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

ADULT INFORMED CONSENT

COH Protocol #19065
TITLE: A PHASE II RANDOMIZED, PLACEBO-CONTROLLED, MULTICENTER TRIAL TO EVALUATE THE PROTECTIVE FUNCTION OF CMV-MVA TRIPLEX VACCINE IN ADULT RECIPIENTS OF HAPLOIDENTICAL HEMATOPOIETIC STEM CELL TRANSPLANT

Protocol Version date: 08/23/19

PRINCIPAL INVESTIGATOR: Ryotaro Nakamura, M.D.

24-HOUR TELEPHONE NUMBER:
DAY TIME TELEPHONE NUMBER FROM THE HOURS OF 8:00 AM TO 5:00 PM: (626) 256-4673, ext 65285

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.

ADULT INFORMED CONSENT

COH Protocol #19065

TITLE: A PHASE II RANDOMIZED, PLACEBO-CONTROLLED, MULTICENTER TRIAL TO EVALUATE THE PROTECTIVE FUNCTION OF CMV-MVA TRIPLEX VACCINE IN ADULT RECIPIENTS OF HAPLOIDENTICAL HEMATOPOIETIC STEM CELL TRANSPLANT

Protocol Version date: 08/23/2019

PRINCIPAL INVESTIGATOR: Ryotaro Nakamura, M.D.

KEY INFORMATION

You are invited to participate in a research study. The purpose of this research study is to evaluate the efficacy of CMV MVA Triplex vaccine in conjunction with letermovir (also known as Prevymis) prophylaxis. The information we learn by doing this research study may help HCT patients in decreasing their chance of CMV reactivation and subsequent hospitalization.

Participants in this study will be vaccinated with Triplex vaccine after the end of letermovir prophylaxis and then followed for CMV reactivation. Participation is expected to last up to 365 days.

The major risks associated with study include skin erythema, lymphocyte count decrease, white blood cell decrease, platelet count decrease, neutrophil count decrease, alkaline aminotransferase increase, and anemia. More details are provided in the Risks section.

You do not have to join this research study. You can choose not to participate in this study. If you are interested in learning more about this study, please continue to read below.

INTRODUCTION

You are invited to take part in a clinical trial, a type of research study, because you are planning to undergo hematopoietic cell transplant (HCT) and you have previously been infected with human cytomegalovirus (CMV). We hope to learn whether an experimental CMV vaccine is safe and helps people resist CMV life-threatening complications.

This research study is sponsored by City of Hope, who made the vaccine being tested. City of Hope has secured grant funding to cover the costs of conducting this study.

It is expected that about 128 people will take part in this research study.

City of Hope has a financial interest in the CMV-MVA Triplex vaccine. The City of Hope Conflict of Interest and Commitment Committee and IRB have reviewed City of Hope's financial interest in CMV-

MVA Triplex and found that this is very unlikely to affect how you will be treated or how the study results will be determined. If you have questions about this, please ask the Principal Investigator or contact the IRB at (626) 256-4673 ext. 62700. You may also contact the City of Hope Conflict of Interest Manager at (626) 256-HOPE (4673), extension 62084.

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, 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 is the first time that CMV-MVA Triplex will be given to people undergoing your type of HCT (haploidentical, involving a half-matched stem cell transplant from a family member).

This 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 CMV-MVA Triplex as a treatment for any disease.

The name of the investigational agent involved in this study is CMV-MVA Triplex Vaccine

CMV is a virus that may be carried in an inactive state for life and does not cause any illness in most healthy individuals. However, in people whose immune systems are lowered (such as those undergoing HCT), CMV can reproduce and cause disease and even death.

The CMV vaccine tested in this clinical study is called CMV-MVA Triplex ('Triplex'). Investigators have discovered that by placing 3 small pieces of CMV DNA (the chemical form of genes) into a very safe, weakened virus, the vaccine can induce immunity (the ability to recognize and respond to an infection) to CMV in animals. The viral vaccine used for this purpose is called "modified vaccinia Ankara" (MVA). The MVA virus cannot grow in humans and has a long record of safe use in people, including infants and patients with weakened immune system (such as patients with HIV and post HCT). Triplex was first tested in 24 healthy adults and found to be well tolerated at the dose levels tested in the study, and to boosted immunity to CMV, but it has not yet been approved by the Food and Drug Administration (FDA). Triplex has also been tested in patients undergoing allogeneic HCT (alloHCT) and demonstrated protective function of the vaccine against CMV infection compared to placebo.

The clinical trial we offer you to participate in includes the latest standard of care update that calls for the use of new FDA approved drug letermovir as a prophylactic measure to decrease the risk of CMV reactivation. This drug was shown to offer improved protection against CMV reactivation during the first 100 days post-HCT, however this effect reduces after completion of letermovir administration. For this reason, we are testing the possible combined effect of letermovir prophylaxis and improved CMV immunity due to vaccine administration. We expect that the sequential use of letermovir and vaccine may decrease the risk of CMV reactivation and related complications better than the use of either letermovir or Triplex vaccine alone.

Letermovir is an FDA approved drug that is used as a standard of care at City of Hope for all CMV-positive allogenic transplant recipients to prevent CMV reactivation. The combination of letermovir and Triplex has not been used before and is not currently approved by the FDA. It is not known whether letermovir in combination with Triplex either decreases CMV reactivation, or is without additional side effects.

B. WHAT IS INVOLVED IN THE STUDY?

All participants will receive standard of care treatment with letermovir.

Randomization: A computer will assign you randomly (by chance, similar to flipping a coin) to receive either the investigational CMV-MVA Triplex vaccine or placebo (saline-like solution) after letermovir is stopped. Neither you nor your doctor will choose the group to which you will be assigned. Neither you nor your doctor will know which group you are assigned to or whether you receive the vaccine or placebo. The reason for randomization between the vaccine and placebo is to assure that any side effects and the results of treatment are in fact due to the specific treatment and not to other factors that might influence choice of treatment.

For participants who will receive CMV-MVA Triplex vaccine, it will be given at a dose found to be safe by the previous studies in healthy volunteers and alloHCT patients.

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.
- **Performance status**, which evaluates how you are able to carry on with your usual activities.

- **Blood tests** to check your blood counts and organ function (about 2 teaspoons of blood will be drawn from a vein in your arm)
- **Blood tests** to check the status of your disease (about 2 teaspoons of blood will be drawn from a vein in your arm)
- **Blood tests** for research purposes, to establish baseline for comparison with research samples taken after the vaccination (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 any abnormalities if they occur.
- **Pregnancy test** (only if you are a woman of childbearing potential) by drawing about ½ teaspoon of blood usually from a vein in your arm or collecting a urine sample.
- **Tests for infectious diseases** You will have blood samples (about 2 tablespoons) taken to test for HIV and Hepatitis. The results of these tests will appear in your medical record and will be shared with health care workers involved in your care. The test results will be shared with the study sponsor(s), its subcontractors and/or its agents to perform functions relating to the conduct of this research. When required by law, any positive results will be shared with a health authority (e.g. the State Department of Health)

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.

Study Procedures:

If you are eligible to participate in this research study, the following test and procedures will occur. Some tests and procedures may be part of your standard of care. The transplant procedure will occur on day 0; no visit related to this study will be performed on that day. You might be asked to have laboratory tests between regular visits if any lab results need to be repeated.

- **Clinical Exams:** At each scheduled visit after screening 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.

- **Performance status** which evaluates how you are able to perform your daily usual activities.

- **Vaccine administration and assessments**: Some time during your recovery, but before 100 days after your transplant procedure (HCT), your doctor will decide if you can participate in the trial, depending on your health status. If you are eligible to participate in the trial, you will receive up to two vaccine injections during your participation in the study. You will receive your first injection into the muscle of your upper arm on 100 days after transplantation. If eligible, you will receive your second injection on day 128 after transplantation. After each injection, you will be observed for 30 minutes.

If, based on your health status your doctor decides to discontinue a second vaccine injection on day 128, you will continue to receive clinical follow-up evaluations. You may also decide to continue having the scheduled blood draws for the study.

- **Blood tests**
  - **Blood tests** to check your blood counts and organ function (about 2 teaspoons of blood per blood draw will be drawn from a vein in your arm)
  - **Blood tests** for routine and research testing, to check your immune system, and to determine whether you are developing an active CMV infection blood will drawn on days 42, 56, 70-93, 100, 114, 128, 140, 180, 210-240, 270 and 365. As part of usual medical care for HCT patients at City of Hope and based on your doctor decision, more frequent visits and blood draws can be necessary, however no study visits/or blood draws will be made which duplicate what is required by the doctor. In general, at each study visit, about 2 tablespoons of blood will be drawn.

The total amount of research blood drawn for this trial will be about 20 tablespoons.

- **Urine test** during the study. Urine will be collected from you for routine laboratory testing to monitor your general health.
- **Pregnancy Test:** If you are a female with childbearing potential, a blood (1/2 teaspoon) or urine sample will be collected at some visits.
- **Prohibited Medications**: being on the study will prohibit you from receiving certain anti viral drugs and vaccines (e.g influenza vaccine) for up to 14 days after the second Triplex vaccination.
- **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.

<u>Research Study Calendar:</u>
You will be required to have a minimum of 11 trial visits and 10 blood draws over 12 months. Most of the blood draws to assess for CMV infection are also part of routine monitoring of transplant patients. You will have: one screening visit, two injections, ten evaluation visits. All visits, blood draws and vaccine injections will be performed at an assigned clinic of City of Hope.

The table below shows when your visits will be scheduled and what will be done at each visit:

Study Day(s)	-60 to 0	0	42	56	70-93	100	114	128	140	180	210-240	270	365
Standard of Care: Stem Cell Transplant		X											
Clinical Evaluation & Symptom Assessment*	X		X	X	X	X	X	X	X	X	X	X	X
Research Procedures: Screening Visit	X												
Injection Regimen						X		X					
Blood Draw**			X	X	X	X	X	X	X	X	X	X	X
Urine Sample***							X		X				

***** Assessments for "graft versus host disease" (a condition that results when cells that are transplanted from a stem cell donor inappropriately attack the body of the recipient) and "performance status" (a measure of how able you are to carry on your normal activities) may be performed more frequently than shown in this table, according to the schedule decided by your doctor.

****** Blood draws to check for CMV infection will be done more frequently than shown in this table, as part of usual medical care for HCT patients and according to your doctor's decision.

******* Only for females of child-bearing potential. First urine sample is standard of care, subsequent ones are research tests.

If you develop symptoms of CMV while on this study, you will receive approved treatments just as if you were not on this study. These treatments may include antiviral medications.

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

You will be in this research study for about 12 months. Even if you relapse or withdraw from the study after vaccination, you may still be followed until day 365.

You may be asked to participate in an extended follow-up of 3 years post-HCT. This will help us understand differences between patients that received the vaccine and those that received placebo.

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.

Triplex Vaccine

The vaccine has been administered in two clinical studies to 24 healthy adults and to 51 allo-HCT patients with minimal discomfort. The adverse events encountered in these two clinical trials did not significantly differ between patients who received vaccine and those who received placebo. Commonly reported side effects of the Triplex vaccine, occurring in about 1 in 3 patients were:

- pain, swelling, redness and itching at the injection site
- muscular aches
- chills
- headache
- tiredness

Less common side effects of the Triplex vaccine, occurring in less than 1 in 10 patients were:

- cough
- nausea
- skin erythema (skin redness)
- decreased lymphocyte count (decreased number of a type of white blood cells. This is associated with an increased risk of infections. Symptoms of infection may include fever, pain, redness, and/or difficulty breathing)
- decreased neutrophil count (decreased number of a type of white blood cells. This is associated with an increased risk of infections)

- decreased white blood cell count (Low white blood counts increase the risk of infection. This is associated with an increased risk of infections)
- platelet count decrease (Low platelet counts increase the risk of bruising and bleeding and might require transfusions.)
- alkaline aminotransferase increase (abnormal liver tests; possible liver damage)
- anemia (Low red blood cell counts may make you feel tired, short of breath and might require transfusions.

These side effects do not generally last more than a few days and usually do not require treatment but you may be given other non-prescription analgesic medications (similar to aspirin) to help relieve the symptoms. If they occur, decreased lymphocyte, neutrophil, and white blood cell count will be managed by your physician according to the current standard of care.

As with all vaccines or drugs, you could have an allergic reaction such as a rash or hives. Allergic reactions can be dangerous; therefore the clinic staff will observe you for 30 minutes after each injection. None of the 24 healthy volunteers who received the Triplex vaccine had an allergic reaction to the vaccine. If you develop an allergic reaction, you will be given medication (Benadryl-like) to counter the reaction.

Other risks that would not be related to this vaccine but that could occur due to the injection process include:

- developing a bruise at the site of injection
- infection
- hypotension (lowering of blood pressure)

These side effects have been seen with other vaccines and could occur when you receive the Triplex vaccine, but they were not observed in the healthy volunteers vaccinated with CMV-MVA Triplex vaccine.

Receiving this vaccine may prevent you from receiving other investigational CMV vaccines at a later date. There is no approved CMV vaccine currently available.

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.

The placebo injection:
The possible risks of the placebo injection include:

- pain
- swelling
- hardness, redness, and itching at the injection site.

Since this is a routine solution, no major reactions are expected.

Letermovir:
Letermovir has not been used in combination with Triplex vaccine before and there is no information that implies possible additional risks of using letermovir and Triplex together.

It is not known whether letermovir in combination with Triplex either decreases CMV reactivation, or is without additional side effects.

Risks Associated with Blood Draw
Blood can usually be drawn from your central venous catheter at the time of the other blood draws required as part of your usual medical care. However, if it is not possible to draw blood from the central catheter, then it will be drawn from a vein. The needle used to draw blood from a vein may cause pain and bruising, and rarely, infection at the site of the blood draw. There is also a risk of anemia (low red blood cell count) or hypotension. Sometimes, having blood drawn will cause people to feel lightheaded or even to faint.

Reproductive Risks:
We do not know whether this vaccine 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. In the event that your partner becomes pregnant, it may be critical to share information regarding your participation in this research study with that person. Your research doctor should also be told if this happens. The study sponsor may want to collect data on your partner's pregnancy. 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 medically effective form of birth control while you are on this study.

The investigational drug(s) may involve risks to you (or to the embryo or fetus, 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)

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.

There are organizations that may inspect your records. These organizations are required to make sure your information is kept private, unless required by law to provide information. Some of these organizations are:

- The study sponsor, City of Hope.
- The Institutional Review Board, IRB, is a group of people who review the research with the goal of protecting the people who take part in the study.
- Regulatory agencies such as the Office for Human Research Protections (OHRP), the Food and Drug Administration (FDA), and the National Cancer Institute (NCI) in the U.S., and similar ones if other countries are involved in the study as required by law.

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.

Future Use of Research Information and Specimens

In the future, the information or specimens that have been collected for this study might/will be coded with unique identifiers that will make individual identification impossible without access to code key. This code key will only be accessible to restricted persons conducting the study (such as Principal Investigator). IRB review and approval will be required prior to releasing the key to other investigators for future research.

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.

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 vaccine in the prevention of CMV reactivation similar to the benefit that was observed in the clinical trial with allogenic HCT. If you are assigned to receive placebo you are not expected to directly benefit from participation. 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?

If you decide not to take part in this study, you have other choices. For example:

- You may choose to have the usual approach for preventing CMV infection
- You may choose to take part in a different study, if one is available

Regardless of whether or not you participate in this trial, you will receive approved treatments which may include antiviral medications if you develop symptoms of CMV.

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

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

Possible Commercial Products

We may use your samples and information to develop a new product or medical test to be sold. The sponsor and hospital may benefit if this happens. 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.

J. WHAT ARE THE COSTS?

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

CMV-MVA Triplex will be provided to you at no cost while you take part in the study. You and your health plan/insurance company will need to cover the cost of the injection of the study drug. It is possible that the CMV-MVA Triplex 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

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?

There may be circumstances in which your participation in this study may be terminated by the investigator without your consent if it is determined to be in your best interest, such as:

- your doctor feels that staying in this trial is harmful for you
- you don't keep appointments or follow trial procedures
- City of Hope or the FDA decide to stop or cancel this trial for any reason

You may decide to stop at any time. You are asked to tell the study doctor if you are thinking about or decide to stop treatment. The study doctor will tell you how to stop safely, evaluate any side effects you may be experiencing, and discuss what follow-up care and testing could be most helpful for you.

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

The principal investigator, Dr. Nakamura or a colleague, _____ 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 or in the event of a research related injury, you can contact Dr. Ryotaro Nakamura (626) 256-HOPE (4673) ext. 65285 or Dr. _____ at (626)-256-HOPE (4673) ext. _____.

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, you may contact a representative of that Board, from the Office of Human Research Subjects Protection, at (626) 256-HOPE (4673) ext. 62700.

O. ADDITIONAL STUDIES SECTION:

This section is about optional studies you can choose to take part in. You will make your selection at the end of this section. You will not get health benefits from any of these studies. The researchers leading this optional study hope the results will help other people with cancer in the future.

The results will not be added to your medical records and you or your study doctor *will not* know the results.

You will not be billed for these optional studies. You can still take part in the main study even if you say "no" to any or all of these studies. If you sign up for but cannot complete any of the studies for any reason, you can still take part in the main study.

At the end of the document, circle your choice of "yes" or "no" for each of the following studies.

Biobanking for Possible Future Studies

Researchers are trying to learn more about cancer, diabetes, and other health problems. Much of this research is done using samples from your tissue, blood, urine, or other fluids. Through these studies, researchers hope to find new ways to prevent, detect, treat, or cure health problems.

Some of these studies may be about genes. Genes carry information about features that are found in you and in people who are related to you. Researchers are interested in the way that genes affect how your body responds to treatment.

If you choose to take part, the researchers ask your permission to store and use your samples and related health information (for example, your results of study tests and medicines you are given) for medical research. The research that may be done is unknown at this time. Storing samples for future studies is called "biobanking".

WHAT IS INVOLVED?

If you agree to take part, here is what will happen next:

1) Your leftover blood sample will be sent to the Biorepository (Biobank).
2) Your sample, and possibly specimens left over from diagnostic and clinical tests and some related health information may be stored in the Biorepository (Biobank), along with samples and information from other people who take part. The samples will be kept until they are used up. Information from your medical record will be updated from time to time.
3) Qualified researchers can submit a request to use the materials stored in the Biorepository (Biobank). An ethics committee review will be done to ensure that the request is necessary and proper. Researchers will not be given your name or any other information that could directly identify you.
4) Neither you nor your study doctor will be notified when research will be conducted or given reports or other information about any research that is done using your samples.
5) Some of your genetic and health information may be placed in central databases that may be public, along with information from many other people. Information that could directly identify you will not be included.

WHAT ARE THE POSSIBLE RISKS?

1) The most common risks related to drawing blood from your arm are brief pain and possibly a bruise.
2) There is a risk that someone could get access to the personal information in your medical records or other information researchers have stored about you.
3) There is a risk that someone could trace the information in a central database back to you. Even without your name or other identifiers, your genetic information is unique to you. The researchers believe the chance that someone will identify you is very small, but the risk may change in the future as people come up with new ways of tracing information.
4) In some cases, this information could be used to make it harder for you to get or keep a job or insurance. There are laws against the misuse of genetic information, but they may not give full protection. There can also be a risk in knowing genetic information. New health information about inherited traits that might affect you or your blood relatives could be found during a study. The researchers believe the chance these things will happen is very small, but cannot promise that they will not occur.

HOW WILL INFORMATION ABOUT ME BE KEPT PRIVATE?

Your privacy is very important to the researchers and they will make every effort to protect it. Here are just a few of the steps they will take:

1) When your sample(s) is sent to the researchers, no information identifying you (such as your name) will be sent. Samples will be identified by a unique code only.
2) The list that links the unique code to your name will be kept separate from your sample and health information. Any Biorepository (Biobank) and staff with access to the list must sign an agreement to keep your identity confidential.
3) Researchers to whom City of Hope sends your sample and information will not know who you are. They must also sign an agreement that they will not try to find out who you are.
4) Information that identifies you will not be given to anyone, unless required by law.
5) If research results are published, your name and other personal information will not be used.

WHAT ARE THE POSSIBLE BENEFITS?

You will not benefit from taking part. Your samples may be helpful to research whether you do or do not have cancer. The researchers, using the samples from you and others, might make discoveries that could help people in the future. 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.

WHAT IF I CHANGE MY MIND?

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 to Continue in Participation in Research Activities" for "IRB #17366, A PHASE II RANDOMIZED, PLACEBO-CONTROLLED, MULTICENTER TRIAL TO EVALUATE THE PROTECTIVE FUNCTION OF CMV-MVA TRIPLEX IN RECIPIENTS OF A HAPLOIDENTICAL HEMATOPOIETIC STEM CELL TRANSPLANT." Please sign the section of this this withdrawal form named "Biological Specimen Withdrawal of Consent" and send it to the principal investigator of this study at City of Hope. Once City of Hope receives this 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.

WHAT IF I HAVE MORE QUESTIONS?

If you have questions about the use of your samples for research, contact the study doctor, Dr Ryotaro Nakamura, M.D., at 626-256-4673 extension 65285.

Please circle your answer to show whether or not you would like to take part in each option

Samples for Future Research Studies:

My samples and related information may be kept in a Biorepository (Biobank) for use in future health research.

YES NO

I agree that my study doctor, or their representative, may contact me or my physician to see if I wish to participate in other research in the future.

YES NO

This is the end of the section about optional studies.

P. 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

COH Protocol #19065: A PHASE II RANDOMIZED, PLACEBO-CONTROLLED, MULTICENTER TRIAL TO EVALUATE THE PROTECTIVE FUNCTION OF CMV-MVA TRIPLEX IN RECIPIENTS OF A HAPLOIDENTICAL HEMATOPOIETIC STEM CELL TRANSPLANT

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 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.

Certain information about you that is highly confidential is needed for the Study. If you sign this form, you are allowing City of Hope and the individuals indicated below to use and disclose the following highly confidential PHI about you: information about HIV/AIDS testing or treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)

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; and the Health Information Management Services Department (i.e., Medical Records Department). 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") and 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 CMV-MVA Triplex vaccine from the FDA or for other FDA reporting.

This study also involves tissue banking (storing your specimens such as blood). The tissue banked as part of this study will be stored at COH tissue banks only. The banked tissue will be stored indefinitely.

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. California law requires that a specific date at which the authorization will expire must be provided. The HIPAA Research Authorization Form currently provides that the authorization will expire 25 years from the date of signature.

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

_____ _____ _____

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