CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Funding Agency / Study Title:	**National Institute of Health (NIH) / "rFVIIa for Acute Hemorrhagic Stroke Administered at Earliest Time (FASTEST) Trial"**
Protocol Number:	**03496883 (FASTEST)**
Principal Investigator (Study Doctor):	**Kyle Walsh, MD, MS**
Telephone:	**513-688-5405 (24-Hour)**
Address:	**University of Cincinnati Gardner Neuroscience Institute** **3113 Bellevue Avenue** **Cincinnati, OH 45219** **University of Cincinnati Medical Center** **234 Goodman Street** **Cincinnati, OH 45219** **UC Health Physicians Office** **222 Piedmont Ave.** **Suite 5300** **Cincinnati, OH 45219** **UC Health Mobile Stroke Unit** **9150 Winton Rd** **Cincinnati, OH 45231-3830**

This form is for use in a research study that involves participants who are unconscious or in a coma and do not have the capacity to consent to take part in the study. You are the legally authorized representative (LAR) of the patient. If you are being asked to give permission for someone else to be in this study, you should try to determine whether that person would want to be in the study. When the participant cannot legally consent to take part, pronouns "you" and "your" should be read as referring to the participant rather than the person (legally authorized representative) who is signing this form for the participant. In cases where the participant's representative gives consent, the participant should be informed about the study to the extent possible given his/her understanding. During the course of the study, if the participant regains the capacity to consent, informed consent will be obtained from the participant and the participant offered the ability to leave the study, if desired.

KEY INFORMATION:

Purpose of the Study:	The purpose of this research study is to see if a medicine used to treat and prevent bleeding improves outcomes after a stroke caused by bleeding in the brain. The medicine is called Recombinant Factor VIIa. Participants in this study will receive either the medicine or a placebo that contains no active medications. This is a research study and use of the medicine is not approved by the U.S. Food and Drug Administration as it is being used in this study.
Length of the Study:	You will be in this study for 180 days. You will have three visits either in-person or remotely (by video or telephone) after you leave the hospital.
Risks:	Serious blood clots that form in veins and arteries with the use of Recombinant Factor VIIa have been reported. These blood clots may cause heart attacks, strokes, and other life-threatening problems.
Benefits of the Study:	Because the purpose of the study is to determine the effectiveness of Recombinant Factor VIIa compared to a placebo, it is not known whether you will benefit from being in this study.
Alternative Procedures:	If you do not participate in this research study, you will be treated with the standard of care.

INTRODUCTION:

You are being asked to be in this study because you had a stroke caused by bleeding in your brain. You are an appropriate candidate for this study, but you do not have to be in it. It is your choice. Either way, you will be treated with the standard of care used for this kind of stroke. If you decide to be in the study, you can stop participating at any time.

This form tells you about the study. Please ask questions about anything that you do not understand.

WHAT IS THE STUDY ABOUT?

The FASTEST study is designed to see if Recombinant Factor VIIa (rFVIIa) works better than a placebo to improve your outcome after your stroke. A placebo contains no active medication. rFVIIa is identical to a protein made in your body to help form blood clots at the site of injury to a blood vessel.

In previous research studies in people that had a stroke caused by bleeding in the brain, treatment with rFVIIa showed different results. In one study, rFVIIa slowed bleeding in the brain compared to placebo and improved outcome at 90 days after a stroke. In another study that included more participants, it also slowed bleeding, but it did not improve outcome. Participants chosen for the current study represent the subgroup of patients with bleeding in the brain from previous studies who may be most likely to benefit. For example, it appeared that participants treated sooner with rFVIIa after their stroke did better. In all of these studies, serious side effects occurred slightly more often in participants that received rFVIIa.

About 860 participants will be in this study.

WHAT IS INVOLVED IN THE RESEARCH STUDY?

You will receive either rFVIIa or a placebo. A placebo looks like rFVIIa but contains no medication. Which one you receive will be determined by chance (like flipping a coin). You will have a 50/50 chance to receive either one. rFVIIa or the placebo will be given to you through a vein in your arm within 2 hours of the start of your symptoms. Neither you nor the study doctors will know which one you receive.

rFVIIa is approved by the U.S. Food and Drug Administration (FDA) for use in inherited bleeding disorders, but not for the treatment of stroke. Therefore, rFVIIa is experimental in stroke treatment; it is not approved by the FDA as it is being used in this study.

We will also try to keep your systolic blood pressure at 140. Systolic blood pressure (the first number) indicates how much pressure your blood is exerting against your artery walls when the heart beats.

You will have a CT scan of your brain 24 hours after the start of your symptoms. This scan is part of the standard of care for patients that have had a stroke caused by bleeding in the brain.

We will check how you are doing in the hospital before you are discharged. We will contact you by video or telephone at 30 and 90 days after you had your stroke to see how you are doing. You will then come into the clinic for a visit 180 days after your stroke to see how you are doing.

You will receive all other standard of care procedures for people that have had a stroke caused by bleeding in the brain.

WHAT ARE THE POSSIBLE RISKS OF TAKING PART IN THE STUDY?

rFVIIa may increase the risk of developing life-threatening blood clots. These blood clots could cause a heart attack, a stroke, or serious lung problems. In previous studies, these events occurred about 5% more often in participants treated with rFVIIa as compared to participants that received placebo. This means if 100 participants received rFVIIa or placebo, about 5 more participants in the rFVIIa group would have one of these serious side effects than participants in the placebo group. Bleeding in the brain, with or without rFVIIa, is associated with increased risk of these conditions because of stress on the heart from the brain injury, increased pressure in the brain from the bleeding in the brain, and inability to get out of bed initially, which increases risk of clots in veins in the leg.

There may be unknown risks to you.

WHAT ARE THE REPRODUCTION RISKS?

Women who are known to be pregnant will not be enrolled in the study, but it may not be possible to obtain the results of a pregnancy test before enrollment. If you are currently pregnant, you should inform the study team and your study doctor. There are no known risks of the single dose of rFVIIa

used in this study to a pregnant woman or a fetus, but there may be risks that are not yet known.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART IN THE STUDY?

Because the purpose of the study is to determine the effectiveness of rFVIIa compared to a placebo, it is not known whether or not you will benefit from being in this study. However, the knowledge gained from this study may help doctors learn more about what treatments are most effective for stroke.

WHAT IS THE ALTERNATIVE TO BEING IN THE STUDY?

If you do not participate in this research study, you will be treated with the standard of care used in a critical care unit with management of blood pressure. There is currently no scientifically proven treatment for strokes caused by bleeding in the brain.

AVAILABILITY OF INFORMATION:

You will receive a copy of this signed and dated consent form, as well as a separate form that tells you about the use and sharing of your information.

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 HAPPENS IF YOU ARE HARMED BY BEING IN THE STUDY?

In the event that you become ill or injured from participating in this research study, emergency medical care will be provided to you. The study site will decide on a case-by-case basis whether to reimburse you for your out of pocket health care expenses.

WHAT ARE YOUR COSTS TO BE IN THIS STUDY?

The study will pay for the rFVIIa and the placebo. The study will not pay for the standard medical care that you receive during the study. The costs of your standard medical care will be billed to you or your insurance.

WILL YOU BE PAID FOR BEING IN THE STUDY?

You will not be paid for being in this study but travel expenses (up to $100.00) for the follow-up visit at 180 days will be provided. You will be reimbursed after you submit your travel receipts to the study staff. Reimbursements will be made by using a reloadable debit card and will be loaded onto the card within two days of receiving reimbursement documentation from you. The debit card will be assigned to you at the 180-day study visit. Details of the system are provided inside the reloadable debit card envelope. You will be asked to complete a W-9 tax form to report the compensation to the Internal Revenue Service. The amount you receive may count as income and may affect your income taxes.

WHAT CAN I EXPECT FROM THE RESEARCHERS?

If at any time the study team finds out about unexpected risks or dangers to you or others in the study, they will inform you and may remove you from the study, if needed, in accordance with

standard medical practice. They will also honor any decision you make to withdraw from the study at any time. Your medical care will not be compromised in any way.

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

- If it appears to be medically harmful to you;
- If you fail to follow directions for participating in the study;
- If it is discovered that you do not meet the study requirements;
- If the study is canceled; or
- For administrative reasons.

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

WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is voluntary. If you decide to take part, you may leave the study at any time. Refusal to participate or leaving the study will not result in any penalty or loss of benefits to you. The data collected on you to the point of withdrawal remains part of the study database and may not be removed. If you withdraw, the study doctor will ask you if you are willing to provide further information from routine medical care. Nothing in this consent form waives any legal rights you may have nor does it release the study doctor, the funder, the institution, or its agents from liability for negligence.

WILL YOUR INFORMATION BE KEPT PRIVATE?

The study site will keep your information private and follow all research regulations. We will use a code rather than your name to label your information, and we will not identify you in research reports. Your records may be reviewed by study funders or the federal FDA, as allowed by research regulations.

Your identity will be kept as confidential as possible as required by law. Except as required by law, you will not be identified by name, social security number, address, telephone number, or any other direct personal identifier outside of NIH StrokeNet.

There is a slight risk in any research study that your personal information could be accidentally released to people who are not supposed to have it.

Your health information will be stored and shared with other researchers. The information will be available for any research question, such as research to understand what causes strokes, or development of new scientific methods.

To further protect your privacy, the researchers have obtained a Certificate of Confidentiality from the Department of Health and Human Services (DHHS). With this certificate, the researchers may not

disclose information (for example, by court order or subpoena) that may identify you in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings. Disclosure will be necessary, however, upon request of DHHS for audit or program evaluation purposes.

The Certificate cannot be used to refuse a request for information from personnel of the U.S. federal or state government agency sponsoring the project that is needed for auditing or program evaluation by the agency which is funding this project or for information that must be disclosed in order to meet the requirements of the federal Food and Drug Administration (FDA).

A Certificate of Confidentiality does not prevent you from voluntarily releasing information about yourself or your involvement in this research. If you want your research information released to an insurer, medical care provider, or any other person not connected with the research, you must provide consent to allow the researchers to release it.

Even with the Certificate of Confidentiality, if the investigator learns about abuse of a child or elderly person or that you intend to harm yourself or someone else, or about certain communicable diseases, they will report that to the proper authorities. If keeping information private would immediately put you or someone else in danger, the researchers would release information to protect you or another person.

The Certificate of Confidentiality will not be used to prevent disclosure for any purpose you have consented to in this informed consent document.

WHOM TO CONTACT ABOUT THIS STUDY?

During the study, if you experience any medical problems, suffer a research-related injury, or have questions, concerns, or complaints about the study, please contact the study doctor at the telephone number listed on the first page of this consent document. If you seek emergency care, or hospitalization is required, alert the treating physician that you are participating in this research study.

An institutional review board (IRB) is an independent committee established to help protect the rights of research participants. If you have any questions about your rights as a research participant, and/or concerns or complaints regarding this research study, contact:

- By mail:
  Study Subject Adviser
  Advarra IRB
  6940 Columbia Gateway Drive, Suite 110
  Columbia, MD 21046
- or call **toll-free**: 877-992-4724
- or by **e-mail**: adviser@advarra.com

Please reference the following number when contacting the Study Subject Adviser: Pro00041014.

CONSENT:

Please print your name, sign, and date below if you agree to be in the study. By signing this consent form, you will not give up any of your legal rights.

Name of Participant (PRINT)	Telephone Number
Signature of Participant (18 or older with capacity to consent)	Date

OR

Name of Legally Authorized Representative (PRINT)	Telephone Number
Signature of Legally Authorized Representative	Date
Relationship or Authority of Legally Authorized Representative to Participant	

Person Obtaining Consent

I attest that the requirements of informed consent for this research project have been satisfied – that the Experimental Subject's Bill of Rights, if appropriate, has been provided and that I have discussed the research and explained in non-technical terms all of the information in this consent form, including risks and adverse reactions that may be expected. I encouraged the participant to ask questions and that all questions asked were answered.

Name of Person Obtaining Consent (PRINT)	
Signature of Person Obtaining Consent	Date

WITNESS STATEMENT (FOR CONSENT):

The participant or LAR is unable to read or sign this consent form because of the following reason(s):

___ The participant or LAR is non-English speaking.
___ The participant or LAR is illiterate.
___ The participant or LAR is visually impaired.
___ The participant or LAR is physically unable to sign the consent form. Please describe:

_____

___ Other (please specify): _____

I confirm that I was present as a witness for the consent process for this study. I confirm that the participant named above was read the information in the consent document and that the participant has agreed to take part in the research study.

_____
Name of Impartial Witness (PRINT)
(may be interpreter if participant/LAR is non-English speaking)

_____ _____
Signature of Impartial Witness Date

REFUSAL OF CONTINUED PARTICIPATION:

Please print your name, sign, and date below if you do not want to continue to participate in this study. By signing this form, you will not give up any of your legal rights.

Name of Participant (PRINT)	Telephone Number
Signature of Participant (18 or older with capacity to consent)	Date

OR

Name of Legally Authorized Representative (PRINT)	Telephone Number
Signature of Legally Authorized Representative	Date
Relationship or Authority of Legally Authorized Representative to Participant	

Person Obtaining Refusal

I attest that the requirements of informed consent for this research project have been satisfied – that the Experimental Subject's Bill of Rights, if appropriate, has been provided and that I have discussed the research and explained in non-technical terms all of the information in this consent form, including risks and adverse reactions that may be expected. I encouraged the participant to ask questions and that all questions asked were answered.

Name of Person Obtaining Refusal (PRINT)	
Signature of Person Obtaining Refusal	Date

WITNESS STATEMENT (FOR REFUSAL OF CONTINUED PARTICIPATION):

The participant or LAR is unable to read or sign this consent form because of the following reason(s):

___ The participant or LAR is non-English speaking.
___ The participant or LAR is illiterate.
___ The participant or LAR is visually impaired.
___ The participant or LAR is physically unable to sign the consent form. Please describe:
_____
___ Other (please specify): _____

I confirm that I was present as a witness for the consent process for this study. I confirm that the participant named above was read the information in the consent document and that the participant has refused to continue to take part in the research study.

_____
Name of Impartial Witness (PRINT)
(may be interpreter if participant/LAR is non-English speaking)

_____ _____
Signature of Impartial Witness Date

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION:

A federal regulation known as the Privacy Rule requires that the researchers get your written permission to use your health care information in this research study. If you sign and date this form, you are giving your authorization for the use and disclosure of your health information for research purposes. You do not have to give this authorization. If you do not give your authorization you cannot be in the research study. However, if you are being treated as a patient at UC Health or UC Hospital, you will still be able to receive care.

Who Will Use and Disclose My Health Information?

The researchers will use your health information to conduct, review, and determine the results of the study. The researchers may also use your information to prepare reports or publications about the study. Your name will not appear in any report or publication without your permission.

Who Will Receive My Health Information?

The following people or groups may receive your health information:

- Representatives of the University of Cincinnati.
- Representatives of NIH StrokeNet National Coordinating Center (NCC).
- Representatives of Advarra IRB (an Institutional Review Board that reviews this study).
- The Food and Drug Administration (FDA) and other U.S. federal and state agencies.
- Government agencies to whom certain diseases (like HIV, hepatitis, and STDs) must be reported.
- Governmental agencies of other countries.
- Outside individuals and companies, such as laboratories and data storage companies, that work with the researchers and sponsor and need to access your information to conduct this study.
- Other research doctors and medical centers participating in this study, if applicable.
- A data safety monitoring board which oversees this study, if applicable.
- The funder of this research, National Institute of Health.
- The NIH StrokeNet National Data Management Center (NDMC), housed in the Data Coordination Unit (DCU) in the Department of Public Health Sciences at the Medical University of South Carolina (MUSC).

Will My Information be Protected by the Privacy Rule After it is Disclosed to Others?
If the groups above share your health information with others, it will no longer be protected by the Privacy Rule.

Will My Authorization Ever Expire?
Your authorization will not expire.

May I Take Back My Authorization?
You may take back your authorization at any time by writing to the study doctor. If you take back your authorization, you will not be able to stay in this study. If you take back your authorization, the study team will not collect any new health information about you. Information that has already been collected may still be used and given to others. If you withdraw your authorization, no new health information will be collected unless you have a side effect related to the study.

May I Look At My Study Information?
You may be able to look at and make copies of your health information collected for this study when the study is completed. However, to ensure the reliability of the study, you will need to wait to see your study records until the study is completed.

AUTHORIZATION:

Please print your name, sign, and date below if you agree to allow study staff to collect, use, and share your health data as described above. You will receive a signed and dated copy of this form for your records. By signing this form, you will not give up any of your legal rights.

Name of Participant (PRINT)	Telephone Number
Signature of Participant (18 or older with capacity to consent)	Date

OR

Name of Legally Authorized Representative (PRINT)	Telephone Number
Signature of Legally Authorized Representative	Date
Relationship or Authority of Legally Authorized Representative to Participant	

WITNESS STATEMENT (FOR AUTHORIZATION):

The participant or LAR is unable to read or sign this authorization form because of the following reason(s):

___ The participant or LAR is non-English speaking.
___ The participant or LAR is illiterate.
___ The participant or LAR is visually impaired.
___ The participant or LAR is physically unable to sign the authorization form. Please describe:

_____

___ Other (please specify): _____

I confirm that I was present as a witness for the authorization process for this study. I confirm that the participant named above was read the information in the authorization document and that the participant has agreed to allow study staff to collect, use, and share his/her health data as described above.

_____

Name of Impartial Witness (PRINT)
(may be interpreter if participant/LAR is non-English speaking)

_____ _____

Signature of Impartial Witness Date