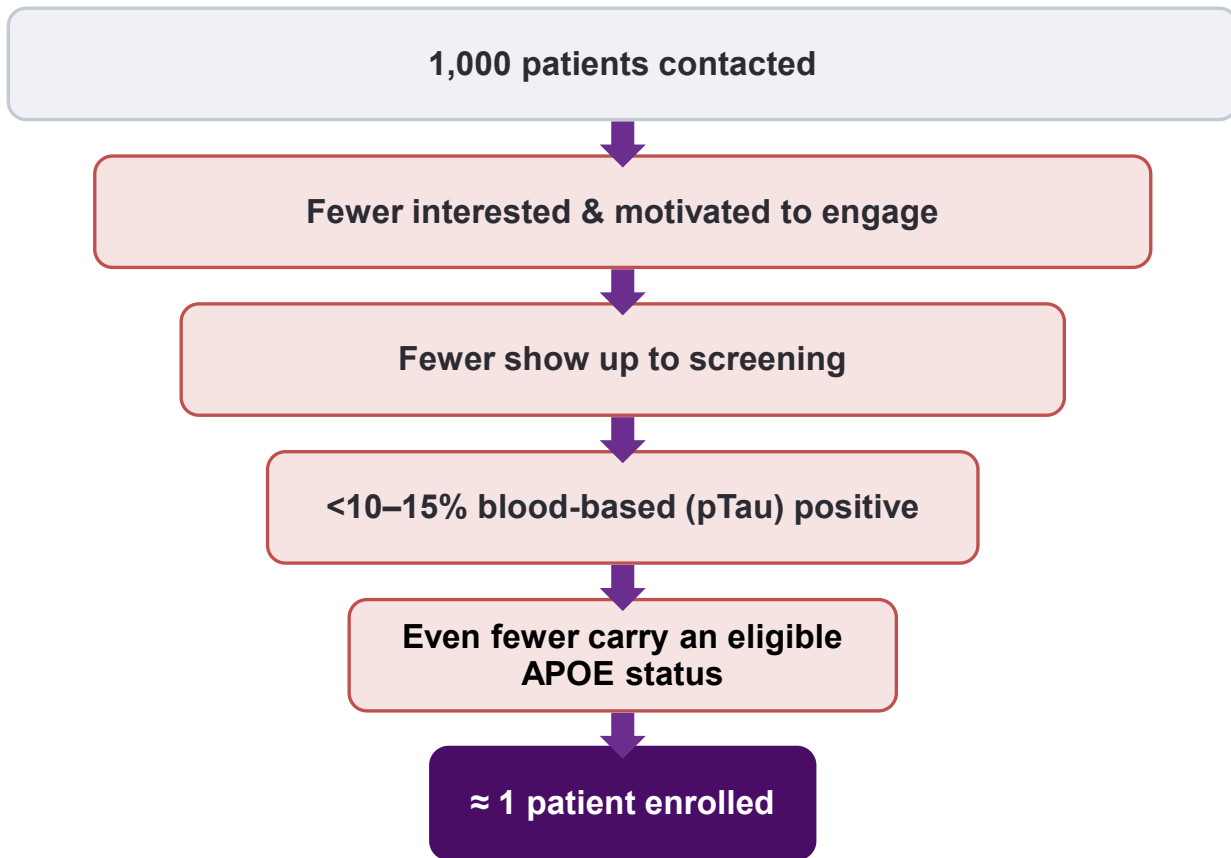
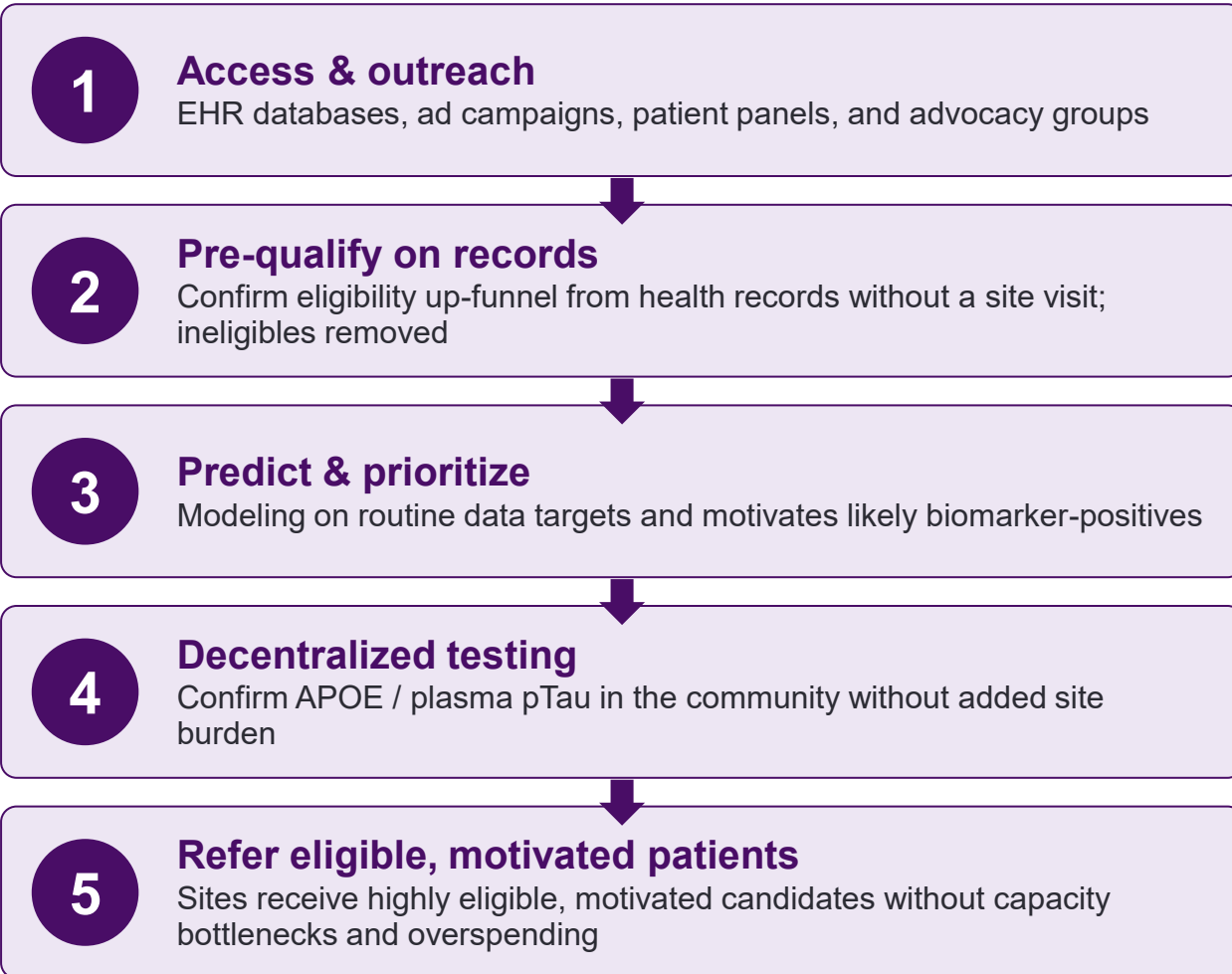


Pre-Screening Protocols as a Scalable Infrastructure for Precision Recruitment in Preclinical Alzheimer’s Disease Trials

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Conducting decentralized, EHR-enabled pre-screening upstream of trial sites builds biomarker-enriched, data-driven trial-ready cohorts: delivering 1.5×+ biomarker positivity, up to 10× lower screen-fail rates, and 90% candidate pull-through in preclinical AD versus traditional site-based screening

INTRODUCTION	METHODS	RESULTS	CONCLUSIONS	REFERENCES																					
AD research is shifting toward earlier, biomarker-defined intervention. In preclinical AD, eligible patients are largely asymptomatic: hard to find, hard to motivate, and hard to confirm. Traditional site-based screening pushes broad, research-naïve referrals to sites, then saves the most expensive step, biomarker confirmation, for last. The result: low biomarker positivity, high screen-failure, and heavy site burden. Without standardized pre-screening infrastructure, trial feasibility for asymptomatic populations is limited.	SiteRx runs decentralized pre-screening upstream of trial sites, integrating: A. Longitudinal structured + unstructured EHR data from the largest US neuro-focused real-world database B. Risk modeling of biomarker positivity (APOE, plasma pTau) C. Protocolized consent, cognitive testing & decentralized biomarkers Candidates are centrally pre-qualified before referral via a “virtual site” with real-time funnel visibility.	Across multiple preclinical AD studies, decentralized pre-screening improved recruitment efficiency: predictive modeling flagged biomarker-likely patients with >65% accuracy, and trial-ready cohorts built before site activation accelerated enrollment and referral-to-randomization conversion. <table><tr><td></td><td>Traditional Model</td><td>Pre-Screening Protocol</td></tr><tr><td>CLINICAL</td><td></td><td></td></tr><tr><td>Biomarker (pTau) positivity</td><td>≤10–15%</td><td>20–30% (1.5×+)</td></tr><tr><td>APOE 4/4 eligibility</td><td><5%</td><td>Up to 15% (≈3×)</td></tr><tr><td>Screen-failure rate</td><td>~95%</td><td>Up to 10× fewer screens</td></tr><tr><td>LOGISTICAL</td><td></td><td></td></tr><tr><td>Candidate pull-through</td><td>50–60%</td><td>up to 90%</td></tr></table> Comparisons are illustrative of pre-screened cohorts vs. standard site-based referral across aggregated preclinical AD programs: biomarker (plasma pTau) positivity, APOE 4/4 genotype eligibility, study-wide screen-failure, and candidate pull-through (share completing pre-screening). Figures to be source-verified. Pre-screened cohorts allow sites to screen far fewer people to randomize each participant.		Traditional Model	Pre-Screening Protocol	CLINICAL			Biomarker (pTau) positivity	≤10–15%	20–30% (1.5×+)	APOE 4/4 eligibility	<5%	Up to 15% (≈3×)	Screen-failure rate	~95%	Up to 10× fewer screens	LOGISTICAL			Candidate pull-through	50–60%	up to 90%	Pre-screening protocols are a paradigm shift: from passive, site-driven screening to proactive, data-driven cohort generation. Integrating real-world data, predictive modeling, and decentralized biomarker testing in one standardized framework enables scalable enrichment of eligible populations. Initiating protocols before site activation builds trial-ready cohorts that accelerate timelines and improve referral-to-randomization conversion. The model is modality-agnostic and adaptable across biomarker strategies and therapeutic programs. Standardized, decentralized pre-screening can make preclinical AD trials faster, more representative, and more feasible, reaching patients who would never have reached a traditional site.	1. FDA. Diversity Action Plans to Improve Enrollment of Participants from Underrepresented Populations in Clinical Studies. 2024. 2. Bateman RJ, et al. N Engl J Med. 2023;389:1862–1876. 3. Boess FG, et al. REACHED pilot study. CTAD 2025. All performance metrics are derived from de-identified, aggregated SiteRx real-world data accessed for these purposes, across multiple preclinical AD programs. SiteRx real-world data is generated through healthcare-operations services provided to physicians via an independent SiteRx practice-services division; all data is de-identified.
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Figure 1. The preclinical AD recruitment challenge Illustrative purposes only; Asymptomatic patients are low-motivation, so broad outreach is required:  Each step multiplies the funnel; precision biomarker and genetic criteria cut the population further. Broad targeting is historically required, resulting in slow, costly, and low-yield recruitment.	Figure 2. Flipping the funnel upstream of the site  How records reach the funnel before the site Candidates are found in real-world data. With patient authorization, SiteRx retrieves longitudinal structured and unstructured EHR from their treating physicians. Records are reviewed against protocol I/E and scored by predictive models, so only pre-qualified, biomarker-likely patients advance. Decentralized cognitive and APOE / plasma-pTau testing confirm eligibility in the community, while a virtual-site layer coordinates consent, navigation, and real-time funnel visibility. As a result, ineligible patients and avoidable tests are kept out of the site.	Figure 3. Traditional Model vs. SiteRx Pre-Screening Protocol <table><tr><th>Traditional Model</th><th>Pre-Screening Protocol</th></tr><tr><td> ✗ Sites bear every step ✗ Records pulled at / after first visit ✗ Ineligibles burn costly biomarker tests ✗ Fragmented hand-offs & patient drop-off ✗ Heavy burden slows site activation </td><td> ✓ Central layer absorbs intake testing ✓ Records pulled upstream of sites ✓ Ineligibles ruled out before costly tests ✓ Warm hand-off of pre-qualified cohort ✓ Lower burden; faster, broader activation </td></tr></table> Outcome: Biomarker-confirmed, trial-ready cohorts built before site activation, with up to 10× lower screen-failures and up to 90% pull-through.	Traditional Model	Pre-Screening Protocol	✗ Sites bear every step ✗ Records pulled at / after first visit ✗ Ineligibles burn costly biomarker tests ✗ Fragmented hand-offs & patient drop-off ✗ Heavy burden slows site activation	✓ Central layer absorbs intake testing ✓ Records pulled upstream of sites ✓ Ineligibles ruled out before costly tests ✓ Warm hand-off of pre-qualified cohort ✓ Lower burden; faster, broader activation	The SiteRx Pre-Screening Approach <table><tr><td>Centralized infrastructure One virtual site filters every source, cutting dropout</td><td>Intelligent filtering Predictive models + record review stop ineligibles early</td></tr><tr><td>Testing efficiency Streamlined decentralized workflows lift test completion</td><td>Enriched populations Targets likely biomarker-positives to boost eligibility</td></tr><tr><td>Site coordination Existing site ties + records speed entry to screening</td><td>Reduced screen fails Pre-qualification against I/E raises site pass rates</td></tr></table>	Centralized infrastructure One virtual site filters every source, cutting dropout	Intelligent filtering Predictive models + record review stop ineligibles early	Testing efficiency Streamlined decentralized workflows lift test completion	Enriched populations Targets likely biomarker-positives to boost eligibility	Site coordination Existing site ties + records speed entry to screening	Reduced screen fails Pre-qualification against I/E raises site pass rates	CONTACT  Daniel Gautieri, SiteRx daniel@siterx.com 101 6th Ave, Floor 10, New York, NY 10013 ALZHEIMER'S ASSOCIATION AAIC>26 About SiteRx SiteRx is on a mission to democratize access to clinical research as a treatment alternative, advancing healthcare and health outcomes for patients and their loved ones today. Learn more by scanning the QR code.											
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