**PPMI Study 001**

<table>
<thead>
<tr>
<th>Trial No.:</th>
<th>001</th>
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<tbody>
<tr>
<td><strong>Title:</strong></td>
<td>The Parkinson’s Progression Markers Initiative (PPMI)</td>
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<tr>
<td><strong>Sponsor:</strong></td>
<td>Michael J. Fox Foundation</td>
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<tr>
<td><strong>Principal Investigator:</strong></td>
<td>Kenneth Marek, MD</td>
</tr>
<tr>
<td><strong>Date of Protocol:</strong></td>
<td>November 27, 2012</td>
</tr>
<tr>
<td><strong>Final Version:</strong></td>
<td>6.2</td>
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<td><strong>Planned Dates Of Trial:</strong></td>
<td>April 1, 2010 – March 31, 2015</td>
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PPMI
Study 001

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PROTOCOL APPROVAL
Amendment 5

The Parkinson’s Progression Markers Initiative (PPMI)

Kenneth Marek, MD
Principal Investigator

Karl Kieburtz, MD, MPH
Clinical Core

Todd Sherer, PhD
Michael J Fox Foundation (Sponsor)
INVESTIGATOR AGREEMENT

Protocol Amendment 5
The Parkinson’s Progression Markers Initiative (PPMI)

I have carefully read this protocol including all appendices and agree that it contains all the necessary information for conducting the study safely.

I will conduct this study in strict accordance with this protocol and according to the current Good Clinical Practice (GCP) regulations and International Conference on Harmonization (ICH) guidelines, and local regulatory requirements. Any changes in procedure will only be made if necessary to eliminate immediate hazards and/or to protect the safety, rights or welfare of subjects.

I will provide copies of the protocol and all other information relating to this project, which were furnished to me, to all physicians and other study personnel responsible to me who participate in this study. I will discuss this information with them to assure that they are adequately informed regarding the conduct of the study.

I agree to keep records on all subject information (case report forms, informed consent statements and all other information collected during the study) in accordance with the current GCP, ICH, local, national and European regulations.

________________________________________________________________________
Site Number Printed Site Name

________________________________________________________________________
Printed Site Investigator Name

________________________________________________________________________
Site Investigator Signature Date
List of Abbreviations and Definitions

AD  Alzheimer disease
ADL  activities of daily living
ADNI  Alzheimer Disease Neuroimaging Initiative
AMADEUS  American and European Union SPECT Imaging Consortium
VMAT-2  Vesicular Monoamine Transporter Type 2
18-F-AV-133  18F-(1)fluoropropyldihydrotetabenazine
β-CIT  2β-carboxymethoxy-3β-(4-iodophenyl) tropane
CFR  Code of Federal Regulations
β-CFT  2β-carboxymethoxy-3β-(4-fluorophenyl) tropane
Beta-HCG  beta-human chorionic gonadotropin
CFR  Code of Federal Regulations
CRF  Case Report Form
CSF  cerebral spinal fluid
CSOC  Clinical Study Oversight Committee
CTCC  Clinical Trials Coordination Center
DAT  dopamine transporter
DaTSCAN  Ioflupane I-123 injection
DNA  Deoxyribonucleic acid
DTI  diffusion tensor imaging
ECG  electrocardiogram
eCRF  electronic Case Report Form
EDC  electronic data capture
ELLDOPA  Earlier versus Later Levodopa Therapy in Parkinson Disease
ESS  Epworth Sleepiness Scale
F-Dopa  fluorodopa
GCP  Good Clinical Practice
GDS  Geriatric Depression Scale
HC  Healthy Control
HIPAA  Health Insurance Portability and Accountability Act
HSPP  Human Subject Protection Program
HVLT-R  Hopkins Verbal Learning Test - Revised
ICH  International Conference on Harmonization
IEC  Independent Ethics Committee
IRB  Institutional Review Board
LONI  Laboratory of Neuro Imaging
MAO-B  Monoamine Oxidase-B
MDS-UPDRS  Movement Disorder Society Unified Parkinson Disease Rating Scale
MJFF  Michael J. Fox Foundation
MoCA  Montreal Cognitive Assessment
MRI  magnetic resonance imaging
OTC  over-the-counter
PARS  Parkinson Associated Risk Study
PD  Parkinson disease
PET  positron emission tomography
List of Abbreviations and Definitions (continued)

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tr>
<td>PPMI</td>
<td>Parkinson's Progression Markers Initiative</td>
</tr>
<tr>
<td>PW</td>
<td>premature withdrawal</td>
</tr>
<tr>
<td>QA</td>
<td>quality assurance</td>
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<td>QC</td>
<td>quality control</td>
</tr>
<tr>
<td>QUIP-S</td>
<td>Questionnaire for Impulsive-Compulsive Disorders</td>
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<td>RBDSQ</td>
<td>REM Sleep Behavior Disorder Screening Questionnaire</td>
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<td>REM</td>
<td>rapid eye movement</td>
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<td>SAB</td>
<td>Scientific Advisory Board</td>
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<td>SAE</td>
<td>serious adverse event</td>
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<td>SC</td>
<td>Steering Committee</td>
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<td>SCOPA-AUT</td>
<td>Scales for Outcomes in Parkinson’s Disease</td>
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<td>SPECT</td>
<td>single-photon emission computed tomography</td>
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<td>ST</td>
<td>symptomatic therapy</td>
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<td>STAI</td>
<td>State-Trait Anxiety Inventory</td>
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<tr>
<td>SWEDD</td>
<td>Scans Without Evidence of Dopaminergic Degeneration</td>
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<tr>
<td>UPSIT</td>
<td>University of Pennsylvania Smell Identification Test</td>
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<tr>
<td>VMAT2</td>
<td>Vesicular Monoamine Transporter 2</td>
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<tr>
<td>Protocol Number</td>
<td>Study 001</td>
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<tr>
<td>Protocol Title</td>
<td>The Parkinson’s Progression Markers Initiative (PPMI)</td>
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<tr>
<td>Sponsor</td>
<td>Michael J Fox Foundation</td>
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<tr>
<td>Investigators</td>
<td>Multi-center trial</td>
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<td>Study Centers</td>
<td>About 24 centers in United States, Europe and Australia</td>
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<td>Study Period</td>
<td>3-5 Years</td>
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<tr>
<td>Study Objective and Specific Aims</td>
<td>The primary objective of this study is to identify clinical, imaging and biologic markers of PD progression for use in clinical trials of disease-modifying therapies.</td>
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<tr>
<td>Study Design</td>
<td>Longitudinal, multi-center study to assess progression of clinical features, imaging and biologic markers in Parkinson disease patients and healthy controls.</td>
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<td>Number of Subjects</td>
<td>700 Subjects Enrolled</td>
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<td>o 400 Parkinson disease (PD)</td>
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<td>o 200 Healthy controls (HC)</td>
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<td>o 100 Prodromal</td>
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<td>In addition, about 80 subjects without evidence of dopaminergic deficit (SWEDD).</td>
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<td>Main Eligibility Criteria</td>
<td>Parkinson Disease (PD) Subjects:</td>
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<tr>
<td></td>
<td>Inclusion:</td>
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<td>• Patients must have at least two of the following: resting tremor, bradykinesia, rigidity (must have either resting tremor or bradykinesia); OR either asymmetric resting tremor or asymmetric bradykinesia.</td>
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<tr>
<td></td>
<td>• A diagnosis of Parkinson disease for 2 years or less at Screening.</td>
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</tbody>
</table>
- Hoehn and Yahr stage I or II at Baseline.
- Confirmation from imaging core that screening dopamine transporter SPECT scan is consistent with dopamine transporter deficit (or for sites where DaTSCAN™ is not available, that VMAT-2 PET scan is consistent with VMAT deficit).
- Not expected to require PD medication within at least 6 months from Baseline.
- Male or female age 30 years or older at time of PD diagnosis.

Exclusion:
- Currently taking levodopa, dopamine agonists, MAO-B inhibitors, amantadine or other PD medication.
- Has taken levodopa, dopamine agonists, MAO-B inhibitors or amantadine within 60 days of Baseline.
- Has taken levodopa or dopamine agonists prior to Baseline for more than a total of 60 days.
- Received any of the following drugs that might interfere with dopamine transporter SPECT imaging: Neuroleptics, metoclopramide, alpha methylldopa, methylphenidate, reserpine, or amphetamine derivative, within 6 months of Screening.
- Current treatment with anticoagulants (e.g., coumadin, heparin) that might preclude safe completion of the lumbar puncture.
- Condition that precludes the safe performance of routine lumbar puncture, such as prohibitive lumbar spinal disease, bleeding diathesis, or clinically significant coagulopathy or thrombocytopenia.
- Use of investigational drugs or devices within 60 days prior to Baseline (dietary supplements taken outside of a clinical trial are not exclusionary, e.g., coenzyme Q10).

Healthy Control (HC) Subjects:
Inclusion:
- Male or female age 30 years or older at Screening.

Exclusion:
- Current or active clinically significant neurological disorder (in the opinion of the Investigator).
- First degree relative with idiopathic PD (parent, sibling, child).
- MoCA score < 26.
- Received any of the following drugs that might interfere with dopamine transporter SPECT imaging: Neuroleptics, metoclopramide, alpha methylldopa, methylphenidate, reserpine, or amphetamine derivative, within 6 months of Screening.
- Current treatment with anticoagulants (e.g., coumadin, heparin) that might preclude safe completion of the lumbar puncture.
- Condition that precludes the safe performance of routine lumbar puncture, such as prohibitive lumbar spinal disease, bleeding diathesis, or
clinically significant coagulopathy or thrombocytopenia.
- Use of investigational drugs or devices within 60 days prior to baseline (dietary supplements taken outside of a clinical trial are not exclusionary, e.g., coenzyme Q10).

**SWEDD Subjects:**
**Inclusion:**
- See Section 4.2.1 for Inclusion Criteria for PD subjects. All criteria apply except a SWEDD subject must have confirmation from imaging core that screening dopamine transporter SPECT scan shows no evidence of dopamine transporter deficit (or for sites where DaTSCAN™ is not available, that VMAT-2 PET scan shows no evidence of VMAT deficit).

**Exclusion:**
- See Section 4.2.2 for Exclusion Criteria for PD subjects which also apply to SWEDD subjects.

**Prodromal Subjects:**
**Inclusion:**
- See Section 4.2.7 for Inclusion Criteria. All subjects must demonstrate hyposmia, RBD, and/or LRRK2 mutation plus must be eligible based on DaTSCAN assessment by Imaging core.

**Exclusion:**
See Section 4.2.8 for Exclusion Criteria.

| Primary Outcome | The primary study outcome is: The mean rates of change and the variability around the mean of clinical, imaging and biomic outcomes in early PD patients, and where appropriate the comparison of these rates between PD patient subsets and between PD, SWEDD, Prodromal and healthy subjects at study intervals from 3 months to 36 months. Specific examples of outcomes include MDS-UPDRS, dopamine transporter imaging striatal uptake, vesicular monoamine transporter type-2 uptake, and serum and CSF alpha-synuclein. PD patient subsets may be defined by baseline assessments, progression milestones and/or rate of clinical, imaging, or biomic change. |
| Secondary Outcome | The secondary outcomes are:  
- Correlations between the rates of change in the mean of clinical, imaging and biomic outcomes in early PD patient subsets and between PD and healthy subjects at study intervals from 3 months to 36 months.  
- Prevalence of measures of clinical, imaging and biomic outcomes in early PD patients and healthy subjects at study intervals from baseline to 36 months.  
- To establish the predictive value of early clinical non-motor features, baseline imaging and biomic outcomes for future course of disease.  
- To examine the proportion of SWEDD subjects that have a change in their clinical management at 24 months (SWEDD Clinical Diagnosis and Management Questionnaire).  
- To conduct exploratory analyses in SWEDD subjects to examine the |
prevalence of measures of clinical, imaging, and biomic outcomes from baseline to 24 months, examine the mean rates of change and the variability among these outcomes from 3 months to 24 months, and to examine the correlations between the rates of change in these outcomes from 3 months to 24 months.

- To conduct exploratory analyses to determine whether the measures and change over time in clinical, imaging, and biomic outcomes are similar among the SWEDD subjects and PD subjects.

<table>
<thead>
<tr>
<th>Safety Assessments</th>
<th>Incidence of adverse events, proportion of withdrawals due to adverse events, vital signs and clinical laboratory assessment changes from baseline.</th>
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<tbody>
<tr>
<td>Statistical Methods</td>
<td>Changes from baseline to the one year, two year and three year evaluations will be calculated and summarized descriptively. We will calculate 95% confidence intervals for the mean rate of change and between subject variability. For this purpose the between subject variability will be estimated by fitting mixed models to all available data. Correlations will be calculated between the different measures, for example between change in total MDS-UPDRS and change in DAT uptake or alpha-synuclein levels.</td>
</tr>
<tr>
<td>Data Access</td>
<td>Data will be securely stored at central data coordinating facilities and will have all personally identifiable information removed before it is shared outside the study. All organizations responsible for data storage will observe the highest precautions to ensure data integrity and security. It is the goal of PPMI to enable timely access to the data by the PD research community.</td>
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### Schedule of Activities – Parkinson Disease (PD) Subjects

<table>
<thead>
<tr>
<th>Visit Description</th>
<th>SC</th>
<th>Months (&lt;30 days)</th>
<th>BL</th>
<th>V01</th>
<th>V02</th>
<th>V03</th>
<th>V04</th>
<th>V05</th>
<th>V06</th>
<th>V07</th>
<th>V08</th>
<th>V09</th>
<th>V10</th>
<th>V11</th>
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<th>PW</th>
<th>ST</th>
<th>Unsch. Visit</th>
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<td>Medical &amp; Family History/Demographics</td>
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<td>Clinical Laboratory Assessments</td>
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<td>MDS-UPDRS (including Hoehn &amp; Yahr)</td>
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<td>Modified Schwab &amp; England ADL</td>
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<td>Hopkins Verbal Learning Test – Revised</td>
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<td>X</td>
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<td>Physical Activity Scale for the Elderly (PASE)</td>
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<td>-45 days</td>
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<td>X</td>
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<tr>
<td>Benton Judgment of Line Orientation</td>
<td>X</td>
<td>-45 days</td>
<td>X</td>
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- Repeat assessment 1hr post treatment for subjects on levodopa or dopamine agonist.
- Not conducted depending on when ST visit completed – see protocol Sect. 5.3.19.
- DAT completed at all sites except Australia; VMAT completed in Australia and selected U.S. sites.
- Blood sample for DNA also collected.
- Conduct as clinically indicated – see protocol Sect. 5.3.17.
- Part IV once subject has started PD medication.

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November 27, 2012

Page 12 of 73
## Schedule of Activities – Healthy Control (HC) Subjects

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- Adverse events assessed at the visit and by phone 7 to 10 days following LP and/or DaTSCAN injection.
- Telephone visit will occur at Months 15, 21, 27, 33, 39, 45, 51 and 57.
- Height and weight also collected.
- Diffusion tensor MRI scan and resting state sequences conducted at selected sites.
- Biometric urine sample also collected.
- Concomitant medication review – see protocol Sect. 5.3.17.
## Schedule of Activities – SWEDD Subjects

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<sup>a</sup> Adverse events assessed at the visit and by phone 7 to 10 days following LP and/or DATSCAN injection.
<sup>b</sup> Telephone visit will occur at Months 15 and 21.
<sup>c</sup> Height and weight also collected.
<sup>d</sup> Diffusion tensor MRI scan and resting state sequences conducted at selected sites.
<sup>e</sup> Biomeric urine sample also collected.
<sup>f</sup> Conduct as clinically indicated – see protocol Sect. 5.3.17.
<sup>g</sup> Part IV once subject has started PD medication.

<sup>h</sup> Repeat assessment 1hr post treatment for subjects on levodopa or dopamine agonist.
<sup>i</sup> Not conducted depending on when ST visit completed – see protocol Sect. 5.3.19.
<sup>j</sup> DAT completed in all sites except Australia; VMAT completed in Australia and selected U.S. sites.
<sup>k</sup> Urine pregnancy test prior to injection for women of childbearing potential.
<sup>l</sup> Subject’s enrolled in U.S. may agree to initial VMAT imaging scan at YR01 rather than Screening. ST = Symptomatic Therapy.

PW = Premature Withdrawal (*if not done in last 3 mths; ^ if not done in last 12 mths)
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*a* Adverse events assessed at the visit and by phone 7 to 10 days following LP and/or DaTSCAN injection.

*b* Telephone visit will occur at Months 15, 21, 27, 33, 39, 45, 51 and 57.

*c* Height and weight also collected.

*d* Diffusion tensor MRI scan and resting state sequences conducted at selected sites.

*e* Biomic sample also collected.

*f* Conduct as clinically indicated – see protocol Sect. 5.3.17.

*g* Repeat assessment 1 hr post treatment for subjects on levodopa or dopamine agonist.

*h* Not conducted depending on when ST visit completed – see protocol Sect. 5.3.19.

*i* Urine pregnancy test prior to injection for women of childbearing potential.

*j* Repeat assessment as clinically indicated.

*k* Part IV once subject has started PD medication.

*l* Conducted at selected sites.

*m* *X* if not done in last 3 mths; *^X* if not done in last 12 mths.
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1. Introduction

1.1. Background

The defining motor features of Parkinson disease (PD) are characterized by their insidious onset and inexorable but variable progression. Reliable and well-validated biomarkers to monitor PD progression would dramatically improve patient care and accelerate research into both PD etiology and therapeutics. During the past two decades much progress has been made in identifying and assessing PD biomarkers, but as yet no fully validated biomarker for PD is currently available. Nonetheless there is increasing evidence that assessment of blood and CSF, and advanced in vivo brain imaging will provide critical tools for PD drug development and ultimately to assist in the medical management of PD patients.

While it is important to acknowledge that a true surrogate marker for PD does not exist, it is even more critical to note that existing and developing biomarkers for PD are and may be extremely useful for disease monitoring and for drug development. In considering biomarkers for PD three crucial issues must be addressed: 1) to identify whether the marker is meaningful or relevant to the disease process; 2) to identify the performance characteristics of the marker in the relevant subject population (e.g., examination of markers for PD progression in early, untreated PD patients); and 3) to determine the generalizability of the biomarker to the larger disease population (e.g., carefully assess how the biomarker is affected by PD stage, subject age or gender, medications, or environment).

Use of biomarkers to complement clinical assessments during a research study

Biomarkers offer the potential to complement the clinical assessments used as a primary study outcome in clinical studies of PD. Although biomarkers are generally objective measures of disease and are more easily standardized and reproducible, standardization of biomarker collection and analysis requires clear and detailed procedures to enable objective data to be pooled at multiple study sites. As a result, biomarkers are most often assessed at a core lab with expertise in analytical methodology. Specific procedures for transfer of biological samples and/or imaging data must be in place. The AMADEUS imaging network, a SPECT imaging consortium for PD, and the Alzheimer Disease Neuroimaging Initiative (ADNI) for AD have demonstrated that both biological and imaging samples can be collected and analyzed in studies of disease progression. Given the multiple genetic etiologies for PD already identified, the marked variability in the loss of dopaminergic markers measured by imaging at motor symptom onset, and the clear heterogeneity of clinical symptoms in PD onset and clinical progression, it is clear that many biomarkers with a focus ranging from clinical symptoms to PD pathobiology to molecular genetic mechanisms will be necessary to fully map PD progression.

Assessment of multiple biomarkers in a single subject

In clinical studies, multiple biomarkers may be assessed in the same subjects. This strategy may enable comparison and correlation of biomarkers from imaging markers, biomic assays, and/or markers that target multiple neuronal systems. When multiple biomarkers are evaluated concurrently, the power of the study may be substantially increased. For example in studies of PD relatives tested for olfactory function and then undergoing dopamine transporter imaging, combining the loss of olfaction and dopamine transporter imaging density identifies a sub-group with increased risk of developing PD. Imaging studies
comparing dopaminergic ligands and metabolic tracers have provided complementary data enhancing the utility of both tracers\(^6\). The potential of combining in vivo radiotracer imaging and/or nigral ultrasound with proteomic, metabolomic and transcriptomic analyses is currently under evaluation in several ongoing studies such as the PARS study and other risk marker assessment studies\(^7,8\).

**Use of biomarkers to define a study cohort**

Biomarkers may be also used in clinical studies to better define or enhance the study cohort. While pre-defining the cohort may reduce generalizability of the study outcome, using biomarkers to define eligibility may ensure a more accurate diagnosis of the study subjects and therefore reduce variance in the outcome. In several studies of newly diagnosed PD in vivo dopaminergic imaging has identified about 10-15\% with scans in the normal range termed scans without evidence of dopaminergic degeneration (SWEDD)\(^2,9,10\). Subsequent follow-up has indicated that those study participants with SWEDD are unlikely to have PD\(^11\). In the ELLDOPA study and REAL PET study data analysis using the imaging biomarker to define the study cohort changed the statistical significance of study outcomes\(^9,10\). In other studies, biomarkers are used as an *a priori* definition of the study cohort as in studies of subjects with a LRRK2 mutation. These studies utilize biomarkers to explore a specific etiology or sub-type of PD.

Furthermore, clinical, genetic and DAT imaging biomarkers identified from existing and ongoing proof of concept studies may be used to identify a cohort of subjects who are at high risk of developing PD (referred to as the ‘Prodromal’ cohort). These studies suggest that subjects with risk due to hyposmia, RBD or LRRK2 mutation, with DAT imaging in the PD range, who do not have motor symptoms consistent with PD, are at risk to develop motor PD within approximately two years of the imaging assessment. Successful identification of this Prodromal cohort will provide evidence for the utility of biomarkers in identification of prodromal PD, which would improve knowledge of early etiology and present an opportunity to target interventions earlier in the disease process.

**Utility of biomarkers in clinical study design**

Perhaps the most important rationale for using biomarkers in clinical studies is the potential for longitudinal biomarker outcomes to provide critical data with a shorter duration of follow-up and a reduced sample size compared to that required of typical clinical outcomes. The sample size requirements for a progression study depend on the effect size and the variance of the outcome measure. For example, in vivo dopamine neuroimaging requires a similar sample size and observation interval to that of common clinical outcomes (change in UPDRS or need for dopaminergic therapy)\(^2,12\). Identifying biomarkers that could provide a more rapid assessment of drug effect would substantially accelerate development of putative disease modifying drugs.

In the PPMI study, a striatal dopamine transporter deficit on dopamine transporter imaging, or (for sites where DaTSCAN\(^\text{TM}\) is not available) a striatal monoamine transporter deficit on VMAT2 imaging, is a requirement for inclusion into the PD cohort. The purpose of providing these inclusion criteria was to increase the probability that the PD subjects (screened with at least an asymmetric motor sign) enrolled in PPMI have a diagnosis of PD or a Parkinsonian Syndrome (PS) with the characteristic signs of degeneration of dopaminergic neurons in the substantia nigra pars compacta. Developing this relatively
‘pure’ PD cohort is especially important for the PPMI study in which the development and evaluation of biomarkers for PD is the main purpose. While the subjects screened as PD without evidence of dopaminergic (or VMAT) deficit (SWEDD) are not enrolled as PD subjects in the PPMI protocol, there is important information to be gained by following these subjects and better understanding their clinical progression, biomarker characterization and ultimately their clinical diagnosis.

Finally, given evidence that pre-motor subjects with hyposmia, RBD or LRRK2 mutation who also have a DAT deficit (compared to healthy subjects) have a high risk of conversion to motor PD, a Prodromal cohort will be enrolled with hyposmia, RBD and/or LRRK2 mutation with DAT binding in the PD range. Since we are uncertain about the exact distribution of DAT binding in this group, and while we anticipate that the majority of subjects will have a range of DAT deficit similar to subjects with early PD, we will also select no DAT deficit or minimal DAT deficit subjects similar in age, gender, and risk profile to those with mild to moderate DAT deficit. Phenoconversion of these at risk subjects to motor PD will be determined according to research based diagnostic criteria as assessed by the Investigator.

Current landscape of biomarkers for PD progression
Progression markers for PD are both a critical and as yet an unmet need. Validated biomarkers of disease progression are necessary to monitor the natural history of PD and to assess therapies that may modify disease progression.

Although no fully validated progression biomarker has been developed, several biomarkers have been tested in PD progression studies. In some studies, biomarkers such as nigral ultrasound hyperechogenicity and microglial activation as a measure of neuroinflammation may be markers of disease risk, but do not appear to change with disease progression\(^{13,14}\). However, other studies have identified biomarkers such as alpha-synuclein, elevated plasma urate and imaging measures such as DAT density that may predict or track disease. While there is little direct data that alpha-synuclein is a progression marker, the age related changes in alpha-synuclein and association with PD severity suggest that it may be possible to measure change as PD progresses\(^{15,16}\). Recent assessment of two large PD clinical trials has demonstrated that elevated urate may be associated with slowed disease progression, possibly predicting PD progression, but not tracking progression\(^{17,17}\).

Imaging tracers targeting presynaptic nigrostriatal function have been the most widely used biomarker to track PD progression. Most of these studies have used either F-Dopa and/or DAT tracers to monitor dopaminergic degeneration\(^{18-25}\). Dopamine ligands are useful to assess PD in so far as they reflect the ongoing dopaminergic degeneration in PD. In the study most directly correlating changes in dopamine pathology and imaging outcomes there is good correlation between dopamine neuron loss and F-Dopa uptake, although conclusions are limited by a very small sample size of only five subjects\(^{26}\). Numerous other studies have shown that the dopamine transporter density is reduced in striatum in postmortem brain from PD patients\(^{27-29}\). In turn numerous clinical imaging studies have shown reductions in F-Dopa, VMAT2 and DAT ligands uptake in PD patients and aging healthy subjects consistent with the expected pathology of PD and of normal aging. Specifically these imaging studies demonstrate asymmetric, putamen>caudate loss of dopaminergic uptake and the imaging loss correlates with worsening clinical symptoms in cross-sectional evaluation\(^{22,30-34}\). In addition, DAT ligands demonstrate reductions in activity with normal aging\(^{35-37}\).
In longitudinal studies of PD progression, F-Dopa, VMAT2, DAT (ß-CIT and CFT), using both PET and SPECT have demonstrated an annualized striatal rate of reduction of about 4% to 13% in PD patients compared with 0% to 2.5% change in healthy controls\textsuperscript{6,9,12,38-43}. Evidence from studies of hemi-PD subjects provides further insight into the rate of progression of disease. In early hemi-PD there is a reduction in F-Dopa, VMAT2 and DAT of about 50% in the effected putamen and of 25-35% in the unaffected putamen. Since most patients will progress clinically from unilateral to bilateral in 3-6 years it is therefore likely that the loss of these in vivo imaging markers of dopaminergic degeneration in the previously unaffected putamen will progress at about 4-10% per annum\textsuperscript{19,33,44,45}.

DAT and F-Dopa imaging have been used to assess the effects of possible disease modifying drugs in several clinical trials. However, several caveats limit the interpretation of these imaging data\textsuperscript{46,47}. There has been concern that the drug under testing or concomitant symptomatic medications might directly regulate the imaging outcome so that it would not be a true measure of disease progression. Given that recent studies demonstrate that the most common symptomatic medications (levodopa and dopamine agonists) do not have a short-term regulatory effect on DAT imaging, there is increased confidence in DAT imaging as a measure of progression\textsuperscript{48}. Nonetheless, future imaging studies must include an assessment of the short-term effect of the test drug on the imaging outcome. A second caveat for imaging studies of disease progression has been the inconsistent correlation of changes in imaging outcomes and clinical outcomes in these clinical trials. The lack of clinical–imaging correlation may be explained since these outcomes reflect very different aspects of the disease (imaging – a physiological measure of dopamine presynaptic function, clinical – a functional measure of disability). Therefore imaging and clinical outcomes may best be considered complementary rather than correlative. Many clinical outcomes may be also confounded by symptomatic medications further complicating the correlation of clinical and imaging outcomes once symptomatic treatment has begun.

In summary, the studies of dopaminergic imaging as a tool for disease progression have both provided useful and important data but have also highlighted the difficulties in validating a progression marker and the as yet unmet need for additional tools to more fully and more rapidly assess disease progression.

**Current landscape for prodromal PD biomarkers**

Parkinson disease has a prolonged pre-diagnostic period during which nigral dopamine degeneration and likely brainstem and olfactory bulb pathology has occurred several years in advance of typical motor symptoms. Accurately defining a pre-diagnostic or prodromal phase for PD requires the ability to reliably identify individuals who are at high risk to phenoconvert to PD, but presents an opportunity to ultimately provide early intervention to treat these individuals prior to the onset of motor symptoms or delay the development of manifest PD.

Numerous studies have demonstrated that at clinical diagnosis of PD, a 40-60% loss of dopaminergic neurons has already occurred during a prodromal period estimated to be 5-15 years in duration\textsuperscript{2,9,40,48-54}. Several lines of evidence demonstrate that dopaminergic imaging can reliably identify subjects with a reduction in dopamine transporter density or F-Dopa during this prodromal phase of their disease. Early non-motor symptoms like olfactory loss, autonomic dysfunction, sleep disturbance, cognitive and behavioral impairment may also
occur prior to typical PD motor symptoms, reflecting early brainstem or extra-nigral pathology. These symptoms may serve as sensitive, but non-specific clinical markers that may enrich a population to be further assessed with dopaminergic imaging markers to more specifically identify PD subjects with early evidence of neurodegeneration. Recent understanding of both these early non-motor manifestations and the molecular genetics of PD have provided several specific strategies to identify those individuals without typical PD motor symptoms, but at increased risk to develop PD. Several proof of concept studies have demonstrated that enriching a population for PD risk by combining non-motor symptoms (olfaction or RBD) or genetic risk with dopamine transporter imaging (DAT) may successfully identify individuals at high risk to phenoconvert to manifest PD.

The PPMI study presents an opportunity to use clinical, genetic and DAT imaging biomarkers tested in these existing and ongoing proof-of-concept studies to develop and follow a cohort at high risk of developing PD within two years of the imaging assessment.

1.2. Rationale for PPMI

Given that lack of validated biomarkers for PD and prodromal PD have impeded therapeutic development, there is increasing consensus that a major initiative to develop biomarkers for disease progression and early detection is both necessary and feasible. Recent advances in molecular genetics, neurobiology, imaging technology and radiochemistry have provided new tools that may be useful in identification of such biomarkers for further studies of disease modifying therapies. The goal of this biomarker initiative is to create a consortium of academic centers, government agencies, PD foundations, and pharmaceutical and biotech companies to collectively design, fund, and implement a comprehensive program to establish markers of PD progression. This strategy has been successfully employed by a consortium of Alzheimer disease researchers to create the ADNI, a group that has now organized infrastructure and has developed a research cohort to examine progression biomarkers in AD.

In PPMI, technologies including neuroimaging modalities, biochemical markers in the CSF and plasma, genetic markers, and early clinical disease markers will be investigated. A major initial focus of this biomarker consortium will be to standardize biomarker acquisition and assessment and to establish well-defined quantitative biomarker outcomes that are consistent among many research sites and laboratories. Core laboratories for biomarker analysis will be used for uniformity of analyses and quality control.

Genetic approaches to understanding disease are complex and rapidly changing; however, we anticipate two approaches that may be applied to this study population. First, focused genotyping that aims to interrogate genetic variability that is implicated in the disease process, either by previous studies or as a plausible biological candidate. This would include, for example, the more common LRRK2 and GBA mutations, in addition to previously validated risk variants in SNCA and MAPT. Second, more broad application of genome wide analyses, both because such approaches may become a more cost effective alternative to focused genotyping and because at some point in the future these patient samples may be included in larger population based studies on the genetics of PD. Such methods would include genome wide association studies, whole exome sequencing and whole genome sequencing.
Imaging tools for PD provide both an opportunity for ensuring accuracy of diagnosis and for assessing disease progression. Early diagnosis of PD in de novo subjects, like those being recruited for PPMI, is difficult because characteristic signs and symptoms have not yet fully emerged and patients may present atypical signs and symptoms. Diagnostic accuracy in a de novo PD population is a function of disease stage (the earlier the stage the more difficult the diagnosis) and examiner expertise, diagnoses by movement disorder specialists being more accurate than by general neurologists. For example, in prior PD clinical trials enrolling newly diagnosed subjects, ten to fourteen percent of subjects have SWEDD. Subsequent follow-up suggests that these subjects are unlikely to have idiopathic PD. Understanding the biomarker profiles in the subjects without dopamine transporter deficit provides a dataset that serves as a ‘disease control’ and offers biomarker information with which to compare with PD and healthy control subjects.

This approach to biomarker development is ambitious and requires cooperation among many in academics, industry, government, and the public sector. The lack of success of recent disease modifying therapeutic trials coupled with the huge expense of these studies has highlighted the need for such an approach to identify and validate biomarkers of PD progression for future clinical studies of disease modifying drugs.

2. Study Objectives

2.1. Primary Objective

The overall objective of this study is to identify clinical, imaging and biologic markers of PD progression for use in clinical trials of disease-modifying therapies.

Specific aims to accomplish this objective are:

a. Establish standardized protocols for acquisition, transfer and analysis of clinical, imaging and biologic data that can be used by the PD research community.

b. Develop a comprehensive and uniformly acquired clinical and imaging dataset and biological samples that can be used to estimate the mean rates of change and the variability around the mean of clinical, imaging and biomic outcomes in early PD patients.

c. Investigate existing and identify novel clinical, imaging, and biomic Parkinson disease progression markers to identify quantitative individual measures or combination of measures that demonstrate optimum interval change in PD patients in comparison to healthy controls, SWEDD subjects, Prodromal subjects, or in sub-sets of PD patients defined by baseline assessments, progression milestones and/or rate of clinical, imaging, or biomic change.

d. Conduct preliminary verification studies on promising biological markers using stored collected samples.

2.2. Secondary Objectives

2.2.1. To evaluate the probability of a change over a 24-month period in the clinical diagnosis of PPMI PD subjects with a baseline dopamine transporter image that shows no evidence for striatal DAT or VMAT deficit (SWEDD).
2.2.2. Assess the influence of dopamine transporter or VMAT2 imaging status on the clinical diagnosis and management of SWEDD subjects.

2.2.3. To evaluate the probability of phenoconversion to PD over a 24-month period for individuals enrolled in the Prodromal cohort.

2.2.4. Investigate existing and identify novel clinical, imaging, and biomic Parkinson disease progression markers to identify quantitative individual measures or combination of measures that demonstrate optimum interval change of SWEDD subjects in comparison to healthy controls, PD subjects, Prodromal subjects or in sub-sets of PD patients defined by baseline assessments, progression milestones and/or rate of clinical, imaging, or biomic change.

2.2.5. Investigate existing and identify novel clinical, imaging, and biomic Parkinson disease progression markers to identify quantitative individual measures or combination of measures that demonstrate optimum interval change of Prodromal subjects in comparison to healthy controls, PD subjects, SWEDD subjects or sub-sets of PD patients defined by baseline assessments, progression milestones and/or rate of clinical, imaging, or biomic change.

3. Study Outcomes

3.1. Primary Outcomes

The mean rates of change and the variability around the mean of clinical, imaging and biomic outcomes in early PD patients, and where appropriate the comparison of these rates between PD patient subsets and between PD, SWEDD, Prodromal and healthy subjects at study intervals from 3 months to 36 months. Specific examples of outcomes include MDS-UPDRS, dopamine transporter striatal uptake, vesicular monoamine transporter type-2 uptake, and serum and CSF alpha-synuclein. PD patient subsets may be defined by baseline assessments, progression milestones and/or rate of clinical, imaging, or biomic change.

3.2. Secondary Outcomes

a) Comparison between the rates of change in the mean of clinical, imaging and biomic outcomes in early PD patients and between PD and healthy subjects at study intervals from 3 months to 36 months.

b) Prevalence of measures of clinical, imaging and biomic outcomes in early PD patients and healthy subjects at study intervals from baseline to 36 months.

c) To establish the predictive value of early clinical non-motor features, baseline imaging and biomic outcomes for future course of disease.

d) Exploratory analysis of comparison between the rates of change in the mean of clinical, imaging and biomic outcomes in prodromal PD with baseline DaTSCAN binding showing minimal to moderate DAT deficit and early PD patients and healthy subjects at study intervals from 3 months to 36 months.

e) Exploratory analysis of prevalence of measures of clinical, imaging and biomic outcomes in prodromal PD compared to early PD patients and healthy subjects at study intervals from baseline to 36 months including the time for phenoconversion.

f) To examine the proportion of Prodromal subjects with one or more risk characteristics [hyposmia (<10<sup>th</sup> percentile by age and gender), RBD, or LRRK2...
mutation, and baseline DaTSCAN binding showing minimal to moderate DAT deficit who phenoconvert within two years. To correlate the baseline DaTSCAN binding with risk of phenoconversion.

g) To conduct exploratory analyses to examine whether the progression of clinical, imaging, and biospecimen biomarkers will predict those subjects likely to phenoconvert. For example, dopamine transfer loss during the prodromal period either independently or in combination with other biomarkers may provide a quantitative outcome associated with prodromal disease progression to phenoconversion.

h) To examine the proportion of SWEDD subjects that have a change in their clinical management at 24 months (SWEDD Clinical Diagnosis and Management Questionnaire).

i) To conduct exploratory analyses in SWEDD subjects to examine the prevalence of measures of clinical, imaging, and biomic outcomes from baseline to 24 months, examine the mean rates of change and the variability among these outcomes from 3 months to 24 months, and to examine the correlations between the rates of change in these outcomes from 3 months to 24 months.

j) To conduct exploratory analyses to determine whether the measures and change over time in clinical, imaging, and biomic outcomes are similar among the SWEDD, Prodromal, and PD subjects.

4. Study Design and Populations

4.1. Overall Study Design

Longitudinal, multi-center study to assess progression of clinical features, imaging and biologic biomarkers in Parkinson disease (PD) patients compared to healthy controls (HC) and in PD patient subtypes. PPMI will be a five-year natural history study (a minimum of 3-year involvement) of de novo idiopathic PD patients and healthy controls. Approximately 400 PD and 200 healthy controls will be recruited from about 24 clinical sites. All subjects will be comprehensively assessed at baseline and every three to six months thereafter. Subjects will undergo clinical (motor, neuropsychiatric and cognitive) and imaging assessments and will donate blood, urine, and cerebral spinal fluid (CSF). A blood sample for DNA will be collected. Data will be collected by each site under uniformly established protocols and data will be stored and analyzed at designated core facilities.

In addition, biomarkers will be assessed in approximately 60 – 100 SWEDD subjects. The SWEDD subjects will be followed over a 2 year (24 month) period at the same intervals and visit schedule as the PD and Control subjects participating in the PPMI study. Subjects will undergo a dopamine transporter imaging scan at screening and 24 months. The clinical diagnosis on the Clinical Diagnosis and Management Questionnaire at the 24 Month visit will serve as the final clinical diagnosis for SWEDD subjects.

An additional cohort of Prodromal subjects will be included in the clinical, imaging and biologic assessments of PPMI. Approximately 100 Prodromal subjects will be enrolled and followed over a 3-4 year period. Prodromal subjects with RBD, hyposmia and/or LRRK2 with DAT binding ranging from no DAT deficit to moderate DAT deficit will be selected (most subjects with DAT binding <80% of age expected striatal DAT binding based on the
existing PPMI healthy subject database). Since we are uncertain about the exact distribution of DAT binding in this group, and while we anticipate that the majority of subjects (approx. 80) will have a range of DAT deficit similar to subjects with early PD, we will also select no DAT deficit or minimal DAT deficit subjects (approx. 20) to be similar in age, gender, and risk profile to those with mild to moderate DAT deficit. Subjects will not be informed of their DAT binding. It is anticipated that approximately 400 screening SPECT scans will be completed in order to identify the 100 Prodromal subjects for participation and enrollment.

\(^{18}\text{F-AV-133 VMAT-2 PET imaging will occur in Australia in place of the dopamine transporter imaging for PD, Control and SWEDD subjects. At selected U.S. sites, participating subjects (PD, HC and SWEDD) may undergo}\) \(^{18}\text{F-AV-133 VMAT-2 PET imaging in addition to the dopamine transporter imaging per the schedule of activities. Refer to the}\) \(^{18}\text{F-AV-133-PPMI companion protocol.}\)

### 4.2. Selection of Study Population

#### 4.2.1. Inclusion Criteria (Parkinson Disease Subjects)

4.2.1.1. Patients must have at least two of the following: resting tremor, bradykinesia, rigidity (must have either resting tremor or bradykinesia); OR either asymmetric resting tremor or asymmetric bradykinesia.

4.2.1.2. A diagnosis of Parkinson disease for 2 years or less at Screening.

4.2.1.3. Hoehn and Yahr stage I or II at Baseline.

4.2.1.4. Not expected to require PD medication within at least 6 months from Baseline.

4.2.1.5. Male or female age 30 years or older at time of PD diagnosis.

4.2.1.6. Confirmation from imaging core that screening dopamine transporter SPECT scan is consistent with dopamine transporter deficit (or for sites where DaTSCAN\textsuperscript{TM} is not available that VMAT-2 PET scan is consistent with VMAT deficit).

4.2.1.7. Ability to provide written informed consent in accordance with Good Clinical Practice (GCP), International Conference on Harmonization (ICH), and local regulations.

4.2.1.8. Willing and able to comply with scheduled visits, required study procedures and laboratory tests.

4.2.1.9. Women may not be pregnant, lactating or planning pregnancy during the course of the study.

- Includes a negative urine pregnancy test on day of Screening scan prior to injection (DaTSCAN\textsuperscript{TM} and/or \(^{18}\text{F-AV-133).}\)

- Includes a negative serum pregnancy test prior to Screening scan injection (\(^{18}\text{F-AV-133 only).}\)

4.2.1.10. Women participating in VMAT-2 PET imaging must be of non-childbearing potential \textbf{or} be using a highly effective method of birth control 14 days prior to until at least 24 hours after injection of \(^{18}\text{F-AV-133).}\)

- Non-child bearing potential is defined as a female that must be either postmenopausal (no menses for at least 12 months prior to
Screening) or surgically sterile (bilateral tubal ligation, bilateral oophorectomy or hysterectomy).

- Highly effective method of birth control is defined as practicing at least one of the following: A birth control method that results in a less than 1% per year failure rate when used consistently and correctly, such as oral contraceptives for at least 3 months prior to injection, an intrauterine device (IUD) for at least 2 months prior to injection, or barrier methods, e.g., diaphragm or combination condom and spermicide. Periodic abstinence (e.g. calendar, ovulation, symptothermal, post-ovulation methods) is not acceptable.

4.2.2. Exclusion Criteria (Parkinson Disease Subjects)

4.2.2.1. Atypical PD syndromes due to either drugs (e.g., metoclopramide, flunarizine, neuroleptics) or metabolic disorders (e.g., Wilson’s disease), encephalitis, or degenerative diseases (e.g., progressive supranuclear palsy).

4.2.2.2. Currently taking levodopa, dopamine agonists, MAO-B inhibitors (e.g., selegiline, rasagiline), amantadine or other PD medication.

4.2.2.3. Has taken levodopa, dopamine agonists, MAO-B inhibitors or amantadine within 60 days of Baseline.

4.2.2.4. Has taken levodopa or dopamine agonists prior to Baseline for more than a total of 60 days.

4.2.2.5. A clinical diagnosis of dementia as determined by the investigator (Appendix 1).

4.2.2.6. Received any of the following drugs that might interfere with dopamine transporter SPECT imaging: Neuroleptics, metoclopramide, alpha methylldopa, methylphenidate, reserpine, or amphetamine derivative, within 6 months of Screening.

4.2.2.7. Subjects participating in VMAT-2 PET imaging have received any of the following medications that might interfere with \(^{18}\text{F}-\text{AV-133}\) PET imaging: neuroleptics, metoclopramide, alpha methylldopa, methylphenidate, reserpine, or amphetamine derivative, within 2 weeks prior to the \(^{18}\text{F}-\text{AV-133}\) injection.

4.2.2.8. Current treatment with anticoagulants (e.g., coumadin, heparin) that might preclude safe completion of the lumbar puncture.

4.2.2.9. Condition that precludes the safe performance of routine lumbar puncture, such as prohibitive lumbar spinal disease, bleeding diathesis, or clinically significant coagulopathy or thrombocytopenia.

4.2.2.10. Any other medical or psychiatric condition or lab abnormality, which in the opinion of the investigator might preclude participation.

4.2.2.11. Use of investigational drugs or devices within 60 days prior to Baseline (dietary supplements taken outside of a clinical trial are not exclusionary, e.g., coenzyme Q10).

4.2.2.12. Previously obtained MRI scan with evidence of clinically significant neurological disorder (in the opinion of the Investigator).
4.2.3. Inclusion Criteria (Healthy Control Subjects)

4.2.3.1. Male or female age 30 years or older at Screening.
4.2.3.2. Ability to provide written informed consent in accordance with Good Clinical Practice (GCP), International Conference on Harmonization (ICH), and local regulations.
4.2.3.3. Willing and able to comply with scheduled visits, required study procedures and laboratory tests.
4.2.3.4. Women may not be pregnant, lactating or planning pregnancy during the course of the study.
   - Includes a negative urine pregnancy test on day of Screening scan prior to injection (DaTSCAN™ and/or 18F-AV-133).
   - Includes a negative serum pregnancy test prior to Screening scan injection (18F-AV-133 only).
4.2.3.5. Women participating in VMAT-2 PET imaging must be of non-childbearing potential or be using a highly effective method of birth control 14 days prior to until at least 24 hours after injection of 18F-AV-133).
   - Non-child bearing potential is defined as a female that must be either postmenopausal (no menses for at least 12 months prior to Screening) or surgically sterile (bilateral tubal ligation, bilateral oophorectomy or hysterectomy).
   - Highly effective method of birth control is defined as practicing at least one of the following: A birth control method that results in a less than 1% per year failure rate when used consistently and correctly, such as oral contraceptives for at least 3 months prior to injection, an intrauterine device (IUD) for at least 2 months prior to injection, or barrier methods, e.g., diaphragm or combination condom and spermicide. Periodic abstinence (e.g. calendar, ovulation, symptothermal, post-ovulation methods) is not acceptable.

4.2.4. Exclusion Criteria (Healthy Control Subjects)

4.2.4.1. Current or active clinically significant neurological disorder (in the opinion of the Investigator).
4.2.4.2. First degree relative with idiopathic PD (parent, sibling, child).
4.2.4.3. MoCA score of 26 or less (i.e., eligible if score is 27 to 30).
4.2.4.4. Received any of the following drugs that might interfere with dopamine transporter SPECT imaging: Neuroleptics, metoclopramide, alpha methyl dopa, methylphenidate, reserpin, or amphetamine derivative, within 6 months of Screening.
4.2.4.5. Subjects participating in VMAT-2 PET imaging have received any of the following medications that might interfere with 18F-AV-133 PET imaging: neuroleptics, metoclopramide, alpha methyl dopa, methylphenidate, reserpin, or amphetamine derivative, within 2 weeks prior to the Screening 18F-AV-133 injection.
4.2.4.6. Current treatment with anticoagulants (e.g., coumadin, heparin) that might preclude safe completion of the lumbar puncture.
4.2.4.7. Condition that precludes the safe performance of routine lumbar puncture, such as prohibitive lumbar spinal disease, bleeding diathesis, or clinically significant coagulopathy or thrombocytopenia.

4.2.4.8. Any other medical or psychiatric condition or lab abnormality, which in the opinion of the investigator might preclude participation.

4.2.4.9. Use of investigational drugs or devices within 60 days prior to baseline (dietary supplements taken outside of a clinical trial are not exclusionary, e.g., coenzyme Q10).

4.2.4.10. Previously obtained MRI scan with evidence of clinically significant neurological disorder (in the opinion of the Investigator).

4.2.5. Inclusion Criteria (SWEDD Subjects)

See Section 4.2.1 for Inclusion Criteria for PD subjects. All criteria apply except a SWEDD subject must have confirmation from imaging core that screening dopamine transporter SPECT scan shows no evidence of dopamine transporter deficit (or for sites where DaTSCAN™ is not available that VMAT-2 PET scan shows no evidence of VMAT deficit).

4.2.6. Exclusion Criteria (SWEDD Subjects)
See Section 4.2.2 for Exclusion Criteria for PD subjects which also apply to SWEDD subjects.

4.2.7. Inclusion Criteria (Prodromal Subjects)

4.2.7.1. Subjects must have at least one of the following characteristics:

- **Hyposmia:**
  a) Male or female age 60 years or older
  b) Confirmation from olfactory core that olfaction as determined by UPSIT is at or below the 10th percentile by age and gender

- **REM Behavior Disorder (RBD):**
  a) Male or female age 60 years or older
  b) Confirmation from sleep core that subject’s Polysomnography (PSG) meets criteria for RBD

- **LRRK2:**
  a) Male or female age 60 years or older
  b) Written confirmation or documentation from testing facility that the individual is LRRK2 mutation positive

4.2.7.2. Confirmation from imaging core that screening dopamine transporter SPECT scan is read as eligible (see below).

- About 80 subjects will have a range of DAT deficit similar to subjects with early PD (mild to moderate DAT deficit). About 20 subjects will be selected with no DAT deficit or minimal DAT deficit similar in age, gender, and risk profile to those with mild to moderate DAT deficit.

4.2.7.3. Ability to provide written informed consent in accordance with Good Clinical Practice (GCP), International Conference on Harmonization (ICH), and local regulations.
4.2.7.4. Willing and able to comply with scheduled visits, required study procedures and laboratory tests.

4.2.7.5. Women may not be pregnant, lactating or planning pregnancy during the course of the study.
   - Includes a negative urine pregnancy test on day of screening scan prior to injection (DaTSCAN™).

4.2.8. Exclusion Criteria (**Prodromal Subjects**)

4.2.8.1. Current or active clinically significant neurological disorder or psychiatric disorder (in the opinion of the Investigator).

4.2.8.2. GDS score greater than or equal to 10 (GDS score of 5 – 9 requires Investigator discretion to enter study).

4.2.8.3. STAI Form Y-1 greater than or equal to 54 requires Investigator discretion to enter study.

4.2.8.4. A clinical diagnosis of dementia[^63] as determined by the investigator (Appendix 1).

4.2.8.5. A clinical diagnosis of Parkinson disease at the Screening visit as determined by the Investigator.

4.2.8.6. Received any of the following drugs that might interfere with dopamine transporter SPECT imaging: Neuroleptics, metoclopramide, alpha methylldopa, methylphenidate, reserpine, or amphetamine derivative, within 6 months of Screening.

4.2.8.7. Current treatment with anticoagulants (e.g., coumadin, heparin) that might preclude safe completion of the lumbar puncture.

4.2.8.8. Condition that precludes the safe performance of routine lumbar puncture, such as prohibitive lumbar spinal disease, bleeding diathesis, or clinically significant coagulopathy or thrombocytopenia.

4.2.8.9. Any other medical or psychiatric condition or lab abnormality, which in the opinion of the investigator might preclude participation.

4.2.8.10. Use of investigational drugs or devices within 60 days prior to Baseline (dietary supplements taken outside of a clinical trial are not exclusionary, e.g., coenzyme Q10).

4.2.8.11. Previously obtained MRI scan with evidence of clinically significant neurological disorder (in the opinion of the Investigator).

4.3. Age and Gender Matching

Enrollments will be monitored centrally by the Steering Committee with the goal of achieving age and gender balance across the PD and Healthy Control subjects. Individual sites should generally attempt to match healthy control subjects as closely as possible in age (target within 5 years) and gender to the PD subjects enrolled at the site. Sites will be instructed if recruitment restrictions need to be implemented as the study progresses in order to maintain a balanced population.
5. Investigational Plan

5.1. Subject Identification Numbers

5.1.1. Subject Identification (ID) Number

A Subject ID Number will be assigned in sequential order by the site from a list provided to the site by the CTCC. This 4-digit number for PD, HC and SWEDD subjects will be used to identify the subject on all study forms and lab specimens.

The Prodromal subjects will be assigned a 5-digit subject ID number assigned in sequential order from a list provided to the site and appropriate cores by the CTCC. This 5-digit number for Prodromal subjects will be used to identify the subject on all study forms and lab specimens.

5.1.2. CTCC Unique ID Number

Subjects will be instructed how to obtain a 9-digit Unique Identification Number at the Screening Visit. This ID system has the ability to track individual subjects across multiple CTCC studies without storing any personally identifiable information. The protected system uses an algorithm of nine data element inputs (last name at birth, first name at birth, gender at birth, day, month and year of birth, city and country of birth, and mother’s maiden name), and produces an electronic “fingerprint” output. The system stores only the “fingerprint” and clears the individual’s inputted data elements from memory. The subject is then assigned a 9-digit CTCC Unique ID Number that is associated with their electronic “fingerprint.”

Once a subject signs the informed consent, the subject and the study coordinator or designated study staff will go to a secure website on a computer at the research clinic and enter the subject’s nine data elements. The CTCC Unique ID Number will be printed and provided to the subject. The study coordinator will record this number on the CTCC Unique ID CRF.

If a subject has participated in previous CTCC studies and already has an existing CTCC Unique ID Number, that number should be used for this study. The site can regenerate a subject’s CTCC Unique ID Number by returning to the secure website, enter the same nine data elements in the exact same way they were entered the first time to receive the same CTCC Unique ID Number.

5.2. Schedule of Activities

Refer to the protocol synopsis Schedule of Activities that summarizes the assessments to be conducted at each visit.

Sites participating in $^{18}$F-AV-133 PET imaging refer to the $^{18}$F-AV-133-PPMI companion protocol Trial Flow Charts for schedule of activities and assessments conducted at each visit.
SWEDD Subjects

SWEDD subjects who completed a PPMI Screening visit 12 months ago or longer will be re-screened with the SWEDD Screening visit activities. SWEDD subjects who completed a PPMI Screening visit less than 12 months ago will proceed with the SWEDD Baseline visit activities. Subjects who were enrolled in PPMI and were then determined to be a SWEDD based on their delayed initial SPECT scan, will proceed with the next follow up study visit as scheduled (e.g., subject completed SPECT scan at PPMI V01 and was deemed a SWEDD, the subject will resume participation at V02 using the SWEDD schedule of activities).

Prodromal Subjects

Subjects being considered for participation in the Prodromal cohort will undergo pre-screening activities including self-administered olfactory testing using the UPSIT (University of Pennsylvania Smell Identification Test), review of already acquired polysomnography (PSG) for signs of REM behavior disorder (RBD) and/or review of genetic testing information to evaluate for the LRRK2 gene. Subjects who meet the criteria for hyposmia, RBD and/or LRRK2 will be invited to a PPMI clinical research site to review the PPMI consent. Subjects consenting to participate in PPMI will complete DAT imaging as part of the Screening visit.

5.3. Study Procedures at Each Visit

Subjects will undergo all procedures as outlined in the sections below for each cohort. Assessments that require completion by the Site Investigator (unless otherwise approved and delegated) include: Neurological Exam, MDS-UPDRS Part Ia (coordinator may conduct if requested in advance, as long as the assessment is completed consistently for all subjects/all visits), Part III, Part IV, Hoehn & Yahr Stage, Modified Schwab & England ADL, Cognitive Categorization, Clinical Diagnosis and Management Questionnaire, Primary Diagnosis, Prodromal Diagnostic Questionnaire and Diagnostic Features.

Specific procedures for the clinical labs, biomic labs, imaging, neuropsychological testing and lumbar puncture are indicated in section 6 and corresponding operation manuals.

Sites participating in $^{18}$F-AV-133 PET imaging refer to $^{18}$F-AV-133-PPMI companion protocol for study procedures required in addition to those detailed below.

5.3.1. Pre-Screening: Pre-screening activities discussed in this section apply only to subjects that have been recruited to participate in the Prodromal cohort. The pre-screening activities are completed to determine if subjects may be eligible to participate in the PPMI Screening visit. There are three types of pre-screening activities through which subjects may become eligible and include: hyposmia based on olfactory testing, polysomnographic evidence of RBD and genetic testing positive for the LRRK2 gene. The recruitment methods and pre-screening activities are detailed below.

- **Hyposmia:** Recruitment and pre-screening activities for hyposmic subjects will occur centrally through the Olfactory Core based at the Institute for Neurodegenerative Disorders (IND). Subjects will be recruited through mailings, newsletters, Fox Trial Finder, and the PPMI website. Interested subjects will be asked to complete a survey and answer
questions related to conditions that may impact their sense of smell. Subjects returning the survey who do not have a condition that could account for the hyposmia will be sent an Informed Consent Form (ICF), an UPSIT to evaluate smell identification, and a brief Self Reporting Questionnaire (SRQ). Once completed, subjects will return the ICF, SRQ and UPSIT by mail to IND. The UPSIT will be scored and compared to a normative database based on age and gender. Subjects who score at or below the 10th percentile for age and gender may be eligible for participation in the PPMI Screening visit. The hyposmic subjects will be notified by phone or mail that they will be contacted by a PPMI clinical site to further discuss possible study participation. Subjects who are not eligible based on their UPSIT score will be contacted by IND and informed of their ineligibility.

- **RBD:** Recruitment and pre-screening activities for subjects with a diagnosis of RBD will occur at selected PPMI sites that have a collaborative relationship with a local sleep center. Sleep Center/Clinic Investigators and staff will review polysomnograms (PSG) obtained in patients who have completed recent sleep studies. Patients that have evidence for RBD based on their PSG will be approached by the Sleep physician or staff who will provide information to the patient about PPMI and ask permission to provide their contact information to the PPMI Investigator or Coordinator. PPMI Investigators and Coordinators will contact patients to obtain initial consent and permission to obtain their recently acquired PSG to determine if they might be eligible for participation in PPMI. Once consent is obtained (oral or written), the PSG is sent to a central reading lab to determine if the PSG meets criteria for RBD as established for PPMI. If the PSG meets RBD criteria the subject is re-contacted and asked to come into the clinic and further discuss possible study participation. Subjects that are not eligible based on PSG are contacted and informed of their ineligibility.

- **LRRK2:** Recruitment and pre-screening activities for subjects with LRRK2 will occur at selected PPMI sites that have access to a clinic population or cohort of LRRK2 gene positive individuals. The PPMI Investigators and staff will review individual charts or databases from their population and contact those that may be interested to obtain initial consent and permission to obtain a copy of their previously obtained genetic testing results to determine if they might be eligible for participation in PPMI. If the gene testing confirms LRRK2 gene positivity, the subject is re-contacted and asked to come into the clinic and further discuss possible study participation. Subjects that are not eligible based on their genetic results are contacted and informed of their ineligibility.

5.3.2. Screening Visit: All subjects will undergo a screening evaluation prior to the Baseline visit. This evaluation will include the following activities and will take about 8 hours to complete:
• An explanation of the purpose, procedures, potential risks and benefits of this study and informed consent will be obtained
• Review of the subject’s medical and family history
• Review of concomitant medications
• Vital signs (blood pressure, heart rate and temperature)
• General physical examination
• General neurological examination
• Movement Disorder Society Unified Parkinson Disease Rating Scale (MDS-UPDRS) Parts I-III (PD and Prodromal subjects only)
• Hoehn and Yahr (PD and Prodromal subjects only)
• Modified Schwab & England (PD and Prodromal subjects only)
• Clinical diagnosis assessment
• Montreal Cognitive Assessment (MoCA)
• Collect blood sample for DNA (may be collected at Baseline if not done at Screening)
• Clinical laboratory assessments
  o Includes serum pregnancy test for women of childbearing potential participating in VMAT-2 PET imaging (see \textsuperscript{18}F-AV-133-PPMI companion protocol)
• Dopamine transporter SPECT imaging scan (see Section 6.3.1), includes urine pregnancy test for women of childbearing potential prior to injection
• ECG for subjects participating in VMAT-2 PET imaging (see \textsuperscript{18}F-AV-133-PPMI companion protocol)
• VMAT-2 PET imaging scan, at selected sites (see Section 6.3.2)
• Review of adverse events in follow up to SPECT (and/or VMAT-2 PET) imaging
• A review of the inclusion/exclusion criteria to confirm that the subject is eligible to continue to the Baseline visit

SWEDD Re-Screen Visit: Conducted for a SWEDD subject who completed a PPMI Screening visit 12 months ago or longer.
• An explanation of the purpose, procedures, potential risks and benefits of this study and informed consent will be obtained
• Clinical laboratory assessments
• Vital signs (blood pressure, heart rate and temperature)
• Review of the subject’s medical and family history
• Review of concomitant medications
• Review of current medical conditions
• General physical examination
• General neurological examination
• Movement Disorder Society Unified Parkinson Disease Rating Scale (MDS-UPDRS) Parts I-III
• Hoehn and Yahr
• Modified Schwab & England
• Montreal Cognitive Assessment (MoCA)
5.3.3. Baseline Visit (Day 0): The activities at the baseline visit will be completed within 45 days of completing the Screening visit. The Baseline visit will include the following activities and will take about 6 hours to complete. All assessments and activities listed below must be completed prior to enrollment of the subject into the study.

- Height and weight
- Vital signs (blood pressure, heart rate and temperature)
- Blood draw for research samples
- Urine collection for research samples
- Olfactory testing using the University of Pennsylvania Smell Identification Test (UPSIT)
- Clinical diagnosis assessment (SWEDD and Prodromal only)
- PASE Exercise Questionnaire (Prodromal subjects only)
- Epworth Sleepiness Scale
- REM Sleep Behavior Disorder Questionnaire
- Geriatric Depression Scale (GDS-15)
- State-Trait Anxiety Inventory
- Questionnaire for Impulsive-Compulsive Disorders
- Scales for Outcomes in Parkinson’s Disease (SCOPA-AUT)
- Letter Number Sequencing
- Hopkins Verbal Learning Test – Revised (Form 1)
- Symbol Digit Modalities Test (Form 1)
- Benton Judgment of Line Orientation (Odd items)
- Animal Fluency
- Cognitive Categorization Assessment
- MDS-UPDRS Parts I-III
- Hoehn and Yahr
- Modified Schwab & England (PD, Prodromal and SWEDD subjects only)
- Brain magnetic resonance imaging (MRI), (MRI will include DTI and resting state sequences at selected sites only)
- Lumbar puncture for collection of cerebral spinal fluid (CSF)
- Review of concomitant medications
- Review of current medical conditions
- Review of adverse events related to lumbar puncture
- Repeat review of the inclusion/exclusion criteria

Once all Baseline activities have been completed and the Investigator determines that all eligibility criteria have been met, the subject may be enrolled into the study.

5.3.4. Visit 01 (3 months ±30 days)

- Vital signs (blood pressure, heart rate and temperature)
- Blood draw for research samples
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- MDS-UPDRS Parts I-III (PD, Prodromal and SWEDD subjects only) (Part IV also conducted for subjects who have started PD medication)
- Hoehn and Yahr scale (PD, Prodromal and SWEDD subjects only)
- Modified Schwab & England (PD, Prodromal and SWEDD subjects only)
- Clinical diagnosis assessment (Prodromal and SWEDD subjects only)
- Review of current medical conditions
- Review of concomitant medications

5.3.5. Visit 02 (6 months ±30 days)
- Vital signs (blood pressure, heart rate and temperature)
- Blood draw for research samples
- Urine collection for research samples
- Lumbar puncture for collection of CSF
- *Epworth Sleepiness Scale
- *REM Sleep Behavior Disorder Questionnaire
- *GDS-15
- *State-Trait Anxiety Inventory
- *Questionnaire for Impulsive-Compulsive Disorders
- *SCOPA-AUT
- *MDS-UPDRS Parts I-III (Part IV also conducted for subjects who have started PD medication)
- *Hoehn and Yahr
- *Modified Schwab & England
- *Cognitive Categorization Assessment
- *Completed for PD, SWEDD and Prodromal subjects only
- Clinical diagnosis assessment (Prodromal and SWEDD subjects only)
- Review of current medical conditions
- Review of concomitant medications
- Review of adverse events related to lumbar puncture

5.3.6. Visit 03 (9 months ±30 days)
- Vital signs (blood pressure, heart rate and temperature)
- Blood draw for research samples
- MDS-UPDRS Parts I-III (PD, Prodromal and SWEDD subjects only) (Part IV also conducted for subjects who have started PD medication)
- Hoehn and Yahr scale (PD, Prodromal and SWEDD subjects only)
- Modified Schwab & England (PD, Prodromal and SWEDD subjects only)
- Clinical diagnosis assessment (Prodromal and SWEDD subjects only)
- Review of current medical conditions
- Review of concomitant medications

5.3.7. Visit 04 (12 months ±30 days)
- General neurological examination
- Height and weight
- Vital signs (blood pressure, heart rate and temperature)
- Blood draw for research samples
- Urine collection for research samples
- Clinical laboratory assessments
- PASE Exercise Questionnaire
- Epworth Sleepiness Scale
- REM Sleep Behavior Disorder Questionnaire
- GDS-15
- State-Trait Anxiety Inventory
- Questionnaire for Impulsive-Compulsive Disorders
- SCOPA-AUT
- Montreal Cognitive Assessment (MoCA)
- Letter Number Sequencing
- Hopkins Verbal Learning Test – Revised (Form 2)
- Symbol Digit Modalities Test (Form 2)
- Benton Judgment of Line Orientation (Even items)
- Animal Fluency
- Cognitive Categorization Assessment
- MDS-UPDRS Parts I-III (Part IV also conducted for subjects who have started PD medication)
- Hoehn and Yahr
- Modified Schwab & England (PD, Prodromal and SWEDD subjects only)
- MDS-UPDRS Part III and Hoehn & Yahr will be repeated one hour following dosing in clinic for subjects who have started levodopa or dopamine agonist
- Review of clinical diagnosis
- Lumbar puncture for collection of CSF
- SPECT imaging (PD and Prodromal subjects only – see Section 6.3.1), includes urine pregnancy test for women of childbearing potential prior to injection
- VMAT-2 PET imaging, at selected sites, PD subjects (see Section 6.3.2)
- MRI-DTI and resting state (PD, Prodromal and HC subjects at selected sites)
- Review of current medical conditions
- Review of concomitant medications
- Review of adverse events in follow up to SPECT (and/or VMAT-2 PET) imaging and/or lumbar puncture

5.3.8. Visit 05 (18 months ±30 days)
- Vital signs (blood pressure, heart rate and temperature)
- Blood draw for research samples
- MDS-UPDRS Parts I-III (PD, Prodromal and SWEDD subjects only) (Part IV also conducted for subjects who have started PD medication)
- Hoehn and Yahr scale (PD, Prodromal and SWEDD subjects only)
- Modified Schwab & England (PD, Prodromal and SWEDD subjects only)
- Clinical diagnosis assessment (Prodromal and SWEDD subjects only)
- Review of current medical conditions
- Review of concomitant medications
5.3.9. Visit 06 (24 months +30 days)
- General neurological examination
- Height and weight
- Vital signs (blood pressure, heart rate and temperature)
- Clinical laboratory assessments
- Blood draw for research samples
- Urine collection for research samples
- PASE Exercise Questionnaire
- Epworth Sleepiness Scale
- REM Sleep Behavior Disorder Questionnaire
- GDS-15
- State-Trait Anxiety Inventory
- Questionnaire for Impulsive-Compulsive Disorders
- SCOPA-AUT
- Montreal Cognitive Assessment (MoCA)
- Letter Number Sequencing
- Hopkins Verbal Learning Test – Revised (Form 3)
- Symbol Digit Modalities Test (Form 1)
- Benton Judgment of Line Orientation (Odd items)
- Animal Fluency
- Cognitive Categorization Assessment
- MDS-UPDRS Parts I-III (Part IV also conducted for subjects who have started PD medication)
- Hoehn and Yahr
- Modified Schwab & England (PD, Prodromal and SWEDD subjects only)
- MDS-UPDRS Part III and Hoehn & Yahr will be repeated one hour following dosing in clinic for subjects who have started levodopa or dopamine agonist
- Review of clinical diagnosis
- Lumbar puncture for collection of CSF
- SPECT imaging (PD, Prodromal and SWEDD subjects only – see Section 6.3.1), includes urine pregnancy test for women of childbearing potential prior to injection
- VMAT-2 PET imaging, at selected sites, PD and SWEDD subjects only (see Section 6.3.2)
- MRI DTI and resting state (PD, Prodromal and SWEDD subjects at selected sites)
- Review of current medical conditions
- Review of concomitant medications
- Review of adverse events in follow up to SPECT (and/or VMAT-2 PET) imaging and/or lumbar puncture
- Conclusion of study participation (SWEDD subjects only)

5.3.10. Visit 07 (30 months +30 days)
- Vital signs (blood pressure, heart rate and temperature)
- Blood draw for research samples
MDS-UPDRS Parts I-III (PD and Prodromal subjects only) (Part IV also conducted for subjects who have started PD medication)
- Hoehn and Yahr scale (PD and Prodromal subjects only)
- Modified Schwab & England (PD and Prodromal subjects only)
- Clinical diagnosis assessment (Prodromal subjects only)
- Review of current medical conditions
- Review of concomitant medications

5.3.11. Visit 08 (36 months ±30 days)
- General neurological examination
- Height and weight
- Vital signs (blood pressure, heart rate and temperature)
- Clinical laboratory assessments
- Blood draw for research samples
- Urine collection for research samples
- PASE Exercise Questionnaire
- Epworth Sleepiness Scale
- REM Sleep Behavior Disorder Questionnaire
- GDS-15
- State-Trait Anxiety Inventory
- Questionnaire for Impulsive-Compulsive Disorders
- SCOPA-AUT
- Montreal Cognitive Assessment (MoCA)
- Letter Number Sequencing
- Hopkins Verbal Learning Test – Revised (Form 4)
- Symbol Digit Modalities Test (Form 2)
- Benton Judgment of Line Orientation (Even items)
- Animal Fluency
- Cognitive Categorization Assessment
- MDS-UPDRS Parts I-III (Part IV also conducted for subjects who have started PD medication)
- Hoehn and Yahr
- Modified Schwab & England (PD and Prodromal subjects only)
- MDS-UPDRS Part III and Hoehn & Yahr will be repeated one hour following dosing in clinic for subjects who have started levodopa or dopamine agonist
- Review of clinical diagnosis
- Lumbar puncture for collection of CSF
- Review of current medical conditions
- Review of concomitant medications
- Review of adverse events related to lumbar puncture

5.3.12. Visit 09 (42 months ±30 days)
- Vital signs (blood pressure, heart rate and temperature)
- Blood draw for research samples
- MDS-UPDRS Parts I-III (PD and Prodromal subjects only) (Part IV also conducted for subjects who have started PD medication)
• Hoehn and Yahr scale (PD and Prodromal subjects only)
• Modified Schwab & England (PD and Prodromal subjects only)
• Clinical diagnosis assessment (Prodromal subjects only)
• Review of current medical conditions
• Review of concomitant medications

5.3.13. Visit 10 (48 months ±30 days)
• General neurological examination Height and weight
• Vital signs (blood pressure, heart rate and temperature)
• Clinical laboratory assessments
• Blood draw for research samples
• Urine collection for research samples
• PASE Exercise Questionnaire
• Epworth Sleepiness Scale
• REM Sleep Behavior Disorder Questionnaire
• GDS-15
• State-Trait Anxiety Inventory
• Questionnaire for Impulsive-Compulsive Disorders
• SCOPA-AUT
• Montreal Cognitive Assessment (MoCA)
• Letter Number Sequencing
• Hopkins Verbal Learning Test – Revised (Form 5)
• Symbol Digit Modalities Test (Form 1)
• Benton Judgment of Line Orientation (Odd items)
• Animal Fluency
• Cognitive Categorization Assessment
• MDS-UPDRS Parts I-III (Part IV also conducted for subjects who have started PD medication)
• Hoehn and Yahr
• Modified Schwab & England (PD and Prodromal subjects only)
• MDS-UPDRS Part III and Hoehn & Yahr will be repeated one hour following dosing in clinic for subjects who have started levodopa or dopamine agonist
• Review of clinical diagnosis
• Lumbar puncture for collection of CSF
• SPECT imaging (PD subjects only – see Section 6.3.1), includes urine pregnancy test for women of childbearing potential prior to injection
• VMAT-2 PET imaging, at selected sites, PD subjects only (see Section 6.3.2)
• MRI DTI and resting state (PD subjects at selected sites)
• Review of current medical conditions
• Review of concomitant medications
• Review of adverse events in follow up to SPECT imaging (and/or VMAT-2 PET) and/or lumbar puncture

5.3.14. Visit 11 (54 months ±30 days)
• Vital signs (blood pressure, heart rate and temperature)
• Blood draw for research samples
• MDS-UPDRS Parts I-III (PD subjects only) (Part IV also conducted for subjects who have started PD medication)
• Hoehn and Yahr scale (PD subjects only)
• Modified Schwab & England (PD subjects only)
• Review of current medical conditions
• Review of concomitant medications

5.3.15. Visit 12 (60 months +30 days)
• General neurological examination Height and weight
• Vital signs (blood pressure, heart rate and temperature)
• Clinical laboratory assessments
• Blood draw for research samples
• Urine collection for research samples
• PASE Exercise Questionnaire
• Epworth Sleepiness Scale
• REM Sleep Behavior Disorder Questionnaire
• GDS-15
• State-Trait Anxiety Inventory
• Questionnaire for Impulsive-Compulsive Disorders
• SCOPA-AUT
• Montreal Cognitive Assessment (MoCA)
• Letter Number Sequencing
• Hopkins Verbal Learning Test – Revised (Form 6)
• Symbol Digit Modalities Test (Form 2)
• Benton Judgment of Line Orientation (Even items)
• Animal Fluency
• Cognitive Categorization Assessment
• MDS-UPDRS Parts I-III (Part IV also conducted for subjects who have started PD medication)
• Hoehn and Yahr
• Modified Schwab & England (PD subjects only)
• MDS-UPDRS Part III and Hoehn & Yahr will be repeated one hour following dosing in clinic for subjects who have started levodopa or dopamine agonist
• Review of clinical diagnosis
• Lumbar puncture for collection of CSF
• Review of current medical conditions
• Review of concomitant medications
• Review of adverse events related to lumbar puncture

5.3.16. Telephone Contacts
Telephone call visits will be conducted 7 to 10 days following a visit when lumbar puncture and/or dopamine transporter SPECT imaging has occurred to assess for adverse events. In addition, after Month 12, telephone call visits will take place 3 months following each in-person visit to discuss any questions, verify whether or not PD medications have been started and to confirm the date of the next scheduled visit.
Refer to $^{18}$F-AV-133-PPMI companion protocol for telephone follow up requirements for subjects participating in VMAT-2 PET imaging.

5.3.17. Unscheduled Visits (Visit U01, U02, etc.), if required
Unscheduled visits may be performed at any time during the study whenever necessary to assess for or to follow up on adverse events or as deemed necessary by the Site Investigator or Coordinator. The following activities will be completed at an Unscheduled Visit:

- Vital signs
- General neurological examination
- Collect blood for clinical laboratory assessments
- Review of current medical conditions
- Review of concomitant medications

*Conducted only if clinically indicated

5.3.18. Premature Withdrawal of Participation
If the subject agrees, the following procedures should be performed when a subject withdraws early from the study:

- General neurological examination
- Height and weight
- Vital signs (blood pressure, heart rate and temperature)
- Clinical diagnosis assessment
- Blood draw for research samples – only if not done in the last 3 months
- Urine collection for research samples – only if not done in the last 3 months
- Clinical laboratory assessments
- PASE Exercise Questionnaire
- Epworth Sleepiness Scale
- REM Sleep Behavior Disorder Questionnaire
- GDS-15
- State-Trait Anxiety Inventory
- Questionnaire for Impulsive-Compulsive Disorders
- SCOPA-AUT
- Montreal Cognitive Assessment (MoCA)
- Letter Number Sequencing
- Hopkins Verbal Learning Test – Revised (version not used at preceding visit)
- Symbol Digit Modalities Test (version not used at preceding visit)
- Benton Judgment of Line Orientation (items not used at preceding visit)
- Animal Fluency
- Cognitive Categorization Assessment
- MDS-UPDRS Parts I-III (Part IV will also be conducted for subjects who have started PD medication)
- Hoehn and Yahr
- Modified Schwab & England (PD and Prodromal subjects only)
• MDS-UPDRS Part III and Hoehn & Yahr will be conducted again one hour following dosing in clinic for subjects who have started levodopa or dopamine agonist
• Lumbar puncture for collection of CSF – only if not done in the last 3 months
• SPECT imaging – only if not done in the last 12 months (PD, Prodromal and SWEDD subjects only – see Section 6.3.1,) includes urine pregnancy test for women of childbearing potential prior to injection
• VMAT-2 PET imaging – only if not done in the last 12 months for PD and SWEDD subjects only (refer to ^18F-AV-133-PPMI companion protocol)
• MRI DTI and resting state (PD, Prodromal and SWEDD subjects at selected sites if MRI not done in the last 12 months)
• MRI DTI and resting state (HC subjects at selected sites if PW visit conducted within first 12 months and MRI not done in the last 6 months)
• Review of current medical conditions
• Review of concomitant medications
• Review of adverse events in follow up to SPECT imaging and/or lumbar puncture

PD, SWEDD, or Prodromal Subjects Starting PD Medication:
If the site becomes aware that a subject will begin PD medication in advance of or at the time of a scheduled visit, the site should determine if the subject is willing to conduct a Symptomatic Therapy (ST) visit prior to starting medications. If a subject is not willing to return for an ST visit prior to starting PD medication, conduct the next study visit per the regular visit schedule. If the subject agrees, an ST visit should be conducted and the appropriate visit schedule below should be followed (see Section 5.3.18 for list of ST visit assessments):

o Before Visit 01: Complete ST visit assessments. Visit 01 will be missed and the subject will return to the regular visit schedule for Visit 02.

o At Visit 01 or prior to Visit 02: Complete ST visit assessments. Visit 02 will be missed and the subject will return to the regular visit schedule for Visit 03.

o At Visit 02 or prior to Visit 03: Complete ST visit assessments. Visit 03 will be missed and the subject will return to the regular visit schedule for Visit 04.

o At Visit 03 or prior to Visit 04: Complete ST visit assessments. Visit 04 will be missed and the subject will return to the regular visit schedule for Visit 05.

o At Visit 04: Complete ST visit assessments. The subject will return to the regular visit schedule for Visit 05 assessments.

o After Visit 04: If an ST visit is conducted within 3 months prior to the next visit’s Target Date, or as part of that next regularly scheduled study visit, the ST visit will replace that visit. The subject will then continue following the Visit Window Schedule. If the subject returns outside of the 3 month window prior to the next visit, conduct the ST visit. The subject will return again for the next regular study visit.
The start of PD medication should be reported to the CTCC and documented on the appropriate source worksheet.

5.3.19. Symptomatic Therapy Visit (PD, SWEDD and Prodromal subjects only)
- Vital signs (blood pressure, heart rate and temperature)
- Blood draw for research samples
- Urine collection for research samples
- Epworth Sleepiness Scale
- REM Sleep Behavior Disorder Questionnaire
- GDS-15
- State-Trait Anxiety Inventory
- Questionnaire for Impulsive-Compulsive Disorders
- SCOPA-AUT
- MDS-UPDRS Parts I-III
- Hoehn and Yahr
- Modified Schwab and England
- Clinical diagnosis assessment
- Lumbar puncture for collection of CSF (not repeated if CSF was collected less than 3 months prior to the ST visit)
- SPECT Imaging
  - Conduct for PD and Prodromal subjects when ST visit replaces a Month 12, Month 24, or Month 48 visit (as applicable)
  - Conduct for SWEDD subject when ST visit replaces Month 24 visit
- VMAT-2 PET Imaging (selected sites only; refer to 18F-AV-133-PPMI companion protocol)
  - Conduct for PD subject when ST visit replaces Month 12, Month 24, or Month 48 visit
  - Conduct for SWEDD subject when ST visit replaces Month 24 visit
- Review of current medical conditions
- Review of concomitant medications
- Review of adverse events day of visit and in follow up to lumbar puncture and/or SPECT (or VMAT-2) imaging (as applicable)

Additional assessments to be completed when ST visit is conducted in place of an annual visit:
- General neurological examination
- Clinical laboratory assessments
- MoCA
- Letter Number Sequencing
- Hopkins Verbal Learning Test – Revised (refer to section 6 of Operations Manual to determine appropriate form to administer)
- Symbol Digit Modalities Test
- Benton Judgment of Line Orientation
- Semantic Fluency
- Cognitive Categorization
6. Study Assessments

6.1. Clinical Assessments

6.1.1. MDS-UPDRS

The MDS-UPDRS is a multimodal scale assessing both impairment and disability and is separated into 4 subscales (Parts I-IV). The MDS-UPDRS includes components assessed by the study investigator as well as sections completed by the subject. Every effort should be made to have the same investigator perform the ratings for an individual subject throughout the course of the study.

- Part I: This assesses non-motor experiences of daily living and is comprised of two components:
  - Part IA contains 6 questions that are assessed by the Investigator and focuses on complex behaviors.
  - Part IB contains 7 questions that are part of the Patient Questionnaire completed by the subject.
- Part II: This assesses motor experiences of daily living. There are an additional 13 questions that are also part of the Patient Questionnaire completed by the subject.
- Part III: This assesses the motor signs of PD and is administered by the Investigator.
- Part IV: This assesses motor complications, dyskinesias and motor fluctuations using historical and objective information. The Investigator will complete this assessment once a subject has started PD medication.

Subjects who have started PD medication (levodopa or dopamine agonist) will have an annual assessment of the motor exam (Part III) and Hoehn and Yahr in a practically defined off state and then these assessments will be repeated one hour after receiving medication in clinic. These subjects will need to be reminded not to take PD medication on the day of each annual study visit. If possible, subjects on PD medication who withdraw prematurely from the study should also have the Part III assessment one hour after receiving medication during the Premature Withdrawal Visit.

6.1.2. Hoehn and Yahr Stage

The Hoehn and Yahr is a commonly used system for describing how the symptoms of Parkinson disease progress. The scale allocates stages from 0 to 5 to indicate the relative level of disability. This scale is included within the MDS-UPDRS and will be completed for all subjects.

- Stage zero: No symptoms.
- Stage one: Symptoms on one side of the body only.
- Stage two: Symptoms on both sides of the body. No impairment of balance.
- Stage four: Severe disability, but still able to walk or stand unassisted.
- Stage five: Wheelchair-bound or bedridden unless assisted.
6.1.3. **Modified Schwab & England Activities of Daily Living**
The Modified Schwab & England Activities of Daily Living (ADL) scale reflects the speed, ease, and independence with which an individual performs daily activities, or personal chores, such as eating, toileting, and dressing. This scale uses a rating scale from 0% to 100%, with 100% representing complete independence in performing daily activities and 0% representing a vegetative, bedridden state.

6.1.4. **The University of Pennsylvania Smell Test**
The University of Pennsylvania Smell Identification TEST (UPSIT) is a 40-item, multiple choice, scratch and sniff test used to evaluate odor identification. It is a forced-choice test in which subjects must identify an odor among four response alternatives. There are four booklets containing ten odorants each. The instructions will be explained to the subjects by the coordinator at the clinical site. Subjects may complete the UPSIT independently. It will be reviewed for completion prior to the end of the visit. The UPSIT will be scored by the coordinator reflecting the number of correct responses out of 40 items.

6.1.5. **Clinical Diagnosis and Management Questionnaire**
The Clinical Diagnosis and Management Questionnaire is being used in the SWEDD cohort of subjects to allow site Investigators to provide a more detailed assessment regarding the subject’s clinical signs and symptoms of disease and to document any changes in diagnosis or management of the clinical diagnosis.

6.1.6. **Prodromal Diagnostic Questionnaire**
The Prodromal Diagnostic Questionnaire is being used for the Prodromal cohort to allow Investigators to provide a detailed assessment regarding any clinical signs and symptoms and to document any changes in diagnosis. This assessment and the Diagnostic Features assessment will be used as research based criteria for determining phenoconversion to motor PD as assessed by the Investigator.

6.1.7. **Neuropsychological and Cognitive Assessments**
The Montreal Cognitive Assessment (MoCA): In early Parkinson disease, when cognitive deficits occur, they are subtle and mild and the patients usually perform in the normal range on the widely used Mini Mental State Examination. The Montreal Cognitive Assessment (MoCA) is a rapid screening instrument like the MMSE but was developed to be more sensitive to patients presenting with mild cognitive complaints. It assesses short term and working memory, visuospatial abilities, executive function, attention, concentration, language and orientation. The total score ranges from 0 to 30.

The Epworth Sleepiness Scale (ESS)\(^{64}\), used extensively in PD related studies, is a self-administered questionnaire collecting information on the propensity to fall asleep in eight different situations encountered commonly in daily life. Each situation is rated from 0 (no chance of dozing) to 3 (high chance of dozing), and the total score ranges from 0 to 24. Total scores of zero to 10 are normal, scores from 10 to 12 are borderline, and scores from 12 to 24 are abnormal.

The Geriatric Depression Scale (GDS-15) is a self-report scale shown to be a useful measure of depressive symptoms in patients with Parkinson disease\(^{65}\). It is particularly
easy for patients to use given its “yes/no” format. The GDS-15 is a validated shortened version of the original scale.

The WMS-III Letter-Number Sequencing Test\(^\text{66}\) is a measure of verbal working memory. In this test, subjects are read a combination of random letters and numbers and are asked to repeat the string back to the experimenter organized so that numbers are first in ascending order and letters next in alphabetical order. The length of the string is increased at each trial. The total score is the number of trials correctly repeated.

The Hopkins Verbal Learning Test-Revised (HVLT-R) is a test of verbal, short-term memory/new learning requiring rapid encoding of information\(^\text{67}\). Subjects must learn a list of 12 words which are grouped into three semantically-related categories each consisting of four words (e.g., dwellings, precious gems, animals). Subjects are given three repeated learning trials followed by a 20-25 minute delayed recall and recognition phase.

The Benton Judgment of Line Orientation Test is a measure of spatial perception and orientation. It is recognized that disturbances of these functions result from brain disease. The booklet consists of 5 practice items in addition to the test stimuli, consisting of line segments appearing at various angled intervals in the top half of the booklet and multiple-choice response cards in the lower half. The test will be conducted such that 15 of the 30 items are completed at each administration.

The Symbol Digit Modalities Test (SDMT) screens cognitive impairment by using a simple substitution task that adults with normal functioning can easily perform. Using a reference key, the examinee has 90 seconds to match specific numbers with geometric figures. Responses may be oral or written, allowing the test to be used with a wide variety of people, including those with motor disabilities or speech disorders. The SDMT is relatively culture free since it uses only geometric figures and numbers. Norms for adults are separated by age group and educational level.

The State-Trait Anxiety Inventory (STAI-Y) is a self rated assessment to measure emotional state anxiety in adults\(^\text{68}\). The 40-item state-trait anxiety questions will be administered. Responses resulting in a higher score indicate greater anxiety.

The REM Sleep Behavior Disorder Screening Questionnaire (RBDSQ) is a 10-item self rated questionnaire to assess sleep-wake disturbances. Patients with clinical characterizations of sleep behavior disorder may represent early manifestations of progressive neurodegenerative disorders, including Parkinson disease\(^\text{69}\), thus making this an important tool for longitudinal prospective studies.

The abbreviated version of the Questionnaire for Impulsive-Compulsive Disorders (QUIP-S) is a 13-item self administered assessment. This questionnaire will measure impulse control disorders and other compulsive behaviors in subjects with Parkinson disease\(^\text{70}\) as compared to a SWEDD and healthy control population.

The Scales for Outcomes in Parkinson’s Disease assessment of autonomic dysfunction (SCOPA-AUT)\(^\text{71}\) is a 26-item self administered test developed to evaluate autonomic
symptoms, such as gastrointestinal and urinary problems, in subjects with PD. The assessment will measure whether subject’s experience an increase in autonomic dysfunction as the disease severity progresses.

6.1.8. **Determination of Dementia/Mild Cognitive Impairment**

The **Cognitive Categorization** assessment will be completed to make a determination of Parkinson Disease Dementia (PDD) and PD with mild cognitive impairment (PD-MCI). The assessment will be made on the basis of criteria developed by the Movement Disorders Society. Information provided by the subject or other informant, the Investigator’s judgement, and results from the cognitive testing covering four cognitive domains will be used for this assessment.

The determination of PDD will be made on the following factors:

1. History of cognitive decline determined by the investigator based on information from the patient, other informant (spouse, family member or friend) and the investigator’s judgment.
2. Cognitive impairment defined as at least 1 test score (out of 6 scores) from at least 2 domains (out of 4 domain) >1.5 SD below the standardized mean.
3. Functional limitation as a result of cognitive impairment.

The determination of PD-MCI will be made based on the following factors:

1. Cognitive complaint by either the patient or informant (spouse, family member or friend).
2. Cognitive impairment defined as at least 2 test scores (out of 6 scores) from at least 1 domain (out of 4) >1.0 SD below the standardized mean.
3. No functional impairment as a result of cognitive impairment.

Cognitive categorization will be performed annually. For subjects who have had visits prior to the implementation of this assessment, the site investigator may be asked to make the determination retrospectively based on his/her best clinical judgment. Retrospective determinations will be noted in the PPMI database.

6.1.9. **Physical Activity Scale for the Elderly (PASE) Assessment**

The PASE assessment is a subject completed questionnaire to evaluate physical activity levels in the PD subjects as compared to the Controls, SWEDD and Prodromal subjects. The assessment will be used to measure the impact of exercise frequency and intensity on the rate of progression of PD disability.

6.2. **Safety Assessments**

6.2.1. **Medical History and Physical/Neurological Examination**

Medical and family history, as well as a complete physical and neurological exam will be captured on all subjects at Screening. A neurological exam will also be conducted annually and at the last completed visit. Healthy control subjects will have a complete neurological examination conducted at screening and every 12 months to ensure no changes have occurred since entry into the study.
6.2.2. **Vital Signs/Weight/Height**

Pulse rate (supine and standing), blood pressure (supine and standing), and oral temperature will be determined at every visit. The supine blood pressure and pulse rate will be determined after 1-3 minutes of quiet rest and the standing pressure and rate will be determined after 1-3 minutes in the standing position. Weight and height will be collected at the Baseline visit and annually.

6.2.3. **Clinical Laboratory Tests**

Routine clinical laboratory tests indicated in the table below will be performed at screening and follow up visits according to the visit schedule. A central laboratory will be implemented in order to guarantee identical analysis methods, consistent normal ranges and thus common interpretation of laboratory changes. If not stated otherwise, venous whole blood will be collected in blood collection tubes (vacutainers). All samples for laboratory analysis must be collected, prepared, labelled, and shipped according to the laboratory’s requirement as detailed in the lab manual. The total amount of blood needed for the clinical lab tests will be no more than 10 ml.

The coagulation panel (PT/PTT) will be collected and shipped by all sites to the central lab for analysis at the Screening visit only. Sites have the option, per clinical practice, to collect an additional blood sample to evaluate coagulation results prior to the conduct of annual lumbar puncture assessment. Sites will be provided with supplies from the central lab; however, the sample should be sent to a local lab facility for analysis (if a site does not have a local lab facility, the coagulation panel will be shipped to the central lab). Results will be evaluated to determine, in the opinion of the Investigator, whether there are any issues that may preclude conduct of the follow up lumbar puncture. Results should be maintained as part of the subject’s study documents; however, will not be included in the study database.

No more than 40 ml will be drawn at any visit, including both clinical and research blood samples.

<table>
<thead>
<tr>
<th>CENTRAL LAB TESTS</th>
<th>METABOLIC PANEL</th>
<th>COMPLETE BLOOD COUNT</th>
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<tr>
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<td>Prothrombin time (PT) – Screening Only</td>
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<td>Partial Thromboplastin Time (PTT) – Screening Only</td>
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</table>
6.3. Other Assessments

6.3.1. Dopamine Transporter Scan and SPECT Imaging
Subjects will have dopamine transporter imaging procedure to measure the amount of dopamine in the brain using single photon emission computed tomography (SPECT). All subjects will undergo SPECT imaging scan at Screening. Parkinson disease, SWEDD and Prodromal subjects will also undergo follow up SPECT scans as indicated in the visit schedule.

The SPECT imaging procedure will be performed at the individual sites using DaTSCAN™ as the dopamine transporter. Should there be any interruption in the availability of DaTSCAN™ during the conduct of the protocol subjects will be asked to travel to the Institute for Neurodegenerative Disorders (IND) in New Haven, CT to complete the SPECT scan. Should DaTSCAN™ be unavailable at IND, subjects will be asked to undergo [123I]β-CIT injection and SPECT scan. [123I]β-CIT is another dopamine transporter ligand that produces an outcome comparable to that of DaTSCAN™. Any subject who travels to IND for the SPECT imaging scan will be given a separate informed consent for signature prior to completion of any SPECT imaging scan activities. Travel to New Haven, CT will be provided for the subject and a companion through study funds.

Upon completion of the initial (Screening) SPECT scan, the imaging core will complete a Visual Interpretation Report.

• If the Visual Interpretation read for a PD subject indicates that the scan does not show evidence of dopamine transporter deficit, the subject may be enrolled as a SWEDD subject (or continue follow up visits as a SWEDD subject if the SPECT scan is completed after the Baseline visit).
• If the Visual Interpretation read for a Control subject indicates that the scan shows evidence of dopamine transporter deficit, the subject may be enrolled (or will remain in the study if the SPECT scan is completed following the baseline visit).
• For subjects undergoing a SPECT scan as a screening procedure for the Prodromal cohort, a quantitative analysis will be completed to determine whether the subject is eligible for enrollment into the Prodromal cohort (see Section 4.1 and 4.2.7.2).

Since this imaging information and the products used to complete the dopamine transporter SPECT scans are investigational as used in the PPMI study, it cannot provide definite information about a clinical diagnosis.

Subjects will be monitored by study personnel for adverse events on the day that a dopamine transporter SPECT scan is obtained. Subjects will also be contacted by phone 7 to 10 days following the injection/scan to assess adverse events. These events will be reported by the site investigator as required to the site’s Institutional Review/Ethics Boards and to his/her Radiation Safety Committee.

The procedures that would take place for a DaTSCAN™ or [123I]β-CIT injection are described below.
6.3.1.1. DaTSCAN™ Imaging Procedure
Women of childbearing potential must have a urine pregnancy test prior to injection of DaTSCAN™. The result must be confirmed as negative prior to proceeding with the injection. Before the DaTSCAN™ injection, subjects will be pre-treated with stable iodine (10 drops of a saturated solution of potassium iodide) to reduce the uptake of DaTSCAN™ by the thyroid. Subjects will be injected with 3-5 mCi of dopamine transporter. Within a 4 hour (+/- 30 minute) window following the injection, subjects will undergo SPECT imaging on the camera. The data and quality assurance procedures to be employed in this study are described in the operations manual.

6.3.1.2. [123I]β-CIT Imaging Procedure
Subjects will be injected with up to 6 mCi of [123I]β-CIT the day before the SPECT scan. Clinical laboratory tests (chem 20 and CBC) may be completed at IND if screening labs are not available or were completed more than 60 days prior to the injection of [123I]β-CIT. An ECG will be acquired at IND prior to injection. In addition, vital signs (blood pressure, pulse) will be completed prior to the injection and approximately 15 minutes post injection. The labs, ECG and vital signs are completed to check the general health of the subject before completing the imaging procedures. Women of childbearing potential will have a urine pregnancy test, as well as a serum pregnancy test prior to injection. The result of the urine pregnancy test must be confirmed as negative prior to proceeding with the injection. Before the [123I]β-CIT injection, subjects will be pre-treated with stable iodine (10 drops of a saturated solution of potassium iodide) to reduce the uptake of [123I]β-CIT by the thyroid. Subjects will return to IND about 20 hours post injection for the SPECT scan. Vital signs will be taken prior to the scan. Markers filled with 57Co will be attached to both sides of the subject’s head at the level of the canthomeatal line before imaging to facilitate post hoc computer reorientation of transaxial images. Projection data will be acquired for about 30 minutes.

6.3.2. VMAT-2 PET Imaging [Refer to the 18F-AV-133-PPMI companion protocol]
Subjects participating in Australia and selected U.S. sites will undergo [18F] AV-133 PET imaging to assess targeting the vesicular monoamine transporter. In Australia, [18F] AV-133 PET imaging will be used as an inclusion criterion for PD subjects and is required of all subjects. In the U.S., [18F] AV-133 PET imaging will be conducted in addition to DAT imaging and will be optional. Subjects in the U.S. may consent to participate in the companion study beginning with the Year 01 (month 12) scan. All subjects in Australia and those participating in the selected U.S. sites will undergo an initial [18F] AV-133 PET imaging scan. Parkinson disease and SWEDD subjects will also undergo follow up [18F] AV-133 PET scans as indicated in the visit schedule. For subjects completing both DAT and [18F] AV-133 imaging, PET scans will be performed 1 to 8 weeks after DAT SPECT imaging (i.e., the initial Screening PET scan may be completed after the subject completes PPMI Baseline visit/enrollment). The imaging information and the products used to complete the VMAT-2 PET scans are investigational. [18F] AV-133 data will not be provided to the study subjects other than to provide information regarding study eligibility.
In Australia, upon completion of the initial (Screening) $[^{18}F]$ AV-133 PET scan, the Imaging core will complete a Visual Interpretation Report. If the Visual Interpretation read for a PD subject indicates that the scan does not show evidence of VMAT deficit, the subject will be excluded from the study as a PD subject. Subjects screened as PD subjects, but without evidence of VMAT deficit may be enrolled as a SWEDD subject.

In the U.S., for subjects receiving both DAT SPECT imaging and $[^{18}F]$ AV-133 PET, if the Visual Interpretation read of the DAT SPECT for a patient screened as a PD subject indicates that the scan does not show evidence of dopamine transporter deficit (regardless of the $[^{18}F]$ AV-133 PET imaging) the subject may be enrolled as a SWEDD subject.

6.3.2.1. $[^{18}F]$ AV-133 Imaging Procedure
Refer to the $^{18}$F-AV-133-PPMI companion protocol and the PPMI Technical Operations Manual for AV-133 PET imaging procedures.

6.3.3. Magnetic Resonance Imaging (MRI) and Diffusion Tensor Imaging (DTI)
Subjects will undergo a structural MRI brain scan at the Baseline visit. At the discretion of the investigator and imaging staff, subjects who have presence of pacemakers, aneurysm clips, artificial heart valves, ear implants, metal fragments or foreign objects in the eyes, skin or body or any other known contra-indication to MRI may be advised not to complete a baseline (or follow-up) MRI scan, but these subjects may still participate in the study. MRI is being conducted to assess the structure of the brain. At selected sites with DTI 3T scanner capabilities, subjects will undergo MRI (DTI) at Baseline and follow up visits as indicated in the visit schedules. The diffusion tensor imaging will be conducted to further assess the pathways that connect parts of the brain and the function of cells in those pathways. In addition, at selected sites, subjects undergoing MRI (DTI) may also have resting state functional magnetic resonance imaging (rsfMRI) sequences collected. The rsfMRI sequences will provide another mechanism to assess the structural networks in the brain as related to PD.

6.3.4. Biologic Sampling (Blood and Urine)
Whole blood (about 6 ml), serum (about 10 ml) and plasma (about 10 ml) will be collected to conduct proteomic, metabolomic and other analyses. Blood will be obtained (about 8 ml) for the extraction of DNA to conduct sequencing and genomic analyses. Blood will also be obtained (about 5 ml) for the extraction of RNA to conduct biochemical analyses. Urine (about 10 ml) will be collected to conduct analyte analyses. It is strongly advised that the research blood samples are collected in a fasted state (i.e., minimum of 8 hours since last meal/food intake) to ensure the quality of samples for future analyses. If fasting is not possible, then subjects should be strongly advised to eat a low lipid diet as provided. All research samples will be sent to a central repository to be stored indefinitely for research purposes. Samples will be made available to researchers to conduct analyses related to PD and other disorders. Subjects will not receive any individual results of analysis or testing conducted on the biologic samples.
6.3.5. Lumbar Puncture
The lumbar puncture (LP) is performed by the site investigator or another qualified clinician appointed by the investigator. A lumbar puncture for the collection of 15-20 ml of CSF will be conducted for all subjects per the visit schedule unless there is evidence of clinically significant coagulopathy or thrombocytopenia that would interfere with the safe conduct of the procedure. While it is expected that all subjects will undergo an LP at Baseline, SWEDD subjects may be permitted to enroll without completion of the baseline LP. The first 2 ml of CSF will be processed at the site’s local lab facility (unless the lab is not able to process the CSF within 4 hours) to conduct standard analyses on cell count, protein and glucose levels. Subjects will be closely monitored during the procedure and following the procedure. Subjects will be contacted by phone 7 to 10 days following an LP to assess for any adverse events. The CSF samples will be sent to a central repository to be stored indefinitely for research purposes. The CSF samples will be made available to researchers to conduct analyses related to PD and other disorders.

7. Concomitant Medications

7.1.1. Initiation of PD Medications
It is anticipated that the majority of PD (and SWEDD) subjects will be able to remain off PD medications for at least 6 months after Baseline. However, PD medications may be initiated at any time after enrollment at the discretion of the patient or treating physician (inclusive of Prodromal subjects). If PD medications are initiated before month 12, subjects will be asked to return for an ST visit or early Visit 04 (see Section 5.3.5). If PD medications are initiated following the Month 12 Visit, willing subjects will be seen at an unscheduled visit prior to initiating PD medications (see Section 5.3.6). The medication used is at the discretion of the treating physician. The investigator will document any new medications or changes in medication at each study visit on the Concomitant Medication Log.

7.1.2. Use of Concomitant Medications
Concomitant medications, including over-the-counter (OTC), dietary supplements (e.g., herbal remedies) or prescriptions, are permitted during the study period, except for the following medications that might interfere with dopamine transporter SPECT imaging which are restricted 6 months prior to a DaTSCAN™ injection: Neuroleptics, metoclopramide, alpha methyl dopa, methylphenidate, reserpine, or amphetamine derivative. For subjects participating in VMAT-2 PET imaging, refer to the 18F-AV-133-PPMI companion protocol Section 5.4 for restricted medications. All concomitant medications reported at the time of the screening visit and for the duration of the subject’s participation should be recorded on the Concomitant Medication Log.

7.1.3. Participation in Clinical Trials
It is preferred that PPMI subjects do not participate in clinical trials of investigational intervention during the entire PPMI study. However, for subjects who choose to participate in clinical trials of investigational interventions, it is preferred that this not occur until after 12 months of participation in PPMI. The investigator will document the study drug dosage, if applicable, and, if unknown, will report on the identity of the study drug and dosage after it is unmasked. If a PD, SWEDD, or Prodromal subject chooses to participate in another clinical trial at any time during participation in PPMI, an ST visit
may need to be conducted before the subject begins investigational intervention. Please contact the CTCC for further instruction.

8. Subject Withdrawals

Subjects will be advised in the written informed consent forms that they have the right to withdraw from the study at any time without prejudice, and may be withdrawn at the investigator’s or sponsor’s discretion at any time. A subject should be withdrawn from the study if the investigator considers it to be medically necessary, or if the subject withdraws consent. All reasons for subject withdrawals from the study will be recorded in the source documentation and appropriate eCRF.

9. Safety/Adverse Events

Site investigators and coordinators will be instructed to assess for adverse events at in-person study visits when an LP or dopamine transporter SPECT imaging activity is conducted, as well as by telephone 7 to 10 days following such activity.

In addition, for select sites, adverse events will be assessed at the in-person visit when $[^{18}\text{F}]$ AV-133 PET imaging is conducted, by telephone 48 (+24) hours following such activity.

Each subject must be carefully monitored for adverse events (AEs). An assessment must be made of the seriousness, intensity, and relationship to the study procedure and/or administration of the study drug (DaTSCAN™ and/or $[^{18}\text{F}]$ AV-133 as applicable).

See table below for adverse event monitoring timelines:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Assessed through visit</th>
<th>48 hours (+/-24 hrs) telephone contact</th>
<th>7 to 10 day telephone contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumbar Puncture</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Dopamine Transporter SPECT Imaging</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AV-133 PET Imaging</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

9.1. Adverse Event Definitions

Adverse Events (AE)

An AE is any undesirable experience occurring to a subject during a clinical trial, whether or not considered related to the investigational product.

Pre-existing conditions (i.e., undesirable experiences, signs or symptoms that begin prior to the Screening Visit) will be recorded on the medical history CRF page. These conditions will
not be reported as an AE unless they worsen in intensity or frequency after the Screening Visit (per the reporting period defined in section 9 above).

Treatment-emergent AEs are undesirable experiences, signs, or symptoms that begin or worsen in intensity or frequency at the time of or after the administration of study drug (per the reporting period defined in section 9 above).

For reporting purposes, Avid (manufacturer of [¹⁸F] AV-133) will distinguish among pre-existing conditions and treatment-emergent AEs.

**Serious Adverse Event (SAE)**

An SAE is an AE that is fatal or life-threatening, or results in hospitalization, prolongation of hospitalization, persistent or significant disability/incapacity, or a congenital anomaly/birth defect. A life-threatening AE is an AE that, in the view of the investigator, places the subject at immediate risk of death from the reaction, as it occurred. Important medical events that may not result in death, be life-threatening, or require hospitalization may be considered an SAE when, based upon appropriate medical judgment, they may jeopardize the subject and may require medical or surgical intervention to prevent one of the outcomes listed in this definition.

Inpatient admission in the absence of a precipitating, treatment-emergent, clinical adverse event is not subject to immediate reporting. For example:

- Admission for treatment of a pre-existing condition not associated with the development of a new adverse event
- Social admission (e.g., subject has no place to sleep)
- Protocol-specific admission during a clinical study (e.g., for a procedure required by another study protocol)
- Optional admission not associated with a precipitating clinical adverse event (e.g., for elective cosmetic surgery)

Inpatient admission does not include the following:

- Emergency Room/Accident and Emergency/Casualty Department visits
- Outpatient/same-day/ambulatory procedures
- Observation/short-stay units
- Rehabilitation facilities
- Hospice facilities
- Respite care (e.g., caregiver relief)
- Skilled nursing facilities
- Nursing homes
- Custodial care facilities

**Unexpected Adverse Event**

For FDA reporting purposes, an unexpected AE is an AE not previously reported or an AE that occurs with specificity, severity or frequency that is not consistent with the current investigator’s brochure.
9.2. Relationship to Investigational Product

The assessment of the relationship of an AE to the administration of the study drug is a clinical decision based on all available information at the time the event is being documented. The following definitions of the relationship between the study drug and the AE (including SAEs) should be considered:

- **Unrelated** - No possible relationship
  The temporal relationship between drug exposure and the adverse event onset/course is unreasonable or incompatible, or a causal relationship to study drug is implausible.

- **Unlikely** - Not reasonably related, although a causal relationship cannot be ruled out
  While the temporal relationship between drug exposure and the adverse event onset/course does not preclude causality, there is a clear alternate cause that is more likely to have caused the adverse event than the study drug.

- **Possible** - Causal relationship is uncertain
  The temporal relationship between drug exposure and the adverse event onset/course is reasonable or unknown, dechallenge or rechallenge information is either unknown or equivocal, and while other potential causes may not exist, a causal relationship to the study drug does not appear probable.

- **Probable** - High degree of certainty for causal relationship
  The temporal relationship between drug exposure and the adverse event onset/course is reasonable. There is a clinically compatible response to dechallenge (rechallenge is not required), and other causes have been eliminated or are unlikely.

- **Definite** - Causal relationship is certain
  The temporal relationship between drug exposure and the adverse event onset/course is reasonable, there is a clinically compatible response to dechallenge, other causes have been eliminated, and the event must be definitive pharmacologically or phenomenologically, using a satisfactory rechallenge procedure if necessary.

9.2.1. **Intensity/Severity of an Adverse Event**

In addition to assessing the relationship of the administration of the investigational product to AEs, an assessment is required of the intensity (severity) of the event. The following classifications should be used:

- **Mild:**
  A mild AE is an AE, usually transient in nature and generally not interfering with normal activities.

- **Moderate:**
  A moderate AE is an AE that is sufficiently discomforting to interfere with normal activities.
• **Severe:**
  A severe AE is an AE that incapacitates the subject and prevents normal activities. Note that a severe event is not necessarily a serious event. Nor must a serious event necessarily be severe.

### 9.3. Recording of Adverse Experiences

Adverse experiences, whether observed by the investigator, elicited from or volunteered by the subject, should be recorded on the Adverse Event Log. This will include a brief description of the experience, the date of onset, the date of resolution, the severity, and seriousness and whether the event was related to participation in the research study.

If the imaging scan is completed at the Institute for Neurodegenerative Disorders, staff at IND will contact the subject by telephone 7 to 10 days following injection to assess adverse events. A copy of all relevant study documentation generated by IND will be sent to the appropriate site Investigator.

Any adverse event ongoing at the final 7 to 10 day reporting telephone visit, or the final 48 hour reporting telephone visit (whichever occurs last), should be followed until resolution or stabilization, but not more than 30 days from last injection of investigational product or lumbar puncture.

### 9.4. Responsibilities for Reporting Serious Adverse Experiences

- The Investigator should notify the CTCC Project Manager (PM) by telephone within 24 hours of his/her becoming aware of the occurrence of a serious adverse experience. The PM will in turn notify the CTCC Clinical Monitor. The site Coordinator will fill out the MedWatch form (Lilly form for AV-133) provided by the CTCC, and email it to the CTCC Project Manager.

- Upon completion of the telephone report, the CTCC Project Manager will enter the appropriate subject information into the Incident Module.

- The following information should be supplied if available at the time of the telephone call: study number, site number, subject number, subject age and gender, date of onset of event, event description, whether event required treatment, death and autopsy report, an identification of which criteria for a serious experience have been met, the Investigator’s current opinion of the relationship between the event and study participation.

- The Investigator will comply with his/her local Institutional Review Board (IRB) and Radiation Safety Committee regulations regarding the reporting of adverse experiences.

- Notwithstanding the estimated data availability timeframe, the CTCC/IND will report to Lilly within 24 hours of notification from the site of an occurrence of any SAEs occurring within 48 hours post $^{18}$F-AV-133 injection.
10. Reportable Events
The following incidents will be considered reportable events and will be reported to the CTCC within 24 hours of the event, or the Site Investigator’s knowledge of the event.

- Initiation of PD medication
- Change of clinical diagnosis
- Participation in any other clinical trial or study
- Premature withdrawal (e.g. withdrawal of consent)
- Serious Adverse Event
- Pregnancy (reported by female subject or female partner of a male subject)
- Death

11. Referrals
If a research assessment, lab or MRI result reveals a clinically significant abnormality (e.g., indication of suicidality, depression, or renal impairment on metabolic profile) the subject should be informed of this result and instructed to follow up with his or her primary care physician. Should there be a safety concern warranting a referral for medical or psychiatric follow-up, the Investigator should provide the subject with the appropriate referral as necessary.

12. Potential Risks

12.1. Blood Sampling
Risks associated with venous blood draw include pain and bruising at the site where the blood is taken. Sometimes people can feel lightheaded or even faint after having blood drawn.

12.2. Lumbar Puncture
The most common risks of a lumbar puncture are pain at the site and a temporary headache usually due to a small amount of CSF leakage around the needle insertion site. Lying down for a few hours after the test can make a headache less likely to occur. There is a slight risk of infection because the needle breaks the skin’s surface, providing a possible portal of entry for bacteria. A temporary numbness to the legs or lower back pain may be experienced. There is a small risk of bleeding in the spinal canal. Subjects will have blood drawn at Screening to test for coagulopathies.

12.3. MRI / DTI
Subjects should notify the study doctor if they suffer from claustrophobia because they may become anxious while in the magnetic resonance scanner. There may be loud noises such as knocking or hammering that occur while the MRI is being conducted. Subjects should also inform the study doctor if they have a pacemaker or metal implants (screws, plates or clips) because this may preclude MR evaluation.

12.4. Imaging
Specific potential risks for dopamine transporter SPECT imaging and VMAT-2 PET imaging are as follows:
1) radiation exposure from DaTSCAN™, ¹⁸F-AV-133, or [¹²³I]β-CIT, the ⁵⁷Co transmission source, and from ⁵⁷Co containing markers,
2) potential pharmacological effects of DaTSCAN™,
3) having an intravenous injection.
Risks of DaTSCAN™: DaTSCAN™ is administered at radiotracer doses and is not expected to have any pharmacological or toxicological effects. DaTSCAN™ binds to the dopamine and serotonin transporter. At pharmacologic doses DaTSCAN™ might be expected to have stimulant-like effects and affect cardiovascular responses. However, in the proposed study the estimated mass dose of DaTSCAN™ is very low - <30.pmol kg. More than 180,000 doses of the drug have been administered to human subjects.

Risks of [18F] AV-133: Refer to 18F-AV-133-PPMI companion protocol Section 6.

Risks of [123I]β-CIT: The U.S. Food and Drug Administration (FDA) has established guidelines for the radiation dose considered acceptable for determining the distribution of radiotracer compounds in normal adult research subjects. The radiation exposure from this study is within the limits specified by the FDA. [123I]β-CIT has been given to over 2000 subjects. In a few subjects (less than 1%) minor headaches and metallic taste in the mouth have occurred. It is possible that unexpected side effects could develop.

Iodine: Prior to each injection subjects will be pretreated with Lugol’s solution, 10 drops of a saturated solution of potassium iodide) to reduce thyroid uptake of the radioactive agent. Subjects may experience a metallic or bitter taste in their mouths from the iodine. Subjects with allergies to iodine might get itching, a rash, bloating, severe blood pressure changes (shock), and death if given iodine. Subjects who are allergic to iodine will be administered potassium perchlorate rather than Lugol’s.

In addition to the known risks listed above, the imaging procedures in this study may cause unknown risks to the participant, or a developing embryo or fetus or possible risks to the future offspring of male participants. Female subjects or a female partner of a male subject who report a pregnancy within 30 days of DaTSCAN™ injection will be asked to have a urine pregnancy test.

13. Statistical Methods

13.1. Statistical Design

PPMI is a longitudinal, multi-center study to assess progression of clinical features and imaging and biomic biomarkers in Parkinson disease patients and healthy controls. PD, Prodromal and control subjects will be evaluated longitudinally for at least 36 months. SWEDD subjects will be evaluated for 24 months.

13.2. Primary Objective

To estimate the mean rates of change and the variability around the mean of clinical, imaging and biomic outcomes in early PD patients, and where appropriate to compare these rates between PD patients subsets, SWEDD subjects, Prodromal subjects and between PD and healthy subjects at study intervals from 3 months to 36 months.

13.3. Secondary Objectives

13.3.1. Comparison between the rates of change in the mean of clinical, imaging and biomic outcomes in early PD patients and between PD and healthy subjects at study intervals from 3 months to 36 months.
13.3.2. To determine the prevalence of measures of clinical, imaging and biomic outcomes in early PD patients and healthy subjects at study intervals from baseline to 36 months.

13.3.3. To establish the predictive value of early clinical non-motor features, baseline imaging and biomic outcomes for future course of disease.

13.3.4. Exploratory analysis of comparison between the rates of change in the mean of clinical, imaging and biomic outcomes in prodromal PD with baseline DaTSCAN binding showing minimal to moderate DAT deficit and early PD patients and healthy subjects at study intervals from 3 months to 36 months.

13.3.5. Exploratory analysis of prevalence of measures of clinical, imaging and biomic outcomes in prodromal PD compared to early PD patients and healthy subjects at study intervals from baseline to 36 months including the time for phenoconversion.

13.3.6. To examine the proportion of Prodromal subjects with one or more risk characteristics [hyposmia (<10th percentile by age and gender), RBD, or LRRK2 mutation, and baseline DaTSCAN binding showing minimal to moderate DAT deficit who phenoconvert within two years. To correlate the baseline DaTSCAN binding with risk of phenoconversion.

13.3.7. To conduct exploratory analyses to examine whether the progression of clinical, imaging, and biospecimen biomarkers will predict those subjects likely to phenoconvert. For example, dopamine transfer loss during the prodromal period either independently or in combination with other biomarkers may provide a quantitative outcome associated with prodromal disease progression to phenoconversion.

13.3.8. To examine the proportion of SWEDD subjects that have a change in their clinical management at 24 months (SWEDD Clinical Diagnosis and Management Questionnaire).

13.3.9. To conduct exploratory analyses in SWEDD subjects to examine the prevalence of measures of clinical, imaging, and biomic outcomes from baseline to 24 months, examine the mean rates of change and the variability among these outcomes from 3 months to 24 months, and to examine the correlations between the rates of change in these outcomes from 3 months to 24 months.

13.3.10. To conduct exploratory analyses to determine whether the measures and change over time in clinical, imaging, and biomic outcomes are similar among the SWEDD, Prodromal, and PD subjects.

13.4. Planned Analyses

Information summarizing planned analyses is described below. Further details regarding the analyses and plans for additional analyses will be contained in the PPMI Data Analysis Plan.

13.4.1. Comparison of baseline characteristics among healthy subjects and PD subjects. The first set of analyses will involve a comparison of baseline characteristics among all healthy subjects and PD subjects. Continuous variables will be examined using a t-test and dichotomous variables will be examined using a chi-square test. Appropriate assumptions will be assessed for each comparison and any necessary adjustments (i.e., transformations)
will be made prior to analysis. All analyses will be conducted at the 0.05 level.

13.4.2. **Comparison of short-term change in progression endpoints.** The second set of analyses will examine the short-term change during the first six months for each progression endpoint. For continuous progression endpoints, the change over time will be modeled using a mixed model approach. For dichotomous progression endpoints, a logistic regression model will be fit. For each ‘full’ model of interest, an initial model will consist of all baseline characteristics, an indicator variable for whether the subject is a PD patient or healthy control, and all possible two-way interactions. We will utilize backwards selection to build a model for each progression endpoint.

13.4.3. **Examination of whether short-term change in progression endpoints is predictive of change in long-term endpoints.** The third set of analyses will examine whether short-term changes in the progression endpoints are predictive of changes in long-term endpoints in the MDS-UPDRS score. This analysis will examine a subset of the progression endpoints. Only progression endpoints that show differences between the healthy subjects and PD patients in analysis group 2 will be considered (since a marker that doesn’t distinguish PD patients from healthy subjects would not be thought to be a biomarker for long-term outcome in PD patients). All progression endpoints that meet these criteria will be modeled in PD patients using a process similar to that described above. The primary focus will be on the long-term change in the UPDRS score. However, additional long-term endpoints may be considered as well. Because this modeling process involves longer term endpoints, which would be much harder to replicate, a ten-fold cross validation procedure will be used to test the predictive validity of each model. If successful, the final model will provide a subset of one or more short-term progression endpoints that are predictive of the change in one or more of the long-term endpoints. This would suggest that these short-term progression endpoints are valid biomarkers for future studies of interventions in PD patient populations.

13.4.4. **Examination of PD Subsets.** Each of the first three sets of analyses will be repeated comparing subsets of PD subjects, rather than PD subjects vs. healthy subjects. If successful, the final model from these subset comparisons will determine whether some of the short-term progression endpoints are more predictive of long-term change in the MDS-UPDRS score for some subsets of PD subjects and less predictive for other subsets of PD subjects.

13.4.5. **Calculation of the proportion of SWEDD subjects that have a change in diagnosis over the 24-month evaluation period.** The analysis will involve identifying all SWEDD subjects that have a change in diagnosis from PD to another diagnosis. The percentage and 95% confidence interval will be reported. The other possible diagnoses will be further divided into 2
13.4.6. **Exploratory analysis of SWEDD subjects.** Although the sample size of the SWEDD cohort will likely limit the power of any comparisons with other groups, a set of exploratory analyses will be conducted to examine any significant effects found in the analyses described in sections 13.4.1-13.4.3. Specifically, any important changes over time that are found among PD subjects will be assessed in the population of SWEDD subjects to determine if this group appears similar or dissimilar to the PD subjects.

13.4.7. **Exploratory analysis of Prodromal subjects that phenoconvert.** The analysis will involve estimating the percentage of Prodromal subjects that phenoconvert to PD within 2 years. The percentage and 95% confidence interval will be reported.

13.4.8. **Exploratory analyses to examine biomarkers at baseline for Prodromal vs. PD subjects vs Healthy subjects.** The demographics and biomarker values will be compared at baseline for the Prodromal and PD and healthy subjects. Continuous variables will be examined using a t-test and dichotomous variables will be examined using a chi-square test. Appropriate assumptions will be assessed for each comparison and any necessary adjustments (i.e., transformations) will be made prior to analysis. All analyses will be conducted at the 0.05 level.

13.4.9. **Exploratory analyses of biomarkers for predicting phenoconversion among Prodromal Subjects.** This set of analyses will examine whether short-term changes in the progression endpoints are predictive of phenoconversion among Prodromal subjects. All progression endpoints will be considered. The examination will involve fitting a logistic regression model for phenoconversion, with each progression endpoint serving as a covariate.

**13.5. Determination of Sample Size**

As summarized above, much of the proposed analysis plan for the PPMI study is focused on a set of exploratory analyses with the goal of identifying short-term progression markers that can be used as biomarkers for future studies in PD patient population. Because of the exploratory nature of these analyses, it is very difficult to provide a formal sample size justification for the entire model building process. Furthermore, the PPMI study has a broad range of goals that reach beyond any single, pre-planned analysis. However, we can examine the ability of the proposed sample size to detect meaningful effects of interest for the preliminary comparisons of baseline characteristics and univariate assessments of progression markers across the groups of interest.

The table below provides generic information about the detectable effect sizes for three types of statistical analysis that may be performed on the PPMI data. For each analysis the two-sided alpha level is set to 0.05 and the beta level to 0.80. The first column gives the total
sample size assumed to be available for the analysis, in the first two rows either 400 (total PD sample) or 300 (PD sample after allowance for 25% withdrawals). The third and fourth rows of the table correspond to the total sample size of 600 (400 PD, 200 HC) when, respectively 75% and 100% of the subjects are available for analysis. The second column gives the detectable correlation coefficient between two continuous measures (e.g., change in striatal β-CIT uptake vs. change in total MDS-UPDRS). The third column gives the detectable difference in prevalence rates of some characteristic (e.g. presence of dopaminergic side effects) between two “halves” of the sample (e.g. the younger patients vs. the older patients, with age dichotomized at the median for the entire group). For the first two rows the third column gives the detectable “effect size”, expressed as ratio of difference in means to standard deviation, for comparing two “halves” of the sample (e.g. younger vs. older patients as above) in relation to a continuous measure (e.g. change in total MDS-UPDRS). For the third and fourth row the comparisons are between PD patients and HC. The table suggests that the PPMI trial is adequately powered to detect effects that would generally be of clinical interest. While possible that smaller effects than those listed in the table might also be of clinical interest, it was determined that the added power for these comparisons did not offset any additional costs and logistical issues that would accompany a larger study in this population. Rather, the proposed study should prove to be effective for screening a large number of variables and identifying those that show the most promise for further exploration in follow-up studies.

<table>
<thead>
<tr>
<th>Total sample size</th>
<th>Detectable Correlation</th>
<th>Detectable Difference in Prevalence</th>
<th>Detectable Difference in Means (Standardized)</th>
</tr>
</thead>
<tbody>
<tr>
<td>300</td>
<td>0.16</td>
<td>17%</td>
<td>0.33</td>
</tr>
<tr>
<td>400</td>
<td>0.14</td>
<td>14%</td>
<td>0.28</td>
</tr>
<tr>
<td>450</td>
<td>0.14</td>
<td>15%</td>
<td>0.28</td>
</tr>
<tr>
<td>600</td>
<td>0.11</td>
<td>13%</td>
<td>0.24</td>
</tr>
</tbody>
</table>

The planned sample size of approximately 80 SWEDD subjects is based on the estimated percentage of SWEDD subjects that will be observed over the recruitment period for the PPMI study. This is based on preliminary data from the study suggesting that about 20% of subjects screened with parkinsonian symptoms have no evidence for dopamine transporter deficit. The clinical and biomarker data from the SWEDD subjects will serve as a disease control population and will allow for a number of important exploratory assessments comparing the SWEDD subjects to the PPMI PD subjects and Healthy Controls.

The planned sample size of approximately 100 for the prodromal cohort is based primarily on prior exploratory studies. Nevertheless, based on preliminary data from studies combining olfactory loss, RBD, or LRRK2 mutation with DAT imaging deficit to define an at-risk population, we estimate 30% phenoconversion during the 24 month evaluation post DAT imaging. Under this assumption, the sample size will allow estimating the phenoconversion rate with a 95% confidence interval width of approximately ± 10%. It is further anticipated that the change in clinical, imaging, and biomarker data from the Prodromal cohort will allow for a number of important exploratory assessments comparing Prodromal subjects who convert to Prodromal subjects who do not convert. Finally, additional exploratory assessments will compare the Prodromal subjects to the PPMI PD subjects, Healthy Controls, and SWEDD subjects.
14. Regulatory / Ethics

14.1. Compliance Statement
This study will be conducted in accordance with the Good Clinical Practice (GCP) and the International Conference on Harmonization (ICH) guidelines and any applicable national and local regulations.

All procedures not described in this protocol will be performed according to the study Operation Manuals unless otherwise stated. Laboratory tests/evaluations described in this protocol will be conducted in accordance with quality laboratory standards as described in the central laboratory manual unless otherwise stated.

14.2. Informed Consent
In accordance with relevant regulations, an informed consent agreement explaining the procedures and requirements of the study, together with any potential hazards/risks must be read by and/or explained to each subject. Each subject will sign such an informed consent form. The subject must be assured of the freedom to withdraw from participation in the study at any time. In addition, a Certificate of Confidentiality has been obtained to provide additional confidentiality protections for subjects at participating PPMI sites in the United States.

It is the Investigator’s responsibility to make sure that the subject understands what she/he is agreeing to and that written informed consent is obtained before the subject is involved in any protocol-defined procedures including screening procedures. It is also the Investigator’s responsibility to retain the original signed consent form and provide each subject with a copy of the signed consent form.

The CTCC must be given an opportunity to review the consent forms prior to site IRB submission and before it is used in the study.

14.3. Institutional Review Board/Independent Ethics Committee
The CTCC will supply all necessary information to the Investigator for submission of the protocol and consent forms to the IRB/IEC for review and approval. The Investigator agrees to provide the IRB/IEC all appropriate material. The trial study will not begin until the Investigator has obtained appropriate IRB/IEC approval. A copy of the approval letter and approved consent form must be submitted to the CTCC.

The Investigator will request from the IRB/IEC a composition of the IRB members reviewing the protocol and informed consents. Appropriate reports on the progress of this study by the Investigator will be made to the IRB/IEC and the CTCC in accordance with institutional and government regulations. The CTCC will notify the site when the IRB/IEC may be notified of study completion. It is the Investigator’s responsibility to notify the IRB when the study ends. This includes study discontinuation, whether it is permanent or temporary. A copy of the site IRB/IEC’s acknowledgement of study completion must be submitted to the CTCC.
14.4. Protocol Amendments
Changes to the protocol should only be made via an approved protocol amendment. Protocol amendments must be approved by the Sponsor, the study’s Steering Committee and each respective site’s IRB/IEC prior to implementation, except when necessary to eliminate hazards and/or to protect the safety, rights or welfare of subjects.

14.5. Subject Confidentiality
The site Investigator must assure that the confidentiality of subjects, including their personal identity and personal medical information, will be maintained at all times. U.S. sites have additional confidentiality obligations to study subjects under the Health Insurance Portability and Accountability Act (HIPAA). Subjects will be identified by code numbers on case report forms and other study materials submitted to the CTCC, the central laboratory, and central biorepository.

After a subject signs an informed consent, it is required that the site Investigator permit the study monitor or regulatory agency personnel to review the signed informed consent(s) and that portion of the subject’s medical record that is directly related to the study. This shall include all study relevant documentation including subject medical history to verify eligibility, laboratory test result reports, admission/discharge summaries for hospital admissions occurring while the subject is in the study, and autopsy reports for deaths occurring during the study (when available).

15. Documentation

15.1. Study File and Site Documents
The Investigator should have the following study documents accessible to the Monitor during the study.

- *Curriculum vitae* for investigator and coordinator
- The signed IRB/IEC form/letter stating IRB/IEC approval of protocol, consent forms, and advertisement notices, documentation of the IRB/IEC composition, and all IRB/IEC correspondence including notification/approval of protocol amendments, notification of serious adverse events to the IRB/IEC, and IRB/IEC notification of study termination
- IRB/IEC approved consent forms (sample) and advertisements as applicable
- Signed protocol (and amendments, where applicable)
- Signed subject consent forms
- Copies of the completed CRF worksheets
- Delegation Log with names, signatures, initials and functional role of all persons completing protocol assessments, providing back-up to the site Investigator and Coordinator, if applicable, as well as staff entering data to the eClinical system.
- Laboratory accreditation and relevant laboratory reference ranges
- Copies of laboratory reports/printouts
- Any source data(records not kept with the subject’s hospital/medical records
- Signed and dated receipt of supplies
• Record of all monitoring visits
• Copies of correspondence to and from CTCC
• Investigator’s Brochure (where applicable)
• Certificate for Human Subject Protection Program (HSPP) or equivalent GCP program for each individual named on the Delegation log who has direct subject contact
• Copy of professional licensure/registration, as applicable, for each individual who has direct subject contact ensuring licensure is in the state-region in which the study will be conducted
• A Note to File indicating the assessments that will be considered source documents
• Any other documentation as required by the CTCC (e.g., Conflict-of-Interest/Financial Disclosure)

The Investigator must also retain all printouts/reports of tests/procedures, as specified in the protocol, for each subject. This documentation, together with the subject’s hospital/medical records, is the subject’s source information for the study.

15.2. Maintenance and Retention of Records
It is the responsibility of the Site Investigator to maintain a comprehensive and centralized filing system of all relevant documentation. Site Investigators must retain all study records required by the CTCC and regulatory authorities in a secure and safe facility with limited access. The Site Investigator will be instructed to consult with the CTCC before disposal of any study records and to notify the CTCC of any change in the location, disposition, or custody of the study files.

An electronic case report form (eCRF) utilizing an Electronic Data Capture (EDC) application will be used for this study. In the event of an audit or regulatory authority inspection, the eCRFs can be printed out.

15.3. Case Report Forms
Sites will enter subject information and data into the eCRF in the EDC application. The eCRFs are used to record study data and are an integral part of the study and subsequent reports. Therefore the eCRFs must be completed according to the subject’s source data on a per-visit basis for each subject screened or enrolled. Authorized study personnel will each be granted access to the electronic data capture tool via provision of a unique password-protected user-ID that will limit access to enter and view data specifically for subjects enrolled at their site. Timely data entry is considered to be data entered into the EDC system within 14 days of a subject’s visit.

Sites will have access to download worksheets that correspond to the electronic case report form (eCRF). The worksheets will serve as source documents as described in the Operations Manual and are to be used to enter data into the eCRFs. Sites will enter all data into the subject’s medical chart and/or onto source documentation worksheets prior to entering data into the eCRFs via computer stations connected remotely to the CTCC’s central server through an Internet browser.
Electronic Signatures:
An electronic signature from the site Investigator (or delegated Sub-investigator) is required on the following eCRFs:
- Signature Form
- Adverse Event Form

It is the site Investigator’s responsibility to ensure that entries are proper and complete. During entry of data, error checks will be performed by the EDC system that will immediately flag problematic data (i.e., missing, out of range, inconsistent) allowing for sites to correct the data at that time. Error checks will be implemented in the EDC system based upon specifications defined in the data management plan.

15.4. Primary Source Documents
The Investigator must maintain primary source documents supporting data collected for each subject. This includes documentation of:
- General information supporting the subject’s consent to participate in the study
- Demographic information
- Evidence supporting the diagnosis/condition for which the subject is being studied
- General history and physical findings
- Hospitalization or Emergency Room records (if applicable)
- Each study visit by date, including any relevant findings/notes by the Investigator(s), occurrence (or lack) of adverse events, and changes in medication usage including the date the medication commenced and completed
- Any additional visits during the study
- Any relevant telephone conversations with the subject regarding the study or possible adverse experiences
- Original, signed informed consent forms for study participation

During monitoring visits the study monitor will need to validate data in the eCRFs against these source data.

16. Data Management
An Internet accessible Electronic Data Capture (EDC) system for data management will be utilized for this study. This system is protected by 128-bit server certificates and utilizes authenticated, password-protected accounts for each site. The EDC system is designed to ensure timeliness and accuracy of data as well as the prompt reporting of data from the study on an ongoing basis to the study principal investigators. The system is compliant with relevant FDA regulatory requirements per 21 CFR Part 11.

Data review, coding and query processing will be done through interaction with the CTCC, site personnel and the Study Monitor. Queries will be generated in real-time as data are entered. Once the data are submitted to the EDC system, they are immediately stored in the central study database located at the CTCC and are accessible for review by data management staff. Any changes to the data will be fully captured in an electronic audit trail. As data recorded by sites in eCRFs are received, narrative text of adverse experiences and concomitant medications will be periodically coded using established coding mechanisms.
The cycle of electronic data entry, review, query identification/resolution, and correction occurs over the course of the study period until all subjects have completed the study.

Data will be securely transferred to the Statistics Core. Once the Statistics Core and the CTCC, in conjunction with the Sponsor and the principal investigator, agree that all queries have been adequately resolved and the database has been deemed “clean.” The database will be officially signed off and deemed locked. All permissions to make changes (append, delete, modify or update) the database are removed at this time.

All data obtained during the conduct of the PPMI study, will be sent to the Laboratory of Neuro Imaging (LONI) in Los Angeles, California to be stored indefinitely for research purposes. Research data will be made available to researchers to conduct analyses related to PD and other disorders.

17. Study Monitoring
In accordance with ICH Guidelines for Good Clinical Practice 5.18 the study will be monitored to verify that:

(a) The rights and well being of human subjects are protected.
(b) The reported trial data are accurate, complete, and verifiable from source documents.
(c) The conduct of the trial is in compliance with the currently approved protocol/amendment(s), with GCP, and with the applicable regulatory requirement(s).

The Steering Committee has the responsibility to monitor all procedures for safety and for GCP and regulatory compliance. The committee members have the expertise to monitor all aspects of this study.

Study data will also be provided to the Clinical Study Oversight Committee (CSOC). The CSOC will convene at least semi annually to review safety data. Any recommendations for changes to the conduct of the study will be conveyed to the Steering Committee.

The study will have ongoing monitoring to ensure that the trial is conducted properly. The monitoring activities will include:

- Verifying that the site investigators and coordinators have adequate qualifications, that resources remain adequate throughout the trial period, and that facilities, equipment, and staff are adequate to safely and properly conduct the trial.
- Verifying that the site investigators follow the approved protocol and all approved amendment(s), if any.
- Verifying that written consent was obtained for each subject participating in the trial.
- Verifying that the investigators are enrolling only eligible subjects.
- Verifying that source documents and other trial records are accurate, complete, kept up-to-date and maintained.
- Verifying that the investigator provides all the required reports, notifications, applications, and submissions, and that these documents are accurate, complete, timely, legible, dated, and identify the trial.
- Monitoring adverse events, concomitant medications and intercurrent illnesses. Determining whether all adverse events (AEs) are appropriately reported within the time periods required by GCP, the protocol, the IRB, and other applicable regulatory requirement(s).
- Communicating deviations from the protocol, Standard Operating Procedures, GCP, and the applicable regulatory requirements to the investigator and taking appropriate action designed to prevent recurrence of the detected deviations.
- Federal regulations 21 CFR §56.109(f) and 45 CFR §46.109(e) state that an IRB shall conduct continuing review of research covered by these regulations at intervals appropriate to the degree of risk, but not less than once per year, and shall have authority to observe or have a third party observe the consent process and the research. Continuing review by the IRB routinely includes interim progress reports, as directed by the Board, review of proposed changes to research, adverse event reports, review of any protocol deviations, visits to the research site, and annual review of the research.
Appendix 1

Features of dementia associated with Parkinson’s disease

I. Core features
1. Diagnosis of Parkinson’s disease according to Queen Square Brain Bank criteria
2. A dementia syndrome with insidious onset and slow progression, developing within the context of established Parkinson’s disease and diagnosed by history, clinical, and mental examination, defined as:
   • Impairment in more than one cognitive domain
   • Representing a decline from premorbid level
   • Deficits severe enough to impair daily life (social, occupational, or personal care), independent of the impairment ascribable to motor or autonomic symptoms

II. Associated clinical features
1. Cognitive features:
   • Attention: Impaired. Impairment in spontaneous and focused attention, poor performance in attentional tasks; performance may fluctuate during the day and from day to day
   • Executive functions: Impaired. Impairment in tasks requiring initiation, planning, concept formation, rule finding, set shifting or set maintenance; impaired mental speed (bradyphrenia)
   • Visuo-spatial functions: Impaired. Impairment in tasks requiring visual-spatial orientation, perception, or construction
   • Memory: Impaired. Impairment in free recall of recent events or in tasks requiring learning new material, memory usually improves with cueing, recognition is usually better than free recall
   • Language: Core functions largely preserved. Word finding difficulties and impaired comprehension of complex sentences may be present
2. Behavioral features:
   • Apathy: decreased spontaneity; loss of motivation, interest, and effortful behavior
   • Changes in personality and mood including depressive features and anxiety
   • Hallucinations: mostly visual, usually complex, formed visions of people, animals or objects
   • Delusions: usually paranoid, such as infidelity, or phantom boarder (unwelcome guests living in the home) delusions
   • Excessive daytime sleepiness

III. Features which do not exclude PD-D, but make the diagnosis uncertain
• Co-existence of any other abnormality which may by itself cause cognitive impairment, but judged not to be the cause of dementia, e.g. presence of relevant vascular disease in imaging
• Time interval between the development of motor and cognitive symptoms not known

IV. Features suggesting other conditions or diseases as cause of mental impairment, which, when present make it impossible to reliably diagnose PD-D
• Cognitive and behavioral symptoms appearing solely in the context of other conditions such as:
   Acute confusion due to
   a. Systemic diseases or abnormalities
   b. Drug intoxication
   Major Depression according to DSM IV
• Features compatible with “Probable Vascular dementia” criteria according to NINDS-AIREN (dementia in the context of cerebrovascular disease as indicated by focal signs in neurological exam such as hemiparesis, sensory deficits, and evidence of relevant cerebrovascular disease by brain imaging AND a relationship between the two as indicated by the presence of one or more of the following: onset of dementia within 3 months after a recognized stroke, abrupt deterioration in cognitive functions, and fluctuating, stepwise progression of cognitive deficits)


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**PPMI Study 001**

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