

Supplementary Appendix

This appendix has been provided by the authors to give readers additional information about their work.

Supplement to: Kohn DB, Booth C, Shaw KL, et al. Autologous ex vivo lentiviral gene therapy for adenosine deaminase deficiency. N Engl J Med. DOI: 10.1056/NEJMoa2027675

Contents

List of investigators	4
Methods	4
Vector, drug product manufacture, transplant, and drug product attributes for trials NCT01852071 and NCT02999984 (U.S. Fresh and Cryo studies)	4
Vector manufacture.....	4
Drug product manufacture	5
Transplantation	5
Drug product attributes.....	5
Vector, drug product manufacture and treatment for NCT01380990 (U.K. study)	6
Vector manufacture.....	6
Drug product manufacture	6
Transplantation	6
Drug product attributes.....	7
Clinical monitoring and follow-up (All studies)	7
Assessment of immunological reconstitution	7
TCR V β phenotyping, vector copy number determination, RCL evaluation and integration site analysis.....	8
Adverse events	8
Long-term follow-up.....	8
Statistical analysis	9
Results	9
Repeat infusions: Patient narratives	9
Treatment failures: Patient narratives.....	9
Acknowledgments	10
References.....	11
Fig. S1. Schematic of EFS-ADA LV.	12
Fig. S2. Vector Insertion Site Analysis.	13
Fig. S3. Kaplan-Meier Curves for Overall Survival.....	38
Fig. S4. Median ADA Enzyme Activity in Peripheral Red Blood Cells	39
Fig. S5. TREC Counts in Peripheral Blood	40
Fig. S6. Serum IgA and IgM Levels and Serum IgG Levels Following IgRT Cessation.....	41
Fig. S7. Severe Infection Rate by Time Period	43
Fig. S8. Comparison of the U.S. Studies Integrated Fresh and Cryopreserved Data for (A) Median VCN in granulocytes (B) Median VCN in PBMCs (C) Median CD3 ⁺ T Cell Counts and (D) Median ADA activity.	44

Table S1. Inclusion and Exclusion Criteria.....	46
Table S2. Summary of Gene Therapy Infusion.....	51
Table S3. Primary and Secondary Endpoints	51
Table S4. Summary of Events, Including Rescue Treatment and Death	56

List of investigators

Donald B. Kohn Kit L. Shaw Theodore B. Moore Satiro De Oliveira Gay Crooks	University of California Los Angeles, CA, U.S.
Claire Booth H. Bobby Gaspar Adrian J. Thrasher Paul Veys	Great Ormond Street Institute of Child Health and Great Ormond Street Hospital NHS Foundation Trust London, U.K.
Harry L. Malech Suk See De Ravin	National Institute of Allergy and Infectious Diseases National Institutes of Health Bethesda, MD, U.S.
Elizabeth Garabedian	National Human Genome Research Institute National Institutes of Health Bethesda, MD, U.S.
Alan Wayne	Pediatric Oncology Branch National Cancer Institute National Institutes of Health, Bethesda, MD, U.S.

Methods

VECTOR, DRUG PRODUCT MANUFACTURE, TRANSPLANT, AND DRUG PRODUCT ATTRIBUTES FOR TRIALS NCT01852071 AND NCT02999984 (U.S. FRESH AND CRYO STUDIES)

VECTOR MANUFACTURE

The vector used in the United States (U.S.) studies was a self-inactivating lentiviral vector (LV) with codon-optimized human adenosine deaminase (ADA) complementary DNA (cDNA) driven by a shortened form of the human elongation factor α -1 gene (EFS) promoter (EFS-ADA LV), and using a Woodchuck hepatitis post-transcriptional regulatory element (WPRE) to stabilize vector transcripts and increase ADA expression (**Fig. S1**). The EFS-ADA LV was produced under Current Good Manufacturing Practice (cGMP) at the Indiana University Vector Production Facility under contract through the National Heart, Lung, and Blood Institute (NHLBI) Gene Therapy Resource Program (contract # HHSN2682012000051). The EFS-ADA LV was packaged by co-transfection of the transfer plasmid containing the lentiviral vector backbone and carrying the *ADA* cDNA, the plasmid encoding human immunodeficiency virus (HIV)-1 GAG and *POL*, the plasmid encoding HIV-1 Rev, and the plasmid encoding the vesicular stomatitis virus G (VSV-G) glycoprotein. The vector was produced and was fully characterized to meet release criteria agreed with the U.S. Food and Drug Administration (FDA), including purity, absence of contaminants (microbiological

control, absence of replication-competent lentivirus), potency (titer, expression of ADA enzyme activity), and identity (sequence confirmation).

DRUG PRODUCT MANUFACTURE

In both the U.S. Fresh and Cryo trials, the drug product was manufactured from CD34⁺ hematopoietic stem and progenitor cells (HSPCs) isolated from bone marrow using immunomagnetic selection with CliniMACS[®] cell purification protocols (Miltenyi Biotec, Bergisch Gladbach, Germany). The cells were plated in serum-free medium supplemented with human serum albumin (HAS) and cytokines (stem cell factor [SCF] 300ng/ml, Flt-3 ligand 300 ng/ml, thrombopoietin [TPO] 100 ng/ml and IL-3 20 ng/ml) at a density of 1×10^6 /ml for prestimulation overnight (20 hours). All cytokines (PeproTech) and culture reagents were approved for ex vivo clinical use. After prestimulation, the EF1 α S-ADA lentiviral vector (EFS-ADA LV, Indiana University Vector Production Unit) was added for ~20 hours. Following transduction, the cells were washed and formulated. Patients treated in the U.S. Fresh Study received OTL-101 as a fresh formulation in which the drug product was formulated in Plasmalyte-A with 1% HSA shortly after harvest. Patients treated in the U.S. Cryo Study received OTL-101 as a cryopreserved formulation in which the drug product was formulated in 100% Cryostor CS5 (BioLife, Bothell, WA, U.S.) and cryopreserved in a control rate freezer.

TRANSPLANTATION

Patients treated in the U.S. Fresh Study received a single dose of intravenous (IV) weight-adjusted busulfan conditioning (4 mg/kg) on the day of stem cell harvest. Busulfan conditioning was initiated after confirmation that the required number of CD34⁺ cells were isolated and in culture. After a 24-hour busulfan washout period, patients were infused intravenously with the fresh formulation of OTL-101. Drug product testing was completed in two stages, pre- and post-infusion.

Patients treated in the U.S. Cryo Study received 2 doses of busulfan conditioning after completion of drug product testing and certification. The first dose of busulfan was weight adjusted (3 mg/kg) and the second dose, given 24 hours later, was PK adjusted to a total target area under the concentration–time curve of 4900 μ mol/l per minute. After a 24-hour washout period, OTL-101 was thawed at the bedside and infused intravenously.

The drug product was infused intravenously at a dose $\geq 1.0 \times 10^6$ (U.S. Fresh Study) or $\geq 2.0 \times 10^6$ (U.S. Cryo Study) CD34⁺ cells/kg body weight. Pegylated adenosine deaminase enzyme replacement therapy (PEG-ADA ERT) was withdrawn 1 month (+/- 6 days) post infusion. If there was no bone marrow recovery by 6 weeks (absolute neutrophil count $<0.5 \times 10^9$ /l or platelets $<20 \times 10^9$ /l) the back-up harvest was re-infused.

DRUG PRODUCT ATTRIBUTES

Final drug product release criteria for infusion of the fresh formulation of OTL-101 were viability $>70\%$; negative in-process bacterial and fungal stains and culture; and endotoxin <5 EU per kilogram. Additional characterization of the final drug product was performed after infusion and reported on the certificate of analysis, including mycoplasma test (BioReliance Corp., Rockville, MD, U.S.) and final sterility. DNA was extracted from a sample of drug product after 14 days *in vitro* culture using the PureLink genomic DNA mini-kit (Invitrogen, Carlsbad, CA, U.S.) and vector copy number (VCN) was determined by digital droplet

polymerase chain reaction (ddPCR). ADA enzyme activity was determined from cell lysates with the ADA enzyme assay by Diazyme (Poway, CA, U.S.). Transduction efficiency was determined by PCR as the percentage of vector-positive colonies after 14 days in methylcellulose culture.

Final drug product release criteria for infusion of the cryopreserved formulation were the same as for the fresh formulation; however, all release testing and certificates of analysis were issued prior to administration of the conditioning regimen and administration of the cryopreserved drug product.

One patient in the U.S. Fresh study and one U.K. study patient were infused with known contaminated fresh drug products (positive for coagulase-negative *Staphylococcus*) alongside antibiotic treatment following approval by the institutional review boards (U.S. studies), independent ethics committees (U.K.), FDA (U.S. studies), and investigators.

VECTOR, DRUG PRODUCT MANUFACTURE AND TREATMENT FOR NCT01380990 (U.K. STUDY)

VECTOR MANUFACTURE

As above for U.S. studies

DRUG PRODUCT MANUFACTURE

The cell product was manufactured from CD34⁺ HSPCs isolated from bone marrow or mobilized peripheral blood. In total, 4×10^6 CD34⁺ cells/kg were required for drug product manufacture, of which $>1 \times 10^6$ cells/kg were used for transduction and the remainder (3×10^6 CD34⁺ cells/kg) was cryopreserved without transduction as a backup sample for potential later use. Patients for whom 4×10^6 CD34⁺ could not be harvested were withdrawn from the study.

Following harvest, CD34⁺ HSPCs were purified, cultured, and transduced at Great Ormond Street Hospital using standard CliniMACs[®] cell purification protocols and seeded into fresh closed cell culture bags or flasks in serum free medium (X-VIVO-20, Lonza) supplemented with 1% human serum albumin (Baxter), and cytokines SCF (300 ng/ml), Flt-3 ligand (300 ng/ml), TPO (100 ng/ml) and IL-3 (20 ng/ml) at a density of 0.5 to 1×10^6 /ml. All cytokines (Peprotech) and culture reagents were approved for ex vivo clinical use. A small culture sample was removed for sterility testing. After ~18 hours total pre-stimulation, cells were cultured with the EFS-ADA LV (Indiana University Vector Production Unit) for ~20 hours in the same complete medium at a cell concentration of 0.5 to 1×10^6 cells/ml. Following transduction, a portion of cells were removed for quality control i.e. analysis of transduction efficiency (using transgene polymerase chain reaction), viability (using trypan blue stain and 7AAD staining), sterility and replication competent lentivirus. The remaining cells were washed and resuspended in 0.9% saline and 2% human serum albumin for administration. Infusion was carried out within 6 hours of final formulation.

TRANSPLANTATION

Patients initiated IV weight-adjusted busulfan conditioning immediately after bone marrow or peripheral blood stem cell collection and pharmacokinetic monitoring of busulfan levels commenced. The drug product was infused intravenously at a dose $>0.5 \times 10^6$ CD34⁺ cells/kg body weight. Pegylated adenosine deaminase enzyme replacement therapy (PEG-ADA ERT)

was withdrawn 1 month (+/- 6 days) post infusion. If there was no bone marrow recovery by 6 weeks (absolute neutrophil count $<0.5 \times 10^9/l$ or platelets $<20 \times 10^9/l$) the back-up harvest was re-infused.

DRUG PRODUCT ATTRIBUTES

Samples were collected during and at the end of the transduction procedure for cell viability (trypan blue stain, 7AAD staining) and sterility (bacteria, fungi, and mycoplasma). The course of action taken in the event of the CD34⁺ HSPCs becoming contaminated with microbial agents during the transduction procedure depended on the status of the patient. If there was evidence of microbial agents and busulfan had already been administered, the cells were to be returned to the patient with appropriate antibiotic cover. If the contamination significantly affected cell viability, causing the total dose to be lower than the required 0.5×10^6 CD34⁺ cells/kg, the transduced cells were not to be infused, and the back-up sample was to be administered to the patient.

CLINICAL MONITORING AND FOLLOW-UP (**ALL STUDIES**)

In the U.S. Fresh Study, patients were seen for assessment and examination by their home physician, the principal investigator or a clinical investigator at months 1, 2, 3, 4, 5, 6, 8, 10, 12, 15, 18, 21, and 24 (± 4 weeks). In the U.S. Cryo Study, assessments were completed at month 1, day 42, and months 3, 6, 9, 12, 18, and 24 (± 2 to 4 weeks).

In the U.K. study, patients were followed up at 1, 1.5, 3, 6, 9, 12, 18, 24, 30, and 36 months post-gene therapy. If after 180 days there was no evidence of the transgene in peripheral blood mononuclear cells (PBMCs) by qPCR or no evidence of T-cell recovery, patients re-started PEG-ADA ERT and were withdrawn from the study.

For all studies, ADA enzymatic activity in hemolysates was determined by a radiochemical-thin layer chromatography method,¹ and expressed as nmol per hour per milligram (mg) hemolysate protein. For the U.S. studies, red blood cell ADA activity and total deoxyadenosine nucleotide (dAXP) measurements were performed at the Hershfield Laboratory at Duke University School of Medicine (Durham, NC, U.S.). For the U.K. study, red blood cell ADA activity and analysis of red blood cell dATP activity was performed at the Purine Research Laboratory at Guy's and St. Thomas' Hospitals, London, U.K.

ASSESSMENT OF IMMUNOLOGICAL RECONSTITUTION

Immune recovery following gene therapy was assessed using a lymphocyte immunophenotyping panel, to detect increases in T lymphocyte numbers and assess the distribution of cell populations. Percentages and absolute counts of CD3⁺, CD4⁺, naïve CD4⁺CD45RA⁺ (U.S. studies) or CD4⁺CD45RA⁺CD27⁺ (U.K. study), CD8⁺, CD19⁺, and CD56⁺ CD16⁺ cells and were evaluated. Immunologic assays for lymphocyte counts and immunoglobulin levels were performed for the U.S. studies at laboratories certified by Clinical Laboratory Improvement Amendments (CLIA) at the Ronald Reagan Medical Center, University of California, Los Angeles, CA, U.S.; the Department of Laboratory Medicine, Clinical Center, National Institutes of Health, Bethesda, MD, U.S.; the Laboratory of Cell-Mediated Immunity, National Cancer Institute, SAIC-Frederick (currently Leidos Biomedical Research, Inc.), Frederick, MD, U.S.; or the clinical laboratories of the patient's primary care

physicians for the U.S. studies. For the U.K. study they were carried out at the Clinical Immunology Laboratory at Great Ormond Street Hospital, London, U.K.

T-cell receptor excision circle (TREC)s were used as a surrogate marker for new thymic emigrants following gene therapy and analysis was performed at the Great Ormond Street Hospital Laboratory, London, U.K.

TCR VB PHENOTYPING, VECTOR COPY NUMBER DETERMINATION, RCL EVALUATION AND INTEGRATION SITE ANALYSIS

Representation of T-cell receptor families by flow cytometric analysis (V β phenotyping), was used for monitoring both physiological and potentially pathological clonal expansions. For the U.K. study T cell receptor V β spectratyping was performed at the Clinical Immunology Laboratory at Great Ormond Street Hospital, London, U.K. and for the U.S. studies it was performed at UCLA and NIH Clinical Immunology laboratories.

For the U.S. studies, vector copy number (VCN) was determined by ddPCR on genomic DNA extracted from nucleated peripheral blood granulocytes and nucleated peripheral blood mononuclear cells at UCLA, CA, U.S.. For the U.K. study, VCN analysis was performed at University College London Great Ormond Street Institute of Child Health (London, U.K.) on sorted cell populations by real-time PCR methodology using the same primers and probe as in the U.S. studies. VCN in granulocytes, PBMCs, CD34⁺ and CD19⁺ cells were assessed at months 3, 6, 12, and 24 months (all studies) and 36 months (U.K. study) following gene therapy.

For all studies, tests for replication-competent lentivirus in peripheral blood were carried out at months 3, 6, 12, and 24 (and 36 months for the U.K. study). Analyses were performed at the National Gene Vector Biorepository at Indiana University Vector Production Facility (Indiana, Ind, U.S.) using qPCR for the VSV-G envelope (limits of detection 10 copies per 0.2 μ g of genomic DNA). Large-scale vector integration site analysis (VISA), combining linear amplification-mediated polymerase chain reaction (PCR) and its nonrestrictive version [(nr)LAM-PCR] followed by subsequent deep sequencing, was used to determine the vector integration profile and potential clonal dominance (GeneWerk GmbH, Heidelberg, Germany). The frequency of the 10 most prominent integration sites detected in peripheral mononuclear cell DNA are presented in **Fig. S2**.²⁻⁵

ADVERSE EVENTS

Adverse events (AEs) and serious AEs (SAEs) were coded using the *Medical Dictionary for Regulatory Activities* version 20.0 and summarized by system organ class and preferred term.

LONG-TERM FOLLOW-UP

Patients were invited to participate in a long-term follow-up study that consists of semi-annual to annual visits and laboratory tests over the subsequent 13 (U.S. studies) and 12 (U.K. study) years.

STATISTICAL ANALYSIS

Gene transfer/engraftment parameters, ADA activity, adenosine nucleotides detoxification in red blood cells and lymphocyte subsets were summarized over time, along with changes from baseline. Descriptive statistics were used and presented in summary and individual plots. Incidence and rates of severe infections were summarized descriptively. Immunologic function was assessed through standard testing by clinical laboratories. These tests included quantitation of lymphocyte subsets and measurement of serum immunoglobulin levels. Use of immunoglobulin replacement therapy and evaluations of serum immunoglobulin levels were summarized descriptively over time.

Results

REPEAT INFUSIONS: PATIENT NARRATIVES

Three U.S. patients (2 from the U.S. Fresh Study, 1 from the U.S. Cryo study) and one U.K. patient were infused with the treatment twice (infusions were administered 1–6 hours apart for U.S. patients [Supplementary Table S2]).

The first patient treated in the U.S. Fresh study had a loss of CD34⁺ HSPCs during cell processing of the initial bone marrow harvest and the product was formulated and cryopreserved. A second harvest was performed, and a fresh product was formulated, approximately 1 year later. Both products were administered to the patient one hour apart on the same day, with the fresh product infused first and the cryopreserved product infused subsequently.

The second patient in the U.S. Fresh study had two fresh products manufactured from the same harvest to compensate for insufficient vector availability on the day of transduction, which were administered 6 hours apart.

A patient in the U.S. Cryo study, had a repeat bone marrow harvest as the first cryopreserved product did not satisfy release criteria (total nucleated cell concentration was below the established limit). The second cryopreserved product was manufactured and administered to the patient 1.5 hours apart on the same day. This patient subsequently failed to engraft and withdrew from the study.

In the U.K. study, one patient received 2 infusions, 3 days apart, the second of which used cryopreserved product. An initial batch of product deemed unlikely to give a good outcome due to a low cell dose (1.44×10^6 CD34⁺ cells/kg) was formulated and cryopreserved for future use. An additional harvest, performed at a later time, yielded a higher cell dose (3.6×10^6 CD34⁺ cells/kg). The patient received both the cryopreserved and fresh formulation of EFS-ADA LV in order to maximize the total dose.

TREATMENT FAILURES: PATIENT NARRATIVES

There were only two treatment failures across all studies. One patient withdrew from the U.K. study 12.2 months post-treatment due to insufficient engraftment, poor T-cell recovery, and low ADA activity levels, and subsequently restarted ERT. ERT had been stopped for this

patient by the investigator 1 week prior to gene therapy in order to provide a survival advantage to gene-modified cells over endogenous cells as this patient had excellent immune recovery on PEG-ADA ERT. The patient had gone on to receive one fresh and one cryopreserved formulation as described above.

In the U.S. Cryo study, one patient restarted ERT and was withdrawn from the study 5.9 months post-infusion due to lack of engraftment. The patient had received two infusions of 2.99×10^6 CD34⁺ cells/kg in a first infusion and 1.26×10^6 CD34⁺ cells/kg in a second infusion, for a combined total cell dose of 4.25×10^6 CD34⁺ cells/kg. Relevant past medical history included trimethoprim/sulfamethoxazole-induced granulocytopenia and positive coronavirus infection, mild pneumatosis intestinalis, and necrotizing enterocolitis that all resolved prior to gene therapy. The patient had a poor response to more than 10 months of treatment with PEG-ADA ERT with minimal increases in lymphocyte counts. The patient also had chronic neutropenia, which is consistent with findings showing ADA-SCID patients may be more susceptible to myeloid dysplasia,⁶ potentially leading to drug-induced neutropenia and prolonged busulfan-induced myelosuppression.

Acknowledgments

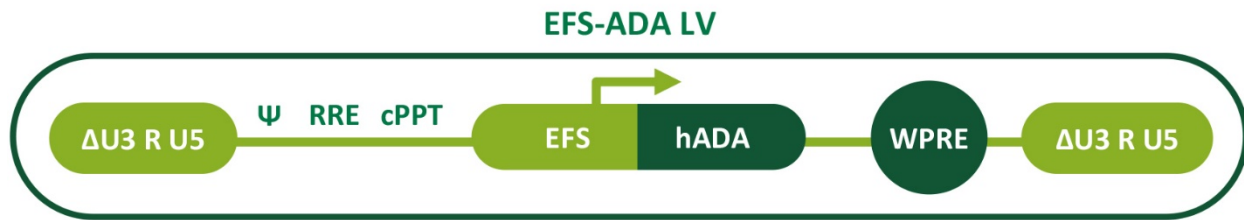
We thank Dr. Linda Griffith (Division of Allergy, Immunology, and Transplantation, NIAID) for support and encouragement for the implementation of the gene-therapy study; the patients and their families and their home doctors and nurses; the physicians who referred the patients who received gene therapy in the United States and participated in their care and evaluations: Dr. Rajni Agarwal (Stanford University, Palo Alto), Dr. Scott Cameron (University of British Columbia, Victoria), Dr. Karin Chen (University of Utah, Salt Lake City), Dr. Geoffrey Cuvelier (CancerCare Manitoba, Winnipeg), Dr. Blachy Davila (Children's National, Washington D.C.), Dr. Maite de la Morena (Children's Health Specialty Center, Dallas), Dr. Morna Dorsey (UCSF Benioff Children's Hospital, San Francisco, 4), Dr. Jose Luis Franco (Medellin), Dr. Eyal Grunebaum (Universidad de Antioquia, Toronto, 3), Dr. Elie Haddad (University of Montreal, Montreal, 2), Dr. Andrew Harris (University of Utah, Salt Lake City), Dr. Nabil Kabbara (Rafic Hariri University Hospital, Beirut), Dr. Neena Kapoor (Children's Hospital Los Angeles, Los Angeles), Dr. Alan Knutsen (SSM Health Cardinal Glennon Children's Hospital St. Louis, St. Louis), Dr. Lisa Kobrynski (Children's Healthcare of Atlanta, Atlanta), Dr. Howard Lederman (Johns Hopkins Hospital, Baltimore), Dr. Rebecca Marsh (Cincinnati Children's Hospital, Cincinnati), Dr. Luis Murguia-Favela (Alberta Children's Hospital, Alberta), Dr. Sung-Yun Pai (Boston Children's Hospital, Boston), Dr. Anne Pham-Huey (University of Ottawa, Ottawa), Dr. Jennifer Puck (UCSF Benioff Children's Hospital, San Francisco, 4), Dr. Marina Salvadori (London Health Sciences Centre, London, ON, 2), Dr. Kirk Schultz (BC Children's Hospital Research Institute, Vancouver), Dr. Evan Shereck (Oregon Health & Science University, Portland), Dr. John Sleasman (Duke Children's Health Center, Durham), Dr. Angela Smith (University of Minnesota Health, Minneapolis), Dr. Elizabeth Stenger (University of Pittsburgh, Atlanta), and Dr. Kenneth I. Weinberg (Stanford Children's Health, Palo Alto); Dr. Suk See De Ravin and Dr. Alan Wayne, for their participation in clinical care at the NIH; the University of California, Los Angeles (UCLA), David Geffen School of Medicine Human Gene and Cell Therapy Program, the UCLA Eli and Edythe Broad Center of Regenerative Medicine and Stem Cell Research, and the UCLA Jonsson Comprehensive Cancer Center, for provision of resources for the study; Dr. Despina Moshous, Dr. Benedicte Neven, and Dr. Nizar Mahlaoui (Necker Enfants Malades University Hospital, Paris); Dr. Tore Abrahamsen and Dr. Torstein Øverland (Oslo University Hospital, Oslo, Norway); Dr. David Moreno Perez (Hospital

Regional Universitario de Malaga, Malaga, Spain); Dr. Rosie Hague (Royal Hospital for Children, Glasgow, U.K.); Dr. Scott Hackett (Heartlands Hospital, Birmingham, U.K.); Dr. Vicky Bordon (Universitair Ziekenhuis, Ghent, Belgium); Dr. Carsten Speckmann (Freiburg University Medical Center, Freiburg, Germany); Dr. Terry Flood (Great North Children's Hospital, Newcastle, U.K.); Dr. Michael Gold (Women's and Children's Hospital, Adelaide, Australia); Dr. Jens Erik Veirum, Dr. Troels Herlin, and Dr. Mette Holm (Aarhus University Hospital, Denmark); Dr. Ronan Leahy (Children's Health Ireland, Cumlin, Ireland); Dr. Paul Veys (Great Ormond Street Hospital, London); Phastar, under the supervision of Frances Lynn (Orchard Therapeutics [Europe]), for performing the statistical analyses; Dr. Robin LeWinter and Dr. Cindy Chen from Orchard Therapeutics (Europe) for their help coordinating the writing of an earlier version of the manuscript; and Dr. Lara Bennett and Dr. Ben Drever (Comradis, U.K.) for editorial support, paid for by Orchard Therapeutics, with an earlier version of the manuscript.

References

1. Arredondo-Vega F, Kurtzberg J, Chaffee S, et al. Paradoxical expression of adenosine deaminase in T cells cultured from a patient with adenosine deaminase deficiency and combined immunodeficiency. *J Clin Invest* 1990;86:444-52.
2. Schmidt M, Schwarzwaelder K, Bartholomae CC, et al. High-resolution insertion site analysis by linear amplification-mediated PCR (LAM-PCR). *Nat Methods* 2007;4:1051-7.
3. Gabriel R, Eckenberg R, Paruzynski A, et al. Comprehensive genomic access to vector integration in clinical gene therapy. *Nat Med* 2009;15:1431-6.
4. Paruzynski A, Arens A, Gabriel R, et al. Genome-wide high-throughput integrome analyses by nrLAM-PCR and next-generation sequencing. *Nat Protoc* 2010;5:1379-95.
5. Afzal S, Wilkening S, von Kalle C, Schmidt M, Fronza R. GENE-IS: time-efficient and accurate analysis of viral integration events in large-scale gene therapy data. *Mol Ther Nucleic Acids* 2017;6:133-9.
6. Sokolic R, Maric I, Kesserwan C, et al. Myeloid dysplasia and bone marrow hypocellularity in adenosine deaminase-deficient severe combined immune deficiency. *Blood* 2011;118:2688-94.

Fig. S1. Schematic of EFS-ADA LV.



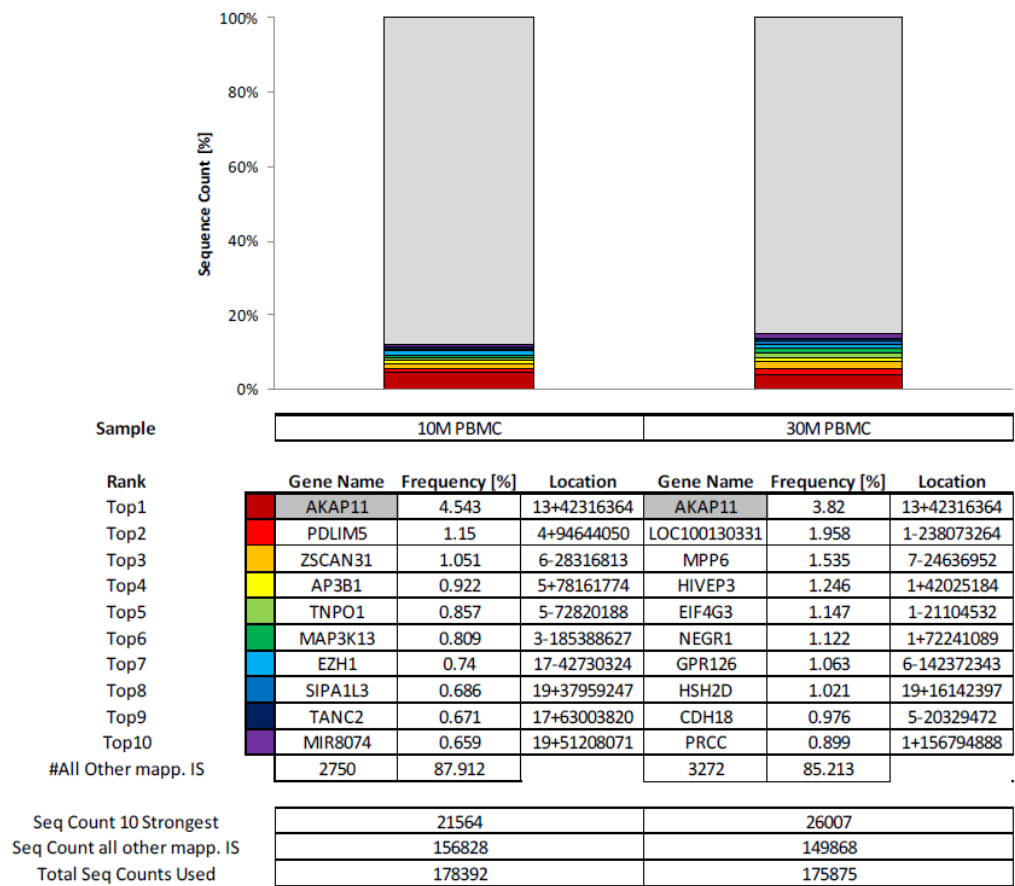
Elongation factor-1 α shortened (EFS)-adenosine deaminase (ADA) lentivirus vector (LV) is a self-inactivating LV with codon-optimized human ADA complementary DNA (cDNA) driven by a shortened promoter sequence of the human elongation factor α -1 gene, and the Woodchuck hepatitis post-transcriptional regulatory element (WPRE), to stabilize vector transcripts and increase ADA expression. cPPT denotes central polypurine tract; hADA human adenosine deaminase, RRE Rev response element, U5 part of viral long terminal repeat, $\Delta U3$ deletion in viral promoter region of long terminal repeat to render the vector as self-inactivating, and Ψ packaging signal.

Fig. S2. Vector Insertion Site Analysis.

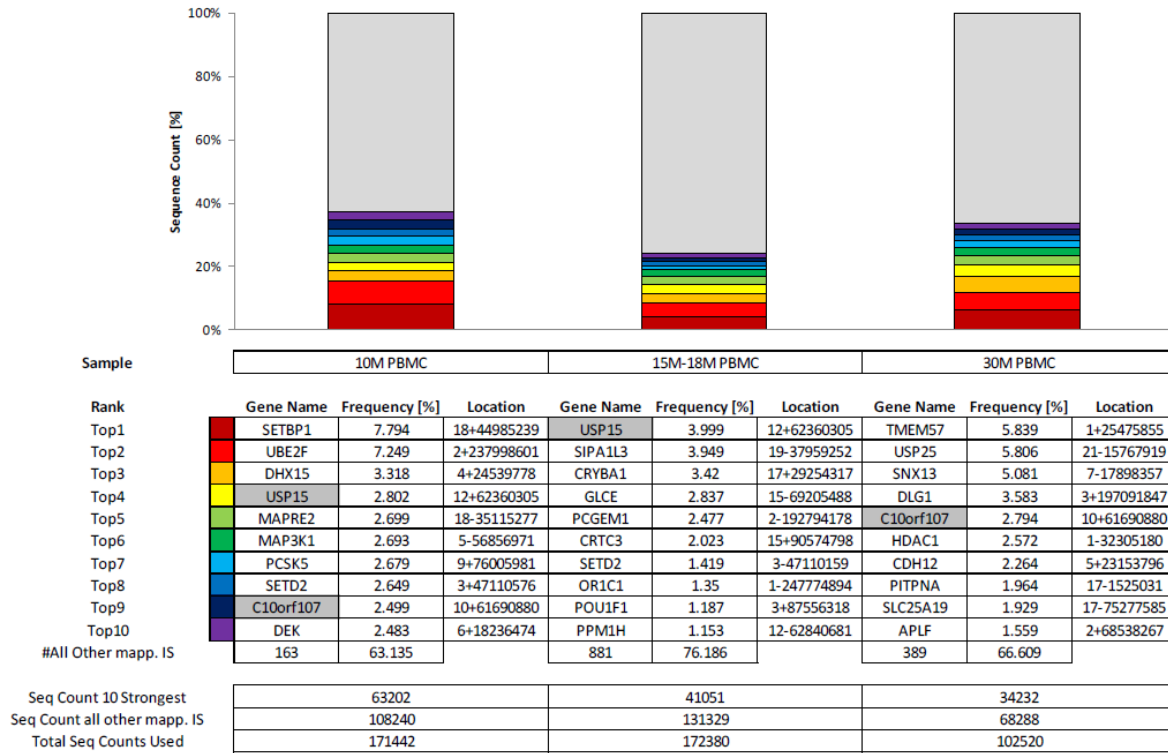
Patients A to CC: Cumulative retrieval frequencies of the 10 most prominent integration sites detected in peripheral blood mononuclear cell (PBMC) DNA of all gene therapy-treated patients are presented. In most cases, the analysis of the drug product after 14-day culture (14D CD34⁺) and longitudinal sampling during the follow-up period are presented. For individual samples at specific time points, sequence data from all linear nonrestrictive amplification-mediated polymerase chain reaction [(nr)LAM-PCR] amplicons are combined. The RefSeq name of genes closest to the respective integration sites are given in the table. The relative sequence count of all detected integration sites was calculated in relation to all sequences which could be mapped to a definite position in the genome (Total Seq Counts Used). Gene names highlighted with gray shading indicate integration sites that have been detected at different time points among the 10 most prominent integration sites detected. Top 10 integration sites from timepoints not shown in the figures, if applicable, are taken into account for repeated integration sites among the top 10. M denotes months.

U.S. studies

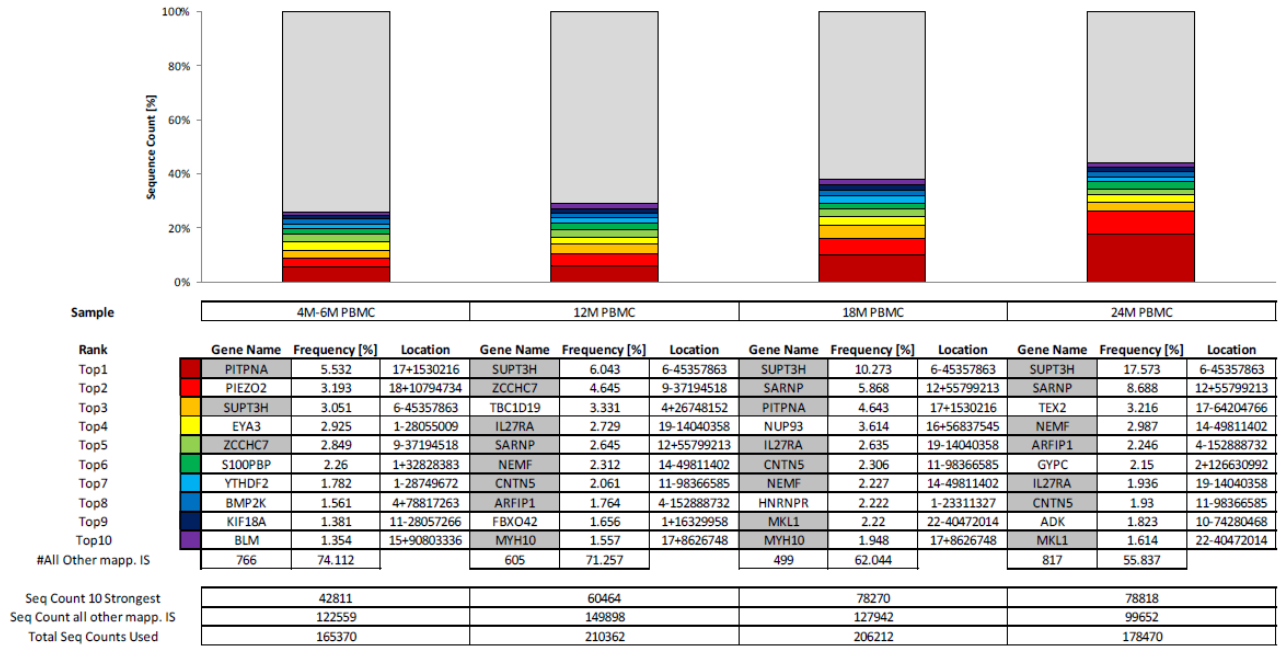
Patient A



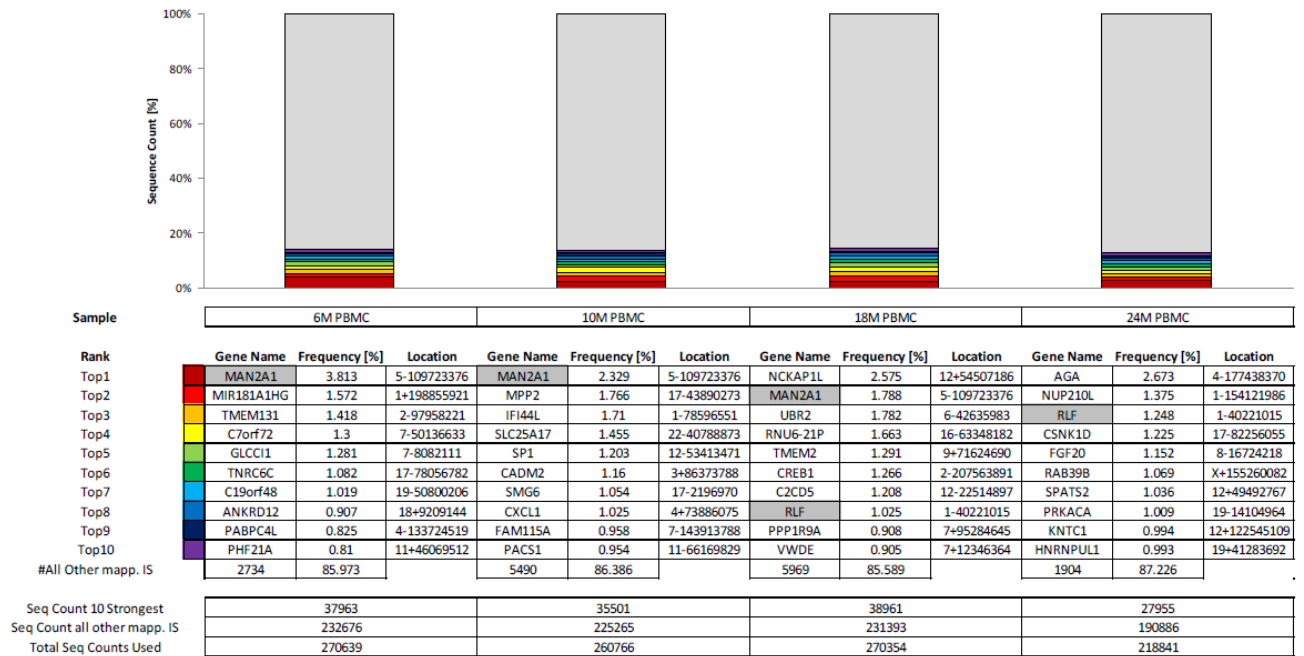
Patient B



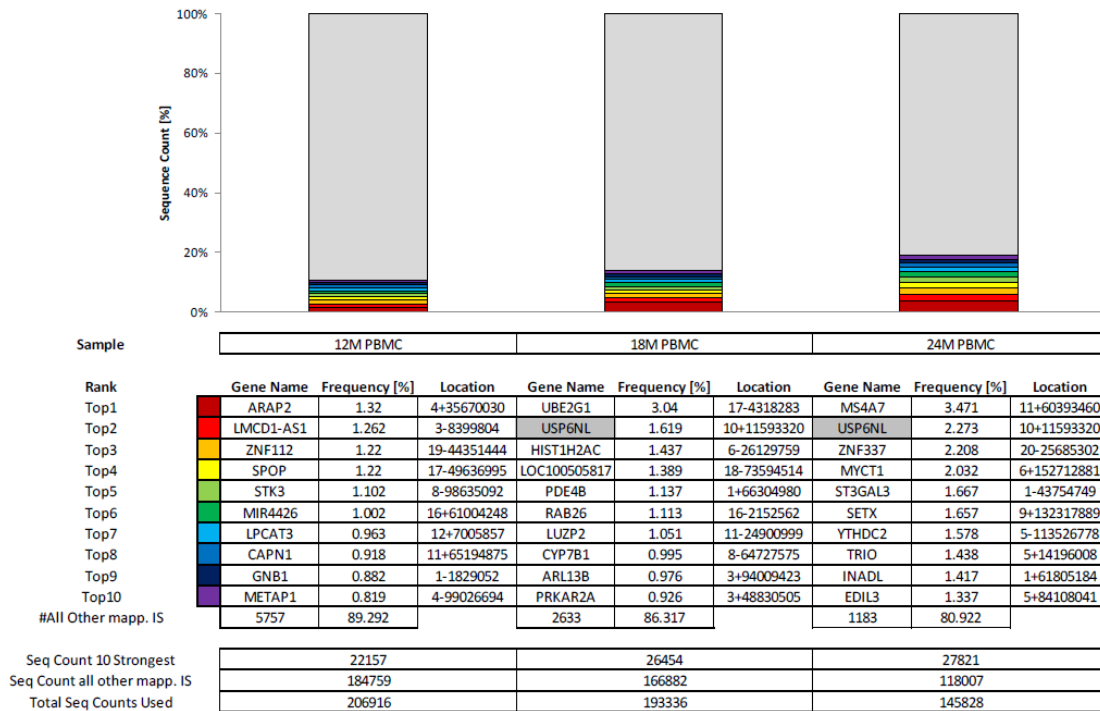
Patient C



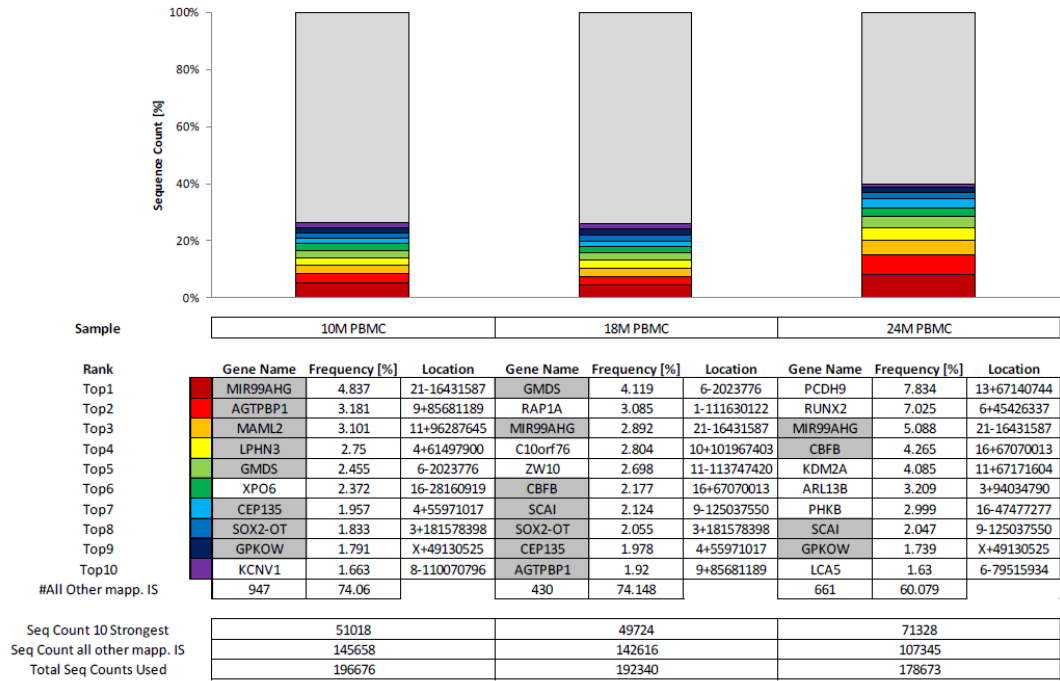
Patient D



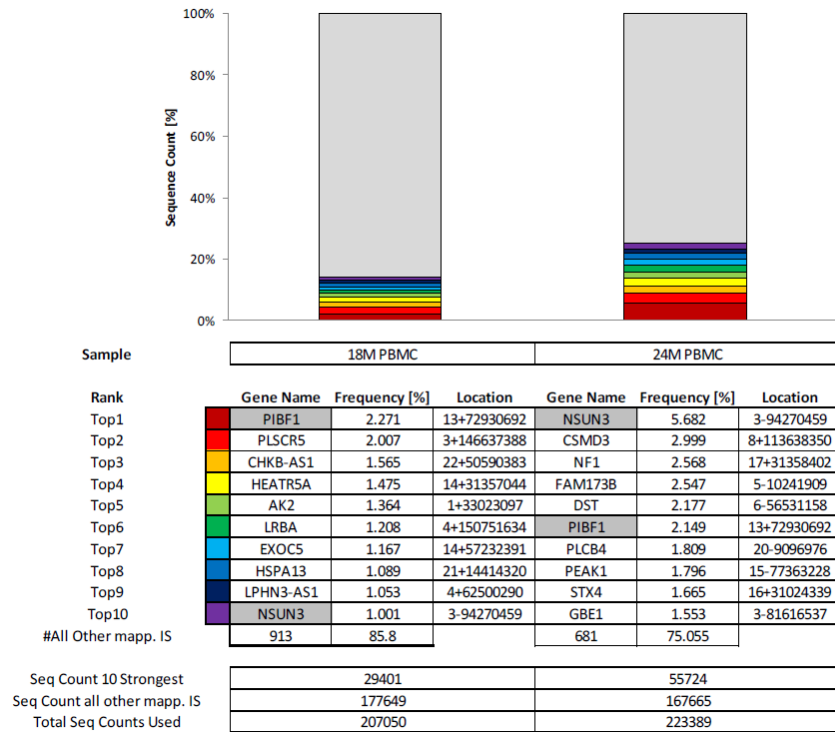
Patient E



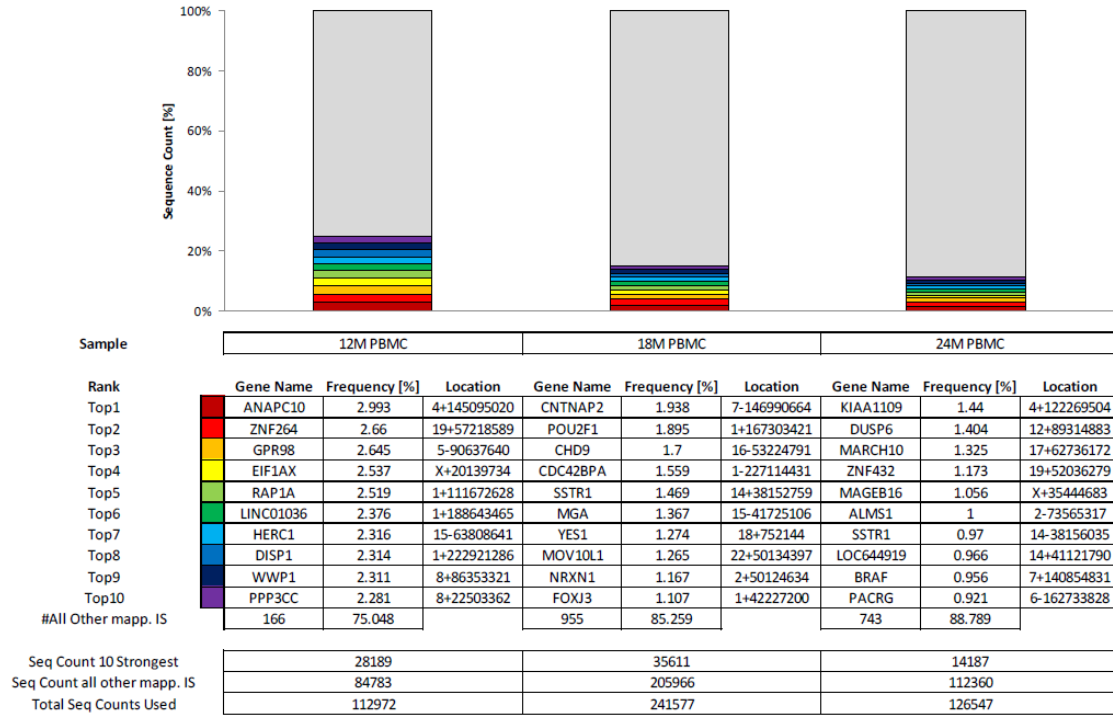
Patient F



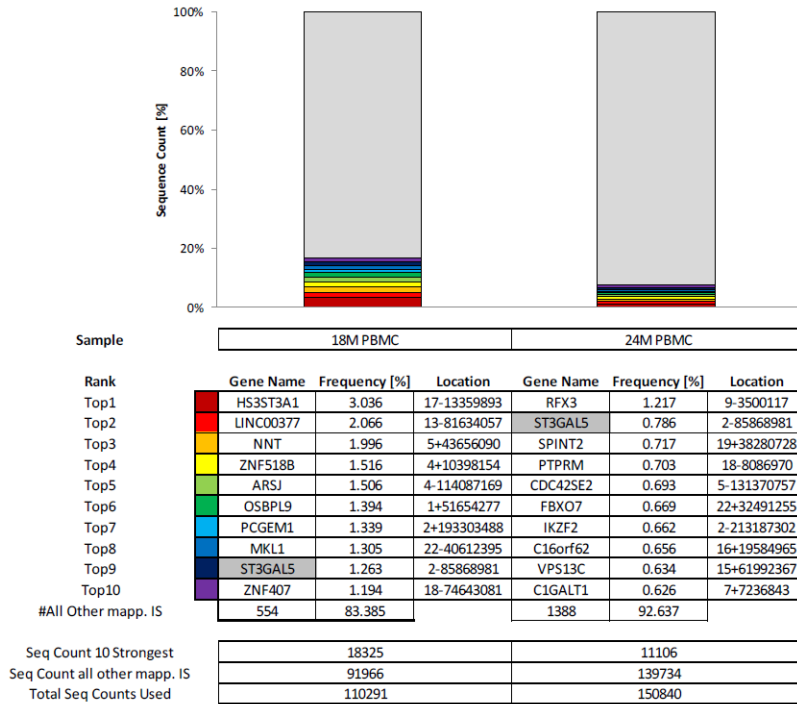
Patient G



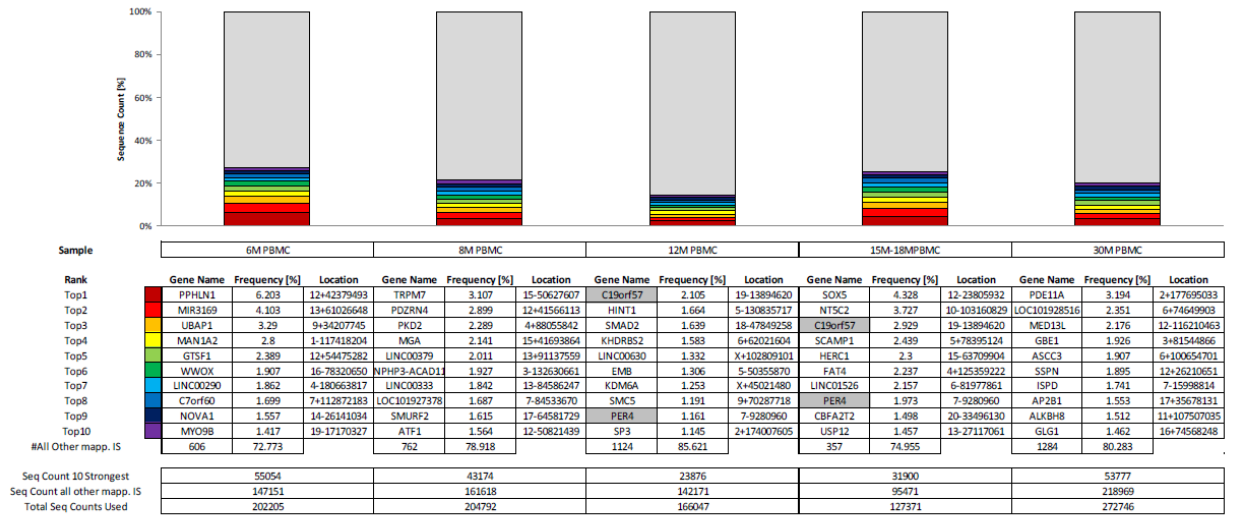
Patient H



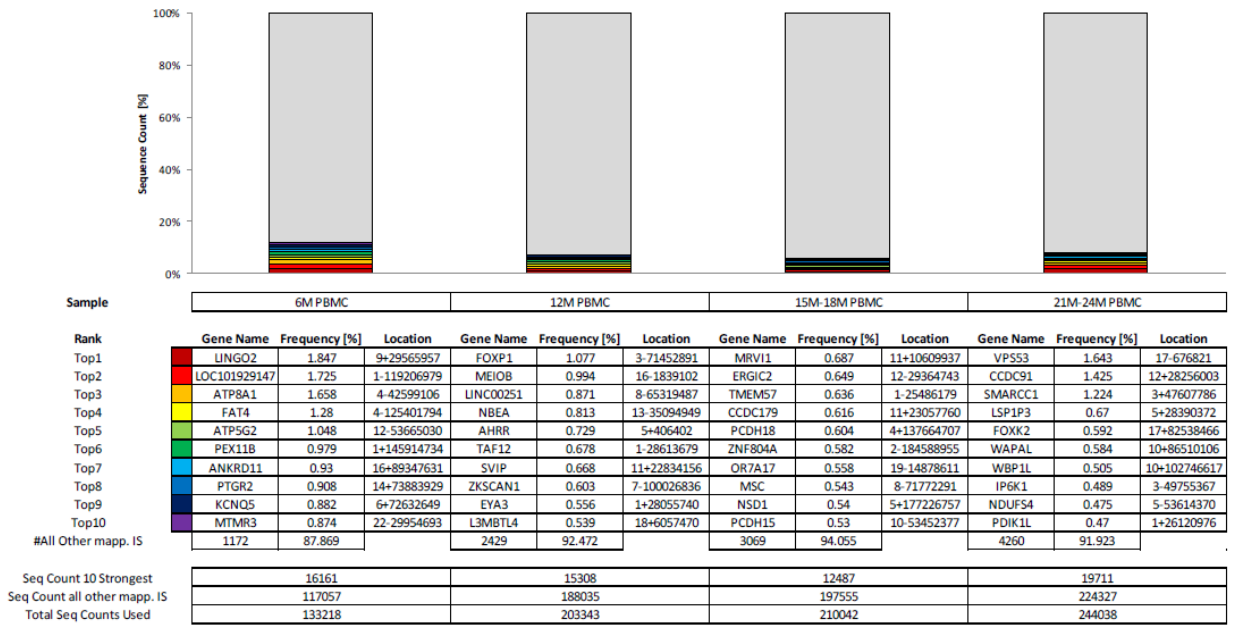
Patient I



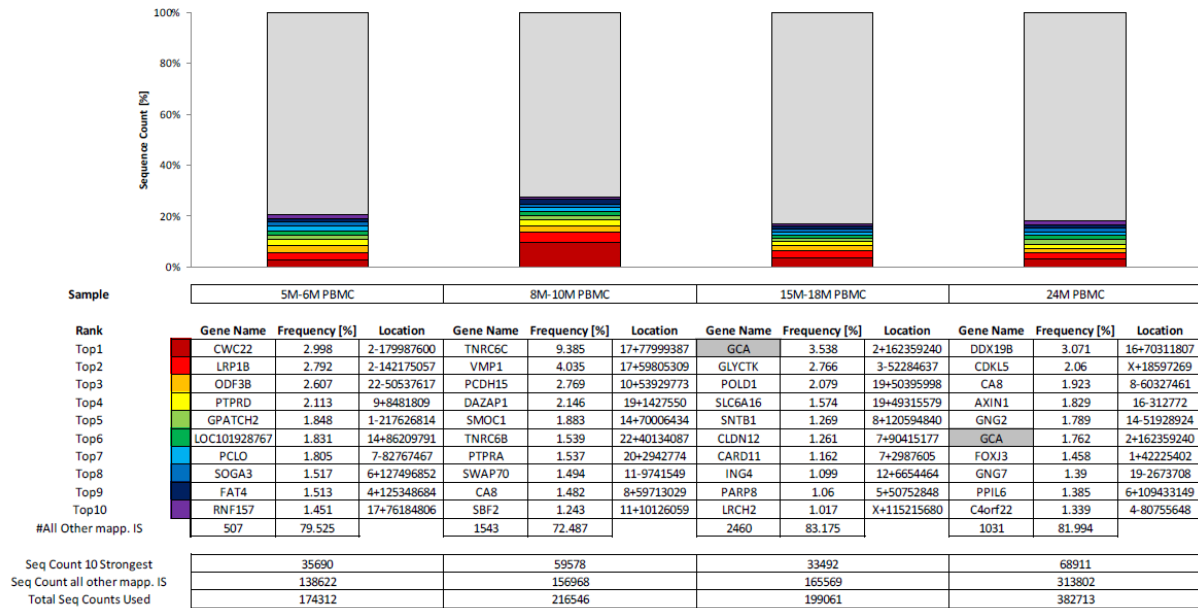
Patient J



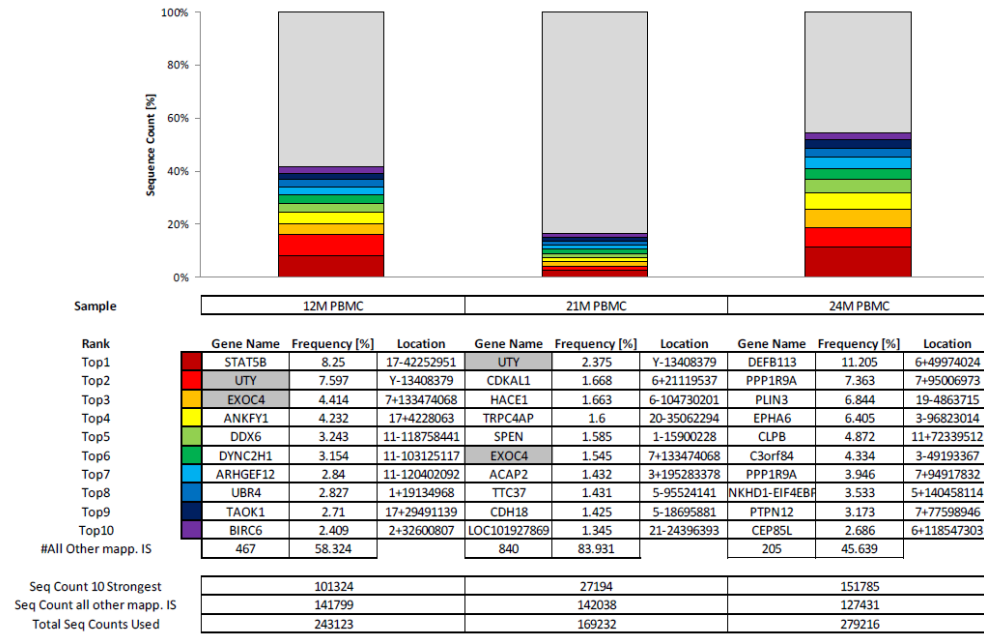
Patient K



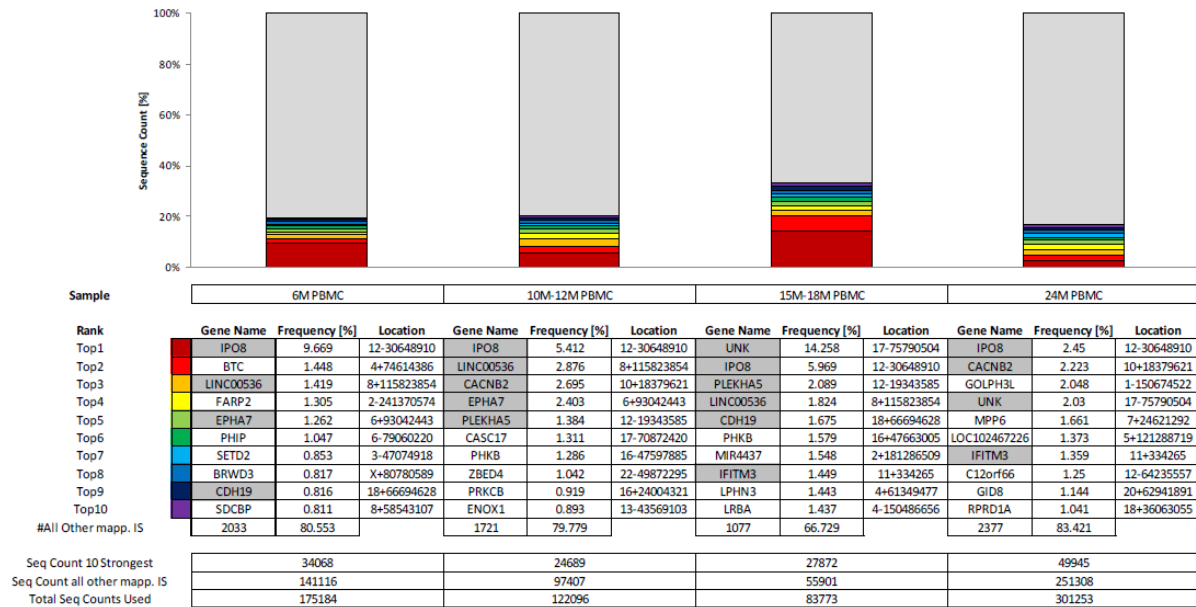
Patient L



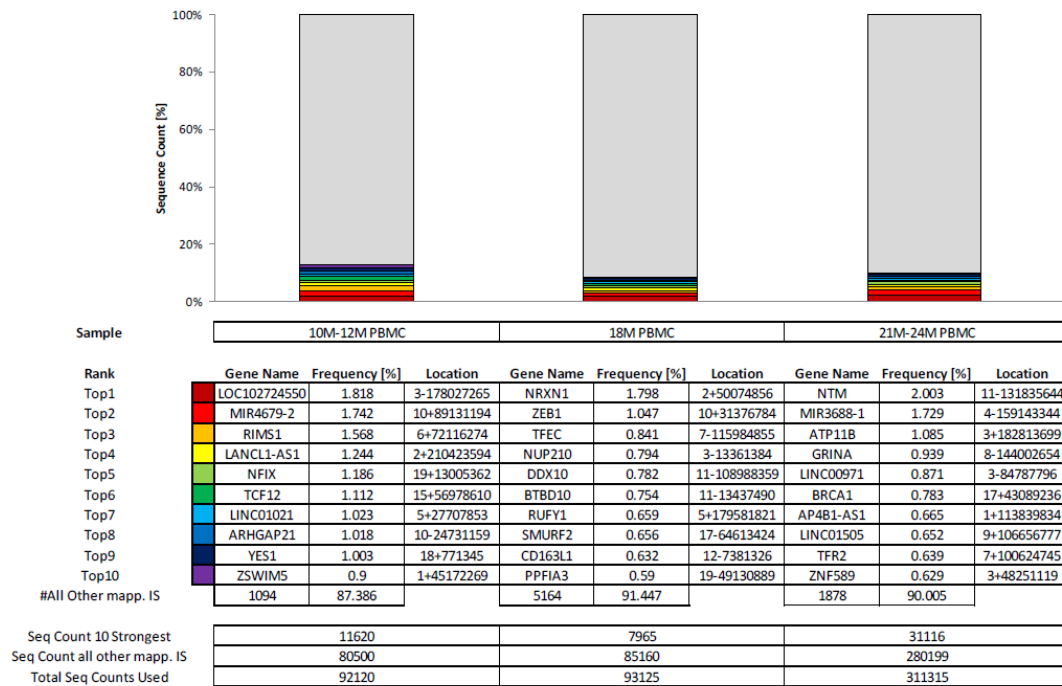
Patient M



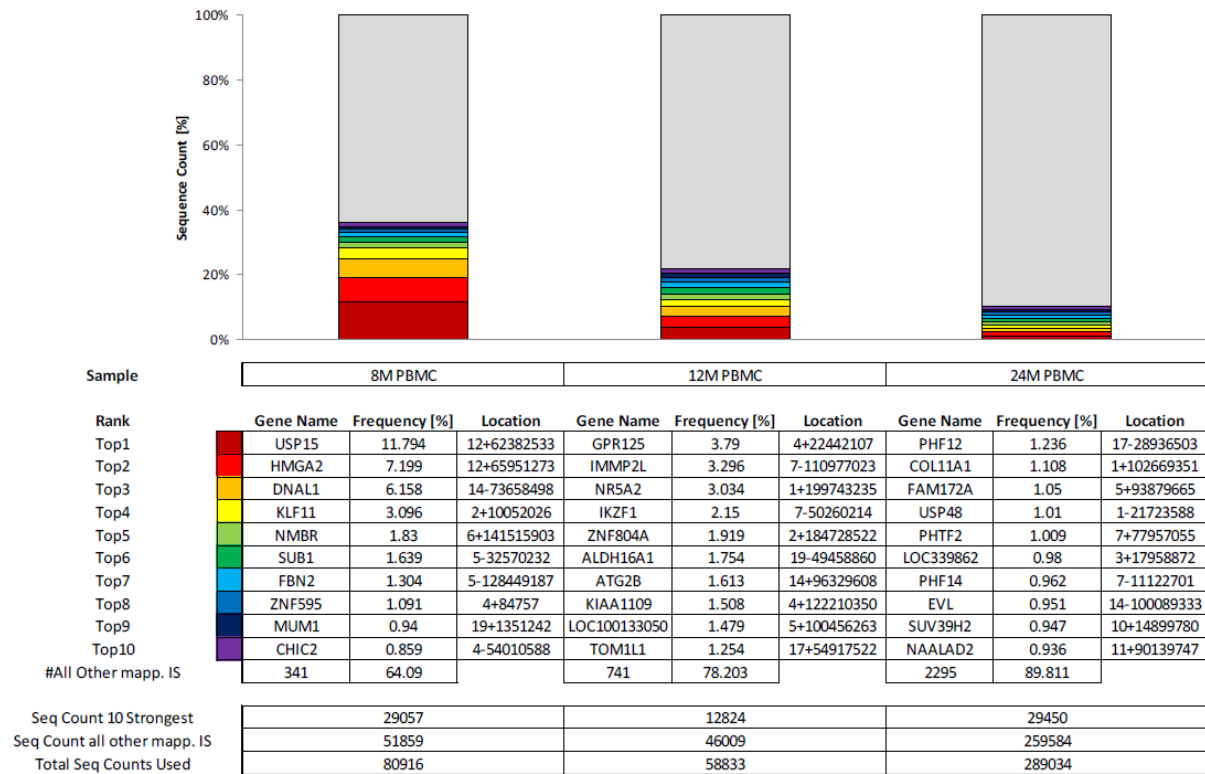
Patient N



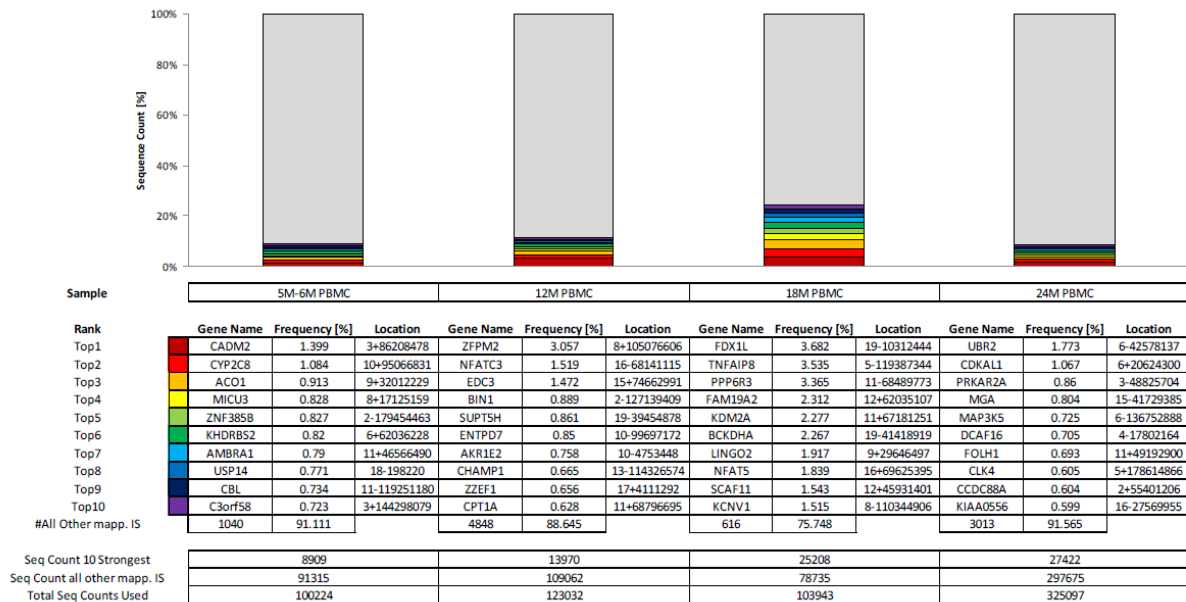
Patient O



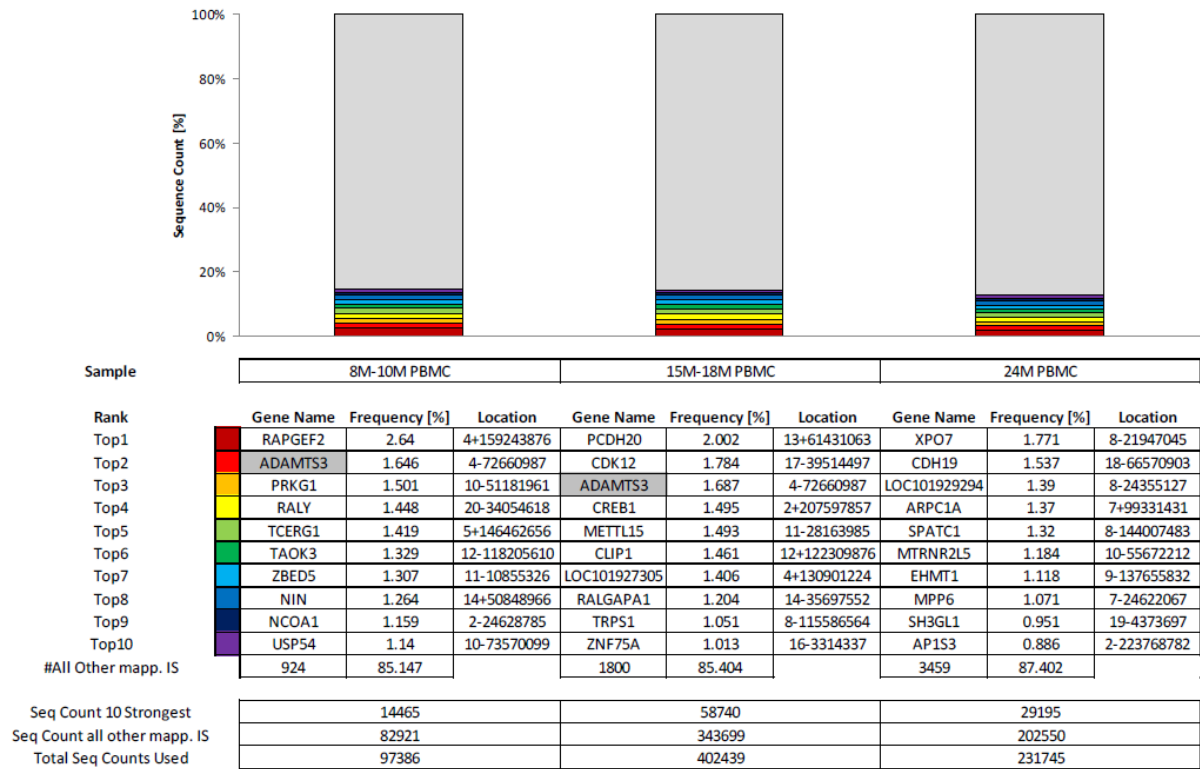
Patient P



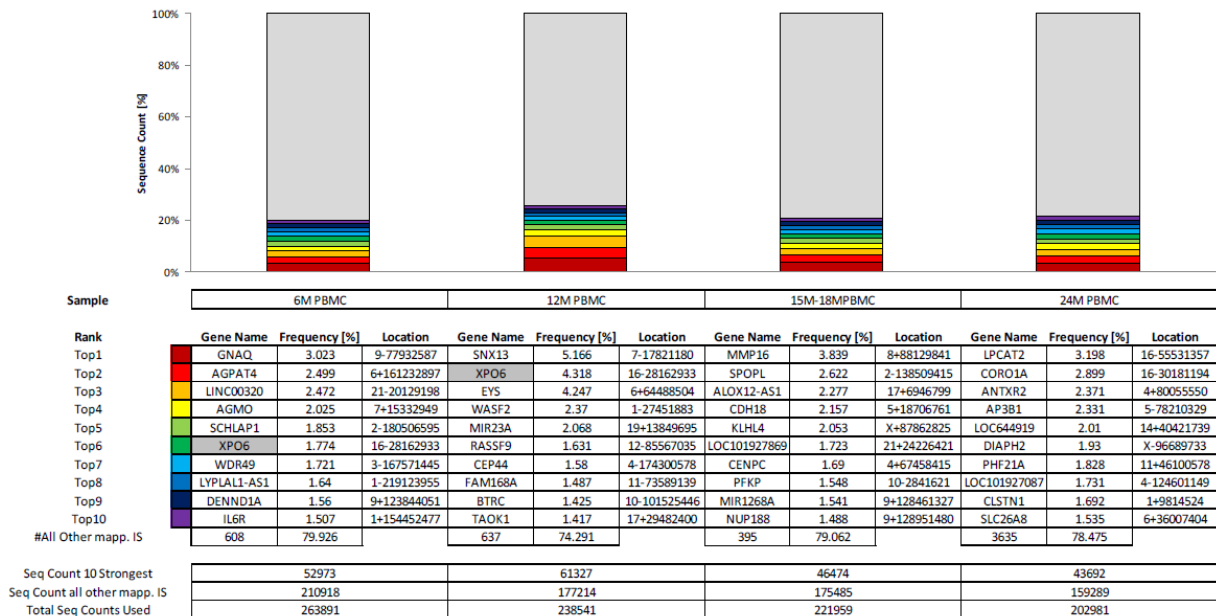
Patient Q



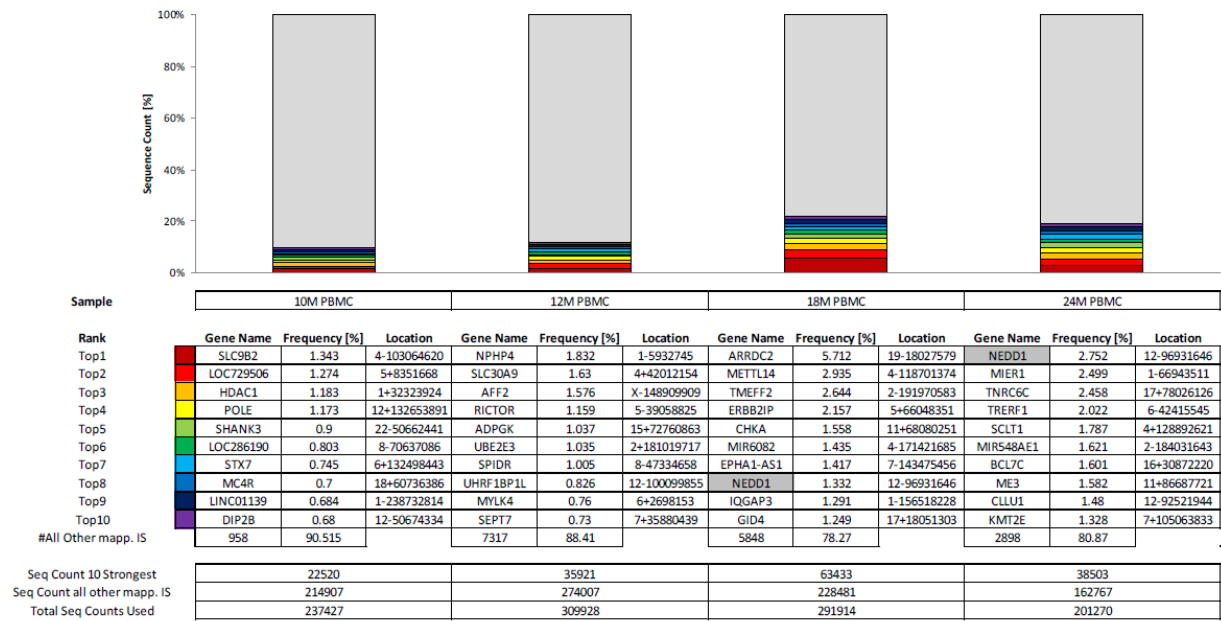
Patient R



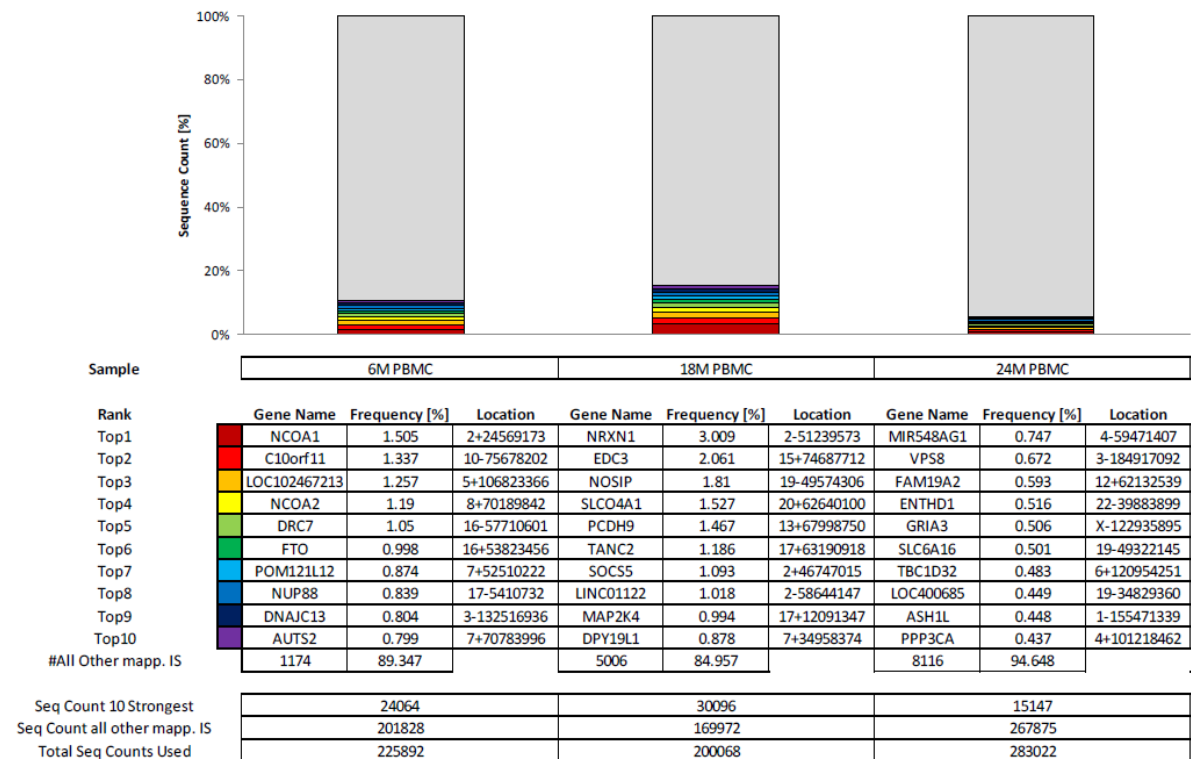
Patient S



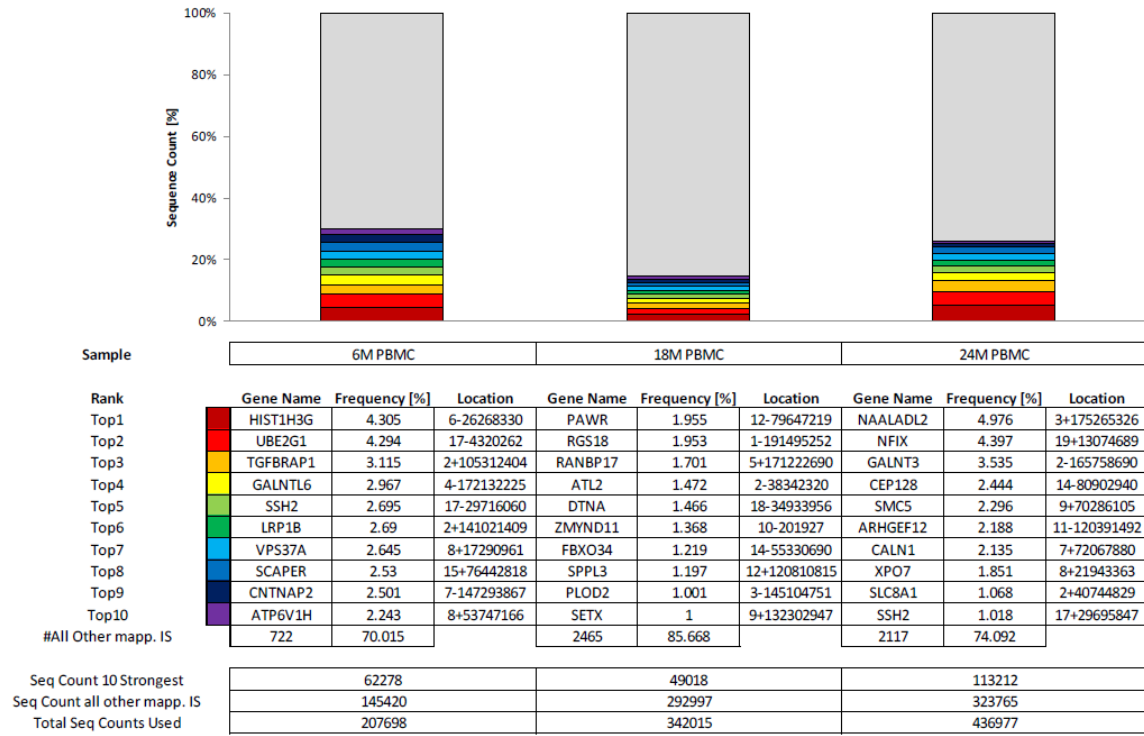
Patient T



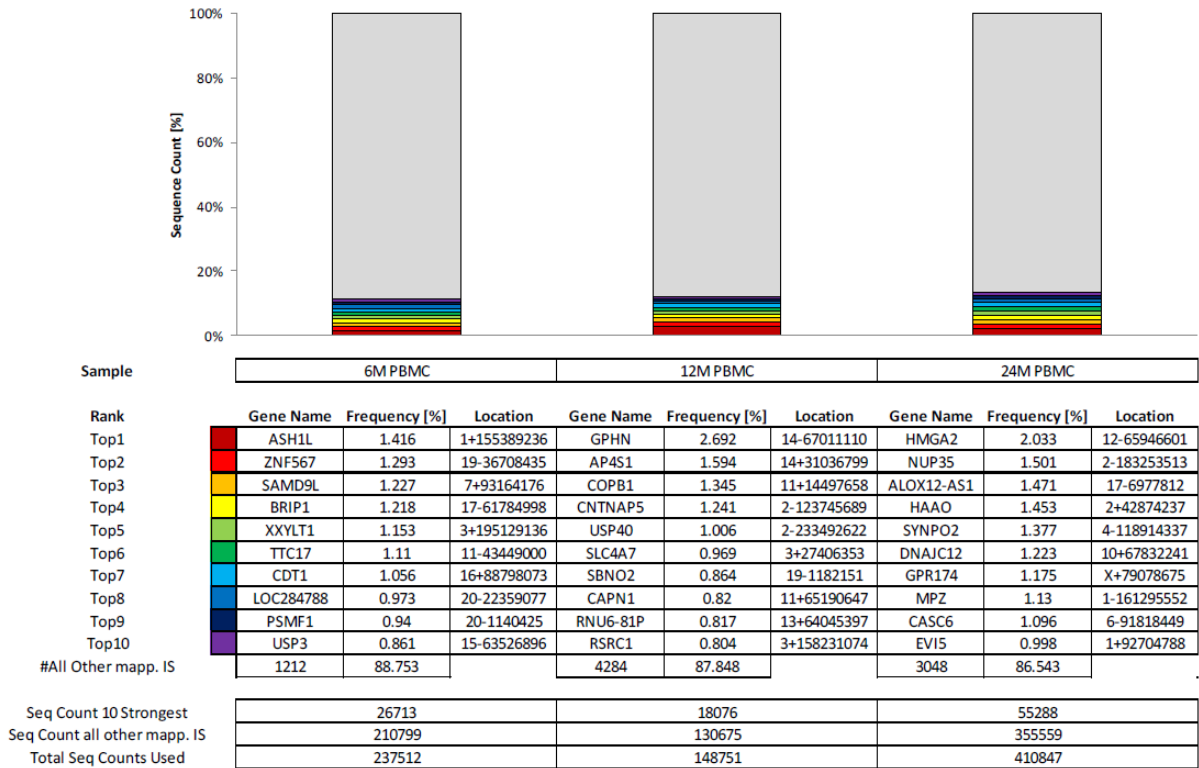
Patient U



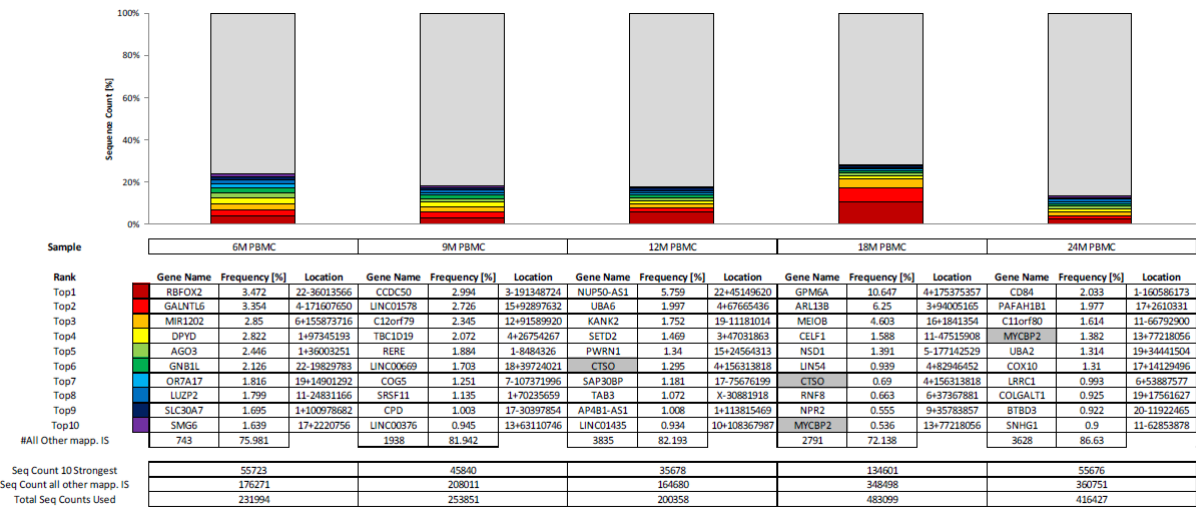
Patient V



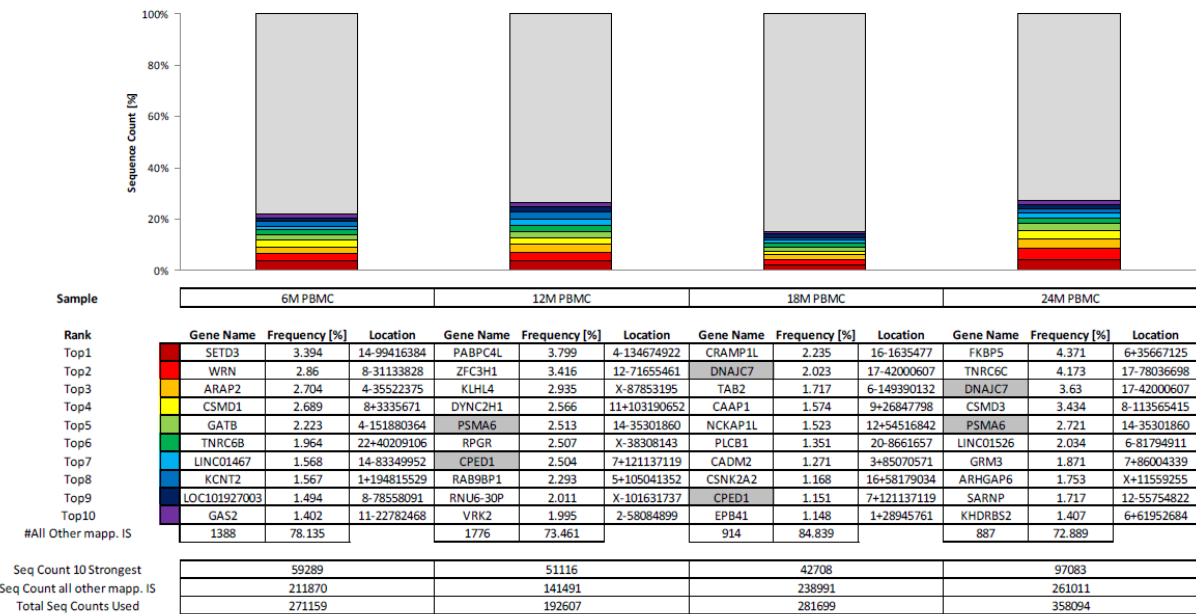
Patient W



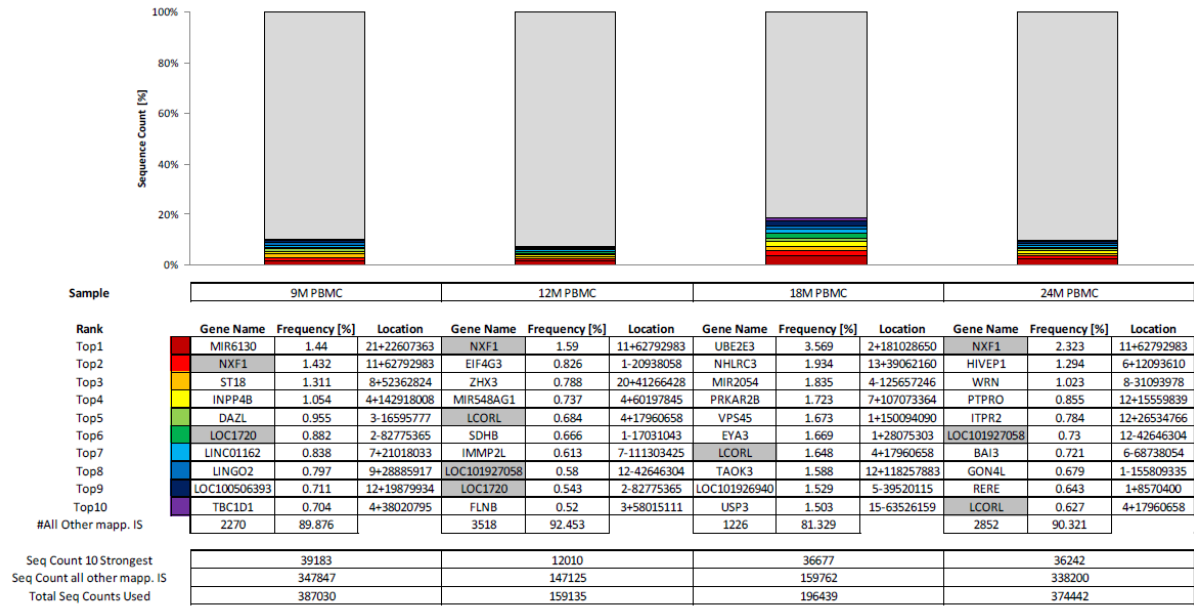
Patient X



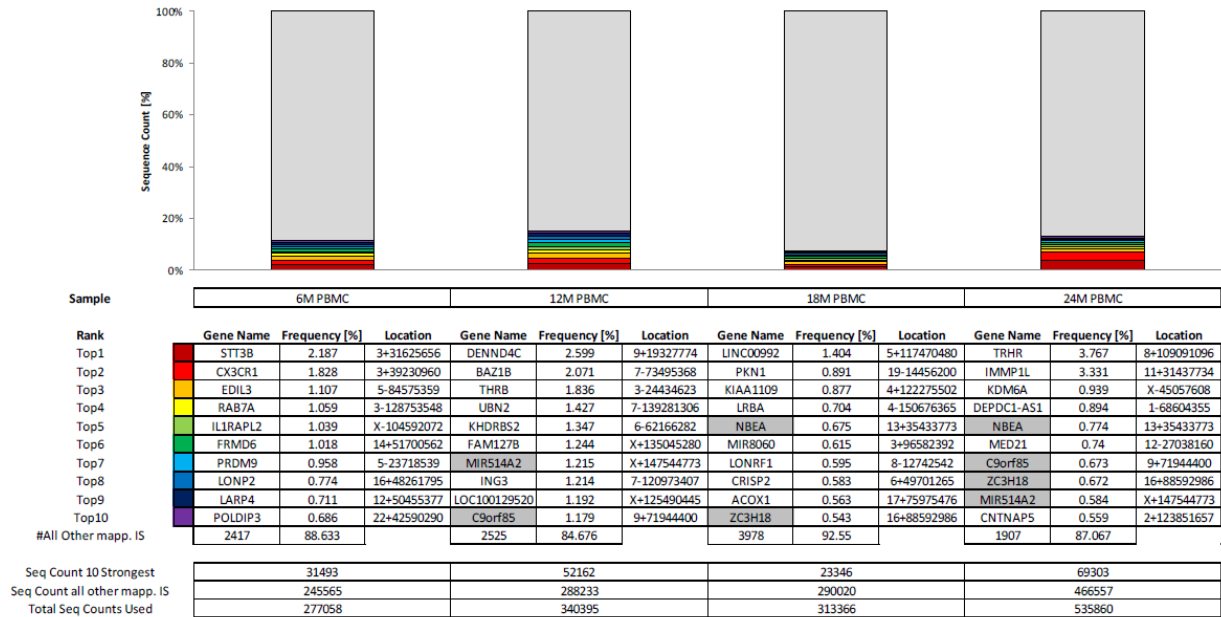
Patient Y



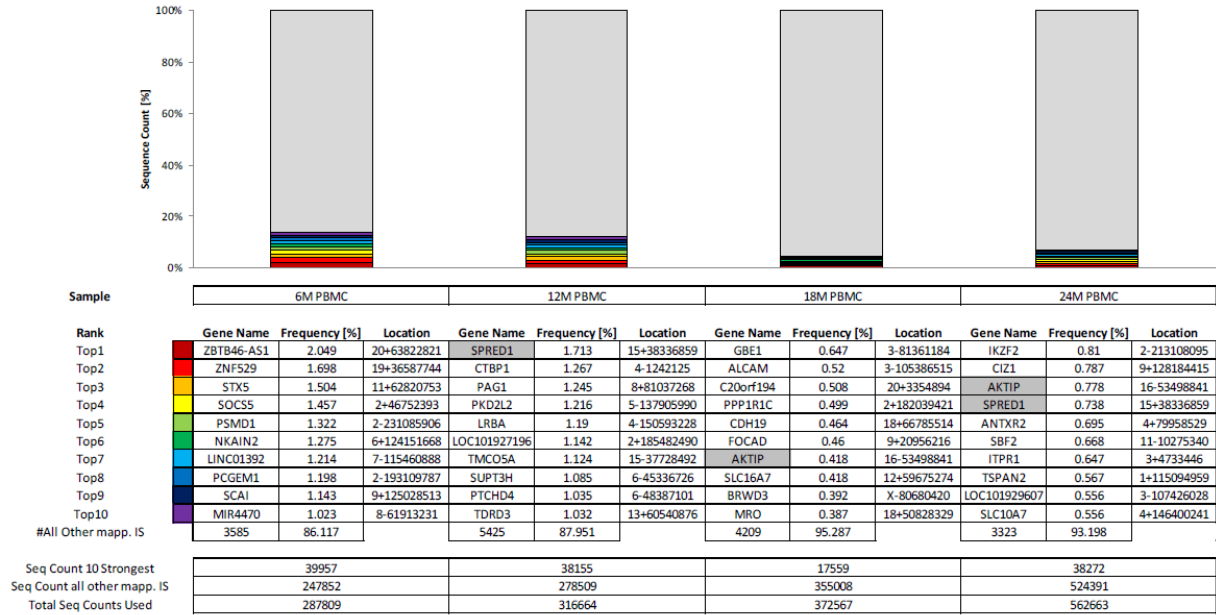
Patient Z



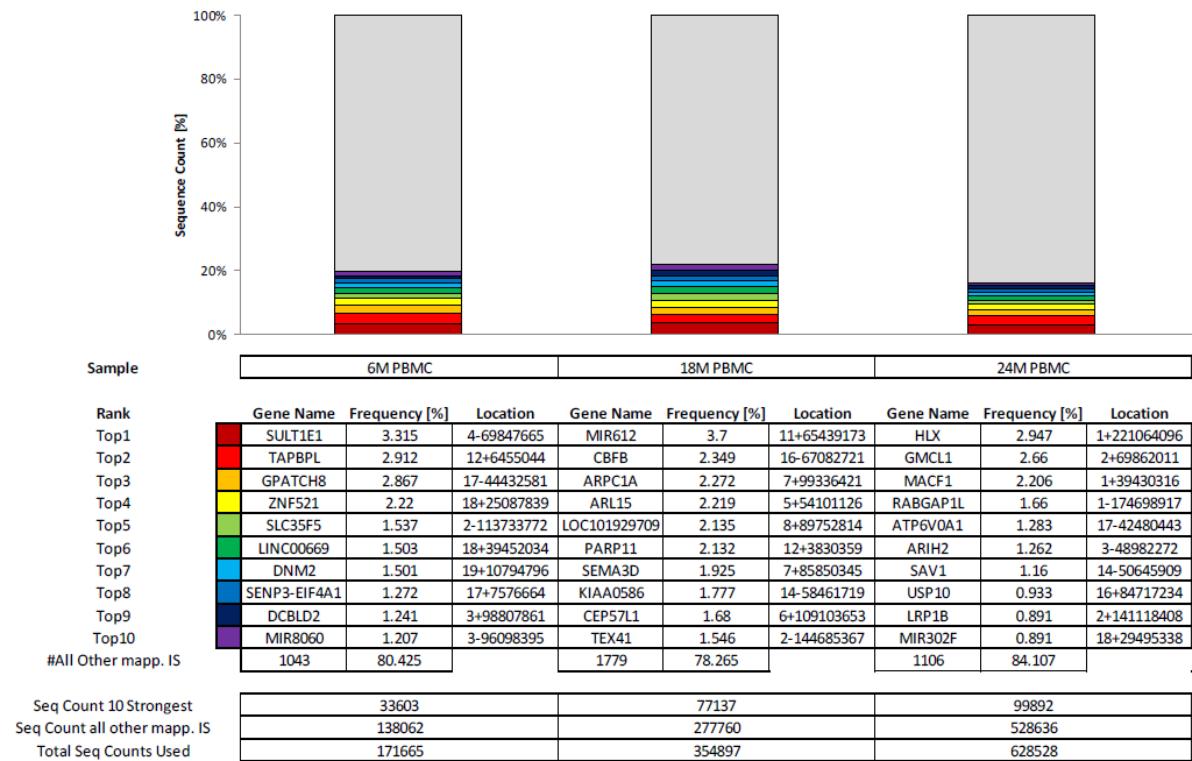
Patient AA



Patient BB

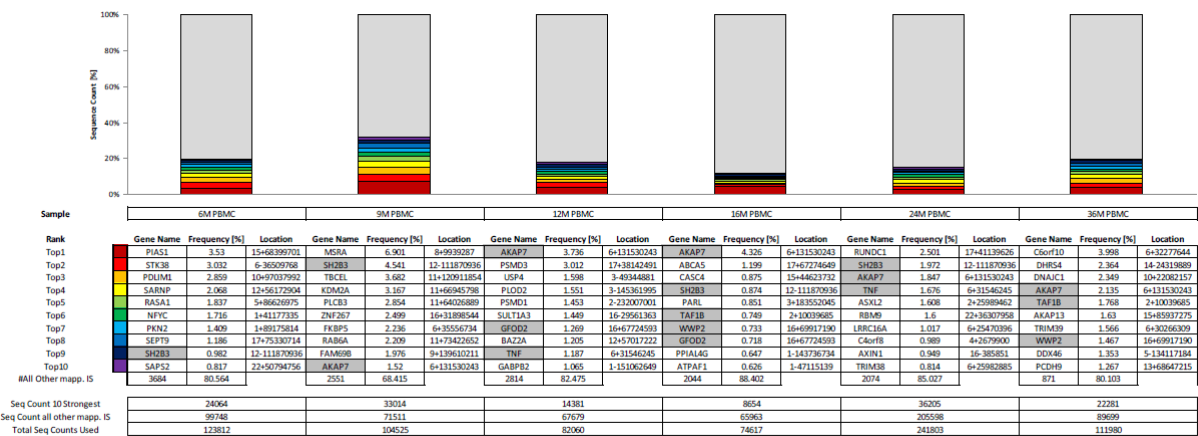


Patient CC

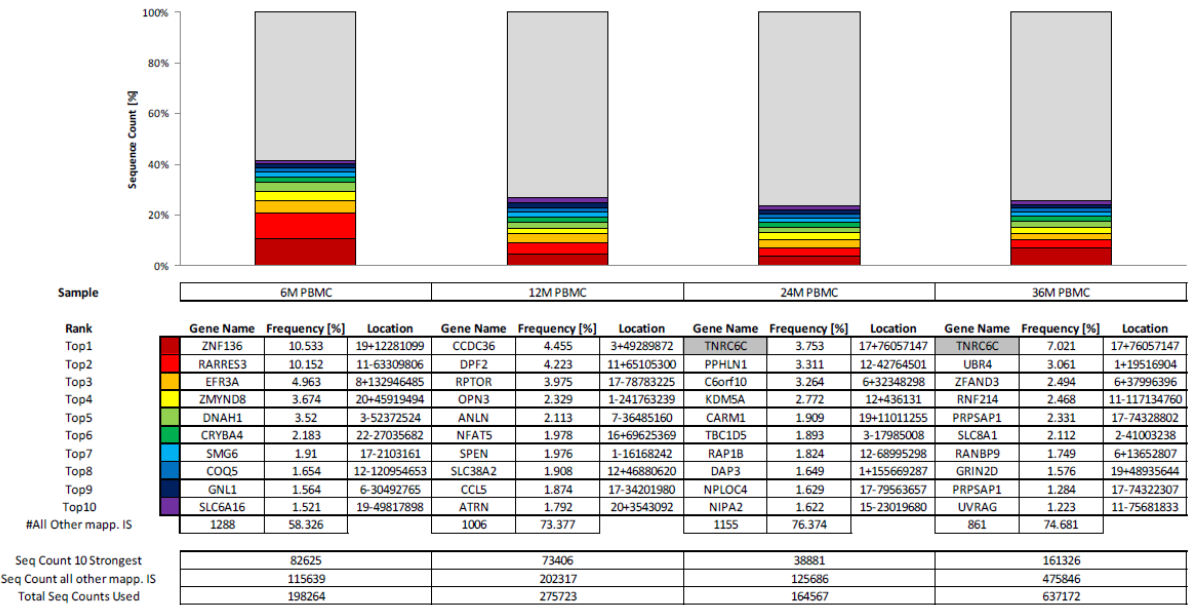


U.K. study

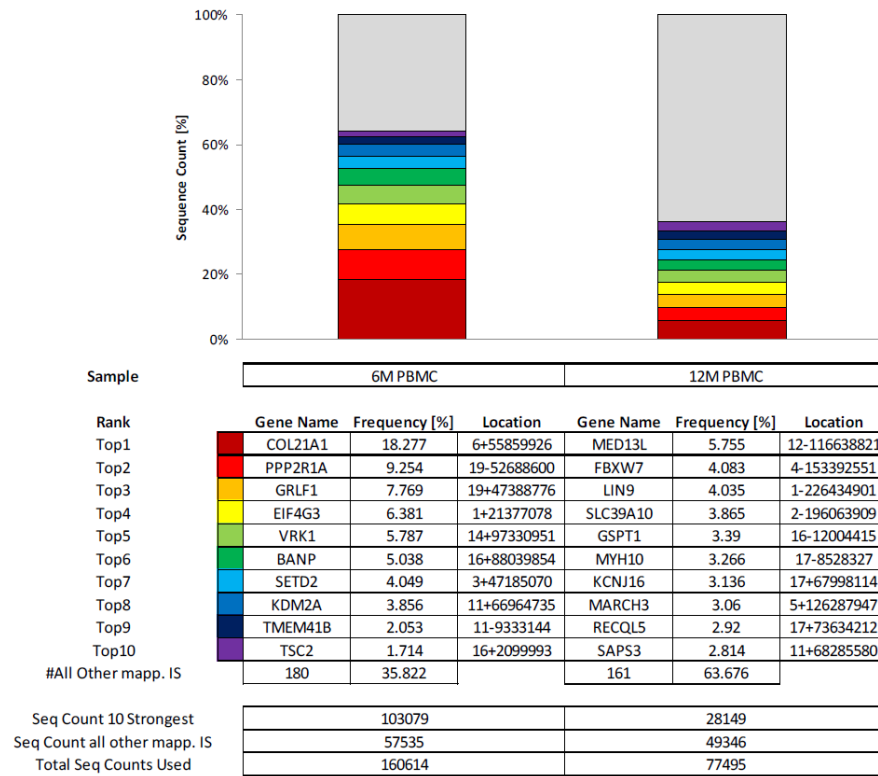
Patient A



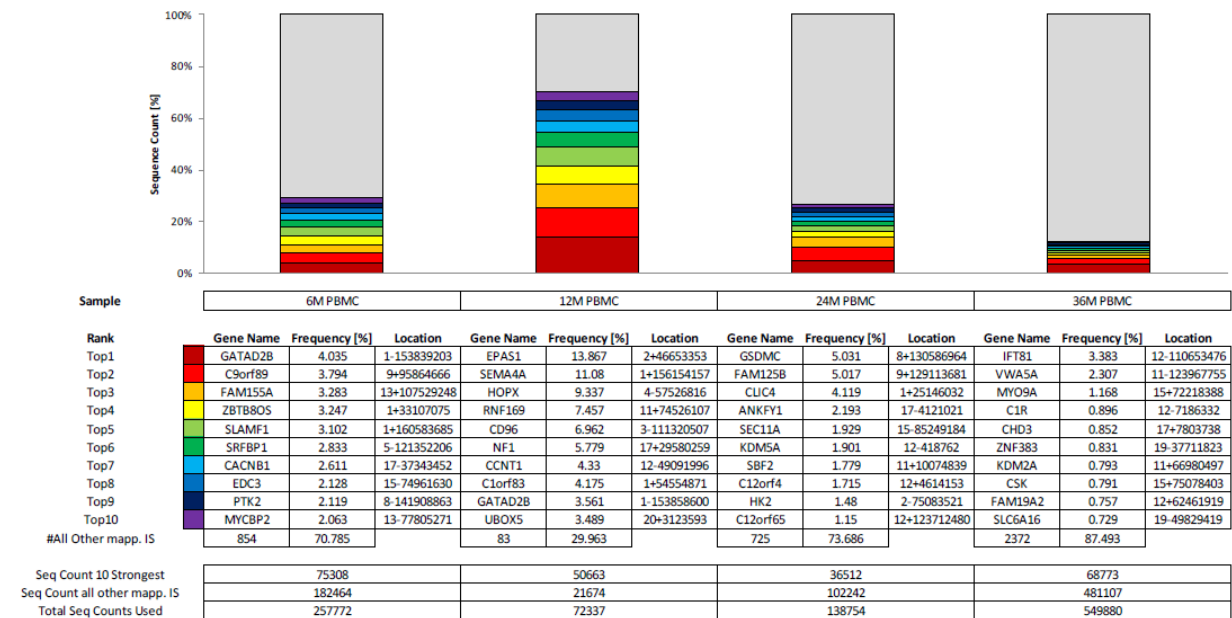
Patient B



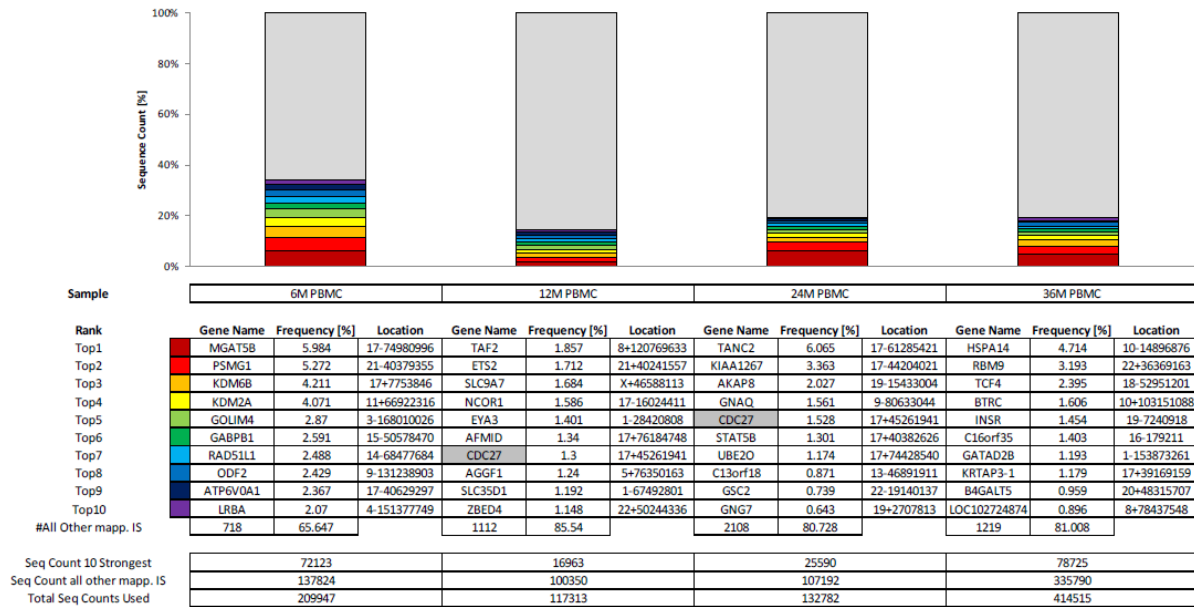
Patient C



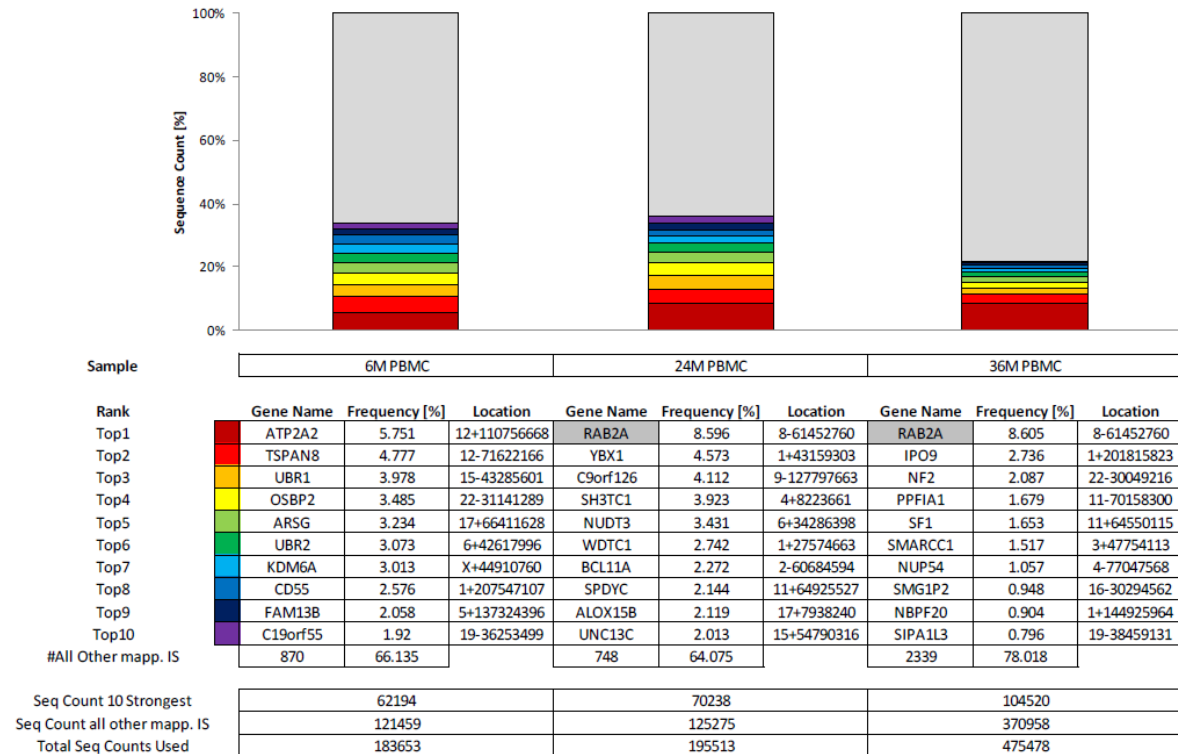
Patient D



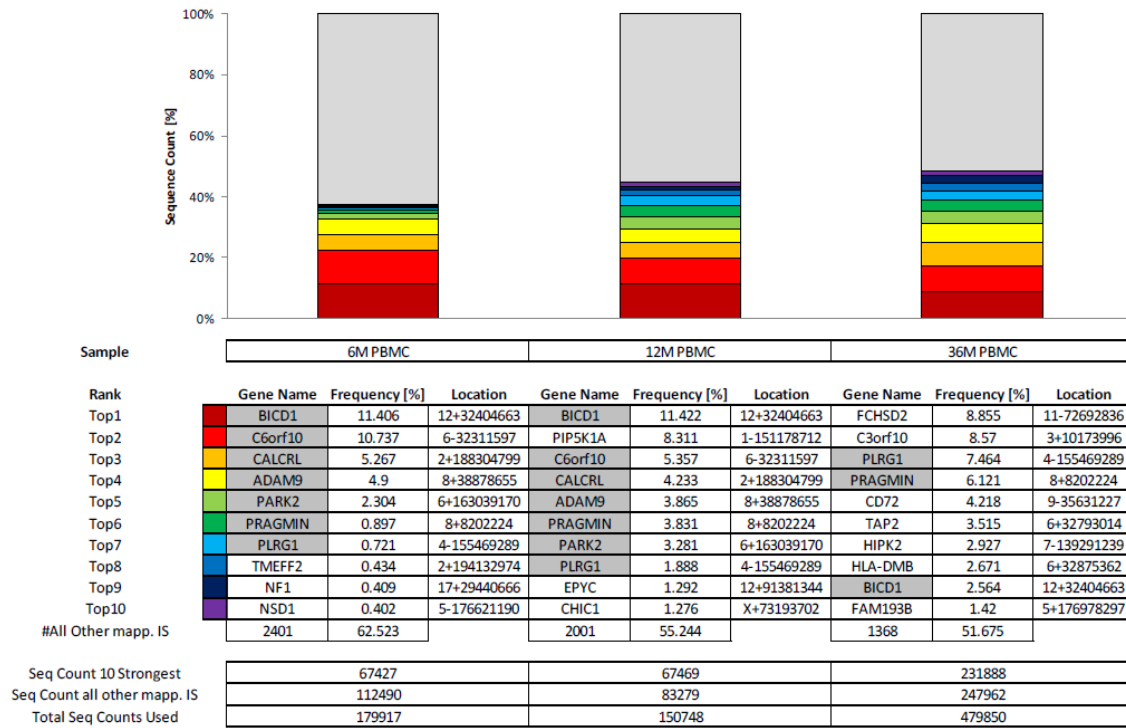
Patient E



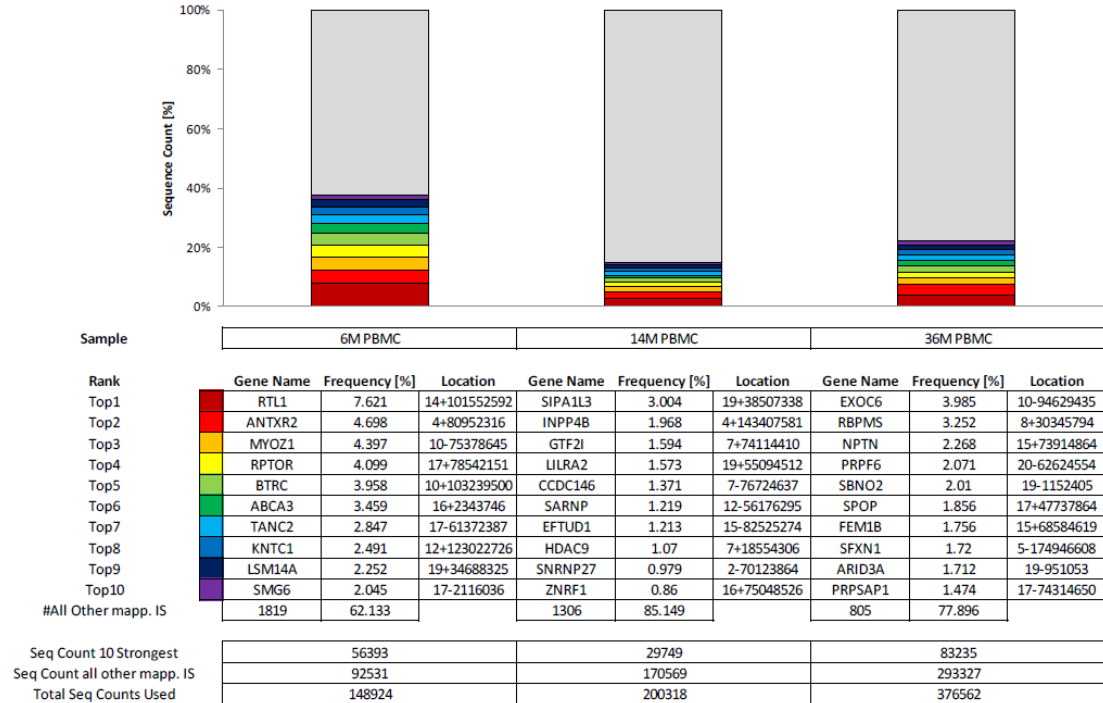
Patient F



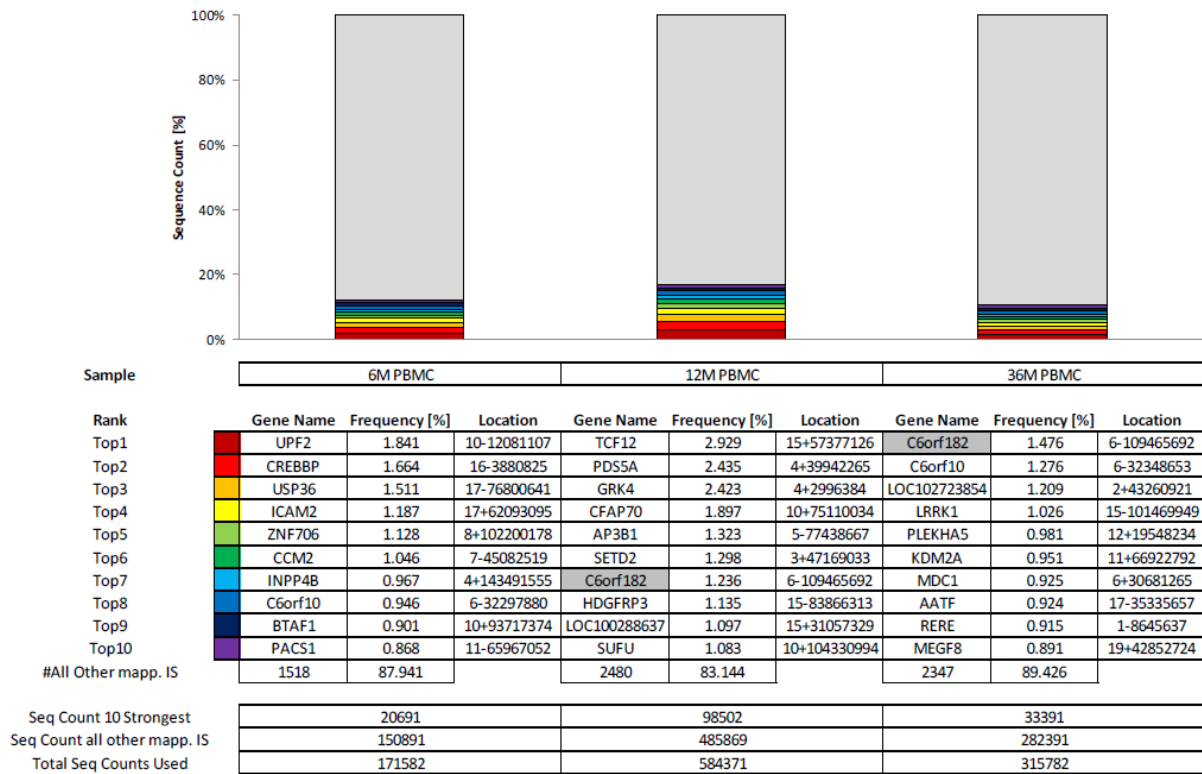
Patient G



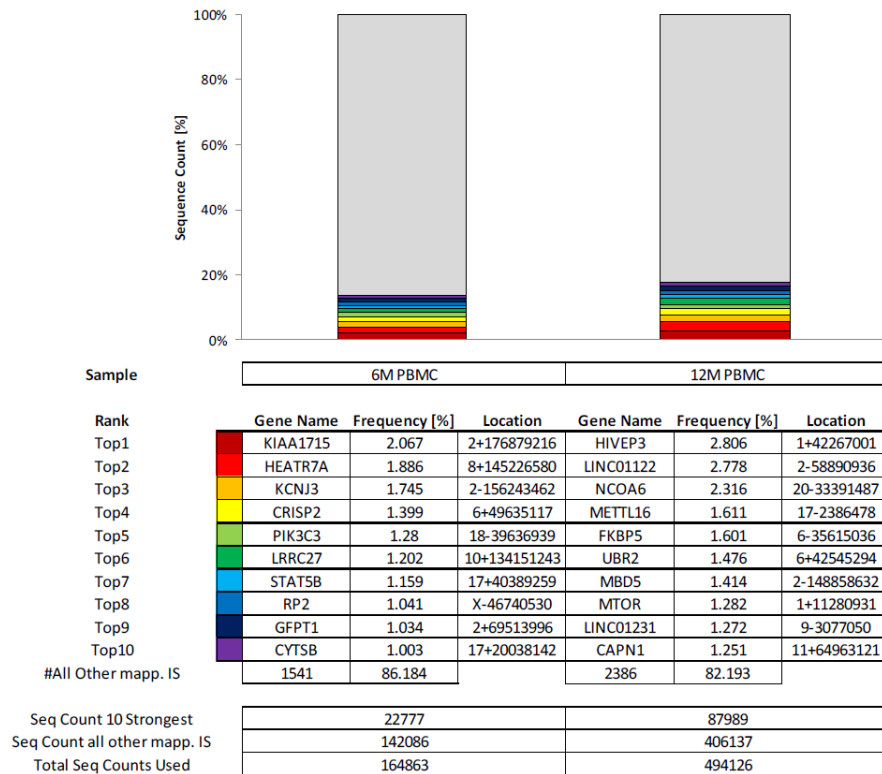
Patient H



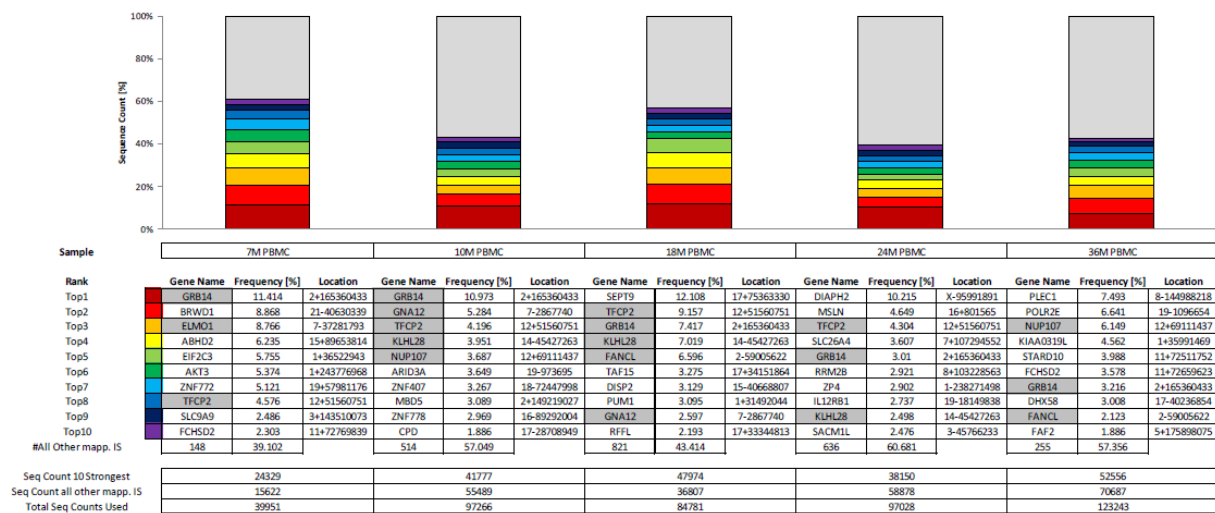
Patient I



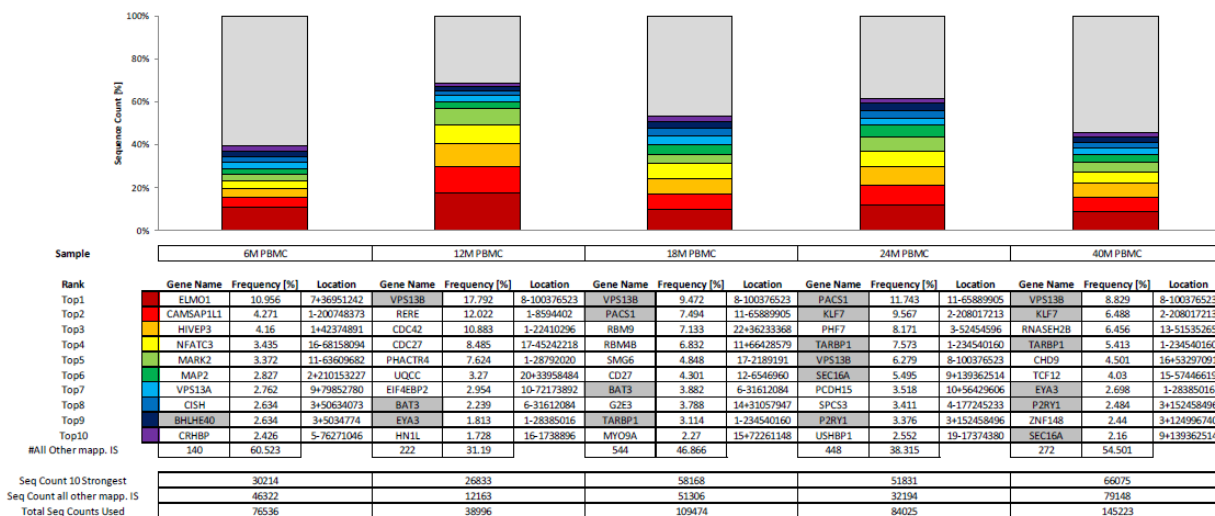
Patient J



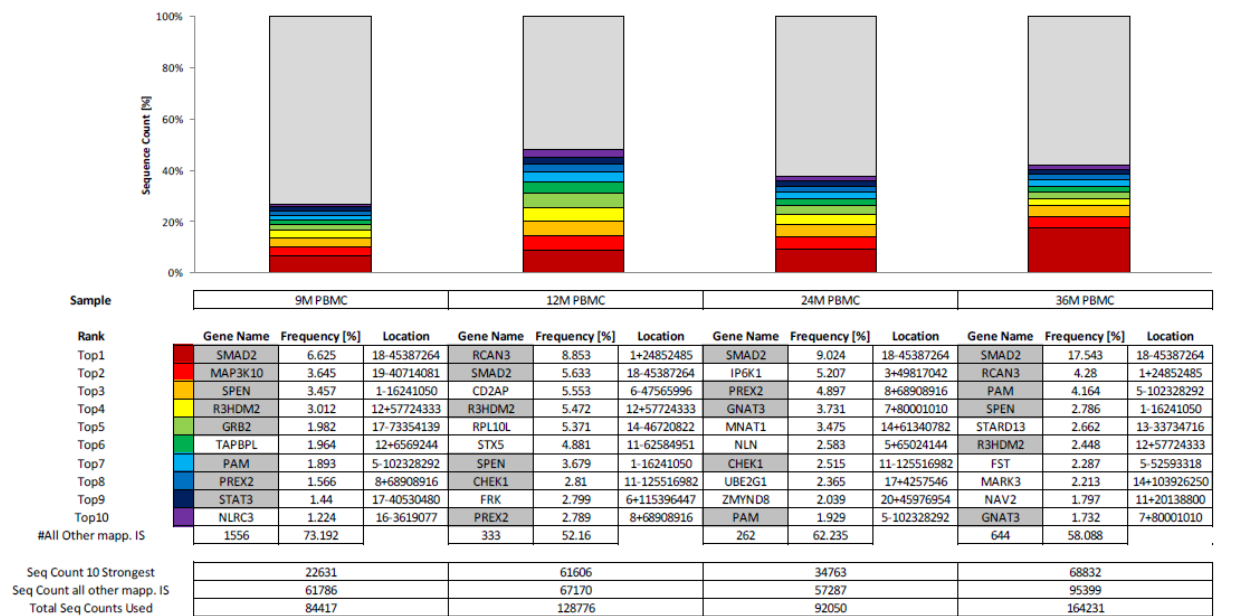
Patient K



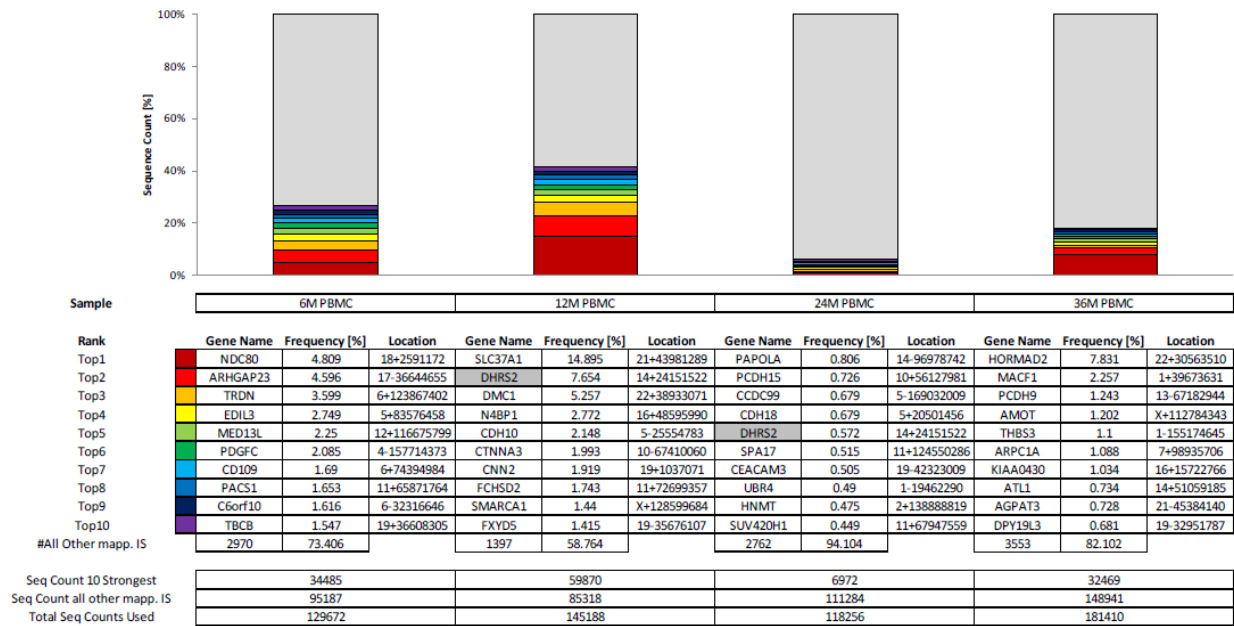
Patient L



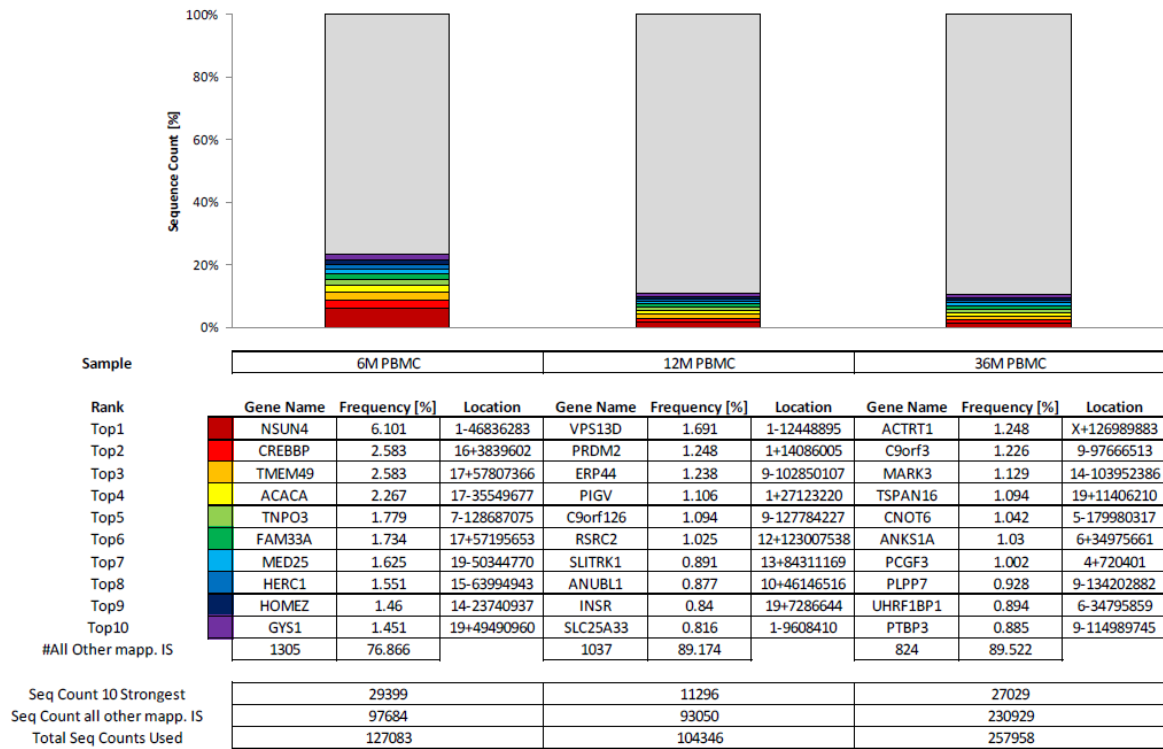
Patient M



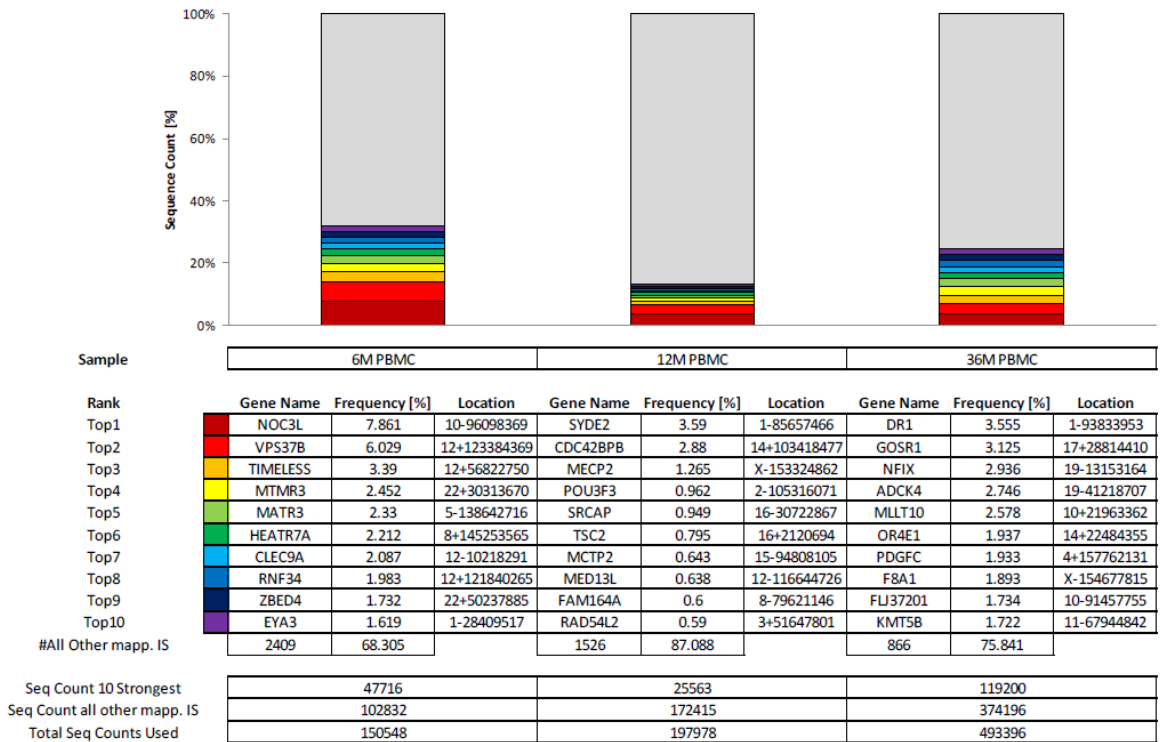
Patient N



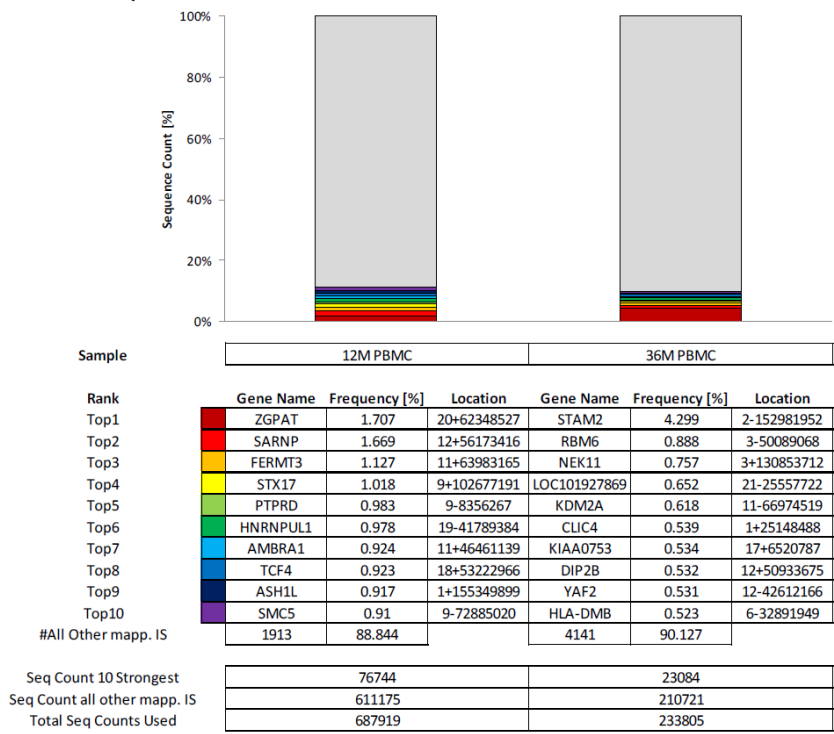
Patient O



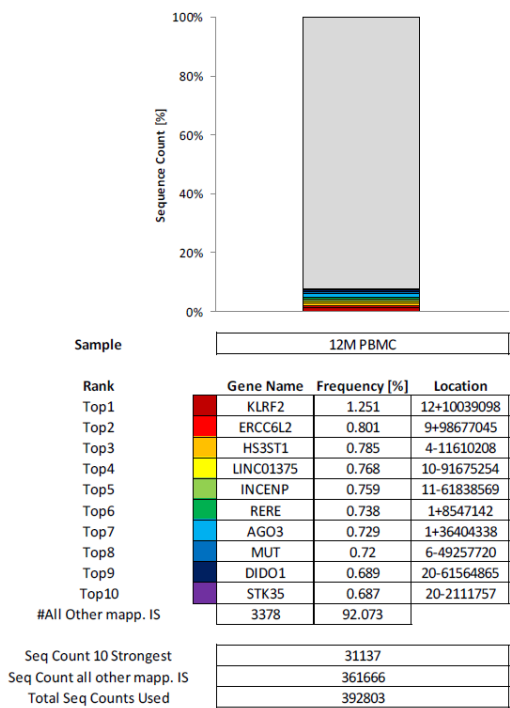
Patient P



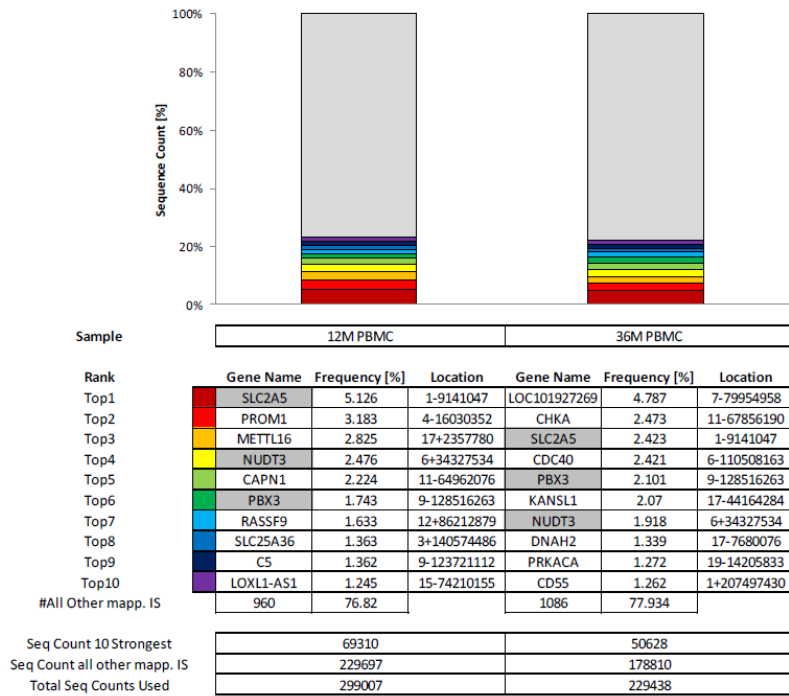
Patient Q



Patient R



Patient S



Patient T

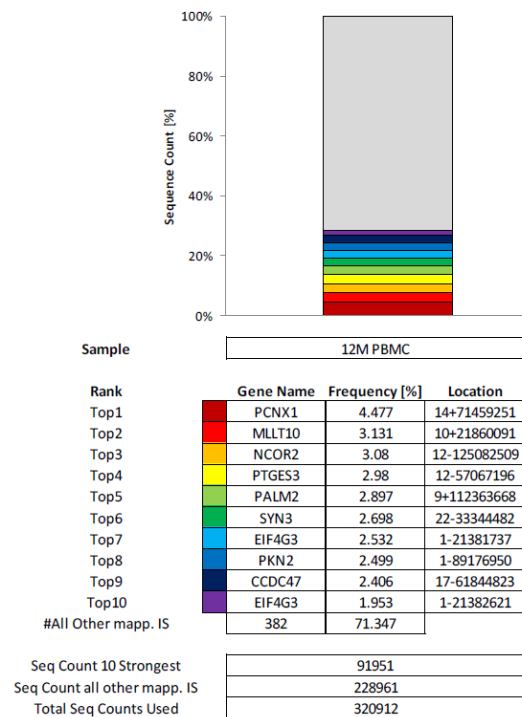
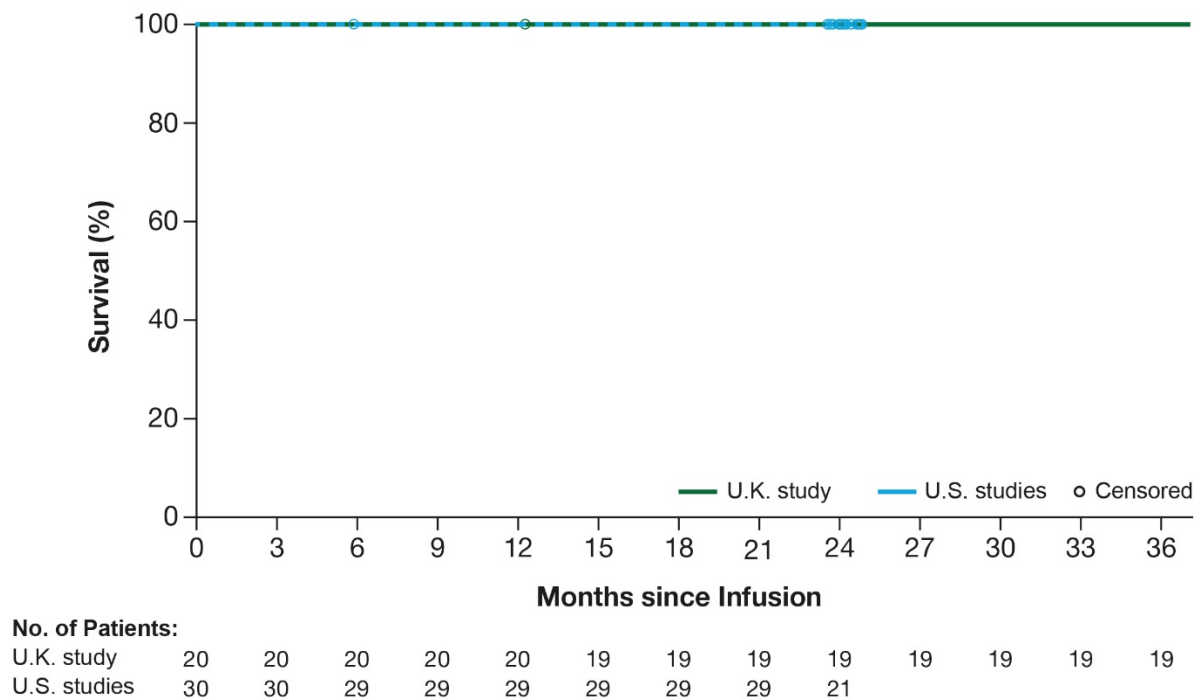


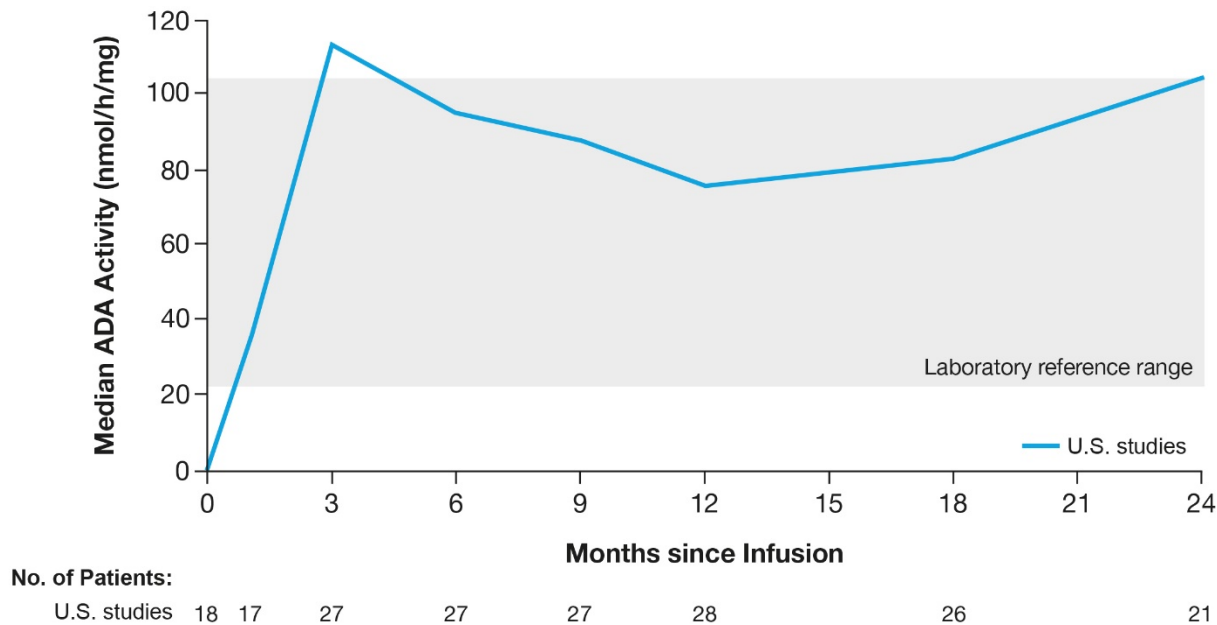
Fig. S3. Kaplan-Meier Curves for Overall Survival



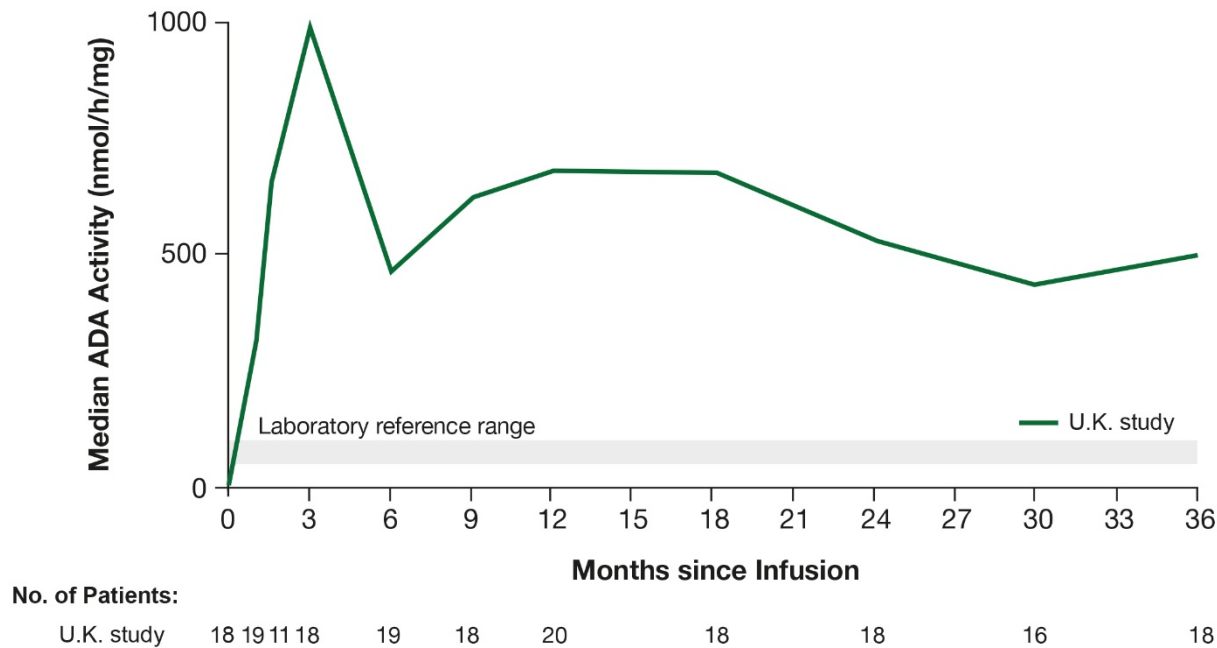
Overall survival over 24 (U.S. studies) and 36 (U.K. study) months in patients who received gene therapy. At 12, 24, and 36 months, overall survival was 100.0% for both U.S. and U.K. patients.

Fig. S4. Median ADA Enzyme Activity in Peripheral Red Blood Cells

A

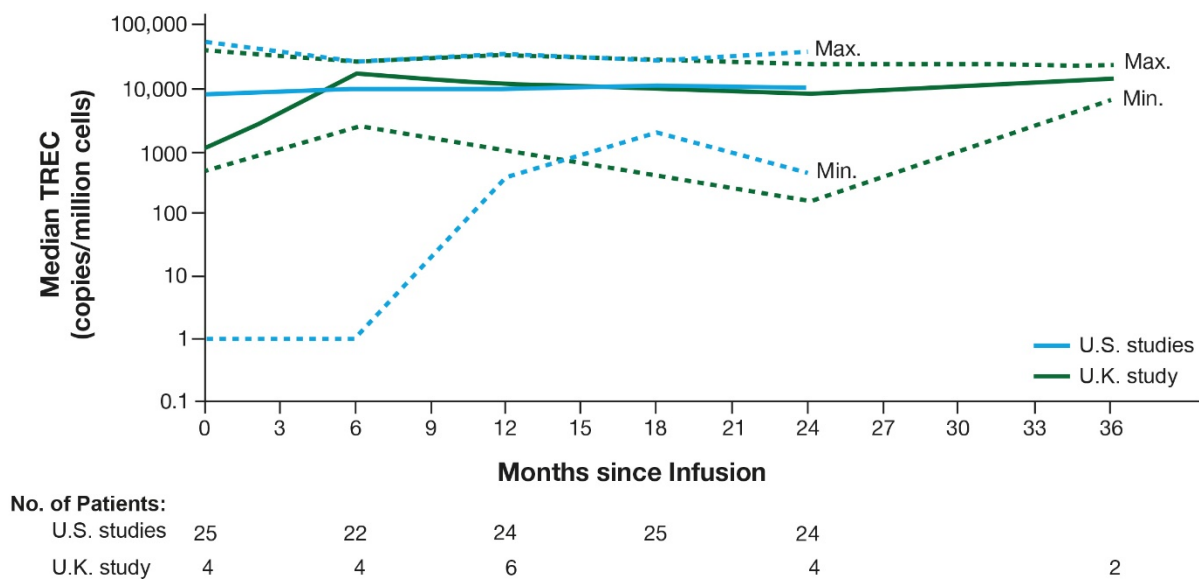


B



ADA activity over 24 months (U.S. studies, Panel A) and 36 months (U.K. study, Panel B) in OTL-101–treated Patients. Median adenosine deaminase (ADA) enzyme activity in peripheral red blood cells. Assays using different systems were employed in the U.S. and U.K. sites.

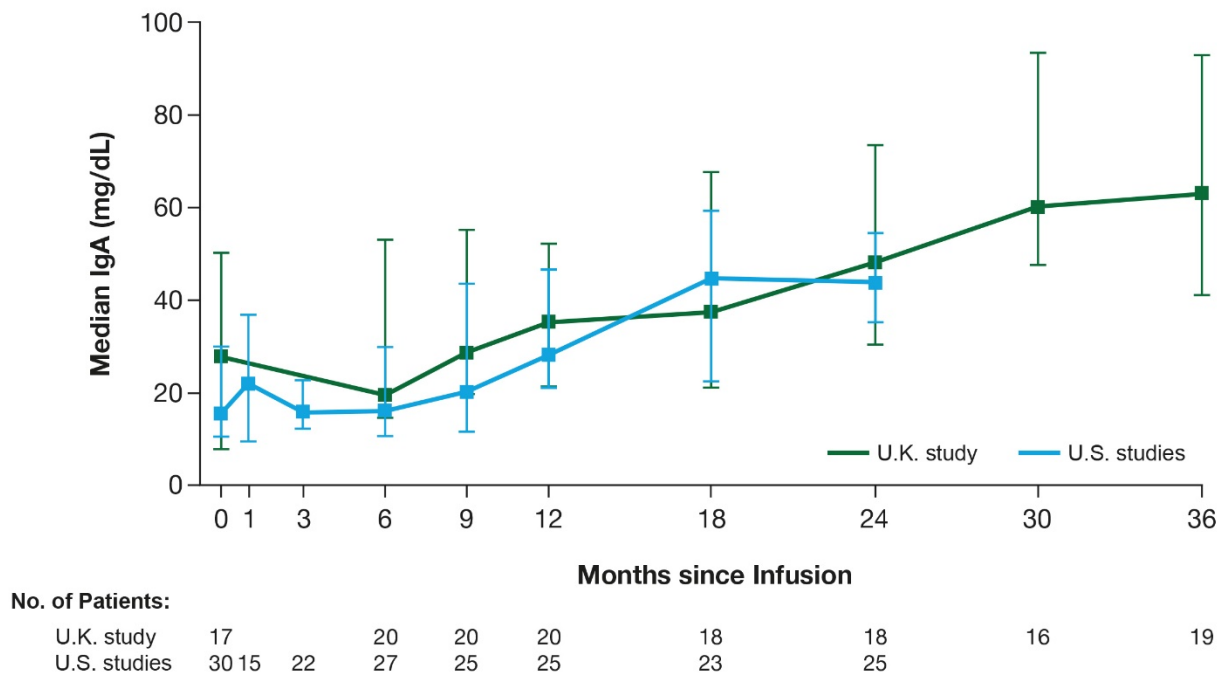
Fig. S5. TREC Counts in Peripheral Blood



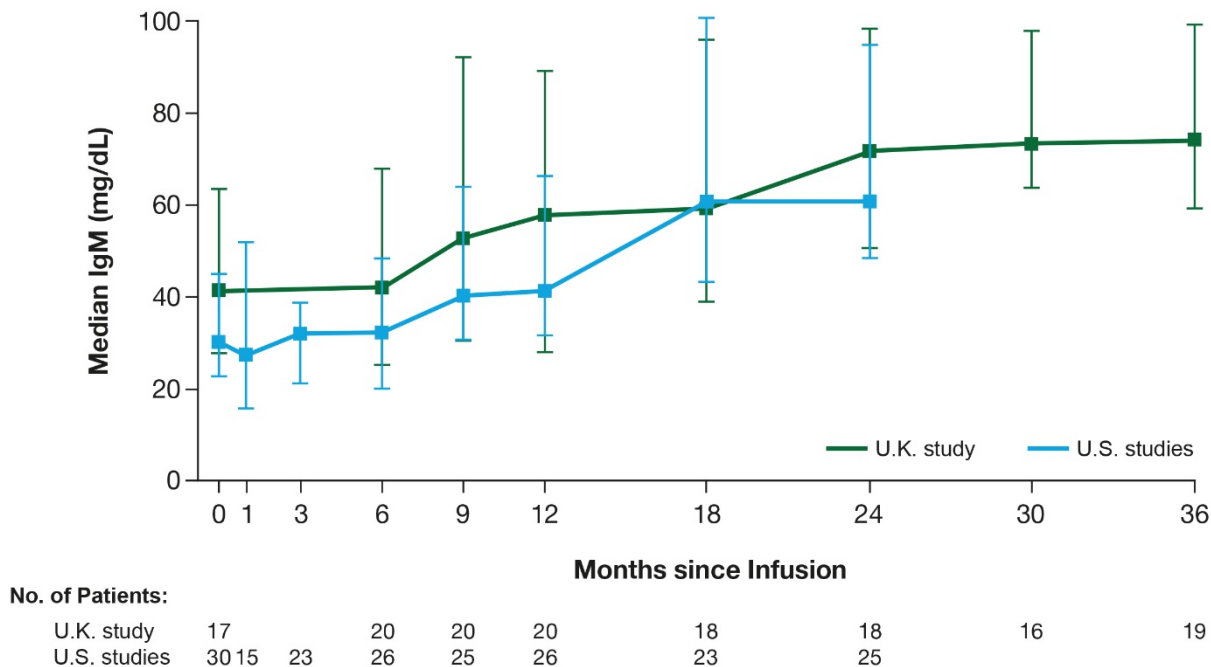
TREC counts over 24 months (U.S. studies) and 36 months (U.K. study) in OTL-101–treated Patients. Median (solid line) and minimum and maximum values (dotted lines) are plotted for all patients. Values of 0 are adjusted to 1. TREC denotes T-cell receptor excision circle.

Fig. S6. Serum IgA and IgM Levels and Serum IgG Levels Following IgRT Cessation

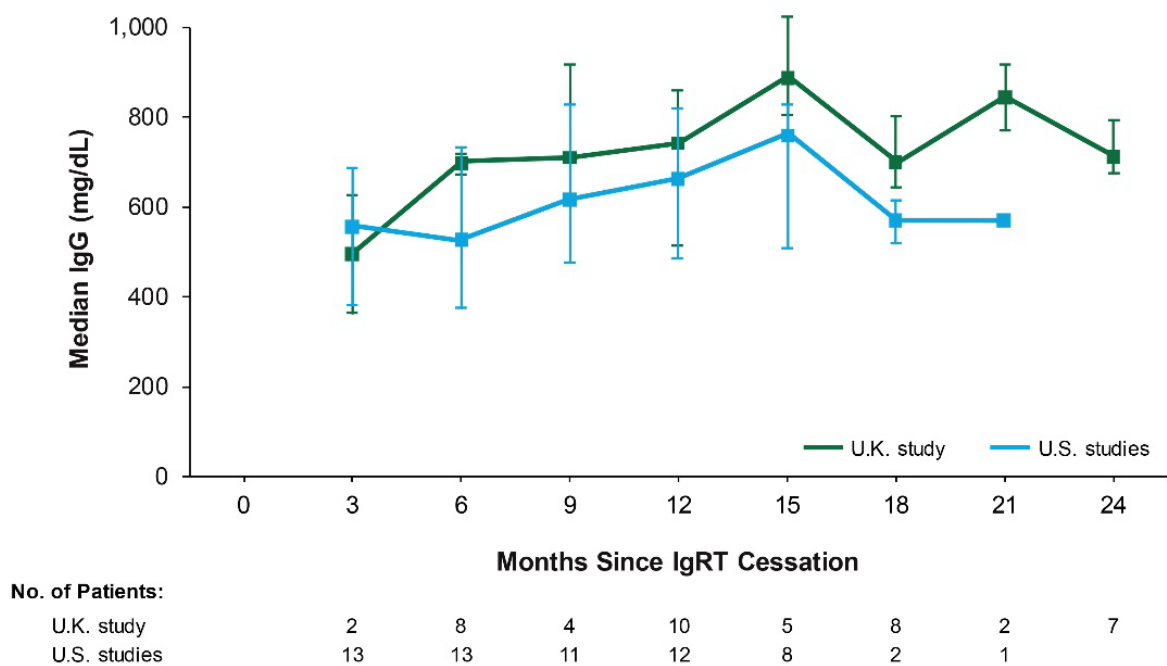
A Serum IgA Levels



B Serum IgM Levels



C IgG after IgRT Cessation



Serum IgA (Panel A), IgM (Panel B) and IgG (Panel C) over 24 months (U.S. studies) and 36 months (U.K. study). Medians and interquartile ranges are plotted. Treatment improved serum IgM and IgA levels, resulting in most patients achieving levels within or above normal limits over time. Median IgG levels remained high following cessation of IgRT.

Ig denotes immunoglobulin and IgRT denotes immunoglobulin replacement therapy.

Fig. S7. Severe Infection Rate by Time Period

Severe infections, ie SAEs coded to Infections and Infestations MedDRA system organ class, were assessed up to 24 months' (U.S. studies) or 36 months' (U.K. study) follow up. Starting at three months post-treatment to last follow-up severe infection rates were similar in the U.S. and U.K. studies.

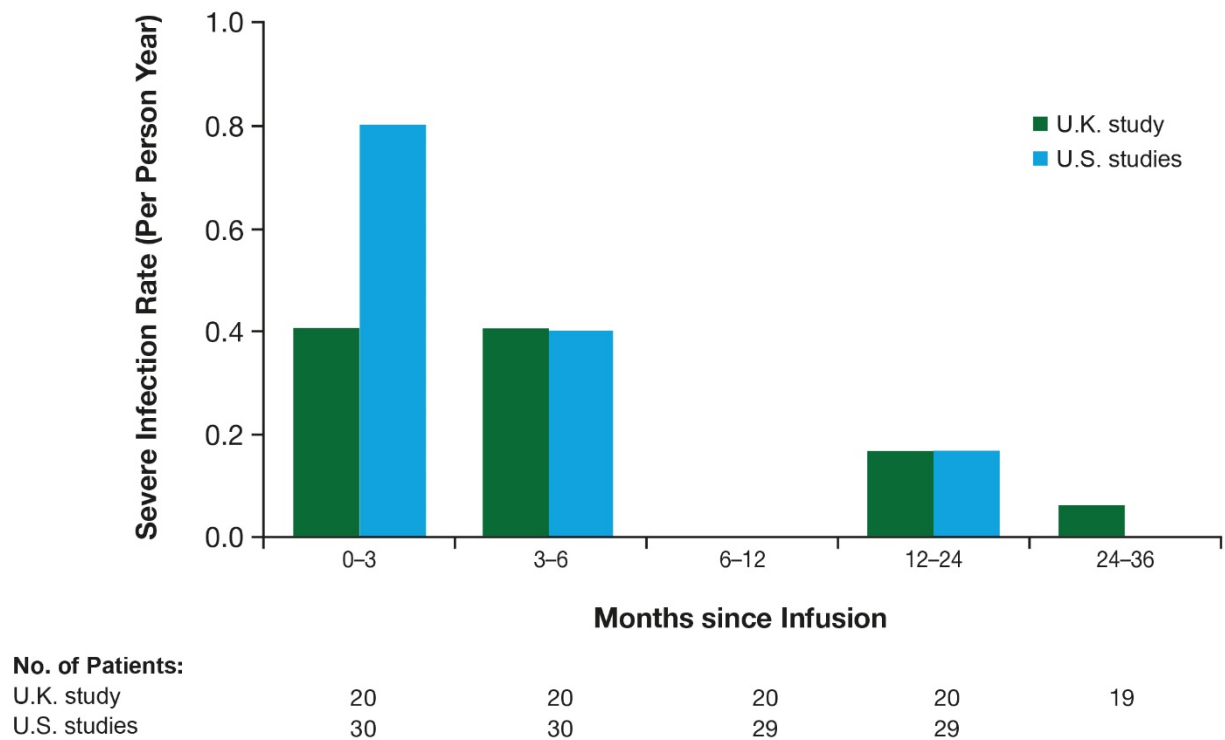
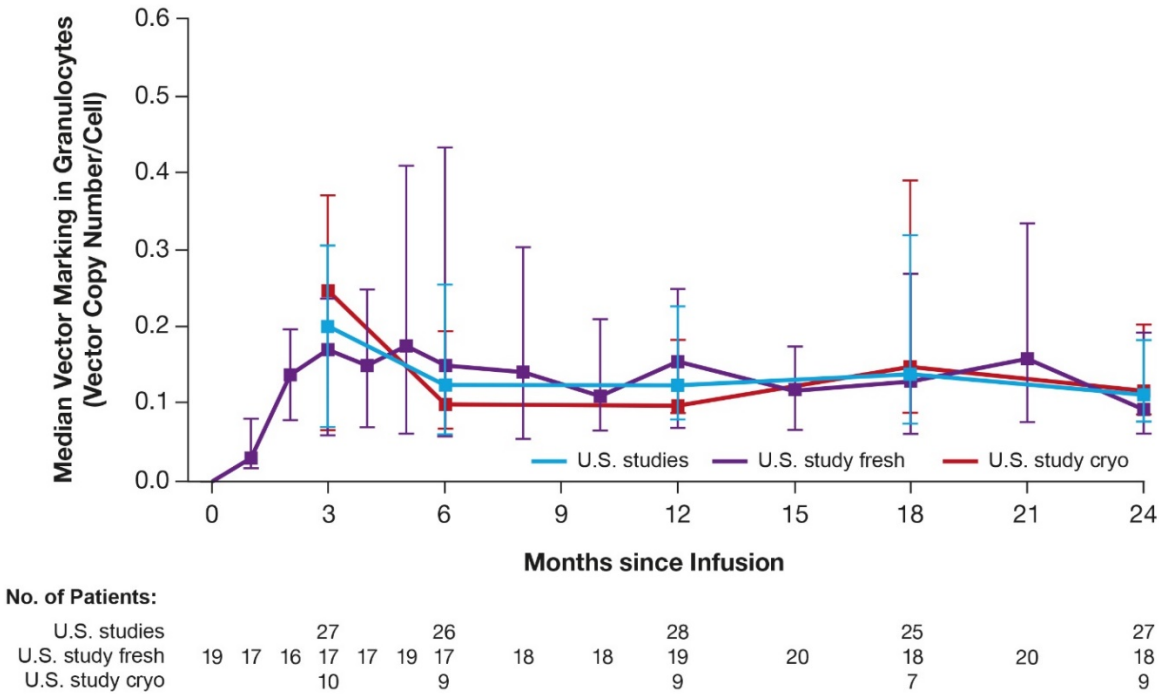
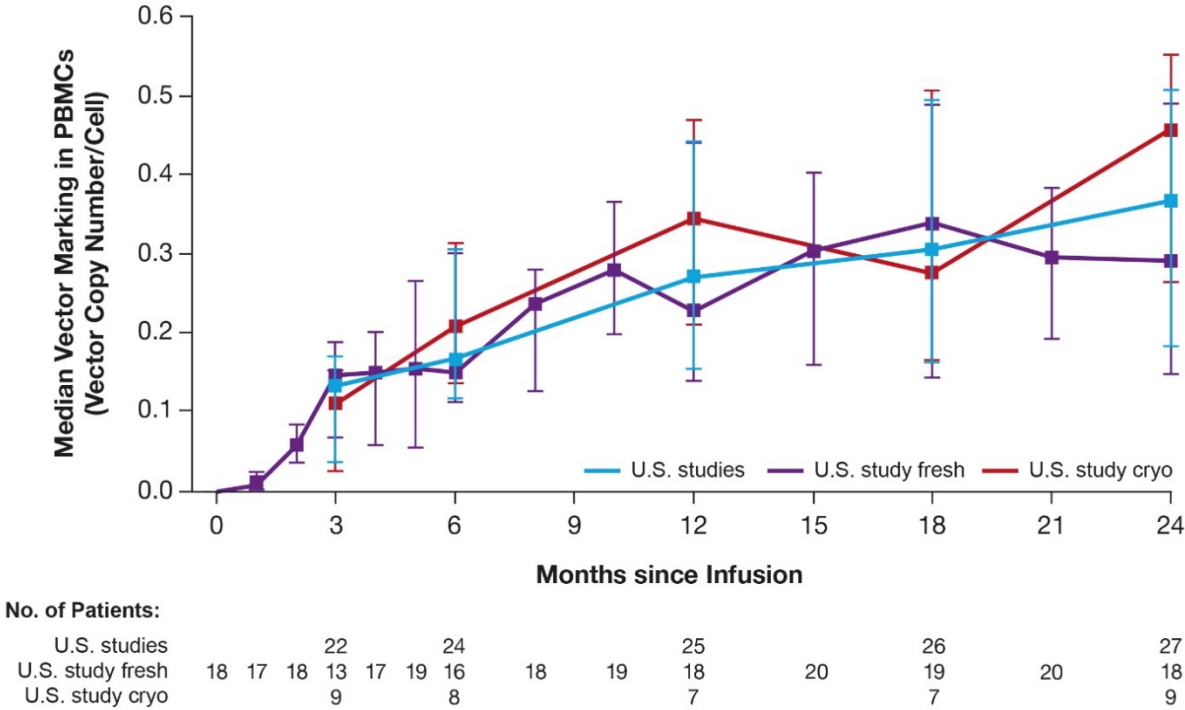


Fig. S8. Comparison of the U.S. Studies Integrated Fresh and Cryopreserved Data for (A) Median VCN in granulocytes (B) Median VCN in PBMCs (C) Median CD3⁺ T Cell Counts and (D) Median ADA activity.

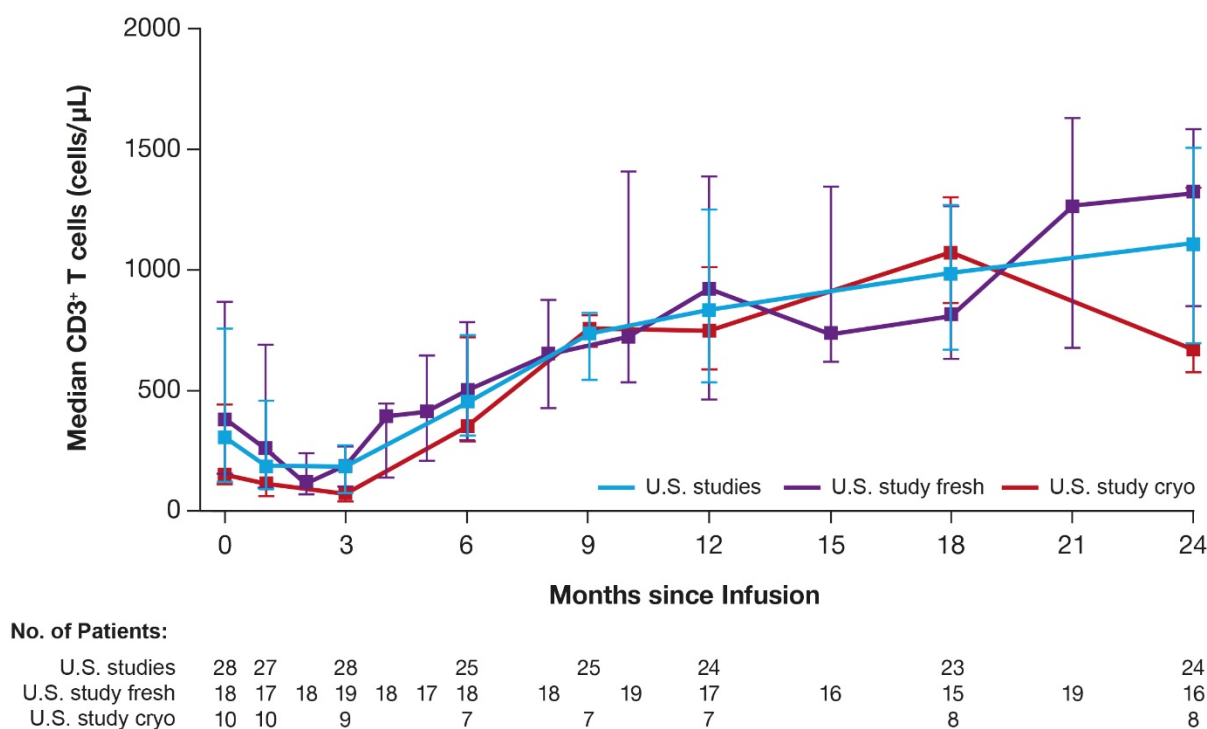
A



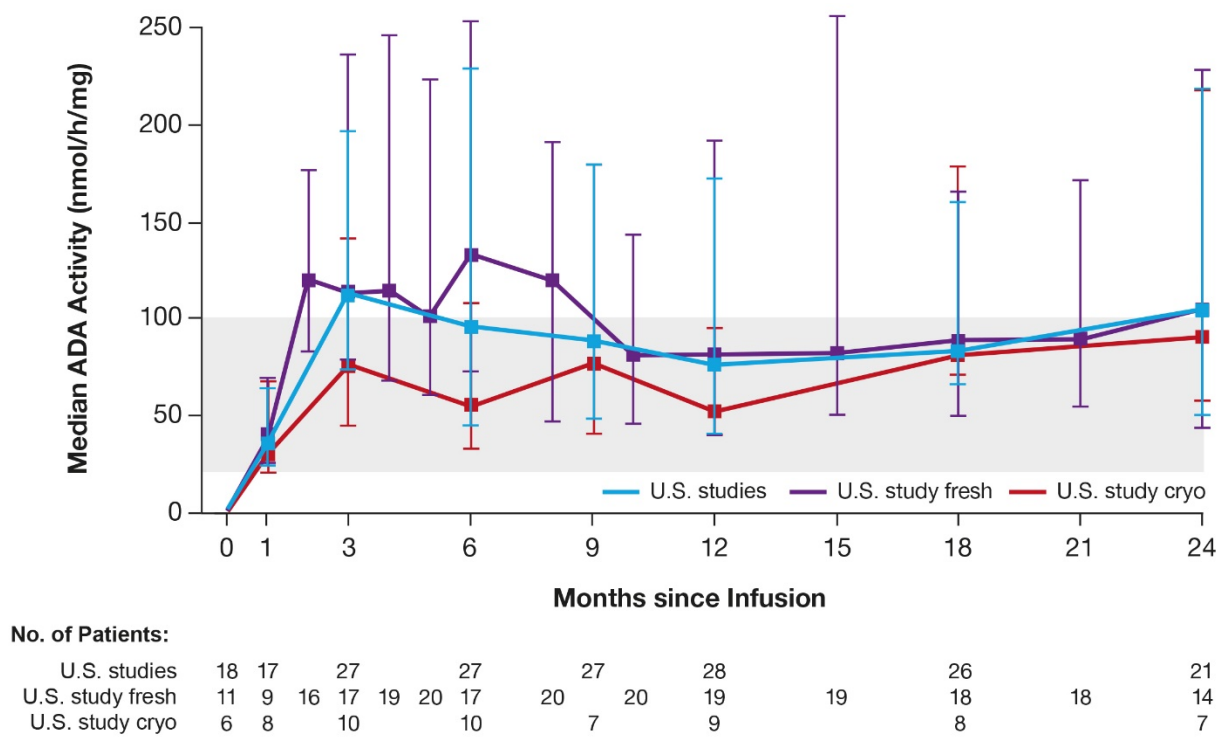
B



C



D



ADA adenosine deaminase, PBMC peripheral blood mononuclear cell, VCN vector copy number

Table S1. Inclusion and Exclusion Criteria.*

Inclusion Criteria		
NCT01852071 (U.S. Fresh Study)	NCT02999984 (U.S. Cryopreserved Study)	NCT01380990 (U.K. study)
1: Children ≥ 1.0 months of age with a diagnosis of ADA-SCID, based on:	1: Children ≥ 30 days and < 18 years of age with a diagnosis of ADA-SCID, based on:	1. Male or female Subject, below 5 years of age OR male or female subjects 5 to 15 years of age who have preserved thymic function, as evidenced by presence of $> 10\%$ naïve T cells ($CD4^+ CD45RA^+ CD27^+$ cells)
2. Evidence of ADA deficiency, defined as: Decreased ADA enzymatic activity in erythrocytes, leukocytes, skin fibroblasts, or cultured fetal cells to levels consistent with ADA-SCID as determined by the reference laboratory, or identified mutations in ADA alleles consistent with a severe reduction in ADA activity Evidence of ADA-SCID based on either: i. Family history of a first-order relative with ADA deficiency and clinical and laboratory evidence of severe immunologic deficiency, or ii. Evidence of severe immunologic deficiency in subjects prior to the institution of immune restorative therapy, based on: - Lymphopenia ($ALC < 400$ cells/ μ l) OR absence or low number of T cells (absolute $CD3^+$ count < 300 cells/ μ l), or - Severely decreased T-lymphocyte blastogenic responses to phytohemagglutinin ($< 10\%$ of lower limit of normal for the diagnostic laboratory, or $< 10\%$ of the response of the normal control of the day, or stimulation index < 10), or - Identification of SCID by neonatal screening revealing low TREC levels	2. Evidence of ADA deficiency, defined as: i. Decreased ADA enzymatic activity in erythrocytes, leukocytes, skin fibroblasts, or in cultured fetal cells to levels consistent with ADA-SCID as determined by the reference laboratory, or ii. Identified mutations in ADA alleles consistent with a severe reduction in ADA activity, Evidence of ADA-SCID based on either: i. Family history of a first order relative with ADA deficiency and clinical and laboratory evidence of severe immunologic deficiency, or ii. Evidence of severe immunologic deficiency in subjects prior to the institution of immune restorative therapy, based on - Lymphopenia (absolute lymphocyte count (ALC) < 400 cells/ μ L) OR absence or low number of T cells (absolute $CD3^+$ count < 300 cells/ μ L), or - Severely decreased T lymphocyte blastogenic responses to phytohemagglutinin (either $< 10\%$ of lower limit of normal for the diagnostic laboratory, or $< 10\%$ of the response of the normal	2. Diagnosis of ADA-SCID confirmed by DNA sequencing OR by confirmed absence of $< 3\%$ of ADA enzymatic activity in peripheral blood (PB) or (for neonates) in umbilical cord blood erythrocytes and/or leucocytes or in cultured fetal cells derived from either chorionic villus biopsy or amniocentesis, prior to institution of PEG-ADA ERT

	control of the day, or stimulation index <10), or - Identification of SCID by neonatal screening revealing low TREC levels.	
3. Ineligible for matched sibling allogeneic bone marrow transplantation Absence of a medically eligible HLA-identical sibling, with normal immune function, who may serve as an allogeneic bone marrow donor	3. Ineligible for matched family allogeneic BM transplantation , defined as the absence of a medically eligible HLA-identical sibling or family donor, with normal immune function, who could serve as an allogeneic bone marrow donor	3. Patients who lack a fully HLA-matched family donor
4. Signed written informed consent according to guidelines of the institutional review board (UCLA Office of Human Research Protection Program and NHGRI Institutional Review Board)	4. Provision of written informed consent prior to any study-related procedures. In this study, consent must be provided by the parents/legal guardians and, where applicable according to local laws, a signed assent from the child	4. Informed consent signed by a parent/guardian
	5. Females of childbearing age will be required to provide a negative pregnancy test 30 days prior to Visit 2	
	Subjects and their parents/legal guardians must be willing and able to comply with study restrictions , to remain at the clinic for the required duration during the study period, and to return to the clinic for the follow-up evaluation as specified in the protocol	
Exclusion Criteria		
1. Hematologic		
Anemia (hemoglobin <10.5 g/dl at <2 years of age, or <11.5 g/dl at >2 years of age)	Anemia (hemoglobin <8.0 g/dl)	
Neutropenia: absolute granulocyte count <500/mm ³	Neutropenia (ANC <500/mm ³). Note: ANC <500/mm ³ with absence of myelodysplastic syndrome on bone marrow aspirate and biopsy and normal marrow cytogenetics are acceptable for eligibility	
Thrombocytopenia (platelet count <150,000/mm ³ at any age)	Thrombocytopenia (platelet count <50,000/mm ³ at any age)	

INR or PT >2xULN, or PTT >2.33xULN (subjects with a correctable deficiency controlled on medication will not be excluded)	PT or INR and PTT >2xULN (subjects with a correctable deficiency controlled on medication will not be excluded)	
Cytogenetic abnormalities in peripheral blood, bone marrow (or amniotic fluid [if available])	Cytogenetic abnormalities in peripheral blood, bone marrow (or amniotic fluid [if available])	1. Cytogenetic abnormalities on peripheral blood
Prior allogeneic HSCT with cytoreductive conditioning	Prior allogeneic HSCT with cytoreductive conditioning	
3. Infections		
Evidence of infection with HIV-1, Hepatitis B, Hepatitis C, or Parvovirus B 19 by DNA PCR within 90 days prior to bone marrow harvest. If other infection is present, it must be under control (e.g., stable or decreasing viral load) at the time of screening	Confirmation of an infectious disease by deoxyribonucleic acid (DNA) PCR positive at time of screening assessment for the following: HIV-1, Hepatitis B, Parvovirus B19	
4. Pulmonary		
Resting O ₂ saturation by pulse oximetry <95% on room air	Resting O ₂ saturation by pulse oximetry <90% on room air	
Chest X-ray indicating active or progressive pulmonary disease	Chest X-ray indicating active or progressive pulmonary disease. Note: Chest X ray indicating residual signs of treated pneumonitis is acceptable for eligibility	
5. Cardiac		
Abnormal ECG indicating cardiac pathology	Abnormal ECG indicating cardiac pathology	
Uncorrected congenital cardiac malformation with clinical symptomatology	Uncorrected congenital cardiac malformation with clinical symptomatology	
Active cardiac disease, including clinical evidence of congestive heart failure, cyanosis, hypotension	Active cardiac disease, including clinical evidence of congestive heart failure, cyanosis, hypotension	
Poor cardiac function as evidenced by left ventricular ejection fraction <40% on echocardiogram	Poor cardiac function as evidenced by left ventricular ejection fraction <40% on echocardiogram	
6. Neurologic		
Significant neurologic abnormality by examination	Significant neurologic abnormality by examination	
Uncontrolled seizure disorder	Uncontrolled seizure disorder	
7. Renal		
Renal insufficiency: serum creatinine ≥1.2 mg/dl (10 ⁶ µmol/l) or ≥3+ proteinuria	Renal insufficiency: serum creatinine ≥1.2 mg/dl (10 ⁶ µmol/l) or ≥3+ proteinuria	

Abnormal serum sodium, potassium, calcium, magnesium, phosphate (fresh: at grade III or IV by Division of AIDS Toxicity Scale; cryopreserved: >2xULN)	Abnormal serum sodium, potassium, calcium, magnesium or phosphate levels at >2 x ULN.	
8. Hepatic/gastrointestinal		
Serum transaminases >5xULN	Serum transaminases >5xULN	
Serum bilirubin >2xULN	Serum bilirubin >2xULN	
Serum glucose >1.5xULN	Serum glucose >1.5xULN	
Intractable severe diarrhea		
9. Oncologic[†] (see below)		
Evidence of active malignant disease other than DFSP	Evidence of active malignant disease other than DFSP	2. Evidence of active malignant disease
Evidence of DFSP expected to require antineoplastic therapy within 5 years following infusion of genetically corrected cells (if anti-neoplastic therapy has been completed, a subject with a history of DFSP can be included)	Evidence of DFSP expected to require anti-neoplastic therapy within the 5 years following the infusion of genetically corrected cells (if anti-neoplastic therapy has been completed, a subject with a history of DFSP can be included)	
Evidence of DFSP expected to be life limiting within 5 years following infusion of genetically corrected cells	Evidence of DFSP expected to be life limiting within 5 years following infusion of genetically corrected cells	
10. Known sensitivity to busulfan	10. Known sensitivity to busulfan	3. Known sensitivity to busulfan
11. General		
Age ≤1.0 months		
Appropriate organ function as outlined below must be observed within 60 days of entering this trial		
Pregnant	The subject is pregnant or has a major congenital anomaly	4. If applicable, confirmed pregnancy (tested in subjects above 12 years old)
Major congenital anomaly		
Ineligible for autologous HSCT by the criteria at the clinical site	Ineligible for autologous HSCT by the criteria at the clinical site	
Expected survival <6 months	Likely to require treatment during the study with drugs that are not permitted by the study protocol	

Other conditions that, in the opinion of the principal investigator and/or co-investigators, contraindicate the bone marrow harvest, administration of busulfan, or infusion of OTL-101 or indicate the subject or their parent/primary caregiver's inability to follow protocol	Other conditions that, in the opinion of the principal investigator and/or co-investigators, contraindicate the harvest of bone marrow, the administration of busulfan and the infusion of transduced cells, or that indicate an inability of the subject or subject's parent/legal guardian to comply with the protocol	
	The subject has previously received another form of gene therapy	

*ADA denotes adenosine deaminase, AIDS acquired immune deficiency syndrome, ALC absolute lymphocyte count, ANC absolute neutrophil count, DFSP dermatofibrosarcoma protuberans, ECG electrocardiogram, HIV human immunodeficiency virus, HLA human leukocyte antigen, HSCT hematopoietic stem cell transplant, INR international normalized ratio, NHGRI National Human Genome Research Institute, PB, peripheral blood, PCR polymerase chain reaction, PEG-ADA ERT pegylated adenosine deaminase enzyme replacement therapy, PT prothrombin time, PTT partial thromboplastin time, SCID severe combined immunodeficiency, TREC T-cell receptor excision circle, UCLA University of California, Los Angeles; and ULN upper limit of normal.

†Subjects receiving active antineoplastic therapy or radiation for any cancer, including DFSP, were not eligible. Subjects with DFSP not being treated with active antineoplastic therapy at the time of enrollment AND who had no plans to receive active antineoplastic therapy in the absence of progressive malignant disease AND whose DFSP was not expected to be life limiting within 5 years following the infusion of genetically corrected cells would have been eligible.

Table S2. Summary of Gene Therapy Infusion.

	U.S. studies (N=30)	U.K. study (N=20)
Number of patients treated	30	20
Busulfan AUC, $\mu\text{mol/l}\cdot\text{min}^*$		
Median	4542.5	4418.0
Minimum, maximum	2360, 5673	2567, 7513
Number of infusions		
1	27	19
2	3	1
Patient weight, kg		
Median	7.9	9.2
Minimum, maximum	5.3, 17.6	4.9, 43.3
Total CD34 ⁺ HSPCs infused by body weight, $\times 10^6$ CD34 ⁺ cells/kg		
Median	7.4	14.4 ^a
Minimum, maximum	2.1, 10.9	3.0, 71.4 ^b

*AUC denotes area under the concentration–time curve, and HSPC hematopoietic stem and progenitor cell.

[†]Statistics were obtained using the sum of each patient's results.

^aThe median according to the clinical database was 14.43×10^6 CD34⁺ cells/kg. A data entry error was confirmed by the site after database lock. After correcting for the error, the median was 12.62×10^6 CD34⁺ cells/kg.

^bThe maximum according to the clinical database was 71.4×10^6 CD34⁺ cells/kg. A data entry error was confirmed by the site after database lock. After correcting for the error, the maximum was 28.7×10^6 CD34⁺ cells/kg.

Table S3. Primary and Secondary Endpoints.

U.S. Fresh Study	U.S. cryopreserved study	U.K. study
Primary Endpoints:		
Safety Incidence and grade of serious adverse events (SAEs). SAEs could manifest as: <ul style="list-style-type: none"> Clinical toxicities Exposure to replication competent lentivirus (RCL) Development of monoclonal expansion or leukoproliferative complications from vector insertional effects 	Safety Assessments of adverse events (AEs, including infections), clinical laboratory test results, vital signs measurements, physical examination results, and use of concomitant medications	Safety Clinical, hematological, and immunological progress of subjects, assessed by evaluating AEs and SAEs, the results of physical examination, and laboratory values (biochemistry and hematology)

	Emergence of RCL, and monoclonal expansion or leukemia due to vector integration	Analysis of the frequency of clonal expansion associated with vector integration near proto-oncogenes
		Analysis of the frequency of vector integration into known proto-oncogenes
Efficacy		
	<p>Evaluation of the gene therapy at 6 months post infusion based on the following parameters and their thresholds:</p> <ul style="list-style-type: none"> • Erythrocyte ADA enzyme activity above baseline/pre-treatment level (i.e. >0 Units) • Absolute CD3⁺ T cell counts ≥200/μl • Granulocyte samples positive for vector sequences by qPCR (≥1/10,000 cells) <p>Subjects must meet all 3 criteria. Subjects not meeting these criteria will be designated a failure (nonresponder) and will be withdrawn from the study. These data will be used to compare subject data from one of the ongoing phase 1/2 studies using the fresh formulation</p>	
Overall and event-free survival by 12 months post-treatment where a treatment failure event is defined by one of the following endpoints: death; reinstitution of PEG-ADA; or need for rescue allogeneic HSCT	Overall and event-free survival by 12 months post-treatment. Overall survival was defined as the proportion of subjects alive. Event-free survival was defined as the proportion of subjects alive with no 'event'; an 'event' was the resumption of PEG-ADA ERT or the need for a rescue allogeneic HSCT	<p>Overall survival of subjects treated with the gene therapy, assessed at 12 months of follow up</p> <p>Event-free survival of subjects treated with the gene therapy, assessed at 12 months of follow up. An 'event' was defined as death, reinstitution of pegylated adenosine deaminase (PEG-ADA) enzyme replacement therapy (ERT), or need for a rescue allogeneic hematopoietic stem cell transplant (HSCT)</p>
		<p>Success of engraftment and resulting immunological and metabolic effects in subjects who received gene therapy, determined by assessing:</p> <ul style="list-style-type: none"> • Vector copy number in peripheral blood leukocytes at month 3, 6, 12, 24, and 36 • Cellular and humoral immune system recovery, determined as changes in T-

		<p>cell numbers, T-cell function (proliferation to phytohemagglutinin and anti-CD3 antibodies), circulating immunoglobulin levels and number of subjects requiring immunoglobulin replacement therapy (IgRT) at each study visit</p> <ul style="list-style-type: none"> • ADA activity and reduction in deoxyadenosine triphosphate (dATP) in erythrocytes at Baseline and month 1, 1.5, 3, 6, 9, 12, 18, 24, 30, and 36
Key Secondary Endpoints:		
Overall and event-free survival at 24 months	Overall and event-free survival at 24 months	
Efficacy of gene transfer/engraftment of HSPCs, expressed as: vector copy number (VCN)		Overall survival and event-free survival outcomes at 2 and 3 years in subjects treated with gene therapy
<p>ADA expression and purine metabolite detoxification, characterized by:</p> <ul style="list-style-type: none"> • ADA enzyme activity in red blood cells • deoxyadenosine nucleotides (dAXP) levels in red blood cells 		
<p>Examine the effects of treatment on immune reconstitution characterized by:</p> <ul style="list-style-type: none"> • Absolute lymphocyte and lymphocyte subset counts • Measures of B cell function (use of IgRT; serum immunoglobulin [Ig] levels; specific antibody responses) • Measures of T-cell reconstitution and function (T-cell receptor excision circles [TRECs] in peripheral blood; T-cell receptor [TCR] Vβ panel; lymphocyte proliferation) 	Immune reconstitution, assessed as counts of T, B, and natural killer (NK) cells in peripheral blood, response to tetanus vaccinations, and use of IgRT	
Assess severe infection rates	Rates of severe infections/opportunistic infectious episodes, defined as infections requiring or prolonging hospitalization and/or documented infections by opportunistic pathogens	Reduction in the frequency of infections, evaluated at 1, 2, and 3 years post treatment on the basis of clinical history and examination. The infections of interest in this study were severe infections or opportunistic infectious episodes, defined as infections requiring hospitalization or prolonging

		hospitalization and/or documented infections by opportunistic pathogens
	Performance outcomes and quality of life, measured by the Karnofsky/Lansky scale and questions relevant to the subjects' general well-being, school attendance and ability to practice sports	
		Assessment of the longitudinal clinical effects of treatment, by evaluation of: <ul style="list-style-type: none"> • TRECs, as a marker of improved thymic function, 2 years after gene therapy administration • Serum levels of immunoglobulin IgA, IgG, and IgM and the number of subjects requiring immunoglobulin replacement therapy, recorded dichotomously
		Growth of pathogenic microorganisms over 3 years, evaluated through the assessment of AEs and SAEs related to infections
		Tolerability of the conditioning regimen, determined by assessing whether hematopoietic recovery has taken place within 6 weeks (absolute neutrophil count $>0.5 \times 10^9$ cells/l)
		Feasibility of the transduction procedure, assessed by: <ul style="list-style-type: none"> • Availability of greater than 0.5×10^6 CD34⁺ cells/kg after transduction • Undetectable replication competent lentivirus (determined retrospectively) • CD45⁺ cell viability after transduction equal to or greater than 50%, in accordance with the final product release criteria
Exploratory endpoints		
	Assess the level of gene correction, engraftment and immune reconstitution: <ul style="list-style-type: none"> • Vector copy number (VCN) in peripheral blood cells 	

	<ul style="list-style-type: none"> • ADA enzyme activity and total adenosine nucleotides in red blood cells • Further indicators of immune reconstitution: <ul style="list-style-type: none"> – Serum immunoglobulin (Ig) levels – TRECs analysis – TCR Vβ repertoire – Lymphocyte proliferative responses 	
	Exploratory safety endpoints included vector integration site analysis and quantification of the clonal diversity of vector integrants	
PEG-ADA ERT use	PEG-ADA ERT use	PEG-ADA ERT use
		T cell receptor V β repertoire
		Morphology (Normal/Abnormal), vector integration (Normal/Abnormal), and vector copy number in bone marrow (bone marrow) mononuclear cells, performed in bone marrow aspirate samples, if collected
		Tetanus vaccination response

ADA, adenosine deaminase, AE adverse event, dATP deoxyadenosine triphosphate, BMT bone marrow transplantation, dATP deoxyadenosine triphosphate, ERT, enzyme replacement therapy, IgRT, immunoglobulin replacement therapy, PEG pegylated, qPCR quantitative polymerase chain reaction, RCL, replication competent lentivirus, SAE serious adverse events, TREC T cell receptor excision circles

Table S4. Summary of Events, Including Rescue Treatment and Death.

Events	U.S. studies	U.K. study
Patients/patients — no. (%)	30 (100.0)	20 (100.0)
Death — no. (%)		
Month 12	0 (0)	0 (0)
Unknown at month 12 [†]	1 (3)	0 (0)
Month 24	0 (0)	0 (0)
Unknown at month 24 [†]	1 (3)	0 (0)
Month 36		
Unknown at month 24 [†]		
Rescue allogeneic HSCT required — no. (%)		
Month 12	0 (0)	0 (0)
Unknown at month 12 [†]	1 (3)	0 (0)
Month 24	0 (0)	0 (0)
Unknown at month 24 [†]	1 (3)	1 (5)
Month 36		0 (0)
Unknown at month 36 [†]		1 (5)
Re-institution of PEG-ADA ERT — no. (%)		
Month 12		0 (0)
Unknown at month 12 [†]	1 (3)	0 (0)
Month 24	0 (0)	1 (5)
Unknown at month 24 [†]	1 (3)	0 (0)
Month 36	0 (0)	1 (5)
Unknown at month 36 [†]		0 (0)

ADA denotes adenosine deaminase, ERT enzyme replacement therapy, HSCT hematopoietic stem cell transplant, PEG pegylated.

[†]A patient's status was classed as 'unknown' if they had not reached this time point or withdrew prior to the visit while still alive.