Safety and Efficacy of Tenapanor for Long-term Serum Phosphorus Control in Maintenance Dialysis: A 52-Week Randomized Phase 3 Trial (PHREEDOM)

DOI: 10.34067/KID.0002002021

Geoffrey Block, Anthony Bleyer, Arnold Silva, Daniel Weiner, Robert Lynn, Yang Yang, David Rosenbaum, and Glenn Chertow

Key Points:
* Tenapanor is a first-in-class inhibitor of NHE3 and acts via a non-phosphate binding mechanism to reduce intestinal phosphate absorption.
* In the efficacy analysis set, patients randomized to tenapanor experienced a decrease in serum phosphorus from 7.7 mg/dL to 5.1 mg/dL.
* Diarrhea was the only drug-related AE reported for more than 5% of patients and resulted in drug discontinuation in 16% of patients.

Abstract:
Background: Treating hyperphosphatemia is a tenet of dialysis care. This trial assessed the safety and efficacy of tenapanor for the management of hyperphosphatemia. Methods: In this 52-week phase 3 study (NCT03427125), participants receiving maintenance dialysis with both hyperphosphatemia (serum phosphorus 6.0-10.0 mg/dl) and a 1.5 mg/dl increase following phosphate binder washout were randomized (3:1) to tenapanor 30 mg twice daily for 26 weeks (randomized treatment period) or sevelamer carbonate (52-week safety control). Participants completing 26 weeks' treatment with tenapanor were re-randomized (1:1) to tenapanor or placebo for 12 weeks (randomized withdrawal period) and were eligible to enter the 14-week safety extension period. With input from the US Food and Drug Administration, the primary efficacy endpoint was the difference in the change in serum phosphorus from the end of the randomized treatment period to the end of the randomized withdrawal period among participants who achieved {greater than or equal to}1.2 mg/dl decrease in serum phosphorus during the randomized treatment period (efficacy analysis set). Efficacy was also evaluated in the intention-to-treat (ITT) analysis set. Results: Of 564 eligible participants randomized to receive tenapanor (n=423) or sevelamer carbonate (n=141) during the randomized treatment period, 255 (60%) in the tenapanor group subsequently were re-randomized to tenapanor (n=128) or placebo (n=127) during the randomized withdrawal period. In the efficacy analysis set (n=131), the difference in estimated mean change in serum phosphorus level between tenapanor and placebo from the beginning to the end of the randomized withdrawal period was −1.4 mg/dl (P<0.0001); in the ITT analysis set (n=243), the estimated mean difference was −0.7 mg/dl (P=0.002). Loose stools were the most frequently reported adverse event (53% during the randomized treatment period). Serious adverse events were reported more frequently for participants treated with sevelamer carbonate (16-23% across the three study periods) compared with tenapanor (11-17%). Conclusions: Tenapanor reduced serum phosphorus concentrations and maintained control of serum phosphorus in participants receiving maintenance dialysis, with an acceptable safety and tolerability profile.

Disclosures: G.A.B. is a Director for Ardelyx, Inc. and is the Associate Chief Medical Officer for US Renal Care, Inc. Anthony J. Bleyer has no affiliation with Ardelyx, Inc. aside from his role as Principal Investigator in the PHREEDOM study. A.L.S. receives research funding from Ardelyx, Inc. D.E.W. is the Medical Director of Clinical Research for Dialysis Clinic, Inc., with support paid to his institution by DCI; he has consulted for Akemia, Cara Therapeutics, Janssen Biopharmaceuticals, and Tricida and has no affiliation with or funding from Ardelyx, Inc., aside from his role as site Principal Investigator in several tenapanor trials. R.I.L. has no affiliation with Ardelyx, Inc. aside from his role as Principal Investigator in the PHREEDOM and NORMALIZE studies. D.P.R. is an employee of and has ownership interest in, Ardelyx, Inc. Y.Y. is an employee of Ardelyx, Inc. G.M.C. is a consultant to and has equity ownership interest in Ardelyx, Inc.

Funding: Ardelyx

Author Contributions: Geoffrey Block: Conceptualization; Formal analysis; Investigation; Methodology; Writing - review and editing Anthony Bleyer: Conceptualization; Investigation; Writing - review and editing Arnold Silva: Conceptualization; Investigation; Writing - review and editing

Copyright 2021 by American Society of Nephrology.
Clinical Trials Registration: Yes

Registration Number: NCT03427125

Registration Date: 09-Feb-2018

How to Cite this article: Geoffrey Block, Anthony Bleyer, Arnold Silva, Daniel Weiner, Robert Lynn, Yang Yang, David Rosenbaum, and Glenn Chertow, Safety and Efficacy of Tenapanor for Long-term Serum Phosphorus Control in Maintenance Dialysis: A 52-Week Randomized Phase 3 Trial (PHREEDOM), Kidney360, Publish Ahead of Print, 10.34067/KID.0002002021
Safety and Efficacy of Tenapanor for Long-term Serum Phosphorus Control in Maintenance Dialysis: A 52-Week Randomized Phase 3 Trial (PHREEDOM)

Geoffrey A. Block, Anthony J. Bleyer, Arnold L. Silva, Daniel E. Weiner, Robert I. Lynn, Yang Yang, David P. Rosenbaum, and Glenn M. Chertow

1US Renal Care, Inc., Plano, TX, USA; 2Section on Nephrology, Wake Forest School of Medicine, Winston-Salem, NC, USA; 3Boise Kidney and Hypertension Institute, Meridian, ID, USA; 4Division of Nephrology, Tufts Medical Center, Boston, MA, USA; 5Department of Medicine, Albert Einstein College of Medicine, New York, NY, USA; 6Kidney Medical Associates, New York, NY, USA; 7Ardelyx, Inc., Fremont, CA, USA; 8Division of Nephrology, Stanford University School of Medicine, Stanford, CA, USA

Correspondence: Dr Geoffrey A. Block, US Renal Care, Inc., 5851 Legacy Circle, Suite 900, Plano, TX 75024, USA. Email: geoff.block@usrenalcare.com
KEY POINTS

- Tenapanor is a first-in class inhibitor of NHE3 and acts via a non-phosphate binding mechanism to reduce intestinal phosphate absorption
- In the efficacy analysis set, patients randomized to tenapanor experienced a decrease in serum phosphorus from 7.7 mg/dL to 5.1 mg/dL.
- Diarrhea was the only drug related AE reported for more than 5% of patients and resulted in drug discontinuation in 16% of patients.

ABSTRACT

Background Treating hyperphosphatemia is a tenet of dialysis care. This trial assessed the safety and efficacy of tenapanor for the management of hyperphosphatemia.

Methods In this 52-week phase 3 study (NCT03427125), participants receiving maintenance dialysis with both hyperphosphatemia (serum phosphorus 6.0–10.0 mg/dl) and a 1.5 mg/dl increase following phosphate binder washout were randomized (3:1) to tenapanor 30 mg twice daily for 26 weeks (randomized treatment period) or sevelamer carbonate (52-week safety control). Participants completing 26 weeks' treatment with tenapanor were re-randomized (1:1) to tenapanor or placebo for 12 weeks (randomized withdrawal period) and were eligible to enter the 14-week safety extension period. With input from the US Food and Drug Administration, the primary efficacy endpoint was the difference in the change in serum phosphorus from the end of the randomized treatment period to the end of the randomized withdrawal period among participants who achieved ≥1.2 mg/dl decrease in serum phosphorus during the randomized treatment period (efficacy analysis set). Efficacy was also evaluated in the intention-to-treat (ITT) analysis set.

Results Of 564 eligible participants randomized to receive tenapanor (n=423) or sevelamer carbonate (n=141) during the randomized treatment period, 255 (60%) in the tenapanor group subsequently were re-randomized to tenapanor (n=128) or placebo (n=127) during the randomized withdrawal period. In the efficacy analysis set (n=131), the difference in estimated mean change in serum phosphorus level between tenapanor and placebo from the beginning to the end of the randomized withdrawal period was −1.4 mg/dl (P<0.0001); in the ITT analysis set (n=243), the estimated mean difference was −0.7 mg/dl (P=0.002).
Loosened stools were the most frequently reported adverse event (53% during the randomized treatment period). Serious adverse events were reported more frequently for participants treated with sevelamer carbonate (16–23% across the three study periods) compared with tenapanor (11–17%).

**Conclusions** Tenapanor reduced serum phosphorus concentrations and maintained control of serum phosphorus in participants receiving maintenance dialysis, with an acceptable safety and tolerability profile.
INTRODUCTION

Hyperphosphatemia is a common complication observed among patients receiving maintenance dialysis, and is associated with dystrophic calcification (affecting vasculature and heart valves), fractures, cardiovascular mortality and all-cause mortality (1-3). Current approaches to hyperphosphatemia management – increasing hemodialysis session length or frequency, dietary phosphate restriction and phosphate binder therapy – are difficult to implement (4-7). Phosphate binder therapy is associated with poor gastrointestinal (GI) tolerability, frequent dosing and a high pill burden (2,8). Adherence to a nutritionally-appropriate diet with reduced phosphate content is challenging, owing in part to the absence of total phosphate content on food labels (5,6). Despite best efforts, the majority of patients receiving dialysis are unable to consistently achieve target serum phosphorus concentrations (4).

Tenapanor is a first-in-class phosphate absorption inhibitor. Whereas phosphate binders act by binding dietary phosphate to form insoluble complexes that pass through the GI tract, tenapanor blocks paracellular absorption of phosphate in the GI tract through local inhibition of the intestinal sodium–hydrogen exchanger 3 (NHE3) (9,10).

Inhibition of NHE3 transiently increases the intracellular proton concentration of cells lining the GI lumen and is proposed to induce a conformational change in tight junction proteins that reduces permeability specific to paracellular phosphate transport (9). The reduction in serum phosphorus concentration that can result from targeted inhibition of paracellular phosphate transport is not available with current treatment options (9,11,12). Recent work has highlighted the potential of targeting this pathway to improve control of hyperphosphatemia (13-15).

In previous 4-week phase 2 and 8-week phase 3 studies, tenapanor significantly lowered serum phosphorus concentration in participants receiving maintenance dialysis (16-18). Here we report on the safety and efficacy of tenapanor when used for up to 52 weeks for the management of hyperphosphatemia in participants receiving maintenance dialysis.
MATERIALS AND METHODS

Study Design

PHREEDOM (ClinicalTrials.gov identifier: NCT03427125) was a multicenter, phase 3 trial comprised of three periods: a 26-week open-label randomized treatment period, a 12-week double-blind placebo-controlled randomized withdrawal period and a 14-week open-label safety extension period (Figure 1). We enrolled participants from 104 centers in the United States, starting in January 2018; the trial was completed in February 2020. Patients with a serum phosphorus 4.0–8.0 mg/dl (inclusive) at the screening visit were eligible to enter the phosphate binder washout period of up to 4 weeks in duration. Patients whose serum phosphorus had increased by ≥1.5 mg/dl during this period and who had a measured serum phosphorus ≥6.0 mg/dl and <10.0 mg/dl at the end of the washout period were randomly assigned (3:1) to receive either tenapanor at a starting dose of 30 mg orally twice daily for 26 weeks (randomized treatment period) or sevelamer carbonate (based on standard of care) for 52 weeks. At the end of the randomized treatment period, we re-randomized (1:1) participants who completed the 26-week treatment with tenapanor to either continue to receive tenapanor treatment at the same dose or switch to placebo for 12 weeks (randomized withdrawal period). Upon completion or discontinuation from the randomized withdrawal period, all re-randomized participants were eligible to enter a 14-week safety extension period wherein tenapanor treatment was provided.

To compare the rates of serious adverse events among the high-risk population enrolled in the study, we followed participants taking open-label sevelamer for the 52-week study as a control group for safety comparison only. Efficacy data are not presented for this group, because these participants received sevelamer as ‘standard of care’. The US Food and Drug Administration (FDA) package insert was used for guidance on starting dose and dose adjustment. Sevelamer could be titrated up or down as needed; there was no upper dose limit specified in the protocol. In accordance with community standard of care, the protocol guidance recommended targeting a serum phosphorus concentration <5.5 mg/dl in
both treatment arms. The use of phosphate binders to treat hyperphosphatemia (other than sevelamer used in the safety control group) was prohibited.

For participants assigned to receive tenapanor, titration was permitted during the randomized treatment period and safety extension period. Investigators were permitted to titrate the tenapanor dose in 10 mg increments down to a minimum of 10 mg twice daily or to increase tenapanor to a maximum dose of 30 mg twice daily, based on serum phosphorus concentration and GI tolerability. Participants receiving tenapanor or placebo were withdrawn from the study based on predefined serum phosphorus: ≤2.5 mg/dl at any time; ≥10.0 mg/dl at any time after week 2 of the randomized treatment period; ≥9.0 mg/dl for two consecutive visits during the randomized treatment period or safety extension period; or ≥9.0 mg/dl during the randomized withdrawal period. Because sevelamer is standard of care, no specific discontinuation criteria were included in the protocol for this arm; however, reasons for discontinuation were recorded for all participants.

The trial was conducted in accordance with the Declaration of Helsinki. All participants provided written informed consent before trial entry. All participating sites obtained independent Ethics Committee/Institutional Review Board approval.

Participants

Full inclusion and exclusion criteria used in this trial are listed in Supplemental Information 1. Men and women aged 18 years or older were eligible for randomization if they had received maintenance hemodialysis three times weekly for ≥90 days with a per-session Kt/V_urea of ≥1.2 within 30 days before screening or had received maintenance peritoneal dialysis for at least 6 months; were taking phosphate binders at least three times daily with stable dosing during the 3 weeks before screening; and had a serum phosphorus 4.0–8.0 mg/dl inclusive, at either screening or re-screening. Participants may have been re-screened after a minimum of 1 week if serum phosphorus concentrations at screening were
outside of the inclusion range and the participant had historical serum phosphorus
>4.5 mg/dl and <7.5 mg/dl during the 2 months immediately before the screening date.

Key exclusion criteria were serum phosphorus >10.0 mg/dl while receiving
phosphate binders at any time point during the 3 months preceding the screening visit; intact
parathyroid hormone (PTH) concentration exceeding 1200 pg/ml; clinical signs of
hypovolemia at enrollment; or a history of inflammatory bowel disease/irritable bowel
syndrome with diarrhea.

Analysis Sets

Two sets of analyses were defined for each of the three study periods: the safety
analysis set, which included all participants who received at least one dose of the study drug
for that study period, and the intention-to-treat (ITT) analysis set, which included all
participants who met the enrollment criteria, received at least one dose of tenapanor and/or
placebo, and had at least one post-treatment serum phosphorus measurement for that study
period. Participants assigned to the sevelamer (safety control) group were not included in
the ITT analysis set for any study period; no prospective efficacy analyses were performed
comparing tenapanor and sevelamer. The 52-week treatment period for participants
receiving sevelamer was split into three study periods (treatment, withdrawal, and safety
extension) to facilitate a safety comparison with participants treated with tenapanor and/or
placebo during the corresponding study periods.

Additionally, a predefined efficacy analysis set was evaluated exclusively during the
randomized withdrawal period. The efficacy analysis set was a subset of participants from
the ITT analysis set of the randomized withdrawal period who had also received at least one
dose of tenapanor during the randomized treatment period, completed the randomized
treatment period, and achieved a reduction of ≥1.2 mg/dl in serum phosphorus from baseline
to the end of the randomized treatment period.
Efficacy Endpoints and Assessments

With input from the regulatory authority (US FDA), the primary efficacy endpoint, which was evaluated for the efficacy analysis set in the primary analysis, was the difference in the change in serum phosphorus from period-specific baseline to the end of the randomized withdrawal period between the pooled tenapanor group (all doses combined; hereafter ‘tenapanor group’) and placebo group. In each study period, the period-specific baseline was defined as the last measurement collected before the first dose of study drug during that study period. Serum phosphorus concentration was measured at each scheduled visit (Supplemental Table 1).

Secondary endpoints assessed included: change in serum phosphorus concentration from period-specific baseline at each post-baseline visit, and relative change from period-specific baseline in intact fibroblast growth factor 23 (iFGF23) and C-terminal FGF23 (cFGF23) at each post-baseline visit (where relative change was defined as the ratio of post-baseline value to period-specific baseline value − 1).

Safety Outcomes and Assessments

Safety assessments were based on reported adverse events (AEs), clinical laboratory tests, vital signs, electrocardiograms, and physical examinations. For analysis purposes, AE reports with the recorded start date before baseline were treated as medical history events. Only treatment-emergent AEs were included for AE summaries in this study; all AEs described herein are treatment-emergent AEs. Drug-related AEs were those that had been judged by the investigator as related or possibly related to study drug.

AEs were coded to system organ class and preferred term using the Medical Dictionary for Regulatory Activities (MedDRA; v21.0).
Statistical Methods

For the primary analysis of the primary efficacy endpoint, we performed a treatment comparison of the mean change in serum phosphorus concentration from period-specific baseline to the end of the randomized withdrawal period using an analysis of covariance (ANCOVA), with treatment and geographic region as factors and period-specific baseline value as a covariate on the efficacy analysis set. Assuming a common standard deviation of 1.6 mg/dl, a sample size of 146 participants (73 participants/group) was expected to provide 96% power to detect a treatment difference of 1.0 mg/dl in the primary efficacy endpoint between the pooled tenapanor and placebo groups using a two-sided t-test at the 0.05 significance level.

To control the overall Type I error rate at the 0.05 level, key secondary analyses of efficacy were performed in a hierarchical manner after the primary analysis on the efficacy analysis set met statistical significance as follows: a treatment comparison between tenapanor and placebo groups using ANCOVA on the ITT analysis set, then comparisons between individual doses of tenapanor (for dose groups with ≥15 participants) and placebo groups on the efficacy analysis set, followed by comparisons for individual doses of tenapanor on the ITT analysis set.

Statistical methods for the subgroup analysis and analysis of secondary endpoints are described in Supplemental Information 2.

We performed all data summaries and inferential analyses using SAS® version 9.4. We described all safety measures by treatment received and for the entire safety analysis set; we did not perform inference testing on safety measures.

RESULTS

Participants

Of 1559 patients screened, 564 individuals met enrollment criteria and were randomly assigned into the 26-week randomized treatment period (Figure 2). There were
423 participants assigned to receive tenapanor, of whom 256 (61%) completed the randomized treatment period. Of 141 participants assigned to receive sevelamer, 117 (83%) completed 26 weeks of treatment. A total of 310 participants completed the 12-week randomized withdrawal period (83% of the 372 participants who entered the period): 112 (96%) participants in the sevelamer group, 99 (78%) participants in the placebo group, and 99 (77%) participants in the tenapanor group. Overall, 334 participants entered the safety extension period, which was completed by 205 (92%) participants in the tenapanor group and 109 (97%) participants in the sevelamer group. Participant baseline characteristics were well balanced between treatment groups in the safety analysis set for each of the three study periods (Table 1). There was a serious breach of Good Clinical Practice identified at one site involved with the study (Supplemental Information 3); participants associated with this site were excluded from all analysis sets.

Mean treatment adherence was greater than 78% for all treatment groups within each study period. For the efficacy analysis set, the fixed tenapanor dose administered during the randomized withdrawal period (and the final tenapanor dose of the randomized treatment period) was 30 mg twice daily for 75 (57%) participants, 20 mg twice daily for 39 (30%) participants and 10 mg twice daily for 17 (13%) participants, with a mean value of 24.4 mg twice daily. For the safety control group, the median starting dose of sevelamer was 4800 grams (6 tablets) daily and median final dose at 52 weeks was 7200 grams (9 tablets) daily.

**Study Assessments**

*Randomized treatment period*

For the ITT analysis set which comprised 407 participants randomized to tenapanor, the mean serum phosphorus decreased from 7.4 mg/dl at period-specific baseline to 5.9 mg/dl at Week 26 (n=248), with a mean (standard deviation) decrease of 1.4 (1.8) mg/dl (Figure 3A). Among the ITT analysis set, 131 participants achieved a reduction of ≥1.2 mg/dl
in serum phosphorus from baseline at Week 26 and continued into the randomized withdrawal period; in this subset of participants, mean serum phosphorus decreased from 7.7 mg/dl at period-specific baseline to 5.2 mg/dl at Week 26 (n=127), with a mean (standard deviation) decrease of 2.5 (1.2) mg/dl (Figure 3B). From period-specific baseline, there were median relative reductions of 23% for iFGF23 and 14% for cFGF23 at the end of the randomized treatment period for participants randomized to tenapanor (ITT analysis set; Supplemental Figure 1A).

Although the trial design did not allow for direct comparison of the efficacy of phosphate lowering between the tenapanor and sevelamer safety control groups, a post hoc analysis demonstrated that the distribution of change in serum phosphorus at the end of the randomized treatment period was nearly identical between participants in the ITT analysis set who received tenapanor for the entire 52-week study (n=88) and those who received sevelamer (n=108) (Supplemental Figure 2).

**Randomized withdrawal period**

In the efficacy analysis set (n=131), the least squares (LS) mean change in serum phosphorus from period-specific baseline to the end of the randomized withdrawal period was 0.4 mg/dl for the tenapanor group and 1.8 mg/dl for the placebo group (primary efficacy endpoint; LS mean difference −1.4 mg/dl; P<0.0001; Figure 4A). In the ITT analysis set (n=243), the least squares (LS) mean change in serum phosphorus from period-specific baseline at the end of the randomized withdrawal period was 0.2 mg/dl for the tenapanor group and 0.9 mg/dl for the placebo group (primary efficacy endpoint; LS mean difference −0.7 mg/dl; P=0.002). At all post-baseline visits during the randomized withdrawal period, there was a statistically significant difference between tenapanor and placebo, both for the efficacy analysis set (P values <0.001; Figure 4A) and ITT analysis set (P values ≤0.0023; Figure 4B). There were also more pronounced mean reductions in serum phosphorus concentration compared with placebo at all doses of tenapanor and in all subgroups (Supplemental Figure 3, Supplemental Table 2). The treatment comparison of the log-
transformed relative change in iFGF23 and cFGF23 was statistically significant at each post-baseline visit measured in the randomized withdrawal period (efficacy analysis set; Supplemental Figures 1B and 1C). From period-specific baseline to the end of the randomized withdrawal period, there were median relative reductions of 19% for iFGF23 and 15% for cFGF23 for participants randomized to tenapanor (ITT analysis set).

Safety Assessments

Table 2 provides a summary of the AEs for the safety analysis sets during the three study periods. For participants treated with tenapanor, the incidence of AEs during the randomized treatment period (80%) occurred at a higher rate than during the randomized withdrawal period (46%) and the safety extension period (46%). AEs that resulted in discontinuation of tenapanor treatment were reported for 102 participants (24%) during the randomized treatment period, 11 participants (9%) during the randomized withdrawal period and three participants (1%) during the safety extension period. Seventeen participants (13%) receiving placebo discontinued study treatment owing to an AE during the randomized withdrawal period.

Diarrhea (per MedDRA preferred term, vide supra) was the only drug-related AE reported for more than 5% of participants. Drug-related diarrhea in participants receiving tenapanor resulted in study drug discontinuation for 67 (16%) participants during the randomized treatment period and for one (1%) participant during the randomized withdrawal period. Diarrhea related to tenapanor was generally reported as mild–moderate in severity; of the participants in the safety analysis set, 26 (6%) experienced severe drug-related diarrhea. Participants typically experienced their first diarrhea event within the first 2 weeks of tenapanor treatment, and the event resolved within approximately 2 weeks. The incidence of diarrhea in the tenapanor group in the second half of the randomized treatment period was similar to that reported for the sevelamer group (Supplemental Table 3). Of the participants who received tenapanor during the randomized treatment period, 43 (10%) were taking loperamide, six (1%) were taking probiotics and three (1%) were taking bismuth
preparations. Anti-diarrheal agents were not prescribed in a systematic manner. There were no reports of constipation from participants receiving tenapanor in the first half of the randomized treatment period; two (0.5%) participants reported constipation in the second half.

Serious AEs (SAEs) were reported more frequently for participants treated with sevelamer (16–23% across all study periods) compared with tenapanor (11–17%) (Table 3). Drug-related SAEs were reported for three (1%) participants receiving tenapanor during the randomized treatment period. During the study, five participants randomized to receive sevelamer and 13 participants randomized to receive tenapanor died (including one participant who died during the randomized withdrawal period after receiving placebo); consistent with the 3:1 randomization of participants. Of the 18 deaths reported during the study, only two deaths were caused by treatment-emergent medical conditions: one participant in the tenapanor group died of respiratory failure during the randomized treatment period and one participant in the sevelamer group who died of cardiorespiratory arrest during the randomized withdrawal period. None of the deaths were deemed to be drug-related.

There were no significant differences in electrocardiographic parameters, vital signs and physical examination between treatment groups during the trial. Similarly, no clinically significant differences between groups were found in the evaluation of key laboratory parameters, including serum bicarbonate, potassium, magnesium and sodium concentrations (Supplemental Table 4). Changes in median levels of PTH were generally similar between groups; notably, meaningful changes in median PTH were observed in the subset of participants with high PTH (≥600 ng/l) at the start of PHREEDOM (Supplemental Table 5).

**DISCUSSION**

In this phase 3 study enrolling patients receiving maintenance dialysis with hyperphosphatemia, the primary endpoint was achieved; treatment with tenapanor resulted
in a statistically significant decrease in serum phosphorus during the randomized withdrawal period (difference of \(-1.4\) mg/dl vs placebo; \(P<0.0001\)). Additionally, during the initial 6-month randomized treatment period, mean serum phosphorus was reduced by 1.4 mg/dl in the tenapanor group. Overall, these results were consistent with a previous study comprised of an 8-week randomized treatment period and 4-week randomized withdrawal period (17). Relative reductions in FGF23 concentrations with tenapanor were consistent with a previous 4-week phase 2 study (18) and two other phase 3 studies (17,19).

Although complex, the study design enabled investigation of several key aspects. The 26-week treatment period that preceded the placebo-controlled period could assess for diminishing response to tenapanor over time, a placebo control was not deemed ethical for the entire study period, the use of a safety control could help to assess safety issues given the high frequency of hospitalization among this patient population, and 52 weeks of total exposure to tenapanor could establish its long-term safety profile.

Results from this study support an acceptable tolerability profile for tenapanor. MedDRA classifies any report of “bothersome” loose stool(s), loose bowels and/or mushy stool(s) as “diarrhea” events, whether or not there was a reported increase in stool frequency, and incidence of MedDRA-classified diarrhea was generally consistent with previous studies of tenapanor (16-18,20,21). This side effect is anticipated, as tenapanor inhibits NHE3, which in addition to reducing paracellular phosphate absorption in the GI tract, reduces dietary sodium absorption and increases the sodium and water content of stools, softening stools and increasing bowel movement frequency (9,10). Rates of drug discontinuation because of loosened stools declined over time, suggesting that participants either became accustomed to the change in stool form or frequency (previously estimated as three additional stools per week (17)) or that tolerability manifested early in the treatment course. Although reported as an AE in accordance with trial conduct, softer stools induced by tenapanor via its known mechanism of action and primary pharmacology of inhibition of sodium absorption could be beneficial in this population. Indeed, tenapanor is currently
approved for use by FDA in irritable bowel syndrome with constipation (22). A sizeable proportion of patients treated with dialysis experience constipation (23); among patients receiving peritoneal dialysis, constipation can be particularly troublesome, as colonic distension with stool can impair dialysate inflow and drainage and can contribute to modality failure (23,24).

Limitations of the trial should be acknowledged. Data suggest that tenapanor and phosphate binder therapy could assume complementary roles in hyperphosphatemia management (19,25); however, we did not include a treatment arm in which participants received dual treatment with tenapanor and sevelamer. Furthermore, the trial was largely nonblinded. Participants who discontinued tenapanor during the randomized treatment period were not included in subsequent study periods; thus, the randomized withdrawal and safety extension periods may have been enriched for individuals who were better able to tolerate tenapanor. Another limitation was that insufficient data were collected on the change in dose of concomitant medications that are known to affect serum phosphorus (eg, active vitamin D analogs, calcimimetics). There were several strengths. PHREEDOM is the longest study to date of tenapanor to treat hyperphosphatemia in patients on dialysis, and all recruitment targets were met. The population was diverse in age, sex, self-reported race, ethnicity, and underlying cause of kidney failure; moreover, patients receiving peritoneal dialysis as well as hemodialysis were included, adding to the robustness and generalizability of the results.

In conclusion, the PHREEDOM trial confirms and extends evidence derived from other shorter-term randomized controlled trials, demonstrating the tolerability and efficacy of tenapanor for hyperphosphatemia in patients receiving maintenance dialysis.

Disclosures
G.A.B. is a Director for Ardelyx, Inc. and is the Associate Chief Medical Officer for US Renal Care, Inc. Anthony J. Bleyer has no affiliation with Ardelyx, Inc. aside from his role as
Principal Investigator in the PHREEDOM study. A.L.S. receives research funding from Ardelyx, Inc. D.E.W. is the Medical Director of Clinical Research for Dialysis Clinic, Inc., with support paid to his institution by DCI; he has consulted for Akebia, Cara Therapeutics, Janssen Biopharmaceuticals and Tricida and has no affiliation with or funding from Ardelyx, Inc., aside from his role as site Principal Investigator in several tenapanor trials. R.I.L. has no affiliation with Ardelyx, Inc. aside from his role as Principal Investigator in the PHREEDOM and NORMALIZE studies. D.P.R. is an employee of, and has ownership interest in, Ardelyx, Inc. Y.Y. is an employee of Ardelyx, Inc. G.M.C. is a consultant to and has equity ownership interest in Ardelyx, Inc.

Funding
This study was funded by Ardelyx, Inc.

Acknowledgments
Ardelyx was the sponsor of the trial. We thank all the participants and investigators involved. Medical writing support was provided by Svetha Sankar BSc BVMS and Steven Inglis PhD of Oxford PharmaGenesis and was funded by Ardelyx.

Individual deidentified participant data and additional study-related documents will not be available.

Author Contributions
Geoffrey Block: Conceptualization; Formal analysis; Investigation; Methodology; Writing - review and editing
Anthony Bleyer: Conceptualization; Investigation; Writing - review and editing
Arnold Silva: Conceptualization; Investigation; Writing - review and editing
Daniel Weiner: Conceptualization; Investigation; Writing - review and editing
Robert Lynn: Conceptualization; Investigation; Writing - review and editing
Yang Yang: Data curation; Formal analysis; Writing - review and editing
David Rosenbaum: Conceptualization; Methodology; Resources; Writing - review and editing
Glenn Chertow: Conceptualization; Investigation; Writing - review and editing
Supplemental Material

Supplemental Information 1. Selection of trial population
Supplemental Information 2. Statistical methods for secondary endpoints and subgroup analysis
Supplemental Information 3. Breach of Good Clinical Practice
Supplemental Figure 1. Change in FGF23 concentrations over (A) the 26-week RTP and (B, C) the RWP.
Supplemental Figure 2. Cumulative distribution function of change in serum phosphorus (mg/dl) at end of the randomized treatment period for participants in the ITT analysis set that received tenapanor continuously (blue) or sevelamer (black) throughout the 52-week study.
Supplemental Figure 3. LS mean difference in change in serum phosphorus (mg/dl) from baseline at end of the randomized withdrawal period for (A) the EAS and subgroups and (B) the ITT analysis set and subgroups.
Supplemental Table 1. Schedule of visits in study
Supplemental Table 2. Analysis of change from period-specific baseline in serum phosphorus concentration (mg/dl) by dose group at end of the randomized withdrawal period for the (A) EAS and (B) ITT analysis set
Supplemental Table 3. Summary of AEs during the 26-week randomized treatment period split by 13-week periods (safety analysis set)
Supplemental Table 4. Summary of changes in clinically important laboratory parameters across study periods (safety analysis set)
Supplemental Table 5. Summary of changes in PTH (safety analysis set)
REFERENCES

   10.1053/j.jrn.2020.02.003


   10.1093/ndt/gfn613


   10.2147/ppa.S145648

   10.1002/14651858.CD006023.pub3


   10.1126/scitranslmed.aam6474

    10.1126/scitranslmed.3007790


22. Ibsrela (tenapanor) tablets [prescribing information]. Freemont, CA, Ardelyx, Inc., 2019
Table 1. Participant demographics and baseline characteristics (safety analysis set)

<table>
<thead>
<tr>
<th>Demographic/Characteristic</th>
<th>26-week randomized treatment period</th>
<th>12-week randomized withdrawal period</th>
<th>14-week safety extension period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SC, n=137</td>
<td>TEN, n=419</td>
<td>TOTAL, N=556</td>
</tr>
<tr>
<td>Age, years</td>
<td>59 (13)</td>
<td>58 (13)</td>
<td>58 (13)</td>
</tr>
<tr>
<td></td>
<td>SC, n=116</td>
<td>PBO, n=126</td>
<td>TEN, n=125</td>
</tr>
<tr>
<td>Male, n (%)</td>
<td>91 (66)</td>
<td>75 (65)</td>
<td>72 (57)</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>60 (52)</td>
<td>49 (39)</td>
</tr>
<tr>
<td>Race, n (%)</td>
<td>70 (51)</td>
<td>60 (52)</td>
<td>49 (39)</td>
</tr>
<tr>
<td>Black or African American</td>
<td>60 (44)</td>
<td>50 (43)</td>
<td>68 (54)</td>
</tr>
<tr>
<td>Othera</td>
<td>7 (5)</td>
<td>6 (5)</td>
<td>9 (7)</td>
</tr>
<tr>
<td>Ethnicity, n (%)</td>
<td>Hispanic or Latino</td>
<td>41 (30)</td>
<td>32 (28)</td>
</tr>
<tr>
<td>Otherb</td>
<td>96 (70)</td>
<td>84 (72)</td>
<td>96 (76)</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>31.4 (9.9)</td>
<td>31.3 (7.5)</td>
<td>31.3 (8.2)</td>
</tr>
<tr>
<td>Duration of ESRD, years</td>
<td>5.1 (5.1)</td>
<td>5.3 (5.3)</td>
<td>4.6 (4.5)</td>
</tr>
<tr>
<td>Hemodialysis, n (%)</td>
<td>122 (89)</td>
<td>102 (88)</td>
<td>116 (92)</td>
</tr>
<tr>
<td>Demographic/Characteristic</td>
<td>26-week randomized treatment period</td>
<td>12-week randomized withdrawal period</td>
<td>14-week safety extension period</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>------------------------------------</td>
<td>-------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td></td>
<td>SC, n=137</td>
<td>TEN, n=419</td>
<td>TOTAL, N=556</td>
</tr>
<tr>
<td>Demographic/Characteristic</td>
<td>SC, n=116</td>
<td>PBO, n=126</td>
<td>TEN, n=125</td>
</tr>
<tr>
<td>Duration of dialysis treatment, months</td>
<td>59.2 (57.5)</td>
<td>61.2 (59.1)</td>
<td>53.6 (50.1)</td>
</tr>
<tr>
<td></td>
<td>54.2 (51.0)</td>
<td>49.4 (47.0)</td>
<td>54.6 (52.2)</td>
</tr>
<tr>
<td></td>
<td>55.5 (52.7)</td>
<td>53.6 (50.1)</td>
<td>54.6 (52.2)</td>
</tr>
<tr>
<td>Baseline s-P (mg/dl)</td>
<td>7.2 (1.5)</td>
<td>7.3 (1.5)</td>
<td>7.2 (1.5)</td>
</tr>
<tr>
<td></td>
<td>7.4 (1.4)</td>
<td>7.2 (1.5)</td>
<td>7.3 (1.3)</td>
</tr>
<tr>
<td></td>
<td>7.4 (1.4)</td>
<td>7.3 (1.5)</td>
<td>7.2 (1.4)</td>
</tr>
<tr>
<td>Baseline iFGF23 (pg/ml)</td>
<td>11,467.0 (14,054.7)</td>
<td>11,891.8 (14,516.5)</td>
<td>11,460.0 (15,026.4)</td>
</tr>
<tr>
<td></td>
<td>12,316.4 (14,772.9)</td>
<td>12,107.1 (14,591.3)</td>
<td>9556.0 (13,391.0)</td>
</tr>
<tr>
<td></td>
<td>12,078.5 (14,772.9)</td>
<td>11,891.8 (14,516.5)</td>
<td>10,948.0 (14,321.8)</td>
</tr>
<tr>
<td>Baseline cFGF23 (RU/ml)</td>
<td>17,057.8 (20,616.4)</td>
<td>17,702.3 (21,422.6)</td>
<td>16,882.8 (22,235.6)</td>
</tr>
<tr>
<td></td>
<td>17,048.5 (20,567.5)</td>
<td>17,050.8 (20,561.0)</td>
<td>16,882.8 (22,235.6)</td>
</tr>
<tr>
<td></td>
<td>17,050.8 (20,567.5)</td>
<td>17,702.3 (21,422.6)</td>
<td>16,882.8 (22,235.6)</td>
</tr>
<tr>
<td>Baseline PTH (pg/ml)</td>
<td>402.0 (255.0)</td>
<td>398.8 (251.2)</td>
<td>445.3 (242.3)</td>
</tr>
<tr>
<td></td>
<td>421.4 (252.2)</td>
<td>416.6 (252.8)</td>
<td>445.3 (242.3)</td>
</tr>
<tr>
<td></td>
<td>416.6 (252.8)</td>
<td>398.8 (251.2)</td>
<td>445.3 (242.3)</td>
</tr>
<tr>
<td>Baseline Ca (mg/dl)</td>
<td>8.4 (0.8)</td>
<td>8.3 (0.8)</td>
<td>8.2 (0.8)</td>
</tr>
<tr>
<td></td>
<td>8.4 (0.8)</td>
<td>8.3 (0.8)</td>
<td>8.2 (0.8)</td>
</tr>
<tr>
<td></td>
<td>8.4 (0.8)</td>
<td>8.3 (0.8)</td>
<td>8.2 (0.8)</td>
</tr>
<tr>
<td></td>
<td>8.4 (0.8)</td>
<td>8.3 (0.8)</td>
<td>8.2 (0.8)</td>
</tr>
<tr>
<td>Concomitant calcimimetic, n (%)</td>
<td>18 (13)</td>
<td>10 (9)</td>
<td>17 (13)</td>
</tr>
<tr>
<td></td>
<td>41 (10)</td>
<td>17 (13)</td>
<td>4 (3)</td>
</tr>
<tr>
<td></td>
<td>59 (11)</td>
<td>10 (9)</td>
<td>17 (13)</td>
</tr>
<tr>
<td></td>
<td>59 (11)</td>
<td>10 (9)</td>
<td>17 (13)</td>
</tr>
<tr>
<td>Concomitant vitamin D and analogues, n (%)</td>
<td>27 (20)</td>
<td>17 (15)</td>
<td>18 (14)</td>
</tr>
<tr>
<td></td>
<td>53 (13)</td>
<td>18 (14)</td>
<td>18 (14)</td>
</tr>
<tr>
<td></td>
<td>80 (14)</td>
<td>17 (15)</td>
<td>18 (14)</td>
</tr>
<tr>
<td></td>
<td>27 (20)</td>
<td>17 (15)</td>
<td>18 (14)</td>
</tr>
<tr>
<td>Demographic/Characteristic</td>
<td>26-week randomized treatment period</td>
<td>12-week randomized withdrawal period</td>
<td>14-week safety extension period</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------</td>
<td>--------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td></td>
<td>SC, n=137</td>
<td>TEN, n=419</td>
<td>TOTAL, N=556</td>
</tr>
<tr>
<td>Concomitant calcium supplements, n (%)</td>
<td>5 (4)</td>
<td>2 (0.5)</td>
<td>7 (1)</td>
</tr>
<tr>
<td></td>
<td>SC, n=116</td>
<td>PBO, n=126</td>
<td>TEN, n=125</td>
</tr>
<tr>
<td></td>
<td>3 (3)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td></td>
<td>SC, n=110</td>
<td>TEN, n=220</td>
<td>TOTAL, N=330</td>
</tr>
<tr>
<td></td>
<td>1 (0.9)</td>
<td>0 (0.0)</td>
<td>1 (0.3)</td>
</tr>
</tbody>
</table>

Unless otherwise indicated, data are mean (SD). Baseline was defined as the last measurement collected before the first dose of study drug in the study. BMI, body mass index; cFGF23, C-terminal fibroblast growth factor 23; ESRD, end-stage renal disease; iFGF23, intact fibroblast growth factor 23; PBO, placebo; PTH, parathyroid hormone; SC, sevelamer carbonate; SD, standard deviation; s-P, serum phosphorus; TEN, tenapanor.

\(^a\)Includes Asian, Native American or Alaskan, Native Hawaiian or Pacific Islander, and other.

\(^b\)Includes ‘Not Hispanic or Latino’, not reported, and unknown.
Table 2. Overview of AEs (safety analysis set)

<table>
<thead>
<tr>
<th></th>
<th>26-week randomized treatment period</th>
<th>12-week randomized withdrawal period</th>
<th>14-week safety extension period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TEN, ( n=419 )</td>
<td>PBO, ( n=126 )</td>
<td>TEN, ( n=125 )</td>
</tr>
<tr>
<td>Participants with any AE</td>
<td>337 (80)</td>
<td>70 (56)</td>
<td>58 (46)</td>
</tr>
<tr>
<td>Participants with any AE related to study drug</td>
<td>244 (58)</td>
<td>17 (13)</td>
<td>12 (10)</td>
</tr>
<tr>
<td>Participants with any drug-related serious AE</td>
<td>3 (1)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Participants with any drug-related AE leading to study drug discontinuation</td>
<td>102 (24)</td>
<td>17 (13)</td>
<td>11 (9)</td>
</tr>
<tr>
<td>Participants with any AE leading to study drug discontinuation</td>
<td>88 (21)</td>
<td>10 (8)</td>
<td>5 (4)</td>
</tr>
<tr>
<td>AEs by preferred term(^a)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>222 (53)</td>
<td>2 (2)</td>
<td>5 (4)</td>
</tr>
<tr>
<td>Hyperphosphatemia</td>
<td>27 (6)</td>
<td>15 (12)(^b)</td>
<td>7 (6)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>15 (4)</td>
<td>0 (0)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Drug-related AEs by preferred term(^a)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>219 (52)</td>
<td>2 (2)</td>
<td>4 (3)</td>
</tr>
</tbody>
</table>

Data are \( n \) (%). Hyperphosphatemia was reported as an AE but may represent a worsening of the participant’s underlying condition or indicative of a lack of treatment effect for that participant. AE, adverse event; PBO, placebo; TEN, tenapanor.

\(^a\)AEs listed here occurred in \( \geq 3\% \) of participants overall in any treatment group and study period.

\(^b\)One participant did not complete the randomized withdrawal period due to hyperphosphatemia and entered the safety extension period per protocol; this participant subsequently died during the safety extension period and was therefore counted under the primary discontinuation reason of ‘Death’ instead of ‘Hyperphosphatemia’.
<table>
<thead>
<tr>
<th></th>
<th>26-week randomized treatment period</th>
<th>12-week randomized withdrawal period</th>
<th>14-week safety extension period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SC, ( n=137 )</td>
<td>TEN, ( n=419 )</td>
<td>TOTAL, ( N=556 )</td>
</tr>
<tr>
<td>Participants with any SAE</td>
<td>32 (23)</td>
<td>73 (17)</td>
<td>105 (19)</td>
</tr>
<tr>
<td>Participants with any drug-related SAE</td>
<td>0 (0)</td>
<td>3 (1)</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Participants with any AEs leading to death(^a)</td>
<td>3 (2)</td>
<td>7 (2)</td>
<td>10 (2)</td>
</tr>
<tr>
<td>SAEs with incidence ≥3% by preferred term(^b)</td>
<td>5 (4)</td>
<td>3 (1)</td>
<td>8 (1)</td>
</tr>
</tbody>
</table>

Data are \( n \) (%). PBO, placebo; SAE, serious adverse event; SC, sevelamer carbonate; TEN, tenapanor.

\(^a\)Participants with any AEs leading to death are tabulated by study period, regardless whether the fatal AEs were treatment-emergent or not. Of the 18 deaths reported during the study, only two deaths were caused by treatment-emergent medical conditions.

\(^b\)SAEs listed here occurred in ≥3% of participants overall in any treatment group and study period.
Figure Legends

**Figure 1. Overview of study design.** The safety analysis set included all participants who received at least one dose of the study drugs for the study period. RTP, randomized treatment period; RWP, randomized withdrawal period; SEP, safety extension period.

**Figure 2. Overview of participant flow through the trial.** The safety analysis set included all participants who received at least one dose of the study drug for the study period. The ITT analysis set included all participants who met the study inclusion criteria, received at least one dose of tenapanor and/or placebo, and had at least one post-treatment serum phosphorus measurement for the study period. The efficacy analysis set included all ITT participants who met the entry criteria, received at least one dose of tenapanor during the 26-week RTP, completed the RTP and achieved a reduction of ≥1.2 mg/dl in serum phosphorus concentration from baseline to the end of the RTP. Participants from the site with a serious GCP breach were excluded from all analysis sets. Participants receiving tenapanor or placebo were to be withdrawn if they had serum phosphorus ≤2.5 mg/dl at any time, serum phosphorus ≥10.0 mg/dl at any time after week 2 of the RTP, serum phosphorus ≥9.0 mg/dl for two consecutive visits during the RTP or SEP, or serum phosphorus ≥9.0 mg/dl during the RWP. Primary reason for discontinuation from the study is listed. GCP, Good Clinical Practice; ITT, intention-to-treat; RTP, randomized treatment period; RWP, randomized withdrawal period; SEP, safety extension period.

**Figure 3. Change in serum phosphorus concentration in participants receiving tenapanor during the 26-week RTP.** Serum phosphorus concentration in participants receiving tenapanor over the 26-week RTP for the (A) ITT analysis set and (B) the subset of participants who achieved a reduction of ≥1.2 mg/dl in serum phosphorus from baseline at Week 26 and continued into the randomized withdrawal period. Data are mean serum phosphorus concentrations ± SD. ITT, intention-to-treat; RTP, randomized treatment period; SD, standard deviation.

**Figure 4. Change in serum phosphorus concentration over the RWP for the (A) efficacy analysis set and (B) ITT analysis set.** ***P<0.001, **P=0.0006, *P≤0.0023 vs placebo. Bar chart data show LS mean change (95% CI ± SEM) in serum phosphorus concentration from period-specific baseline to the end of the RWP. Line graph data show LS mean change (± SEM and P value) from period-specific baseline in serum phosphorus concentration at post-baseline visits during the RWP. CI, confidence interval; ITT, intention-to-treat; LS, least squares; RWP, randomized withdrawal period; SEM, standard error of the mean.
Screening ($N=1559$) → Washout 1–4 weeks → Randomization ($n=564$) → Sevelamer carbonate ($n=141$) → Re-randomization ($n=255$) → Tenapanor ($n=423$) → Sevelamer carbonate ($n=112$) → End of treatment

RTP: 26 weeks → RWP: 12 weeks → SEP: 14 weeks
Figure 2

Screening (N=1559)
- Excluded (n=995)
  - Did not meet inclusion criteria (n=896)
  - Participant withdrew consent (n=44)
  - Other (n=55)

Participants randomized (n=564)

Tenapanor (n=423)
- Discontinued (n=167)
  - Adverse event (n=77)
  - Death (n=7)
  - Hyperphosphatemia (n=22)
  - Hypophosphatemia (n=5)
  - Withdrawal by participant (n=34)
  - Other (n=22)

Sevelamer carbonate (n=141)
- Discontinued (n=24)
  - Adverse event (n=2)
  - Death (n=3)
  - Hyperphosphatemia (n=1)
  - Withdrawal by participant (n=10)
  - Other (n=8)

Tenapanor (n=228)
- Discontinued (n=29)
  - Adverse event (n=3)
  - Death (n=1)
  - Hyperphosphatemia (n=7)
  - Hypophosphatemia (n=1)
  - Withdrawal by participant (n=8)
  - Other (n=9)

Sevelamer carbonate (n=117)
- Discontinued (n=5)
  - Death (n=1)
  - Withdrawal by participant (n=2)
  - Physician decision (n=2)

Placebo (n=127)
- Completed (n=99)

Tenapanor (n=222)
- Discontinued (n=17)
  - Adverse event (n=2)
  - Death (n=4)
  - Hyperphosphatemia (n=1)
  - Other (n=10)

Sevelamer carbonate (n=112)
- Discontinued (n=3)
  - Death (n=1)
  - Withdrawal by participant (n=1)
  - Physician decision (n=1)

Completed (n=256)

Participants re-randomized (n=255)

Completed (n=117)

Completed (n=112)

Completed (n=205)

RTP (26 weeks)

RWP (12 weeks)

SEP (14 weeks)
Figure 3

(A) Pooled tenapanor

(B) Pooled tenapanor

Serum phosphorus concentration (mg/dl)

Time into the RTP (weeks)

n = 407 399 382 366 329 309 298 271 248

n = 131 129 126 131 130 125 131 131 127
Figure 4

(A) LS mean change in serum phosphorus concentration (mg/dl)

- Pooled tenapanor: 0.43 (0.04, 0.83)
- Placebo: 1.80 (1.41, 2.19)

Difference, -1.37 (-1.92, -0.82), \( P < 0.0001 \)

(B) LS mean change in serum phosphorus concentration (mg/dl)

- Pooled tenapanor: 0.22 (-0.07, 0.51)
- Placebo: 0.88 (0.58, 1.17)

Difference, -0.66 (-1.07, -0.24), \( P = 0.002 \)