# Patient information and informed consent form for the study

## Management of congestion in the patient with Heart Failure acute, by adding Dapagliflozin to conventional therapy ENDORSE-HF

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**Contents:**

**1 Why was I given this consent to read?**
**You are being invited** to **voluntarily participate** in a clinical research study **to determine whether the drug Forxiga (Dapagliflozin) is safe and has beneficial effects when given to people with left ventricular (LV)** dysfunction **and/or pulmonary congestion. Before** you **agree to participate in this study, you should** be aware of **the risks and benefits so that you can make an informed** decision . **This process is known as " informed consent ."**

This consent **form outlines the study you are being invited** to **participate in. Please read the information carefully and discuss it with anyone you wish. If you have any questions, please ask the study doctor or a member of the study staff.**
**Your decision to participate in this study is voluntary. This means** that: • **You are free** to **decide whether** or not **to participate in this study. • You can stop the study treatment** and **study-related activities** at any time **without having to give a reason.**

• **If you do not want** to **participate in this study, this decision will not affect** your care **medical.**

**2 What is a clinical research study?**

**A clinical research study is a study that involves people** to answer specific health questions. **Carefully conducted clinical research studies are the safest and most effective way to identify treatments that work in people and to establish new ways to improve medical care. Clinical research has two goals:**

1. **to identify a treatment that may be better or safer than the treatment already available existing.**
2. **to obtain information that may be beneficial to other people, even though at this time no one can be sure** that **this investigational treatment can help** you .

**3 What is the purpose of this clinical research study?**
**This clinical research study is not sponsored by a pharmaceutical company.**
**The purpose of this study is to verify whether Dapagliflozin administered once daily to patients with acute heart failure along with other specific treatments is safe** and effective in reducing congestion in heart failure, reducing hospitalization for **heart failure (HF), and death.**

**Dapagliflozin is a drug that has been approved by the National** Agency **for Medicines and Medical Devices for the treatment of people suffering** from **chronic heart failure . (NYHA Class II-IV) and reduced ejection** fraction.

**The reason for this study is to find out if these drugs are a better treatment for patients** with HF and **LV dysfunction and/or pulmonary congestion.** LV **dysfunction is a** condition **in which the heart is unable** to **adequately pump blood through the heart, which leads to fluid accumulation, most often in the lungs. Pulmonary congestion is the accumulation of fluid in the lungs that leads to difficulty breathing.**

**3.1 Who will participate in this study?**

**The study will include both men and women who show signs of LV** dysfunction **and/or pulmonary congestion, at least 18 years old, and who are hospitalized in the cardiology department with a diagnosis of acute heart failure.**

## 3.2 How long will my participation in the study last?

**The duration of participation in this study is 30 days.**

**4 What will happen if I participate in this study?**

## 4.1 What happens before the initiation of study treatment?

**If you agree** to **participate** in the study by signing this **informed** consent **form, your study doctor will** ask you **some questions about your health , medical history , and any medications** you **are** taking.

- **Your study doctor will perform a physical examination, including measuring your height, weight, blood pressure, pulse , and other physical characteristics.**
- **The study doctor may also perform other tests, including an electrocardiogram (or ECG or EKG), blood and urine laboratory tests , chest X-ray , and echocardiography. • The study doctor may also** ask you **for the results** of **previous** tests **inpatients, such as blood tests, laboratory tests, ECG evaluations, echocardiography, and chest X-ray.**

**The study doctor will analyze the results of the selection procedures and inform** you if **meet the requirements for continued participation in the study; if you do not meet them, your participation will end after the selection period.**

## 4.2 What happens during study treatment?

**During the study treatment, you will receive Forxiga 10mg/day.** You will **be asked** to **take one tablet / day, and other medications prescribed by the doctor during hospitalization and after discharge. Your doctor may adjust the doses of other medications** you are taking. **If** necessary , **your doctor may also ask** you to **stop taking the study medication or other unrelated medications you are taking, either temporarily or permanently. It is important to know** that **even if you stop** taking the **study medication, you must** still **attend study visits so that your doctor** can **continue to monitor your progress and** report **any** important **events in your health .**

**The following checks will be performed at all study visits, i.e. 14 and 30 days after discharge**

- **You will have a clinical examination. The study doctor will discuss all the components of these visits. •** Your weight, blood pressure, **and pulse will be recorded . • The study doctor will assess for signs and symptoms of heart failure. • You will be asked questions about how** you are feeling **and any changes in your other medications you are** taking.
- You will **be asked about any changes in your health since your last visit.**
- **Every 30 days, a blood sample will be taken for laboratory analysis. Each time , will collect 10-12 ml (about 2 to 3 teaspoons) of blood. •** You will **be asked** to **fill out some questionnaires about how** you are feeling

**You will be asked** to **return** to your **study doctor's office** at regular intervals for monitoring **of your condition. The study doctor may also ask** you to:
**return to the study site for any visits other than those** mentioned in this **informed** consent **form .** Detailed **information** about when your **study doctor will visit and the procedures that will be performed** will be provided to you by your doctor or **study staff.**

**During long-term treatment, your doctor may** need **to** adjust **the dose of your study medication or other medications** you are taking. **You must** take **your study medication as** directed **by your study doctor. It is important not** to **miss any doses. Your study doctor may decide** to **stop** your study medication if you have any of the following:

**treatment either temporarily or permanently. You** will **be asked** to continue **to attend** all **study visits and** report **any changes in your health , even if you are no longer taking the study medication. This is very important because the study doctor needs to continue to monitor your progress until the study is complete. If** you **are unable to attend any of the study visits, you must** inform **your** study **doctor . The study doctor may also** contact you **periodically to see how** you are feeling **and if** you have **noticed any changes in your health.** You will **be asked** to **provide the name and** telephone number **of one or more contact persons who can be called if** you **are unable to attend a visit or cannot be reached by telephone, so that your doctor or study nurse/coordinator** can **find out details about your health .**

**Prohibited drugs**

**There are different types of medications that you cannot take during the study because they can** increase **the chance that the study drug** will **harm** you . **This is why it is very important** to **tell your study doctor about any medications you are taking or any new medications you start taking** during **the study. This includes prescription medications and over-the-counter medications ( such as pain relievers,** cough/cold medications, **herbal/ homeopathic medicines, herbal remedies, salt** substitutes , **and vitamins). If**

**If you experience any unusual symptoms , contact your study doctor or study staff.**

### 4.3 What biological samples will be collected during the study?

### The blood samples collected during the study will be the usual ones: Complete blood , count, urea creatinine, blood glucose, transaminases, NT-proBNP, troponin, ferritin ionogram.

### 4.4 Can I stop during the study treatment or decide not to continue the study?

**Yes, you can.**
Please inform **your doctor or study staff if you decide** you **no longer want** to participate .
**continue study treatment.**
You will **be asked** to **return to the study center as soon as possible to see how** you are **feeling.**
You **may** be **asked** to **continue study visits after you stop study treatment so that all or some of the assessments can be completed.** This **will improve the study even if** you are **no longer taking the study medication.**

**If you are unable or unwilling** to **continue** to attend **visits while you are off the study medication, your doctor or study staff may contact** you by phone until **the end of the study to see how** you are **feeling.**

**New information** that **may affect** your **participation in the study will be communicated** to you **as it becomes available. You can decide whether you want** to **continue** with **the study treatment** and other **study-related activities .**

**You may decide** that **you want** to **stop the study treatment but also not** to attend **any further visits ,** have any **further assessments or** have any **further contact with the doctor which will be considered . This will be as withdrawing your consent to participate in this study. If** you
**If you wish to do so, it is important** to **inform your study doctor of your decision to withdraw** your consent.

**Choosing to withdraw from this study will not** affect your **medical care.**
**You can return to your usual** medical care **and** discuss **this with your study doctor.**
Although **you have the right to withdraw** your consent **to continue participating in the study, including being contacted by study staff,** you will **be asked if you allow study staff** to:
**determine your health status based on data obtained from a medical professional, from public or medical records, or from other available sources.**

**4.5 Is there any reason why my study treatment or participation in the study may be stopped early?**

**The study physician** may remove you **from this study for any justified reason, according to the protocol.**
**Here are some examples of reasons why you should** stop **some** or all **study activities ,** including study treatment:

**1. You need a treatment that is not allowed in this study 2. You do not follow** the instructions **3. You experience side effects of the study treatments that you consider unacceptable.**
4. Your **study doctor** believes that **keeping you in the study would be harmful to you.**

**4.6 What will happen after I finish my studies?**

**At** the end **of the study** you will **return to your usual medical care, with or without treatment depending on how well you tolerate Forxiga.**

**After the study is completed, a summary of the study results will be sent to your study doctor. The study doctor and/or representatives may** communicate **these results** to you , as **appropriate. necessary.**

**5 What are the possible benefits to me if I choose to participate in this study?**

**You may** not **receive any direct benefit from participating in this study. However, you may benefit** from **intensive monitoring and** follow-up, **which is necessary throughout the study, whether** or not **you receive the study drug. Your participation may help** other **patients** get **better in the future.**

**6 What are the possible risks to me if I choose to participate in this study?**

**Risks are possible side effects of the study treatment or other medication, of the tests performed during the study, and of blood collection. Clinical studies conducted to date have shown** that **Forxiga is safe and well tolerated. Side effects reported in patients receiving Forxiga are shown in Table 6-1.**

**Table 6-1 Adverse events considered to be expected for reporting purposes Forxiga**

| Classification by organs, systems and systems | Very common* | Frequent* | Uncommon ** | rarely | Very rare |
|---|---|---|---|---|---|
| Infections and infestations | | Vulvovaginitis, balanitis and related genital infections*,b,c Urinary tract infection *,b,d | Infection fungous** | | fascitis necrotic that affects perineum (gangrene Fournier) b,i |
| Metabolic and nutritional disorders | Diabetic when used hypoglycemia ( when used in diabetes) SU or insulin) b | Ketoacidosis when (when when together with type 1 sugar )b,i,k | Volume depletion Thirst** | Ketoacidosis DIABETIC- (when it was used in diabetes sugary type | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | 2)b,i,l | |
| Nervous system disorders | | Dizziness | | | |
| Gastrointestinal disorders | | | Constipation | | |
| Kidney and urinary tract disorders | | Dysuria<br>Polyuria | | | |

**Important aspects about side effects:**

- **Your study doctor cannot predict who will experience side effects and who will not.**
  **not**
- **Some side effects may** go away **quickly, some may last longer, others may** not **go away never**
- **Some side effects can be serious and can lead to death**
- **As with** any **medicine,** an **allergic reaction can occur . These reactions can be mild or more severe. Common symptoms include** rash , **itching, skin problems, swelling of** the face **and throat , and difficulty breathing. If you suspect** you **are having** an **allergic reaction ,** call **your study doctor immediately at** _____ **or go to your doctor.**

  **Here are some important points about how you can alleviate the side effects, yourself and the study**

  **doctor: • Tell the study doctor if you notice or** feel **anything is different** • The **study doctor may treat side effects or adjust the study treatment to try** to **reduce side effects • Ask your study doctor for more information about the possible risks and side effects of the study treatment. In** rare cases **where a nurse, doctor or laboratory technician is exposed to your blood, tissue or body fluids through a needle** stick , **cut or splash on mucous membranes or wounds, it may be necessary** to **have** a **blood,** tissue or body fluid **test to identify certain viral infections including hepatitis B and C, as well as** HIV on the sample already collected. **This is to allow the person** to **receive counseling, monitoring and treatment, if necessary. In this case, the study doctor** will give you **information relevant to your health and** recommend **next** steps. **The confidentiality of your test** results **will be maintained at all times.**

**7 What do I need to know about contraception and pregnancy?**

**Pregnant or breastfeeding women cannot participate in this study. You** must **confirm** that **after** To the best of your **knowledge , you are not currently pregnant and** do **not intend** to **become pregnant during the study.**

**Studies in pregnant animals have shown** that **one of the medications you will** be **taking in this study may have adverse effects on** your **unborn baby .** To participate in this study, **you must use** a **highly reliable method of contraception,** as it is not **yet known whether the study treatment may adversely affect** the **fetus .** Please discuss **with your study doctor** which **method of contraception is most effective for you and your cultural and religious situation.**

**Examples of highly effective methods of**

**contraception: • Complete abstinence , when this fits your preferred and** usual **lifestyle . Periodic** abstinence **such as the calendar method,** ovulation method, **sympto-thermal method, post-ovulation method , and withdrawal method are not accepted as methods of contraception.**

- **Sterilization, if** you have **already been surgically sterilized before the study by bilateral excision of the ovaries (the female reproductive system that stores and releases eggs for fertilization and produces female sex hormones) with or without hysterectomy or ligation (tubal ligation) at** least **six** weeks **ago.**

- **Sterilization of the male partner (at** least **6 months before the first visit) justified with the relevant documentation. The sterilized male partner must** be **your only partner.**
- Use of **oral, hormonal (estrogen and progesterone), injected or implanted contraceptive methods** or placement of an intrauterine device or intrauterine system or use of other forms of **hormonal** contraception **with similar** effectiveness **(failure rate less than 1%) such as a hormonal vaginal ring or transdermal hormonal** contraception. **If using oral contraception ,** you must have **taken the same pill for at** least **3 months before you** take **the study treatment. If local** legislation **differs** from **the contraceptive methods listed in** section 7, then **local legislation applies.**
  **For safety reasons,** you **must also** agree **not** to **become pregnant while participating in this study.** Please inform **your doctor or study staff if you think you** may be **pregnant and want** to **stop the study treatment immediately. If** If **you become pregnant,** you will **be asked** to **read and** sign **a separate informed consent form, agreeing** to **be contacted** by the **study doctor and asked** questions **about your pregnancy, birth , and the health of your child.**

**8 What are my responsibilities and are there any costs I have to bear if I agree to participate in the study?**
**If you agree** to **participate in this study,** you will **have the following responsibilities: Related to consultations/visits and procedures within the study:**

• Follow the instructions **of the study doctor and study staff** • Attend all **study appointments** If **you need** to **miss any appointment, you must** contact **the study doctor or study staff for a reschedule.**

- Complete **the required study activities** as **instructed, such** as **fill out questionnaires**

**Related to the study treatment: •**

**It is very important** to **take the study treatment as** directed **by the study doctor and not** to **use it for anything else. Do not skip any doses of the study treatment.** • Keep **the study treatment in a safe place,** out **of** the **reach of children and use only you.**

- **You can talk to a doctor or healthcare professional who is not directly involved in the study about health or medical issues related to your study** treatment .

**Related to side effects and other medications you may be taking:**

- Tell **the study doctor or study staff if you experience any unusual symptoms , any side effects , and about other visits or hospitalizations you have had . • You must** tell the study doctor about any medications you are **currently taking** or **might take during the study, including prescription medications , over** -the-counter **medications , vitamins , and supplements.**
- **If you are taking other medications, you may** need **to** stop **them or** reduce the **dose to manage side effects. The goal is to avoid combining the effects of other medications with those of the study treatment. Your study doctor will discuss this with you.**

**Cost-related: • You**

**will not have** to **pay for any of the tests and procedures performed solely for the purpose of research.**

**9. What will happen if I am injured because I participate in this study?**
**It is important** to strictly **follow all** instructions **provided by the study doctor and** his/her **staff regarding the study.**
**If** you **become ill or are** physically **injured** as a **result of participating in this study ,** please **contact the study doctor or a member of the study team immediately;**

**Name of Principal Investigator: _____ Phone No.:**

_____

**Name of other study team member:** _____ **Phone number:**

_____

**He (she) will treat** you or refer you **to another doctor for treatment.**

**10. 1What will happen to my personal data? What is personal data?**

**The study physician will collect your Personal Data, i.e. name, initials, address, gender, age/date of birth, health information , biological samples and medical imaging.**

**If necessary, the study doctor** may contact your **personal doctor to collect more medical information about you. He or she may also check your health status using public records if the law allows it.**

## 10.2 What will my personal data be used for?

Your **personal data** will be reviewed to see if **the study is accurate and if the study medicine is safe and effective. It will be analyzed together with the personal data obtained from** all **other participants in this study so that** we can **learn more about the effects of the medicine.**

**Your personal data may also be combined with data from other studies.**
**This helps us** to **better analyze and** understand the safety **and effectiveness of the study medicine. Personal data may be used to verify that the study is accurate and conducted correctly.**

**Authorize access to your Personal Data, including your** records **original medical.**

## 10.3 Where is personal data stored and secured?

Your **personal data** will be stored at the study center for the period required by **local regulations .**

**A summary of the results will also be published at conferences or in journals. If the results of the study are made public, your name will not be mentioned.**

## 10.4 Who can see my personal data?

Your **personal data** will be **kept secure and will only be communicated to the persons listed below:**

**• Study physician and study staff,**

- **Ethics committees that review** the ethical aspects of **the study, • Health authorities or other authorities, as appropriate.**
- **Other third parties (which may include third parties from other jurisdictions),**

**However, these individuals must** maintain **the confidentiality of Personal Data. They may be located in** Switzerland, **countries within** the European Economic Area **(EEA), or other countries , such as the United States.**

### 10.5 Your exact rights regarding personal data

**You have the right to review your Personal Data. However, during the study, access to your Personal Data may be limited if it affects its integrity. You may** have access to your **Personal Data** at the end of the study.

**If you have any questions about the collection and use of your information , you should contact** your **study** physician . **You should also let them know if you wish** to **exercise** any of your **rights regarding this information; for example, if you wish** to **have some of your Personal Data corrected or** to have your **withdraw** consent.

**You can contact the person indicated in the contact details section of this** consent at any time **if you have any questions about the Informed Consent Form or the** collection , **processing or use of your Personal Data as described above. You also have the right by law to file complaints with the competent data privacy authority .**

**In accordance with Law no. 677/2001, you benefit, under** the conditions **mentioned above, from the right of access, intervention on the data, the right of opposition, the right not to be subject to an individual decision and the right to** address **the** justice. **Refusal to provide the above data determines** the impossibility of **your participation in the study. If you have any questions regarding the collection and use of information concerning** you **or if you wish** to **exercise** your **rights under the law, please** contact your **study doctor** with **a written, dated and signed** request.

### 11 Where can I get more information?

**If you have any questions about the study,** please contact **the study doctor or a member of the study team .**

Investigator

**12 Signature page**

**Study title:**

**I have read this document/** its contents **have been explained to me. I understand the purpose of this study and what will happen to me during this study. I freely consent** to **participate in this study as described to me in this document. I understand** that **I will receive a copy of this document as signed below.**

**By signing this consent form , I authorize the use, access and transmission of my Personal Data as described in the Section "What will happen to my personal data?" This consent is valid until and only if I revoke it.**

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_____ _____ _____

Patient Signature Date

*(name clearly)*

_____ _____ _____

Investigator Signature Date

*(name clearly)*

_____ _____ _____

Witness (if patient cannot sign) Signature Date