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 # 22189

TITLE: A Prospective Study of the RefleXion [18F]- DCFPyL PET-CT Subsystem Imaging Performance in Patients with Prostate Cancer

Protocol Version date: 05/03/2022

PRINCIPAL INVESTIGATOR: Jeffrey Wong, M.D.

24-HOUR TELEPHONE NUMBER: 626-256-HOPE (4673), Extension 85200
DAY TIME TELEPHONE NUMBER FROM THE HOURS OF 8:00 AM TO 5:00 PM: 626-256-HOPE (4673), Extension 82247

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 # 22189

TITLE: A Prospective Study of the RefleXion [18F]- DCFPyL PET-CT Subsystem Imaging Performance in Patients with Prostate Cancer

PRINCIPAL INVESTIGATOR: Jeffrey Wong, M.D.

KEY INFORMATION

You are invited to participate in a research study since you will be undergoing a standard-of-care (SOC) 18F-DCFPyL-PET/CT (Pylarify) scan. The purpose of this research study is to see how well images look on the RefleXion imaging system as compared to a standard PET/CT machine in patients who are undergoing a standard-of-care 18F-DCFPyL-PET/CT scan. The information we learn by doing this research study may help patients in the future receive more accurate delivery of radiotherapy using 18F-DCFPyL-PET/CT scan to target their cancer in real time.

Participants in this study will have an additional scan on the RefleXion PET/CT system after undergoing a standard-of-care 18F-DCFPyL-PET/CT scan for prostate cancer. This will occur on the same day. Active participation is expected to last approximately 3 hours, and total participation will be approximately 3 days.

The risks associated with this study include being exposed to a small amount of additional radiation by the RefleXion PET/CT machine.

You do not have to join this research study. You can choose to receive standard methods to image your prostate cancer instead of participating on 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 have prostate cancer and will be undergoing a standard-of-care 18F-DCFPyL PET/CT scan. This study will help to improve PET/CT imaging on the RefleXion system. This information will be used in the future to improve planning and delivery of radiotherapy that will target (in real time) the signal released from the 18F-DCFPyL-PET/CT tracer. This research study is also looking to see if 18F-DCFPyL imaging can be done on the RefleXion imaging system at the same time as planning for radiation therapy, which would reduce the number of scans needed to plan for radiation for prostate cancer.

This research study is sponsored by City of Hope and RefleXion is the company that makes the imaging system that will be used. They provide funding to cover the costs of conducting this study.

It is expected that about 25 people will take part in this research study.

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 research study is a Pilot Study, which is the first-time investigators are examining this study intervention.

The the U.S. Food and Drug Administration(FDA) has not approved the use of the RefleXion imaging system for 18F-DCFPyl PET/CT scans.

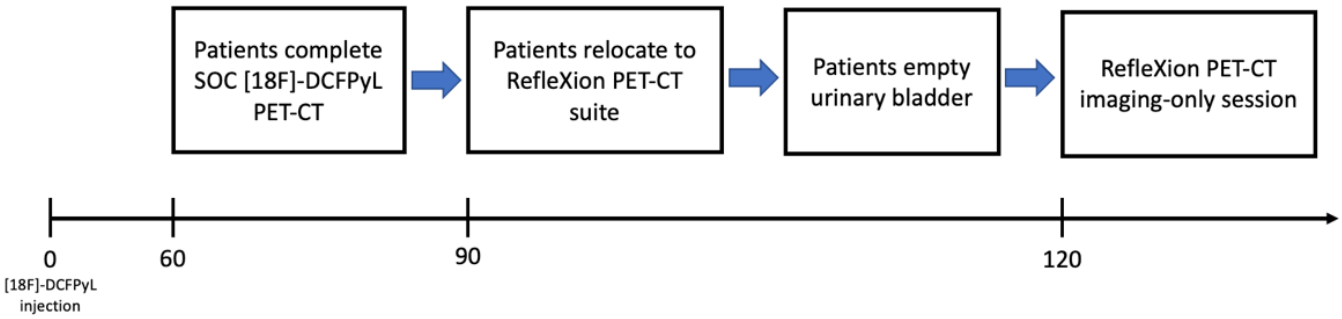
The names of the study interventions involved in this study are:

- Undergoing a scan on the RefleXion imaging system

In this research study, we are using the RefleXion Medical Radiotherapy System (RMRS) which is a combination imaging-therapy system that is FDA cleared and designed to deliver biology-guided radiotherapy (BgRT). The system uses PET emissions to guide radiotherapy delivery in real-time and has been studied for use with fluorodeoxyglucose (FDG) (which is an agent used in standard PET/CT scans that targets glucose). 18F-DCFPyL-PET has been approved by the FDA to image prostate cancer in patients with suspected metastases who are candidates for initial therapy, or patients with suspected prostate cancer recurrence based on raised blood prostate specific antigen (PSA) levels. We would like to see how the RefleXion system images patients who received 18F-DCFPyL, with the eventual goal of obtaining FDA approval for the RefleXion system to both image and deliver therapy by targeting areas that have prostate-specific membrane antigen (PSMA) which is contained in prostate cancer cells.

B. WHAT IS INVOLVED IN THE STUDY?

If you decide to take part, this is what will happen: You will be already scheduled for a standard-of-care (SOC) 18F-DCFPyL PET/CT scan that had been ordered by your doctor (which consists of an injection into a vein of the 18F-DCFPyL agent, then 60 minutes later you will lay on the standard PET/CT scanner at COH Radiology and undergo the scan, which should take about 30 minutes). On that same day, as soon as you are done with the 18F-DCFPyL PET/CT scan, you will be taken to COH department of Radiation Oncology into the RefleXion PET/CT suite and will be asked to empty your bladder. You will then be instructed to lay on the RefleXion imaging system table and will undergo a scan on the RefleXion imaging system. This additional scan may take up to 60 minutes. See schema below:



Once you are done with the additional scan on the RefleXion imaging system, you will be allowed to go home. Within 3 days following the imaging, you will be contacted by our study nurse to see how you are feeling. Then, you will be completely done with the study.

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.
- **Height and weight** will be taken.
- **18F-DCFPyL PET/CT scan** will be scheduled, if not already scheduled.

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. A chart summarizing the timing of these tests and procedures is also provided below. Some tests and procedures may be part of your standard of care.

- **Scans (or Imaging tests):** You will undergo a standard-of-care (SOC) 18F-DCFPyL PET scan in the COH radiology department.

- **Relocation:** Right after you are done with the SOC 18F-DCFPyL PET scan, you will be relocated to the COH Radiation Oncology Department RefleXion imaging suite and asked to empty your bladder.
- **Scans (or Imaging tests):** Within 60 minutes of completing the 18F-DCFPyL PET scan, you will be instructed to lay on the RefleXion imaging system table and will undergo a scan on the RefleXion imaging system. This additional scan may take up to 60 minutes.

Research Study Calendar:

Assessments	Baseline*	Day 0	Follow-up^
Informed Consent	X		
Demographics	X		
Medical History	X		
Height/Weight	X		
SOC [18F]-DCFPyL PET-CT		X	
RefleXion PET Imaging-only session		X	
Toxicity Collection			X

*Within thirty days prior to the RefleXion PET Imaging-only session:

^Within 72 hours of completion of RefleXion PET Imaging-only session: Adverse Events assessment by telephone call by research nurse.

Planned Follow-up:
Within 3 days following the scan on the RefleXion imaging system, the research nurse will call you to see how you are doing.

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

You will be in this research study for about 3 days.

D. WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

There are risks to taking part in any research study. 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 scan on the RefleXion imaging system. Appropriate medical care will be provided, if necessary, including additional treatment, hospitalization and/or surgery.

Possible risks and discomforts you could experience during this study include:

Radiation Risks Associated with the additional imaging scan on the RefleXion imaging system:

The imaging scan on the RefleXion imaging system that you will receive in this study will expose you to low amounts of radiation. Every day, people are naturally exposed to low levels of radiation that come from the sun and the environment. This type of radiation is called "background radiation". No one knows for sure whether exposure to low amounts of radiation is harmful for your body. However, scientists believe that being exposed to too much radiation can cause harmful side effects, including the potential to cause a new cancer.

Harm to you from this amount of radiation is thought to be low and less than the exposure from a standard of care PET/CT scan. This is comparable to about 5 years' worth of background radiation. However, scientists believe that if you get extra radiation that is more than about 30 years' worth of background radiation, the risk of harm increases and there is a chance of having a harmful side effect, including the potential to cause a new cancer.

Other Risks:

Because of side effects or the time required for tests and clinic visits while you are on this research study, you may be unable to keep up with your normal daily activities. Additionally, laying on the scanner for an additional period of time may cause some discomfort.

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 and RefleXion are supporting the study.
- 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 de-identified, which means any information that could be used to identify you will be removed from the information or specimens. The de-identified information or specimens may be used for future research studies or shared with other researchers. You will not be informed of or asked to consent to these future research activities.

G. WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART IN THIS RESEARCH STUDY?

You are not expected to receive any benefits from this study. Results from this study may benefit others in the future. 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 RefleXion imaging system 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 imaging approach for your cancer,
- You may choose to take part in a different study, if one is available

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

You will not receive any payments for taking part in this study.

J. WHAT ARE THE COSTS?

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

The additional imaging scan on the RefleXion imaging system will be provided to you at no cost while you take part in the study.

The 18F-DCF-PyL PET scan is routinely used to image prostate cancer. You would receive this scan even if you were not participating in this study. You or your health plan/insurance company will need to pay for this routine scan. You will also be responsible for any co-payments or deductibles required by your health plan/insurance company.

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.

RefleXion will pay your costs for reasonable and necessary care if you have been injured as a result of taking part in this research study. If you receive Medicare and RefleXion pays for medical treatment for injury relating to your participation in this research, RefleXion will need to collect certain personal information about you, such as your name, date of birth, gender, social security number or Medicare identification number and information related to this research study. By signing this informed consent form, you are giving permission to RefleXion to collect your personal and treatment related information and report it to the Centers for Medicare & Medicaid Services (CMS), while participating in the study and for as long as RefleXion is required by the government to report this information. The sponsor will not use this information for any other purpose.

There are no plans for any of the sponsors of this study 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?

You may be removed from this study without your consent for any of the following reasons: you do not follow the investigator's instructions, at the discretion of the investigator or the sponsor, or the sponsor closes the study. If this happens, the investigator will discuss other options with you.

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

The principal investigator, Dr. Jeffrey Wong, 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. Jeffrey Wong at (626) 256-HOPE (4673) ext. 82247.

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.

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

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, its affiliated research doctors, healthcare providers, and physician network 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, , 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.

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; the Health Information Management Services Department (i.e., Medical Records Department), and

affiliated research doctors and other medical centers participating in the research, if applicable. 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.

Your information will also be shared, with ***Reflexion,*** the "Research funder" and its employees, agents or contractors who are involved in the administration of the Study.

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.

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. **<u>Your Rights Under this Authorization</u>**: 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.

Although you have the right to access medical and billing records that City of Hope maintains about you, this right will be temporarily partially suspended during the conduct of this Study to protect the integrity of the study. Your right to access these records will be reinstated upon the completion of this research. Your right to access to those standard of care procedures will not be affected.

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

NOTE: To determine who should sign below, review the guidance document, *Consenting Non English Speaking Research Participants (Pediatric or Adult) – Who Signs What?*

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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