INFORMED CONSENT FOR CLINICAL RESEARCH

Molecular Determinants of Acquired Clinical Resistance to Crizotinib in Non-small Cell Lung Cancer Harboring a Translocation or Inversion Event Involving the *ALK* Gene Locus

You have been asked to participate in a research study. In order to decide whether or not you should agree to be part of this research study, you should know enough about its risks and benefits in order to make a sound judgment. This process is known as informed consent.

A member of the study staff will explain the research study to you. Research studies include only people who choose to take part. Please take your time to make your decision about taking part. You may discuss your decision with your family and friends.

This consent form gives you detailed information about the research study. Once you understand the study, its risks, and its benefits, you will be asked to sign the form if you wish to take part. You will be given a copy to keep.

Why is this study being done?

The purpose of this study is to try to learn more about how small molecule kinase inhibitor medications work in treating lung cancer. Crizotinib (PF-02341066) is a drug that has been shown to shrink tumors in some patients with lung cancer. While we know how this drug works to stop the growth of tumors that depend on change in the gene named ALK (also called EML4-ALK), we do not know why the drug stops working. We would like to examine your tumor to help us better understand why crizotinib has stopped working as well as it once did. Your tumor will be examined with multiple tests to look for the reason that crizotinib stopped working.

Is there a potential conflict of interest for this study?

One of the investigators involved in this research study is a consultant for companies that are developing drugs for the same purpose. If you are interested in details about the steps MSKCC has taken to protect your best interests on this study, please speak to our patient representative, Jorge Capote, RN at 212-639-8254.

How was I selected to be in this study?

You are being asked to take part in this study because you have non-small cell lung cancer that is dependent upon a protein called ALK and you have benefited from treatment with crizotinib, but have now developed disease progression.

How many people will take part in the study?

About 30 people will take part in this study at MSKCC.

What will happen if I take part in this research study?

Before you begin the study …

In this study, you will undergo a biopsy. Your doctor will determine the type of biopsy based on your CT scan results. Prior to the biopsy, you will talk with the physician performing the biopsy. You will be given a chance to talk about the procedure and its potential adverse effects. You will have a physical examination as well as routine blood work and a pregnancy test to be sure the biopsy is safe.

If you have already undergone a biopsy or have a procedure that includes a biopsy scheduled, you do not need any additional tests. Instead, a piece of your prior biopsy sample will be used in this study.

During the study…

If you choose to take part, you will meet with the interventional radiologist who will perform the biopsy at MSKCC. You will sign a separate consent form for the biopsy procedure. The procedure is performed as an outpatient. You are not put to sleep for the procedure but instead are given medicines to make you comfortable during the procedure. The procedure takes approximately 2-3 hours. After the procedure, you will go home.

After the study…

After the biopsy procedure is finished your participation in the study will be complete. The biopsy specimen obtained will be tested in one or more laboratories at MSKCC.

How long will I be in the study?

You will be asked to take part in the study for as long as is required for you to undergo a biopsy of your cancer.

Can I stop being in the study?

Yes. You can decide to stop at any time. Tell the study doctor if you are thinking about stopping or decide to stop.

Your doctor may stop you from taking part in this study at any time if he/she believes it is in your best interest; if you do not follow the study rules; or if the study is stopped.

What side effects or risks can I expect from being in the study?

The specific risks to you are dependent upon the biopsy procedure being done. When you provide consent for the biopsy procedure itself, the doctor(s) performing the procedure will tell you more about any additional risks.

Patients will undergo two CT or ultrasound-guided core needle biopsies. The risks of the biopsy will vary slightly by the site biopsied and will be explained by the physician doing the procedure.

The risks of undergoing a biopsy of the lung are:

Likely

- Bruising or tenderness at the biopsy site

Less Likely

- Infection at the biopsy site

Rare but serious

- Pneumothorax (a collapsed lung) which may require follow-up monitor and/or hospitalization
- Bleeding
- Over sedation from narcotic and/or sedatives used for the procedure

The risks of undergoing a biopsy of the liver:

Likely

- Bruising or tenderness at the biopsy site

Less Likely

- Infection at the biopsy site

Rare but serious

- Perforation of the bowel
- Bleeding
- Over sedation from narcotic and/or sedatives used for the procedure

The risks of undergoing a biopsy of a lymph node are:

Likely

- Bruising or tenderness at the biopsy site

Less Likely

- Infection at the biopsy site

Rare but serious

- Bleeding
- Over sedation from narcotic and/or sedatives used for the procedure

For more information about the risks and adverse effects, ask your doctor.

Are there benefits to taking part in the study?

Taking part in this study will not make your health better. We do know that the information from this study will help doctors learn more about crizotinib as treatment for cancer and why the cancer stops responding to crizotinib. This information could help future cancer patients.

Will I receive the results from the study?

All results from this study are considered research. You will not be made aware of your results.

Do I have to take part in this study?

The choice to take part in this study or not is yours. Make your choice based on what we have explained to you and what you have read about the study.
Your other choices may include:

- Getting treatment or care for your cancer without being in a study
- Taking part in another study

Will my medical information be kept private?

Every effort will be made to keep your study records private. It is the responsibility of the research staff at Memorial Hospital to make sure that your records are managed to protect your privacy. If information from this study is used in any reports or publications, your name and anything else that could identify you will not be used. Trained staff at Memorial Hospital may review your records if necessary. Access to your medical information will be limited to those listed in the Research Authorization Form, which is a part of the informed consent process.

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.

What are the costs of taking part in this study?

You will not be charged for the biopsy, anesthesia, or pathology costs as part of this clinical trial. You will not be charged for the research tests being performed. If you need hospitalization or any other medical care as a result of this biopsy, your health insurance company will be charged for this care.

You will not be paid for taking part in this study.

What happens if I am injured because I took part in this study?

You will get medical treatment if you are injured as a result of taking part in this study. You and/or your health plan will be charged for this treatment. The study will not pay for the medical treatment.

What are my rights if I take part in this study?

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you and you will not lose any of your regular benefits. Leaving the study will not affect your medical care. You can still get your medical care from our institution.

We will tell you about new information or changes in the study that may affect your health or your willingness to continue in the study.

In the case of injury resulting from this study, you do not lose any of your legal rights to seek payment by signing this form.

Who can answer my questions about the study?

You can talk to your study doctor about any questions or concerns you have about this study. Contact your study doctor Dr. Gregory J. Riely at (646)-888-4191.

Any hospital that does research on people has an institutional review board (IRB). This board reviews all new studies to make sure that the patient's rights and welfare are protected. The IRB at MSKCC has reviewed this study.

For a non-physician whom you may call for more information about the consent process, research patients' rights, or research related injury is Jorge Capote, RN, Patient Representative, telephone number: (212) 639-8254

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RESEARCH AUTHORIZATION

Research Participant Name: _____

Research Participant MRN :_____

Information about you and your health is personal. It is "Protected Health Information." We cannot use any of your health information for research unless you tell us that we can. If you take part in this research, the people or organizations that can look at your information are listed below. You will have to sign this form to tell us we have your permission to share your protected health information.

The following persons and/or organizations may use or disclose your information for purposes related to this research:

- The people in charge of the study and their assistants and support staff.

The following persons and/or organizations may look at your information for purposes related to this research:

- Members and staff of the hospital's Office of Clinical Research, Computing Resource Group that manages research databases, Data Safety Monitoring Board, and the Quality Assurance Committee.
- Members and staff of the hospital's Institutional Review Board and Privacy Board.
- The National Cancer Institute, National Institutes of Health, U.S. Food and Drug Administration, and other agencies responsible for oversight.
- The following sponsor(s) of this research: Memorial Sloan Kettering Cancer Center

The following information will be used and/or disclosed for this research:

- Your entire research record.
- HIV-related information. This includes any information showing that you had an HIV-related test, have HIV infection, HIV-related illnesses or AIDS, or any information that could mean you might have been exposed to HIV. New York State requires us to obtain this consent.
- HIV-related information collected during this study if you choose to disclose it when talking to any of the staff.
- Your medical records from the hospital
- The following information:
  - Tumor tissue

If you sign this form, it means you are giving us permission to share your protected health information. We can only share it with the people or organizations describe above. The purpose for the use and sharing of this information is to conduct this study. This signed form allows us to make sure that everyone who needs information related to this study can get it.

Your protected health information may also be used for your research treatment, to collect payment for care you receive while on the study (when applicable), and to run the business operations of the hospital.

Some of the people or organizations listed above may not be subject to privacy laws. This means they could share your information again.

You do not have to sign this form. If you do not sign it, you will not be able to take part in the study. Your health care outside the study will not be affected. The payment for your health care or your health benefits will not be affected.

You have the right to withdraw from the study at any time. If you sign this authorization form, you also have the right to withdraw it at any time. If you withdraw it, we cannot use or share anymore of your research data. If the hospital has already used or shared your information, it cannot be taken back. This authorization allows us to use your information until you say we cannot use it anymore. If you want to withdraw your authorization, write to: Dr. Gregory J. Riely at the Department of Medicine, Memorial Sloan-Kettering Cancer Center.

Notice About HIV-Related Information

Once we have shared your HIV-related information, it can only be shared again if federal or state laws allow it. You have the right to ask for a list of any people who get your HIV-related information that are not listed above. There are two agencies to help protect your rights. Call them if you think you have been singled out or harmed because of HIV-related information.

- New York State Division of Human Rights (800) 523-2437 or (212) 480-2493
- New York City Commission of Human Rights (212) 306-7450 or (212) 306-7500

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Statement of professional obtaining consent

I have fully explained this clinical research study to the participant or his/her Legally Authorized Representative (**LAR**). In my judgment and the participant's or that of his/her Legally Authorized Representative, there was sufficient access to information, including risks and benefits to make an informed decision.

Consenting Professional Must Personally Sign & Date		
Assent (Minor between the ages of 7 and less than 18): If the participant is a minor, I have obtained his/her assent to participate in the study to the best of their ability to understand. ☐ **YES** ☐ **NO** ☐ **N/A (Adult or Child <7)**		
Consenting Professional's Signature		**Date:**
Consenting Professional's Name (Print)		

Participant's (or Legally Authorized Representative's (LAR)) statement

I have read this form with the description of the clinical research study. I have also talked it over with the consenting professional to my satisfaction. By signing below, I am agreeing to the following: (1) to voluntarily be a participant in this clinical research study (2) authorizing for the use and disclosure of my/their protected health information (data about myself) and (3) that I received a signed copy of this consent form.

Participant/LAR Must Personally Sign & Date		
Participant/LAR Signature		**Date:**
Participant/LAR Name (Print)		
LAR Relationship to Participant		

Witness Signature (If Required)

☐ **Non-English Speaking Participant Witness and/or Interpreter:** I declare that I am fluent in both English and participant's (or LAR) language and confirm that the consent discussion was appropriately translated for the participant (or LAR).

☐ **Other:** I confirm that the consent discussion was appropriate for the participant's (or LAR's) understanding of the study.

Name of Witness: _____

Signature of Witness: _____ Date: _____

The Participant/Legally Authorized Representative Must Be Provided With A Signed Copy Of This Form