ADEZA®

23 August 2006

Teresa Watkins
Food and Drug Administration
Center for Drug Evaluation and Research
Office of Executive Programs
Advisors and Consultants Staff
Rockville, MD 20857

Re: NDA 21-945 Alternative Analysis for the Advisory Committee Meeting on August 29, 2006

Dear Teresa,

Please find attached a document which describes an alternative Intent-to-Treat analysis which Adeza Biomedical will present to the Advisory Committee on Tuesday. This analysis is an alternative to the ITT analysis provided in the Adeza Biomedical Advisory Committee Briefing Document dated 25 July 2006.

Also included in the document is an errata discussion correcting a mathematical error calculation that is specific to secondary pregnancy outcomes presented in Adeza Biomedical's Briefing Document dated 25 July 2006.

Thank you,

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Alternative Analysis

For

Advisory Committee Briefing Document

For

17 α-Hydroxyprogesterone Caproate Injection, 250 mg/mL

NDA 21-945

Adeza Biomedical Corporation
1240 Elko Drive
Sunnyvale, CA 94089

23 August 2006

In the Adeza Biomedical Advisory Committee Briefing Document dated 25 July 2006, the Intent-to-Treat (ITT) analysis classified patients who were lost to follow-up as treatment failures at each definition of preterm delivery (ie, <37, <35, <32, <30, <28 and <24 weeks). This ITT analysis was conducted even though the last known date pregnant was available for the lost to follow-up patients. For example, the lost to follow-up patient delivered at 36^4 weeks was classified as a treatment failure in all six of the preterm delivery definitions.

An alternative, and perhaps more appropriate, ITT analysis that classifies lost to follow-up patients as delivering at their last known date pregnant was undertaken and is provided below. This analysis did not affect the primary outcome of preterm delivery at <37 weeks.

Table 1. ITT Population with Last Known Date Pregnant

Pregnancy Outcome	17P (N=310) N (%)	Placebo (N=153) N (%)	Relative Risk (95% CI)	*P* value*
Preterm Birth $<37^0$	115 (37.1%)	84 (54.9%)	0.68 (0.55-0.83)	0.0003
Preterm Birth $<35^0$	66 (21.3%)	47 (30.7%)	0.69 (0.50-0.95)	0.0263
Preterm Birth $<32^0$	37 (11.9%)	30 (19.6%)	0.61 (0.39-0.95)	0.0273
Preterm Birth $<30^0$	30 (9.7%)	24 (15.7%)	0.62 (0.37-1.02)	0.0581
Preterm Birth $<28^0$	29 (9.4%)	16 (10.5%)	0.89 (0.50-1.60)	0.7063
Preterm Birth $<24^0$	17 (5.5%)	5 (3.3%)	1.68 (0.63-4.46)	0.2918

Note: The 4 patients lost to follow-up were in the 17P group and are counted as treatment failures based on the last known date pregnant of 18^4, 22^0, 34^3, and 36^4 weeks.
* *P* value is for 17P vs. placebo and is from the chi-square test

Figure 1 reflects the numbers provided in Table 1 and illustrates the effectiveness of 17P in reducing preterm birth irrespective of the definition applied. Following treatment with 17P, the incidence of preterm birth was reduced by approximately 38%, 39%, 31%, and 32% and when defined as $<30^0$, $<32^0$, $<35^0$, and $<37^0$ weeks, respectively. Adeza Biomedical will present this alternative ITT analysis at the Advisory Committee Meeting on 29 August 2006.

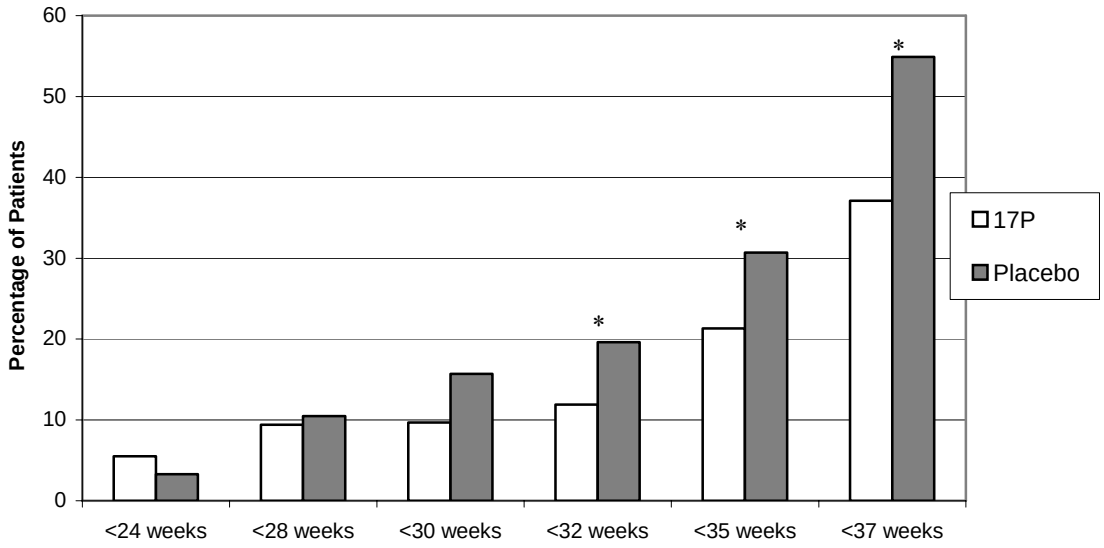

Figure 1. Preterm Birth <37^0, <35^0, <32^0, <30^0, <28^0, and <24^0 Weeks

*Statistically significant difference; P <0.05.

Errata

For

Advisory Committee Briefing Document

For

17 α-Hydroxyprogesterone Caproate Injection, 250 mg/mL

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Errata:

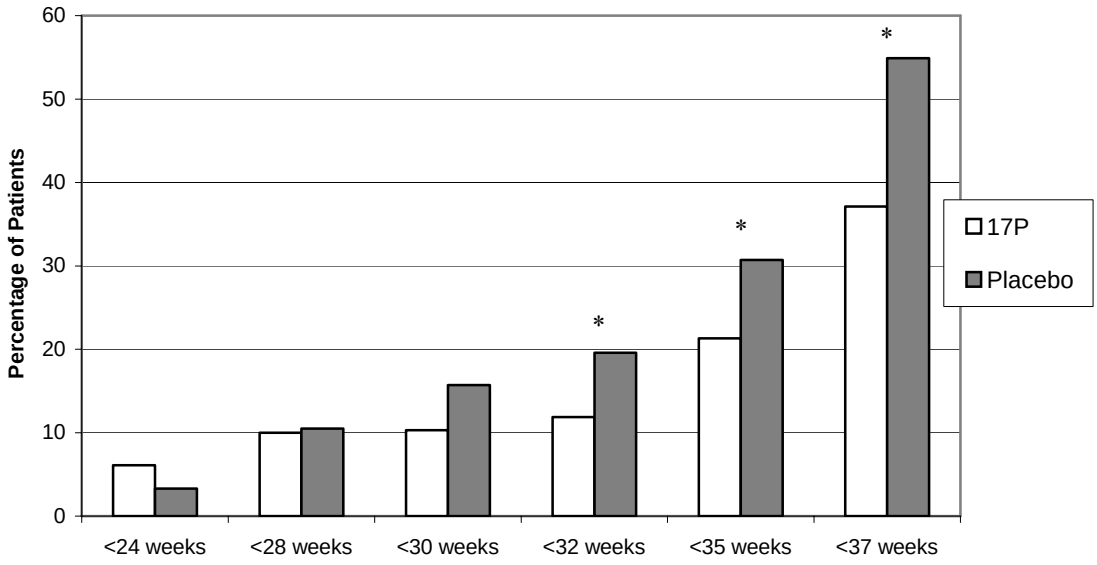
Table 4-6 entitled "Secondary Pregnancy Outcomes" (page 30) of the Adeza Biomedical Advisory Committee Briefing Document dated 25 July 2006 contains a mathematical error that is corrected with this document. Four patients who were lost to follow-up in the CT-002 study were inadvertently omitted from the secondary pregnancy outcomes of preterm delivery at <30, <28 and <24 weeks gestation. These patients should have been included in each of these outcomes as treatment failures. Note that the data for the <35 and <32 week definitions of preterm birth are correct in the original Briefing Document. The corrected Table 4-6 (corrections highlighted), associated Figure 4-4, and associated text are provided below.

Corrected Table 4-6. Secondary Pregnancy Outcomes

Pregnancy Outcome	**17P (N=310) N (%)**	**Placebo (N=153) N (%)**	**Relative Risk (95% CI)**	***P* value***
Preterm Birth $<35^0$	67 (21.6%)	47 (30.7%)	0.70 (0.51-0.97)	0.0324
Preterm Birth $<32^0$	39 (12.6%)	30 (19.6%)	0.64 (0.42-0.99)	0.0458
Preterm Birth $<30^0$	32 (10.3%)	24 (15.7%)	0.66 (0.40-1.08)	0.0959
Preterm Birth $<28^0$	31 (10.0%)	16 (10.5%)	0.96 (0.54-1.69)	0.8781
Preterm Birth $<24^0$	19 (6.1%)	5 (3.3%)	1.88 (0.71-4.93)	0.1915

Abbreviations: confidence interval (CI)
Note: Data presented are from the ITT analysis. The ITT population is all randomized patients. Patients with missing outcome data were classified as having a preterm birth at each preterm birth interval (ie, treatment failure).
* *P* value is for 17P vs. placebo and is from the chi-square test

Corrected Figure 4–4 illustrates the effectiveness of 17P in reducing preterm birth irrespective of the definition applied. Following treatment with 17P, the incidence of preterm birth was reduced by approximately 34%, 36%, 30%, and 32% when defined as $<30^0$, $<32^0$, $<35^0$, and $<37^0$ weeks, respectively.



Corrected Figure 4-4. Preterm Birth <37^0, <35^0, <32^0, <30^0, <28^0, and <24^0 Weeks

*Statistically significant difference; *P* <0.05.

As a result of this error, the *P* value associated with <30 weeks gestation was incorrectly reported as statistically significant. The text on pages 29 (Section 4.1.3.3), 36 (Section 4.1.4) and 66 (Section 6) incorrectly report that the preterm birth rate at <30 weeks is statistically significant. The correct *P* value is 0.0959.