Informed Consent to Participate in Research

Information to Consider Before Taking Part in This Research Study

IRB Study # Pro00005134

You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you. Please ask him/her to explain any words or information you do not clearly understand. We encourage you to talk with your family and friends before you decide to take part in this research study. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

Please tell the study doctor or study staff if you are taking part in another research study.

We are asking you to take part in a research study called:

Multi-Institutional Neo-adjuvant Therapy MammaPrint Project I (MINT I Study)

The person who is in charge of this research study is Dr. Charles E. Cox. This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge.

This research will be conducted at the University of South Florida as well as at multiple other institutions throughout the United States.

This research is being sponsored by Agendia, LLC.

Purpose of the study

The purpose of this study is to find out if certain laboratory tests can predict whether women with breast cancer will respond to neoadjuvant chemotherapy. “Neoadjuvant” means that drug therapy is given before surgery rather than afterwards.

Should you take part in this study?

- This form tells you about this research study. After reading this form and having the research explained to you, you can decide if you want to take part in it.

- You may have questions this form does not answer. If you do have questions, feel free to ask the
study doctor or the person explaining the study, as you go along.

- Take your time to think about the information that is being provided to you.
- Talk it over with your regular doctor.

**This form explains:**

- Why this study is being done.
- What will happen during this study and what you will need to do.
- Whether there is any chance of benefits from being in this study.
- The risks involved in this study.
- How the information collected about you during this study will be used and with whom it may be shared.

Providing informed consent to participate in this research study is up to you. If you choose to be in the study, then you should sign the form. If you do not want to take part in this study, you should not sign this form.

**Why are you being asked to take part?**

You have been diagnosed with *locally advanced breast cancer*. This means that your breast tumor is medium to large in size. A recently accepted standard treatment for this type of cancer is *neoadjuvant chemotherapy*. This means that drug treatments are given to shrink the tumor before surgery is performed to remove the tumor. We want to find out if certain laboratory tests can predict which patients will respond to this type of therapy. These tests might also be able to predict which drugs are best to use for each individual patient based on their tumor type.

**What will happen during this study?**

For the purposes of this study, your doctors are especially interested in whether your cancer has spread to your lymph nodes. Therefore, you will need one or more tests to determine your lymph node status before you undergo chemotherapy. These tests are commonly done as part of your normal medical care. However, the research protocol may change the requirement and/or the order in which these tests are done. Your doctor will decide which of these tests are the most appropriate for your particular situation.

As part of your normal medical care, your doctors are using new lab tests to gain more information about your tumor. These *genomic tests* look at large numbers of normal genes to determine whether they are turned on or off in your tumor tissue. For example, *MammaPrint®* is a new FDA-cleared lab test that uses DNA technology to predict the chance of your cancer coming back later. The purpose of this research is to study whether these tests can also be used to predict how well you will respond to your chemotherapy.

If you agree to participate in this study no additional examinations, blood tests, or x-rays will be performed above and beyond your regular medical care. However, as part of the research, the following additional lab tests will be performed on the tumor tissue that is removed as part of your diagnosis and treatment:

- **Whole Human Genome Microarray** is a panel of over 44,000 gene tests. This panel is designed to assess the expression (turned on or off) of all known human genes in your tumor.
- **p53 Mutation Analysis** is a test that looks for common mutations (changes) of an important cancer-related gene called **p53**.
Your doctor will receive the results of all of the above tests, but results from the research tests will not be used to make decisions about your treatment. This is because we are not sure now what the results of these tests might mean for an individual person. Based on your unique medical history, your doctor will choose a recommended therapy from several well-accepted and presumed equivalent chemotherapy treatment plans.

The results of your tests will also be stored in a database with additional medical information about you and your cancer. This includes, but is not limited to, your age, race/ethnicity, the size and hormone status of your tumor, your treatment and the response to your treatment. No personal information will be stored in the database, but there will be a code that links your identity to your data.

**Total Number of Participants**

About 50 individuals will take part in this study at the University of South Florida and Florida Hospital Tampa. A total of 250 individuals will participate in the study at all sites.

**Alternatives**

You do not have to participate in this research study. You can receive the standard medical care without the additional tests being done on the tumor tissue.

**Benefits**

It is unlikely that you will receive any direct benefits by taking part in this research study. However, the knowledge gained from this research may benefit future patients with locally advanced breast cancer.

**Risks or Discomfort**

This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

**Compensation**

You will receive no payment or other compensation for taking part in this study. The findings from this research may result in the future development of products that are of commercial value. There are no plans to provide you with financial compensation or for you to share in any profits if this should occur.

**Cost**

There will be no additional costs to you as a result of being in this study. However, routine medical care for your condition (care you would have received whether or not you were in this study) will be charged to you or your insurance company. You may wish to contact your insurance company to discuss this further.

**Authorization to Use and Disclose Protected Health Information**

Who will see your health information?
In this research study, we use and share your health information to the extent authorized (permitted) by you. We know that this information is private. The federal privacy regulations of the Health Insurance Portability & Accountability Act (HIPAA) protect your identifiable health information. If you authorize us to use your information we will protect it as required by the law.

Research at Agendia, LLC is conducted jointly with the University of South Florida. By signing this form, you are permitting Agendia and the University of South Florida to use personal health information collected about you for research purposes. You are also allowing Agendia to share your personal health information with individuals or organizations who are also involved in the research and listed below.

**Who will disclose (share), receive, and/or use your information?**

To conduct this research, USF and the people and organizations may use or share your information. They may only use and share your information:

- **With the people and organizations on this list;**
- **With you or your personal representative; and**
- **As allowed by law.**

In addition to the people and organizations listed below in the Privacy and Confidentiality section of this document, the following groups of people may also be able to see information about you and may use the information to conduct the research:

- The medical staff that takes care of you and those who are part of this research study;
- Each research site for this study. This includes the research and medical staff at each site and USF;
- Any laboratories, pharmacies, or other individuals and organizations that use your health information as part of the approved plan for this study;
- Data Safety Monitoring Boards or others who monitor the data and safety of the study;
- Additionally, there may be other people and/or organizations who may be given access to your personal health information.

**Who else can use and share this information?**

Anyone listed above may use consultants in this research and for the purpose of this study, may share your information with them. If you have questions about who they are, you should ask the study team. Individuals who receive your health information for this research study may not be required by the HIPAA Privacy Rule to protect it. If so, they may share your information with others without your permission. They can only do so if permitted by the laws governing them. For example, the study sponsor may share your information with others. If the sponsor or others share your information, your information may no longer be protected under the HIPAA Privacy Rule.

**How will my information be used?**

By signing this form, you are giving your permission to use and/or share your health information as described in this document for all study related purposes. Your authorization to use your health information will not expire unless you revoke it in writing.

As part of this research, USF may collect, use, and share the following information:

- Your whole research record
- All of your past, current or future medical and other health records held by USF, other health care providers or any other site affiliated with this study
• The results of your tissue tests will be stored in a centralized database with additional depersonalized medical information about you and your cancer. This includes, but is not limited to, your age, race/ethnicity, the size and hormone status of your tumor, your treatment and the response to your treatment.

You can list any particular information that you do not want us to use or share in the space below. If you list nothing here, we can use and share all of the information listed above for this research but for nothing else.

**For the Research Participant (you) to complete:**

- I am asking USF and the researchers not to include, use, or share the following health information in this research: (If blank, then no information will be excluded.)

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**Your Rights:**

You can refuse to sign this form. If you do not sign this form, you will not be able to take part in this research study. This means that the research-related tests will not be done. However, your health care outside of this study and benefits will not change.

**How Do I Withdraw Permission to Use My Information?**

You can revoke this form at any time by sending a letter clearly stating that you wish to withdraw your authorization to use your health information in the research. If you revoke your permission:

- You will no longer be a participant in this research study;
- We will stop collecting new information about you;
- We will use the information collected prior to the revocation of your authorization. This information may already have been used or shared with other, or we may need it to complete and protect the validity of the research; and
- Staff may need to follow-up with you if there is a medical reason to do so.

To revoke this form, please write to:

**Principal Investigator: Charles E. Cox, M.D.**
**For IRB Study # Pro00005134**
**USF Breast Health Program**
**3000 Medical Park Drive, MDC 25**
**Tampa, FL 33613**

While we are conducting the research study, we cannot let you see or copy the research information we have about you. After the research is completed, you have a right to see the information about you, as allowed by USF policies.

**Privacy and Confidentiality**

We will keep your study records private and confidential. Certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:
• The research team, including the Principal Investigator, study coordinator, research nurses, and all other research staff.

• Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.

• Any agency of the federal, state, or local government that regulates this research. This includes the Food and Drug Administration (FDA), the Florida Department of Health, the Department of Health and Human Services (DHHS) and the Office for Human Research Protection (OHRP).

• The USF Institutional Review Board (IRB) and its related staff who have oversight responsibilities for this study, staff in the USF Office of Research and Innovation, USF Division of Research Integrity and Compliance, and other USF offices who oversee this research.

• The sponsor of this study, Agendia, LLC.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are.

**Voluntary Participation / Withdrawal**

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

**New information about the study**

During the course of this study, we may find more information that could be important to you. This includes information that, once learned, might cause you to change your mind about being in the study. We will notify you as soon as possible if such information becomes available.

**What if you get sick or hurt while you are in the study?**

If you need emergency care:

• Go to your nearest hospital or emergency room right away or call 911 for help. It is important that you tell the doctors at the hospital or emergency room that you are participating in a research study. If possible, take a copy of this informed consent form with you when you go. USF does not have an emergency room or provide emergency care.

• Call the study doctors as soon as you can. They will need to know that you are hurt or ill. Call Dr. Charles E. Cox at **(813) 793-4272 (ext. 202)** or **(813) 974-8252**.

If you do NOT need emergency care:

• Go to your regular doctor. It is important that you tell your regular doctor that you are participating in a research study. If possible, take a copy of this informed consent form with you when you go.

• The USF Medical Clinics may not be able to give the kind of help your needs.
Will I be compensated for research related injuries?

If you believe you have been harmed because of something that is done during the study, you should call Dr. Charles E. Cox at (813) 793-4272 (ext. 202) immediately. The University of South Florida will not pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. The cost of such care or treatment will be your responsibility. In addition, the University of South Florida will not pay for any wages you may lose if harmed by this study. The University of South Florida is considered a state agency and therefore cannot usually be sued. However, if it can be shown that the researcher, or other USF employee, is negligent in doing his or her job in a way that harms you during the study, you may be able to sue. The money that you might recover from the State of Florida is limited in amount.

You can also call the USF Self Insurance Programs (SIP) at 1-813-974-8008 if you think:

- You were harmed because he/she took part in this study.
- Someone from the study did something wrong that caused you to be harmed, or did not do something they should have done.
- Ask the SIP to look into what happened.

What happens if you decide not to take part in this study?

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study to please the study doctor or the research staff. If you decide not to take part in the study you will not be in trouble or lose any rights you normally have. You will still have the same health care benefits and get your regular treatments from your regular doctor.

You can decide after signing this informed consent document that you no longer want to take part in this study for any reason at any time. If you decide you want to stop taking part in the study, tell the study staff as soon as you can.

- We will tell you how to stop safely. We will tell you if there are any dangers if you stop suddenly.
- If you decide to stop, you can continue getting care from your regular doctor.

Even if you want you to stay in the study, there may be reasons we will need to withdraw you from the study. You may be taken out of this study if we find out it is not safe for you to stay in the study. We will let you know the reason for withdrawing you from this study.

You can get the answers to your questions, concerns, or complaints.

If you have any questions, concerns or complaints about this study, call Dr. Charles E. Cox at (813) 793-4272 (ext. 202).

If you have questions about your rights, general questions, complaints, or issues as a person taking part in this study, call the USF IRB at (813) 974-5638.
Consent to Take Part in Research

And Authorization for the Collection, Use and Disclosure of Health Information

It is up to you to decide whether you want to take part in this study. If you want to take part, please read the statements below and sign the form if the statements are true. I freely give my consent to take part in this study and authorize that my health information as agreed above, be collected/disclosed in this study. I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

______________________________________________
Signature of Person Taking Part in Study Date

Printed Name of Person Taking Part in Study

Statement of Person Obtaining Informed Consent and Research Authorization

I have carefully explained to the person taking part in the study what he or she can expect from their participation. I hereby certify that when this person signs this form, to the best of my knowledge, he/ she understands:

- What the study is about;
- What procedures/interventions/investigational drugs or devices will be used;
- What the potential benefits might be; and
- What the known risks might be.

I can confirm that this research subject speaks the language that was used to explain this research and is receiving an informed consent form in the appropriate language. Additionally, this subject reads well enough to understand this document. If not, this person is able to hear and understand when the form is read to him or her. This subject does not have a medical/psychological problem that would compromise comprehension, thus making it hard to understand what is being explained. Therefore, this subject can give legally effective informed consent. This subject is not under any type of anesthesia or analgesic that may cloud their judgment or make it hard to understand what is being explained. Therefore, this subject can be considered competent to give informed consent.

______________________________________________
Signature of Person Obtaining Informed Consent / Research Authorization Date

Printed Name of Person Obtaining Informed Consent / Research Authorization
Addendum to the Consent and Authorization to obtain and store tissue samples.

We are asking you to allow us to obtain and store samples of your tissue for use in future research. These samples may be used for research on your disease or condition and others to assist in the development of new treatments for disease. We will take some of your breast tumor tissue. This will not be in addition to the tissue already being obtained for treatment or research purposes.

When you sign below, you are agreeing to let us store and use your tissue for future research studies. We may use these samples to help us:

- Learn more about your disease.
- Learn how the genomic lab tests work.
- Find new ways to help people with your disease or condition or other conditions.
- Someday learn how to cure your disease or condition.

Your tissue sample will be stored at Agendia indefinitely (or until it is used up). Your sample will be stored with identifying information. We will not tell other people your name or other information that identifies your unless it is required by law.

Your sample is linked to your identifying information such as name or medical record number. Therefore, should you choose to withdraw your consent to use the sample at a later date, please contact the study doctor. The study doctor will remove your sample from the research and immediately destroy it so that it can no longer be used. Please understand that part your sample may have been used prior to the withdrawal of your consent.

You can decide if you want us to store and use your samples in the future. You do not have to agree to this in order for you to take part in the study that has been explained to you. By singing this form, you give consent to provide your tumor tissue for future research purposes.

________________________________________________ __________________
Signature of Legally Authorized Representative Date

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Printed Name of Legally Authorized Representative

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Signature of Person Obtaining Informed Consent Date

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Printed Name of Person Obtaining Informed Consent