Annex 1: Clinical trial Application Form

REQUEST FOR AUTHORISATION OF A CLINICAL TRIAL ON A MEDICINAL PRODUCT FOR HUMAN USE TO THE COMPETENT AUTHORITIES AND FOR OPINION OF THE ETHICS COMMITTEES IN THE COMMUNITY

To be filled in by the applicant
The questions in this form for the request for authorisation from the Competent Authority are also relevant for the opinion from an Ethics Committee (it represents module 1 of the form for applying to an ethics committee) and can be used as part of that application. Please indicate the relevant purpose in a box below.

REQUEST FOR AUTHORISATION TO THE COMPETENT AUTHORITY: **Yes •**
REQUEST FOR OPINION OF THE ETHICS COMMITTEE: **No •**

A. TRIAL IDENTIFICATION

A.1	Member State in which the submission is being made:	**Denmark - DHMA**
A.2	EudraCT number:	**2020-001395-15**
A.3	Full title of the trial:	
	English	**Low dose hydrocortisone in patients with COVID-19 and severe hypoxia – the COVID STEROID Trial**
	Danish	**Lavdosis hydrokortison til patienter med COVID-19 sygdom og svær hypoxi – COVID STEROID forsøget**
A.3.1	Title of the trial for lay people, in easily understood, i.e. non-technical, language:	
	English	**Low dose hydrocortisone in patients with COVID-19 and severe oxygen deficiency – the COVID STEROID Trial**
	Danish	**Lavdosis hydrokortison til patienter med COVID-19 sygdom og svær iltmangel – COVID STEROID forsøget**
A.3.2	Name or abbreviated title of the trial where available:	
	English	**COVID-STEROID trial**
A.4	Sponsor's protocol code number, version and date[1]:	
A.4.1	Sponsor's protocol code number:	**Awaiting**
A.4.2	Sponsor's protocol version:	
A.4.3	Sponsor's protocol date:	**2020-03-26**
A.5	Additional international study identifiers (e.g. WHO, ISRCTN[2] , US NCT Number[3]) if available	
A.5.1	ISRCTN number:	
A.5.2	US NCT number:	
A.5.3	WHO Universal Trial Number (UTN):	
A.5.4	Other Identifier:	
A.6	Is this a resubmission?	**No •**
	If 'Yes', indicate the resubmission letter[4]:	**First Submission**
A.7	Is the trial part of an agreed Paediatric Investigation Plan?	**No •**
A.8	EMA Decision number of Paediatric Investigation Plan:	

B. IDENTIFICATION OF THE SPONSOR RESPONSIBLE FOR THE REQUEST

B.1	SPONSOR	
B.1.1	Name of organisation:	**Deparment of Intensive Care, Rigshospitalet**
B.1.2	Name of the person to contact:	
B.1.2.1	Given name	**Anders**
B.1.2.2	Middle name	
B.1.2.3	Family name	**Perner**
B.1.3	Address:	
B.1.3.1	Street address	**Blegdamsvej 9**
B.1.3.2	Town/city	**København Ø**
B.1.3.3	Post code	**2100**
B.1.3.4	Country	**Denmark**
B.1.4	Telephone number:	**0045 35458333**
B.1.5	Fax number:	
B.1.6	E-mail:	**anders.perner@regionh.dk**

B.2	**LEGAL REPRESENTATIVE[5] OF THE SPONSOR IN THE COMMUNITY FOR THE PURPOSE OF THIS TRIAL** (if different from the sponsor)
B.2.1	Name of organisation:
B.2.2	Name of person to contact:
B.2.2.1	Given name
B.2.2.2	Middle name
B.2.2.3	Family name
B.2.3	Address:
B.2.3.1	Street address
B.2.3.2	Town/city
B.2.3.3	Post code
B.2.3.4	Country
B.2.4	Telephone number:
B.2.5	Fax number:
B.2.6	E-mail:

B.3	STATUS OF THE SPONSOR:	
B.3.1	Commercial:	**No •**
B.3.2	Non commercial:	**Yes •**

B.4	Source(s) of Monetary or Material Support for the clinical trial (repeat as necessary):	
B.4.1	Name of organisation:	**Novo Nordic Foundation**
B.4.2	Country:	**Ecuador**

B.5	Contact point[6] designated by the sponsor for further information on the trial	
B.5.1	Name of organisation:	**Department of Intensive Care, Rigshospitalet**
B.5.2	Functional name of contact point (e.g. "Clinical Trial Information Desk"):	**Clinical Trials Information**
B.5.3	Address:	
B.5.3.1	Street address	**Blegdamsvej 9**
B.5.3.2	Town/city	**København Ø**
B.5.3.3	Post code	**2100**
B.5.3.4	Country	**Denmark**
B.5.4	Telephone number:	**0045 35458333**
B.5.5	Fax number:	
B.5.6	E-mail: (use a functional e-mail address rather than a personal one)	**anders.perner@regionh.dk**

C. APPLICANT IDENTIFICATION, (please tick the appropriate box)

C.1	REQUEST FOR THE COMPETENT AUTHORITY	
C.1.1	Sponsor	
C.1.2	Legal representative of the sponsor	
C.1.3	Person or organisation authorised by the sponsor to make the application	**Yes** •
C.1.4	Complete the details of the applicant below even if they are provided elsewhere on the form:	
C.1.4.1	Name of Organisation:	**Department of Intensive Care, Rigshospitalet**
C.1.4.2	Name of contact person:	
C.1.4.2.1	Given name	**Marie Warrer**
C.1.4.2.2	Middle name	
C.1.4.2.3	Family name	**Petersen**
C.1.4.3	Address:	
C.1.4.3.1	Street address	**Blegdamsvej 9**
C.1.4.3.2	Town/city	**København Ø**
C.1.4.3.3	Post code	**2100**
C.1.4.3.4	Country	**Denmark**
C.1.4.4	Telephone number:	**0045 30742123**
C.1.4.5	Fax number:	
C.1.4.6	E-mail:	**marie.warrer.petersen.01@regionh.dk**
C.1.5	Request to receive a copy of CTA data as XML:	
C.1.5.1	Do you want a copy of the CTA form data saved on EudraCT as an XML file?	**Yes** •
C.1.5.1.1	If Yes provide the e-mail address(es) to which it should be sent (up to 5 addresses): **marie.warrer.petersen.01@regionh.dk**	
C.1.5.1.2	Do you want to receive this via password protected link(s)[7]?	**No** •

If you answer No to question C.1.5.1.2 the .xml file will be transmitted by less secure e-mail link(s)

D. INFORMATION ON EACH IMP

Information on each 'bulk product' before trial-specific operations (blinding, trial specific packaging and labelling) should be provided in this section for each investigational medicinal product (IMP) being tested including each comparator and each placebo, if applicable. ***For placebo go directly to D.8****. If the trial is performed with several products use extra pages and give each product a sequential number in D.1.1. If the product is a combination product, information should be given for each active substance.*

D.1	**IMP IDENTIFICATION**	
Indicate which of the following is described below, then repeat as necessary for each of the numbered IMPs to be used in the trial (assign numbers from 1-n):		
D.1.1	This refers to the IMP number:	**PR1**
D.1.2	IMP being tested	**Yes •**
D.1.3	IMP used as a comparator	**No •**

D.2	**STATUS OF THE IMP**	
D.2.1	Has the IMP to be used in the trial a marketing authorisation?	**Yes •**
If the IMP has a marketing authorisation in the Member State concerned by this application, but the trade name and marketing authorisation holder are not fixed in the protocol, go to section D.2.2.		
D.2.1.1	If 'Yes', specify the product to be used in the clinical trial:	
D.2.1.1.1	Trade name **Solu-Cortef**	
D.2.1.1.1.1	EV Product Code (where applicable)	
D.2.1.1.2	Name of the Marketing Authorisation Holder:	**Pfizer**
D.2.1.1.3	Marketing Authorisation number (if Marketing Authorisation granted by a Member State):	
D.2.1.1.4	Is the IMP modified in relation to its Marketing Authorisation?	**No •**
D.2.1.1.4.1	If 'Yes', please specify:	
D.2.1.2	The country that granted the Marketing Authorisation	**Denmark**
D.2.1.2.1	Is this the Member State concerned with this application?	**Yes •**

D.2.2	Situations where an IMP to be used in the CT has a Marketing Authorisation in the Member State concerned, but the protocol allows that any brand of the IMP with a Marketing Authorisation in that Member State be administered to the trial subjects and it is not possible to clearly identify the IMP(s) in advance of the trial start	
D.2.2.1	In the protocol, is treatment defined only by active substance?	**Yes •**
D.2.2.1.1	If 'Yes', give active substance in D.3.8 or D.3.9	
D.2.2.2	In the protocol, do treatment regimens allow different combinations of marketed products used according to local clinical practice at some or all investigator sites in the MS?	**No •**
D.2.2.2.1	If 'Yes', give active substance in D.3.8 or D.3.9	
D.2.2.3	The products to be administered as IMPs are defined as belonging to an ATC group[9]	**No •**
D.2.2.3.1	If 'Yes', give the ATC group of the applicable authorised codes in the ATC code field (level 3 or the level that can be defined) in D.3.3	
D.2.2.4	Other:	**No •**
D.2.2.4.1	If 'Yes', please specify:	

D.2.3	IMPD submitted:	
D.2.3.1	Full IMPD:	**No •**
D.2.3.2	Simplified IMPD:	**No •**
D.2.3.3	Summary of product characteristics (SmPC) only:	**Yes •**
D.2.4	Has the use of the IMP been previously authorised in a	**No •**

	clinical trial conducted by the sponsor in the Community?	
D.2.4.1	If 'Yes' specify which Member States:	
D.2.5	Has the IMP been designated in this indication as an orphan drug in the Community?	**No •**
D.2.5.1	If 'Yes', give the orphan drug designation number[10]:	

D.2.6	Has the IMP been the subject of scientific advice related to this clinical trial?	**No •**
D.2.6.1	If 'Yes' to D.2.6, please indicate source of advice and provide a copy in the CTA request:	
D.2.6.1.1	CHMP[11]?	**No •**
D.2.6.1.2	National Competent Authority?	**No •**

D.3	**DESCRIPTION OF THE IMP**	
D.3.1	Product name where applicable[12]:	**Solu-Cortef**
D.3.2	Product code where applicable[13]:	
D.3.3	ATC codes, if officially registered[14]:	**H02AB09**
D.3.4	Pharmaceutical form (use standard terms):	**Powder and solvent for solution for injection/infusion**
D.3.4.1	Is this a specific paediatric formulation?	**No •**
D.3.5	Maximum duration of treatment of a subject according to the protocol:	
	7 days	
D.3.6	Dose allowed:	
D.3.6.1	For first trial only:	
	Specify per day or total	**Total •**
	Specify total dose (number and unit):	
	Route of administration (relevant to the first dose):	
D.3.6.2	For all trials	
	Specify per day or total	**Per day •**
	Specify total dose (number and unit):	**200 mg milligram(s)**
	Route of administration (relevant to the maximum dose):	**Intravenous use**
D.3.7	Routes of administration (use standard terms):	**Intravenous use**

D.3.8	Name of each active substance (INN or proposed INN if available):	
	hydrocortisone	
D.3.9	Other available name for each active substance (provide all available):	
D.3.9.1	CAS[15] number	
D.3.9.2	Current sponsor code	
D.3.9.3	Other descriptive name	
	HYDROCORTISONE SODIUM SUCCINATE	
D.3.9.4	EV Substance code	**SUB02569MIG**
D.3.9.5	Full Molecular formula	
D.3.9.6	Chemical/biological description of the Active Substance	
D.3.10	Strength (specify all strengths to be used):	
D.3.10.1	Concentration unit:	**mg milligram(s)**
D.3.10.2	Concentration type ("exact number", "range", "more than" or "up to"):	**equal**
D.3.10.3	Concentration (number).	**100**

D.3.11	Type of IMP	
Does the IMP contain an active substance:		
D.3.11.1	Of chemical origin?	**Yes •**
D.3.11.2	Of biological / biotechnological origin (other than Advanced Therapy IMP (ATIMP)?	**No •**
Is this a:		

D.3.11.3	Advanced Therapy IMP (ATIMP)?	**No** •
D.3.11.3.1	Somatic cell therapy medicinal product[16]?	**No** •
D.3.11.3.2	Gene therapy medicinal product[17]?	**No** •
D.3.11.3.3	Tissue Engineered Product[18]?	**No** •
D.3.11.3.4	Combination ATIMP (i.e. one involving a medical device[19])?	**No** •
D.3.11.3.5	Has the Committee on Advanced Therapies issued a classification for this product?	**No** •
D.3.11.3.5.1	If 'Yes' please provide that classification and its reference number:	
D.3.11.4	Combination product that includes a device, but does not involve an Advanced Therapy?	**No** •
D.3.11.5	Radiopharmaceutical medicinal product?	**No** •
D.3.11.6	Immunological medicinal product (such as vaccine, allergen, immune serum)?	**No** •
D.3.11.7	Plasma derived medicinal product?	**No** •
D.3.11.8	Extractive medicinal product?	**No** •
D.3.11.9	Recombinant medicinal product?	**No** •
D.3.11.10	Medicinal product containing genetically modified organisms?	**No** •
D.3.11.10.1	Has the authorisation for contained use or release been granted?	**No** •
D.3.11.10.2	Is it pending?	**No** •
D.3.11.11	Herbal medicinal product?	**No** •
D.3.11.12	Homeopathic medicinal product?	**No** •
D.3.11.13	Another type of medicinal product?	**No** •
D.3.11.13.1	If 'another type of medicinal product' specify the type of medicinal product:	
D.3.12	Mode of action (*free text*[20])	
D.3.13	Is it an IMP to be used in a first-in-human clinical trial?	**No** •
D.3.13.1	If 'Yes', are there risk factors identified, according to the guidance FIH?[21]	

D.4	**SOMATIC CELL THERAPY INVESTIGATIONAL MEDICINAL PRODUCT (NO GENETIC MODIFICATION)**	
D.4.1	Origin of cells	
D.4.1.1	Autologous	**No** •
D.4.1.2	Allogeneic	**No** •
D.4.1.3	Xenogeneic	**No** •
D.4.1.3.1	If 'Yes', specify the species of origin:	
D.4.2	Type of cells	
D.4.2.1	Stem cells	**No** •
D.4.2.2	Differentiated cells	**No** •
D.4.2.2.1	If 'Yes', specify the type (e.g. keratinocytes, fibroblasts, chondrocytes...):	
D.4.2.3	Others:	**No** •
D.4.2.3.1	If others, specify:	

D.5	**GENE THERAPY INVESTIGATIONAL MEDICINAL PRODUCTS**	
D.5.1	Gene(s) of interest:	
D.5.2	In vivo gene therapy:	**No** •
D.5.3	Ex vivo gene therapy:	**No** •
D.5.4	Type of gene transfer product	
D.5.4.1	Nucleic acid (e.g. plasmid):	**No** •
	If 'Yes', specify if:	
D.5.4.1.1	Naked:	**No** •
D.5.4.1.2	Complexed	**No** •

D.5.4.2	Viral vector:	**No •**
D.5.4.2.1	If 'Yes', specify the type: adenovirus, retrovirus, AAV, ...:	
D.5.4.3	Others	**No •**
D.5.4.3.1	If others, specify:	
D.5.5	Genetically modified somatic cells:	**No •**
If 'Yes', specify the origin of the cells:		
D.5.5.1	Autologous:	**No •**
D.5.5.2	Allogeneic:	**No •**
D.5.5.3	Xenogeneic:	**No •**
D.5.5.3.1	If 'Yes', specify the species of origin:	
D.5.5.4	Specify type of cells (hematopoietic stem cells...):	

D.6	**TISSUE ENGINEERED PRODUCT**	
The indication which determines that this is a Tissue Engineered Product as opposed to a Cell Therapy product is given in section E.1.1.		
D.6.1	Origin of cells	
D.6.1.1	Autologous	**No •**
D.6.1.2	Allogeneic	**No •**
D.6.1.3	Xenogeneic	**No •**
D.6.1.3.1	If 'Yes', specify the species of origin:	
D.6.2	Type of cells	
D.6.2.1	Stem cells	**No •**
D.6.2.2	Differentiated cells	**No •**
D.6.2.2.1	If 'Yes', specify the type of cells(e.g. keratinocytes, fibroblasts, chondrocytes, ...):	
D.6.2.3	Others:	**No •**
D.6.2.3.1	If others, specify:	

D.7	**PRODUCTS CONTAINING DEVICES (i.e. MEDICAL DEVICES, SCAFFOLDS ETC.)**	
D.7.1	Give a brief description of the device:	
D.7.2	What is the name of the device?	
D.7.3	Is the device implantable?	**No •**
D.7.4	Does this product contain:	
D.7.4.1	A medical device?	**No •**
D.7.4.1.1	Does this medical device have a CE mark?	**No •**
D.7.4.1.1.1	The notified body is:	
D.7.4.2	Bio-materials?	**No •**
D.7.4.3	Scaffolds?	**No •**
D.7.4.4	Matrices?	**No •**
D.7.4.5	Other?	**No •**
D.7.4.5.1	If other, specify:	

D.1	**IMP IDENTIFICATION**	
Indicate which of the following is described below, then repeat as necessary for each of the numbered IMPs to be used in the trial (assign numbers from 1-n):		
D.1.1	This refers to the IMP number:	**PR2**
D.1.2	IMP being tested	**No •**
D.1.3	IMP used as a comparator	**Yes •**

D.2	**STATUS OF THE IMP**

D.2.1	Has the IMP to be used in the trial a marketing authorisation?	**Yes •**
If the IMP has a marketing authorisation in the Member State concerned by this application, but the trade name and marketing authorisation holder are not fixed in the protocol, go to section D.2.2.		
D.2.1.1	If 'Yes', specify the product to be used in the clinical trial:	
D.2.1.1.1	Trade name	**Isotonic Sodium Chloride (0.9%)**
D.2.1.1.1.1	EV Product Code (where applicable)	
D.2.1.1.2	Name of the Marketing Authorisation Holder:	
D.2.1.1.3	Marketing Authorisation number (if Marketing Authorisation granted by a Member State):	
D.2.1.1.4	Is the IMP modified in relation to its Marketing Authorisation?	**No •**
D.2.1.1.4.1	If 'Yes', please specify:	
D.2.1.2	The country that granted the Marketing Authorisation	**Denmark**
D.2.1.2.1	Is this the Member State concerned with this application?	**Yes •**

D.2.2	Situations where an IMP to be used in the CT has a Marketing Authorisation in the Member State concerned, but the protocol allows that any brand of the IMP with a Marketing Authorisation in that Member State be administered to the trial subjects and it is not possible to clearly identify the IMP(s) in advance of the trial start	
D.2.2.1	In the protocol, is treatment defined only by active substance?	**Yes •**
D.2.2.1.1	If 'Yes', give active substance in D.3.8 or D.3.9	
D.2.2.2	In the protocol, do treatment regimens allow different combinations of marketed products used according to local clinical practice at some or all investigator sites in the MS?	**No •**
D.2.2.2.1	If 'Yes', give active substance in D.3.8 or D.3.9	
D.2.2.3	The products to be administered as IMPs are defined as belonging to an ATC group[9]	**No •**
D.2.2.3.1	If 'Yes', give the ATC group of the applicable authorised codes in the ATC code field (level 3 or the level that can be defined) in D.3.3	
D.2.2.4	Other:	**No •**
D.2.2.4.1	If 'Yes', please specify:	

D.2.3	IMPD submitted:	
D.2.3.1	Full IMPD:	**No •**
D.2.3.2	Simplified IMPD:	**No •**
D.2.3.3	Summary of product characteristics (SmPC) only:	**Yes •**
D.2.4	Has the use of the IMP been previously authorised in a clinical trial conducted by the sponsor in the Community?	**Yes •**
D.2.4.1	If 'Yes' specify which Member States:	**Czech Republic** **Denmark** **Finland** **Italy** **Spain** **Sweden** **United Kingdom**
D.2.5	Has the IMP been designated in this indication as an orphan drug in the Community?	**No •**
D.2.5.1	If 'Yes', give the orphan drug designation number[10]:	

D.2.6	Has the IMP been the subject of scientific advice related to this clinical trial?	**No •**
D.2.6.1	If 'Yes' to D.2.6, please indicate source of advice and provide a copy in the CTA request:	
D.2.6.1.1	CHMP[11]?	**No •**
D.2.6.1.2	National Competent Authority?	**No •**

D.3	DESCRIPTION OF THE IMP	
D.3.1	Product name where applicable[12]:	**Sodium Chloride**
D.3.2	Product code where applicable[13]:	
D.3.3	ATC codes, if officially registered[14]:	**B05BB01**
D.3.4	Pharmaceutical form (use standard terms):	**Infusion**
D.3.4.1	Is this a specific paediatric formulation?	**No •**
D.3.5	Maximum duration of treatment of a subject according to the protocol: **7 days.**	
D.3.6	Dose allowed:	
D.3.6.1	For first trial only:	
	Specify per day or total	**Not Answered •**
	Specify total dose (number and unit):	
	Route of administration (relevant to the first dose):	
D.3.6.2	For all trials	
	Specify per day or total	**Per day •**
	Specify total dose (number and unit):	**200 ml millilitre(s)**
	Route of administration (relevant to the maximum dose):	**Intravenous use**
D.3.7	Routes of administration (use standard terms):	**Intravenous use**

D.3.8	Name of each active substance (INN or proposed INN if available): **Sodium Chloride**	
D.3.9	Other available name for each active substance (provide all available):	
D.3.9.1	CAS[15] number	
D.3.9.2	Current sponsor code	
D.3.9.3	Other descriptive name **SODIUM CHLORIDE SOLUTION 0.9%**	
D.3.9.4	EV Substance code	**SUB20079**
D.3.9.5	Full Molecular formula	
D.3.9.6	Chemical/biological description of the Active Substance	
D.3.10	Strength (specify all strengths to be used):	
D.3.10.1	Concentration unit:	**% (W/V) percent weight/volume**
D.3.10.2	Concentration type ("exact number", "range", "more than" or "up to"):	**equal**
D.3.10.3	Concentration (number).	**0.9**

D.3.11	Type of IMP	
Does the IMP contain an active substance:		
D.3.11.1	Of chemical origin?	**Yes •**
D.3.11.2	Of biological / biotechnological origin (other than Advanced Therapy IMP (ATIMP)?	**No •**
Is this a:		
D.3.11.3	Advanced Therapy IMP (ATIMP)?	**No •**
D.3.11.3.1	Somatic cell therapy medicinal product[16]?	**No •**
D.3.11.3.2	Gene therapy medicinal product[17]?	**No •**
D.3.11.3.3	Tissue Engineered Product[18]?	**No •**
D.3.11.3.4	Combination ATIMP (i.e. one involving a medical device[19])?	**No •**
D.3.11.3.5	Has the Committee on Advanced Therapies issued a classification for this product?	**No •**
D.3.11.3.5.1	If 'Yes' please provide that classification and its reference number:	
D.3.11.4	Combination product that includes a device, but does not involve an Advanced Therapy?	**No •**
D.3.11.5	Radiopharmaceutical medicinal product?	**No •**

D.3.11.6	Immunological medicinal product (such as vaccine, allergen, immune serum)?	**No** •
D.3.11.7	Plasma derived medicinal product?	**No** •
D.3.11.8	Extractive medicinal product?	**No** •
D.3.11.9	Recombinant medicinal product?	**No** •
D.3.11.10	Medicinal product containing genetically modified organisms?	**No** •
D.3.11.10.1	Has the authorisation for contained use or release been granted?	**No** •
D.3.11.10.2	Is it pending?	**No** •
D.3.11.11	Herbal medicinal product?	**No** •
D.3.11.12	Homeopathic medicinal product?	**No** •
D.3.11.13	Another type of medicinal product?	**No** •
D.3.11.13.1	If 'another type of medicinal product' specify the type of medicinal product:	
D.3.12	Mode of action (*free text*[20])	
D.3.13	Is it an IMP to be used in a first-in-human clinical trial?	**No** •
D.3.13.1	If 'Yes', are there risk factors identified, according to the guidance FIH?[21]	

D.4	**SOMATIC CELL THERAPY INVESTIGATIONAL MEDICINAL PRODUCT (NO GENETIC MODIFICATION)**	
D.4.1	Origin of cells	
D.4.1.1	Autologous	**No** •
D.4.1.2	Allogeneic	**No** •
D.4.1.3	Xenogeneic	**No** •
D.4.1.3.1	If 'Yes', specify the species of origin:	
D.4.2	Type of cells	
D.4.2.1	Stem cells	**No** •
D.4.2.2	Differentiated cells	**No** •
D.4.2.2.1	If 'Yes', specify the type (e.g. keratinocytes, fibroblasts, chondrocytes...):	
D.4.2.3	Others:	**No** •
D.4.2.3.1	If others, specify:	

D.5	**GENE THERAPY INVESTIGATIONAL MEDICINAL PRODUCTS**	
D.5.1	Gene(s) of interest:	
D.5.2	In vivo gene therapy:	**No** •
D.5.3	Ex vivo gene therapy:	**No** •
D.5.4	Type of gene transfer product	
D.5.4.1	Nucleic acid (e.g. plasmid):	**No** •
	If 'Yes', specify if:	
D.5.4.1.1	Naked:	**No** •
D.5.4.1.2	Complexed	**No** •
D.5.4.2	Viral vector:	**No** •
D.5.4.2.1	If 'Yes', specify the type: adenovirus, retrovirus, AAV, ...:	
D.5.4.3	Others	**No** •
D.5.4.3.1	If others, specify:	
D.5.5	Genetically modified somatic cells:	**No** •
If 'Yes', specify the origin of the cells:		
D.5.5.1	Autologous:	**No** •
D.5.5.2	Allogeneic:	**No** •
D.5.5.3	Xenogeneic:	**No** •
D.5.5.3.1	If 'Yes', specify the species of origin:	
D.5.5.4	Specify type of cells (hematopoietic stem cells...):	

D.6	TISSUE ENGINEERED PRODUCT	
The indication which determines that this is a Tissue Engineered Product as opposed to a Cell Therapy product is given in section E.1.1.		
D.6.1	Origin of cells	
D.6.1.1	Autologous	**No •**
D.6.1.2	Allogeneic	**No •**
D.6.1.3	Xenogeneic	**No •**
D.6.1.3.1	If 'Yes', specify the species of origin:	
D.6.2	Type of cells	
D.6.2.1	Stem cells	**No •**
D.6.2.2	Differentiated cells	**No •**
D.6.2.2.1	If 'Yes', specify the type of cells(e.g. keratinocytes, fibroblasts, chondrocytes, ...):	
D.6.2.3	Others:	**No •**
D.6.2.3.1	If others, specify:	

D.7	PRODUCTS CONTAINING DEVICES (i.e. MEDICAL DEVICES, SCAFFOLDS ETC.)	
D.7.1	Give a brief description of the device:	
D.7.2	What is the name of the device?	
D.7.3	Is the device implantable?	**No •**
D.7.4	Does this product contain:	
D.7.4.1	A medical device?	**No •**
D.7.4.1.1	Does this medical device have a CE mark?	**No •**
D.7.4.1.1.1	The notified body is:	
D.7.4.2	Bio-materials?	**No •**
D.7.4.3	Scaffolds?	**No •**
D.7.4.4	Matrices?	**No •**
D.7.4.5	Other?	**No •**
D.7.4.5.1	If other, specify:	

D.8 INFORMATION ON PLACEBO (if relevant; repeat as necessary)

D.8.1	Is there a placebo:	**Yes •**
D.8.2	This refers to placebo number:	**PL1**
D.8.3	Pharmaceutical form:	**Infusion**
D.8.4	Route of administration:	**Intravenous use**
D.8.5	Which IMP is it a placebo for? Specify IMP Number(s) from D.1.1	**PR1**
D.8.5.1	Composition, apart from the active substance(s):	
D.8.5.2	Is it otherwise identical to the IMP?	**No •**
D.8.5.2.1	If not, specify major ingredients:	
	The Isotonic Sodium Chloride also registered as an IMP is placebo for Solu-Cortef.	

D.9 SITE(S) WHERE THE QUALIFIED PERSON CERTIFIES BATCH RELEASE[22]

*This section is dedicated to **finished** IMPs, i.e. medicinal products randomised, packaged, labelled and certified for use in the clinical trial. If there is more than one site or more than one IMP is certified, use extra pages and give each IMP its number from section D.1.1 or D.8.2 In the case of multiple sites indicate the product certified by each site*

D.9.1	Do not fill in section D.9.2 for an IMP that: *Has a MA in the EU* ***and*** *Is sourced from the EU market* ***and*** *Is used in the trial without modification(e.g. not overencapsulated)* ***and*** *The packaging and labelling is carried out for local use only as per article 9.2. of the Directive 2005/28/EC (GCP Directive)* If all these conditions are met tick • and list the number(s) of each IMP including placebo from sections D.1.1 and D.8.2 to which this applies **PR1** **PR2** **PL1**

D.9.2	**Who is responsible in the Community for the certification of the finished IMPs?** This site is responsible for certification of (list the number(s) of each IMP including placebo from sections D.1.1 and D.8.2): please tick the appropriate box:	
D.9.2.1	Manufacturer	?
D.9.2.2	Importer	?
D.9.2.3	Name of the organisation:	
D.9.2.4	Address:	
D.9.2.4.1	Street Address	
D.9.2.4.2	Town/City	
D.9.2.4.3	Post Code	
D.9.2.4.4	Country	
D.9.2.5	Give the manufacturing authorisation number:	
D.9.2.5.1	If No authorisation, give the reasons:	

Where the product does not have a MA in the EU, but is supplied in bulk and final packaging and labelling for local use is carried out in accordance with article 9.2 of Directive 2005/28/EC (GCP Directive) then enter the site where the product was finally certified for release by the Qualified Person for use in the clinical trial at D.9.2 above.

E. GENERAL INFORMATION ON THE TRIAL

This section should be used to provide information about the aims, scope and design of the trial. When the protocol includes a sub-study in the MS concerned section E.2.3 should be completed providing information about the sub-study. To identify it check the sub-study box in the 'Objective of the trial' question below.

E.1	MEDICAL CONDITION OR DISEASE UNDER INVESTIGATION				
E.1.1	Specify the medical condition(s) to be investigated[23] (free text): **English** **Adult patients with COVID-19 and severe hypoxia.**				
E.1.1.1	Medical condition in easily understood language **English** **Adult patients with COVID-19 and severe oxygen deficiency.**				
E.1.1.2	Therapeutic area **Diseases [C] - Virus Diseases [C02]**				
E.1.2	MedDRA version, system organ class, level, term and classification code[24]:				
	Version	System Organ Class	Classification Code	Term	Level
	20.1	**10021881 - Infections and infestations**	**10053983**	**Corona virus infection**	**PT**
	21.1	**10038738 - Respiratory, thoracic and mediastinal disorders**	**10021143**	**Hypoxia**	**PT**
E.1.3	Is any of the conditions being studied a rare disease[25]? **No •**				

E.2	OBJECTIVE OF THE TRIAL	
E.2.1	Main objective: **English**	**To assess benefits and harms of low dose IV hydrocortisone versus placebo on patient-important outcome measures in adult patients with COVID-19 and severe hypoxia.**
E.2.2	Secondary objectives: **English**	**Not applicable.**
E.2.3	Is there a sub-study? **No •**	
E.2.3.1	If 'Yes', give the full title, date and version of each sub-study and their related objectives:	

E.3	PRINCIPAL INCLUSION CRITERIA *(list the most important)*	
	English	**All the following criteria must be fulfilled:** **- Aged 18 years or above AND** **- Confirmed SARS-CoV-2 (COVID-19) requiring hospitalisation AND** **- Use of one of the following:** **•☐Invasive mechanical ventilation OR** **•☐Non-invasive ventilation or continuous use of continuous positive airway pressure (CPAP) OR** **•☐Oxygen supplementation with an oxygen flow of at least 10 L/min independent of delivery system**

E.4	PRINCIPAL EXCLUSION CRITERIA *(list the most important)*	
	English	**We will exclude patients who fulfil any of the following criteria:** **- Use of systemic corticosteroids for any other indication than COVID-19** **- Invasive mechanical ventilation for more than 48 hours** **- Documented invasive fungal infection** **- Known pregnancy** **- Known hypersensitivity to hydrocortisone** **- A patient for whom the clinical team has decided not to use mechanical**

	ventilation **- Consent not obtainable**

E.5	**END POINT(S):**	
E.5.1	Primary End Point (repeat as necessary)[26]	
	English	**Days alive without life support (i.e. invasive mechanical ventilation, circulatory support or renal replacement therapy) from randomisation to day 28.**
E.5.1.1	Timepoint(s) of evaluation of this end point	
	English	**Day 28.**
E.5.2	Secondary End Point (repeat as necessary)	
	English	**-☐All-cause mortality at day 28** **-☐Days alive without life support at day 90** **-☐All-cause mortality at day 90** **-☐Number of participants with one or more serious adverse reactions (SARs) at day 14 defined as new episodes of septic shock, invasive fungal infection, clinically important GI bleeding or anaphylactic reaction to IV hydrocortisone** **-☐Days alive and out of hospital at day 90** **-☐All-cause mortality at 1 year after randomisation** **-☐Health-Related Quality of Life (HRQoL) at 1 year after randomisation using EQ-5D-5L and EQ-VAS**
E.5.2.1	Timepoint(s) of evaluation of this end point	
	English	**Day 14; Day 28; Day 90; 1 year**

E.6	**SCOPE OF THE TRIAL – Tick all boxes where applicable**	
E.6.1	Diagnosis	**No •**
E.6.2	Prophylaxis	**No •**
E.6.3	Therapy	**Yes •**
E.6.4	Safety	**Yes •**
E.6.5	Efficacy	**Yes •**
E.6.6	Pharmacokinetic	**No •**
E.6.7	Pharmacodynamic	**No •**
E.6.8	Bioequivalence	**No •**
E.6.9	Dose Response	**No •**
E.6.10	Pharmacogenetic	**No •**
E.6.11	Pharmacogenomic	**No •**
E.6.12	Pharmacoeconomic	**No •**
E.6.13	Others	**No •**
E.6.13.1	If others, specify:	

E.7	**TRIAL TYPE AND PHASE[27]**	
E.7.1	Human pharmacology (Phase I)	**No •**
Is it:		
E.7.1.1	First administration to humans	**No •**
E.7.1.2	Bioequivalence study	**No •**
E.7.1.3	Other:	**No •**
E.7.1.3.1	If other, please specify:	
E.7.2	Therapeutic exploratory (Phase II)	**No •**
E.7.3	Therapeutic confirmatory (Phase III)	**Yes •**
E.7.4	Therapeutic use(Phase IV)	**No •**

E.8	DESIGN OF THE TRIAL		
E.8.1	Controlled	**Yes •**	
	If 'Yes', specify:		
E.8.1.1	Randomised:	**Yes •**	
E.8.1.2	Open:	**No •**	
E.8.1.3	Single blind:	**No •**	
E.8.1.4	Double blind:	**Yes •**	
E.8.1.5	Parallel group:	**Yes •**	
E.8.1.6	Cross over:	**No •**	
E.8.1.7	Other:	**No •**	
E.8.1.7.1	If other specify:		
E.8.2	If controlled, specify the comparator:		
E.8.2.1	Other medicinal product(s)	**No •**	
E.8.2.2	Placebo	**Yes •**	
E.8.2.3	Other	**No •**	
E.8.2.3.1	If 'Yes' to other, specify :		
E.8.2.4	Number of treatment arms in the trial	**2**	
E.8.3	Single site in the Member State concerned (see also section G):		**No •**
E.8.4	Multiple sites in the Member State concerned(see also section G):		**Yes •**
E.8.4.1	Number of sites anticipated in Member State concerned	**16**	
E.8.5	Multiple Member States:	**No •**	
E.8.5.1	Number of sites anticipated in the EEA:		
E.8.6	Trial involving sites outside the EEA:		
E.8.6.1	Trial being conducted both within and outside the EEA:	**No •**	
E.8.6.2	Trial being conducted completely outside of the EEA:	**No •**	
E.8.6.3	If E.8.6.1 or E.8.6.2 are Yes, specify the regions in which trial sites are planned:		
E.8.6.4	If E.8.6.1 or E.8.6.2 are Yes, specify the number of sites anticipated outside of the EEA:		
E.8.7	Trial having an independent data monitoring committee:	**Yes •**	
E.8.8	Definition of the end of trial: If it is the last visit of the last subject, please enter "LVLS". If it is not LVLS provide the definition:		
	English	**The trial will end when the last patient enrolled has completed 1-year follow up (last-patient last-visit).**	
E.8.9	Initial estimate of the duration of the trial[28] (years, months and days)		
E.8.9.1	In the Member State concerned	**1 years 9 months days**	
E.8.9.2	In all countries concerned by the trial	**1 years 9 months days**	
E.8.10	Proposed date of start of recruitment		
E.8.10.1	In the Member State concerned	**2020-04-15**	
E.8.10.2	In any country	**2020-04-15**	

F. POPULATION OF TRIAL SUBJECTS

F.1	AGE RANGE		
F.1.1	Are the trial subjects under 18? If 'Yes', specify the estimated number of subjects planned in each age range for the whole trial:		**No •**
		Approx. No. of patients[29]	
F.1.1.1	In utero	()	**No •**
F.1.1.2	Preterm newborn infants (up to gestational age < 37 weeks)	()	**No •**
F.1.1.3	Newborns (0-27 days)	()	**No •**
F.1.1.4	Infants and toddlers (28 days - 23 months)	()	**No •**
F.1.1.5	Children (2-11 years)	()	**No •**
F.1.1.6	Adolescents (12-17 years)	()	**No •**
F.1.2	Adults (18-64 years)	(**400**)	**Yes •**
F.1.3	Elderly (>= 65 years)	(**600**)	**Yes •**

F.2	GENDER	
F.2.1	Female	**Yes •**
F.2.2	Male	**Yes •**

F.3	GROUP OF TRIAL SUBJECTS	
F.3.1	Healthy volunteers	**No •**
F.3.2	Patients	**Yes •**
F.3.3	Specific vulnerable populations	**Yes •**
F.3.3.1	Women of child bearing potential not using contraception	**Yes •**
F.3.3.2	Women of child bearing potential using contraception	**Yes •**
F.3.3.3	Pregnant women	**No •**
F.3.3.4	Nursing women	**Yes •**
F.3.3.5	Emergency situation	**Yes •**
F.3.3.6	Subjects incapable of giving consent personally	**Yes •**
F.3.3.6.1	If 'Yes', specify: **English**	**All patients with COVID-19 and severe hypoxia will be temporarily incompetent because of the acute illness, low oxygen saturation and stress-response associated with lack of oxygen.**
F.3.3.7	Others:	**No •**
F.3.3.7.1	If 'Yes', specify:	

F.4	PLANNED NUMBER OF SUBJECTS TO BE INCLUDED:	
F.4.1	In the member state	**1000**
F.4.2	For a multinational trial:	
F.4.2.1	In the EEA	
F.4.2.2	In the whole clinical trial	

F.5	PLANS FOR TREATMENT OR CARE AFTER THE SUBJECT HAS ENDED HIS/HER PARTICIPATION IN THE TRIAL. **please specify** (free text): **English** **None.**

G. CLINICAL TRIAL SITES/INVESTIGATORS IN THE MEMBER STATE CONCERNED BY THIS REQUEST

G.1	CO-ORDINATING INVESTIGATOR (for multicentre trial) and principal investigator (for single centre trial)	
G.1.1	Given name:	**Lothar**
G.1.2	Middle name, if applicable:	
G.1.3	Family name:	**Wiese**
G.1.4	Qualification (MD.....)	**MD, PhD**
G.1.5	Professional address:	
G.1.5	Institution name	**Zealand University Hospital, Roskilde**
G.1.5	Institution department	**Department of Infectious Diseases**
G.1.5.1	Street address	**Sygehusvej 10**
G.1.5.2	Town/city	**Roskilde**
G.1.5.3	Post code	**4000**
G.1.5.4	Country	**Denmark**
G.1.6	Telephone number:	
G.1.7	Fax number:	
G.1.8	E-mail:	

G.1	CO-ORDINATING INVESTIGATOR (for multicentre trial) and principal investigator (for single centre trial)	
G.1.1	Given name:	**Mette**
G.1.2	Middle name, if applicable:	
G.1.3	Family name:	**Friberg**
G.1.4	Qualification (MD.....)	**MD, PhD**
G.1.5	Professional address:	
G.1.5	Institution name	**Zealand University Hospital, Køge**
G.1.5	Institution department	**Internal Medicine Department, Endocrinology**
G.1.5.1	Street address	**Lykkebækvej 1**
G.1.5.2	Town/city	**Køge**
G.1.5.3	Post code	**4600**
G.1.5.4	Country	**Denmark**
G.1.6	Telephone number:	
G.1.7	Fax number:	
G.1.8	E-mail:	

G.1	CO-ORDINATING INVESTIGATOR (for multicentre trial) and principal investigator (for single centre trial)	
G.1.1	Given name:	**Merete**
G.1.2	Middle name, if applicable:	
G.1.3	Family name:	**Storgaard**
G.1.4	Qualification (MD.....)	**MD, Clinical Associate Professor**
G.1.5	Professional address:	
G.1.5	Institution name	**Aarhus University Hospital**
G.1.5	Institution department	**Department of Clinical Medicine - Department of Infectious Diseases**
G.1.5.1	Street address	**Palle Juul-Jensens Boulevard 45**
G.1.5.2	Town/city	**Aarhus N**
G.1.5.3	Post code	**8200**
G.1.5.4	Country	**Denmark**
G.1.6	Telephone number:	
G.1.7	Fax number:	
G.1.8	E-mail:	

G.1	CO-ORDINATING INVESTIGATOR (for multicentre trial) and principal investigator (for single centre trial)

G.1.1	Given name:	**Marie Warrer**
G.1.2	Middle name, if applicable:	
G.1.3	Family name:	**Petersen**
G.1.4	Qualification (MD.....)	**MD**
G.1.5	Professional address:	
G.1.5	Institution name	**Rigshospitalet**
G.1.5	Institution department	**Department of Intensive Care**
G.1.5.1	Street address	**Blegdamsvej 9**
G.1.5.2	Town/city	**Valby**
G.1.5.3	Post code	**2500**
G.1.5.4	Country	**Denmark**
G.1.6	Telephone number:	**0045 30742123**
G.1.7	Fax number:	
G.1.8	E-mail:	**marie.warrer.petersen.01@regionh.dk**

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Marie**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Helleberg**
G.2.4	Qualification (MD.....)	**MD, PhD, DMSc**
G.2.5	Professional address:	
G.2.5	Institution name	**Rigshospitalet**
G.2.5	Institution department	**Department of Infectious Diseases**
G.2.5.1	Street address	**Blegdamsvej 9**
G.2.5.2	Town/city	**2100**
G.2.5.3	Post code	**København Ø**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Niels**
G.2.2	Middle name, if applicable:	**Erikstrup**
G.2.3	Family name:	**Clausen**
G.2.4	Qualification (MD.....)	**MD**
G.2.5	Professional address:	
G.2.5	Institution name	**Bispbjerg Hospital**
G.2.5	Institution department	**Department of Anaesthesia and Intensive Care**
G.2.5.1	Street address	**Bispebjerg Bakke 23**
G.2.5.2	Town/city	**2400**
G.2.5.3	Post code	**København NV**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Klaus**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Tjelle**
G.2.4	Qualification (MD.....)	**MD**
G.2.5	Professional address:	

G.2.5	Institution name	**Hvidovre Hospital**
G.2.5	Institution department	**Department of Anaesthesia and Intensive Care**
G.2.5.1	Street address	**Kettegård Alle 30**
G.2.5.2	Town/city	**Hvidovre**
G.2.5.3	Post code	**2650**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Thomas**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Benfield**
G.2.4	Qualification (MD.....)	**MD, DMSc, Professor**
G.2.5	Professional address:	
G.2.5	Institution name	**Hvidovre Hospital**
G.2.5	Institution department	**Department of Infectious Diseases**
G.2.5.1	Street address	**Kettegård Alle 30**
G.2.5.2	Town/city	**Hvidovre**
G.2.5.3	Post code	**2650**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Charlotte**
G.2.2	Middle name, if applicable:	**Suppli**
G.2.3	Family name:	**Ulrik**
G.2.4	Qualification (MD.....)	**MD, DMSc, Professor**
G.2.5	Professional address:	
G.2.5	Institution name	**Hvidovre Hospital**
G.2.5	Institution department	**Department of Respiratory Medicine**
G.2.5.1	Street address	**Kettegård Alle 30**
G.2.5.2	Town/city	**Hvidovre**
G.2.5.3	Post code	**2650**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Ann-Sofie**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Andreasen**
G.2.4	Qualification (MD.....)	**MD, PhD**
G.2.5	Professional address:	
G.2.5	Institution name	**Herlev Hospital**
G.2.5	Institution department	**Department of Anaesthesia and Intensive Care**
G.2.5.1	Street address	**Borgmester Ib Juuls Vej 1**
G.2.5.2	Town/city	**Herlev**
G.2.5.3	Post code	**2730**
G.2.5.4	Country	**Denmark**

G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Thomas**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Mohr**
G.2.4	Qualification (MD.....)	**MD, PhD**
G.2.5	Professional address:	
G.2.5	Institution name	**Gentofte Hospital**
G.2.5	Institution department	**Department of Intensive Care**
G.2.5.1	Street address	**Gentofte Hospitalsvej 1**
G.2.5.2	Town/city	**Hellerup**
G.2.5.3	Post code	**2900**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Jens Ulrik**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Jensen**
G.2.4	Qualification (MD.....)	**MD, PhD**
G.2.5	Professional address:	
G.2.5	Institution name	**Gentofte Hospital**
G.2.5	Institution department	**Department of Respiratory Medicine**
G.2.5.1	Street address	**Gentofte Hospitalsvej 1**
G.2.5.2	Town/city	**Hellerup**
G.2.5.3	Post code	**2900**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Morten**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Bestle**
G.2.4	Qualification (MD.....)	**MD, PhD**
G.2.5	Professional address:	
G.2.5	Institution name	**North Zealand Hospital**
G.2.5	Institution department	**Department of Anaesthesia and Intensive Care**
G.2.5.1	Street address	**Dyrehavevej 29**
G.2.5.2	Town/city	**Hillerød**
G.2.5.3	Post code	**3400**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**David**
G.2.2	Middle name, if applicable:	**Levarett**
G.2.3	Family name:	**Buck**
G.2.4	Qualification (MD.....)	**MD**
G.2.5	Professional address:	
G.2.5	Institution name	**Holbæk Hospital**
G.2.5	Institution department	**Department of Anaesthesiology**
G.2.5.1	Street address	**Smedelundsgade 60**
G.2.5.2	Town/city	**Holbæk**
G.2.5.3	Post code	**4300**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Lone**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Poulsen**
G.2.4	Qualification (MD.....)	**MD**
G.2.5	Professional address:	
G.2.5	Institution name	**Zealand University Hospital, Køge**
G.2.5	Institution department	**Department of Anaesthesia and Intensive Care**
G.2.5.1	Street address	**Lykkebækvej 1**
G.2.5.2	Town/city	**Køge**
G.2.5.3	Post code	**4600**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Thomas**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Hildebrandt**
G.2.4	Qualification (MD.....)	**MD**
G.2.5	Professional address:	
G.2.5	Institution name	**Zealand University Hospital, Roskilde**
G.2.5	Institution department	**Department of Anaesthesia and Intensive Care**
G.2.5.1	Street address	**Sygehusvej 10**
G.2.5.2	Town/city	**Roskilde**
G.2.5.3	Post code	**4000**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Helle**
G.2.2	Middle name, if applicable:	**Scharling**
G.2.3	Family name:	**Pedersen**

G.2.4	Qualification (MD.....)	**MD**
G.2.5	Professional address:	
G.2.5	Institution name	**Nykøbing F. Sygehus**
G.2.5	Institution department	**Department of Anaesthesia**
G.2.5.1	Street address	**Fjordvej 15**
G.2.5.2	Town/city	**Nykøbing F.**
G.2.5.3	Post code	**4800**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Anders**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Møller**
G.2.4	Qualification (MD.....)	**MD**
G.2.5	Professional address:	
G.2.5	Institution name	**Slagelse Hospital**
G.2.5	Institution department	**Department of Anaesthesia**
G.2.5.1	Street address	**Ingemanns vej 18**
G.2.5.2	Town/city	**Slagelse**
G.2.5.3	Post code	**4200**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Christoffer**
G.2.2	Middle name, if applicable:	**G.**
G.2.3	Family name:	**Sølling**
G.2.4	Qualification (MD.....)	**MD, PhD**
G.2.5	Professional address:	
G.2.5	Institution name	**Viborg Hospital**
G.2.5	Institution department	**Department of Anaesthesia and Intensive Care**
G.2.5.1	Street address	**Heibergs Alle 5A**
G.2.5.2	Town/city	**Viborg**
G.2.5.3	Post code	**8800**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Anne**
G.2.2	Middle name, if applicable:	**Craveiro**
G.2.3	Family name:	**Brøchner**
G.2.4	Qualification (MD.....)	**MD, PhD**
G.2.5	Professional address:	
G.2.5	Institution name	**Kolding Hospital**
G.2.5	Institution department	**Department of Anaesthesia and Intensive Care**
G.2.5.1	Street address	**Sygehusvej 24**
G.2.5.2	Town/city	**Kolding**

G.2.5.3	Post code	**6000**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Bodil**
G.2.2	Middle name, if applicable:	**Steen**
G.2.3	Family name:	**Rasmussen**
G.2.4	Qualification (MD.....)	**MD, PhD, Professor**
G.2.5	Professional address:	
G.2.5	Institution name	**Aalborg University Hospital**
G.2.5	Institution department	**Department of Anaesthesia and Intensive Care**
G.2.5.1	Street address	**Hobrovej 18-22**
G.2.5.2	Town/city	**Aalborg**
G.2.5.3	Post code	**9000**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Henrik**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Nielsen**
G.2.4	Qualification (MD.....)	**MD, DMSc, Professor**
G.2.5	Professional address:	
G.2.5	Institution name	**Aalborg University Hospital**
G.2.5	Institution department	**Deparment of Infectious Diseases**
G.2.5.1	Street address	**Hobrovej 18-22**
G.2.5.2	Town/city	**Aalborg**
G.2.5.3	Post code	**9000**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Steffen**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Christensen**
G.2.4	Qualification (MD.....)	**MD, PhD**
G.2.5	Professional address:	
G.2.5	Institution name	**Aarhus University Hospital**
G.2.5	Institution department	**Department of Anaesthesia and Intensive Care**
G.2.5.1	Street address	**Palle Juul-Jensens Boulevard 99**
G.2.5.2	Town/city	**Aarhus N**
G.2.5.3	Post code	**8200**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Thomas**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Strøm**
G.2.4	Qualification (MD.....)	**MD, PhD**
G.2.5	Professional address:	
G.2.5	Institution name	**Odense University Hospital**
G.2.5	Institution department	**Department of Anaesthesia and Intensive Care**
G.2.5.1	Street address	**J. B. Winsløws vej 4**
G.2.5.2	Town/city	**Odense C**
G.2.5.3	Post code	**5000**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Isik**
G.2.2	Middle name, if applicable:	**Somuncu**
G.2.3	Family name:	**Johansen**
G.2.4	Qualification (MD.....)	**MD, DMSc, Professor**
G.2.5	Professional address:	
G.2.5	Institution name	**Odense University Hospital**
G.2.5	Institution department	**Department of Infectious Diseases**
G.2.5.1	Street address	**J. B. Winsløws vej 4**
G.2.5.2	Town/city	**Odense C**
G.2.5.3	Post code	**5000**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.2	**PRINCIPAL INVESTIGATORS** ***(for multicentre trial ; where necessary, use additional forms)***	
G.2.1	Given name:	**Vibeke**
G.2.2	Middle name, if applicable:	
G.2.3	Family name:	**Jørgensen**
G.2.4	Qualification (MD.....)	**MD, PhD**
G.2.5	Professional address:	
G.2.5	Institution name	**Rigshospitalet**
G.2.5	Institution department	**Department of Thoracic Anaesthesiology**
G.2.5.1	Street address	**Blegdamsvej 9**
G.2.5.2	Town/city	**København Ø**
G.2.5.3	Post code	**2100**
G.2.5.4	Country	**Denmark**
G.2.6	Telephone number:	
G.2.7	Fax number:	
G.2.8	E-mail:	

G.3	**CENTRAL TECHNICAL FACILITIES TO BE USED IN THE CONDUCT OF THE TRIAL**
	Laboratory or other technical facility, in which the measurement or assessment of the main evaluation criteria are centralised (repeat as needed for multiple organisations).

G.3.1	Name of organisation:	
G.3.2	Department	
G.3.3	Name of contact person:	
G.3.3.1	Given name	
G.3.3.2	Middle name	
G.3.3.3	Family name	
G.3.4	Address:	
G.3.4.1	Street address	
G.3.4.2	Town/city	
G.3.4.3	Post code	
G.3.4.4	Country	
G.3.5	Telephone number:	
G.3.6	Fax number:	
G.3.7	E-mail:	
G.3.8	Enter the details of any duties subcontracted to this central technical facility in this trial	
G.3.8.1	Routine clinical pathology testing	**Yes ? No ? Not Answered ?**
G.3.8.2	Clinical chemistry	**Yes ? No ? Not Answered ?**
G.3.8.3	Clinical haematology	**Yes ? No ? Not Answered ?**
G.3.8.4	Clinical microbiology	**Yes ? No ? Not Answered ?**
G.3.8.5	Histopathology	**Yes ? No ? Not Answered ?**
G.3.8.6	Serology/ endocrinology	**Yes ? No ? Not Answered ?**
G.3.8.7	Analytical chemistry	**Yes ? No ? Not Answered ?**
G.3.8.8	ECG analysis/ review	**Yes ? No ? Not Answered ?**
G.3.8.9	Medical image analysis/ review - X-ray, MRI, ultrasound, etc.	**Yes ? No ? Not Answered ?**
G.3.8.10	Primary/ surrogate endpoint test	**Yes ? No ? Not Answered ?**
G.3.8.11	Other Duties subcontracted?	**Yes ? No ? Not Answered ?**
G.3.8.11.1	If 'Yes', specify the other duties	

G.4	**NETWORKS TO BE INVOLVED IN THE TRIAL (e.g. Paediatric Networks involved in the trial)**	
G.4.1	Name of organisation:	**Copenhagen Trial Unit, Centre for Interventional Research**
G.4.2	Name of contact person:	
G.4.2.1	Given name	
G.4.2.2	Middle name	
G.4.2.3	Family name	
G.4.3	Address:	
G.4.3.1	Street address	**Tagensvej 22**
G.4.3.2	Town/city	**Copenhagen**
G.4.3.3	Post code	**2200**
G.4.3.4	Country	**Denmark**
G.4.4	Telephone number:	
G.4.5	Fax number:	
G.4.6	E-mail:	
G.4.7	Activities carried out by the network: **Methods center**	

G.5	**ORGANISATIONS TO WHOM THE SPONSOR HAS TRANSFERRED TRIAL RELATED DUTIES AND FUNCTIONS**	
G.5.1	**Has the sponsor transferred any major or all the sponsor's trial related duties and functions to another organisation or third party?**	**Yes •**
Repeat as necessary for multiple organisations:		
G.5.1.1	Organisation name:	**Copenhagen University Hospital GCP Unit**
G.5.1.2	Organisation department	
G.5.1.3	Name of contact person :	
G.5.1.3.1	Given name	

G.5.1.3.2	Middle name	
G.5.1.3.3	Family name	
G.5.1.4	Address:	
G.5.1.4.1	Street address	**Nordre Fasanvej 57, Skadestuevej 1, parterre**
G.5.1.4.2	Town/city	**Frederiksberg**
G.5.1.4.3	Post code	**2000**
G.5.1.4.4	Country	
G.5.1.5	Telephone number:	**0045 28635620**
G.5.1.6	Fax number:	
G.5.1.7	E-mail:	**gcp-enheden.bispebjerg-frederiksberg-hospitaler@regionh.dk**
G.5.1.8	All tasks of the sponsor	**No •**
G.5.1.9	Monitoring	**Yes •**
G.5.1.10	Regulatory (e.g. preparation of applications to CA and ethics committee)	**No •**
G.5.1.11	Investigator recruitment	**No •**
G.5.1.12	IVRS[30] – treatment randomisation	**No •**
G.5.1.13	Data management	**No •**
G.5.1.14	E-data capture	**No •**
G.5.1.15	SUSAR reporting	**No •**
G.5.1.16	Quality assurance auditing	**No •**
G.5.1.17	Statistical analysis	**No •**
G.5.1.18	Medical writing	**No •**
G.5.1.19	Other duties subcontracted?	**No •**
G.5.1.19.1	If 'Yes' to other, please specify:	

H. COMPETENT AUTHORITY / ETHICS COMMITTEE IN THE MEMBER STATE CONCERNED BY THIS REQUEST

H.1	TYPE OF APPLICATION	
If this application is addressed to the Competent Authority, please tick the Ethics Committee box and give information on the Ethics committee concerned. If this application is addressed to the Ethics Committee, please tick the Competent Authority box and give the information on the Competent Authority concerned.		
H.1.1	Competent Authority	**No •**
H.1.2	Ethics Committee	**Yes •**

H.2	INFORMATION ON ETHICS COMMITTEE	
H.2.1	Name:	**The Committees for Health Research Ethics for the Capital Region of Denmark**
H.2.2	Address	
H.2.2.1	Street address	**Kongens Vænge 2**
H.2.2.2	Town/city	**Hillerød**
H.2.2.3	Post code	**3400**
H.2.2.4	Country	**Denmark**
H.2.3	Date of submission:	

H.3	OPINION	
H.3.1	To be requested	**Yes •**
H.3.2	Pending	**No •**
H.3.3	Given	**No •**
	If 'Given', specify:	
H.3.3.1	Date of opinion:	
H.3.3.2	Opinion favourable	**No •**
H.3.3.3	Opinion not favourable	**No •**
	If not favourable, give:	
H.3.3.3.1	The reasons	
H.3.3.3.2	The eventual anticipated date of resubmission:	

I. SIGNATURE OF THE APPLICANT IN THE MEMBER STATE

I.1	I hereby confirm that /confirm on behalf of the sponsor (delete which is not applicable) that: • the information provided is complete; • the attached documents contain an accurate account of the information available; • the clinical trial will be conducted in accordance with the protocol; and • the clinical trial will be conducted, and SUSARs and result-related information will be reported, in accordance with the applicable legislation.

I.2	**APPLICANT OF THE REQUEST FOR THE COMPETENT AUTHORITY** (as stated in section C.1):
I.2.1	Date: 3/4/2020
I.2.2	Signature[31]:
I.2.3	Print name: A. PERNER

I.3	**APPLICANT OF THE REQUEST FOR THE ETHICS COMMITTEE** (as stated in section C.2):
I.3.1	Date:
I.3.2	Signature[32]:
I.3.3	Print name: