INFORMATION SHEET AND INFORMED CONSENT FORM

for observational study in an adult patient capable of personally giving consent

PRINCIPAL INVESTIGATOR: Dr. Luca Testa

UNIT: Hospital Cardiology, CCU (Coronary Care Unit) and Interventional Cardiology

TELEPHONE: [redacted]

INFORMATION SHEET

Dear Madam/Sir,

An observational study entitled "JenaValve Trilogy for patients with pure native aortic valve regurgitation: ARTEMIS data collection study" and distinguished by the code ARTEMIS is being conducted at this Institute for Hospitalization and Scientific Care (IRCCS), Policlinico San Donato.

This research is national, single-centre.

To carry out this research, we need the collaboration and availability of people who, like you, meet the scientific requirements suitable for the evaluation that will be performed. Before you decide whether or not to give consent to participate, however, please read these pages carefully, taking all the time necessary, and ask for clarification if you have not fully understood or need further details. Furthermore, if you wish, before deciding you can ask for the opinion of your family members or your trusted doctor.

WHAT IS THE OBJECTIVE OF THIS STUDY?

The observational study is a study intended to collect data from normal clinical practice without intervening to alter the patient's normal diagnostic-therapeutic path.

The general objective of this study is to observe and monitor the safety and effectiveness of the JenaValve Trilogy™ cardiac valve system for transcatheter aortic valve replacement (TAVR) in subjects with severe native aortic regurgitation (AR) who are candidates for TAVR.

The study will last a total of 36 months, of which approximately 24 months will be dedicated to patient enrollment. The expected duration of the study for a single enrolled patient will be 12 months. A total

number of 75 patients will be enrolled: 25 for the retrospective part of the study and 50 for the prospective part (in which we ask you to participate).

WHAT DOES PARTICIPATION IN THE STUDY INVOLVE?

If you agree to participate in this study, please consider that the diagnostic and laboratory evaluations, the transcatheter procedure, and the subsequent follow-up visits you will undergo represent the standard of care, regardless of your adherence to the study.

The study only involves the administration of questionnaires and rating scales, which are additional to normal clinical practice:

- Heart Failure Test (KCCQ)
- Frailty Assessment Test
- Modified Rankin Scale (mRS)

Furthermore, the study involves the collection of information relating to your clinical history, the transcatheter aortic valve replacement procedure you will undergo, and the data from the subsequent follow-up visits which will be performed at this hospital at 30 days and 12 months after the procedure.

Study Schedule

Diagnostic Assessments	**First Visit**	**Baseline**	**Procedure [Day 0]**	**Discharge**	**30-Day Follow-up Visit [-7/+21 days]**	**12-Month Follow-up Visit [+45 days]**
Signature of Informed Consent		x				
Demographic Data	x					
Clinical History	x					

Diagnostic Assessments	**First Visit**	**Baseline**	**Procedure [Day 0]**	**Discharge**	**30-Day Follow-up Visit [-7/+21 days]**	**12-Month Follow-up Visit [+45 days]**
Physical Examination	x			x	x	x
Surgical Risk Calculation (STS & EuroSCORE II)	x					
NYHA Classification	x				x	x
Frailty Assessment Test		x				
Pharmacological Therapy		x		x	x	x
Angiography Computed Tomography (chest-abdomen-pelvis) CT	x					
Modified Rankin Scale (mRS)		x		x	x	x
Electrocardiogram (ECG)	x		x	x	x	x
Transthoracic Echocardiogram (TTE)	x		x	x	x	x
Cardiac Angiography			x			

Diagnostic Assessments	**First Visit**	**Baseline**	**Procedure [Day 0]**	**Discharge**	**30-Day Follow-up Visit [-7/+21 days]**	**12-Month Follow-up Visit [+45 days]**
Heart Failure Test (KCCQ)		x			x	x
Complete Blood Count and Platelet Count	x					
Creatinine	x		x	x		
Prothrombin Time INR (in subjects on Warfarin therapy)		x			x	x
Cardiac Enzymes (Troponin/CK-MB)			x	x		
Adverse Events		x	x	x	x	x

HOW WILL THE STUDY RESULTS BE COMMUNICATED AND THE CONFIDENTIALITY OF THE COLLECTED INFORMATION BE MAINTAINED?

All your data will be coded and recorded in computerized format. You will be assigned a personal numerical or alphanumeric code that will not allow you to be identified outside of this research centre (pseudonymization[1]). Regarding the processing of personal data, you can refer to the information notice for expressing consent to the processing of personal data, which will be provided to you separately.

WHAT ARE THE RISKS RESULTING FROM PARTICIPATING IN THE STUDY?

As this is an observational study, participation does not involve performing investigations or treatments different from those provided in normal clinical practice. Therefore, there will be no supplementary risks for you in the study compared to those associated with undergoing common diagnostic investigations and/or laboratory tests. It should be noted that, since the study does not involve experimental risks for the individual, it does not include specific insurance coverage.

WHAT ARE THE BENEFITS YOU MIGHT RECEIVE FROM PARTICIPATING IN THE STUDY?

No direct benefits are expected for you from participating in this study, but your participation will allow us to acquire additional information about the condition you are affected by and the relative treatment, information that may also be useful for future patients.

WHAT HAPPENS IF YOU DECIDE NOT TO PARTICIPATE IN THE STUDY?

You are free not to participate in the study. In this case, you will still receive all the standard care provided for your condition, without any penalty, and the doctors will continue to follow you with the necessary and customary care and attention. You do not need to provide any explanation for your choice.

WHAT HAPPENS IF YOU DECIDE TO STOP PARTICIPATION

Participation in this research is completely voluntary, and you may withdraw from the study at any time without providing any explanation.

By signing this consent form, you explicitly agree that, should you decide to withdraw from the study, the medical data collected prior to withdrawal may still be processed, always in a pseudonymized form, along with other data collected within the scope of the study.

The sponsor may terminate the study early at any time by communicating the reasons to the Ethics Committee. In this case, the termination of the study will be communicated to you.

[1] Pseudonymization means the processing of personal data in such a way that the personal data can no longer be attributed to a specific data subject without the use of additional information, provided that such additional information is kept separately and is subject to technical and organizational measures to ensure that the personal data are not attributed to an identified or identifiable natural person (Article 4, point 5), of the GDPR (5).

WHAT INFORMATION WILL I RECEIVE ABOUT THE STUDY RESULTS?

If you request it, at the end of the study you will be informed of the data and results concerning you and, in general, the results of the study.

WHAT OTHER INFORMATION CAN I RECEIVE?

For further information and communications during the study, you may contact the following medical personnel: Dr. Luca Testa [redacted]

You have free access to the documentation related to the study (clinical-scientific, pharmaceutical-therapeutic) and to the evaluation expressed by the Ethics Committee, by requesting it from the Ethics Committee itself. The study protocol proposed to you was drafted in compliance with the European Union's Good Clinical Practice Guidelines and the current revision of the Declaration of Helsinki, and has been approved by the Ethics Committee of this facility. You may report any facts you deem appropriate to highlight regarding this research to the Ethics Committee of this facility (Comitato Etico Territoriale Lombardia 1 - Via Olgettina 60, 20132 Milano).

WHO ORGANIZES AND SPONSORS THIS STUDY?

The study is sponsored by IRCCS Policlinico San Donato.

INFORMED CONSENT DECLARATION

This declaration must be personally signed and dated by the patient and the physician who conducted the informed consent discussion **ONLY IF THE PATIENT HAS DECIDED TO PARTICIPATE IN THE STUDY.**

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I, the undersigned (name and surname)
…… declare

that I have received exhaustive explanations from Dr. (name and surname)

…… regarding the request to participate in the study in question, as reported in the attached information sheet, a copy of which was delivered to me with sufficient advance notice.

I also declare that I have been able to discuss these explanations, that I have asked all the questions I deemed necessary, and have received satisfactory answers, as well as having had the opportunity to seek information regarding the study details from a person of my trust.

I therefore freely agree to participate in the study, having understood the meaning of the request and having understood the risks and benefits involved. I am aware of my right to discontinue participation at any time.

Furthermore, I have been informed of my right to free access to the documentation related to the study (clinical-scientific, pharmaceutical-therapeutic) and to the evaluation expressed by the Ethics Committee.

I am also aware that, during the study, a representative of the Sponsor or its delegate (whether industrial or non-profit), the Ethics Committee, or national or international Regulatory Authorities may monitor the progress of the study and verify the accuracy of the data reported in my medical record/data collection form.

Date …… **Signature of the physician who informed the patient**

……

Date …… **Signature of the patient**

……

(N.B. If the patient is unable to read or personally sign, a witness independent of the Investigator and the Sponsor must be present during the entire informed consent discussion. The witness must personally sign and date the informed consent declaration after the form itself and any other written information have been read and explained to the subject and the subject has verbally expressed consent to participate in the study).

In this case:

I, the undersigned (name and surname)
…… attest that Dr. (name and surname)…….. has exhaustively explained the characteristics of the study in question to Mr./Ms. (name and surname)
……, as reported in the attached information sheet, and that he/she, having had the opportunity to ask all the questions deemed necessary, has freely agreed to participate in the study.

Date……... **Signature of the independent witness** ……..

Date……... **Signature of the physician who informed the patient**

……...