Consent to Participate in a Research Study
Template for use in sites outside of Duke University Health System
Guiding Evidence Based Therapy Using Biomarker Intensified Treatment (GUIDE-IT)
ICF Version May 21, 2013

You are being asked to take part in this research study because you have been admitted to the hospital with heart failure. Research studies are voluntary and include only people who choose to take part. Please read this consent form carefully and take your time making your decision. As your study doctor or study staff discusses this consent form with you, please ask him/her to explain any words or information that you do not clearly understand. We encourage you to talk with your family and friends before you decide to take part in this research study. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

Please tell the study doctor or study staff if you are taking part in another research study.

Everyone who takes part in research should know that

- Research is meant to gain knowledge that may help in solving problems. You may not benefit from participating. Taking part may also involve some risks.
- Taking part in research is completely voluntary. You can choose not to take part. If you choose to take part, you can quit at any time.
- No matter what you decide, now or in the future, it will not affect your medical care.

WHO WILL PROVIDE FUNDING?
The majority of funding for this study comes from a grant from the National Heart, Lung, and Blood Institute (NHLBI). Additional funding support is being provided by Roche Diagnostics to support the study. Portions of ***(PI's Name)*** and his/her research team's salaries will be paid by this grant and the additional Roche Diagnostics funding.

WHO WILL BE MY DOCTOR ON THIS STUDY?
If you decide to participate, ***Dr.*** _____ will be your doctor for the study. Dr. _____will be in contact with your regular health care provider throughout the time that you are in the study.

WHY IS THIS STUDY BEING DONE?
The purpose of this study is to see if using the results of a blood test for NT-proBNP (a hormone released from the heart also known as a Biomarker) can help doctors decide the best drug treatment for patients with heart failure (HF).

Heart failure is a common disorder in which the heart cannot pump enough blood to meet the needs of the rest of the body. Common symptoms of heart failure include shortness of breath, swelling, and fatigue. Standard treatment for heart failure include diuretics to control fluid, as well as drugs called "neurohormonal antagonists" (such as beta-blockers and ACE-inhibitors) that help the heart work more efficiently and prevent worsening of heart function. Typically, doctors adjust these medicines based on their clinical judgment about what doses and combination will work best for you. We are testing whether the use of a blood test called NT-proBNP (which

measures a hormone released by the heart) can help doctors do a better job of adjusting these heart failure medicines over time than clinical judgment alone.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?
Approximately 1100 people will take part in this study at approximately 35-40 different hospitals in North America and medical facilities, and approximately ____ people will take part at this institution.

WHAT IS INVOLVED IN THE STUDY?
If you are interested in hearing about the study, we will review this consent form with you and answer any questions you may have. If you decide to take part, we will ask you to sign and date the consent form before you are discharged from the hospital or within 4 weeks of your hospital discharge or clinical equivalent (completion of Heart Failure treatment within an Emergency Room or Observational Unit).

Then you will be "randomized" into one of two study groups described below. Randomization means that you are assigned by chance, like flipping a coin. You have an equal chance of being in either group (Usual Care or Biomarker Guided Therapy), and neither you nor the study doctor can choose which group you are assigned.

No matter which arm you are randomized to, the study has a plan for how to make changes as needed for your care, but your doctor's recommendations may be different than what your doctor would have chosen if you were not in the study.

If you are part of the Usual Care group, you will receive standard heart failure treatment based on your doctor's best judgment and following the recommendation of current guidelines. This will typically include the use of medicines such as beta-blockers, ACE-inhibitors, and diuretics, all of which are approved, recommended treatments for heart failure. This would be similar to how you would be treated if you were not participating in this study.

If you are part of the Biomarker Guided Therapy group, you will receive the standard heart failure treatments. In addition your doctor will use the results of a blood test called NT-proBNP to help adjust the treatments and drug doses for your condition.

Regardless of your group, once you are enrolled in the study, you will be asked to return to the clinic for study visits at 2 weeks, 6 weeks, 3 months, and then every 3 months for a minimum of 12 months and a maximum of 24 months. If there are changes in your medications, there may be additional visits to monitor you more closely.

In addition to the below assessments, the baseline visit assessments include the following:

- 6 minute walk test—a measurement of the distance walked on level ground in 6 minutes
- Blood collection of DNA sample for biorepository—a blood sample from your arm (total of approximately 10 mLs)

- Quality Of Life questionnaires—you will be asked to take about 15 minutes to fill out questionnaires about your overall health and symptoms of heart failure

The assessments at these visits and during the follow-up phone calls include:

- A brief physical examinations, including vital signs (blood pressure, height and weight)
- A medical history (including treatment you have already received for your condition)
- A review of medication(s) you are now taking and reasons your heart failure treatment therapy may have been changed
- Blood collection (including serum creatinine, blood urea nitrogen (BUN), electrolytes and NT-proBNP) (approximately 3 teaspoon or 15mLs)
- Blood collection for biorepository—a blood sample from your arm (total of 220 mLs during the course of the study, 20 mLs per visit)

Follow up assessments after change in therapy or hospitalization

If you have a change in your heart failure medications based on the local lab NT-proBNP level or if you have been hospitalized, you will be asked to have a follow up visit approximately 2 weeks later. The assessments at these visits include:

- A brief physical examinations
- Blood collection (including serum creatinine, blood urea nitrogen (BUN), electrolytes and NT-proBNP) (NT-proBNP assessment will only be in the Biomarker Guided arm only)(approximately 3 teaspoon or 15mLs)

At the time you are enrolled, the staff of **<insert name of your medical facility>** will ask you questions about your health and any heart symptoms you may be having, about your physical and social activities, how you are feeling emotionally, and some questions about your work status and education. These questions are part of the GUIDE-IT Trial and will take about 20 minutes to answer. You may refuse to answer any of the questions.

- You will be asked to fill out a Confidential Patient Information (contact) form in order for representatives from the <**insert name of your medical facility if it is not allowed for patients to be contacted by an outside source in your state or country>** or the Duke Clinical Research Institute's Economics and Quality of Life Coordinating Center to contact you to collect follow-up information. This form will ask specific information such as your name, address, phone numbers of family members or close friends whom you designate to respond to the follow-up questions in the event that you are unable to do so. This contact information will only be available to <**insert name of your medical facility> and representatives of Duke Clinical Research Institute** Economics and Quality of Life Coordinating Center**.**

- The staff of <**insert name of your medical facility if it is not allowed for patients to be contacted by an outside source in your state or country>** or representatives of the DCRI Economics and

Quality of Life Coordinating Center will contact you by telephone, mail, or email at 3 months. 6 months, 12 months, and yearly until the end of the study to ask you questions about how you are doing about changes in how you feel, changes in your ability to perform daily activities, or changes in your working status. All of this information will allow us to understand the effects of the GUIDE-IT study on the quality of patients' lives.

To help understand how the use of this blood test affects the cost of medical care, study investigators will also collect information about other medical procedures that occur just prior to and during the time you are participating in this study. Hospital and physician billing data (including inpatient hospital care, inpatient physician care, outpatient physician care, outpatient testing, and outpatient medications from hospital bills, and medicare worksheets) will be collected by the Duke Clinical Research Institute Economics and Quality of Life group (DCRI EQOL). Once received, in order to maintain confidentiality, your name will be removed and replaced with a study number and patient initials before processing.

As a part of this study, we would like to collect and store samples and health information for future research studies, from study participants. Through these future studies, researchers hope to find new ways to detect, treat, and maybe even prevent or cure disease. The samples and information will be stored at the LabCorp facility in Kannapolis, N.C., and will be managed by Duke University Health System.

The sample you provide for future research will be used to test your DNA – also called genetic testing. DNA is short for deoxyribonucleic acid. A gene, or DNA, contains information that determines in part the traits, such as eye color, height, or disease risk, that are passed on from parent to child. Genetic testing may tell us how a disease affects different types of people or it may help us find the type of person who will respond best to treatment.

If you agree to provide samples to be stored for possible use in future research:

- We will collect and store approximately 44 teaspoons (220 mL) of blood for future research (4 teaspoons (20 mL) of blood at each study visit). These tests may tell us more about a disease or how a disease responds to treatment.

- We will collect and store approximately 2 teaspoons (10 mL) of blood for future DNA testing. DNA is what makes up your genes that tell your cells what to do. DNA testing may tell us how a disease affects different types of people or it may help us find the type of person who will respond best to treatment.

The samples you give will be securely stored and labeled with a unique code number. The samples will be kept indefinitely (banked) and will only be identified by a number or code to protect your privacy. Results from this research and the use of your samples will not be used to evaluate your medical condition or provide you with additional treatment

The genetic studies described are for research purposes only. Therefore, you will receive no results from these genetic studies (except as described below). It is not the purpose of these studies to look for or provide you with any medical information or diagnoses relating to your present condition or any other disease or illness. These studies are not being used as diagnostic tests for any disease or illness. Your participation in this research project is not a substitute for your regular medical care or check-ups. An IRB will review each specific study request for sample research and will determine if results will be used to evaluate your medical condition, result in additional treatment and if you will have access to your sample or any information obtained from the study of the samples.

Potential Risks and the Genetic Information Non-Discrimination Act (GINA): There is a potential risk of loss of confidentiality. Every effort will be made to protect your confidential information, but this cannot be guaranteed. The genetic information obtained as a result of your participation in this research will not be included in your medical record. Information from which you may be personally identified will be maintained in a confidential, secure location at DUHS, accessible only by authorized members of the study team, and will not be disclosed to third parties except as described in this consent form, with your permission, or as may be required by law.

The Genetic Information Nondiscrimination Act (GINA) is a Federal law that will protect you in the following ways:

- Health insurance companies and group plans may not request genetic information from this research;
- Health insurance companies and group plans may not use your genetic information when making decisions regarding your eligibility or premiums;
- Employers with 15 or more employees may not use your genetic information when making a decision to hire, promote, or fire you or when setting the terms of your employment.

GINA does not protect you against genetic discrimination by companies that sell life insurance, disability insurance, or long-term care insurance. GINA also does not protect you against discrimination based on an already-diagnosed genetic condition or disease.

Samples collected as part of this study may be valuable for scientific, research, or teaching purposes or for the development of a new medical product. The sponsor and/or the developers will assert all rights of ownership in the samples and all rights arising from use of the samples and may profit from this. In this event, there is no plan to compensate you.

IF I AGREE TO PROVIDE SAMPLES, CAN I REQUEST THAT MY SAMPLES BE DESTROYED?

If you decide later that you would like your samples destroyed, you must let [insert name] know you are withdrawing your permission for your samples to be stored and used for future research.

- During the main study, please contact [Insert Name], in writing. The mailing address is [list address].

- After the main study, please contact [Insert Name], in writing. The mailing address is [list address].

If the information linking your coded samples to you has already been destroyed, your samples can no longer be linked to you and we will be unable to locate them for destruction.

Also, even though your samples will be destroyed,

- We cannot get back samples or information that we have already given out to researchers
- You cannot withdraw your samples and information from studies that have already begun

Please initial your choice as to whether you agree to have your blood samples stored for possible future research.
_____ I agree to allow my blood samples to be stored for possible future research of heart failure related conditions.
_____ I DO NOT agree to allow my blood samples to be stored for possible future research.

Please initial your choice as to whether you agree to have your blood sample stored and used for future genetic (DNA) sampling.
_____ I agree to allow my blood sample to be stored for possible future genetic (DNA) sampling.
_____ I DO NOT agree to allow my blood sample to be stored for possible future genetic (DNA) sampling.

HOW LONG WILL I BE IN THIS STUDY?
The total duration of your participation in this study will be between 12 and 24 months.

WHAT ARE THE RISKS OF THE STUDY?
As a result of your participation in this study, you are at risk for the following side effects. You should discuss these with the study doctor and your regular health care provider if you choose.

Risk of Usual Care group:
In the usual care group your doctor will decide which standard heart failure drug treatments and what doses to prescribe based clinical judgment and following clinical guidelines. This is similar to how you would be treated if you were not taking part in the study. The NT-proBNP blood test will not be used to manage your care if you are in the usual care group.

Risk of Biomarker Guided Therapy group:
In the biomarker guided therapy group your doctor will use the results of the blood test NT-proBNP to help decide which drug treatments and what doses to prescribe for your heart failure. This may result in the use of higher doses of medications that would standardly be prescribed if you were not in the study. In general, this strategy will try to increase the doses of the type of drugs (called neurohormonal antagonists) that are proven to improve survival in patients with heart failure. It may also include increases doses of diuretics (water pills), especially if you have signs of extra fluid in your body. Potential side effects of these increased doses of medication could include low blood pressure, dizziness, fatigue, kidney problems, or changes in blood minerals (called electrolytes) such as potassium.

However, the study doctors will be monitoring your condition very closely and will address any problems that may arise due to medication changes and adjust your medications as needed.

Risks of Both Groups:
Risk of Drawing Blood: Risks associated with drawing blood from your arm include momentary discomfort and/or bruising. Infection, excess bleeding, clotting, or fainting are also possible, although unlikely. Whenever possible, study blood draws will be combined with those you would have done as part of your normal clinical care.

Women who are able to get pregnant: Because some drugs used for heart failure may affect unborn children, if you are pregnant or think you have a reasonable chance of being pregnant, you should tell your doctor immediately and not enroll in this study.

Confidentiality: There is a potential risk of loss of confidentiality. Every effort will be made to protect your confidential information but this cannot be guaranteed. Study records that identify you will be kept confidential, as required by law.

There may be risks, discomforts, drug interactions or side effects that are not yet known.

ARE THERE BENEFITS TO TAKING PART IN THE STUDY?
You may not rreceive any medical benefit from your participation in this study. We hope that in the future the information learned from this study will benefit other people who have the same condition.

WHAT ALTERNATIVES ARE THERE TO PARTICIPATION IN THIS STUDY?
If you choose not to participate in this study, your doctor will treat you according to standard medical care; refusal to participate does not prevent you from receiving optimal care.

WHAT PERSONAL HEALTH INFORMATION ARE YOU ASKING PERMISSION TO GET FROM MY MEDICAL RECORD?

Federal Privacy Regulations provide safeguards for privacy, security, and authorizes access to your health information. If you sign this consent form, you are giving your permission for the following people or groups to give the researchers certain information about you:

- Any health care providers/professionals who have provided you health services or treatment, such as physicians, clinics, hospitals, home health agencies, diagnostics centers, laboratories, treatment or surgical centers, or government health agencies
- Any agencies that provide payment for health care, such as insurers, or government agencies

This is the health information about you that the people or groups listed above may give to the researchers to use in this research study**:**

- Hospital medical records related to study participation (including admission and discharge medical records)
- Laboratory reports such as your blood counts and tests to measure the function of your heart, liver, and kidneys

We may share your information with the following groups so that they may carry out their duties related to this study:

- The sponsor of this study, the National Heart, Lung and Blood Institute, and its consultants who are helping conduct the study
- The research organization that is managing this study, Duke University, the Duke Clinical Research Institute
- LabCorp (the laboratory company where your blood samples will be sent)
- Duke University Institutional Review Board
- The Food and Drug Administration

Anybody who receives your information from us could share it with others without your permission and it may no longer be protected by the Federal Privacy Regulations. To help protect your confidential information, we will use and share your information in a way that nobody can tell it is your information or identify you.

If you want to participate in this study, you have to sign this consent form to allow access to your medical records. If you choose to not sign it, you are still able to receive medical care for your condition, but you will not be enrolled in this study. If you do sign it, you can change your mind later by writing a letter that states you are taking back your permission for us to access your confidential information. Mail the letter to *[Address]* or you can send us an email at *[List email address]*. Taking back your permission will prevent sharing of information in the future, but will not affect any information that has already been shared.

Research information collected about you might be put in your medical record. It's possible that you may not be able to see the research study information that has become part of your medical record until the entire research study is over.

The permission you give us to access your medical record will last until the end of the study.

WILL MY INFORMATION BE KEPT CONFIDENTIAL?

Except when required by law, you will not be identified by name, social security number, address, telephone number, or any other direct personal identifier in study records disclosed outside of your hospital. For records disclosed outside of your hospital, you will be assigned a unique code number. The key to the code will be kept at _____ (local institution office) and the Duke Clinical Research Institute (DCRI), in Durham, North Carolina. As part of the study, results of your study-related tests will be reported to the data coordinating center, the DCRI.

Representatives from the DCRI will ask Dr [PI] and his staff to send copies of parts of your record to DCRI to monitor the study. Monitoring means that DCRI staff will review study records to ensure that your information was entered correctly. A copy of this signed consent form, along with copies of your laboratory reports and records of important medical events that occur while you are in the study will be sent to DCRI via a secured electronic system. Trained personnel at the site will ensure that your name is removed from all medical record documents (except the signed consent form and Economics and Quality of Life (EQOL) information) before they are sent to the sponsor or DCRI, and that you are identified only by your unique study code number on all the documents that are sent. These documents will be maintained through DCRI's password protected electronic file system. DCRI will remove your name from the EQOL information and replace it with a study number and your initials. Trained personnel will receive your data and enter it into a password protected database and your information will be assigned a unique study code. Trained interviewers will have access to your contact information in order to complete the interviews.

Your records may be reviewed in order to meet federal or state regulations. Direct access to your original medical records for verification of clinical study procedures and/or data may be granted, to the extent permitted by the applicable laws and regulations, to the following representatives:

- the National Institutes of Health
- the Food and Drug Administration
- your hospital's Institutional Review Board
- the Duke University Health System Institutional Review Board, and
- the DCRI

If your research record is reviewed by any of these groups, they may also need to review your entire medical record. Your research record will be maintained for at least six years after the study is completed. Any research information in your medical record will be kept indefinitely.

While the information and data resulting from this study may be presented at scientific meetings or published in a scientific journal, your identity will not be revealed.

Your confidentiality will be protected to the extent permitted by applicable laws and regulations.

The National Heart Lung and Blood Institute (the Institute that funds this study) requires that the data collected during a research study are made available to qualified investigators and non-study researchers. However, the institute also requires that your personal information, dates, or data that can identify you be removed or changed. The data will only be provided to investigators who agree in advance to adhere to established policies for distribution.

Specific measures will be taken to remove information that identifies you from your blood samples. All samples will be kept and stored in a secure place. Your sample will be identified by a unique code and your study identification number. Your name will not be on the sample. However, this code and your study identification number can be linked to your age, gender, ethnic background, and other information collected about you during the study. If the information linking your coded samples to you is destroyed, your samples can no longer be linked to you.

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.

WHAT ARE THE COSTS?
There will be no additional costs to you as a result of being in this study. However, routine medical care for your condition (care you would have received whether or not you were in this study) will be charged to you or your insurance company. Please ask <insert name> if you would like to know more about which tests and studies are being done solely for research purposes.

WHAT ABOUT COMPENSATION?
You will receive no monetary compensation for participation in the study.

WHAT ABOUT RESEARCH RELATED INJURIES?
Immediate necessary medical care is available at **(insert Site's name here**) in the event that you are injured as a result of your participation in this research study. However, there is no commitment by the NHLBI, Duke University, DCRI or **(insert Site's name and Site's PI name here)** to provide monetary compensation or free medical care to you in the event of a study-related injury.

For questions about the study or research-related injury, contact ***(insert PI's name here)*** at ***(insert PI's number here with area code)*** during regular business hours and at ***(insert PI's 24-hour number here with area code)*** after hours and on weekends and holidays.

WHAT ABOUT MY RIGHTS TO DECLINE PARTICIPATION OR WITHDRAW FROM THE STUDY?

You can withdraw from the study at any time, without penalty. The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped. If you withdraw, no new information will be collected for study purposes unless the data concern an adverse event (a bad effect) related to the study. If such an adverse event occurs, we may need to review your entire medical record.

Your decision not to participate or to withdraw from the study will not involve any penalty or loss of benefits to which you are entitled, and will not affect your access to health care. If you do decide to withdraw, we ask that you contact Dr. [PI] in writing and let [him/her] know that you are withdrawing from the study.

WHOM DO I CALL IF I HAVE QUESTIONS OR PROBLEMS?

For questions about the study or a research-related injury, or if you have problems, concerns, questions or suggestions about the research, contact Dr. ***(PI's Name)*** at ***(PI's Number with Area Code)*** during regular business hours and at ***(PI's 24-hour Number with Area Code)*** after hours and on weekends and holidays.

For questions about your rights as a research participant, or to discuss problems, concerns or suggestions related to the research, or to obtain information or offer input about the research, contact [*insert site IRB contact information*].

STATEMENT OF CONSENT

The purpose of this study, procedures to be followed, the study's risks and benefits have been explained to me. I have been allowed to ask questions, and my questions have been answered to my satisfaction. I have been told whom to contact if I have questions, to talk about problems, concerns, or suggestions related to the research, or to obtain information or offer input about the research. I have read this consent form (or it has been read to me) and I agree to be in this study, with the understanding that I may withdraw at any time. I have been told that I will be given a signed and dated copy of this consent form and it will become part of my medical record.

_____ _____
Signature of Research Subject Date

_____
Printed Name of Research Subject

_____ _____
Signature of Research Team Member Who Obtained Consent Date Time

_____
Printed Name of Research Team Member Who Obtained Consent