Medical University of South Carolina
CONSENT TO BE A RESEARCH SUBJECT

TITLE OF RESEARCH: Fenofibrate in Type 2 Diabetes- Novel Biomarkers and Mechanisms

SUMMARY

You are being asked to volunteer for a research study. Research studies are voluntary and include only people who choose to take part. This is a research study to try to understand how a medication called fenofibrate works in type 2 diabetes, by using a technology called 'proteomics' that measures hundreds of proteins in your blood. Taking fenofibrate is recommended in your case because levels of a kind of fat in your blood (triglycerides) are too high. Fenofibrate is FDA approved as a treatment for high triglycerides.

If you agree to participate, you will have two visits, one before and one after taking fenofibrate. Both visits include a blood draw and a physical exam to assess your health. You will be given study medication to take once a day for six weeks, so that the total duration you are in the study will be approximately six weeks. Each visit will last about two hours.

Recent data suggest that fenofibrate has also helped people with diabetic eye disease, kidney damage, nerve damage, and other associated conditions. Therefore, you may get added benefit from being in this study, but that cannot be guaranteed. There are risks to the study drug that include: muscle pains and decreased liver function. You do not have to participate in this study. There are no alternative treatments, as we are studying the way the drug works, not its effect on a specific disease.

If you are interested in learning more about this study, please continue reading below.

A. PURPOSE OF THE RESEARCH

Please read this consent form carefully and take your time making your decision. As your study doctor or study staff discusses this consent form with you, please ask him/her to explain any words or information that you do not clearly understand. You are being asked to participate in this study because you have type 2 diabetes and high triglycerides. The purpose of this study is to evaluate the effects of fenofibrate on certain proteins in the blood. The study is sponsored by the Delaware Clinical Translational Research ACCEL program. The investigator in charge of this study at MUSC is Dr. Timothy Lyons. The study is being done at one site. Approximately 40 people will take part in this study.

B. PROCEDURES

If you agree to be in this study, the following will happen:

1. Your medical chart will be reviewed to make sure you are a good candidate for the study.
2. After the consenting process, you will be scheduled for a visit at the MUSC research clinic. This clinic is located in the Clinical Sciences Building on campus.
3. You will be instructed to fast before your research visit.
4. Upon arrival at the research clinic, you will have a physical examination and blood and urine will be collected for laboratory tests. Approximately 5 ½ tablespoons of blood will be drawn for these tests to study what fenofibrate does in your body. Specifically we will measure fats, proteins and sugars in your blood and urine. In the future we may perform some genetic studies, but you are free to opt out of this (see below).

5. If you are a woman of childbearing potential, we will ask you to take a urine pregnancy test, and precautions should be taken throughout the study to prevent pregnancy. Examples of acceptable methods of birth control for participants involved in the study include: birth control pills, patch, IUD, condom, sponge, diaphragm with spermicide, or avoiding sexual activity that could cause you to become pregnant.
6. You will receive the drug fenofibrate, to be taken 1 time/day for 6 weeks.
7. At the end of your first visit, you will be provided breakfast and you will be scheduled for your second visit.
8. You will be instructed to fast before visit 2.
9. Upon arrival at the research clinic, you will have a physical examination and blood and urine will be collected for laboratory tests. Approximately 5 ½ tablespoons of blood will be drawn for these tests to study what fenofibrate does in your body. Specifically we will measure fats, proteins and sugars in your blood and urine. In the future we may perform some genetic studies, but you are free to opt out of this (see below).
11. Each visit will take about 2 hours to complete.

C. RISKS AND DISCOMFORTS

While you take part in this study, you may be at risk for side effects. Risks associated with drawing blood from your arm include momentary discomfort and/or bruising. Infection, excess bleeding, clotting, or fainting are possible, although unlikely.

Risks associated with fenofibrate use include muscle pains, (in clinical studies occurred in 3.4% of fenofibrate patients vs. 2.5% of patients on placebo) and elevation of liver enzymes (in clinical studies occurred in 7.5% of fenofibrate patients vs. 1.4% of patients on placebo). (A placebo is an inactive substance given in the same form as the active drug.)

There is also a risk of a loss of confidentiality of your personal information as a result of participation in this study.

D. MEDICAL RECORDS

Because you are an MUSC patient, you have an MUSC medical record. Results of research tests or procedures will be included in your MUSC medical record. All information within your medical record can be viewed by individuals authorized to access the record We will make every effort to keep confidential all research information in the medical record that identify you to the extent allowed by law.

E. BENEFITS

There have been two studies that suggest fenofibrate may improve complications of type 2 diabetes such as eye disease. This is no guarantee that you will have any added benefit from participating in this study.

F. COSTS

There will be no cost to you as a result of participation in this study.

G. PAYMENT TO PARTICIPANTS

In return for your time and effort, you will be paid $25 for each study visit for a total amount of $50.

Payment for study visits will be made using a pre-paid debit card, called a ClinCard. It works like a bank debit card and you may use the card to purchase goods or services everywhere Debit MasterCard is accepted. You will be given a ClinCard at the completion of your first visit. Each time you receive payment for participation in this study, the money will be added to your card, as outlined in the payment schedule above. Details of the debit card system are explained on an additional sheet.

Payments that you receive from MUSC for participating in a research study are considered taxable income per IRS regulations. Payment types may include, but are not limited to: checks, cash, gift certificates/cards, personal property, and other items of value. If the total amount of payment you receive from MUSC reaches or exceeds $600.00 in a calendar year, you will be issued a Form 1099.

H. ALTERNATIVES

Your alternative is to not participate in this study.

I. DATA SHARING

Information about you (including your identifiable private information and/or any identifiable biospecimens) may have all of your identifiers removed and used for future research studies or distributed to other researchers for future research without additional informed consent from you or your legally authorized representative.

K. DISCLOSURE OF RESULTS

We may learn things about you from the study activities which could be important to your health or to your treatment. If this happens, this information will be provided to you.

L. AUTHORIZATION TO USE AND DISCLOSE (RELEASE) MEDICAL INFORMATION

As part of this research study, your study doctor and his research team will keep records of your participation in this study.

The health information MUSC may use or disclose (release) for this research study includes information in your medical record, results of physical exams, medical history, lab tests or certain health information indicating or relating to your condition.

Your study doctor and his research team will use and disclose (release) your health information to conduct this study. The health information listed above may be used by and/or disclosed (released) to the following, as applicable:

- The sponsor of the study including its agents such as data repositories or contract research organizations monitoring the study;
- Other institutions and investigators participating in the study;
- Data Safety Monitoring Boards;
- Accrediting agencies;
- Clinical staff not involved in the study whom may become involved if it is relevant;
- Parents of minor children if less than 16 years old. Parents of children 16 years old or older require authorization from the child; or

- Health insurer or payer in order to secure payment for covered treatment;
- Federal and state agencies and MUSC committees having authority over the study such as: The Institutional Review Board (IRB) overseeing this study; committees with quality improvement responsibilities; Office of Human Research Protections; Food and Drug Administration; National Institutes of Health; other governmental offices, such as a public health agency or as required by law.

Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them. You do not have to sign this consent form. If you choose not to sign, it will not affect your treatment, payment or enrollment in any health plan, or affect your eligibility for benefits. However, you will not be allowed to be a participant in this research study.

You will be given a copy of this consent form. Your authorization will expire at the conclusion of this study or, if you are participating in a study designed for the development of a drug or device, your authorization will remain in effect until the drug or device is approved by the FDA or until the company's application to study the drug/device is withdrawn. You have the right to withdraw your agreement at any time. You can do this by giving written notice to your study doctor. If you withdraw your agreement, you will not be allowed to continue participation in this research study. However, the information that has already been collected will still be used and released as described above. You have the right to review your health information that is created during your participation in this study. After the study is completed, you may request this information.

Your health information will be used or disclosed when required by law. Your health information may be shared with a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability and for conducting public health surveillance, investigations or interventions. No publication or public presentation about the research study will reveal your identity without another signed authorization from you.

If you have questions or concerns about this Authorization or your privacy rights, please contact MUSC's Privacy Officer at (843) 792-8740.

Regulations require that you be given a copy of the MUSC Notice of Privacy Practices (NPP) describing the practices of MUSC regarding your health information. One can be found at the end of this form.

In addition to the main study, you have the option of participating in (insert the optional types of research that may be performed). Your protected health information may be used or shared with others outside of MUSC for this research as well. Please initial below if we may use/disclose your protected health information for the optional research portion/s of this study.

____Yes, you may use my protected health information for the optional research portions of this study.

____No, you may not use my protected health information for the optional research portions of this study.

M. STUDENT PARTICIPATION

Your participation or discontinuance will not constitute an element of your academic performance, nor will it be a part of your academic record at this Institution.

N. EMPLOYEE PARTICIPATION

Your participation or discontinuance will not constitute an element of your job performance or evaluation, nor will it be a part of your personnel record at this Institution.

O. COLLECTION OF SPECIMENS

As part of this study, we would like to store tissue specimens collected from you for future research on vascular complications. This future research may be conducted by Dr. Lyons or by other researchers who obtain IRB approval for their research. This research may involve genetic studies. There are several things you should know before allowing your tissues to be studied or to be stored.

1. The specimens will be labeled with a code that only study personnel can link back to you. Researchers outside of this study will not be given a link between the code number and your name or any other identifying information. While we hope this will prevent any potential loss of privacy or confidentiality, we cannot make any guarantees.
2. In addition to your name, other information about you might be connected to your sample. For instance, information about race, ethnicity, sex, your medical history, and so forth might be available to investigators studying your specimen. Such information might be important for research or public health. It is possible that this information (including genetic information) might come to be associated with your racial or ethnic group.
3. The specimens obtained from you in this research may help in the development of a future commercial product. There are no plans to provide financial compensation to you should this occur.

In this study, investigators will not contact you if a test becomes available to diagnose a condition you might have or later develop.

GENETIC INFORMATION NONDISCRIMINIATION ACT (GINA)

A 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 it protect you against genetic discrimination by all employers.

Genetic Studies. Please initial by your choice below:

____ I agree to allow genetic analyses of the samples I have provided for this study.

____ I choose not to allow genetic analyses of the samples I have provided for this study.

You may request at any time that your research samples be removed from storage and not be used for future research. If you decide you want your samples removed, you may contact Dr. Timothy Lyons via written communication at the following address: 96 Jonathan Lucas Street, MSC624, Charleston, SC 29425. Once the request is received, and if your samples have not already been used for other research, they will be destroyed. If you do not make such a request, your specimens will be stored indefinitely or until completely used.

P. FUTURE CONTACT

The researcher in charge of this study might like to contact you in the future about other research opportunities. Please initial by your choice below:

____Yes, I agree to be contacted

____No, I do not agree to be contacted

Results of this research will be used for the purposes described in this study. This information may be published, but you will not be identified. Information that is obtained concerning this research that can be identified with you will remain confidential to the extent possible within State and Federal law. The sponsor and the Food and Drug Administration (FDA) will receive copies of the research records. The investigators associated with this study, employees of the sponsor, the FDA, and the MUSC Institutional Review Board for Human Research will have access to identifying information. All records in South Carolina are subject to subpoena by a court of law.

In the event of a study related injury, you should immediately go to the emergency room of the Medical University Hospital, or in case of an emergency go to the nearest hospital, and tell the physician on call that you are in a research study. They will call your study doctor who will make arrangements for your treatment. If the study sponsor does not pay for your treatment, the Medical University Hospital and the physicians who render treatment to you will bill your insurance company. If your insurance company denies coverage or insurance is not available, you will be responsible for payment for all services rendered to you.

Your participation in this study is voluntary. You may refuse to take part in or stop taking part in this study at any time. You should call the investigator in charge of this study if you decide to do this. The data collected on you to this point remains part of the study database and may not be removed. Your decision not to take part in the study will not affect your current or future medical care or any benefits to which you are entitled.

The investigators and/or the sponsor may stop your participation in this study at any time if they decide it is in your best interest. They may also do this if you do not follow the investigator's instructions.

Volunteers Statement

I have been given a chance to ask questions about this research study. These questions have been answered to my satisfaction. If I have any more questions about my participation in this study

or study related injury, I may contact ***Dr. Timothy Lyons*** ***at 843-792-2529***. I may contact the Medical University of SC Patient and Family Care Liaison (843) 792-5555 concerning medical treatment.

If I have any questions, problems, or concerns, desire further information or wish to offer input, I may contact the Medical University of SC Institutional Review Board for Human Research IRB Manager or the Office of Research Integrity Director at (843) 792-4148. This includes any questions about my rights as a research subject in this study.

_____ _____

Signature of Person Obtaining Consent Date *Name of Participant

_____

Signature of Participant Date

Participant's Personal Representative (if applicable):

_____

Name of Personal Representative *(Please print)*

_____

Signature of Personal Representative Date

Relationship: ___ Spouse ___ Parent ___Next of Kin ___Legal Guardian* ____ DPOA for Healthcare*

**(If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient)*

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

NOTICE OF PRIVACY PRACTICES

MUSC Organized Health Care Arrangement (OHCA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Medical University of South Carolina and its affiliates (including but not limited to the Medical University Hospital Authority, MUSC Physicians, and MUSC Physicians Primary Care) participate in a clinically integrated health care setting. As a result of this clinical integration, these organizations function as an Organized Health Care Arrangement (OHCA) as defined by the Health Insurance Portability and Accountability Act (HIPAA). For purposes of this notice, the members of the MUSC OHCA are collectively referred to in this document as "MUSC." **We collect or receive this information about your past, present or future health condition to provide health care to you, to receive payment for this health care, or to operate the hospital and/or clinics.**

HOW WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION (PHI)

A. The following uses do NOT require your authorization, except where required by SC law:

1. **For treatment.** Your PHI may be discussed by caregivers to determine your plan of care. For example, the physicians, nurses, medical students and other health care personnel may share PHI in order to coordinate the services you may need.

2. **To obtain payment**. We may use and disclose PHI to obtain payment for our services from you, an insurance company or a third party. For example, we may use the information to send a claim to your insurance company.

3. **For health care operations.** We may use and disclose PHI for hospital and/or clinic operations. For example, we may use the information to review our treatment and services and to evaluate the performance of our staff in caring for you.

4. **For public health activities.** We report to public health authorities, as required by law, information regarding births, deaths, various diseases, reactions to medications and medical products.

5. **Victims of abuse, neglect, domestic violence.** Your PHI may be released, as required by law, to the South Carolina Department of Social Services when cases of abuse and neglect are suspected.

6. **Health oversight activities.** We will release information for federal or state audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions, as required by law.

7. **Judicial and administrative proceedings.** Your PHI may be released in response to a subpoena or court order.

8. **Law enforcement or national security purposes.** Your PHI may be released as part of an investigation by law enforcement.

9. Uses and disclosures about patients who have died. We provide coroners, medical examiners and funeral directors necessary information related to an individual's death.

10. For purposes of organ donation. As required by law, we will notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.

11. Research. We may use your PHI if the Institutional Review Board (IRB) for research reviews, approves and establishes safeguards to ensure privacy.

12. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may release limited information to law enforcement personnel or persons able to prevent or lessen such harm.

13. For workers compensation purposes. We may release your PHI to comply with workers compensation laws.

14. Marketing. We may send you information on the latest treatment, support groups and other resources affecting your health.

15. Fundraising activities. We may use your PHI to communicate with you to raise funds to support health care services and educational programs we provide to the community. You have the right to opt out of receiving fundraising communications with each solicitation.

16. Appointment reminders and health-related benefits and services. We may contact you with a reminder that you have an appointment.

B. You may object to the following uses of PHI:

1. Hospital directories. Unless you object, we may include your name, location, general condition and religious affiliation in our patient directory for use by clergy and visitors who ask for you by name.

2. Information shared with family, friends or others. Unless you object, we may release your PHI to a family member, friend, or other person involved with your care or the payment for your care.

3. **Health plan.** You have the right to request that we not disclose certain PHI to your health plan for health services or items when you pay for those services or items in full.

C. Your prior written authorization is required (to release your PHI) in the following situations:

You may revoke your authorization by submitting a written notice to the privacy contact identified below. If we have a written authorization to release your PHI, it may occur before we receive your revocation

1. Any uses or disclosures beyond treatment, payment or healthcare operations and not specified in parts A & B above.

2. Psychotherapy notes.

3. Any circumstance where we seek to sell your information.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

Although your health record is the physical property of MUSC, the information belongs to you, and you have the following rights with respect to your PHI:

A. The Right to Request Limits on How We Use and Release Your PHI. You have the right to ask that we limit how we use and release your PHI. We will consider your request, but we are not always legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Your request must be in writing and state (1) the information you want to limit; (2) whether you want to limit our use, disclosure or both; (3) to whom you want the limits to apply, for example, disclosures to your spouse; and (4) an expiration date.

B. The Right to Choose How We Communicate PHI with You. You have the right to request that we communicate with you about PHI in a certain way or at a certain location (for example, sending information to your work address rather than your home address). You must make your request in writing and specify how and where you wish to be contacted. We will accommodate reasonable requests.

C. The Right to See and Get Copies of Your PHI. You have the right to inspect and receive a copy of your PHI (including an electronic copy), which is contained in a designated record set that may be used to make decisions about your care. You must submit your request in writing. If you request a copy of this information, we may charge a fee for copying, mailing or other costs associated with your request. We may deny your request to inspect and receive a copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.

D. The Right to Get a List of Instances of When and to Whom We Have Disclosed Your PHI. This list may not include uses such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory as described above in this Notice of Privacy Practices. This list also may not include uses for which a signed authorization has been received or disclosures made more than six years prior to the date of your request.

E. The Right to Amend Your PHI. If you believe there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we amend the existing information or add the missing information. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is correct and complete or if it originated in another facility's record.

F. The Right to Receive a Paper or Electronic Copy of This Notice: You may ask us to give you a copy of this Notice at any time. For the above requests (and to receive forms) please contact: Health Information Services (Medical Records), Attention: Release of Information / 169 Ashley Avenue / MSC 369 / Charleston, SC 29425. The phone number is (843) 792-3881.

G. The Right to Revoke an Authorization. If you choose to sign an authorization to release your PHI, you can later revoke that authorization in writing. This revocation will stop any future release of your health information except as allowed or required by law.

H. The Right to be Notified of a Breach. If there is a breach of your unsecured PHI, we will notify you of the breach in writing.

HEALTH INFORMATION EXCHANGES

MUSC, along with other health care providers belongs to health information exchanges. These information exchanges are used in the diagnosis and treatment of patients. As a member of these exchanges, MUSC shares certain patient health information with other health care providers. Should you require treatment at another location that is a part of one of these exchanges, that provider may gather historical health information to assist with your treatment. You have the option of saying that this cannot be done. If you choose not to take part in these alliances, please contact the MUSC Privacy Office at 792-4037.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think your privacy rights may have been violated, or you disagree with a decision we made about access to your PHI, you may file a complaint with the office listed in the next section of this Notice. **Please be assured that you will not be penalized and there will be no retaliation for voicing a concern or filing a complaint. We are committed to the delivery of quality health care in a confidential and private environment.**

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this Notice or any complaints about our privacy practices please call the Privacy Officer (843) 792-4037, the Privacy Hotline (800) 296-0269, or contact in writing: HIPAA Privacy Officer / 169 Ashley Avenue / MSC 332 / Charleston SC 29425. You also may send a written complaint to the Office of Civil Rights. The address will be provided at your request.

CHANGES TO THIS NOTCE

We reserve the right to change the terms of this Notice at any time. We also reserve the right to make the revised or changed Notice effective for existing as well as future PHI. This Notice will always contain the effective date. You may view this notice and any revisions to it at: http://www.musc.edu/privacy.

EFFECTIVE DATE OF THIS NOTICE

This Notice went into effect on April 14, 2003.

Revised September 2013.