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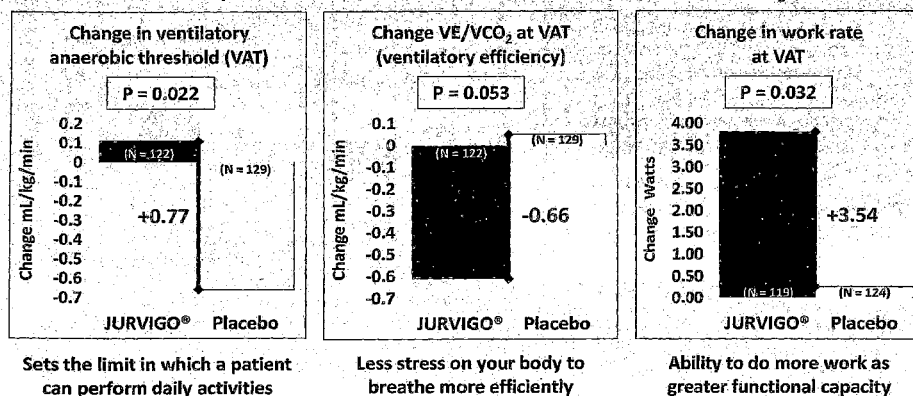
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(54) Title: METHODS AND COMPOSITIONS FOR IMPROVING EXERCISE PERFORMANCE

FUEL trial

All secondary endpoints improved

JURVIGO® improved ALL submaximal cardiopulmonary exercise (peak $\text{VO}_2 < 80\%$)



All data has been weight adjusted where possible.

FIG. 21

(57) Abstract: Various methods and compositions for treating single ventricle heart disease (SVHD) patients, including patients who have undergone Fontan surgery and who have Fontan circulation (Fontan patient), to improve exercise performance, especially to improve exercise performance at peak or max VO_2 in a sub-super Fontan population, i.e., a subgroup of Fontan patients who have a baseline peak or max VO_2 of less than ($<$) 80% predicted, and to improve exercise performance at ventilatory anaerobic threshold ("VAT") in both the super Fontan population, i.e., Fontan patients who have a baseline peak or max VO_2 of greater than ($>$) 80% predicted, and the sub-super Fontan population.

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METHODS AND COMPOSITIONS FOR IMPROVING EXERCISE PERFORMANCE**Statement of Government Interests**

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Related Applications

This provisional application claims priority from provisional application Serial Number 63/291,858, which was filed on December 20, 2021. Related provisional applications include provisional application Serial Number 62/905,350, which was filed on September 24, 2019, provisional application Serial Number 62/936,497, which was filed on November 16, 2019 and provisional application Serial Number 63/023,070, which was filed on May 11, 2020. The

5 **Field of the Invention**

Methods for improving exercise performance in single ventricle heart disease (“SVHD”) patients, including SVHD patients with Fontan physiology (“Fontan patients”), especially to improve exercise performance at peak or max VO_2 in a sub-super Fontan population, i.e., a subgroup of Fontan patients who have a baseline peak or max VO_2 of less than ($<$) 80% predicted, and to
10 improve exercise performance at ventilatory anaerobic threshold (“VAT”) in both the super Fontan population, i.e., Fontan patients who have a baseline peak or max VO_2 of greater than ($\geq$) 80% predicted, and the sub-super Fontan population.

Background

The heart is a muscular organ that pumps blood through the blood vessels of the circulatory
15 system. In humans, the heart is located between the lungs and the chest and is divided into left and right sides. The normal human heart has four chambers, a left atrium and left ventricle, the left side, and a right atrium and right ventricle, the right side. The oxygen-poor blood (“blue blood”) enters the right side through the right atrium and freshly oxygenated blood (“red blood”) exits the left side through the left ventricle. The heart has four valves, the tricuspid valve, the
20 pulmonic valve, the mitral valve and the aortic valve. These valves prevent backflow of blood within the heart and force blood to flow to the lungs and body in a forward direction.

A human heart beats (expands and contracts) approximately 100,000 times per day, pumping five to six quarts of blood each minute, or about 2,000 gallons per day. The left ventricle, the main pumping chamber of the heart, pumps freshly oxygenated blood (red blood) to the body
25 through the aortic valve. The blood then circulates to all parts of the body through arteries and arterioles, delivering oxygen and nutrients. As the blood flows through the circulation, it exchanges oxygen and nutrients for carbon dioxide and metabolic wastes. In this process, the blood transitions from oxygen-rich blood (red blood) to oxygen-poor blood (blue blood). The oxygen-poor blood then returns to the right atrium through the veins of the body. The blue blood
30 passes through the tricuspid valve from the right atrium to the right ventricle, and then it is pumped to the lungs by the right ventricle to exchange carbon dioxide for oxygen. The now freshly oxygenated blood (red blood) returns from the lungs to the left atrium via the pulmonary

5 veins. The blood passes through the mitral valve from the left atrium to the left ventricle, and then is pumped to the body to start the circulation anew.

Thus, the normal human cardiovascular system consists of pulmonary and systemic circulations that are connected in series and powered by the pumping of the right and left ventricles.

10 Gewillig M.: Congenital heart disease. THE FONTAN CIRCULATION. *Heart*, 91:839-846 (2005).

Single ventricle heart disease (SVHD) is a rare pediatric disease that includes a group of cardiac malformations, each of which results in the presence of only a single functional ventricle (pumping chamber). In other words, unlike newborns born with normal hearts (four chambers and two ventricles). SVHD newborns are born with only one functioning ventricle (one pumping
15 chamber), i.e., single ventricle hearts. The non-functioning or missing ventricle (pumping chamber) may be smaller than the single ventricle such that it does not sufficiently function, it may be absent altogether, or it may be configured in such a way as to prevent it from contributing to the normal flow of blood through the circulation. Examples of SVHD include hypoplastic left heart syndrome, tricuspid atresia, double inlet left ventricle, and others.

20 Typically, SVHD newborns are cyanotic, blue in color, since a mixture of oxygen-poor blood (blue blood) and oxygen-rich blood (red blood) mix together in the single ventricle. The amount of oxygen within the blood mixture leaving the heart is very dependent upon the type, severity and location of the SVHD heart defect. Some SVHD newborns will be mildly cyanotic, whereas others will be severely cyanotic, requiring early intervention to meet the oxygen demands of the
25 body to survive. Unfortunately, without surgical intervention most newborns born with SVHD will not survive.

SVHD can be thought of as having two primary subtypes. In the first subtype, the left ventricle and the aorta (the main artery to the body) are under-developed and the heart is not able to pump blood to the body without an interventional procedure. In the second subtype, the right ventricle
30 and the pulmonary artery (the main artery to the lungs) are under-developed and the heart is not able to pump blood to the lungs.

5 For those infants born with an under-developed left ventricle and aorta, the first subtype, an urgent intervention is required within the first few days or weeks of life to stabilize blood flow to the body. This intervention is called the Norwood operation, see **FIG. 5**, and involves rebuilding the aorta (the main artery to the body) using the pulmonary valve and pulmonary artery along with patch material. Since the Norwood operation repurposes the pulmonary artery to supply
10 blood to the body, it also must include a way for blood to get to the lungs. This is accomplished by the inclusion of a “shunt” of blood from the aortic circulation to the pulmonary circulation. This shunt is generally a tube graft that is placed between the right subclavian artery (the artery that supplies blood to the right arm) and the right pulmonary artery. The Norwood operation allow newborns to survive infancy, but is not a permanent solution. This temporary procedure
15 forces the single pumping chamber of the heart to pump blood to both the body and to the lungs, putting it under stress. To relieve this stress, two additional procedures are performed. The first of these, the Glenn shunt or hemi-Fontan, see **FIG. 6**, occurs at 4-6 months and involves connecting the superior vena cava (the main vein of the upper body) directly to the pulmonary arteries. This allows the blue blood from the upper body to return to the lungs for oxygen
20 repletion without the need for a ventricular pump. The final surgery, the Fontan operation, See **FIG. 1A and FIG. 7**, typically occurs at 18-48 months of age and involves connecting the inferior vena cava (the main vein of the lower body) directly to the pulmonary arteries. This allows blue blood from the lower body to return to the lungs for oxygen repletion without the need for a ventricular pump specifically pumping the blood to the lungs. After the Fontan
25 operation, all blue blood returns to the lungs and all red blood returns from the lungs to the heart but this is accomplished without the assistance of a ventricular pump dedicated to pumping blood through the lungs to the heart, as with a normal four-chamber heart.

For those infants born with an under-developed right ventricle and pulmonary artery, the second subtype, an urgent neonatal intervention is often not required. This group of babies requires close
30 monitoring to determine if there is too little blood flow to the lungs, too much blood flow to the lungs, or an appropriate amount of blood flow to allow for growth and development. If there is too little blood flow to the lungs, a shunt is often placed, similar to what is done as part of the Norwood operation. If there is too much blood flow to the lungs, a restrictor may be placed around the pulmonary artery to reduce the amount of blood flow to the lungs to avoid the
35 development of congestive heart failure. If the amount of blood flow to the lungs is appropriate,

5 infants born with an under-developed right ventricle and pulmonary artery may go through their initial months of life without the need for a surgical intervention. Whether there is too little, too much, or an appropriate amount of blood flow to the lungs, infants born with this type of SVHD still require the Glenn shunt or hemi-Fontan at 4-6 months of age and the Fontan at 18-48 months of age to relieve the burden from the heart and to separate the blue blood from the red
10 blood.

After the Fontan operation, the subtype of single ventricle heart disease is less important as all patients are left with a common physiology: (i) passive blood flow from the superior and inferior vena cava directly to the lungs bypassing the heart and (ii) a single ventricle that pumps blood to the body. Although this “Fontan circulation” has allowed for the survival of many thousands of
15 patients over the last 40-50 years, it is far from normal. In the absence of a ventricular pump to push blood through the lungs and back to the heart, the Fontan circulation must rely on pressure generated in the veins of the body to accomplish this task. This results in a very elevated ‘blood pressure’ within the veins and also limits the amount of flow that can circulate through the body in a given amount of time - this is called reduced cardiac output.

20 Over time, the combination of elevated pressure in the veins and reduced cardiac output lead to a predictable set of long-term complications and, ultimately, to a significantly diminished duration of survival. Complications related to the Fontan circulation include: damage to the kidneys and liver, overload of the lymphatic circulation leading to protein loss in the lungs or gastrointestinal tract, bleeding and blood clotting disorders including the risk of stroke, and progressive
25 dysfunction of the pumping ability of the heart itself.

The ability to perform exercise is used in many forms of heart disease as a marker of the health of the circulation. For those with a Fontan circulation, exercise is likewise an important measure of health and a good predictor of outcomes. While exercise ability is often preserved for those with a Fontan circulation during childhood, it typically begins to drop during adolescence and
30 early adulthood. This deterioration correlates with an increase in the prevalence of heart failure symptoms, hospitalizations, and mortality, often due to the complications of the Fontan circulation itself. In some cases, cardiac transplantation may remain a therapeutic option, but cardiac transplantation comes with its own sets of risks, and patients with Fontan circulation may

5 often be poor candidates for a heart transplant due to chronic and progressive dysfunction of many organ systems.

Notwithstanding this long-standing very serious congenital heart disease, to date, no pharmacotherapy has been approved by the U.S. Food & Drug Administration (FDA) or any other equivalent agency through-out the world for the treatment of SVHD patients, including
10 Fontan patients. Accordingly, there is a real need and demand for new pharmacotherapies for SVHD patients, including Fontan patients, relating to complications of SVHD and the Fontan circulation, with the goals of increasing the life span of SVHD patients, including Fontan patients, and avoiding or delaying the progression of the disease and the need for cardiac transplantation.

15 There is also a real need and demand for new pharmacotherapies for SVHD patients, including Fontan patients, to (i) improve the myocardial performance index ("MPI"), (ii) improve single ventricular performance, (iii) improve exercise capacity at the ventilatory anaerobic threshold (VAT) and/or the maximal aerobic capacity (max VO_2 or VO_2 max), (iv) improve the work rate at VAT, (v) improve the ventilatory equivalents of carbon dioxide (VE/VCO_2) at VAT, and/or
20 (vi) improve cardiac performance of the single ventricle.

Summary of the Invention

The present invention overcomes the above-mentioned drawbacks and disadvantages associated with current treatments of SVHD patients, including Fontan patients, through the discovery of novel methods of treating SVHD patients, including Fontan patients.

25 Generally speaking, the methods of the present invention are directed to the use of udenafil or a pharmaceutically acceptable salt thereof, to treat SVHD patients, including Fontan patients.

More specifically, methods of the present invention comprise administering, preferably daily, to a SVHD patient, including a Fontan patient, an effective amount of udenafil or a pharmaceutically acceptable salt thereof to improve, amongst other things, their MPI and
30 exercise capacity or performance.

5 In general, the methods of the present invention include administering daily an effective amount of udenafil or a pharmaceutically acceptable salt thereof, to the SVHD patient, including a Fontan patient, to improve:

- (a) ventricular performance of the SVHD patient's single functioning ventricle as measured by MPI;
- 10 (b) exercise capacity as measured by oxygen consumption at VAT;
- (c) exercise capacity as measured by oxygen consumption at maximal effort or max VO_2 ;
- (d) work rate at VAT;
- (e) VE/VCO_2 at VAT;
- 15 (f) diastolic blood pressure at rest; and
- (g) oxygen saturation (%) at rest, each individually, collectively or in any

combination.

Preferably, the methods of the present invention improve (a)-(g) listed above, including individually, collectively or in any combination thereof. Preferably, the methods of the present invention improve at least the combination of (a)-(e) listed above. Most preferably, (a)-(g) listed
20 above, including individually, collectively or in any combination thereof, are improved in accordance with the present invention by administering daily to a SVHD patient, including a Fontan patient, an effective amount of udenafil or a pharmaceutical acceptable salt thereof.

Improvements in single ventricle performance in accordance with the methods of the present
25 invention include improvements in both systolic and diastolic function. These can be demonstrated by improvements in, but not limited to, blood pool MPI, tissue Doppler MPI, cardiac output (estimated by the product of the integral under the Doppler derived outflow curve and the heart rate), and other measures of single ventricle heart performance. Improvements in exercise capacity or performance in accordance with the methods of the present invention
30 include, but are not limited to, improvements in exercise capacity or performance at anaerobic threshold ("VAT") and/or improvements in exercise capacity or performance at maximal effort or max VO_2 . Also in accordance with the present invention, there are improvements in work rate at VAT, ventilatory equivalents of carbon dioxide at VAT (VE/VCO_2), diastolic blood pressure

5 at rest and/or oxygen saturation (%) at rest, when the methods of the present invention are practiced with regard to SVHD patients, including Fontan patients.

Generally, “effective amount” is used herein to mean an amount of udenafil or a pharmaceutically acceptable salt thereof, that is sufficient to elicit or induce a therapeutic or pharmacologic effect without causing treatment-limiting side effects.

10 More specifically, “effective amount” is used herein to mean an amount of udenafil or a pharmaceutically acceptable salt thereof, that is sufficient to elicit or induce a therapeutic or pharmacologic effect in a SVHD patient, including a Fontan patient, without causing treatment-limiting toxicity, treatment limiting side effects associated with inhibition of PDE6 and/or PDE11, and/or any other treatment-limiting side effects.

15 An example of an “effective amount” of udenafil or a pharmaceutically acceptable salt thereof in accordance with the present invention includes a total daily amount in a range that includes, but is not limited to, from about 87.5 mg to about 175 mg. More preferably, an “effective amount” of udenafil or a pharmaceutically acceptable salt thereof in accordance with the present invention includes a total daily amount in a range from about 125 mg to about 175 mg. Even more
20 preferably, an “effective amount” of udenafil or a pharmaceutically acceptable salt thereof in accordance with the present invention includes an oral dosage amount that includes, but is not limited to, a single dosage amount administered daily, including a single dosage amount of about 75 mg or 87.5 mg administered once or twice a day and a single dosage amount of about 125 mg administered once daily.

25 The present invention also contemplates methods which comprise administering, preferably daily, an effective amount of udenafil or a pharmaceutically acceptable salt thereof, to a SVHD patient, including a Fontan patient, for improving, amongst other things, MPI, ventricular performance, cardiac output, exercise capacity or performance at VAT, exercise capacity or performance at maximal effort or VO_2 max, work rate at VAT, VE/VCO_2 at VAT, diastolic blood pressure at
30 rest and oxygen saturation (%) at rest, individually, collectively or in any combination, without causing treatment-limiting side effects, for example, interference with visual transduction or function, back pain, myalgia, sperm concentration or quality. In other words, the present invention contemplates treatments, preferably daily, of a SVHD patient, including a Fontan

5 patient, with an effective amount of an effective PDE5 inhibitor, preferably udenafil or a pharmaceutically acceptable salt thereof, without causing treatment limiting side effects associated with inhibition of phosphodiesterase-6 (“PDE6”) and/or phosphodiesterase-11 (“PDE11”). As used herein, PDE6 includes any isoenzyme, variant, catalytic subunit and/or inhibitory subunit of PDE6, such as PDE6a, PDE6P, PDE6Y, PDE6R and/or PDE6C,
10 individually, collectively, or in any combination, As used herein PDE11, includes phosphodiesterase-11A (PDE11A) and any isoenzyme, variant, catalytic subunit and or inhibitory subunit of PDE11, such as PDE11A, including PDE11A1, PED11A2, PDE11A3 and/or PDE11A4, individually, collectively, or in any combination.

In one embodiment, the present invention is directed to a method of improving the MPI in a
15 SVHD patient, including a Fontan patient. As used herein MPI measures both systolic and diastolic function for the assessment of global heart function. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to the patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

It is to be understood that by “improve, improving, improvement in or improved”, with respect to
20 MPI in accordance with the present invention, it means herein to improve single ventricle performance, i.e., to improve the diastolic and systolic function of the single functioning ventricle. In other words, the single functioning ventricle squeezes better or more efficiently per heartbeat. As a result, the cardiac output and the amount of blood flow that can circulate in a given amount of time throughout the body of the SVHD patients, including Fontan patients, who
25 practice or who are treated in accordance with the methods of the present invention are increased or improved, especially as compared to SVHD patients, including Fontan patients, who are not treated in accordance with the methods of the present invention. Thus, the methods of the present invention result in MPI, or other disclosed measures of ventricular performance, improvement in a SVHD patient, including a Fontan patient, as compared to MPI, or other disclosed measures of
30 single ventricular performance in the absence of the methods of the present invention (e.g., in the absence of udenafil administration). For example, the improvement can be about 5, about 6, about 7, about 8, about 9, about 10, about 11, about 12, about 13, about 14, about 15, about 16, about 17, about 18, about 19, about 20, about 21, about 22, about 23, about 24, about 25, about 26, about 27, about 28, about 29, or about 30% or greater as compared to blood pool MPI, or

5 other disclosed measures of single ventricular performance in the absence of the methods of the present invention (e.g., in the absence of daily udenafil administration).

The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to the patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

10 In one embodiment, the present invention is directed to a method of improving systolic function of the single functioning ventricle of a SVHD patient, including a Fontan patient. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor or a pharmaceutically acceptable salt thereof to the SVHD patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

15 In one embodiment, the present invention is directed to a method of improving diastolic function of the single functioning ventricle of a SVHD patient, including a Fontan patient. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor or a pharmaceutically acceptable salt thereof to the SVHD patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

20 In one embodiment, the present invention is directed to a method of improving cardiac output of the single functioning ventricle of a SVHD patient, including a Fontan patient. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor or a pharmaceutically acceptable salt thereof to the SVHD patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

25 In one embodiment, the present invention is directed to a method of improving the ability of the single functioning ventricle in a SVHD patient, including a Fontan patient to squeeze. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor or a pharmaceutically acceptable salt thereof to the SVHD patient, including a Fontan patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt
30 thereof.

In another embodiment, the present invention is directed to a method of improving the venous pressure by decreasing the elevation in venous pressure in a SVHD patient, including a Fontan

5 patient. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to the SVHD patient, including a Fontan patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

In one embodiment, the present invention is directed to a method of improving the amount of blood flow that can circulate through the body of the SVHD patient, including a Fontan patient,
10 in a given amount of time. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor or a pharmaceutically acceptable salt thereof to the SVHD patient, including a Fontan patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

Thus, the present invention is directed to a method of improving global single ventricular
15 performance of the single functioning ventricle in a SVHD patient, including a Fontan patient. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor or a pharmaceutically acceptable salt thereof to the SVHD patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

In yet another embodiment, the present invention is directed to a method of improving diastolic
20 blood pressure at rest in a SVHD patient, including a Fontan patient, whereby the SVHD patient's, including the Fontan patient's, diastolic blood pressure at rest is significantly lowered. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to the SVHD patient, including a Fontan patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

25 In yet another embodiment, the present invention is directed to a method of improving oxygen saturation (%) at rest in a SVHD patient, including a Fontan patient. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to the SVHD patient, including a Fontan patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

30 In yet another embodiment, the present invention is directed to a method of improving exercise performance or capacity in a SVHD patient, including a Fontan patient. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to the SVHD

5 patient, including a Fontan patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

In another embodiment, the present invention is directed to a method of improving exercise performance or capacity at the ventilatory anaerobic threshold ("VAT") in a SVHD patient, including a Fontan patient. The methods of the present invention result in improved VO_2 at VAT
10 in SVHD patient, including the Fontan patient, as compared to VO_2 at VAT in SVHD patients, including Fontan patients, who are not treated with or do not practice the methods of the present invention (e.g., in the absence of daily udenafil administration in accordance with the methods of the present invention). For example, the improvement can be about 1, about 2, about 3, about 4, about 5, about 6, about 7, about 8, about 9, about 10, about 11, about 12, about 13, about 14,
15 about 15, about 16, about 17, about 18, about 19, about 20, about 21, about 22, about 23, about 24, about 25, about 26, about 27, about 28, about 29, or about 30% or greater as compared to VO_2 at VAT in the absence of the methods of the present invention (e.g., in the absence of daily udenafil administration). The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to the SVHD patient, including a Fontan patient, where
20 the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

In another embodiment, the present invention is directed to a method of improving exercise performance or capacity at maximal effort or max VO_2 in a SVHD patient, including a Fontan patient. The methods of the present invention result in improved VO_2 at the SVHD patient's, including the Fontan patient's, maximal effort, as compared to VO_2 at maximal effort in the
25 absence of the methods of the present invention (e.g., in the absence of daily udenafil administration). For example, the improvement can be about 1, about 2, about 3, about 4, about 5, about 6, about 7, about 8, about 9, about 10, about 11, about 12, about 13, about 14, about 15, about 16, about 17, about 18, about 19, about 20, about 21, about 22, about 23, about 24, about 25, about 26, about 27, about 28, about 29, or about 30% or greater, as compared to VO_2 at
30 maximal effort in the absence of the methods of the present invention (e.g., in the absence of daily udenafil administration). The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to the SVHD patient, including a Fontan patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

5 In another embodiment, the present invention is directed to a method of improving work rate at VAT in a SVHD patient, including a Fontan patient. The methods of the present invention result in improved work rate at the SVHD patient's, including the Fontan patient's, VAT, as compared to the work rate at VAT in the absence of the methods of the present invention (e.g., in the absence of daily udenafil administration). For example, the improvement can be about 1, about 2,
10 about 3, about 4, about 5, about 6, about 7, about 8, about 9, about 10, about 11, about 12, about 13, about 14, about 15, about 16, about 17, about 18, about 19, about 20, about 21, about 22, about 23, about 24, about 25, about 26, about 27, about 28, about 29, or about 30% or greater, as compared to VO_2 at VAT in the absence of the methods of the present invention (e.g., in the absence of daily udenafil administration). The method comprises administering, preferably daily,
15 an effective amount of an effective PDE5 inhibitor to the SVHD patient, including a Fontan patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

In another embodiment, the present invention is directed to a method of improving ventilatory equivalents of carbon dioxide at the VAT ("VE/ VCO_2 ") at VAT in a SVHD patient, including a
20 Fontan patient. The methods of the present invention result in improved VE/ VCO_2 at the SVHD patient's, including the Fontan patient's, VAT, as compared to the VE/ VCO_2 at VAT in the absence of the methods of the present invention (e.g., in the absence of daily udenafil administration). For example, the improvement can be about 1, about 2, about 3, about 4, about 5,
25 about 6, about 7, about 8, about 9, about 10, about 11, about 12, about 13, about 14, about 15, about 16, about 17, about 18, about 19, about 20, about 21, about 22, about 23, about 24, about 25, about 26, about 27, about 28, about 29, or about 30% or greater, as compared to VO_2 at VAT in the absence of the methods of the present invention (e.g., in the absence of daily udenafil administration). The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to the SVHD patient, including a Fontan patient, where the PDE5
30 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

In one embodiment, the present invention is directed to improved methods for treating a SVHD patient, including a Fontan patient, who has undergone heart reconstruction of the abnormal SVHD heart, wherein the daily methods of the present invention result in fewer or less severe

5 adverse events, as compared to conventional methods of treating such a SVHD patient, including a Fontan patient.

In another embodiment, the methods of the present invention result in few, if any, serious adverse events, moderate adverse events, or mild adverse events. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to the SVHD
10 patient, including a Fontan patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

In one embodiment, the present invention is directed to improved methods for treating a SVHD patient who has undergone a Fontan procedure. In one such embodiment, the Fontan patient is diagnosed with hypoplastic left heart syndrome (HLHS), but first had a Norwood procedure, see,
15 e.g., **FIG. 5**, followed by a Hemi-Fontan or Bi-directional Glenn procedure, see, e.g., **FIG. 6**, before undergoing the Fontan procedure, see, e.g., **FIG. 1A** and **FIG. 7**. In another such embodiment, the Fontan patient first had a Hemi-Fontan or Bi-directional Glenn procedure before undergoing the Fontan procedure. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to the SVHD patient, including a Fontan
20 patient, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof.

In one embodiment, the present invention is directed to improved methods for treating a SVHD patient, including a Fontan patient, wherein the SVHD is selected from a group of SVHDs consisting of patients having an atrioventricular canal defect (AV Canal), a double inlet left
25 ventricle (DILV), a double outlet right ventricle (DORV), Ebstein's anomaly, HLHS, mitral valve atresia (usually associated with HLHS), pulmonary atresia with intact ventricular septum (PA/IVS), a single left ventricle, tricuspid valve atresia and tricuspid valve atresia with stenosis. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to the SVHD patient, including a Fontan patient, where the PDE5 inhibitor is preferably
30 udenafil or a pharmaceutically acceptable salt thereof. In an exemplary embodiment, the methods of the present invention comprise administering an effective amount of an effective PDE5 inhibitor or a pharmaceutically acceptable salt thereof, where the PDE5 inhibitor is preferably

5 udenafile or a pharmaceutically acceptable salt thereof, once a day to a SVHD patient, including a Fontan patient.

In another embodiment, the methods of the present invention comprise administering an effective amount of an effective PDE5 inhibitor or a pharmaceutically acceptable salt thereof, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof,
10 twice a day to a SVHD patient, including a Fontan patient.

In another embodiment, the methods of the present invention comprise administering an effective amount of an effective PDE5 inhibitor or a pharmaceutically acceptable salt thereof, where the PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof, three or more times a day to a SVHD patient, including a Fontan patient.

15 In another embodiment, the SVHD patient, including a Fontan patient, is a pediatric patient of about 2 to about 18 years of age. Treatment of adult patients are also encompassed by the methods of the invention.

In yet another embodiment, the present invention is directed to improved methods for treating a SVHD patient, including a Fontan patient, wherein the methods of the present invention show an
20 improvement in the SVHD patient's, including Fontan patient's, compliance with a dosing schedule of udenafil or a pharmaceutically acceptable salt thereof, as compared to SVHD patients, including Fontan patients, prescribed a non-udenafil drug.

Finally, in yet another embodiment, the methods of the present invention may result in a unique characteristic pharmacokinetic profile. The pharmacokinetic profile can comprises a $C_{\max}$
25 between 300 and 700 ng/ml, or more specifically, about 500 ng/ml; a $T_{\max}$ between 1 and 1.6 hr, or more specifically, about 1.3 hr; an AUC_t between 2550 and 4150 ng•hr/ml or more, specifically about 3350 ng•hr/ml; and an AUC_{0-24} between 5110 and 8290 ng•hr/ml or more, specifically about 6701 ng•hr/ml.

It is to be understood that present invention contemplates udenafil drug products that are
30 therapeutically equivalent to the udenafil drug products of the present invention. In other words, the present invention contemplates udenafil drug products that (i) are therapeutically equivalent, (ii) are bioequivalent, (iii) are interchangeable, and (iv) have bio availabilities that, when

5 administered to a SVHD patient, including a Fontan patient in accordance with the methods of the present invention, are effective in carrying out or performing the objectives of the present invention.

Thus, in accordance with one embodiment of the present invention, the present invention contemplates drug formulations that have a 90% confidence interval (90% CI) for a
10 pharmacokinetic profile wherein the ratio of the means lies within the range of between about 0.8 and about 1.25. In another embodiment in accordance with the present invention, the present invention contemplates interchangeable sildenafil drug formulations that have a 90% confidence interval (90% CI) for a pharmacokinetic profile wherein the ratio of the means lies within the range of between about 0.8 and about 1.2. The present invention therefore contemplates SVHD
15 patients, including Fontan patients, who are treated with or practice the methods of the present invention, having a sildenafil plasma concentration that can vary by up to about 45% (i.e. -20 to +25%) of a pharmacokinetic profile, such as their $C_{\max}$, $T_{\max}$ and AUC. More preferably, the present invention contemplates SVHD patients, including Fontan patients, who are treated with or practice the methods of the present invention, having a sildenafil plasma concentration that can
20 vary by up to about 40% (i.e. -20 to +20%) of a pharmacokinetic profile, such as their $C_{\max}$, $T_{\max}$, AUC_t and AUC_{0-24} . By way of example, the present invention contemplates SVHD patients, including Fontan patients, who are treated with or practice the methods of the present invention, having a sildenafil pharmacokinetic profile:

- 25 (a) $C_{\max}$ plasma concentration of about -20 to about +25% of about 500 ng/ml, and more preferably a sildenafil $C_{\max}$ plasma concentration of about -20 to about +20% of about 500 ng/ml;
- (b) $T_{\max}$ of about -20 to about +25% of about 1.3 hr, and more preferably a sildenafil $T_{\max}$ of about -20 to about +20% of 1.3 hr;
- 30 (c) AUC_t of about -20 to about +25% of about 3350 ng•hr/ml, and more preferably a sildenafil AUC_t of about -20 to about +20% of about 3350 ng•hr/ml; and
- (d) AUC_{0-24} of about -20 to about +25% of about 6701 ng•hr/ml, and more preferably a sildenafil AUC_{0-24} of about -20 to about +20% of about 6701 ng•hr/ml, individually, collectively, or in any combination.

5 Thus, the present invention contemplates bioequivalent and interchangeable udenafil drug products for use in accordance with the methods of the present invention. In addition, the present invention contemplates udenafil drug products that produce the above referenced $C_{\max}$, $T_{\max}$, AUC_t and/or AUC_{0-24} in SVHD patients, including Fontan patients, when administered to SVHD patients, including Fontan patients, in accordance with the methods of the present invention.

10 Methods of the present invention include but are not limited to:

1. A method of treating a single ventricular heart disease (SVHD) patient who has a single functioning ventricle and Fontan physiology following a Fontan procedure (Fontan patient) and who is in need of treatment to improve the Fontan patient's exercise capacity as measured by oxygen consumption at maximal effort or peak VO_2 , wherein the Fontan patient has a baseline
15 peak or max VO_2 of less than ($<$) 80% predicted, and wherein the Fontan's exercise capacity is adversely affected due to a decline in the Fontan patient's heart function after the Fontan procedure, said method comprising

administering to the Fontan patient daily an effective amount of udenafil, or a pharmaceutically acceptable salt thereof, to improve the Fontan patient's exercise capacity as measured by oxygen
20 consumption at maximal effort or peak VO_2 .

2. The method according to claim 1, wherein the effective amount is a total daily dosage of udenafil or a pharmaceutically acceptable salt thereof in an amount of between about 125 mg and 175 mg.

25

3. The method according to claim 1, wherein the effective daily amount is a total daily dosage of udenafil or a pharmaceutically acceptable salt the in an amount of about 175 mg.

- 5 4. The method according to claim 3, wherein the total daily dosage consists of two individual doses of udenafil or a pharmaceutically acceptable salt thereof, wherein each said individual dose is about 87 mg of udenafil or a pharmaceutically acceptable salt thereof.
- 10 5. The method according to claim 4, wherein each said individual dose is in a solid oral dosage form.
6. The method according to claim 5, wherein the udenafil or a pharmaceutically acceptable salt thereof is in a solid or semi-solid oral dosage form selected from a group consisting of a tablet, a capsule, a gel, a liquid, a liquid dispersion, a pill, a powder, and a suspension.
- 15
7. The method according to claim 1, wherein the udenafil or a pharmaceutically acceptable salt thereof is in a solid oral dosage form.
- 20
8. The method according to claim 7, wherein the solid oral dosage form is a solid or semi-solid oral dosage form selected from a group consisting of a tablet, a capsule, a gel, a liquid, a liquid dispersion, a pill, a powder, and a suspension.
- 25 9. The method of according to claim 1, wherein the Fontan patient is at least 12 years of age.
10. The method according to claim 1, wherein said method further improves the Fontan patient's:

- 5 (a) ventricular performance of the Fontan patient's single functioning ventricle as measured by myocardial performance index (MPI);
- (b) exercise capacity as measured by oxygen consumption at ventilatory anaerobic threshold (VAT);
- (c) work rate at VAT; and
- 10 (e) VE/VCO₂ at VAT, alone or in any combination.

11. A method of treating a single ventricular heart disease (SVHD) patient who has a single functioning ventricle and Fontan physiology following a Fontan procedure (Super Fontan patient) and who is in need of treatment to improve the Super Fontan patient's exercise capacity as measured by oxygen consumption at maximal effort or peak VO₂, wherein the Super Fontan

15 patient has a baseline peak or max VO₂ of greater than ($\geq$) 80% predicted, and wherein the Super Fontan's exercise capacity is adversely affected due to a decline in the Super Fontan patient's heart function after the Fontan procedure, said method comprising

administering to the Super Fontan patient daily an effective amount of udenafil, or a pharmaceutically acceptable salt thereof, to improve the Super Fontan patient's exercise capacity

20 as measured by oxygen consumption at ventilatory anaerobic threshold (VAT).

12. The method according to claim 11, wherein the effective amount is a total daily dosage of udenafil or a pharmaceutically acceptable salt thereof is in an amount of between about 125 mg and 175 mg.

13. The method according to claim 11, wherein the effective amount is a total daily dosage of

25 udenafil or a pharmaceutically acceptable salt thereof in an amount of about 175 mg.

14. The method according to claim 13, wherein the total daily dosage consists of two individual doses of udenafil or a pharmaceutically acceptable salt thereof, wherein each said individual dose is about 87 mg of udenafil or a pharmaceutically acceptable salt thereof.

15. The method according to claim 14, wherein each said individual dose is in a solid oral

30 dosage form.

- 5 16. The method according to claim 15, wherein the udenafil or a pharmaceutically acceptable salt thereof is in a solid or semi-solid oral dosage form selected from a group consisting of a tablet, a capsule, a gel, a liquid, a liquid dispersion, a pill, a powder, and a suspension.
17. The method according to claim 11, wherein the udenafil or the pharmaceutically acceptable salt thereof is in a solid oral dosage form.
- 10 18. The method according to claim 17, wherein the solid oral dosage form is a solid or semi-solid oral dosage form selected from a group consisting of a tablet, a capsule, a gel, a liquid, a liquid dispersion, a pill, a powder, and a suspension.
19. The method of according to claim 11, wherein the Super Fontan patient is at least 12 years of age.
- 15 20. The method according to claim 11, wherein said method further improves the Super Fontan patient's:
- (a) ventricular performance of the Super Fontan patient's single functioning ventricle as measured by myocardial performance index (MPI);
 - (b) work rate at VAT; and
 - 20 (d) VE/VCO₂ at VAT, alone or in any combination.

It should be further understood that the above summary of the present invention is not intended to describe each disclosed embodiment or every implementation of the present invention. The foregoing description further exemplifies illustrative embodiments and provides explanation of the present invention as claimed. In several places throughout the specification, guidance is
25 provided through examples, which examples can be used in various combinations. In each instance, the examples serve only as representative groups and should not be interpreted as exclusive examples.

Brief Description of the Drawings

The foregoing and other objects, advantages and features of the present invention, and the
30 manner in which the same are accomplished, will be readily apparent to those of skill in the art

5 from the following brief description of the drawings, the detailed description of the present invention and the examples, which illustrate embodiments, wherein:

FIG. 1A is a schematic drawing of an exemplary Fontan physiology;

FIG. 1B is a screening process (Randomization and Treatment of the Participants) used for the Fontan Udenafil Exercise Longitudinal (FUEL) Trial as described in the Examples 1-2. Peak
10 VO_2 (VO_2 max) denotes oxygen consumption at peak exercise. RER denotes respiratory exchange ratio;

FIG. 2A demonstrates the difference in the change in mean peak or max VO_2 from Baseline to Week 26 along with the standard deviation for each treatment arm. **FIG. 2B** demonstrates the percentage of subjects (y axis) who demonstrated improvement in peak VO_2 by the reference
15 percentage or greater (x axis);

FIG. 3A demonstrates the difference in the change in mean VO_2 at VAT from Baseline to Week 26 along with the standard deviation for each treatment arm. **FIG. 3B** demonstrates the percentage of subjects (y axis) who demonstrated improvement in VO_2 at VAT by the reference percentage or greater (x axis);

20 **FIG. 4A** demonstrates the difference in the change in mean work rate at VAT from Baseline to Week 26 along with the standard deviation for each treatment arm. **FIG. 4B** demonstrates the percentage of subjects (y axis) who demonstrated improvement in work rate by the reference percentage or greater (x axis);

FIG. 5 is a schematic drawing of an exemplary Norwood procedure (Stage 1) of a reconstructed
25 SVHD heart with Hypoplastic Left Heart Syndrome (HLHS);

FIG. 6 is a schematic drawing of an exemplary Bidirectional Glenn procedure (Stage 2) of a reconstructed SVHD heart with Hypoplastic Left Heart Syndrome (HLHS);

FIG. 7 is a schematic drawing of an exemplary Fontan procedure (Stage 3), an Extracardiac Fenestrated Fontan procedure, of a reconstructed SVHD heart with Hypoplastic Left Heart
30 Syndrome (HLHS);

- 5 **FIG. 8** shows Cumulative Incidence Plots of Primary and Secondary Outcomes Stratified by Change in Peak Oxygen Consumption (Cunningham 2017);
- FIG. 9** shows CPET performance when stratified by the subsequent primary clinical outcome of death or transplant (Cunningham, 2017);
- FIG. 10** shows prognostic value of serial CPET testing in Fontan Subjects;
- 10 **FIG. 11** shows improvement in Peak VO_2 by Treatment Group. ITT Analysis of FUEL Trial;
- FIG. 12** shows improvement in Peak VO_2 by Treatment Group: Analysis of Subpopulation of Fontan Subjects that had a Predicted Peak VO_2 at Baseline of $< 80\%$;
- FIG. 13** shows improvement in Peak VO_2 by Treatment Group: Analysis of Subpopulation of Fontan Subjects that had a Predicted Peak VO_2 at Baseline of $\geq 80\%$, Super Fontans;
- 15 **FIG. 14** shows percent change in Peak VO_2 by Treatment Group and FUEL Analysis;
- FIG. 15** shows annualized Change in Peak VO_2 by Treatment Group. Analysis of Subpopulation of Fontan Subjects that had a Predicted Peak VO_2 at Baseline of $< 80\%$;
- FIG. 16** shows change in Peak VO_2 after Exercise Training;
- FIG. 17** shows improvement in VO_2 at VAT by Treatment Group in FUEL ITT Analysis;
- 20 **FIG. 18** shows percent change in VO_2 at VAT by Treatment Group in FUEL ITT Analysis;
- FIG. 19** shows mean change from Baseline in Peak or Max VO_2 (mL/min) in FUEL and FUEL OLE. **Placebo** = results from the FUEL Trial for participants randomized to placebo. **Udenafil Naïve** = results from FUEL OLE for participants randomized to placebo in the FUEL Trial plus participants newly enrolled patients in FUEL OLE. **Udenafil** = results from FUEL and FUEL
- 25 OLE for those randomized to udenafil in the FUEL Trial who continued to FUEL OLE;
- FIG. 20** shows FUEL Trial Effect of “Super Fontan” Subjects on Statistical Endpoint; and
- FIG. 21** shows FUEL Trial Effect on All Secondary Endpoints.

5

Detailed Description of the Invention

I. Fontan Physiology

The Fontan physiology is the definitive palliation for those classes of congenital heart defects that share the common feature of a functional single ventricle. They include defects that result in hypoplastic (malfunctioning) left or right ventricles. Usually through a series of 2 or 3 operations, the systemic and pulmonary circulations are separated to significantly eliminate the mixing of oxygenated and un-oxygenated blood caused by the congenital heart defects. This is accomplished by directly attaching the superior and inferior vena cavae to the pulmonary arteries, i.e., the total cavopulmonary connection. This results in a Fontan physiology that works as follows: (1) the single systemic ventricle pumps oxygenated blood (red blood) out the aorta to the body's systemic arterial vascular bed, (2) the systemic venous blood (blue blood) then returns by the vena cavae and the blue blood flows passively through the pulmonary vascular bed for oxygen uptake in the lungs without the aid of a sub-pulmonary ventricle to oxygenate the blue blood, and (3) the now oxygenated blood (red blood) then returns to the functioning single systemic ventricle pump via the common systemic functioning atrium and the red blood-blue blood circulation cycle is repeated. This anatomy is illustrated in **FIG. 1A** and **FIG. 7**.

The Fontan operation, which creates a total cavopulmonary connection, separates the systemic and pulmonary circuits and eliminates both hypoxemia and ventricular volume overload.

However, following the Fontan operation there is no ventricular pump to propel the blue blood into the pulmonary arteries. Instead, the blue blood returns to the lungs via passive flow from the systemic veins. Thus, the major physiologic consequence of this type of palliation is that pulmonary blue blood flow is completely dependent upon the pressure gradient from the systemic venous bed to the atrium. The normal circulation flow through the pulmonary bed is augmented by the increased pressure generated by the right ventricle. In a healthy adolescent, this results in an increase of about 20 to 25 mm Hg in the pressure present in the pulmonary arteries at rest, which may double with exercise. With the Fontan physiology, there is no sub-pulmonary ventricle and thus no augmentation of pressure as the blue blood enters the pulmonary arteries. At rest, the pressure gradient across the pulmonary vascular bed is

5 significantly less. The ability to increase this pressure gradient with exercise is extremely limited by the body's ability to tolerate increasingly elevated central venous pressures.

As a consequence of being entirely dependent upon the passive drop in venous pressure to drive pulmonary blood flow, the Fontan physiology is exquisitely sensitive to changes in pulmonary vascular resistance. Even increases that are well within the normal range for pulmonary
10 resistance in normal physiology will have detrimental effects on the Fontan physiology. The use of udenafil offers a potential therapy that is unique to this class of palliated congenital heart defects. Unlike other uses for PDE-5 inhibitors, this therapy would be to lower pulmonary vascular resistance in a population without elevated pulmonary vascular resistances or pressures. This is a distinctly different use of this class of agents as compared to patients with (i)
15 structurally normal hearts and pulmonary vascular disease, such as pulmonary arterial hypertension (PAH) and chronic obstructive pulmonary disease (COPD), (ii) heart failure, such as congestive heart disease, or (iii) the very rare patient with congenital heart disease palliated with a two ventricle repair (and thus having a sub-pulmonary ventricle) and associated pulmonary vascular disease.

20 **II. Clinical Measurements Relevant to Fontan Patients**

For children born with functional single ventricle or single ventricular congenital heart disease, the Fontan procedure is the current standard of care. The Fontan procedure is palliative, rather than curative, and while it has greatly increased the survival of pediatric subjects with functional single ventricle heart disease, the procedure also results in a series of side effects and
25 complications that can lead to attrition of patients, with complications such as arrhythmias, ventricular dysfunction, and unusual clinical syndromes of protein-losing enteropathy (PLE) and plastic bronchitis, as well as hepatic and kidney complications.

In certain embodiments, the disclosed present invention relates to improving or preventing the decline of specific clinically relevant physiological measurements that are indicative of a
30 patient's health following a Fontan procedure. Such measurements include, but are not limited to, exercise testing, vascular function testing, and echocardiographic assessment of ventricular performance.

5 **III. Exercise Testing**

Exercise testing can include assessment of VO_2 values during maximal effort or at the ventilator anaerobic threshold (VAT). VO_2 max, or maximal oxygen consumption, refers to the maximum amount of oxygen that an individual can utilize during intense exercise. This measurement is generally considered a reliable indicator of cardiovascular fitness and aerobic endurance. The
10 more oxygen a person can use during high level exercise, the more energy that person can produce. This test has been the standard for cardiorespiratory fitness because muscles need oxygen for prolonged (aerobic) exercise; blood carries oxygen to the muscles and the heart must pump adequate amounts of blood to meet the demands of aerobic exercise.

VO_2 is often measured by putting a mask on a subject, and measuring the volume and gas
15 concentrations of inhaled and expired air. This measurement is often used in both clinical settings and research and is considered the most accurate. Testing commonly involves either exercising on a treadmill or riding a cycle ergometer at increasing intensity until exhaustion, and is designed to provide readings at a maximal effort of the subject and/or at the subject's anaerobic threshold.

20 SVHD patients, including SVHD patients that have previously undergone a Fontan procedure, will generally see a decline in VO_2 measurements over time. However, when practicing or treating a SVHD patient, including a Fontan patient, is treated with a method according to the present invention, the VO_2 measurement (i) is maintained at a similar level, demonstrating that there has been no further decline in VO_2 measurement, or (ii) improved with therapy,
25 demonstrating that there has been an increase in VO_2 , and/or the rate of decline in VO_2 measurement is reduced, thus, improved, each indicating that the treatments or methods of the present invention are clinically beneficial. In some SVHD patients, treatment in accordance with the present invention may significantly slow or decrease the decline in VO_2 measured during exercise.

30 In one embodiment, the present invention is directed to a method of improving or maintaining VO_2 measurements of a SVHD patient or a subject who has previously had a Fontan procedure. The method of the present invention comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to a SVHD patient, including a Fontan patient, where the

5 PDE5 inhibitor is preferably udenafil or a pharmaceutically acceptable salt thereof. In some embodiments of the present invention, VO_2 is measured at maximal effort, while in other embodiments, VO_2 is measured at the subject's anaerobic threshold (VAT).

In some embodiments, the disclosed methods and compositions of the present invention are administered to a SVHD patient, including a Fontan patient, and result in no decrease, or a
10 minimal decrease, in exercise capacity over time. More specifically, the disclosed methods and compositions of the present invention may result in a decrease in exercise capacity of less than about 40, less than about 35, less than about 30, less than about 25, less than about 20, less than about 15, less than about 10, or less than about 5% over time. The time period between a first and second measurement used to calculate the decrease in exercise capacity can be, for example,
15 about 1, about 2, about 3, about 4, about 5, about 6, about 7, about 8, about 9, about 10, about 11, or about 12 months; about 1, about 2, about 3, about 4, about 5, about 6, about 7, about 8, about 9, about 10, about 11, about 12, about 13, about 14, or about 15 years, or any combination thereof, e.g., 1 year, 3 months; 4 years, 7 months, etc.

In some embodiments, the disclosed methods and compositions of the present invention may be
20 administered to a SVHD patient, including a Fontan patient, and result in an improvement of exercise capacity. More specifically, the disclosed methods and compositions of the present invention may result in a 1, 2, 5, 10, 15, 20, 25, 30, 35, 40, 45, or 50% or more improvement in VO_2 at maximal effort. Alternatively, the disclosed methods and compositions of the present invention may result in a 1, 2, 5, 10, 15, 20, 25, 30, 35, 40, 45, or 50% or more improvement in
25 VO_2 at the SVHD patient's, including the Fontan patient's, ventilatory anaerobic threshold (VAT).

IV. Vascular Function Testing

Vascular endothelial dysfunction is an important outcome for assessing vascular health in intervention studies. It is now well established that vascular endothelial dysfunction is positively
30 associated with traditional cardiovascular disease (CVD) risk factors, and independently predicts cardiovascular events over intervals of 1 to 6 years.

Pulse amplitude tonometry (PAT), a FDA-approved method for assessing vascular function, is increasingly being used as an alternative measure of endothelium-dependent dilation in response

5 to reactive hyperemia and flow-mediated dilation (FMD). The PAT device records digital pulse wave amplitude (PWA) using fingertip plethysmography. PWA can be measured continuously during three phases: a quiet baseline period, 5-min forearm occlusion, and reactive hyperemia following cuff release. Unlike FMD, PAT testing is not dependent upon a highly skilled technician and post-test analysis is largely automated. Most importantly, at least one longitudinal study has shown that PAT measures of endothelial function predict CVD events over a 6-year follow-up period. These significant advantages may make PAT testing suitable for clinical practice if prognostic significance and reliability can be verified.

SVHD patients, including SVHD patients that have previously undergone a Fontan procedure, will generally see a decline in vascular function over time. Treating a SVHD patient, including a Fontan patient, that improves or prevents further decline in vascular function of a SVHD patient, including a Fontan patient, would indicate that the treatment is clinically beneficial and may improve the SVHD patient's, including the Fontan patient's, quality of life or prevent decline in cardiovascular function.

In one embodiment, the present invention is directed to a method of improving or maintaining vascular function of SVHD patients, including SVHD patients that have previously undergone a Fontan procedure. The method comprises administering, preferably daily, an effective amount of an effective PDE5 inhibitor to a SVHD patient, including a Fontan patient, where the PDE5 inhibitor is preferably sildenafil or a pharmaceutically acceptable salt thereof. In some embodiments, vascular function is measured using a PAT index.

25 In some embodiments, the disclosed methods and compositions of the present invention are administered to a SVHD patient, including a Fontan patient, and result in no decrease, or a minimal decrease, in vascular function over time. Vascular function can be measured using any conventional known technique, including but not limited to pulse amplitude tonometry measurements, the natural log of reactive hyperemia index, Reactive Hyperemia Index, Framingham (RHI), area under the curve to max-occlusion/control, average up to max-occlusion/control, and other known EndoPAT indices. In some embodiments of the present invention, vascular function is measured using a PAT index. More specifically, the disclosed

5 methods and compositions of the present invention may result in a decrease in vascular function of less than about 40, less than about 35, less than about 30, less than about 35, less than about 20, less than about 15, less than about 10, or less than about 5% over time. The time period between a first and second measurement used to calculate the decrease in vascular function can be, for example, about 1, about 2, about 3, about 4, about 5, about 6, about 7, about 8, about 9,
10 about 10, about 11, or about 12 months; about 1, about 2, about 3, about 4, about 5, about 6, about 7, about 8, about 9, about 10, about 11, about 12, about 13, about 14, or about 15 years, or any combination thereof, e.g., 1 year, 3 months; 4 years, 7 months, etc.

In some embodiments, the disclosed methods and compositions of the present invention may be administered to a SVHD patient, including a Fontan patient and result in an improvement of
15 vascular function. Vascular function can be measured using any conventional known technique, including but not limited to pulse amplitude tonometry measurements, the natural log of reactive hyperemia index, Reactive Hyperemia Index, Framingham RHI, area under the curve to max-occlusion/control, average up to max-occlusion/control, and other known EndoPAT indices. In some embodiments of the present invention, vascular function is measured using a PAT index.
20 More specifically, the disclosed methods and compositions may result in about a 1, about 2, about 5, about 10, about 15, about 20, about 25, about 30, about 35, about 40, about 45, or about 50% or more improvement in one or more measurements of vascular function, including but not limited to pulse amplitude tonometry measurement, the natural log of reactive hyperemia index, Reactive Hyperemia Index, Framingham RHI, area under the curve to max-occlusion/control,
25 average up to max-occlusion/control, and other known EndoPAT indices.

V. Echocardiographic Assessment of Ventricular Performance

Ventricular performance and cardiac contractility are important measurements that can reveal impairment of cardiovascular health before overt heart failure is present. Ventricular performance can be assessed using echocardiographic methods and quantified via a myocardial
30 performance index or MPI. MPI is an index that combines systolic and diastolic function.

Specifically, MPI is defined as the sum of isovolumic contraction time and isovolumic relaxation time divided by the ejection time.

5 Various versions of MPI are known in the art, and each version of MPI may be used to assess ventricular performance. For instance, MPI indices may include, but are not limited to, blood pool MPI and tissue Doppler MPI. MPI can be measured by using pulsed-wave tissue Doppler echocardiography (TDE). To calculate MPI using TDE, isovolumetric contraction time (IVCT), isovolumetric relaxation time (IVRT) and ejection time (ET) of the functioning single ventricle
10 are measured. MPI is then determined by adding together the IVCT and the IVRT and dividing the sum by ET.

Patients that have previously undergone a Fontan procedure will generally see a decline in ventricular performance over time. Treating a patient such that the patient's ventricular performance is maintained, exhibits minimal decrease over time, or increases indicates that the
15 treatment is clinically beneficial and may improve patient quality of life or prevent decline in cardiovascular function.

In one embodiment, the present invention is directed to a method of maintaining, producing a minimal decrease in, or increasing ventricular performance of a subject who has previously had a Fontan procedure. The method of the present invention comprises administering, preferably daily,
20 an effective amount of an effective PDE5 inhibitor to the patient, where the PDE5 inhibitor is preferably sildenafil or a pharmaceutically acceptable salt thereof. In some embodiments of the present invention, ventricular performance is measured using a myocardial performance index (MPI). In some embodiments, the MPI may be a blood pool MPI, while in other embodiments the MPI may be a tissue Doppler MPI.

25 In some embodiments, the disclosed methods and compositions of the present invention may be administered to a Fontan patient and result in minimal or no decrease in ventricular performance over time. Ventricular performance can be measured using any conventional known technique, including but not limited to myocardial performance index (MPI), blood pool MPI, tissue doppler MPI, average isovolumetric contraction and relaxation, and other known ventricular
30 performance indices. More specifically, the disclosed methods and compositions of the present invention may result in a decrease in ventricular performance of less than about 40, less than about 35, less than about 30, less than about 25, less than about 20, less than about 15, less than about 10, or less than about 5% over time. The time period between a first and second

- 5 measurement used to calculate the decrease in ventricular performance can be, for example, about 1, about 2, about 3, about 4, about 5, about 6, about 7, about 8, about 9, about 10, about 11, or about 12 months; about 1, about 2, about 3, about 4, about 5, about 6, about 7, about 8, about 9, about 10, about 11, about 12, about 13, about 14, or about 15 years, or any combination thereof, e.g., 1 year, 3 months; 4 years, 7 months, etc.
- 10 In some embodiments, the disclosed methods and compositions of the present invention may be administered to a SVHD patient, including a Fontan patient, and result in an improvement of ventricular performance over time. Ventricular performance can be measured using any conventional known technique, including but not limited to myocardial performance index (MPI), blood pool MPI, tissue doppler MPI, average isovolumetric contraction and relaxation, and other
- 15 known ventricular performance indices. For example, the disclosed methods and compositions of the present invention may result in about a 1, about 2, about 5, about 10, about 15, about 20, about 25, about 30, about 35, about 40, about 45, or about 50% or more improvement in ventricular performance, as measured by any known technique, including but not limited to myocardial performance index (MPI), blood pool MPI, tissue doppler MPI, average
- 20 isovolumetric contraction and relaxation, and other known ventricular performance indices.

VI. Methods According to the Invention

- The disclosed methods of the present invention relate to improving exercise and ventricular performance in a SVHD patient, including a Fontan patient, and who is in need of improvement in exercise capacity and/or ventricular performance. In general, the methods include
- 25 administering daily an effective amount of an effective PDE5 inhibitor or a pharmaceutically acceptable salt thereof, preferably as udenafil or a pharmaceutically acceptable salt thereof, to the SVHD patient, including a Fontan patient, to improve:

- (a) ventricular performance of the SVHD patient's single functioning ventricle as measured by MPI;
- 30 (b) exercise capacity as measured by oxygen consumption at VAT;
- (c) exercise capacity as measured by oxygen consumption at maximal effort or max VO_2 ;
- (d) work rate at VAT;

- 5 (e) VE/VCO₂ at VAT, each individually or in any combination;
(f) diastolic blood pressure at rest; and
(g) oxygen saturation (%) at rest, each individually, collectively or in any combination.

Preferably, the methods of the present invention improve (a)-(g) listed above, including
10 individually, collectively or in any combination thereof. More preferably, (a)-(g) listed above, including individually, collectively or in any combination thereof, is improved in accordance with the present invention by administering daily to a SVHD patient, including a Fontan patient, an effective amount of udenafil or a pharmaceutical acceptable salt thereof.

As discussed above and used herein, an effective PDE5 inhibitor inhibits the degradative action
15 of cGMP-specific phosphodiesterase type 5 (PDE5) on cyclic GMP in the smooth muscle cells lining the blood vessels that supply blood to various tissues.

As also discussed above and used herein, MPI is a measure of ventricular systolic and diastolic function and a prognostic and progression marker for various heart diseases, as determined by a focused echocardiogram. This numeric value is defined as the sum of isovolumetric contraction
20 time (ICT) and isovolumetric relaxation time (IRT) divided by ejection time (ET) and can be calculated for a single ventricle. The change in the myocardial performance index is determined by velocities obtained from blood pool Doppler assessment of the inflow and outflow tract of the single functioning ventricle. In other words, MPI is a measure of global systolic and diastolic time intervals to assess global cardiac dysfunction and ventricular performance. Moreover,
25 because the MPI is a Doppler index, it is independent of ventricular geometry and can be applied to either left and right ventricular function, depending upon which ventricle is the single functioning ventricle in the SVHD patients.

More specifically, the methods include administering daily an effective amount of an effective PDE5 inhibitor or a pharmaceutically acceptable salt thereof, preferably udenafil or a
30 pharmaceutically acceptable salt thereof, to effect one or more of the above improvements without causing treatment-limiting side effects including, but not limited to, blindness or loss of vision via inhibition of photoreceptor phosphodiesterase enzyme (PDE6), back pain and/or myalgia via inhibition of PDE11, such as 11A1 (PDE11A1) and/or decrease in sperm

5 concentration via inhibition of PDE11, such 11A3 (PDE11A3). Kayik, G. *et al.*: Investigation of PDE5/PDE6 and PDE5/PDE11 selective potent tadalafil-like PDE5 inhibitors using combination of molecular modeling approaches, molecular fingerprint-based virtual screening protocols and structure-based pharmacophore development. *Journal of Enzyme Inhibition and Medicinal Chemistry*, 32(1):311-330 (2017); Pomara G. and Morelli G.: Inhibition of phosphodiesterase 11
10 (PDE11) impacts on sperm quality. *Int J Impot Res*, 17:385-386 (2005), and Huang S.A. and Lie, J.D.: Phosphodiesterase-5 (PDE5) Inhibitors. In the Management of Erectile Dysfunction. *Pharmacy and Therapeutics*, 38(7):407-419 (July 2013).

Quite uniquely and surprisingly, the methods of the present invention increase and/or maximize oxygen consumption at the ventilatory anaerobic threshold (VAT) and at maximum effort or max
15 VO_2 to improve exercise capacity, and increase and/or maximize work rate at VAT and VE/VCO_2 at VAT in SVHD patients, including Fontan patients.

Also, quite uniquely and surprisingly, the methods of the present invention improve the MPI of the SVHD patients, namely, the Fontan patients. In other words, the methods of the present invention improve both systolic and diastolic function of the single functioning ventricle and the
20 global heart function. In other words, the methods of the present invention improve the filling and emptying characteristics, i.e., the squeezing ability of the single functioning ventricle and the overall ability of the reconstructed abnormal SVHD heart of the SVHD patients, including the Fontan patients, to pump the freshly oxygenated blood to the body for peripheral tissue needs.

The clinical value of the MPI improvement is evidenced by the statistically significant
25 improvement in the MPI in those SVHD patients, and in particular the Fontan patients, who were treated with the methods of the present invention, as compared to those SVHD patients, namely the Fontan patients, who were treated with placebo during the FUEL Trial.

The clinical value of the MPI improvement is also evidenced by the improvement of the single ventricular performance as measured by the isovolumic contraction time, isovolumic relaxation
30 time and ejection time using TDE, as discussed above.

By “isovolumetric contraction time” (IVCT), it is meant herein to mean a single ventricular event that occurs early in systole, during which the single ventricle contracts without volume

5 change (isovolumetrically). This period of the cardiac cycle, the squeeze event, takes place while all heart valves are closed.

By “isovolumic relaxation time” (IVRT), it is meant herein to mean the interval period of the cardiac cycle, i.e., the squeeze and relax cycle, that concerns the second heart sound emanating from the closure of the valve to the onset filling of the functioning single ventricle by following the opening of the valve. The IVRT may indicate diastolic dysfunction of the functioning single ventricle.

By “ejection time” (ET), it is meant herein to mean the single ventricular ejection time (UVET) of the reconstructed abnormal heart determined by the opening and closing of the valve during which the pressure differences across the valve are measured.

15 By “stroke volume,” it is meant herein to mean the amount of freshly oxygenated blood that the single functioning ventricle can pump out into the circulatory system in one contraction.

By “cardiac output,” it is meant herein to mean the amount of blood the single functioning ventricle in an SVHD patient, including a Fontan patient, can pump through the circulatory system in one minute.¹ The stroke volume and the heart rate determine cardiac output.

20 While each of the improvements in the treatment of SVHD patients, including Fontan patients, in accordance with the methods of the present invention are individually unique and surprising, the combination of improvements in the treatment of SVHD patients, including Fontan patients, is especially unique and surprising.

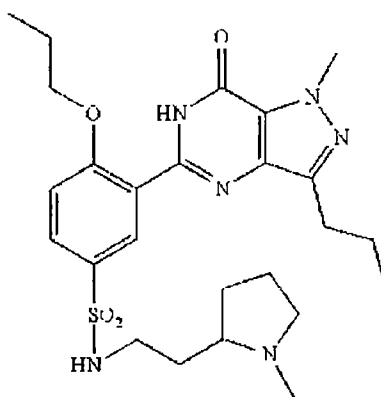
In another embodiment, it was surprising that that the methods of the invention show improved results when udenafil is administered as compared to prior very limited studies using a non-udenafil PDE5 inhibitor, such as sildenafil or tadalafil. In yet another embodiment, it was surprising that the methods of the invention show fewer side effects, and/or less severe side effects when udenafil is administered, as compared to other prior treatments using a non-udenafil PDE5 inhibitor, such as sildenafil or tadalafil.

¹A normal adult has a cardiac output on average of about 4.7 liters (5 quarts) of blood per minute.

5 In some embodiments, the Fontan patient can be an adult human, whereas in other embodiments, the Fontan patient can be an adolescent human. In some embodiments, the Fontan patient can be between about 12 and about 19 years old, whereas in other embodiments, the Fontan patient can be between about 12 and 18 years old. In yet other embodiments, the Fontan patient can be from about 12 to about 16 years old. In yet other embodiments, the Fontan patient can be from about 6
10 years old to adult. In one embodiment, the Fontan patient can be less than 18 years old.

VII. Doses and Dosage Forms

The structure of udenafil is shown below:



15 In some embodiments, udenafil or a pharmaceutically acceptable salt thereof can be administered at total daily dosage amounts of about 0.01 to about 150 mg/kg. In another embodiment, the udenafil or a pharmaceutically acceptable salt thereof can be administered at total daily doses of about 0.01 mg/kg up to about 30 mg/kg. In another embodiment, udenafil or a pharmaceutically acceptable salt thereof can be administered in a dosage amount of from about 2.5 mg to about
20 275 mg, such as about 2.5 mg, about 5 mg, about 7.5 mg, about 10 mg, about 12.5 mg, about 15 mg, about 17.5 mg, about 20 mg, about 22.5 mg, about 25 mg, about 27.5 mg, about 30 mg, about 32.5, about 35 mg, about 37.5 mg, about 40 mg, about 42.5 mg, about 45 mg, about 47.5 mg, about 50 mg, about 52.5 mg, about 55 mg, about 57.5 mg, about 60 mg, about 62.5 mg, about 65 mg, about 67.5 mg, about 70 mg, about 72.5 mg, about 75 mg, about 77.5 mg, about 80
25 mg, about 82.5 mg, about 85 mg, about 87.5 mg, about 90 mg, about 92.5 mg, about 95 mg, about 97.5 mg, about 100 mg, about 102.5 mg, about 105 mg, about 107.5 mg, about 110 mg, about 112.5 mg, about 115 mg, about 117.5 mg, about 120 mg, about 122.5 mg, about 125 mg, about 127.5 mg, about 130 mg, about 132.5 mg, about 135 mg, about 137.5 mg, about 140 mg,

5 about 142.5 mg, about 145 mg, about 147.5 mg, about 150 mg, about 152.5 mg, about 155 mg,
about 157.5 mg, about 160 mg, about 162.5 mg, about 165 mg, about 167.5 g, about 170 mg,
about 172.5 mg, about 175 mg, about 180 mg, about 182.5 mg, about 185 mg, about 187.5 mg,
about 190 mg, about 192.5 mg, about 195 mg, about 197.5 mg, about 200 mg, about 202.5 mg,
about 205 mg, about 207.5 mg, about 210 mg, about 212.5 mg, about 215 mg, about 217.5 mg,
10 about 220 mg, about 222.5 mg, about 225 mg, about 227.5 mg, about 230 mg, about 232.5 mg,
about 235 mg, about 237.5 mg, about 240 mg, about 242.5 mg, about 245 mg, about 247.5 mg,
about 250 mg, about 252.5 mg, about 255 mg, about 257.5 mg, about 260 mg, about 262.5 mg,
about 265 mg, about 267.5 mg, about 270 mg, about 272.5 mg or about 275 mg, so long as any
such individual dosage amount does not cause treatment-limiting toxicity or treatment-limiting
15 side effects to the extent that the drug product would not be approved for market. In yet another
embodiment, udenafil or a pharmaceutically acceptable salt thereof can be administered at total
daily doses of from about 5 mg to about 275 mg, such as about 5 mg, about 10 mg, about 15 mg,
about 20 mg, about 25 mg, about 27.5 mg, about 30 mg, about 32.5, about 35 mg, about 37.5 mg,
about 40 mg, about 42.5 mg, about 45 mg, about 47.5 mg, about 50 mg, about 55 mg, about 60
20 mg, about 65 mg, about 70 mg, about 75 mg, about 80 mg, about 85 mg, about 87.5 mg, about 90
mg, about 95 mg, about 100 mg, about 125 mg, about 150 mg, about 175 mg, about 200 mg,
about 225 mg, about 250 mg, or about 275 mg, so long as any such individual total daily dose
does not cause treatment-limiting toxicity or treatment-limiting side effects to the extent that the
total daily dose would not be approved for market.

25 In still another embodiment, udenafil or a pharmaceutically acceptable salt thereof can be
administered in total daily doses of from about 25 mg to about 700 mg, such as about 25 mg,
about 37.5 mg, about 50 mg, about 75 mg, about 87.5 mg, 125 mg, about 175 mg, about 200 mg,
about 225 mg, about 250 mg, about 275 mg, about 300 mg, about 325 mg, about 350 mg, about
375 mg, about 400 mg, about 425 mg, about 450 mg, about 475 mg, about 500 mg, about 525
30 mg, about 550 mg, about 575 mg, about 600 mg, about 625 mg, about 650 mg, about 675 mg, or
about 700 mg, so long as any such individual total daily dose does not cause treatment-limiting
toxicity or treatment-limiting side effects to the extent that the total daily dose would not be
approved for market.

5 In a further embodiment, udenafil or a pharmaceutically acceptable salt thereof can be administered at a total daily dose of about 37.5 mg, about 75 mg, about 87.5 mg, 125 mg, or about 175 mg. In a further embodiment, udenafil or a pharmaceutically acceptable salt thereof can be administered at a total daily dose range of from about 37.5 mg to about 175 mg, preferably, a total daily dose range of from 75 mg to about 175 mg, more preferably, a total daily
10 dose range of from about 87.5 mg to about 175 mg and, most preferably, a total daily dose range of from 125 mg to about 175 mg. In a preferred embodiment, udenafil or any pharmaceutically acceptable salt thereof can be administered to a Fontan patient in any dosage amount or in any total daily dose, so long as any selected individual dosage amount or any selected individual total daily dose does not cause treatment-limiting toxicity or treatment-limiting side effects to the
15 extent that the total daily dose would not be approved for market.

Thus, the present invention contemplates administration of udenafil or a pharmaceutically acceptable salt thereof to SVHD patients, including Fontan patients, at any dosage amount, at any total daily dose, at any treatment regimen and in any dosage form, so long as when any such dosage amount, total daily dose, treatment regimen or dosage form is selected, it does not cause
20 treatment-limiting toxicity or treatment-limiting side effects to the extent that such would not be approved for market. In particular, the present invention contemplates administration of udenafil or a pharmaceutically acceptable salt thereof in an effective amount to SVHD patients, including Fontan patients to improve MPI, single ventricular performance, systolic and/or diastolic function, ventricular squeeze capability, cardiac output, exercise capacity or performance at VAT
25 and/or max VO_2 , work rate at VAT, VE/CO_2 at VAT, diastolic blood pressure at rest, oxygen saturation (%) at rest and/or decrease the rate of decline of progression of SVHD, as compared to untreated SVHD patients, so long as the therapeutically effective amount does not cause treatment-limiting toxicity, treatment limiting side effects associated with inhibition of PDE6 and/or PDE11, and/or treatment-limiting side effects to the extent that the drug product would
30 not be approved for market.

In one embodiment, the udenafil or a pharmaceutically acceptable salt thereof can be administered once a day.

5 In another embodiment, the udenafil or a pharmaceutically acceptable salt thereof can be administered once daily or in divided multiple dosages, such as twice a day, three times a day, four times a day or more.

In yet another embodiment, the udenafil or a pharmaceutically acceptable salt thereof can be administered twice a day such that therapeutically effective blood levels are maintained for at
10 least about 1.5 to about 24 hours, more particularly at least about 1.5, about 2, about 3, about 4, about 5, about 6, about 7, about 8, about 9, about 10, about 11, about 12, about 13, about 14, about 15, about 16, about 17, about 18, about 19, about 20, about 21, about 22, about 23 or about 24 hours of a 24 hour dosing period. Thus, the present invention therefore contemplates udenafil and/or any udenafil active metabolite, such as DA8164 active metabolite, maintaining an
15 effective blood level for any period of time within a 24 hour dosing period.

In some embodiments, the total daily dosage amount of udenafil or a pharmaceutically acceptable salt administered twice a day can be less than the total daily dosage amount of udenafil or a pharmaceutically acceptable salt thereof administered once a day.

In some embodiments, the total daily dosage amount of udenafil or a pharmaceutically
20 acceptable salt thereof administered twice a day, can maintain therapeutically effective blood levels for the same number of hours in a 24 hour period as a higher dosage of udenafil or a pharmaceutically acceptable salt thereof when administered once a day. In other embodiments, the total daily dosage amount of udenafil or a pharmaceutically acceptable salt thereof administered twice a day, can maintain therapeutically effective blood levels for a higher number
25 of hours in a 24 hour period as the same dosage of udenafil or a pharmaceutically acceptable salt thereof when administered once a day. Thus, the present invention contemplates administration of any total daily dosage amount of udenafil or any acceptable salt thereof once daily or in divided doses multiple times a day, such as twice daily, three times daily, four times daily or more, to maintain therapeutically effective blood levels throughout a 24 hour period.

30 In one embodiment, it is surprising that the administration of twice a day udenafil or a pharmaceutically acceptable salt thereof results in fewer side effects than the administration of once a day udenafil or a pharmaceutically acceptable salt thereof. In another embodiment, it is surprising that twice a day administration of udenafil or a pharmaceutically acceptable salt

5 thereof can achieve therapeutically effective levels of udenafil at a lower total daily dosage than a once a day administration.

In some embodiments, the pharmaceutically acceptable salt of udenafil can be an acid addition salt. In one embodiment, the acid addition salt of udenafil can be an inorganic acid addition salt such as, hydrochloric, hydrobromic, sulfuric, or phosphoric acid addition salt. In another
10 embodiment, the acid addition salt can be an organic acid addition salt such as citrate, tartarate, acetate, lactate, maleate, fumarate, gluconate, methanesulfonate (mesylate), glycolate, succinate, p-toluenesulfonate (tosylate), galacturonate, embonate, glutamate, aspartate, oxalate, benzensulfonate, camphorsulfonate, cinnamate, adipate, or cyclamate. In a particular
15 embodiment, the pharmaceutically acceptable salt of udenafil can be an oxalate, benzensulfonate, camphorsulfonate, cinnamate, adipate, or cyclamate salt.

In some embodiments, the udenafil or a pharmaceutically acceptable salt thereof can be administered as a pharmaceutical composition. In one embodiment, the pharmaceutical composition comprising udenafil or a pharmaceutically acceptable salt thereof can be formulated in a wide variety of oral or parenteral dosage forms on clinical application. Each of the dosage
20 forms can contain various disintegrating agents, surfactants, fillers, thickeners, binders, diluents such as wetting agents or other pharmaceutically acceptable excipients.

The udenafil composition can be administered using any pharmaceutically acceptable method, such as intranasal, buccal, sublingual, oral, rectal, ocular, parenteral (intravenously, intradermally, intramuscularly, subcutaneously, intracisternally, intraperitoneally), pulmonary,
25 intravaginal, locally administered, topically administered, topically administered after scarification, mucosally administered, via an aerosol, or via a buccal or nasal gel or spray formulation.

Further, the udenafil composition can be formulated into any pharmaceutically acceptable dosage form, such as a solid dosage form, including but not limited to a tablet, pill, lozenge, capsule, caplet, orally-disintegrating dosage form, sublingual dosage form, buccal dosage form, liquid,
30 liquid dispersion, liquid suspension, solution, aerosol, pulmonary aerosol, nasal aerosol and semi-solid, namely, ointment, cream, thin film, and gel, and patches such as transdermal patches.

5 Further, the composition may be a controlled release formulation, sustained release formulation, immediate release formulation, modified release formulation or any combination thereof.

Further, the composition may be a transdermal delivery system.

In another embodiment, the pharmaceutical composition comprising udenafil or a pharmaceutically acceptable salt thereof can be formulated into a solid dosage form for oral
10 administration, and the solid dosage form can be powders, granules, capsules, tablets, caplets, caches, orally-disintegrating dosage forms, sublingual dosage forms, buccal dosage forms, lozenges or pills. In yet another embodiment, the solid dosage form can include one or more excipients such as calcium carbonate, starch, sucrose, lactose, microcrystalline cellulose or gelatin. In addition, the solid dosage form can include, in addition to the excipients, a lubricant
15 such as talc or magnesium stearate. In some embodiments, the oral dosage form can be immediate release, or a modified release form. Modified release dosage forms include controlled, sustained, modified or extended release, enteric release, and the like. The excipients used in the modified release dosage forms are commonly known to a person of ordinary skill in the art.

For example, a solid carrier may be one or more substance that may also act as diluents,
20 flavoring agents, binders, preservatives, oral dosage form disintegrating agents, or an encapsulating material. The oral dosage forms, such as powders, granules, capsules, tablets, caplets, caches, lozenges or pills, preferably contain from 5% to 70% of the udenafil. Suitable carriers are magnesium carbonate, magnesium stearate, talc, sugar, lactose (e.g., lactose monohydrate), pectin, dextrin, starch (e.g., corn starch), gelatin, tragacanth, methylcellulose,
25 sodium carboxymethylcellulose, hydroxypropyl cellulose, low substituted hydroxypropyl cellulose, silicon dioxide (e.g., colloidal silicon dioxide), a low melting wax, cocoa butter, and the like. The term "preparation" is intended to include the formulation of the udenafil solid, liquid or semi-solid matrix with or without encapsulating material.

Liquid form preparations include solutions, suspensions and emulsions, for example, water or
30 water/propylene glycol solutions. For parenteral injection, liquid preparations can be formulated in solution in aqueous polyethylene glycol solution. For example, aqueous solutions suitable for oral use can be prepared by dissolving the udenafil in water and adding suitable colorants,

5 flavors, stabilizers, and thickening agents as desired. In another example, aqueous suspensions suitable for oral use can be made by dispersing the finely divided udenafil in water with viscous material, such as natural or synthetic gums, resins, methylcellulose, sodium carboxymethylcellulose, and other well-known suspending agents.

Also included are solid form preparations that are intended to be converted, shortly before use, to
10 liquid form preparations for oral administration. Such liquid forms include solutions, suspensions, and emulsions. In one embodiment, the pharmaceutical composition can be formulated in a liquid dosage form for oral administration, such as suspensions, emulsions or syrups, which may contain, in addition to the udenafil, colorants, flavors, stabilizers, buffers (e.g., buffers to adjust the pH to a desirable range for intravenous use such as salts of inorganic acids such as phosphate,
15 borate, and sulfate), artificial and natural sweeteners, dispersants, thickeners, solubilizing agents, and the like. In other embodiments, the liquid dosage form can include, in addition to commonly used simple diluents such as water and liquid paraffin, various excipients such as humectants, sweeteners, aromatics or preservatives. In particular embodiments, the composition comprising udenafil or a pharmaceutically acceptable salt thereof can be formulated to be suitable for
20 administration to a pediatric patient.

In one embodiment, the pharmaceutical composition can be formulated in a dosage form for parenteral administration, such as sterile aqueous solutions, suspensions, emulsions or non-aqueous solutions. In other embodiments, the non-aqueous solutions or suspensions can include propyleneglycol, polyethyleneglycol, vegetable oils such as olive oil or injectable esters such as
25 ethyl oleate. Alternatively, the pharmaceutical composition can be formulated in a dosage form for rectal or vaginal administration. As a base for suppositories, witepsol, macrogol, tween 61, cacao oil, laurin oil or glycerinated gelatin can be used.

The pharmaceutical preparation may require a surfactant or other appropriate co-solvent in the composition. Such co-solvents include: Polysorbate 20, 60, and 80; Pluronic F-68, F-84, and P-
30 103; cyclodextrin; and polyoxyl 35 castor oil. Such co-solvents are typically employed at a level between about 0.01 % and about 2% by weight. Viscosity greater than that of simple aqueous solutions may be desirable to decrease variability in dispensing the formulations, to decrease physical separation of components of a suspension or emulsion of formulation, and/or otherwise

5 to improve the formulation. Such viscosity building agents include, for example, polyvinyl alcohol, polyvinyl pyrrolidone, methylcellulose, hydroxy propyl methylcellulose, hydroxyethyl cellulose, carboxymethyl cellulose, hydroxy propyl cellulose, chondroitin sulfate and salts thereof, hyaluronic acid and salts thereof, and combinations of the foregoing. Such agents are typically employed at a level between about 0.01% and about 2% by weight.

10 The pharmaceutical preparation is preferably in unit dosage form. In such form the preparation is subdivided into unit doses containing appropriate quantities of the udenafil or any acceptable pharmaceutical salt thereof. The unit dosage form can be a packaged preparation, such as a sachet, the package containing discrete quantities of preparation, such as packeted tablets, caplets, capsules, orally-disintegrating dosage forms, sublingual dosage forms, buccal dosage forms and
15 powders in vials or ampoules. Also, the unit dosage form can be a capsule, tablet, caplets, pills, orally-disintegrating dosage forms, sublingual dosage forms, buccal dosage forms, cachet, or lozenge itself, or it can be the appropriate number of any of these in packaged form.

The pharmaceutical compositions may include components to provide immediate release, sustained release, extended release, modified release, convenience and/or comfort. Such
20 components include high molecular weight, anionic mucomimetic polymers, gelling polysaccharides, and finely-divided drug carrier substrates.

In a further embodiment, the pharmaceutical composition comprising udenafil or a pharmaceutically acceptable salt thereof can be formulated as an orally-disintegrating, sublingual or buccal dosage form. Such dosage forms comprise sublingual tablets or solution compositions
25 that are administered under the tongue and buccal tablets that are placed between the cheek and gum.

The pharmaceutical preparation may be prepared by further containing a coating agent for example, the light shielding agent capable of generating free radical by UV light, metal oxides such as titanium oxide and the like are described, and as the free radical scavenger, for example,
30 organic acids such as benzoic acid and the like. In addition, the coating agent may further include, but not be limited to, an water-soluble polymer (e.g., hypromellose or hydroxypropyl cellulose,), an enteric coating layer containing polyethylene glycol, triethyl citrate, cellulose acetate phthalate, hydroxypropyl methyl cellulose acetate succinate, polyvinyl acetate phthalate, methyl

5 methacrylate-methacrylic acid copolymers, shellac, cellulose acetate succinate, cellulose acetate trimellitate, hydroxypropyl methyl cellulose phthalate, zein, sodium alginate, and mannitol, and/or enteric coating aqueous solution including, for example, ethylcellulose, medium chain triglycerides, oleic acid, sodium alginate, stearic acid.

10 In yet a further embodiment, the pharmaceutical composition comprising udenafil or a pharmaceutically acceptable salt thereof can be formulated as a nasal dosage form. Such dosage forms of the present invention comprise solution, suspension, emulsion, and gel compositions for nasal delivery.

15 In one embodiment, the pharmaceutical composition can be formulated in a liquid dosage form for oral administration, such as solutions, suspensions, emulsions or syrups. In other embodiments, the liquid dosage form can include, in addition to commonly used simple diluents such as water and liquid paraffin, various excipients such as humectants, sweeteners, aromatics or preservatives. In particular embodiments, the composition comprising udenafil or a pharmaceutically acceptable salt thereof can be formulated to be suitable for administration to a pediatric patient.

20 The dosage of the pharmaceutical composition can vary depending on the patient's weight, age, gender, administration time and mode, excretion rate, and the severity of disease.

VIII. Exercise Testing

Exercise testing can include assessment of VO_2 values during maximal effort or at ventilator anaerobic threshold ("VAT"). VO_2 max ("peak VO_2 "), or maximal ("peak") oxygen
25 consumption, refers to the maximum amount of oxygen that an individual can utilize during intense exercise. This measurement is generally considered a reliable indicator of cardiovascular fitness and aerobic endurance. Theoretically, the more oxygen a person can use during exercise, the more energy that person can produce. This test is often used for cardiorespiratory fitness because muscles need oxygen for prolonged (aerobic) exercise; blood carries oxygen to the
30 muscles and the heart must pump adequate amounts of blood to meet the demands of aerobic exercise. However, while peak VO_2 may be useful as a surrogate for many cardiovascular disease states, it may not be as relevant an endpoint after the Fontan operation. In this unique physiology, central venous pressure, rather than right ventricular contraction (pumping), is the

5 primary driver of transpulmonary blood flow and, therefore, cardiac output. Gewillig M and
Goldberg DJ. Failure of the fontan circulation. *Heart Fail Clin.* 10(1):105-116 (Jan 2014); Egbe
AC, Connolly HM, Miranda WR, Ammash NM, Hagler DJ, Veldtman GR and Borlaug BA.
Hemodynamics of Fontan Failure: The Role of Pulmonary Vascular Disease. *Circ Heart Fail.*
10(12): e004515 (Sept. 2017); Gewillig M, Brown SC, Eyskens B, Heying R, Ganame J, Budts
10 W, La Gerche A and Gorenflo M. The Fontan circulation: who controls cardiac output? *Interact*
Cardiovasc Thorac Surg. 10(3):428-433 (Mar 2010); and Goldberg DJ, Avitabile CM, McBride
MG and Paridon SM. Exercise capacity in the Fontan circulation. *Cardiol Young.* 23(6):824-830
(Dec 2013). As the demand for cardiac output increases with exertion, central venous pressure in
the Fontan circulation must rise to meet that demand, but eventually reaches a critical ceiling
15 beyond which it can rise no further. Navaratnam D, Fitzsimmons S, Grocott M, Rossiter HB,
Emmanuel Y, Diller GP, Gordon-Walker T, Jack S, Sheron N, Pappachan J, Pratap JN,
Vettukattil JJ and Veldtman G. Exercise-Induced Systemic Venous Hypertension in the Fontan
Circulation. *Am J Cardiol.* 117(10):1667-1671 (May 15, 2016). At submaximal exertion, the
elevation in central venous pressure does not reach this physiologic ceiling and thus outcomes at
20 this level of exercise may be more sensitive to pharmacologic manipulation of the pulmonary
vasculature.

VO₂ is often measured by putting a mask on a subject, and measuring the volume and gas
concentrations of inhaled and expired air. This measurement is often used in both clinical
settings and research and has been considered the most accurate. Testing commonly involves
25 either exercising on a treadmill or riding a cycle ergometer at increasing intensity until
exhaustion, and is designed to provide readings at a maximal effort of the subject and/or at the
subject's anaerobic threshold.

Patients that have previously undergone a Fontan procedure will generally see a decline in VO₂
measurements over time. Treating a patient with methods disclosed herein such that the patient's
30 VO₂ measurement is either maintained at a similar level, demonstrating that there has been no
further decline in VO₂ function, or improved with therapy indicates that the treatment is
clinically beneficial and may improve cardiovascular function or prevent or slow the rate of
decline in cardiovascular function.

IX. Myocardial Performance Index (MPI)

Generally speaking, MPI (also referred to as the Doppler-derived index or Tei Index) is a measure of ventricular systolic and diastolic function as determined by a focused echocardiogram. It combines systolic and diastolic time intervals to assess heart function. More specifically, MPI can be used to assess ventricular performance represented by a numeric value using cardiac time intervals. This numeric value equals the sum of isovolumetric contraction time (ICT) and isovolumetric relaxation time (IRT) divided by ejection time (ET) and can be determined for either the left or right ventricle. Pellett, A.A., et al.: The Tei Index: Methodology and Disease State Values. *Echocardiography: A Jnl. of CV Ultrasound & Allied Tech.* 21(7):669-672 (2004); and Ulugay, A., Tatli E.: Myocardial performance index. *Anadolu Kardiyol Derg.* 8(2):143-8 (April, 2008), both of which are incorporated herein by reference in their entireties. In the FUEL Trial, the MPI measured the performance of the single functioning ventricle. Thus, the MPI results from the FUEL Trial were determined by velocities obtained from blood pool Doppler assessment of the inflow and outflow tract of the functioning single ventricle. In other words, the FUEL Trial MPI was determined by measuring the cardiac time intervals using pulsed-wave Doppler velocity spectra of the ventricular inflow and outflow of the single functioning ventricle.

X. Echocardiogram Testing

Echocardiograms were performed by sonographers with specific training for this protocol. The primary outcome of interest was MPI using Doppler-based measures of inflow and outflow duration. The duration of inflow into the dominant ventricle and outflow across the dominant semilunar valve were measured and used to calculate MPI using the standard formula. Tei C, Ling LH, Hodge DO, et al.: New index of combined systolic and diastolic myocardial performance: a simple and reproducible measure of cardiac function-a study in normals and dilated cardiomyopathy. *J Cardiol*, 26(6):357-66 (1995); and Pellet AA et al.: The Tei Index: Methodology and Disease State Values. *Echocardiography: A Jnl Of CV Ultrasound & Allied Tech*, 21(7):669-672 (2004). Additional tissue Doppler images were obtained and used to calculate the tissue Doppler based MPI as previously described. Harada K, Tamura M, Toyono M et al.: Comparison of the right ventricular Tei index by tissue Doppler imaging to that obtained by pulsed Doppler in children without heart disease. *Am J Cardiol*, 90(5):566-9 (2002).

5 Whenever possible, three measurements were made and the mean duration was used for the calculation.

XI. Super Fontan Patients having a baseline %- predicted max or peak VO_2 is $\geq 80\%$ and Subgroup Fontan Patients having a baseline %- predicted max or peak VO_2 is $< 80\%$

10 The FUEL Trial in Example 1 below did not exclude Fontan patients based on an upper limit of aerobic exercise capacity (peak or max VO_2). This trial design led to the enrollment of a substantial number of participants with a baseline peak $\text{VO}_2 \geq 80\%$ (20% of the analyzable ITT cohort), subjects with normal or near-normal exercise capacity. Only recently has this subgroup of super Fontan patients been formally recognized in academia, where they have been termed

15 “high-performers” or “Super-Fontans” (Powell 2020 and Weinreb 2020). When the FUEL Trial was designed, it was not well recognized that these Fontan high performers or super Fontan patients existed. Moreover, the physiologic explanations for their unique limitations to exercise were not well understood. Thus, therapy with a pulmonary vasodilator may not augment an already high pulmonary vascular reserve (i.e., a fully vasodilated state at baseline) in these

20 Fontan subjects. Therefore, inclusion of this high-performer subgroup may have served to dilute the measurable clinical impact of pulmonary vasodilator therapy on peak VO_2 in the ITT cohort overall. The following findings support this assertion and the conclusion of udenafil efficacy in patients with SVHD palliated to Fontan circulation: 1. Despite inclusion of Fontan high-performers, the overall ITT results nevertheless surprisingly demonstrated clinical improvement

25 and near statistical significance in udenafil effect on Peak VO_2 ($p=0.092$ when peak VO_2 is expressed as ml/kg/min and $p=0.071$ when expressed as ml/min).

Baseline %-predicted peak or max VO_2 affected the treatment response. See **FIG. 2**. Robust responses are evident in the udenafil group, but only for Fontan patients in whom the baseline %-

30 predicted max or peak VO_2 is $< 80\%$. For the patients with baseline peak $\text{VO}_2 \geq 80\%$, there appears to be little response at peak or max VO_2 exercise. Note that responses in the placebo group are negligible across all of the baseline strata. This concentration of udenafil drug effect in the low performers surprisingly offers the most opportunity for pharmacologic improvement in peak or max exercise capacity to the Fontan patients most at risk for adverse clinical events.

35

- 5 The Exclusion of the high-performing Fontan subgroup (peak $\text{VO}_2 \geq 80\%$ of predicted) generated a cohort for whom there was both clinical and statistically significant improvement in peak VO_2 on udenafil drug ($p=0.023$ when peak VO_2 is expressed as ml/kg/min and $p=0.030$ when expressed as ml/min). This Fontan subgroup represented the majority of subjects enrolled in the FUEL Trial (80% of the analyzable ITT cohort) and is the subgroup most at risk for near-
10 term adverse clinical outcomes (**Table 1**). These findings are highly supported by information that was not available at the time the FUEL Trial was planned. It is simply not feasible to improve pulmonary vasodilatation in patients who have normal pulmonary vasodilatory reserve, and inclusion of such patients in the FUEL Trial would have diluted the treatment effect.
- 15 Remarkably, VO_2 at VAT was associated with both clinical and statistically significant improvement in the overall ITT cohort ($p=0.012$) and the Fontan subgroup with high-performing Fontan subjects excluded ($p=0.022$). This finding offers mechanistic insights into and confirmatory evidence of udenafil efficacy in Fontan circulation: pulmonary vasodilator therapy is able to shift (delay) the transition from aerobic to anaerobic metabolism but may not be able to
20 further improve peak exercise capacity in the Super Fontan patients, for the reasons detailed above.

With time, even the high-performing Fontan subjects will deteriorate, with decline in peak or max VO_2 to the abnormal range. Thus, it is reasonable to believe that while treatment with
25 pulmonary vasodilator therapy may not necessarily improve peak or max VO_2 when normal or near-normal (high performer), such treatment could delay or mitigate the inevitable decline in peak VO_2 demonstrated in natural history studies across all Fontan patients.

The methods may be further understood with the following non-limiting examples.

30

EXAMPLE 1

The Fontan Udenafil Exercise Longitudinal (FUEL) Trial

The FUEL Trial was conducted at 30 centers around the world. The FUEL Trial was a Phase 3, randomized, double-blind, placebo-controlled trial of udenafil in adolescents with SVHD who
35 had undergone Fontan palliation. (Funded by Mezzion Pharma Co. Ltd., and conducted by the

5 National Heart, Lung, and Blood Institute-funded Pediatric Heart Network; ClinicalTrials.gov number NCT02741115).

The primary aim was to determine the effect of udenafil on exercise capacity in adolescents with Fontan physiology over a six-month period. The primary outcome was the change in oxygen consumption at peak exercise (max or peak VO_2) from baseline to the 26-week visit. Secondary exercise outcomes included change in additional measures at maximal exertion, as well as change in measures of submaximal exercise at the ventilatory anaerobic threshold (VAT). The primary outcome for clinical secondary aims included change in myocardial performance index (MPI), an echocardiographically-derived measure of systolic and diastolic ventricular function, change in log-transformed reactive hyperemia index (lnRHI), a PAT-derived measure of peripheral vascular function, and change in log-transformed serum BNP level. Safety was monitored through adverse event reports, which were collected according to a pre-specified protocol of study coordinator outreach, and through *ad hoc* patient and family communication with members of the study team at each site.

Trial Population

20 Individuals between the ages of 12 and 18 years (inclusive) who had undergone the Fontan procedure, who were not receiving treatment with a PDE5 inhibitor, who were >40 kg, and who met the minimum height requirement for cycle ergometry (>132 cm) were eligible for enrollment. To isolate the effect of udenafil on exercise performance, patients with severe ventricular dysfunction, severe atrioventricular valve insufficiency, or those with a prior clinical exercise test in which peak oxygen consumption was <50% of predicted for age and gender, were excluded. The full list of inclusion and exclusion criteria are listed in **Table 1**.

Table 1
FUEL inclusion and exclusion criteria

30	Inclusion criteria
	1 Males and females with Fontan physiology 12-<19 y of age at enrollment
	2 Participant consent or parental/guardian consent with participant assent
	3 Participant fluent in English, Spanish, or Korean
35	Exclusion criteria
	1 Weight <40 kg
	2 Height <132 cm
	3 Hospitalization for acute decompensated heart failure within the last 12 m
	4 Current intravenous inotropic drugs
	5 Undergoing evaluation for heart transplantation or listed for transplantation
	6 Diagnosis of active protein-losing enteropathy or plastic bronchitis within the last 3 y, or a history of liver cirrhosis

- 5 7 Known Fontan baffle obstruction, branch pulmonary artery stenosis, or pulmonary vein stenosis resulting in a mean gradient of >4 mm Hg between the regions proximal and distal to the obstruction as measured by either catheterization or echocardiography, obtained prior to screening for the trial
- 8 Single lung physiology with greater than flow to 1 lung
- 9 VO_2 max less than 50% of predicted for age and gender at enrollment
- 10 10 Severe ventricular dysfunction assessed qualitatively by clinical echocardiography within 6 m prior to enrollment
- 11 Severe valve regurgitation, ventricular outflow obstruction, or aortic arch obstruction assessed by clinical echocardiography within 6 m prior to enrollment
- 12 Significant renal (serum creatinine >2.0), hepatic (serum AST and/or ALT >3 times upper limit of normal), gastrointestinal, or biliary disorders that could impair absorption, metabolism, or excretion of orally administered medications based on laboratory assessment 6 wk prior to screening for the trial
- 13 Inability to complete exercise testing at baseline screening
- 14 History of PDE-5 inhibitor use Within 3 m before study onset
- 15 15 History of any other medication for treatment of pulmonary hypertension within 3 m before study onset
- 16 Known intolerance to oral udenafil
- 17 Frequent use of medications or other substances that inhibit or induce CYP3A4
- 18 Current use of α -blockers or nitrates
- 19 Ongoing or planned participation in another research protocol that would either prevent successful completion of planned study testing or invalidate its results
- 20 20 Noncardiac medical, psychiatric, and/or social disorder that would prevent successful completion of planned study testing or would invalidate its results
- 21 Cardiac care, ongoing or planned, at a nonstudy center that would impede study completion
- 22 For females: pregnancy at the time of screening, pregnancy planned before study completion, or refusal to use an acceptable method of contraception for study duration if sexually active
- 23 Inability to abstain from or limit intake of grapefruit juice during the duration of the trial
- 25 24 Refusal to provide written informed consent/assent
- 25 25 In the opinion of the primary care physician, the subject is likely to be noncompliant with the study protocol

ALT alanine aminotransferase; *AST*, aspartate aminotransferase; *CWU44*, cytochrome P450 3A4.

More particularly, the FUEL Trial was designed to evaluate the 26-week change in exercise capacity in patients randomized to udenafil vs. placebo. When the study was conceived, it was accepted that Fontan patients with severely limited exercise capacity (baseline peak or max $\text{VO}_2 < 50\%$ of predicted) would be excluded from the trial. The rationale for this exclusion was based upon (1) safety, and (2) the understanding that this subset population would unlikely provide valid cardiopulmonary maximal exercise test data. At the time of the FUEL Trial design, there was no consideration of an upper limit on predicted peak VO_2 nor the possibility of excluding patients with high exercise capacity at baseline, because the extent of these unique, high exercise performers had not been identified or appreciated.

Importantly, since the FUEL trial and its protocol design, there has been a change in circumstance. New information has come to light after the FUEL Trial had been initiated and after the breaking of the blind. Specifically, four publications surfaced that recognized that a subset of Fontan patients with high exercise capacity exists. (Cordina 2018, Powell, 2019, Weinreb, 2020, and Goldberg, 2021) Cordina et al noted 14/133 (11%) Fontan patients had an exercise capacity $> 80\%$ predicted Peak VO_2 . Similarly, Powell identified 22/112 (25%) Fontan patients with high exercise capacity, defined as $> 80\%$ predicted peak VO_2 . In retrospect, the

5 “high performers” should have been excluded from the FUEL trial, at least with respect to the testing of peak or max VO_2 because such Fontan patients with high exercise capacity at baseline are unlikely to benefit from treatment, as assessed by peak cardiopulmonary exercise performance. Such high Fontan performers do not represent the typical Fontan population. An analysis of the subset of the ITT population that excludes the Fontan “high performers,”
10 analyzed otherwise per protocol, provides a statistically significant result on the primary peak or max VO_2 endpoint ($p=0.023$) and clinical relevancy.

Randomization and Study Procedures

Enrolled participants were assigned to udenafil or placebo in a 1:1 ratio using randomly permuted blocks and stratified by ventricular morphology (left ventricle versus right ventricle or
15 mixed). Randomization assignments were generated by a web-based algorithm after confirmation of trial eligibility and consent.

Baseline clinical testing completed before drug initiation included a blood draw to measure brain-type natriuretic peptide (BNP) level, a cardiopulmonary exercise test (CPET) using a standardized cycle ergometer ramp protocol, a standardized echocardiogram, and an assessment
20 of peripheral vascular function using peripheral arterial tonometry (PAT) measured by finger cuff (EndoPAT; Itamar Medical, Israel). Participants who achieved maximal effort, defined as respiratory exchange ratio (RER) ≥ 1.10 at peak exercise during CPET, were eligible for randomization and study drug initiation. Participants who did not achieve maximal effort were given a subsequent opportunity to repeat the exercise test within two weeks of the initial attempt.
25 End-of-study clinical testing included repeat measurement of serum BNP, CPET, echocardiogram, and PAT.

Statistical Analysis

A sample size of 200 participants per arm was chosen to allow for 90% power to detect a mean treatment difference in change from baseline to 26-week testing in max VO_2 of 10% with a type
30 1 error of 0.05. The following assumption were made: a baseline standard deviation of 7.235 ml/kg/min, a correlation between max VO_2 measurements of 0.33, a drop-out and incomplete testing rate of 10%, and failure to reach maximal effort at the 26-week exercise testing in 15% of

5 participants. These assumptions were based on historical data and reflect a conservative approach to assessing within-participant correlations and failure to reach maximal effort.

The primary analysis used the intention-to-treat population to evaluate the difference in the change in the primary outcome between treatment arms. This difference was assessed with an analysis of covariance (ANCOVA) with fixed factors for ventricular morphology (single left
10 versus single right or mixed) and treatment group, with a continuous covariate of baseline max VO_2 . For those without data at the 26-week visit, this value was imputed as equal to the baseline value (no change). Secondary analyses included participants who successfully completed the protocol with measurable values at each of the secondary endpoints. Secondary outcomes of continuous data points were analyzed in the manner described for the primary outcome. In order
15 to assess the generalizability of findings at the ventilatory anaerobic threshold, demographic and clinical characteristics were compared between participants without paired VO_2 at VAT data and those comprising the remainder of the cohort.

Trial Results

From July 2016 to May 2018, 1376 patients at 30 centers were screened. **FIG. 1B.** Of these, 200
20 were randomly assigned to udenafil and 200 to placebo. Mean age at randomization was 15.5 years, mean height was 163.6 cm, and mean weight was 58.1 kg. Sixty percent of participants were male and 81% described their racial identity as white. Those in the placebo group were taller, compared to those in the udenafil group, but baseline characteristics were otherwise similar between groups.

Primary Aim - Exercise Measures

Maximal exercise data (VO_2 max) were available for all participants at baseline testing, and for 379 participants at 26-week testing (189 in the udenafil group and 190 in the placebo group).

Reasons for absence of data at 26-week testing included patient dropout or errors in data capture (n=14), and participant inability to generate an $\text{RER} \geq 1.10$ (n=7). There was no difference in the
30 change from baseline to 26-week testing in resting heart rate, respiratory rate, or systolic blood pressure between the udenafil and placebo groups. There was a small but statistically significant

- 5 increase in resting oxygen saturation and a small but statistically significant decrease in diastolic blood pressure in the udenafil group.

Resting data and exercise performance results are provided in Table 2.

Table 2: Resting Data and Exercise performance with comparison based on treatment arm. Summaries presented as mean $\pm$ standard deviation (n)*.

	Udenafil			Placebo			p value
<i>Resting data</i>	Baseline	26-week	Change	Baseline	26-week	Change	
Heart rate (bpm)	87.5 $\pm$ 15.3 (200)	86.6 $\pm$ 15.4 (191)	-0.9$\pm$12.7 (191)	88.1 $\pm$ 14.1 (200)	87.4 $\pm$ 16.1 (195)	-0.6$\pm$12.7 (195)	0.78
Systolic blood pressure (mmHg)	112.3 $\pm$ 12.1 (200)	110.5 $\pm$ 12.0 (191)	-1.8$\pm$12.2 (191)	113.2 $\pm$ 12.9 (200)	112.8 $\pm$ 11.6 (195)	-0.2$\pm$12.2 (195)	0.18
Diastolic blood pressure (mmHg)	68.4 $\pm$ 9.5 (200)	65.3 $\pm$ 9.9 (191)	-2.9$\pm$9.7 (191)	69.3 $\pm$ 10.1 (200)	69.4 $\pm$ 9.1 (195)	0.2$\pm$10.7 (195)	0.003
Oxygen Saturation (%)	92.8 $\pm$ 3.9 (200)	93.3 $\pm$ 3.5 (191)	0.5$\pm$2.4 (191)	93.2 $\pm$ 3.8 (200)	92.9 $\pm$ 3.7 (195)	-0.3$\pm$2.8 (195)	0.002
<i>Peak Exercise</i>							
Oxygen consumption (mL/min)*	1562 $\pm$ 437 (200)	1606 $\pm$ 452 (200)	44$\pm$245 (200)	1627 $\pm$ 414 (200)	1623 $\pm$ 432 (200)	-3.7$\pm$228 (200)	0.071
Work rate (W)	120 $\pm$ 32 (198)	124 $\pm$ 32 (187)	3.2$\pm$14 (186)	123 $\pm$ 32 (199)	127 $\pm$ 32 (189)	2.6$\pm$14 (188)	0.85
Heart rate (bpm)	165 $\pm$ 20 (200)	165 $\pm$ 20 (189)	-1.4$\pm$11 (189)	168 $\pm$ 22 (199)	166 $\pm$ 21 (190)	-2.5$\pm$13 (189)	0.56
Respiratory rate (breaths/min)	51 $\pm$ 11 (199)	50 $\pm$ 12 (188)	-1.1$\pm$10 (187)	51 $\pm$ 13 (200)	50 $\pm$ 12 (189)	-1.5$\pm$10 (189)	0.72
Minute ventilation (L/min)	71 $\pm$ 21 (199)	73 $\pm$ 22 (189)	1.2$\pm$14 (188)	76 $\pm$ 22 (200)	76 $\pm$ 21 (190)	-0.1$\pm$14 (190)	0.84
Oxygen saturation (%)	89.2 $\pm$ 5.3 (195)	89.6 $\pm$ 4.9 (190)	0.4$\pm$3.4 (186)	89.8 $\pm$ 5.0 (197)	89.7 $\pm$ 5.0 (192)	-0.1$\pm$3.4 (190)	0.21
<i>Anaerobic Threshold</i>							
Oxygen consumption (mL/min)	1039 $\pm$ 301 (170)	1059 $\pm$ 292 (185)	29.7$\pm$177 (170)	1021 $\pm$ 280 (181)	1014 $\pm$ 277 (191)	-8.0$\pm$183 (181)	0.023
Work (W)	66.2 $\pm$ 26 (167)	69.2 $\pm$ 26 (181)	3.5$\pm$15 (167)	66.1 $\pm$ 23 (177)	66.6 $\pm$ 23 (186)	0.31$\pm$13.3 (177)	0.029
Ve/VCO2	34.3 $\pm$ 4.9 (170)	33.6 $\pm$ 4.8 (185)	-0.76$\pm$3.6 (155)	34.8 $\pm$ 5.2 (181)	34.7 $\pm$ 4.9 (191)	-0.06$\pm$3.1 (162)	0.011

- 10 *P-value was assessed using ANCOVA with fixed factors for ventricular morphology (single left versus single right or mixed) and treatment group with a continuous covariate of baseline maximal VO₂. Note: Last observation carried forward was used to impute missing values at Week 26.

Analysis at resting of the diastolic blood pressure demonstrated a statistically significant change (a decrease shows improvement) in diastolic blood pressure in the udenafil group (-2.9 decrease, improvement) compared to the placebo group (+0.2 increase, no improvement) (p=0.003).

- 15 Analysis at resting of the oxygen saturation (%) demonstrated a statistically significant change (an increase shows improvement) in oxygen saturation (%) in the udenafil group (+0.5 increase, improvement) compared to the placebo group (-0.3 decrease, no improvement) (p=0.002).

Analysis at maximal exercise demonstrated an increase in VO₂ max of 44 mL/min (2.8%) in the udenafil group compared to a decline of 3.7 mL/min (-0.2%) in the placebo group, although the

- 20 difference did not reach statistical significance (p=0.071).

5 Further, metabolic data for the calculation of VO_2 at VAT were available for 317 participants; 170 in the udenafil group and 181 in the placebo group, as shown in **Table 2** above. There was no difference in the baseline demographic or clinical characteristics of this subgroup compared to the larger cohort. For those with paired VO_2 at VAT data, there was a statistically significant improvement of 30 mL/min (1.92%) in the udenafil group compared to a decrease of 8 mL/min
 10 (-0.7%) in the placebo group ($p=0.023$). Ventilatory equivalents of carbon dioxide measured at VAT (VE/VCO_2) significantly decreased (improved ventilatory efficiency) by 0.8 (2.1%) in the udenafil group compared to 0.05 (0.2%) in the placebo group ($p=0.011$), while the work rate significantly improved by 3.5 Watts (5.5%) in the udenafil group compared to 0.31 Watts (0.78%) in the placebo group ($p=0.029$). Thus, treatment of Fontan patients with 87.5 mg, twice daily,
 15 demonstrated statistically significant improvements in multiple measures of exercise performance at the ventilatory anaerobic threshold.

Secondary Aims Measures

Paired echocardiographic data for the measure of MPI were available in 250 participants (63%); 122 in the udenafil group and 128 in the placebo group. **Table 3**. There was a statistically
 20 significant change (a decrease shows improvement) in MPI in the udenafil treated group (-0.02 decrease, improvement) as compared to the placebo group +0.01 increase, no improvement) ($p=0.028$).

Paired PAT-derived vascular function data were available in 328 participants (81%); 163 in the udenafil group and 165 in the placebo group. There were non-significant improvements in lnRHI
 25 in both the udenafil and placebo groups (0.07 vs 0.05, $p=0.59$). Paired measures of serum BNP level were available in 378 participants (95%); 187 in the udenafil group and 191 in the placebo group. The change in log serum BNP level was not different between groups ($p=0.18$). The paired echocardiographic data, the paired PAT-derived vascular function data, and the paired measure of serum BNP level is provided in **Table 3**.

5 **Table 3: Secondary Outcomes with Comparison Based on Treatment Arm**

Endocardiography				
Myocardial Performance Index (MPI) by Visit and Treatment Arm Difference Between Week 26 and Baseline Visits (ITT Population)				
	Udenafil	Placebo	LS Mean Dif A-B(SE)***	P-Value
Baseline, N: Mean (SD)	150: 0.45 (0.173)	155: 0.45 (0.156)	-0.0 (0.018)	0.818*
Week 26, N: Mean (SD)	146: 0.42 (0.147)	148: 0.46 (0.177)	-0.04 (0.018)	0.024*
Difference, Week 26-Baseline N: Mean (SD)	122: -0.02 (0.113)	128: 0.01 (0.133)	-0.03 (0.014)	0.028**
Median (Interquartile Range) of the difference	-0.01 (-0.11, 0.05)	0.01 (-0.08, 0.08)		
Min, Max of the difference	(-0.3, 0.2)	(-0.5, 0.4)		

*P value was assessed using ANOVA with the fixed factors for ventricular morphology (single left versus single right or mixed) and treatment group

10 **P value was assessed using ANCOVA with fixed factors for ventricular morphology (single left versus single right or mixed) and treatment group with a continuous covariate of baseline maximal VO₂

***LS Mean (least square mean) was the estimated treatment mean difference from the analysis model

Endpoint	Udenafil (N=200)	Placebo (N=200)	Difference LS Mean (SE)	p-value^a
Log-transformed reactive hyperemia index	n=170	n=173		
Difference, Week 26 - baseline, mean (SD)	0.06 (0.301)	0.04 (0.370)	0.02 (0.030)	0.591
Log brain natriuretic peptide (pg/mL)	n=187	n=191		
Difference, Week 26 - baseline, mean (SD)	0.08 (0.905)	0.03 (1.137)	0.13 (0.094)	0.169

15 ANCOVA = analysis of covariance; ITT = intent-to-treat; LS = least squares; SD = standard deviation; SE = standard error

a P-value was assessed using ANCOVA with fixed factors for ventricular morphology (single left versus single right or mixed) and treatment group with a continuous covariate of baseline maximal minute oxygen consumption.

Note: Brain natriuretic peptide values reported by the laboratory as <2.0 were imputed as 1.0.

5 Safety and Tolerability

Table 4: Non-Serious Adverse Events. Number of participants that experienced an adverse event presented as n (%).

	Udenafil (200)	Placebo (200)
Headache	79 (39.5)	51 (25.5)
Flushing	32 (16.0)	12 (6.0)
Dizziness	16 (8.0)	17 (8.5)
Nausea / vomiting	31 (15.5)	14 (7.0)
Increased erection*	13 (11.7)	2 (1.6)
Epistaxis	21 (10.5)	5 (2.5)

*Percentage of male participants.

Udenafil and placebo were well tolerated by study participants. There were no deaths in the study cohort. A total of 24 participants (6%) experienced a serious adverse event; 14 in the udenafil group and 10 in the placebo group. There were 3 events in the udenafil group and 2 events in the placebo group that were thought to have a possible, probable, or definite relationship to study drug. Those that occurred in the udenafil group included unilateral retinal artery and vein thrombosis, transient lower extremity diplegia, and transient dyspnea. Frequent non-serious adverse events thought to have a possible, probable, or definite relationship to study drug that occurred in at least 5% of participants in either treatment group are provided in **Table 4**. Headache, facial flushing, abdominal pain, epistaxis, and erection (male participants) were more common in the udenafil group. All other adverse events occurred with similar frequency between the groups.

20 EXAMPLE 2

Additional FUEL Trial Results

The following example additionally describes the above-referenced FUEL trial, as referenced in Goldberg, DJ, et al.: Results of the Fontan Udenafil Exercise Longitudinal (FUEL) Trial.

Circulation, 141(8):141:641-651 (2020), which is hereby incorporated herein by reference in its entirety.

5 The Fontan operation creates a total cavopulmonary connection, a circulation in which the importance of pulmonary vascular resistance is magnified. Over time, this circulation leads to deterioration of cardiovascular efficiency associated with a decline in exercise performance.

Rigorous clinical trials aimed at improving physiology and guiding pharmacotherapy are lacking.

10 The FUEL Trial was a Phase III clinical trial conducted at 30 centers. Participants were randomly assigned udenafil, 87.5 mg twice daily, or placebo in a 1:1 ratio. The primary outcome was the between group difference in change in oxygen consumption at peak exercise. Secondary outcomes included between group differences in changes in sub-maximal exercise at the ventilatory anaerobic threshold (VAT), the myocardial performance index (MPI), the natural log of the reactive hyperemia index (lnRHI), and serum brain-type natriuretic peptide (BNP).

15 Between 2017 and 2019, 30 clinical sites in North America and the Republic of Korea randomized 400 participants with Fontan physiology. The mean age at randomization was 15.5 ± 2 years; 60% of participants were male and 81% were White. All 400 subjects were included in the primary analysis with imputation of the 26-week endpoint for 21 participants with missing data (11 randomized to udenafil and 10 to placebo). Among randomized participants, peak
20 oxygen consumption increased by 44 ± 245 mL/min (2.8%) in the udenafil group and declined by 3.7 ± 228 mL/min (-0.2%) in the placebo group ($p=0.071$). Analysis at VAT demonstrated statistically significant improvements in the udenafil group versus the placebo group in oxygen consumption ($+33 \pm 185$ (3.2%) vs -9 ± 193 (-0.9%) mL/min, $p=0.012$), ventilatory equivalents of carbon dioxide (-0.8 vs -0.06, $p=0.014$), and work rate ($+3.8$ vs $+0.34$ Watts, $p=0.021$). Analysis
25 of MPI also demonstrated statistically significant improvement in the udenafil treated group ($p=0.028$) compared to the group taking placebo over the same time period. There was no difference in change in lnRHI, or serum BNP level.

In the FUEL trial, treatment with udenafil (87.5 mg twice daily) was associated with an improvement in oxygen consumption at peak exercise ($p=0.071$) and statistically significant
30 improvements in (i) multiple measures of exercise performance at the ventilatory anaerobic threshold (VAT), (ii) MPI, (iii) diastolic blood pressure at rest, and (iv) oxygen saturation (%) at rest.

5 The FUEL trial was Funded by Mezzion Pharma Co. Ltd., and conducted by the National Heart, Lung, and Blood Institute-funded Pediatric Heart Network. ClinicalTrials.gov number NCT02741115, which is hereby incorporated herein by reference in its entirety.

Clinical Perspective

New aspects

- 10 • The Circulation publication describes the results of the Fontan Udenafil Exercise Longitudinal (FUEL) Trial, the largest medical intervention trial in congenital heart disease. Goldberg D.J. *et al.*: Results of the FUEL Trial. *Circulation*, 141(8):141:641- 651 (2020)
- 15 • The Circulation errata to Goldberg D.J. *et al.*: Results of the FUEL Trial. *Circulation*, 141(8):141:641-651 (2020), as incorporated in Example 4, describes the corrected MPI results of the FUEL Trial.
- While treatment with udenafil did not result in a statistically significant increase in peak oxygen consumption, it did result in a notable increase in peak oxygen consumption.
- Treatment with udenafil did result in statistically significant improvements in measures of exercise performance at the ventilator anaerobic threshold (VAT), work rate at VAT, ventilatory equivalents of carbon dioxide (VE/VCO₂) at VAT, MPI, diastolic blood pressure at rest, and oxygen saturation at rest.
- 20 • Udenafil was well tolerated by the FUEL Trial subjects with side effects limited to those previously known to be associated with phosphodiesterase type 5 inhibitors.

25 **Clinical Implications**

- Udenafil is the first medication evaluated in a large-scale, phase III clinical trial to demonstrate a quantifiable benefit in measures of exercise capacity in adolescents after Fontan palliation.
- These findings suggest that therapy with udenafil may improve the physiology, the exercise capacity, the work rate, the VE/VCO₂, the MPI, the cardiac output, the squeezing performance, the amount of flow that can circulate through the body in a given amount of time, diastolic blood pressure and/or oxygen saturation at rest, and the performance of the
- 30

- 5 single functioning ventricles of the cohort of patients who have undergone a total cavopulmonary connection.
- Ongoing surveillance is needed to determine the effect of chronic treatment with udenafil on the long-term clinical course of those living with single ventricle congenital heart disease.

10 Children born with single ventricle congenital heart disease (SVHD) require a series of staged surgical interventions to reconstruct their defective hearts for long-term survival. The Fontan operation, the final planned palliative procedure in this series of staged surgical interventions to reconstruct the heart, separates the systemic and pulmonary circulations by creating a total cavopulmonary connection. Fontan F and Baudet E. Surgical repair of tricuspid atresia. *Thorax*. 15 26(3):240-248 (May 1971); and Kreutzer G, Galindez E, Bono H, De Palma C and Laura JP. An operation for the correction of tricuspid atresia. *The Journal of thoracic and cardiovascular surgery*. 66(4):613-621 (Oct 1973).

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30 the Pediatric Heart Network's (PHN) Fontan Udenafil Exercise Longitudinal (FUEL) trial (NCT02741115), we evaluated the effect of udenafil on exercise performance and other cardiovascular and functional outcomes over a six-month period in adolescents who have undergone Fontan palliation.

5 **Methods**

The FUEL trial was an international, multicenter, randomized, double-blind, placebo-controlled trial of udenafil, in addition to standard care, in adolescents with SVHD who had undergone Fontan palliation. The trial was supported by the National Heart, Lung, and Blood Institute (NHLBI)-funded PHN in partnership with the regulatory sponsor, Mezzion Pharma Co. Ltd.,
 10 under a Special Protocol Assessment through the Food and Drug Administration. The FUEL protocol and consent forms and all subsequent amendments were approved by the DSMB, the institution review board or equivalent at each study center, and regulatory agencies from the United States, Canada, and the Republic of Korea. Consent was obtained from the study participant, or the legal guardian for those <18 years of age. Assent was obtained from
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Trial Population

Individuals between the ages of 12 and 18 years (inclusive) who had undergone the Fontan procedure, who were not receiving treatment with a PDE5 inhibitor, who were >40 kg, and who met the minimum height requirement for cycle ergometry (>132 cm) were eligible for enrollment.
 25 To isolate the effect of udenafil on exercise performance, patients with severe ventricular dysfunction, severe atrioventricular valve insufficiency, or those with a prior clinical exercise test in which peak oxygen consumption was <50% of predicted for age and sex, were excluded. The full list of inclusion and exclusion criteria are listed in **Table 1** above for the study protocol.

Randomization and Study Procedures

30 Enrolled participants were assigned to udenafil or placebo in a 1:1 ratio in a double-blind manner using randomly permuted blocks and stratified by ventricular morphology (left ventricle versus right ventricle or mixed). Randomization assignments were generated by a web-based algorithm after confirmation of trial eligibility and consent.

5 Baseline clinical testing completed before drug initiation included a blood draw to measure brain-type natriuretic peptide (BNP) level, a cardiopulmonary exercise test (CPET) using a standardized cycle ergometer ramp protocol (previously described in children and adolescents with Fontan physiology, Sleeper LA, Anderson P, Hsu DT, Mahony L, McCrindle BW, Roth SJ, Saul JP, Williams RV, Geva T, Colan SD, Clark BJ and Pediatric Heart Network I. Design of a
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15 randomization and study drug initiation. Participants who did not achieve maximal effort were given a subsequent opportunity to repeat the exercise test within two weeks of the initial attempt. End-of-study clinical testing included repeat measurement of serum BNP, CPET, echocardiogram, and PAT.

Primary and Secondary End Points

20 The primary aim was to determine the effect of udenafil on exercise capacity in adolescents with Fontan physiology over a six-month period. The primary outcome was the between group difference in the change in oxygen consumption at peak exercise (peak VO_2) from baseline to the 26-week visit. Secondary exercise outcomes included between group differences in change in additional measures at maximal exertion, as well as change in measures of submaximal exercise
25 at the ventilatory anaerobic threshold (VAT). All measurement of values for exercise testing were initially made by the exercise physiologists and physicians at the individual participating sites. These were subsequently reviewed for accuracy in a blinded fashion at each site by one of two trained reviewers (MGM, SMP) in conjunction with the sites' exercise teams prior to finalization. For both peak VO_2 and VO_2 at VAT, unindexed oxygen consumption was evaluated
30 to avoid the introduction of confounding based on short-term change in body habits. An analysis of oxygen consumption corrected for body weight is included in **Table 5**.

5 **Table 5: Oxygen consumption indexed to weight for peak exercise and the anaerobic threshold with comparison based on treatment arm. Summaries presented as mean $\pm$ standard deviation (n).**

		<i>Peak exercise</i> Oxygen consumption (mL/kg/min)	<i>Anaerobic Threshold</i> Oxygen consumption (mL/kg/min)
	Baseline	27.84 $\pm$ 6.88 (200)	18.35 $\pm$ 4.63 (170)
<i>Udenafil</i>	26-week	27.61 $\pm$ 6.87 (200)	18.20 $\pm$ 4.51 (185)
	Change	-0.23$\pm$4.06 (200)	-0.07$\pm$3.0 (170)
	Baseline	28.01 $\pm$ 6.13 (200)	17.71 $\pm$ 4.30 (181)
<i>Placebo</i>	26-week	27.12 $\pm$ 6.63 (200)	16.99 $\pm$ 4.13 (191)
	Change	-0.89$\pm$3.67 (200)	-0.68$\pm$3.2 (181)
	<i>p</i> value	0.092**	0.012**

10 **P_value was assessed using ANCOVA with fixed factors for ventricular morphology (single left versus single right or mixed) and treatment group with a continuous covariate of baseline maximal VO₂. Imputations were done as follows:

• Subjects who were known to be alive, but who discontinued from the study (and were missing maximal VO₂ at Week 26) were assigned the latest value available (e.g., value from end of study visit if available and from baseline visit otherwise).

15 • Subjects who completed Week 26, but were physically unable to reach maximum effort in cardiopulmonary exercise testing after two attempts, were assigned their baseline value when the subject met maximum effort in Baseline exercise testing. One exception was subject 330011 who was adjudicated to be included as RER was 1.10

The primary outcome for clinical secondary aims included the between group differences in change in myocardial performance index (MPI), an echocardiographically-derived measure of
20 systolic and diastolic ventricular function, change in log-transformed reactive hyperemia index (lnRHI), a PAT-derived measure of peripheral vascular function, and change in log-transformed serum BNP level. Measurements for each of these secondary outcomes were performed at core labs. Safety was monitored through adverse event reports, which were collected according to a pre-specified protocol of study coordinator outreach, and through *ad hoc* patient and family
25 communication with members of the study team at each site.

5 Statistical Analysis

A sample size of 200 participants per arm was chosen to allow for 90% power to detect a mean treatment difference in change from baseline to 26-week testing in peak VO₂ of 10% with a type 1 error of 0.05. We assumed a baseline standard deviation of 7.235 ml/kg/min, a correlation between peak VO₂ measurements of 0.33, a drop-out and incomplete testing rate of 10%, and
10 failure to reach maximal effort at the 26-week exercise testing in 15% of participants. These assumptions were based on historical data and reflect a conservative approach to assessing within-participant correlations and failure to reach maximal effort and the analysis was performed using a two-sample, independent means t-test. The primary analysis used the intention-to-treat population to evaluate the difference in the change in the primary outcome
15 between treatment arms. This difference was assessed with an analysis of covariance (ANCOVA) with fixed factors for ventricular morphology (single left versus single right or mixed) and treatment group, with a continuous covariate of baseline peak VO₂. For those without data at the 26-week visit, this value was imputed as equal to the baseline value (no change). The alpha level was set at 0.05 with two-sided testing. All statistical analyses were performed using SAS
20 statistical software 9.4 (SAS Institute, Inc., Cary, North Carolina). Secondary analyses included participants who successfully completed the protocol with measurable values at each of the secondary endpoints. Secondary outcomes of continuous data points were analyzed in the manner described for the primary outcome. In order to assess the generalizability of findings at the ventilatory anaerobic threshold, demographic and clinical characteristics were compared
25 between participants without paired VO₂ at VAT data and those comprising the remainder of the cohort using the Student's t-test and Fisher's exact test. Fisher's exact test was used to compare adverse events between the udenafil and placebo cohorts.

Results

Participants: From July 2016 to May 2018, 1376 patients at 30 centers were screened. **FIG. 1B.**
30 Of these, 200 were randomly assigned to udenafil and 200 to placebo. Mean age at randomization was 15.5 years, mean height was 163.6 cm, and mean weight was 58.1 kg. Sixty percent of participants were male and 81% described their racial identity as white. Those in the placebo group were taller, compared to those in the udenafil group, but baseline characteristics were otherwise similar between groups in **Table 6.**

5 **Table 6: Demographic and clinical baseline characteristics for the 400 subjects randomized to a treatment arm; summaries presented as mean (standard deviation) unless otherwise noted as n (%).**

	Total (n=400)	Udenafil (n=200)	Placebo (n=200)
Age, years	15.5 (2.0)	15.4 (2.0)	15.6 (2.0)
Female, n (%)	161 (40.3)	89 (44.5)	72 (36.0)
Race, n (%)			
White	324 (81.0)	169 (84.5)	155 (77.5)
Asian	38 (9.5)	17 (8.5)	21 (10.5)
Black	23 (5.8)	10 (5.0)	13 (6.5)
Other	15 (3.8)	4 (2.0)	11 (5.5)
Predominant Ventricular morphology, n (%)			
Right	176 (44.0)	89 (44.5)	87 (43.5)
Left	189 (47.3)	94 (47.0)	95 (47.5)
Other (indeterminant and biventricular)	35 (8.8)	17 (8.5)	18 (9.0)
Subjects with a patent fenestration, n (%)	131 (32.8)	73 (36.5)	58 (29.0)
Height, cm	163.6 (9.6)	162.5 (10.4)	164.7 (8.7)
Weight, kg	58.1 (13.6)	57.1 (13.9)	59.0 (13.2)
Body mass index, kg/m ²	21.6 (4.1)	21.5 (3.9)	21.7 (4.2)

*t-test for continuous variables, Fisher exact test for categorical

Exercise Measures

- 10 Resting, submaximal, and maximal exercise measures are presented in **Table 2**. Maximal exercise data were available for all participants at baseline testing, and for 379 participants at 26-week testing (189 in the udenafil group and 190 in the placebo group). Reasons for absence of data at 26-week testing included patient dropout or errors in data capture (n=14) and participant inability to generate an RER >1.10 (n=7). There was no difference in the change from baseline to
- 15 26-week testing in resting heart rate, respiratory rate, or systolic blood pressure between the udenafil and placebo groups. Peak minute ventilation at baseline (pre-drug exposure) was higher in the placebo group, but there was no difference in the change in minute ventilation between groups. There was a small but statistically significant increase in resting oxygen saturation and a small but statistically significant decrease in diastolic blood pressure in the udenafil group.
- 20 Analysis at maximal exercise demonstrated an increase in peak VO₂ of 44 mL/min (2.8%) in the udenafil group compared to a decline of 3.7 mL/min (-0.2%) in the placebo group, although the difference did not reach statistical significance. **FIGS. 2A- 2B, p=0.071**. Metabolic data for the calculation of VO₂ at VAT were available for 351 participants; 170 in the udenafil group and 181

in the placebo group. There was no difference in the baseline demographic or clinical characteristics of this subgroup compared to the larger cohort. **Table 7.** For those with paired VO₂ at VAT data, there was a statistically significant improvement of 29.7 mL/min (2.85%) in the udenafil group compared to a decrease of 9 mL/min (-0.8%) in the placebo group. **FIGS. 3A-3B**, p=0.023. Ventilatory equivalents of carbon dioxide measured at VAT (VE/VCO₂) significantly decreased (improved ventilatory efficiency) by 0.8 in the udenafil group compared to 0.05 in the placebo group (p=0.0114), while the work rate significantly improved by 3.5 Watts (5.2%) in the udenafil group compared to 0.31 Watts (0.5%) in the placebo group. **FIGS. 4A- 4B**, p=0.029.

Table 7: Demographic and clinical baseline characteristics for subjects with versus without paired data for VO₂ at VAT; summaries presented as mean (standard deviation) unless otherwise noted as n (%).

	Total (n=400)	Paired Data (n=317)	No Paired Data (n=83)	p value*
Age, years	15.5 (2.0)	15.6 (2.0)	15.4 (2.2)	0.50
Female, n (%)	161 (40.3%)	128 (40.4%)	33 (39.8%)	1.0
Race, n (%)				0.16
White	324 (81.0%)	256 (80.8%)	68 (81.9%)	
Asian	38 (9.5%)	34 (10.7%)	4 (4.8%)	
Black	23 (5.8%)	15 (4.7%)	8 (9.6%)	
Other	15 (3.8%)	12 (3.8%)	3 (3.6%)	
Predominant Ventricular morphology, n (%)				0.97
Right	176 (44.0%)	138 (43.5%)	38 (45.8%)	
Left	189 (47.3%)	151 (47.6%)	38 (45.8%)	
Other (indeterminant and biventricular)	35 (8.8%)	28 (8.8%)	7 (8.4%)	
Subjects with a patent fenestration, n (%)	131 (32.8%)	104 (32.8%)	27 (32.5%)	1.0
Height, cm	163.6 (9.6)	164.0 (9.5)	162.0 (10.0)	0.095
Weight, kg	58.1 (13.6)	58.0 (13.6)	58.3 (13.5)	0.85
Body mass index, kg/m ²	21.6 (4.1)	21.5 (4.0)	22.1 (4.3)	0.19
Baseline VO ₂ at peak exercise	1594 (426)	1614 (432)	1518 (400)	0.07
Baseline VO ₂ at the anaerobic threshold	1030 (290)	1034 (294)	993 (251)	0.44

*t-test for continuous variables, Fisher exact test for categorical. Differences between those with and without paired data.

Secondary aims

Paired echocardiographic data for the measure of MPI were available in 250 participants (63%); 122 in the udenafil group and 128 in the placebo group. **Table 3.** There was a statistically significant change (decrease shows improvement) in MPI in the udenafil-treated group (-0.02 decrease, improvement) as compared to the placebo group (+0.01 increase, no improvement)

5 (p=0.028). Paired PAT-derived vascular function data were available in 328 participants (81%);
163 in the udenafil group and 165 in the placebo group. There were non-significant
improvements in lnRHI in both the udenafil and placebo groups (0.07 vs 0.05, p=0.59). Paired
measures of serum BNP level were available in 378 participants (95%); 187 in the udenafil
group and 191 in the placebo group. The change in log serum BNP level was not different
10 between groups (p=0.18).

Safety and tolerability

Udenafil and placebo were well tolerated by study participants. There were no deaths in the
study cohort. A total of 24 participants (6%) experienced a serious adverse event; 14 in the
udenafil group and 10 in the placebo group. There were 3 events in the udenafil group and 2
15 events in the placebo group that were thought to have a possible, probable, or definite
relationship to study drug. Those that occurred in the udenafil group included unilateral retinal
artery and vein thrombosis, transient lower extremity diplegia, and transient dyspnea. Frequent
non-serious adverse events thought to have a possible, probable, or definite relationship to study
drug are listed in **Table 4**. Headache, facial flushing, abdominal pain, epistaxis, and erection
20 (male participants) were more common in the udenafil group. There were no reported episodes
of priapism. All other adverse events occurred with similar frequency between the groups.

Discussion

The FUEL trial was a phase III clinical trial of udenafil in children with SVHD who have
undergone the Fontan operation. Although the relative improvement in peak VO₂ in the udenafil
25 group did not reach statistical significance when compared between treatment arms, treatment
with udenafil did lead to statistically significant improvements in pre-specified secondary
outcome measures of sub-maximal exercise. Participants randomized to udenafil had superior
gains in oxygen consumption, work rate, ventilatory efficiency at the anaerobic threshold, and
the myocardial performance index. A relative improvement in the PAT-derived reactive
30 hyperemia index was not seen. Overall, udenafil was well tolerated with few serious adverse
events and side effects limited to those known to be associated with PDE5 inhibitor therapy.
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Paridon SM and Rychik J. Impact of oral sildenafil on exercise performance in children and

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15 physiology for those with a sub-pulmonary ventricle in whom central venous pressure changes very little during exercise and for whom trends in improvement or decline in VO_2 at VAT and peak VO_2 are usually equivalent.

Despite the importance of the findings reported here, there are limitations to this trial. First, to minimize burden to participants, the study design did not include detailed measures of
20 hemodynamics such as might be obtained with cardiac magnetic resonance imaging or invasive catheterization study. Additionally, evaluation of the PAT outcome did not reveal a benefit to udenafil over placebo. [?] Further interrogation of the multiple measures provided by these studies was not performed in this initial analysis but will be the subject of future analyses. Finally, the duration of the FUEL trial precluded a long-term assessment of safety, although this
25 is being addressed by the ongoing FUEL open-label extension study.

Treatment with udenafil (87.5 mg twice daily), in addition to standard therapy, was not associated with a statistically significant improvement in oxygen consumption at peak exercise but did demonstrate statistically significant improvements in multiple measures of exercise performance at the ventilatory anaerobic threshold. As the first large, multicenter, placebo-
30 controlled, randomized trial to demonstrate a measurable physiologic benefit for Fontan patients, the FUEL trial represents a milestone in the nearly 50-year experience with the Fontan circulation and serves as a model of how public-private partnership can advance science in congenital heart disease. Further study is warranted to determine if udenafil is selectively

- 5 beneficial for subpopulations within the larger cohort with SVHD, and to evaluate the long-term tolerability and safety of treatment.

The disclosures cited in this **EXAMPLE 2** are incorporated herein by reference in their entireties as if fully set forth herein.

EXAMPLE 3

10 Formulation of Udenafil Tablet

An exemplary formulation of a tablet containing 87.5 mg of the udenafil is detailed in **Table 11**. The udenafil formulation as reported in Table 11 was used with Fontan patients enrolled in the FUEL trial, which is discussed in Examples 1 and 2 above.

Table 11: Composition of Udenafil Tablets, 87.5 mg.

Component	Quality Standard	Function	Quantity (mg/tablet)
Core tablet			
Udenafil	In-house	Active	about 87.5
Lactose monohydrate	NF	Diluent	about 100.00
Corn starch	NF	Diluent	about 20.00
Low substituted hydroxypropyl cellulose	NF	Disintegrant	about 12.50
Colloidal silicon dioxide	NF	Disintegrant	about 12.50
Hydroxypropyl cellulose	NF	Binder	about 7.50
Purified water	USP	Granulating solvent	NA ¹
Talc	USP	Glidant	about 7.50
Magnesium stearate	NF	Lubricant	about 2.50
Total core tablet weight			about 250.0 mg
Tablet coating			
Purified water	USP	Solvent	NA ¹
Opadry white ³	In-house	Coating material	about 8.00 ²
Total Tablet Weight			about 258.00

- 15 ¹ Purified Water, USP is removed during the manufacturing process and is not part of the final formulation.

² Based on a nominal coating weight gain of 3.2% w/w

5 ³ Opadry white contains hypromellose, hydroxypropyl cellulose, titanium dioxide, and polyethylene glycol

EXAMPLE 4

10 Udenafil effect on echocardiographic indices of myocardial performance in SVHD subjects with Fontan Palliation

An objective of the FUEL Trial was to determine the effect of udenafil on echocardiographic measures of myocardial performance in adolescents, ages about 12 to about 18, with a functional single-ventricle physiology after Fontan surgery. The FUEL Trial was a randomized, double-blind, placebo-controlled, trial and was conducted in adolescents, ages about 12 to about 18, after
15 the Fontan operation, at 30 different sites located in the United States (26), Canada (2) and South Korea (2). The Fontan patients were randomized to receive placebo or udenafil (87.5 mg twice daily) for 26 weeks.

Each subject underwent an echocardiogram at the start and finish of the 26 weeks. Paired echocardiographic data for the measure of MPI were available in 250 participants (63%); 122 in
20 the udenafil group and 128 in the placebo group. **Table 3.** There was a statistically significant change in MPI in the udenafil treated group (-0.02 decrease, improvement) as compared to the placebo group (+0.01 increase, no improvement) (p=0.028). The change in the MPI was determined by velocities obtained from blood pool Doppler assessment of the inflow and outflow tract of the single functioning dominant ventricle. All measurements were made by the
25 echocardiography core lab at the Children's Hospital of Wisconsin. The subjects treated with udenafil demonstrated statistically significant improvement (decrease shows improvement) in their myocardial performance index (MPI), p=0.028, compared to subjects taking placebo over the same time period.

These data demonstrate an improvement in MPI in the udenafil group relative to the placebo
30 group (-0.02 vs +0.01, p=0.028). Myocardial performance is an important factor in the longterm health of those with SVHD, including those with SVHD who have undergone Fontan surgery, and improvement in this aspect of physiology complements the improvement noted in exercise performance and suggests that the benefit of treatment with udenafil may be multifactorial.

5 All disclosures, including all patents, patent documents, articles, abstracts, errata and publications, that are referenced or cited herein, including application for U.S. patent, Serial Number 14/788,211, U.S. Patent Publication No. 2019/0030037, U.S. Patent No. 10,137,128, and application for U.S. Patent, Serial Number 15/887,523, U.S. Patent Publication No. 2018/0169103, U.S. Patent No. 10,653,698, Goldberg, D.J. *et al.*: Results of the FUEL Trial.
10 *Circulation*. 141:641-651 (February 25, 2020) and Goldberg, D.J. *et al.*: Correction to: Results of the FUEL Trial. *Circulation*. 142:e31 (July, 14, 2020), are incorporated herein by reference in their entireties, as if each were individually and completely incorporated and set forth herein.

In case of conflict with other related earlier filed applications cited under "Related Applications," this present specification, including definitions, shall control.

15 Various modifications and alterations to this invention will become apparent to those skilled in the art without departing from the scope and spirit of this invention. Illustrative embodiments and examples are provided as examples only and are not intended to limit the scope of the present invention. The scope of the invention is limited only by the claims set forth as follows.

EXAMPLE 5

20 This Example 5 demonstrates udenafil efficacy for the sub-Super Fontan population with a baseline peak or max $\text{VO}_2 < 80\%$ predicted, udenafil secondary point efficacy for both the sub-super Fontan patients and the Super Fontan patients, the importance of VO_2 at VAT in all Fontan patients, including the Super Fontan patients that have a baseline peak $\text{VO}_2 \geq 80\%$ predicted and
25 the sub-super Fontan population, and FUEL OLE trial confirmation of the clinical benefit of treating the Fontan population with udenafil.

(a) Peak VO_2 for sub-Super Fontan Patients with a Baseline Percent Predicted Peak $\text{VO}_2 < 80\%$

30 The following demonstrates that the Fontan population with a baseline peak $\text{VO}_2 < 80\%$ predicted, which represents 75% of the total enrolled population of the FUEL Trial is an appropriate population for analyzing udenafil drug effect at peak exercise for improving exercise capacity in Fontan patients, an orphan, pediatric population, with a serious and life threatening unmet need.

5

At the start of the FUEL Trial, it was not yet established in the scientific community that a subset of the Fontan population, the so-called “Super Fontan” patients, could achieve peak exercise levels at or near the normal level for those with two-ventricle (normal) hearts. It wasn’t until the FUEL trial was close to completing enrollment in June of 2018 that the concept of the “Super
10 Fontan,” defined as those with peak $\text{VO}_2 \geq 80\%$ of predicted, began to emerge in the medical literature. See Cordina 2018, Powell 2019 and Weinrab 2020. The relevance, or even existence, of this Super Fontan subset was essentially unknown during clinical trial design of the FUEL Trial and could not have been anticipated at the time the FUEL trial was designed and presented to the FDA for review and agreement.

15

Alongside the emergence of an understanding of the Super Fontan patients has been the growth in understanding of the physiologic ceiling for peak exercise in Fontan circulation. When Super Fontan patients achieve peak levels of exercise, central venous pressure, the driver of cardiac output, is at a near-maximum physiologic value and thus cannot meaningfully rise
20 further. (Goldberg 2021) and (Navaratnam 2016). It is believed that this physiologic ceiling on central venous pressure limits the ability to further augment peak exercise in this population. However, despite this limitation in the ability to improve peak exercise, augmentation of exercise at the ventilatory anaerobic threshold (“VAT”) was unexpectedly realized for the Super Fontan patients because it is believed that the ventilatory anaerobic threshold occurs below the
25 physiologic ceiling of central venous pressure.

In light of the clinical justification for this subgroup analysis provided above, the response of individual subjects to udenafil treatment depended, in part, on their peak or max exercise capacity at trial entry. An analysis of covariance with fixed factors for treatment group (udenafil vs placebo) was performed, baseline peak exercise capacity subset (percent
30 predicted peak $\text{VO}_2 < 80\%$ vs $\geq 80\%$ subgroup; a cut-point defined in the Fontan medical literature) and treatment group by subset interaction. This analysis for peak or max VO_2 as well as for measures of exercise at the ventilatory anaerobic threshold (“VAT”) and for myocardial performance index (MPI) were performed. Results are displayed in Table 1.

35

Table 1: Comparison of Difference in Change of Outcome (Treatment Group – Placebo Group) by Baseline Peak VO₂ for Participants with Paired Data.

All Participants	Baseline Peak VO ₂ <80%		Baseline Peak VO ₂ ≥80%		Treatment Group-by-Subset Interaction Term p value **
	N	26 Week - BL	N	26 Week - BL	
Peak VO ₂ (ml/kg/min)	301	1.12 (p=0.023)	77	-0.89 (p=0.32)	0.037
Peak VO ₂ (% change) #	301	5.0 (p=0.040)	77	-2.39 (p=0.35)	0.11
VO ₂ at VAT (ml/kg/min)	251	0.77 (p=0.022)	66	0.38 (p=0.16)	0.66
Work at VAT (watts)	243	3.54 (p=0.032)	66	3.15 (p=0.39)	0.93
VE/VCO ₂ at VAT	251	-0.66 (p=0.053)	66	-1.18 (p=0.11)	0.58
MPI	189	-0.04 (p=0.006)	60	0.01 (p=0.35)	0.17

VO₂: oxygen consumption; VAT: ventilatory anaerobic threshold; VE/VCO₂: ventilatory efficiency slope; MPI: myocardial performance index.

Analysis based on natural log transformed data. Mean % change from baseline ratio Udenafil/Placebo.

**P-value for the interaction term from the linear model with factors for treatment group (Udenafil, Placebo), subset (< 80% of Predicted Peak VO₂ at Baseline, ≥80%), and treatment group-by-subset interaction term.

The interaction term tests the hypothesis of homogeneity of treatment effect (Udenafil minus Placebo) across the two subsets (<80% vs. ≥80%). The p-value reflects the probability of observing the magnitude of the differing treatment effects between the two subsets, under the assumptions that the treatment effect is equal for the two subsets.

The ANCOVA with fixed factors analyses confirmed the significant interaction between the treatment group and baseline peak exercise capacity subset for the outcome measure of peak VO₂ (p=0.037) but demonstrated no significant interaction between the treatment group and subset for exercise outcomes at the ventilatory anaerobic threshold (p≥0.58 for all) and for MPI (p=0.17). It is believed that these results confirm that baseline peak exercise capacity significantly impacts drug treatment effect for peak or max VO₂, whereas baseline exercise capacity does not significantly impact drug treatment effect on other (secondary) outcome measures. Taken together, these results support the new understanding of Fontan physiology that was first published in the medical literature in 2018 and reveal the deleterious impact of including Fontan patients with baseline percent predicted peak VO₂ ≥80% specifically on the primary outcome of peak or max VO₂ in the FUEL trial (e.g., de-enriching the trial cohort).

(b) Evidence of Clinical Efficacy.

In the FUEL Trial, the p-value for the improvement in Peak VO₂, the primary outcome measure, was 0.092 – a near miss statistically but nevertheless still effective. Given the new scientific knowledge in Fontan physiology since FUEL trial design (e.g., “Super Fontan” and the ceiling effect), and confirmation of that understanding in the analysis above, udenafil was statistically significant for the sub-Super Fontan patients with a baseline percent predicted peak VO₂ <80%. In fact, analysis captures the exact population that would have studied prospectively in the FUEL

5 trial (e.g., with addition of a trial exclusion criteria for baseline peak $\text{VO}_2 \geq 80\%$), had the new medical knowledge been in place during trial design. Importantly, this subgroup analysis incorporates the Fontan patients with diminished peak exercise performance, precisely those patients who are at greatest risk for near-term adverse outcomes, including mortality, transplantation or hospitalization for heart failure (Udholm 2018; Giardini 2007; Diller 2010; 10 Fernandes 2011, Ohuchi 2015). It should be noted that the overall sample size for this subgroup analysis was n=301.

As shown in Table 2, the subgroup analysis of those with a baseline percent predicted peak $\text{VO}_2 < 80\%$ demonstrates a significant improvement in peak or max VO_2 . This improvement in peak 15 or max VO_2 is consistent with the statistically significant improvements noted for both the ITT cohort and in the subgroup analysis in all secondary outcome measures, including exercise at VAT and MPI, the primary outcome for ventricular performance. These submaximal findings are expected based on the new analysis presented above; the improvements at VAT are found regardless of baseline peak exercise capacity (e.g., even when including the “Super Fontan” 20 patients in the ITT cohort).

Table 2: Difference in change from baseline to 26 weeks, comparing udenafil to placebo for all subjects in the FUEL trial, and with subjects in the FUEL trial with baseline Peak $\text{VO}_2 \geq 80\%$ excluded.

	Udenafil		Placebo		
	N	26 Week - Baseline	N	26 Week - Baseline	p value
All Participants					
Peak VO_2 (ml/kg/min)	200	-0.23	200	-0.89	0.092
Peak VO_2 (% change, ml/kg/min)	200	-1.0	200	-4.3	0.072
% Predicted Peak VO_2	189	-0.90	190	-2.49	0.077
VO_2 at VAT (ml/kg/min)	170	-0.07	181	-0.68	0.012
Work at VAT (watts)	167	3.46	177	0.31	0.029
VE/ VCO_2 at VAT	170	-0.76	181	-0.05	0.011
MPI	122	-0.02	127	0.01	0.024
Excluding those with baseline peak $\text{VO}_2 \geq 80\%$	Udenafil		Placebo		
	N	26 Week - Baseline	N	26 Week - Baseline	p value
Peak VO_2 (ml/kg/min)	150	0.23	151	-0.89	0.023
Peak VO_2 (% change, ml/kg/min)	150	0.4	152	-4.6	0.040
% Predicted Peak VO_2	150	0.43	151	-2.25	0.009
VO_2 at VAT (ml/kg/min)	122	0.11	129	-0.66	0.022
Work at VAT (watts)	119	3.80	124	0.26	0.032

VE/VCO ₂ at VAT	122	-0.61	129	0.05	0.053
MPI	94	-0.03	95	0.01	0.006
VO ₂ : oxygen consumption, VAT: ventilatory anaerobic threshold, VE/VCO ₂ : ventilatory efficiency slope. P-value for difference in change from baseline, comparing udenafil to placebo, using ANCOVA with fixed factors for ventricular morphology (single left versus single right or mixed) and a continuous covariate of baseline peak VO ₂					

5

While the benefit of udenafil for the sub-Super Fontan patients with peak or max VO₂ <80% predicted at baseline is clear, the results for the Super Fontan patients with a peak or max VO₂ ≥80% of predicted appeared to be negative. In fact, the 26-week change in peak or max VO₂ in this small subgroup (n=77) revealed no significant udenafil treatment effect (Table 1; p=0.32).

10 The appearance of a marginally negative treatment effect of udenafil in this Super Fontan subgroup was not statistically significant, in part reflecting the small sample size, and would not be anticipated to become significant even if adequately powered given that all secondary exercise measures demonstrate a positive udenafil treatment effect across the whole study population. This discussion is continued in Section below in connection with **FIG. 6**.

15 (c) The Clinical Significance of the Udenafil Treatment Effect in the Intent-To-Treat Analysis and the Post-Hoc Subpopulation Analysis of Patients with Baseline Peak VO₂ <80% of Predicted.

There is recent literature (Cunningham, 2017 and Egbe, 2017) that relates changes in exercise performance (peak VO₂, mL/kg/min) to the short- and medium-term risks of death and cardiac
20 transplantation in Fontan patients. The Cunningham and Egbe investigations provide strong support that the FUEL outcome (peak VO₂, mL/kg/min) is highly clinically significant, unexpected and relevant.

(1) Clinical Significance: Change in Peak VO₂ (mL/kg/min) in Fontan Population

In a 2017 study from Boston Children's Hospital, Cunningham and colleagues investigated the
25 impact of change in peak VO₂ on short-term clinical outcomes in 130 adolescent and young adult Fontan patients (mean age 26.8 ± 9.4 years) with paired cardiopulmonary exercise testing (CPET) studies 1.4 ± 0.5 years apart. When change in peak VO₂ was evaluated as a continuous variable, higher peak VO₂ (mL/kg/min) at the second CPET was strongly associated with a decreased short-term risk of death or transplantation. Specifically, an increase of 1 mL/kg/min in
30 peak VO₂ was associated with a HR of 0.79 (95% CI 0.68-0.92, p=0.004) for death or

transplantation. Moreover, for every 10% decline in peak VO_2 , there was a doubling of the hazard for death or transplantation (HR 1.96, 95% CI 1.2-3.1, $p=0.004$). When peak VO_2 was evaluated as a dichotomous outcome, as displayed in **FIG. 8** (increased VO_2 [blue series] vs. unchanged/decreased VO_2 [red series]), any decline in peak VO_2 was associated with a significantly increased short-term risk of a) death or transplantation ($p=0.027$); b) death, transplantation, or heart failure hospitalization ($p=0.024$); and c) near-significant risk of death, transplantation or non-elective cardiovascular hospitalization ($p=0.14$).

Additionally, (Cunningham (2017) evaluated CPET performance stratified by the subsequent primary clinical outcome of death or transplant. See **FIG. 9**. Fontan survivors (grey) demonstrated an increase in %-predicted peak VO_2 (left) and %-change in peak VO_2 (right) between CPET studies, whereas Fontan patients who subsequently met the primary clinical outcome (black) demonstrated decline in both exercise measures.

Egbe et al (2017) investigated the prognostic value of serial CPET testing in young adults with prior Fontan operation. In this important study from Mayo Clinic, inclusive of 145 Fontan patients with mean age of 24 ± 3 years, the investigators assessed CPET studies 3.8 ± 0.3 years apart. Cardiovascular adverse events occurred in 37% of patients during medium-term follow-up of 8 ± 3 years. A number of risk factors for cardiovascular adverse events were considered. **FIG. 10** depicts freedom from cardiovascular adverse events, stratified by annual decline in %-predicted peak $\text{VO}_2 \geq 3\%$ (blue) or $< 3\%$ (red). The only predictor of 5-year risk of cardiovascular adverse events was a decline in %-predicted peak $\text{VO}_2 \geq 3\%$ per year ($p=0.03$).

In the intent-to-treat analysis (ITT) of the FUEL Trial, **FIG. 11**, without imputation of missing data, 46% ($n=86$) of udenafil patients demonstrated an increase in peak VO_2 , whereas only 36% ($n=68$) of the placebo patients had an increase in peak VO_2 . This difference is a near miss for statistical significance ($p=0.075$) and corresponds to a number needed to treat (NNT) of 10, implying that 10 patients would need treatment with udenafil for one patient to experience an increase in peak VO_2 . Or, stated in context of the outcomes data provided by the Cunningham study, the NNT of 10 implies that 10 patients would need treatment with udenafil for one patient to exhibit a substantial reduction in the short-term risk of death or transplantation.

5 In the post-hoc subgroup analysis (excluding patients with baseline peak $\text{VO}_2 \geq 80\%$ of predicted) of the FUEL trial, **FIG. 12**, 50% (n=75) of udenafil patients demonstrated an increase in peak VO_2 , whereas only 38% (n=57) of the placebo patients had an increase in peak VO_2 . This difference is statistically significant ($p=0.037$) and corresponds to a number needed to treat (NNT) of 8.2, implying approximately 8 patients would need treatment with udenafil for one
10 patient to demonstrate an increase in peak VO_2 . Considering the outcomes data from Cunningham et al, approximately 8 patients would need treatment with udenafil for one patient to exhibit a substantial reduction in short-term risk of death or transplantation.

Given concerns raised at the Late Cycle Meeting for a possible negative udenafil treatment effect in the Super Fontan cohort, this same analysis was also performed for the post-hoc subgroup of
15 patients with baseline peak $\text{VO}_2 \geq 80\%$ of predicted in the FUEL trial. See **FIG. 13**. We found that an equivalent low percentage of patients, 28 to 29% in each treatment group, demonstrated positive change, whereas an equivalent high percentage of patients, 71 to 72% in each treatment group, demonstrated negative change, with no difference between treatment arm ($p>0.99$). These findings are consistent with the results of the ANCOVA with fixed effects analysis, that
20 baseline peak VO_2 subgroup has an important interaction with treatment group (e.g., a high baseline exercise capacity precluded further benefit on drug). More importantly, it is important to recognize that in this Super Fontan subgroup, udenafil treatment appears to offer no significant short-term impact (beneficial or adverse) on the outcome measure of peak VO_2 .

Next, we present %-change in peak VO_2 across the 26-week FUEL trial, **FIG. 14**, for both the
25 ITT cohort (left) as well as for the post-hoc subgroup (excluding patients with baseline peak $\text{VO}_2 \geq 80\%$ of predicted, right). In the ITT analysis, both groups demonstrate a negative %-change in peak VO_2 , albeit to a much lesser extent in the udenafil arm, with no statistical difference between groups ($p=0.072$). However, in the post-hoc subgroup analysis, the mean effect on peak VO_2 in the udenafil group was positive, whereas the placebo group again shows
30 worsening. This difference is statistically significant ($p=0.037$). Considering the Cunningham study findings, our data project that for Fontan patients in the post-hoc subgroup analysis, udenafil would be associated with a reduction in the short-term risk of death or transplantation.

Now, annualized change in %-predicted peak VO_2 is displayed, **FIG. 15**; determined by doubling the change over the 6-month FUEL trial), for the ITT cohort (left) and for the post-hoc

5 subgroup (excluding patients with baseline peak $\text{VO}_2 \geq 80\%$ of predicted, right). Annualizing the 6-month change in FUEL facilitates direct comparison with the Fontan cohort from Egbe. In the ITT analysis, both groups demonstrate a reduction in %-predicted peak VO_2 , though only the placebo group exceeds the threshold 3% annual decline, from Egbe et al, associated with an increased 5-year risk of cardiovascular adverse events. This difference is not statistically significant (p=0.077). However, in the post-hoc subgroup analysis, the udenafil group demonstrates an increase in %-predicted peak VO_2 , whereas the placebo group again shows a decline. This difference is statistically significant (p=0.009). Further, only the placebo group exceeds the threshold 3% annual decline associated with an increased 5-year risk of cardiovascular adverse events (Egbe 2017).

15 Finally, in the absence of an existing pharmacotherapy for the treatment of SVHD patients after Fontan palliation, it is prudent to compare the treatment effect in FUEL to non-pharmacotherapeutic treatment options aimed at improving exercise capacity in this population. Few exist, but physical exercise training or cardiac rehabilitation is the most rational non-pharmacotherapy and has an available evidence-base available for review. Scheffers et al 2021 recently undertook a systematic review of 16 studies reported in 22 publications, including 264 Fontan patients with mean age range 8.7–31 years. In this systematic review, the authors report a significant increase in peak VO_2 after training in just 9 (56%) of the studies, with a mean increase of +1.72 ml/kg/min in those studies that demonstrated a benefit. Notably, this reported increase does not reflect a placebo-adjusted treatment effect but, rather, is simply the mean increase in those patients that received exercise training. However, when all studies are included in the calculation of change in peak VO_2 , as displayed in **FIG. 16**, the mean increase was just slightly greater than 0 ml/kg/min. Given the persistent presence of equipoise surrounding physical training as a treatment for preservation or improvement of exercise capacity in Fontan patients, the Fontan Fitness Intervention Trial (F-FIT), a randomized multicenter controlled study of adolescent and adult Fontan patients is currently underway in Australia (Tran 2022).

This review of recent and relevant Fontan literature, relating change in exercise performance (peak VO_2 , mL/kg/min) to short- and medium-term risk for adverse clinical outcomes (including death and cardiac transplantation) is relevant to interpretation of the results from the FUEL trial primary and post-hoc subgroup analyses. These data and analyses provide strong support that

5 the FUEL outcome (peak VO_2 , mL/kg/min) is highly clinically significant, unexpected and relevant. Moreover, in the absence of available pharmacotherapy indicated for treatment of the Fontan circulation, alternative treatments must be weighed. In the Fontan population, physical training (cardiac rehabilitation) has been trialed repeatedly, with resultant benefit only evident approximately half of the time, and an overall impact on peak VO_2 that is negligible across the
10 entirety of the analyzed cohort. Lastly, the short-term nature of these risks, including death and transplant, suggest the real-time need for an effective treatment option in the Fontan population. Each year of delay in access to an effective treatment option will necessarily result in the loss of a sizable population of Fontan patients to the ongoing hazards of mortality or cardiac transplant.

15 (d) The Importance of VO_2 at VAT in the Clinical Management of the Fontan Population, including Super Fontan Patients.

Peak VO_2 is an important marker of overall cardiovascular health and a predictor of cardiac adverse events, but it is not often achieved in a patients' daily life. VO_2 at VAT, on the other hand, is the upper level of sustained physical activity and sets the limit within which an individual patient will be able to perform routine physical activity. This measure is the point
20 during progressive physical activity when the metabolic demands of the exercising muscles exceed the ability of the cardiovascular system to maintain adequate blood flow for oxygen delivery and therefore metabolism switches from aerobic to anaerobic. In healthy teens and children, this point normally occurs at approximately 55 to 60% of the subject's maximal VO_2 and is the limit of physical activity that can be sustained indefinitely. In the FUEL Trial,
25 treatment with udenafil resulted in a robust increase in the VO_2 at VAT compared to placebo in the overall intent-to-treat population, as well as in the super Fontan patient analysis.

The clinical relevance of this finding is very important. Individuals rarely, if ever, function near their maximal VO_2 during their daily activities. So, although Peak VO_2 is an important marker of overall cardiovascular health and a well-described predictor of cardiovascular adverse events,
30 it has limited impact on how a patient feels or functions in their daily life. VO_2 at VAT, on the other hand, sets the limits within which an individual patient will have to function on a daily basis. These limits dictate capacity for routine activities including work, school, and recreation.

5 Any improvement in VO_2 at VAT will necessarily result in an improvement in tolerance of these routine activities.

While VO_2 at VAT is a highly clinically relevant endpoint, it can be a challenge to obtain. To measure VAT both accurately and precisely the respiratory rate and tidal volume must be consistent. In clinical practice, erratic breathing at the onset of anaerobic metabolism prevents
10 accurate assessment in about 15% to 20% exercise tests performed. This difficulty in measurement is a particular concern when designing clinical trials with VO_2 at VAT as an endpoint as the sample size calculation must be inflated to account for anticipated data loss. Given the concern about data availability and with the understanding that it was going to be a challenge to recruit participants in this orphan disease space, the Pediatric Heart Network chose
15 to use VO_2 at VAT as a secondary endpoint. However, although as anticipated paired VAT data was available in about 80% of the cohort, this measure nevertheless demonstrated a clinically and statistically significant response across the entire population.

The importance of VO_2 at VAT as an endpoint was highlighted in a 2007 report from McCrindle et al (McCrindle 2007) in which they investigated the relationship between parent/patient
20 perception of functional health status and measures of exercise performance in 147 Fontan patients at median age of 11.6 years (range 7 - 18.4 years). In that cohort, the mean percent predicted peak VO_2 was $67\% \pm 15\%$, which is directly comparable to the performance of the FUEL cohort. The authors found that greater exercise capacity was related to higher scores for global health, physical functioning, impact of physical limitations, freedom from bodily pain,
25 general health perceptions and physical functioning summary score ($p < 0.05$ for each). In fact, for several key measures of functional status, including global health, physical functioning, impact of physical limitations, and self-esteem, the correlation with measures of exercise capacity was stronger for percent predicted VO_2 at VAT than for peak VO_2 . Given clinically relevant correlations between percent predicted VO_2 at VAT and global health ($R\ 0.45$, $p < 0.05$)
30 and self-esteem ($R\ 0.28$, $p < 0.05$), respectively, even modest drug effect would be anticipated to produce perceptible functional benefit to patient and parent(s). Indeed, as demonstrated in **FIG. 17**, there are more patients who experienced a positive change in VO_2 at VAT while on udenafil treatment, than placebo, although this difference was not statistically significant ($p = 0.311$). More importantly, as shown in **FIG. 18**, there is substantially better preservation of VO_2 at VAT

5 on udenafil treatment, compared to placebo, in both the ITT cohort overall ($p=0.026$), as well as in the subgroup analysis excluding super Fontan patients ($p=0.052$). In context of the McCrindle data, this suggests that udenafil therapy would be associated with better maintenance of existing functional status, when compared to the inevitable decline in functional status experienced off therapy (e.g., placebo or Fontan natural history). These findings support the notion that udenafil-mediated improvement in VO_2 at VAT, in addition to the improvement in peak VO_2 , would be associated with clinically significant improvement in multiple domains of functional health status.

(e) Confirmation of Clinical Benefit in the Fontan Population From FUEL OLE (Open-Label Extension) Trial

15 As confirmation of the udenafil benefit demonstrated in FUEL, we evaluated the available clinical data from participants in the FUEL OLE trial. Like most extension studies, the FUEL open label extension trial was not a placebo-controlled trial, but was instead designed to establish a safety profile over a longer duration of drug exposure - and is an independent source of data from FUEL. Despite the inherent limitations of this extension study, FUEL OLE provides supportive evidence of udenafil efficacy as depicted across the 18 months of FUEL and FUEL OLE in **FIG. 19** below. In those treated with udenafil in the FUEL trial, there is persistence of benefit, while for those naïve to udenafil, there is new benefit that recapitulates what was observed, relative to placebo, in the FUEL trial. In the OLE study, from 26- to 78-weeks, all patient groups demonstrate substantial clinical benefit from udenafil treatment.

25 The FUEL and FUEL OLE trials have unexpectedly and surprisingly demonstrated that udenafil is safe and effective for improving exercise capacity in Fontan palliated patients who are at least 12 years of age. The data provided by these trials are compelling and demonstrate meaningful clinical benefit for this orphan disease population, a population lacking approved pharmacotherapeutic options. The analysis of the efficacy data of the Fontan subgroup, that is most in need of therapy – those with less than normal exercise capacity, i.e., having a baseline percent predicted peak $VO_2 \leq 80\%$ – the udenafil drug effect seen in this subpopulation is remarkably clinically relevant. Furthermore, it is believed that the improvement observed in all of the important secondary measures of exercise function, as well as the in the Myocardial

5 Performance Index, as measured in the FUEL Trial, constitutes substantial evidence of udenafil efficacy and supports the clinical benefit of udenafil therapy in the Fontan population, including the super Fontan patients. This important clinical benefit, along with the very low safety risk, in the Fontan population evidences remarkable and unexpected results.

10 (2) References, each of which is incorporated herein by reference in its entirety:

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- 10 Scheffers LE, Berg L, Ismailova G, Dulfer K, Takkenberg J, Helbing W. Physical Exercise Training in Patients with a Fontan Circulation: A systematic review. *Eur J Prev Cardiol* 2020;0(0) 1-12.

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Udholm S, Aldweib N, Hjortdal VE, Veldtman GR. Prognostic power of cardiopulmonary exercise testing in Fontan patients: A systematic review. *Open Heart.* 2018;5(1):e000812.

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20 2020;9(24):e016850.

Each and every article, reference, patent document and disclosure cited herein is incorporated herein by reference in its entirety as if fully set forth herein.

The present disclosure has been described with reference to example embodiments.

- Modifications and alterations will occur to others upon reading and understanding the preceding
25 detailed description. It is intended that the present disclosure be construed as including all such modifications and alterations insofar as they come within the scope of the appended claims or the equivalents thereof.

5 Having described my invention, I claim:

1. A method of treating a single ventricular heart disease (SVHD) patient who has a single functioning ventricle and Fontan physiology following a Fontan procedure (Fontan patient) and who is in need of treatment to improve the Fontan patient's exercise capacity as measured by
10 oxygen consumption at maximal effort or peak VO_2 , wherein the Fontan patient has a baseline peak or max VO_2 of less than ($<$) 80% predicted, and wherein the Fontan's exercise capacity is adversely affected due to a decline in the Fontan patient's heart function after the Fontan procedure, said method comprising
administering to the Fontan patient daily an effective amount of udenafil, or a
15 pharmaceutically acceptable salt thereof, to improve the Fontan patient's exercise capacity as measured by oxygen consumption at maximal effort or peak VO_2 .
2. The method according to claim 1, wherein the effective amount is a total daily dosage of udenafil or a pharmaceutically acceptable salt thereof in an amount of between about 125 mg and
20 175 mg.
3. The method according to claim 1, wherein the effective daily amount is a total daily dosage of udenafil or a pharmaceutically acceptable salt thereof in an amount of about 175 mg.
- 25 4. The method according to claim 3, wherein the total daily dosage consists of two individual doses of udenafil or a pharmaceutically acceptable salt thereof, wherein each said individual dose is about 87 mg of udenafil or a pharmaceutically acceptable salt thereof.
5. The method according to claim 4, wherein each said individual dose is in a solid oral
30 dosage form.
6. The method according to claim 5, wherein the udenafil or a pharmaceutically acceptable salt thereof is in a solid or semi-solid oral dosage form selected from a group consisting of a tablet, a capsule, a gel, a liquid, a liquid dispersion, a pill, a powder, and a suspension.

35

- 5 7. The method according to claim 1, wherein the udenafil or a pharmaceutically acceptable salt thereof is in a solid oral dosage form.
8. The method according to claim 7, wherein the solid oral dosage form is a solid or semi-solid oral dosage form selected from a group consisting of a tablet, a capsule, a gel, a liquid, a liquid dispersion, a pill, a powder, and a suspension.
- 10 9. The method of according to claim 1, wherein the Fontan patient is at least 12 years of age.
- 15 10. The method according to claim 1, wherein said method further improves the Fontan patient's:
- (a) ventricular performance of the Fontan patient's single functioning ventricle as measured by myocardial performance index (MPI);
 - (b) exercise capacity as measured by oxygen consumption at ventilatory anaerobic threshold (VAT);
 - (c) work rate at VAT; and
 - (e) VE/VCO₂ at VAT, alone or in any combination.
- 20 11. A method of treating a single ventricular heart disease (SVHD) patient who has a single functioning ventricle and Fontan physiology following a Fontan procedure (Super Fontan patient) and who is in need of treatment to improve the Super Fontan patient's exercise capacity as measured by oxygen consumption at maximal effort or peak VO₂, wherein the Super Fontan patient has a baseline peak or max VO₂ of greater than ($\geq$) 80% predicted, and wherein the Super Fontan's exercise capacity is adversely affected due to a decline in the Super Fontan patient's heart function after the Fontan procedure, said method comprising:
- 25 administering to the Super Fontan patient daily an effective amount of udenafil, or a pharmaceutically acceptable salt thereof, to improve the Super Fontan patient's exercise capacity as measured by oxygen consumption at ventilatory anaerobic threshold (VAT).
- 30

- 5 12. The method according to claim 11, wherein the effective amount is a total daily dosage of
udenafil or a pharmaceutically acceptable salt thereof is in an amount of between about 125 mg
and 175 mg.
13. The method according to claim 11, wherein the effective amount is a total daily dosage of
10 udenafil or a pharmaceutically acceptable salt thereof in an amount of about 175 mg.
14. The method according to claim 13, wherein the total daily dosage consists of two
individual doses of udenafil or a pharmaceutically acceptable salt thereof, wherein each said
individual dose is about 87 mg of udenafil or a pharmaceutically acceptable salt thereof.
- 15 15. The method according to claim 14, wherein each said individual dose is in a solid oral
dosage form.
16. The method according to claim 15, wherein the udenafil or a pharmaceutically acceptable
salt thereof is in a solid or semi-solid oral dosage form selected from a group consisting of a
tablet, a capsule, a gel, a liquid, a liquid dispersion, a pill, a powder, and a suspension.
- 20 17. The method according to claim 11, wherein the udenafil or the pharmaceutically
acceptable salt thereof is in a solid oral dosage form.
18. The method according to claim 17, wherein the solid oral dosage form is a solid or semi-
solid oral dosage form selected from a group consisting of a tablet, a capsule, a gel, a liquid, a
liquid dispersion, a pill, a powder, and a suspension.
- 25 19. The method of according to claim 11, wherein the Super Fontan patient is at least 12
years of age.
20. The method according to claim 11, wherein said method further improves the Super
Fontan patient's:
- (a) ventricular performance of the Super Fontan patient's single functioning ventricle as
30 measured by myocardial performance index (MPI);
- (b) work rate at VAT; and
- (c) VE/VCO₂ at VAT, alone or in any combination.

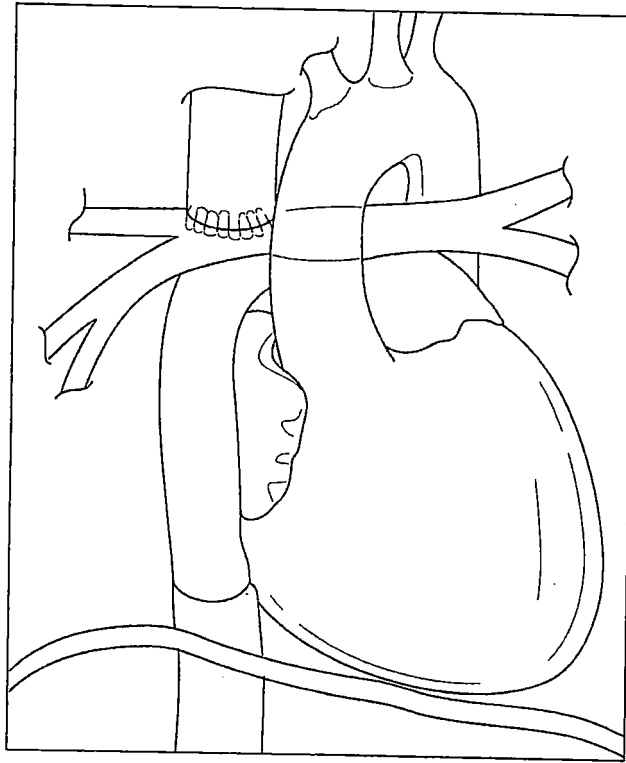


FIG. 1A

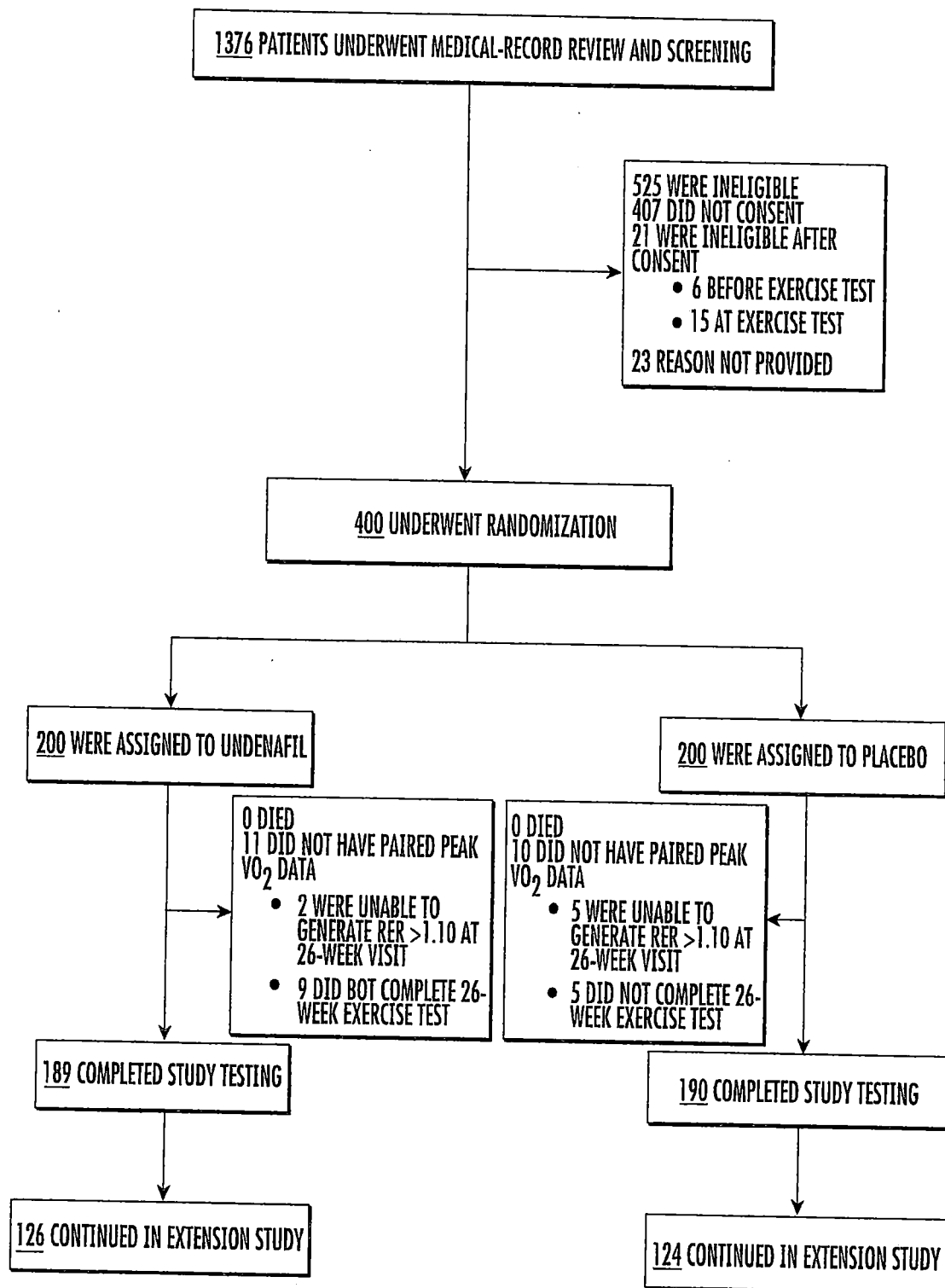


FIG. 1B

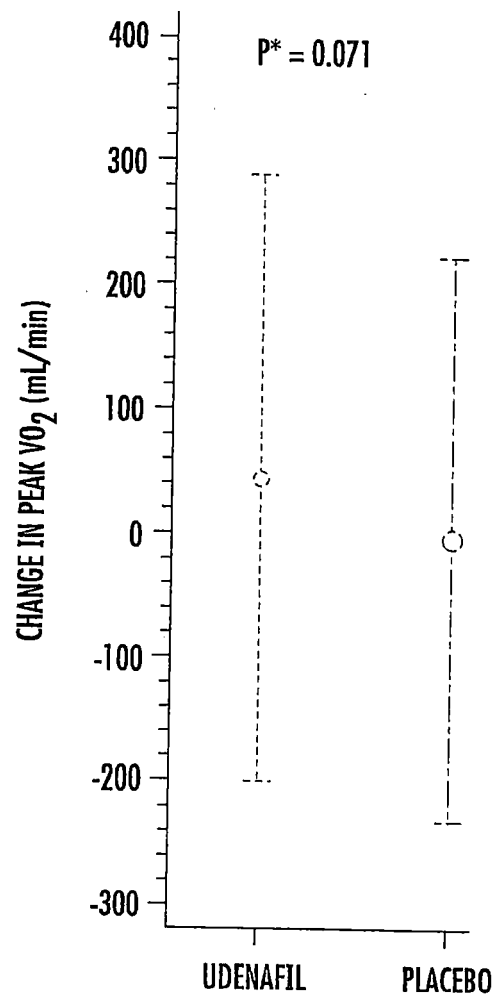


FIG. 2A

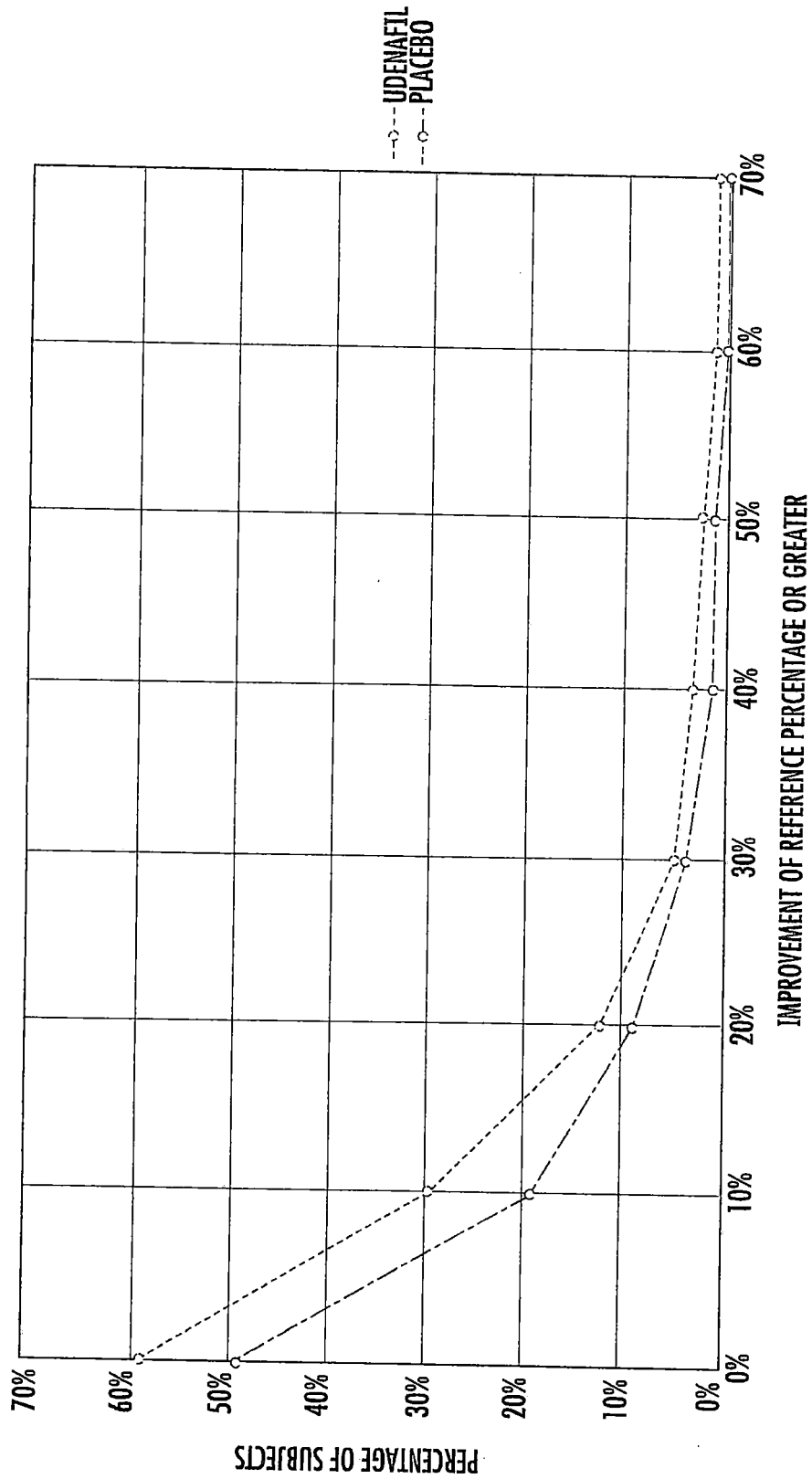


FIG. 2B

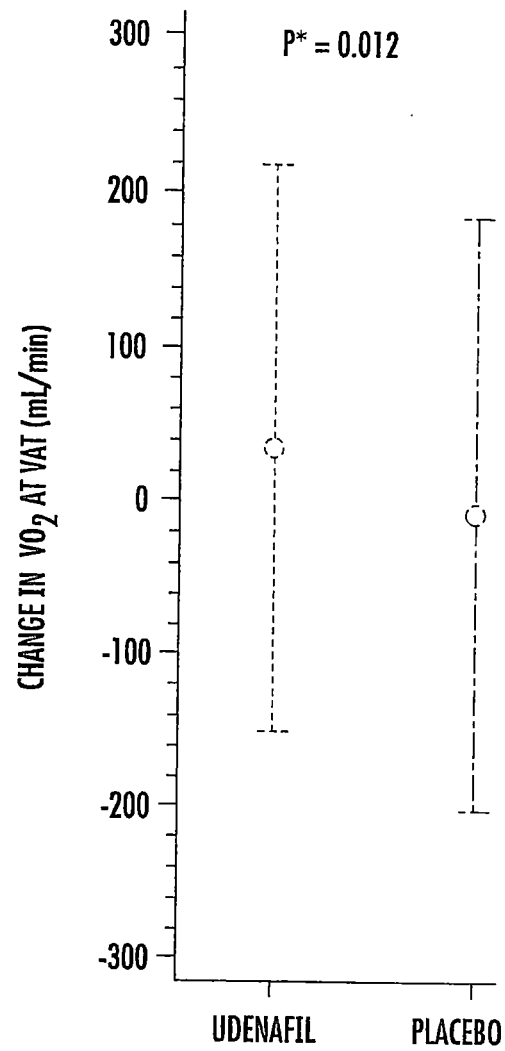


FIG. 3A

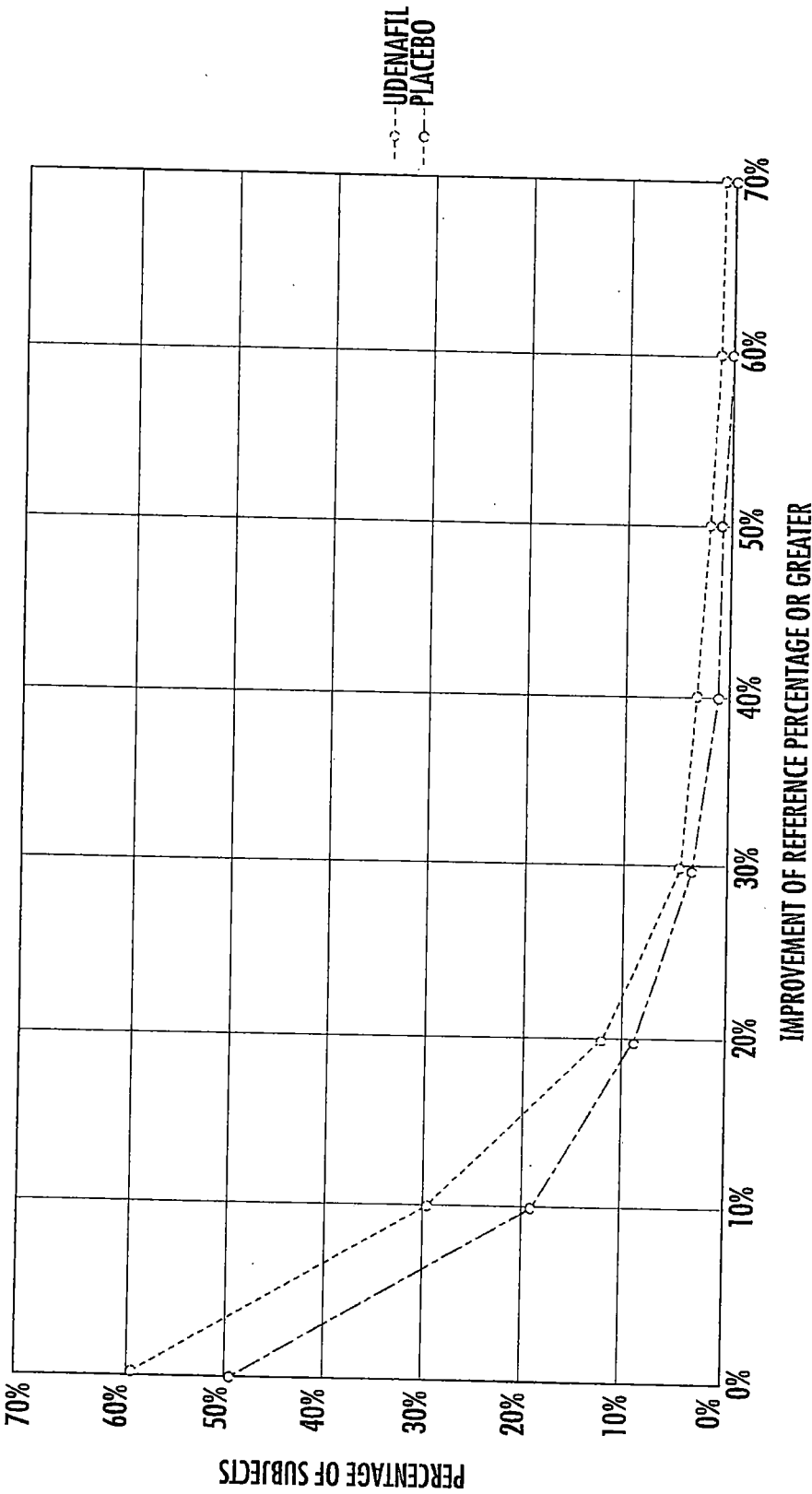


FIG. 3B

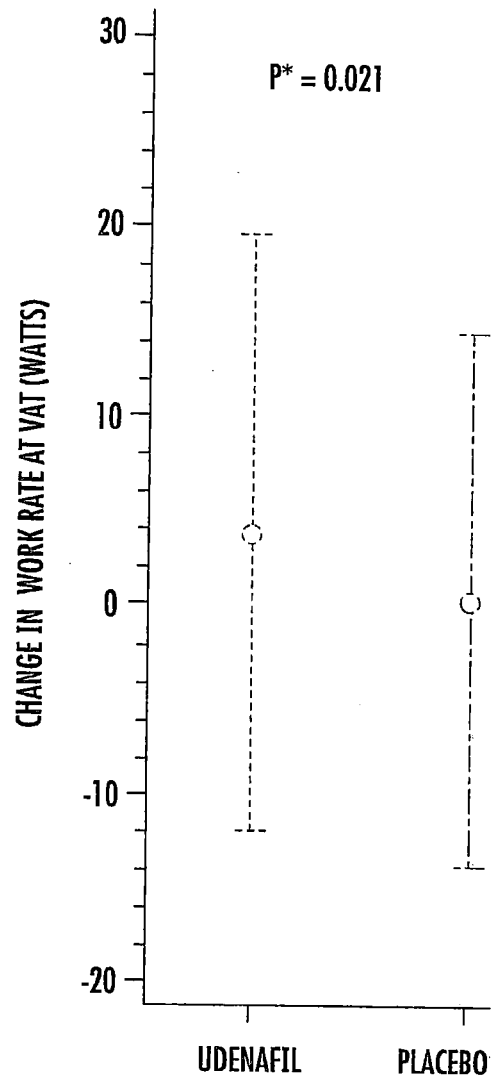


FIG. 4A

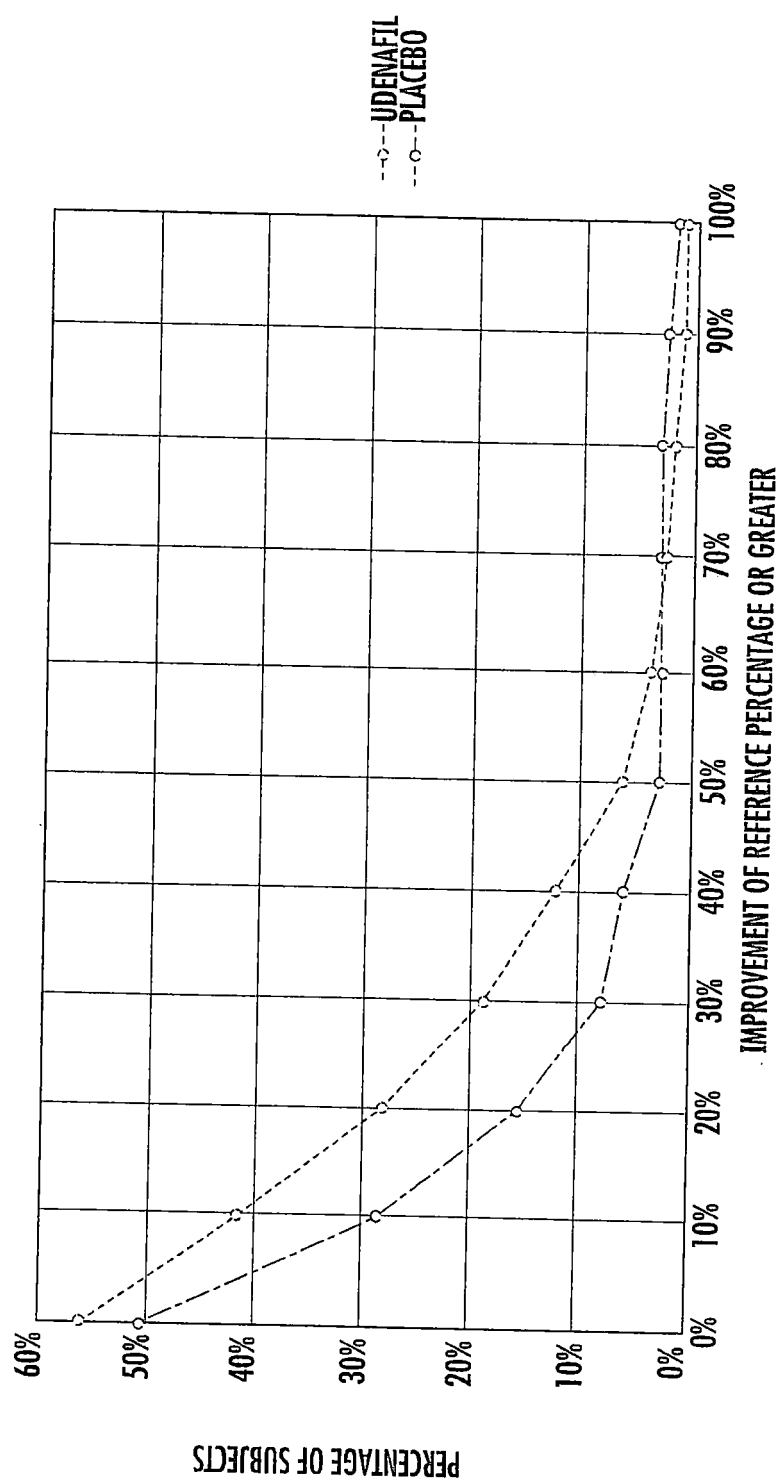
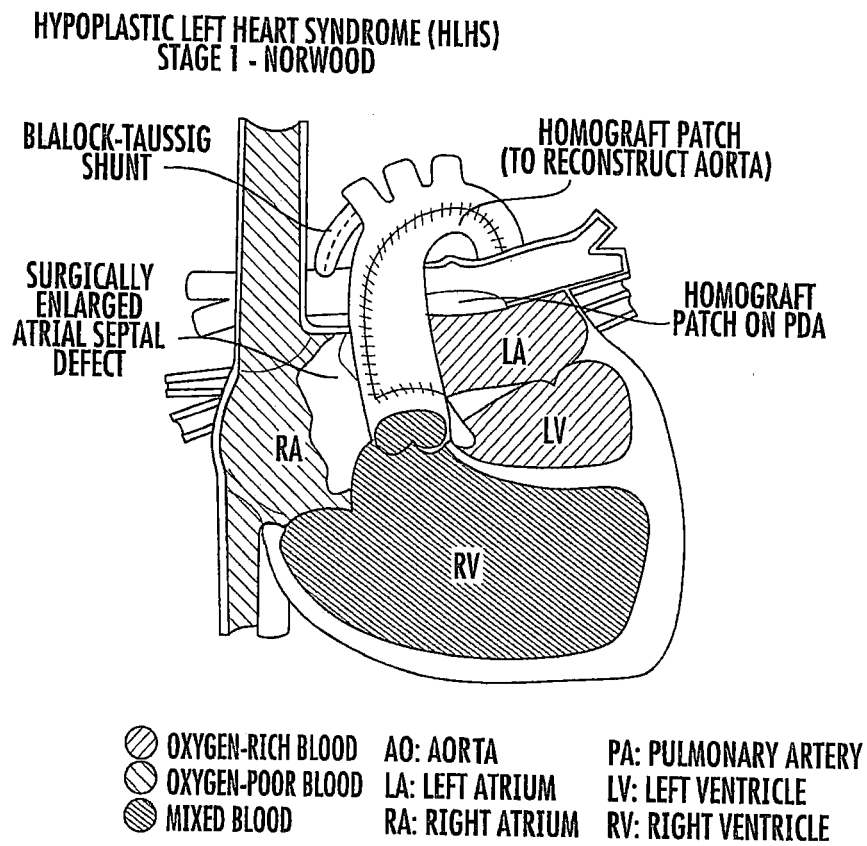


FIG. 4B

**FIG. 5**

**HYPOPLASTIC HEART SYNDROME (HLHS)
STAGE 2 - BIDIRECTIONAL GLENN**

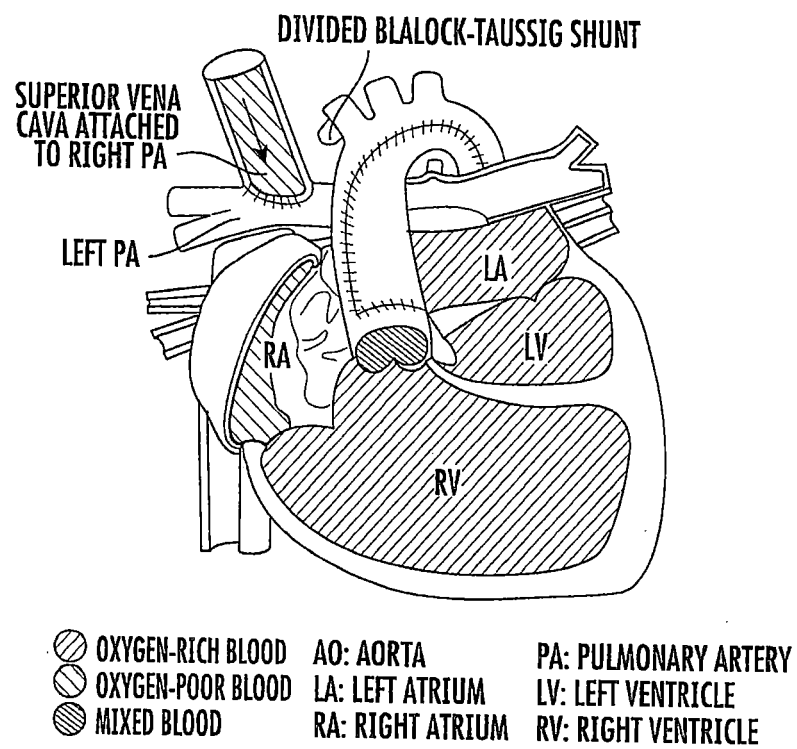
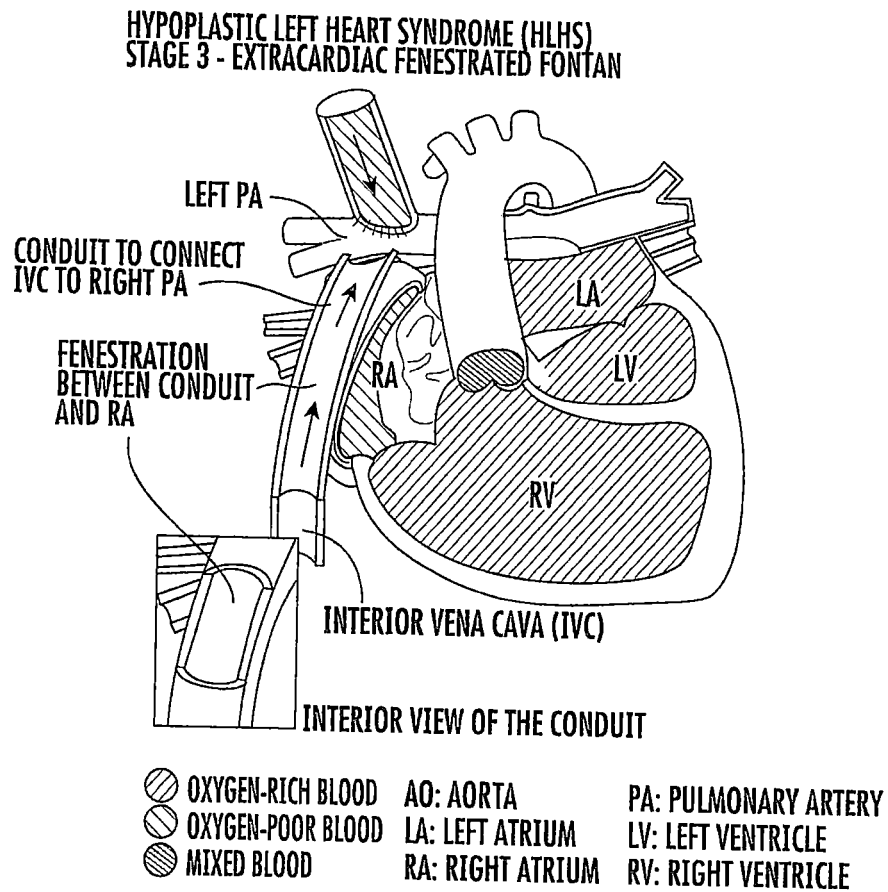
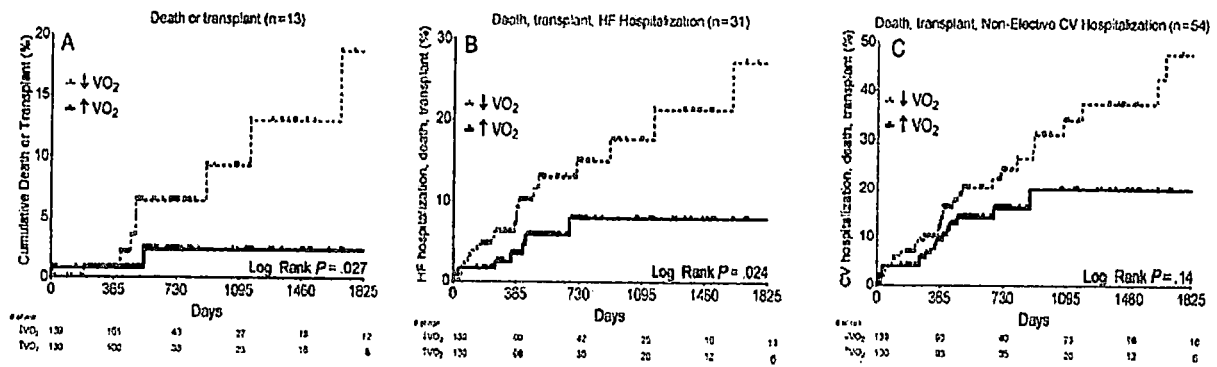


FIG. 6

**FIG. 7**



Cumulative incidence plots of primary and secondary outcomes stratified by change in peak oxygen consumption. The cumulative incidence of the primary outcome (death or heart transplant, A) and 2 secondary composite outcomes (B and C) during follow-up for patients whose peak VO₂ increased (blue line) or was unchanged/decreased (red line) between the 2 CPETs preceding the follow-up period. Log-rank P values are presented. Number at risk is presented annually for each group below the x-axis. CV, cardiovascular; HF, heart failure.

FIG. 8

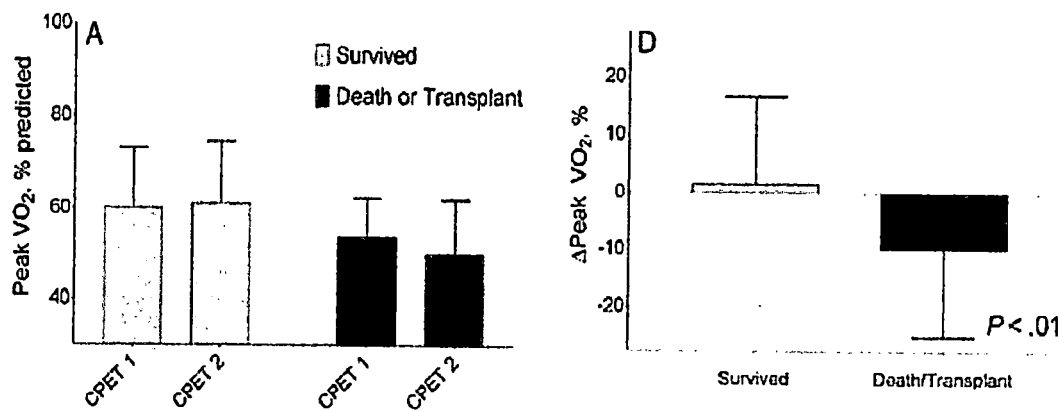


FIG. 9

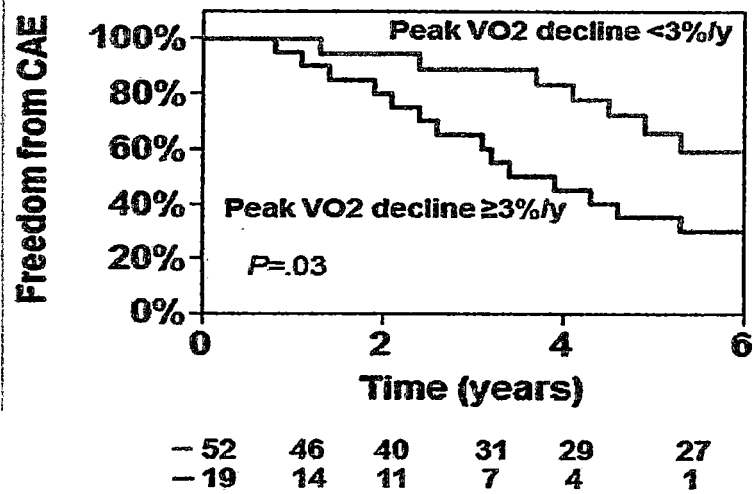


FIG. 10

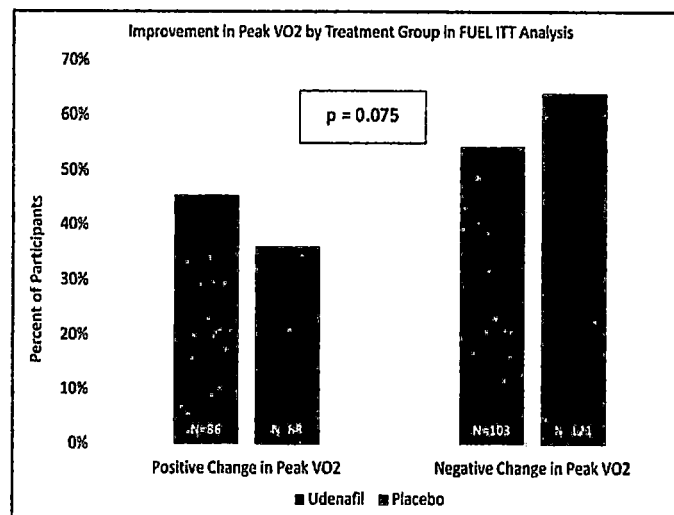


FIG. 11

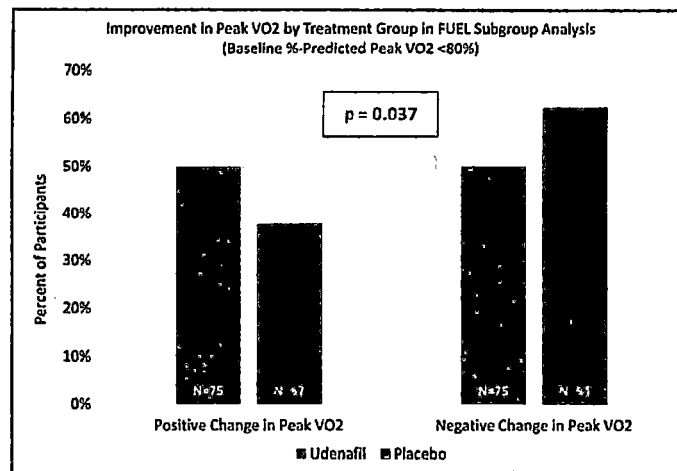


FIG. 12

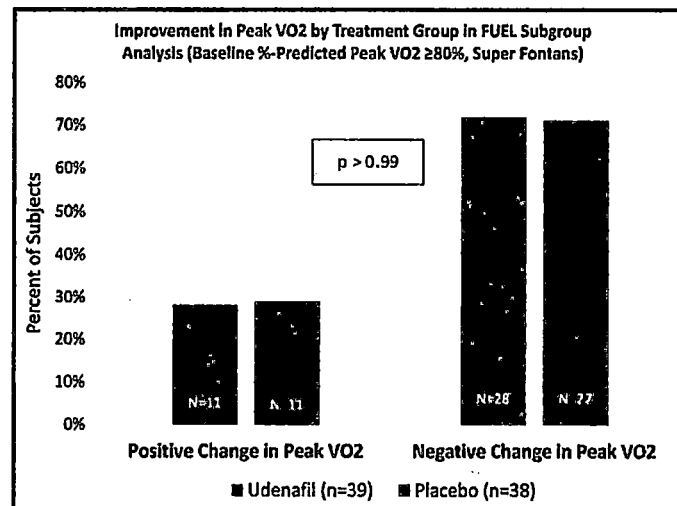


FIG. 13

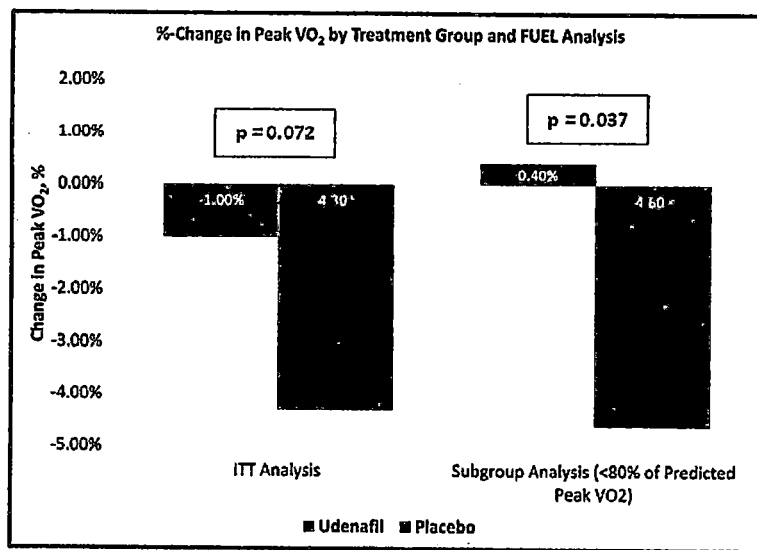


FIG. 14

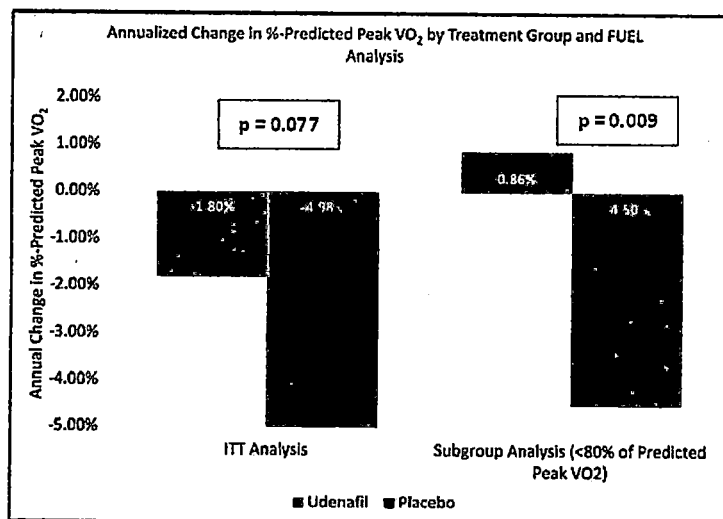


FIG. 15

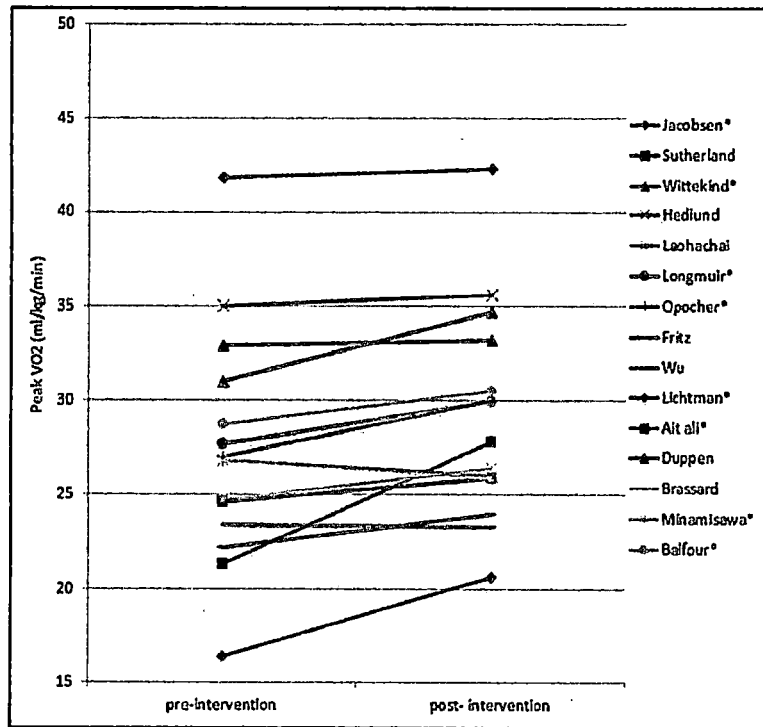


FIG. 16

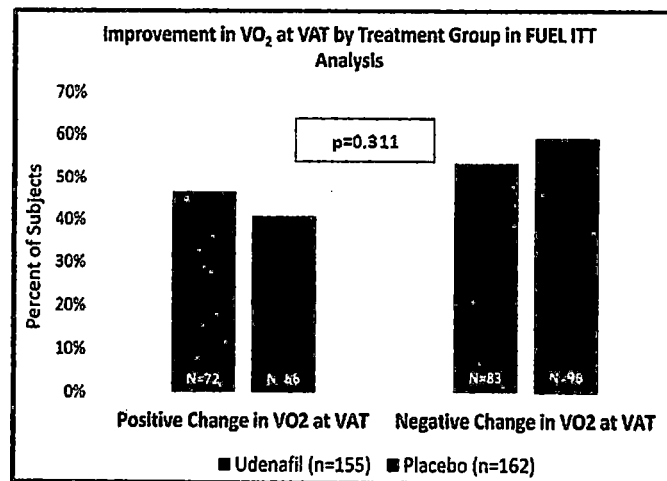


FIG. 17

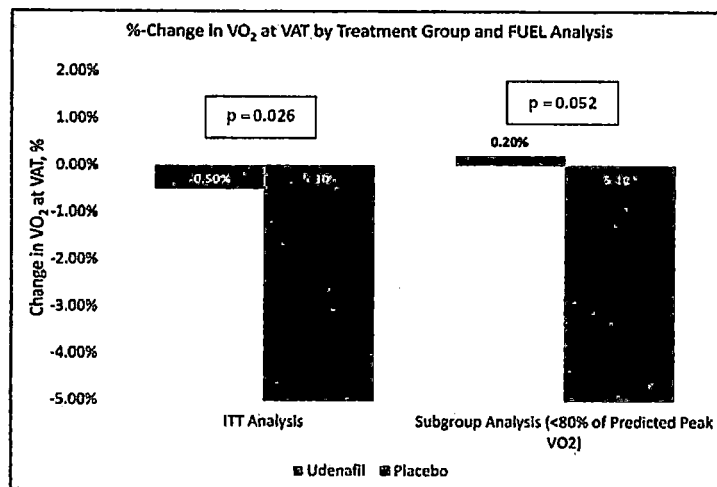


FIG. 18

Mean Change from Baseline in Peak VO_2 (mL/min) in FUEL and FUEL OLE

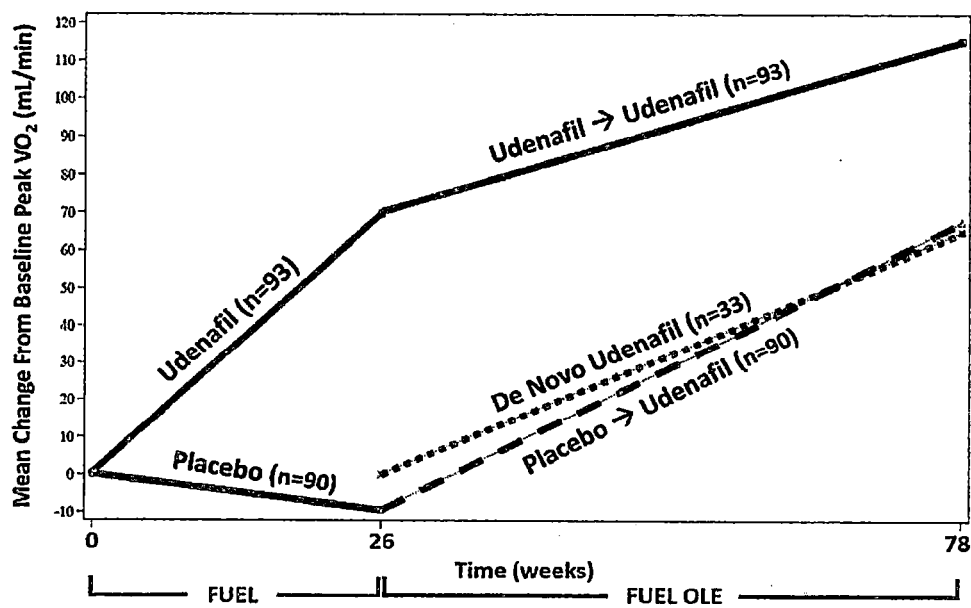
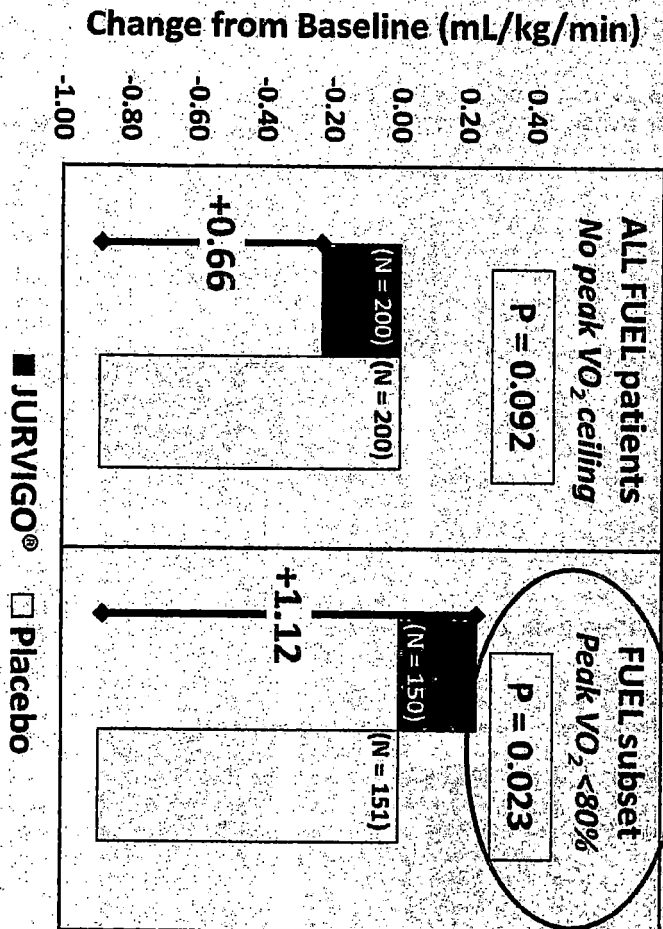


FIG. 19

FUEL trial

Effect of "Super Fontan" subjects on statistical endpoint

Change in peak VO_2 comparing FUEL treatment group to FUEL subset excluding 'Super Fontan' patients¹



- Fontan patients with peak $\text{VO}_2 \geq 80\%$ (25% of FUEL) are unlikely to respond to peak $\text{VO}_{2,1,2,3,4}$
- While JURVIGO[®] did not meet statistical improvement for all of FUEL (p = 0.092), JURVIGO[®] did meet statistical significance for Fontan subjects with peak $\text{VO}_2 < 80\%$ (p=0.023)

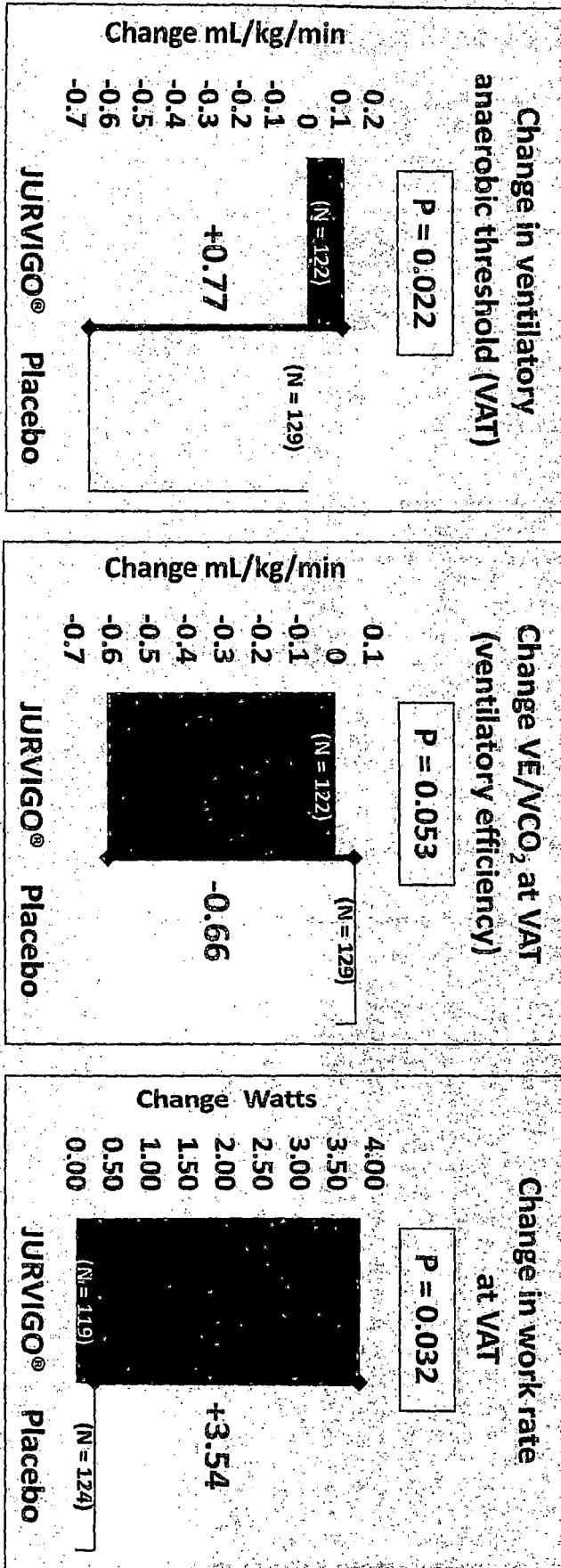
Super Fontan Defined as Peak $\text{VO}_2 \geq 80\%$ of Predicted. 1. Cordina et al, J Thorac Cardiovasc Surg 2018; 2. Powell et al, Can J Cardiol 2020; 3. Weinreb et al, J Am Heart Assoc 2020; 4. Goldberg et al, Pediatr Cardiol 2021

FIG. 20

FUEL trial

All secondary endpoints improved

JURVIGO® improved ALL submaximal cardiopulmonary exercise (peak $\text{VO}_2 < 80\%$)



Sets the limit in which a patient can perform daily activities

Less stress on your body to breathe more efficiently

Ability to do more work as greater functional capacity

All data has been weight adjusted where possible.

File. 21