

| Patient Agreement to Systemic Therapy: Consent Form | |
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| Everolimus & Lenvatinib | |
| Patient's details / addressograph: | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| | Special requirements (e.g. other language/other communication method) |
| | Consultant: |

Name of proposed course of treatment:**Everolimus and Lenvatinib**

Everolimus tablet and Lenvatinib capsule, both taken by mouth once daily continuously, until disease progression

Macmillan leaflet given

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have discussed what the treatment is likely to involve (including inpatient / outpatient treatment, timing of the treatment, follow-up appointments) and location.

The intended benefits

- Curative – to give you the best possible chance of being cured
- Palliative – the aim is not to cure but to control or shrink the disease. The aim is to improve both quality of life and survival
- Adjuvant – therapy given after surgery to reduce the risk of recurrence of cancer
- Neo-adjuvant – therapy given before surgery or radiotherapy to shrink the cancer

Significant, unavoidable or frequently occurring risks:

Common side-effects: diarrhoea (very common), sore mouth and ulcers, raised blood pressure, presence of protein in the urine, swelling of your arms, hands, feet, ankles or other parts of your body (oedema), feeling sick (nausea) and being sick (vomiting), tiredness and feeling weak, effects on the skin (rash, redness, dryness or itching), anaemia (low number of red blood cells), unusual bleeding and bruising (for example, nose bleeds, or you may bruise more easily, or notice blood in your urine), raised blood sugar, raised cholesterol and other blood fats, taste changes and loss of appetite, headache, hoarse voice, thyroid problems (symptoms of an underactive thyroid may include tiredness, weight gain, constipation, aches, feeling cold, dry skin and hair).

Less common but potentially life threatening side-effects: lung or breathing problems, reduced resistance to infection which can lead to a potentially fatal blood infection, increased risk of stroke or heart attack, gastrointestinal perforation, allergic reaction, kidney failure

Other less common side-effects include: your liver may be affected

Rare (less than 1%) cases of reversible encephalopathy with seizures, headache, altered mental status and visual disturbances have been reported.

Cancer can increase your risk of developing a blood clot (thrombosis), and treatment with everolimus and lenvatinib may increase this risk further. A blood clot may cause pain, redness and swelling in a leg, or breathlessness and chest pain - you must tell your doctor straight away if you have any of these symptoms.

Everolimus and lenvatinib may both have an effect on fertility.

I have warned the patient that there is an unknown risk of everolimus and lenvatinib affecting fertility (in men and in women)

Everolimus and lenvatinib may both damage the development of a baby in the womb (foetus), leading to the many risks associated with an abnormal pregnancy. Therefore, I have discussed the issues of protected sex. The patient has been advised not to become pregnant / not to get a partner pregnant during the period of treatment and for 8 weeks after treatment has stopped.

Any other risks:

| | |
|---------------------------------|----------------|
| Clinician Signature | |
| Signed..... | Date |
| Full Name (print) / | Job Title..... |
| (Forename) | (Surname) |

Statement of patient

| | |
|---|------------|
| Patient Signature | |
| Please read this form carefully, which describes the benefits and risks of the proposed treatment. You have the right to change your mind at any time, including after you have signed this form. | |
| I agree to undergo chemotherapy. I understand the treatment and am aware of the potential side-effects arising from this treatment. | |
| I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate training and experience. | |
| Signed..... | Name..... |
| Date..... | |
| A witness should sign below if the patient is unable to sign but has indicated his or her consent. | |
| Signature | Date |
| Name (PRINT) | |

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed Date

Name (PRINT)

Copy accepted by patient: yes/no (please ring)
Copy to be retained in patient's notes

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|------------------------|--|
| Reason for Update: N/A | Checked and approved by Consultant: Dr A Michael |
| Version: 1 | Date: 16.1.18 |