Minor of age participant INFORMATION SHEET

(Participants aged between 16 and 17)

STUDY TITLE	Prospective, randomised, double-blind, placebo-controlled multicenter clinical trial of efficacy and safety with *Dermatophagoides pteronyssinus* and *Dermatophagoides farinae* mannan-conjugated allergoids in patients with rhinitis/rhinoconjunctivitis, allergic to *Dermatophagoides pteronyssinus* and/or *Dermatophagoides farinae*
STUDY CODE	MM09-SIT-069
SPONSOR	INMUNOTEK S.L.
STUDY DOCTOR	
CENTRE	
CONTACT Email/telephone	
24-HOUR CONTACT Telephone	

INTRODUCTION

We are writing to inform you about a research study in which you are invited to take part, also known as a clinical trial. The study has been approved by the Portuguese Ethics Committee for Clinical Research (CEIC) and by the National Authority for Medicines and Health Products I.P. (INFARMED) in accordance with current legislation: European Regulation 536/2014 of 16 April, which regulates clinical trials involving medicinal products; Decree-Law No. 102/2007 (Good Clinical Practice); EU Regulation 2016/679 of 27 April 2016 (General Data Protection Regulation – GDPR); Law No. 58/2019 of 8 August, which ensures the implementation of the GDPR within the national legal framework; and Decree-Law No. 176/2006 of 30 August (Medicines Act), as currently in force.

Our aim is to provide you with accurate and sufficient information so that you can decide whether or not you wish to take part in this study. Please read this information sheet carefully. We will answer any questions you may have.

Furthermore, you may seek the advice of anyone you consider appropriate.

VOLUNTARY PARTICIPATION

You have been invited to take part in the study because you have been diagnosed with allergic rhinitis/rhinoconjunctivitis, with or without mild to moderate asthma.

Please be aware that your participation in this study is voluntary and that you may decide NOT to take part. If you decide to take part, you may change your mind and withdraw your consent at any time, without this affecting your relationship with your study doctor or resulting in any detriment to your healthcare.

The sponsor will not follow up with participants once they have completed the study.

AIM OF THE STUDY

Immunotherapy (allergy vaccines) is currently the only available treatment that addresses the root cause of the condition and involves the administration of vaccines over a specific period of time.

The other medicines you have probably already taken are symptomatic treatments for the condition, which means they do not treat the cause of the allergy, but only the troublesome symptoms when they occur. This is precisely why this study will be conducted using a vaccine designed to treat house dust mite allergy.

The safety and clinical efficacy of a vaccine will be tested by comparing it with a placebo treatment. The ultimate aim is to determine whether the vaccine is safe and effective for treating your allergy.



[redacted]

[redacted]

[redacted]

[redacted]

RISKS AND DISCOMFORT RESULTING FROM YOUR PARTICIPATION IN THE STUDY

Please note that the vaccine under investigation is not commercially available. However, there is a great deal of information available to the public regarding the side effects of immunotherapy (allergy vaccines).

The drawbacks of your participation in the study include possible adverse reactions to the treatment and to the diagnostic skin test, the need to attend appointments, as well as the risks associated with any blood sampling, such as pain, bleeding, bruising and, in very rare cases, infection at the injection site.

Adverse reactions that may occur during allergy treatment can be classified into two groups:

- Local reactions:

Redness, swelling, itching or hardening at the injection site are common.

- General/systemic reactions:

These include feeling unwell, dizziness, gastrointestinal discomfort, nasal symptoms (itching, runny nose, congestion or itching), eye symptoms (itching, redness), difficulty breathing, coughing, wheezing, as well as rarer symptoms such as vaginal bleeding and even more serious reactions such as a generalised allergic reaction, known as anaphylaxis, although this is very rare.

Anaphylaxis can include symptoms such as itching and redness on the palms of the hands and soles of the feet, a feeling of warmth, a rapid heart rate, difficulty breathing and low blood pressure, amongst others. In between these extremes, symptoms such as sneezing, hives, and irritation of the eyes and nose may occur.

These reactions occur relatively infrequently, and their likelihood depends mainly on the symptoms you usually experience before vaccination. If these symptoms occur, contact your doctor immediately.

Due to these possible adverse reactions, you will need to remain in the Allergy Department for at least 30 minutes after the first subcutaneous administration of the vaccine. This is standard practice both for participation in the study and for routine treatment, and your study doctor is prepared to intervene if necessary. For the following three hours, you should not engage in strenuous physical exercise or take a hot bath, although you may take a shower.

POSSIBLE BENEFITS

[redacted]

[redacted] **PREGNANCY**

[redacted]

[redacted]

PARTICIPANTS' OBLIGATIONS

If you agree to take part in this study, you must:

- Attend the study visits and take part in the study activities scheduled by the research team.
- Inform the research team of any adverse events that occur during the study.
- Inform the research team of any changes to your medication. Except in an emergency, you must not change the medication you are taking or take any other medicines or 'herbal remedies' without first consulting the study doctor.
- Inform the research team if you become pregnant or if your partner becomes pregnant from the start of the study until its completion.
- Follow all instructions given by the research team.
- Answer all questions from the research team truthfully.

[redacted]

EXPENSES AND FINANCIAL COMPENSATION

The study involves specific research work, so both the hospital and the professionals taking part in the study, including the research team, will receive financial compensation. The study sponsor is responsible for managing the study's funding. To carry out the study, the sponsor has signed a contract with the study doctor and the centre where the study will take place.

You will not have to pay for the study medicines or the specific tests carried out as part of the study. Your participation in the study will not incur any additional costs beyond your usual clinical practice.

Your participation in the study does not entitle you to any salary or remuneration; this is not permitted by law. However, you will be reimbursed for expenses incurred as a result of your participation in the study (for example, meals, parking and travel costs) up to a maximum of €40 (forty euros) per visit. Please keep all receipts relating to these expenses.

In the event of a loss of earnings during the study due to your participation in it, you will be entitled to compensation for lost earnings upon providing evidence. To be considered eligible for reimbursement, you must submit the necessary documents, including a statement from your employer or proof from Social Security indicating that you are not receiving sickness or unemployment benefit. Reimbursement of expenses and lost wages also applies to accompanying persons in the case of participants who are minors.

The finance department at the study centre will need access to the necessary details to process the financial compensation. A receipt must be issued for each amount received that may be subject to tax.

WHAT TREATMENT WILL I RECEIVE AT THE END OF THE CLINICAL TRIAL?

[redacted]

INSURANCE

The study sponsor holds an insurance policy that complies with current legislation (European Regulation 536/2014 and Article 15 of Law 21/2014), and will provide compensation and indemnity in the event of damage to your health or injury that may occur in connection with your participation in the study, provided that such damage or injury is not a consequence of the disease under investigation or the progression of your disease as a result of the treatment's ineffectiveness. The insurance covers pecuniary and non-pecuniary damage caused by the

the trial to participants whilst the clinical trial is ongoing and for one year following its completion. If you would like further information on this section, please speak to the study doctor at your centre.

Please be aware that your participation in this clinical trial may alter the general and specific terms (coverage) of your insurance policies (life, health, accident, etc.). We therefore recommend that you contact your insurer to determine whether your participation in this study will affect your existing insurance policy.

The insurance policy will only cover those taking part in the study. If the partner of a male participant in the clinical trial becomes pregnant, neither the woman nor the baby will be covered by the insurance.

In the event of pregnancy, neither the participant nor the baby will be covered by the insurance policy taken out by the sponsor, as, as indicated in the 'Pregnancy Notice' section, the participant will be withdrawn from the study.

PROTECTION OF PERSONAL DATA

The processing, disclosure and transfer of the personal data of all participants will comply with the legislation in force (Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016, on the protection of personal data and Law No. 58/2019 of 8 August) and may exercise their rights of access, rectification, objection and erasure of data, as well as the right to restrict the processing of incorrect data, request a copy or request the transfer of data to third parties; to do so, they should contact their study doctor.

Please note that your data cannot be deleted, even if you cease to participate in the study, in order to ensure the validity of the study and to comply with legal obligations and the authorisation requirements for medicinal products.

[redacted]

[redacted]

WHAT WILL HAPPEN TO THE STUDY RESULTS?

[redacted]

OTHER RELEVANT INFORMATION

Any new information regarding the medicines used in the study that may affect your willingness to take part in the study and that comes to light whilst you are taking part will be communicated to you by your study doctor as soon as possible.

Please be aware that you may be excluded from the study if the study sponsor or the study doctor deems it appropriate, either for safety reasons, due to any adverse events occurring with the study medicine, or because they consider that you are not complying with the established procedures. In any such case, you will be given a proper explanation of the reason for your withdrawal from the study.

By signing the attached consent form, you agree to comply with the study procedures described to you. Please note that your GP may be informed of your participation in this study.

COLLECTION AND USE OF BIOLOGICAL SAMPLES

[redacted]

[redacted]

INCIDENTAL FINDINGS

[redacted]

CONTACT IN CASE OF QUESTIONS

If, during your participation, you have any queries or require further information, please contact the study doctor at your centre, whose contact details are provided on the first page of this document.

For matters relating to data protection, please contact the centre's data protection officer via email <add email>:_____.

Any questions regarding your rights and responsibilities as a participant in this clinical trial may be addressed to the following independent body, which has reviewed and approved this trial:

[redacted]

ACKNOWLEDGEMENTS

Whatever your decision, the sponsor and the research team thank you for your time and attention.

Minor of age participant INFORMED CONSENT
(Participants aged between 16 and 17)

I, ...

(participant's first name and surname)

.....years old.

- ✓ I understand everything I have read or that has been read to me in the information sheet.
- ✓ My study doctor has answered all the questions I asked.
- ✓ I know that I can say I do not wish to take part and that this is fine.
- ✓ I know that I can ask my study doctor any questions, either now or later.
- ✓ I know that later, if I no longer wish to take part in this study, I can say so and nobody will tell me off for it.
- ✓ I confirm that I have received a signed and dated copy of this information sheet and the informed consent form.

I wish to take part in the clinical trial.

Signature of the **PARTICIPANT**	Signature of **the STUDY DOCTOR**
Date: ___/___/_____	Date: ___/___/_____

(Handwritten signature and date)

The study doctor will tick the appropriate box:

The child has understood everything I have explained	YES □ NO □
Have the parents/guardians signed the informed consent form?	YES □ NO □

INFORMED CONSENT before witnesses

STUDY TITLE: Prospective, randomised, double-blind, placebo-controlled multicenter clinical trial of efficacy and safety with *Dermatophagoides pteronyssinus* and *Dermatophagoides farinae* mannan-conjugated allergoids in patients with rhinitis/rhinoconjunctivitis, allergic to *Dermatophagoides pteronyssinus* and/or *Dermatophagoides farinae*

I, ...(witness's first name and surname)

in my capacity as a witness, hereby declare that, in my presence, Mr/Ms .....

(participant's first name and surname)

- read (or had read to them, in the event that the participant is unable to read) and understood the information sheet
  provided to them.
- They were given the opportunity to ask questions about the study.
- They received sufficient information about the study.

Spoke to .....(researcher's first name and surname)

You understand that your participation is voluntary and that you may withdraw from the study:

1. Whenever you wish.
2. Without giving any reason.
3. Without this affecting your medical care.

Within the limits of the law, you authorise the access, use and sharing of your personal data, as described in the section 'Protection of personal data'.

The participant has received a signed and dated copy of this information sheet and the informed consent form. Yes ☐A No ☐

The participant wishes to be informed of incidental findings that have an impact on them.	Yes ☐ No ☐
The participant wishes to be informed about incidental findings that have an impact on their family.	Yes ☐ No ☐
The participant agrees that their attending doctor should be informed of any incidental findings.	Yes ☐ No ☐

The participant freely consents to taking part in the study. Yes ☐ No ☐

WITNESS'S SIGNATURE *(As per ID card)* Date: ___/___/_____	Signature of **the STUDY DOCTOR** Date: ___/___/_____

(Handwritten signature and date)