



Informed Consent

INFORMED CONSENT/AUTHORIZATION FOR PARTICIPATION IN RESEARCH

Transcranial direct current stimulation (tDCS) to reduce pain in patients with chemotherapy induced peripheral neuropathy: A Pilot Study
2018-0541

Study Chair: Salahadin Abdi

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

The goal of this clinical research study is to learn about the effects of transcranial direct current stimulation (tDCS) for chronic pain that is experienced by cancer patients.

This is an investigational study. The tDCS process is FDA approved and commercially available for patients with brain injuries such as strokes as well as for mental health issues such as depression. It is investigational to use the procedure for the treatment of chronic pain.

The study doctor or the research team members can describe how tDCS is designed to work.

The tDCS may help to control pain that you are experiencing. 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 side effects, potential expenses, and time commitment. If you take part in this study, you may experience headaches. You may choose not to take part in this study because you do not want to have any electrical stimulator on your forehead/head.

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

Your participation in the study will be over after the follow-up visit.

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

You may choose not to take part in this study. Instead of taking part in this study, you may choose to receive standard therapy. You may choose to receive other investigational therapy, if available. You may choose not to have treatment for your pain at all. In all cases, you will receive appropriate medical care, including treatment for pain and other symptoms if applicable.

1. STUDY DETAILS

Up to 10 participants will be enrolled in this study. All will take part at MD Anderson.

You must tell the study doctor or study staff about all medications you are taking or plan to take while on study.

If you agree to take part in this study, you will receive the tDCS procedure 5 days each week (Monday-Friday) for 3 weeks (up to 15 total procedures). During each procedure, a pair of electrodes will be placed on different areas of your head based on a computer model. A low current will be passed through your head over the course of about 20 minutes each time.

After you have received tDCS for 3 weeks, you will have a phone interview every week for 3 weeks. Each phone interview should last about 15 minutes. You will be asked questions about how you are doing and about any effects the procedure may have had on you.

About 4 weeks after you have finished receiving the procedure, you will have a follow-up visit in the clinic at which you will complete questionnaires about pain and how you are feeling. It should take about 10-12 minutes to complete the questionnaires.

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.

The most common side effect of tDCS is pain or discomfort at or near the treatment site during the procedure. This does not occur for most patients after about a week of receiving the procedure. Rarely, the device may cause seizures. You should discuss the side effects with the study doctor or with the research team members.

Also, the **questionnaires** may contain questions that are sensitive in nature. You may refuse to answer any question that makes you feel uncomfortable. If you have

concerns about completing the questionnaire, you are encouraged to contact your doctor or the study chair.

This study may involve unpredictable risks to the participants.

Pregnancy Related Risks

Taking part in this study can result in risks to an unborn or breastfeeding baby, so you should not become pregnant, breastfeed a baby, or father a child while on this study. You must use birth control during the study if you are sexually active.

Birth Control Specifications: If you can become pregnant or father a child, you must agree that you and your partner will use a form of birth control (such as spermicide with a condom, diaphragm or cervical cap, or use an intrauterine device [IUD]) that is medically acceptable to your study doctor while taking part in this research study and for 4 weeks after your last procedure.

Males: Tell the doctor right away if your partner becomes pregnant or suspects pregnancy.

Females: If you are pregnant, you will not be enrolled on this study. If you become pregnant or suspect that you are pregnant, you must tell your doctor right away.

Getting pregnant may result in your removal from this study.

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, procedures, and/or drugs 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, procedures, and/or drugs. 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. Salahadin Abdi, at 713-745-7246) 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 and you may be asked to sign another informed consent and authorization form stating your continued willingness to participate in this study.
8. MD Anderson may benefit from your participation and/or what is learned in this study.

Future Research

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

Before being shared for future research, every effort will be made to remove your identifying information from any data. 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 are used for future research. If this research is performed at MD Anderson, the researchers must get approval from the Institutional Review Board (IRB) of MD Anderson before your data 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.

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

- A. During the course of this study, MD Anderson will be collecting and using your 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 or receive study-related treatment 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.
- E. A description of this clinical trial will be available on <http://www.ClinicalTrials.gov>, as required by U.S. Law. This Web site will not include information that can identify you. At most, the Web site will include a summary of the results. You can search this Web site at any time.

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

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

RELATIONSHIP TO PARTICIPANT

WITNESS TO CONSENT

I was present during the explanation of the research to be performed under Protocol **208-0541**.

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.

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

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
(OTHER THAN TRANSLATOR, PARENT/GUARDIAN,
OR STUDY CHAIR)

DATE