Consent Cover Page

Official Title of the Study:

Title: TRANSITION: An observational study of the effects on sweat chloride and clinical outcomes of transition from lumacaftor/ivacaftor to tezacaftor/ivacaftor

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National Jewish Health®
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NATIONAL JEWISH HEALTH
INFORMED CONSENT AND HIPAA AUTHORIZATION FORM FOR RESEARCH WITH HUMAN SUBJECTS

Protocol Title:
TRANSITION: An observational study of the effects on sweat chloride and clinical outcomes of transition from lumacaftor/ivacaftor to tezacaftor/ivacaftor

Principal Investigator: Jennifer Taylor-Cousar, MD

Phone number: 303-398-1453

In this consent and authorization form, "you", always refers to the subject. If you are a legally authorized representative (such as the parent), remember that "you" refers to the study participant.

Introduction

You are being invited to participate in a research study. Research studies include only people who choose to take part. Please take your time making a decision. Feel free to discuss it with your friends, family, and doctors. Before agreeing to take part in this research study, it is important that you read this consent and authorization form because it describes the study and any of the risks that it may involve. No guarantees or promises can be made regarding your experience in the study. Please ask the study doctor or the study staff to explain any words, ideas, or information not clear to you.

Why is this study being done?

You are being invited to take part in a research study.

The purpose of this study is to see the possible change in the symptoms of Cystic Fibrosis (CF) as a result of changing from treatment with lumacaftor/ivacaftor to tezacaftor/ivacaftor.

You are being asked to be in the study because you are a patient with CF aged 12 years or older and your clinical doctor is changing your CF treatment from lumacaftor/ivacaftor to tezacaftor/ivacaftor.

How many people will be in this study?

Up to 28 people will participate in the study at National Jewish Health. Study participation is for about 6 months.

What will happen if I enroll in this study?

The following table outlining which procedures will be performed at which study visits. Explanations of each procedure follow the table. All procedures performed for study purposes, and the analysis on the data collected from the procedures are all considered experimental.

STUDY FLOWCHART

	Baseline	**Post-transition**	**Post-transition**	**Post-transition**
Visit	**1**	**2**	**3**	**4**
	Up to 5 hours	Up to 3 hours	Up to 3 hours	Up to 5 hours
Day(s)	0	30 ± 7	90 ± 7	180 ± 7
Informed consent	x			
Demographics	x			
Medical history	x			
Concomitant medications and airway clearance	x	x	x	x
Adverse events	x	x	x	x
Vital signs	x	x	x	x
Pregnancy test#	x	x	x	x
Height	x			
Weight	x	x	x	x
Questionnaires	x	x	x	x
Spirometry	x	x	x	x
Blood draw	x	x	x	x
Stool collection	x	x	x	x
Sweat testing	x	x	x	x
Oral Glucose Tolerance Test (OGTT)	x*			x

#for women of child-bearing potential
*If not done within 1 year of baseline visit

What is involved in each procedure?

Medical History We will review your medical chart and ask you questions about your health including current and past illnesses and use of medications. If you are female, we may ask you questions about your period.

Height and Weight: We will measure and record your height and weight.

Pregnancy Test: If you are female, we may ask you to do a urine pregnancy test.

Urine Pregnancy Testing: If you are a woman of child bearing potential, you will be asked to urinate in a cup.

Blood Draw: We will use a small needle to collect blood from a vein in your arm. We will collect a blood sample (about 2 teaspoons per visit) for testing including complete blood count (CBC), chemistry panel, and a sugar form of hemoglobin (HbA1c).

Spirometry: We will measure your lung function. You will take a deep breath and then blow into a mouthpiece as hard as you can and for as long as you can.

Sweat Chloride Test: We will collect your sweat by using a battery-powered machine attached to two circular probes placed on the skin of your arm. Each probe is about the size of a quarter. One probe is red and the other one is black. We will put a gel-like medicine called Pilocarpine onto each probe and then attach it to the skin on your arm with a Velcro strap. The machine will send a small amount of electricity to the probes. After 5 minutes, the probes are removed. The red probe is replaced with a sweat collection disc. After 30 minutes, the disc is removed. We then repeat the process on your other arm. This is a standard test for people who have CF.

Stool Collection: We will collect stool ('poop') samples for testing and banking. We will give you instructions and containers designed for you to collect a portion of your stool at home before coming to your visit if you choose.

Oral GlucoseTolerance Test (OGTT): This test will be performed at your baseline visit if you have not performed one clinically for the past 12 months. It will be performed for research purposes at Visit 4 (6 month visit). You will do this test after not eating or drinking (except for water) for 8 hours. We will measure your blood sugar level by drawing your blood (about 1/2 teaspoon) 4 times over 2 hours. About 2 teaspoons total of blood will be drawn for this test. These blood draws may be done individually or to make the blood sampling easier we may place an intravenous needle and plastic tube (IV) in a vein in your arm. If you would like, we can put a numbing medicine on your skin before the needle is used. We will use this IV to collect the blood samples for testing and banking described above. The IV will stay in your arm until the end of the test. We will draw your blood around 15 minutes before you drink a sweet liquid called GlucoCrush, and then we will repeat drawing your blood at 30, 60 and 120 minutes.

Note: If you are on insulin therapy, we will ask you to stop taking all rapid-acting insulin delivered by injection or by insulin pump bolus 6 hours before this test. You may continue your long acting insulin.

How will my samples be used?

Your samples will only be used for purposes of this study. Depending on the sample, it will be discarded either directly after testing or after data analysis is complete.

What are the possible risks and side effects of the study?

Questionnaires: Some questions may make you feel upset.

Blood Draw: You would feel a needle poke when we take your blood. Some people may get a small bruise that will go away in 1 to 2 days. People sometimes feel dizzy or faint. There is also a very small chance you could get an infection where the needle pokes the skin.

Sweat sample: You could feel tingling at or near the place where the probes are put on your skin. In some people, blister-like welts could form; this would disappear within 2 to 3 hours. There is a possibility of minor skin burn; it would be very rare for this to happen (around 1 in 50,000 people). When this occurs, the injuries are minor and resolve within 1 to 2 weeks with little or no scarring.

OGTT: Oral glucose tolerance test (OGTT) and Breath test: You could feel lightheaded from not eating. We will give you a snack after you finish the test to minimize this risk. Some people could experience mild nausea from drinking GlucoCrush.

Spirometry: There is a small risk of wheezing and shortness of breath.
Discuss all side effects with your study doctor and your regular doctor.

There is a potential risk of loss of confidentiality, but every effort will be made to protect you confidentiality. Your study records will be stored in a locked office and your coded, electronic data will be stored on password-protected computers.

It is not expected that study participants will have all of these side effects. The study may include risks that are unknown at this time.

What happens if I am hurt or become ill during the study?

In the event of an injury or illness resulting from your participation in this research study, your study doctor will assist you in receiving appropriate health care, including first aid, emergency treatment and follow-up care either at National Jewish Health or another appropriate health care facility. If medical costs are incurred, your insurance company may be billed. In accordance with general policy, National Jewish Health makes no commitment to provide free medical care or other compensation for injury or illness resulting from your participation in this study. By signing this form you have not given

up your legal rights. For further information, please contact Jennifer Taylor-Cousar, MD, the Principal Investigator of this study.

If you believe you have experienced any study related illness, adverse event, or injury, you must notify the study doctor as soon as possible.

This has been explained to me and all my questions have been answered.

_____
Subject's or Parent/Guardian's Initials

Are there any possible benefits to being in the study?

This study is not designed to treat any illness or to improve your health. There will be no direct medical benefits to you.

Knowledge gained from the study may benefit future patients with CF.

What other choices do I have?

You may choose not to take part in this study.

The treating clinician may be both your health care provider and the investigator for this study. This clinician is interested both in your clinical welfare and in the conduct of this study. Before entering this study, or at any time during the study, you may ask for a second opinion about your care from another clinician who is not associated in any way with this study.

Who is paying for this study?

This study is being paid for by a donation to National Jewish Health for CF research.

Will I have to pay for anything?

It will not cost you anything to be in the study.

Will I be paid for being in the study?

You will be paid for each visit you complete as follows:

Visit 1: $120*
Visit 2: $75
Visit 3: $75
Visit 4: $150*

*Subjects who must undergo OGTT will receive an additional $50 for each visit at which it is performed as a result of the extra time for OGTT

This will add up to a total of $420.00 if you complete all of the visits, $520.00 if OGTT testing is required for you. If you leave the study early, or if we have to take you out of the study, you will be paid only for the visits you have completed. A payment schedule that best fits your needs will be agreed upon at study enrollment.

Payment for taking part in a research study may be considered taxable income. If this payment is more than $600.00 in any one calendar year, National Jewish Health will have to report the amount to the Internal Revenue Service (IRS). This information will be reported using a 1099 (Miscellaneous Income) form. Your social security number will need to be collected. This form will be issued to you and a copy will be sent to the IRS.

Because CF is a rare disease, please note that if you are currently receiving SSI, Medicaid or Medicare low-income subsidies, you are now able to receive up to $2000 in a calendar year as payment for study participation without it affecting your continued eligibility for these benefits. Please ask your study coordinator for details.

Is taking part in the study voluntary?

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you choose to take part, you have the right to stop at any time. If you refuse or decide to stop later, you will not lose any benefits or rights to which you are entitled.

If you leave this study prior to completion, we encourage you to talk to a member of the research staff so that they know why you are leaving the study. You will still receive your normal medical care. The only medical care that you will lose is the medical care you are getting as part of this study.

If there are any new findings during the study that may affect whether you want to continue to take part, you will be told about them.

Can I be removed from this study?

The study doctor may decide to stop your participation without your permission if the study doctor thinks that being in the study may cause you harm or if you become pregnant. You may be taken out of the study even if you do not want to leave the study.

Who do I call if I have questions or problems?

You may ask any questions you have at this time. If you have questions, concerns, or complaints later, you may call your study coordinator at 303-398-1453.

If you have questions or concerns about your rights as someone in this study, please call the National Jewish Health Institutional Review Board (IRB) at 303-398-1477.

Who will see my research information?

National Jewish Health has rules to protect information about you. Federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA), also protect your privacy. This part of the informed consent form tells you what information about you may be collected in this study and who might see or use it.

The institutions involved in this study include:

- *National Jewish Health*

We cannot do this study without your permission to see, use and give out your information. You do not have to give us permission. If you do not, then you may not join the study.

We will see, use, share and copy your information only as described in this form and in our Notice of Privacy Practices; however, people outside National Jewish Health may not be covered by this promise and may further share your information. We will do everything we can to keep your records private. It cannot be guaranteed. At minimum, we will keep your study data in a locked office only accessible to authorized personnel or on a secured storage medium if the information is electronic.

The use and sharing of your information has no time limit. You can withdraw your permission to use and share your information at any time by contacting the Privacy Officer in writing at the address listed below. If you do withdraw your permission, your part in this study will end and no further information about you will be collected. Your cancellation would not affect information already collected for the study.

Privacy Officer
National Jewish Health
1400 Jackson St., M109
Denver, CO 80206
303-398-1466
877-CALL-NJH ext.1466
877-225-5654 ext.1466

The records that identify you and the consent form signed by you may be looked at by others who have a legal right to see that information. Your information may be shared with:

- The study doctor and his/her team of researchers
- Officials at National Jewish Health who are in charge of making sure that we follow all of the rules for research
- National Jewish Health Institutional Review Board (IRB), the ethics board responsible for overseeing this research
- Federal agencies such as the Office for Human Research Protections that protect research subjects like you.
- Department of Health and Human Services

We might talk about this research study at meetings. We might also print the results of this research study in medical journals or medical magazines. But we will always keep the names or other information that could identify you private.

You have the right to request access to your personal health information from the Investigator or from National Jewish Health. However, we may ask you not to look at your health information while you are participating in the study. If you look at your records while the study is in progress, it may compromise the integrity of the study results and it may be necessary for you to stop participating in the study.

Test results and other medical information gathered in this study will be stored in your medical record and research study file and will be treated with the same confidentiality as other medical records here at National Jewish Health as required by state and federal regulations. When stored in the medical record, we may receive requests from health insurance providers for copies of this record. Records will be released according to state and federal laws. The release of this information may affect your insurability either now or in the future. You have the right to restrict specific research-related procedures from being provided to your health insurance provider. Please talk to a study Investigator or a member of his or her staff to learn more about your options.

Information about you that will be seen, collected, used, and shared in this study:

- Name and demographic information (age, sex, ethnicity, address, phone number, etc)
- Your social security number for payment purpose only
- Portions of your previous and current medical records that are relevant to this study, including but not limited to diagnosis(es), history and physical, laboratory or tissue studies, radiology studies, procedure results
- Questionnaires
- Blood/urine/sweat/stool samples and the data with those samples
- Spirometry

What happens to Data, Tissue, Blood and Specimens that are collected in this study?

Scientists at National Jewish Health work to find the causes of and cures for disease. The data, tissue, and blood specimens collected from you during this study are important. If you join this study:

- The data, tissue, blood, or other specimens given by you to the investigators for this research no longer belong to you.
- The investigators and any sponsor of this research may study your data, tissue, blood, or other specimens collected from you.
- If data, tissue, blood, or other specimens are in a form that identifies you, National Jewish Health or other organizations involved in this study may use

them only in a manner consistent with this form and with Institutional Review Board approval.

- Any product or idea created by the researchers working on this study will not belong to you.
- There is no plan for you to receive any financial benefit from the creation, use or sale of such a product or idea.

Agreement to be in this study and use my data

I have read and initialed each page of this informed consent and HIPAA authorization form (or it was read to me). I was informed about the possible risks and benefits of being in this study. I know that being in this study is voluntary. I choose to be in this study. I know I can stop being in this study at any time. I will get a copy of this form after it is signed.

Printed Name of Participant (or Child)	Date	Signature of Participant (Adults only)
Signature of Parent or Legal Guardian if applicable	Date	Printed Name of Parent or Legal Guardian

Relationship to Child: _____

Signature of Person Obtaining Consent	Date	Printed Name of Person Obtaining Consent