Certification of Completion of the Informed Consent

IRB #

Title:

I have discussed the "Informed Consent for Participation in Research Activities" in its entirety for the above referenced research study, with the research participant listed below (or the research participant's legally authorized representative). During the review of the consent form, the possible benefits, risks and discomforts involved in his/her participation on the study, as well as potential alternatives were reviewed.

The research participant has been encouraged to ask questions, and all questions asked by the participant have been answered. The research participant affirmed that he/she has received all information that he/she desires at this time, and a copy of the signed consent form has been provided to the participant.

| PRINTED NAME of Person Obtaining Informed (Consenter) | SIGNATURE | TITLE | DATE | TIME |
|---|---|---|---|---|
| | | | | |

IRB APPROVED
AS MODIFIED
Jun 18, 2024

City of Hope

# INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

**TITLE:** Phase 2 Trial of Leflunomide in African-American and European-American Patients with High-Risk Smoldering Multiple Myeloma

**PROTOCOL NO.:** COH Protocol #21049
WCG IRB Protocol #20210449

**VERSION DATE:** 06/05/2024

**SPONSOR:** City of Hope

**INVESTIGATOR:** Michael A. Rosenzweig, MD
1500 East Duarte Road
Duarte, California 91010
United States

**STUDY-RELATED PHONE NUMBER(S):** (626) 256-HOPE(4673) ext. 89200
(626) 256-HOPE(4673) ext. 95200 (24 hours)

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## EXPERIMENTAL PARTICIPANT'S BILL OF RIGHTS

The rights below are the rights of every person who is asked to be in a research study, also known as an experiment or clinical trial. As a research participant, you have the following rights:

1. To be told what the research study is trying to find out.
2. To be told what will happen to you and whether any of the procedures to be used are different from what would be used in standard practice.
3. To be told about the discomforts, side effects and risks of the things that will happen to you as part of the research study.
4. To be told if you can expect any benefit from participating in the research study.
5. To be told of the other choices you have and how they may be better or worse than being in the research study.
6. To be told what medical treatment is available if any complications arise.
7. To be allowed to ask any questions concerning the research study, both before agreeing to be in the study and during the course of the study.
8. To refuse to participate in the research study or to change your mind about participation after the study is started. To be informed that this decision will not affect your right to receive the care you would receive if you were not in the study.
9. To receive a copy of the signed and dated research study consent form.
10. To be free of pressure when considering whether you wish to agree to be in the research study.

**KEY INFORMATION**

You are invited to participate in a research study. The purpose of this research study is to test leflunomide in African-American and European patients with high risk smoldering multiple myeloma (SMM). The information we learn by doing this research study may help us learn if the study drug leflunomide can delay the symptoms of multiple myeloma in in both African-American and European patients with high risk smoldering multiple myeloma (SMM).

Participants in this study will take 100 mg of study drug leflunomide orally for 3 days and then at 20 mg daily. Participation is expected to last until your disease progresses.

The major risks associated with study include anemia (including iron deficiency anemia), ecchymosis, pancytopenia, agranulocytosis, neutropenia, thrombocytopenia, and leukopenia.

You do not have to join this research study. The current standard of care for smoldering multiple myeloma is for doctors to observe how the patient is doing without giving treatments. Alternatives to participation in this study therefore include observation. If you are interested in learning more about this study, please continue to read below.

**PURPOSE OF THE STUDY**

You are invited to take part in a clinical trial, a type of research study, because you have been diagnosed with high risk smoldering multiple myeloma and are either of African-American or European-American descent. We hope to learn if the study drug leflunomide can delay the symptoms of multiple myeloma in patients of African-American and European descent. This research study is looking at leflunomide as a possible future treatment for this diagnosis. Leflunomide is a commercially available oral immunosuppressive agent that has been FDA approved since 1998 for the treatment of rheumatoid arthritis (RA) as a single agent or in combination with methotrexate. Its use in this study is investigational.

This research study is sponsored by City of Hope. It is expected that about 56 people will take part in this research study.

We encourage you to take some time to think this over, to discuss it with other people and your primary doctor, and to ask questions now and at any time in the future. Please take as much time as you need to read the consent form. If you find any of the language difficult to understand, please ask questions. If

you decide to participate, you will be asked to sign this form. We will give you a copy so that you can refer to it while you are involved in this research study. If you choose not to participate in this research study, or choose to withdraw at any time, there will be no penalties or loss of benefits to which you are otherwise entitled, and the research doctors will discuss other treatment options with you and/or refer you back to your primary doctor.

## A. WHY IS THIS RESEARCH STUDY BEING DONE?

This research study is a Phase II clinical trial. Phase II clinical trials test the safety and effectiveness of an investigational (experimental) intervention to learn whether the intervention works in treating a specific disease. "Investigational" means that the intervention is being studied.

The FDA (the U.S. Food and Drug Administration) has not approved leflunomide for your specific disease but it has been approved for other uses.

## B. WHAT IS INVOLVED IN THE STUDY?

If you decide to take part, this is what will happen:

You will be instructed to take each dose of leflunomide orally, once a day, at approximately the same time each day with or without food.

If you take part in this research study you will be given a drug diary. You will be asked to document information in the drug diary about the study drug you are being asked to take.

**Before the research starts (screening):**
After signing this consent form, you will be asked to undergo some screening tests or procedures to find out if you can be in the research study. Many of these tests and procedures are likely to be part of regular cancer care and may be done even if it turns out that you do not take part in the research study. If you have had some of these tests or procedures recently, they may or may not have to be repeated.

- **A medical history,** which includes questions about your health, current medications, and any allergies.
- **An assessment of your tumor** by one or more of the following standard assessment tools: X-ray, CT (Computerized Tomography) scan, MRI (Magnetic Resonance Imaging) or PET (Positron Emission Tomography) scans

- **Blood tests** to check the status of your disease (about 2 tablespoons of blood will be drawn from a vein in your arm)
- **Urine test.** Urine will be collected from you for routine laboratory testing to monitor your general health.
- **Pregnancy test** if you are a woman of childbearing potential by drawing about ½ teaspoon of blood usually from a vein in your arm.

If these tests show that you are eligible to participate in the research study, you will begin the study treatment. If you do not meet the eligibility criteria, you will not be able to participate in this research study.

**Additional research procedures to be performed at the time of screening but not required to determine eligibility:**

- **Blood tests**: including baseline tests so that we can measure any additional effect of the study drug and disease status or to look for a marker for your particular type of cancer.
- **Pharmacokinetic (PK) blood samples:** PK blood samples to monitor how your body absorbs and breaks down the study drug. Each blood sample will be approximately 2 teaspoon.

**Study Procedures:**

If you are eligible to participate in this research study, the following test and procedures will occur. A chart summarizing the timing of these tests and procedures is also provided below. Some tests and procedures may be part of your standard of care.

- **Oral Study Drug(s):** Patients will begin treatment with a dose of oral leflunomide 100 mg daily for 3 days then proceed with the treatment. Each treatment cycle lasts 28 days during which time you will be taking the study drug by mouth 1 time per day. This will continue until you disease worsens.
- **Allowed Medications**: While you are receiving study treatment, you should not take other medications without first discussing them with the study doctor. Medications that are allowed include allopurinol, anti-emetics, anti-diarrheals, FDA-approved bisphosphonates, erythropoietin, transfusions (as necessary), and palliative radiation. You may be pre-medicated with drugs to reduce the chance of having a sensitivity reaction to the study treatment. If you tolerate the study treatment without a reaction, then pre-medications may be changed by your doctor.
- **Clinical Exams:** During this visit you will have a physical exam and you will be asked questions about your general health and specific questions about any problems that you might be having and any medications you may be taking.
- **Scans (or Imaging tests):** We will assess your tumor by MRI

- **Blood tests**
  - **Blood tests** to check the status of your disease (about 2 tablespoons of blood per blood draw will be drawn from a vein in your arm)
  - **Blood tests** for research purposes to test the effect of the study drug (about 6 tablespoons of blood per blood draw will be drawn from a vein in your arm)
- **Urine test** during the study. Urine will be collected from you for routine laboratory testing to monitor your general health.
- **Prohibited Medications**: Concurrent treatment with any other anti-cancer therapies will not be permitted while on study treatment. Concurrent administration of live vaccines will not be permitted while on study.
- **Optional Research Tests:** At the end of this consent form, you will be asked to decide if we can keep your samples and store them for future testing.

Research Study Calendar:

| | Screening | Cycle 1+ | End of Treatment | | | | Active Follow-Up | Long Term Follow-Up |
|---|---|---|---|---|---|---|---|---|
| | | | D 0 | D 1-11 | D 14 | D 30 | | |
| Informed Consent | X | | | | | | | |
| Inclusion/Exclusion Criteria | X | | | | | | | |
| Registration | X | | | | | | | |
| Medical history | X | | | | | | | |
| Physical exam | X | X | | | | X | | |
| Vital signs | X | X | | | | X | | |
| Adverse events assessment | | X | X | | | X | | |
| Concomitant meds review | X | X | X | | | X | | |
| ECOG status | X | X | | | | X | | |
| Pregnancy test | X | | | | | | | |
| TB antigen test | X | | | | | | | |
| Hepatitis A, B, C testing | X | | | | | | | |
| Pulmonary function test | X | | | | | | | |
| Skeletal survey | X | | | | | | | |
| ECG | X | | | | | | | |
| MRI | X | | | | | | | |
| Clinical bone marrow aspiration/biopsy with research use of leftover samples | X[a,b] | | | | | | | |
| CBC with differential | X | X | | | | X | X | |
| Chemistry panel | X | X | | | | X | X | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Myeloma labs | X | X | X | | | X | X | |
| Teriflunomide clinical testing | | | X | | X | X | | |
| Leflunomide | | Daily | | | | | | |
| Cholestyramine | | | | X | | | | |
| Quality of Life assessments | Pre-treatment | Every 6 months | | | | | | |
| Correlative blood | Pre-treatment | 1 wk after treatment, C1 day 14, C2 and C3 days 1 and 14 and day 1 of all subsequent cycles | Progression | | | | | |
| Correlative bone marrow aspirate | Pre-treatment | Cycle 12 | Progression | | | | | |

a. **Perform bone marrow biopsy and/or aspirate at baseline and to confirm suspected progression.**
b. **Myeloma labs and bone marrow and response assessments are not to be taken on Cycle 1 Day 1; Screening labs will be used as baseline values.**

**Planned Follow-up:**
We would like to keep track of your medical condition for the rest of your life. We would like to do this by calling you on the telephone once a year to see how you are doing. Keeping in touch with you and checking your condition every year helps us look at the long-term effects of the research study.

## C. HOW LONG WILL I BE IN THIS RESEARCH STUDY?

You will be in this research study until your disease progresses.

## D. WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

There are risks to taking part in any research study. One risk is that you may get a study drug that does not help treat your disease or that makes your condition or disease worse. Another risk is that there may be side effects.

All cancer treatments can have side effects, which can range from mild and reversible to severe, long lasting and possibly life-threatening. There is a great deal of variability among side effects of different cancer treatments and between individuals. In a research study, all of the risks or side effects may not be known before you start the study. **You need to tell your doctor or a member of the study team immediately if you experience any side effects.**

Everyone in the research study will be watched carefully for side effects. You will be monitored during the administration of study drugs to keep track of your blood counts and organ function, particularly your kidney and liver function. If you experience side effects, they may go away after you stop taking the study drug. You will be monitored closely for any severe, life-threatening side effects listed below. Some of these side effects may be permanent. Appropriate medical care will be provided, if necessary, including additional treatment, hospitalization and/or surgery.

Possible risks and discomforts you could experience during this study include:

**RISKS ASSOCIATE WITH LEFLUNOMIDE**

***Commonly Occurring Side Effects (1 in 10 research participants)***

- Gastrointestinal: diarrhea
- Infections: respiratory infection*,
- Nervous system: headache*, peripheral neuropathy* (including peripheral numbness, tingling, burning, severe pain, cold sensation in the distal extremities, or extremity weakness),
- Skin and subcutaneous tissue: maculopapular rash*, dry skin*, alopecia*, hair discoloration*
- Miscellaneous: weight loss*, leg cramps*,

***Occasional Side Effects (1 in 50-100 research participants)***

- Blood and lymphatic system: anemia (including iron deficiency anemia), ecchymosis
- Cardiac: angina pectoris, migraine, palpitation, tachycardia, vasodilatation
- Endocrine: diabetes mellitus, hyperthyroidism
- Eye: blurred vision, cataract, conjunctivitis, eye disorder
- Gastrointestinal: abdominal pain, dyspepsia, nausea, vomiting, oral ulceration, anorexia, constipation, esophagitis, flatulence, gastritis, gingivitis, melena, oral moniliasis, pharyngitis, salivary gland enlarged, stomatitis (or aphthous stomatitis), tooth disorder
- Hepatobillary: elevated hepatic enzymes (primarily ALT and AST)
- Immune system: allergic reactions
- Infections: infections (including bronchitis, rhinitis, sinusitis, pharyngitis, pneumonia, and urinary tract infections, oral or vaginal candidiasis, herpes simplex, herpes zoster, and fungal dermatitis

- Metabolism and nutrition: hyperglycemia, creatine phosphokinase increased, hyperlipidemia
- Musculoskeletal and connective tissue: arthrosis, bone necrosis, bone pain, bursitis, muscle cramps, myalgia, tendon rupture
- Neoplasms: cyst
- Nervous system: paresthesias, taste perversion (dysgeusia), anxiety, depression, dry mouth, insomnia, neuralgia, neuritis, sleep disorder, sweating increased, vertigo, migraine
- Renal and urinary: albuminuria, cystitis, dysuria, hematuria, hypophosphaturia, hyperuricemia, increased urinary frequency
- Reproductive: menstrual irregularity/disorder, menstrual disorder, vaginal moniliasis vaginal moniliasis, prostate disorder
- Respiratory: asthma, dyspnea, epistaxis, lung disorder
- Skin and subcutaneous tissue: acne, contact dermatitis, fungal dermatitis, hematoma, nail disorder, skin discoloration, skin disorder, skin nodule, subcutaneous nodule, skin ulcer
- Miscellaneous: fever, peripheral edema, hernia, neck pain, pelvic pain, pain, abscess, malaise

***Rarely Seen Side Effects (less than 1 in 100 research participants) ("**" means a rare but possibly serious event)***

- Blood and lymphatic system: pancytopenia**, agranulocytosis**, neutropenia**, thrombocytopenia**, leukopenia**
- Gastrointestinal: pancreatitis**
- Hepatobillary: cirrhosis**, hepatitis**, hepatic failure**, acute hepatic necrosis**, cholelithiasis**, cholestasis**
- Immune system: anaphylactoid reactions**
- Infections: opportunistic and/or severe infections**
- Neoplasms: secondary malignancy**
- Respiratory: interstitial lung disease** (sometimes fatal), interstitial pneumonitis**, pulmonary fibrosis**
- Skin and subcutaneous tissue: Stevens-Johnson syndrome**, toxic epidermal necrolysis**, erythema multiforme**, cutaneous lupus erythematosus**
- Vascular: varicose veins, hypertension***, cutaneous necrotizing vasculitis**
- Miscellaneous: jaundice**, allergy related angioedema**

Since the effect of the study drug(s) taken with other medications may not be known, it is important that you tell the research doctor about all prescription and non-prescription drugs, herbal preparations and nutritional supplements that you are taking or planning to take. There may also be some foods that you should avoid while on this research study and your research doctor will review this information with you.

This research may involve risks to the subject which are currently unforeseeable.

**Risks Associated with Blood Draw**
Risks of blood draws include mild pain or discomfort, bruising and swelling around the puncture site, dizziness or fainting, or infection.

Cancer research often includes biopsies, scans, x-rays that are also provided as routine care. The following describes the side effects of procedures done only for the purposes of research.

**Risks Associated with Bone Marrow Aspiration:**
For this procedure, a numbing drug is injected into the skin over the same hipbone. A needle is then inserted into the hipbone and a sample of bone marrow fluid is removed. Risks of this procedure are small, but may include:

- Pain from the needle sticks
- Pain from aspirating the bone marrow with a syringe
- Bleeding
- Infection
- Local nerve damage

**Risks Associated with MRI Scans:**
When having an MRI (Magnetic Resonance Imaging) scan, you will lie still on a table that slides into a tunnel slightly wider than your body. People who feel uncomfortable in confined spaces (claustrophobia) may feel uncomfortable in the narrow cylinder. If you feel uncomfortable in confined spaces, please tell your research doctor. Your doctor may give you a medication to make you feel more comfortable. As images are taken, a loud banging noise will be produced. Earplugs or headphones will be available if needed. If you have metallic objects, there may be injury of tissue around the metallic objects and movement of the metallic if not attached to bone. The MRI can be stopped at any time at your request, but the scan may not be complete.

**Risks Associated with Pulmonary Function Testing:**
Risks include dizziness, shortness of breath or coughing. If you have asthma, you may have an increased risk for an asthma attack.

**Incidental Findings:**

It is possible the research procedures could find a medical problem unrelated to the purpose of this study that you did not know about before. If during the research procedures we learn information that may be important for you to know about, such as the possibility of a previously unknown medical condition, we will tell you. You may authorize the release and communication of the findings to your personal doctor. These findings may require additional testing or treatment. You will be responsible for the cost of any additional tests or related treatment.

Results of genetic research will not be used in your medical care. The results will not be given to you, the study doctor, or your personal doctor.

**Reproductive Risks:**

We do not know whether this study drug might hurt an unborn child. While participating in this research study, you should not become pregnant or father a baby, and should not nurse a baby. We can provide counseling about preventing pregnancy for either male or female study participants. Let your doctor know immediately if you become pregnant or find out that you are going to be the father of a child.

If you are pregnant or nursing a baby and do not want to stop, you cannot take part in this study. If you are a woman who can become pregnant, a urine pregnancy test will be obtained before treatment is started If you are sexually active and capable of bearing or fathering a child, both you and your partner must agree to use a two medically effective *forms* of birth control while you are on this study. The investigational drug(s) may involve risks to you (or to the embryo, fetus, or breastfeeding child if you or your partner become pregnant), which is currently unforeseeable.

You must use birth control while on this study. Acceptable medically effective forms of birth control are:

- Abstinence,
- Surgical sterilization (tubal ligation or hysterectomy for women, or vasectomy for men),
- Double-barrier methods (i.e. condoms, diaphragm, cervical cap, or sponge used with spermicidal gel or foam),
- Intrauterine device (IUD) (i.e. Progestin, Copper),
- Hormonal Contraceptives (Birth control patches, implants, pills, rings, or injections)

**Other Risks:**

**Risks associated with Breach of Confidentiality:**
There is a small risk that people who are not connected with this study will learn your identity or your personal information.

Results of this genetic research will not be used in your medical care. The results will not be given to you, the study doctor, or your personal doctor. Some people may find it upsetting to learn that they have certain mutations or errors in genes that could lead to future health problems for themselves or their children.

The Genetic Information Nondiscrimination Act of 2008 (GINA) is a federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health, and may prevent discrimination by health insurers and employers based on genetic information. GINA is intended to ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health, and enable people to take part in research studies such as this without fear that their DNA information might be used against them by health insurers or their workplace. This protection does not extend to disability or life insurance. Additional information can be found at http://www.genome.gov/10002328.

**Genetic Data Sharing Risks:**

**Who else will have access to my genetic information?**
The researchers may decide to share data gathered from your samples to help further research into cancer and other diseases. One way to do this is by putting information into scientific databases where it is stored along with information from participants in other studies. Researchers can then study the combined information to learn even more about science and health. If you agree to take part in the study, some of your genetic and health information might be placed into a Controlled access means that only researchers who apply for and get permission to use the information for a specific research project will be able to access the information.

Your name and other information that could directly identify you will never be placed into a scientific database. However, because your genetic and health information is unique to you, there is a small chance that someone could trace it back to you. The risk of this happening is very small, but may grow in the future. There are many safeguards in place to protect your information while is it stored in data repositories and used for research.

Some of this research may result in new inventions or discoveries that may be of potential commercial value and may be patented and licensed for the development of new products. Donors of blood, tissue and other biological materials do not retain any property rights to the materials. Therefore, you would not share in any money or other benefits that any entity might receive for these inventions or discoveries. Your decision not to allow storage or future use of your tissue or specimens will not affect your ability to participate in this study.

If you agree to allow your specimens to be used for future research, you can change your mind later. If you change your mind, please ask for the "Withdrawal of Informed Consent" form. Please sign this withdrawal form and send it to the principal investigator of this study at the City of Hope. Once the City of Hope notifies the City of Hope of this withdrawal of informed consent and the City of Hope processes your signed withdrawal of informed consent, your specimens will not be used in any new research. At that time, any of your existing specimens will be destroyed.

I agree to have tissue stored for future research:

☐ Yes ☐ No Initials: _____

**E. WILL YOU RECEIVE NEW INFORMATION ABOUT THIS STUDY?**

During the research study, you will be notified of newly discovered side effects or significant findings, which may affect your health or willingness to participate. You may be asked to sign a new consent form that shows that you have been informed of new information relating to this research study.

**F. HOW WILL YOUR INFORMATION BE KEPT CONFIDENTIAL?**

Any information learned from this study in which you might be identified will be confidential and disclosed only with your permission. Every effort will be made to keep any information collected about you confidential. However, it is impossible to guarantee that information about you will not be mistakenly released. If, despite our best efforts, identifying information about you is released, it could negatively impact you or your family members. This risk is small.

By signing this form, however, you allow the researchers to make your information available to the City of Hope Institutional Review Board (IRB) Office, the Cancer Protocol Review and Monitoring Committee (CPRMC), the Office for Human Research Protections (OHRP), the National Cancer Institute (NCI), City of Hope committees responsible for overseeing the conduct, safety and compliance of research, the Federal

and Drug Administration (FDA) and other regulatory agencies as required by law. If information learned from this study is published, you will not be identified by name.

The information or specimens that have been collected for this study will not be used for future research studies or shared with other researchers beyond the research activities described in this consent form.

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.

**Certificate of Confidentiality**

This research is covered by a Certificate of Confidentiality from the National Institutes of Health. The Certificate protects against the release of information, documents or biospecimens that may identify you that was collected during the period the Certificate is in effect to individuals not connected with the research. For example, the researchers involved in the studies cannot be forced to disclose the identity or any information collected in the study in any legal proceedings at the federal, state, or local level, regardless of whether they are criminal, administrative, or legislative proceedings. However, federal agencies may review our records under limited circumstances, such as a DHHS request for information for an audit or program evaluation or an FDA request under the Food, Drug and Cosmetics Act.

The Certificate does not prevent you from voluntarily releasing information about yourself or your involvement in this research. If you choose to voluntarily disclose the protected information under certain circumstances (for example, if you request the release of information in writing), the Certificate does not protect against that voluntary disclosure. Additionally, the Certificate of Confidentiality will not protect against the required reporting by hospital staff of information on suspected child abuse, reportable communicable diseases, and/or possible threat of harm to self or others. The Certificate of Confidentiality will not be used to prevent disclosure for any purpose you have consented to in this informed consent document, for other scientific research, as allowed by federal regulations protecting research subjects, or for your medical treatment.

**Future Use of Research Information and Specimens**

In the future, the information or specimens that have been collected for this study might/will be de-identified, which means any information that could be used to identify you will be removed from the information or specimens. The de-identified information or specimens may be used for future research studies or shared with other researchers. You will not be informed of or asked to consent to these future research activities.

## G. WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART IN THIS RESEARCH STUDY?

There is no guarantee that you will receive any benefits from this study. The possible benefit of the study drug in the treatment of Smoldering Multiple Myeloma cancer is not known. If you decide to participate in this study, your health will be monitored very closely. By being in this study, you will give doctors more information about how well the study drug works. It may help doctors understand your condition better and may help future patients with this medical condition.

## H. WHAT OTHER OPTIONS ARE THERE?

Taking part in this study is voluntary. If you decide not to take part in this study, there will be no penalties or loss of benefits to which you are otherwise entitled. If you choose not to take part in this study, you have other choices. For example:

- You may choose to have the usual approach for your cancer,
- You may choose to take part in a different study, if one is available, or
- You may choose not to be treated for cancer but you may want to receive comfort care to relieve symptoms. Comfort care includes pain medication and other supportive measures. It aims to maintain your comfort and dignity rather than cure disease. Many times this care can be provided at home.

  If you think you might prefer comfort care, please discuss this with your family, friends and your doctor.

## I. ARE THERE ANY PAYMENTS TO YOU FOR TAKING PART IN THE STUDY?

You will not receive any monetary compensation for taking part in this clinical trial.

## J. WHAT ARE THE COSTS?

Taking part in this research study might lead to added costs to you or your insurance company.

Leflunomide will be provided to you at no cost while you take part in the study. It is possible that the Leflunomide may not continue to be supplied while you are on the study. If this occurs, the research doctor will talk to you about your options.

Most of the tests, procedures, and/or drugs provided to you as part of this study are routinely used to treat your illness. You would receive these tests, procedures, and/or drugs even if you were not

participating in this study. You or your health plan/insurance company will need to pay for this routine care. You will also be responsible for any co-payments or deductibles required by your health plan/insurance company. Some health plans/insurance companies will not pay the costs associated with these tests, procedures, and/or drugs because you are in a research study. If your health plan/insurance company will not pay these costs, you will have additional expenses from being in this study, such as the costs associated with treating side effects.

If you have questions about your insurance coverage, or the items you might be required to pay for, please call financial services for information. The contact information for financial services are:

- City of Hope Financial Support Services: 626-256-HOPE (4673), extension: 80258.

The National Cancer Institute provides an online resource to help people participating in cancer clinical trials understand which services their insurance company is required by law to pay. This can be found at the website below or can be provided by the study team:

www.cancer.gov or 1-800-4-CANCER (1-800-422-6237)

## K. WHAT HAPPENS IF YOU GET INJURED AS A RESULT OF THIS STUDY?

If you think you have been hurt by taking part in this study, tell the person in charge of this research study as soon as possible. The research doctor's name and phone number are listed in this consent form. City of Hope will offer you the care needed to treat injuries directly resulting from taking part in this research. This care will be billed to you or your insurance company. You will be responsible for deductible and co-payments, or any costs not paid by your insurer. There are no plans to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

There are no plans for any of the sponsors of this study to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

## L. WHAT ARE YOUR RIGHTS IF YOU TAKE PART IN THIS STUDY AND WHAT WILL HAPPEN IF YOU DECIDE NOT TO PARTICIPATE?

Your participation in this research study is voluntary. You are free to withdraw your consent for participation in this study without any loss of benefits, penalty, or interference with any future treatment at City of Hope.

You can decide to stop at any time and you may still be treated at your hospital or clinic. Tell your study doctor if you are thinking about stopping or decide to stop. You should talk to the doctor about leaving the study before you decide so that he/she can find out if you are having any side effects from study treatment. Another reason to tell your doctor that you are thinking about stopping is so that he/she can talk to you about any other treatments that could be helpful to you.

If you decide to stop being in this study, you will still be asked to come back to the hospital or clinic for the end of treatment tests described above. You may also be asked to take part in the follow-up phone calls and/or visits. This information is important to make sure that there are no lasting side effects from the study treatment and to see if your cancer got better, stayed the same, or got worse after treatment.

## M. CAN YOU BE REMOVED FROM THE STUDY?

You may be removed from this study without your consent for any of the following reasons: you do not follow the investigator's or study doctor's instructions, at the discretion of the investigator or study doctor or the sponsor, your disease gets worse, or the sponsor closes the study. If this happens, the investigator or study doctor will discuss other options with you.

## N. WHOM DO YOU CALL IF YOU HAVE QUESTIONS OR CONCERNS?

The principal investigator, Dr. Michael A. Rosenzweig, responsible for your care or treatment, has offered to and has answered any and all questions regarding your participation in this research study. If you have any further questions, concerns, or complaints, or in the event of a research related injury, you can contact Dr. Michael A. Rosenzweig at (626) 256-HOPE(4673) ext. 89200 or (626) 256-HOPE(4673) ext. 95200 (24 hours)

This study has been reviewed and approved by the Institutional Review Board (IRB). If you have any questions regarding your rights as a research participant, or questions, concerns or complaints about the study you may contact a representative of that Board, from the Office of Human Research Subjects Protection, at (626) 256-HOPE (4673) ext. 62700.

This research is being overseen by WCG IRB. An IRB is a group of people who perform independent review of research studies. You may talk to them at 855-818-2289 or clientcare@wcgclinical.com if:

- You have questions, concerns, or complaints that are not being answered by the research team.
- You are not getting answers from the research team.
- You cannot reach the research team.
- You want to talk to someone else about the research.
- You have questions about your rights as a research subject.

## O. SIGNATURE SECTION

**SIGNATURE FOR CONSENT**: By signing this consent form, you are making a decision to participate in this research study. Your signature on this informed consent form indicates that you:

1. Have read and understood the information in this form.
2. Have had the information in this form explained to you.
3. Have had a chance to ask questions and these questions were answered to your satisfaction.
4. Have been informed that you will receive a copy of this signed consent form, which includes the "Experimental Subject's Bill of Rights."

I hereby agree to be a research participant in this research study:

_____ _____ _____
Research Participant's Signature Date Time
(For paper consent only, date and time must be in research participant's handwriting)

_____
Print Research Participant's Name

**INDIVIDUAL OBTAINING CONSENT SIGNATURE**

_____ _____ _____
Signature of Individual Obtaining Consent Date Time

_____
Print Name of Individual Obtaining Consent

**FOR USE WITH IRB APPROVED TRANSLATED SHORT/LONG CONSENT FORMS FOR NON ENGLISH SPEAKING PARTICIPANTS ONLY**

NOTE: To determine who should sign below, review the guidance document, *Consenting Non English Speaking Research Participants (Pediatric or Adult) – Who Signs What?*

**Interpreter**: By signing here, I attest that I have acted as interpreter and facilitated this consent process.

_____ _____ _____

Interpreter's Signature Date Time

_____

Print Interpreter's Name

**FOR USE WHEN A WITNESS IS REQUIRED:**

**Witness**: By signing here, I attest that I witnessed the consent process and that the entire consent form was discussed.

_____ _____ _____

Witness' Signature Date Time

_____

Print Witness' Name

**Phase 2 Trial of Leflunomide in African-American and European-American Patients with High-Risk Smoldering Multiple Myeloma**

## AUTHORIZATION TO USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI) FOR PURPOSES OF THIS STUDY:

**I.** **Purpose of this Authorization**: The information about your health is something that is protected by law and cannot, except for certain purposes, be disclosed (shared) without your permission. As part of this research, you are agreeing to allow City of Hope, its affiliated research doctors, healthcare providers, and physician network to use and share with others your protected health information ("PHI"), as needed for the research. If you agree to participate in the study named above (called the "Study"), you must sign this authorization in addition to the *Study Consent Form*.

**II.** **The Information About You that is Covered By this Authorization**: PHI refers to information that we maintain about you that identifies you and includes the information contained in your medical record. Your medical record consists of information related to your health and the treatment we provide to you, such as your medical history, the results of physical exams, blood tests, x-rays and other diagnostic and medical procedures. If you sign this authorization, you are allowing City of Hope and the individuals indicated below to use and share any PHI we maintain about you that is required for your participation in the Study.

**III.** **Purposes for Uses and Sharing of your PHI; Who Will Use, Share and Receive your PHI**: Your PHI will be used and shared with others for the purpose of doing this research as described in the *Study Consent Form*. Your PHI will also be used to keep the research sponsor informed about this Study, for reporting to those individuals and authorities responsible for overseeing our research activities to make sure that the activities are properly conducted, and to report to regulatory agencies as required by the Study.

The people authorized to use and share your PHI for purposes of the Study include the Principal Investigator and the research staff supporting the Study; your City of Hope physicians and the health care team; the Health Information Management Services Department (i.e., Medical Records Department), and affiliated research doctors and other medical centers participating in the research, if applicable. This also includes any agents or contractors used by these individuals or groups for purposes of conducting or managing this Study. At the City of Hope, the Institutional Review Board ("IRB"), and other City of Hope research regulatory committees will have access to your PHI as necessary to monitor research.

You are also allowing your PHI to be shared with the Office for Human Research Protections ("OHRP") and with any person or agency as required by law. In addition, certain other regulatory agencies, including, the Food and Drug Administration ("FDA"); the National Cancer Institute ("NCI") will have access to your PHI.

Use and disclosure of your PHI may also continue for as long as the sponsor needs to maintain the PHI for purposes of obtaining approval of the from the FDA or for other FDA reporting.

This authorization will allow us to use and share your PHI for the Study. No other additional uses and disclosures other than for the purposes of the Study is included in this authorization. City of Hope's Notice of Privacy Practices will continue to protect your non-Study information. If necessary, another separate permission will be obtained from you for any non-Study uses or sharing of your PHI.

**IV.** **Expiration of this Authorization**: This authorization to use and share your PHI will expire twenty-five (25) years from the date that you sign this authorization.

**V.** **Further Sharing of Your PHI**: Your privacy is important and this is the reason for having rules which control who can use or see your PHI. City of Hope maintains control over your PHI at present, but once we share this information with a third

party (for example, an individual or agency outside of the City of Hope), then it is no longer possible to maintain the same level of protection. The persons outside our control may not be governed by federal or state privacy laws and it is possible that they could share your PHI with others for whom you have not given permission.

The information from this Study may be published in scientific journals or presented at scientific meetings but your identity will be kept confidential.

**VI.** **Your Rights Under this Authorization**: You may cancel this permission to use and share your PHI at any time by contacting City of Hope's Privacy Officer at (626) 256-HOPE (4673) ext. 64025. You should ask for the form, *Revocation (Cancellation) of Authorization for Use of Protected Health Information for Research*. Fill this form out and return it as the form instructs. Your cancellation begins when the Health Information Management Department of City of Hope receives this form. If you cancel this authorization to use and share your PHI, you will no longer be able to participate in the Study. This is because the research under this Study cannot be conducted without your PHI.

Once you cancel your permission to use and share your PHI, the researchers and others involved in conducting the Study will no longer be able to use or share your PHI for this research. PHI already used and shared up to this point as part of this Study will continue to be used for purposes of this research. This means that any uses of your PHI and any PHI shared about you by City of Hope prior to receiving your cancellation (revocation) form cannot be taken back. While no further PHI about you will be shared for the Study, your PHI already shared will continue to be used in the overall Study.

**VII.** **<u>Signing this Authorization is Your Choice</u>:** Your ability to obtain care at the City of Hope will not be affected by your decision to sign this authorization form. You will be able to continue to receive health care at City of Hope if you choose not to sign this authorization form or if you sign this form and later cancel your permission to use and share your PHI.

If you agree to the use and sharing of your PHI, please sign below. You will be given a copy of this authorization form.

_____ _____ _____
Research Participant's Signature Date Time
(date and time must be in research participant's handwriting)

_____
Print Research Participant's Name

**INDIVIDUAL OBTAINING CONSENT SIGNATURE**

_____ _____ _____
Signature of Individual Obtaining Consent Date Time

_____
Print Name of Individual Obtaining Consent

**FOR USE WITH IRB APPROVED TRANSLATED SHORT/LONG CONSENT FORMS FOR NON ENGLISH SPEAKING PARTICIPANTS ONLY**

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Interpreter's Signature Date Time

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Print Interpreter's Name

**FOR USE WHEN A WITNESS IS REQUIRED:**

**Witness**: By signing here, I attest that I witnessed the consent process and that the entire consent form was discussed.

_____ _____ _____

Witness' Signature Date Time

_____

Print Witness' Name