The Ohio State University Combined Consent to Participate in Research and HIPAA Research Authorization

Study Title:	**Effect of Early Integrated Neuropsychological Care in Patients with Brain Metastases – A Phase 2 Randomized Controlled Trial**
Principal Investigators:	**Joshua Palmer MD, Haley Perlow MD**
Sponsor:	**Department of Radiation Oncology, Ohio State University**

- **This is a consent form for research participation.** It contains important information about this study and what to expect if you decide to participate. Please consider the information carefully. Feel free to discuss the study with your friends and family and to ask questions before making your decision whether or not to participate.
- **Your participation is voluntary.** You may refuse to participate in this study. If you decide to take part in the 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 usual benefits. Your decision will not affect your future relationship with The Ohio State University. If you are a student or employee at Ohio State, your decision will not affect your grades or employment status.
- **You may or may not benefit as a result of participating in this study.** Also, as explained below, your participation may result in unintended or harmful effects for you that may be minor or may be serious depending on the nature of the research.
- **You will be provided with any new information that develops during the study that may affect your decision whether or not to continue to participate.** If you decide to participate, you will be asked to sign this form and will receive a copy of the form. You are being asked to consider participating in this study for the reasons explained below.

Key Information About This Study

The following is a short summary to help you decide whether or not to be a part of this study. As a part of this study, you will receive radiation therapy for your brain metastases. This would be either be stereotactic radiation therapy (pinpoint radiation just to where your tumors are) or radiation to your entire brain. Using physician discretion, dexamethasone and memantine will be prescribed to you during this study. If you would like to receive a standard of care activity that is not specific to your assigned study group, you can choose to not be in the study.

More detailed information is listed later in this form.

A neuropsychologist is a psychologist who specializes in assessment and treatment of brain/behavior-related issues, including cognitive impairment. This is a study that assesses the impact of integrating a neuropsychologist onto your treatment team. We hope that will improve the quality of life of patients with metastatic cancer to the brain. This study will last for 12 months after you finish radiation therapy. You will complete additional assessments at the time of your radiation oncology appointments, and if randomized into the interventional arm, you will see a neuropsychologist three times, with each appointment lasting 1-2 hours. The most important risks or discomforts of this study include spending more time at the doctor's office than usual and also that you may be asked sensitive or private questions which you do not normally discuss. If you choose not to take part in this study, you will receive standard of care radiation therapy for your metastatic disease to the brain.

1. Why is this study being done?

You are being asked to take part in this research study because you have metastatic cancer to the brain. People who are not in a study are usually treated with radiation to part of the brain or the whole brain to control the cancer. Specialized radiation techniques are used to best preserve cognitive function. This study investigates whether early integrated neuropsychological care before, during, and after radiation therapy can better preserve quality of life and cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) for patients with brain metastases.

The purpose of this study is to compare any good and bad effects of integrating a neuropsychologist onto your treatment team prior to receiving radiation therapy, because both metastatic cancer and radiation can impact your quality of life, memory, and thinking. It also is possible that seeing a neuropsychologist could have no benefit. This study will allow the researchers to know whether this different approach is better, the same, or worse than the usual approach.

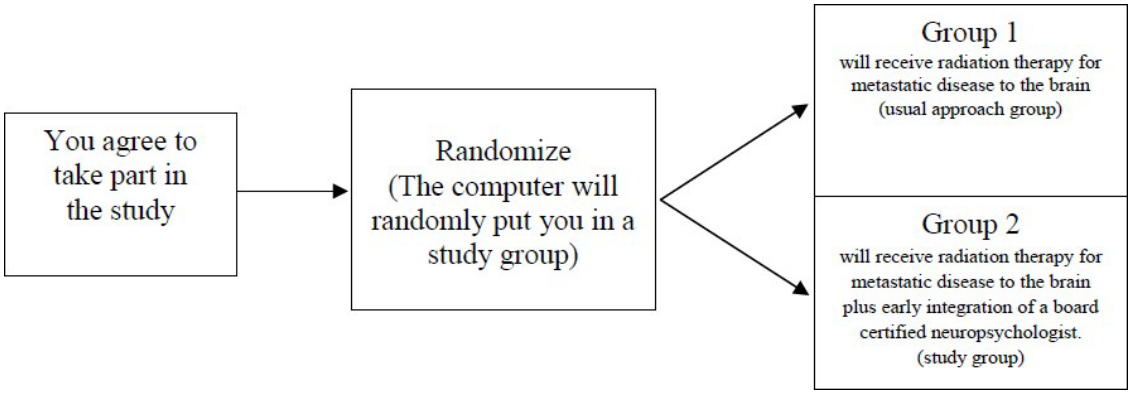
The first purpose of this study will test if integration of a neuropsychologist onto your treatment team better preserves your quality of life. The second portion of the study will test if integration of a neuropsychologist reduces side effects related to memory and thinking.

2. How many people will take part in this study?

There will be approximately 110 patients taking part in this study.

3. What will happen if I take part in this study?

There will be two groups in this study. A computer will by chance assign you to one of the groups. This is called randomization. This is done by chance because no one knows if one study group is better or worse than the other. You will have an equal chance at being placed in either study group.
Another way to understand the randomization process is to read the chart below. Start reading at the left side and read across to the right, following the lines and arrows.



Most of the exams, tests, and procedures you will have are part of the usual approach for your cancer. However, there are some extra assessments that you will need to have if you take part in this study including the Functional Assessment of Cancer Therapy-Brain (Fact-Br), European Organization for the Research and Treatment of Cancer Quality of Life Questionnaire (EORTC-QLQ-30), Patient Health Questionnaire-9 (PHQ-9), Hopkins Verbal Learning Test-Revised (HVLT-R), Trail Making Test A/B (TMTA/B), Controlled Oral Word Association Test (COWAT). Patient Health Questionnaire-9 (PHQ-9), General Anxiety Disorder-9 (GAD-7), and Patient-Reported Outcomes Measurement Information System-8 (PROMIS-8).

During the study:
• If you have 15 or fewer brain metastases, you will be eligible to receive stereotactic radiation therapy, which involves focused doses of radiation directed to your brain tumors.
• If you have more than 15 brain metastases, you will receive whole brain radiation therapy
• Your radiation doctor will describe the exact treatment you are receiving in further detail as part of routine care
• As a part of this study, you may be prescribed supportive medications including dexamethasone and memantine. Dexamethasone is a medication that can decrease swelling or inflammation in your brain, and memantine is a medication that can help you with your thinking and memory
• The doctor prescribing dexamethasone and memantine will review with you further details on how and when to take the medications as part of your routine care
• Multiple tests to see how the study is affecting your thinking abilities, such as memory, administered by a trained test administrator in the clinic that take about 1-1.5 hours to complete. They are completed at baseline prior to beginning radiation therapy and at 3, 6, 9, and 12 months from the start of radiation. These tests include the Fact-Br, EORTC-QLQ-30, PHQ-9, HVLT-R, TMTA/B, and COWAT. The Fact-Br is a written test that is used to assess cancer related quality of life issues. The EORTC-QLQ-30 is another written test that assesses the quality of life of cancer patients. The HVLT-R is an oral test that assesses your verbal learning and memory. The COWAT is an oral test that examines your ability to think and process information. The PROMIS-8 is a written test that assesses the functional ability of patients diagnosed with cancer.

• At these same intervals (prior to beginning radiation therapy and at 3, 6, 9, and 12 months from the start of radiation), you will be asked to fill out two forms with questions about how you are feeling physically and emotionally. These forms will take a total of 10 minutes to complete. The PHQ-9 is a written test that can screen for common mental disorders including depression. The GAD-7 is a patient questionnaire used to screening tool for anxiety. Researchers will use this information to learn more about how cancer and cancer treatment affects people. The forms will ask about things like fatigue, hopefulness, or cognitive functioning. You may feel uncomfortable answering some of the questions, and you can skip any you do not want to answer. • If randomized to Group 2, you will see a neuropsychologist prior to your radiation oncology treatment, 6 weeks after radiation treatment concludes, and 3 months after radiation treatment concludes. The initial visit and the 3 month follow up visit will be approximately 2.5 hours and include a 30 minute clinical interview, a 60-90 minute neuropsychological testing session (exact tests will be chosen by the neuropsychologist and may be different for each patient), and a 30-60 minute feedback session on evaluation results and recommendations. A six week touch base visit will be completed by video or on site (based on patient preference). At this touch base visit, the patient's progress in executing the recommendations will be reviewed, and additional strategies and/or referrals will be made to optimize the patient's daily functioning. This "touch-base appointment will take approximately 30-60 minutes.

4. How long will I be in the study?

The overall duration of this study is 12 months.

5. Can I stop being in the study?

You may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your future relationship with The Ohio State University.

6. What risks, side effects or discomforts can I expect from being in the study?

If you choose to take part in this study, there is a risk that:

- There may be a breach in database security but this is being safeguarded by security controls
- The study approach may not be better, and could possibly be worse, than the usual approach for your cancer.
- You may be asked sensitive or private questions which you normally do not discuss
- You may lose time at work or home and spend more time in the hospital or doctor's office than usual
- You might have side effects from the radiation including fatigue, hair loss, headaches, nausea, vomiting, radiation injury due to inflammation or swelling, or changes in your memory or thinking
- You might have side effects from the memantine which may include high blood pressure, weight gain, vomiting, inability to control your urination, or aggressive behavior.

- You might have side effects from dexamethasone including high blood sugar, weight gain, increased appetite, emotional changes, personality changes, impaired wound healing, or changes in your skin

7. What benefits can I expect from being in the study?

It is not possible to know at this time if the study approach (early integration of a neuropsychologist) is better than the usual approach (standard of care). This study may or may not help you. This study will help researchers learn things that will help people in the future.

8. What other choices do I have if I do not take part in the study?

You may choose not to participate without penalty or loss of benefits to which you are otherwise entitled.

9. What are the costs of taking part in this study?

You and/or your health plan/insurance company will need to pay for all of the costs of treating your cancer while in this study, including the cost of tests, procedures, or medicines to manage any side effects, unless you are told that certain tests are supplied at no charge. Before you decide to be in the study, you should check with your health plan or insurance company to find out exactly what they will pay for. These study interventions will be charged as standard of care and should be covered by insurance.

10. Will I be paid for taking part in this study?

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

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

If you suffer an injury from participating in this study, you should notify the researcher or study doctor immediately, who will determine if you should obtain medical treatment at The Ohio State University Wexner Medical Center.

The cost for this treatment will be billed to you or your medical or hospital insurance. The Ohio State University has no funds set aside for the payment of health care expenses for this study.

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

If you choose to participate in the study, you may discontinue participation at any time without penalty or loss of benefits. By signing this form, you do not give up any personal legal rights you may have as a participant in this study.

You will be provided with any new information that develops during the course of the research that may affect your decision whether or not to continue participation in the study.

You may refuse to participate in this study without penalty or loss of benefits to which you

are otherwise entitled.

An Institutional Review Board responsible for human subjects research at The Ohio State University reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of research participants.

13. Will my de-identified information be used or shared for future research?

Yes, it/they may be used or shared with other researchers without your additional informed consent.

14. Will my study-related information be kept confidential?

Efforts will be made to keep your study-related information confidential. However, there may be circumstances where this information must be released. For example, personal information regarding your participation in this study may be disclosed if required by state law. Confidentiality may also be broken if you express suicidal thoughts.

Also, your records may be reviewed by the following groups (as applicable to the research):

- Office for Human Research Protections or other federal, state, or international regulatory agencies;
- U.S. Food and Drug Administration;
- The Ohio State University Institutional Review Board or Office of Responsible Research Practices;
- The sponsor supporting the study, their agents or study monitors; and University Hospitals Seidman Cancer Center
- Your insurance company (if charges are billed to insurance).

15. HIPAA AUTHORIZATION TO USE AND DISCLOSE INFORMATION FOR RESEARCH PURPOSES

I. What information may be used and given to others?

- Past and present medical records;
- Research records;
- Records about phone calls made as part of this research;
- Records about your study visits;
- Information that includes personal identifiers, such as your name, or a number associated with you as an individual;
- Information gathered for this research about:
  HIV / AIDS
  Hepatitis infection
  Sexually transmitted diseases
  Other reportable infectious diseases
  Physical exams

Laboratory, x-ray, and other test results
Diaries and questionnaires
The diagnosis and treatment of a mental health condition

- Records about any study drug you received;

II. Who may use and give out information about you?

Researchers and study staff.

III. Who might get this information?

- The sponsor of this research. "Sponsor" means any persons or companies that are:
  - working for or with the sponsor; or
  - owned by the sponsor.
- Authorized Ohio State University staff not involved in the study may be aware that you are participating in a research study and have access to your information;
- If this study is related to your medical care, your study-related information may be placed in your permanent hospital, clinic, or physician's office record;
- Other: University Hospitals Seidman Cancer Center will participate in this study

IV. Your information <u>may</u> be given to:

- The U.S. Food and Drug Administration (FDA), Department of Health and Human Services (DHHS) agencies, and other federal and state entities;
- Governmental agencies in other countries;
- Governmental agencies to whom certain diseases (reportable diseases) must be reported; and
- The Ohio State University units involved in managing and approving the research study including the Office of Research and the Office of Responsible Research Practices.

V. Why will this information be used and/or given to others?

- To do the research;
- To study the results; and
- To make sure that the research was done right.

VI. When will my permission end?

There is no date at which your permission ends. Your information will be used indefinitely. This is because the information used and created during the study may be analyzed for many years, and it is not possible to know when this will be complete.

VII. May I withdraw or revoke (cancel) my permission?

Yes. Your authorization will be good for the time period indicated above unless you change your mind and revoke it in writing. You may withdraw or take away your permission to use and disclose your health information at any time. You do this by

sending written notice to the researchers. If you withdraw your permission, you will not be able to stay in this study. When you withdraw your permission, no new health information identifying you will be gathered after that date. Information that has already been gathered may still be used and given to others.

VIII. What if I decide not to give permission to use and give out my health information?

Then you will not be able to be in this research study and receive research-related treatment. However, if you are being treated as a patient here, you will still be able to receive care.

IX. Is my health information protected after it has been given to others?

There is a risk that your information will be given to others without your permission. Any information that is shared may no longer be protected by federal privacy rules.

X. May I review or copy my information?

Signing this authorization also means that you may not be able to see or copy your study-related information until the study is completed.

16. Who can answer my questions about the study?

For questions, concerns, or complaints about the study, or if you feel you have been harmed as a result of study participation, you may contact you should notify the researcher or study doctor (Dr. Joshua Palmer) at (614) 293-0871 who will determine if you should obtain medical treatment at The Ohio State University Wexner Medical Center.

For questions related to your privacy rights under HIPAA or related to this research authorization, please contact a HIPAA Privacy Officer at 614-293-6482

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact the Office of Responsible Research Practices at 1-800-678-6251.

If you are injured as a result of participating in this study or for questions about a study-related injury, you may contact you should notify the researcher or study doctor immediately (Dr. Joshua Palmer) at (614) 293-0871 who will determine if you should obtain medical treatment at The Ohio State University Wexner Medical Center.

Signing the consent form

I have read (or someone has read to me) this form and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study.

I am not giving up any legal rights by signing this form. I will be given a copy of this combined consent and HIPAA research authorization form**.**

Printed name of participant	**Signature of participant**
	AM/PM
	Date and time
Printed name of person authorized to consent for participant (when applicable)	**Signature of person authorized to consent for participant (when applicable)**
Relationship to the participant	**AM/PM**
	Date and time

Investigator/Research Staff

I have explained the research to the participant or his/her representative before requesting the signature(s) above. There are no blanks in this document. A copy of this form has been given to the participant or his/her representative.

Printed name of person obtaining consent	**Signature of person obtaining consent**
	AM/PM
	Date and time

Witness(es) - *May be left blank if not required by the IRB*

Printed name of witness	**Signature of witness**
	AM/PM
	Date and time
Printed name of witness	**Signature of witness**
	AM/PM