NCT05482867

Exploratory Open-Label Study for the Development of a Method to Detect Dendritic Cell Recruitment in Alzheimer's Disease (DC RAD)

INFORMED CONSENT FORM
AND
AUTHORIZATION TO USE AND DISCLOSED PROTECTED HEALTH INFORMATION

Sponsor / Study Title:	**MindImmune Therapeutics, Inc. / "Exploratory Open-Label Study for the Development of a Method to Detect Dendritic Cell Recruitment in Alzheimer's Disease (DCRAD)"**
Protocol Number:	**ICG-001**
Principal Investigator: (Study Doctor)	**Haig Armen Goenjian, MD**
Telephone:	**1-866-787-4257** **1-714-910-9247 (24-Hour)**
Address:	**Collaborative Neuroscience Research, LLC.** **3771 Katella Ave, Suite 200 and 300** **Los Alamitos, CA 90720**

This form is for use in a research study that may involve subjects who may or may not have the capacity to consent to take part in the study. When the subject cannot legally consent to take part, pronouns "you" and "your" should be read as referring to the subject rather than the person (legally authorized representative) who is signing this form for the subject. In cases where the subject's representative gives consent, the subject should be informed about the study to the extent possible given his/her understanding. During the course of the study, if the subject regains the capacity to consent, informed consent will be obtained from the subject and the subject offered the ability to leave the study if desired.

KEY INFORMATION
You are invited to take part in a research study. This research study is a non-interventional, pilot study (meaning there will be no investigational drug taken). The purpose of the study is to determine if immune cells in the blood can be labeled with a dye such that those cells can be tracked into the brain. The dye that will be used is already approved for use by the Food and Drug Administration (FDA). In this study, the dye will be administered in a novel way, by intravenous infusion.

The study is being conducted by MindImmune Therapeutics, Inc. (MindImmune). Your study doctor is being paid by MindImmune to conduct this study.

Please read this form carefully. Take your time to ask the study doctor or study staff as many questions about the study as you would like. The study doctor or study staff can explain words or information that you do not understand. Reading this form and talking to the study doctor or

study staff may help you decide whether to take part or not. If you decide to take part in this study, you must sign your name at the end of this form and date it.

BACKGROUND AND PURPOSE

You are being asked to participate in this research study because either you are a healthy adult subject ages 21-55, a healthy elderly subject ages 65-90, or have been told by your doctor that you are likely to have Alzheimer's Disease and are between the ages of 50-90.

The purpose of this research study is to:

- Determine if certain cells in your blood can be "labeled or marked" with dye and then be detected 48 hours later in your brain
- Determine the amount of dye in the brain of healthy elderly subjects compared to that in subjects likely to have Alzheimer's disease
- To test the safety of the novel method of administering the dye in normal healthy adults, normal healthy elderly adults, and adults with Alzheimer's disease

NUMBER OF SUBJECTS

Approximately 51 subjects will participate in this study. This is a 4-part study.

Part 1 – 5 Healthy adult subjects – dye infusion at 1 mg/min over 2 hours
Part 2 – 10 Healthy adult subjects – dye infusion at 2 mg/min over 2 hours
Part 3 – 15 Healthy elderly adult subjects – dye infusion at 2 mg/min over 2 hours
Part 2a – 3 Healthy adult subjects – dye infusion at 2 mg/min over 2 hours
Part 3a – 3 Healthy elderly adult subjects – dye infusion at 2 mg/min over 2 hours
Part 4 – 15 Alzheimer's subjects – dye infusion at 2 mg/min over 2 hours

WHAT WILL HAPPEN DURING THE STUDY

If you are eligible for this study, your participation in this study may last up to 38 days and will include approximately 3 study visits to the study center.

<u>Screening Visit (In office visit 1)</u>:

Before any study-related tests and procedures are performed, you will be asked to read, sign and date this consent document. The following tests and procedures will be performed to determine if you qualify to take part in this study:

- Collection of your demographic information.
- Review of your medical and psychiatric history.
- You will be asked about what medications you are currently taking.
- Your study doctor will ask you questions about suicidality (for example, thoughts of harming yourself).
    - If you are having suicidal thoughts, call the study doctor at the telephone number listed on the first page of this form. If you feel in crisis, you can call 911 and/or a Nationwide Suicide Hotline that is answered 24 hours a day with a

skilled, trained counselor. One example is the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

- Your heart function will be assessed with an electrocardiogram (ECG - a test that measures and records the electrical activity of your heart).
- A physical examination will be performed, including measurement of your vital signs (blood pressure, heart rate, and blood oxygen level), weight and height.
- You will have blood and urine samples collected for testing. You will be tested for HIV. The study doctor may be required by law to report the result of this test to local public health authorities.
- An alcohol breathalyzer test to ensure you are not under the influence of alcohol.
- You will be asked how you are feeling.
- If you are aged 65-90, additional cognitive testing will be performed. This test is a Mini Mental State Exam (MMSE).
- If you are an Alzheimer's subject or a healthy elderly adult subject, additional cognitive testing will be performed. This test is the Mini Mental State Exam (MMSE).
- If you are an Alzheimer's subject, additional cognitive testing will be performed. This test is the Modified Hachinski Ischemia Scale (MHIS).

<u>Dosing and Measurements Visit (In office visit 2)</u>

The following tests and procedures will be performed:

- Review of any changes in your health and medications since your last visit.
- Review all medications you are taking.
- Measurement of your vital signs (blood pressure, heart rate) will be taken multiple times over a course of 4.5 hours. Your oxygen level will be collected prior to the start of infusion only.
- You will have urine samples collected for testing after dosing.
- Your heart function will be assessed twice with an electrocardiogram (ECG - a test that measures and records the electrical activity of your heart).
- You will be asked how you are feeling.
- The study doctor and study staff will insert a catheter into your arm and infuse the dye into your veins over 2 hours.
- Imaging sensors will be placed on your forehead which will be used to measure the concentration of oxygen in your blood along with capturing brain function. This is called Near Infrared Spectroscopy (NIRS), and it will be recording around 4.5 hours.
- Blood samples will be drawn 30 minutes prior to dosing and at 60, 120, 150, and 240 minutes after dosing.

<u>48 hours later and prior to discharge from site (In office visit 3, about 1.5 hours)</u>

The following tests and procedures will be performed:

- Review of any changes in your health and medications since your last visit.
- Review all medications you are taking.
- Your study doctor will ask you questions about suicidality (for example, thoughts of harming yourself).

- You will have blood and urine samples collected for testing.
- The final 30 minutes of NIRS recording will be captured.
- Your vital signs (blood pressure, heart rate, and blood oxygen level) will be taken.
- You will be discharged once confirmed it is safe for you to leave.

About 1 week later, Follow-up Visit (Phone call, about 15 minutes):
You will receive a phone call about 7 days after being discharged from the dosing and measurement visit:

- You will also be asked about any medications that you have taken since your last study visit.
- You will be asked how you are feeling.

If you qualify to take part in this study, then the following will happen:

EXPECTATIONS
If you participate in this study, you will be expected to:

- Attend each scheduled visit and follow instructions from the study staff.
- Tell the study doctor about any change in your health and medications (including over-the-counter medications).

RISKS, SIDE EFFECTS, AND/OR DISCOMFORTS
Risks of side effects
Participation in a clinical research study involves the risk that side effects could occur. Indocyanine (IC)-Green (ICG dye) most common adverse events are:

Allergic reaction risks:
With any infusion, there is a risk of allergic reactions that can be life-threatening or fatal (cause death). These reactions usually start shortly after the infusion.

Some symptoms of allergic reactions are:

- Skin itching, redness, rash
- Wheezing and difficulty breathing
- Dizziness and fainting
- Swelling around the mouth, throat or eyes
- A fast pulse
- Sweating

If you have an allergic reaction, you will get emergency medical care immediately.

RISKS OF STUDY PROCEDURES
You may feel discomfort during some of the tests and there are some risks, such as:

- Blood samples: Possible side effects from blood drawing include lightheadedness or dizziness, inflammation of the vein, pain, bruising, swelling or bleeding at the site of puncture. There is also a slight possibility of infection.

- Electrocardiogram (ECG): Skin irritation is rare but could occur during an ECG from the electrodes or gel that is used.
- Questionnaire: The questionnaire used in this study may be upsetting. You do not need to answer any questions that you are not comfortable with. If you decide not to complete the questionnaire, you may not be eligible to continue participation in this study.

  If you are having suicidal thoughts call the study doctor at the telephone number listed on the first page of this form. If you feel in crisis, you can call 911 and/or a Nationwide Suicide Hotline that is answered 24 hours a day with a skilled, trained counselor. One example is the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).
- ICG Dye Infusion: Possible side effects from the ICG infusion include cough, difficulty with swallowing, dizziness, fast heartbeat, hives, itching, skin rash, puffiness or swelling of the eyelids or around the eyes, face, lips, or tongue, redness of the skin, tightness in the chest, and unusual tiredness or weakness.

UNFORESEEN RISKS

There may be unforeseen risks to participating in this study, including fetal human risk if you become pregnant during the study.

BIRTH CONTROL REQUIREMENTS

Taking the dye may involve risks to a pregnant woman, an embryo, fetus (unborn baby) or nursing infant. Therefore, if you are pregnant, planning to become pregnant, or are breastfeeding a child, you cannot participate in this study. If you are pre-menopausal, you must practice two methods of birth control for 3 months prior to the study and for 1 week after.

Except abstinence, no one method of contraception is 100% effective. If you think you may have become pregnant even though you used correct contraception while in the study, you should contact the study doctor or the study staff immediately (see telephone number at the first page of this form).

Females:

If you are abstinent, the study doctor will require you to use acceptable methods of birth control if you become sexually active during the course of the study. To reduce the risk of pregnancy, you must use two effective methods of birth control while you are participating in this study (and for 1 week after the last dose of the dye). If you are already using birth control, the study doctor or study staff will discuss with you whether your current methods are acceptable for use during this study.

- Surgical sterility (hysterectomy or bilateral ligation) or post-menopausal (cessation of menses for at least 12 months prior to screening)
- Sexual partner is sterile, or of the same sex
- Implants of levonorgestrel in females
- Oral contraceptive (combined, patch, vaginal ring, injectable, implant) in females

- Double-barrier method (any combination of physical and chemical methods)
- Intrauterine device with a failure rate less than 1% per year

ALTERNATIVES TO PARTICIPATION
This research study is for research purposes only. The only alternative is to not participate in this study.

NEW FINDINGS
Any new important information that is discovered during the study and which may influence your willingness to continue participating in the study will be provided to you.

BENEFITS
This study is for research purposes only. There is no direct benefit to you from your participation in the study. Information learned from the study may inform the study staff on future research.

COMPENSATION FOR PARTICIPATION
You will be reimbursed up to a total of $1,850.00 of all study visits are completed. You will be reimbursed for each completed visit according to the following schedule:

- Screening: $250.00
- Study Treatment Day 0: $450.00
- Study Treatment Day 1 (as applicable): $350.00
- Study Treatment Day 2: $350.00
- Follow Up Phone Call: $75.00
- Completion Bonus : $375.00

If you provide your own transportation to and from study visits, you may be eligible for reimbursement. Reimbursement will be dependent upon approval and will require verification of the amounts being requested. (e.g. receipts from transportation service, address verification for mileage requests, etc).

Payment received as a research participant may be considered taxable income. If payment is $600.00 or more in a calendar year, the study investigator or clinic will have to report this to the Internal Revenue Service (IRS). Personal information about you, including your name, address, social security number (SSN) or Individual Taxpayer Identification Number (TIN) may be released for the purpose of payment and for tax reporting to the Internal Revenue Service (IRS). The facility will issue you an IRS form 1099-MISC, Miscellaneous Income, listing your payment as reportable income. Without a social security number or Individual Taxpayer Identification Number (TIN), you may be subject to withholding of 24% percent of your stipend at the time of payment under Internal Revenue Code Section 1441.

If you do not complete the study, you will only be compensated for the visits that you have completed. You will be reimbursed at least quarterly with final payment within 30 days of the end of your participation in the study.

If you test positive for disallowed drugs during the screening process, you will not be paid for that study visit and will not be eligible to participate in the study. If you are discovered participating in another study at any other site, you will be terminated from this study and will not be paid for the current study visit.

If you have any questions regarding your compensation for participation, please contact the study staff.

CONFIDENTIALITY

Records of your participation in this study will be held confidential except when sharing the information is required by law or as described in this informed consent. The study doctor, the sponsor or persons working on behalf of the sponsor, and under certain circumstances, the United States Food and Drug Administration (FDA) and the Institutional Review Board (IRB) will be able to inspect and copy confidential study-related records which identify you by name. This means that absolute confidentiality cannot be guaranteed. If the results of this study are published or presented at meetings, you will not be identified.

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.

COMPENSATION FOR INJURY

If you become ill or are injured while you are in the study, get the medical care that you need right away. You should inform the healthcare professional treating you that you are participating in this study. If you tell the study staff that you think you have been injured, then they will help you get the care you need.

If you are injured from procedures done for the purpose of this study, the sponsor will pay for those medical expenses necessary to treat your injury that are not covered by your medical insurance or any other third-party coverage. You will not lose any of your legal rights or release the sponsor, the study doctor, the study staff, or study site from liability for mistakes by signing this consent document.

To pay medical expenses, the sponsor will need to know some information about you like your name, date of birth, and Medicare Beneficiary Identifier (MBI). This is because the sponsor has to check to see if you receive Medicare and if you do, report the payment it makes to Medicare.

COSTS

There will be no charge to you for your participation in this study. The study-related procedures, and study visits will be provided at no charge to you or your insurance company.

WHOM TO CONTACT ABOUT THIS STUDY

During the study, if you experience any medical problems, suffer a research-related injury, or have questions, concerns or complaints about the study such as:

- Whom to contact in the case of a research-related injury or illness;
- Payment or compensation for being in the study, if any;
- Your responsibilities as a research subject;
- Eligibility to participate in the study;
- The study doctor's or study site's decision to exclude you from participation;
- Results of tests and/or procedures;

Please contact the study doctor at the telephone number listed on the first page of this consent document.

If you seek emergency care, or hospitalization is required, alert the treating physician that you are participating in this research study.

An institutional review board (IRB) is an independent committee established to help protect the rights of research subjects. If you have any questions about your rights as a research subject, contact**:**

- By mail:
  Study Subject Adviser
  Advarra IRB
  6100 Merriweather Dr., Suite 600
  Columbia, MD 21044
- or call **toll free**: 877-992-4724
- or by **email**: adviser@advarra.com

Please reference the following number when contacting the Study Subject Adviser: Pro00065041.

VOLUNTARY PARTICIPATION / WITHDRAWAL

Your decision to participate in this study is voluntary. You may choose to not participate, or you may withdraw from the study at any time for any reason without penalty or loss of benefits to which you are otherwise entitled and without any effect on your future medical care. The FDA requires that any information collected up to the point of your withdrawal cannot be removed from the study.

The study doctor or the sponsor can stop your participation at any time without your agreement for the following reasons:

- If it appears to be medically harmful to you;
- If you fail to follow directions for participating in the study;
- If it is discovered that you do not meet the study requirements;
- If the study is canceled; or
- For administrative reasons, including competitive enrollment - the target number of subjects has entered the study.

If you leave the study for any reason, the study doctor may ask you to have some end-of-study tests for your safety.

PRIMARY HEALTH CARE PROVIDER NOTIFICATION OPTION

I consent to having my family doctor or primary health care provider notified by the study site of my participation in this study and/or any significant findings related to my health (please check yes or no).

❒ Yes (If yes, please complete the information below)
❒ No, I do not want the study doctor to inform my primary care physician/ specialist of my participation in this study.
❒ I do not have a primary care physician/ specialist
❒ The study doctor is my primary care physician/ specialist

Name and address of family doctor or primary health care provider:	Name:
	Address:
Telephone and Fax Number:	Tel:
	Fax:

CONSENT

I have read and understand the information in this informed consent document. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction. I voluntarily agree to participate in this study until I decide otherwise. I do not give up any of my legal rights by signing this consent document. I will receive a copy of this signed and dated consent document.

_____

Subject's Printed Name

_____ _____

Subject's Signature Date

_____

Printed Name of Legally Authorized Representative

_____ _____

Signature of Legally Authorized Representative Date

_____

Printed Name of the Person Conducting the Consent Discussion

_____ _____

Signature of the Person Conducting the Consent Discussion Date

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

If you decide to be in this study, the study doctor and study staff will use and share health data about you to conduct the study. Health data may include:

- Your name.
- Address.
- Phone number.
- Date of birth.
- Medical history.
- Information from your study visits, including all test results.

Health data may come from your study records or from existing records kept by your doctor or other health care workers.

For this study, the study staff may share health data about you with authorized users. Authorized users may include:

- Representatives of MindImmune Therapeutics, Inc.
- Representatives of Cognitive Research Corporation (the company contracted by MindImmune to run the study)
- Representatives of Advarra IRB (an Institutional Review Board that reviews this study).
- The Food and Drug Administration (FDA) and other US federal and state agencies.
- Government agencies to whom certain infectious diseases (like HIV, hepatitis, and STDs) must be reported.
- Governmental agencies of other countries.
- Outside individuals and companies, such as laboratories and data storage companies, that work with the researchers and sponsor and need to access your information to conduct this study.
- Other research doctors and medical centers participating in this research, if applicable.
- A data safety monitoring board which oversees this research, if applicable.

Your health data will be used to conduct and oversee the study, including for instance:

- To see if the ICG dye works for the purpose of the study.

Once your health data has been shared with authorized users, it may no longer be protected by federal privacy law and could possibly be used or disclosed in ways other than those listed here.

Your permission to use and share health data about you will end in 50 years unless you revoke it (take it back) sooner.

You may take back your permission to use and share health data about you at any time by writing to the study doctor at the address listed on the first page of this form. If you do this, you will not be able to stay in this study. No new health data that identifies you will be gathered after your written request is received. However, health data about you that has already been gathered may still be used and given to others as described in this form.

Your right to access your health data in the study records will be suspended during the study to keep from changing the study results. When the study is over, you can access your study health data.

If you decide not to sign this form, you will not be able to take part in the study.

STATEMENT OF AUTHORIZATION

I have read this form and its contents were explained to me. My questions have been answered. I voluntarily agree to allow study staff to collect, use and share my health data as specified in this form. I will receive a signed and dated copy of this form for my records. I am not giving up any of my legal rights by signing this form.

_____

Printed Name of Subject

_____ _____

Signature of Subject Date

_____

Printed Name of Legally Authorized Representative

_____ _____

Signature of Legally Authorized Representative Date