CRF Completion Guidelines

IDCRC-21-0012

Version 9.0

CRF Completion Guidelines

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Protocol Number:	IDCRC21-0012
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CRF Completion Guidelines

The following instructions are study-specific data completion instructions intended to assist site staff when completing electronic case report forms (eCRFs) and paper case report forms (CRFs). Detailed guidance on general data collection, entry, navigation, and general use of Medidata Rave is provided in the Medidata Rave Electronic Data Capture (EDC) Training Manual, which is found on the IDC003-21-0012 Protocol page: https://atlas.scharp.org/cpas/project/IDCRC/DMID%2021-0012/begin.view?

General Guidelines

- The Participant ID is automatically assigned by Rave EDC as a 9-digit field, starting with the 3-digit site number followed by a randomly assigned 5-digit participant number, and 1-digit check number.
- All data entered in Rave must match the data on any source documents/paper CRFs.
- Complete all required data fields. Ensure that all entries are in English and are accurate, consistent, complete, and medically logical.
- If “Other” is chosen as a response, further details must be provided by responding to the “If ‘Other’, specify” field.
- Text box fields have character limits. Text exceeding the limit will not be saved and a “Non-conformant” icon will appear.
- Visit dates must be complete and in chronological order according to the protocol.
- Most date fields must be entered as Day/Month/Year (dd/mmm/yyyy) (e.g., 01 NOV 2020). Exceptions are detailed in specific form sections where applicable.
- Drop-down menus are available for many fields. Use these menus, when available, to select the appropriate response.
- Avoid using abbreviations, symbols, or special characters.
- Avoid hitting the return or enter key in text fields.
- If a scheduled visit is missed, do not enter data on the forms required for the visit, except for the Follow-up Visit Y/N form. Marking “no” on the “Follow-up Visit Y/N” form will add the “Missed Visit” form to the visit folder for completion.
- Log forms allow you to make multiple entries over the course of the study. All entries at the same time in “Complete View” and “View individual entries” in portrait view.
- The following log forms for this study are available in the ongoing logs folder at the bottom of the sidebar on the Participant’s home page:
    - Medical History
    - Concomitant Medications
    - Adverse Event
    - Protocol Deviations
- Correct/update data fields by clicking the pencil icon at the far right of the field, correct/update the value and give the reason for the change, if applicable. Save the form to apply the changes.
- If an incorrect data entry is made, a system query will fire. Correct the error and save the form.

- System generated queries that do not contain a query response will automatically close with a form correction.
- System generated queries with a query response will change into a manual query that will need to be closed by the data management team.

- All actions performed on a data field are tracked in the audit trail. If data is modified inadvertently, the change is also shown in the audit trail for that field.
- The site Principal Investigator (PI), or Co-Investigator, will sign all forms after the participant's data has been reviewed. After the signature is applied, no further changes or additions to the forms are expected.
- Any modifications that are made to forms after the PI or Co-I have signed off will remove the signature. Once the data has been reviewed, the signature will need to be applied again.
- The SCHARP Clinical Data Manager will provide direction for when the Investigator should perform the final review and sign the eCRF pages.

Add Event

- The **Add Event** drop-down menu can add select forms and visit folders to a participant's casebook.
- Folders available in **Add Event**:
  - Interim Visit
  - Pregnancy

Interim Visits

- Add an Interim Visit folder to a participant's casebook by clicking on the **Add Event** button on the PTID (Subject)-level page and selecting "Interim Visit", then clicking "Add". An Interim Visit folder will appear in the participant's casebook.
- Open the Interim Visit folder to access the Interim Visit form. On the Interim Visit form, select the forms that were completed at the interim visit. The selected forms will then load in the folder.
- On the Interim Visit form, enter the visit date as the earliest date visit procedures were performed for that interim visit.

Loading of Forms in Visit Folder

- Medidata Rave will add forms to a visit folder in a participant's casebook based on specified responses on forms. Below are a few key examples.
  - **Example 1**: Follow-up Visit Y/N form
    - If question "Did the participant complete this visit" is marked "No", the Missed Visit form will add to the visit folder and the required forms for that visit will not appear in the visit folder.
    - Most forms under "Additional Procedures/Forms" on the Follow-up Visit Summary form that are checked will be added to the visit folder. If a checked form does not load, please contact the study clinical data manager, who will load the form manually.
  - **Example 2**: Interim Visit form
    - Forms under "What study procedures were completed at this visit?" on the Interim Visit form that are checked will be added to the Interim Visit folder.

Loading of Folders in Participant Casebook

- Medidata Rave will add folders to a participant's casebook based on how certain forms are completed. See Table 1 for actions required to add folders to a participant's casebook.

Table 1. Folder Dynamics

Folder	Action Required to Add Folder
V0 – Screening Date of Visit – C1/C2 V1 – Enrollment – C1/C2 Ongoing Logs	Save Participant Identifier form.
V2 – Day 8 – Phone Visit – C1 V3 – Day 15 – C1 V4 – Day 29 – C1 V5 – Day 91 – C1 V6 – Day 169 – C1 V7 – Day 366 – C1 Discontinuations	Select "Cohort 1" for the question "Was this participant enrolled into Cohort 1 or Cohort 2? On the Enrollment CRF and save the form.
V102 – Day 8 – Phone Visit – C2 V103 – Day 29 – C2 V104 – Day 36 – Phone Visit – C2 V105 – Day 43 – C2 V106 – Day 1B – C2 V107 – Day 8B – Phone Visit – C2 V108 – Day 15B – C2 V109 – Day 29B – C2 V110 – Day 91B – C2 V111 – Day 169B – C2 V112 – Day 366B – C2 Discontinuations	Select "Cohort 2" for the question "Was this participant enrolled into Cohort 1 or Cohort 2? On the Enrollment CRF and save the form.
Interim Visit	Select "Interim Visit" from the Add Event menu.
Pregnancy	Select "Pregnancy" from the Add Event menu.

Dynamic Search Lists

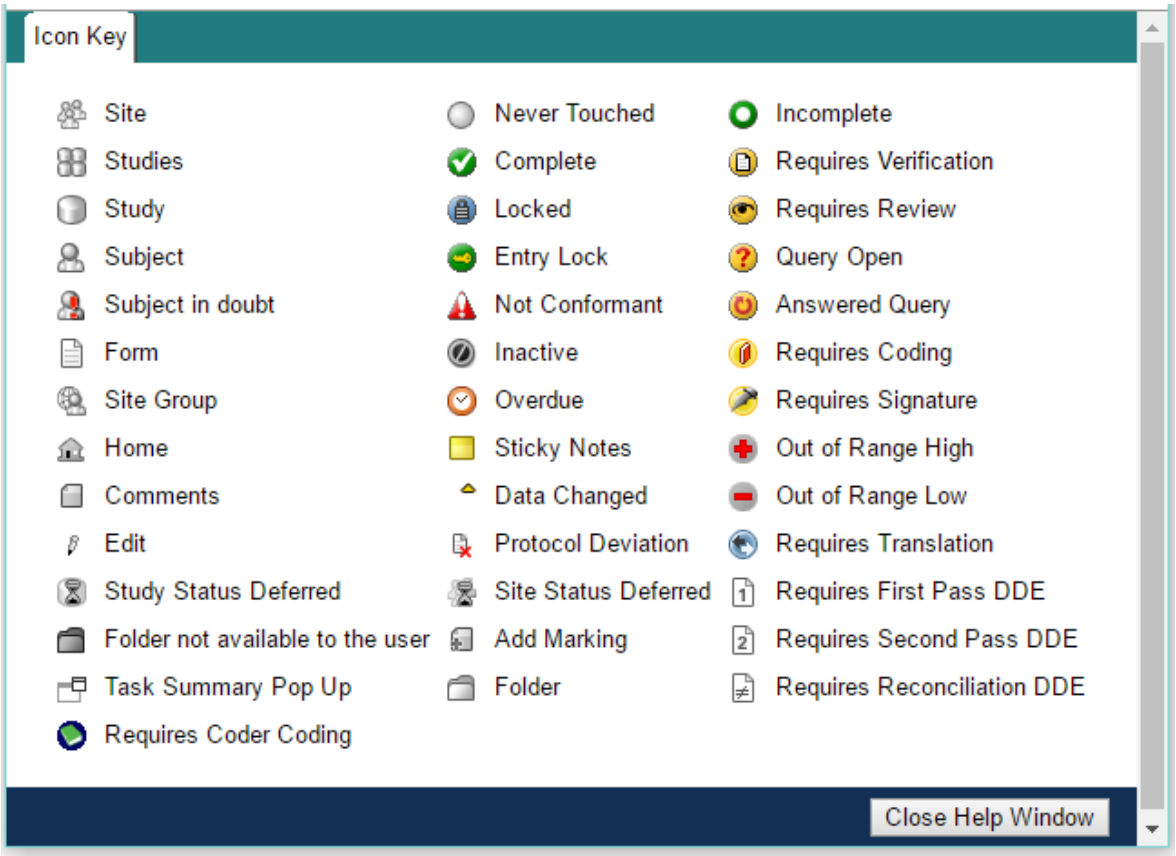
- Some forms have data fields with 'dynamic' drop-down lists of available options. Options are populated by corresponding log form entries.
- Dynamic drop-down lists will be blank until entries are made and saved in the corresponding log form.
- Your selection in the dynamic search list can be deleted if entered in error.
- Changing the original log data or inactivating a log form entry that has been selected for a dynamic search list field, will make that field non-conformant and it will need to be updated.

- For Example:
  - An AE of "*FEVER*" started on 05APR2021 and is reported on the Adverse Events log form
  - On the Concomitant Medications log form, if a listed medication was used for this AE, a dynamic search list can be used to select the applicable AE record from the dropdown list.
  - The start date for AE "*FEVER*" is corrected to 06APR2021 on the Adverse Events log form.
  - The selection on the Concomitant Medication log form becomes non-conformant.
  - To resolve the non-conformant data, re-select the AE "*FEVER*" from the dynamic search list with the corrected start date.

Icon Key

A link to an Icon Key is available on the PTID (Subject)-level page. The key contains pictures and descriptions of the icons used in Rave. Below is a screen shot of the Icon Key.

Figure 1. Icon Key

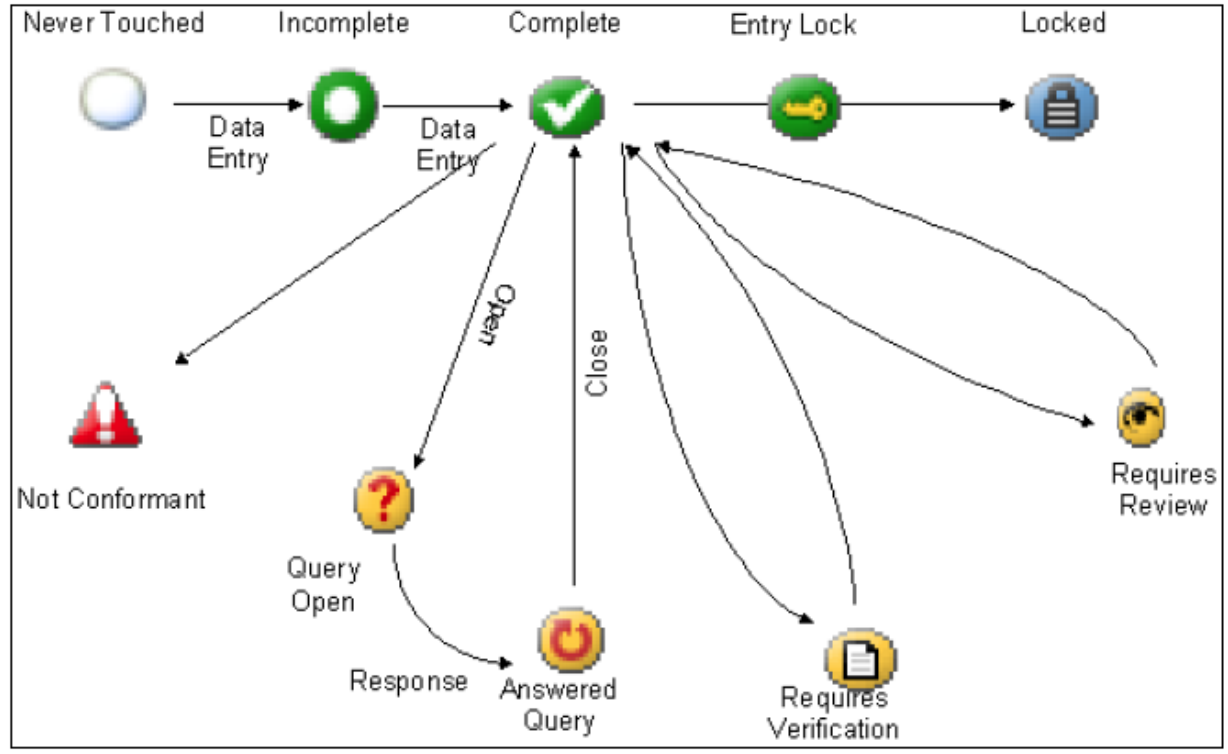


Icon Progression

The life cycle of participants, folders, forms, and fields follows a logical progression starting with “never touched” and moving toward “complete” and “locked”. Graphical icons are used throughout Rave to show status.

The following figure illustrates the status represented by each icon and the progression of icons through the life cycle.

Figure 2. Icon Progression



Task Summary

The Task Summary displays all pending tasks for the study. It displays the number of participants with outstanding tasks that need site review (see Figure 3); for example, open queries. Clicking on the arrow next to the task expands it to show the specific participants with open queries (see Figure 4). Clicking on a PTID will open the participant's casebook.

Figure 3. Site-Level Task Summary

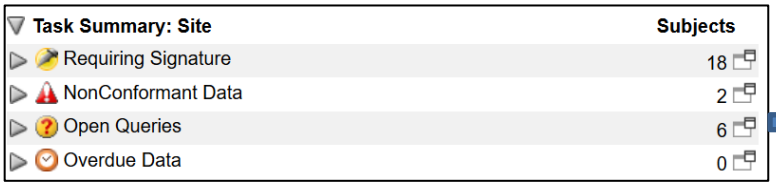
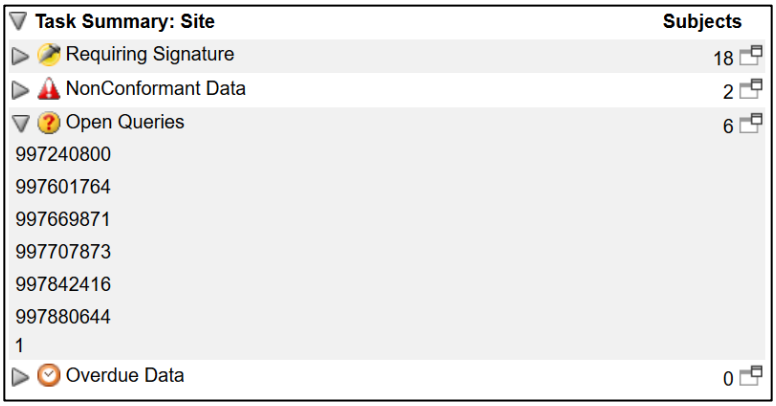
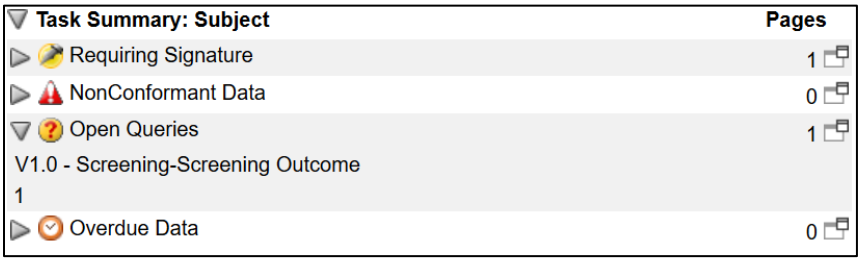


Figure 4. Site-Level Task Summary



At the Subject level, the Task Summary displays the number of pages for that participant that need site review. In Figure 5 below, there is one open query on the Screening Outcome form at v1.0 – Screening. In the expanded task summary view, clicking on this form link will open the form.

Figure 5. Subject-Level Task Summary



General Guidelines – Paper CRF Completion

CRF PDFs are generated from Rave and posted on the Atlas protocol webpage at https://atlas.scharp.org/cpas/project/IDCRC/DMID%2021-0012/begin.view?. Paper CRFs are not required, however when choosing to complete a paper CRF prior to entering data into the eCRF, refer to detailed instructions for data collection pertaining to the specific form and fields on that form in this document.

- Based on Good Clinical Practices (GCPs), refer to the following guidelines to complete paper CRFs:
  - Use a black or dark blue medium ballpoint pen. Do not use any other type of writing tool.
  - Print all data and comments legibly by hand. Do not use cursive/script handwriting.
  - Record data on the front side of the paper only.
  - If the spaces/lines provided for a response are not large enough, continue in another blank area of the paper CRF.
  - Mark only one answer unless instructions state to mark or select all that apply.
  - A response is required for every data field unless skip instructions are provided.
  - Do not use correction fluid (“White-Out”) or correction tape on paper CRFs.

Recording Dates – Rave Form and/or Paper CRF

- Dates are entered using the “dd MMM yyyy” format, where “dd” represents the two-digit day, “MMM” represents the three-letter abbreviation of the month (in capital letters), and “yyyy” represents the four digits of the year.
- Month abbreviations are shown below. In Rave EDC, these abbreviations are in a drop-down list in the month field.

Month	Abbreviation	Month	Abbreviation
January	JAN	July	JUL
February	FEB	August	AUG
March	MAR	September	SEP
April	APR	October	OCT
May	MAY	November	NOV
June	JUN	December	DEC

For example, record September 20, 2016 as:

Recording Time – Rave Form and/or Paper CRF

- Use a 24-hour clock (00:00-23:59), where hours are designated from 0–23.
- Midnight is recorded as 00:00, not 24:00.

The following chart shows equivalencies between the 12- and 24-hour clocks:

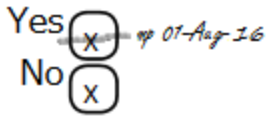
12-hour clock (a.m.)	24-hour clock	12-hour clock (p.m.)	24-hour clock
Midnight	00:00	Noon	12:00
1:00 a.m.	01:00	1:00 p.m.	13:00
2:00 a.m.	02:00	2:00 p.m.	14:00
3:00 a.m.	03:00	3:00 p.m.	15:00
4:00 a.m.	04:00	4:00 p.m.	16:00
5:00 a.m.	05:00	5:00 p.m.	17:00
6:00 a.m.	06:00	6:00 p.m.	18:00
7:00 a.m.	07:00	7:00 p.m.	19:00
8:00 a.m.	08:00	8:00 p.m.	20:00
9:00 a.m.	09:00	9:00 p.m.	21:00
10:00 a.m.	10:00	10:00 p.m.	22:00
11:00 a.m.	11:00	11:00 p.m.	23:00

For example, record 2:25 p.m. as: 14 25 24-hour clock

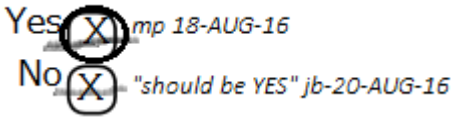
Data Corrections and Additions – Rave Form and/or Paper CRF

- Data fields may need to be updated or corrected, such as in response to a query or after site review.
- If the source document is non-CRF in nature (i.e., lab report), it is sufficient to make data updates in the study database itself. If a paper CRF was completed, make changes to the paper CRF first and then enter the updated data into Rave.
- Use the standards below when changing, clarifying, or amending data:
  - Draw a single horizontal line through the incorrect entry. Do not obscure the entry or make it unreadable with multiple cross-outs.
  - Place the correct or clarified answer near the previous response.
  - If an **X** is marked in the wrong response box, correct it by doing the following:
    - draw a single horizontal line through the incorrectly marked box,

- mark the correct box, and
- initial and date the correction as shown below:



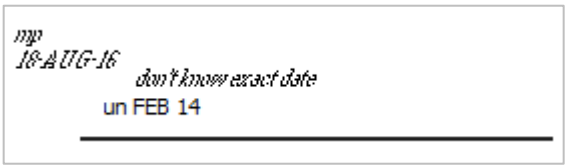
- If the correct answer has previously been crossed out, do the following:
  - circle the correct response,
  - write an explanation in the white space near the response, and
  - initial and date all corrections as shown below:



Missing and Unknown Data – Rave Form and/or Paper CRF

On paper CRFs, if the answer to a required question is unknown, unavailable, or if the participant refuses to answer, draw a single horizontal line through the applicable question and initial and date. It is helpful to write “don’t know,” “refuses to answer,” “UNK” (unknown), “N/A” (not applicable), or “REF” (refused) near the fields.

- For example, when recording a date, if the exact day is not known, write “un” to designate the “dd” (or date) and write “don’t know” next to the response, as shown below. Initials and date are required for any data that are refused, missing, unknown, or not applicable, regardless of whether they are marked as such during the initial form completion, or as an update to the form.



- In Rave, where the data are missing or unknown, enter “UN” for the day and/or select ‘UNK’ from the drop-down list for the month.

Form-Specific Instructions by Visit: V0 – Screening Date of Visit

This Visit is common to both Cohort 1 and Cohort 2 participants.

Participant Identifier

Purpose:
This form generates a PTID for the participant. Complete this form first for each participant.

General Instructions:
This form is in the "Screening" folder and is only completed once, on the date of screening.

Field-specific Instructions:

Field	Instructions
Participant ID	• To add a participant to the study database, select the 'Add Subject' link on the study home page. The Participant Identifier form will load. • No data are required from the site on this form. Click the "Save" button at the bottom of the form. A pop-up box will appear to indicate that a participant has been added to the database. The participant's home page will appear. • The link for the Participant Identifier form is at the top of each participant's home page. PTID will appear on each form in participant's casebook. • If recording source data on paper copies of the eCRFs, the PTID must be written at the top of each CRF PDF completed for a participant. • The first three digits of each PTID is the Rave site ID number.

Screening Date of Visit

Purpose:
This form is used to collect the screening date of visit.

General Instructions:
This form is in the "Screening" folder and is only completed once, on the date of screening.

Field-specific Instructions:

Field	Instructions
Screening visit date	A complete date is required.
Was this participant originally screened for Cohort 1 or Cohort 2?	Select the appropriate response for the participant.
If Cohort 1, Select Group	If the participant was screened for Cohort 1, please select the appropriate study group.

Form-Specific Instructions by Visit: V1 – Enrollment

This Visit is common to both Cohort 1 and Cohort 2 participants.

Demographics

Purpose:
This form documents a participant's demographic information, as well as some physical characteristics based on the time of admission to the study.

General Instructions:
Complete and submit this form for participants who have signed a study-specific consent form, regardless of if they enroll in the study or not. This form is completed at the Enrollment visit. Responses should reflect the participant's status at screening and should not be changed after screening unless correction is required to correct a data entry error. If the participant is found to be ineligible prior to the collection of all demographic data, enter all available data and respond to system queries with "Not Collected".

Field-specific Instructions:

Field	Instructions
Date of birth	Record the participant's date of birth. A complete date is required.
Age	The age field is calculated automatically based on the "Date of birth" field and the "Screening visit date" field on the Screening Date of Visit form. No data entry is required.
Sex at birth	This is the sex that the participant was assigned at birth.
Ethnicity	Record the participant's ethnicity based on self-definition. Multiple selections on race are allowed. If race is unknown or not reported, please select that option.
Race	Record the participant's race based on self-definition. Multiple selections on race are allowed. If race is unknown or not reported, please select the "Other" option.
If "Other", specify	Specify the "Other" race as applicable. Maximum 200 characters.

Informed Consent

Purpose:
This form is used to collect the date the informed consent was signed by the participant.

General Instructions:
This form is in the "Enrollment" folder and is only completed once.

Field-specific Instructions:

Field	Instructions
Informed consent date	A complete date is required.

Contraception – Screening

Purpose:
This form is used to document contraception/birth control and any changes from original documentation.

General Instructions:
This form will only be available if Sex assigned at birth = Female on the Demographics CRF.

Field-specific Instructions:

Field	Instructions
Was the contraception assessment performed?	Enter Yes or No. If "No", select the reason why the assessment was not performed. ****NOTE** If the participant has undergone a sterilization procedure, then the assessment WAS performed and "Sterilization" should be one of the selection(s) in the section, "What type of birth control method are you currently using?"**
If no, why?	Select the reason why the assessment was not performed from the menu items or select "Other".
If Other, specify:	If the reason why the assessment was not performed is selected as "Other", detail the reason in this section.
What type of birth control method are you currently using?	Select all that apply. As applicable, update the Concomitant Medications and Medical History CRFs. **"Sterilization" and "Abstinence" should not be recorded on the Concomitant Medications CRF and should not be linked.**
If, "Other", specify	Record any other method of contraception not listed. This may include a vasectomized partner
Select Concomitant Medication Log line.	Link the appropriate Concomitant Medication(s) that are present in the Concomitant Medications Log. Space for two medications is available. **"Sterilization" and "Abstinence" should not be recorded on the Concomitant Medications CRF and should not be linked.**

Vital Signs – Screening

Purpose:
This form documents the participant vital signs.

General:
If height, weight, and body temperature are not measured in metric units, please convert.

Field-specific Instructions:

Field	Instructions
Were vital signs done?	Enter Yes or No. If "No", submit the form.
Date of assessment	Enter the date the participant's vital signs were measured. A complete date is required.
Time of assessment	Enter the time the participant's vital signs were measured. Use a 24-hour clock (00:00-23:59), where hours are designated from 0–23.
Height	Enter the subject height in cm. Height is only required on the Vital Signs – Enrollment form.
Weight	Enter the subject weight in kg.
BMI calculated	The BMI field is calculated automatically based on the "Height" and "Weight" entered. No data entry is required.
Body Temperature	Enter the subject body temperature at the time of assessment. Temperature is recorded in °C.
Systolic blood pressure	Enter the subject systolic blood pressure at the time of assessment. Systolic blood pressure is recorded in mmHg.
Diastolic blood pressure	Enter the subject diastolic blood pressure at the time of assessment. Diastolic blood pressure is recorded in mmHg.
Pulse	Enter the subject pulse at the time of assessment. Pulse is recorded in beats per minute.

Vital Signs – Post Vaccination

Purpose:
This form documents the participant vital signs after receiving their booster or vaccination injection.

General:
If body temperature is not measured in metric units, please convert.

Field-specific Instructions:

Field	Instructions
Were vital signs done?	Enter Yes or No. If "No", submit the form.
Date of assessment	Enter the date the participant's vital signs were measured. A complete date is required.
Time of assessment	Enter the time the participant's vital signs were measured. Use a 24-hour clock (00:00-23:59), where hours are designated from 0–23.
Systolic blood pressure	Enter the subject systolic blood pressure at the time of assessment. Systolic blood pressure is recorded in mmHg.
Diastolic blood pressure	Enter the subject diastolic blood pressure at the time of assessment. Diastolic blood pressure is recorded in mmHg.
Pulse	Enter the subject pulse at the time of assessment. Pulse is recorded in beats per minute.

Inclusion/Exclusion Criteria

Purpose:
This form documents a participant's eligibility status.

General Instructions:
Complete this form for each participant screened in IDC003-21-0012, whether-or-not the participant will enroll in the study.

Field-specific Instructions:

Field	Instructions
Did the participant meet all eligibility criteria?	Select "Yes"' or "No" to indicate if the participant met all eligibility criteria.
Eligibility Status	Record the applicable eligibility status by selecting from the drop-down menu. If participant met all eligibility criteria, and Eligibility Status is set to 'Eligible and enrolled', then end/submit the form. If it is determined post-enrollment, that a participant failed an inclusion and/or exclusion criteria, but was erroneously enrolled in the study, select "Ineligible/enrolled".
Date participant was found "Eligible/Not Enrolled", "Ineligible", or "Incomplete Screening".	If the participant was deemed "Eligible/Not Enrolled", "Ineligible" or "Incomplete screening", record the date. A complete date is required.
Select reason(s) why participant is "Eligible/Not Enrolled" or "Ineligible".	If participant is deemed ineligible per inclusion or exclusion criteria, use the drop-down menu to select a reason and save. If there is more than one reason for ineligibility per inclusion or exclusion criteria, click on the "Add a new Log line" and select another reason. Add all applicable reasons as appropriate. If a reason for ineligibility per inclusion or exclusion criteria is recorded inaccurately, click on "Inactivate", select the incorrect "Reason?" from the drop-down menu on the left and click Inactivate. If a previously inactivated "Reason?" requires reactivation, click on "Reactivate", select the "Reason?" to be reactivated from the drop-down menu on the left and click Reactivate.

Enrollment

Purpose:
This form documents a participant's enrollment date and cohort.

General Instructions:
Complete this form for each participant in IDC003-21-0012.

Field-specific Instructions:

Field	Instructions
Enrollment date	Enter the date the participant was enrolled in the study. A complete date is required.
Was this participant enrolled into Cohort 1 or Cohort 2?	Record the cohort assignment for the participant.
If Cohort 1, Select Group	Record the group assignment for the participant, based on the previously dosed vaccine and booster.
If this participant is enrolling in Cohort 1, group "15E: Previously dosed Janssen – Ad26.COV2-S; Novavax – NVX-CoV2373 booster", was this participant previously enrolled in Cohort 1, Group "4E: Previously dosed Janssen – Ad26.COV2-S; Janssen – Ad26.COV2-S booster"?	This item applies to group 15E participants only. Select "Yes" or "No". If yes, provide this participant's PTID for group 4E

SARS-CoV-2 Vaccination

Purpose:
This form documents a participant's prior SARS-CoV-2 vaccination record.

General Instructions:
Complete this form for each participant in IDC003-21-0012.

Field-specific Instructions:

Field	Instructions
How was vaccination information obtained?	Record how the participant's vaccine information was obtained. If one of the selections is not appropriate, record "Other" and specify in the field below.
If "Other", specify	Specify the other methodology of how the participant's vaccine information was obtained.
Vaccine manufacturer	Record the participant's vaccine manufacturer. If one of the selections is not appropriate, record "Other" and specify in the field below.
If "Other", specify	Specify the other vaccine manufacturer.
Date of first vaccination	Enter the date the participant received their first (or only) SARS-COV-2 vaccination. A complete date is required.
Date of second vaccination, if applicable	Enter the date the participant received their second SARS-COV-2 vaccination, if applicable. The second dose is not applicable to all vaccine manufacturers. If a second dose was not administered, leave the date field blank. If a date is entered, a complete date is required.

Booster

Purpose:
This form documents a participant's SARS-CoV-2 booster vaccination.

General Instructions:
Complete this form for each participant in IDC003-21-0012.

Field-specific Instructions:

Field	Instructions
Date of booster	Enter the date the booster was given. A complete date is required.
Time of injection	Enter the time of the injection. Use a 24-hour clock (00:00-23:59), where hours are designated from 0–23.
Location of injection	Enter the location the booster was given.
Product manufacturer	Record the vaccine manufacturer. If the manufacturer and booster version is not listed, record “Other” and specify in the field below.
If “Other”, specify	Specify the other vaccine manufacturer.
Were there any study product administration errors?	Were there any study product administration errors? If “Yes” complete the Study Product Administration Form.
Comments	Detail any comments regarding the booster. Maximum 450 characters.

Physical Exam

Purpose:
This form documents physical exam findings.

General Instructions:
Complete this form for each participant in IDC003-21-0012.

Field-specific Instructions:

Field	Instructions
Was a physical exam performed?	Select “Yes”’ or “No” to indicate if a physical exam was performed. If “No”, skip to comments.
Date of exam	Enter the date of the physical exam. A complete date is required.
Body System	For each organ or body system, mark “Normal”, “Abnormal” or “Not done”. If “Abnormal” describe findings in corresponding “If “Abnormal”, specify:” box.
Other system finding If “Other system”, specify system:	If no additional body system is evaluated, select “Not done”. If a body system is evaluated that is not listed on the form, enter body system in the “If “Other system finding”, specify:” box.

If "Abnormal", specify:	If "Abnormal" enter findings in the "If "Abnormal", specify:" box.
Comments	Detail any comments regarding the physical exam. Maximum 200 characters.

Pregnancy Test Results

Purpose:
This form documents pregnancy test results.

General Instructions:
This form will only be available if Sex assigned at birth = Female on the Demographics CRF.

Field-specific Instructions:

Field	Instructions
Was a urine pregnancy test performed?	Record if a pregnancy test was done by entering "Yes" or "No". If "No" is selected, complete the reason not done. • If a pregnancy test was not done, please do NOT complete the "Specimen date", "Specimen type", Collection time" or "Pregnancy test result". • If the sample was collected, then complete "Specimen date", "Specimen type", Collection time" and "Pregnancy rest result".
If no, specify reason not done	Select the most applicable reason. If the reason is not listed, select "Other" and record the "Other" reason.
If Other, specify	If a sample was not collected, record the reason. Maximum 200 characters.
Specimen date	Record the date that the pregnancy test was collected and NOT the date the results were reported or recorded within the form for this visit. A complete date is required.
Collection time	Record the time that the pregnancy test sample was collected.
Pregnancy test result	If participant is pregnant (tests positive): • DO NOT ADMINISTER STUDY PRODUCT if on planned study product administration date. • Complete the **Pregnancy Report and Pregnancy History** forms
Comments	Record any comments on the pregnancy test results. Maximum 450 characters.

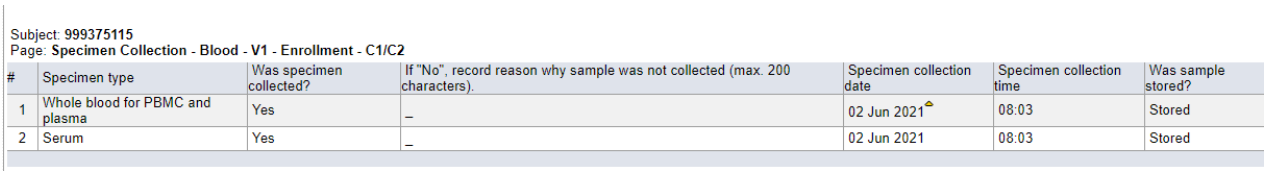
Specimen Collection and Storage

Purpose: This form is used to define date and time of research specimen collection and storage.

General Instructions:
Refer to the MOP for the number and type of tube(s) required at each visit.

The Specimen Collection and Storage CRF will auto-populate at each required visit, but it can also be added through the Interim Visit CRF. On each form, the specimen type fields are automatically populated. Not every specimen is collected at every visit.

At visits where both "Whole blood for PBMC and plasma" AND "Serum" is collected, the whole blood collection information is displayed initially in portrait format when the CRF is selected. Complete the information and submit. Once submitted, the serum collection information will be available for entry, however it will appear in the log instead of initially presented in portrait mode. Click the "Serum" log line to display the serum collection information in portrait mode. Enter and submit. You should now have both log lines visible with collection information. See below for an example.



Subject: 999375115
Page: **Specimen Collection - Blood - V1 - Enrollment - C1/C2**

#	Specimen type	Was specimen collected?	If "No", record reason why sample was not collected (max. 200 characters).	Specimen collection date	Specimen collection time	Was sample stored?
1	Whole blood for PBMC and plasma	Yes	_	02 Jun 2021	08:03	Stored
2	Serum	Yes	_	02 Jun 2021	08:03	Stored

Do not use this form to document any local lab specimens. Use this form only to document the collection of research blood specimens that will be sent to the site processing lab.

Field-specific Instructions:

Field	Instructions
Was specimen collected?	Select "Yes" or "No"
If "No", record reason why sample was not collected	Detail the reason the sample was not collected. Maximum 200 characters.
Specimen collection date	Record the date that the sample was *collected*. A complete date is required.
Specimen collection time	Record the time that the sample was *collected*. Use a 24-hour clock (00:00-23:59), where hours are designated from 0–23.
Was sample stored?	Select "Stored" or "Not stored"
If "Not stored", record reason why sample was not stored	If a sample was not stored, record the reason. Maximum 200 characters.
Is this specimen being collected for secondary research?	Select "Yes" or "No"

Reactogenicity – Baseline and Early

Purpose: This form is used to collect reactogenicity assessments for both pre-injection and 30-60 minutes post-injection and is only available on injection study days. Do not use this form to record daily reactogenicity assessments.

General Instructions:

The Reactogenicity – Baseline and Early CRF will auto-populate at each required visit. The AE log page must be entered into Rave prior to linking the AE on the Reactogenicity form for the AE to be available to select with the drop-down field.

Baseline assessment: The reactogenicity assessment performed immediately prior to vaccination.

Early assessment: The reactogenicity assessment performed 30-60 minutes post-vaccination.

At the vaccination visits, where both Baseline and Early assessments are collected, the "Baseline" collection information is displayed initially in portrait format when the CRF is selected. Complete the information and submit.

Once submitted, the "Early assessment" collection information will be available for entry, however it will appear in the log instead of initially presented in portrait mode. Click the "Early assessment" log line to display the early assessment collection information in portrait mode. Enter and submit. You should now have <u>both</u> log lines visible with collection information. See below for an example.

Subject: **999472565**
Page: **Reactogenicity - Baseline and Early - V1 - Enrollment - C1/C2**

#	Reactogenicity Assessment Performed	Reason Not Done	Time Point	Assessment Date	Assessment Time	Body Temperature	Severity grade	Adverse Event	Chills	Adverse Event	Malaise/Fatigue	Adverse Event	Myalgia	Adverse Event	Arthralgia	Adverse Event	Headache	Adverse Event
1	Yes	_	Baseline	02 Jun 2021	08:33	38.5	None	_	None	_	None	_	None	_	None	_	None	_
2	Yes	_	Early assessment	02 Jun 2021	09:45	38.2	None	_	None	_	None	_	None	_	None	_	None	_

Nausea	Adverse Event	Injection Number	Location of Local Assessment	Pain/Tenderness	Adverse Event	Vaccine Related Lesion	Erythema/Redness Diameter	Severity grade	Adverse Event	Induration/Swelling Diameter	Severity grade	Adverse Event	Comments	
None	_	Vaccination 1	Right deltoid	None	_	_	0.0	None	_	0.0	None	_	_	
None	_	Vaccination 1	Right deltoid	None	_	No	0.0	None	_	0.0	None	_	_	

Field-specific Instructions:

Field	Instructions
Was assessment done?	Select "Yes" or "No"
Reason not done	Detail the reason the assessment was not done. Maximum 200 characters.
Assessment time point	This is a non-editable field and will display the assessment collection time point. Information should be entered for the defined time point only.
Date of assessment	Record the date the assessment was performed. A complete date is required.
Time of assessment	Record the time the assessment was performed. Use a 24-hour clock (00:00-23:59), where hours are designated from 0–23.
Body temperature	Record the participant's body temperature in °C. If the participant's body temperature is equal to or exceeds 38.0°C at **baseline**, the study product should not be administered. If not assessed, leave this field empty.

Severity grade	Record the severity grade of the body temperature reading. **If the symptom was assessed, but measurement is less than required for severity grade 1 (mild) per the FDA Tox Table, put "Not gradable".** **If Body Temperature was NOT assessed, leave the "Body temperature" field blank, and record "Not assessed" in Severity grade, leave the "Adverse event" field blank and record the reason for not assessing the site in the page comments.**
Adverse event	If the symptom assessment meets the criteria for reporting on the AE log, link the event to a recorded event by selecting the applicable event from the menu.
Systemic Symptoms Chills Malaise and/or fatigue Myalgia/body aches Arthralgia/joint pain Headache Nausea	Assess the participant for the systemic symptom. If the symptom is present record the severity grade of the specific symptom. In addition, if the assessment meets the criteria for reporting on the AE log, link the event to a recorded event by selecting the applicable event from the menu. If the participant was assessed for a specific symptom, and that symptom is not present, record "None" in Severity grade and leave the Adverse event field blank. If the participant was NOT assessed for a specific symptom, record "Not assessed" in Severity grade, leave the Adverse event field blank and record the reason for not assessing the site in the page comments.
Injection number	Record the vaccination number assessed.
Location of local assessment	Record the location of the assessment. For Baseline assessments, this location should be for **planned** location where the injection will be administered. For post-injections assessments, it's the actual location of injection.
Local Symptoms Pain and/or tenderness	Assess the injection site. If Pain and/or tenderness is present record the severity grade of the specific symptom. In addition, if the assessment meets the criteria for reporting on the AE log, link the event to a recorded event by selecting the applicable event from the menu. If the injection site was assessed and Pain and/or tenderness is not present, record "None" in Severity grade and leave the Adverse event field blank. If the injection site was NOT assessed, leave the measurement field blank for the assessment that was not measured, record "Not assessed" in Severity grade, leave the Adverse event field blank and record the reason for not assessing the site in the page comments. If the participant's "Pain and/or tenderness" assessment is equal to or exceeds Moderate at **baseline**, the study product should not be administered

Is a vaccine-related lesion visible?	For the baseline assessment: Assess for lesion(s) at the planned injection site. If non-vaccine-related lesions are present, document the information in "Comments". For the early (30-minutes post-dose) assessment: Assess for lesion(s) at the actual injection site. Any AEs/SAEs will be recorded on the appropriate DCF prior to discharge from the clinic.

Local Symptoms Erythema/redness largest diameter Induration/swelling largest diameter	Assess the injection site. If Erythema/redness or Induration/swelling is present, measure and record the diameter in cm*. Enter the severity grade of the specific symptom. In addition, if the assessment meets the criteria for reporting on the AE log, link the event to a recorded event by selecting the applicable event from the menu. **Erythema/redness:** If the injection site was assessed and Erythema/redness is not present, record 0.0 in the diameter, record "None" in Severity grade and leave the Adverse event field blank. If Erythema/redness was measured, but measurement is less than the specified minimum for severity grade 1 (mild) per the FDA Toxicity Table, record as "Not gradable". If the injection site was NOT assessed, leave the measurement field blank for the assessment that was not measured, record "Not assessed" in Severity grade, leave the Adverse event field blank and record the reason for not assessing the site in the page comments. **Induration/swelling:** If the injection site was assessed for induration/swelling but not measured, leave the measurement field blank and record the severity grade. Record the reason for not measuring the site in the page comments. If Induration/swelling was measured, but measurement is less than the specified minimum for severity grade 1 (mild) per the FDA Toxicity Table, record as "Not gradable" or appropriate severity grade based on functionality. Record that the severity was based on functionality reported by the participants in the page comments. **Please refer to the FDA Toxicity Table for Adults, as provided below and at https://www.fda.gov/media/73679/download:**

<table>
<tr><td></td><td>

A. Tables for Clinical Abnormalities

Local Reaction to Injectable Product	Mild (Grade 1)	Moderate(Grade 2)	Severe (Grade 3)	Potentially Life Threatening (Grade 4)
Pain	Does not interfere with activity	Repeated use of non-narcotic pain reliever > 24 hours or interferes with activity	Any use of narcotic pain reliever or prevents daily activity	Emergency room (ER) visit or hospitalization
Tenderness	Mild discomfort to touch	Discomfort with movement	Significant discomfort at rest	ER visit or hospitalization
Erythema/Redness *	2.5 – 5 cm	5.1 – 10 cm	> 10 cm	Necrosis or exfoliative dermatitis
Induration/Swelling **	2.5 – 5 cm and does not interfere with activity	5.1 – 10 cm or interferes with activity	> 10 cm or prevents daily activity	Necrosis

* In addition to grading the measured local reaction at the greatest single diameter, the measurement should be recorded as a continuous variable.

** Induration/Swelling should be evaluated and graded using the functional scale as well as the actual measurement.

*Please note that the memory aid collects diameter in mm, requiring conversion to cm prior to CRF data entry (1 mm=0.1 cm).

</td></tr>
<tr><td>Comments</td><td>Record any comments on the reactogenicity assessment. Maximum 450 characters.</td></tr>
</table>

Reactogenicity – Daily Log

Purpose: This form is used to collect reactogenicity assessments daily, for 7-days post injection. Do not use this form to record baseline and early reactogenicity assessments.

General Instructions:

The Reactogenicity – Daily Log will auto-populate at each required visit. The AE log page must be entered into Rave prior to linking the AE on the Reactogenicity form for the AE to be available to select with the drop-down field.

At the vaccination visits, where daily reactogenicity assessments are collected, the “Day 1” collection information is displayed initially in portrait format when the CRF is selected. Complete the information and submit. Once submitted, the subsequent time point (Days 2-8) collection information will be available for entry, however each will appear in the log instead of initially presented in portrait mode. Click the “Day 2” log line to display the next assessment collection information in portrait mode, and so on. Enter and submit.

You should now have all log lines visible with collection information as entered. See below for an example.

Subject: 999472565
Page: **Reactogenicity - Daily Log - V1 - Enrollment - C1/C2**

Complete the Daily Assessment Log through day 8. If symptoms continue past Day 8, record the resolution date on the Reactogenicity - Resolution of Symptoms form.

#	Reactogenicity Assessment Performed	Reason Not Done	Time Point	Assessment Date	Body Temperature	Severity grade	Adverse Event	Chills	Adverse Event	Malaise/Fatigue	Adverse Event	Myalgia	Adverse Event	Arthralgia	Adverse Event	Headache	Adverse Event	Nausea	Adverse Event
1	Yes	_	Day 1	02 Jun 2021	35.6	None	_	None	_	None	_	None	_	None	_	None	_	None	_
2	_	_	Day 2	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_
3	_	_	Day 3	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_
4	_	_	Day 4	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_
5	_	_	Day 5	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_
6	_	_	Day 6	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_
7	_	_	Day 7	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_
8	_	_	Day 8	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_

Injection Number	Location of Local Assessment	Is a vaccine-related lesion visible?	Pain/Tenderness	Adverse Event	Erythema/Redness Diameter	Severity grade	Adverse Event	Induration/Swelling Diameter	Severity grade	Adverse Event	Comments	
Vaccination 1	Right deltoid		None	_	0.0	None	_	0.0	None	_	_	
_	_		_	_	_	_	_	_	_	_	_	
_	_		_	_	_	_	_	_	_	_	_	
_	_		_	_	_	_	_	_	_	_	_	
_	_		_	_	_	_	_	_	_	_	_	
_	_		_	_	_	_	_	_	_	_	_	
_	_		_	_	_	_	_	_	_	_	_	

Field-specific Instructions:

Field	Instructions
Was assessment done?	Select “Yes” or “No”
Reason not done	Detail the reason the assessment was not done. Maximum 200 characters.
Assessment time point	This is a non-editable field and will display the assessment collection time point. Information should be entered for the defined time point only.
Date of assessment	Record the date the assessment was performed. A complete date is required.
Time of assessment	Record the time the assessment was performed. Use a 24-hour clock (00:00-23:59), where hours are designated from 0–23.
Body temperature	Record the participant’s body temperature in °C. **If not assessed, leave this field empty.**

Severity grade	Record the severity grade of the body temperature reading. If the symptom was not assessed, select “Not assessed”. If the symptom was assessed, but measurement is less than required for severity grade 1 (mild) per the FDA Tox Table, put “Not gradable”. If Body Temperature was NOT assessed, leave the “Body temperature” field blank, and record “Not assessed” in Severity grade, leave the “Adverse event” field blank and record the reason for not assessing the site in the page comments.
Adverse event	If the symptom assessment meets the criteria for reporting on the AE log, link the event to a recorded event by selecting the applicable event from the menu.
Systemic Symptoms Chills Malaise and/or fatigue Myalgia/body aches Arthralgia/joint pain Headache Nausea	Assess the participant for the systemic symptom. If the symptom is present record the severity grade of the specific symptom. In addition, if the assessment meets the criteria for reporting on the AE log, link the event to a recorded event by selecting the applicable event from the menu. If the participant was assessed for a specific symptom, and that symptom is not present, record “None” in Severity grade and leave the Adverse event field blank. If the participant was NOT assessed for a specific symptom, record “Not assessed” in Severity grade, leave the Adverse event field blank and record the reason for not assessing the site in the page comments.
Injection number	Record the vaccination number assessed.
Location of local assessment	Record the location of assessment. This is the same as the sire of injection.
Local Symptoms Pain and/or tenderness	Assess the injection site. If Pain and/or tenderness is present record the severity grade of the specific symptom. In addition, if the assessment meets the criteria for reporting on the AE log, link the event to a recorded event by selecting the applicable event from the menu. If the injection site was assessed and Pain and/or tenderness is not present, record “None” in Severity grade and leave the Adverse event field blank. If the injection site was NOT assessed, leave the measurement field blank for the assessment that was not measured, record “Not assessed” in Severity grade, leave the Adverse event field blank and record the reason for not assessing the site in the page comments.

Local Symptoms Erythema/redness largest diameter Induration/swelling largest diameter	Assess the injection site. If Erythema/redness or Induration/swelling is present, measure and record the diameter in cm*. Enter the severity grade of the specific symptom. In addition, if the assessment meets the criteria for reporting on the AE log, link the event to a recorded event by selecting the applicable event from the menu. **Erythema/redness:** If the injection site was assessed and Erythema/redness is not present, record 0.0 in the diameter, record "None" in Severity grade and leave the Adverse event field blank. If Erythema/redness was measured, but measurement is less than the specified minimum for severity grade 1 (mild) per the FDA Toxicity Table, record as "Not gradable". If the injection site was NOT assessed, leave the measurement field blank for the assessment that was not measured, record "Not assessed" in Severity grade, leave the Adverse event field blank and record the reason for not assessing the site in the page comments. **Induration/swelling:** If the injection site was assessed for induration/swelling but not measured, leave the measurement field blank and record the severity grade. Record the reason for not measuring the site in the page comments. If Induration/swelling was measured, but measurement is less than the specified minimum for severity grade 1 (mild) per the FDA Toxicity Table, record as "Not gradable" or appropriate severity grade based on functionality. Record that the severity was based on functionality reported by the participants in the page comments. **Please refer to the FDA Toxicity Table for Adults, as provided below and at https://www.fda.gov/media/73679/download:**

A. Tables for Clinical Abnormalities

Local Reaction to Injectable Product	Mild (Grade 1)	Moderate(Grade 2)	Severe (Grade 3)	Potentially Life Threatening (Grade 4)
Pain	Does not interfere with activity	Repeated use of non-narcotic pain reliever > 24 hours or interferes with activity	Any use of narcotic pain reliever or prevents daily activity	Emergency room (ER) visit or hospitalization
Tenderness	Mild discomfort to touch	Discomfort with movement	Significant discomfort at rest	ER visit or hospitalization
Erythema/Redness *	2.5 – 5 cm	5.1 – 10 cm	> 10 cm	Necrosis or exfoliative dermatitis
Induration/Swelling **	2.5 – 5 cm and does not interfere with activity	5.1 – 10 cm or interferes with activity	> 10 cm or prevents daily activity	Necrosis

* In addition to grading the measured local reaction at the greatest single diameter, the measurement should be recorded as a continuous variable.

** Induration/Swelling should be evaluated and graded using the functional scale as well as the actual measurement.

*Please note that the memory aid collects diameter in mm, requiring conversion to cm prior to CRF data entry (1 mm=0.1 cm).

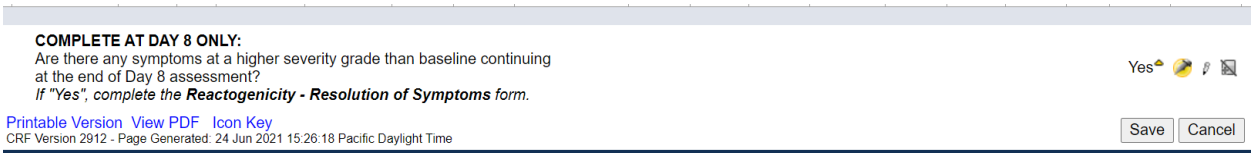
Comments	Record any comments on the reactogenicity assessment. Maximum 450 characters.

Reactogenicity – Resolution of Symptoms

Purpose: This form is used to collect resolution information for any reactogenicity symptom that persist 7 days post injection.

General Instructions:

The Reactogenicity – Resolution of Symptoms form will auto-populate after the Day 8 assessment has been completed and the question “Are there any symptoms at a higher severity than baseline continuing at the end of Day 8 assessment?” is marked “Yes” on the Reactogenicity Daily Log CRF page. The AE log page must be entered into Rave prior to linking the AE on the Reactogenicity form for the AE to be available to select with the drop-down field.



Field-specific Instructions:

Field	Instructions
Maximum body temperature	Record the participant's maximum body temperature in °C. **If not assessed, leave this field empty.**
Severity grade	Record the severity grade of the body temperature reading. If the symptom is not present after Day 8, record "None" in Severity grade and leave the Resolution date and Adverse event fields blank. All symptoms must have an entry in Severity grade. If the symptom was not assessed, select "Not assessed" and leave the Resolution date and Adverse event field blank. If the symptom was assessed, but measurement is less than required for severity grade 1 (mild) per the FDA Tox Table, put "Not gradable".
Resolution Date	Record the resolution date
Adverse event	If the symptom assessment meets the criteria for reporting on the AE log, link the event to a recorded event by selecting the applicable event from the menu.
Systemic Symptoms Chills Malaise and/or fatigue Myalgia/body aches Arthralgia/joint pain Headache Nausea	If the systemic symptom is ongoing at the end of the Day 8 assessment, continue to observe for the symptom until it is no longer present. Record the maximum severity of the specific symptom and resolution date for ALL symptoms ongoing at the end of the Day 8 assessment. In addition, if the assessment meets the criteria for reporting on the AE log, link the event to a recorded event by selecting the applicable event from the menu. If the symptom is not present after Day 8, record "None" in Severity grade and leave the Resolution date and Adverse event fields blank. All symptoms must have an entry in Severity grade. If the symptom was not assessed, select "Not assessed" and leave the Resolution date and Adverse event field blank.
Location of injection	Enter the location the injection was given.
Injection number	Record the vaccination number assessed.
Local Symptoms Pain and/or tenderness	<u>Not assessed</u> If the participant did not assess for the symptom after Day 8, record "Not assessed". Leave all measurement fields blank. <u>Assessed, but not present</u>

	If the symptom was not present on Day 8, but the participant assessed for the symptom after Day 8 and the symptom was not present, record "None". Leave all measurement fields blank. <u>Assessed and present</u> If the systemic symptom is ongoing at the end of the Day 8 assessment, continue to observe for the symptom until it is no longer present. Record the maximum severity of the specific symptom and resolution date for ALL symptoms ongoing at the end of the Day 8 assessment. Record the maximum measurement where applicable. In addition, if the assessment meets the criteria for reporting on the AE log, link the event to a recorded event by selecting the applicable event from the menu.
Local Symptoms Erythema/redness largest diameter Induration/swelling largest diameter	Assess the injection site. If Erythema/redness and/or Induration/swelling is ongoing at the end of the Day 8 assessment, measure and record the MAXIMUM diameter in cm*. Enter the severity grade of the specific symptom. In addition, if the assessment meets the criteria for reporting on the AE log, link the event to a recorded event by selecting the applicable event from the menu. **<u>Erythema/redness:</u>** If the injection site was assessed and Erythema/redness is not present, record 0.0 in the diameter, record "None" in Severity grade and leave the Adverse event field blank. If Erythema/redness was measured, but measurement is less than the specified minimum for severity grade 1 (mild) per the FDA Toxicity Table, record as "Not gradable". If the injection site was NOT assessed, leave the measurement field blank for the assessment that was not measured, record "Not assessed" in Severity grade, leave the Adverse event field blank and record the reason for not assessing the site in the page comments. **<u>Induration/swelling:</u>** If the injection site was assessed for induration/swelling but not measured, leave the measurement field blank and record the severity grade. Record the reason for not measuring the site in the page comments. If Induration/swelling was measured, but measurement is less than the specified minimum for severity grade 1 (mild) per the FDA Toxicity Table, record as "Not gradable" or appropriate severity grade based on functionality. Record that the severity was based on functionality reported by the participants in the page comments.

Please refer to the FDA Toxicity Table for Adults, as provided below and at https://www.fda.gov/media/73679/download:

A. Tables for Clinical Abnormalities

Local Reaction to Injectable Product	Mild (Grade 1)	Moderate(Grade 2)	Severe (Grade 3)	Potentially Life Threatening (Grade 4)
Pain	Does not interfere with activity	Repeated use of non-narcotic pain reliever > 24 hours or interferes with activity	Any use of narcotic pain reliever or prevents daily activity	Emergency room (ER) visit or hospitalization
Tenderness	Mild discomfort to touch	Discomfort with movement	Significant discomfort at rest	ER visit or hospitalization
Erythema/Redness *	2.5 – 5 cm	5.1 – 10 cm	> 10 cm	Necrosis or exfoliative dermatitis
Induration/Swelling **	2.5 – 5 cm and does not interfere with activity	5.1 – 10 cm or interferes with activity	> 10 cm or prevents daily activity	Necrosis

* In addition to grading the measured local reaction at the greatest single diameter, the measurement should be recorded as a continuous variable.

** Induration/Swelling should be evaluated and graded using the functional scale as well as the actual measurement.

*Please note that the memory aid collects diameter in mm, requiring conversion to cm prior to CRF data entry (1 mm=0.1 cm).

Study Product Administration Error

Purpose:
This form is used to document any study product administration errors.

General Instructions:
This form is will populate when the question “Were there any study product administration errors?” is answered “Yes” on any vaccination CRF or the Booster CRF.

Field-specific Instructions:

Field	Instructions
Date of visit when study product administration error(s) occurred	Record the date of the study product administration error.
Describe the administration error(s). Mark all that apply.	Record any and all of administration errors listed
If “Other”, specify	Record any other administration error not listed. Maximum 200 characters.
What action was taken as a result of study product administration	Select what action was taken as a result of the administration error.

error(s) described above?	
If “Other”, specify	Record any other action taken not listed. Maximum 200 characters.

Cohort 1-Specific Instructions by Visit: V2 – Day 8 Phone Visit (Cohort 1)

Follow-up Visit Summary

Purpose:
This form is used to document whether a regular study visit was completed.

General Instructions:
This form is completed for each scheduled visit, even if the visit was missed. This eCRF is present in each follow-up visit folder, starting at Visit 2 through Visit 7.

Field-specific Instructions:

Field	Instructions
Did the participant complete this visit?	Select “Yes” or “No”. If “No”, a Missed Visit eCRF appears dynamically and can then be completed. The remaining forms associated with this visit will not be present in the applicable visit folder. If “Yes”, then any other forms required at this visit can be added via the Additional Study Procedures CRF.
Visit Date	Record the visit date. A complete date is required.
Additional Information Study Termination Medical History Adverse Event Concomitant Medications Protocol Deviations Additional Study Procedures	Record, by selecting “yes” any findings. If any Additional Study Procedures were performed, auto-populate this form by selecting “Yes” and submitting. All other forms are available in the Ongoing Logs or Discontinuations folders.

Missed Visit

Purpose:
This form is used to when a regular study visit is not completed.

General Instructions:
Complete whenever an enrolled participant misses a required visit according to the study manual. A Missed Visit form will be added to the visit folder if the response to “Did the participant complete this visit?” is “No” on the Follow-up visit summary form.

Field-specific Instructions:

Field	Instructions
Target visit date	Record the target date of the visit that was missed. A complete date is required.
Reason visit was missed	Record the most appropriate reason the visit was missed.
If "Other", specify	If "Reason visit was missed" is selected as "Other" detail the reason. Maximum 200 characters.
Steps taken to address the missed visit (corrective action plan)	Detail the steps take to address the missed visit.

Additional CRFs

Visit 2 – Day 8 is a phone visit but if for any reason the participant may need to come into the clinic for procedures the following additional forms can be accessed with the Additional Study Procedures form.

Additional Study Procedures

Purpose:
This form is used to add additional CRFs to a study visit.

General Instructions:
This form is triggered using the Follow-up Visit Summary CRF by selecting "Yes" on the Additional Study Procedures question. If any procedure was completed during the visit, simply select the tick box next to the procedure, submit the form and the CRF is made available.

Field-specific Instructions:

Field	Instructions
Select any additional forms completed at this visit.	Select the tick box next to the procedure, submit the form and the CRF is made available within the visit folder.

These CRFs can be added to follow-up visits if needed.

Contraception

Purpose:
This form is used to document contraception/birth control and any changes from original documentation.

General Instructions:
This form is triggered by two methods. This form will only be available if Sex assigned at birth = Female on the Demographics CRF, or by using the Follow-up Visit Summary CRF by selecting "Yes" on the Additional Study Procedures question and then ticking the Contraception check box.

Field-specific Instructions:

Field	Instructions
Was the contraception assessment performed?	Enter Yes or No. If "No", select the reason why the assessment was not performed. ****NOTE** If the participant has undergone a sterilization procedure, then the assessment WAS performed and "Have you had a tubal ligation, bilateral oophorectomy, bilateral salpingectomy, hysterectomy, successful essure, or has your partner been vasectomized since last visit?" should be "Yes".**
If no, why?	Select the reason why the assessment was not performed from the menu items or select "Other".
If Other, specify:	If the reason why the assessment was not performed is selected as "Other", detail the reason in this section.
Visit	Select the visit associated with this assessment.
If 'Interim visit', provide interim visit code	If the visit specified above is an interim visit, record the visit code, otherwise leave this field blank. The interim visit code should be the numbered for the visit after the closest scheduled visit, but as sub-visit 0.1. For example, an interim visit between Visits 3 and 4, would be numbered Interim Visit 3.1. Refer to the study manual for more information on visit codes.
Have there been any changes to your method(s) of birth control since the last visit?	Select "Yes", "No", or "Not applicable". If "No" is selected, end the form, and submit.
Please select the Concomitant Medications that are current but have had updates.	Link the appropriate concomitant medications that are present in the Concomitant Medications Log but have updates. Space for two medications is available. **Please note, this is not the location to record new or discontinued birth control medications.**
Have you had a tubal ligation, bilateral oophorectomy, bilateral salpingectomy, hysterectomy, successful essure, or has you partner been vasectomized since last visit?	Select "Yes" or "No" as applicable.
If yes, Date of procedure	If "Yes" was selected, enter the date of the procedure. A complete date is required.

Have you started practicing abstinence, started a new oral contraceptive, an intrauterine device also called IUD, received an injection, started a contraceptive patch, had a contraceptive vaginal ring inserted, had a new implant or inserted, or started any other contraceptive since last visit?	Link the appropriate concomitant medications that are present in the Concomitant Medications Log but are newly **started** since the last assessment. Space for two medications is available. If yes (with the exception of abstinence), please update Concomitant Medications and select the medication(s) in the next field. **"Sterilization" and "Abstinence" should not be recorded on the Concomitant Medications CRF and should not be linked.** ****NOTE** New medications are not required to be collected/entered on this form after Visit 4 for Cohort 1 and Visit 109 for Cohort 2.**
Have you stopped practicing abstinence, stopped use of oral contraceptive, an intrauterine device also called IUD or contraceptive patch, stopped receiving injections, had a contraceptive vaginal ring or implant removed, or stopped any other contraceptive since last visit?	Link the appropriate concomitant medications that are present in the Concomitant Medications Log but are newly **stopped** since the last assessment. Space for two medications is available. If yes (with the exception of abstinence), please update Concomitant Medications and select the medication(s) below. **"Sterilization" and "Abstinence" should not be recorded on the Concomitant Medications CRF and should not be linked.**

Physical Exam

General Instructions:
Review the Vital Signs completion instructions located in the V1 – Enrollment section of this document.

Vital Signs

General Instructions:
Review the Vital Signs completion instructions located in the V1 – Enrollment section of this document.

Pregnancy Test Results

Purpose:
This form documents pregnancy test results.

General Instructions:
This form is triggered using the Follow-up Visit Summary CRF by selecting "Yes" on the Additional Study Procedures question. Review the Pregnancy Test Results completion instructions located in the V1 – Enrollment section of this document.

Specimen Collection – Blood

General Instructions:
Review the Vital Signs completion instructions located in the V1 – Enrollment section of this document.

Specimen Collection – NP/Nasal Swab

Purpose: This form is used to identify the date and time of a nasopharyngeal or nasal swab collection.

General Instructions:
This form is triggered using the Follow-up Visit Summary CRF by selecting "Yes" on the Additional Study Procedures question. If any procedure was completed during the visit, simply select the tick box next to the procedure, submit the form and the CRF is made available.

Field-specific Instructions:

Field	Instructions
Was specimen collected?	Select "Yes" or "No". If "No", provide reason and submit the form.
Primary reason specimen was not collected	Select the most appropriate response to why the specimen was not collected. If the reason is not listed, select "Other" and record the "Other" reason.
If "Other", specify	Detail the "Other" reason the specimen was not collected. Maximum 200 characters.
Specimen collection date	Record the date that the sample was *collected*. A complete date is required.
Specimen collection time	Record the time that the sample was *collected*. Use a 24-hour clock (00:00-23:59), where hours are designated from 0–23.
Was the procedure performed by participant or by staff?	Select the applicable entry.
Swab type	Select the applicable entry.
Comments	Record any comments on the NP/Nasal Swab collection. Maximum 600 characters.

SARS-CoV-2 Test Results

Purpose: This form is used to collect information about SARS-CoV-2 test results. This form should be used to record both antigen and molecular SARS-CoV-2 test results, collected both in and outside of study. Please refer to the MOP for further guidance on recording positive SARS-CoV-2 test results.

General Instructions: This form is triggered using the Follow-up Visit Summary CRF by selecting "Yes" on the Additional Study Procedures question. If any procedure was completed during the visit, simply select the tick box next to the procedure, submit the form and the CRF is made available.

Field-specific Instructions:

Field	Instructions
Specimen collection date	Record the date that the sample was *collected*. A complete date is required.
Test result	Select the most appropriate response for the SARS-CoV-2 test result.

Field	Instructions
Test type	Select “Molecular”, “Antigen”, or “Unknown”.

Participant Transfer

Purpose: This form documents when a participant is permanently transferring to another study site.

General Instructions:
This form is triggered using the Follow-up Visit Summary CRF by selecting “Yes” on the Additional Study Procedures question. If any procedure was completed during the visit, simply select the tick box next to the procedure, submit the form and the CRF is made available.

- The transferring site adds the Participant Transfer form to the appropriate visit folder by marking it on the Follow-up Visit Summary form or Interim Visit Summary form.
- For more information, refer to the Manual of Procedures (MOP).

Field-specific Instructions:

Field	Instructions
Name of transferring study site	Select the name of the transferring study site.
Name of receiving study site	Select the name of the receiving study site.
Visit of last completed contact with participant	Select the visit last completed from the menu.
If “Interim visit”, specify Interim visit code	If the visit specified above is an interim visit, record the visit code, otherwise leave this field blank. The interim visit code should be the numbered for the visit after the closest scheduled visit, but as sub-visit 0.1. For example, an interim visit between Visits 3 and 4, would be numbered Interim Visit 3.1. Refer to the study manual for more information on visit codes.
Date participant received at receiving site	Record the date that the participant’s records were *sent.* A complete date is required.

Participant Receipt

Purpose: This form documents when a transferred participant has signed informed consent at the receiving study site.

General Instructions: This form is triggered using the Follow-up Visit Summary CRF by selecting “Yes” on the Additional Study Procedures question. If any procedure was completed during the visit, simply select the tick box next to the procedure, submit the form and the CRF is made available.

- The participant will retain the PTID assigned by the original study site. Do not assign a new PTID.
- Receiving site will gain access to the participant's electronic casebook after the transfer procedures are complete at the transferring site.
- The receiving site adds the Participant Receipt form to the visit folder by marking it on the Follow-up Visit Summary form or Interim Visit Summary form.
- The Participant Receipt form must be added to the same visit folder as the corresponding Participant Transfer form.

Field-specific Instructions:

Field	Instructions
Name of receiving study site	Select the name of the receiving study site.
Name of transferring study site	Select the name of the transferring study site.
Date participant received at receiving site	Record the date that the participant was *received*. A complete date is required.

Cohort 1 Specific Instructions by Visit:

The following CRFs are required for each visit in Cohort 1. All additional CRFs can be added to the visit folder via the Additional Study Procedures form.

V3 – Day 15, V4 – Day 29

Follow-up Visit Summary

General Instructions:
Review the Follow-up Visit Summary completion instructions located in the V2 – Day 8 Phone Visit section of this document.

OR

Missed Visit

General Instructions:
Review the Missed Visit completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Physical Exam

General Instructions:
Review the Physical Exam completion instructions located in the V1 – Enrollment section of this document.

Vital Signs

General Instructions:
Review the Vital Signs completion instructions located in the V1 – Enrollment section of this document.

Contraception (if applicable)

General Instructions:
Review the Contraception completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Specimen Collection – Blood

General Instructions:
Review the Specimen Collection Blood completion instructions located in the V1 – Enrollment section of this document.

See Additional CRFs section located in the V2 – Day 8 Phone Visit section of this document for additional CRFs. Use the Additional Study Procedures form to add additional CRFs.

Additional Study Procedures

General Instructions:
Review the Additional Study Procedures completion instructions located in the V2 – Day 8 Phone Visit section of this document.

V5 – Day 91, V6 – Day 169, V7 – Day 366

Follow-up Visit Summary

General Instructions:
Review the Follow-up Visit Summary completion instructions located in the V2 – Day 8 Phone Visit section of this document.

OR

Missed Visit

General Instructions:
Review the Missed Visit completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Physical Exam

General Instructions:
Review the Physical Exam completion instructions located in the V1 – Enrollment section of this document.

Contraception (if applicable)

General Instructions:
Review the Contraception completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Specimen Collection – Blood

General Instructions:
Review the Specimen Collection – Blood completion instructions located in the V1 – Enrollment section of this document.

See Additional CRFs section located in the V2 – Day 8 Phone Visit section of this document for additional CRFs. Use the Additional Study Procedures form to add additional CRFs.

Additional Study Procedures

General Instructions:
Review the Additional Study Procedures completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Cohort 2 Specific Instructions by Visit:

Enrollment

Enrollment CRFs are the same as Cohort and can be reviewed in the Screening and Enrollment section of this document. The only difference is the Vaccination – Enrollment form will be completed for Cohort 2 instead of the Booster form.

Informed Consent

General Instructions:
Review the Informed Consent completion instructions located in the V1 – Enrollment section of this document.

Contraception – Screening (if applicable)

General Instructions:
Review the Contraception – Screening completion instructions located in the V1 – Enrollment section of this document.

Vital Signs – Screening

General Instructions:
Review the Vital Signs – Screening completion instructions located in the V1 – Enrollment section of this document.

Inclusion Exclusion Criteria

General Instructions:
Review the Inclusion Exclusion Criteria completion instructions located in the V1 – Enrollment section of this document.

Enrollment

General Instructions:
Review the Enrollment completion instructions located in the V1 – Enrollment section of this document.

Vaccination – Enrollment

Purpose:
This form documents a participant's SARS-CoV-2 enrollment vaccination.

General Instructions:
Complete this form for each participant in IDC003-21-0012 in Cohort 2.

Field-specific Instructions:

Field	Instructions
Date of vaccination	Enter the date the vaccination was given. A complete date is required.
Time of injection	Enter the time of the injection. Use a 24-hour clock (00:00-23:59), where hours are designated from 0–23.
Location of injection	Enter the location the vaccination was given.
Product manufacturer	Record the vaccine manufacturer. If Moderna-mRNA-1273 is not appropriate, record "Other" and specify in the field below.
If "Other", specify	Specify the other vaccine manufacturer.
Were there any study product administration errors?	Were there any study product administration errors? If "Yes" complete the Study Product Administration Form.
Comments	Detail any comments regarding the booster. Maximum 450 characters.

Physical Exam

General Instructions:
Review the Physical Exam completion instructions located in the V1 – Enrollment section of this document.

Pregnancy Test Result (if applicable)

General Instructions:
Review the Pregnancy Test Result completion instructions located in the V1 – Enrollment section of this document.

Specimen Collection – Blood

General Instructions:
Review the Specimen Collection – Blood completion instructions located in the V1 – Enrollment section of this document.

Reactogenicity Baseline and Early

General Instructions:
Review the Reactogenicity Baseline and Early completion instructions located in the V1 – Enrollment section of this document.

Reactogenicity Daily Log

General Instructions:
Review the Reactogenicity Daily Log completion instructions located in the V1 – Enrollment section of this document.

Reactogenicity Resolution (if needed)

General Instructions:
Review the Reactogenicity Resolution completion instructions located in the V1 – Enrollment section of this document.

V102 – Day 8 (Phone Visit)

Follow-up Visit Summary

General Instructions:
Review the Follow-up Visit Summary completion instructions located in the V2 – Day 8 Phone Visit section of this document.

OR

Missed Visit

General Instructions:
Review the Missed Visit completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Contraception (if applicable)

General Instructions:
Review the Contraception completion instructions located in the V2 – Day 8 Phone Visit section of this document.

See Additional CRFs section located in the V2 – Day 8 Phone Visit section of this document for additional CRFs. Use the Additional Study Procedures form to add additional CRFs.

Additional Study Procedures

General Instructions:
Review the Additional Study Procedures completion instructions located in the V2 – Day 8 Phone Visit section of this document.

V103 – Day 29

Vaccination Follow-up

Purpose:
This form documents a participant's SARS-CoV-2 follow-up vaccination.

General Instructions:
Complete this form for each participant in IDC003-21-0012.

Field-specific Instructions:

Field	Instructions
Date of vaccination	Enter the date the vaccination was given. A complete date is required.

Time of injection	Enter the time of the injection. Use a 24-hour clock (00:00-23:59), where hours are designated from 0–23.
Location of injection	Enter the location the vaccination was given.
Product manufacturer	Record the vaccine manufacturer. If Moderna-mRNA-1273 is not appropriate, record “Other” and specify in the field below.
If “Other”, specify	Specify the other vaccine manufacturer.
Were there any study product administration errors?	Were there any study product administration errors? If “Yes” complete the Study Product Administration Form.
Comments	Detail any comments regarding the booster. Maximum 450 characters.

Follow-up Visit Summary

General Instructions:
Review the Follow-up Visit Summary completion instructions located in the V2 – Day 8 Phone Visit section of this document.

OR

Missed Visit

General Instructions:
Review the Missed Visit completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Physical Exam

General Instructions:
Review the Physical Exam completion instructions located in the V1 – Enrollment section of this document.

Vital Signs

General Instructions:
Review the Vital Signs completion instructions located in the V1 – Enrollment section of this document.

Contraception (If applicable)

General Instructions:
Review the Contraception completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Pregnancy Test Results

General Instructions:
Review the Pregnancy Test Results completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Specimen Collection – Blood

General Instructions:
Review the Specimen Collection – Blood completion instructions located in the V1 – Enrollment section of this document.

Reactogenicity Baseline and Early

General Instructions:
Review the Reactogenicity Baseline and Early completion instructions located in the V1 – Enrollment section of this document.

Reactogenicity Daily Log

General Instructions:
Review the Reactogenicity Daily Log completion instructions located in the V1 – Enrollment section of this document.

Reactogenicity Resolution (if needed)

General Instructions:
Review the Reactogenicity Resolution completion instructions located in the V1 – Enrollment section of this document.

See Additional CRFs section located in the V2 – Day 8 Phone Visit section of this document for additional CRFs. Use the Additional Study Procedures form to add additional CRFs.

Additional Study Procedures

General Instructions:
Review the Additional Study Procedures completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Missed Study Product Administration

Purpose:
This form is used to document when a schedule study product administration was missed for cohort 2.

General Instructions:
This form is will populate when the box for “Missed study product administration” has been checked on the Additional Study Procedures CRF.

Field-specific Instructions:

Field	Instructions
Visit date of missed study product administration	Record the date that the study product administration was missed. If "Pregnancy", complete Pregnancy Report and Pregnancy History forms. If "Adverse event", complete Adverse Event log if condition meets AE reporting requirements as specified in the protocol, and select the appropriate AE suing the dynamic search list on this form. If “Reactogenicity event” select the appropriate reactogenicity event using the dynamic search list.

	If “Other”, specify in the text box. Max 200 characters.
If "Adverse event" or "Reactogenicity event", indicate who made the decision to not administer study product.	Mark all that apply. If “Other”, specify. Max 200 characters.
Comments	Detail any additional comments regarding the missed study product administration at this visit. Max 200 characters.

V104 – Day 36, Phone Visit

Follow-up Visit Summary

General Instructions:
Review the Follow-up Visit Summary completion instructions located in the V2 – Day 8 Phone Visit section of this document.

OR

Missed Visit

General Instructions:
Review the Missed Visit completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Contraception (if applicable)

General Instructions:
Review the Contraception completion instructions located in the V2 – Day 8 Phone Visit section of this document.

See Additional CRFs section located in the V2 – Day 8 Phone Visit section of this document for additional CRFs. Use the Additional Study Procedures form to add additional CRFs.

Additional Study Procedures

General Instructions:
Review the Additional Study Procedures completion instructions located in the V2 – Day 8 Phone Visit section of this document.

V105 – Day 43

Follow-up Visit Summary

General Instructions:
Review the Follow-up Visit Summary completion instructions located in the V2 – Day 8 Phone Visit section of this document.

OR

Missed Visit

General Instructions:
Review the Missed Visit completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Physical Exam

General Instructions:
Review the Physical Exam completion instructions located in the V1 – Enrollment section of this document.

Contraception (if applicable)

General Instructions:
Review the Contraception completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Specimen Collection – Blood

General Instructions:
Review the Specimen Collection – Blood completion instructions located in the V1 – Enrollment section of this document.

See Additional CRFs section located in the V2 – Day 8 Phone Visit section of this document for additional CRFs. Use the Additional Study Procedures form to add additional CRFs.

Additional Study Procedures

General Instructions:
Review the Additional Study Procedures completion instructions located in the V2 – Day 8 Phone Visit section of this document.

V106 – Day 1B

Follow-up Visit Summary

General Instructions:
Review the Follow-up Visit Summary completion instructions located in the V2 – Day 8 Phone Visit section of this document.

OR

Missed Visit

General Instructions:
Review the Missed Visit completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Booster

Purpose:
This form documents a participant's SARS-CoV-2 booster vaccination.

General Instructions:
Complete this form for each participant in IDC003-21-0012.

Field-specific Instructions:

Field	Instructions
Date of booster	Enter the date the booster was given. A complete date is required.
Time of injection	Enter the time of the injection. Use a 24-hour clock (00:00-23:59), where hours are designated from 0–23.
Location of injection	Enter the location the booster was given.
Product manufacturer	Record the vaccine manufacturer. If Moderna-mRNA-1273 is not appropriate, record "Other" and specify in the field below.
If "Other", specify	Specify the other vaccine manufacturer.
Were there any study product administration errors?	Were there any study product administration errors? If "Yes" complete the Study Product Administration Form.
Comments	Detail any comments regarding the booster. Maximum 450 characters.

Physical Exam

General Instructions:
Review the Physical Exam completion instructions located in the V1 – Enrollment section of this document.

Vital Signs

General Instructions:
Review the Vital Signs completion instructions located in the V1 – Enrollment section of this document.

Contraception (If applicable)

General Instructions:
Review the Contraception completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Pregnancy Test Results

General Instructions:
Review the Pregnancy Test Results completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Specimen Collection – Blood

General Instructions:
Review the Specimen Collection – Blood completion instructions located in the V1 – Enrollment section of this document.

Reactogenicity Baseline and Early

General Instructions:
Review the Reactogenicity Baseline and Early completion instructions located in the V1 – Enrollment section of this document.

Reactogenicity Daily Log

General Instructions:
Review the Reactogenicity Daily Log completion instructions located in the V1 – Enrollment section of this document.

Reactogenicity Resolution (if needed)

General Instructions:
Review the Reactogenicity Resolution completion instructions located in the V1 – Enrollment section of this document.

See Additional CRFs section located in the V2 – Day 8 Phone Visit section of this document for additional CRFs. Use the Additional Study Procedures form to add additional CRFs.

Additional Study Procedures

General Instructions:
Review the Additional Study Procedures completion instructions located in the V2 – Day 8 Phone Visit section of this document.

V107 – Day 8B (Phone Visit)

Follow-up Visit Summary

General Instructions:
Review the Follow-up Visit Summary completion instructions located in the V2 – Day 8 Phone Visit section of this document.

OR

Missed Visit

General Instructions:
Review the Missed Visit completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Contraception (if applicable)

General Instructions:
Review the Contraception completion instructions located in the V2 – Day 8 Phone Visit section of this document.

See Additional CRFs section located in the V2 – Day 8 Phone Visit section of this document for additional CRFs. Use the Additional Study Procedures form to add additional CRFs.

Additional Study Procedures

General Instructions:
Review the Additional Study Procedures completion instructions located in the V2 – Day 8 Phone Visit section of this document.

V108 – Day 15B, V109 – Day 29B

Follow-up Visit Summary

General Instructions:
Review the Follow-up Visit Summary completion instructions located in the V2 – Day 8 Phone Visit section of this document.

OR

Missed Visit

General Instructions:
Review the Missed Visit completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Physical Exam

General Instructions:
Review the Physical Exam completion instructions located in the V1 – Enrollment section of this document.

Vital Signs

General Instructions:
Review the Vital Signs completion instructions located in the V1 – Enrollment section of this document.

Contraception (if applicable)

General Instructions:
Review the Contraception completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Specimen Collection – Blood

General Instructions:
Review the Specimen Collection – Blood completion instructions located in the V1 – Enrollment section of this document.

See Additional CRFs section located in the V2 – Day 8 Phone Visit section of this document for additional CRFs. Use the Additional Study Procedures form to add additional CRFs.

Additional Study Procedures

General Instructions:
Review the Additional Study Procedures completion instructions located in the V2 – Day 8 Phone Visit section of this document.

V110 – Day 91B, V111 – Day 169B, V112 – 366B

Follow-up Visit Summary

General Instructions:
Review the Follow-up Visit Summary completion instructions located in the V2 – Day 8 Phone Visit section of this document.

OR

Missed Visit

General Instructions:
Review the Missed Visit completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Physical Exam

General Instructions:
Review the Physical Exam completion instructions located in the V1 – Enrollment section of this document.

Contraception (if applicable)

General Instructions:
Review the Contraception completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Specimen Collection – Blood

General Instructions:
Review the Specimen Collection – Blood completion instructions located in the V1 – Enrollment section of this document.

See Additional CRFs section located in the V2 – Day 8 Phone Visit section of this document for additional CRFs. Use the Additional Study Procedures form to add additional CRFs.

Additional Study Procedures

General Instructions:
Review the Additional Study Procedures completion instructions located in the V2 – Day 8 Phone Visit section of this document.

Form-Specific Instructions by Visit: Ongoing Logs

Medical History Y/N

Purpose:
This form is used to trigger the Medical History Log.

General Instructions:
This form is only completed once, at the time the first medical history condition/event is reported. This form is not used again once the Medical History Log is triggered.

Field-specific Instructions:

Field	Instructions
Does the participant have any medical history to report?	If "Yes" is selected, then the **Medical History** log loads and entries are required. If the participant has no **Medical History** select "No" and proceed to the next CRF.

Medical History

Purpose:
This form documents a snapshot of the participant's medical history at screening.

General Instructions:

- Record only medical conditions experienced up to study product initiation unless otherwise specified in the protocol.
- Include current medical conditions. Refer to study manual for definition of collected medical history events.
- Surgeries/treatments should only be list in the comments section and not the verbatim term.
- Complete one log line for each medical history condition/event.
- Add additional log lines by clicking "Add a new Log line".
- If a participant recalls additional medical history after enrollment, update the **Medical History** log by adding a new log line.
- Do not update existing log lines after the Enrollment Visit.

Field-specific Instructions:

Field	Instructions
Date medical condition/event reported	Record the initial date that the medical history of the participant was *reported*.
Description of medical history condition/event	Whenever possible, provide a diagnosis instead of listing a cluster of symptoms. If no diagnosis is identified, record each symptom as a separate entry on the **Medical History** log.
Start date of medical history condition/event	If the participant is unable to recall the date, obtain participant's best estimate. At a minimum, the year is required. If the date is within the same year as study enrollment, the month and year are both required. • If the exact day is unknown, enter 'UN' for the day field. • If the exact month is unknown, then select 'UNK' for the month field. • Example: UN-Jan-2020 or UN-UNK-2020.

	If the condition is diagnosed due to an abnormal lab result, record the date on which the specimen was collected. If a diagnosis is not available, record the date of onset of condition.
Is the condition ongoing?	Review and update conditions marked “ongoing” only prior to and including the Enrollment Visit.
Date medical condition/event ended/resolved	A date is required if required if ‘Is the condition ongoing?’ is “No”. If the exact day is unknown, enter ‘UN’ for the day field. If the exact month is unknown, then select ‘UNK’ for the month field. At a minimum, a year is required. Record the date the medical condition was considered resolved. For surgeries/procedures, record the date the surgery/procedure was completed.
Comments	Detail any comments regarding the Medical History. Maximum 200 characters.

Concomitant Medications Y/N

Purpose:
This form is used to trigger the Concomitant Medication log.

General Instructions:
This form is in the “Ongoing Logs” folder and is only completed once, at the time the first concomitant medication is reported or at the end of the study if no concomitant medications are reported. This form is not used again once the Medical History Log is triggered.

Field-specific Instructions:

Field	Instructions
Is the participant taking any concomitant medications?	If “Yes” is selected, the **Concomitant Medications** log loads in the Ongoing Logs folder. At the end of Day 28, mark “No” if no concomitant medications were reported. Concomitant Medications are not recorded after Day 28.

Concomitant Medications

Purpose:
This form documents all medication(s), other than study product, that are used by the participant during the study (including the protocol-defined screening period).This includes, but is not limited to, prescription and non-prescription drugs, vitamins, topical products, alternative/complimentary medicines (e.g., herbal and health food supplements), recreational drugs, vaccinations, contraceptive medications, and allergy shots.

General Instructions:

Complete a separate entry (e.g., log line) for each reported concomitant medication when entering into the study database. Use the “Add a new Log line” button to add an additional concomitant medication in Medidata Rave.

Field-specific Instructions:

Field	Instructions
Medication name	Record the medication name as reported by the participant. For example, if the participant reports taking a trade name medication, report the trade name. If a trade name is not available or not reportable per national guidelines, record the generic name of the medication. If a medication’s trade or generic name is unknown to the participant, record “unknown” and a description or drug class. A combination medication can be recorded as one entry using the generic name. If a combination medication does not have a generic name or the generic name is unknown, each active ingredient must be reported as a separate entry.
If the medication entered is a booster received outside of the study or protocol, check this box	Check this box if the medication entered is a Concomitant Medication is a SARS-CoV-2 booster obtained outside of the study. If this box is checked, enter "SARS-CoV-2 Booster: [Manufacturer]" under "Indication" below, and complete a Protocol Deviation.
Indication	Record the indication for each medication as initially prescribed or self-treated. For health supplements, such as multivitamins, record “general health”. For preventive medications, record “prevention of [insert condition]” (e.g., for flu shot, record “prevention of influenza”). For recreational drugs, record “recreation”. If a medication previously recorded for one indication is then taken for another, record this use as a new entry (with the new indication and new Date Started).

Date started	• If the participant is unable to recall the exact date, obtain participant’s best estimate. At a minimum, the year is required.
	  ○ If the exact day is unknown, enter ‘UN’ for the day field.
	  ○ If the exact month is unknown, then select ‘UNK’ for the month field.
	  ○ For example, a partial date may be recorded as: UN-Jan-2020 or UN-UNK-2020
	• For injections
	  ○ If it is a one-time injection (including contraception), record each injection as a separate entry, with the same date used for date started and stopped.

	○ If it is a series of injections, record the date of the first injection as date started and the date of the last injection as the date stopped. • For implants/devices ○ Record the date the implant/device was inserted as the date started and the date it was removed as the date stopped.
Date stopped *Or* Ongoing	If a medication is stopped for a clinically significant period of time, record a stop date. If the medication is later restarted, record on a new log line. At the participant's Termination visit, the "Date Stopped" must be recorded for each medication or "Ongoing" must be checked. At a minimum, the year is required.
Dose	Record the dose amount. Expected format is a number in whatever dose units are to be recorded.
Dose Units	Select/record the applicable dose units provided in the drop-down list. If "Other" is selected, specify the dose units in the corresponding "If "Other", specify" field provided.
If "Other", specify	Specify the "Other" dose units as applicable. Maximum 200 characters.
Frequency	Select the frequency from options provided in the drop-down list. For injections, frequency should be 'Once', with same date used for the start and stop dates. If "Other" is selected, specify the frequency in the corresponding "If "Other", specify" field provided.
If "Other", specify	Specify the "Other" frequency as applicable. Maximum 200 characters.
Route	Select the route from options provided in the drop-down list. If "Other" is selected, specify the route in the corresponding "If "Other", specify" field provided.
If "Other", specify	Specify the "Other" route as applicable. Maximum 200 characters.
Taken for a reported unsolicited AE or SAE as recorded in the AE log	Record whether this medication was taken for an unsolicited adverse event or SAE recorded in the Adverse Events Log by selecting "Yes" or "No". If "No" is selected, end the form. If "Yes", is selected, pick the appropriate adverse event in the list below.
If "Yes", select adverse event.	If the "Taken for reported AE?" field was marked as "Yes", link to the adverse event by selecting it from the populated list of adverse events.

Adverse Event Y/N

Purpose:
This form is used to trigger the Adverse Event log.

General Instructions:
This form is in the “Ongoing Logs” folder and is only completed once, at the time the first adverse event is reported or at the end of the study if no adverse events are reported. This form is not used again once the Adverse Event Log is triggered.

Field-specific Instructions:

Field	Instructions
Has the participant experienced an adverse event during the study?	If "Yes" is selected, the **Adverse Event** log loads in the Ongoing Logs folder. At the end of study participation, mark "No" if no adverse events were reported.

Adverse Event

Purpose:
This form documents Adverse Events (AEs) reported by the participant or clinically observed as defined by the protocol.

General Instructions:
Complete a separate entry (e.g., a new log line) for each adverse event.

Use the "Add a new Log line" button to add an additional adverse event in Medidata Rave.

Only list conditions that start on or after enrollment date, otherwise record as pre-existing condition.

Whenever possible, report a diagnosis instead of listing a cluster of symptoms. If no diagnosis is identified, each symptom must be recorded as separate AE log entries as applicable. If a cluster of symptoms reported on separate AE Log pages is later attributed to a single diagnosis, change/update the earliest reported symptom page to the diagnosis. In the study database, these other symptoms can be deleted by clicking "Inactivate" and selecting the applicable rows that should be inactivated.

Do not record a condition as an AE if it existed at enrollment as a pre-existing condition unless the condition increases in severity or frequency. Record increases in severity/frequency as new events with corresponding start/stop dates.

Field-specific Instructions:

Field	Instructions
Date AE reported to site	Record the date the adverse event was reported to, or identified by, site personnel. A complete date is required.
Adverse event (AE)	Describe the adverse event using medical terminology. Record a diagnosis/anatomical location if available. For lab abnormalities, format is (increased/decreased [test name]).
Onset Date	Record the onset date of the adverse event. A complete date is required. The onset date is the date on which the participant reports first experiencing the AE. If the AE is discovered during a study visit, record the date of the study visit. If the AE is an abnormal lab result, record the date on which the specimen was collected.

Is this a solicited AE (reactogenicity)?	Record "Yes" or "No" as to whether this AE is part of the Reactogenicity assessments – a solicited AE.
At which visit was this adverse event first reported?	Record the specific study visit at which the adverse event was reported. If the visit is an interim visit, record the visit code below. If not, proceed to "Is the AE still ongoing?"
If "Interim visit", specify interim visit code.	If the visit specified above is an interim visit, record the visit code, otherwise leave this field blank. The interim visit code should be the numbered for the visit after the closest scheduled visit, but as sub-visit 0.1. For example, an interim visit between Visits 3 and 4, would be numbered Interim Visit 3.1. Refer to the study manual for more information on visit codes.
Is the AE still ongoing?	Record whether the adverse event is still ongoing by entering "Yes" or "No". If "No" is selected, skip to "Outcome date" and specify the adverse event outcome date. This field should be revised through the last study visit as the adverse event is assessed. If the adverse event is ongoing at participant termination from the study, this field should be marked as "Yes".
If "No", outcome date	Record one of the following as appropriate: The date on which the participant no longer experienced the AE. The date of the study visit or specimen collection at which the change in status/outcome is first noted. This field should be revised through the last study visit as the adverse event is assessed. If the adverse event is ongoing at participant termination from the study, this field should be left blank.
Severity grade	If any values meet the criteria for severity grade 1 or greater according to the FDA Guidance for Industry; Toxicity Grading Scale for Healthy Adult and Adolescent Volunteers Enrolled in Preventive Vaccine Clinical Trials. Assign the relevant toxicity grade. https://www.fda.gov/media/73679/download • Grade 1 (Mild) • Grade 2 (Moderate) • Grade 3 (Severe) • Grade 4 (Potentially life-threatening) • Grade 5 (Death)
Relationship to study product	Mark the assessment of the relationship between the AE and the study product. "Related" – reasonable possibility that the AE may be related to the study product.

	"Not related" – not a reasonable possibility that the AE is related to the study product. Record pertinent details for relationship assessment in "Comments".
If "Not related", specify alternate etiology.	If the "Relationship to study product" is "Not related", specify any alternate etiology as applicable. It is acceptable to have similar or the same alternate etiology as the AE term or the diagnosis. Alternatively, specify "possible' or "probable" in the alternate etiology if the diagnosis in the alternate etiology is not definitive. If not known, enter "Unknown" Maximum 200 characters.
Action taken with study product	***Dose not changed:*** Mark if the participant is expected to continue to use study product and the AE does NOT result in a dose change, study product interruption or permanent discontinuation. ***Dose reduced:*** Mark if the AE results in a study product dose reduction. (This option does not apply and should not be selected for this study.) ***Drug withdrawn:*** Mark if the AE results in a study product discontinuation. If multiple AEs are reported at the same visit, mark "Drug withdrawn" for the AE(s) that contributed to the discontinuation. ***Drug interrupted:*** Mark if the AE results in a study product hold. If multiple AEs are reported at the same visit, mark "Drug interrupted" for the AE(s) that contributed to the hold. ***Not applicable:*** Mark if the AE occurred after the participant had completed all administration of the study product. Mark if the study product is held or permanently discontinued for a different AE or other reason. Mark if the AE is grade 5-death.
Action taken	Record any other action taken as related to the adverse event. If no additional actions are taken, check "None" and skip to "Status/Outcome". Mark all actions that apply. If an action taken is not listed, mark "Other" and detail the action in "Other, specify".
If "Other", specify	Record the detail for the "Other" action taken for this adverse event. Maximum 200 characters.
Status/Outcome	***Recovered/Resolved:*** Recovered/Resolved: AE is no longer present, has returned to baseline severity/frequency, or has increased in severity/frequency. If AE has increased in severity/frequency, add in

	the comments field that the AE has increased in severity/frequency and that a new AE has been submitted. If a participant is taking a medication to control an AE that arose during study participation, it is not considered resolved. ***Recovering/resolving:*** AE is continuing and has not yet resolved or returned to baseline severity/frequency. ***Recovered/resolved with sequelae:*** Participant has recovered from the AE, but with remaining effects or impairment. ***Not recovered/Not resolved:*** Whenever an AE is continuing at the time of participant termination from the study. ***Fatal:*** Severity of this AE is grade 5. Update any other Aes continuing at the time of death to "Not Recovered/Not Resolved." ***Unknown:*** Outcome of AE is unknown (e.g. lost to follow-up) Note that decreases in severity should not be recorded as new Aes, but their status/outcome can be updated to "recovering/resolving." Note that if an AE increases in severity or frequency (worsens) after it has been reported on an AE log CRF, the "old" AE should be marked "recovered/resolved" and the new AE should be submitted. When an AE improves to a lower severity or becomes less frequent, a new AE submission is not necessary. This field should be revised through last study visit as the adverse event is assessed. If the adverse event is unresolved at participant termination from the study, this field should indicate the status at the end of the participant's participation in the study. If not resolved at that time, mark "Not recovered/Not resolved".
Is this a serious adverse event (SAE) according to ICH/GCP or protocol guidelines?	Record whether this adverse event qualifies as a serious adverse event according to ICH/GCP or protocol guidelines by selecting "Yes" or "No". If "No" is selected, skip to "Does this AE meet criteria for an AE of Special Interest (AESI)?" If "Yes", check all the reasons it's considered serious. Check all that apply.
Does this AE meet criteria for an AE of Special Interest (AESI)?	Record whether this adverse event is considered an AE of Special Interest (AESI)? By selecting "Yes" or "No". If "Yes", enter the onset date.

SAE/AESI onset date	Provide the date the adverse event first meets protocol guidance for seriousness or an AE of Special Interest. A complete date is required.
Does this AE meet criteria for a Suspected Unexpected Serious Adverse Reaction (SUSAR)?	Record whether this adverse event meets the criteria for a Suspected Unexpected Serious Adverse Reaction according to protocol guidelines by selecting “Yes” or “No”.
Does this AE meet criteria for a New-Onset Chronic Medical Condition (NOCMC)?	Record whether this adverse event meets the criteria for a New-Onset Chronic Medical Condition according to protocol guidelines by selecting “Yes” or “No”.
Does this AE meet criteria for a Medically Attended Adverse Event (MAAE)?	Record whether this adverse event meets the criteria for a Medically Attended Adverse Event according to protocol guidelines by selecting “Yes” or “No”.
If MAAE, specify	If “Yes” is selected, specify how this event meets those criteria.
Does this AE meet criteria for an Unanticipated Problem (UP)?	Record whether this adverse event meets the criteria for an Unanticipated Problem according to protocol guidelines by selecting “Yes” or “No”.
Event to be evaluated for halting criteria?	Record whether this adverse event qualifies as an event to be evaluated for halting criteria according to protocol guidelines by selecting “Yes” or “No”.
Was this AE a worsening of a baseline medical condition?	Record whether this adverse event qualifies as a worsening of a baseline medical condition by selecting “Yes” or “No”. If “Yes” is selected, make sure the baseline condition is recorded on the Medical History eCRF.
Comments	Record any applicable comments regarding this adverse event. Maximum 450 characters.

Protocol Deviations Y/N

Purpose:
This form is used to trigger the Protocol Deviations log in Rave.

General Instructions:
This form is in the “Ongoing Logs” folder and is only completed once, at the time the first protocol deviation is reported or at the end of the study if no protocol deviations are reported.

Field-specific Instructions:

Field	Instructions
Have any protocol deviations been reported?	If “Yes” is selected, the **Protocol Deviations** log loads in the Ongoing Logs folder.

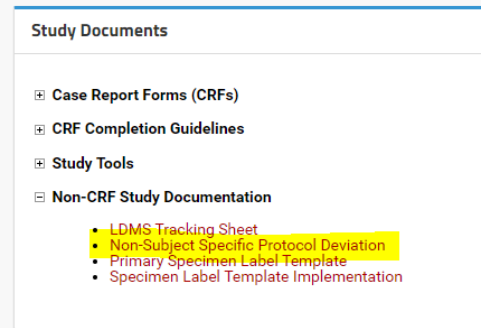
	At the end of study participation, mark “No” if no protocol deviations were reported.

Protocol Deviations

Purpose:
This form documents and reports protocol deviations identified for study participants during the conduct of the study as defined in the protocol and Manual of Operations (MOP). This form is not used again once the Protocol Deviations Log is triggered.

General Instructions:
Complete this form each time a protocol deviation is identified for a participant during study participation (including the screening period). Once the Protocol Deviation Log form has been created, complete one page per protocol deviation when entering in the study database. To add an additional deviation within Medidata Rave, clicking “Add a new Log line” will add an additional page for a new deviation to be completed.

Note that Non-Participant Specific Protocol Deviations should be recorded in the Non-Participant Specific Protocol Deviations log located on the study Atlas page, under the “Study Documents” section (see image below). Further details on recording Non-Participant Specific Protocol Deviations can be located in the MOP.



Field-specific Instructions:

Field	Instructions
Site awareness date	Record the date the site became aware of the deviation. A complete date is required.
Deviation date	Record the date the deviation occurred (start date). This date may not be the same as the site awareness date. A complete date is required.
Visit	Use the dropdown menu to select the visit at which the Protocol Deviation occurred. If “Interim visit”, specify the interim visit code. OR, if the protocol deviation did not occur during a visit, check the box for “OR if protocol deviation did not occur during a visit, check this box”.

Has or will this deviation be reported to local IRB/EC?	Select "Yes" or "No".
Type of deviation	Record the applicable deviation by selecting from the drop-down menu. *Please see table below for the types of deviations.* When entering the type of deviation, the first few letters of the description can be entered within the drop-down search list to find the applicable deviation to be entered. Record "other" if none of the listed categories match.
Description of deviation	Use the text field to briefly describe the specific details of the deviation. This is inclusive of the who, what, when, and where.
Plans and/or action taken to address the deviation	Use the text field to provide a brief description of the plans to address the deviation.
Plans and/or action taken to prevent future occurrences of the deviation	Use the text field to provide a brief description of the plans to address future deviations.
Deviation reported by	Enter name of staff member that reported the deviation

PROTOCOL DEVIATION CODE LIST

Description	Description
Inappropriate enrollment: Inappropriate enrollment may include: • Participant who were enrolled and did not meet all inclusion criterion • Participant who were enrolled and met exclusion criterion	**Physical assessment deviation:** Includes when a protocol-specified exam or assessment was not performed.
Failure to follow randomization or blinding procedures: Include instances where randomization procedures were not followed by site staff, or product blinding procedures were not followed by pharmacy staff.	**Lab assessment deviation:** Include missed, or incomplete lab specimen collection. This may include: • Blood not collected. • Urine not collected • Other specimen(s) not collected
Study product management deviation: The site staff did not instruct the participant to hold, permanently discontinue, or resume study product use per protocol requirements. This may include	**Too few aliquots obtained:** the number of aliquots obtained was less than the number specified in the protocol

study product temperature excursion or specimen temperature excursion	
Study Product dispensing error: The wrong study product was dispensed to a participant, or study product was dispensed to a participant who permanently discontinued study product use.	**Mishandled lab specimen:** Include errors in labeling, physical handling, processing, testing, storage, or shipment of collected lab specimens.
Study Product use/non-use deviation: Select this option when: • Participant declines product use. • Missed treatment administration. Delayed treatment administration	**Staff performing duties that they are not qualified to perform:** use for any instance when any study procedure, including clinical and administrative procedures, is completed by a staff member who is not adequately qualified AND delegated to perform the procedure.
Conduct of non-protocol procedure: A clinical or administrative procedure was performed that was not specified in the protocol and was not covered under local standard of care practice. For example: • A specialized blood test was ordered that was not required in the protocol and did not fall in standard of care.	**Use of non-IRB/EC-approved materials:** Include use of ANY study-related material that requires IRB or EC approval for use per site requirements.
Improper AE/SAE: use when an AE is not followed per protocol.	**Use of excluded concomitant medications, devices, or non-study products.**
Unreported AE: Site staff become aware of an AE, but do not report it per protocol requirements.	**Informed consent process deviation:** Examples include: • Failure to accurately execute and/or document any part of the informed consent process. • Incorrect version of Informed Consent Form (ICF) signed • ICF not signed prior to study procedures
Unreported SAE/AESI/UP: Site staff become aware of an SAE or AESI or UP, but do not report it per protocol.	**Visit completed outside of window:** Use when visit procedures for a visit are done within the wrong window or not in a designated visit window. For example, if visit 3.0 procedures are done in the visit 4.0 window.
Breach of confidentiality: Include potential and actual cases where participant confidentiality is breached. For example, a staff member put a participant's name on a case report form.	**Other:** This option can be used for other types of deviations, including, but not limited to: • Required procedure not conducted. • Required procedure done incorrectly. • Specimen result not obtained. • Unreported pregnancy

Study product management deviation: The site staff did not instruct the participant to hold, permanently discontinue, or resume study product use per protocol requirements. This may include study product temperature excursion or specimen temperature excursion	**Required Procedure not conducted:** Use this option when an assessment or other protocol-specified procedure was not performed. This applies to individual assessments missed by study staff or the participant. For example: • Participant failed to record Body Temperature in the Reactogenicity Daily Log. • Study Staff failed to perform the Physical Assessment as specified in the protocol.

Form-Specific Instructions by Visit: Discontinuations

Study Termination

Purpose:
This form is used to document a participant's exit from the study (i.e., scheduled, or early study termination).

General Instructions:
This form is present within the Discontinuations folder. Complete this form for each enrolled participant at either the scheduled exit/end of study visit or when the participant is no longer participating in the study.

Field-specific Instructions:

Field	Instructions
Date of study exit	Record the date when the participant was permanently exited the study. A complete date is required.
Primary reason for completion/discontinuation	Record the most applicable reason for completion/discontinuation. If the participant completed all visits, select "Scheduled exit visit/end of study". If the subject the subject did not complete all visits, record the most applicable reason for completion/discontinuation. If "Other" is selected, specify the reason for study exit in the "If "Other", specify" field provided. If "Death" is selected, record the date of death. If "Adverse event" or "Death" is selected, record the applicable adverse event from the drop-down menu.
If "Other", specify	Specify the "Other" reason for study exit. Maximum 200 characters.
If "Protocol Deviation", select applicable protocol deviation	If the "Primary reason for completion/discontinuation?" field was marked as "Protocol Deviation", link to the protocol deviation by selecting it from the populated list of protocol deviations.

If "Adverse event" or "Death" or "Confirmed SARS CoV-2 infection", select applicable adverse event.	If the "Primary reason for completion/discontinuation?" field was marked as "Adverse event", "Death", or "Confirmed SARS CoV-2 infection", link to the adverse event by selecting it from the populated list of adverse events, as applicable. If no applicable AE for 'Confirmed SARS CoV-2 infection', leave blank and respond to system query with 'Not applicable'.
If "Death", enter date of death	Record the participant date of death. A complete date is required.

Discontinuation of Study Product (Cohort 2 only)

Purpose:
This form documents a participant's permanent discontinuation of study product use. This form will only populate for Cohort 2 participants.

General Instructions:
This form is present within the "Discontinuations" folder. Complete this form for each enrolled participant when study product use is permanently discontinued (early or scheduled study product use end).

Field-specific Instructions:

Field	Instructions
Date that study product completion or discontinuation.	A complete date is required. Record the date when the participant was permanently discontinued from study product.
Primary reason for ending study product use	Record the primary reason from the drop-down menu. If "Adverse Event" or "Death" is selected, specify the AE entry (in Medidata Rave, choose the AE from the AE dynamic drop-down list). **Note**: If study product is permanently discontinued due to an AE, the AE log page must be entered into Rave prior to linking the AE on the Product Discontinuation form for the AE to be available to select with the drop-down field. If "Other", then specify relevant details in the "If, Other, specify" text field provided.
If "Adverse Event" or "Death" or "Confirmed SARS CoV-2 infection", select applicable event.	If the "Primary reason for completion/discontinuation?" field was marked as "Adverse event", "Death", or "Confirmed SARS CoV-2 infection" link to the adverse event by selecting it from the populated list of adverse events, as applicable. If no applicable AE for 'Confirmed SARS CoV-2 infection', leave blank and respond to system query with 'Not applicable'.

Form-Specific Instructions by Visit: Add Event

Interim Visit Summary

Purpose:
This form is used to summarize information at an interim visit and to record all procedures or assessments the participant received at any interim study visit (e.g., if a clinically indicated physical exam is performed) completed during the study.

General Information/Instructions:
This form is required for each interim visit completed for a participant.

Field-specific Instructions:

Field	Instructions
Visit Date	Record the visit date. A complete date is required.
Interim Visit code	Enter the applicable interim visit code. The interim visit code should be the numbered for the visit after the closest scheduled visit, but as sub-visit 0.1. For example, an interim visit between Visits 3 and 4, would be numbered Interim Visit 3.1. Refer to the study manual for more information on visit codes.
Did the participant exit/terminate the study at this visit?	Select "Yes" or "No". If "Yes"', then complete a Study Termination form within the Discontinuations folder.
Were any new medical condition/events reported at this visit?	Select "Yes" or "No". Select "Yes"' if at least one new medical condition/event was reported for this visit. Navigate to the ongoing logs folder to complete an entry for the applicable Medical History).
Were any new adverse events (Aes) reported at this visit?	Select "Yes" or "No". Select "Yes"' if at least one Adverse Event (AE) was newly completed for this visit. Navigate to the ongoing logs folder to complete an entry for the applicable AE(s).
Is the participant taking any concomitant medications that have not been previously reported?	Select "Yes" or "No". Select "Yes"' if at least one concomitant medication was newly completed for this visit. Navigate to the ongoing logs folder to complete an entry for the applicable medication(s).
Were any protocol deviations reported at this visit?	Select "Yes" or "No". Select "Yes"' if at least one protocol deviation was newly completed for this visit. Navigate to the ongoing logs folder to complete an entry for the applicable protocol deviation(s).

Reason(s) for interim visit (select all that apply)	Select the applicable checkboxes for the reason an interim visit was performed. The reasons include “AE report or follow-up”, “Completion of missed visit procedures” and “Other”. If “Completion of missed visit procedures” is selected, record the appropriate missed visit from the drop-down menu. If ‘Other’ is selected, specify the reason for interim visit in the “If “Other”, specify” field provided.
If “Other”, specify	Specify the “Other” Reason for interim visit. Maximum 200 characters.
What study procedures were completed at this visit?	Select the applicable procedures that were completed at the study visit. The applicable form(s) will then be added to the participant’s visit folder. For example, if a pregnancy test performed, select the checkbox for **Pregnancy Test Results**. Procedures that were not completed at this visit should be left blank.

Pregnancy Report

Purpose:
Complete this form when reporting a pregnancy of a study participant post enrollment through study discontinuation.

General Instructions:
This form will dynamically be added to the Pregnancy folder when a positive Pregnancy test is recorded on the Pregnancy Test form by study staff. Participants whose “sex at birth” is “Male” should not complete this CRF.

Field-specific Instructions:

Field	Instructions
Date pregnancy reported to site	Record the date the pregnancy was reported to site staff. A complete date is required.
Visit at which this pregnancy was reported	Use the dropdown menu to select the appropriate visit. If "Interim visit", specify Interim visit code.
If "Interim visit", specify visit code	Enter the applicable interim visit code. The interim visit code should be the numbered for the visit after the closest scheduled visit, but as sub-visit 0.1. For example, an interim visit between Visits 3 and 4, would be numbered Interim Visit 3.1. Refer to the study manual for more information on visit codes.
Date of onset of last menstrual period	A complete date is required. Record best estimate if date not known. If the participant is amenorrheic, tick the checkbox for "Amenorrheic for past 6 months" and leave the "Date of onset of last menstrual period" blank.
Amenorrheic for past 6 months	If the participant is amenorrheic, tick this checkbox and leave the "Date of onset of last menstrual period" blank.
Estimated date of delivery	Record the estimated date of delivery. A complete date is required.
What primary information was used to estimate the date of delivery?	Use the dropdown menu to indicate what primary information was used to estimate the date of delivery. If another method was used which are not covered by the currently listed methods, please select "Other" and describe in the 'If Other, specify' text field provided.
If delivery date was determined by ultrasound, please provide date of ultrasound?	If ultrasound was used to estimate delivery date, record date of ultrasound.
If "Other", specify	Specify the "Other" method used to estimate the date of delivery. Maximum 200 characters.

Pregnancy History

Purpose

This form is used to document a participant's pregnancy history.

Generation Instructions:

Complete this form only once per participant, even if she has multiple pregnancies during follow-up.

Field-specific Instructions:

Field	Instructions
Has the participant ever been pregnant before?	If "Yes" is selected, complete the remainder of the form. If "No" is selected, leave the rest of the form blank.
Number of extremely preterm live births (<25 weeks)	A whole number is required if a participant has been pregnant.
Number of very preterm live births (25 – 31 weeks)	A whole number is required if a participant has been pregnant.
Number of early preterm live births (32 – 33 weeks)	A whole number is required if a participant has been pregnant.
Number of late preterm live births (34 – 36 weeks)	A whole number is required if a participant has been pregnant.
Number of early term live births (37 – 38 weeks)	A whole number is required if a participant has been pregnant.
Number of full-term live births (39 – 40 weeks)	A whole number is required if a participant has been pregnant.
Number of late term live births (4 weeks)	A whole number is required if a participant has been pregnant.
Number of post term live births (>= 42 weeks)	A whole number is required if a participant has been pregnant.
Number of spontaneous fetal deaths and/or still births (>=20 weeks)	A whole number is required if a participant has been pregnant.
Number of spontaneous abortions (Less than 20 weeks)	A whole number is required if a participant has been pregnant.
Number of therapeutic/elective abortions	A whole number is required if a participant has been pregnant.
Number of ectopic pregnancies	A whole number is required if a participant has been pregnant.

Does the participant have a history of pregnancy complications or fetal/infant congenital anomalies?	If "Yes" is selected, provide concise details in the "If yes, specify" box provided.

Pregnancy Outcome

Purpose:
This form is used to report pregnancy outcome information for any pregnancies after study enrollment during study follow-up.

General Instructions:
This form will be present in the Pregnancy folder. Participants whose "sex at birth" is "Male" should not complete this CRF.

Field-specific Instructions:

Field	Instructions
Is the outcome of this pregnancy obtainable?	Select "Yes" or "No". If "No", then end the form.
How many pregnancy outcomes resulted from this reported pregnancy?	Record the number of outcomes.
Outcome Date	Record the date of the pregnancy outcome. A complete date is required.
Place of delivery/outcome	Enter the place of delivery/outcome from the drop-down menu. If "Other", specify in the "If, Other, specify" text field provided.
If "Other", specify	Specify the "Other" place of delivery/outcome. Maximum 200 characters.
Specify Outcome	Specify the outcome from the drop-down menu. If the outcome is still birth/intrauterine fetal demise, spontaneous abortion, therapeutic/elective abortion, or ectopic pregnancy, the outcome itself is not an adverse event (AE). If "Other", then specify relevant details in the "If, Other, specify" text field provided.
If "Other", specify	Specify the "Other" outcome. Maximum 200 characters.
If "Stillbirth/intrauterine fetal demise" was an autopsy done?	Select "Yes" or "No".

If "Yes" was the reason for the stillbirth/intrauterine fetal demise determined? Please explain.	Record the reason for the stillbirth/intrauterine fetal demise if determined. If pending, enter 'Pending' or unknown, enter 'Unknown'.
If spontaneous, therapeutic, or elective abortion What was the gestational age of the fetus in weeks?	If spontaneous, therapeutic, or elective abortion, record the gestational age in weeks.
What was the gestational age of the fetus in days?	If spontaneous, therapeutic, or elective abortion, record the gestational age in days.
Gestational age of fetus unavailable	Mark checkbox if gestational age of fetus is unavailable
If spontaneous, therapeutic, or elective abortion Were there any abnormalities? If Yes, please explain	If spontaneous, therapeutic, or elective abortion, record any abnormalities here.
If the abortion was for therapeutic reasons, was it due to the mother or the fetus?	If the abortion was for therapeutic reasons due to the mother select "Mother", if due to the fetus select "Fetus".
Method	Select the method of delivery from the drop-down menu only if the outcome is "full term live birth (≥37 weeks)" or "premature term live birth (< 37 weeks)". "Vaginal normal" is defined as normal, unassisted vaginal birth. "Vaginal assisted" is defined as an assisted vaginal birth (forceps, vacuum). If "Vagina Normal" or "Vaginal assisted" delivery, indicate if delivery was breech in the narrative section.
Provide a brief narrative of the circumstances	Include information on medical conditions associated with the outcome, including early contractions, rupture of membranes, and cramping, along with actions taken as a result of these conditions. This item is only required if **not** a full-term live birth.
Post pregnancy weight	Record post pregnancy weight in kilograms
Date of post pregnancy weight	Record date of post pregnancy weight.

Were there any complications related to the pregnancy outcome?	Select “Yes” or “No” to indicate if there were any complications related to the pregnancy outcome. If “No”, then skip to “Were any fetal/infant congenital anomalies identified?”
Delivery related complications	Select the specific delivery-related complication, or mark “None”. If “Other”, then specify relevant details in the “If, Other, specify” text field provided.
If “Other”, specify	Specify any “Other” delivery-related outcome. Maximum 200 characters.
Non delivery-related complications	Record the specific non delivery-related complication, or mark “None”. If “Other”, then specify relevant details in the “If, Other, specify” text field provided.
If “Other”, specify	Specify any “Other” non delivery-related outcome. Maximum 200 characters.
Were any fetal/infant congenital anomalies identified?	Record if any fetal/infant congenital anomalies were identified. If “Yes”, check all that apply and describe the congenital anomaly/defect in the text field provided. If “No”, “Unknown” or “Not assessed”, go to question “Complete the infant items below for live births only”
Describe congenital anomaly/defect	Describe the child’s congenital anomaly/defect. Maximum 200 characters.
Has the infant been ill or hospitalized? (Does not include well-child visits)	Select “Yes” or “No”.
If “Yes”, specify	Specify any illness and/or hospitalization since birth
Infant sex	Select “Male” or “Female” to indicate the infant’s sex
Infant birth weight	Record the infant’s birth weight in kilograms.
Infant birth weight unavailable	If the infant’s birth weight is unavailable, leave “Infant birth weight” blank and tick this box.
Infant birth length	Record the infant’s birth length in centimeters.

Infant birth length unavailable	If the infant's birth length is unavailable, leave "Infant birth length" blank and tick this box.
Infant birth head circumference	Record the infant's head circumference in centimeters.
Infant birth head circumference unavailable	If the infant's head circumference is unavailable, leave "Infant birth head circumference" blank and tick this box.
Infant birth abdominal circumference	Record the infant's abdominal circumference in centimeters.
Infant birth abdominal circumference unavailable	If the infant's abdominal circumference is unavailable, leave "Infant birth abdominal circumference" blank and tick this box.
Infant gestational age by examination in weeks Infant gestational age by examination in days	Record the infant's gestational age at birth, in weeks and days. A whole number is expected in each section. If the infant's gestational age is determined using the Ballard method, record "0" in the "days" box.
Infant gestational age by examination unavailable	Check the "unavailable" box if no medical record documentation of the infant's gestational age is available and end the form.
Size for gestational age	Select "SGA", "AGA", or "LGA" from drop-down list
If "Other", specify	Specify the "Other" method used to determine the infant's gestational age at birth. Maximum 200 characters.
1 minute Apgar score	Record infant's 1-minute APGAR score
5 minute Apgar score	Record infant's 5-minute APGAR score
Cord pH	Record infant's cord blood pH in "X.X" format

Schedule of Forms

Cohort 1 – Visits	Form Name
V0 – Screening	Screening Date of Visit
V1 – Enrollment Visit	Demographics
	Informed Consent
	Contraception -Screening (if applicable)
	Vital Signs-Screening
	Inclusion Exclusion Criteria
	Enrollment
	SARS Cov-2 Vaccination
	Booster
	Physical Exam
	Pregnancy Test Results (if applicable)
	Specimen Collection – Blood
	Reactogenicity Baseline and Early
	Reactogenicity Daily Log
V2 –Day 8- Phone Visit	Follow-up Visit Summary
	Contraception (if applicable)
V3 – Day 15, V4 – Day 29	Follow-up Visit Summary
	Physical Exam
	Vital Signs
	Contraception (if applicable)
	Specimen Collection – Blood
V5 – Day 91, v6 – Day 169, V7 – Day 366	Follow-up Visit Summary
	Physical Exam

	Contraception (if applicable)
	Specimen Collection – Blood

Cohort 2 – Visits	Form Name
V1 – Enrollment Visit	Demographics
	Informed Consent
	Contraception -Screening (if applicable)
	Vital Signs-Screening
	Inclusion Exclusion Criteria
	Enrollment
	Vaccination – Enrollment
	Physical Exam
	Pregnancy Test Results (if applicable)
	Specimen Collection – Blood
	Reactogenicity Baseline and Early
	Reactogenicity Daily Log
V102 – Day 8 – Phone Visit	Follow-up Visit Summary
	Contraception (if applicable)
V103 – Day 29	Vaccination – Follow Up
	Follow-up Visit Summary
	Physical Exam
	Vital Signs
	Contraception (if applicable)
	Pregnancy Test Results (if applicable)
	Specimen Collection – Blood

	Reactogenicity Baseline and Early
	Reactogenicity Daily Log
V104 – Day 36 – Phone Visit	Follow-up Visit Summary
	Contraception (if applicable)
V105 – Day 43	Follow-up Visit Summary
	Physical Exam
	Contraception (if applicable)
	Specimen Collection – Blood
V106 – Day 1B	Follow-up Visit Summary
	Booster
	Physical Exam
	Vital Signs
	Contraception (if applicable)
	Pregnancy Test Results (if applicable)
	Specimen Collection – Blood
	Reactogenicity Baseline and Early
	Reactogenicity Daily Log
V107 – Day 8B – Phone Visit	Follow-up Visit Summary
	Contraception (if applicable)
V108 – Day 15B, V109 Day 29B	Follow-up Visit Summary
	Physical Exam
	Vital Signs
	Contraception (if applicable)
	Specimen Collection – Blood
	Follow-up Visit Summary

V110 – Day 91B, V111 – Day 169B, V112 – 366B	Physical Exam
	Contraception (if applicable)
	Specimen Collection – Blood

Change History

Summary of Changes to Study CCG

Version		Affected Section(s) or Form(s)	Summary of Revisions
Number	Date		
2.0	25JUN2021	Reactogenicity Baseline and Early	Removed contradictory instructions for local symptoms, updated adverse event instructions
2.0	25JUN2021	Reactogenicity Daily Log	Removed contradictory instructions for local symptoms, updated adverse event instructions
2.0	25JUN2021	Reactogenicity Resolution	Removed contradictory instructions for local symptoms, updated adverse event instructions
2.0	25JUN2021	Specimen Collection and Storage	Added instructions for new secondary sample field
2.0	25JUN2021	Contraception – Screening	Added instructions for new “If “Other”, specify” field.
2.0	25JUN2021	Contraception	Updated field label to include for sterilization to include vasectomized partner
2.0	25JUN2021	Enrollment	Updated general instructions to show group name will include initial vaccine and booster name for Cohort 1
2.0	25JUN2021	Concomitant Medications	Updated instructions for combination drugs.
3.0	20JUL2021	General	Updated version and version date throughout. Removed Jean Paul Pease from authorship and added Brian Ingersoll.
3.0	20JUL2021	Screening Date of Visit	Added instructions for 2 new questions.
3.0	20JUL2021	Booster	Updated the list instructions so all boosters are allowed.
3.0	20JUL2021	Visits	Updated the visit structure for Cohort 2 to add new visit 107 and update subsequent visits. Changes made at reference points throughout document.

Version		Affected Section(s) or Form(s)	Summary of Revisions
Number	Date		
4.0	16AUG2021	Inclusion/Exclusion	Rewrote Eligibility Status section.
4.0	16AUG2021	Contraception – Screening	Added instructions for all fields not previously noted. Revised instructions to limit recording of Sterilization or Abstinence in Concomitant Medications.
4.0	16AUG2021	SARS-CoV-2 vaccination	Added instructions for new data fields.
4.0	16AUG2021	Reactogenicity Baseline and Early	Added instruction text for “Is a vaccine-related lesion visible?”. Re-ordered reactogenicity assessment list to match CRF update. Added new screenshots.
4.0	16AUG2021	Reactogenicity Daily Log	Re-ordered reactogenicity assessment list to match CRF update. Added new screenshots.
4.0	16AUG2021	Reactogenicity Resolution	Re-ordered reactogenicity assessment list to match CRF update. Revised instructional text.
5.0	16/SEP2021	Missed Study Product Administration	Added instructions for new Missed Study Product Administration CRF (C2)
5.0	16/SEP2021	Screening	Added text to instructions to not record Abstinence or Sterilization on Concomitant Medications.
6.0	28/Sep/2021	Reactogenicity Baseline and Early	Added clarifying text for measurements and severity grading..
6.0	28/Sep/2021	Reactogenicity Daily Log	Added clarifying text for measurements and severity grading..
6.0	28/Sep/2021	Reactogenicity Resolution	Added clarifying text for measurements and severity grading..
6.0	28/Sep/2021	Contraception	Added text regarding when to complete Concomitant Medication log in relation to changes to contraception.

6.0	28/Sep/2021	Protocol Deviations	Added instructions on accessing the Non-Participant Specific Protocol Deviations Log on Atlas and reference to MOP. Added more examples of types of protocol deviations to Protocol Deviations Code List
6.0	28/Sep/2021	All sections	Reformatting for table consistency/page breaks. Updated TOC.
7.0	02/Dec/2021	Reactogenicity – Resolution of Symptoms	Updated instructions related to “Local Symptoms Pain and/or tenderness” for clarification.
7.0	02/Dec/2021	Adverse Events	Updated instructions related to “If “Not related”, specify alternate etiology” for clarification.
7.0	02/Dec/2021	Protocol Deviations	Updated paragraph on “purpose” to reference protocol and MOP. Added instructions for “Visit” and sub-fields for “Interim visit code” and “if protocol deviation did not occur during a visit, check this box”. Added reference to “who, what, when, and where” to description of deviation. Updated Protocol Deviation Code List to include “Too few aliquots obtained”, and “Required Procedure not conducted”. Added example under “Conduct of non-protocol procedure”. Updated description of “Unreported SAE/AESI/UP” for clarification.
8.0	18/Jan/2022	Discontinuation of Study Product and Study Terminations	Added “If no applicable AE for ‘Confirmed SARS CoV-2 infection’, leave blank and respond to system query with ‘Not applicable’”
8.0	18/Jan/2022	SARS-CoV-2 Test Results	Added “This form should be used to record both antigen and molecular SARS-CoV-2 test results, collected both in and outside of study. Please refer to the MOP for further guidance on recording positive SARS-CoV-2 test results.” And new field instructions for “Test Type”

8.0	18/Jan/2022	All sections	Corrected references to SSP to study MOP as needed. Corrected reference to “Date of Visit” to “Follow-up Visit Summary” CRF, as needed.
9.0	28/Feb/2022	Enrollment	Added instructions for completion of new fields related to Version 6.0 of the protocol: If this participant is enrolling in Cohort 1, group "15E: Previously dosed Janssen – Ad26.COV2-S; Novavax – NVX-CoV2373 booster", was this participant previously enrolled in Cohort 1, Group "4E: Previously dosed Janssen – Ad26.COV2-S; Janssen – Ad26.COV2-S booster"? Corrected date associated with CCGs version 8.0 change history from 18/Jan/2021 to 18/Jan/2022 (this was a typo correction).