OPTIONAL Dual Energy X-Ray Absorptiometry (DXA) SUBSTUDY
SUBJECT INFORMATION AND INFORMED CONSENT FORM
AND
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Protocol Title:	A Phase 3b, Randomized, Double-Blind Switch Study to Evaluate the Safety and Efficacy of Emtricitabine/Rilpivirine/Tenofovir Alafenamide (FTC/RPV/TAF) Fixed Dose Combination (FDC) in HIV-1 Positive Subjects who are Virologically Suppressed on Emtricitabine/Rilpivirine/Tenofovir Disoproxil Fumarate (FTC/RPV/TDF)
Substudy Sponsor:	Gilead Sciences, Inc. 333 Lakeside Drive Foster City, CA 94404
Protocol Number:	GS-US-366-1216
Date of Protocol:	14 November 2014
Principal Investigator:	Pablo Tebas, M.D.
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24 Hour Emergency Number (215) 662-6059 Ask for the Immunodeficiency Program Doctor on call

INTRODUCTION TO RESEARCH SUBSTUDY

You have already agreed to take part in a research study involving an experimental combination medication named FTC/RPV/TAF FDC for the treatment of HIV-1 infection.

An optional substudy will take place with approximately **300** subjects; about 5-10 persons are expected to participate in this substudy at the University of Pennsylvania. This optional substudy involves **Dual Energy X-Ray Absorptiometry (DXA)** scans for the assessment of hip and spine bone mineral density (BMD). DXA scans are the established standard of care for measuring BMD, this is not experimental.

Your study doctor or study nurse will go over this with you and answer any questions you may have regarding the substudy. Ask your study doctor or study nurse to explain any words or information in this consent form you do not clearly understand. You should understand the purpose of the substudy, how taking part may help you, any potential risks to you, and what is expected of you during the substudy.

If you agree to take part in this substudy, you will be asked to sign and date this consent form and will be given a signed and dated copy to keep. No one can force you to take part in this substudy. Even if you agree to take part now, you can decide otherwise and stop at any time without penalty or loss of benefits to which you would otherwise be entitled. You can still continue to participate in the main study even if you do not agree to participate in this substudy. You must have reviewed and signed the main study consent form before signing this consent form. This consent form is not meant to replace the main study consent, and the contents of the main study consent apply to this substudy.

PURPOSE OF THE SUBSTUDY

Decreases in bone mineral density have been observed in patients receiving tenofovir-TDF which suggest bone changes. An X-Ray called dual energy x-ray absorptiometry (DXA) will be performed on your hip and spine to measure changes in your bone mineral density. It is not known if these changes in DXA scan results may have an impact on the clinical treatment of HIV-infected patients.

The purpose of this substudy is to evaluate the safety of the two study treatment arms as determined by the measurable change in hip and spine BMD based upon the DXA scan results through Week 48 of your clinic visits.

PROCEDURE

If you are asked to participate in the DXA substudy and you agree, you will be one of the approximately 300 subjects who will take part in this substudy. You will have DXA scans performed on or before the Baseline/Day 1 visit and then every 24 weeks throughout the study and at the Early Study Drug Discontinuation visit, if it has been more than 12 weeks since your last scan.

The scans will be performed by a DXA technologist. You will be asked to change into a gown and remove any jewelry, pins, metals, etc. to avoid obstruction of the scanner field. If any jewelry or metal items are unable to be removed, please inform the technologist.

You will be asked to sit or lay down in the proper position as required by the scanner's manufacturer for an extended period of time. A head pillow can be provided to you if needed for additional comfort.

After the scans are completed, the technologist will send the images to Gilead's DXA vendor, BioClinica, for analysis. The site will be informed of the DXA scan results and will be discussed with you by your study doctor.

RISKS

It is not known if DXA scan results may have an impact on the health of HIV-infected patients. The risk of bone fracture associated with bone changes is unknown.

The risks associated with the DXA scan are generally considered to be minimal. However, you may experience some discomfort when placed in the proper positioning for optimal scanning. DXA scans involve exposure to radiation. Therefore, you will receive a radiation dose. This radiation dose is not necessary for your medical care and will occur only as a result of your participation in the study. At doses much higher than you will receive, radiation is known to increase the risk of developing cancer after many years. At the doses you will receive, it is very likely that you will see no effects at all.

There will be no additional risks or discomforts beyond those of the main study. Please refer to the Risks section in the main consent form for the complete risks associated with this study.

POSSIBLE BENEFITS OF THE SUBSTUDY

There is no guarantee that you will receive personal benefit from taking part in this substudy. However, clinical research studies such as this are a way for doctors to determine if a drug is useful in fighting a disease. Your taking part in this substudy may benefit the community, scientists and doctors who work with HIV by providing increased knowledge and information about the treatment of your disease.

WITHDRAWAL FROM SUBSTUDY AND REFUSAL TO PARTICIPATE

Like your participation in the main research study, the substudy is completely voluntary. You may participate in the main research study EVEN IF YOU ARE NOT PART OF THE SUBSTUDY. You can refuse to take part or stop at any time without stating a reason. Your withdrawal will not result in penalty or loss or affect your access to other medical care to which you would otherwise be entitled.

The results of your tests from this substudy will be available to your study doctor.
If you consent to the substudy and decide at a later date that you would like to withdraw your consent, you will need to do so in writing to your study doctor at the address listed on the first page of this form.

If you withdraw participation from this substudy, the results of any previously performed DXA scans and related information must remain in any database(s) that were created for the research substudy. The reason for this is to comply with regulations that require us to make data available for review by the United States Food and Drug Administration (FDA) or other appropriate regulatory authorities, or if this research is used to support an application for FDA approval to market the study drugs.

If you withdraw consent for participation in the main study or are discontinued from the main study, the DXA scan results will continue to be available for the substudy as stated above.

PAYMENT FOR PARTICIPATION

Compensation of $25 will be provided for regular study visits that require a DEXA scan; there are 3 DEXA scans required (Baseline, week 24 and 48 and one every 24 wks for visits beyond week 48). You will be paid following the completion of each visit. Thus if you complete the 3 DEXA scans, the compensation you will receive is $75.00.

MEDICAL TREATMENT AND COMPENSATION FOR STUDY-RELATED INJURY

If you become sick or injured as a direct result of taking the study drug and/or following the study procedures, the University of Pennsylvania will provide you with medical treatment. The Sponsor, Gilead Sciences, Inc., will reimburse you or the University of Pennsylvania for the reasonable and necessary costs of such medical treatment. No other form of reimbursement for study-related injury or illness is offered by Gilead. You should immediately contact your study doctor at the contact information shown below in the event you experience any study-related illness or injury.

If you receive Medicare benefits, Gilead is required by law to report payments made to you for treatment, complications, and injuries that arise from this study. Information that you are taking part in the study, medical treatments received, Medicare claims, and other personal information about you such as your name, social security number, and date of birth, will be provided to the Centers of Medicare and Medicaid Services and its agents and/or contractors for this purpose.

You do not give up any legal rights by signing this form. You are not prohibited from seeking to collect compensation for injury related to malpractice, fault, or blame on the part of those involved in the research.

SOURCE FOR ADDITIONAL INFORMATION

You can ask questions about this consent form or the substudy (before you decide to start the study or at any time during the study). Questions may include:

- Who to contact in the case of a research-related injury or illness.
- Any payment for being in the study.
- Your rights and your responsibilities as a study subject.
- Other questions.

Contact the study doctor or study staff with any questions or concerns. Their telephone number is printed on the first page of this form. If you have any questions or complaints about your rights as a research subject, contact:

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

Please reference the following number when contacting the Study Subject Adviser: Pro00010961.

GENERAL STATEMENT ABOUT PRIVACY

Records identifying you will be kept confidential and, to the extent permitted by applicable laws and/or regulations, will not be made publicly available. All of your study data will be kept in a secure location. In the event of any publication regarding this study, your identity will remain confidential.

Representatives from government agencies, including the U.S. Food and Drug Administration (FDA), institutional review boards (IRB), Gilead and/or Gilead's authorized representatives may need access to your original medical records and study records for the purpose of checking data collected for the study. By signing this consent form, you authorize this access.

AUTHORIZATION TO USE AND DISCLOSE RECORDS

During this substudy, your study doctor, nurses and other study site personnel will record information about you, your health and your participation in the substudy on forms provided by the Sponsor. These forms are known as case report forms. You will not be able to participate in this substudy if you do not consent to the collection of this information about you.
The information collected about you, will be held by the study site, the Sponsor and the Sponsor's authorized representatives. To ensure that your personal information is kept confidential, your name and any other information that allows you to be identified directly will not be entered on the case report forms or included in any records or samples your study doctor provides to the Sponsor or the Sponsor's authorized representatives. Instead, you will only be identified by your initials and a code. The code is used so that your study doctor can identify you if necessary.

The Sponsor and its authorized representatives will analyze and use the coded information they receive for the purposes of this substudy. Such purposes include:

- checking your suitability to take part in the substudy,
- monitoring your treatment with the study drug,
- comparing and pooling your study treatment results with those of other subjects in clinical studies,
- establishing whether the study drug meets the appropriate standards of safety set by the authorities,
- establishing whether the study drug is effective,
- supporting the development of the study drug,
- supporting the licensing application for regulatory approval of the study drug anywhere in the world,
- supporting the marketing, distribution, sale and use of the study drug anywhere in the world, and/or
- as otherwise required or authorized by law.

If necessary for these purposes, the Sponsor may share your information with its affiliates, people and companies with whom the Sponsor works, and regulatory or other governmental agencies. Although efforts will be made to protect your privacy, absolute confidentiality of your records cannot be guaranteed. Your medical information and records may be re-disclosed and no longer protected by federal privacy law.

As explained in this consent form, your participation in this substudy is voluntary and you may withdraw from the substudy at any time by informing your study doctor. By signing this consent, you authorize the collection and use of information about you as described in this consent. You may revoke (take back) this authorization for the collection and use of information about you by informing your study doctor in writing at the address listed on the first page of this form.

If you withdraw from the substudy or if you revoke your authorization for the collection and use of information about you, your participation in the substudy will end and the study personnel will stop collecting information from you. The Sponsor will need to keep and use any research results, and may need to keep and use any samples, that have already been collected. The Sponsor must do this to comply with its legal obligations and to maintain the scientific integrity of the substudy. Your decision to withdraw from the substudy or to revoke your authorization for the collection and use of information about you will not result in any penalty or loss of access to treatment or other benefits to which you are entitled.

This authorization has no expiration date, unless and until you revoke it.
If you have any questions about the collection and use of information about you, you should ask your study doctor.

The authorization part of the consent gives more detailed information about how your personal health information may be used and disclosed by the University of Pennsylvania Health System (UPHS), the School of Medicine and the individual Principal Investigator, subject to University of Pennsylvania procedures.

What personal health information is collected and used in this study and might also be disclosed?
The following personal health information will be collected, used for research, and may be disclosed during your involvement with this research study:

- Name, address, telephone number, date of birth
- Social Security Number (if you receive more than $600 for participating in studies at PENN, we will need your SSN for the W-9)
- Personal and family medical history
- Current and past medications or therapies
- Results of physical exams, laboratory tests and procedures you will undergo during this research study

Why is your personal contact and health information being used?
Your personal contact information is important for the research team to contact you during the study. Your personal health information and results of tests and procedures are being collected as part of this research study. In some situations, your personal health information might be used to help guide your medical treatment.

Which of our personnel may use or disclose your personal health information?
The following individuals may use or disclose your personal health information for this research study:

- The Principal Investigator and the Investigator's study team
- Authorized members of the workforce of the UPHS and the School of Medicine, and University of Pennsylvania support offices, who may need to access your information in the performance of their duties (for example: for research oversight

and monitoring, to provide treatment, to manage accounting or billing matters, etc.).

Who, outside of UPHS and the School of Medicine, might receive your personal health information?
As part of the study, the Principal Investigator, the study team and others listed above, may disclose your personal health information, including the results of the research study tests and procedures. This information may be disclosed to those listed below:

Individuals or organizations responsible for administering the study:

- Pharmaceutical sponsor (Gilead Sciences): This is the company that supplies drugs for the main study. Information regarding safety and adverse effects needs to be collected and monitored.
- Contract Research Organization: Monitors will visit the site on a regular basis to review data and assure accuracy and completeness of information before the data are analyzed.
- Regulatory and safety oversight organizations
- The Office of Human Research Protections
- Chesapeake IRB
- The Study Monitoring Committee

Once your personal health information is disclosed to others outside of UPHS or the School of Medicine, it may no longer be covered by federal privacy protection regulations. Data are reported to the sponsor on Case Report Forms that identify you by your unique study number and not your name or medical record number. Information regarding your health, such as side effects of the study medications you experience will be reported only by code number. All samples collected for analysis will be labeled with your study number, visit number and date of your visit.

The Principal Investigator or study staff will inform you if there are any additions to the list above during your active participation in the trial. Any additions will be subject to University of Pennsylvania procedures developed to protect your privacy.

How long may UPHS and the School of Medicine be able to use or disclose your personal health information?
Your authorization for use of your personal health information for this specific study does not expire.

Your information may be held in a research repository (database). However, UPHS and the School of Medicine may not re-use or re-disclose information collected in this study for a purpose other than this study unless:

- You have given written authorization to do so
- The University of Pennsylvania's Institutional Review Board grants permission after ensuring that appropriate privacy safeguards are in place
- As permitted by law

Will you be able to access your records?
Since this is an open-label study, you will be able to access some or all of your medical records after the study is over. The Principal Investigator is not required to release research information to you that is not part of your medical record.

Can you change your mind?
Yes, at any time you may withdraw your approval to allow the use and disclosure of your personal health information as described here. You must do so in writing to the Principal Investigator at the address on the first page. Even if you withdraw your permission, your personal health information that was collected before we received your written request may still be used and disclosed, as necessary for the study. If you withdraw your permission to use your personal health information, you will also be withdrawn from the research study.

If you withdraw your permission to use any blood or tissue obtained for the study, the Sponsor may need to retain and use any samples that have already been collected to comply with its legal obligations and to maintain the scientific integrity of the study.

You will be given a copy of this Research Subject HIPAA Authorization describing your confidentiality and privacy rights for this study. You will also be given the UPHS and School of Medicine's Notice of Privacy Practices that contains more information about the privacy of your personal health information.

AGREEMENT TO BE IN THE SUBSTUDY

By signing this informed consent form, I acknowledge that:

(1) I have carefully read and understand the information presented in this consent document.
(2) The purpose and procedures related to this research substudy have been fully explained to me and I have had the opportunity to ask questions and all of my questions were answered to my satisfaction.
(3) I have been informed of the parts of the program that are experimental and of the possible discomforts, symptoms, adverse events and risks that I might reasonably expect, and the possible complications, if any, that I might reasonably experience from both known and unknown causes as a result of my participation.
(4) I understand that I am free to withdraw this authorization and to discontinue my participation in this substudy any time.
(5) I understand that such withdrawal will not affect my ability to receive medical care to which I might otherwise be entitled.

Subject

_____

Subject Printed Name Signature Date

Person Obtaining Consent

_____

Printed Name & Title Signature Date

Witness (if applicable)

_____

Witness Printed Name Signature Date