first line treatment. Thus, in certain embodiments of the methods or BC-TTM of the disclosure, the subject previously received no treatment for Wilson disease (*i.e.*, a treatment-naïve subject).

[0088] The methods or BC-TTM of the disclosure are also useful as a second line treatment and/or a first line maintenance treatment of WD. Thus, in certain embodiments of the methods or BC-TTM of the disclosure, the subject has previously received a standard of care (SoC) treatment for WD. For example, in certain embodiments, the subject has previously received trientine (also known as triethylenetetramine; *N*-[2-(2-aminoethylamino)ethyl]ethane-1,2-diamine). Trientine may be sold under name CUPRIOR® (GMP-Orphan United Kingdom Ltd), SYPRINE® (Aton Pharma, Inc.), or Cufence (Univar, Inc.). In certain other embodiments, the subject has previously received trientine and zinc. In certain embodiments, the subject has previously received D-penicillamine (also known as penicillamine; (2*S*)-2-amino-3-methyl-3-sulfanylbutoic acid). D-penicillamine may be sold under name CUPRIMINE® (Valeant Pharmaceuticals) or DEPEN® (Meda Pharmaceuticals). In certain other embodiments, the subject has previously received D-penicillamine and zinc. In certain embodiments, the subject has previously received zinc. In certain embodiments, the subject has previously received trientine, D-penicillamine, and/or zinc. In certain other embodiments, the subject has previously received trientine and/or D-penicillamine.

[0089] In certain embodiments of the methods or BC-TTM of the disclosure, the subject has received standard of care treatment for WD for no more than 4 weeks.

[0090] In certain embodiments of the methods or BC-TTM of the disclosure, the subject has received standard of care treatment for WD for at least 4 weeks. In certain embodiments, the standard of care treatment was at least 6 weeks, or at least 12 weeks, or at least 24 weeks, or at least 36 weeks, or at least 48 weeks, or at least 52 weeks long. In certain embodiments, the standard of care treatment was at least 41 months. In certain embodiments, the standard of care treatment was about 41 months to about 228 months. In certain embodiments, the standard of care treatment was at least 116 months. In certain embodiments, the standard of care treatment was at least 155 months.

[0091] The standard of care treatment need not be continuous. For example, the subject may receive the treatment on-and-off totaling at least 4 weeks (e.g., at least 6, or at least 12, or at least 24, or at least 36, or at least 48, or at least 50 or at least 52 weeks or at least 103 weeks, or at least 41 months, or about 41 months to about 228 months, or at least 116 months, or at least 155) of treatment. In certain embodiments, however, the standard of care treatment is continuous.

[0092] In certain embodiments of the methods or BC-TTM of the disclosure, the subject previously received no treatment or the subject previously received a standard of care treatment for no more than 4 weeks for the copper metabolism-associated disease or disorder, such as for Wilson disease.

[0093] In the methods or BC-TTM of the disclosure as described herein, the subject completed the standard of care treatment at least 2 weeks prior to administering bis-choline tetrathiomolybdate. In certain embodiments, the subject completed the standard of care treatment at least 3 weeks, at least 4 weeks, or at least 6 weeks prior to administering bis-choline tetrathiomolybdate.

[0094] In certain embodiments, when values are expressed as approximations, by use of the antecedent "about," it will be understood that the particular value forms one possible embodiment and variation of the given value is possible (e.g., about 80 may include $80 \pm 10\%$). It will be further understood that the endpoints of each of the ranges are significant both in relation to the other endpoint, and independently of the other endpoint.

[0095] As used herein, "total copper" refers to the sum of all copper species in blood (for example, in serum or plasma). Total copper includes both ceruloplasmin (Cp)-bound copper and all species of non-ceruloplasmin bound copper. In general, total copper may be directly measured with high sensitivity and specificity by mass-spectroscopy, such as inductively coupled plasma-mass spectrometry (ICP-MS).

[0096] The term “NCC” refers to the fraction of total copper that is not bound to ceruloplasmin (i.e., “non-ceruloplasmin-bound copper”). Under commonly used estimation methods, NCC is estimated using direct measurements of total copper and Cp in the blood (such as, e.g., serum or plasma) and the following formula:

$$\text{NCC } (\mu\text{M}) = \frac{\text{PTC } (\mu\text{g/L}) - (3.15 \times \text{ceruloplasmin } (\text{mg/L}))}{63.5 \text{ } (\mu\text{g}/\mu\text{mol})}$$

[0097] The term “cNCC” refers to NCC as calculated using this formula. The calculation is premised on an assumption that six copper atoms are always bound to a single Cp molecule, and that NCC and ceruloplasmin concentrations are directly correlated. In reality, Cp may show considerable heterogeneity in the number of copper atoms associated per Cp molecule. This formula assumes that six copper atoms bind per one Cp molecule, but the copper/Cp ratio varies with disease state. In fact, 6-8 copper atoms can actually bind to Cp, and in WD usually fewer than six copper atoms are associated per Cp molecule.

[0098] In subjects treated with BC-TTM, non-ceruloplasmin-bound copper includes the fraction of total copper that is bound to albumin, transcuprein, and other less abundant plasma proteins (collectively referred to as LBC) or in tetrathiomolybdate-Cu-albumin tripartite complexes (TPCs). The concentration of TPCs cannot be directly measured, but in certain embodiments, the concentration of TPCs may be estimated using molybdenum concentration as a surrogate.

[0099] The term “NCC_{corrected}” refers to the fraction of total copper that is not bound to ceruloplasmin or in a TPC (i.e., LBC) and which is calculated by subtracting a direct measure of molybdenum in the blood (such as, e.g., serum or plasma) from the estimated NCC (or cNCC). “NCC_{corrected}” is thus a correction of the cNCC value to account for the presence of molybdenum-copper-albumin tripartite complexes in the blood of BC-TTM-treated subjects.

[0100] The term “dNCC” refers to NCC as directly measured using an NCC assay. For example, in certain embodiments, dNCC is directly measured using the NCC assay as disclosed in PCT Patent Application Publication No. WO2021/050850, filed on September 11, 2020, herein incorporated by reference in its entirety.

[0101] The terms “LBC” or “labile-bound copper” refer to the fraction of total copper which is bound to albumin, transcuprein, and other less abundant plasma proteins. LBC thus comprises the fraction of total copper which is not bound to either ceruloplasmin or TPCs. In certain embodiments, the LBC fraction is directly measured using an LBC assay. For example, in certain embodiments, the LBC assay is as disclosed in PCT Patent Application Publication No. WO2021/050850, filed on September 11, 2020, herein incorporated by

reference in its entirety. In a biological sample in which no TPC is present, the NCC and the LBC fractions are the same.

[0102] The methods and uses of the disclosure are illustrated further by the following Examples, which are not to be construed as limiting the disclosure in scope or spirit to the specific procedures and compounds described therein.

Example 1:

Overall Design

[0103] Study 301 (registered with ClinicalTrials.gov, number NCT03403205) was conducted to assess the efficacy and safety of BC-TTM, a novel, first-in-class, copper-protein binding agent versus standard of care (SoC) in patients with Wilson disease (WD) who were 12 years of age or older, or 18 years and older. Currently available drugs have high rates of treatment discontinuation due to tolerability and efficacy issues. They also need to be dosed 2 to 4 times per day and must be taken in the fasted state. Their AE profiles and complicated dosing regimens lead to poor treatment compliance and high rates of treatment failure, a major concern in WD, which is a disease that requires life-long treatment.

[0104] Unlike currently available treatments for WD, BC-TTM is designed to provide an alternative copper-protein transport mechanism, and rapidly form copper-protein complexes with very high specificity for copper to quickly treat the underlying disease by mobilizing excess tissue copper.

Objectives	Endpoints
Primary	
To evaluate the efficacy of BC-TTM administered for 48 weeks, compared to standard of care (SoC), on copper control in WD patients aged 12 years and older	Daily mean area under the effect-time curve (AUEC) of directly measured non-ceruloplasmin-bound copper (dNCC) from baseline to 48 weeks
Secondary	
Establish the safety and tolerability of individualized dosing of BC-TTM	Incidence of - Adverse events/serious adverse events (AE/SAEs) from baseline through 48 weeks (Primary Period); also Extension Period: baseline through up to 60 months - Clinical laboratory test data - Neurological and physical examination findings 12-lead electrocardiogram (ECG) data - Vital signs
Evaluate the effects of BC-TTM on disability status	Change from baseline in the Unified Wilson disease Rating Scale (UWDRS) Part II total score through

	48 weeks (Primary Period); also Extension Period: baseline through up to 60 months
Evaluate the effects of BC-TTM on neurological status	Change from baseline in UWDRS Part III total score and individual item/subscales (arising from a chair, gait, handwriting, and speech) through 48 weeks (Primary Period); also Extension Period: baseline through up to 60 months
Evaluate the global effects of BC-TTM on global clinical symptoms	- Clinical Global Impression-Improvement Scale (CGI-I) through 48 weeks (Primary Period); also Extension Period: baseline through up to 60 months - Change from baseline in Clinical Global Impression-Severity Scale (CGI-S) through 48 weeks (Primary Period); also Extension Period: baseline through up to 60 months
Evaluate the efficacy of BC-TTM administered for 48 weeks, compared to SoC, on copper control in WD patients aged 12 years and older.	- Absolute change from baseline (Day 1) to 48 weeks in calculated NCC (cNCC) in plasma. - Percentage change from baseline in cNCC in plasma. For BC-TTM-treated patients, the cNCC in plasma will be corrected for the amount of copper bound to the BC-TTM tripartite complex (TPC) (cNCC_{corrected})
Evaluate the effects of BC-TTM on the cNCC responder rate	cNCC responder rate at baseline through 48 weeks (Primary Period); also Extension Period: baseline through up to 60 months
Explore other directly measured pharmacodynamics (PD) and biomarkers of BC-TTM	- Plasma total copper, plasma ultrafiltrate (PUF)-copper, dNCC, labile bound copper (LBC), ceruloplasmin (Cp), and ceruloplasmin-bound copper (CpC) concentration-time profiles in plasma - Daily mean AUEC of plasma dNCC (from 0 to 24 and 24 to 48 weeks) - Daily mean AUEC of LBC from 0 to 48 weeks - Daily mean AUEC of plasma total copper from 0 to 48 weeks - Absolute and percentage change from baseline (Day 1) to 48 weeks in dNCC - Absolute and percentage change from baseline (Day 1) to 48 weeks in LBC

• Explore BC-TTM effect on initial sequestering and decoppering phase compared to SoC based on directly measured pharmacokinetic (PK)/PD and biomarkers	• Time to first confirmed increase in plasma dNCC and total copper concentration • Time to minimum and maximum concentration of: ○ Plasma total copper ○ Plasma dNCC ○ Plasma LBC ○ Ratio plasma dNCC:total copper ○ Ratio plasma LBC:total copper ○ Urinary molybdenum ○ Ratio urinary molybdenum:copper ○ Ratio urinary molybdenum:dosed molybdenum ○ Plasma Cp ○ Plasma CpC ○ Ratio plasma Cp:total copper ○ Ratio plasma CpC:total copper ○ Ratio plasma CpC:Cp
• Explore BC-TTM effect on subsequent maintenance phase compared to SoC based on directly measured PK/PD and biomarkers	• Time for return to pre-dose baseline for the following measures: ○ Plasma total copper ○ Plasma dNCC ○ Plasma LBC ○ Ratio plasma dNCC: total copper ○ Ratio plasma LBC:total copper ○ Urinary molybdenum ○ Ratio urinary molybdenum:copper ○ Ratio urinary molybdenum:dosed molybdenum ○ Plasma Cp concentration ○ Plasma CpC concentration ○ Ratio plasma Cp:total copper ○ Ratio plasma CpC:total copper ○ Ratio plasma CpC:Cp
• Explore PK of BC-TTM	• Total molybdenum and PUF-molybdenum concentration-time profiles in plasma
• Evaluate the effects of BC-TTM on the LBC responder rate	• LBC responder rate at 48 weeks
• Explore the change in 24-hour urinary copper and urinary molybdenum	• Change from baseline to 48 weeks in 24-hour urinary copper and urinary molybdenum

Abbreviations: AE = adverse event; AESI = adverse event of special interest; AUEC = area under the effect-time curve; CGI-I = Clinical Global Impression-Improvement Scale; CGI-S = Clinical Global Impression-Severity Scale; Cp = ceruloplasmin; CpC = ceruloplasmin-bound copper; ECG = electrocardiogram; LBC = labile bound copper; (d)(c)NCC = (directly measured) (calculated) non-ceruloplasmin-bound copper; cNCC_{corrected} = calculated corrected NCC; PD = pharmacodynamics; PK = pharmacokinetics; PUF = plasma ultrafiltrate; SAE = serious adverse event; SoC = standard of care; TPC = tripartite complex; UWDRS = Unified Wilson Disease Rating Scale

[0105] Figure 1 provides a schematic view of the study design. This was a randomized, rater-blinded, multi-center study assessing the efficacy and safety of BC-TTM versus standard of care (SoC). This study is referred throughout as Study 301. In the Primary Evaluation Period, efficacy and safety was assessed for an individualized BC-TTM dosing regimen compared with SoC administered for 48 weeks in patients with WD who are aged 12 years and older, or 18 years and older.

[0106] Patients meeting all inclusion and no exclusion criteria were enrolled into the study and studied as outpatients. Eligible patients with WD were enrolled into 1 of 2 cohorts.

- Cohort 1: Patients who had received SoC therapy (i.e., chelation therapy with penicillamine or trientine, zinc therapy, or a combination of both chelation and zinc therapy) for > 28 days
- Cohort 2: Patients who were treatment-naïve or who had received SoC therapy for ≤ 28 days

All patients were enrolled by cohort in a 3:1 ratio and be randomized within cohort in a 2:1 ratio to treatment with BC-TTM or SoC (either as continued therapy in Cohort 1 or as continued or initial therapy in Cohort 2). Treatments were assigned randomly, stratified by cohort, utilizing an interactive voice/web response system (Figure 1B).

[0107] Patients who were randomized to receive BC-TTM were required to withhold treatment with SoC for ≥48 hours immediately prior to first study assessment on Day 1. Patients who were randomized to BC-TTM received BC-TTM as delayed-release tablets for oral administration at doses ranging from 15 mg every other day (QOD) to 60 mg QD. Efficacy and safety assessments were performed at scheduled visits, while AEs and concomitant medications were monitored continuously throughout the study. Patients randomized to SoC initiated treatment or continued treatment on their current regimen where possible, without compromising the safety of individual patients.

[0108] The Primary Evaluation Period consisted of an up to 28-day Screening Period, a 1-day Enrollment Visit, a 48-week Treatment Period, and a Follow-up Visit 4 weeks after the last dose for patients who do not elect to continue in the Extension Period.

[0109] Patients in Study 301 who completed the 48-week Treatment Period were offered the opportunity to participate in an up to 60-month Extension Period to evaluate the long-term safety and efficacy of BC-TTM.

[0110] Control of exchangeable copper is important for management of hepatic and neuropsychiatric manifestations in patients with WD. Results from related studies support a proposed mechanism of action of BC-TTM whereby copper is mobilized to the bloodstream

and sequestered through the formation of stable TPCs, with a low risk for neurologic worsening due to copper exchange from chelators with a lower affinity for copper. Study 301 is the first prospective, randomized study to compare tetrathiomolybdate with penicillamine, trientine or zinc in WD.

[0111] The primary endpoint integrated copper mobilization and sequestration (i.e., copper control) throughout the 48-week Primary Treatment Period by assessment of daily mean area under the effect-time curve (AUEC) of directly measured non-ceruloplasmin-bound copper (dNCC) concentration. AUEC characterizes and measures the cumulative effect of BC-TTM. Measurement of dNCC in plasma is highly sensitive and accurate, requiring no special formulas or assumptions. As proposed, dNCC AUEC_{0-48w} is an indirect measure of copper mobilization and sequestration. Results from a related study, 201, were strongly suggestive of rapid onset of TPC formation within hours following BC-TTM administration and potent mobilization of excess copper from tissue into plasma persisting through Week 12, which appeared nearly complete by Week 24. Over the course of 24-48 weeks of treatment with BC-TTM in Study 201, the plasma dNCC concentration continued to gradually decrease to baseline. The gradual, sustained reduction of plasma dNCC concentrations over time indicates that copper mobilized by BC-TTM is not simply redeposited back into the tissue, as both plasma concentrations of tetrathiomolybdate (from a daily weighted average dose of 30 mg BC-TTM administration) and circulating bodily albumin (the other 2 components of TPC) remained essentially constant and sufficiently available for TPC formation throughout the study. Thus, daily mean dNCC AUEC_{0-48w} is suitable as a quantitative measure of BC-TTM treatment effect in WD based on its mechanism of action.

[0112] Measurement of the AUEC for dNCC as the primary outcome measure overcomes many of the limitations of the estimated cNCC approach. Calculated estimates of NCC rely on separate measurements of plasma total copper and ceruloplasmin protein. The amount of copper within Cp is further estimated based on an assumed ratio of 6 copper atoms per molecule of Cp, which may be an overestimate in WD. Overestimation of ceruloplasmin-bound copper (CpC) results in approximately 20% of samples yielding physiologically impossible negative values for cNCC. In patients treated with BC-TTM, estimation of cNCC requires additional correction for the presence of copper in the TPC. TPC copper cannot be measured directly but must instead be estimated based on the plasma concentration of molybdenum.

[0113] For the primary evaluation of efficacy and safety, a treatment period of 1 year was chosen to allow sufficient time for evaluation of changes in biochemical measures of copper, as well as changes in liver function and neurologic disability and an adequate evaluation of safety and tolerability.

[0114] Following the Primary Evaluation Period, patients randomized to SoC during the Primary Evaluation Period switched to treatment with BC-TTM in the Extension Period, providing further evaluation of changes in copper, liver function and neurologic dysfunction. The Extension Period of up to 5 additional years will allow further evaluation of the long-term efficacy, safety, tolerability, and clinical outcomes in patients treated with BC-TTM.

[0115] The UWDRS scoring system was developed specifically for the motor and movement disorders associated with chronic copper neurotoxicity in WD. Some individual items/subscales of the UWDRS Part III (arising from a chair, gait, handwriting, and speech) in addition to the UWDRS Parts I, II, and III overall, were assessed to further define the range of burdensome signs and symptoms of WD, so as to further understand the assessment of treatment effects on patients with WD. The UWDRS scores for consciousness (Part I) and abnormal neurologic examination findings (Part III) will be determined by a trained neurologist rater who is blinded to study treatment randomization. These scores were used to provide a rigorous dataset for evaluating changes from baseline.

[0116] Inclusion of adolescents ≥ 12 years in this protocol is justified by the natural history of WD. In a large European cohort of 1357 patients, the average age at diagnosis of WD was 19.8 years, and half of all patients were diagnosed before the age of 18. Compared with adults, children and adolescents are more likely to present with hepatic symptoms rather than neuropsychiatric manifestations. The goal of treatment in adolescents is the same as in adults, namely prompt and effective removal of excess copper from tissues.

Drug Dosing

[0117] BC-TTM daily dosing intended for use in this study was based on the doses established as safe and effective in the previous WD studies performed with BC-TTM. Daily doses of 30 to 60 mg have been shown as effective in de-coppering newly diagnosed patients with WD or maintaining a normal copper level in patients with WD previously treated with SoC. In patients with WD treated with BC-TTM, asymptomatic elevation hepatic transaminases and/or gamma glutamyltransferase were seen in 39% of patients. Elevation of liver enzymes was dose-dependent and reversible with interruption or dose reduction of BC-TTM. Therefore, the dose of BC-TTM in the current study started at 15 mg daily and was limited to a maximum of 60 mg daily, the highest dose studied and considered to have a good safety profile in healthy volunteers. The intent was to individually titrate the dose of BC-TTM, as is done with the currently available chelators, to an appropriate dose based on cNCC levels adjusted for molybdenum plasma concentration, hematology values, and liver function tests. The dosing regimen for BC-TTM, therefore, included the following features: initial dosing QD as described below; and up titration design and individualized dosing as indicated by neurological and liver function testing.

[0118] In line with currently available WD treatments, the dose of BC-TTM was adjusted in individual patients, depending on clinical response and safety, as appropriate, based on protocol specified guidelines. A detailed dosing guide for BC-TTM dose modifications is outlined below and in Table 1.

[0119] To the extent possible, without compromising the safety of individual patients, the type and dose of SoC medication was not changed throughout the 48-week study period.

[0120] BC-TTM was supplied as white, round, delayed-release tablets for oral administration. Each tablet contained 15 mg of the bis-choline salt of tetrathiomolybdate, bis[2-hydroxyethyl) trimethyl-ammonium] tetrathiomolybdate, and the following excipients: tribasic calcium phosphate, sodium carbonate, sodium starch glycolate, and magnesium stearate. The tablets were coated with an inner pre-coat (Opadry 03K19229 clear) and outer enteric coat (Acryl-EZE white). Tablets were debossed on 1 side with a hexagon.

[0121] BC-TTM was supplied in treatment kits containing 28 tablets. The treatment kit consisted of thermoform blister strips mounted into a cardboard wallet.

[0122] BC-TTM was administered on Day 1. BC-TTM was administered orally at doses ranging from 15 mg QOD to 60 mg QD. BC-TTM was administered QD or QOD in the fasted state (1 hour before or 2 hours after meals).

[0123] Individualized BC-TTM dosing was utilized throughout the study based on the following parameters:

- Clinical criteria: dose-titration based on hepatic and neurological status;
- $NCC_{corrected}$: dose-titration instructed based on $cNCC$ levels adjusted for the amount of copper bound to the BC-TTM TPC;
- Safety monitoring: dose modification criteria were based on regularly scheduled assessments for recognized hematological effects of Cu lowering, hepatic testing, and neurological test.

[0124] In all patients, BC-TTM was administered at a 15 mg QD starting dose on Day 1 continuing for the first 4 weeks. After 4 weeks, up-titration to 30 mg QD could be performed at the discretion of the Investigator, if the disease was not adequately controlled, taking into account the patient's clinical status and free blood copper levels, as measured by $cNCC/cNCC_{corrected}$, and none of the Dose Modification Criteria apply. Further dose increases were possible at the discretion of the Investigator in 15 mg increments at least 4 weeks apart following the same aforementioned criteria. The dose should have been lowered or interrupted if any of the relevant Dose Modification Criteria were met.

[0125] When $\text{cNCC}_{\text{corrected}}$ levels have fallen to within the normal range ($< 2.3 \mu\text{mol/L}$), and/or the clinical status of the patient was stable or improved for 2 consecutive study visits, BC-TTM dosage may be maintained or reduced at the discretion of the Investigator. To avoid over-treatment, the dose may be reduced at any time, at the discretion of the Investigator, guided by the following: if the patient's clinical status indicates possible over-treatment and/or $\text{cNCC}/\text{cNCC}_{\text{corrected}}$ values were below the normal range. Specific criteria for dose modification of BC-TTM were detailed in Table 1.

[0126] To the extent possible, without compromising the safety of individual patients, the type of SoC medication should not be changed throughout the 48-week study period, unless required as part of the treatment (e.g., if a patient initiates SoC at the start of the study). Similarly, to the extent possible, without compromising the safety of individual patients, the dosing of the SoC medication should remain consistent throughout the 48-week study period, unless required as part of the treatment (e.g., titration of SoC initiated at the start of the study).

Table 1: BC-TTM Dose Modifications for Individual Patients

Test	Result	Conditions	Action With BC-TTM Dosing	Changes in Safety Monitoring ^a	Re-Challenge ^{b,c,d}
ALT	> 5 × ↑ from baseline	ALT above normal range at baseline	Temporary interruption	Contact patient within 48 hours to arrange repeat testing Weekly repeat testing	At 15 mg QOD when ALT < 2 × ↑ from baseline.
	> 5 × ULN	ALT within normal range at baseline	Temporary interruption	Contact patient within 48 hours to arrange repeat testing Weekly repeat testing	At 15 mg QOD when ALT < 2 × ULN.
	> 2 × ↑ from baseline	ALT above normal range at baseline	Reduce dose to previous dose level if up-titration has occurred or reduce dose to 15 mg QOD if on 15 mg QD. No further dose ↑ until resolution of abnormality.	Weekly repeat testing	Not applicable.
	> 2 × ULN	ALT within normal range at baseline	Reduce dose to previous dose level if up-titration has occurred or reduce dose to 15 mg QOD if on 15 mg QD. No further dose ↑ until resolution of abnormality.	Weekly repeat testing	Not applicable.
Hemoglobin	< 8 g/dL in the absence of bleeding	None	Temporary interruption	Weekly repeat testing	At 15 mg QOD when hemoglobin and other hematology parameters (neutrophils and platelets) were at baseline level.
	> 30% ↓ from baseline	None	Reduce dose to previous dose level if up-titration has occurred or reduce dose to 15 mg QOD if on 15 mg QD. No further dose ↑ until resolution of abnormality.	Weekly repeat testing	Not applicable.

Test	Result	Conditions	Action With BC-TTM Dosing	Changes in Safety Monitoring ^a	Re-Challenge ^{b,c,d}
Platelets	< 30,000 μL	None	Temporary interruption	Weekly repeat testing	At 15 mg QOD when platelets and other hematology parameters (neutrophils and hemoglobin) were at baseline level.
	> 30% ↓ from baseline	Platelets below normal range at baseline	Reduce dose to previous dose level if up-titration has occurred or reduce dose to 15 mg QOD if on 15 mg QD. No further dose ↑ until resolution of abnormality.	Weekly repeat testing	Not applicable.
Neutrophils	< $1.0 \times 10^3/\mu\text{L}$	None	Temporary interruption	Weekly repeat testing	At 15 mg QOD when neutrophils and other hematology parameters (hemoglobin and platelets) were at baseline level.
	> 30% ↓ from baseline	Neutrophils below normal range at baseline	Reduce dose to previous dose level if up-titration has occurred or reduce dose to 15 mg QOD if on 15 mg QD. No further dose ↑ until resolution of abnormality.	Weekly repeat testing	Not applicable.
Bilirubin	> 2 × ULN	Accompanied by ALT > 3 × ULN, indicative of liver injury.	Temporary interruption	Weekly repeat testing	At 15 mg QOD or less frequent, when bilirubin is below ULN. Re-challenge under these conditions requires approval of the Medical Monitor.

Test	Result	Conditions	Action With BC-TTM Dosing	Changes in Safety Monitoring ^a	Re-Challenge ^{b,c,d}
UWDRS-III and clinical neurological assessment	Increase in UWDRS-III score from baseline as follows, AND is deemed clinically significant by the Investigator: Baseline UWDRS-III score < 20: ≥ 4 point increase OR Baseline UWDRS-III score ≥ 20: ≥ 6 point increase		Investigator and Medical Monitor will evaluate the need for dose modification (interruption, increase or decrease) based on copper control parameters and relevant clinical data. Rationale for dosing decision must be documented in study record and re-evaluated at the next study visit.	Report neurologic adverse event of special interest and perform UWDRS exam part I, II and III. Re-evaluate neurologic status, including complete UWDRS examination, no later than next study visit, even if not planned per the SoA.	Discuss with the Medical Monitor.
Psychiatric assessment	Clinically significant signs of psychiatric worsening		Investigator and Medical Monitor will evaluate the need for dose modification (interruption, increase or decrease) based on copper control parameters and relevant clinical data. Rationale for dosing decision must be documented in study record and re-evaluated at the next study visit.	Re-evaluate psychiatric status no later than next study visit, even if not planned per the SoA.	Discuss with the Medical Monitor.

a. For changes in safety monitoring, weekly repeat testing for laboratory parameters can be completed by a home healthcare nurse if a routine study visit is not scheduled during this time period.

b. A maximum of 3 re-challenges will be allowed for BC-TTM.

c. For re-challenges, patients who were on 15 mg QOD should be re-challenged at the 15 mg QOD dose.

d. The Investigator, in consultation with the Medical Monitor, may change dose and dose frequency in patients who require re-challenge.

Abbreviations: ALT = alanine aminotransferase; QD = once daily; QOD = every other day; SoA = Schedule of Activities; ULN = upper limit of normal; UWDRS = Unified Wilson Disease Rating Scale.

[0127] All patients were treated with BC-TTM in the Extension Period. Patients who received BC-TTM in the Primary Evaluation Period of Study 301 continued to receive the same dose they received at last study visit in the Primary Evaluation Period; individualized dosing was subsequently managed as described herein. Patients who transitioned from SoC in the Extension Period were administered BC-TTM as described herein. Dose modification, if required, was made as described herein.

Efficacy Assessments

[0128] The Week 48 visit was the end of the Primary Evaluation Period and the beginning of the Extension Period (i.e., the Week 48 visit and the Extension Day 1 visit occurred on the same day). All assessments for the Week 48 visit were performed prior to dosing of BC-TTM. Dosing of BC-TTM on Extension Day 1 marked the beginning of the Extension Period. Patients who did not enter the Extension Period discontinued dosing at Week 48 and had a final study visit for safety follow up at Week 52.

[0129] **Assessment of Copper:** Measurements of plasma dNCC concentration were the primary assessment for the efficacy of BC-TTM treatment in WD. The AUEC for plasma dNCC concentration over time aims to quantify the dynamic tissue Cu mobilization and Cu sequestration effect of BC-TTM. This assessment is also applicable to SoC treatments. In addition, plasma Cp, CpC, plasma total copper, and LBC were measured with AUEC calculated for plasma total copper and LBC.

[0130] The LBC method measures exchangeable plasma copper that is not bound to either Cp or TPC.

[0131] **Unified Wilson Disease Rating Scale (Parts I, II, and III):** The UWDRS is a clinical rating scale designed to evaluate the neurological manifestations of WD that generally can be divided into 3 movement disorder syndromes: dystonic, ataxic, and Parkinsonian syndrome. The UWDRS comprises 3 parts: UWDRS Part I (level of consciousness, item 1), UWDRS Part II (a patient-reported review of daily activity items [disability], items 2 to 11), and UWDRS Part III (a detailed neurological examination, items 12 to 34).

[0132] The UWDRS Part I and Part III were assessed by a neurologist who is blinded to the treatment randomization, while UWDRS Part II may be reported to a non-blinded member of the study team by the patient, family member, or caregiver. The UWDRS has not been formally evaluated in adolescents. However, the components of Part I (level of consciousness), Part II (patient or caregiver-reported disability) and Part III (neurologic examination findings) were not fundamentally different between adults and adolescents. Patients aged 12 years and older were expected to be able to comply with UWDRS assessments.

[0133] Clinical Global Impression-Improvement Severity Scale and the Clinical Global Impression-Severity Improvement Scale: The Clinical Global Impression (CGI) rating scales were commonly used measures of symptom severity, treatment response, and the efficacy of treatments in treatment studies of adult and pediatric patients with mental disorders.

[0134] The Clinical Global Impression-Severity scale (CGI-S) is a 7-point scale that requires the clinician to rate the severity of the patient's illness at the time of assessment, relative to the clinician's past experience with patients who have the same diagnosis. Considering total clinical experience, a patient was assessed on severity of illness at the time of rating as: 1, normal, not at all ill; 2, borderline ill; 3, mildly ill; 4, moderately ill; 5, markedly ill; 6, severely ill; or 7, extremely ill.

[0135] The Clinical Global Impression-Improvement scale (CGI-I) is a 7-point scale that requires the clinician to assess how much the patient's illness has improved or worsened relative to a baseline state at the beginning of the intervention and rated as: 1, very much improved; 2, much improved; 3, minimally improved; 4, no change; 5, minimally worse; 6, much worse; or 7, very much worse.

Adverse Events and Serious Adverse Events

[0136] An AE is any untoward medical occurrence in a participant or clinical investigation participant administered a pharmaceutical product and which does not necessarily have to have a causal relationship with this treatment (ICH E2A).

[0137] A SAE is defined as any untoward medical occurrence that, at any dose: results in death; is life-threatening; requires inpatient hospitalization or prolongation of existing hospitalization; results in persistent disability/incapacity; is a congenital anomaly/birth defect; or other situations that result in, for example, invasive or malignant cancers, intensive treatment in an emergency room or at home for allergic bronchospasm, blood dyscrasias or convulsions that do not result in hospitalization, or development of drug dependency or drug abuse.

[0138] Adverse events were reported by the patient (or, when appropriate, by a caregiver, surrogate, or the patient's legally authorized representative). The Investigator and any qualified designees were responsible for detecting, documenting, and recording events that meet the definition of an AE or SAE and remain responsible for following up AEs that were serious, considered related to the study intervention or study procedures, or that caused the patient to discontinue the study.

[0139] **Adverse Events of Special Interest:** Any new neurological symptom or clinically significant worsening of an ongoing neurological symptom after initiation of study drug (BC-TTM or SoC) was designated to be an AESI, whether serious or non-serious.

[0140] If a patient has an AESI, in addition to assessments deemed clinically relevant by the Investigator, the following assessments should be performed to the extent possible to help assess the AE and patient status: UWDRS Part III, non-verbal Stroop Interference Test, Digit Span Test, and the CGI-I and CGI-S. The Investigator or Sub Investigator can perform additional assessments or laboratory testing at their discretion.

Pharmacokinetics, Pharmacodynamics, and Biomarkers

[0141] Pre-dose whole blood samples were collected at each designated visit for the measurement of the following BC-TTM PK, PD, and biomarker analysis:

[0142] **Pharmacokinetics:** Blood samples for PK analysis were collected to measure plasma total molybdenum and plasma ultrafiltrate (PUF) molybdenum.

[0143] **Pharmacodynamics:** Blood samples were collected to directly measure plasma total copper, PUF copper, dNCC, and LBC. Calculations may be performed for cNCC and cNCC_{corrected}, the latter of which is non-ceruloplasmin-bound and non-molybdenum-albumin-bound copper.

[0144] **Biomarkers and Biobank Samples:** Blood samples were collected to measure plasma Cp and CpC. Urine samples were collected for analysis of urine copper and molybdenum. Additional biomarker or biobank samples were collected for the analysis of molybdenum and/or copper species associated with treatment.

Statistical Considerations

[0145] A general description of the statistical methods used to analyze the efficacy and safety data is outlined below.

[0146] Statistical analyses were carried out using SAS®, Version 9.3 or later, SAS Institute, Cary, North Carolina, USA. Baseline for all assessments were defined as the last assessment yielding non-missing valid values taken prior to first dose of study drug (BC-TTM or SoC). Analysis Populations included:

[0147] The **Full Analysis Set** includes all randomized patients who received at least 1 dose of randomized treatment. Patients were analyzed as randomized.

[0148] The safety analysis was performed on the **Safety Analysis Set**. This dataset includes all patients who received at least 1 dose of randomized treatment. Patients were summarized according to the treatment actually received.

[0149] The **Per-Protocol Set** includes all patients who were randomized and had at least baseline and 48-week efficacy assessments for dNCC in the Primary Evaluation Period. Patients with major protocol deviations that were likely to impact the primary efficacy analysis were excluded from the Per-Protocol Set.

[0150] The **Extension Analysis Set** includes all patients who entered the Extension Period and received at least 1 dose of BC-TTM in the Extension Period.

Primary Efficacy Analysis

[0151] The primary estimand is the difference in daily mean dNCC AUEC from 0 to 48 weeks between BC-TTM and SoC in patients with WD, regardless of less-than-complete adherence or use of another medication that affects plasma dNCC, with no benefit derived from treatment after death.

[0152] The AUEC for dNCC concentration was calculated using the trapezoidal rule, and then divided by number of days to yield a mean daily AUEC plasma dNCC concentration from baseline to Week 48 (expressed as $\mu\text{mol/L}$ and described as AUEC_{0-48W}).

[0153] The AUEC_{0-48W} was compared between BC-TTM and SoC using an analysis of covariance (ANCOVA) statistical model; treatment arm, baseline plasma dNCC concentration, and cohort, will be included in the model. Tests were performed at a significance level of 0.05 (2-sided).

[0154] Model-based estimates of the difference between randomized treatments (BC-TTM – SoC) in AUEC_{0-48W}, along with a 2-sided 95% CI and p-value were provided. If the lower 2-sided 95% CI exceeds 0 μM , superiority was concluded.

[0155] **Cohort 1: Patients previously treated for > 28 days.** The supportive analysis of the primary endpoint within Cohort 1 mirrored that described for the overall population analysis except that the analysis removed Cohort 2 from the model.

[0156] **Cohort 2: Patients who were treatment-naïve or previously treated for $\leq$ 28 days.** The AUEC_{0-48W} was analyzed descriptively; there was no formal statistical comparison made between the randomized treatment arms. The AUEC_{0-48W} was estimated using the same model terms as described for the analysis of Cohort 1 patients.

Patient Population

[0157] Patients were eligible to be included in the study only if all of the following criteria applied:

1. Established diagnosis of WD by Leipzig-Score $\geq$ 4 documented by testing as outlined in the 2012 European Association for the Study of Liver WD Clinical Practice Guidelines.

2. 12 years of age or older at time of informed consent/assent (18 years or older in Germany).
3. Willing to withhold treatment with SoC for ≥ 48 hours immediately prior to first study assessment on Day 1.
4. Willing to avoid use of vitamins and/or minerals containing copper, zinc, or molybdenum throughout the study duration
5. Willing to avoid intake of foods and drinks with high contents of copper throughout the study duration.

[0158] Patients were excluded from the study if any of the following criteria applied:

1. Decompensated hepatic cirrhosis
2. MELD (Model for End-stage Liver Disease) score > 13
3. Modified Nazer score > 7
4. Clinically significant GI bleed within past 3 months
5. Alanine aminotransferase $> 2 \times$ upper limit of normal (ULN) for patients treated for > 28 days with WD therapy (Cohort 1)
6. Alanine aminotransferase $> 5 \times$ ULN for treatment-naïve patients or patients who have been treated for ≤ 28 days (Cohort 2)
7. Marked neurological disease requiring either nasogastric feeding or intensive inpatient medical care
8. Hemoglobin < 9 g/dL
9. Participation in a clinical study of an experimental or unapproved/unlicensed therapy during the screening period or within 4 weeks prior to informed consent
10. History of seizure activity within 6 months prior to informed consent
11. Pregnant (or women who were planning to become pregnant) or breastfeeding women
12. Known sensitivity to BC-TTM, BC-TTM excipients (anhydrous di-calcium phosphate, anhydrous sodium carbonate), or any of the ingredients contained in BC-TTM or related compounds
13. Active infection with hepatitis B virus (positive hepatitis B surface antigen) or C virus (patients with positive hepatitis C antibody result would require confirmation of active disease with a positive hepatitis C polymerase chain reaction test), or seropositivity for human immunodeficiency virus (HIV)
14. Previous treatment with tetrathiomolybdate
15. Any disease, disability, illness or abnormal laboratory values in the opinion of the Investigator, compromise patient safety or interfere with the collection or interpretation of study results

16. Patients with end-stage renal disease on dialysis (chronic kidney disease stage 5 [CKD 5]) or creatinine clearance < 30 mL/min.

[0159] Patients in the Primary Evaluation Period were randomized to either BC-TTM or SoC treatment, and enrolled into 1 of 2 cohorts as noted above. All patients in the Extension Period will receive treatment with BC-TTM.

[0160] Approximately 180 eligible patients with WD aged 12 years and older (18 years and older in Germany) were enrolled in this study. The assignment per Cohort and treatment is provided in Table 2.

Table 2. Patient assignment per Cohort and Treatment

		2:1 Ratio		
		BC-TTM	SoC	
				Total
3:1 Ratio	Cohort 1	90	45	135
	Cohort 2	30	15	45
	Total	120	60	180

[0161] Ultimately 214 patients enrolled; all had preserved liver function and 79% had neurological symptoms. Of the 214 patients, 207 were randomized: 137 to BC-TTM (with 104 to Cohort 1 and 33 to Cohort 2) and 70 to SoC (with 56 to Cohort 1 and 14 to Cohort 2). Overall patient demographics are provided in Tables 3-1 and 3-2, and the history of prior treatment for WD is provided in Table 4.

Table 3-1. Patient Demographics

Variable	Statistic	BC-TTM N = 137	SoC N = 70
Sex	% Male	59.9	52.9
Race	% White	78.1	75.7
BMI [§] (kg/m ²)	Mean (SD)	23.9 (4.75)	23.8 (4.27)
Age (years)	Mean (SD)	34.3 (13.67)	32.1 (13.37)
>=12 to <18 years	N (%)	12 (8.8)	6 (8.6)
>=18 to <65 years	N (%)	123 (89.8)	62 (88.6)
>=65 years	N (%)	2 (1.5)	2 (2.9)

[§] <18.5 is underweight, ≥18.5 to <25 is normal, ≥25.0 to <30 is overweight, ≥30.0 is obese

Table 3-2. Patient and Baseline Characteristics

Variable	Statistic	Cohort 1		Cohort 2	
		BC-TTM N = 104	SoC N = 56	BC-TTM N = 33	SoC N = 14
Sex	% Male	58 (55.8)	26 (46.4)	24 (72.7)	11 (78.6)
Race	% White	80 (76.9)	41 (73.2)	27 (81.8)	12 (85.7)
BMI [§] (kg/m ²)	Mean (SD)	23.7 (4.79)	23.6 (4.29)	24.7 (4.58)	24.8 (4.23)

Age (years)	Mean (SD)	36.2 (14.11)	33.7 (14.17)	28.5 (10.34)	26.0 (7.01)
≥12 to <18 years	N (%)	10 (9.6)	4 (7.1)	2 (6.1)	2 (14.3)
≥18 to <65 years	N (%)	92 (88.5)	50 (89.3)	31 (93.9)	12 (85.7)
≥65 years	N (%)	2 (1.9)	2 (3.6)	0	0
dNCC	Mean (SD)	0.799 (0.6432)	0.631 (0.4198)	1.885 (1.0432)	2.300 (2.1408)
UWDRS Part II score (0 to 40)	Mean (SD)	4.0 (8.0)	3.5 (6.5)	3.7 (6.6)	3.6 (6.9)
UWDRS Part III score (0 to 175)	Mean (SD)	16.0 (20.7)	12.8 (18.4)	15.1 (19.4)	6.5 (9.8)
CGI-S score (1 to 7)	Mean (SD)	2.9 (1.6)	2.4 (1.3)	3.1 (1.7)	2.7 (1.7)
MELD score (6 to 40)	Mean (SD)	8.4 (1.8)	8.4 (2.2)	8.9 (1.8)	8.0 (1.9)
Cirrhosis	%	34.6	46.4	30.3	28.6
Race					
Asian	%	18.3	23.2	15.2	0
Black or African American	%	1	3.6	0	0
White	%	76.9	73.2	81.8	85.7
Other	%	2.9	0	0	14.3
Unknown	%	0	0	3.0	0
Not Reported	%	1.0	1.0	1.0	1.0

§ <18.5 is underweight, ≥18.5 to <25 is normal, ≥25.0 to <30 is overweight, ≥30.0 is obese. At the neurological examination (UWDRS Part III), signs/symptoms were present in 79% of patients but scores were mild for most. Mean CGI-S scores indicate that patients were mildly ill. Compensated cirrhosis was reported for 28.6–46.4% of patients at baseline, and no patients with decompensated cirrhosis were included.

Table 4. Prior Treatments for WD

Variable	Cohort 1		Cohort 2	
	BC-TTM N = 104	SoC N = 56	BC-TTM N = 33	SoC N = 14
Cumulative Duration of Prior WD Treatment (months)				
N	104	56	17	5
Mean (SD)	155.5628 (147.31796)	144.7897 (149.95991)	0.6068 (0.24589)	0.6308 (0.31718)
Median (IQR)	116.1561 (185.9548)	100.4517 (193.4456)	0.6571 (0.3943)	0.7556 (0.2300)
Q1, Q3	41.6, 228	26.9, 220	0.427, 0.821	0.591, 0.821
Min, Max	2.201, 672.526	1.248, 624.789	0.066, 0.920	0.099, 0.887
Cumulative History of Prior WD Therapy (N (%))				
Zinc Monotherapy	15 (14.4)	9 (16.1)	7 (41.2)	1 (20.0)
Penicillamine or Trientine (± Zinc)	89 (85.6)	47 (83.9)	10 (58.8)	4 (80.0)
Penicillamine (± Zinc)	40 (38.5)	25 (44.6)	6 (35.3)	4 (80.0)
Trientine (± Zinc)	22 (21.2)	10 (17.9)	4 (23.5)	0

Variable	Cohort 1		Cohort 2	
	BC-TTM N = 104	SoC N = 56	BC-TTM N = 33	SoC N = 14
Penicillamine + Trientine (± Zinc)	27 (26.0)	12 (21.4)	0	0

[0162] Ultimately 184 patients completed the 48-week Treatment Period: 119 to BC-TTM (with 91 to Cohort 1 and 28 to Cohort 2) and 65 to SoC (with 52 to Cohort 1 and 13 to Cohort 2); and 178 patients entered the Extension Period: 117 to BC-TTM (with 89 to Cohort 1 and 28 to Cohort 2) and 61 to SoC (with 49 to Cohort 1 and 12 to Cohort 2).

[0163] The number of patients in the SoC group who received each treatment was as follows: Zinc monotherapy: Cohort 1, n = 23 (41%), Cohort 2, n = 0 (0%), Overall, n = 23 (33%); Penicillamine (± zinc): Cohort 1, n = 19 (39%), Cohort 2, n = 10 (71%), Overall, n = 29 (41%); Trientine (± zinc): Cohort 1, n = 14 (25%), Cohort 2, n = 4 (29%), Overall, n = 18 (26%).

Copper mobilization and sequestration

[0164] The primary objective of the study was to evaluate the efficacy of BC-TTM administered for 48 weeks, compared to standard of care (SoC), on copper control in WD patients aged 12 years and older (or 18 year and older in Germany). The results from the primary endpoint, daily mean AUEC_{0-48w} of dNCC, for the primary evaluation period are provided in Table 4. These results show superiority of BC-TTM over SoC in mobilizing copper as demonstrated by the primary efficacy endpoint, daily mean dNCC AUEC_{0-48 wks}; the value for BC-TTM is 3.18 (standard error [SE] = 0.167) and for SoC is 1.00 (SE = 0.219), with a p < 0.0001 for the difference.

Table 5. Mean Daily dNCC AUEC_{0-48w} (µmol/L) with multiple imputation; Full Analysis Set

Statistic ⁱ	Cohort 1		Cohort 2		Overall	
	BC-TTM N = 104	SoC N = 56	BC-TTM N = 33	SoC N = 14	BC-TTM N = 137	SoC N = 70
n	91	51	27	12	118	63
Mean (SD)	2.68 (2.118)	0.72 (0.643)	4.58 (2.526)	1.09 (0.484)	3.12 (2.347)	0.79 (0.629)
LSM ⁱⁱ (SE)	2.50 (0.150)	0.87 (0.204)	4.76 (0.319)	0.96 (0.487)	3.18 (0.167)	1.00 (0.219)
95% CI	(2.21, 2.79)	(0.46, 1.27)	(4.13, 5.38)	(0.01, 1.92)	(2.85, 3.51)	(0.58, 1.43)
LSM Diff (SE)	1.64 (0.254)		3.79 (0.584)		2.18 (0.244)	
95% CI	(1.14, 2.13)		(2.65, 4.94)		(1.70, 2.65)	

P-value		<0.0001		<0.0001		<0.0001	
Within Group	LSM (SE)	2.59 (0.165)	0.88 (0.221)	4.64 (0.315)	0.95 (0.472)	3.06 (0.179)	0.93 (0.226)
	95% CI	(2.27, 2.92)	(0.44, 1.32)	(4.00, 5.28)	(0.00, 1.91)	(2.70, 3.41)	(0.49, 1.38)
Between Group	LSM Diff (SE)	1.72 (0.277)		3.68 (0.568)		2.12 (0.253)	
	P-value	<0.0001		<0.0001		<0.0001	

- i. Data analyzed using an ANOCA model that included treatment, cohort, and baseline value. For cohort analysis, analysis was performed on each cohort using ANCOVA model, cohort term was removed from model. Analysis results were combined using Rubin's rules. Missing imputation was performed: 1) for intermediate missing, interpolation was used to fill out missing values. 2) For patients who died, baseline dNCC was carried forward from discontinuation to week 48. 3) For others, multiple imputation was used to impute missing dNCC values assuming data were missing not at random. Responses for both treatment groups were imputed with multiple imputation based on the response for SoC patients. Cohort, baseline, and previous visit value were included in the imputation model.
- ii. Least Squares Means (LSM) is a statistical method that determines the line of best fit for a dataset.

[0165] The study results show that BC-TTM is statistically superior to SoC for mobilizing copper from tissue (Figure 2). Overall, mean daily dNCC AUEC_{0-48W} (μmol) was 3.2-fold higher in patients treated with BC-TTM versus SoC. Overall results, and those in each cohort, were statistically significant ($P < 0.00001$). Mean values for patients treated with BC-TTM were 2.9-fold higher in treatment experienced (Cohort 1) and 4.9-fold higher in treatment inexperienced patients (Cohort 2). While more copper was mobilized in treatment inexperienced patients (Cohort 2) than in treatment experienced (Cohort 1), these results show that tissue-bound copper remains built-up in the tissue even in patients who have been on SoC therapy for many years, e.g., an average of ten or more years. As can be seen from the results in Table 4, duration of prior treatment does not meaningfully affect the magnitude of benefit even though the magnitude of effect differs between the cohorts. In contrast to SoC, BC-TTM has significant impact on mobilizing and safely sequestering copper from tissues.

[0166] BC-TTM mobilized copper even in Cohort 1 participants who had been on SoC therapy for a mean of more than 10 years. As shown in Table 5, the daily mean dNCC AUEC_{0-48 weeks} of SoC assessed at equivalent time points to BC-TTM is measurable but low (1.0 or less), regardless of prior treatment status.

[0167] The plot of plasma dNCC over time in participants treated with BC-TTM shows an immediate rise, peak at 4 to 6 weeks, and gradual return toward baseline by 48 weeks (Figure 2). Tissue copper mobilization is seen in both cohorts, even in Cohort 1 participants who had been treated with SoC for an average of 10 years. Further, Figure 2 also shows that the time until dNCC returns to baseline is greater (longer) for Cohort 2 compared with Cohort 1; this reflects greater mobilization of larger excess tissue copper stores among participants with little or no prior treatment.

[0168] For participants treated with SoC, the plots of plasma dNCC at equivalent time points (where available) were essentially flat (Figure 3, Figure 4, Figure 5, and Figure 6), indicating minimal change in the circulating non-ceruloplasmin bound copper. Figure 23 shows that 24-hour urinary copper was lower with BC-TTM than SoC chelator therapy. Overall, there was little change in the levels of either plasma total copper or of non-ceruloplasmin bound copper during SoC treatment. The superiority of BC-TTM over SoC in mobilizing copper from tissues has been demonstrated.

[0169] To evaluate whether tissue copper mobilization from BC-TTM treatment have any effect on the most important plasma copper carrier ceruloplasmin (Cp) and the number of copper atoms carried per molecule of ceruloplasmin (CpC), Table 6 summarizes plasma CpC/Cp ratios. An average of 3 to 4 copper molecules were bound per molecule of ceruloplasmin at pre-dose baseline. Data were also presented in Figure 7 for visual inspection. The average CpC/Cp values post-dose during the entire 48-week treatment period remained relatively stable for BC-TTM while slightly reduced for SoC. This implies that both BC-TTM and SoC have limited impact on the CpC/Cp ratio over 48 weeks of treatment. This observation is likely due to either the much higher binding affinity of ceruloplasmin to copper or limited, if any, BC-TTM and SoC impact on holoceruloplasmin formation by the liver.

Table 6: Summary of Plasma CpC/Cp Ratio by Treatment (BC-TTM vs Standard of Care) in Study 301 (PD and Biomarker Analysis Set)

	CpC/Cp Ratio			
Treatment	BC-TTM	BC-TTM	SoC	SoC
Period	Pre-dose	Post-dose to Week 48	Pre-dose	Post-dose to Week 48
N/n	N = 137	n = 1010	N = 70	n = 505
Mean	3.312	3.122	3.619	3.062
SD	2.987	1.563	3.290	1.686
CV%	1.109	1.998	1.100	1.816
Median	2.890	2.963	3.127	2.946

	CpC/Cp Ratio			
Treatment	BC-TTM	BC-TTM	SoC	SoC
Period	Pre-dose	Post-dose to Week 48	Pre-dose	Post-dose to Week 48
Minimum	0.806	0.297	1.377	0.695
Maximum	34.240	20.771	20.567	16.477

[0170] Preliminary population PK analysis including data from healthy participants (Studies 104, 106, 107, 108, and 109) and those with WD (Studies 201 and 301) has shown that age is not a significant covariate for plasma total molybdenum clearance. Elimination half-life was also similar across the age subgroups. Study 106 is a phase 1 study that assessed the pharmacokinetics (PK), pharmacodynamics (PD), biomarkers, and safety of BC-TTM in healthy Japanese and non-Japanese subjects, and is described in Example 1 of U.S. Provisional Patent Application No. 63/339,307, filed May 6, 2022, and incorporated by reference herein. Study 104 is registered with EudraCT under study number 2019-000516-28; Study 107 is registered with ClinicalTrials.gov, number NCT04560816; Study 108 is registered with ClinicalTrials.gov, number NCT04594252; and Study 109 is registered with ClinicalTrials.gov, number NCT04610580.

[0171] After 48 weeks of treatment with BC-TTM in Study 301, the calculated plasma total molybdenum $AUC_{(0-48 \text{ weeks})}$ (Table 7 and Figure 8) and values for plasma total copper, dNCC, and LBC $AUEC_{()}$ (Table 8 and Figure 9) have shown comparable central values for adults and adolescents.

Table 7: Summary of Calculated $AUC_{(0-48 \text{ weeks})}$ Values for Plasma Total and Ultrafiltrate Molybdenum by Age Group (Adult vs Adolescent; Study 301) (PK Analysis Set)

	Daily Mean $AUC_{(0-48 \text{ weeks})}$ (mmol/L)			
Matrix	Total Mo	Total Mo	PUF Mo	PUF Mo
Age Group	Adolescent	Adult	Adolescent	Adult
N*	12	106	10	105
Mean	1.4	1.9	0.1	0.1
SD	0.6	1.2	0.2	0.09
CV%	44.4	61.3	151.6	80.5
Median	1.3	1.7	0.05	0.09
Minimum	0.7	0.3	0.04	0.02
Maximum	2.7	6.4	0.6	0.8

Table 8: Summary of Calculated AUEC_(0-48 weeks) Values for Plasma Total Copper, dNCC, and LBC by Age Group (Adult vs Adolescent; Study 301) (PD and Biomarker Analysis Set)

AUEC _(0-48 week) (mmol/L)	dNCC	dNCC	LBC	LBC	PTC	PTC
Age Group	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult
N*	12	106	12	106	12	108
Mean	2.7	3.2	1.5	1.8	7.5	7.8
SD	1.5	2.4	0.7	1.3	4.7	4.7
CV%	56.2	76.7	44.4	69.8	63.1	59.5
Median	2.3	2.2	1.2	1.2	5.4	7.3
Minimum	1.5	0.6	0.8	0.3	2.6	1.6
Maximum	6.9	10.7	2.7	6.3	17.1	18.9

[0172] Study 204 is an exploratory study with aim to investigate the effects of BC-TTM on Cu balance in participants with WD. Study 204 is registered with ClinicalTrials.gov, number NCT04573309, and is described in Example 1 of U.S. Provisional Patent Application No. 63/237,120, filed August 25, 2021, and incorporated by reference herein. Study 204 specifically evaluates the effects of the 15 mg and 30 mg doses BC-TTM as well as the duration of treatment on Cu balance. The participants remained on a Cu-controlled diet, and Cu and Mo balance were measured on all intake (i.e., investigational agent, food and fluids) and all output (urine and feces). The Cu and Mo concentration of each sample was determined by inductively coupled plasma mass spectrometry (ICP-MS). Copper and Mo content of all intake and output was calculated based on the volume or weight of intake and output and the concentration of representative samples.

[0173] Collection periods for feces and urine varied in duration from 3 to 15 days to support assessment of both Cu and Mo balance before and at steady state for both 15 mg and 30 mg. Equilibration periods on Cu/Mo-controlled diets were a minimum of 48 hours. Copper balance was calculated as the mean daily Cu balance over each of the 4 collection periods. The interpretation of Cu balance was based on the criteria previously established when undertaking Cu balance studies with zinc treatment. For assessment of BC-TTM effect on Cu balance, the time period for analysis took into consideration the average bowel transit of approximately 40 hours (male: 33 hours; female: 47 hours).

[0174] The interim results of Study 204 showed a net increase in daily fecal copper output after exposure of participants with WD to BC-TTM. Results are available for the initial 3 participants enrolled in this open-label copper balance/molybdenum mass balance study. These participants had all intake (food and drink) and output (urine and feces) collected from

Day -4 through Day -1 (baseline), from Day 1 through Day 8, and Day 25 through Day 39. They were to be dosed with BC-TTM at 15 mg/day for 28 days (Period 1), then at 30 mg/day for 11 days (Period 2); however, only 1 participant was able to escalate to the higher dose while the other 2 reduced the dose to 15 mg QOD due to alanine aminotransferase (ALT) elevations.

[0175] The patient information of Study 204 is provided in Table 9. The results from the primary endpoint of Study 204, mean daily Cu balance, are provided in Table 10. As noted above, mean daily Cu balance is measured by the calculated difference between Cu intake (in food and drink) and Cu output (in feces and urine) during BC-TTM accumulation and steady-state periods for each dose.

Table 9. Study 204 Patient Demographics, Baseline Characteristics and Prior Treatments for WD

Variable	Statistic/Category	Value
Age (in years)	Mean (SD)	31.7 (7.23)
Sex	Female, n (%)	1 (33.3)
Race	White, n (%)	3 (100)
BMI [§] (kg/m ²)	Mean (SD)	31.20 (7.363)
Time Since WD Diagnosis (months)	Mean (SD)	89.21 (69.802)
Cirrhosis	Yes, n (%)	1 (33.3)
Cumulative Duration of Prior WD Treatment (months)	Mean (SD)	76.9 (81.59)
Prior WD Therapy:		
Zinc Monotherapy		1 (33.3)
Penicillamine or Trientine (± Zinc)		2 (66.7)
Penicillamine (± Zinc)		1 (33.3)
Penicillamine + Trientine (± Zinc)		1 (33.3)

[§] <18.5 is underweight, ≥18.5 to <25 is normal, ≥25.0 to <30 is overweight, ≥30.0 is obese

Table 10. Daily Net Copper Balance

Daily Net Copper Balance (mg)	Total (N=3)	
	Value	Change from Baseline
Baseline		
N	3	
Mean (SD)	1.2503 (0.33263)	
Median (IQR)	1.2893 (0.6618)	
Q1, Q3	0.8999, 1.5617	
Min, Max	0.900, 1.562	
95% CI	(0.4240, 2.0766)	
Days 1-8 (Accumulation 15 mg/day)		
N	3	3
Mean (SD)	0.7654 (0.35380)	-0.4848 (0.11902)
Median (IQR)	0.6678 (0.6871)	-0.4291 (0.2176)
Q1, Q3	0.4707, 1.1578	-0.6215, -0.4039
Min, Max	0.471, 1.158	-0.621, -0.404
95% CI	(-0.1135, 1.6443)	(-0.7805, -0.1892)
Days 25-28 (Steady State 15 mg/day)		
N	3	3
Mean (SD)	0.7638 (0.91381)	-0.4865 (0.59933)
Median (IQR)	1.1434 (1.7052)	-0.1459 (1.0434)
Q1, Q3	-0.2787, 1.4266	-1.1785, -0.1351
Min, Max	-0.279, 1.427	-1.179, -0.135
95% CI	(-1.5063, 3.0338)	(-1.9753, 1.0023)
Days 31-35 (Accumulation 30 mg/day)		
N	3	3
Mean (SD)	0.8577 (0.34265)	-0.3925 (0.05781)
Median (IQR)	0.8312 (0.6838)	-0.3707 (0.1093)
Q1, Q3	0.5291, 1.2129	-0.4581, -0.3488
Min, Max	0.529, 1.213	-0.458, -0.349
95% CI	(0.0065, 1.7089)	(-0.5362, -0.2489)
Days 36-39 (Steady State 30 mg/day)		
N	3	3
Mean (SD)	0.8582 (0.25646)	-0.3921 (0.11676)
Median (IQR)	0.7986 (0.5024)	-0.4225 (0.2275)
Q1, Q3	0.6367, 1.1391	-0.4906, -0.2632
Min, Max	0.637, 1.139	-0.491, -0.263
95% CI	(0.2211, 1.4952)	(-0.6822, -0.1021)

[0176] Based on interim results from the 3 participants with WD in Study 204, copper mobilization consequent to treatment with 15 mg/day (or every other day) or 30 mg/day for a total duration of 39 days was significant compared with pre-dose baseline. Consistent results among the 3 participants completing the study to date indicate that BC-TTM produces rapid and sustained mobilization of copper from tissues into blood where copper is safely sequestered in the tripartite complex. This is evidenced by the rapid and sustained increase from baseline in dNCC displayed in Table 11 and Figure 10, and the increase from baseline in fecal copper excretion displayed in Table 12 and Figure 11.

Table 11: BC-TTM Mobilization of Copper from Tissue to Blood: Increase from Baseline in Directly Measured NCC ($\mu\text{mol/L}$) (Full Analysis Set)

Study Treatment Day	Time	N	Mean (SD)	95% CI
Day 1	2 Hours Post-Dose	3	0.50042 (0.710475)	(-1.26449, 2.26534)
	4 Hours Post-Dose	3	1.96026 (1.803672)	(-2.52031, 6.44083)
	5 Hours Post-Dose	3	2.71929 (2.533892)	(-3.57525, 9.01383)
	6 Hours Post-Dose	3	2.32430 (2.086336)	(-2.85844, 7.50705)
	8 Hours Post-Dose	3	2.40193 (2.182723)	(-3.02025, 7.82412)
	12 Hours Post-Dose	3	1.72473 (1.575050)	(-2.18791, 5.63738)
	24 Hours Post-Dose	3	1.06327 (1.074232)	(-1.60527, 3.73181)
Day 4	Pre-Dose	3	2.67733 (1.296508)	(-0.54338, 5.89803)
Day 5	Pre-Dose	3	3.14418 (1.369506)	(-0.25786, 6.54622)
Day 6	Pre-Dose	3	3.57431 (1.569784)	(-0.32525, 7.47387)
Day 7	Pre-Dose	3	3.70021 (1.708767)	(-0.54460, 7.94502)
Day 25	-0.5 Hours	3	2.12130 (0.611005)	(0.60348, 3.63912)*
	2 Hours Post-Dose	3	2.55143 (1.063471)	(-0.09038, 5.19324)
	4 Hours Post-Dose	3	3.44318 (2.008214)	(-1.54551, 8.43186)
	5 Hours Post-Dose	3	3.38023 (2.477964)	(-2.77538, 9.53583)
	6 Hours Post-Dose	3	4.43983 (2.949162)	(-2.88630, 11.76595)
	8 Hours Post-Dose	3	5.10077 (2.491247)	(-1.08783, 11.28937)
	12 Hours Post-Dose	3	4.91717 (2.463080)	(-1.20146, 11.03580)
	24 Hours Post-Dose	3	3.43793 (1.754247)	(-0.91986, 7.79572)
Day 27	Pre-Dose	2	2.76729 (1.754803)	NA
Day 28	Pre-Dose	2	2.32666 (1.376469)	NA
Day 29	-0.5 Hours	3	2.66159 (1.208535)	(-0.34058, 5.66376)

Study Treatment Day	Time	N	Mean (SD)	95% CI
	2 Hours Post-Dose	3	2.81371 (0.883991)	(0.61775, 5.00967)*
	4 Hours Post-Dose	3	3.38023 (1.494311)	(-0.33185, 7.09230)
	5 Hours Post-Dose	3	4.07789 (1.938972)	(-0.73879, 8.89456)
	6 Hours Post-Dose	3	4.68637 (2.236808)	(-0.87017, 10.24291)
	8 Hours Post-Dose	3	5.30534 (2.311221)	(-0.43605, 11.04673)
	12 Hours Post-Dose	3	4.74932 (2.204810)	(-0.72774, 10.22637)
	24 Hours Post-Dose	3	3.54284 (1.396901)	(0.07275, 7.01293)*
Day 31	Day 31, Pre-Dose	2	4.12064 (2.778532)	NA
Day 32	Day 32, Pre-Dose	1	8.13112 (NA)	NA
Day 33	Day 33, Pre-Dose	2	4.23079 (4.113829)	NA
Day 34	Day 34, Pre-Dose	2	4.10254 (3.872363)	NA
Day 35	Day 35, Pre-Dose	2	4.49045 (4.525546)	NA
Day 36	Day 36, Pre-Dose	2	3.46521 (3.015547)	NA
Day 37	Day 37, Pre-Dose	2	4.16785 (4.069319)	NA
Day 38	Day 38, Pre-Dose	1	7.64328 (NA)	NA
Day 39	-0.5 Hours	3	3.41170 (3.688041)	(-5.74990, 12.57330)
	2 Hours Post-Dose	3	3.81561 (3.942598)	(-5.97835, 13.60957)
	4 Hours Post-Dose	3	5.57811 (5.922419)	(-9.13399, 20.29022)
	5 Hours Post-Dose	3	6.26003 (6.244712)	(-9.25269, 21.77276)
	6 Hours Post-Dose	3	6.65869 (5.703557)	(-7.50973, 20.82711)
	8 Hours Post-Dose	3	7.31963 (6.096329)	(-7.82449, 22.46375)
	12 Hours Post-Dose	3	6.55378 (4.695286)	(-5.10996, 18.21752)
	24 Hours Post-Dose	3	4.54474 (3.676985)	(-4.58940, 13.67888)

Table 12: BC-TTM Elimination of Copper via Feces: Increase from Baseline in Average Daily Fecal Copper Excretion (mg) (Full Analysis Set)

Study Treatment Days (PK Dosing Epoch)	Change from Baseline	
	Mean (SD)	(95% CI)
Days 1-8 (Accumulation 15 mg/day)	0.3278 (0.31900)	(-0.4646, 1.1202)
Days 25-28 (Steady State 15 mg/day)	0.4931 (0.49554)	(-0.7379, 1.7241)
Days 31-35 (Accumulation 30 mg/day)	0.3879 (0.41929)	(-0.6537, 1.4295)
Days 36-39 (Steady State 30 mg/day)	0.0899 (0.20206)	(-0.4120, 0.5918)

Table 12-1: BC-TTM Elimination of Copper via Urine: Increase from Baseline in Average Daily Urine Copper Excretion (mg) (Full Analysis Set)

Study Treatment Days (PK Dosing Epoch)	Change from Baseline	
	Mean (SD)	(95% CI)
Days 1-8 (Accumulation 15mg/day)	-0.0108 (0.01119)	(-0.0386, 0.0170)
Days 25-28 (Steady State 15mg/day)	0.1042 (0.08556)	(-0.1084, 0.3167)
Days 31-35 (Accumulation 30mg/day)	0.0744 (0.05427)	(-0.0604, 0.2092)
Days 36-39 (Steady State 30mg/day)	0.1042 (0.04328)	(-0.0033, 0.2118)

[0177] Per protocol, the dose of BC-TTM was to be increased from 15 mg daily (Days 1-28) to 30 mg daily from Days 29-39. In 2 participants, this dose escalation was not carried out due to elevation of liver enzymes (maximum Grade 2 on Common Terminology Criteria for Adverse Events [CTCAE] toxicity scale). Participant 0344-1001 received 15 mg daily from Days 1-31, followed by 15 QOD from Days 32-39. Participant 0344-1003 received 15 mg daily from Days 1-24, followed by 15 mg QOD from Days 25-39. The lower mean daily dose of BC-TTM in Period 2 may explain the smaller change in dNCC for Days 31-35 and 36-39.

[0178] The increased mobilization of copper by BC-TTM is evidenced by the decrease from baseline in net copper balance displayed in Table 13 and Figure 12 (where net balance = copper input – copper output).

Table 13: BC-TTM Decreased Accumulation of Copper: Decrease from Baseline in Average Daily Net Copper Balance (mg) (Full Analysis Set)

Study Treatment Period Days (Dosing)	Change from Baseline	
	Mean (SD)	(95% CI)
Days 1-8 (Accumulation 15 mg/day)	-0.4848(0.11902)	(-0.7805, -0.1892)*
Days 25-28 (Steady State 15 mg/day)	-0.6381 (0.76730)	(-2.5442, 1.2680)
Days 31-35 (Accumulation 30 mg/day)	-0.3925 (0.05781)	(-0.5362, -0.2489)*
Days 36-39 (Steady State 30 mg/day)	-0.2765 (0.31378)	(-1.0560, 0.5030)
Days 1-39	-0.44799 (0.146889)	(-0.81288, -0.08310)*

Key secondary endpoints of Study 301

[0179] The key secondary endpoints of Study 301, meant to provide evidence of direct clinical benefit, were:

- Change from baseline in the UWDRS Part II total score (activities of daily living)
- Change from baseline in the UWDRS Part III Functional Subscale
- Change from baseline in the UWDRS Part III individual functional items: arising from a chair, gait, speech, and handwriting

After adjusting for multiplicity using hierarchical testing, none of the key secondary efficacy endpoints were statistically significantly different between BC-TTM and SoC, as demonstrated in Table 14. There were trends toward stability/improvement for both treatment groups. A possible explanation for the relative lack of improvement in neurology scores is the good baseline status of the majority of patients, as demonstrated by data in Table 15. As approximately 50% of patients had baseline UWDRS scores of 0, and those patients that did have scores greater than zero were relatively low in the respective UWDRS Part II (score range: 0-40) and UWDRS Part III (score range: 0-175) scale range, there was little room for improvement. Additional UWDRS scores, by cohort, were presented in Figure 20 and Figure 21.

[0180] While transformed CGI-I (TCGI-I) assesses how the WD patients' condition changed compared to baseline, CGI-I may indicate the overall clinical improvement of the patients in the study compared to baseline for each treatment arm. Analysis outside of the multiplicity testing sequence showed significant improvements in transformed CGI-I scores at week 48 in cohort 1 and overall, as illustrated in Figure 22.

Table 14: UWDRS Scores on BC-TTM and SoC; Full Analysis Set

UWDRS Measure (scoring range)	BC-TTM Treatment, N=137		SoC Treatment, N=70		Difference at 48 weeks
	Baseline	Change from Baseline at 48 weeks	Baseline	Change from Baseline at 48 weeks	
Part II (0 – 40)					
Mean	3.9	-0.6	3.5	-0.3	
(SD)	(7.65)	(2.86)	(6.53)	(2.94)	
LSM (SE)		-0.1 (0.30)		-0.5 (0.42)	0.4 (0.51)
95% CI		(-0.7, 0.5)		(-1.3, 0.3)	(-0.6, 1.4)
P-value					0.4430
Part III (0 - 175)					
Mean	15.75	-2.20	11.53	-1.02	
(SD)	(20.300)	(8.038)	(17.150)	(6.207)	
LSM (SE)		-0.60 (0.808)		-0.50 (1.111)	-0.09 (1.322)
95% CI		(-2.19, 1.00)		(-2.70, 1.69)	(-2.70, 2.52)
P-value					0.9441

UWDRS Measure (scoring range)	BC-TTM Treatment, N=137		SoC Treatment, N=70		Difference at 48 weeks
	Baseline	Change from Baseline at 48 weeks	Baseline	Change from Baseline at 48 weeks	
Part III functional subscale (0 – 10) Mean (SD) LSM (SE) 95% C P-value	1.523 (2.1772)	-0.147 (0.7796) 0.001 (0.0814) (-0.160, 0.163)	1.269 (2.1127)	-0.042 (0.5383) 0.068 (0.1126) (-0.154, 0.291)	-0.067 (0.1344) (-0.333, 0.199) 0.6191
Part III–arising from chair (0 – 4) Mean (SD) LSM (SE) 95% CI P-value	0.3 (0.90)	0.0 (0.41) 0.0 (0.04) (-0.1, 0.1)	0.3 (0.91)	-0.1 (0.50) 0.0 (0.05) (-0.1, 0.1)	0.0 (0.06) (-0.1, 0.1) 0.6869
Part III–gait (0 – 10) Mean (SD) LSM (SE) 95% CI P-value	1.51 (2.477)	-0.06 (1.238) 0.06 (0.119) (-0.18, 0.29)	1.32 (2.397)	0.04 (1.079) 0.21 (0.164) (-0.12, 0.53)	-0.15 (0.192) (-0.53, 0.23) 0.4325
Part III–speech (0 – 4) Mean (SD) LSM (SE) 95% CI P-value	0.9 (1.16)	-0.1 (0.51) 0.0 (0.04) (-0.1, 0.0)	0.7 (1.05)	0.0 (0.39) 0.0 (0.06) (-0.1, 0.1)	0.0 (0.07) (-0.2, 0.1) 0.7238
Part III–handwriting (0–4) Mean (SD) LSM (SE) 95% CI P-value	0.7 (1.00)	-0.1 (0.63) -0.1 (0.05) (-0.2, 0.0)	0.5 (0.94)	0.0 (0.47) 0.0 (0.07) (-0.2, 0.1)	-0.1 (0.09) (-0.2, 0.1) 0.5077
T-CGI-I (-3 to 3, -3 is very much improved) Mean (SD) LSM (SE) 95% CI P-value	N/A	-0.7 (0.93) -0.7 (0.09) (-0.8, -0.5)	N/A	-0.3 (0.95) -0.3 (0.12) (-0.6, -0.1)	-0.3 (0.15) (-0.6, 0.0) 0.0316
CGI-S (1–7, 1 is normal) Mean (SD) LSM (SE) 95% CI P-value	2.9 (1.60)	-0.5 (0.88) -0.3 (0.08) (-0.5, -0.2)	2.5 (1.41)	-0.1 (0.85) -0.1 (0.11) (-0.4, 0.1)	-0.2 (0.13) (-0.4, 0.1) 0.2290

Abbreviation: SoC = standard of care; SD = standard deviation; LSM = least squared mean; SE = standard error; CI = confidence interval; UWDRS = Unified Wilson's Disease Rating Scale; T-CGI-I=Transformed Clinical Global Impression of Improvement, CGI-S=Clinical Global Impression of Severity, negative change means improvement

[0181] Another possible explanation for the relative lack of significant change in neurology scores is the low total baseline UWDRS scores in the overall population (data in Table 15). Overall, 55.9% and 51.4% of BC-TTM and SoC participants, respectively, had a baseline UWDRS Part II total score of 0, and 21.3% and 18.6% of BC-TTM and SoC participants, respectively, had a baseline UWDRS Part III total score of 0. Combined, 19.4% (40/206) of participants had a baseline total UWDRS score of 0 on both Part II and Part III. The impact of this is low overall population means for Part II (3.5 to 4.0 on a 40-point scale) and Part III (6.50 to 15.97 on a 175-point scale). At the population comparison level, there was little room for overall improvement; however, at the individual participant level changes in scores on individual items could potentially capture meaningful clinical changes for the individual participant over time.

Table 15. UWDRS Part II Baseline Scores on BC-TTM and SoC (Range 0-40); Full Analysis Set

UWDRS Measure (Scoring Range)	Visit Statistic	Cohort 1		Cohort 2		Overall	
		BC-TTM	SoC	BC-TTM	SoC	BC-TTM	SoC
Part II (0 – 40)	No. patients	103	56	33	14	136	70
	Mean (SD)	4.0 (7.98)	3.5 (6.49)	3.7 (6.63)	3.6 (6.92)	3.9 (7.65)	3.5 (6.53)
	Median (IQR)	0.0 (3.0)	0.0 (3.0)	0.0 (3.0)	1.0 (4.0)	0.0 (3.0)	0.0 (3.0)
	Q1, Q3	0.0, 3.0	0.0, 3.0	0.0, 3.0	0.0, 4.0	0.0, 3.0	0.0, 3.0
	No. (%) with score of 0	57 (55.3%)	30 (53.6%)	19 (57.6%)	6 (42.9%)	76 (55.9%)	36 (51.4%)
	No. (%) with score of > 0	46 (44.7%)	26 (46.4%)	14 (42.4%)	8 (57.1%)	60 (44.1%)	34 (48.6%)
Part III (0 – 175)	No. patients	103	56	33	14	136	70
	Mean (SD)	15.97 (20.664)	12.79 (18.392)	15.06 (19.415)	6.50 (9.788)	15.75 (20.300)	11.53 (17.150)
	Median (IQR)	7.00 (23.00)	5.00 (11.00)	7.00 (17.00)	2.00 (3.00)	7.00 (21.00)	4.50 (11.00)
	Q1, Q3	1.00, 24.00	2.00, 13.00	2.00, 19.00	2.00, 5.00	1.00, 22.00	2.00, 13.00
	No. (%) with score of 0	22 (21.4%)	11 (19.6%)	7 (21.2%)	2 (14.3%)	29 (21.3%)	13 (18.6%)

UWDRS Measure (Scoring Range)	Visit Statistic	Cohort 1		Cohort 2		Overall	
		BC-TTM	SoC	BC-TTM	SoC	BC-TTM	SoC
	No. (%) with score of > 0	81 (78.6%)	45 (80.4%)	26 (78.8)	12 (85.7)	107 (78.7%)	57 (81.4%)

Abbreviations: SoC = standard of care; No. = number of participants; SD = standard deviation; IQR = inter-quartile range; Q1, Q3 = quartile 1, quartile 3

[0182] A modest reduction from baseline was seen in UWDRS scores 0-48W for symptomatic patients: Part II score change (mean) was -1.7 BC-TTM and -0.8 SoC; Part III score change (mean [95% CI]) was -2.91 [-4.74, -1.09] BC-TTM and -1.17 [-3.20, 0.86] SoC. Table 15-1 summarizes the UWDRS Part III score change at 48W for the patients who were symptomatic at baseline.

Table 15-1. UWDRS Part III Baseline Scores on BC-TTM and SoC; Full Analysis Set

Visit Statistic	Cohort 1		Cohort 2		Overall	
	BC-TTM	SoC	BC-TTM	SoC	BC-TTM	SoC
No. patients	81	44	26	12	107	56
Week 48, Change from Baseline						
N	73	37	21	10	94	47
Mean (SD)	-2.86 (8.206)	-1.95 (6.984)	-3.10 (11.207)	1.70 (6.183)	-2.91 (8.897)	-1.17 (6.923)
Median (IQR)	-2.00 (7.00)	-2.00 (4.00)	-3.00 (9.00)	-1.00 (3.02)	-2.00 (7.00)	-1.00 (4.00)
Q1, Q3	-6.00, 1.00	-4.00, 0.00	-8.00, 1.00	-1.00, 2.02	-6.00, 1.00	-3.00, 1.00
Min, Max	-28.0, 31.0	-22.0, 11.0	-34.0, 20.0	-5.0, 17.0	-34.0, 31.0	-22.0, 17.0
95% CI	(-4.78, -0.95)	(-4.27, 0.38)	(-8.20, 2.01)	(-2.72, 6.13)	(-4.74, -1.09)	(-3.20, 0.86)
LSM (SE)	-2.68 (0.885)	-1.89 (1.207)	1.43 (2.748)	1.37 (4.119)	-1.54 (0.954)	-1.21 (1.325)
95% CI	(-4.43, -0.93)	(-4.28, 0.50)	(-4.25, 7.10)	(-7.13, 9.88)	(-3.43, 0.35)	(-3.83, 1.41)
LSM Diff (SE)	-0.79 (1.498)		0.05 (5.041)		-0.33 (1.637)	
95% CI	(-3.76, 2.18)		(-10.36, 10.46)		(-3.57, 2.91)	
P-value	0.5997		0.9921		0.8420	

Abbreviations: SoC = standard of care; No. = number of participants; SD = standard deviation; IQR = inter-quartile range; Q1, Q3 = quartile 1, quartile 3

LSM and its 95% CI and 2-sided p-value are calculated using an REML based MMRM with fixed effects for baseline, cohort, visit, and cohort-by-visit interaction. For cohort analysis, analysis was performed on each cohort removing cohort and cohort-by-visit interaction. The Kenward-Rodger approximation is used to estimate denominator degrees of freedom. CI's and MMRM estimates are only displayed when $n \geq 3$.

[0183] The symptoms and the associated impacts of WD generally fall into neurologic, psychiatric, and hepatic categories. Previous work, including concept elicitation interviews with WD patients, has provided insight into the complexity and heterogeneity among patients. Consistent with this, participants enrolled in Study 301 presented with a wide array of symptoms and these have different types of impacts on their lives.

[0184] Exit interviews were conducted with a sample of participants (n = 10) to understand their experiences with BC-TTM treatment. These exit interviews reflect the diversity in neurologic dysfunction and the need to better understand treatment experience with a review of the participant level data. Overall, the qualitative information suggests that participants who were symptomatic at the start of treatment with BC-TTM experienced improvements or maintenance across several neurologic symptoms (including walking, balance, speech and tremor) that were considered meaningful. Conversely, participants who did not report experiencing any symptoms at the start of the study did not develop any symptoms while on treatment and considered any worsening (experiencing symptoms or deterioration) as meaningful. The exit interview insights provide deeper insight into the experience of the participants interviewed and add to the observation that at the population comparison level there is little room for overall improvement.

[0185] Data from participants who have taken BC-TTM for longer than 48 weeks are being analyzed to assess the longer-term safety and efficacy (continued control of copper and clinical benefit) of this therapy. This includes 19 participants from Phase 2 Study 201 who transferred into the Study 301 Extension and have received treatment with BC-TTM for more than 5 years, as well as participants who enrolled into Study 301 and were randomized and treated with BC-TTM either in the Primary Evaluation Period or the open-label extension. Pooled results from all such participants will be integrated together into one timeline to allow analyses of changes in UWDRS, long-term copper control, and long-term safety laboratory data.

[0186] The UWDRS Part II total score results for this pooled population are presented in Table 16 and Figure 13 and the UWDRS Part III total score results are in Table 17 and Figure 14. The UWDRS Part III Functional Subscale (comprised of the items arising from a chair, gait, handwriting and speech) results for this pooled population are presented in Table 18 and Figure 15. All tables document decreases in the mean and least squares mean (LSM) values over time, with generally greater decreases at the later timepoints. This indicates an improvement in the overall population, as lower scores denote improvement in signs and symptoms. After 36 weeks of exposure to BC-TTM, significance in mean and LSM is reached (0 is excluded from the mean and LSM 95% CIs) and maintained in virtually every instance. The graphical representations show lines sloping downward over time, indicating a

slow but steady improvement during treatment with BC-TTM. These results indicate that participant reported UWDRS Part II scores and clinical/neurologist reported UWDRS Part III and Part III Functional Subscale scores all demonstrate continuing improvement over up to 5 years of BC-TTM treatment, evidenced by statistically significant reductions from baseline.

Table 16: Improvement in UWDRS Part II Scores (Range 0-40) over 5 Years of BC-TTM Treatment from Baseline (Pooling Full Analysis Set, Studies 301 and 201)

BC-TTM Exposure (Weeks)	N	Mean (SD)	Mean 95% CI	LSM (SE)	LSM 95%CI
Baseline	222	4.0 (7.73)	(3.0, 5.0)	NA	NA
4	220	-0.3 (2.28)	(-0.6, 0.0)	-0.4 (0.19)	(-0.8, 0.0)
12	209	-0.4 (2.76)	(-0.8, 0.0)	-0.4 (0.27)	(-0.9, 0.1)
24	190	-0.4 (3.42)	(-0.9, 0.1)	-0.4 (0.32)	(-1.1, 0.2)
36	161	-0.9 (4.11)	(-1.6, -0.3)*	-0.7 (0.29)	(-1.3, -0.2)*
48	159	-1.2 (4.24)	(-1.9, -0.6)*	-1.0 (0.26)	(-1.5, -0.5)*
60	145	-1.4 (4.35)	(-2.1, -0.7)*	-1.2 (0.25)	(-1.7, -0.7)*
72	128	-1.9 (4.74)	(-2.7, -1.0)*	-1.5 (0.25)	(-2.0, -1.0)*
96	67	-2.5 (6.11)	(-4.0, -1.0)*	-1.6 (0.31)	(-2.2, -1.0)*
120	51	-3.1 (6.82)	(-5.0, -1.2)*	-2.6 (0.23)	(-3.0, -2.1)*
144	42	-3.3 (6.61)	(-5.3, -1.2)*	-3.0 (0.24)	(-3.5, -2.6)*
168	19	-6.2 (10.17)	(-11.1, -1.3)*	-3.3 (0.25)	(-3.8, -2.7)*
192	19	-5.9 (9.88)	(-10.7, -1.1)*	-3.0 (0.38)	(-3.8, -2.2)*
216	14	-7.1 (10.90)	(-13.4, -0.8)*	-3.8 (0.25)	(-4.3, -3.3)*
240	17	-6.6 (10.09)	(-11.8, -1.4)*	-3.5 (0.32)	(-4.2, -2.8)*
264	16	-6.2 (9.02)	(-11.0, -1.4)*	-3.3 (0.73)	(-4.8, -1.8)*

Note: Baseline contains observed values and other timepoints are change from baseline.

Note: LSM and its 95% CI are calculated using an REML based MMRM with fixed effects for visit, cohort, baseline-by-visit interaction, and baseline value as a covariate. The Kenward-Roger approximation is used to estimate degrees of freedom. MMRM was performed for each cohort subset using the same fixed effect terms in the model except for removing cohort term.

Note: * = statistically significant with two-sided alpha = 0.05 since 95%CI does not contain 0.

Note: For UWDRS, negative change means improvement.

Table 17: Improvement in UWDRS Part III (Range 0-175) over 5 Years of BC-TTM from Baseline (Pooling Full Analysis Set, Studies 301 and 201)

BC-TTM Exposure (Wks)	N	Mean (SD)	Mean 95% CI	LSM (SE)	LSM 95%CI
Baseline	220	15.43 (19.833)	(12.79, 18.06)	NA	NA
4	215	-0.72 (6.701)	(-1.62, 0.18)	-0.83 (0.607)	(-2.03, 0.36)
12	204	-1.11 (7.065)	(-2.08, -0.13)*	-1.13 (0.612)	(-2.34, 0.07)
24	182	-0.97 (8.447)	(-2.21, 0.26)	-1.10 (0.629)	(-2.34, 0.13)
36	156	-2.38 (8.581)	(-3.73, -1.02)*	-1.85 (0.657)	(-3.14, -0.56)*
48	156	-3.37 (9.778)	(-4.91, -1.82)*	-2.76 (0.675)	(-4.09, -1.43)*
60	141	-2.00 (6.40)	(-5.58, -2.18)*	-3.24 (0.700)	(-4.62, -1.87)*
72	125	-4.93 (11.682)	(-7.00, -2.86)*	-4.43 (0.734)	(-5.87, -2.99)*

BC-TTM Exposure (Wks)	N	Mean (SD)	Mean 95% CI	LSM (SE)	LSM 95%CI
96	66	-7.95 (14.078)	(-11.41, -4.49)*	-6.32 (0.881)	(-8.05, -4.59)*
120	50	-8.92 (15.045)	(-13.19, -4.64)*	-6.69 (1.027)	(-8.71, -4.68)*
144	42	-9.78 (15.423)	(-14.58, -4.97)*	-7.70 (1.153)	(-9.97, -5.44)*
168	18	-18.08 (19.127)	(-27.59, -8.57)*	-9.48 (1.616)	(-12.66, -6.31)*
192	19	-12.65 (19.476)	(-22.04, -3.27)*	-6.13 (1.783)	(-9.63, -2.63)*
216	14	-16.17 (19.323)	(-27.33, -5.01)*	-6.52 (2.013)	(-10.47, -2.56)*
240	13	-11.48 (16.473)	(-21.43, -1.52)*	-6.49 (2.137)	(-10.68, -2.29)*
264	13	-14.00 (16.513)	(-23.98, -4.02)*	-9.57 (2.222)	(-13.93, -5.21)*

Note: Baseline contains observed values and other timepoints are change from baseline.

Note: LSM and its 95% CI are calculated using an REML based MMRM with fixed effects for visit, cohort, baseline-by-visit interaction, and baseline value as a covariate. The Kenward-Roger approximation is used to estimate degrees of freedom. MMRM was performed for each cohort subset using the same fixed effect terms in the model except for removing cohort term.

Note: *= statistically significant with two-sided alpha = 0.05 since 95% CI does not contain 0.

Note: For UWDRS, negative change means improvement.

Table 18: Improvement in UWDRS Part III Functional Subscale Scores (Range 0-10) over 5 Years of BC-TTM from Baseline (Pooling Full Analysis Set, Studies 301 and 201)

BC-TTM Exposure (Wks)	N	Mean (SD)	Mean 95% CI	LSM (SE)	LSM 95%CI
Baseline	220	1.590 (2.2640)	(1.289, 1.890)	NA	NA
4	215	-0.072 (0.6009)	(-0.153, 0.009)	-0.083 (0.0575)	(-0.197, 0.030)
12	206	-0.137 (0.7864)	(-0.245, -0.029)*	-0.141 (0.0753)	(-0.289, 0.008)
24	183	-0.157 (0.9091)	(-0.290, -0.025)*	-0.146 (0.0789)	(-0.301, 0.010)
36	156	-0.286 (0.9929)	(-0.443, -0.129)*	-0.202 (0.0762)	(-0.352, -0.051)*
48	156	-0.345 (1.0940)	(-0.518, -0.172)*	-0.285 (0.0759)	(-0.434, -0.135)*
60	141	-0.422 (1.0814)	(-0.602, -0.242)*	-0.355 (0.0737)	(-0.500, -0.209)*
72	125	-0.494 (1.2826)	(-0.721, -0.267)*	-0.399 (0.0814)	(-0.559, -0.239)*
96	66	-0.900 (1.5193)	(-1.273, -0.527)*	-0.607 (0.0882)	(-0.781, -0.433)*

BC-TTM Exposure (Wks)	N	Mean (SD)	Mean 95% CI	LSM (SE)	LSM 95%CI
120	50	-0.946 (1.7746)	(-1.450, - 0.442)*	-0.660 (0.0890)	(-0.836, - 0.483)*
144	42	-1.042 (1.7227)	(-1.579, - 0.505)*	-0.803 (0.0922)	(-0.986, - 0.620)*
168	18	-1.841 (2.1818)	(-2.926, - 0.756)*	-0.903 (0.1189)	(-1.142, - 0.664)*
192	19	-1.250 (2.1459)	(-2.284, - 0.216)*	-0.437 (0.2007)	(-0.849, - 0.032)*
216	14	-1.519 (2.3987)	(-2.904, - 0.134)*	-0.430 (0.2362)	(-0.913, 0.053)
240	13	-0.898 (1.3384)	(-1.707, - 0.090)*	-0.607 (0.2176)	(-1.054, - 0.160)*
264	13	-0.995 (1.2369)	(-1.742, - 0.247)*	-0.818 (0.2025)	(-1.242, - 0.394)*

Note: Subscale recommended by FDA outcomes group, includes speech, handwriting, arising from chair, and gait.

Note: Baseline contains observed values and other timepoints are change from baseline.

Note: LSM and its 95% CI are calculated using an REML based MMRM with fixed effects for visit, cohort, baseline-by-visit interaction, and baseline value as a covariate. The Kenward-Roger approximation is used to estimate degrees of freedom. MMRM was performed for each cohort subset using the same fixed effect terms in the model except for removing cohort term.

Note: * = statistically significant with two-sided alpha = 0.05 since 95%CI does not contain 0

Note: For UWDRS, negative change means improvement.

[0187] Table 18-1 provides some interim long term safety and efficacy results through the extension period of Study 301. These results represent an integrated data set of 301 study participants who either started on BC-TTM or transitioned to BC-TTM after the 48-week Primary Period. They demonstrate statistically significant improvements from baseline in key secondary endpoints, such as UWDRS and CGI, in patients treated with BC-TTM. In addition, these results demonstrate that the level of improvement increases with continuing BC-TTM treatment over time.

Table 18-1: BC-TTM Treatment Long Term Safety and Efficacy Set (Study 301)

BC-TTM Treatment Long Term Safety and Efficacy Set N=178							
Measure (scoring range)	Baseline	Change from Baseline at Week					
		24	48	72	96	120	144
UWDRS Part II (0–40)							
N	174	155	131	108	47	31	24
Mean (SD)	3.4 (7.04)	-0.3 (1.99)	-0.7 (2.70)	-1.2 (2.92)	-1.1 (3.61)	-1.4 (3.48)	-2.0 (4.68)
95% CI		(-0.6, 0.0)	(-1.2, -0.3)*	(-1.7, -0.6)*	(-2.2, -0.1)*	(-2.7, -0.1)*	(-4.0, 0.0)
LSM (SE)		-0.4 (0.20)	-0.7 (0.21)	-1.0 (0.22)	-1.1 (0.30)	-1.7 (0.35)	-2.0 (0.39)
95% CI		(-0.8, 0.0)	(-1.1, -0.3)*	(-1.4, -0.6)*	(-1.7, -0.6)*	(-2.4, -1.0)*	(-2.7, -1.2)*
UWDRS Part III (0–175)							
N	172	148	128	105	46	30	24
Mean (SD)	13.99 (19.113)	-0.74 (5.937)	-2.32 (7.735)	-3.27 (9.840)	-4.09 (10.827)	-4.08 (11.618)	-5.99 (12.215)
95% CI		(-1.70, 0.22)	(-3.67, -0.96)*	(-5.18, -1.37)*	(-7.31, -0.87)*	(-8.42, 0.26)	(-11.14, -0.83)*
LSM (SE)		-1.32 (0.619)	-2.47 (0.638)	-3.47 (0.672)	-4.77 (0.865)	-5.27 (1.016)	-6.38 (1.112)
95% CI		(-2.53, -0.10)*	(-3.73, -1.22)*	(-4.79, -2.15)*	(-6.47, -3.08)*	(-7.26, -3.27)*	(-8.56, -4.20)*
UWDRS Part III functional subscale (0–10)							
N	172	149	128	105	46	30	24
Mean (SD)	1.390 (2.1420)	-0.139 (0.4540)	-0.235 (0.6976)	-0.290 (0.8908)	-0.503 (0.9648)	-0.410 (1.1867)	-0.573 (1.2617)
95% CI		(-0.212, -0.065)*	(-0.357, -0.113)*	(-0.463, -0.118)*	(-0.790, -0.217)*	(-0.853, 0.033)	(-1.106, -0.040)*
LSM (SE)		-0.158 (0.0547)	-0.230 (0.0569)	-0.253 (0.0604)	-0.386 (0.0801)	-0.392 (0.0952)	-0.489 (0.1046)
95% CI		(-0.265, -0.050)*	(-0.341, -0.118)*	(-0.372, -0.135)*	(-0.543, -0.229)*	(-0.578, -0.205)*	(-0.694, -0.284)*
UWDRS Part III–arising from chair (0–4)							
N	172	149	128	105	46	30	24
Mean (SD)	0.3 (0.89)	0.0 (0.38)	0.0 (0.40)	-0.1 (0.57)	-0.2 (0.76)	-0.2 (0.83)	-0.3 (1.03)
95% CI		(-0.1, 0.0)	(-0.1, 0.0)	(-0.2, 0.0)	(-0.4, 0.1)	(-0.5, 0.1)	(-0.7, 0.2)
LSM (SE)		-0.1 (0.03)	0.0 (0.04)	-0.1 (0.04)	-0.1 (0.05)	-0.1 (0.06)	-0.2 (0.07)
95% CI		(-0.1, 0.0)	(-0.1, 0.0)	(-0.1, 0.0)	(-0.2, 0.0)	(-0.2, 0.0)	(-0.3, 0.0)

BC-TTM Treatment Long Term Safety and Efficacy Set N=178									
Measure (scoring range)	Baseline	Change from Baseline at Week							
		24	48	72	96	120	144		
UWDRS Part III-gait (0-4)									
N	172	149	128	104	46	29	24		
Mean (SD)	1.40	-0.17 (1.113)	-0.18 (1.262)	-0.12 (1.321)	-0.11 (1.390)	0.26 (1.683)	0.00 (1.950)		
95% CI	(2.406)	(-0.35, 0.01)	(-0.40, 0.04)	(-0.38, 0.14)	(-0.52, 0.30)	(-0.38, 0.90)	(-0.82, 0.82)		
LSM (SE)		-0.21 (0.100)	-0.26 (0.104)	-0.15 (0.110)	-0.12 (0.143)	0.04 (0.172)	-0.25 (0.186)		
95% CI		(-0.41, -0.02)*	(-0.47, -0.06)*	(-0.37, 0.07)	(-0.40, 0.16)	(-0.30, 0.38)	(-0.61, 0.12)		
UWDRS Part III-speech (0-4)									
N	172	149	128	105	46	30	24		
Mean (SD)	0.8	-0.1 (0.38)	-0.1 (0.53)	-0.1 (0.51)	-0.2 (0.57)	-0.1 (0.61)	-0.2 (0.59)		
95% CI	(1.13)	(-0.1, 0.0)	(-0.2, 0.0)	(-0.2, 0.0)	(-0.3, 0.0)	(-0.3, 0.1)	(-0.5, 0.0)		
LSM (SE)		-0.1 (0.04)	-0.1 (0.04)	-0.1 (0.04)	-0.2 (0.05)	-0.2 (0.06)	-0.3 (0.07)		
95% CI		(-0.2, 0.0)	(-0.2, 0.0)	(-0.2, -0.1)*	(-0.3, -0.1)*	(-0.3, 0.0)	(-0.4, -0.1)*		
UWDRS Part III-handwriting (0-4)									
N	171	148	128	105	45	30	23		
Mean (SD)	0.6	-0.1 (0.38)	-0.2 (0.59)	-0.2 (0.59)	-0.4 (0.66)	-0.5 (0.68)	-0.5 (0.59)		
95% CI	(0.99)	(-0.1, 0.0)	(-0.3, -0.1)*	(-0.3, -0.1)*	(-0.6, -0.2)*	(-0.8, -0.2)*	(-0.7, -0.2)*		
LSM (SE)		0.0 (0.04)	-0.1 (0.04)	-0.2 (0.05)	-0.3 (0.06)	-0.3 (0.07)	-0.3 (0.08)		
95% CI		(-0.1, 0.0)	(-0.2, -0.1)*	(-0.2, -0.1)*	(-0.4, -0.2)*	(-0.5, -0.2)*	(-0.4, -0.1)*		
Transformed CGI-I-1**	n/a**								
N		151	134	106	49	33	23		
Mean (SD)		-0.5 (0.82)	-0.7 (0.91)	-0.5 (0.86)	-0.5 (0.98)	-0.7 (0.92)	-0.7 (0.76)		
95% CI		(-0.6, -0.3)*	(-0.8, -0.5)*	(-0.6, -0.3)*	(-0.8, -0.2)*	(-1.0, -0.4)*	(-1.0, -0.4)*		
LSM (SE)		-0.6 (0.07)	-0.8 (0.07)	-0.6 (0.08)	-0.6 (0.10)	-0.7 (0.12)	-0.8 (0.14)		
95% CI		(-0.7, -0.4)*	(-0.9, -0.6)*	(-0.7, -0.4)*	(-0.8, -0.4)*	(-1.0, -0.5)*	(-1.0, -0.5)*		

BC-TTM Treatment Long Term Safety and Efficacy Set N=178							
Measure (scoring range)	Change from Baseline at Week						
	Baseline	24	48	72	96	120	144
CGI-S (1 to 7, 1 is normal)							
N	172	147	130	103	47	33	23
Mean (SD)	2.7	-0.2 (0.79)	-0.5 (0.94)	-0.6 (1.10)	-0.6 (0.97)	-0.6 (1.06)	-0.6 (0.78)
95% CI	(1.58)	(-0.4, -0.1)*	(-0.6, -0.3)*	(-0.8, -0.4)*	(-0.9, -0.3)*	(-1.0, -0.3)*	(-0.9, -0.3)*
LSM (SE)		-0.3 (0.07)	-0.4 (0.07)	-0.5 (0.07)	-0.5 (0.09)	-0.7 (0.11)	-0.6 (0.12)
95% CI		(-0.4, -0.2)*	(-0.6, -0.3)*	(-0.6, -0.3)*	(-0.7, -0.3)*	(-0.9, -0.4)*	(-0.8, -0.4)*
*==statistically significant with two-sided alpha=0.05 since 95%CI does not contain 0.							
**==Clinician impression of change from baseline. Accordingly there is no baseline value. Scores transformed to range from -3 to 3 where: -3 = Very much improved, -2 = Much improved, -1 = Minimally improved, 0 = No change, 1 = Minimally worse, 2 = Much worse, 3 = Very much worse.							

Adverse Events of Special Interest (AESI):***Neurologic events***

[0188] Acute worsening of neurologic symptoms typically within 6 months of start of therapy is a known complication associated with chelation therapy for WD. The presumed mechanism is a rapid mobilization of unbound copper resulting in higher blood NCC and triggering a cytotoxic effect in neuronal tissue with subsequent neurologic deterioration in treated patients. Neurologic AESI for Study 301 were considered as all AEs in the Medical Dictionary for Regulatory Activities (MedDRA) System Organ Class (SOC) "Nervous system disorders" or any other AE judged by the Investigator as an AESI.

[0189] Overall, neurologic AESI were reported under the SOC of "Nervous system disorders" and "Psychiatric disorders" in 47 (34.3%) and in 5 (3.6%) participants, respectively. Adverse events reported as AESI in both these SOC are described below.

Nervous system disorders (SOC)

[0190] The incidence of AEs reported in the SOC "Nervous system disorders" was higher in BC-TTM treatment group compared with SoC group (34.3% vs 21.4%). The commonly reported AEs in both groups were headache (8.0% vs 8.6%) and tremor (7.3% vs 2.9%). Of the neurologic AEs, a significant difference between the treatment groups (BC-TTM and SoC) was observed for the event of tremor. Twelve events of tremor occurred in 10 (7.3%) participants. All events were nonserious and low grade (Grade 1 and Grade 2). Of the 10 (7.3%) participants, 6 participants reported the event as a "worsening" or "increasing of tremor." Dose was interrupted due to 3 tremor events; for 2 events the outcome was "resolved" and for 1 event was "not recovered." For the remaining 9 events, dose was not modified and the outcome was "not recovered" for 3 events, "recovered" for 4 events and "recovering" for 2 events.

[0191] The incidence of participants with the highest severity grade AEs was similar in both treatment groups for Grade 1 (24.1% vs 21.4%) AEs, and higher in the BC-TTM treatment group for Grade 2 AEs (13.9% vs 4.3%). No Grade 3 AEs were observed in either treatment group, and Grade 4 and Grade 5 AEs were observed in 1 participant each in the BC-TTM treatment group. One AE (Preferred Term "neurologic deterioration") led to treatment withdrawal.

[0192] Similar to the overall AEs, the incidence of SAEs was higher in the BC-TTM treatment group compared with the SoC group [6 (4.4%) vs 1 (1.4%)]. Seven SAEs were reported in 6 participants. In the BC-TTM treatment group, SAE severity was reported as Grade 1 in 1 participant, Grade 2 in 4 participants, no Grade 3 events, Grade 4 in 1 participant (same participant also experienced a Grade 2 SAE), and Grade 5 in 1 participant

with an SAE of "Hepatic encephalopathy." All SAEs in both treatment groups were assessed as unrelated.

[0193] Most common SAEs system organ class for BC-TTM were nervous system disorders (n = 6 [4.4%]) and SoC were gastrointestinal disorders and musculoskeletal and connective tissue disorders (n = 2 [2.9%] each).

Psychiatric disorders (SOC)

[0194] Neurologic AESI in the SOC "Psychiatric disorders" were only observed in the BC-TTM treatment group. Seven events in 5 (3.6%) participants were reported: depression, enuresis, insomnia, paranoia, sleep disorder, and apathy and irritability (both in 1 participant). All except one event were non-serious and low grade (Grade 1 and Grade 2). Of the 7 events, only 2 resulted in dose modification (1 dose reduction and 1 dose increase). The outcome for 3 events was "resolved" and for 4 events was "ongoing." Only 1 SAE was reported ("Paranoia aggravated"). No Grade 4 or 5 events were reported, and no events led to study drug discontinuation.

Other Significant Events and Laboratory Findings

Liver Effects (Elevations in liver transaminase levels)

[0195] Overall, hepatic enzyme elevation (ALT, aspartate aminotransferase [AST], and/or GGT) AEs were reported in a higher percentage of participants treated with BC-TTM compared with SoC in Study 301 (see Table 19). The most commonly reported event for BC-TTM groups was ALT increased (14.6% vs 2.9% for SoC), and, in the BC-TTM groups, accounted for 4.3% (25/577) of treatment-emergent adverse events (TEAEs). These events typically occurred in the first 4-12 weeks and were generally mild to moderate in severity, asymptomatic, reversible, and normalized with dose adjustments and/or interruptions. Hepatic enzyme elevation AEs are summarized in Table 19.

[0196] Based on laboratory data, 29 participants treated with BC-TTM had post-baseline elevation of ALT of $\geq 3 \times$ upper limit of normal (ULN):

- 14 (10.2%) participants had ALT $> 3 \times$ ULN but $\leq 5 \times$ ULN
- 10 (7.3%) participants had ALT $> 5 \times$ ULN but $\leq 10 \times$ ULN
- 1 (0.7%) participants had ALT $> 10 \times$ ULN but $\leq 20 \times$ ULN
- 4 (2.9%) participants had elevated ALT $> 20 \times$ ULN

[0197] In participants treated with SoC, 6 had post-baseline elevation of ALT $\geq 3 \times$ ULN: 3 (4.3%) participants each in the ranges ALT $> 3 \times$ ULN but $\leq 5 \times$ ULN and ALT $> 5 \times$ ULN but $\leq 10 \times$ ULN.

[0198] One BC-TTM-treated participant experienced ALT > 3 × ULN and concurrently total bilirubin > 2 × ULN. The participant's underlying hepatic disease was a confounding factor and this case was adjudicated as unlikely related to BC-TTM by an independent hepatic adjudication panel. Treatment with BC-TTM was re-initiated and liver tests remained normal.

[0199] Mean and 95% CI for ALT and GGT values over time are depicted in Figure 16 and Figure 17, respectively. In the BC-TTM group, ALT levels increased from baseline and peaked at week 6, then trended to decrease towards baseline by week 24. GGT levels increased from baseline until week 6, stabilized until week 12, then trended towards baseline until week 36 in the BC-TTM group. Overall, in the SoC group, no clinically significant changes from baseline in ALT and GGT were observed.

Table 19: Hepatic Enzyme Elevation Adverse Events (Primary Evaluation Period - Safety Set)

MedDRA Preferred Term	BC-TTM, N = 137		SoC, N = 70	
	N (%)	E	N (%)	E
ALT increased	20 (14.6)	25	2 (2.9)	2
AST increased	4 (2.9)	4	0	0
GGT increased	3 (2.2)	3	0	0
Hepatic enzyme increased	3 (2.2)	5	0	0
LFT increased	4 (2.9)	4	0	0
LFT abnormal	2 (1.5)	2	0	0
Hepatic function abnormal	3 (2.2)	3	0	0
Hypertransaminasemia	2 (1.5)	4	0	0
Liver disorder	1 (0.7)	1	1 (1.4)	1
Hyperbilirubinemia	1 (0.7)	1	0	0
Jaundice	1 (0.7)	1	0	0

Abbreviations: ALT = alanine transaminase; AST = aspartate aminotransferase; E = events; GGT = gamma-glutamyl transferase; LFT = liver function tests; MedDRA = Medical Dictionary for Regulatory Activities; N = number of participants; SoC = standard of care.

[0200] **Dyslipidemia:** Routine lipid monitoring was not originally included in the clinical studies. Through medical monitoring and review of available local laboratory data, it was identified that three 301 participants experienced liver enzyme elevations with concurrent elevations in cholesterol and TG. Review of data from Study 201 showed that 7 participants experienced total cholesterol increase above the ULN and all 7 had concurrent ALT elevations. Consequently, routine lipid monitoring was added to Study 301 and retrospective analysis was performed on all participants using available retained samples.

[0201] The retrospective analysis identified an imbalance of lipid results at baseline between the BC-TTM and SoC groups. Elevated cholesterol at baseline was found in 19% of those on BC-TTM and 10% of those on SoC; 13 (9.5%) of those on BC-TTM and 5 (7.1%) of those on SoC had decreased high density lipoprotein (HDL); 10.9% of those on BC-TTM and 7.1% of

those on SoC had elevated low density lipoprotein (LDL). The proportion with elevated TG was similar in both groups at baseline (16.8% of those on BC-TTM and 17.1% of those on SoC.)

[0202] Shift analysis from baseline to worst value during study for cholesterol and TG was performed. The results showed a higher percentage of participants in the BC-TTM group in comparison with SoC experienced Grade 1 (43.8% vs 32.9%), Grade 2 (5.1% vs 0), and Grade 3 (3.6% vs 0) cholesterol elevations. Worst values during study were higher in the BC-TTM group compared with the SoC group for Grade 2 (12.4% vs 2.9%), Grade 3 (5.1% vs 1.4%), and Grade 4 (2.9% vs 0) TG. Shift from baseline to worst values during study for cholesterol and triglycerides are presented in Table 20.

Table 20: Summary of Lipid Shifts from Baseline by CTCAE Toxicity Grade (Primary Evaluation Period - Safety Set)

Primary- Worst Highest Post- Baseline	Grade 0 N (%)		Grade 1 N (%)		Grade 2 N (%)		Grade 3 N (%)		Grade 4 N (%)	
	BC- TTM	SoC	BC- TTM	SoC	BC- TTM	SoC	BC- TTM	SoC	BC- TTM	SoC
	N = 137	N = 70	N = 137	N = 70	N = 137	N = 70	N = 137	N = 70	N = 137	N = 70
Cholesterol	65 (47.4)	47 (67.1)	60 (43.8)	23 (32.9)	7 (5.1)	0	5 (3.6)	0	0	0
Triglycerides	63 (46.0)	32 (45.7)	46 (33.6)	35 (50.0)	17 (12.4)	2 (2.9)	7 (5.1)	1 (1.4)	4 (2.9)	0

[0203] Mean and 95% CI in total cholesterol over time are depicted in Figure 18 where elevations over baseline are seen throughout the primary study analysis period in the BC-TTM group but not the SoC group. In the BC-TTM group, cholesterol levels increased from baseline and peaked around week 6, then trended to decrease towards baseline until week 24 and ultimately stabilizing at slightly higher levels than baseline. In Figure 19, changes in TG were mainly limited to the early part of the treatment period with an increase from baseline until week 6, then gradual return to baseline by week 36.

[0204] Analysis of the lipid profile was conducted retrospectively, using frozen plasma biomarker specimens collected at scheduled study visits. Events under the Cardiac disorder SOC were reviewed, with identification of only one AE potentially correlated with dyslipidemia.

[0205] Events under the Gastrointestinal disorders SOC were also reviewed, with no events (e.g., pancreatitis) identified as potentially correlated with dyslipidemia. As described above, lipid abnormalities and liver enzyme elevations have been reported during the primary analysis period of Study 301, and these elevations were more frequent in the BC-TTM group

than SoC. Generally, the lipid abnormalities were asymptomatic, transient, and not associated with any significant clinical consequences.

[0206] Cytopenia: Copper is an essential micronutrient involved in the catalytic function of several key enzymes involved in various processes throughout the body, including processes in bone marrow and central nervous system. Acquired or inherited copper deficiency may manifest in multiple organ systems but hematologic abnormalities were the most common. Copper deficiency manifests with anemia, neutropenia, and less frequently also with thrombocytopenia.

[0207] Hematologic AEs were observed in the clinical program for BC-TTM and are presented in Table 21. The majority of the hematologic events were non-serious, low grade, and resolved with dose modifications. Treatment with BC-TTM was discontinued due to an AE of neutropenia (Grade 2) and anemia (Grade 1) in 1 participant each. Overall, the incidence of hematologic AEs was similar among the BC-TTM and SoC treatment groups.

Table 21: Summary of Hematological Adverse Events (Primary Evaluation Period – Safety Set)

MedDRA Preferred Term	Overall			
	BC-TTM, N = 137		SoC, N = 70	
	N (%)	E	N (%)	E
Anemia	6 (4.4)	7	2 (2.9)	2
Neutropenia	6 (4.4)	6	2 (2.9)	2
Neutrophil count decreased	2 (1.5)	4	0	0
Leukopenia	2 (1.5)	3	3 (4.3)	3
Thrombocytopenia	1 (0.7)	2	2 (2.9)	2

[0208] At baseline, decreased neutrophil levels (0.7% vs 1.4%) were similar between BC-TTM and the SoC group, decreased platelet levels (21.9% vs 28.6%) were higher in the SoC group compared to BC-TTM group, and decreased hemoglobin levels (17.5% vs 14.3%) were slightly higher in BC-TTM group compared with SoC group.

[0209] Shift from baseline to worst values during study for neutrophils, platelets, and hemoglobin are presented in Table 22. Overall, the results showed a similar percentage in shift from baseline to worst values for neutrophils, platelets, and hemoglobin; except for Grade 1 hemoglobin (41.6% vs 24.3%), Grade 1 platelets (24.1% vs 17.1%), and Grade 3 neutrophils (6.6% vs 2.9%) which were higher in BC-TTM group than the SoC group.

Table 22: Summary of Hematologic Shifts from Baseline by CTCAE Toxicity Grade (Primary Evaluation Period - Safety Set)

Primary-Worst Highest Post-Baseline	Grade 0 N (%)		Grade 1 N (%)		Grade 2 N (%)		Grade 3 N (%)		Grade 4 N (%)	
	BC-TTM N = 137	SoC N = 70	BC-TTM N = 137	SoC N = 70	BC-TTM N = 137	SoC N = 70	BC-TTM N = 137	SoC N = 70	BC-TTM N = 137	SoC N = 70
Neutrophils	107 (78.1)	57 (81.4)	0 ^a	0 ^a	19 (13.9)	10 (14.3)	9 (6.6)	2 (2.9)	2 (1.5)	1 (1.4)
Platelets	90 (65.7)	46 (65.7)	33 (24.1)	12 (17.1)	8 (5.8)	6 (8.6)	5 (3.6)	4 (5.7)	1 (0.7)	2 (2.9)
Hemoglobin	74 (54.0)	50 (71.4)	57 (41.6)	17 (24.3)	5 (3.6)	3 (4.3)	1 (0.7)	0	0	0

^a The central laboratory's lower limit of normal for neutrophils is 1000 cells/ μ L. The CTCAE definition of Grade 1 neutrophils reduced is <LLN to 1500 cells/ μ L. Based on LLN=1000 cells/ μ L, there is no possible result which meets the CTCAE definition for Grade 1 neutrophils reduced. Any neutrophil result less than 1000 cells/ μ L is reported as Grade 3 or Grade 4.

Safety Findings in Participants Who Switched from SoC to BC-TTM in the Extension Period

[0210] An analysis was performed on preliminary data to compare AEs from Study 301 participants receiving SoC during the Primary Evaluation Period (48 weeks) and the subset of those participants who switched to BC-TTM during the Extension Period. The analysis was performed to identify imbalances in AE reporting after the switch from SoC to BC-TTM and compare the results to the imbalances observed in events by SoC during the Primary Evaluation Period [BC-TTM vs SoC].

[0211] During the Primary Evaluation Period in Study 301, disproportionate SoCs (> 5% difference) between BC-TTM and SoC included Ear and labyrinth disorders [5.1% vs 0%], General disorders and administration site conditions [21.2% vs 10.0%], Hepatobiliary disorders [6.6% vs 1.4%], Investigations [33.6% vs 2.9%], Nervous system disorders [34.3% vs 21.4%], Psychiatric disorders [19.0% vs 4.3%], and Skin and subcutaneous tissue disorders [21.9% vs 5.7%]. These are presented in Table 23.

[0212] Among the participants who switched from SoC to BC-TTM, there were 4 SoCs identified with a higher percentage (defined as > 5% difference) of participants experiencing AEs which included the following: General disorders and administration site conditions [10% vs 18%], Investigations [2.9% vs 29.5%], Metabolism and nutrition disorders [4.3% vs 11.5%], and Skin and subcutaneous tissue disorders [5.7% vs 13.1%]. The imbalances observed within the respective SoCs were driven by events of fatigue, ALT elevation, lipid

elevations (i.e., hyperlipidemia, hypertriglyceridemia, and dyslipidemia), and pruritus as shown in Table 24.

[0213] There was no disproportionality in AE reporting identified from any other SoC (see Table 24-1). Notably, and in contrast to the imbalance observed in the Primary Evaluation Period, the switch analysis did not show an imbalance in the Nervous system disorders or Psychiatric disorders SoCs.

Table 23: Disproportionate SOC (> 5%) (Primary Evaluation Period in Study 301, 48 Weeks)

System Organ Class Preferred Term	BC-TTM N = 137 PY = 118.9	SoC N = 70 PY = 62.4
	N (%)	N (%)
Ear and labyrinth disorders	7 (5.1)	0
General disorders and administration site conditions	29 (21.2)	7 (10.0)
Fatigue	13 (9.5)	3 (4.3)
Pyrexia	8 (5.8)	0
Hepatobiliary disorders	9 (6.6)	1 (1.4)
Investigations	46 (33.6)	2 (2.9)
Alanine aminotransferase increased	20 (14.6)	2 (2.9)
Aspartate aminotransferase increased	4 (2.9)	0
Gamma-glutamyltransferase increased	3 (2.2)	0
Hepatic enzyme increased	3 (2.2)	0
Neutrophil count decreased	2 (1.5)	0
Nervous system disorders	47 (34.3)	15 (21.4)
Psychiatric disorders	26 (19.0)	3 (4.3)
Skin and subcutaneous tissue disorders	30 (21.9)	4 (5.7)
Pruritus	5 (3.6)	0
Rash	9 (6.6)	1 (1.4)

Abbreviations: N = number of participants; PY = patient years; SOC = System Organ Class

Table 24: Disproportionate Terms (> 5% difference) by SoC and Selected Preferred Terms in Participants Who Switched from SoC to BC-TTM

System Organ Class Preferred Term	Weeks 0-48 on Study SoC N = 70 PY = 62.4		Weeks 49-96 on Study BC-TTM N = 61 PY = 55.4	
	N (%)	E	N (%)	E
General disorders and administration site conditions	7 (10.0)	8	11 (18.0)	12
Fatigue	3 (4.3)	3	5 (8.2)	5
Pyrexia	0	0	1 (1.6)	1
Investigations	2 (2.9)	2	18 (29.5)	29
Alanine aminotransferase increased	2 (2.9)	2	12 (19.7)	14
Aspartate aminotransferase increased	0	0	4 (6.6)	4
Gamma-glutamyltransferase increased	0	0	3 (4.9)	3
Hepatic enzyme increased	0	0	3 (4.9)	3
Neutrophil count decreased	0	0	1 (1.6)	1
Metabolism and nutrition disorders	3 (4.3)	4	7 (11.5)	10
Hyperlipidaemia	0	0	1 (1.6)	1
Hypertriglyceridaemia	0	0	1 (1.6)	3
Dyslipidemia	0	0	1 (1.6)	1
Skin and subcutaneous tissue disorders	4 (5.7)	7	8 (13.1)	15
Pruritus	0	0	2 (3.3)	2
Rash	1 (1.4)	1	1 (1.6)	5
Rash pruritic	0	0	1 (1.6)	1
Eczema	0	0	1 (1.6)	1
Hand dermatitis	0	0	1 (1.6)	1

Table 24-1: Proportionate Terms by SOC and Selected Preferred Term in Participants Who Switched from SoC to BC-TTM

System Organ Class Preferred Term	Weeks 0-48 on Study SoC N = 70 PY = 62.4		Weeks 49-96 on Study BC-TTM N = 61 PY = 55.4	
	N (%)	E	N (%)	E
Blood and lymphatic system disorders	9 (12.9)	10	7 (11.5)	18
Cardiac disorders	3 (4.3)	4	3 (4.9)	5
Congenital, familial, and genetic disorders	1 (1.4)	1	0	0
Ear and labyrinth disorders	0	0	1 (1.6)	1
Eye disorders	1 (1.4)	1	0	0
Gastrointestinal disorders	23 (32.9)	39	18 (29.5)	30
Hepatobiliary disorders	1 (1.4)	1	2 (3.3)	3
Infections and infestations	24 (34.3)	36	17 (27.9)	23
Injury, poisoning and procedural complications	6 (8.6)	8	7 (11.5)	13

System Organ Class Preferred Term	Weeks 0-48 on Study SoC N = 70 PY = 62.4		Weeks 49-96 on Study BC-TTM N = 61 PY = 55.4	
	N (%)	E	N (%)	E
Musculoskeletal and connective tissue disorders	12 (17.1)	13	7 (11.5)	7
Neoplasms benign, malignant, and unspecified (incl cysts and polyps)	1 (1.4)	1	1 (1.6)	1
Nervous system disorders	15 (21.4)	32	11 (18.0)	12
Product issues	1 (1.4)	1	0	0
Psychiatric disorders	3 (4.3)	3	3 (4.9)	3
Anxiety	0	0	1 (1.6)	1
Sleep disorder	0	0	1 (1.6)	1
Restlessness	1 (1.4)	1	0	0
Affective disorder	1 (1.4)	1	0	0
Attention deficit hyperactivity disorder	1 (1.4)	1	0	0
Post-traumatic stress disorder	0	0	1 (1.6)	1
Renal and urinary disorders	2 (2.9)	2	1 (1.6)	2
Reproductive system and breast disorders	4 (5.7)	4	0	0
Respiratory, thoracic, and mediastinal disorders	9 (12.9)	12	3 (4.9)	4
Vascular disorders	3 (4.3)	3	3 (4.9)	5

[0214] Overall, most AEs observed in Study 301 were nonserious, mild or moderate, manageable, and did not result in treatment discontinuation. The commonly (> 10%) observed AEs included ALT increased and nasopharyngitis. The risks observed in participants treated with BC-TTM including hepatic effects (elevations in liver transaminase levels), dyslipidemia, and cytopenias were generally asymptomatic, reversible with dose modification, and not associated with any clinical consequences.

[0215] Consistent with the above, analysis of data in participants who switched from SoC treatment to BC-TTM showed an increased incidence of laboratory abnormalities (increased ALT, increased cholesterol and increased TG, decreased neutrophils), further supporting an association with BC-TTM.

[0216] Worsening of neurologic symptoms is a known concern for SoC; this is primarily associated with penicillamine but has also been observed with trientine and zinc. The mechanism of neurologic worsening is unknown but association with unbound copper has been previously hypothesized. The data from the Primary Evaluation Period in Study 301 showed an imbalance in neurologic and psychiatric events with a higher incidence in participants treated with BC-TTM vs SoC; however, these imbalances were not observed in the participants who switched from SoC treatment to BC-TTM during the Extension Period. As Study 301 is an open-label study, there is the potential for biased reporting by

participants who know they are receiving the investigational medication. The cited finding suggests a lack of an association between BC-TTM and neurologic and psychiatric AEs.

[0217] Overall, BC-TTM has an acceptable safety profile and is generally well-tolerated in participants with WD.

[0218] ***Cirrhosis at Baseline and Albumin Levels During BC-TTM Treatment.*** Across the 301, 201, and 205 studies, 102 participants had cirrhosis at baseline. Study 205 is registered with ClinicalTrials.gov, number NCT04422431, and incorporated by reference in its entirety. Of the total 102, 13 participants experienced changes in albumin levels (indicative of changes in synthetic liver function) over the course of treatment with BC-TTM. The albumin levels in the other 89 participants remained stable (indicative of stable liver function) during the studies. The changes in albumin levels in these 13 participants are listed in Table 25 below (units shown are mg/dL throughout).

Table 25: Albumin Levels in Cirrhotic Participants Who Experienced Changes in Liver Function During BC-TTM Treatment

Time Point	Albumin Level (mg/dL)	Note
Study 301 (Normal Reference Range: 35 -55 mg/dL)		
Participant 1		
Baseline	33	
Week 48	47	
Week 96	48	
Participant 2		
Baseline	37	
Week 48	34	
Week 60	25	Early termination from study
Participant 3		
Baseline	34	
Week 48	36	
Week 60	34	
Participant 4		
Baseline	28	
Week 48	31	
Participant 5		
Baseline	32	
Week 48	37	
Week 96	37	
Participant 6		
Baseline	29	
Week 24	35	
Week 48	42	
Week 96	40	
Participant 7		
Baseline	42	Week 48 Extension Day 1
Week 8	37	
Week 24	36	

Week 30	35	
Week 48	35	
Week 144	37	
Participant 8		
Baseline	42	Week 48 Extension Day 1
Week 120	32	Early termination from study
Study 201 (Normal Reference Range: 33-49 mg/dL)		
Participant 9		
Baseline	29	
Week 48	45	
Week 150	46	Early termination from study
Participant 10		
Baseline	29	
Week 48	40	
Week 98	40	
Week 163	39	Early termination from study
Participant 11		
Baseline	31	
Week 48	44	
Week 98	46	
Week 150	44	
Study 205 (Normal Reference Range: 35-55 mg/dL)		
Participant 12		
Baseline	36	
Day 43	33	Unscheduled visit
Day 57	30	Unscheduled visit
Day 169	34	
Day 253	34	Unscheduled visit
Day 337	37	Early termination from study
Participant 13*		
Baseline	45	
Day 345	27	

*This patient ultimately experienced SAE and underwent liver transplant.

[0219] These results demonstrate that out of 102 participants with cirrhosis at baseline, 87% maintained liver function (as measured by albumin levels) during BC-TTM treatment. Of the 13 cirrhotic participants who experienced changes in liver function, 7 participants undergoing BC-TTM treatment experienced improvements such that albumin levels that had fallen outside the normal range returned to the normal range during BC-TTM treatment.

Example 2:

[0220] In this Copper Absorption study, the primary objective was to investigate the effect of BC-TTM on intestinal absorption and hepatic copper uptake in healthy subjects compared to the effects of penicillamine, trientine, and placebo. The secondary objective was to investigate the effect of BC-TTM on copper uptake in the gallbladder, pancreas, kidney, heart, and small and large intestine compared to the effects of penicillamine, trientine, or placebo. Blood was collected at several time points to assess plasma copper kinetics.

[0221] The study was carried out as a randomized, placebo-controlled intervention study. Positron emission tomography - computed tomography (PET-CT) scans allowed for the monitoring and assessment of an orally administered radioactive copper isotope tracer, $^{64}\text{CuCl}_2$ (^{64}Cu), in 32 healthy subjects (Figure 24). Uptake and tissue distribution of ^{64}Cu were assessed by PET-CT scan prior to copper-reducing treatment.

[0222] The subjects were then randomized to one of four anti-copper treatments (8 for each arm; penicillamine 600mg twice daily, trientine 300mg in the morning and 225mg in the evening, BC-TTM 15mg, or matching placebo) to be taken by mouth once daily for 7 days. On Day 8, oral $^{64}\text{CuCl}_2$ was administered and PET-CT imaging were repeated to assess the change from baseline in copper absorption and tissue distribution.

[0223] The study assessed the previously listed organs and the effect of anti-copper treatment by comparing the mean standard uptake value (SUV) in the organs of interest. The SUV allows for semiquantitative assessment of copper in a desired volume of interest for each organ by measuring the ratio of observed copper activity to the total dose of copper administered. The dynamic baseline scans and the subsequent static scans were compared across all treatments. Preliminary results of the effect of each treatment on copper absorption are reported below.

[0224] A visual representation of the marked reduction in ^{64}Cu absorption after treatment with BC-TTM in a healthy subject is illustrated in Figure 25. Before anti-copper treatment, the majority of the copper can be seen distributed between the liver and gastrointestinal tract. This reflects the normal physiology of copper absorption from the intestine and transport to the liver via the portal vein³. After treatment with BC-TTM, there was virtually no copper uptake in the liver one hour after oral administration of ^{64}Cu tracer. Nearly all of the ^{64}Cu tracer remained in the gastrointestinal tract.

[0225] Hepatic copper uptake was therefore used to quantitate the effect of anti-copper treatments on gastrointestinal ^{64}Cu absorption. Prior to treatment, there were no significant differences between the treatment groups with respect to mean SUV ^{64}Cu in the liver. All subjects were then treated with anti-copper therapy or placebo for 7 days prior to the second ^{64}Cu absorption test. As provided in Figure 26, following treatment with BC-TTM, the mean SUV liver was markedly reduced compared with baseline or placebo. At 1 hour and 15 hours after oral administration of ^{64}Cu , the mean SUV liver was significantly lower in healthy subjects receiving BC-TTM compared with penicillamine or trientine. Hepatic uptake of labeled copper following treatment with trientine was significantly lower than with penicillamine at 1 and 15 hours. The effect of penicillamine was not different from placebo.

[0226] The reduction in mean SUV ^{64}Cu in the liver by BC-TTM treatment persisted at the 13 hour scan, with a slightly wider range of reduction in hepatic copper uptake for the healthy subjects receiving BC-TTM (60%-90%). Placebo had no effect on ^{64}Cu absorption. These results indicate a potent effect of BC-TTM to reduce absorption of orally administered copper.

[0227] Compared to penicillamine or trientine, BC-TTM caused a greater reduction in hepatic copper uptake. At the 1hr scan post treatment, mean hepatic copper uptake is reduced in healthy subjects by approximately 25% in those receiving penicillamine, 50% in those receiving trientine, and 90% in those receiving BC-TTM. There was no change in healthy subjects receiving placebo.

[0228] In healthy subjects receiving BC-TTM, reduced blood levels of ^{64}Cu were consistent with the observed reduction in hepatic copper uptake. The reduced ^{64}Cu levels in both the blood and liver are the result of decreased intestinal absorption of copper. The mean SUV ^{64}Cu in healthy subjects receiving BC-TTM was significantly different post treatment compared to other treatment groups and placebo for the following other organs:

- Gallbladder: lower than penicillamine, trientine and placebo after 15hours;
- Colon: higher than penicillamine and placebo after 15 hours;
- Urinary bladder: lower than penicillamine, trientine and placebo after 1 hour;
- Pancreas: lower than penicillamine, trientine and placebo after 1 hour.

Absorption of orally-administered copper was significantly reduced in healthy subjects treated with BC-TTM compared to penicillamine, trientine, or placebo.

Example 3:

[0229] A Copper Excretion Study (Figure 27) was carried out to investigate the effect of BC-TTM on biliary copper excretion and plasma copper kinetics in patients with WD. This was a single-arm study in which the distribution of intravenously administered ^{64}Cu was studied in 4 patients with WD using positron emission tomography-magnetic resonance (PET-MR) scans before and after treatment with BC-TTM. 15 minutes after intravenous administration of ^{64}Cu , a dynamic PET-MR scan was performed, followed by additional scans at 1, 2, 6, 20, 48, 54, and 68 hours. Venous blood samples were collected for quantitation of radioactivity at multiple time points.

[0230] Following completion of the pre-treatment ^{64}Cu PET-MR study, subjects were administered BC-TTM 15mg once daily for a total of 11 days. The post-treatment ^{64}Cu PET-MR study was initiated on the 7th day, with serial PET-MR imaging conducted 1, 2, 6, 20, 48, 54, and 68 hours after intravenous administration of ^{64}Cu .

[0231] The study also assessed the kinetics of ^{64}Cu in the blood and its distribution among organs of interest. The SUV allows for semiquantitative assessment of copper in a desired volume of interest by measuring the ratio of observed copper activity to the total dose administered.

[0232] The 2hr and 48hr PET scans demonstrated a marked reduction in hepatic copper uptake after treatment with BC-TTM. The scans also demonstrated an increase of ^{64}Cu distributed to the kidneys (Figure 28, arrows). The reduction of hepatic copper uptake after treatment with BC-TTM can be seen in a scan obtained 6 hours after intravenous administration of ^{64}Cu . There was no increase in ^{64}Cu in the gallbladder, indicating that BC-TTM did not promote biliary excretion of copper (Figure 29).

[0233] The mean SUV for static PET-MR scans in 4 WD patients receiving BC-TTM was plotted against time for various organs (Figure 30). Following treatment with BC-TTM, the mean SUV of the liver decreased, the mean SUV of the kidney increased, and the mean SUV of the gallbladder did not change. The mean SUV for the other organs did not change after treatment with BC-TTM.

[0234] The ^{64}Cu concentration in blood was measured as the median percent of injected dose (ID) before and after treatment with BC-TTM (Figure 31). Prior to treatment with BC-TTM, ^{64}Cu was cleared quickly from the blood (diamond, solid line) to the liver (circle, solid line). Following BC-TTM treatment, ^{64}Cu reached a higher peak in the blood and its clearance from blood was delayed (diamond, dashed line). Hepatic uptake of ^{64}Cu was reduced by treatment with BC-TTM (circle, dashed line). ^{64}Cu uptake in the kidneys increased after treatment with BC-TTM (triangle, dashed line), though the absolute change (as % of injected dose) was relatively small.

[0235] Intravenously injected ^{64}Cu distributed quickly in the blood, reaching a peak after approximately one minute (Table 26, Figures 31, 32). The mean ^{64}Cu concentration in blood was not significantly different before and after treatment with BC-TTM during the first 10 minutes after intravenous injection. This observation is consistent with immediate distribution of ^{64}Cu throughout the circulation, prior to uptake into organs. Prior to treatment with BC-TTM, there was rapid disappearance of ^{64}Cu from the blood after this initial distribution. This was consistent with normal hepatic uptake of copper from blood and corresponds with the PET-MR scans. Following treatment with BC-TTM, there was significantly more ^{64}Cu in the blood from 1 hour to 48 hours. The significantly increased mean concentration of ^{64}Cu in blood after BC-TTM treatment is consistent with reduced hepatic uptake of copper.

Table 26: Intravenously injected ^{64}Cu in the blood

	5 sec	15 sec	60 sec	120 sec	200 sec	300 sec	600 sec
Pre	0.00 (0.00)	0.00 (1.44)	5.30 (7.16)	5.15 (4.28)	5.13 (2.94)	5.88 (1.24)	4.35 (0.59)
Post	0.05 (0.22)	1.02 (3.96)	4.16 (9.66)	3.47 (4.65)	5.01 (3.47)	6.99 (3.61)	7.03 (3.47)
Panksum p (Prob > z)	0.1306	0.5083	0.7728	0.5637	1.0000	0.3865	0.1489
	1 hour	2 hours	6 hours	20 hours	48 hours	54 hours	68 hours
Pre	0.78 (0.19)	0.64 (0.16)	0.42 (0.09)	0.32 (0.06)	0.33 (0.08)	0.28 (0.11)	0.25 (0.07)
Post	5.43 (2.20)	5.09 (1.60)	2.54 (1.59)	0.77 (0.41)	0.51 (0.11)	0.42 (0.11)	0.42 (0.09)
Ranksum p (Prob > z)	0.0209	0.0209	0.0209	0.0202	0.0433	0.1102	0.0433

[0236] WD patients treated with BC-TTM demonstrated a significant reduction in hepatic copper uptake that corresponded with delayed clearance of ^{64}Cu from the blood. Following treatment with BC-TTM, there was a modest increase in copper uptake in the kidneys. Biliary copper excretion was not detected before or after BC-TTM treatment.

[0237] It is understood that the examples and embodiments described herein are for illustrative purposes only and that various modifications or changes in light thereof are suggested to persons skilled in the art and are to be incorporated within the spirit and purview of this application and scope of the appended claims. All publications, patents, and patent applications cited herein are hereby incorporated herein by reference for all purposes.

What is claimed is:

Claim 1. A method for reducing copper concentration in tissues of a subject, the method comprising: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate, wherein the subject is at least 12 years old.

Claim 2. The method of claim 1, wherein the subject is at least 18 years old.

Claim 3. The method of claim 1 or claim 2, wherein the administering of the therapeutically effective amount of bis-choline tetrathiomolybdate is for at least 48 weeks.

Claim 4. A method for treating a copper metabolism-associated disease or disorder in a subject, the method comprising: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate for at least 48 weeks, wherein the subject is at least 12 years old.

Claim 5. The method of claim 5, wherein the subject is at least 18 years old.

Claim 6. The method of claim 4 or claim 5, wherein the copper metabolism-associated disease or disorder is Wilson disease.

Claim 7. The method of any one of claims 1 to 6, wherein the subject previously received no treatment for the copper metabolism-associated disease or disorder, such as for Wilson disease (i.e., a treatment-naïve subject).

Claim 8. The method of any one of claims 1 to 6 wherein the subject previously received a standard of care treatment for the copper metabolism-associated disease or disorder, such as for Wilson disease.

Claim 9. The method of claim 8, wherein the subject previously received standard of care treatment for no more than 4 weeks, or no more than 2 weeks.

Claim 10. The method of claim 8, wherein the subject previously received standard of care treatment for at least 4 weeks, or for at least 6 weeks, or for at least 12 weeks, or for at least 24 weeks, or for at least 48 weeks.

Claim 11. The method of claim 8, wherein the subject previously received standard of care treatment for at least 41 months, or about 41 months to about 228 months.

Claim 12. The method of claim 8, wherein the subject previously received standard of care treatment for at least 116 months.

Claim 13. The method of claim 8, wherein the subject previously received standard of care treatment for at least 155 months.

Claim 14. The method of any one of claims 1 to 13, wherein the subject previously received no treatment or the subject previously received a standard of care treatment for no more than 4 weeks for the copper metabolism-associated disease or disorder, such as for Wilson disease.

Claim 15. The method of any one of claims 8 to 14, wherein the standard of care treatment comprises trientine, D-penicillamine, and/or zinc.

Claim 16. The method of any one of claims 8 to 14, wherein the standard of care treatment comprises trientine and/or D-penicillamine.

Claim 17. The method of any one of claims 1 to 16, wherein the therapeutically effective amount of bis-choline tetrathiomolybdate is in the range of about 15 mg to about 60 mg per day.

Claim 18. The method of any one of claims 1 to 16, wherein the therapeutically effective amount of bis-choline tetrathiomolybdate is about 15 mg daily or about 15 mg every other day.

Claim 19. The method of any one of claims 1 to 18, further comprising determining a concentration of one or more of total copper, ceruloplasmin, ceruloplasmin-bound copper (CpC), non-ceruloplasmin-bound copper (such as calculated, cNCC, or directly measured, dNCC), and labile-bound copper (LBC) in the subject's plasma.

Claim 20. The method of any one of claims 1 to 19, further comprising determining a daily mean area under the effect-time curve (AUEC) of directly measured non-ceruloplasmin-bound copper (dNCC) (such as from baseline to 48 weeks).

Claim 21. The method of claim 20, further comprising adjusting the therapeutically effective amount of bis-choline tetrathiomolybdate if the subject's daily mean $AUEC_{0-48W}$ for dNCC is outside a reference range for daily mean $AUEC_{0-48W}$ for dNCC.

Claim 22. The method of any one of claims 1 to 21, further comprising determining a concentration of total molybdenum and/or plasma ultrafiltrate (PUF) molybdenum in the subject's plasma.

Claim 23. The method of any one of claims 19 to 22, wherein the determining is performed at baseline, at or after 6 weeks of administration, at or after 24 weeks of administration, and/or at or after 48 weeks of administration.

Claim 24. The method of any one of claims 19 to 22, wherein the determining is performed at baseline, and to 6 weeks of administration, or to 24 weeks of administration, or to 48 weeks of administration, or to at least 48 weeks or more of administration.

Claim 25. The method of any one of claims 1 to 24, further comprising evaluating the patients for improvements in disability and neurologic symptoms as measured according to Unified Wilson Disease Rating Scale (UWDRS), part II and/or part III.

Claim 26. The method of any one of claims 1 to 25, further comprising evaluating the patients for improvements in disability status, psychiatric symptoms, clinical symptoms, treatment satisfaction, or a combination thereof.

Claim 27. The method of any one of claims 1-3 and 7-26, wherein the copper concentration in tissues of the subject is reduced by at least 2.9-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC with the therapeutically effective amount of bis-choline tetrathiomolybdate compared to a therapeutically effective amount of standard of care therapy.

Claim 28. The method of claim 27, wherein the copper concentration in tissues of the subject is reduced by at least about 3.3-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC.

Claim 29. The method of claim 27, wherein the copper concentration in tissues of the subject is reduced by at least about 4.9-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC.

Claim 30. A method for sequestering copper in a subject, the method comprising: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate for at least 48 weeks, wherein the subject is at least 12 years old, and wherein the bis-choline tetrathiomolybdate sequesters copper in the subject by at least about 3.3-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC and as compared to standard of care therapy.

Claim 31. A method for sequestering copper in a subject, the method comprising: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate for at least 48 weeks, wherein the subject is at least 12 years old and treatment-naïve or previously received standard of care therapy for ≤ 28 days, and wherein

the bis-choline tetrathiomolybdate sequesters copper in the subject by at least about 4.9-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC and as compared to standard of care therapy.

Claim 32. A method for sequestering copper in a subject, the method comprising: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate for at least 48 weeks, wherein the subject is at least 12 years old and previously received standard of care therapy for > 28 days, and wherein the bis-choline tetrathiomolybdate sequesters copper in the subject by at least about 2.9-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC and as compared to standard of care therapy.

Claim 33. The method of any one of claims 30 to 32, wherein the sequestered copper is from the subject's liver.

Claim 34. The method of any one of claims 30 to 33, wherein the sequestering is by formation of stable Cu-tetrathiomolybdate-albumin tripartite complexes.

Claim 35. The method of any one of claims 30 to 34, wherein the sequestering is by rendering Cu-tetrathiomolybdate-albumin tripartite complexes and LBC available in the systemic circulation in the subject for transportation and/or elimination.

Claim 36. The method of any one of claims 30 to 35, wherein the concentration of copper in urine decreases relative to baseline in the time interval ranging from day 0 to week 24 post administration as measured by 24-hour urine copper test.

Claim 37. The method of claim 36, wherein the concentration of copper in urine decreases by at least 1%, or by at least 2%, or by at least 5%, or by at least 7%, or by at least 10%, or by at least 20%, relative to baseline in the time interval ranging from day 0 to week 24 post administration as measured by 24-hour urine copper test.

Claim 38. The method of any one of claims 30 to 37, wherein the sequestering occurs within a time interval ranging from day 0 to week 24 post administration.

Claim 39. The method of any one of claims 30 to 37, wherein the sequestering occurs within a time interval ranging from day 0 to week 7 post administration.

Claim 40. The method of any one of claims 30 to 39, wherein, in the subject being administered bis-choline tetrathiomolybdate, the sequestering is higher (at least 10% higher, or at least 15% higher, or at least 20% higher, or at least 25% higher, or at least 30% higher, or at least 35% higher, or at least 40% higher, or at least 45% higher, or at least 50% higher)

as compared to the sequestering in the subject when the subject receives standard of care treatment (as described in any of claims 79 to 83).

Claim 41. The method of claim 40, wherein the sequestering is unchanged relative to baseline in the time interval ranging from day 0 to week 24 post administration of the standard of care treatment.

Claim 42. The method of any one of claims 30 to 41, wherein the sequestering is assessed by determining a concentration of total copper in the subject's plasma.

Claim 43. The method of claim 42, wherein the concentration of total copper in the subject's plasma is measured by inductively coupled plasma-mass spectrometry (ICP-MS).

Claim 44. The method of either claim 42 or claim 43, wherein the concentration of total copper in the subject's plasma is determined using equation [I]:

$$\text{AUEC}_{\text{plasma total Cu}} \times \text{CL}_{\text{plasma total Cu}} \quad [\text{I}]$$

(e.g., over a period of 0 to 24 weeks or 0 to 48 weeks).

Claim 45. The method of any one of claims 42 to 44, further comprising determining a concentration of LBC in the subject's plasma (e.g., LBC is in the range of about 0.7 to 5.9 $\mu\text{mol/L}$ for female subjects and in the range of about 0.9 to 4.4 $\mu\text{mol/L}$ for male subjects).

Claim 46. The method of claim 45, wherein the concentration of LBC in the subject's plasma is determined using LBC assay.

Claim 47. The method of claim 45, wherein the concentration of LBC in the subject's plasma is determined using equation [II]:

$$\text{AUEC}_{\text{plasma LBC}} \times \text{CL}_{\text{plasma LBC}} \quad [\text{II}]$$

(e.g., over a period of 0 to 24 weeks or 0 to 48 weeks).

Claim 48. The method of any one of claims 45 to 47, further comprising determining the ratio of LBC to total copper in the subject's plasma.

Claim 49. A method for mobilizing copper in a subject, the method comprising: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate for at least 48 weeks, wherein the subject is at least 12 years old, and wherein the bis-choline tetrathiomolybdate mobilizes copper in the subject by at least about 3.3-fold as measured by daily mean $\text{AUEC}_{0-48\text{W}}$ for dNCC and as compared to standard of care therapy.

Claim 50. A method for mobilizing copper in a subject, the method comprising: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate for at least 48 weeks, wherein the subject is at least 12 years old and treatment-naïve or previously received standard of care therapy for ≤ 28 days, and wherein the bis-choline tetrathiomolybdate mobilizes copper in the subject by at least about 4.9-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC and as compared to standard of care therapy.

Claim 51. A method for mobilizing copper in a subject, the method comprising: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate for at least 48 weeks, wherein the subject is at least 12 years old and previously received standard of care therapy for > 28 days, and wherein the bis-choline tetrathiomolybdate mobilizes copper in the subject by at least about 2.9-fold as measured by daily mean $AUEC_{0-48W}$ for dNCC and as compared to standard of care therapy.

Claim 52. The method of any one of claims 49 to 51, wherein the copper is mobilized from tissue of the subject.

Claim 53. The method of claim 52, wherein the tissue is liver.

Claim 54. The method of claim 52, wherein the tissue is brain.

Claim 55. The method of any one of claims 49 to 54, wherein the mobilization occurs within a time interval ranging from day 0 to week 24 post administration.

Claim 56. The method of any one of claims 49 to 54, wherein the highest level of mobilization is within a time interval ranging from day 0 to week 7 post administration.

Claim 57. A method for blocking absorption of copper in tissue of a subject, the method comprising: administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate for at least 48 weeks, wherein the subject is at least 12 years old, wherein the therapeutically effective amount of bis-choline tetrathiomolybdate is sufficient to block absorption of copper in tissue of a subject.

Claim 58. The method of claim 57, wherein the tissue is liver and/or gastrointestinal tract.

Claim 59. The method of claim 57 or 58, wherein the therapeutically effective amount of bis-choline tetrathiomolybdate is sufficient to inhibit progression of liver damage.

Claim 60. The method of claim 57, wherein the tissue is brain.

Claim 61. The method of claim 57 or 60, wherein the therapeutically effective amount of bis-choline tetrathiomolybdate is sufficient to inhibit progression of neurological damage.

Claim 62. The method of claim 57 or 60 wherein the therapeutically effective amount of bis-choline tetrathiomolybdate is sufficient to improve or maintain one or more of neurological symptoms, psychiatric symptoms, clinical symptoms, disability status, and treatment satisfaction.

Claim 63. A method for treating a copper metabolism-associated disease or disorder in a subject, the method comprising: blocking absorption of copper in tissue of the subject and sequestering copper in the subject by administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate for at least 48 weeks, wherein the subject is at least 12 years old.

Claim 64. The method of claim 63, wherein the tissue is liver and/or gastrointestinal tract.

Claim 65. The method of claim 63 or 64, wherein the therapeutically effective amount of bis-choline tetrathiomolybdate is sufficient to inhibit progression of liver damage.

Claim 66. The method of claim 63 wherein the tissue is brain.

Claim 67. The method of claim 63 or 66, wherein the therapeutically effective amount of bis-choline tetrathiomolybdate is sufficient to inhibit progression of neurological damage.

Claim 68. The method of claim 63 or 66 wherein the therapeutically effective amount of bis-choline tetrathiomolybdate is sufficient to improve or maintain one or more of neurological symptoms, psychiatric symptoms, clinical symptoms, disability status, and treatment satisfaction.

Claim 69. A method for treating a copper metabolism-associated disease or disorder in a subject, the method comprising:

- determining a concentration of total copper in the subject's plasma; and
- administering to the subject a therapeutically effective amount of bis-choline tetrathiomolybdate.

Claim 70. The method of claim 69, wherein the copper metabolism-associated disease or disorder is Wilson Disease.

Claim 71. The method of either claim 69 or claim 70, wherein the concentration of total copper in the subject's plasma is measured by inductively coupled plasma-mass spectrometry (ICP-MS).

Claim 72. The method of any one of claims 69 to 71, wherein the concentration of total copper in the subject's plasma is determined using equation [I]:

$$\text{AUEC}_{\text{plasma total Cu}} \times \text{CL}_{\text{plasma total Cu}} \quad [\text{I}]$$

(e.g., over a period of 0 to 24 weeks or 0 to 48 weeks).

Claim 73. The method of any one of claims 69 to 72, further comprising determining a concentration of LBC in the subject's plasma (e.g., LBC is in the range of about 0.7 to 5.9 $\mu\text{mol/L}$ for female subjects and in the range of about 0.9 to 4.4 $\mu\text{mol/L}$ for male subjects).

Claim 74. The method of claim 73, wherein the concentration of LBC in the subject's plasma is determined using LBC assay.

Claim 75. The method of claim 73, wherein the concentration of LBC in the subject's plasma is determined using equation [II]:

$$\text{AUEC}_{\text{plasma LBC}} \times \text{CL}_{\text{plasma LBC}} \quad [\text{II}]$$

(e.g., over a period of 0 to 24 weeks or 0 to 48 weeks).

Claim 76. The method of any one of claims 73 to 75, further comprising determining the ratio of LBC to total copper in the subject's plasma.

Claim 77. The method of claim 76, further comprising determining the therapeutically effective amount of bis-choline tetrathiomolybdate based on the ratio of LBC to total copper in the subject's plasma.

Claim 78. The method of any one of claims 30 to 77, wherein the subject is at least 18 years old.

Claim 79. The method of claim 30 to 78, wherein the subject previously received standard of care treatment for at least 41 months, or about 41 months to about 228 months.

Claim 80. The method of claim 30 to 78, wherein the subject previously received standard of care treatment for at least 116 months.

Claim 81. The method of claim 30 to 78, wherein the subject previously received standard of care treatment for at least 155 months.

Claim 82. The method of any one of claims 30 to 81, wherein the standard of care treatment comprises trientine, D-penicillamine, and/or zinc.

Claim 83. The method of any one of claims 30 to 81, wherein the standard of care treatment comprises trientine and/or D-penicillamine.

Claim 84. The method of any one of claims 30 to 83, wherein the therapeutically effective amount of bis-choline tetrathiomolybdate is in the range of about 15 mg to about 60 mg per day.

Claim 85. The method of any one of claims 30 to 83, wherein the therapeutically effective amount of bis-choline tetrathiomolybdate is about 15 mg daily or about 15 mg every other day.

FIGURE 1A

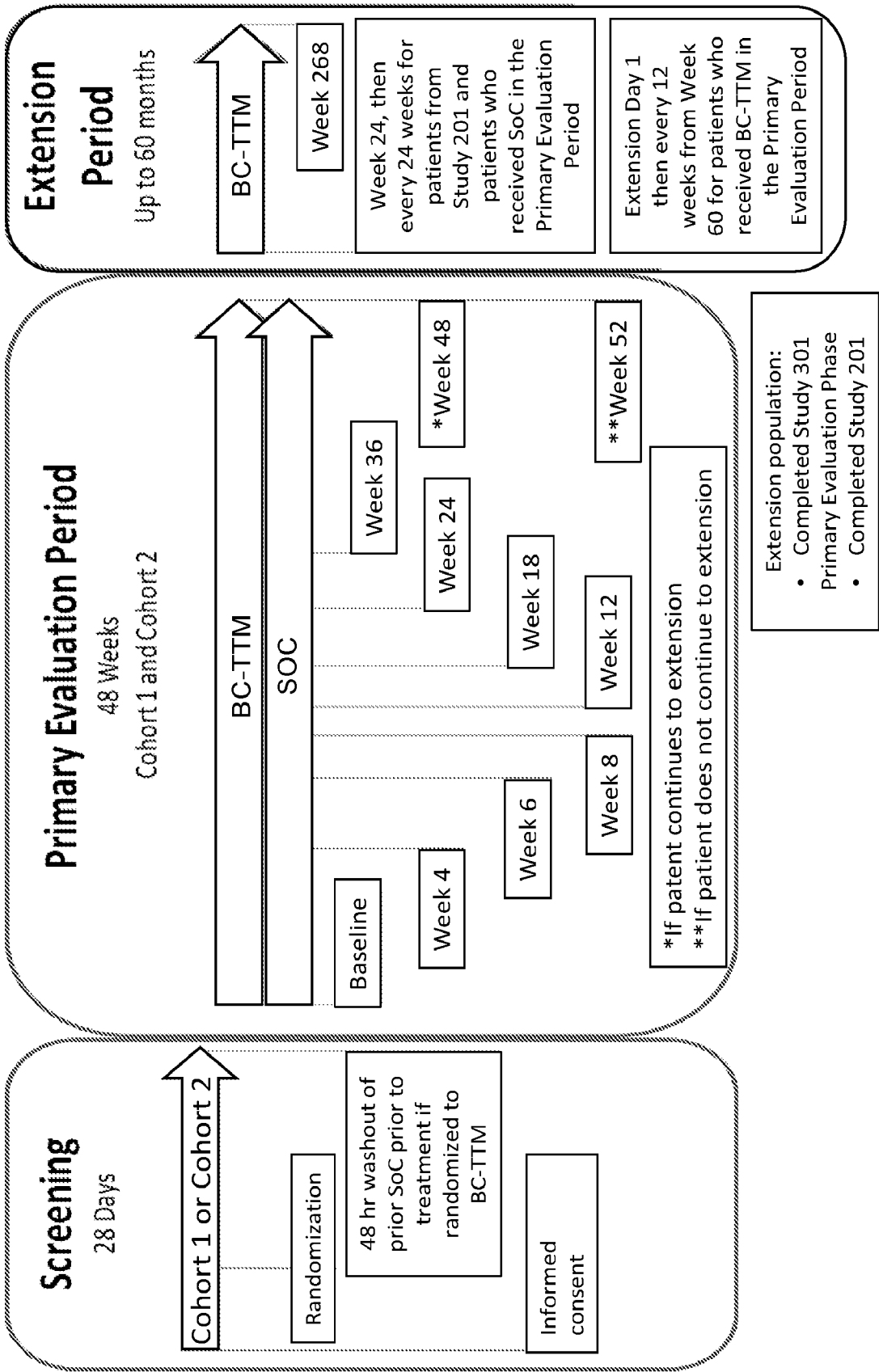


FIGURE 1B

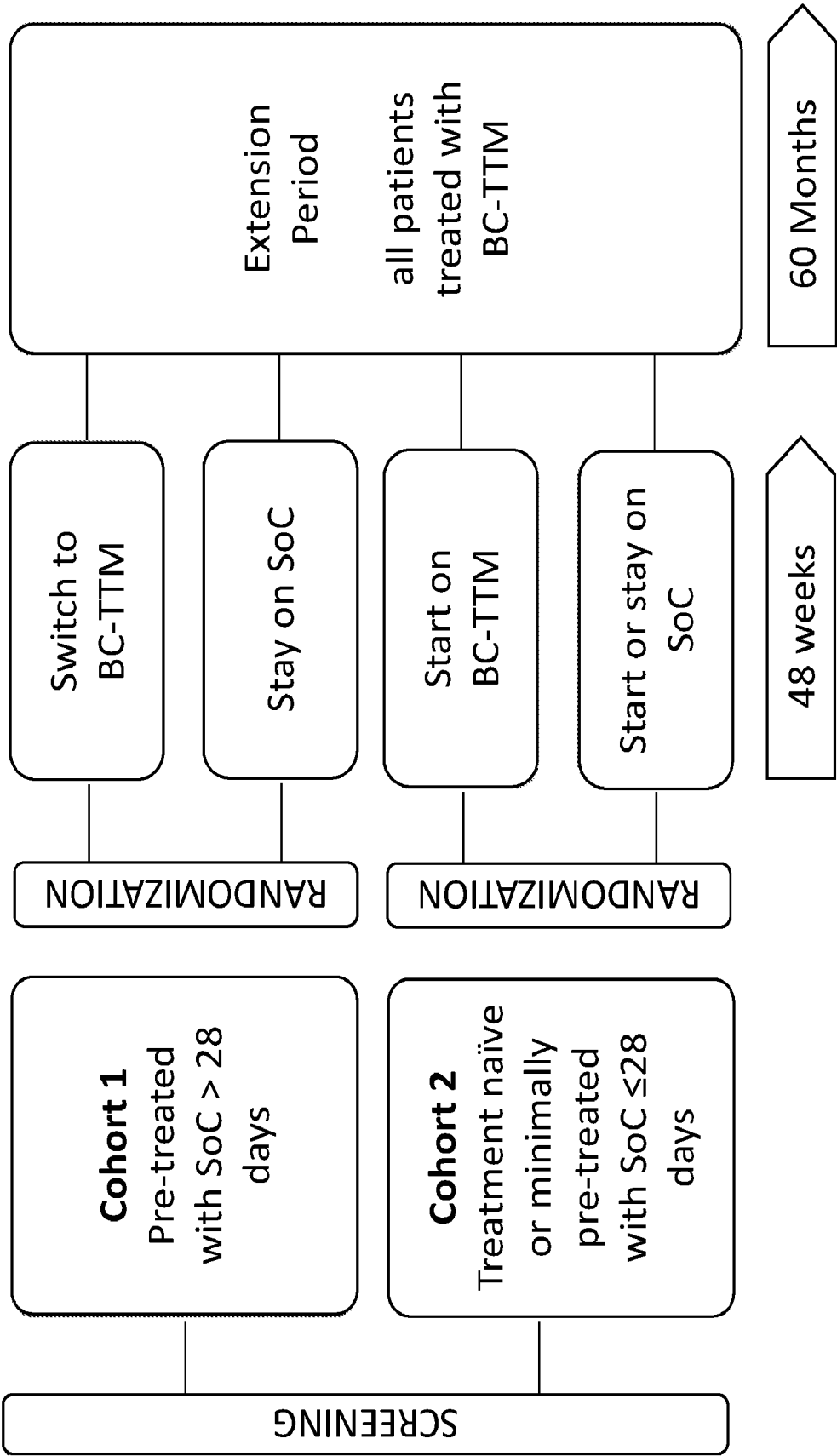


FIGURE 2

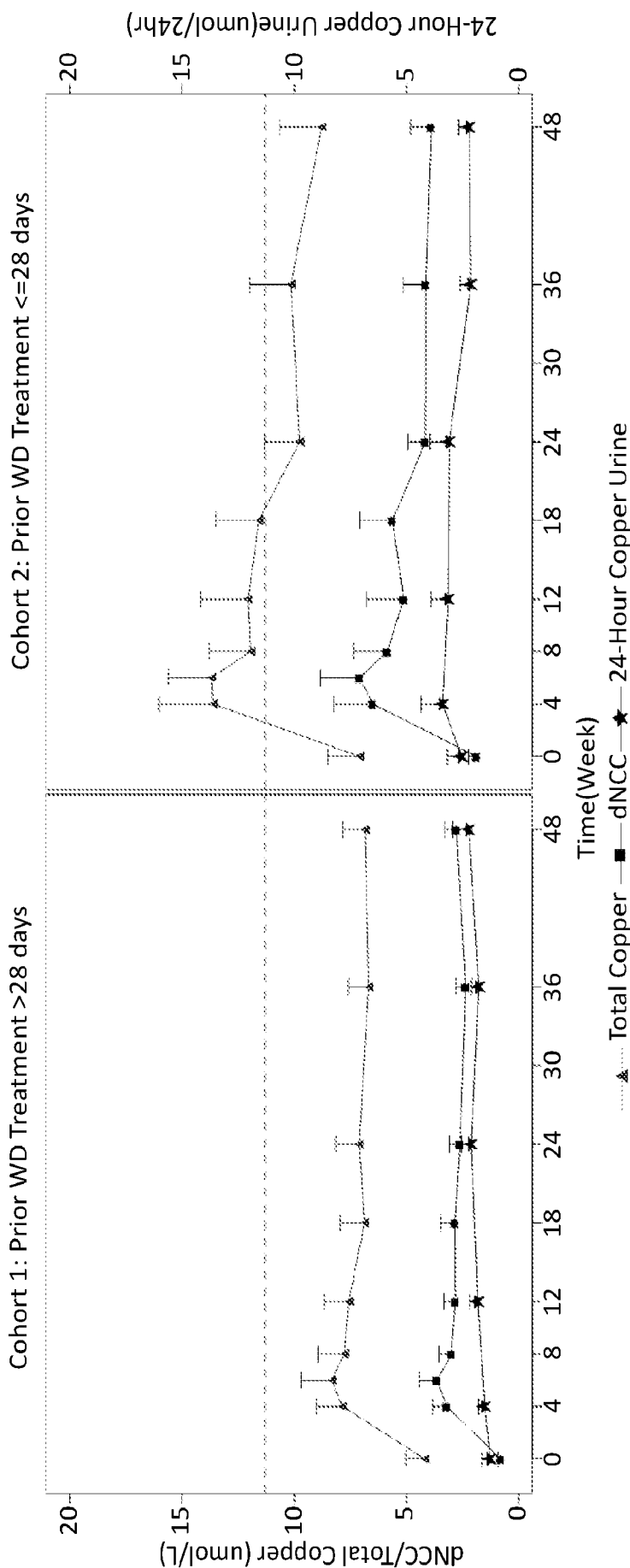


FIGURE 3

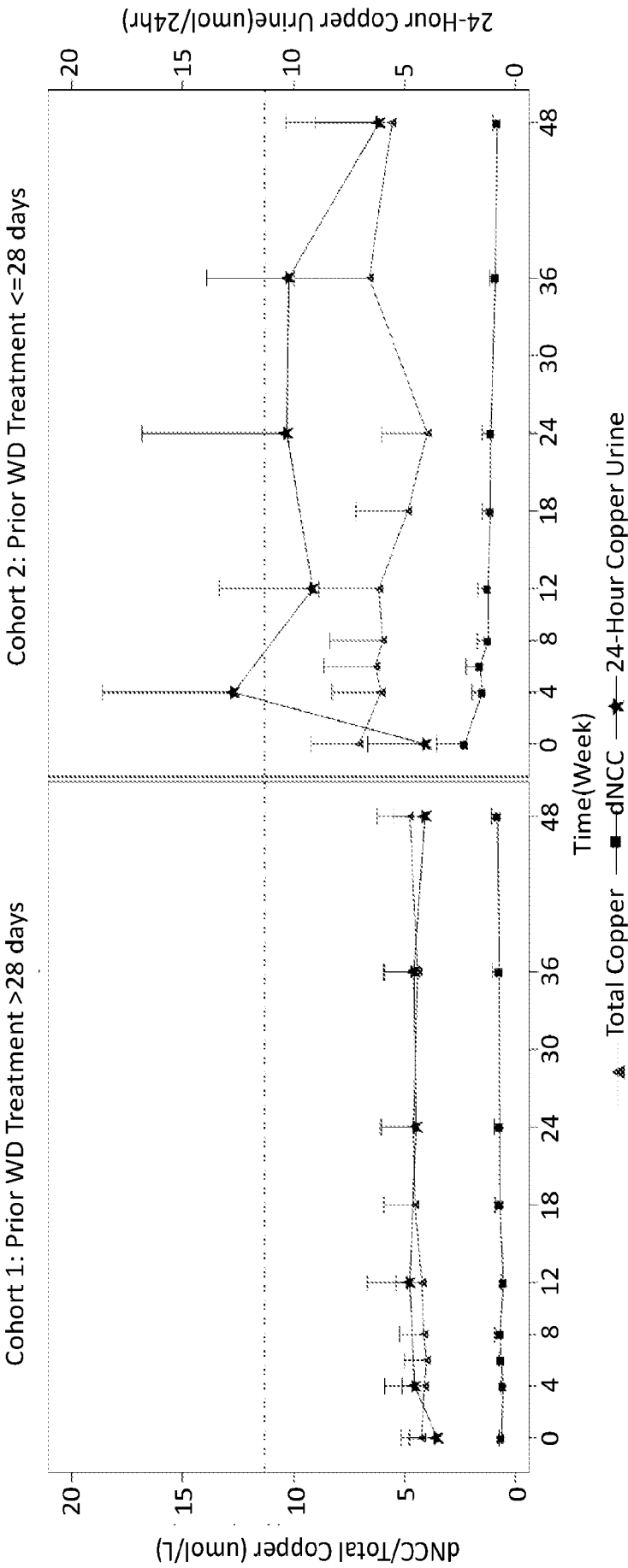


FIGURE 4

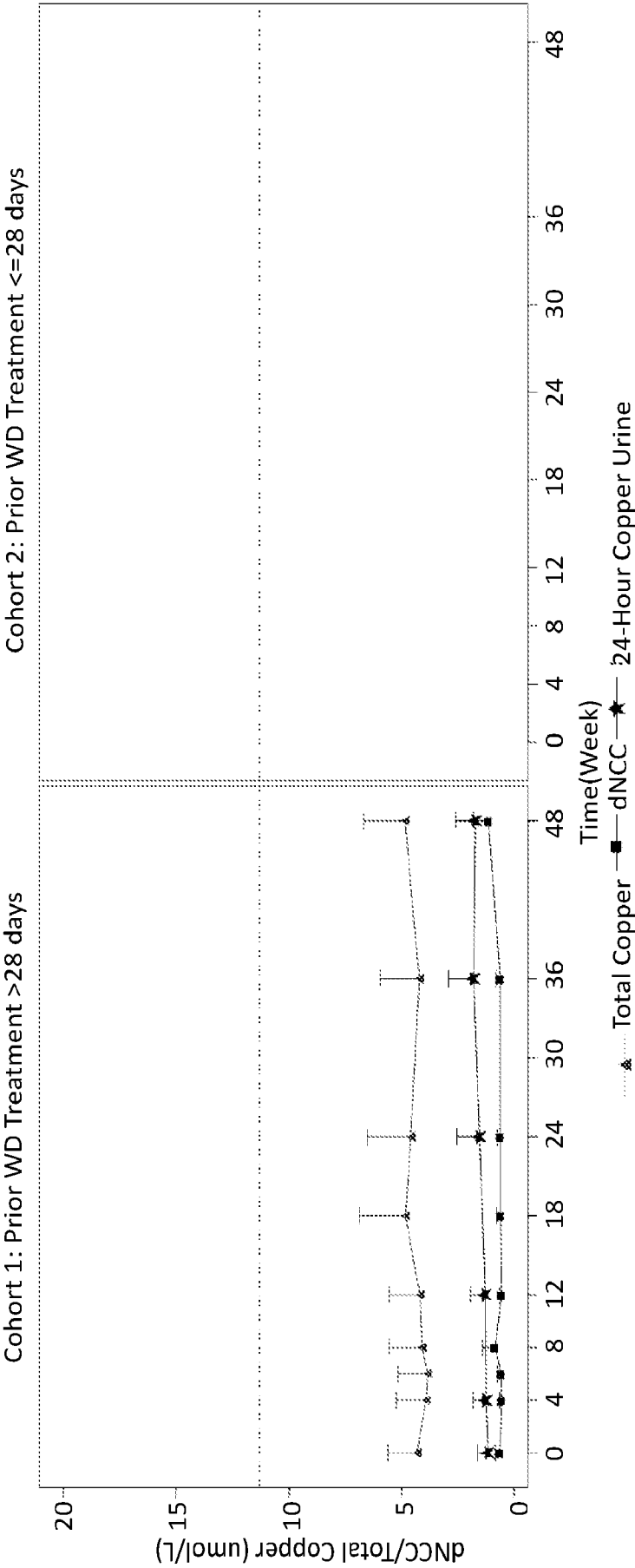


FIGURE 5

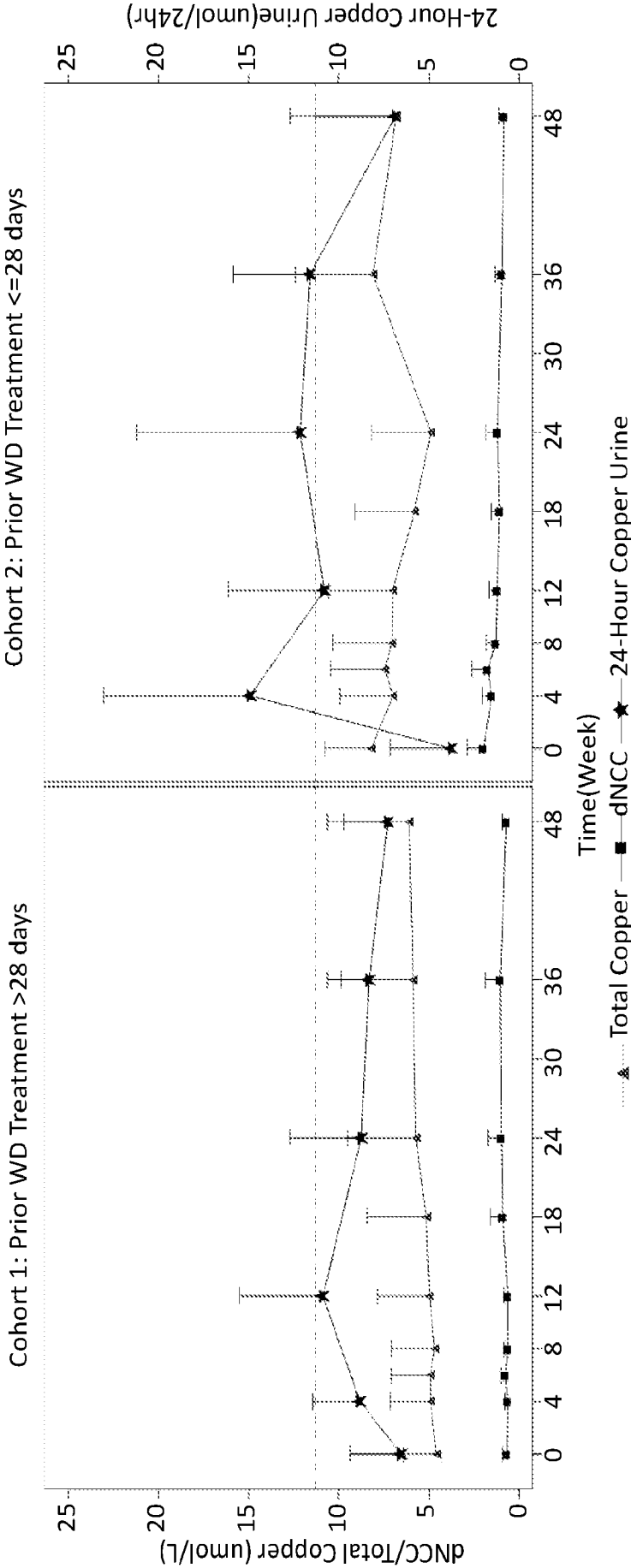


FIGURE 6

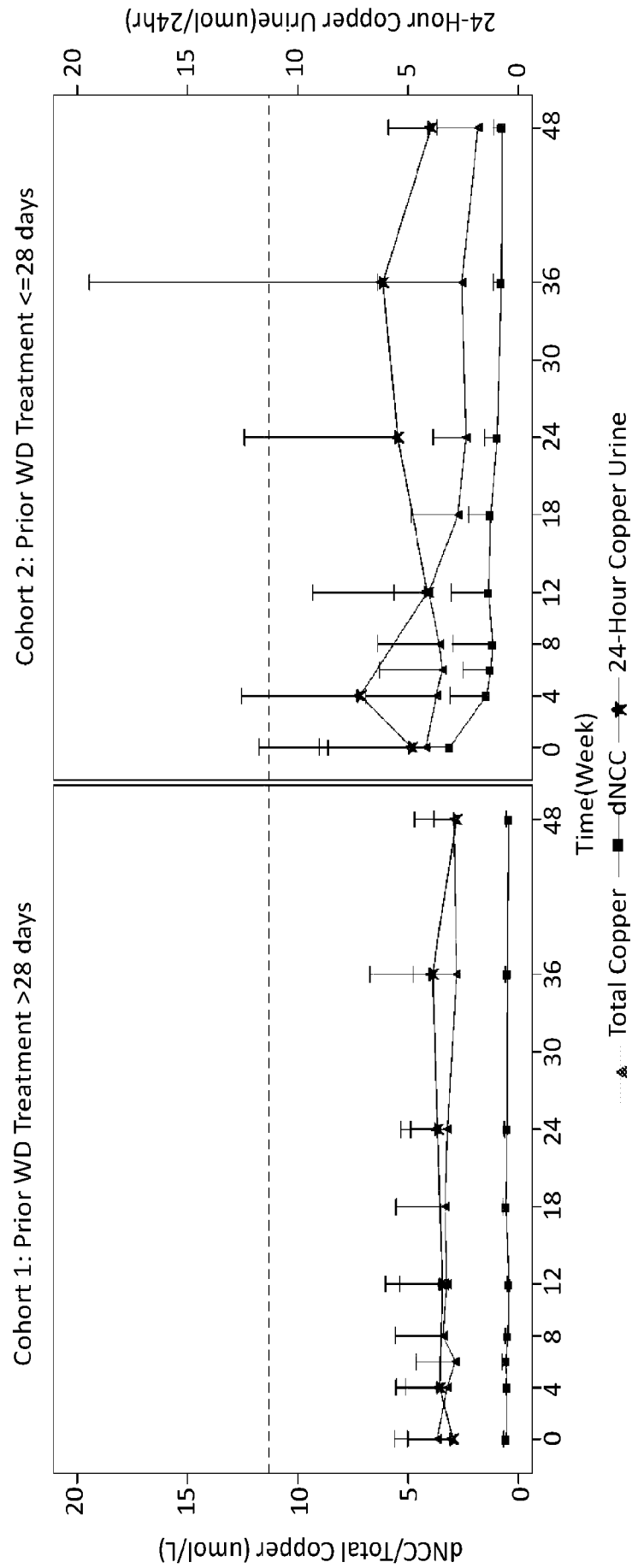


FIGURE 7

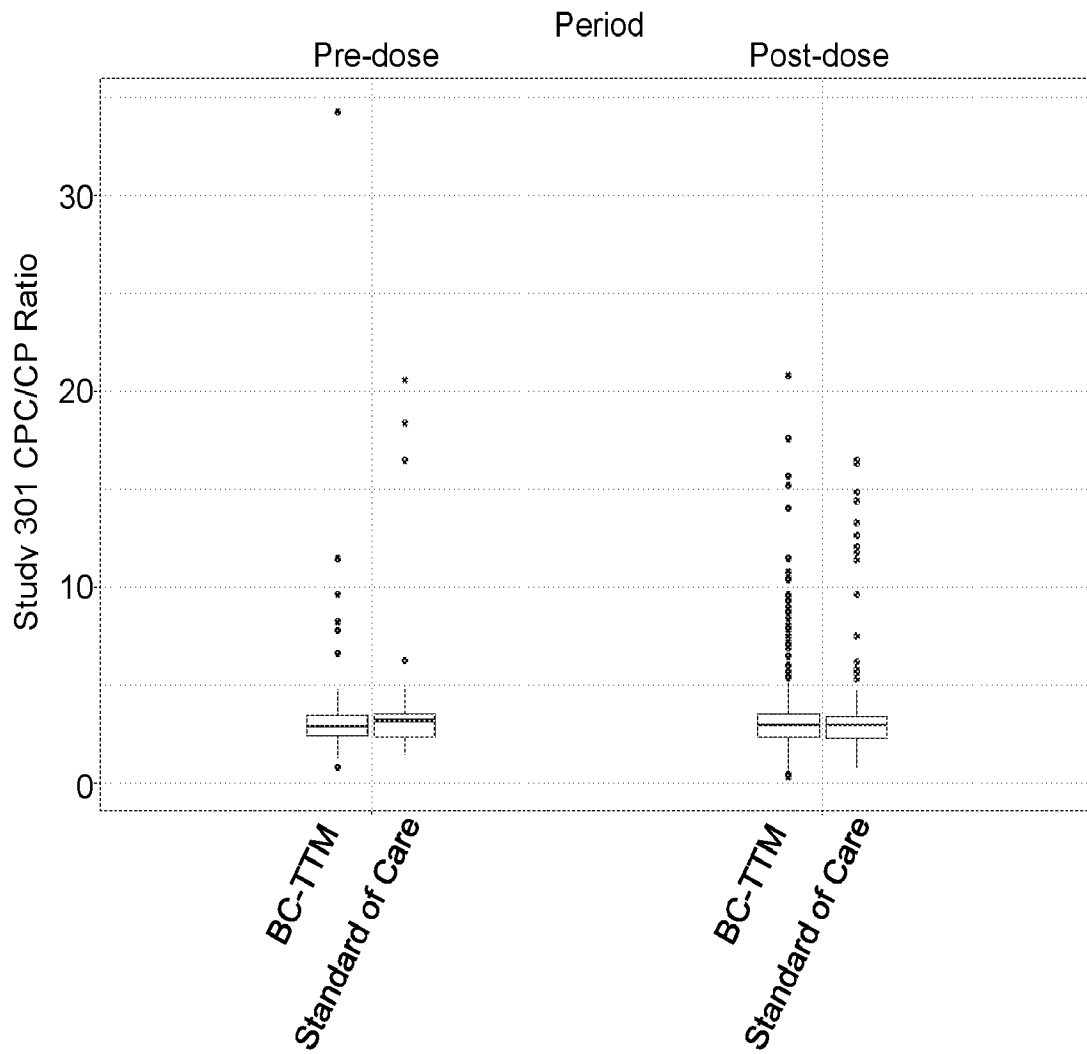


FIGURE 8

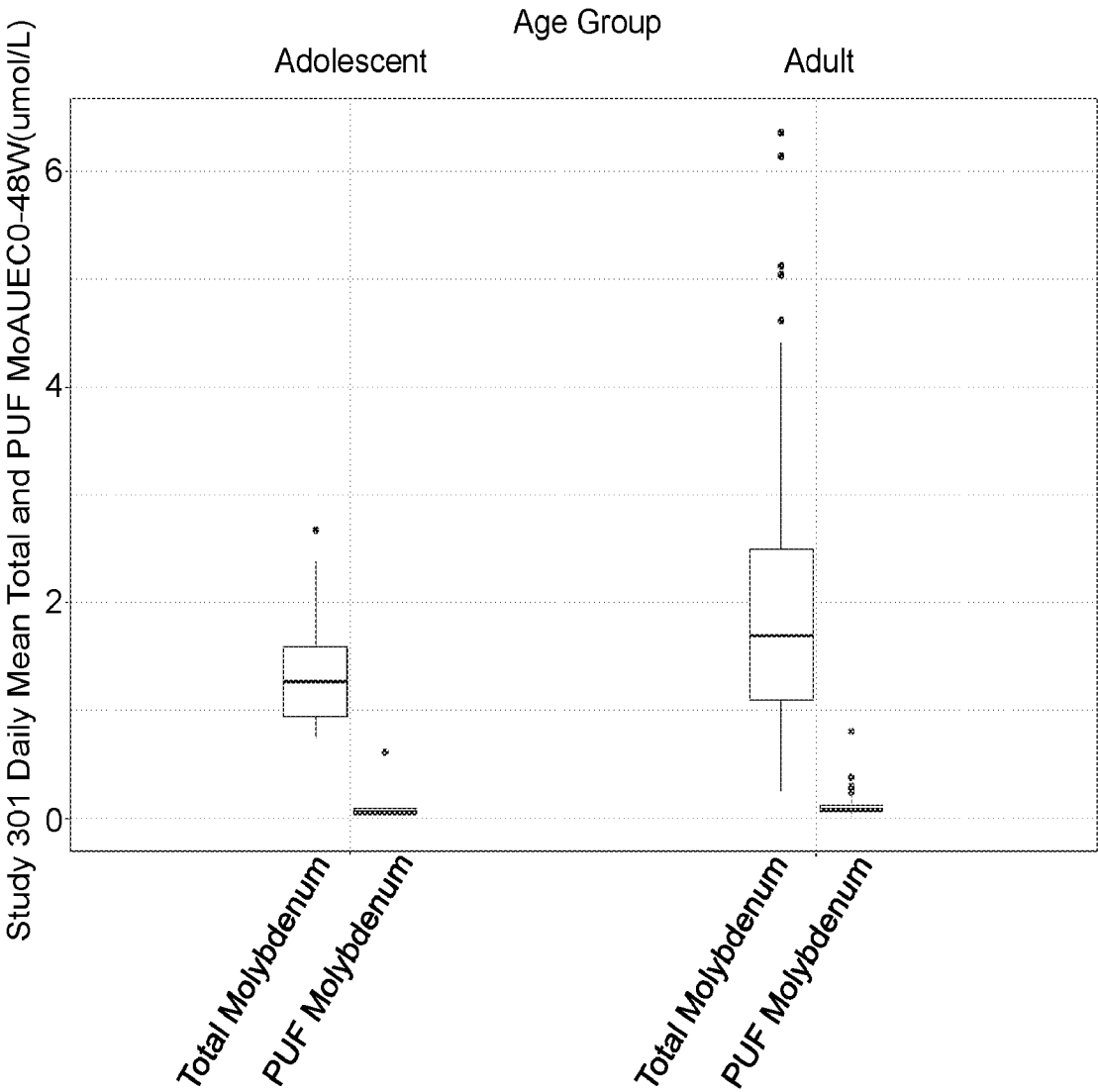


FIGURE 9

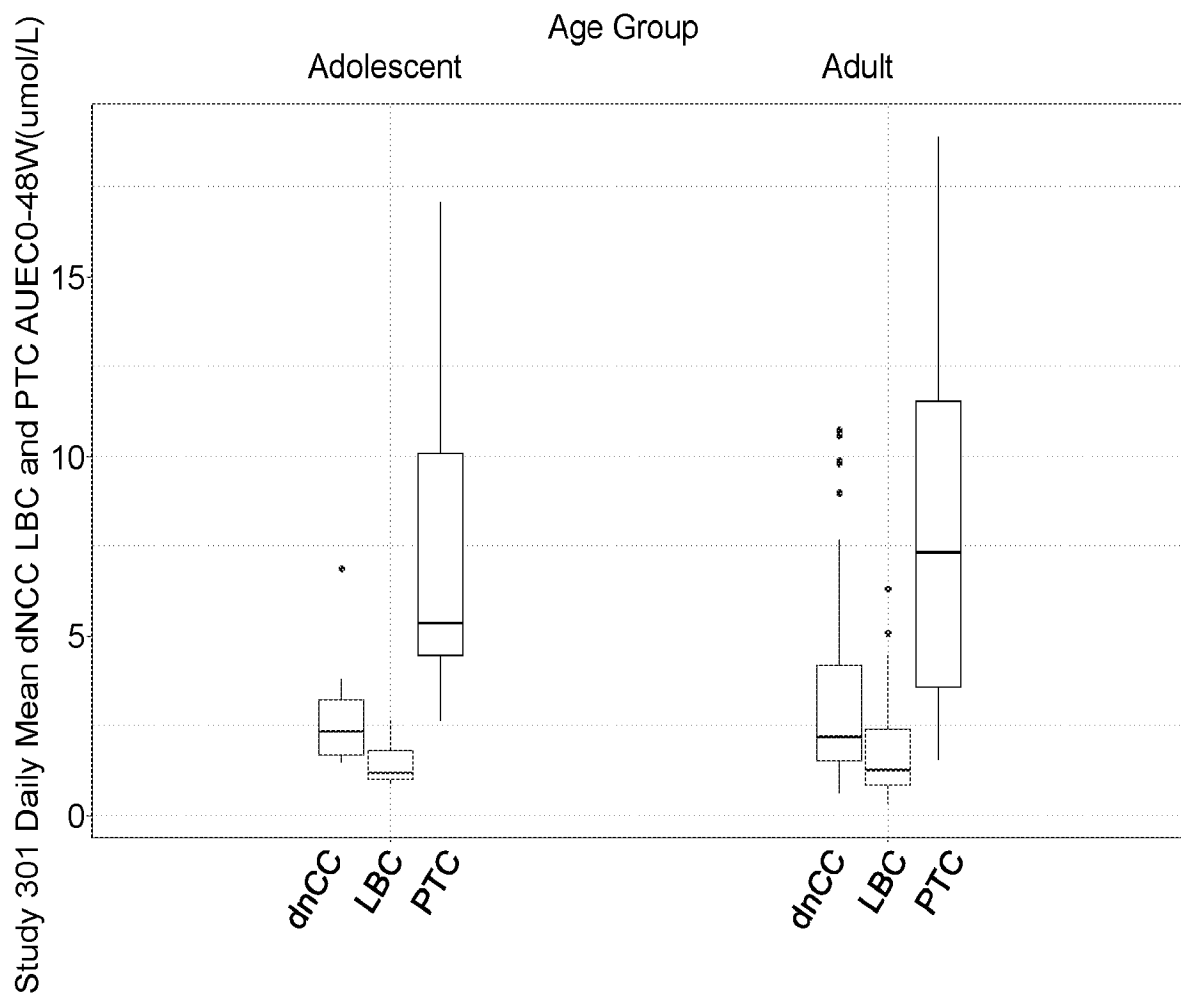


FIGURE 10

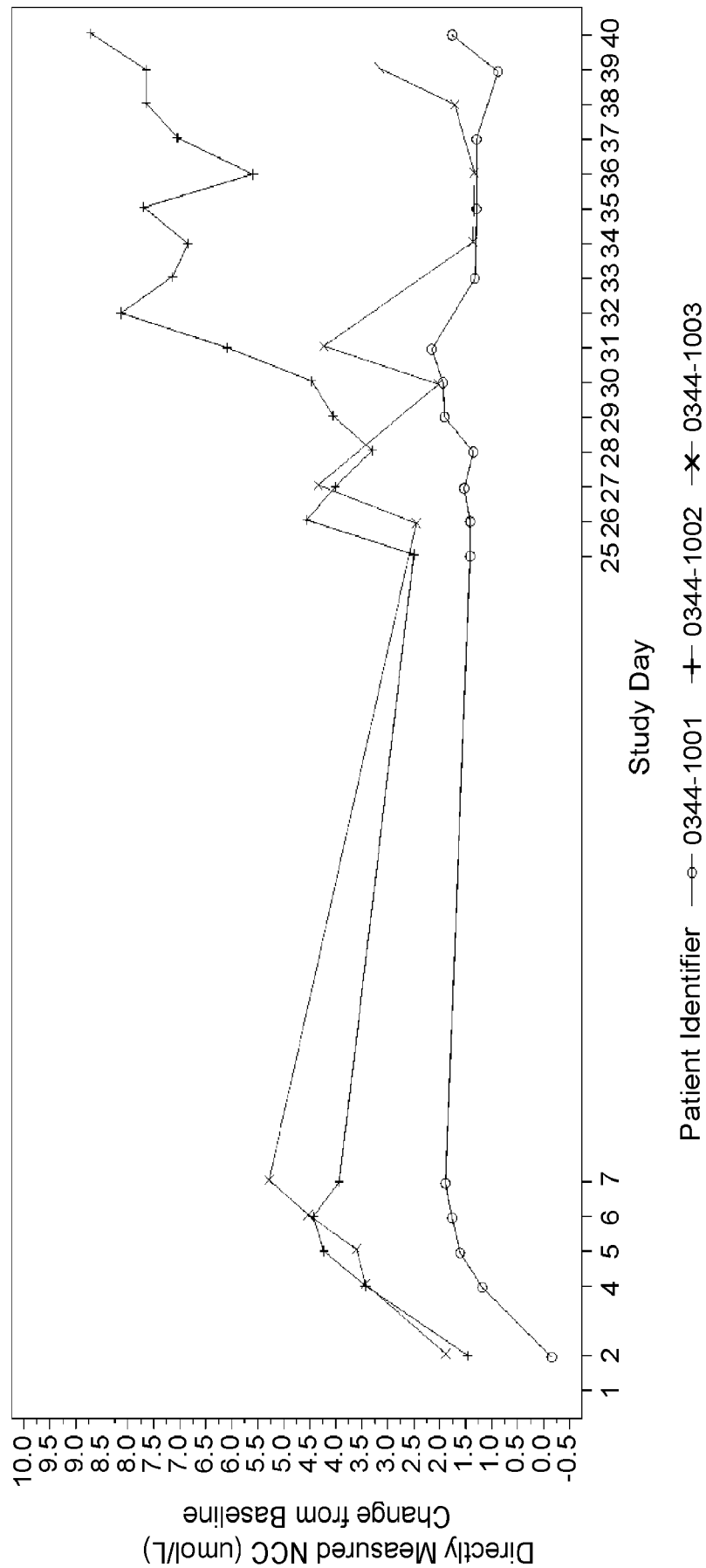


FIGURE 11

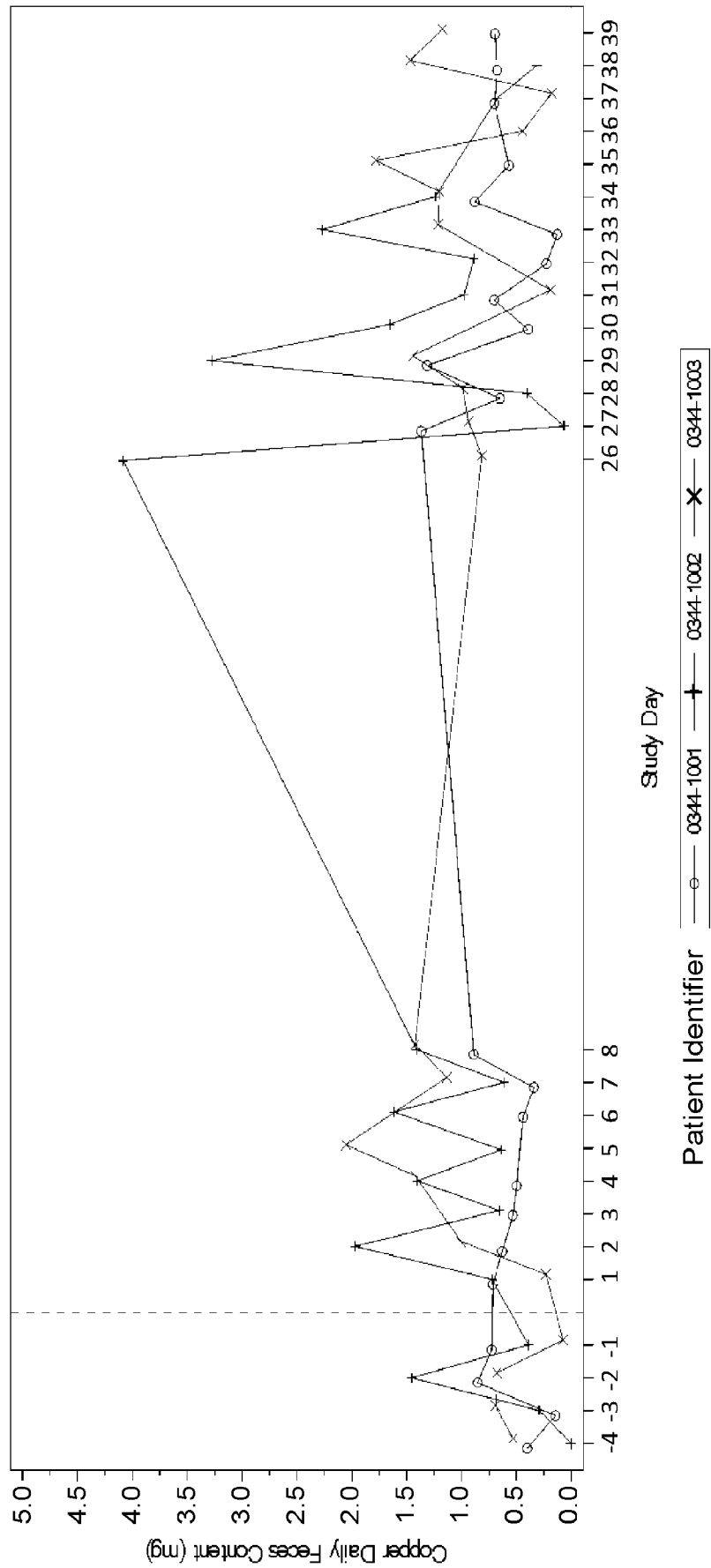


FIGURE 12

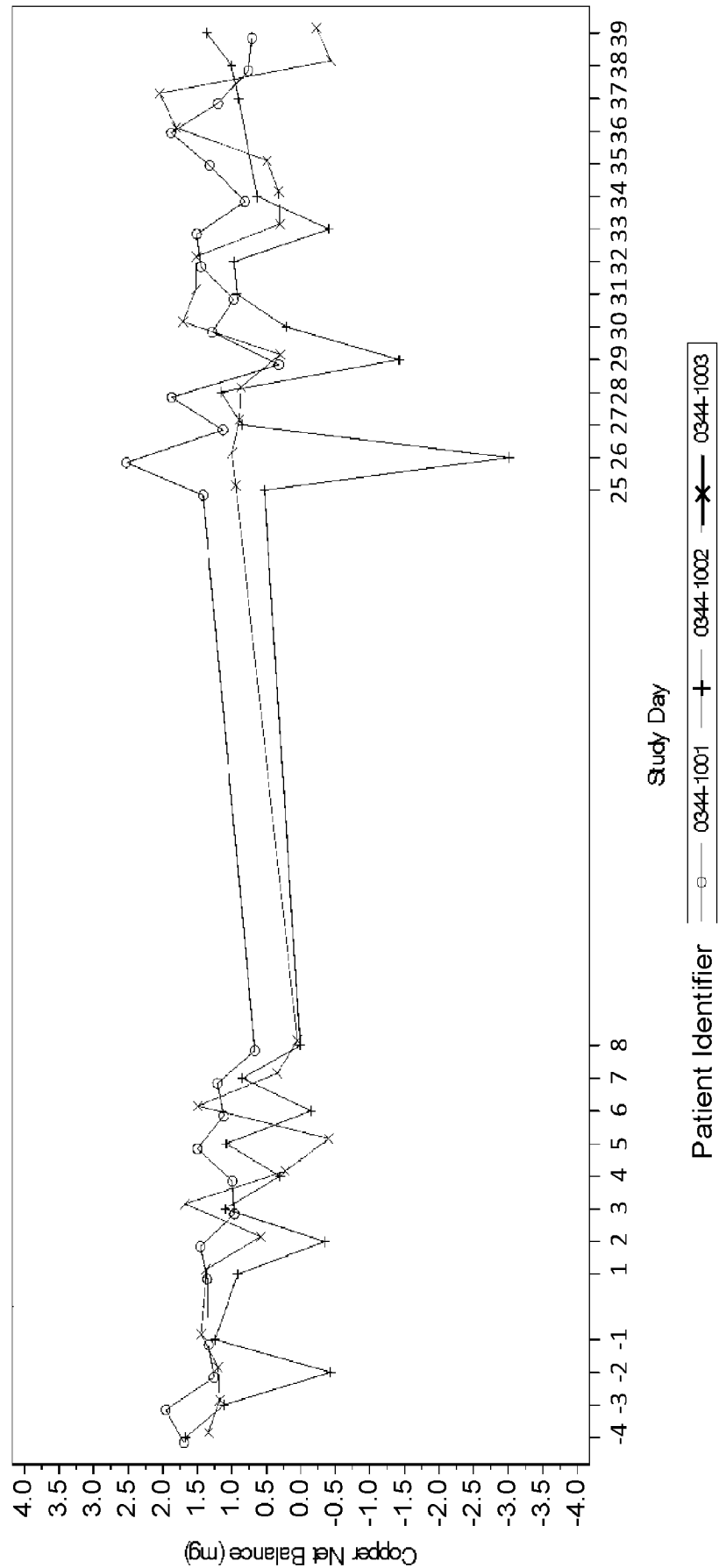


FIGURE 13

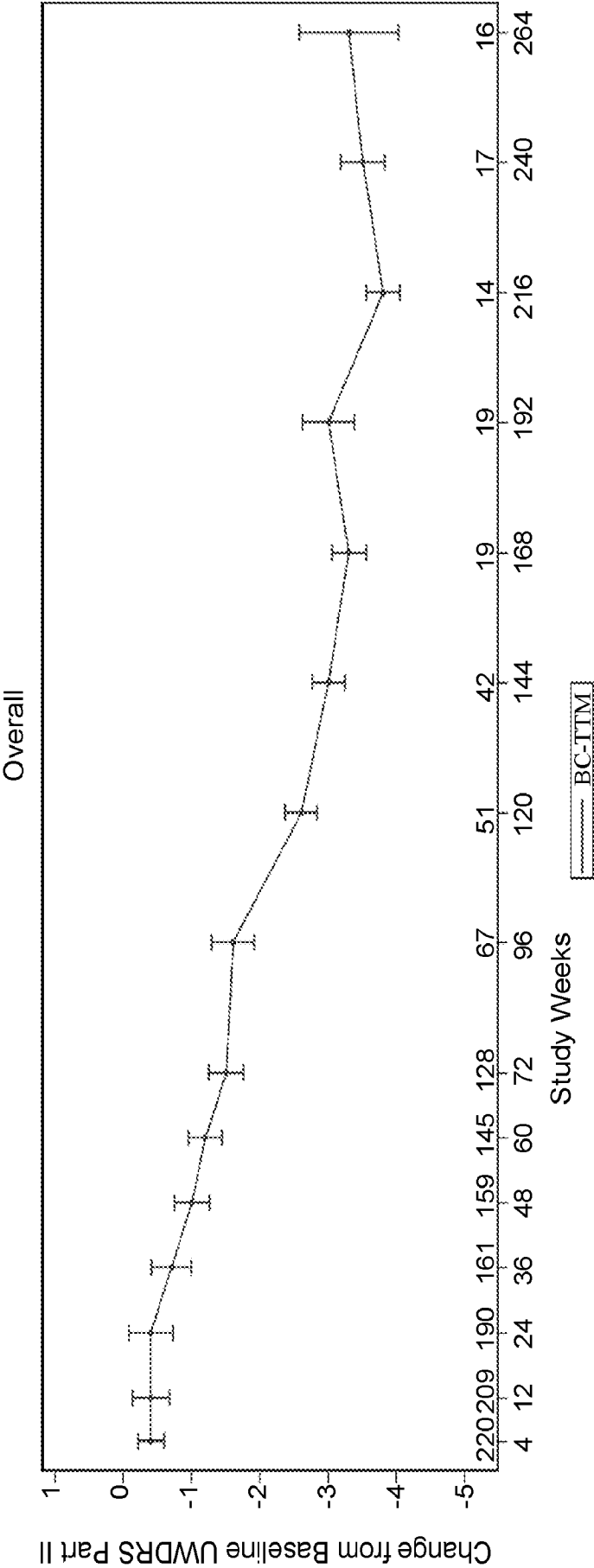


FIGURE 14

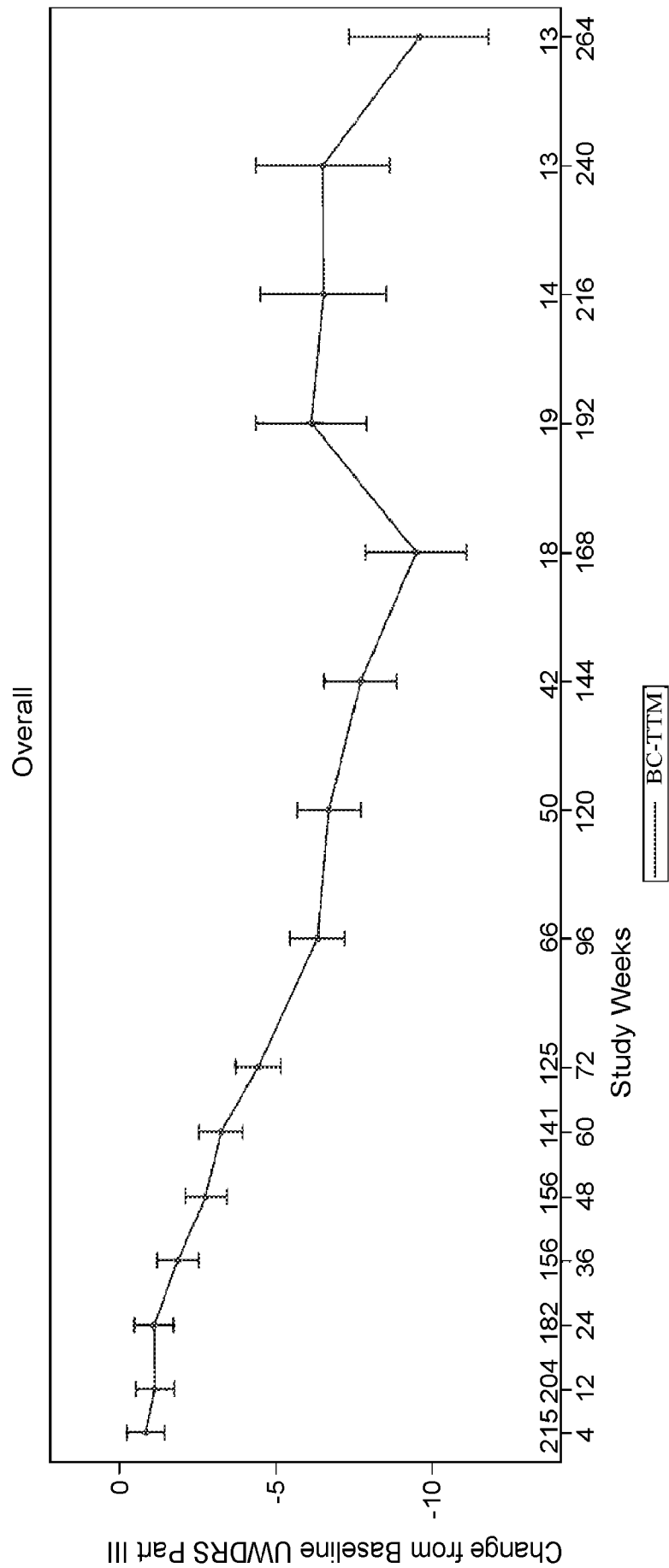


FIGURE 15

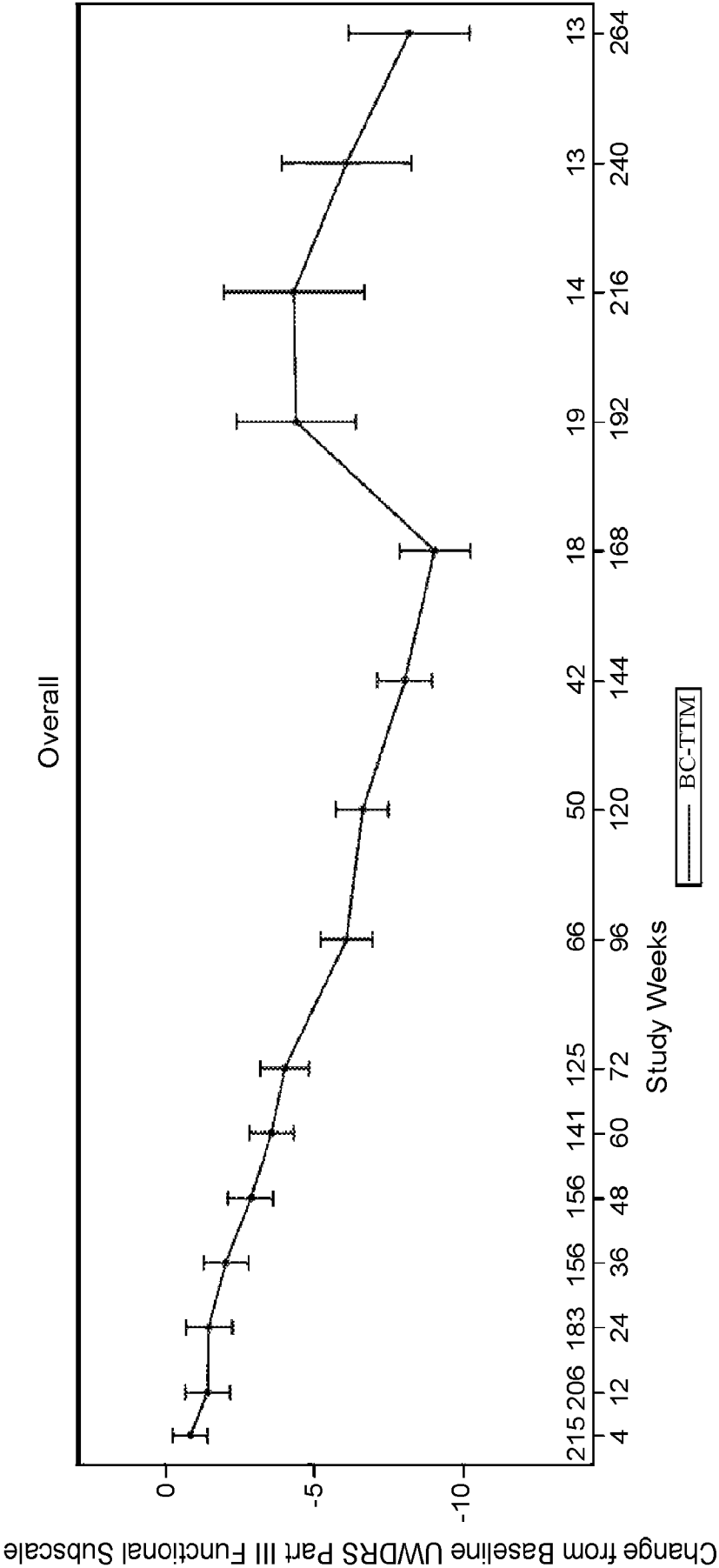


FIGURE 16

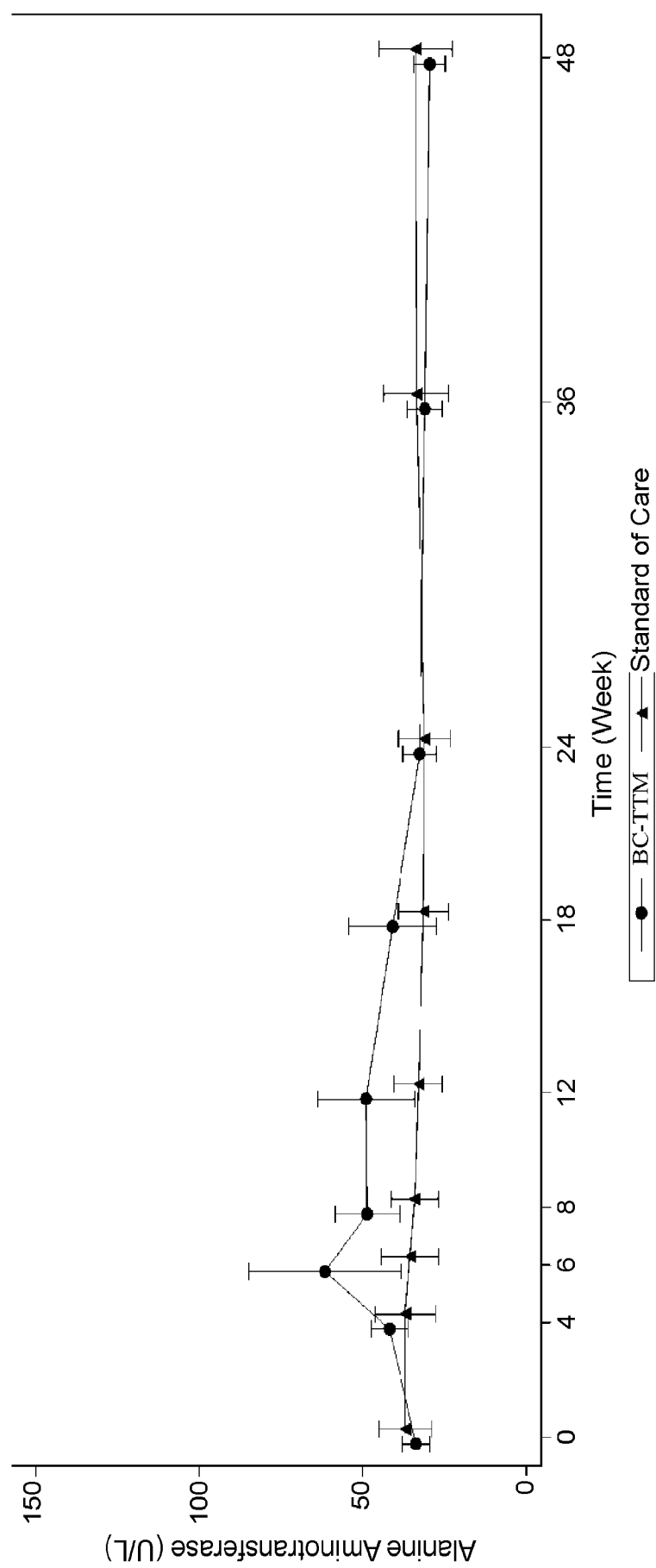


FIGURE 17

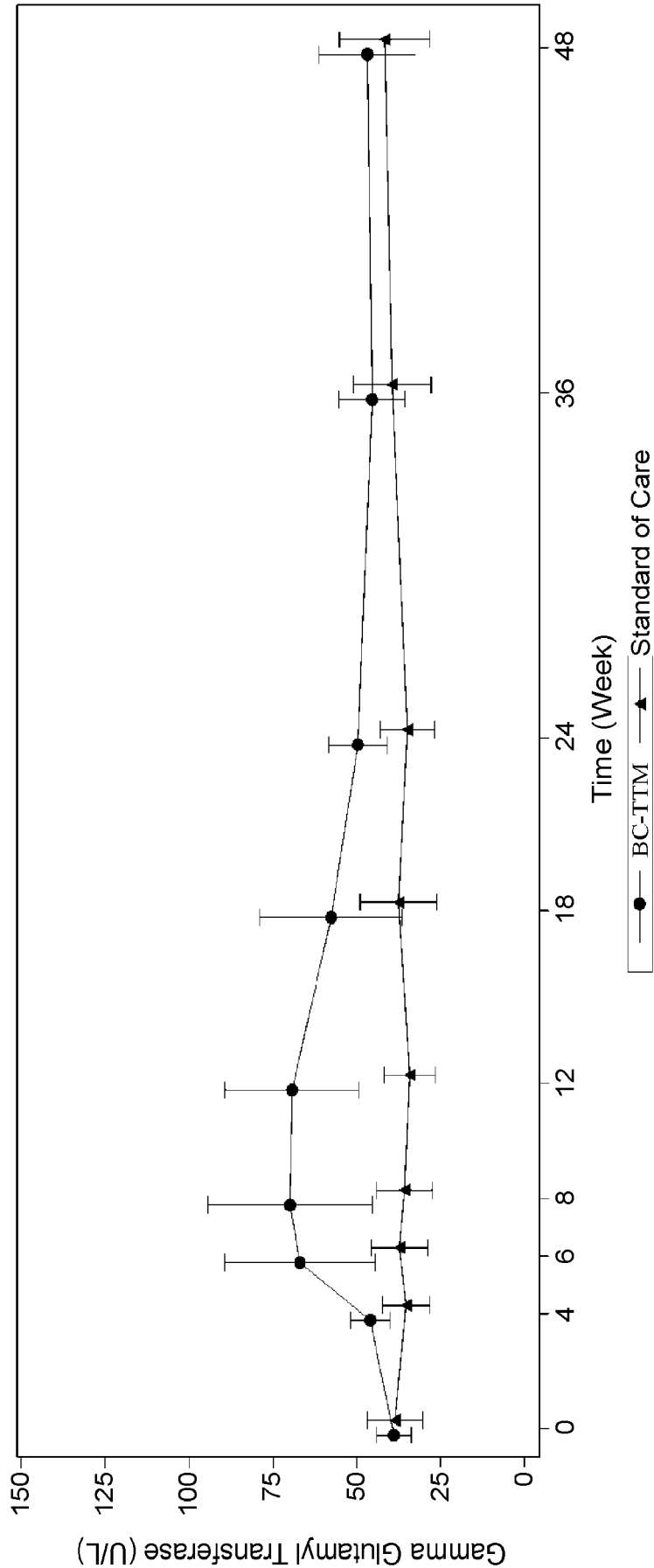


FIGURE 18

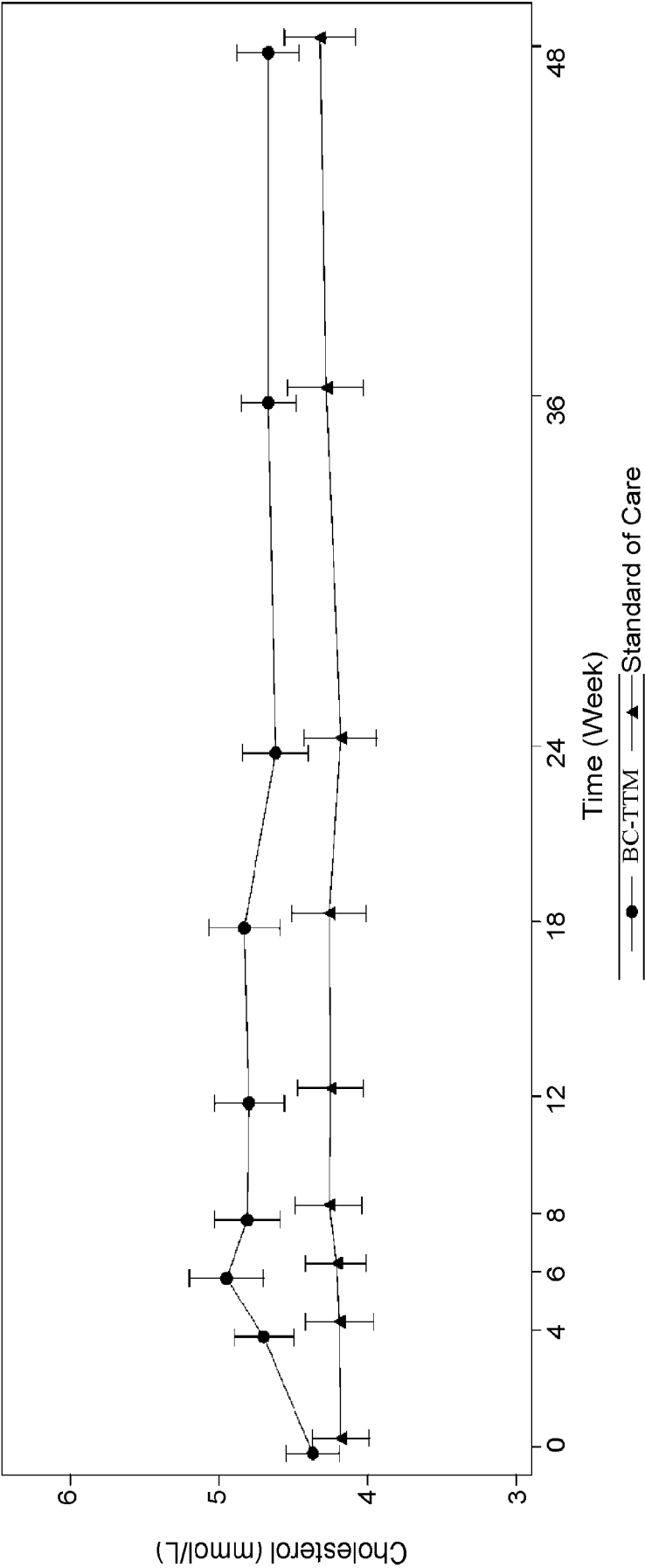


FIGURE 19

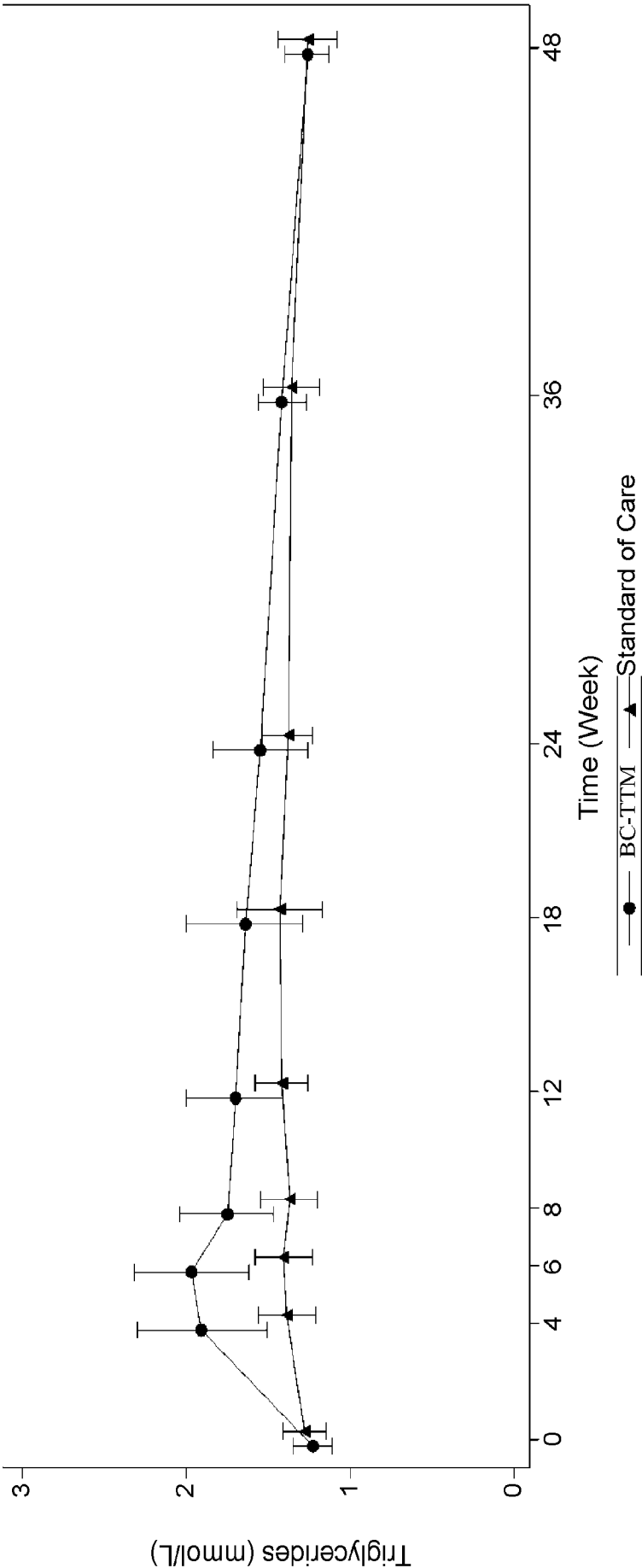


FIGURE 20

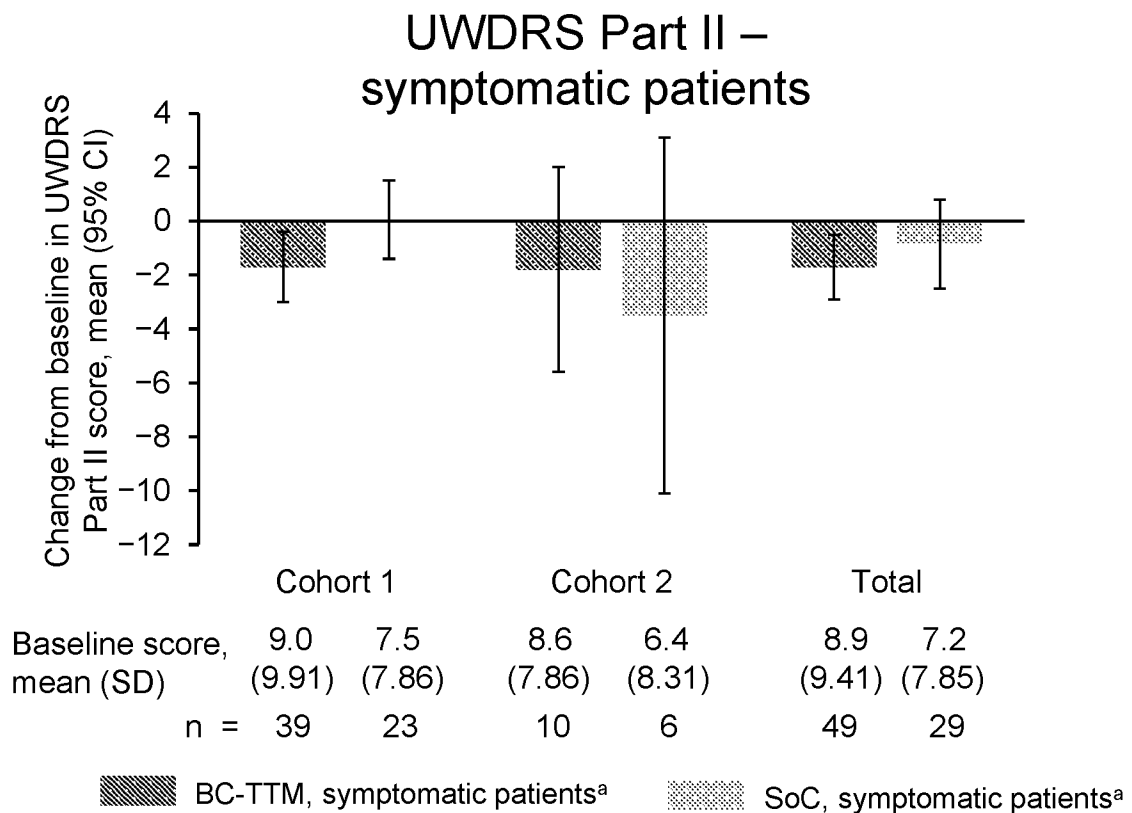
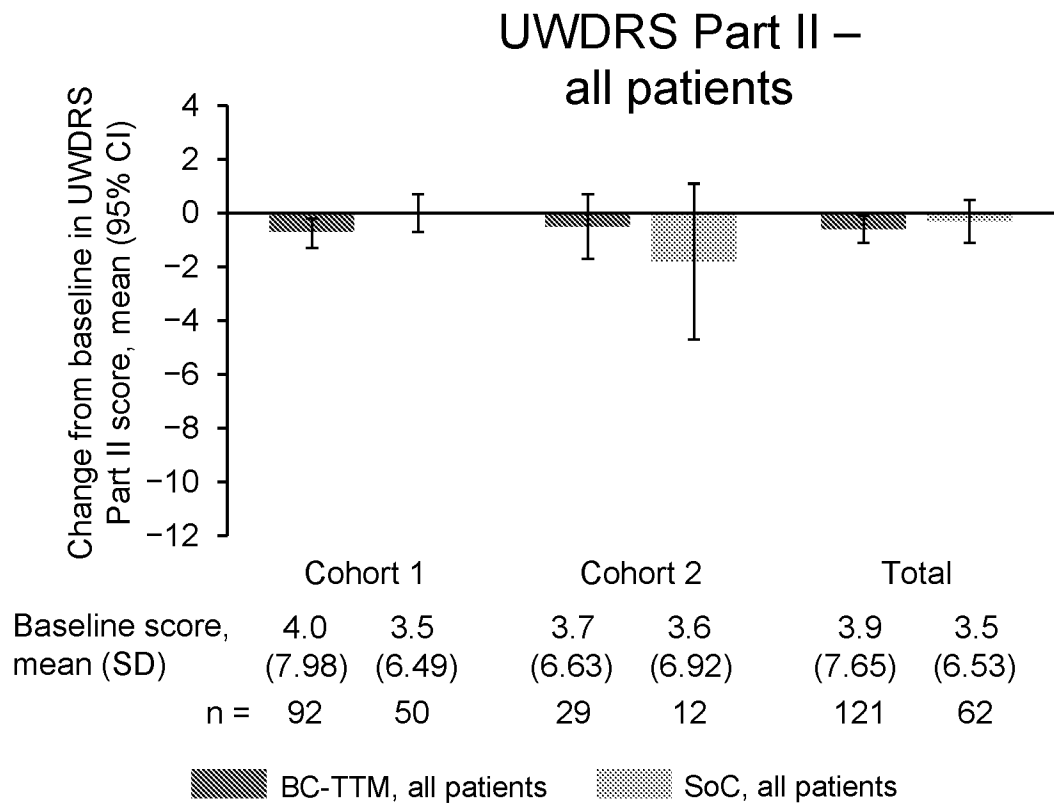


FIGURE 21

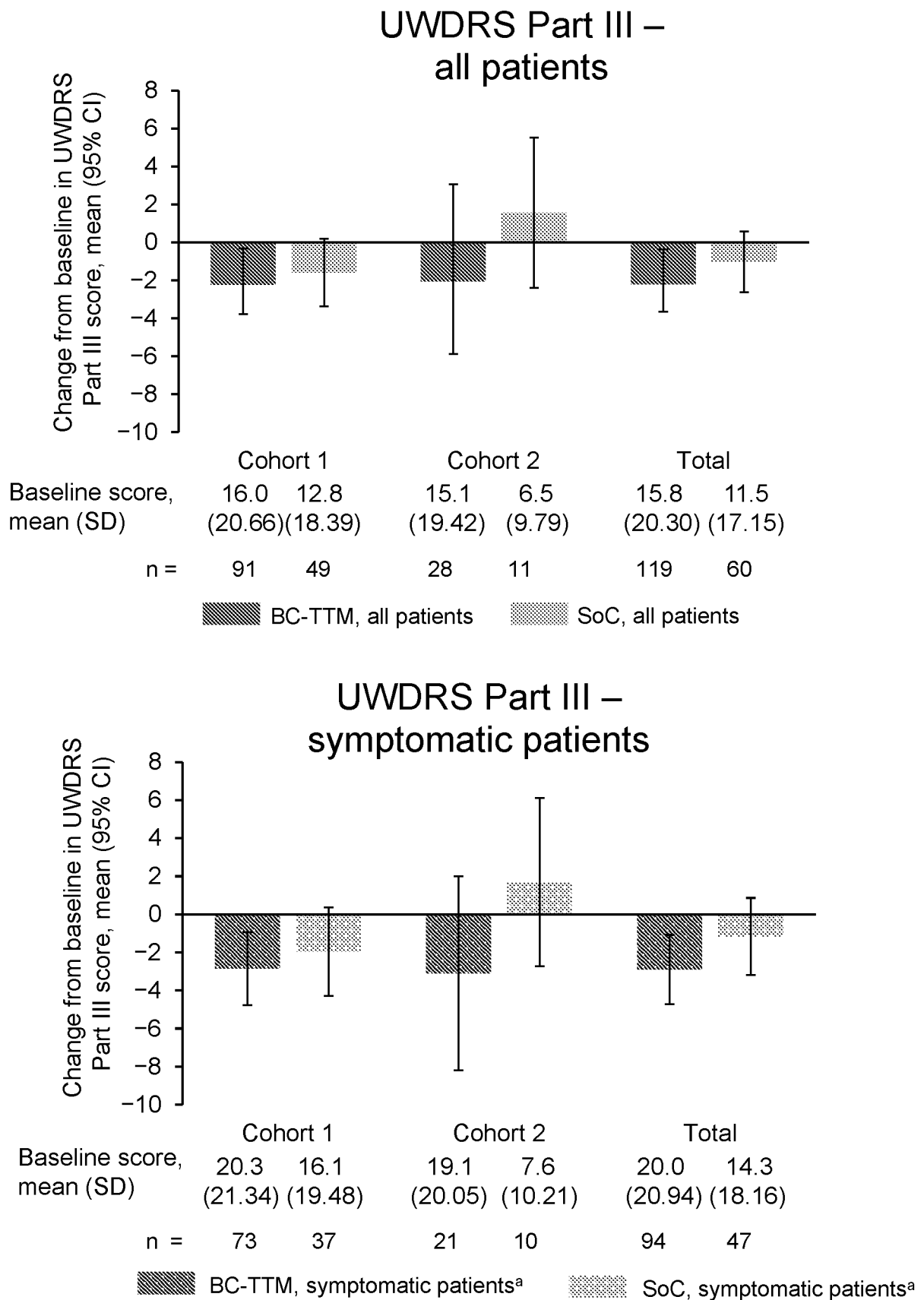


FIGURE 22

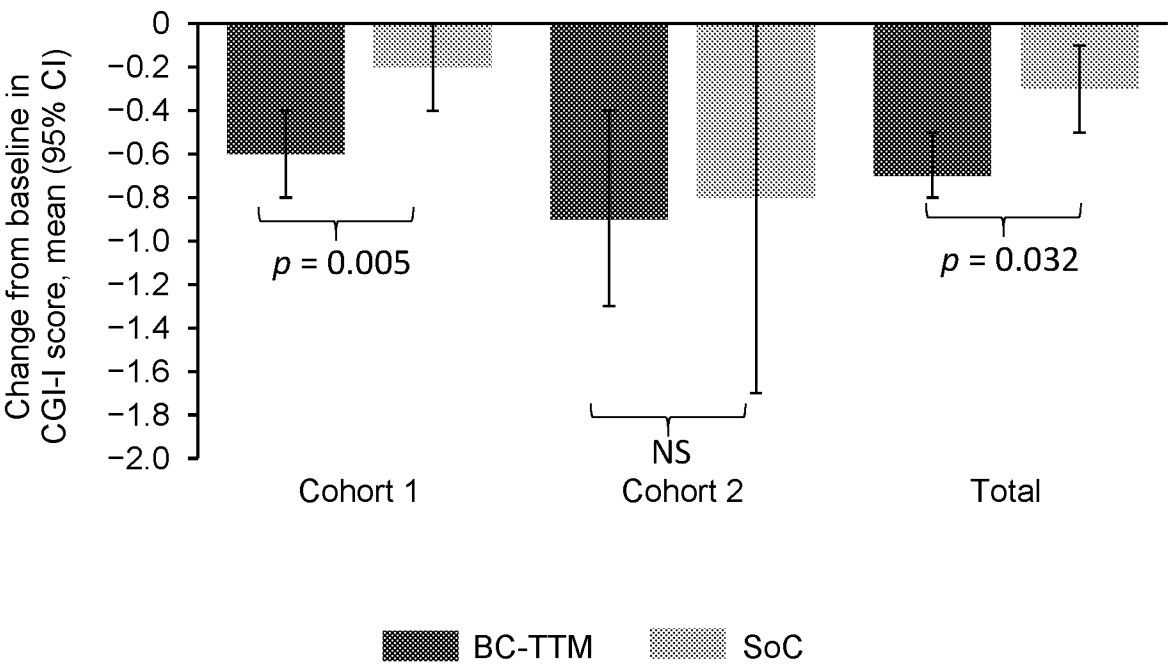


FIGURE 23

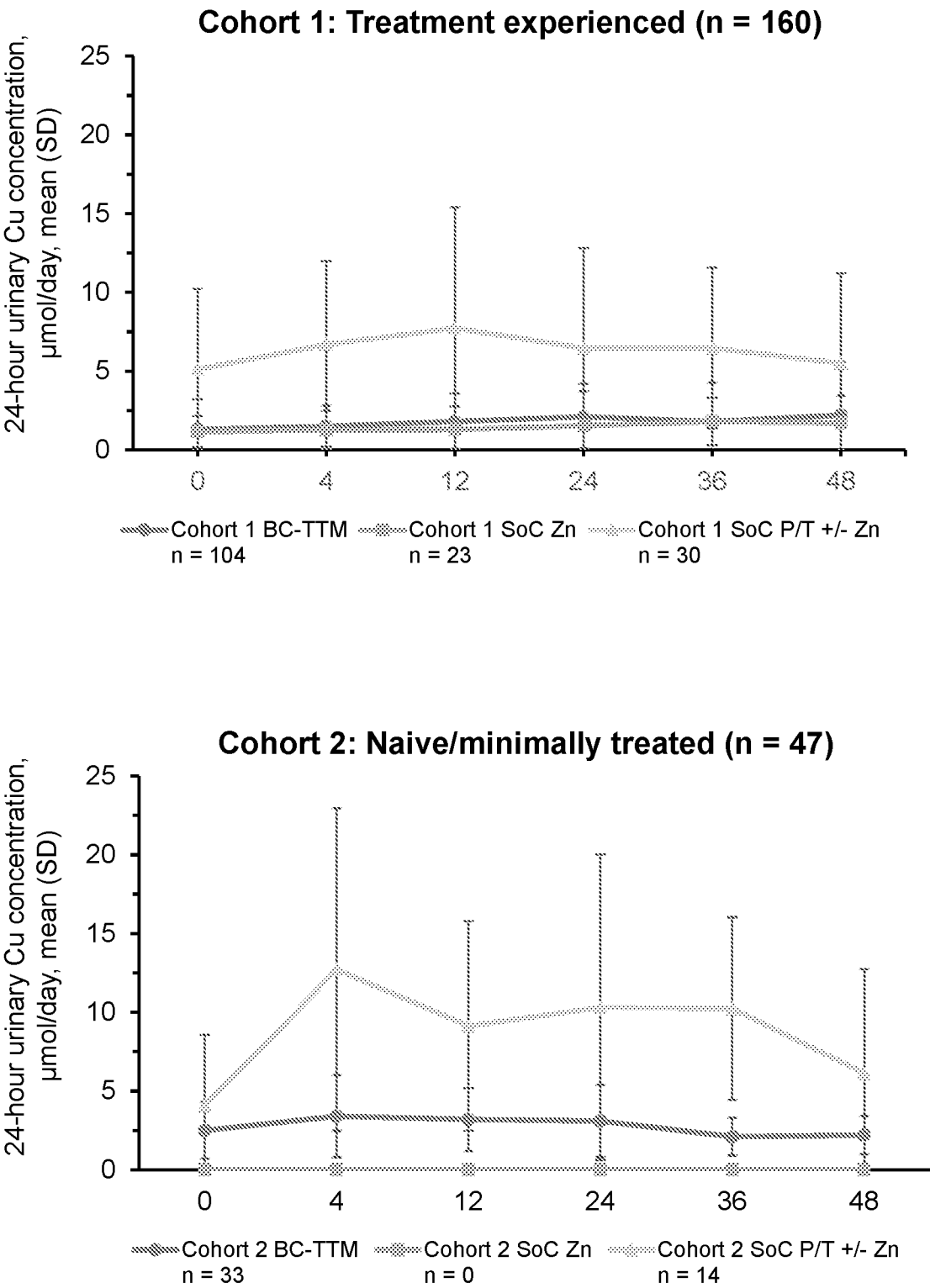


FIGURE 24

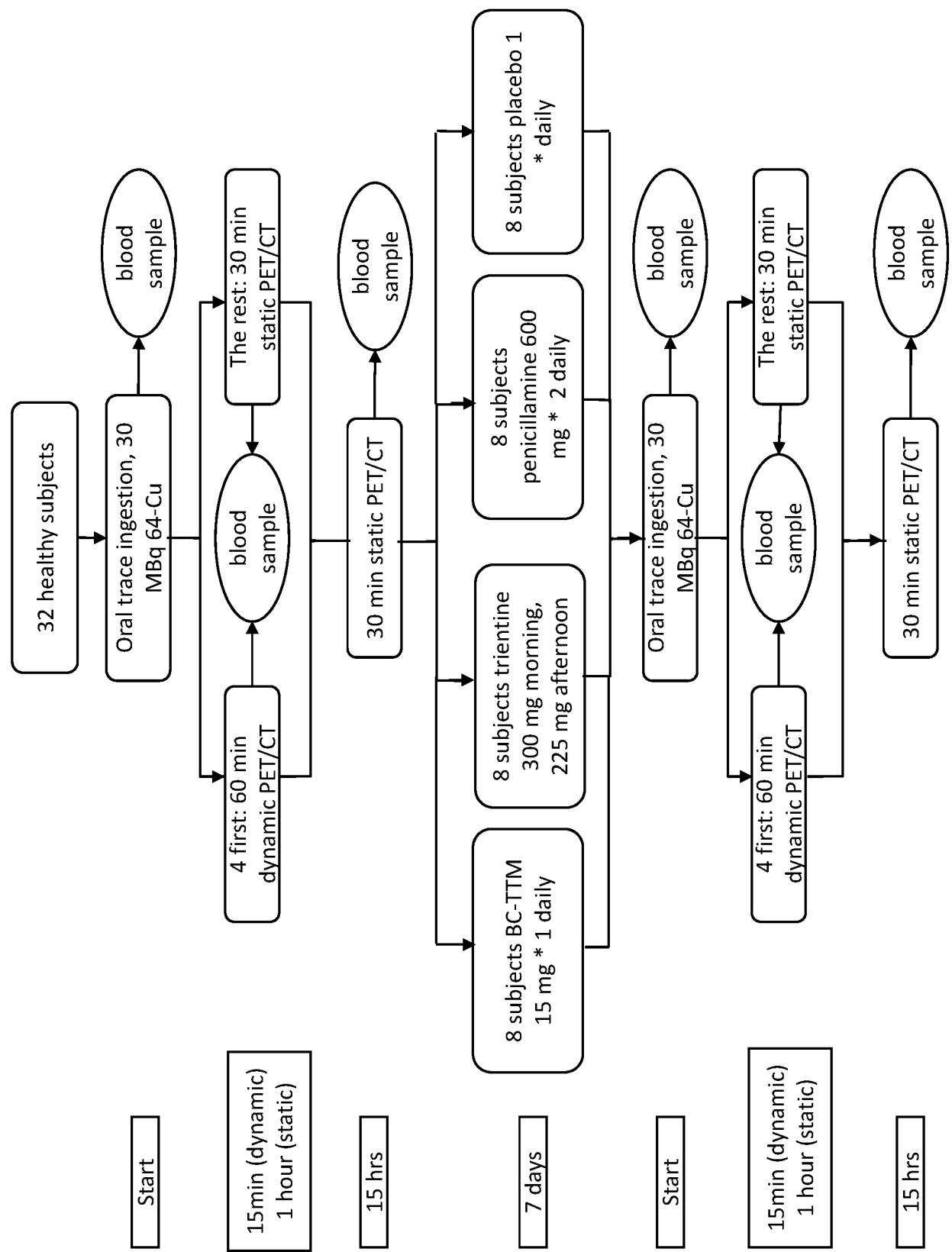
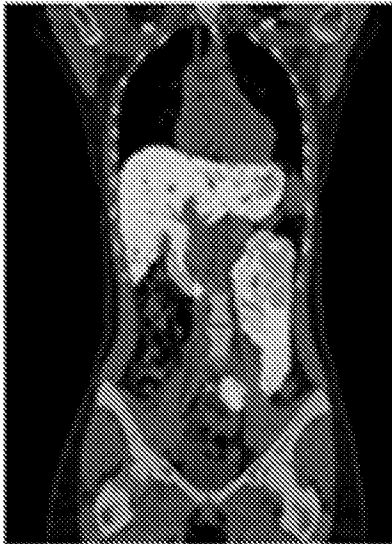


FIGURE 25

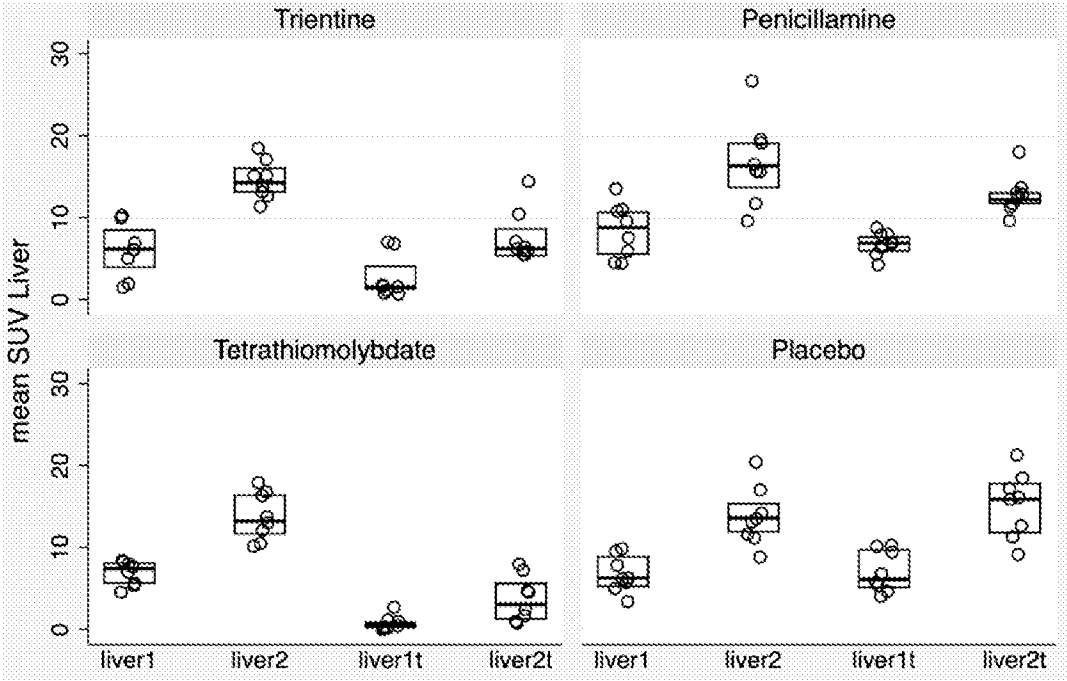


Before treatment

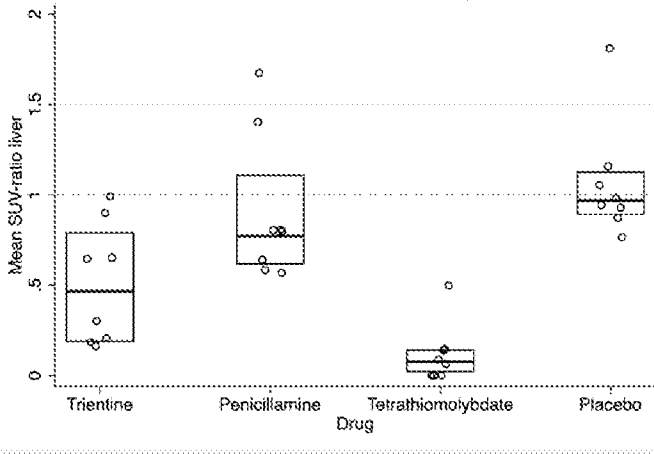


After treatment

FIGURE 26



Mean SUV-ratio in liver. 1 hour post 64Cu.



Mean SUV-ratio in liver. 15 hour post 64Cu.

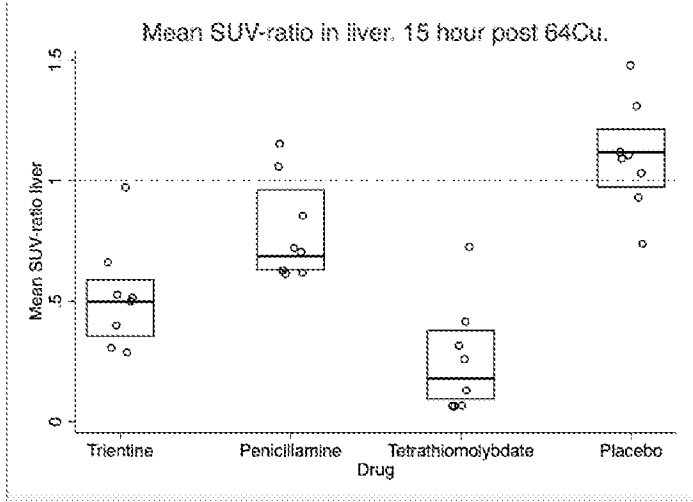


FIGURE 27

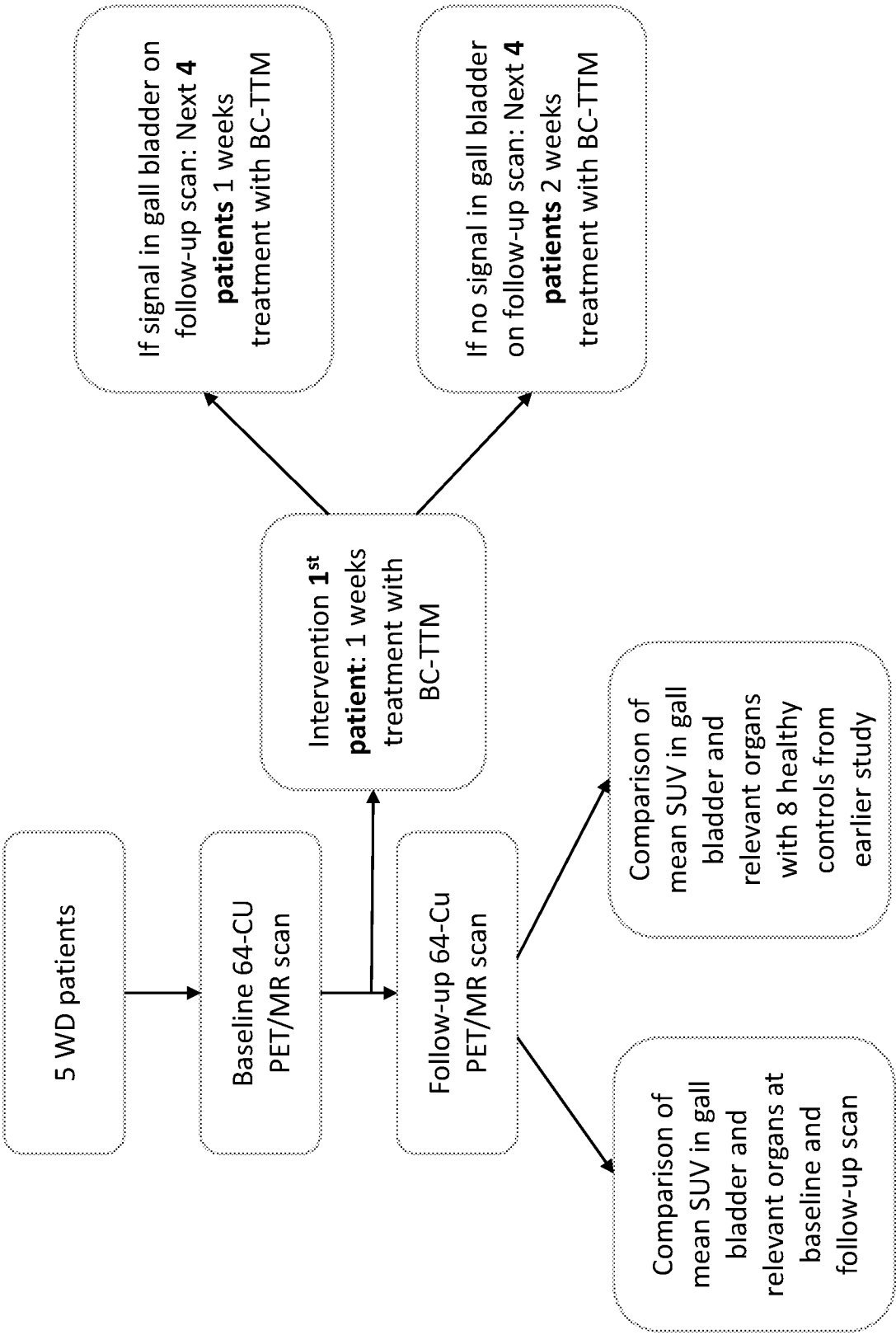
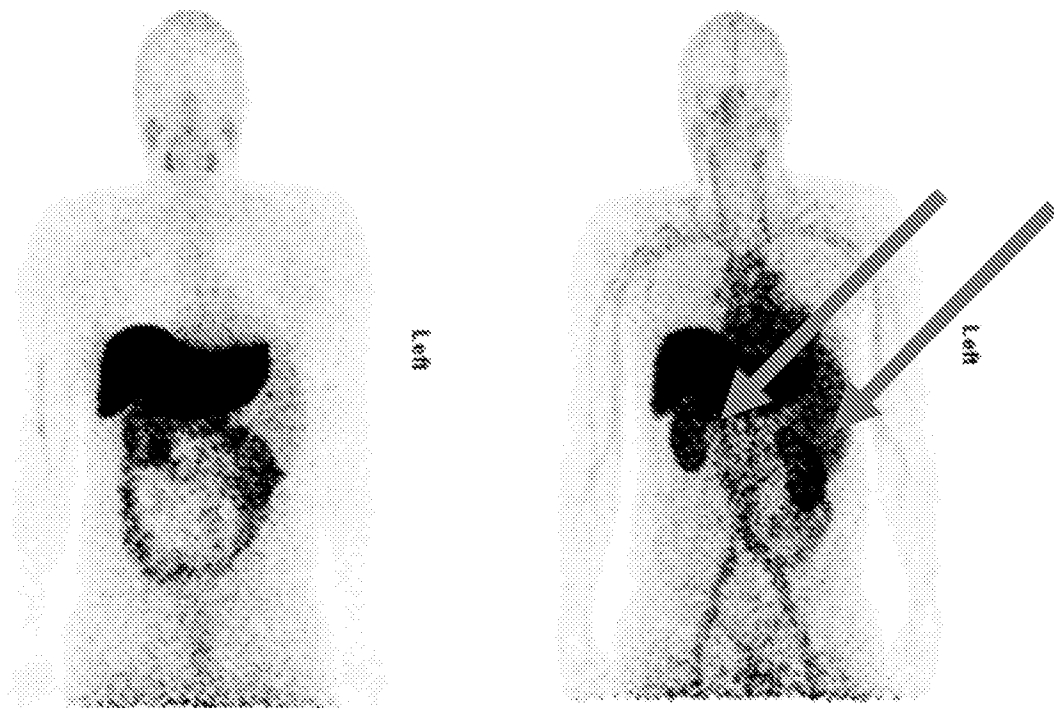
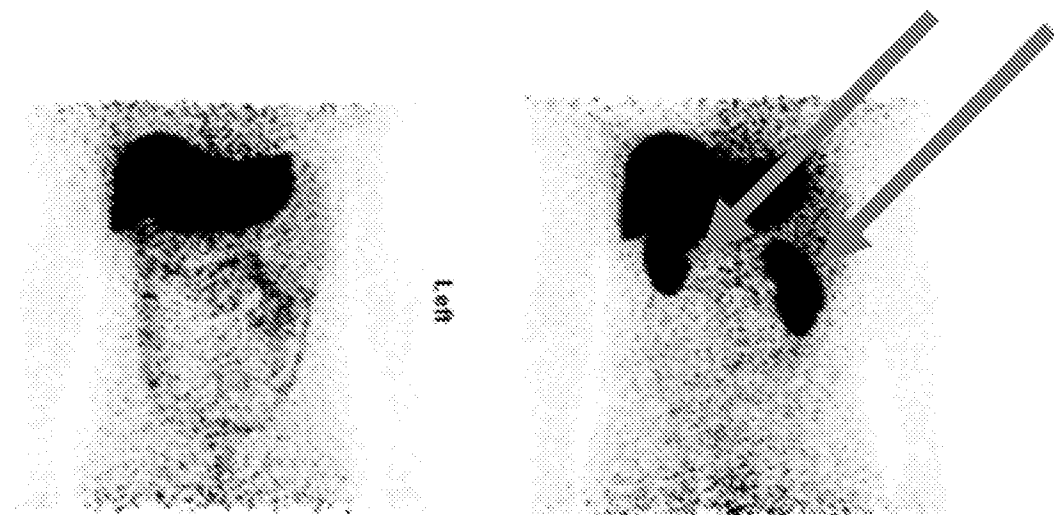


FIGURE 28



2 hour scan pre/post

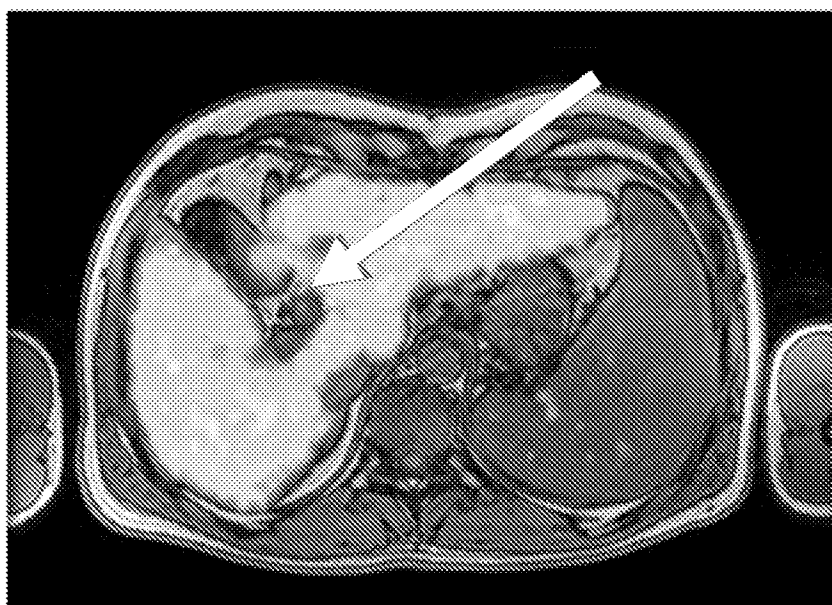


48 hour scan pre/post

FIGURE 29



6 hour pre



6 hour post

FIGURE 30

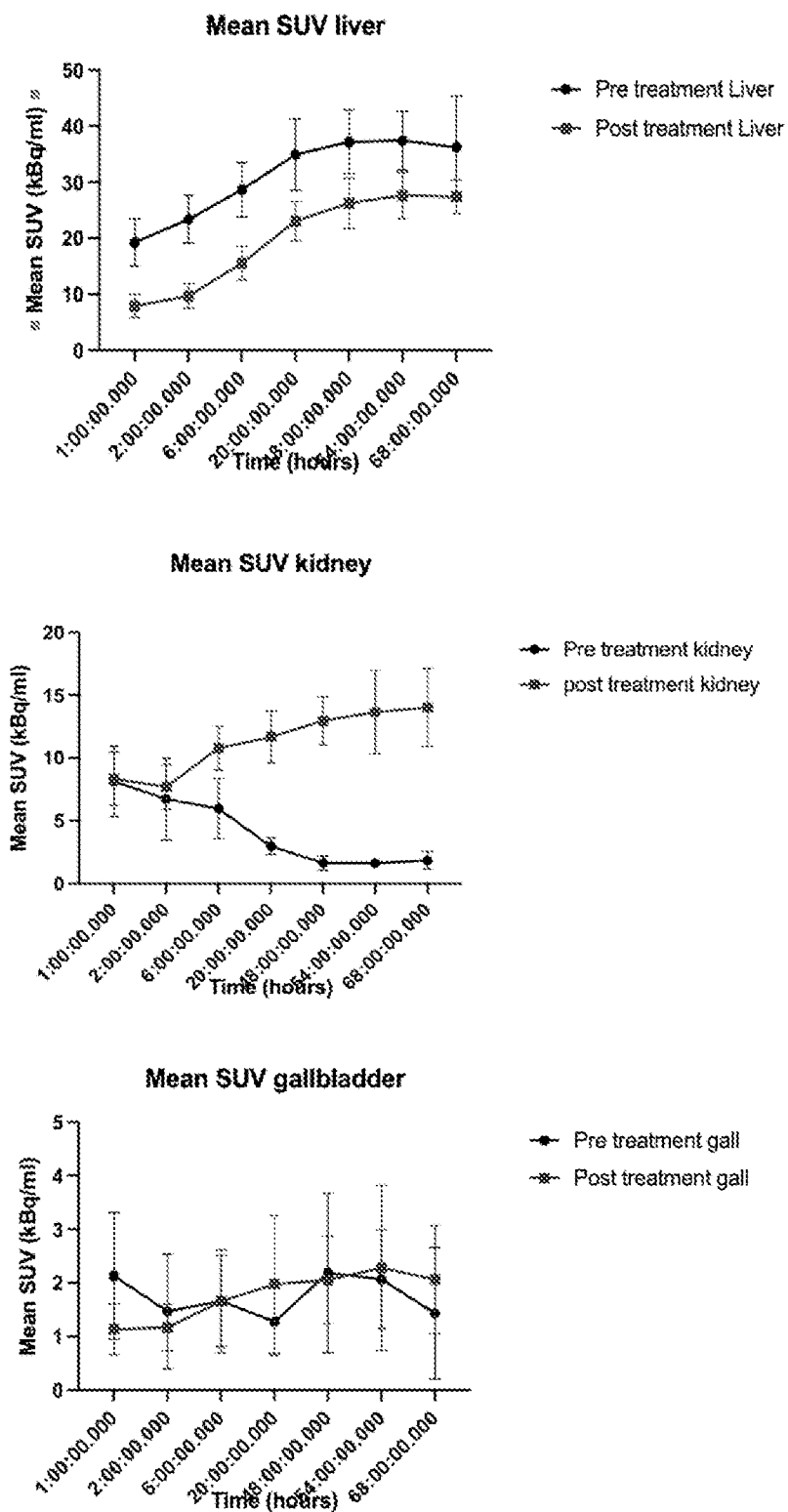
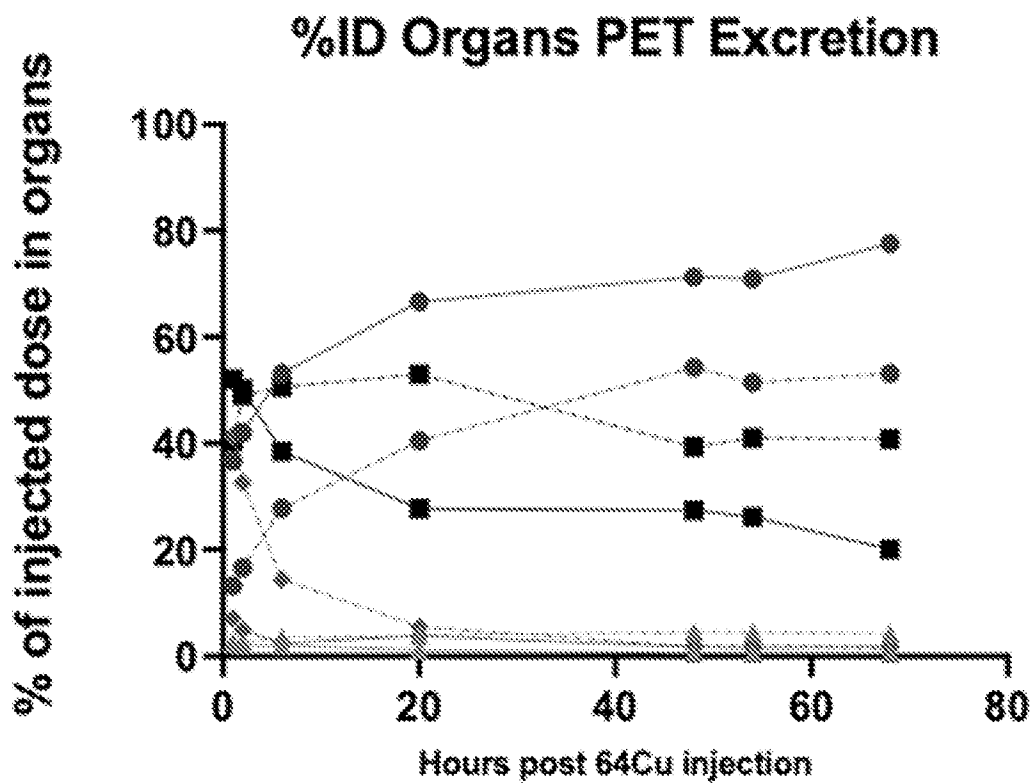


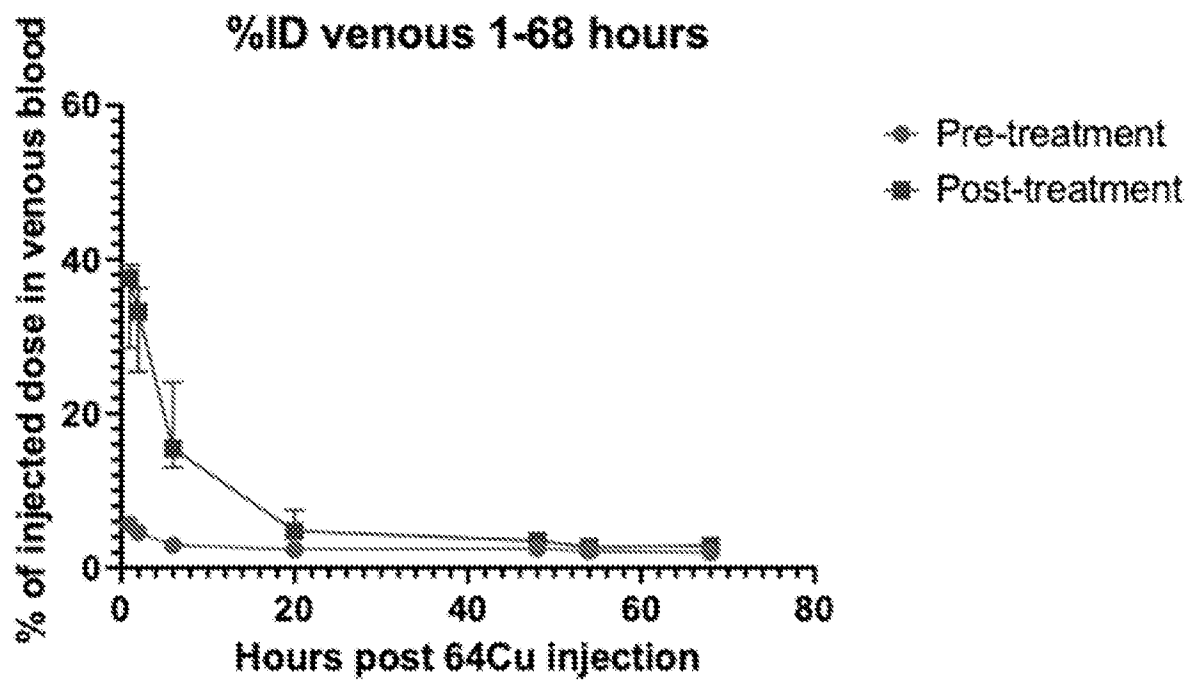
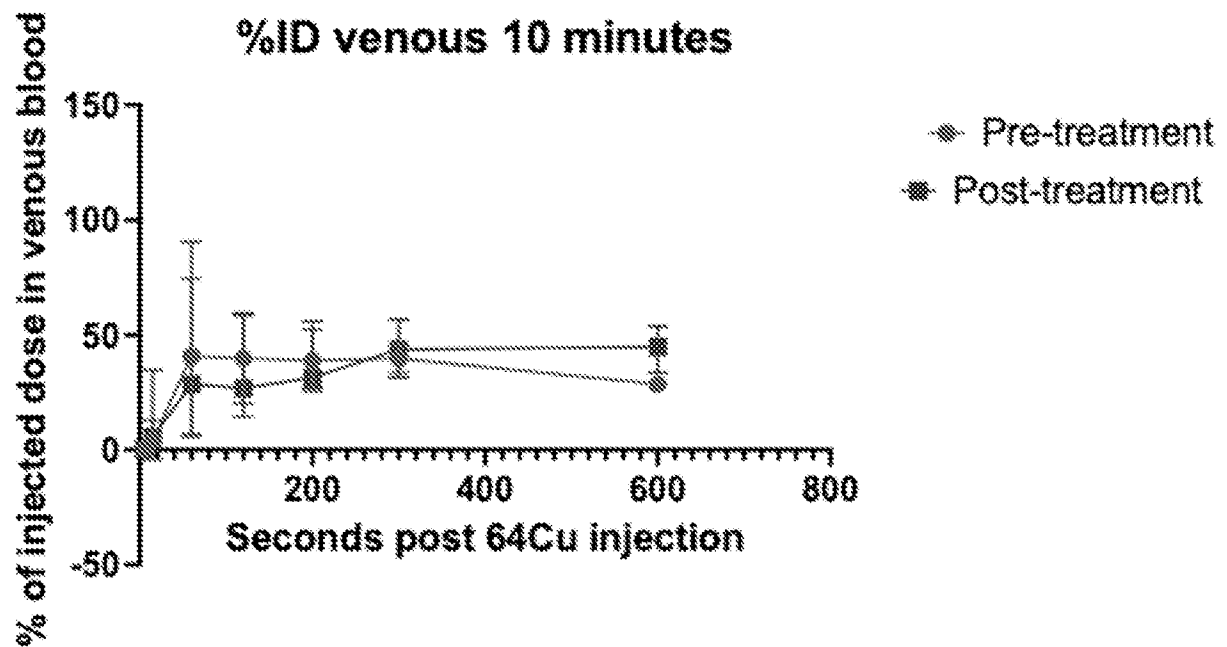
FIGURE 31



%ID = % of injected dose. (Median (IQR))

- ◆ %ID Liver Pre-treatment
- %ID Liver Post-treatment
- ✕ %ID Kidney Pre-treatment
- * %ID Kidney Post-treatment
- ◆ %ID Blood Pre-treatment
- ✕ %ID Blood Post-treatment
- %ID Other Pre-treatment
- %ID Other Post-treatment

FIGURE 32



INTERNATIONAL SEARCH REPORT

International application No

PCT/US2022/040663

A. CLASSIFICATION OF SUBJECT MATTER

INV. A61K33/00 A61P3/00

ADD.

According to International Patent Classification (IPC) or to both national classification and IPC

B. FIELDS SEARCHED

Minimum documentation searched (classification system followed by classification symbols)

A61K

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

Electronic data base consulted during the international search (name of data base and, where practicable, search terms used)

EPO-Internal, WPI Data

C. DOCUMENTS CONSIDERED TO BE RELEVANT

Category*	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
X	US 2021/093588 A1 (BJARTMAR CARL [SE] ET AL) 1 April 2021 (2021-04-01)	1, 2, 7-9, 14, 15, 17-21, 25, 26
Y	paragraphs [0004], [0153], [0160], [0189]; claims 1, 8, 13; table 11 ----- -/--	1-85



Further documents are listed in the continuation of Box C.



See patent family annex.

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"O" document referring to an oral disclosure, use, exhibition or other means

"P" document published prior to the international filing date but later than the priority date claimed

"T" later document published after the international filing date or priority date and not in conflict with the application but cited to understand the principle or theory underlying the invention

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Date of the actual completion of the international search

11 October 2022

Date of mailing of the international search report

24/10/2022

Name and mailing address of the ISA/

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Fax: (+31-70) 340-3016

Authorized officer

Cattell, James

INTERNATIONAL SEARCH REPORT

International application No

PCT/US2022/040663

C(Continuation). DOCUMENTS CONSIDERED TO BE RELEVANT		
Category*	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
X	WEISS KARL HEINZ ET AL: "Bis-cholinetetrathiomolybdate in patients with Wilson's disease: an open-label, multicentre, phase 2 study", THE LANCET - GASTROENTEROLOGY & HEPATOLOGY, ELSEVIER, US, vol. 2, no. 12, 30 November 2017 (2017-11-30), pages 869-876, XP009511454, ISSN: 2468-1253, DOI: 10.1016/S2468-1253(17)30293-5 [retrieved on 2017-10-05]	1, 2, 7, 14, 17, 19, 25
Y	Methods; page 872; figures 2, 3 -----	1-85
Y	WO 2021/102379 A1 (ALEXION PHARMA INC [US]; BORCHARD SABINE [DE]; ZISCHKA HANS [DE]) 27 May 2021 (2021-05-27) paragraphs [0039], [0040], [0049] - [0053], [0054], [0057] -----	1-85
Y	HOUWEN RODERICK: "Bis-cholinetetrathiomolybdate for Wilson's disease", THE LANCET - GASTROENTEROLOGY & HEPATOLOGY, ELSEVIER, US, vol. 2, no. 12, 30 November 2017 (2017-11-30), pages 839-840, XP009511445, ISSN: 2468-1253, DOI: 10.1016/S2468-1253(17)30325-4 [retrieved on 2017-10-05] the whole document -----	1-85
X	Alexion: "Efficacy and Safety Study of WTX101 (ALXN1840) in Adult Wilson Disease Patients", ClinicalTrials.gov / 24 October 2014 (2014-10-24), XP002807708, Retrieved from the Internet: URL:https://clinicaltrials.gov/ct2/show/NC T02273596 the whole document -----	1-85

INTERNATIONAL SEARCH REPORT

Information on patent family members

International application No

PCT/US2022/040663

Patent document cited in search report	Publication date	Patent family member(s)	Publication date
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WO 2021102379 A1	27-05-2021	EP 4061353 A1	28-09-2022
		WO 2021102379 A1	27-05-2021