

**DIRECTIONS**

- All ISS requests must be unsolicited. This ISS Concept Form must be independently completed by the requestor and submitted to Adamas Medical Affairs.
- ISS research grants may be provided to independent third parties in support of independent scientific and clinical research that align with Adamas Pharmaceuticals therapeutic areas of interests.
- Adamas personnel may not guarantee funding of an ISS research grant prior to review of the study concept, and they may not assist ISS grant requestors in developing protocols or budgets, or handling day-to-day research or administrative tasks.

| GRANT REQUESTOR INFORMATION   |                              |
|---|------------------------------|
| Requestor's Name & Title:   |                              |
| Requestor's Degree/Credentials:   |                              |
| Requestor's State License(s) & NPI number(s), if applicable:              |                              |
| Requestor's Specialty:  |                              |
| Requestor's Institution's Name:   |                              |
| Requestor's Intuition's Address:  |                              |
| Requestor's Phone:  | Requestor's Fax:             |
| Requestor's Email Address:  |                              |
| PRIMARY INVESTIGATOR INFORMATION  |                              |
| <input type="checkbox"/> Please check if information is the same as above |                              |
| Primary Investigator(s) Name(s) & Title(s):                               |                              |
| Primary Investigator(s) Degree(s)/Credential(s):                          |                              |
| Primary Investigator(s) State License(s) & NPI number(s), if applicable:  |                              |
| Primary Investigator(s) Specialty(ies):                                   |                              |
| Primary Investigator(s) Institution(s):                                   |                              |
| Primary Investigator(s) Institution Address(es):                          |                              |
| Primary Investigator(s) Phone(s):   | Primary Investigator(s) Fax: |
| Primary Investigator(s) email address(es):                                |                              |

| STUDY INFORMATION  |  |
|--|--|
| Please check if study is: <input type="checkbox"/> Pre-clinical or <input type="checkbox"/> Clinical                   | If Pre-clinical, only fields below with an asterisk (*) are needed |
| *Study Title:  |  |
| *Therapeutic Area:   |  |
| *Primary Product:  |  |
| *Have You Contacted Anyone at Adamas Regarding this Study?   |  |
| *Scientific Basis/ Rationale:  |  |
| *Hypothesis:   |  |
| *Study Objective(s):   |  |
| Trial Design Type: (Randomized, Non-Randomized, Retrospective, Registry, Open-Label, Single-blind, Double-blind, etc.) |  |
| Study Phase: (Phase 1, 2, 3, 4)  | Number of Sites:   |
| Treatment Regimen:   |  |
| Inclusion Criteria:  |  |
| Exclusion Criteria:  |  |
| Primary Endpoint:  |  |
| Secondary Endpoint:  |  |
| Sample Size/ Statistical Analysis:   |  |

Safety/ Risk Plan for Study:

**ENROLLMENT/ MILESTONES**

Total # of Subjects Expected to Be Enrolled?

Duration of Enrollment Period:

**REGULATORY INFORMATION**

Do you plan to file any regulatory document: (e.g. IND)?

Yes  No

**PLANNED PUBLICATIONS**

Please provide timing and delivery of study output/ final data?

**STUDY SUPPORT**

Type & Amount of Support Requested:

Estimated Total Cost/Funding:

Have you received, or will receive funding from another source outside of Adamas Pharmaceuticals for this study?

Yes  No If Yes, please comment:

Additional Attachments:

See Study Description Attachment

**\*INTERNAL ADAMAS USE ONLY\***  
**REVIEWED & APPROVED BY**

Medical Science Liaison's Name (optional):

Research Grant Review Committee Administrator Name:

Research Grant Review Committee Action:  Approved  Not approved

Signature: \_\_\_\_\_

Date: \_\_\_\_\_