

INFORMED CONSENT FORM

Title of Study: CARVEDILOL IN THE PHARMACOTHERAPY OF HYPERTENSION

NCT#02056626

Sponsor: National Institutes of Health

Principal Investigator: John Bisognano, M.D., Ph.D.

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Institution: University of Rochester School of Medicine and Dentistry

Introduction:

This consent form describes a research study and what you may expect if you decide to participate. You are being asked to participate in this study because you are an adult diagnosed with mild hypertension (mild high-blood pressure). You are encouraged to read this consent form carefully and ask the person who presents it any further questions you may have before making your decision whether or not to participate.

This consent form is only a part of the overall process of informed consent. A member of our staff will talk to you about the study and what your participation will involve to help you decide whether or not to participate in this study. You may take an unsigned copy of this consent form to read it carefully for further consideration, think about it, and discuss it with family members and/or friends before making your decision. Please ask your study doctor or a member of the research staff any questions you have. You will receive a copy of this consent form for your records.

In reading this consent form, keep in mind these four points:

- It is entirely up to you whether or not you take part in this study.
- If you choose not to take part, your employment or routine medical care will not be changed in any way.
- You may not benefit yourself from being a part of this study, but your participation in this study may help you or other patients in the near future.
- You may drop out of this study at any time without it affecting your employment or medical care.

This study is being conducted by the University of Rochester's Department of Cardiology.

Purpose of the Study

The purpose of this study is to evaluate different dosing schedules of the hypertension drug,

carvedilol (Coreg®), for the treatment of patients with mild hypertension.

Background

This study involves a drug called carvedilol that has been approved by the FDA for the treatment of patients with hypertension. This study will evaluate whether changing the dose of carvedilol can have the same beneficial results that are seen when the standard dose of this drug is administered, while lowering side-effects. Carvedilol is not the only treatment for hypertension. The standard treatments for patients with mild hypertension include lifestyle changes, diuretics (water pills), angiotensin converting enzyme inhibitors and calcium channel blockers.

Number of Subjects

We expect 121 subjects with mild hypertension to participate in this study.

Study Procedures

Your participation in this study will take between three and eight weeks, depending on how your hypertension responds to therapy. Information about your participation in this study will be included in your electronic medical record.

If you decide to participate in this study, you will be asked to complete the following:

Initial Evaluation: The study doctor will carefully review your health to make sure it is safe for you to take the study drug carvedilol. A blood draw may be needed to make sure your kidneys are working well enough for you to use carvedilol.

Study Phase: You will be assigned (like choosing numbers from a hat) to one of the four study groups. During this study you may receive different daily amounts of the study drug carvedilol varying between no drug and 25 mg of carvedilol (some days you may be instructed to take no study drug at all). The dosing schedule will be explained to you when you receive your study drug.

In addition, each week, you will also be asked to complete 2 brief questionnaires that measure psychological distress.

The study team members will also instruct you in the use of an automated device for the measurement of your blood pressure at home. You will be given this blood pressure instrument in order for you to record your blood pressure twice (one after the other) in the morning, and again twice (one after the other) in the evening each day.

Other Visits

You will have weekly visits during the study which may last up to 8 weeks.

Every week you will:

- Have vital signs measures (temperature, heart rate and 2 blood pressure measures)
- Discuss any problems with the study doctor and review your diary of side effects
- Receive your supply of medicine for the week
- Complete 2 brief questionnaires that measure psychological distress.

Schedule of Events

Evaluation/Procedure	Registration	Baseline	Study Period
Informed Consent	X		
Assess Eligibility	X	X	
Medical History		X	
Physical Exam		X	Weekly
Vital Signs		X	Weekly
Study			Weekly
Evaluation/Assessments			
Concomitant Medications		X	Weekly
Dispense Study Agent		X	Every other week
Review Diary/Record			Weekly
Adverse Events			Weekly
Assessment			
Randomization		X	
Blood Pressure			2 x day in the am
Measurements			2 x day in the pm (one after the other)

Risks of the Study

Risks of Carvedilol – Carvedilol medicine may cause dizziness, lightheadedness, or fainting. Make sure you understand how you react to this medicine before you drive, use machines, or do anything else that could be dangerous if you are dizzy or not alert. Dizziness, lightheadedness, or fainting may occur, especially when you get up from a lying or sitting position suddenly. These symptoms are more likely to occur when you begin taking this medicine, or when the dose is increased. Sitting or lying down may help alleviate these unwanted effects.

Before having any kind of surgery (including dental surgery) or emergency treatment, tell the medical doctor or dentist in charge that you are taking this medicine.

Check with your study doctor immediately if any of the following occur:

- Allergy, which may include itching, rash and swelling;
- Blood in urine;
- Chest pain, discomfort, tightness, or heaviness;
- Confusion;
- Diarrhea;
- Dizziness, lightheadedness, or fainting;
- General feeling of discomfort and illness;
- Slow or irregular heartbeat;
- Numbness or tingling in hands, feet, or lips;
- Shortness of breath or difficulty breathing;
- Stomach pain (severe) with nausea and vomiting;
- Unexplained nervousness;
- Unusual tiredness or weakness;
- Weakness or heaviness of the legs;
- Weight loss

Your blood pressure may not improve or may worsen during this study. Individuals who have a reason to access your electronic medical record in the University of Rochester Medical Health System (Strong Memorial Hospital, Highland Hospital, URM primary care and specialist physician offices, etc.) will have access to the results of testing performed as part of this research study and will know that you participated in this research study.

For diabetic patients: This medicine may cause changes in your blood sugar levels. Also, this medicine may cover up signs of hypoglycemia (low blood sugar), such as rapid pulse rate. Check with your physician if you have these problems or if you notice a change in the results of your blood or urine sugar tests.

For patients who wear contact lenses: Carvedilol may cause your eyes to form tears less than they do normally. Check with your doctor if you have dry eyes.

Reproductive Risks: Because the drug used in this study can affect the fetus, you should not become pregnant while in this study. If you are a female of childbearing age you have to agree to the use of adequate birth control methods as well as agree to a pregnancy test every 2 weeks. You should not nurse your baby while in this study.

Risks associated with completing the questionnaires: Answering some of the questions may make you feel uncomfortable. You don't have to answer any questions you don't want to.

Risks associated with blood draw: You may feel minimal pain if your blood is drawn from a vein during initial evaluation. The most common side effects include bruising, occasionally dizziness and fainting, and rarely infection.

Risks associated with loss of privacy and confidentiality: Because we will collect data from your medical record there is a risk of loss of privacy and confidentiality. Protected health data will be kept as confidential as it can be but complete confidentiality cannot be assured.

A description of this clinical trial will be available on <http://www.ClinicalTrials.gov>, as required by U.S. Law. This website will not include information that can identify you. At most, the website will include a summary of the results. You can search this website at any time.

Benefits

You may not benefit from being in this research study.

Alternatives to Participation

If you decide not to join this study, other options are available to you. You should discuss these alternatives with your primary care provider. Other treatments include therapeutic lifestyle changes and prescription medications taken on a regular basis.

Costs

There will be no cost to you to participate in this study.

Payment for Participation

You may receive up to \$300 for participating in this study depending on the number of study visits you complete via check or cash. Additionally, you will receive parking vouchers or travel vouchers to cover your transportation expenses.

1st payment: \$100.00 upon completion of study weeks 1-2

2nd payment: \$100.00 upon completion of study weeks 3-4

3rd payment: \$100.00 upon completion of study weeks 5-8.

Not all subjects will participate in weeks 3-8.

Leaving the study early

- You can agree to be in the study now and change your mind later
- If you wish to stop, please tell us right away
- Leaving this study early will not affect your employment or stop you from getting regular medical care

Circumstances for dismissal from the study

You may be taken out of the study if:

- Staying in the study would be harmful
- You need treatment not allowed in this study
- You fail to follow instructions
- You become pregnant
- The study is cancelled
- There may be other reasons to take you out of the study that we do not know at this time

Compensations for Injury

If you are directly injured by the procedures solely required to participate in the study, you may need to pay for treatment of your injuries, but you will not be required to pay for emergency medical treatment provided at Strong Memorial Hospital or Highland Hospital. The University may seek payment for this care from your health insurer or third parties. Decisions regarding care and compensation for any other research related injury will be made on a case-by-case basis.

Sponsor Support

The University of Rochester is receiving payment from the National Institutes of Health (NIH).

Confidentiality of Records and HIPAA Authorization

While we will make every effort to keep information we learn about you private, this cannot be guaranteed. Other people may need to see the information. While they normally protect the privacy of the information, they may not be required to do so by law. Results of the research may be presented at meetings or published for scientific purposes, but your name will not be used.

The federal Health Insurance Portability and Accountability Act (HIPAA) requires us to get your permission to use health information about you that we either create or use as part of the research. This permission is called an Authorization. We will use your research record, related information from your medical records, results of laboratory tests, and both clinical

and research observations made while you take part in the research, such as case report forms, survey forms and questionnaires.

We will use your health information to conduct the study, to determine research results, to monitor your health status, to measure effects of drugs/procedures, and possibly to develop new tests, procedures, and commercial products. Health information is used to report results of research to sponsors and federal regulators. It may be audited to make sure we are following regulations, policies and study plans. Strong Health policies let you see and copy health information after the study ends, but not until the study is completed. If you have never received a copy of the Strong Health HIPAA Notice, please ask the investigator for one.

To meet regulations or for reasons related to this research, the study investigator may share a copy of this consent form and records that identify you with the following people: the Food and Drug Administration (FDA); the Department of Health and Human Services; and the University of Rochester.

If you decide to take part, your Authorization for this study will not expire unless you cancel (revoke) it. The information collected during your participation will be kept indefinitely. You can always cancel this Authorization by writing to the study investigator. If you cancel your Authorization, you will also be removed from the study. However, your employment, standard medical care and any other benefits to which you are otherwise entitled will not be affected. Canceling your Authorization only affects uses and sharing information after the study investigator gets your written request. Information gathered before then may need to be used and given to others. For example, by Federal law, we must send study information to the FDA for drug and device studies it regulates. Information that may need to be reported to the FDA cannot be removed from your research records.

As stated in the section on Voluntary Participation below, you can also refuse to sign this consent/Authorization and not be part of the study. You can also tell us you want to leave the study at any time without cancelling the Authorization. By signing this consent form, you give us permission to use and/or share your health information as stated above.

Contact Persons

For more information concerning this research or if you believe that you have suffered a research related injury, emotional or physical discomfort, please contact:

Dr. John Bisognano at 585-275-6168

If you are injured or ill as a result of being in the study, contact John Bisognano at 585-275-2222 in the Department of Medicine.

If you have any questions about your rights as a research subject, or any concerns or complaints, you may contact the Human Subjects Protection Specialist at the University of Rochester Research Subjects Review Board, Box 315, 601 Elmwood Avenue, Rochester, NY 14642-8315, Telephone (585) 276-0005. For long-distance you may call toll-free (877) 449-4441. You may also call these numbers if you cannot reach the research staff or wish to talk to someone else.

Voluntary Participation

Your participation in this study is voluntary. You are free not to participate or withdraw at any time, for whatever reason, without risking loss of present or future care you would otherwise expect to receive. In the event that you do withdraw from this study, the information you have already provided will be kept in a confidential manner.

SIGNATURE/DATES

Subject Consent

I have read (or have had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I agree to participate in this study. I have received (or will receive) a signed copy of this form for my records and future reference.

Subject Name

Signature of Subject

Date

Person Obtaining Consent

I have read this form to the subject and/or the subject has read this form. I will provide the subject with signed copy of this consent form. An explanation of the research was given and questions from the subject were solicited and answered to the subject's satisfaction. In my judgment, the subject has demonstrated comprehension of the information. I have given the subject adequate opportunity to read the consent before signing.

Name and Title

Signature of Person Obtaining Consent

Date