BIOMEDICAL RESEARCH ALLIANCE OF NEW YORK LLC
WEILL CORNELL MEDICINE

SUBJECT INFORMATION AND INFORMED CONSENT FORM

Project Title: The LUCINDA Trial: Leuprolide plus Cholinesterase Inhibition to reduce Neurological Decline in Alzheimer's

Protocol #: 057681
Sponsor: National Institutes of Health
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KEY INFORMATION ABOUT THIS RESEARCH STUDY

You are being asked to be a subject in a research study because you have Mild Cognitive Impairment (MCI) likely due to Alzheimer's Disease (AD) or AD.

The following table is a concise and focused presentation of key information to assist you in understanding why you might or might not want to participate in the research.

Purpose	This is a research study to determine if the medication Leuprolide can slow or prevent decline in thinking abilities and functioning in women with Alzheimer's Disease (AD) or MCI due to AD who are also taking the medication donepezil (Aricept.)
Experimental/ Investigational	Leuprolide is approved by the Food and Drug Administration (FDA) for several conditions. However, it is NOT approved for Alzheimer's Disease, so its use is experimental in this study. This means that it is being tested. You may receive placebo ('dummy drug') used to compare results to the experimental drug.
Voluntary Participation	Your decision to be in this study is voluntary.
Withdrawal	If you decide to be in this study and then change your mind, you can leave the study at any time without penalty.
Length of Participation	Your participation is expected to last about 1 year.

Procedures	The main procedures in the study include: ---Study drug injections ---Blood draws --- Electrocardiogram (ECG) --- Magnetic Resonance Imaging (MRI) --- Neuraceq Positron Emission Tomography (PET) All procedures are being done for research purposes; they are not part of your standard care.
Risks	Taking part in this research may expose you to risks (side effects). There are risks from the study drug and from study procedures. Not all risks of the study drug are known at this time. Side effects may range from being mild to life-threatening and may go away with treatment or be permanent. The common/main risks of the study drug include: --- Injection site discomfort The study doctor will explain the risks of this research to you before you decide about participation.
Benefit	There is no guarantee that you will benefit as a result of your participation in this study, however the study results may help people in the future.
Alternative(s) to Study Participation	You do not have to participate in this research study. The study doctor will discuss study alternatives with you and their risks and benefits.
Costs	The study sponsor will pay for the cost of the study drug and for procedures that are required for the study.
Confidentiality	There are provisions in place to help protect the privacy and confidentiality of your personal health information and study information.

This overview does not include all of the information you need to know before deciding whether or not to take part. Much additional detail is given in the full consent document, which can be found on the pages that follow. Be sure to review the rest of this consent form before deciding about participation.

INFORMED CONSENT FORM

INTRODUCTION

You are invited to consider participating in a research study. You were selected as a possible participant in this study because you are a woman over age 65 who has been diagnosed with Alzheimer's Disease (AD) or Mild Cognitive impairment likely due to AD and you are taking the medication donepezil (Aricept) prescribed by your treating physician.

Please take your time to make your decision. It is important that you read and understand several general principles that apply to all who take part in our studies:

(a) Taking part in the study is entirely voluntary.
(b) Personal benefit to you may or may not result from taking part in the study, but knowledge gained from your participation may benefit others;

(c) You may decide not to participate in the study or you may decide to stop participating in the study at any time without loss of any benefits to which you are entitled.

The purpose and nature of the study, possible benefits, risks, and discomforts, other options, your rights as a participant, and other information about the study are discussed below. Any new information discovered which might affect your decision to participate or remain in the study will be provided to you while you are a participant in this study. You are urged to ask any questions you have about this study with members of the research team. You should take whatever time you need to discuss the study with your physician and family. The decision to participate or not to participate is yours. If you decide to participate, you will be asked to sign and date this document.

DISCLOSURE OF FINANCIAL INTERESTS

The National Institute on Aging, a part of the National Institutes of Health, is providing funds to Weill Cornell Medicine to conduct this research study.

WHAT IS THE PURPOSE OF THIS STUDY?

The main purpose of this study is to determine whether the medication Eligard (leuprolide acetate subcutaneous injection) may slow or prevent decline in thinking abilities and functioning in women with Alzheimer's Disease (AD) who are also taking the medication donepezil (Aricept.) We also want to find out whether Leuprolide affects brain structure and/or certain blood tests related to AD.

Use of Leuprolide for Alzheimer's Disease is experimental, which means that the Food and Drug Administration (FDA) has not approved Leuprolide for this purpose.

NUMBER OF SUBJECTS AND LENGTH OF STUDY PARTICIPATION

About 300 subjects are expected to participate in this study at three research sites worldwide.
Your participation in this study is expected to last 1 year.

WHAT WILL HAPPEN DURING THIS STUDY?

This is a "randomized" study. Randomized means that you are put into a group by chance. It is like

flipping a coin. You will be randomly assigned to receive either Leuprolide or placebo injection. You will have an equal chance of being placed in either group. Neither you nor the researchers can choose what group you will be in. Neither you nor the researchers will know what group you are in, but the study doctor can find out if medically necessary.

This study involves approximately eight study visits spread out over one year. Study visits are described below. Some parts of some visits may be done remotely. This means you could stay at your home and communicate with the study staff member using a phone, computer, or other electronic means. After screening and baseline visits you will be asked to return for visits at 12 weeks, 24 weeks, 36 weeks, 48 weeks and 52 weeks. Most visits will take up to approximately 4 hours. The screening neuroimaging visit and seventh (second-to-last) visit may take longer (up to 5-6 hours) because you will also undergo brain imaging at these visits. Any study visit can be broken up into several shorter visits for convenience and/or to avoid fatigue.

Initial Screening Visit:
You will have an initial screening consultation during which you will be provided with information about the study, the schedule of events and this informed consent form. This screening visit may be conducted remotely using phone, computer, or other electronic means. If you agree to participate in this study, you will be asked to sign and date this consent form. As part of the screening visit, you will undergo a number of assessments to determine if you are eligible to participate in the study. You will undergo the following procedures at this initial screening visit:

- You will be asked about your medical history and medications
- You will undergo testing of your memory and thinking abilities and complete questionnaires related to your diagnosis of Mild Cognitive Impairment or Alzheimer's Disease.
- If the screening visit takes place in person, then the procedures below will also be done. If the visit is done via phone or videoconferencing, these procedures will be done at the following visit:
- Approximately 4 tablespoons of blood will be taken from you for testing to help determine if it is safe for you to be in the study.
- Electrocardiogram (ECG)

Screening Neuroimaging Visit:
During this visit you will undergo imaging of your brain (neuroimaging). This will typically be performed on a separate day from the initial screening visit because of the length of time required for each imaging exam, however it may be performed on the same day as initial screening should time allow. You will have two types of neuroimaging exams:

- Magnetic Resonance Imaging (MRI)
- Neuraceq Positron Emission Tomography (PET)
- Physical exam (if not already done at the prior visit)
- Approximately 4 tablespoons of blood will be taken from you for testing (if not already done at the prior visit)
- ECG (if not already done at the prior visit)

Baseline Visit:
If you meet all of the study eligibility criteria, you will be asked to return for a baseline visit. You will be

randomly assigned (like the flip of a coin) to be treated with either the active study drug (Leuprolide) or the non-active placebo. You will undergo the following procedures at this visit:

- You will undergo testing of your memory and thinking abilities and complete questionnaires.
- You will be asked about the medications you take and undergo a physical exam including vital signs and measurement of your weight.
- Approximately 2 tablespoons of blood will be taken from you for APOE genotyping (a genetic test). There is more information about genetic testing below.
- Approximately 4 tablespoons of blood will be taken from you for other tests.
- You will be injected with the first dose of the study drug (either :Leuprolide or placebo.)

Follow up Visits (Week 12, Week 24 and Week 36):
You will return after 12 weeks, 24 weeks and 36 weeks for study drug injection and additional testing. You will undergo the following procedures at each follow-up visit:

- You will undergo testing of your memory and thinking abilities and complete questionnaires.
- You will be asked about the medications you take and undergo a physical exam including vital signs and measurement of your weight.
- Approximately 4 tablespoons of blood will be taken from you.
- You will be injected with the study drug.
- You will be asked whether you have experienced any adverse events.

Follow up Visit (Week 48):
This visit will be similar to the previous three visits except you will also undergo MRI. This visit may be split up into two or more visits for convenience. You will undergo the following procedures at this final visit:

- You will undergo testing of your memory and thinking abilities and complete questionnaires.
- You will be asked about the medications you take and undergo a physical exam including vital signs and measurement of your weight.
- Approximately 4 tablespoons of blood will be taken from you.
- You will be asked whether you have experienced any adverse events.
- You will undergo MRI.

Final Visit (Week 52):
You will undergo the following procedures at this final visit:

- Approximately 4 tablespoons of blood will be taken from you.
- You will be asked whether you have experienced any adverse events.

In addition to study visits listed above, you will be contacted by phone 2-5 days after each study drug administration to assess any adverse events. You will be contacted by a member of the study team.

All visits performed as part of this research study are considered performed for research purposes only.

Below is a more detailed description of each Research Procedure:

Study Drug Injection: Study drug will be injected by a nurse or medical assistant into your buttocks or

another fleshy part of your body.

PET scan: You will have a PET scan at the screening neuroimaging visit. The PET scan may be done at the same time as MRI using a combined MRI/PET scan machine or it may be done on a separate machine. PET scans use a radioactive dye to image the brain. Before the PET scan begins, a needle (or IV) will be inserted into a vein in your arm, and a small amount of the radioactive dye will be injected. During the scan, you will lie very still on a table that will slide into the scanner to take pictures of your brain. The PET scan will use an FDA approved dye called 18F-florbetaben or Neuraceq. This type of PET scan measures a protein in the brain called amyloid. Amyloid builds up in the brains of people with Alzheimer's disease. The results of the PET can be shared with you and/or your physician.

Blood for APOE genetic testing: At the baseline visit, some of the blood that is sampled will be used to test for a gene called Apolipoprotein E (APOE.) One form of the APOE gene increases the risk of Alzheimer's Disease. This testing is done for research purposes only and may help determine whether Leuprolide is more or less helpful in people with different forms of the APOE gene. The results of this analysis will be kept confidential. Neither you nor your caregiver will be given genetic test results. APOE testing is a required study procedure. More information about genetic testing is provided in the section below called GENETIC TESTS AS PART OF THIS RESEARCH STUDY.

MRI scan: MRI uses a strong magnet to image your brain. For the MRI, you will lie very still on a table that will slide into the scanner. During the scan, you will hear knocking sounds. You will be given earplugs to reduce any discomfort from the noise. To be sure that it is safe for you to have an MRI exam, you will be asked to complete standard MRI screening questionnaires. Since the MRI machine uses a strong magnet that will attract other metals, you may not take part in this study if you have a pacemaker, an implanted defibrillator, or certain other implanted electronic or metallic devices, shrapnel, or other metal. The person doing the scan (MRI technician) will be able to communicate with you during the scan, and you will be given a button that will allow you to stop the scan at any point if you do not want to continue. Each MRI scan will take approximately 1 hour. Over the course of this study, you will have a total of 2 MRI scans performed at the screening neuroimaging visit and the final visit.

Interviews and questionnaires: You and your caregiver or study partner will be asked questions about your age, level of education, history of smoking and drug use, your mood, whether you are experiencing any pain, and your ability to function at home such as being able to eat, dress and clean. Your memory and thinking abilities will also be tested by asking you to remember words and pictures. Some of these tests and questionnaires may be conducted remotely using phone, computer, or other electronic means.

Audiotaping: We may record (audiotape) some of the memory and thinking tests so that they can be scored accurately later. Only the research team will be able to listen to the tapes. The tapes will be erased once they are no longer needed.

Blood Samples: We will take blood samples at the screening visit and then about once every three months. Altogether, there will be a total of seven blood samples taken over the 52 week study period. The total amount of blood drawn will be about 30 tablespoons or 1.9 cups. A standard blood donation is about 2 cups.

WHAT ARE THE RISKS OF THIS STUDY?

You may experience one or more of the risks indicated below from being in this study. There may also be unknown risks, or risks we did not anticipate.

Risk of Study Drug Injection

Leuprolide has been used to treat hormone-sensitive conditions in adults and children for three decades. It is considered to be a fairly safe medication. However, taking Leuprolide may cause you to have one or more of the side effects listed below. These side effects have been noted in adults taking Leuprolide for prostate cancer, endometriosis and uterine fibroids. The use of Leuprolide in Alzheimer's Disease is experimental, and it is not known if Leuprolide's side effects are different in Alzheimer's Disease as compared to other conditions. There may be rare and unknown side effects. Some of these side effects may be bad enough to cause death.

It is important for you to tell the study staff and study doctor about any changes you feel after you begin taking the study drug. You can tell the study staff at your scheduled in-person study visits, during scheduled phone calls after each injection of study drug, or by calling the staff and telling them how you feel. If you are not honest with the study staff during this study, it may not be safe for you to stay in the study.

Potential Risks of Study Drug injection include:

LIKELY: Injection Site Discomfort. The most common side effect of study drug injection (Leuprolide or placebo) is mild burning/pain/bruising at the injection site. You may also notice a small bump under your skin at the injection site.

POSSIBLE: Menopause Effects. Because Leuprolide suppresses sex hormones, it may cause side effects similar to those experienced during menopause such hot flashes (flushing), increased sweating, night sweats, tiredness, headache, upset stomach, breast changes, acne, joint/muscle aches, trouble sleeping, reduced sexual interest, vaginal discomfort/dryness, vaginal bleeding, swelling of the ankles/feet, increased urination at night, or dizziness. However, since only post-menopausal women older than 65 will be in this study, these menopause-like side effects should not be an issue.

POSSIBLE: Bone Effects. Long term use of Leuprolide causes loss of bone density in men and pre-menopausal women. This effect is due to decreased sex hormone levels. Since women after menopause already have low sex hormone levels, Leuprolide is not expected to have any additional negative effect on bone density.

RARE: Mental/mood changes (e.g., depression, thoughts of suicide, mood swings, aggression), new/worsening bone pain, easily broken bones, increased thirst/urination, chest/jaw/left arm pain, weakness on one side of the body, slurred speech, seizures, fast/irregular heartbeat, severe dizziness, fainting. Get medical help right away if you have any of these rare but serious side effects.

RARE: Pituitary Apoplexy. Rarely, a serious problem with your pituitary gland (pituitary apoplexy) may occur, usually in the first hour to 2 weeks after your first injection. Get medical help right away if any of these very serious side effects occur: sudden severe headache, sudden severe mental/mood

changes (e.g., severe confusion, difficulty concentrating), vision changes, severe vomiting.

RARE: Allergy. As with any drug, an allergic reaction can occur. Allergic reactions can be mild or more serious and can even result in death. Common symptoms of an allergic reaction are rash, itching, skin problems, swelling of the face and throat or trouble breathing. If you think you are having an allergic reaction, call the study doctor right away at the phone number at the top of page 1 of this consent form. If you are having trouble breathing, call 911 immediately.

NOTE: Because this study involves a placebo, there is a chance you will not actually be taking Leuprolide. You could miss the benefits or harms (if any) of the study medication.

Other Risks

Risk of Covid-19 infection

Because this research study involves leaving your home for study visits, it may increase your risk of exposure to the novel coronavirus that began spreading around the world in 2020. This virus can cause severe illness or death. Older people and people with underlying health conditions are particularly at risk. We will minimize this risk by following all recommendations by scientific and medical experts such as: making your visits as short as possible, scheduling visits to minimize your contact with other people, frequent handwashing, wearing masks as recommended, frequent facility deep cleanings.

Risk of PET scan: Radiation

During this study, you will have exposure to radiation from the Neuraceq PET/CT scan. This radiation exposure is not necessary for your medical care and is for research purposes only. The additional amount of radiation that you will receive as a result of participating in this study will be a maximum of approximately 8.8 mSv, which is equivalent to approximately 3 times the yearly exposure from natural background radiation in the US (3 mSv). The more radiation you receive during your life, the greater the risk of causing changes to the cells in your body or of having cancerous tumors. The radiation from this study is not expected to greatly increase these risks, but the exact increase in such risks is not known.

Risk of PET scan: Neuraceq (florbetaban F18) injection

Florbetaben is an FDA-approved PET radiotracer (dye) used to identify the protein amyloid in the brain.
COMMON: The most common side effect of Neuraceq injection is pain and redness at the injection site, affecting 1-4% of people.

Risk of Magnetic Resonance Imaging (MRI)

MRI uses a strong magnetic field to create images of the body. While no significant risks have been found from the use of MRI scans, you may be bothered by the MRI machine noise and by feelings of being closed in (claustrophobia).

Risk of PET and MRI scans: Incidental Findings

The PET scan and MRI scans that are done as part of this study will be read and interpreted by a licensed radiologist and the report will be provided to the Principal Investigator listed at the top of this document. If there are any unsuspected, incidental findings that you should know about, study personnel will share the findings with you or a physician who you may designate. Incidental findings noted on the PET and MRI scans might or might not have clinical significance and might or might not

lead to further medical tests or treatments. It will be up to you and your designated physician to determine if any further testing or treatment is necessary on the basis of this information. However, you should know that the limited neuroimaging that is done for this study is not meant to be a comprehensive examination, therefore we may not detect abnormalities or diseases which may be present and might be detected in a full clinical and diagnostic examination. Should we find abnormalities in our limited imaging examination of your brain, your doctor might recommend that you undergo a full diagnostic neuroimaging study, which would then no longer be considered a part of this study.

Risk of ECG
The sticky pads (electrodes) that are placed on your chest may cause discomfort such as redness or itching. If we need to shave your chest before we attach the pads, irritation from shaving may also occur.

Risk of Blood Draws
A needle will be used to draw blood and inject dye during the PET scan. Insertion of the needle may cause pain or stinging, bruising, bleeding, a blood clot, and rarely can cause infection.

Risk of Genetic Testing (APOE Genotyping)
Genetic testing can generate information about a subject's personal health risks and can cause or increase anxiety, damage family relationships, and/or compromise insurability, employability and can even lead to discrimination. The genetic samples will be labeled with only a subject number thereby greatly reducing the possibility of psychological or social risks that could arise from knowledge of this genetic information, such as risk for your employability or insurability or the risk of discrimination. In addition, you will not be informed of genetic testing results.

There is a federal law called the Genetic Information Nondiscrimination Act (GINA). In general, this law makes it illegal for health insurance companies, group health plans and employers with greater than 15 employees to discriminate against you based on your genetic information. However, it does not protect you against discrimination by companies that sell life insurance, disability insurance or long term-care insurance. Additional information about genetic testing for this study is provided in the section titled GENETIC TESTS AS PART OF THIS RESEARCH STUDY.

Risks Related to Thinking and Memory Testing
Some of the thinking or memory testing being performed during this study might be stressful or cause you anxiety. If any question makes you uncomfortable, you may discuss the need to answer it with study personnel. You may choose not to answer any question with which you still feel uncomfortable.

Risks of Breach of Confidentiality
One risk of participating in this study is that confidential information about you may be accidently disclosed. We will use our best efforts to keep the information about you secure. Please see the section in this consent form titled HOW WILL YOU KEEP MY INFORMATION CONFIDENTIAL? for more information.

Clinically Relevant Results
If results of study procedures (e.g. blood tests, imaging scans) give clinical information that may be important to your health care, you will be told about those results.

WHAT ARE THE BENEFITS OF THIS STUDY?

We cannot and do not guarantee that you will receive any benefits from this study. We hope the information learned from this study will benefit other patients with Alzheimer's Disease in the future.

WHAT OTHER TREATMENT OPTIONS ARE THERE?

You do not have to participate in this research study. The study doctor will discuss study alternatives with you and their risks and benefits.

WILL IT COST ME ANYTHING TO BE IN THIS STUDY?

There will be no costs to you for participating in this research study. The study drug will be provided to you at no charge. All procedures and tests performed as part of this study are performed for research purposes so they will be covered by the study and will not be charged to you or your insurance company. However, you or your insurance company will be charged for continuing medical care and/or hospitalization that are not a part of the study.

WILL I BE PAID FOR PARTICIPATING?

You will receive compensation for participating in this study. You will receive a stipend of $50 for each completed in-person study visit. This will be paid to you in the form of a check or debit card approximately six weeks after you complete the visit.

You may be eligible to receive reimbursement of your travel expenses, depending on the distance you travel to come for study visits. You will be required to provide the study coordinator with receipts of your travel expenses. Please ask the researchers for additional information.

Your biospecimens, with or without identifiers, may be used for commercial profit and you will not share in this profit.

Tax law may require the payer (e.g. research institution or third party) to report the amount of payment you receive from that payer to the Internal Revenue Service (IRS) or other agencies, as applicable. Generally this reporting would take place if you receive $600 or more from the payer in a calendar year. You would be responsible for paying the taxes on the payment you received from the study.

WHAT IF I AM INJURED AS A RESULT OF THIS STUDY?

For medical emergencies, call 911. If you are hurt from being in the study, you will receive medical care and treatment as needed from **WEILL CORNELL MEDICINE**. You will be responsible for the costs of such medical treatment, directly or through your medical insurance or other forms of medical coverage. No money will be given to you for treatment. No compensation will be offered by **WEILL CORNELL MEDICINE**, the sponsor (NIH) or Biomedical Research Alliance of New York for things such as lost wages, disability, or discomfort as part of this study.

You are not waiving any legal right to seek additional compensation through the courts by signing this form.

HOW WILL YOU KEEP MY INFORMATION CONFIDENTIAL?

To the extent allowed by law, every effort will be made to keep your personal information confidential.

However, information from this study will be submitted to the study sponsor and to the U.S. Food and Drug Administration. It may be submitted to governmental agencies in other countries where the study product may be considered for approval. Medical records, which identify you and the consent form signed by you, will be looked at by the sponsor or the sponsor's representatives and may be looked at by the FDA and other regulatory agencies, the Institutional Review Board, and the Biomedical Research Alliance of New York. While these parties are aware of the need to keep your information confidential, total confidentiality cannot be guaranteed. The results of this research project may be presented at meetings or in publications; however, you will not be identified in these presentations and/ or publications.

A description of this clinical trial will be available on *http://www.ClinicalTrials.gov*, as required by U.S. Law. This Web site will not include information that can identify you. At most, the Web site will include a summary of the results. You can search this web site at any time.

AUTHORIZATION TO USE AND DISCLOSE PERSONAL HEALTH INFORMATION

Federal regulations give you certain rights related to your health information. These include the right to know who will be able to get the information and why they may be able to get it. The study doctor must get your authorization (permission) to use or give out any health information that might identify you. If you choose to be in this study, the study doctor will get personal information about you. This may include information that might identify you. The study doctor may also get information about your health, including:

- Past and present medical records
- Research records
- Records about phone calls made as part of this research
- Records about your study visits
- Information obtained during this research about laboratory test results
- Results from diagnostic and medical procedures including but not limited to MRI and PET scans, physical examinations and medical history
- Billing records

Information about your health may be used and given to others by the study doctor and staff. They might see the research information during and after the study. Your information may be given to the National Institute of Health, the sponsor of this research. Information about you and your health which might identify you may be given to:

- The U.S. Food and Drug Administration
- Department of Health and Human Services agencies
- Biomedical Research Alliance of New York (BRANY)
- The Institutional Review Board
- Accrediting agencies
- Data safety monitoring boards
- Health insurers and payers
- Institutions involved in this study: Weill Cornell Medicine, University of Miami, New York University Medical School, and University of Wisconsin – Madison
- Institutions which may be involved in this study in the future, for example if an investigator

moves to a different institution.
- Investigators on this project including Dr. Tracy Butler, Dr. James Galvin and Dr. Craig Atwood

Your personal health information may be further shared by the groups above. If shared by them, the information will no longer be covered by the U.S. federal privacy laws. However, these groups are committed to keeping your personal health information confidential. If you give permission to give your identifiable health information to a person or business, the information may no longer be protected. There is a risk that your information will be released to others without your permission.

Information about you and your health that might identify you may be given to others to carry out the research study. The sponsor and/or members of a Data and Safety Monitoring Board (DSMB) may analyze and evaluate the results of the study. They will follow how the study is done, and they will be reviewing your information for this purpose. The information may be given to the FDA. The information may also be used to meet the reporting requirements of governmental agencies.

This authorization does not have an expiration date. If you do not withdraw this authorization in writing, it will remain in effect indefinitely.

By signing this consent form, you are giving permission to use and give out the health information listed above for the purposes described above. You do not have to sign this consent form. If you choose not to sign this consent form, you will not be able to be in this research study. Your decision not to sign this consent form will not have any effect on your medical care and you will not lose any benefits or legal rights to which you are entitled. You have the right to review and copy your health information. However, if you decide to be in this study and sign this permission form, you may not be allowed to look at or copy your information until after the research is completed.

You may withdraw or take away your permission to use and disclose your health information at any time. You do this by sending written notice to the study doctor at the address at the top of this informed consent form. If you withdraw your permission, you will not be able to continue being in this study, but you will not have any penalty or loss of access to treatment or other benefits to which you are entitled. When you withdraw your permission, no new health information which might identify you will be gathered after that date. Information that has already been gathered may still be used and given to others as this is necessary for the research to be reliable.

Identifiable Biospecimens: Identifiers might be removed from your identifiable private information or identifiable biospecimens. After such removal, the information or biospecimens could be used for future research studies or distributed to another investigator for future research studies without your additional informed consent (or consent from your legally authorized representative).

Notice Concerning HIV-Related Information: HIV-related information that either is collected as part of the research or that may already exist in your medical record might be accessed for the research by the research staff and the study sponsor, but will not be shared with others without your authorization, unless federal or state law requires the disclosure. You have a right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State

Division of Human Rights or New York City Commission on Human Rights. These agencies are responsible for protecting your rights.

CERTIFICATE OF CONFIDENTIALITY

This research is covered by a Certificate of Confidentiality from the National Institutes of Health. The researchers with this Certificate may not disclose or use information, documents, or biospecimens that may identify you in any federal, state, or local civil, criminal, administrative, legislative, or other action, suit, or proceeding, or be used as evidence, for example, if there is a court subpoena, unless you have consented for this use. Information, documents, or biospecimens protected by this Certificate cannot be disclosed to anyone else who is not connected with the research except, if there is a federal, state, or local law that requires disclosure (such as to report child abuse or communicable diseases but not for federal, state, or local civil, criminal, administrative, legislative, or other proceedings, see below); if you have consented to the disclosure, including for your medical treatment; or if it is used for other scientific research, as allowed by federal regulations protecting research subjects.

GENETIC TESTS AS PART OF THIS RESEARCH STUDY

A genetic test for APOE genotype will be done as part of this study APOE genotype is a risk factor for Alzheimer's Disease. Your genes are in the cells in your body. Genes make you different from anyone else. Some genes are responsible for inherited traits like hair and eye color. Some genes affect the chances that a person will get a certain disease or how their body responds to drugs. It is possible that response to the study drug may differ based on APOE genotype and this is why we need this genetic information.

These results will not be verified in a certified genetic testing laboratory and neither you nor your physician will not be notified of the results of the genetic testing.

Your genetic information will be kept confidential in accordance with State and Federal law. An approved coding system that protects the identity of individuals who provide samples will be used.

To the extent permitted by law, under no circumstances will any information linking you to specific genetic test results be disclosed to any individual or organization without your written consent. The results from the genetic tests may be disclosed to the following individuals or groups:
Researchers on this study at Weill Cornell Medicine and collaborating institutions Florida Atlantic University and University of Wisconsin - Madison.

A new Federal law, called the Genetic Information Nondiscrimination Act (GINA), generally makes it illegal for health insurance companies, group health plans, and most employers to discriminate against you based on your genetic information. This law generally will protect you in the following ways:

- Health insurance companies and group health plans may not request your genetic information that we get from this research.
- Health insurance companies and group health plans may not use your genetic information when making decisions regarding your eligibility or premiums.
- Employers with 15 or more employees may not use your genetic information that we get from this research when making a decision to hire, promote, or fire you or when setting the terms of your employment.

Be aware that this new Federal law does not protect you against genetic discrimination by companies that sell life insurance, disability insurance, or long-term care insurance. Nor does this Federal law prohibit discrimination on the basis of an already manifest genetic disease or disorder.

WILL YOU SAVE MY SAMPLES OR RESEARCH DATA TO USE IN FUTURE RESEARCH STUDIES?

We will store your blood samples and other data including genetic data in a RESEARCH REPOSITORY at Weill Cornell Medicine (WCM.) A research repository is a collection of samples and information from the health and medical records of many individuals and can sometimes include identifiable specimens (like your blood). The repository may share the information with researchers who study medical conditions and diseases including AD.

The repository includes codes that identify each person whose information is collected. However, the repository does not share information with researchers unless the researchers promise to keep the information confidential.

If you do not want your protected health information and specimens stored in the research repository then you cannot participate in this research study.

CAN WE CONTACT YOU FOR FUTURE STUDIES?

We request permission to contact you to see if you may be interested in participating in other research studies in the future. Participation would be completely optional.

RESEARCH PARTICIPANT: Please initial your choice below that describes your wishes:

_____Yes, you may contact me for possible participation in future studies.
_____ No, do not contact me for possible participation in future studies.

CANCELING AUTHORIZATION

If you change your mind and do not want us to store and use your blood for future research you should contact the research team member identified at the top of this document. The blood will no longer be used for research purposes. However, if some research with your blood has already been completed, the information from that research may still be used. Also, if the data has been shared with other researchers it might not be possible to withdraw the data to the extent that it has been shared.

CAN WE CONTACT YOU BY EMAIL OR OTHER ELECTRONIC MEANS?

We would like to contact you by email for the purposes listed below. Some of these emails may contain health information that identifies you.

- patient education
- appointment scheduling
- testing and questionnaires

Only the research team will have access to your email communications. We will only communicate by email to send you the information listed above. If you have any questions or need to contact us for an

urgent or emergent situation, please contact the research team member identified at the top of this document.

You should be aware that there are risks associated with sending your health information via email.

- There is always a risk that the message could be intercepted or sent to the wrong email address. To avoid sending messages to the wrong email address, the first email we send you will be a test message to ensure we have the correct email address.
- When using any computer you should be careful to protect your username and password. Make sure you log-out before getting up from the computer.
- If you share a home computer with other family members, and do not want them to know you are participating in this study make sure you provide an email address that only you can access.
- Your employer will have access to any email communications sent or received on any electronic devices used for work or through a work server.

Do you agree to allow us to send your health information via email or other electronic means?

_____ Yes _____No
Initials Initials

WILL I RECEIVE NEW INFORMATION ABOUT THE STUDY WHILE PARTICIPATING?

If we obtain any new information during this study that might affect your willingness to continue participating, we will promptly provide you with that information.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

Your participation in this study is voluntary. You may decide not to participate or you may stop your participation at any time, without penalty or loss of benefits or medical care to which you are otherwise entitled. If you decide to leave the study, please tell the study doctor.

Your participation in this study may be stopped without your consent at any time and for any reason by the study doctor, the sponsor, the FDA and other regulatory authorities. Reasons you may be withdrawn from the study include it is determined to be in your best interest, you need treatment not allowed in this study, you do not follow the study instructions, the study is stopped, or for other administrative reasons. If you leave the study early, you may be asked to return to the study doctor's office for a final study visit for your safety.

CONTACTS FOR QUESTIONS, COMPLAINTS, CONCERNS

If you have any questions or requests for information relating to this research study or your participation in it, or if you want to voice a complaint or concern about this research, or if you have a study related injury, you may contact Dr Tracy Butler at **646-962-9711 or 646-248-6734 (24 Hours)**

If you have any questions about your rights as a research subject or complaints regarding this research study, or you are unable to reach the research staff, you may contact a person independent of the research team at the Biomedical Research Alliance of New York Institutional Review Board at 516-318-6877. Questions, concerns or complaints about research can also be registered with the Biomedical Research Alliance of New York Institutional Review Board at www.branyirb.com/concerns-about-research.

This consent form is not a contract. It is a written explanation of what will happen during the study if you decide to participate. You are not waiving any legal rights by agreeing to participate in this study. As a participant you have rights and responsibilities as described in this document and including:

- To be given enough time before signing below to weigh the risks and potential benefits and decide if you want to participate without any pressure from the research team or others.
- To understand all of the information included in the document, have your questions answered, and receive an explanation of anything you do not understand.
- To follow the procedures described in this document and the instructions of the research team to the best of your ability unless you choose to stop your participation in the research study.
- To give the research team accurate and complete information.
- To tell the research team promptly about any problems you have related to your participation, or if you are unable to continue and wish to stop participating in the research study.

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a signed and dated copy of this form.

_____ _____
(Signature of Participant) (Date)

_____
(Participant's name – printed)

_____
(Signature of Particpant's Legal Authorized Representative – if Applicable)

_____
(Legal Authorized Representative's name – printed)

Statement of Person Who Obtained Consent

The information in this document has been discussed with the participant or, where appropriate, with the participant's legally authorized representative. The participant has indicated that he or she understands the risks, benefits, and procedures involved with participation in this research study.

_____ _____

(Signature of Person who Obtained Consent) (Date)

_____

(Name of Person who Obtained Consent - printed)