



Informed Consent

INFORMED CONSENT/AUTHORIZATION FOR PARTICIPATION IN RESEARCH

Bone Loss in Cancer Survivors Receiving Adjuvant Immune Checkpoint Inhibitor Therapy 2020-0353

Study Chair: Noha Abdelwahab Hassan

Participant's Name

Medical Record Number

This is an informed consent and authorization form for a research study. It includes a summary about the study. A more detailed description of procedures and risks is provided after the summary.

STUDY SUMMARY

Nivolumab and pembrolizumab are immunotherapy drugs (drugs that boost your immune system) used to prevent cancer from coming back in patients with melanoma. However, these drugs can cause serious side effects.

The goal of this research study is to learn more about the bone-related side effects caused by immunotherapy drugs. Specifically, researchers want to learn if there is any relationship between receiving immunotherapy and bone density (thickness) and body composition (fat and muscle mass) measured by a whole body dual-energy X-ray absorptiometry (DXA) scan.

This is an investigational study.

You may benefit from this study as well. If the results of your bone scans show poor bone density then you will be referred to the Rheumatology and Bone Health clinic. Future patients may benefit from what is learned. There may be no benefits for you in this study.

Your participation is completely voluntary. Before choosing to take part in this study, you should discuss with the study team any concerns you may have, including potential expenses and time commitment (an additional 30 minutes of your time to have a DXA scan). If you take part in this study, you may experience side effects. The DXA scan involves radiation exposure, which is less than a person would receive from a standard chest X-ray or a dental X-ray.

You can read a list of potential risks below in the Possible Risks section of this consent.

Your participation in this study will be over after 24 months.

There will be no cost to you for taking part in this study.

You may choose not to take part in this study.

1. STUDY DETAILS

Up to 40 participants will be enrolled in this study. All will take part at MD Anderson.

If you agree to take part in this study, as soon as possible after starting immunotherapy as part of your standard of care, you will have a DXA scan and then again 12 months later. The DXA scan will measure your bone density and the amount of fat and lean (non-fat) tissue in your body. For this scan, you will be asked to lie flat on your back on a table as the scanning machine moves above your body. The DXA scan is like an X-ray and takes about 5-10 minutes. The study team will set up an appointment with the Assessment, Intervention and Measurement core team located in the Behavioral Research and Treatment Center (BRTC) at MD Anderson. You will arrive at the location and will be asked to change into appropriate attire and the scan will be done. The entire process should not take more than 30 minutes of your time.

2. POSSIBLE RISKS

While on this study, you are at risk for side effects. You should discuss these with the study doctor. The known side effects are listed in this form, but they will vary from person to person.

DXA scan involves radiation exposure, which is less than a person would receive from a standard chest X-ray or a dental X-ray.

This study may involve unpredictable risks to the participants.

3. COSTS AND COMPENSATION

If you suffer injury as a direct result of taking part in this study, MD Anderson health providers will provide medical care. However, this medical care will be billed to your insurance provider or you in the ordinary manner. You will not be reimbursed for expenses or compensated financially by MD Anderson for this injury. You may also contact the Chair of MD Anderson's IRB at 713-792-6477 with questions about study-related injuries. By signing this consent form, you are not giving up any of your legal rights

Certain tests, and/or procedures, that you may receive as part of this study may be

without cost to you because they are for research purposes only. However, your insurance provider and/or you may be financially responsible for the cost of care and treatment of any complications resulting from the research tests, and/or procedures. Standard medical care that you receive under this research study will be billed to your insurance provider and/or you in the ordinary manner. Before taking part in this study, you may ask about which parts of the research-related care may be provided without charge, which costs your insurance provider may pay for, and which costs may be your responsibility. You may ask that a financial counselor be made available to you to talk about the costs of this study.

There are no plans to compensate you for any patents or discoveries that may result from your participation in this research.

You will receive no compensation for taking part in this study.

Additional Information

4. You may ask the study chair (Dr. Noha Abdelwahab Hassan, at 713-794-3232) any questions you have about this study. You may also contact the Chair of MD Anderson's Institutional Review Board (IRB - a committee that reviews research studies) at 713-792-6477 with any questions that have to do with this study or your rights as a study participant.
5. You may choose not to take part in this study without any penalty or loss of benefits to which you are otherwise entitled. You may also withdraw from participation in this study at any time without any penalty or loss of benefits. If you decide you want to stop taking part in the study, it is recommended for your safety that you first talk to your doctor. If you withdraw from this study, you can still choose to be treated at MD Anderson.
6. This study or your participation in it may be changed or stopped without your consent at any time by the study chair, the U.S. Food and Drug Administration (FDA), the Office for Human Research Protections (OHRP), or the IRB of MD Anderson.
7. You will be informed of any new findings or information that might affect your willingness to continue taking part in the study, including the results of all of your standard tests performed as part of this research, and you may be asked to sign another informed consent and authorization form stating your continued willingness to participate in this study.

You may receive a summary of the study results at the end of the study, if you request it.

8. MD Anderson may benefit from your participation and/or what is learned in this study.

Future Research

Data

Your personal information is being collected as part of this study. These data may be used by researchers at MD Anderson and/or shared with other researchers and/or institutions for use in future research.

Samples

Samples (such as blood and/or tissue) are being collected from you as part of this study. Researchers at MD Anderson may use any leftover samples that are stored at MD Anderson in future research.

Before being used or shared for future research, every effort will be made to remove your identifying information from any data and/or research samples. If all identifying information is removed, you will not be asked for additional permission before future research is performed.

In some cases, all of your identifying information may not be removed before your data or research samples are used for future research. If future research is performed at MD Anderson, the researchers must get approval from the Institutional Review Board (IRB) of MD Anderson before your data and/or research samples can be used. At that time, the IRB will decide whether or not further permission from you is required. The IRB is a committee of doctors, researchers, and community members that is responsible for protecting study participants and making sure all research is safe and ethical.

If this research is not performed at MD Anderson, MD Anderson will not have oversight of any data and/or samples.

Genetic Research

Research samples collected from you as part of this study may be used for genetic research, which may include whole genome sequencing. Whole genome sequencing is a type of testing in which researchers study your entire genetic makeup (DNA). This may help researchers learn how changes in the ordering of genes may affect a disease or response to treatment. If genetic research is done with your samples, those who have access to those samples may be able to identify you. The results of this research may also be able to be linked to you.

Authorization for Use and Disclosure of Protected Health Information (PHI):

- A. During the course of this study, MD Anderson will be collecting and using PHI, including identifying information, information from your medical record, and study results. For legal, ethical, research, and safety related reasons, your doctor and the research team may share your PHI with:
- Federal agencies that require reporting of clinical study data (such as the FDA, National Cancer Institute [NCI], and OHRP)
 - The IRB and officials of MD Anderson
 - Study monitors and auditors who verify the accuracy of the information
 - Individuals who put all the study information together in report form
- B. Signing this consent and authorization form is optional but you cannot take part in this study if you do not agree and sign.

- C. MD Anderson will keep your PHI confidential when possible (according to state and federal law). However, in some situations, the FDA could be required to reveal the names of participants.

Once disclosed outside of MD Anderson, federal privacy laws may no longer protect your PHI.

- D. The permission to use your PHI will continue indefinitely unless you withdraw your authorization in writing. Instructions on how to do this can be found in the MD Anderson Notice of Privacy Practices (NPP) or you may contact the Chief Privacy Officer at 713-745-6636. If you withdraw your authorization, you will be removed from the study and the data collected about you up to that point can be used and included in data analysis. However, no further information about you will be collected.

CONSENT/AUTHORIZATION

I understand the information in this consent form. I have had a chance to read the consent form for this study, or have had it read to me. I have had a chance to think about it, ask questions, and talk about it with others as needed. I give the study chair permission to enroll me on this study. By signing this consent form, I am not giving up any of my legal rights. I will be given a signed copy of this consent document.

SIGNATURE OF PARTICIPANT

DATE

PRINTED NAME OF PARTICIPANT

LEGALLY AUTHORIZED REPRESENTATIVE (LAR)

The following signature line should only be filled out when the participant does not have the capacity to legally consent to take part in the study and/or sign this document on his or her own behalf.

SIGNATURE OF LAR

DATE

PRINTED NAME and RELATIONSHIP TO PARTICIPANT

WITNESS TO CONSENT

I was present during the explanation of the research to be performed under **Protocol 2020-0353**.

SIGNATURE OF WITNESS TO THE VERBAL CONSENT
PRESENTATION (OTHER THAN PHYSICIAN OR STUDY CHAIR)

DATE

A witness signature is only required for vulnerable adult participants. If witnessing the

assent of a pediatric participant, leave this line blank and sign on the witness to assent page instead.

PRINTED NAME OF WITNESS TO THE VERBAL CONSENT

PERSON OBTAINING CONSENT

I have discussed this research study with the participant and/or his or her authorized representative, using language that is understandable and appropriate. I believe that I have fully informed this participant of the nature of this study and its possible benefits and risks and that the participant understood this explanation.

PERSON OBTAINING CONSENT

DATE

PRINTED NAME OF PERSON OBTAINING CONSENT

TRANSLATOR

I have translated the above informed consent as written (without additions or subtractions) into _____ and assisted the people
(Name of Language)
obtaining and providing consent by translating all questions and responses during the consent process for this participant.

NAME OF TRANSLATOR SIGNATURE OF TRANSLATOR DATE

☐ Please check here if the translator was a member of the research team. (If checked, a witness, other than the translator, must sign the witness line below.)

SIGNATURE OF WITNESS TO THE VERBAL TRANSLATION DATE
(OTHER THAN TRANSLATOR, PARENT/GUARDIAN,
OR STUDY CHAIR)

PRINTED NAME OF WITNESS TO THE VERBAL TRANSLATION