Washington University in St. Louis

INFORMED CONSENT DOCUMENT

Project Title: Safety, efficacy, and cost-effectiveness of a reduced Infliximab infusion protocol

Principal Investigator: Chien-Huan Chen

Research Team Contact: Suha Abushamma , 314-482-1947

This consent form describes the research study and helps you decide if you want to participate. It provides important information about what you will be asked to do during the study, about the risks and benefits of the study, and about your rights and responsibilities as a research participant.

- You should read and understand the information in this document including the procedures, risks and potential benefits.
- If you have questions about anything in this form, you should ask the research team for more information before you agree to participate.
- You may also wish to talk to your family or friends about your participation in this study.
- Do not agree to participate in this study unless the research team has answered your questions and you decide that you want to be part of this study.

WHAT IS THE PURPOSE OF THIS STUDY?

This is a research study. We invite you to participate in this research study because you are a patient receiving infliximab (Remicade) or biosimilar drug infusions at one of our infusion centers for inflammatory bowel disease. The purpose of this research study is to see if we can safely and effectively shorten the time it takes to complete your infusion. We are doing this by having some patients shorten their infusion time from the normal 2-hour infusion, to a faster 1 hour infusion.

Infliximab (Remicade) and biosimilar drugs are approved by the U.S. Food and Drug Administration to treat inflammatory bowel disease (e.g., Crohn's Disease, Ulcerative Colitis).

WHAT WILL HAPPEN DURING THIS STUDY?

If you agree to participate, you would be randomly (by chance, like rolling dice) assigned to one of two groups. The first group of patients will have their infusion time shortened from 2 hours to 1 hour. The second group of patients will have their infusion time unchanged and will continue to receive their infusions as they normally would over 2 hours. Patients are assigned to each of these groups through a random computer randomizer. You have an equally likely chance to be assigned to either of these 2 groups. Once you are assigned to one of the groups, you will continue to receive your infusions as prescribed by your Gastroenterologist at the rate you are assigned for as long as the accelerate protocol continues (6 months). At the completion of the study, your infusions will return to the normal 2 hour infusion time. The timing interval and dose of your infusion will not change unless changed by the prescribing physician.

All patients will receive standard monitoring during their infusion. We will monitor patients and record any infusion reactions that occur during or within 1 hour of your infusion. The purpose of our study is to compare the number of the infusion reactions in the shortened infusion group to the standard 2-hour group. We do not expect that there will be any increased incidence of infusion reactions based on the results of several preliminary studies done elsewhere.

Will you save my research information to use in future research studies?

- Identifiers may be removed from your private information and used for future research or shared with others. If this occurs, we will not ask you for additional consent.

HOW MANY PEOPLE WILL PARTICIPATE?

Approximately 300 people will take part in this study conducted by investigators at Washington University.

HOW LONG WILL I BE IN THIS STUDY?

If you agree to take part in this study, your involvement will last for as long as you are receiving your infliximab (Remicade) or biosimilar drug infusions.

WHAT ARE THE RISKS OF THIS STUDY?

You may experience one or more of the risks indicated below from being in this study. In addition to these, there may be other unknown risks, or risks that we did not anticipate, associated with being in this study.

Some risks described in this consent document, if severe, may cause death.

Infusion Reaction
The goal of our study is to assess the safety of using faster infusion times for infliximab (Remicade) or biosimilar drugs. There is a theoretical risk that increasing the rate of your infusion could increase the risk for having an infusion reaction. Infusion reactions can range from mild, such as itching, flushing, or chills, to severe reactions such as increased heart rate, shortness of breath, low blood pressure, or anaphylaxis (severe allergic reaction). Recent studies have compared faster infusion times to the normal 2-hour infusion, and these studies have shown that there is no increased risk for having an infusion reaction in the faster infusion times. We believe that the shortened infusion time will be safe without any increased risk of any infusion reactions.

For patients that do have an infusion reaction, there is an established protocol which involves stopping the infusion, increased monitoring, and possible medications depending on the type of reaction that you experience. If you are receiving the medication at the faster infusion time and have an infusion reaction that is moderate or severe, your infusion time will be changed back to the standard 2-hour infusion for the duration of the study.

Infliximab (Remicade) or biosimilar drug
This medication has been associated with side effects, including serious side effects with the potential to

cause death. As part of your standard of clinical care, your gastroenterologist will discuss the risks associated with this medication prior to enrollment into this study.

More Common Side Effects:
Mild: The most common side effects of infliximab (Remicade) or biosimilar drug are: upper respiratory infectsions (such as a sinus infections or sore throat), headache, cough, or pain in the abdomen (belly). Most of these side effects may go away within a few days or a couple of weeks. But if they become more severe or don't go away, talk with your doctor or pharmacist.

Serious Side Effects:
Serious side effects from Remicade aren't common, but they can occur. Call your doctor right away if you have serious side effects. Call 911 if your symptoms feel life threatening or if you think you're having a medical emergency.

Infusion reactions – either while receiving an infusion or a within a few hours after an infusion – can include symptoms of allergic reaction, such as rash/itching; flushed skin; swelling of the face, lips, tongue, or throat; difficulty breathing; dizziness; or a fast heart rate. If severe, the allergic reaction can cause death.

Infections. Serious infections such as tuberculosis or disseminated fungal infections have occurred in patients receiving infliximab or biosimilar drug

Malignancy. Use of infliximab or biosimilar drug has been associated with increased risk of lymphoma

New or worsening heart failure. Symptoms can include: shortness of breath, edema (swelling, typically in your ankles and feet), sudden weight gain

Heart attack. Symptoms can include: chest pain or discomfort, arm pain, shortness of breath, anxiety, lightheadedness or fainting, sweating, or nausea or vomiting

Abnormal heart rhythms. Symptoms can include: fast or slow heart rate, fluttering heart rate, pounding in the chest

Stroke. Symptoms can include: weakness on one side of the body confusion, trouble speaking or understanding others, trouble seeing in one or both of the eyes, trouble standing or walking, dizziness, severe headache

Liver problems. Symptoms can include: tiredness, fever, jaundice (yellowing of your skin and the white of your eyes), dark-colored urine, pain on the right side of your belly

Blood disorders, such as a low level of white blood cells. Symptoms can include: bruising or bleeding easily, pale skin, fever that lasts longer than 48 hours, frequent infections

Nervous system disorders, such as seizures or vision problems. Symptoms can include: numbness or tingling of body parts, weakness in your arms or legs, vision loss or changes in how you see color

New or worsening psoriasis (a condition in which itchy, red patches form on your skin). Symptoms include: scaly, red patches on skin, raised bumps on skin that are filled with pus.

Breach of Confidentiality
One risk of participating in this study is that confidential information about you may be accidentally disclosed. We will use our best efforts to keep the information about you secure. Please see the section in this consent form titled *"How will you keep my information confidential?"* for more information.

WHAT ARE THE BENEFITS OF THIS STUDY?

You may or may not benefit from being in this study.

However, we hope that, in the future, other people might benefit from this study because it would significantly reduce the inconvenience to patients who receive regular maintenance infusions if it can be shown that infusion rates can be safely increased for these patients.

WHAT OTHER TREATMENT OPTIONS ARE THERE?

Before you decide whether or not to be in this study, your doctor will discuss the other options that are available to you. Instead of being in this study, you could continue to receive the standard 2-hour infusion.

WILL IT COST ME ANYTHING TO BE IN THIS STUDY?

You will not have any costs for being in this research study.

You and/or your medical/hospital insurance provider will remain responsible for your regular medical care expenses.

WILL I BE PAID FOR PARTICIPATING?

You will not be paid for being in this research study.

WHO IS FUNDING THIS STUDY?

The University and the research team are not receiving payment from other agencies, organizations, or companies to conduct this research study.

WHAT IF I AM INJURED AS A RESULT OF THIS STUDY?

Washington University investigators and staff will try to reduce, control, and treat any complications from this research. If you feel you are injured because of the study, please contact the investigator at 314-482-1947 and/or the Human Research Protection Office at 1-(800)-438-0445.

Decisions about whether payment for medical treatment for injuries relating to your participation in research will be made by Washington University. If you need to seek medical care for a research-related injury, please notify the investigator as soon as possible.

HOW WILL YOU KEEP MY INFORMATION CONFIDENTIAL?

Other people such as those indicated below may become aware of your participation in this study and may inspect and copy records pertaining to this research. Some of these records could contain information that personally identifies you. We will keep your participation in this research study confidential to the extent permitted by law.

- Government representatives (including the Office for Human Research Protections) to complete federal or state responsibilities
- The U.S. Food and Drug Administration
- Hospital or University representatives to complete Hospital or University responsibilities
- Information about your participation in this study may be documented in your health care records and will be available to anyone with access to your health care record, including your health insurance company. This information may also be released as part of a release of information request.
- The last four digits of your social security number may be used in hospital or University systems to track billing information for research procedures.
- Washington University's Institutional Review Board (a committee that oversees the conduct of research involving human participants) and the Human Research Protection Office. The Institutional Review Board has reviewed and approved this study.
- Any report or article that we write will not include information that can directly identify you. The journals that publish these reports or articles require that we share your information that was collected for this study with others to make sure the results of this study are correct and help develop new ideas for research. Your information will be shared in a way that cannot directly identify you.

To help protect your confidentiality, we will store all hard copies in a safe locked cabinet which can only be accessed by team members of the research study. To maintain patient confidentiality, the computer which will be utilized for data analysis is password protected and in a locked facility. Password encrypted files will be used for transfer of information. Each patient will be identified with a unique patient number (UPN) for this study. Patients will also be identified by first, middle, and last initials. If the patient has no middle initial, a dash will be used.

Are there additional protections for my health information?

Protected Health Information (PHI) is health information that identifies you. PHI is protected by federal law under HIPAA (the Health Insurance Portability and Accountability Act). To take part in this research, you must give the research team permission to use and disclose (share) your PHI for the study as explained in this consent form. The research team will follow state and federal laws and may share your health information with the agencies and people listed under the previous section titled, "How will you keep my information confidential?"

Once your health information is shared with someone outside of the research team, it may no longer be protected by HIPAA.

The research team will only use and share your information as talked about in this form or as permitted or required by law. When possible, the research team will make sure information cannot be linked to you (de-identified). Once information is de-identified, it may be used and shared for other purposes not discussed in this consent form. If you have questions or concerns about your privacy and the use of your PHI, please contact the University's Privacy Officer at 866-747-4975.

Although you will not be allowed to see the study information, you may be given access to your health care records by contacting your health care provider.

If you decide not to sign this form, it will not affect

- Your treatment or the care given by your health provider.
- Your insurance payment or enrollment in any health plans.
- Any benefits to which you are entitled.

However, it will not be possible for you to take part in the study.

If you sign this form:

- You authorize the use of your PHI for this research.
- This authorization does not expire.
- You may later change your mind and not let the research team use or share your information (you may revoke your authorization).
    - To revoke your authorization, complete the withdrawal letter, found in the Participant section of the Human Research Protection Office website at https://hrpo.wustl.edu/participants/withdrawing-from-a-study/ or you may request that the investigator send you a copy of the letter.
        - **If you revoke your authorization:**
            - The research team may only use and share information already collected for the study.
            - Your information may still be used and shared as necessary to maintain the integrity of the research, for example, to account for a participant's withdrawal from the research study or for safety reasons.
            - You will not be allowed to continue to participate in the study.

IS BEING IN THIS STUDY VOLUNTARY?

Taking part in this research study is completely voluntary. You may choose not to take part at all. If you decide to be in this study, you may stop participating at any time. Any data that was collected as part of your participation in the study will remain as part of the study records and cannot be removed.

If you decide not to be in this study, or if you stop participating at any time, you won't be penalized or lose any benefits for which you otherwise qualify.

What if I decide to withdraw from the study?

You may withdraw by telling the study team you are no longer interested in participating in the study or you may send in a withdrawal letter. A sample withdrawal letter can be found at https://hrpo.wustl.edu/participants/withdrawing-from-a-study/ under Withdrawing from a Research Study.

Will I receive new information about the study while participating?

If we obtain any new information during this study that might affect your willingness to continue participating in the study, we'll promptly provide you with that information.

Can someone else end my participation in this study?

Under certain circumstances, the investigator might decide to end your participation in this research study earlier than planned. This might happen for no reason or because in our judgement it would not be safe to continue infusion reactions at an accelerated rate because it is unsafe, or if your condition worsens necessitating changing of medication

WHAT IF I HAVE QUESTIONS?

We encourage you to ask questions. If you have any questions about the research study itself, please contact: Suha Abushamma, 314-482-1947. If you experience a research-related injury, please contact: Suha Abushamma, 314-482-1947.

If you have questions, concerns, or complaints about your rights as a research participant, please contact the Human Research Protection Office 1-(800)-438-0445, or email hrpo@wustl.edu. General information about being a research participant can be found on the Human Research Protection Office web site, http://hrpo.wustl.edu. To offer input about your experiences as a research participant or to speak to someone other than the research staff, call the Human Research Protection Office at the number above.

This consent form is not a contract. It is a written explanation of what will happen during the study if you decide to participate. You are not waiving any legal rights by agreeing to participate in this study. As a participant you have rights and responsibilities as described in this document and including:

- To be given enough time before signing below to weigh the risks and potential benefits and decide if you want to participate without any pressure from the research team or others.
- To understand all of the information included in the document, have your questions answered, and receive an explanation of anything you do not understand.
- To follow the procedures described in this document and the instructions of the research team to the best of your ability unless you choose to stop your participation in the research study.
- To give the research team accurate and complete information.
- To tell the research team promptly about any problems you have related to your participation, or if you are unable to continue and wish to stop participating in the research study.

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a signed and dated copy of this form.

Do not sign this form if today's date is after EXPIRATION DATE: 06/30/23.

_____ _____
(Signature of Participant) (Date)

_____
(Participant's name – printed)

Statement of Person Who Obtained Consent

The information in this document has been discussed with the participant or, where appropriate, with the participant's legally authorized representative. The participant has indicated that they understand the risks, benefits, and procedures involved with participation in this research study.

_____ _____
(Signature of Person who Obtained Consent) (Date)

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(Name of Person who Obtained Consent - printed)