Supplemental Online Content

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

2 eMethods

2.1 Trial procedures

The trial was approved nationally by the ethics committee on March 23, 2020 (file #20.03.20.56342, CPP Île De France VI, EudraCT: 2020-001246-18), by the French Medical Products Agency and by the Commission Nationale Informatique et Liberté. Written informed consent was obtained from all patients or from the patient's legal representative if the patient was too unwell to provide consent for entering the CORIMUNO Cohort. In this consent, patients were made aware that a number of trials may occur via the cohort, and that they will likely be offered to participate in some of them. A specific additional written consent was obtained from eligible patients who were randomly selected to be offered TCZ and accept the offer to participate. The cohort and trial were conducted in accordance with the principles of the Declaration of Helsinki and the Good Clinical Practice guidelines of the International Conference on Harmonization. An executive coordination committee, was responsible for the design, conduct, and reporting of the trial. An independent data and safety monitoring board oversaw all CORIMUNO trials once a week.
The randomization schedule was computer-generated, stratified according to site, blocked (with randomly varying block sizes of two and four), and concealed with the use of a Web-based, locked central randomization system in permuted blocks.
For the patients assigned to receive TCZ, a second written consent was obtained. Eligible patients assigned to receive standard care are not notified about the trial. TCZ was administered at a dose of 8 mg per kilogram at D1. Administration of an additional fixed dose of the assigned drug (TCZ 400 mg) was recommended if no response (no decrease of oxygen requirement of more than 50%) at D3. Usual care (UC) was to be provided at the discretion of the clinicians and comprised, as necessary, supplemental oxygen, noninvasive and invasive ventilation, antibiotic agents, anti-viral agents, corticosteroids, vasopressor support, anticoagulants, renal-replacement therapy, and extracorporeal membrane oxygenation (ECMO).

2.2 Data sources

All information required by the protocol had to be entered in the electronic case report forms used for the whole CORIMUNO-19 cohort. Research nurses, clinical research assistants and investigators used the patient's hospital records and all relevant hospital information systems (Laboratory, Radiology, Pharmacy Information System and Patients) to capture data from day 0 to day 14. A core set of clinical measures was recorded daily the first 2 weeks and then every week. The core measures included key clinical events such as changes in oxygen-support requirements (ambient air, low-flow oxygen, nasal high-flow oxygen, non-invasive positive pressure ventilation [NIPPV], invasive mechanical ventilation, and extracorporeal membrane oxygenation [ECMO], organ failures). These measures allowed classifying the patient's state according to the WHO 10 points-Clinical Progression Scale. Reported adverse events, including those leading to discontinuation of treatment, serious adverse events, time to hospital discharge and death were also recorded. In addition, biological measures routinely prescribed for care were collected. Clinical end-points for discharged patients were obtained by contacting the patients or first-degree relatives by telephone at day 14 and day 28.

2.3 Patients

Patients entering the CORIMUNO-19 cohort were hospitalized male and female patients 18 years of age or older with a SARS-CoV-2 infection as determined by PCR, or other commercial or public health assay in any specimen < 72 hours and/or CT Scan prior to inclusion with typical radiological findings (ground glass abnormalities, and absence of lymphadenopathy, pleural effusion, pulmonary nodules, lung cavitation) and illness of any duration and severity with symptoms (fever, cough, respiratory difficulties, shortness of breath), and at least one of the following: i) Radiographic infiltrates by imaging (CT scan), ii) Clinical assessment (evidence of rales/crackles on exam or respiratory rate >25/min) AND SpO2≤94% on room air, iii) SpO2≤97 % with O2 > 5L/min or Respiratory rate>=30/min, iv) Requiring mechanical ventilation. Patients with comorbidities such as acute kidney injury, cardiovascular condition, pulmonary disease, obesity, high blood pressure, diabetes, chronic kidney diseases, hematological diseases, sickle cell diseases, autoimmune and auto-inflammatory, pregnant women, HIV infected were not excluded.
Eligible patients for CORIMUNO-TOCI-1 were patients not requiring ICU at admission with moderate and severe pneumopathy according to the WHO Criteria of severity of COVID pneumopathy, i.e. requiring oxygen by mask or nasal prongs : i) Moderate cases showing fever and respiratory symptoms with radiological findings of pneumonia and Requiring between 3L/min and 5L/min of oxygen to maintain an Oxygen saturation (SaO2) of 97% or more , ii) Severe cases meeting any of the following criteria: Respiratory distress (30 breaths/ min or more); Oxygen saturation of 93% or less at rest in ambient air or Oxygen saturation of 97 % or less with O2 > 5L/min; a ratio of the partial pressure of oxygen (Pao2) to the fraction of inspired oxygen (Fio2) (Pao2:Fio2) at

or below 300 mmHg. Exclusion criteria included known hypersensitivity to TCZ, pregnancy, current documented bacterial infection, patients with any of following laboratory results out of the ranges detailed below at screening: absolute neutrophil count (ANC) 1.0 $\times 10^9$/L or less or platelets (PLT) less 50 G /L.

2.4 WHO progression ten-category ordinal scale

WHO ordinal scale consisted of the following categories: 0, Uninfected; 1, Asymptomatic; viral RNA detected ; 2, Symptomatic; Independent ; 3, not hospitalized with resumption of normal activities; 2, not hospitalized, but unable to resume normal activities; 3, Symptomatic; Assistance needed; 4, hospitalized, not requiring oxygen; 5, hospitalized, requiring oxygen by mask or nasal prongs; 6, hospitalized, requiring nasal high-flow oxygen therapy, noninvasive mechanical ventilation, or both; 7, hospitalized, requiring Intubation and Mechanical ventilation, pO2/FIO2 u150 OR SpO2/FIO2>=200; 8, hospitalized, requiring Mechanical ventilation, (pO2/FIO2<150 OR SpO2/FIO2<200) OR vasopressors (norepinephrine less than 0.3 microg/kg/min); 9, Mechanical ventilation, pO2/FIO2<150 AND vasopressors (norepinephrine more than 0.3 microg/kg/min), OR Dialysis OR ECMO hospitalized, requiring; 10, Dead.

2.5 Changes to the protocol

After an amendment following the first interim analysis of the CORIMUNO-19-SARI (Sarilumab) trial, and before any analysis of the CORIMUNO-19-TOCI (Tocilizumab) trial, the protocol for the CORIMUNO-19 platform (version 5.0 at the date of 06/04/2020) redefined the groups of patients at inclusion (that were to be analysed separately) as:

- *Group 1: Cases meeting all of the following criteria*
  - *Requiring more than 3L/min of oxygen*
  - *OMS/WHO progression scale = 5*
  - *No NIV or High flow*
- *Group 2: Cases meeting all of the following criteria*
  - *Respiratory failure AND (requiring mechanical ventilation OR NIV OR High flow)*
  - *OMS/WHO progression scale >=6*
  - *No do-not-resuscitate order (DNR order)*

The present article only reports on “Group 1” patients.

Primary outcomes were redefined as:

Co Primary Endpoints for Group 1

1. Survival without needs of ventilator utilization (including **non-invasive ventilation and high flow**) at day 14. Thus, events considered are needing ventilator utilization (including Non Invasive Ventilation, NIV or high flow), or death. New DNR order (if given after the inclusion of the patient) will be considered as an event at the date of the DNR.
2. Early endpoint: proportion of patients alive without non-invasive ventilation of high low at day 4 (WHO progression scale ≤ 5). A patient with new DNR order at day 4 will be considered as with a score > 5.

These modifications imply considering patients with non-invasive ventilation or high flow (WHO-CPS score 6) in the group 2 rather than group 1, owing 1) to the possible severity of these patients that could be included a few hours before mechanical ventilation and 2) the possibility to include a patient under non-invasive ventilation (NIV) in the group 1, which would imply the realization of the longer-term primary outcome as soon as inclusion.

2.6 Data quality monitoring

Data quality monitoring was performed in accordance with the study monitoring plan as for any studies sponsored by Assistance Publique - Hôpitaux de Paris (APHP). This monitoring was performed under the supervision of one clinical research unit officially representing the APHP sponsor (Clinical Trial Unit, CTU, Unité de Recherche Clinique Saint-Louis) and one contract research organization for the clinical site located in Strasbourg. This monitoring plan was elaborated in collaboration with the statistical team and the data managers of the CTU according to the protocol and the expected risks for patients. Data quality monitoring included both remote data monitoring (during the containment period in France) and on-site monitoring. During the main phase of the pandemic in Paris, study monitors were not allowed to go on-site and reviewed remotely the status of electronic case report form pages via web-access, to ensure that consents were valid, forms were being completed per instructions and queries were being resolved correctly. Predefined set of consistency checks predefined were ran by the data manager of the clinical research unit and by the statistical team in an attempt to further validate the data and raised queries that were issued directly on the study database. The on-site monitoring was performed

secondarily by trained dedicated staff independent of the site investigators from all APHP clinical research units. Remote monitoring was performed. On-site monitoring included 100% source data verification performed for all patients recruited at every site for all critical data points as specified below.
All "consent" & "consent withdrawn" documents were verified to ensure these were completed in accordance with the ethics committee approved requirements and, if consent was withdrawn, this was documented appropriately. All "Do-not resuscitate orders" were also verified and documented. They verified that all inclusion criteria were fulfilled and no exclusions were present at the time of randomization. They verified also that the primary outcomes were correctly measured. They checked especially the OMS scores at all days between day one and day 14 and at Day 28, the type and start and stop dates of ventilation (high flow, non-invasive ventilation, mechanical ventilation), the dates and causes of deaths, the dates of discharges. Source data verification was also performed on the relevant case report form sections for any trial participants where Serious Adverse Events were reported. In addition, the following case report form sections were also verified for 100% of patients at each site: 1. Baseline form: comorbidities, baseline physiology, other treatments received at baseline, SpO2, PaO2, and FiO2. 2. Daily data form: all oxygen-related variables. 3. Discharge and death form: ICU and hospital discharge date and time. 4. Adverse event form: all questions on the form. 5. Protocol violations for tocilizumab therapeutic scheme. 6. Concomitant treatments received.

2.7 Statistical Methods

The trial was planned to provide rapid information of the clinical efficacy of TCZ in the setting of the COVID-19 public health emergency, with very limited prior information on clinical outcomes in the trial population. To maximize information from limited data generated, while allowing rapid decision, a Bayesian monitoring of the trial based on the co-primary outcomes was used. The original sample size was set at 120, with an interim analysis when 60 had reached day 4, and a provision to increase the sample size to 180 in case of promising, though not formally conclusive, results at the final analysis. Interim analyses were then presented weekly to the Data Safety Monitoring Board of the CORIMUNO-19 cohort. Non-binding stopping rules for efficacy and futility were indicated in the protocol. The treatment effect was expressed in terms of absolute risk difference (ARD) for the day 4 outcome and hazard ratio (HR) for the day 14 outcome. Posterior probabilities of ARD < 0 and HR < 1 were computed, representing the posterior probability of efficacy. If these probabilities were > 0.99 at the interim analysis and > 0.95 at the final analysis, the treatment could be considered as showing efficacy. We also computed the posterior probabilities of ARD <-5.5% and HR < 0.85, both denoting a similar reasonable effect under the assumption of a 50% event rate at time of analysis. If these posterior probabilities were lower than 0.20, the trial might be stopped for futility. With one interim analysis, numerical evaluation for binary outcomes showed that this design controlled for a frequentist one sided 5% type I error rate.
Primary efficacy analysis was performed on an intention-to-treat basis and included all the patients who had undergone randomization, analyzed in the arm they were allocated to. One patient was excluded after consent withdrawal and explicit request that the data would not be used for analysis. According to European Data protection regulation, it is not possible to keep such data, and they were erased accordingly.
For the day 4 outcome, missing data were considered as failure for the primary analysis (no missingness occurred). The posterior distributions of the difference in outcome rate was computed analytically, and the posterior distribution of the odds ratio adjusted for age and center (as a random effect) was obtained using Monte Carlo Markov chains (MCMC).
For the day 14 primary outcome, patients discharged alive before day 14 without information on respiratory status at day 14 were considered as being alive without need for ventilation at day 14 (or maximum theoretical follow-up if shorter than 14 days).
The protocol specified that new Do-Not-Resuscitate (DNR) orders were to be considered as events. The precise definition of a "new DNR order" was a DNR order posterior to the date of randomization and that had been noted as having been effectively used to limit care in the patient medical records.
Survival without ventilation was portrayed by Kaplan–Meier plots. The posterior distribution of the hazard ratio was calculated by a Bayesian Cox proportional-hazards model estimated using Monte Carlo Markov Chains, adjusted for age at inclusion and center (as a random effect).
Posterior distributions were summarized by the median value and 90% and 95% credible intervals. The 90% level matches the 0.95 posterior probability threshold for efficacy, and the 95% level is more usual. For each Bayesian analysis, four different chains with different starting values were used, with a burn-in of 10,000 iterations, and 100,000 additional iterations with a thinning interval of 10, leading to keeping 10,000 values per chain, 40,000 in total. The convergence of the MCMC samples was assessed using the Gelman-Rubin statistic and by visual inspection of the trace of coefficients. For the primary analyses, a non-informative flat prior distribution for the log HR was used, as a Gaussian distribution with mean 0 and variance 10^6. More details on the Bayesian analyses are presented in the Statistical Analysis Plan, including the use of different prior distributions for the analysis of survival without need for ventilation.

An analysis only accounting for mechanical ventilation (and not non-invasive ventilation or high flow) was added as a sensitivity analysis. Preplanned subgroup analyses according to antivirals at baseline and post-hoc subgroup analyses according to corticosteroid therapies at baseline were performed using a frequentist approach.
Survival up to day 14 and day 28 was analyzed using a Cox proportional hazards model adjusted for age and center (as a random effect). Time to discharge and time to oxygen supply independency were analyzed in a competing risks framework using Fine-Gray models adjusted for age and center (as a random effect), death being the competing event. The WHO ordinal scale was analyzed using a Bayesian proportional odds models comparing the distribution of ordinal scores at day 4, 7 and 14, adjusted for age and center, and a longitudinal version of the model with a time effect and a random subject effect to analyze all scores up to day 14.
Because the statistical analysis plan did not include a provision for correcting for multiplicity in tests for secondary outcomes, results are reported as point estimates and 95% confidence intervals. These intervals should not be used to infer definitive treatment effects for secondary outcomes. Statistical analyses were conducted with SAS software, version 9.4 (SAS Institute), R version 3.6.1 and JAGS version 4.3.0.

eTable 1. Operational characteristics of the design for the day 4 and day 14 outcomes under different scenarios.

Results were obtained analytically for the binary day 4 outcome, and from 10,000 numerical simulation runs for the day 14 outcome. In the latter we used exponential simulations, assuming a median survival with control of 14 days and accrual of 120 patients over 10 days, interim analysis at 10 days, and final analysis after 24 days (when the last patient would have attained 14 days follow-up).

	Treatment effect		
	No effect	**Very large effect**	**Large effect**
Day 4 outcome			
Event rates with UC (C) or TCZ (E)	p_C=0.5, p_E=0.5	p_C=0.5, p_E=0.2	p_C=0.5, p_E=0.3
Probability of early stopping for efficacy	0.0087	0.558	0.228
Probability of efficacy at 2nd stage	0.038	0.413	0.510
Overall probability of rejection	0.047	0.972	0.739
Day 14 outcome			
Hazard ratio	1	0.32	0.51
Probability of early stopping for efficacy	0.011	0.478	0.204
Probability of efficacy at 2nd stage	0.043	0.507	0.623
Overall probability of rejection	0.054	0.985	0.827

3 Supplemental Results

eTable 2 Treatments received prior and after randomization until Day 14. Values are n (%).

	Tocilizumab (N=63)		UC (N=67)	
	Prior randomization	**After randomization**	**Prior randomization**	**After randomization**
Anticoagulants	35 (56%)	39 (62%)	33 (49%)	38 (57%)
Azithromycin	13 (21%)	10 (16%)	13 (19%)	10 (15%)
Hydroxychloroquine	4 (6%)	5 (8%)	7 (10%)	8 (2%)
Antiviral drugs	6 (10%)	1 (2%)	12 (18%)	4 (6%)
Lopinavir/Ritonavir	5 (8%)	1 (2%)	11 (16%)	3 (4%)
Lopinavir	1 (2%)	0 (0%)	0 (0%)	0 (0%)
Remdesivir	0 (0%)	0 (0%)	0 (0%)	1 (1.5%)
Oseltamivir	0 (0%)	0 (0%)	1 (1.5%)	0 (0%)
Immuno-modulators	0 (0%)	1* (2%)	0 (0%)	4** (6%)
Corticosteroids	10 (16%)	19 (30%)	12 (18%)	37 (55%)
Dexamethasone	4 (6%)	9 (14%)	5 (7%)	19 (28%)

*Anakinra (n=1); ** Anakinra (n=3) and Eculizumab (n=1)

eTable 3. Day 4 outcome.

In the protocol the D4 primary outcome is defined as a WHO-CPS score ≤ 5 at day 4, and patients with a new DNR at, or before, day 4 where considered as with a WHO-CPS score > 5. Results are presented as proportions with a WHO-CPS score > 5, so that an effective treatment would result in a risk reduction.

	Tocilizumab	UC	Absolute Risk Difference	Adjusted Odds Ratio
N	63	67		
N (%) WHO-CPS > 5	12 (19%)	19 (28%)		
Posterior Median	19.7%	28.8%	-9.0%	0.57
90% CrI			-21.0 to +3.1	0.28 to 1.15
95% CrI	11.3 to 30.5	19.0 to 40.1	-23.3 to +5.5	0.24 to 1.32
Posterior probabilities*				
P(Any benefit)			0.890	0.905
P(Moderate or greater benefit)			0.684	0.823

* P(Any benefit)=P(ARD < 0) or P(OR < 1), P(Moderate or greater benefit) = P(ARD < -5.5%) or P(OR < 0.85)

eTable 4. Details of events for the primary outcome at day 14.

	Tocilizumab	UC
Number randomized	63	67
Number of events	15	24
Events		
Non-invasive ventilation/High flow	8	13
Then invasive ventilation (death)	*2 (0)*	*6 (3)*
Then death	*2*	*1*
Invasive ventilation (death)	3 (1)	8 (4)
Death	2	0
Do-Not-Resuscitate order (death)	2 (2)	3 (3)
Cumulative incidence at day 14 (95% CI)	24% (13 to 34)	36% (23 to 46)
Difference (95% CI)	-12% (-28 to +4)	

eTable 5. Sensitivity analyses for the primary outcome.

Summary of the posterior distribution and frequentist analysis.

Parameter	Adjusted analysis (primary analysis)	Unadjusted analysis	Frequentist analysis*
Median HR	0.58	0.60	0.58
90% CrI	0.33 to 1.00	0.35 to 1.03	0.34 to 1.00
95% CrI	0.30 to 1.11	0.31 to 1.14	0.30 to 1.11
P(HR < 1)	0.9505	0.9415	
P(HR < 0.95)	0.9314	0.9196	
P(HR < 0.85)	0.8744	0.8502	
P(HR < 0.8)	0.8314	0.8034	
P-value	-	-	0.0495

HR: hazard ratio
* For the frequentist analysis, the point estimate of the hazard ratio is given, with 90% and 95% confidence intervals instead of credible intervals. Posterior probabilities are not relevant, but a one-sided p-value is given instead.

eTable 6. Analysis in the subgroup of patients with rRT-PCR-confirmed SARS-CoV-2 infection.

	Tocilizumab	UC	Comparison
N positive rRT-PCR	56	61	
D4 outcome			
N (%) WHO > 5	12 (21%)	17 (28%)	Risk Difference
Posterior Median	22.1%	28.3%	-6.2%
90% CrI			-19.0 to +6.8
95% CrI			-21.4 to +9.3
P(RD < 0)			0.785
P(RD < 0.055)			0.535
Day 14 outcome			
N event (NIV, HFO, MV, or death)	15	22	
Day 14 cumulative incidence (95% CI)	27% (14 to 38)	36% (23 to 47)	Hazard ratio
Median HR			0.66
90% CrI			0.37 to 1.14
95% CrI			0.33 to 1.27
P(HR < 1)			0.895
P(HR < 0.95)			0.864
P(HR < 0.85)			0.776
P(HR < 0.8)			0.718

eTable 7. WHO-CPS scores during follow-up.

Adjusted OR was obtained from Bayesian proportional odds models. For longitudinal data, time was used as a main effect in the model. No imputation was performed, but a window of plus/minus 2 days was used for day 14 scores.

	Tocilizumab (n=63)		UC (n=67)		
	N	Median (IQR)	N	Median (IQR)	Adjusted OR (95% CrI)
Day 4	63	5 (5 to 5)	67	5 (5 to 6)	0.60 (0.27 to 1.28)
Day 7	55	5 (5 to 5)	64	5 (5 to 6)	0.86 (0.43 to 1.71)
Day 14	59	2 (2 to 5)	65	4 (2 to 7)	0.76 (0.40 to 1.42)
Longitudinal analysis	63	-	67	-	0.44 (0.14 to 1.36)

eTable 8. Overall survival.

After 14 days, the protocol specified visits at 28 and 90 days for patients discharged. Currently no patient achieved 90 days follow-up, so that deaths are reported for hospitalized patients or as serious adverse events, but no information on vital status is available for most discharged patients. Accordingly no survival analysis beyond 28 days is undertaken.

	Tocilizumab (n=63)		SoC (n=67)		Adjusted HR
	N deaths	OS (95% CI)	N deaths	OS (95% CI)	(95% CI)
Day 14	7	89% (81 to 97)	6	91% (84 to 98)	1.19 (0.40 to 3.55)
Day 28	7	89% (81 to 97)	8	88% (80 to 96)	0.92 (0.33 to 2.53)
Overall	7	-	11	-	-

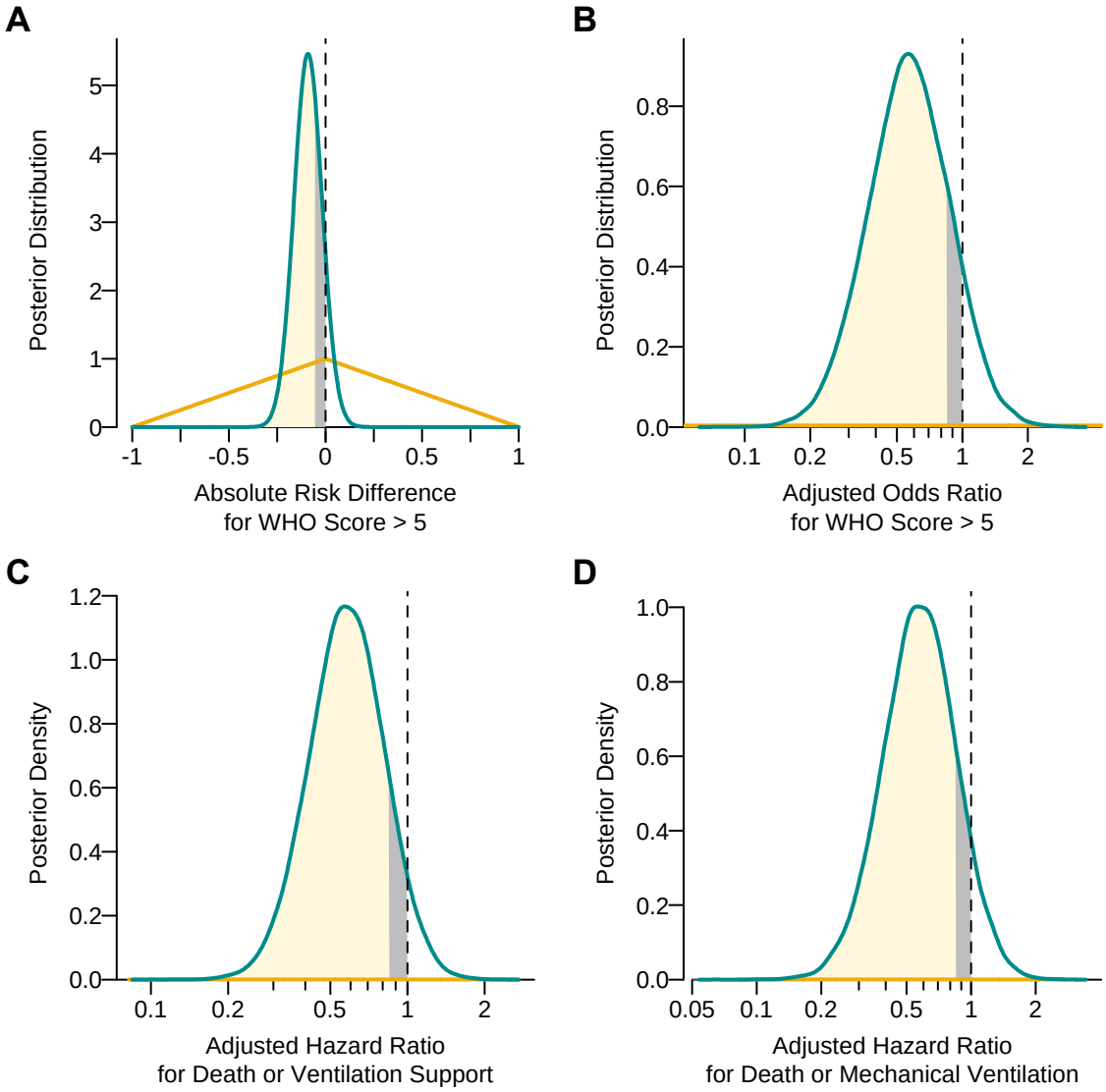
eTable 9. Cumulative incidence of oxygen supply independency and discharge until 28 days.

	Tocilizumab (n=63)		UC (n=67)		Adjusted HR
	N events	CIF (95% CI)	N events	CIF (95% CI)	(95% CI)
Oxygen supply independency					
Day 14	44	70% (57 to 80)	44	66% (53 to 76)	-
Day 28	55	89% (78 to 95)	50	75% (62 to 83)	1.41 (0.98 to 2.01)
Discharge					
Day 14	40	63% (50 to 74)	37	55% (42 to 66)	-
Day 28	52	83% (70 to 90)	49	73% (61 to 82)	1.52 (1.02 to 2.27)

CIF: cumulative incidence function; HR: hazard ratio

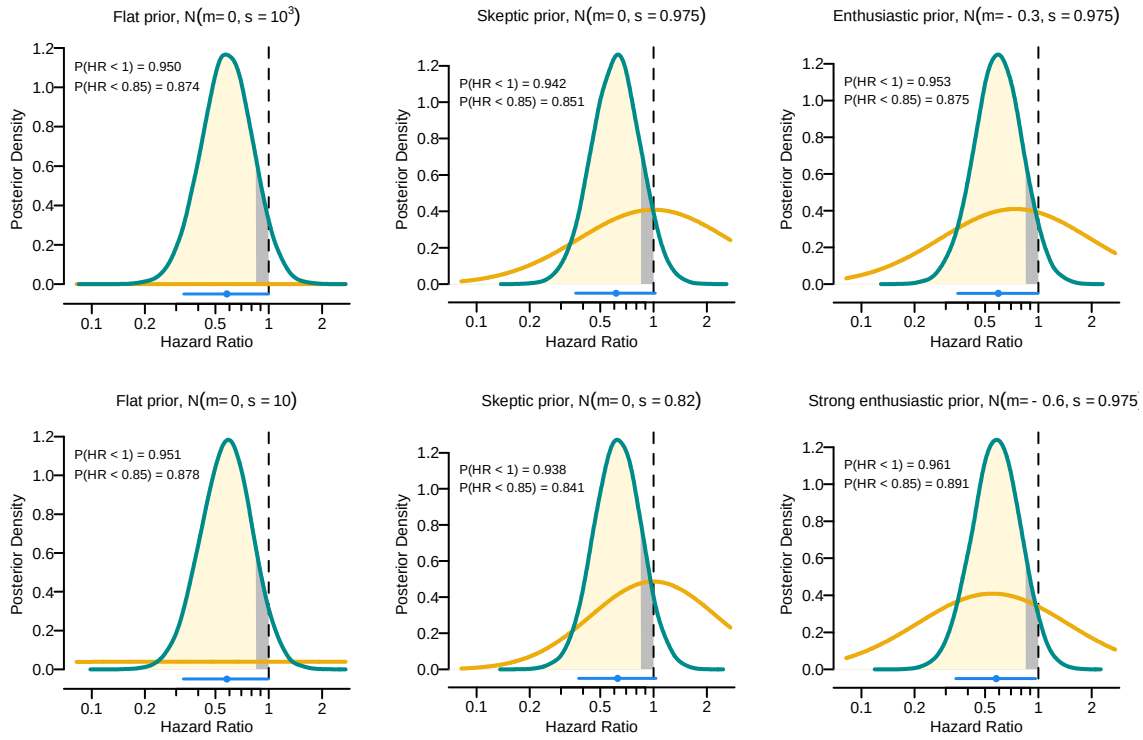
eFigure 1. Posterior distributions.

The plots give the posterior (cyan line) and minimally informative prior (gold line) distribution of parameters in Bayesian analyses for the absolute risk difference of WHO > 5 at D4 (**A**), the adjusted odds ratio of WHO > 5 (**B**), the adjusted hazard ratio for death or ventilation support (mechanical ventilation, high-flow or non-invasive ventilation) (**C**), and the adjusted hazard ratio for death or mechanical ventilation (**D**). The black dashed lines indicate no treatment effect. The yellow shaded regions show the posterior probabilities of ARD < -5.5%, OR < 0.85 or HR < 0.85 (moderate or greater effect) and the gray shaded plus the yellow shaded regions the posterior probabilities of ARD < 0, OR < 1 or HR < 1 (any effect).



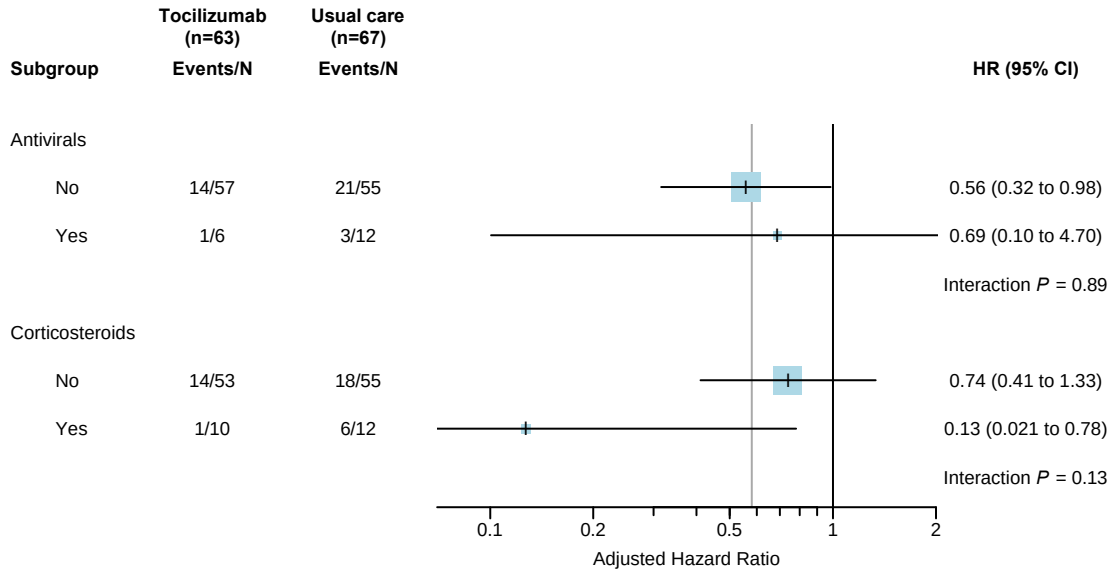
eFigure 2. Sensitivity to the prior distribution.

Posterior density of the adjusted hazard ratio for the primary outcome (cyan line) according to different priors represented in gold. The dashed line indicates a HR of 1 representing no treatment effect. Posterior probabilities of HR < 0.85 (yellow shaded region) and of HR < 1 (gray shaded plus yellow shaded regions) are also presented. The priors are given for the log hazard ratio. The blue point and line present the posterior median and 90% credible interval of the HR. The flat prior N(m = 0, s = 10^3) is the minimally informative prior in the primary analysis. Skeptic priors are determined so that high effects are unlikely, namely P(HR < 0.2) = P(HR > 5) = 0.05 (s = 0.975) and (HR < 0.2) = P(HR > 5) = 0.025 (s = 0.82). Enthusiastic priors are centred on half the log HR (-0.30) or the log HR (-0.60) reported for death in an observational study (Somers et al. https://doi.org/10.1101/2020.05.29.20117358), and are informative (s = 0.975). In all cases, results are virtually unaffected by the prior distribution, with median adjusted HR ranging from 0.590 to 0.640, and posterior probabilities of any effect P(HR < 1) ranging from 0.928 to 0.957.



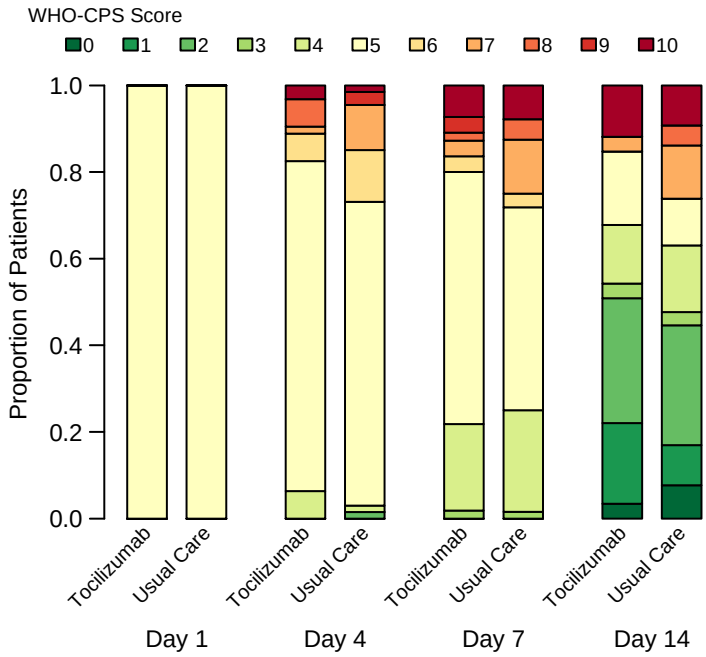
eFigure 3. Subgroup analyses for the primary outcome.

Results presented are adjusted hazard ratios for death or ventilation support (mechanical ventilation, high-flow or non-invasive ventilation). Dexamethasone at baseline was given in 4 patients in the tocilzumab arm (0 event) and 5 in the UC arm (3 events), and no hazard ratio was estimated in this subgroup. For those without dexamethasone, there were 15 events out of 59 in the tocilizumab arm and 21 out of 62 in the UC arm. The adjusted HR for patients without dexamethasone at baseline was 0.66 (95% CI 0.38 to 1.15).



eFigure 4. WHO Clinical Progression Scale score during follow-up.

WHO-CPS: 10-point WHO Clinical Progression Scale



eFigure 5. Evolution of biological parameters.

The box and whisker plots present the median (thick line) and first and third quartiles (box limits). Outer whiskers extend to the most extreme data point which is no more than 1.5 times the interquartile range from the box. Isolated points denote observations outside this range.