INFORMED CONSENT FORM AND AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Sponsor / Study Title:	**University of Minnesota / "Randomized Controlled Trial of Losartan for Patients with COVID-19 Not Requiring Hospitalization"**
Principal Investigator: (Study Doctor)	**«PiFullName»**
Telephone:	**«IcfPhoneNumber»**
Address:	**«PiLocations»**

If your doctor is also the person responsible for this research study, please note that he is interested in both your clinical care and the conduct of this research study. You have the right to discuss this study with another person who is not part of the research team before deciding whether to participate in the research.

Key Information About This Research Study

The following is a short summary to help you decide whether or not to be a part of this research study. More detailed information is listed later on in this form.

What is research?

Doctors and investigators are committed to your care and safety. There are important differences between research and treatment plans:

- The goal of research is to learn new things in order to help groups of people in the future. Investigators learn things by following the same plan with a number of participants, so they do not usually make changes to the plan for individual research participants. You, as an individual, may or may not be helped by volunteering for a research study.
- The goal of clinical care is to help you get better or to improve your quality of life. Doctors can make changes to your clinical care plan as needed.

Research and clinical care are often combined. One purpose of this informed consent document is to provide you clear information about the specific research activities of this study.

Why am I being asked to take part in this research study?

We are asking you to take part in this research study because you have tested positive for COVID-19 (novel coronavirus) and you are recovering at home.

What should I know about a research study?

- Someone will explain this research study to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part and later change your mind.
- Your decision will not be held against you. You will not be penalized or lose benefits you are otherwise entitled to.
- You can ask all the questions you want before you decide.

Why is this research being done?

The virus COVID-19 uses a specific protein on the surface of your cells to enter the cell. This protein is important to protect your lung from circulating hormones. COVID-19 blocks this protein and damages your lungs. In this study, we want to see if giving you a study drug (called Losartan) that can block this lung damaging hormone helps reduce problems with breathing while you recover from COVID-19. Losartan is approved by the U.S. Food and Drug Administration (FDA) to treat high blood pressure and diabetic kidney disease in patients with type 2 diabetes and high blood pressure. Losartan has not been approved to treat COVID-19 or its symptoms. The use of this drug in this study is considered experimental.

How long will the research last?

We expect that you will be in this research study for up to 90 days. You will take study drug for 10 days or until you are admitted to the hospital, whichever comes first.

What will I need to do to participate?

Prior to being assigned to a treatment arm, we will need to do some additional safety screening procedures. If you do not have documentation of a blood pressure, creatinine and potassium levels in your medical record within the 7 days prior to enrollment, you will be asked to visit a clinic location prepared to accept known COVID-19 positive patients. The additional screening procedures at that visit will include: a blood pressure and a blood draw (1 teaspoon) to check creatinine, and potassium levels. Additional vials of blood (1 tablespoons and 2 teaspoons) will be drawn at this time for research to understand how the virus affects the human body and to help guide future research to combat the virus. Once you are assigned to a treatment group in the study, you will be asked to take and record your temperature and blood pressure daily. You will also be asked to provide oral mouth swabs every three days (with a kit provided to you), answer questions about symptoms or side effects every other day, and take your study drug twice daily. If you are a woman capable of becoming pregnant, you will need to take a pregnancy test showing you are not pregnant, prior to taking any study medication. This will either be done with the blood draw at the screening clinic or you will be sent a urine pregnancy test to take at home. You will be randomly assigned to receive either Losartan or a placebo (a pill that looks just like Losartan but doesn't have any active drug in it). You have a 50:50 chance of taking either pill during this study, like flipping a coin. Neither you nor the study staff will know what you are taking, but they can find out if they need to.

More detailed information about the study procedures can be found under ***"What happens if I say yes, I want to be in this research?"***

Is there any way that being in this study could be bad for me?

Risks of Losartan include:

- Feeling tired, weak or dizzy (more common, 2-3 out of 100 people)
- Diarrhea (less common)
- Chest pain (more common, 1-2 out of 100 people)
- Low red blood cell count (less common)
- Low blood pressure (more common)
- Worsening kidney function (less common)
- Abnormal levels of electrolytes or "minerals" in your blood (less common
- Allergic reaction (less common)

There is also a small risk that someone who is not part of the study team might see information collected about you for this research. We store your data securely to try to avoid this.

You will be emailed a PDF copy of this signed and dated consent form. There may be risks of loss of privacy and confidentiality if the PDF copy of this consent form is viewed and/or stored on a personal electronic device (PED), especially if that PED is shared with other users or is lost, hacked, or subject to a search warrant or subpoena. Also, the PDF copy of the consent may not be able to be permanently removed from a PED.

Since the use of this study drug is experimental, there may be other risks that are unknown. Additionally, there may be unknown risks to a pregnancy, embryo, or fetus if you become pregnant.

Any new important information that is discovered during the study and that may influence your willingness to continue participation in the study will be provided to you.

Will being in this study help me in any way?

We cannot promise any benefits to you or others from your taking part in this research. However, if you receive Losartan and if this study drug works, you might need less oxygen or mechanical ventilation.

What happens if I do not want to be in this research?

You do not have to participate in this research. Instead of being in this research study, you can continue to receive supportive care as directed by your doctor.

Detailed Information About This Research Study

The following is more detailed information about this study in addition to the information listed above.

How many people will be studied?

We expect about 580 people will be in this research study.

What happens if I say "*Yes, I want to be in this research*"?

If you decide you want to be in this research, you will participate for 90 days. You will receive a bottle of study drug and asked to take 1 study pill either once or twice a day (1 or 2 pills per day total, depending on your kidney function) for 10 days or until you are admitted to the hospital, whichever comes first. During your participation you can expect the following procedures:

- If you haven't recently had your blood pressure taken or kidney function tested, you will need to come to clinic for a blood pressure measurement and a blood test.
    - You will have a blood draw of about 2 tablespoons at the screening visit (for Potassium, Creatinine, and research how COVID-19 affects the body).
    - You will have a pregnancy test either with screening labs or a urine pregnancy test at

home before starting medication.

- If you are eligible for this study, you will be randomly assigned to receive either Losartan or a placebo. You have a 50:50 chance of receiving either treatment, like flipping a coin. You will not know which treatment you are receiving; study staff will not know but if they need to find out during an emergency, they can.
- You will have the following done once you are enrolled in this study:
    - Study staff will ask you some questions about symptoms or side-effects
    - You will be asked to send the study team a swab of saliva samples taken from your mouth on days 0, 3, 6, and 9; this will be picked up from your home by a courier service.
    - You will be given a bottle of study medication (either Losartan or placebo) and asked to take 1 pill once or twice a day for 10 days (1 or 2 pills per day total)
    - You will be asked to take your blood pressure and temperature daily for the 10 days you are taking the study medication. You will be asked to return to the clinic for a blood draw for follow up creatinine and potassium levels and the research how COVID-19 affects the body (about 2 tablespoons of blood) and a mouth swab around 15 days after you enroll in the study.
- You have the choice to have your samples of blood, saliva stored for future research. You can choose if you want to give that permission at the end of this consent form.
- You have the choice to participate in two optional blood draws (a little over 1 tablespoon) 2-3 months and 5-7 months after starting the study. This blood will be used in the development of a vaccine against COVID-19 by the National Institute of Health. You can choose if you want to participate in this effort at the end of this form.
- Around day 30 and 90, the study team may contact you by phone to complete end of study assessments.

What happens if I say "Yes", but I change my mind later?

If you take part in this research study, and want to leave, you should tell us. Your choice not to be in this study will not negatively affect your right to any present or future medical care, your academic standing as a student, or your present or future employment.

We will make sure that you stop the study safely. We will also talk to you about follow-up care, if needed.

If you decide to leave the research study, study staff will ask you if it is okay to conduct a final study visit for safety testing.

If you stop being in the research, information about you that has already been collected may not be removed from the study database. You will be asked whether the study doctor can collect information from your routine medical care, such as your medical records after you leave the study. If you agree, you will be asked to sign and date an additional consent form (Clinical Data Collection after Withdrawal Consent Addendum) and HIPAA authorization to document your agreement to participate in ongoing data collection.

Can I be removed from the research?

It's possible that we will have to ask you to leave the study before you finish it. If this happens, we will tell you why. We will also help arrange other care for you, if needed.

What do I need to know about reproductive health and/or sexual activity if I am in this study?

Losartan has additional risks to a fetus or baby. Women who are pregnant or breastfeeding are not eligible to participate in this study. Women of child bearing potential must already be using highly effective contraception and continue to use it until the study is completed.

Will it cost me anything to participate in this research study?

- There will be no cost to you for any of the study activities or procedures.
- There will be no cost to you for the lab tests, drug, and follow-up visits that are done for research purposes only and are not part of your regular care.
- You will have to pay for basic expenses like any childcare, food, parking, or transportation related to study activities.
- You or your insurance company will have to pay for all costs for medical care not related to participation in this study, including copayments and deductibles. You will have to pay for any costs your insurance does not cover. If you have any questions about these costs, or what out-of-pocket expenses you may have to pay, you should contact your insurance company. If you do not have health insurance, you will have to pay all costs for your medical care just as you would if you did not take part in this study.
- If you need treatment for side effects while you are on the study, you or your insurance will need to pay for this treatment.

What happens to the information collected for the research, including my health information?

We try to limit the use and sharing of your information, including research study records, any medical records and any other information about you, to people who have a need for this information. But we cannot promise complete confidentiality.

<u>Overview</u>

If you participate in this study, your information, including your health information, will be used and shared for purposes of conducting this research. As described later in this Consent Form, your information may also be used and shared for publishing and presenting the research results, future research, and any optional elements of the research you agree to in this Consent Form, which may include creating audio and video recordings of you. If you sign this Consent Form, you are giving us permission to use and share your health information for these purposes, and if we are using your medical records, you are giving permission to any health care providers who are treating you to share your medical records with us.

What health information will be made available?

Health information about you to be used and shared for the research includes those items checked by the research team below:

☒ Your medical records, which may include records from hospital and clinic visits, emergency room

visits, immunizations, medical history and physical exams, medications, images and imaging reports, progress notes, psychological tests, EEG/EKG/ECHO reports, lab and pathology reports, dental records and/or financial records. These records may be used and shared for as long as this research continues.

☒ Information collected as part of this research study, including research procedures, research visits, and any optional elements of the research you agree to, all as described in this Consent Form. This information might not be part of your medical record, and may include things like responses to surveys and questionnaires, and information collected during research visits described in this Consent Form.

What about more sensitive health information?

Some health information is so sensitive that it requires your specific permission. If this research study requires any of this sensitive information, the boxes below will be marked and you will be asked to initial to permit this information to be made available to the research team to use and share as described in this Consent Form.

☐ My drug & alcohol abuse, diagnosis & treatment records ______ (initial)

☐ My HIV/AIDS testing records ______ (initial)

☐ My genetic testing records ______ (initial)

☐ My mental health diagnosis/treatment records ____ (initial)

☐ My sickle cell anemia records _______ (initial)

Who will access and use my health information?

If you agree to participate in this study, your information will be shared with:

- The University of Minnesota research team and any institutions or individuals collaborating on the research with us;

- Others at the University of Minnesota and M Health/Fairview who provide support for the research or who oversee research (such as the Institutional Review Board or IRB, which is the committee that provides ethical and regulatory oversight of research at the University, systems administrators and other technical and/or administrative support personnel, compliance and audit professionals (Such as the Quality Assurance Program of the Human Research Protection Program (HRPP)) , individuals involved in processing any compensation you may receive for your participation, and others);

- The research sponsor(s), any affiliates, partners or agents of the sponsor(s) involved in the research, organizations funding the research, and any affiliates, partners or agents of the funding organization(s) involved in the research;

- Organizations who provide accreditation and oversight for research and the research team, and others authorized by law to review the quality and safety of the research (such as U.S. government agencies like the Food and Drug Administration, the Office of Human Research

Protections, the Office of Research Integrity, or government agencies in other countries); and

- Organizations that process any payments that may be made to you for participating in this study, and any other individuals or organizations specifically identified in this Consent Form.

Additional sharing of your information for mandatory reporting

If we learn about any of the following, we may be required or permitted by law or policy to report this information to authorities:

- Current or ongoing child or vulnerable adult abuse or neglect;
- Communicable, infectious or other diseases required to be reported under Minnesota's Reportable Disease Rule;
- Certain wounds or conditions required to be reported under other state or federal law; or
- Excessive use of alcohol or use of controlled substances for non-medical reasons during pregnancy.

How will my information be used in publications and presentations?

We may publish the results of this research in scientific, medical, academic or other journals or reports, or present the results at conferences. Information that makes it easy to identify you (such as your name and contact information, SSN and medical records number) will not be part of any publication or presentation. If you have an extremely unique or rare condition that is not shared by many others, it is possible that some people may be able to determine your identity even without these identifiers. Once your health data has been shared with authorized users, it may no longer be protected by federal privacy law and could possibly be used or disclosed in ways other than those listed here.

Your permission to use and share health data about you will end in 50 years unless you revoke it (take it back) sooner.

You may revoke (take back) your permission to use and share health data about you at any time by writing to the study doctor at the address listed on the first page of this form. If you do this, you will not be able to stay in this study. No new health data that identifies you will be gathered after your written request is received. However, health data about you that has already been gathered may still be used and given to others as described in this form.

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 (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.

The Certificate cannot be used to refuse a request for information from personnel of the United States federal or state government agency sponsoring the project that is needed for auditing or program evaluation by the agency which is funding this project or for information that must be disclosed in order to meet the requirements of the federal Food and Drug Administration (FDA). You should understand that a Certificate of Confidentiality does not prevent you from voluntarily releasing information about yourself or your involvement in this research. If you want your research information released to an insurer, medical care provider, or any other person not connected with the research, you must provide consent to allow the researchers to release it.

The Certificate of Confidentiality will not be used to prevent disclosure as required by federal, state, or local law of, for instance, child abuse or neglect, harm to self or others, and communicable diseases.

The Certificate of Confidentiality will not be used to prevent disclosure for any purpose you have consented to in this informed consent document.

What will be done with my data and specimens when this study is over?

Your data and/or samples may be used for future research after this study is complete. The future research will be looking at the virus and your health status during the study.

A description of this clinical trial will be available at http://www.ClinicalTrials.gov, as required by U.S. Law. This Web site will not include your name or any other direct identifiers such as your contact information. The Web site may include a summary of the results of this research. You can search this Web site at any time.

Will I receive research test results?

Most tests done on samples in research studies are only for research and have no clear meaning for health care. The investigator(s) will not contact you or share your individual test results.

Will anyone besides the study team be at my consent meeting?

You may be asked by the study team for your permission for an auditor to observe your consent meeting. Observing the consent meeting is one way that the University of Minnesota makes sure that your rights as a research participant are protected. The auditor is there to observe the consent meeting, which will be carried out by the people on the study team. The auditor will not document any personal (for example, name, date of birth) or confidential information about you. The auditor will not observe your consent meeting without your permission ahead of time.

Whom do I contact if I have questions, concerns or feedback about my experience?

During the study, if you experience any medical problems, suffer a research-related injury, or have questions, concerns or complaints about the study, please contact the Investigator at the telephone number listed on the first page of this consent document. If you seek emergency care, or hospitalization is required, alert the treating physician that you are participating in this research study.

An institutional review board (IRB) is an independent committee established to help protect the rights of research subjects. If you have any questions about your rights as a research subject, and/or concerns or complaints regarding this research study, contact:

- By mail:
  Study Subject Adviser
  Advarra IRB
  6940 Columbia Gateway Drive, Suite 110
  Columbia, MD 21046
- or call **toll free**: 877-992-4724
- or by **email**: adviser@advarra.com

Please reference the following number when contacting the Study Subject Adviser: Pro00042760.

To share feedback privately with the University of Minnesota Human Research Protection Program (HRPP) about your research experience, call the Research Participants' Advocate Line at 612-625-1650 (Toll Free: 1-888-224-8636) or go to z.umn.edu/participants. You are encouraged to contact the HRPP if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research participant.
- You want to get information or provide input about this research.

Will I have a chance to provide feedback after the study is over?

The University of Minnesota Human Research Protection Program (HRPP) may ask you to complete a survey that asks about your experience as a research participant. You do not have to complete the survey if you do not want to. If you do choose to complete the survey, your responses will be anonymous.

If you are not asked to complete a survey, but you would like to share feedback, please contact the study team or the HRPP. See the "Investigator Contact Information" of this form for study team contact information and "Whom do I contact if I have questions, concerns or feedback about my experience?" of this form for HRPP contact information.

What happens if I am injured while participating in this research?

In the event that this research activity results in an injury, treatment will be available, including first aid, emergency treatment and follow-up care as needed. Care for such injuries will be billed in the ordinary manner to you or your insurance company. If you think that you have suffered a research related injury, let the study doctor know right away. By signing this document, you will not lose any of your legal rights or release anyone involved in the research from responsibility for mistakes.

Due to the coronavirus public health crisis, the federal government has issued an order that may limit your ability to recover damages if you are injured or harmed while participating in this COVID-19 clinical study. If the order applies, it limits your ability to recover damages from the University, researchers, healthcare providers, study sponsor, manufacturer or distributor involved with the study. However, the federal government has a program that may provide compensation to you or your family if you experience serious physical injuries or death due to this study. To find out more about this "Countermeasures Injury Compensation Program" go to https://www.hrsa.gov/cicp/about/index.html or call 1-855-266-2427.

Will I be compensated for my participation?

You will be compensated $25 for your time spent on the day 15 study visit. This single payment will be made using a pre-paid debit card called Greenphire ClinCard. It works like a bank debit card. You may use this card at any store that accepts MasterCard or you can use a bank machine to remove cash. However, there may be fees drawn against the balance of the card for cash withdrawals (ATM use) and inactivity (no use for 3 months). We will give you the ClinCard Frequently Asked Questions information sheet that answers common questions about the debit card. You will also receive letters with additional information on how you can use this card and who to call if you have any questions. Be sure to read these letters, including the cardholder agreement, for details about fees. The debit card system is administered by an outside company. The company, Greenphire, will be given your name, address, and date of birth. They will use this information only as part of the payment system. Your information will not be used for any other purposes and will not be given or sold to any other company. Greenphire will not receive any information about your health status or the study in which you are participating. Payment you receive as compensation for participation in research is considered taxable income. If payment from the University of Minnesota to an individual equals or exceeds $600 in any one calendar year, the University of Minnesota is required to report this information to the Internal Revenue Service (IRS). Research payments to study participants that equal or exceed $600 during any calendar year will result in a FORM 1099 (Miscellaneous Income) being issued to you and a copy sent to the IRS.

Participant Phone Number: ____________________________________

Participant Email Address:
____

Are you signing this consent in person (at the hospital with study staff) or remotely?
O Yes
O No

All of my questions have been answered, and I have been given the opportunity to decline this research.
O Yes
O No

Signature Block:

Your signature documents your permission to take part in this research. You will be provided a copy of this signed and dated document.

____
Printed Name of Participant

____ ___________________
Signature of Participant Date

____ ___________________
Signature of Person Obtaining Consent Date

____
Printed Name of Person Obtaining Consent

____

For the Consent of Non-English Speaking Participants when an Interpreter is Used:
As someone who understands both English and the language spoken by the participant, I represent that the English version of the consent form was presented orally to the participant in their own language, and that they were given the opportunity to ask questions.

____________________________________ ________________
Signature of Interpreter Date

____
Printed Name of Interpreter

OR:

Signature for Optional Future Scientific Research

We are asking you to take part in this optional future scientific research because you have already agreed to take part in the main study, named above. You are now being asked to give permission for your biologic samples to be used for future scientific research which may include examining your genes. This future research will examine how individuals respond to COVID-19 infection.

Your biologic samples will be stored indefinitely. You have the right to change your mind at any time about participating in this optional research. And your biological samples will be destroyed if you ask. Any information gained from your biological samples before you change your mind will not be destroyed. These samples will not have any identifying information (name, date of birth, medical record number, SSN, etc.) with them.This portion of the study is optional.

All of your rights as a research participant are covered in the main study Consent Form.

This form only provides additional information for you to decide if you want to give your permission for this future scientific research. You may stay in the main study even if you decide not to take part in this future research. Before you consent to give your sample for future research, please read this form. Ask as many questions as you need to before you decide if you want to take part.

Your signature documents your permission to take part in this optional research. You will be provided a copy of this signed document.

____
Printed Name of Participant

____ __________________

Signature of Participant Date

____ __________________

Signature of Person Obtaining Consent Date

____

Printed Name of Person Obtaining Consent

Signature for Optional National Institute of Health (NIH) Vaccine Research

We are asking you to take part in this optional NIH vaccine research because you have already agreed to take part in the main study, named above. You are now being asked to give permission for your biologic samples to be used by the NIH Vaccine Research Center (https://www.niaid.nih.gov/about/vrc) to find a vaccine against COVID-19.

This optional part of this study includes two extra blood draws (around 2 teaspoons of blood) at 2-3 months and 5-7 months after you start the study. Additionally 1 extra teaspoon of blood will be drawn at your day 0 and 15 blood draw.

Your biologic samples will be stored indefinitely. You have the right to change your mind at any time about participating in this optional research. And your biological samples will be destroyed if you ask. Any information gained from your biological samples before you change your mind will not be destroyed. These samples will not have any identifying information (name, date of birth, medical record number, SSN, etc.) with them.

This portion of the study is optional.

All of your rights as a research participant are covered in the main study Consent Form.

This form only provides additional information for you to decide if you want to give your permission for this COVID-19 vaccine research. You may stay in the main study even if you decide not to take part in this vaccine research. Before you consent to give your sample for this optional research, please read this form. Ask as many questions as you need to before you decide if you want to take part.

Your signature documents your permission to take part in this optional vaccine research. You will be provided a copy of this signed document.

____

Printed Name of Participant

____ __________________

Signature of Participant Date

____ ___________________
Signature of Person Obtaining Consent Date

____
Printed Name of Person Obtaining Consent