CRF Completion Guidelines (CCGs)
Protocol #: MTN-035
V3.0 (09 JUN 2020)

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Completion Guidelines for Standard CRFs

The following instructions are study-specific data completion instructions intended to assist site staff when completing Case Report Forms (CRFs) for MTN-035 (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 posted on the MTN-035 Atlas web page: https://atlas.scharp.org/cpas/project/MTN/035/begin.view?

General Guidelines – Medidata Rave eCRFs (electronic CRF completion)

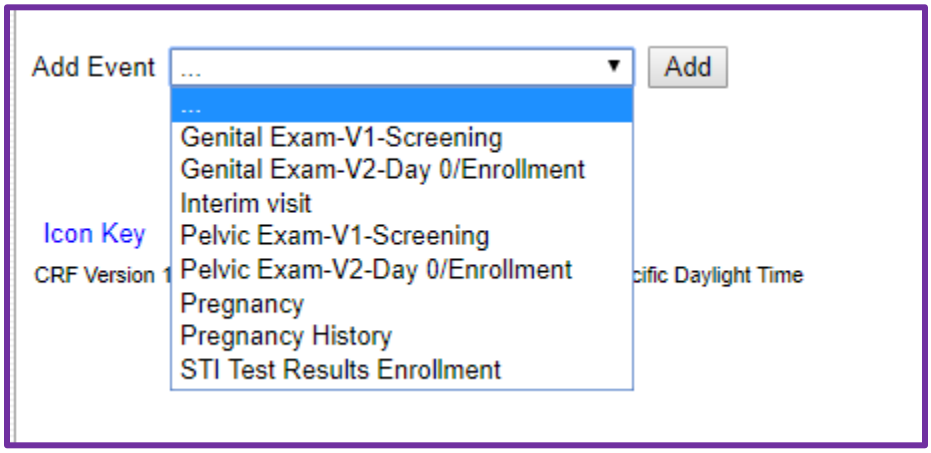
- The Participant ID is automatically assigned by Rave as a 9-digit field, starting with the 3-digit site number followed by a randomly assigned 6-digit participant number.
- All data entered in the eCRF should correspond accurately with the source documents/paper CRFs.
- Complete all required fields on the screens. Please ensure all entries are in English and are accurate, consistent, complete and medically logical.
- Ensure there are no missing data in the eCRF. Where requested to "specify" for an item, ensure that a specific entry is made.
    - Visit dates should be complete and chronological according to the protocol.
    - All date fields are entered as Day/Month/Year (dd/mmm/yyyy) (e.g., 16 OCT 2017).
- Dropdown menus are available for many fields. Use these menus, when available, to select the appropriate response.
- Avoid using abbreviations and symbols wherever possible. Do not use special characters unless explicitly stated or hit the Return key in text fields.
- If a scheduled visit was missed, do not enter data on any of the eCRF pages for the visit, with the exception of the Follow-up Visit Summary Yes/No and the Missed Visit eCRFs, which should be completed.
- Log (or repeating) forms have been provided. Log forms allow you to enter multiple items on one form, and to switch between portrait and log formats for ease of viewing or data entry. The following are log forms or have the log format within the form for this study: Adverse Events, Concomitant Medications, Protocol Deviations, Baseline Medical History, and Social Impact.
    - Click "Add a new Log line" to add a row.
    - Log lines can be inactivated by clicking "Inactivate" and specifying the log line number if needed.
- If corrections are needed: Click the "pencil" icon. The field will become editable so that you can then correct the value and give the reason for the change (if needed).
- In case of an incorrect data entry, a system query will fire. System queries will close automatically after saving the form if the data point is entered or corrected (A response to a system query is not required). However, answering a system query prior to updating the data point field will make the query change into a manual query that will need to be closed by SCHARP.
- Data changes can be reviewed in the audit trail. If data is modified inadvertently, the change is also saved in the audit trail.
- The Investigator of Record (IoR) will sign all pages after the participant's data has been reviewed, no further changes or additions to the eCRFs are necessary and the casebook status is frozen.

The SCHARP Clinical Data Manager(s) will provide directions for the timing of when the Investigator should perform the final review and sign the eCRF pages.

Add Event

- The **Add Event** dropdown menu can add select forms and visits to a participant's casebook.

- The following folders can be added to a participant's casebook:
  - Interim Visits (see section on "Interim Visits" on how to add interim visits to a participant's casebook
- The following forms can be added to the V2.0 – Enrollment folder:
  - Genital Exam-V1-Sceening
  - Pelvic Exam-V1-Sceening
- The following forms can be added to the V1.0 – Screening folder:
  - Interim Visit
  - STI Test Results
  - Genital Exam-V2-Day 0/Enrollment
  - Pelvic Exam-V2-Day 0/Enrollment



Interim Visits

- Should unscheduled assessments be required for a non-routine visit or procedure, add the visit by clicking on the **Add Event** button. Select "Interim Visit". An Interim Visit folder will appear in the participant's casebook.

- Open the Interim Visit folder to access the "Interim Visit Summary" eCRF. On the Interim Visit Summary eCRF, select "Yes" for each assessment that was performed. The selected forms will be populated automatically within the applicable Interim Visit folder.

- On the Interim Visit Summary eCRF, enter the visit date as the earliest date visit procedures performed at the visit.

Auto-population of Medidata Rave Forms

- Medidata Rave will dynamically add eCRFs to a visit folder within a participant's casebook based on specified responses on the eCRFs. Below are a few examples:

  - Example 1: Randomization form - Enrollment folder
    - If item "Is the participant ready to be randomized?" is marked "yes", the applicable regular visit folders from V3 – V8 (Study Termination) will be added to the matrix. Within each visit folder is the Follow-up Y/N eCRF.
  - Example 2: Follow-up Yes/No eCRF
    - If item "Did the participant complete this visit" is "No', the Missed Visit eCRF will be added to the visit folder and required eCRFs for that visit will not appear in the visit folder.
    - Selecting "Yes" will automatically add the applicable eCRFs that are required to be completed per protocol to the applicable visit folder.
  - Example 3: Adverse Event Summary eCRF
    - Selecting "Yes" for "Has the participant experienced an Adverse Event during the study?" will dynamically add the Adverse Event Log eCRF to the Ongoing Logs folder.

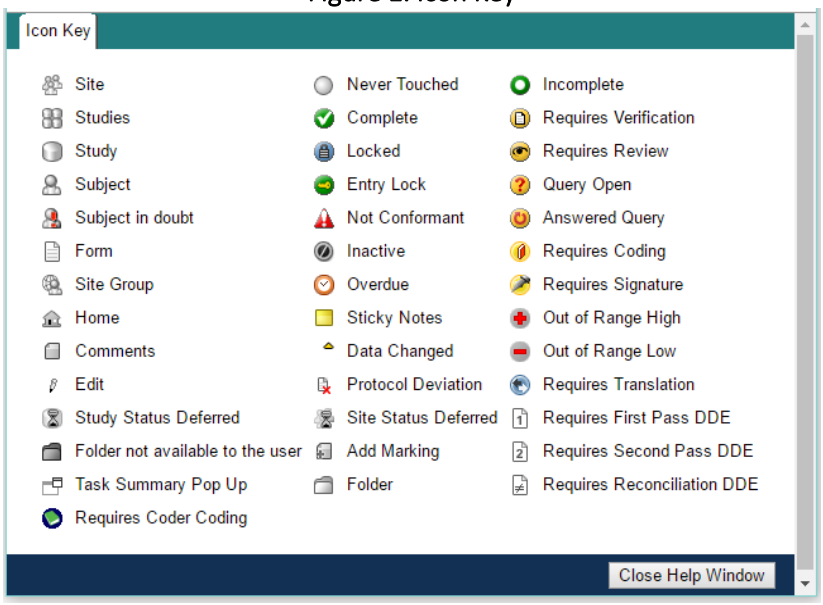
Dynamic Search List Functionality

- Dynamic searchlist functionality is used to look up Adverse Event data *(AE log line, start date, and term, e.g. "1- 05JAN2017-FEVER")*.
- Dynamic searchlist functionality is present on the following eCRFs: Concomitant Medications, Genital Exam, Discontinuation of Study Product, Study Termination, and Participant Replacement Assessment
- For Example:
  - An AE of "*FEVER*" started on 05JAN2017 and is reported on the Adverse Events eCRF
  - On the Concomitant Medications form, if a listed medication was used for this AE, a dynamic searchlist can be used to select the applicable AE record from the dropdown list.
  - The dynamic search list for "AE log line, start date, and term" shows records entered on the AE form
  - Your selection can be manually deleted if entered in error
    - **Note:** If the original data (e.g., AE term and/or start date, MH term) changed or the log line was inactivated, the previous selection becomes non-conformant. You will need to correct the item by re-selecting from the search list to correspond with the latest data.

Icon Key

Within Rave, an Icon Key is available. The key contains a description and picture of the commonly used icons. To access the Icon Key, click on the Icon Key hyperlink. The Icon Key will open in a separate pop-up window. Below is a screen shot of the Icon Key.

Figure 1. Icon Key

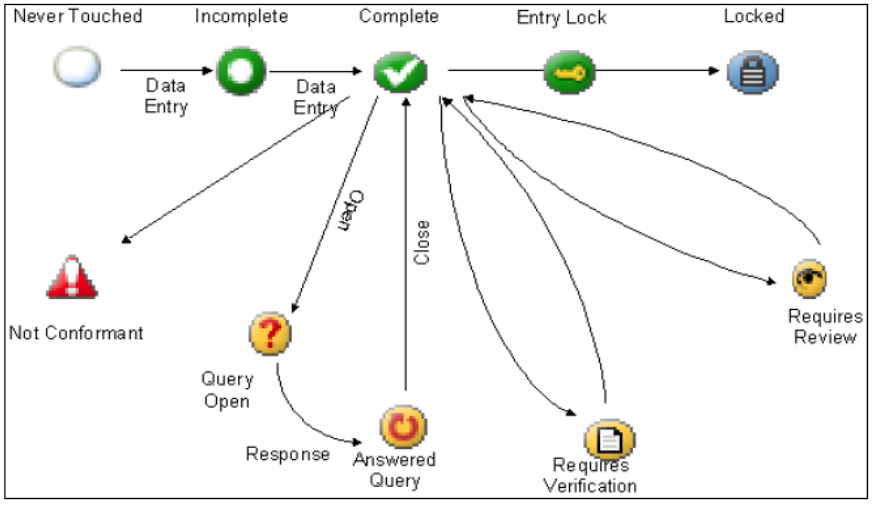


Icon Progressions

The life cycle of folders, forms, fields, etc., follows a logical progression starting with never touched and moving toward complete and locked. Graphical icons are used throughout Rave to visually denote 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 Listing displays all pending tasks for a study. At the Site level, it displays the number of participants within the site that contain the selected item (see Figure 3). For example, 8 participants within the site have open queries. If the "Open Queries task is expanded, the 8 participants are displayed (see Figure 4).

Figure 3. Site-Level Task Summary

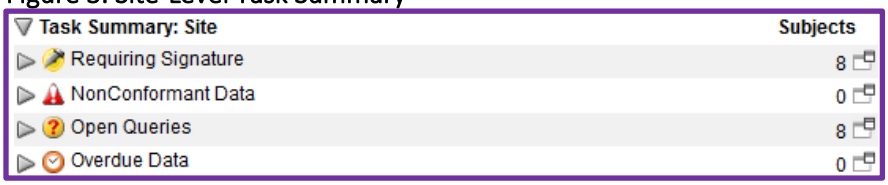
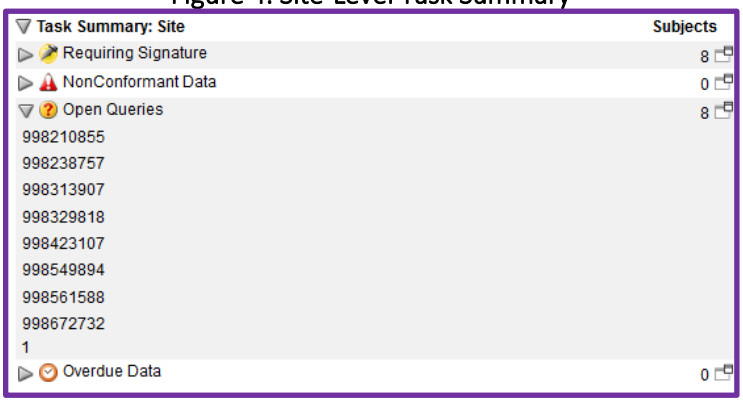
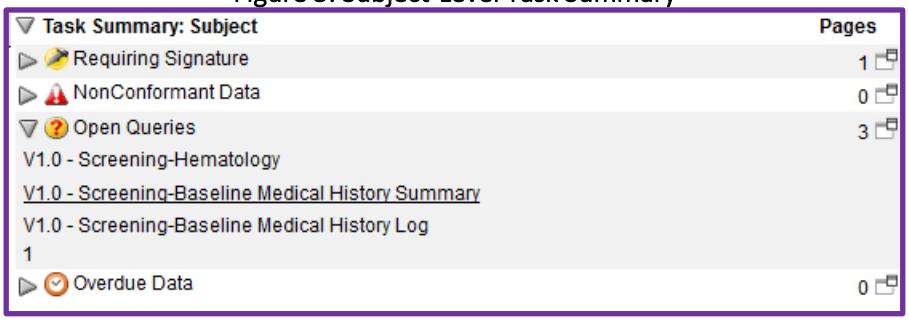


Figure 4. Site-Level Task Summary



- At the Subject (participant) level, the Task Summary displays the number of pages/forms for the participant that contain the selected item. In Figure 5 below, there are 3 open queries on 3 eCRFs. In the expanded task summary view, if a form name is clicked that form is displayed.

Figure 5. Subject-Level Task Summary



General Guidelines – Paper CRF Completion

When completing a paper CRF, refer to detailed instructions on data collection pertaining to the specific form and fields on that form in this document.

Based on Good Clinical Practices (GCPs), the following guidelines should be used for completing paper CRFs:

- Use a black or dark blue medium ballpoint pen. Do not use any other type of writing tool.
- Press firmly when recording data or writing comments.
- Print all data and comments legibly by hand. Entries that cannot be read may result in incorrect data entry.
- Do not use cursive/script handwriting, as it can be difficult to read.
- Write numbers as large as possible on the line specified.

- Record data on the front of CRFs only.
- If the lines provided for written responses are not long enough, continue in another blank area of the form (within the page margins).
- Mark only one answer except when given the instruction "Mark/Select all that apply."
- A response is required for every item unless instructed otherwise by a skip pattern, as noted in the CCGs.
- **Never** use correction fluid ("white-out") or correction tape on CRFs.

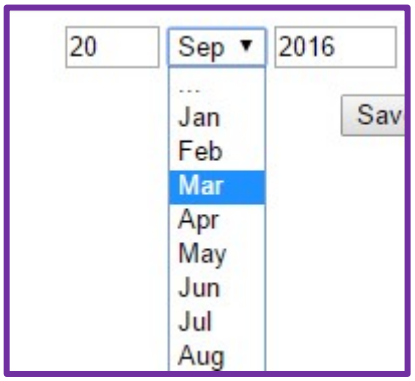
How to Record Dates - Electronic and/or Paper

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.

The month field must be entered with the three-letter abbreviation in English. Abbreviations are shown below. In the study database, these abbreviations will be selected from a dropdown 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
Unknown	UNK		

For example, September 20, 2016 is recorded as:



Some items allow for partial dates. When recording partial dates, the following guidance applies:

- Enter UN for the day
- Select "UNK" for the month from the dropdown menu.

How to Record Time - Electronic and/or Paper

Time is recorded on CRFs using the 24-hour clock (00:00-23:59), in which hours are designated from 0–23. For example, in the 24-hour clock 2:25 p.m. translates to 14:25 (2 p.m. = 14), which would be recorded as follows:

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

How to Record Numbers (non-dates)

When recording numbers, please enter the whole number without leading zeros. Instead of "00', this should be recorded as "0". "3" should be recorded as 3, not "03" and so on.

Data Corrections and Additions - Electronic and/or Paper

Sometimes, data on a CRF (paper or electronic) may need to be changed, clarified, or amended. There are many reasons why data may need to be changed, such as in response to a query or as a result of site review.

If the electronic CRF is source, it is sufficient to make data updates in the study database itself. If a paper CRF is completed, it is important to make changes to the original CRF first, then enter the updated data into the study database.

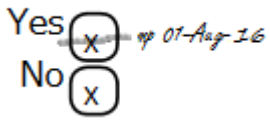
Note for paper CRFs: Never write over an entry once it is recorded. Use the standards outlined in the following paragraphs when changing, clarifying, or amending data.

Whenever an entry on a paper CRF is changed, do the following:

- draw a single horizontal line through the incorrect entry (do not obscure the entry or make it un-readable with multiple cross-outs),
- place the correct or clarified answer near the box, and

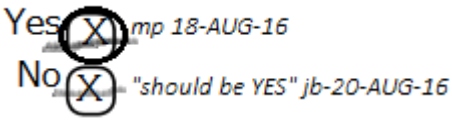
If an X is marked in the wrong response box, correct it by doing the following:

- 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 item,
- write an explanation in the white space near the item, and
- initial and date all corrections as shown below:



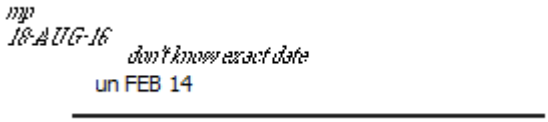
The standards above must ***always*** be followed whenever a paper CRF is changed, clarified, or amended.

How to Handle Missing and Unknown Data

If the answer to an item is not known, is not available, or if the participant refuses to answer for a required item:

- On paper CRFs: draw a single horizontal line through the applicable item and initial and date the item for which the data is unknown. 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 item that is refused, missing, unknown, or not applicable, regardless of whether it is marked as such during the initial paper form completion, or as an update to the form.



- On eCRFs: enter “UN” or select the “UNK” option from the dropdown list of the applicable field for which the data is missing/unknown if applicable. If there is no

unknown option and data cannot be obtained, save the form and denote this in response to the system query.

A skip pattern, as noted in the CCGs, is the only valid reason to leave a response blank.

Case Report Forms

Additional Study Procedures

Purpose:

This form is used to identify additional "as-needed" study procedures conducted during study visit and to add the applicable forms to the participant's visit folder for completion.

General Instructions:

Select the applicable procedures that were completed at the study visit. The applicable form(s) will be added to the participant's visit folder. For example, if a pelvic exam is performed as indicated, select the checkbox for "Pelvic Exam?". Additional procedures that were not completed at this visit can be left blank.

Adverse Event Log

Purpose:

This form is used to document any Adverse Events (AE) reported by the participant or clinically observed as defined by the protocol.

General Instructions:

Complete a separate entry (e.g. log line) for each adverse event when entering into the study database. Use the "Add a new log line" button to add an additional adverse event in Medidata Rave.

Whenever possible, report a diagnosis instead of listing a cluster of symptoms. If no diagnosis is identified, each symptom must be recorded as a separate AE as separate 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 it increases in severity or frequency.

If an AE increases in severity/frequency, a new AE should be reported. The original AE should be recorded as "Recovered/resolved" and have an Outcome Date equal to the Onset Date of the new AE. Note that decreases in severity (AE improvements) are not recorded as new AEs.

Item-specific Instructions:

Field	Instructions
Date AE reported to site	Record the date the site became aware of the AE. For lab AEs, record the date the lab result was received. A complete date is required.
Adverse event (AE)	Use medical terminology to describe the AE. Record a diagnosis if available. Include the anatomical location if applicable. Do not include text on the relationship to study product or timing of AE onset with regard to product use. For lab abnormalities, record the lab name with the direction (i.e., increased or decreased). For example, "increased ALT".
Onset date	At a minimum, a month and year are required. Record one of the following, as appropriate: the date on which the participant reports first experiencing the AE (onset of first symptom if diagnosis has multiple associated symptoms); date of the study visit/study exam (for physical or genital exam findings); specimen collection date (for lab abnormality AEs).
Is the AE still ongoing?	Select "Yes" if the AE is continuing at the time it is first reported. If "Yes', leave the Outcome Date blank.
If no, outcome date	If the AE is not ongoing, record the outcome date. For the outcome date, a month and year are required, at a minimum. Record one of the following, as appropriate: the date on which the participant reports no longer experiencing the AE or associated symptoms, or the date of the study visit or specimen collection at which it is first noted the AE has resolved or returned to baseline status.
Severity Grade	Record the severity grade using the current version of the *Division of AIDS (DAIDS) Table for Grading the Severity of Adult and Pediatric Adverse Events* (including relevant appendices/addendums).
Relationship to Study Product	Select "Related" if there is a reasonable possibility that the AE may be related to the study product. Select "Not related" if there is not a reasonable possibility that the AE is related to the study product. Provide the clinical rationale (the reason) the AE is judged to be "Related" or "Not related" in the applicable Comments section/text field provided for each reported AE.
Action taken with study product	***Dose not changed***: Select if there is no change to the participant's planned use of study product as a result of the AE. This option should be selected if the participant is still in the product use period and the AE does not result in a clinician-initiated product hold or permanent discontinuation of study product. ***Dose reduced:*** This option does not apply and should not be selected in MTN-035. ***Dose increased:*** This option does not apply and should not be selected in MTN-035.

	Drug withdrawn: Select if the AE results in permanent discontinuation of study product. If multiple AEs are reported at the same visit, mark "drug withdrawn" for each AE contributing to the permanent discontinuation. Ensure a Treatment Discontinuation eCRF is completed with item "Did the participant complete study product use through Visit 6 (Last Study Pharmacy Dispensation Visit)?" selected as "No". *Drug interrupted*: Select if the AE results in a clinician-initiated product hold. If multiple AEs are reported at the same visit, select "drug interrupted" for each AE contributing to the hold. *Not applicable*: Select if the AE's onset date is on or after the date the participant permanently discontinues study product use.
Other action(s) taken	Mark "None" or mark all that apply. *Medication*: Select "Medication" only if the participant reports taking medication. Report the medication(s) on the "Concomitant Medications Log" CRF. If medication is indicated, but not yet used, select "Other" and describe the medication indicated in the "Other, specify" text field provided; update this item to "Medication" once the medication has been used and report on the "Concomitant Medications Log". If "Therapeutic procedure/surgery", or "Diagnostic procedure" is selected, then record applicable details in the Comments section at the bottom of the CRF. If "Other', then specify relevant details in the "Other, specify" text field provided.
Status/Outcome	*Recovered/resolved:* AE is no longer present, has returned to baseline severity/frequency, or has increased in severity/frequency. Note that if a participant started taking medication once enrolled to control an AE, the AE is not considered resolved while the medication is still indicated. *Recovering/resolving*: AE is continuing and has not yet resolved or returned to baseline severity/frequency. *Resolved with sequelae:* Participant has recovered from the AE, but with remaining effects or impairment. These remaining effects can be temporary, but are still present at the time of the report. *Not recovered/resolved*: Select this option whenever an AE is continuing at the time of participant termination from the study. *Fatal*: Select only if the severity grade of this AE is Grade 5. Any other AEs continuing at the time of death should be changed to "not recovered/resolved".

	Severity/frequency increased: The severity of the AE has increased in severity/frequency
Is this a serious adverse event according to ICH/GCP or protocol guidelines?	Select "Yes" or "No". If "No", go to "Was this AE a worsening of a baseline medical condition?" If "Yes", check all that apply.
Was this AE a worsening of a baseline medical condition?	Select "Yes" or "No".
Comments	This is a required field and should be used to be record the relationship to study product at a minimum.

Adverse Event Y/N

Purpose:

This form documents if an adverse event was experienced by the participant during the study.

General Instructions:

This form is located within the "Ongoing Logs" folder.

Item-specific Instructions:

Field	Instructions
Has the participant experienced an Adverse Event during the study?	Select "Yes" or "No". If "Yes" is selected, then the "Adverse Event" log form appears dynamically within the "Ongoing Logs" folder and can then be completed. Complete as many Adverse Event CRFs as needed.

Anorectal Exam

Purpose:

This form is used to document the anorectal exam findings identified via perianal visual inspection, digital rectal examination, and anoscopy.

General Information/Instructions:

This form is completed at V1.0 - Screening, V2.0 - Enrollment, and Visits 3.0, 5.0 and 7.0 – PUEV 1-3. At Screening and Enrollment, evaluate any abnormalities for eligibility. At Enrollment, update the Medical History Log as applicable. During follow-up, complete or update the Adverse Event Log when applicable.

Item-specific Instructions:

Field	Instructions
Perianal Examination (findings from the perianal examination)	Select "Not done', "No abnormal findings', or "Abnormal findings". If "Not done" is selected, then this is the end of this section and all remaining perianal finding items should be left blank. Continue to Digital Rectal Examination section. Select "Abnormal findings" or "No abnormal findings" to indicate any findings from the perianal exam. If "No abnormal findings" is selected, then skip the "Abnormal findings" section.
Anorectal exam date	A complete date is required.
PERIANAL EXAMINATION (findings from the perianal examination)	Mark the box to the right of each abnormal finding observed, mark all that apply. If an observed abnormal finding is not listed, select "Other abnormal findings" and specify/describe the abnormal findings in the text field provided, including the anatomical location. If no abnormal findings, then skip to DIGITAL RECTAL EXAMINATION".
DIGITAL RECTAL EXAMINATION (findings from the digital rectal examination)	Select "Not done", "No abnormal findings", or "Abnormal findings" from the dropdown menu for the digital rectal exam. Describe any abnormal findings from the digital rectal examination in the text field provided. If examination was not done, select "Not done", then skip to the ANOSCOPY section.
ANOSCOPY (findings from anoscopy)	Select "Not done", "No abnormal findings", or "Abnormal findings" from the dropdown menu for Anoscopy. If "Not done" or "No abnormal findings" is selected, then this is the end of this section and all remaining Anoscopy finding items should be left blank. Continue to "Were any new anorectal finding AEs reported at this visit?". Mark the box to the right of each abnormal finding observed, mark all that apply. If an observed abnormal finding is not listed, select "Other abnormal findings" and specify/describe the abnormal findings in the text field provided, including the anatomical location.
Were any new anorectal finding AEs reported at this visit?	Record whether an AE was identified and reported at this visit as part of the anorectal exam assessment by selecting "Yes" or "No". If an AE was reported at the study visit, select the corresponding AE log form within the dynamic search list function on the eCRF. Up to 3 AEs can be selected. This item should be "No" prior to participant enrollment in the study (i.e., prior to the AE reporting period).

Behavioral Assessments Summary

Purpose:

This form is used to document participant completion of the Computer-assisted Self Interview (CASI) and/or In-depth interview (IDI) questionnaires at Enrollment and during follow-up.

General Instructions:

Complete this form at Enrollment, all PUEV visits (V3, V5, and V7) and Termination or Early Termination visit (V8).

Item-specific Instructions:

Field	Instructions
Was a CASI questionnaire completed at this visit?	Select "Yes" or "No" to indicate whether an CASI questionnaire was completed at this visit. If "Yes" is selected, the "CASI Tracking" form appears dynamically for completion. If an CASI questionnaire was completed by a participant, this item should be marked "Yes" regardless of whether the questionnaire was eventually uploaded to SCHARP. If "No" is selected, then record the reason why it was not done in the text field below. A "CASI Tracking" form does not need to be completed.
Was an in-depth interview completed at this visit?	Select "Yes" or "No" to indicate whether an IDI was completed at this visit. If "No", is selected, then record the reason why it was not done in the text field below.
Complete the following item at Visit 8 only. Was a conjoint analysis assessment completed at this visit?	Select "Yes" or "No" to indicate whether a conjoin analysis was completed at the Study Termination (Visit 8) or not. If "No", is selected, then record the reason why it was not done in the text field below.

CASI Tracking

Purpose:

This form is used to document participant completion of the Computer-assisted Self Interview (CASI) questionnaires at Enrollment, during follow-up, and at the Termination visit (visit 8).

General Instructions:

Selecting "Yes" on the CASI Tracking Summary form will open up the CASI Tracking form. Complete this form at Enrollment, during follow-up (V3, V5 and V7 PUEVs), and at the Termination or Early Termination visit (V8).

Item-specific Instructions:

Field	Instructions
CASI collection date	A full date is required.
Which questionnaire was completed?	Select the appropriate questionnaire from the dropdown menu.
CASI ID	Input the corresponding CASI ID
Were there any problems or issues related to the administration or completion of the questionnaire?	Select "Yes" or "No" to indicate whether there were any issues related the administration or completion of the questionnaire at this visit. If "Yes" is selected, use the text box provided to describe the problem or issue.

Concomitant Medications Log

Purpose:

This form is used to document all medications taken by the participant starting at the Screening Visit. This includes, but is not limited to: prescription medications, non-prescription (i.e., over-the-counter) medications, contraceptive hormonal medications, preventive medications and treatments (e.g., allergy shots, flu shots, and other vaccinations), herbal preparations, vitamin supplements, and naturopathic preparations.

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.

Item-specific Instructions:

Field	Instructions
Medication name	Record the trade or generic name of the medication based on exactly what the participant is taking. If a trade name is not available or not reportable per national guidelines, record the generic name of the medication. A combination medication can be recorded as one entry.
Indication	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"). In most instances (excluding nutritional supplements and/or prophylactic treatments), the indication should correspond to an item on the Medical History and/or Adverse Event eCRF(s).
Date started	If the participant is unable to recall the exact date of medication initiation, obtain participant's best estimate. At a minimum, the year is required. For injections, record each injection as a separate entry, with the same date used for start and stop date.

Date stopped Or Ongoing	Enter the stop date of this medication if known. At a minimum, the month and year is required. This item can be completed at any time during study participation when the stop date is known. At the participant's Study Exit/Termination Visit, the "Date Stopped" must be recorded for each medication OR the "Continuing at the end of study" box must be checked.
Dose	Record the dose. If the participant does not know the exact dose units (e.g., "250 mg"), record an estimate (e.g., "1 tablet"). For multivitamin tablets or liquids, record the number of tablets or liquid measurement (e.g. "1" pill or "1" tablespoon") if the exact dosage is unknown. If the dose is unknown, check "Unknown" and leave the dose field blank. When documenting medical devices with no active medication, such as an IUCD, enter the dose as "1". For topical applications, if exact quantity is not known, record the number of applications instead (e.g. "one application'").
Dose Units	Select/record the applicable dose units provided in the dropdown list. If the participant does not know the exact dose units (e.g., "250 mg"), record an estimate (e.g., "1 tablet"). If no information on units is known, select the "Unknown" option. When documenting medical devices with no active medication, such as an IUCD, mark the Dose Unit as "Other" and specify "device" in the "If other dose units, specify" text field provided. For topical applications, if exact quantity is not known, record the number of applications instead (e.g. "one application"). If "Other" is selected, specify in the corresponding "If other, specify" text field provided.

Frequency	Select the frequency from options provided in the dropdown list. Below is a list of common frequency abbreviations: PRN: as needed QD: every day BID: twice daily TID: three times daily QID: four times daily QM: every morning QH: every hour QHS: at bedtime ONCE: one time Other: alternative dosing schedule or unknown If "Other" is selected, specify in the corresponding "If other, specify" text field provided. For injections, frequency should be "Once", with same date used for start and stop dates.
Route	Select the route from options provided in the dropdown list. If "Other" is selected, specify in the corresponding "If 'Other', specify" text field provided.
Taken for a reported AE?	If the concomitant medication was administered to treat a reported AE, select "Yes". The relevant AE log form must be completed to link the concomitant medication to the AE log form entered. Choose the applicable AE from the dropdown menu. Up to 3 AEs can be selected. If the medication was not administered to treat an AE, select "No', and end the form.

Concomitant Medications Y/N

Purpose:

This form documents if any concomitant medications were reported the participant during the study.

General Instructions:

This summary eCRF is located within the "Ongoing Logs" folder.

Item-specific Instructions:

Field	Instructions
Were any concomitant medications taken?	Select "Yes" or "No". If "Yes" is selected, then the "Concomitant Medications" log form appears dynamically within the "Ongoing Logs" folder. Complete as many Concomitant Medication eCRFs as needed.

Demographics

Purpose:

This form is used to document a participant's demographics information.

General Instructions:

This form is completed at the Screening Visit. Responses should reflect the participant's status at screening and should not be changed after screening unless correction is needed.

Item-specific Instructions:

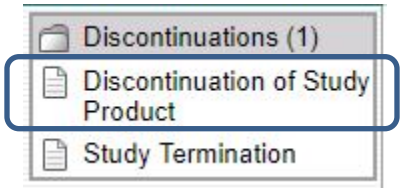
Field	Instructions
Date of birth?	Please provide the date of birth. A complete date is required.
Age	This is an automatically derived field based on the participant's date of birth and the date of initial data entry. No data entry is required.
Sex at birth	Select "male" or "female". Note that this response will trigger the applicable forms in the participant's casebook. For example, if male, then the "Pregnancy Test Result" CRF will not appear in the participant's casebook. However, this will be available for completion if this response is selected as "Female".
Race	Record the participant's race based on self-definition. In the case of mixed race, mark all that apply. If a race is other than those listed, select "Other" and specify in the "If Other, specify" text field provided. Per NIH policy, Latino/a is considered an ethnic group and not a race and should not be entered as a Race.
Ethnicity	This item is based on self-definition. Per NIH policy, Latino/a or Hispanic includes a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
Ethnic group or tribe	*Note that this item should only be completed for international sites.* Use the dropdown menu to select the appropriate ethnic group or tribe.
Current gender	Mark all the apply. If "Self-identify" is selected, specify in the corresponding "Self-identify, specify" text field provided. Site staff is encouraged to document in chart notes if the participant during study participation prefers to be referred to by a specific pronoun or gender.

Discontinuation of Study Product

Purpose:

This form documents a participant's permanent discontinuation of study product use.

General Instructions:
This form is present within the "Discontinuations" folder. Complete this form when a participant completes a given product use period (i.e. at each PUEV)", or when study product is discontinued for any other reason.



Item-specific Instructions:

Field	Instructions
Date study product use ended:	A complete date is required. Record the date when the participant completed or was permanently discontinued from study product.
Primary reason for ending study product use	Record the primary reason from the dropdown menu. "Scheduled study product use period complete" should only be selected at applicable PUEVs. If "Reported use of non-study rectal medications or products", select applicable concomitant medication If the primary reason is "Other, specify", provide additional details in the "If 'other', specify" text field provided. If "Adverse Event" is selected, choose the AE from the AE dynamic dropdown list. Note: If study product is permanently discontinued due to an AE or concomitant medication, the corresponding AE or Concomitant Medications log page must be entered into Rave prior to linking on the Product Discontinuation CRF via the dropdown menus.
Visit at which study product was discontinued	Select the visit at which study product was discontinued using the drop-down menu If "Interim visit", specify interim visit code.
Type of study product discontinued	Specify type of study product discontinued.

Enrollment

Purpose:
This form is used to document a participant's study enrollment. This form is completed at Enrollment for participants who have provided informed consent and who are eligible to participate in the study.

General Instructions:
Complete this form for each participant who is enrolled into MTN-035. This form is completed at the V2.0 – Enrollment visit.

Item-specific Instructions:

Field	Instructions
Product Sequence participant was randomized to (auto-populated by Medidata Balance):	This field will be populated based on the study product sequence the participant has been randomized to through Medidata Balance.
Is this a replacement participant?	Select "Yes" or "No". If "Yes", then record the PTID of the participant being replaced in the text box provided next to "PTID of participant being replaced".

Genital Exam

Purpose:
This form is used to document the participant's genital exam assessment.

General Instructions:
Complete this form when clinically indicated at all study visits. If this form is needed for the Screening or Enrollment visit, it will need to be added via the "Add Event" on the participant's home page. If this needs to be completed at a follow-up visit, this form can be added via the Additional Study Procedures form. If the Genital Exam is completed during the 'V1.0 – Screening' or 'V2.0 Day 0/Enrollment' visit you will need to add the Genital Exam form to the respective Screening or Enrollment folder through "Add Event" on the participant's home page.

Item-specific Instructions:

Field	Instructions
Genital exam assessment	Select "Abnormal findings" or "No abnormal findings" to indicate any findings from the genital exam. If "No abnormal findings" is selected, then skip the "Abnormal findings" section.
Exam Date	A complete date is required.
Abnormal findings	Select the box to the right of each abnormal finding observed and check all that apply. Specify additional details in the text field provided where applicable. If an observed abnormal finding is not listed, specify and describe the abnormal findings in the "Other, specify" text field provided, including the anatomical location. Please record any baseline abnormalities on the Medical History Log eCRF. Any post-baseline abnormalities or baseline conditions that worsened post baseline should be reported on the Adverse Event eCRF.

	In general, for abnormal findings reported as adverse events within the AE Log, use the abnormal finding text provided on this form as the AE descriptive text.
Inguinal lymph node (right and left)	Select "Normal", "Enlarged and painless", or "Enlarged and painful".
Were any new genital finding AEs reported at this visit?	Record whether an AE was identified and reported at this visit as part of the Genital Exam assessment by selecting "Yes" or "No". If an AE was reported at the study visit, select the corresponding AE within the dynamic searchlist function on the eCRF. Up to 3 AEs can be selected. This item should be "No" prior to participant enrollment in the study (i.e., prior to the AE reporting period).

HIV Confirmatory Results

Purpose:

This form is used to document HIV confirmatory results from local lab confirmatory HIV testing once a participant has a newly positive or indeterminate HIV test result.

General Instructions:

Complete this form any time when a participant has a newly positive or indeterminate HIV test result. Record HIV specimen test results on this form as they become available from the local laboratory. Select "Not done" for any applicable tests in the event that a specimen was not collected, or if the specimen was collected, but a result is not available due to specimen loss or damage.

Item-specific Instructions:

Field	Instructions
Was sample 1 collected for HIV Confirmatory testing?	Select "Yes" or "No". If "No", the remaining items for sample 1 HIV testing do not need to be completed. Proceed to "Was sample 2 collected for HIV Confirmatory testing?".
Collection date	Record the date that the first specimen(s) was collected, NOT the date the results were reported or recorded on the form for this visit. A complete date is required.
ARCHITECT HIV Ag/Ab Combo	Select "Non reactive", "Reactive" or "Not done"
Geenius HIV-1/2	Select the appropriate response from the dropdown menu.
Aptima HIV-1 RNA Qualitative assay	Select "non-reactive", "Reactive", "Invalid" or "Not done" *If negative or indeterminate consult the MTN LC.* *If positive, collect sample 2*
Was sample 2 collected for HIV Confirmatory testing?	Select "Yes" or "No".

	If "No", the remaining items for sample 2 HIV testing do not need to be completed. Proceed to "Final HIV status".
Collection date	Record the date that the first specimen(s) was collected, NOT the date the results were reported or recorded on the form for this visit. A complete date is required.
ARCHITECT HIV Ag/Ab Combo	Select "non-reactive", "Reactive" or "Not done"
Geenius HIV-1/2	Select the appropriate response from the dropdown menu.
Aptima HIV-1 RNA Qualitative assay	Select "non-reactive", "Reactive", "Invalid" or "Not done"
Was sample 2 stored?	Select "Stored" or "Not stored". If not stored, enter reason in "If not stored, specify reason" field.
Final HIV Status	Once a participant's HIV status has been determined, record the final HIV status. If the participant's final HIV status is determined to be positive (according to the protocol testing algorithm), update the Product Discontinuation as applicable to reflect permanent discontinuation of study product. If the participant status is not clearly negative or clearly positive, select the "pending" item and update this item once the participant's final HIV status is known.

HIV Test Results

Purpose:

This form is used to document HIV rapid test results from local laboratories.

General Instructions:

Complete this form at V1.0 – Screening, V2.0 – Enrollment, Visit 7.0, and as indicated during follow-up. Record HIV specimen test results on this form as they become available from the local lab.

Item-specific Instructions:

Field	Instructions
Was Rapid HIV test sample 1 collected for testing?	Select "Yes" or "No". If "No" the remaining items for Rapid HIV test sample 1 do not need to be completed. Proceed to Rapid HIV test 2.
Rapid HIV test 1 Kit	Use the dropdown menu to select the appropriate Rapid HIV test 1 kit. If "Other", use the "If 'Other', specify" text field.
Rapid HIV test 1 collection date	Record the date that the first specimen(s) was collected, NOT the date the results were reported or recorded on the form for this visit. A complete date is required.
Rapid HIV test 1	Use the dropdown menu to select "Antibody positive", "Antigen positive", "Antibody and antigen positive", or "Negative".

	Note: If result is "Positive" or "Indeterminate" during follow-up, complete the HIV Confirmatory Results form and Product Discontinuation eCRFs as applicable.
Rapid HIV test 2 Was Rapid HIV test sample 2 collected for testing?	Select "Yes" or "No". If "No", the remaining items for "Rapid HIV test sample 2" do not need to be completed; proceed to "Was an HIV-EIA test done?"
Rapid HIV test 2 Kit	Use the dropdown menu to select the appropriate Rapid HIV test 2 kit. If "Other", use the "If 'Other', specify" text field.
Rapid HIV test 2 collection date	Record the date that the first specimen(s) was collected, NOT the date the results were reported or recorded on the form for this visit. A complete date is required.
Rapid HIV test 2	Use the dropdown menu to select "Antibody positive", "Antigen positive", "Antibody and antigen positive", or "Negative". *Note: If result is "Positive" or "Indeterminate" during follow-up, complete the HIV Confirmatory Results form and Product Discontinuation eCRFs as applicable.*
Was an HIV-EIA test done?	Select "Yes" or "No". If "No", end of form.
HIV-EIA collection date	Record the date that the first specimen(s) was collected, NOT the date the results were reported or recorded on the form for this visit. A complete date is required.
HIV-EIA test result	Select "Positive", "Negative", or "Indeterminate".

Inclusion Exclusion Criteria

Purpose:

This form is used to document participant eligibility for enrollment in MTN-035, and if applicable, the reasons for study ineligibility per the inclusion and exclusion criteria per protocol. This form is present in the V1.0 – Screening folder.

General Instructions:

Complete this form for each participant screened in MTN-035. Complete this form when it is determined whether the participant will enroll in the study. If the participant has a second screening attempt, update this form with data from the second screening attempt (do not complete a new form).

Item-specific Instructions:

Field	Instructions
Did the participant meet all eligibility criteria?	Select "Yes" or "No" to indicate if the participant met all eligibility criteria.
Informed consent date	Record the exact day, month and year the participant signed the informed consent.

Eligibility Status	Record the applicable eligibility status by selecting from the dropdown menu. If participant met all eligibility criteria, and Eligibility Status is "Eligible and enrolled" or Incomplete screening, then end of form.
Was the participant enrolled into MTN-035?	Select "Yes" or "No" depending on if the participant was enrolled.
If Eligible/Not enrolled, specify reason.	Record the reason an eligible participant did not enroll. This text field should only be completed if "Eligibility status" is "Eligible/Not enrolled".
Select reason(s) why participant is ineligible.	If participant is deemed ineligible per inclusion or exclusion criteria, use the dropdown menu to select a reason and save. Note that it may be necessary to scroll to the right to access dropdown menu. You may need to click the "Next" or Back" buttons on the dropdown menu to find the applicable reason. Alternatively, the first few characters of each criterion can be keyed in to bring up a more selective list. If there is more than one reason for ineligibility per inclusion or exclusion criteria, click on "return to complete view" then click on "Add a new log line" and select another reason. Add all applicable reasons as appropriate.
If investigator decision, specify	If "Has a condition that, in the opinion of the IoR/designee, would preclude informed consent…" was selected, record reason in the specify text box. If any other response was selected, leave this field blank.

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.

Item-specific Instructions:

Field	Instructions
Visit Date	A complete date is required.
Interim visit code	Enter the applicable interim visit code. Refer to the Data Collection SSP for more information on visit codes.
Was study product held at this visit?	Select "Yes" or "No".

	If "Yes", then complete a Product Hold form within the Ongoing Logs folder.
Was study product use permanently discontinued (scheduled or early) at this visit?	Select "Yes" or "No". If "Yes", then complete a Discontinuation of Study Product form within the Discontinuations folder.
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 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 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 Concomitant Medications Log within the Ongoing Logs folder to complete an entry for the applicable medication(s).
Have any protocol deviations been reported at this visit?	Select "Yes" or "No". Select "Yes" if at least one protocol deviation occurred for this visit. Navigate to the Protocol Deviations Log, within the Ongoing Logs folder to complete an entry for the applicable protocol deviation(s).
Reason for interim visit	Select the applicable checkboxes if an AE report or follow-up was completed or if product was returned or provided. Check the box for "Completion of missed visit procedures" if procedures from a missed visit were completed at this Interim Visit. Select the appropriate missed visit from the dropdown menu. If the reason for interim visit is "Other", complete the "If 'Other', specify: text box.
What study procedures were completed at this visit?	Select the checkbox for each study procedure completed at the interim visit. For example, if a physical exam was performed, select the checkbox for Physical Exam. At least one procedure must be completed at an Interim Visit.

	The applicable form(s) will then be added to the participant's visit folder. As indicated procedures that were not completed at this visit may be left blank.

Medical History Log

Purpose:

This form is used to document information on the participant's medical history, including but not limited to: history of hospitalizations, surgeries, allergies, any condition that required prescription or chronic medication (that is, more than 2 weeks in duration), and acute conditions ongoing at screening and/or that occur between screening and enrollment.

This form will appear in the Ongoing Logs folder after the "Medical History Summary" prompt has been answered as "Yes". Use the "Add a new Log line" button to add an additional medical history condition/event in Medidata Rave.

General Instructions:

- At the Screening Visit, record relevant medical history. This includes conditions and symptoms reported by the participant during the medical history as well as any conditions identified via genital exam, anorectal exam, physical exam, or laboratory testing.
- At the Enrollment Visit, review and update as needed. Navigate back to the Ongoing Logs folder to update this log form or add additional entries as needed. Those conditions that are ongoing at the time of enrollment (including ongoing chronic conditions) are considered the participant's pre-existing conditions.
- Do record baseline medical conditions identified during follow-up. Write a chart note to explain why the entry was added after the Enrollment visit.
- Complete a separate entry (e.g. log line) for each medical history condition/event when entering into the study database.

Item-specific Instructions:

Field	Instructions
Date medical history collected	Record the date the medical history condition/event was reported by the participant. A complete date is required.
Description of medical history condition/event	Whenever possible, provide a diagnosis instead of listing a cluster of symptoms. If no diagnosis is identified, each symptom must be recorded as a separate term. If an abnormal lab value is reported at the Enrollment visit, record the lab assay with the direction (i.e., increased or decreased) of the abnormality. For example, "decreased hematocrit" or "increased ALT". Additional information on the frequency and duration of chronic condition outbreaks can also be provided within this description.

Is condition/event gradable?	If a condition is not gradable (ex: below Grade 1), select "No". Review and update as needed for conditions that are ongoing during the study. If a condition is gradable, select "Yes" and complete the Severity grade.
Severity grade	This item is required if "Is condition/event gradable?" is "Yes". Select from the options provided in the dropdown list. Review and update as needed for conditions ongoing at the Enrollment Visit. The toxicity grade reported in Medical History should reflect the status at baseline. • If the severity grade has increased or decreased in severity or frequency during the study AE reporting period, then this should be reported as an AE and the Severity Grade should remain unchanged on this CRF. However, this should be updated as needed if the severity grade and increased or decreased on or prior to the Enrollment Visit. • If the condition improves in severity or resolves during the study, then the Severity Grade should remain unchanged on this CRF. For each condition, grade the severity using the current version of the *Division of AIDS (DAIDS) Table for Grading the Severity of Adult and Pediatric Adverse Events* (including relevant appendices/addendums).
Start date of medical history condition/event	Record the date the medical condition was first diagnosed or the date the surgery/procedure was performed as applicable. If the participant is unable to recall the exact date, obtain their best estimate. At a minimum, a 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-2010 or UN-UNK-2010.
Is the condition ongoing?	Select "Yes" for chronic conditions, as well as any other conditions that are currently ongoing. During each follow-up visit, routinely follow-up on any and all ongoing conditions. If this item is selected "Yes", then this is the end of form and the "Date medical condition/event ended/resolved" should be left blank.
Date medical history/condition 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.

Medical History Y/N

Purpose:

To document any medical history conditions/events reported at the Screening visit or recalled by the participant during Enrollment or follow-up.

General Instructions:

This prompt will be available in the Ongoing Logs folder.

Item-specific Instructions:

Field	Instructions
Does the participant have any medical history to report?	Select "Yes" or "No". If "Yes" is marked, then the "Medical History" log form appears dynamically within the Ongoing Logs folder. Complete entries within the Medical History Log eCRF as needed. If "No" is selected, no further action is required. If the participant reports any medical history conditions/events after the Screening visit, update the response to this field to "Yes" and complete the Medical History Log as needed.

Missed Visit

Purpose:

Complete this form in the event that an enrolled participant misses a required visit according to the visit window outlined in the protocol or Study-specific Procedures (SSP) manual.

General Information/Instructions:

A missed visit form will be dynamically added to a visit folder if the response to "Was this visit completed?" on the Follow-up Visit Summary from is "No". Complete the Missed Visit form only for this visit.

Item-specific Instructions:

Field	Instructions

Target Visit Date	Record the target date of the visit. A complete date is required.
Reason visit was missed	Select the reason that the participant missed the visit from the dropdown list. If the reason that the participant missed the visit is not included in this list, select "Other", and specify the reason that the reason was missed in the "If 'Other', specify" text field provided.
Steps taken to address the missed visit (corrective action plan)	Record the corrective steps that have been taken or will be taken to address the missed visit and help prevent future missed visits.

Participant Identifier

Purpose:

The Participant Identifier page within Medidata Rave will generate each participant's PTID. This page is the first form completed within Medidata Rave for each participant.

General Instructions:

Complete this form for every MTN-035 participant once they have provided written informed consent for study screening and enrollment.

Item-specific Instructions:

Field	Instructions
Participant ID	To add a participant to the study database, select the "Add Subject" link on the MTN-035 site-specific home page. The Participant Identifier page will appear. This is the first page that should be completed for each participant. No data entry is required by 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 and the home page for the participant's file will appear. The link to refer back to the Participant Identifier page is located at the top of each participant's home page. The participant ID will appear on each eCRF generated in Medidata Rave. The participant ID should be written at the top of each paper CRF completed for a participant. The first three digits of each participant ID will comprise of the Rave site ID. Therefore, each participant ID will begin with the site ID. A list of Rave site IDs is provided in the table below:

CRS Name	DAIDS ID	Rave Site ID
Pittsburgh	1001	702
Birmingham	31788	821
Blantyre	30301	760
Chiang Mai Univ. AIDS Prevention	31458	791
Hillbrow	31639	805
Lima – San Miguel	11302	715
San Francisco	30305	764

Participant Receipt

Purpose:

Complete this form when a transferred participant has provided informed consent at the receiving study clinic/site.

General Instructions:

The Participant Transfer form is completed by the receiving site (the site at which the participant will continue their study visits) when the participant's electronic case book has been transferred to the receiving site. This form should be added to the participant case book by selecting it from the list of optional study procedures within the **Additional Study Procedures** or **Interim Visit Summary** form within the last completed study visit at the transferring site (i.e., the Participant Transfer and Participant Receipt form should be completed within the same visit folder). The Participant Receipt form will then be added to the applicable study visit folder within Rave.

The participant will retain her original Participant ID (PTID) assigned by the original study site. Do not assign a new Participant ID.

For more information on Participant Transfer and Receipt, refer to the MTN-035 protocol, Study-specific Procedures (SSP) manual, and/or Manual of Operations (MOP).

Item-specific Instructions:

Field	Instructions
Name of receiving study site	Select the transferring site from the dropdown field.
Name of transferring study site	Select the receiving site from the dropdown field.
Date informed consent signed at receiving site	A complete date is required.

Participant Replacement Assessment

Purpose:

This form is used to assess whether a participant meets criteria for replacement in the study.

General Instructions:

Complete this form on an as-needed basis. It is required for each participant who will be replaced in the study. To dynamically add this eCRF to visit folder, select "Participant replacement assessment" on the Additional Study Procedures form.

Item-specific Instructions:

Field	Instructions
Date of assessment	A complete date is required.
Does this participant meet protocol-specified criteria for replacement?	Select 'Yes' or 'No'. If the response is 'No', then end the form and leave remaining items blank.
Why is this participant being replaced?	Select the replacement criteria from the dropdown menu. If replacement criteria is other than what is listed, select 'Other' and record the reason in the "If Other, specify" text field provided.

Participant Transfer

Purpose:

Complete this form when a participant is permanently transferring to another study clinic/site.

General Instructions:

The Participant Transfer form is completed by the transferring site (the site that the participant is leaving). This form should be added to the participant case book by selecting it from the list of optional study procedures within the Additional Study Procedures or Interim Visit Summary form. The Participant Transfer form should be added to the folder at which the participant is transferred to another site.

For more information on participant transfers, refer to the MTN-035 protocol, Study-specific Procedures (SSP) manual, and/or Manual of Operations (MOP).

Field	Instructions
Name of transferring study site	Select the transferring site from the dropdown field.
Name of receiving study site	Select the receiving site from the dropdown field.
Visit of last completed contact with participant	Select the appropriate visit. This will be the last visit the participant completed at the study site they are transferring FROM. If "Interim visit", record the Interim visit code in the text box provided.
Date participant records were sent to receiving study site	A complete date is required.

Pelvic Exam

Purpose:

This form is used to document the participant's pelvic exam assessment.

General Instructions:

Complete this form when clinically indicated at all study visits. If this form is needed at the Screening or Enrollment visit, it will need to be added via the "Add Event" on the participant's home page. If this needs to be completed at a follow-up visit, this form can be added via the Additional Study Procedures form. If the Pelvic Exam is completed during the 'V1.0 – Screening' or 'V2.0 Day 0/Enrollment' visit you will need to add the Pelvic Exam form to the respective Screening or Enrollment folder through "Add Event" on the participant's home page.

Item-specific Instructions:

Field	Instructions
Pelvic exam assessment	Select "Abnormal findings" or "No abnormal findings" to indicate any findings from the pelvic exam. If "no abnormal findings" is selected, then skip the "Abnormal findings" section.
Exam Date	A complete date is required.
Abnormal findings	Select the box to the right of each abnormal finding observed and check all that apply. Please record any baseline abnormalities on the Medical History Log CRF. Any post-baseline abnormalities or baseline conditions that worsened post baseline should be reported on the Adverse Event CRF. If Condyloma, specify location in the text field provided. Abnormal blood or bleeding: If unexpected blood or bleeding is observed, briefly describe the color, amount, and location of the blood/bleeding in the text field provided. Assess the blood/bleeding for AE reporting purposes.

	If an observed abnormal finding is not listed, select "Other abnormal findings" and specify/describe the abnormal findings in the text field provided, including the anatomical location.
Were any new pelvic finding AEs reported at this visit?	Record whether an AE was identified and reported at this visit as part of the pelvic exam assessment by selecting "Yes" or "No". If an AE was reported at the study visit, select the corresponding AE log form within the dynamic searchlist function on the eCRF. Up to 3 AEs can be selected. This item should be "No" prior to participant enrollment in the study (i.e., prior to the AE reporting period).

Pharmacy Dispensation

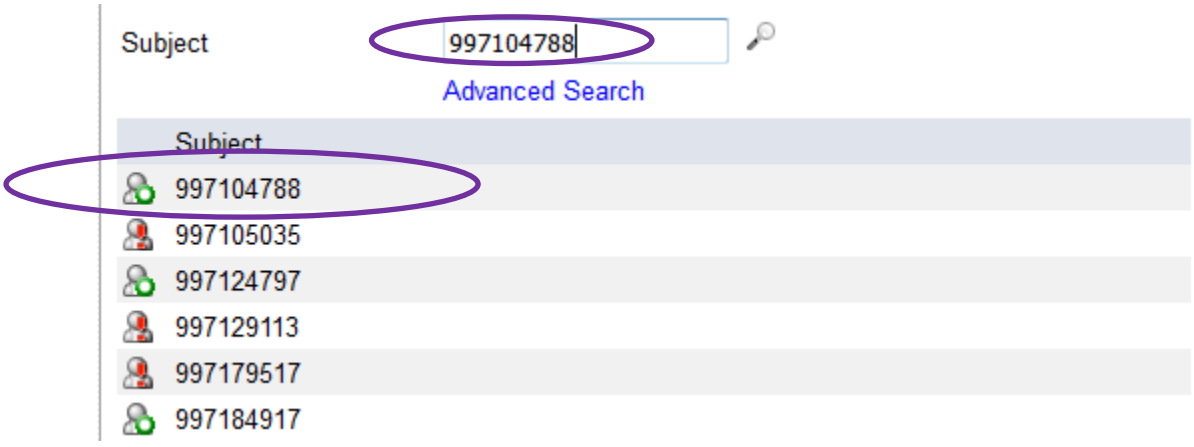
Purpose:

This form is used to collect study product rectal applicator dispensation information.

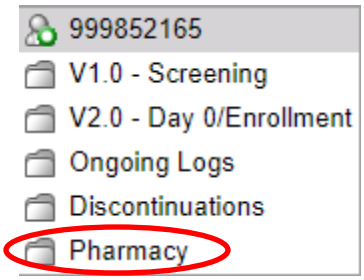
General Instructions:

Complete this form at Visit 2.0, 4.0 and 6.0. The sequence the participant is randomized to will only appear after the form has been saved. The pharmacy staff needs to confirm the sequence against what was entered in "which sequence is the participant enrolled in?". **This form is completed by pharmacy staff only and is not visible to site clinic staff. Only pharmacists who have been granted this role will be able to view and enter data on this eCRF.**

- Select the applicable PTID as documented on the prescription. The search list can be used to find the PTID.



- Navigate to the Pharmacy folder to complete the Pharmacy Dispensation eCRF.



- Complete the Pharmacy Dispensation eCRF and save the form.
- Confirm the sequence entered in "Study Product Sequence" against the auto-populated sequence in "Study Product Sequence (autopopulated from Medidata Balance".

Item-specific Instructions:

Field	Instructions
Study Product Sequence	Select Sequence A, B, C, D, E or F depending on the sequence the participant has been randomized to by Medidata Balance.
Visit study product dispensed	Use the dropdown menu to select the appropriate visit at which study product is being dispensed. If "Interim visit", specify the visit code.
Date study product dispensed	Record the exact day, month and year study product was dispensed.
Which product was dispensed at this visit?	Used to radio buttons to select which study product was dispensed to the participant at this visit. You may select: • "Placebo rectal inserts" OR • "Placebo rectal suppositories" OR • "Empty rectal enema bottles" AND "Rectal enema tips"
How many of the following study products were dispensed?	Use the dropdown menu options for each product. Each product requires an answer. Select "NA" for study products that were not dispensed. Note that placebo rectal inserts and placebo rectal suppositories are dispensed in packs of 20, so you can either select "NA" or "20" for these study products. You may dispense up to 4 empty bottle tips at a time and up to 20 empty bottle tips at a time. Select "Yes" or "No" depending on if study lubricant was provided to the participant at this visit.

Physical Exam

Purpose:

This form is used to document the participant's physical exam findings.

General Instructions:
Complete this form at V1.0 - Screening, V2.0 - Enrollment, and when clinically indicated during follow-up. If abnormal findings are found for any of the assessments, enter the information on the Medical History Log or Adverse Event Log eCRF(s) as applicable.

Item-specific Instructions:

Field	Instructions
Was a physical exam performed?	Select "Yes" or "No".
Date of exam	Enter the date the physical exam was performed. A complete date is required.
Body System	For each organ system or body part evaluated, indicate whether the findings were normal or abnormal. If abnormal, describe the abnormality in the corresponding text field, "If 'Abnormal', specify". For any baseline abnormal and clinically significant findings, record the associated condition(s) on the Medical History Log eCRF. Any post-baseline abnormalities or baseline conditions that worsened post baseline should be reported on the Adverse Events Log eCRF. Normal findings may also be described in the text field/space, but it is not required. If not evaluated, select "Not done". Additional information may also be provided in the text field for why "Not Done", but this is not required.
Other system, specify:	If other systems were assessed not covered by the pre-defined assessments, then please specify the body system and findings in "Other system, specify" text field regardless of whether the findings were "Abnormal" or "Normal". If no other components as indicated were assessed, select "Not Done". If findings were "Abnormal", describe in the "If 'Abnormal', specify" text field provided.
Was a Genital Exam performed at this visit?	Select "Yes" or "No" depending on if a Genital Exam was performed at this visit. Per protocol, a genital exam is not required, and is performed as indicated.
Was a Pelvic Exam performed at this visit?	Select "Yes" or "No" depending on if a Pelvic Exam was performed at this visit. Per protocol, a pelvic exam is not required, and is performed as indicated.

Pregnancy History

Purpose:

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

General Instructions:
A Pregnancy History form is required once for a participant who becomes pregnant during the study.

To complete a Pregnancy History form within Medidata Rave, navigate to the "Add Event" on the Participant's homepage. Click "Pregnancy History" then "Add" and a pregnancy history folder will appear for data entry.

Item-specific Instructions:

Field	Instructions
Date pregnancy history collected	A full date is required.
Has the participant ever been pregnant before?	If the participant has never been pregnant before, select "No" and end the form. If "yes", an entry is required for each of the following: Number of full term live births (>=37 weeks), Number of premature live births (less than 37 weeks), Number of spontaneous fetal deaths and/or still births (>=20 weeks), Number of spontaneous abortions (less than 20 weeks), Number of therapeutic/elective abortions, Number of ectopic pregnancies. Enter "00" for any that do not apply.
Does the participant have a history of pregnancy complication or fetal/infant congenital anomalies?	If the participant does not have a history of pregnancy complications, select "No" and end the form. If "Yes", then include information on pregnancy complications and fetal/infant congenital anomalies experienced prior to enrolling in the study as well as any conditions experienced/reported during the study in the corresponding text field provided.

Pregnancy Outcome Log

Purpose:
This form is used to report pregnancy outcome information for a pregnancy reported post-enrollment. A Pregnancy Outcome Log line must be completed for each pregnancy reported during the study.

General Instructions:
This form can be added by selecting "Pregnancy" through "Add Event" on the participant's home screen. For each pregnancy outcome, complete one log line. To add another pregnancy outcome (if needed), use the "Add a new Log line" button to add each additional pregnancy outcomes.

Item-specific Instructions:

Field	Instructions
Is the outcome of this pregnancy obtainable?	Selects "Yes" or "No". If the outcome of the pregnancy is not able to be obtained, select "No" and end the form.

How many pregnancy outcomes resulted from this reported pregnancy?	If the pregnancy results in two or more outcomes, complete a Pregnancy Outcome Log form (new log line) for each outcome. If the item is completed as greater than "1", additional Pregnancy Outcome Log lines will be added to the Pregnancy Outcome Log form, as needed. Each Pregnancy Outcome form will have different outcome numbers.
Outcome Date	A complete date is required.
Place of delivery/outcome	Enter the place of delivery/outcome from the dropdown menu. If "Other", then specify relevant details in the "If, Other, specify" text field provided.
Specify Outcome	Specify the outcome from the dropdown menu. If the outcome is still birth/intrauterine fetal demise, spontaneous abortion, ectopic pregnancy, or therapeutic/elective abortion, the outcome itself is not an adverse event (AE). If a therapeutic/elective abortion is performed due to a pregnancy complication, the pregnancy complication should be reported on an Adverse Event (AE) Log, if prior to termination, with "therapeutic procedure/surgery" checked for item "Action taken with study product". If there are any maternal complications as a result of the pregnancy outcome, refer to the protocol, Study-specific Procedures (SSP) manual, and *Manual for Expedited Reporting of Adverse Events to DAIDS, Version 2* for guidance on AE and expedited AE reporting requirements. If "Other", then specify relevant details in the "If, Other, specify" text field provided.
Method	Select the method from the dropdown menu only if the outcome is "full term live birth (≥37 weeks)" or "premature term live birth (<37 weeks)". "Operative Vaginal" delivery includes delivery with forceps and/or vacuum. If the outcome is "full term live birth", skip to "Were there any complications related to the pregnancy outcome?"
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.
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 items "Delivery-related complications" and "Non-delivery related complications" are not required.
Delivery-related complications	Select "None" or check all that apply. If "Other", then specify relevant details in the "If, Other, specify" text field provided.
Non-delivery related complications	Select "None" or check all that apply. If "Other", then specify relevant details in the "If, Other, specify" text field provided.

Were any fetal/infant congenital anomalies identified?	Record if any fetal/infant congenital anomalies were identified using the dropdown menu. If "No" or "Unknown", go to statement "Complete the infant items below for live births only" above "Infant gender".
Congenital anomalies identified.	If there were fetal/infant congenital anomalies identified, then check all that apply. If a woman on study has a baby with a congenital anomaly, report the event on an Adverse Event (AE) Log form, if prior to study discontinuation. On the AE Log form, record "Congenital Anomaly in Offspring" in the AE description, record the Outcome Date as the Onset Date, and record the specific anomaly in the Comment Section. Submit an Expedited Adverse Event (EAE) Reporting form.
Describe the congenital anomaly/defect	Describe the congenital anomaly/defect in the text field provided.
Specify congenital anomaly/defect AE	The corresponding AE log form must be completed to link the congenital anomaly/defect AE to the AE log form entered. Choose the applicable AE from the dropdown list.
Infant items	Complete the infant items for live births only. Otherwise, end the form.
Infant Gender, Infant birth weight, Infant birth length, Infant birth head circumference, Infant birth abdominal circumference	Complete these items for live births only. Record the information as documented in medical records. If no medical record documentation of the information is available, complete this item based on participant report. Check the "unavailable" box if no medical record documentation is available and the participant does not know the information.
Infant Gestational age by examination in days and weeks	Record the infant's gestational age at birth. If the infant's gestational age is determined using the Ballard method, record "0" in the "days" box. Check the "unavailable" box if no medical record documentation of the infant's gestational age is available and end the form. If "other" method is selected for "Method used to determine gestational age", specify in the corresponding "If other, specify" text field.

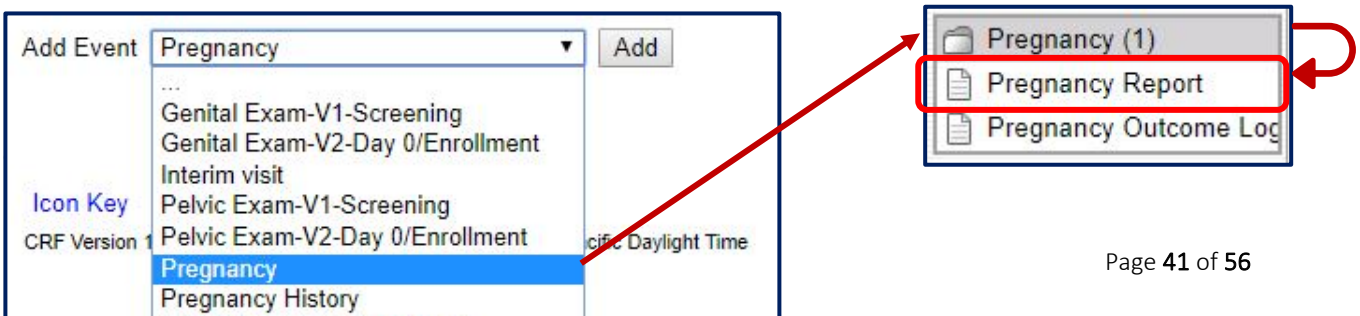
Pregnancy Report

Purpose:

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

General Instructions:

This form will be added **when "Pregnancy" is added through the "Add Event" option on the participant's home screen**.



Item-specific Instructions:

Field	Instructions
Date pregnancy was reported to site	A full date is required.
Visit at which this pregnancy was reported	Select the appropriate visit from the dropdown menu. If "Interim visit", specify the Interim visit code in the text box provided.
Date of onset of last menstrual period	A complete date is required. Record best estimate if date not known. If the participant is amenorrheic, select the checkbox for the next item, "Amenorrheic for past 6 months" and leave the "Date of onset of last menstrual period" blank.
Estimated date of delivery	A complete date is required.
What primary information was used to estimate the date of delivery?	Select the appropriate method of information using the dropdown menu. If "Other" is selected, describe in the "If 'Other', specify" text field provided.
Is this the participant's first pregnancy since enrollment in this study?	Select "Yes" or "No".
Does the participant have a history of pregnancy complications or fetal/infant congenital anomalies?	If the participant does not have a history of pregnancy complications, select "No" and end the form. If "Yes", complete the Pregnancy History form.

Pregnancy Test Result

Purpose:

This form is used to document the pregnancy test result as the result becomes available from the local lab.

General Instructions:

This form is required as indicated.

Item-specific Instructions:

Field	Instructions
Was a pregnancy test done?	Record if a pregnancy test was done by entering "Yes" or "No". If "No" is selected, then end of form and leave remaining items blank. • If a pregnancy test was not done, please do NOT complete the "Date of Pregnancy Test", or "Test result". • If the sample was collected, then complete "Date of Pregnancy Test" and "Test result".
Collection 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 was collected. A time is required.
Pregnancy test result	Record the result of the pregnancy test – "Positive" (pregnant) or "Negative" (NOT pregnant) by selecting the appropriate radio button. If the result is "Positive" at a follow-up visit, then complete a Product Hold form, Pregnancy Report form, and Pregnancy History form. The pregnancy History form will only need to be completed once if there is more than one pregnancy reported during the time the participant is enrolled into the study.

Product Hold Log

Purpose:

This form is used to document temporary clinical holds of study product use as instructed by study site staff.

General Instructions:

This form is completed each time a participant is instructed by study staff to temporarily stop (hold) study product use. If, at the same visit, a product hold is initiated for more than one reason, complete one Product Hold log line for each reason. To add an additional Product Hold log line within Medidata Rave, click "Add a new Log line" to add an additional log line for a new product hold to be completed.

Complete this form for any clinical reason that warrants a product hold regardless of whether participant chooses to use the study product during the study. Do not complete this form in cases where a participant themselves has decided to not use the study product.

Item-specific Instructions:

Field	Instructions
Date when study product hold was initiated	Record the date when the product hold was initiated or would have been initiated in instances where the participant has chosen not to use the study product. A complete date is required.

Visit study product hold was initiated	Select the appropriate visit from the dropdown menu. If "Interim visit" is chosen, provide a response for "If Interim visit" is chosen, provide interim visit code.
Why is study product being held?	Record the reason that study product is being held using the dropdown menu. If study product is held for any reason not specified, mark "Other" and specify the reason in the "If 'Other', specify" text box provided. Note that participant decline or refusal of study product is not documented as a product hold. Do not record this as a reason in '"If, 'Other', specify".
Adverse Event	If study product is being held due to "Adverse Event", select the applicable AE from the dropdown field provided. *Note: If study product is being held due to an AE, the AE log page must be entered into Rave prior to completion of the Clinical Product Hold log form in order for the AE to be available to select with the dropdown field.*
Concomitant Medication	If study product is being held due to "Reported use of PEP", specify the corresponding concomitant medications log form on which the medication was reported in from the dropdown field provided with Rave. At least one medication must be specified and up to four medications can be recorded. Note: If the product hold is due to report of medication use, the corresponding concomitant medications log page must be entered into Rave prior to completion of the Product Hold log form in order for the medication be to be available within the dropdown field.
Date of last study product use	Record the last date the study product was used. Use a best estimate if the actual date cannot be determined.
Was the participant instructed to resume study product use?	If "Yes", enter below the date that the participant was instructed to resume study product. Mark, "No – hold continuing for another reason" if the participant would have been instructed to resume study product based on the resolution of the reason indicated on this form. If "No – hold continuing for another reason", enter below the "date study product hold continuing for another reason". Mark, "No – early termination" if the product hold was ongoing at the visit at which the participant terminated early from the study.* Mark, "No – hold continuing at scheduled PUEV" if the product hold was ongoing at time of the participant's scheduled Product Use End Visit.* Mark, "No – permanently discontinued" if the participant was permanently discontinued from study product due the reason indicated on this form.* *If "No - early termination", "No - permanently discontinued", or "No – hold continuing at scheduled PUEV" complete the Discontinuation of Study Product form.
Date study product resumed	Record the date that the participant was instructed to resume study product.
Date study product hold continuing for another reason	Record the date that the participant would have been instructed to resume study product based on the resolution of the reason indicated on this form.

Date study product hold continuing for another reason	If the study product hold continues for another reason, record the data here and also add a new Product Hold Log line for this new or subsequent reason.

Product Hold Y/N

Purpose:

This form documents if a clinician-initiated product hold was applied during the study.

General Instructions:

This form is present within the "Ongoing Logs" folder. Selecting 'Yes' to the "Does the participant have any clinical product holds to be applied?" prompt will add the "Product Hold Log" to the "Ongoing Logs" folder.

Item-specific Instructions:

Field	Instructions
Does the participant have any clinical product holds to be applied?	Select 'Yes' or 'No'. If 'Yes' is selected, then the "Product Hold Log" appears dynamically and can then be completed.

Protocol Deviations Log

Purpose:

This form documents and reports protocol deviations identified for study participants during the implementation of MTN-035.

General Information/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. Consult the MTN Regulatory Team (mtnregulatory@mtnstopshiv.org) and the Study Management Team if you are unsure if an event requires reporting as a deviation.

Item-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). A complete date is required.
Has or will this deviation be reported to local IRB/EC?	Select "Yes" or "No".

Field	Instructions
Has or will this deviation be reported to DAIDS as a critical event?	Select "Yes" or "No".
Type of deviation	Record the applicable deviation by selecting from the dropdown 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 dropdown search list to find the applicable deviation to be entered. You may also click the "next" button within the dropdown menu for more options. 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.
Plans and/or actions to address the deviation	Use the text field to provide a brief description of the plans to address the deviation.
Plans and/or actions to address for future deviations	Use the text field to provide a brief description of the plans to address future deviations.
Deviation reported by	Enter the staff code of the site staff person who completed the form. Sites will need to assign a four-digit staff code to each site staff person who will be completing this form. This list is created, maintained and kept at the study site.

Protocol Deviations Code List

Code	Definition
Inappropriate enrollment	The participant enrolled and not all eligibility requirements were met.
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.
Study product management deviation	The site staff did not instruct the participant to hold, permanently discontinue, or resume study product use per protocol requirements.
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. Pharmacy staff must follow up with the MTN Pharmacist separately.
Study product use/non-use deviation	Participant did not use the study product (including refusals) for more than 3 days.
Study product sharing	Participant has shared study product with another person or study participant.
Study product no returned	Study product was not returned by the participant per protocol requirements.
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.
Improper AE/EAE	use when an AE or EAE* is not followed per protocol. For example, a clinical finding/lab result is not re-assessed as outlined in the protocol.
Unreported AE	Site staff become aware of an AE, but do not report it per protocol requirements.
Unreported EAE*	EAEs do not apply to MTN-035
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.
Physical assessment deviation	Include missed or incomplete physical/pelvic exam assessments.
Lab assessment deviation	Include missed, or incomplete lab specimen collection
Mishandled lab specimen	Include errors in labeling, physical handling, processing, testing, storage, or shipment of collected lab specimens.
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.
Questionnaire administration deviation	A required questionnaire was not completed according to protocol requirements. Include instances where the wrong questionnaire was completed.
Counseling deviation	Protocol-required counseling was not done and/or not documented correctly.

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.
Use of excluded concomitant medications, devised or non-study products	
Informed consent process deviation	Examples include failure to accurately execute and/or document any part of the informed consent process.
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.
Other	

* EAEs do not apply to the MTN-035 protocol

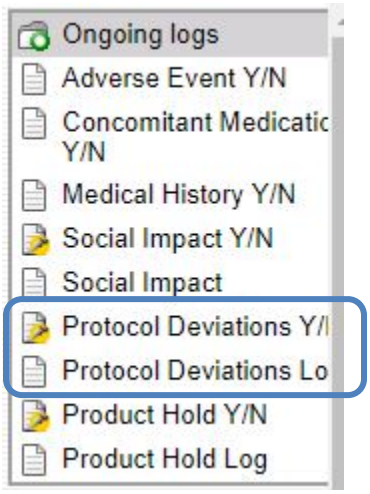
Protocol Deviations Y/N

Purpose:

This form documents if a protocol deviation has occurred.

Generation Instructions:

This form is present within the "Ongoing Logs" folder. Selecting "Yes" in the "Protocol Deviations Summary" will add the "Protocol Deviation Log" form.



Item-specific Instructions:

Field	Instructions
Have any protocol deviations occurred?	Select "Yes" or "No". If "Yes" is selected, then the "Protocol Deviation Log" form appears dynamically within the Ongoing Logs folder and can then be completed.

Randomization

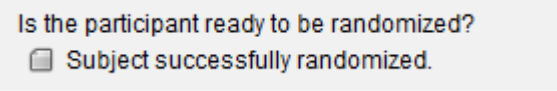
Purpose:

This form is used to officially randomize a participant for MTN-035. This form is completed at Enrollment for participants who have provided informed consent and who are eligible to participate in the study.

General Instructions:

Complete this form for each participant who will enroll in MTN-035 indicating the participant is ready to be randomized. The Randomization Date and Time will be auto-populated from Medidata Balance into Medidata Rave. Upon saving this form, the participant's treatment assignment will be generated in Medidata Balance. The item "Did the participant meet all eligibility criteria?" on the ~~Eligibility~~ Inclusion/Exclusion Criteria form must be completed before the Randomization form in order for the randomization to be successful.

Item-specific Instructions:

Field	Instructions
Is the participant ready to be randomized?	Select "Yes" and Save the form. If the participant is successfully randomized, a note will appear under this item as shown below:  If randomization was not successful, this message will not appear and the Randomization Date and Time will not automatically populate. If successful, the participant will be assigned to a sequence arm in the Medidata Balance module.
Randomization Date and Time	Once "Is the participant ready to be randomized?" is saved as "Yes", then the randomization Date and Time will automatically populate. The Randomization Time will be auto-populated in Coordinated Universal Time (UTC).

Screening Date of Visit

Purpose:

This form is used to document the date of the participant's Screening Visit.

General Instructions:

If screening procedures conducted across multiple days, this date should correspondent to the first day where screening procedures are done. If a participant has a second screening attempt, update this form with the date from the second screening attempt (do not complete a new form).

Social Impact Log

Purpose:

This form records the occurrence, update, and resolution of adverse social harms reported by participants at any time during the study.

General Instructions:

This form should be completed only when a participant has a negative experience associated with study participation. A new form should be completed whenever a new social impact is reported. This form should also be updated, as applicable.

To add an additional social impact within Medidata Rave, clicking "Add a new Log line" will add an additional page for a new social impact to be completed.

Item-specific Instructions:

Field	Instructions
Date reported to site	A full date is required.
Concisely describe social impact	Describe the social impact in one or two sentences in the text box provided.
Onset date	Record the date the negative experience first started. At a minimum, a month and year are required.
Reported at visit code	Select the visit at which the social harm was reported. If the social harm was reported at an interim visit, select "interim visit" and record the interim visit code using the following format: (x)x.x.
Social impact	Record the applicable social impact type by selecting from the dropdown menu.
What impact did this situation have on the participant's quality of life?	Assess the impact of the social harm on the participant's quality of life based on participant self-report.
Describe what was done by staff and participant to address social impact.	Describe any steps taken by the participant to address the social impact in the "Participant" text box provided. Describe any steps taken by the study staff to address the social impact in the "Staff" text box provided.
Record current status	Record the current status of the social impact using the dropdown menu provided. This item may be updated at subsequent visits.
If social impact status "Unable to resolve; no further action taken" or "Resolved" is marked, record closure date	Record the closure date if the current status is selected as "unable to resolve; no further action taken", or "resolved". Leave this item blank if the current status is selected as "Unresolved" or "Unresolved at end of study".

Social Impact Y//N

Purpose:

This form documents if a social impact has been reported by the participant during the study.

General Instructions:

This form is present within the "Ongoing Logs" folder. Selecting 'Yes' in the "Social Impact Yes/No" prompt will add the "Social Impact" form.

Item-specific Instructions:

Field	Instructions
Did a social impact occur?	Select "Yes" or "No". If 'Yes' is selected, then the "Social Impact" form appears dynamically and can then be completed.

Specimen Storage

Purpose:

This form is used to document collection and storage of plasma specimens by the local site laboratory during follow-up.

General Instructions:

Complete this form at Visit 2.0 – Enrollment.

Item-specific Instructions:

Field	Instructions
Specimen type	Select "Plasma for archive" from the dropdown menu if collected.
Was specimen collected?	Select "Yes" or "No". If "No", then do not complete the date and time of collection and storage item(s).
Collection Date	Record the date that the first specimen(s) was collected, NOT the date the results were reported or recorded on the form for this visit. A complete date is required.
Was sample stored?	Enter "Stored" for specimens that are collected and sent to the lab for processing. If the specimen is required to be stored, but for some reason it is not stored, select "Not stored" and record the reason in the corresponding "If 'No', record reason why sample was not stored" text field provided.

STI Test Results

Purpose:

This form is used to document STI test results performed by the local site laboratory.

General Instructions:

Complete this form at the V1.0 - Screening Visit, V7 - PUEV and as indicated during the study. To generate this form at Enrollment, select "STI Test Results at Enrollment" via Add Event.

If any or all of the lab tests listed on this form are repeated (re-drawn) between the Screening and Enrollment Visit, document the repeated results on the same STI Test Results form. If the participant enrolls, the updated results should be submitted into the study database.

At Screening, record STI diagnoses on the Baseline Medical History Log form when applicable. During follow-up, if a test result(s) recorded within this form indicates that the participant has a new (or increased severity) laboratory-confirmed infection or diagnosis, this infection/diagnosis must be recorded as an adverse event in the Adverse Event Log eCRF as applicable.

Item-specific Instructions:

Field	Instructions
Was a urine sample collected for NAAT for GC/CT/Trichomonas?	Select "Yes" or "No". If "No", the remaining items for "Was a urine sample collected for NAAT for GC/CT/Trichomonas?" do not need to be completed; skip to "Was a pharyngeal swab collected for NAAT for GC/CT?"
Date of collection	Record the date that the specimen was collected, NOT the date the result was reported or recorded on the form for this visit. A complete date is required.
N. gonorrhea	Select "Positive", "Negative", or "Not done".
C. trachomatis	Select "Positive", "Negative", or "Not done".
Trichomonas test	Select "Positive", "Negative", or "Not done".
Was a pharyngeal swab collected for NAAT for GC/CT?	Select "Yes" or "No". If "No", then the remaining items for "Was a pharyngeal swab collected for NAAT for GC/CT?" do not need to be completed. Proceed to "Was a vaginal swab collected for NAAT for GC/CT?"
Date of collection	Record the date that the specimen was collected, NOT the date the result was reported or recorded on the form for this visit. A complete date is required.
N. gonorrhea – Pharyngeal test result	Select "Positive" or "Negative", or "Not done".
C. trachomatis – Pharyngeal test result	Select "Positive" or "Negative", or "Not done".

Was a vaginal swab collected for NAAT for GC/CT?	Select "Yes" or "No". If "No", then the remaining items for "**Was a vaginal swab collected for NAAT for GC/CT?**" do not need to be completed. Proceed to "Was a vaginal sample collected for NAAT for Trichomonas?"
Date of collection	Record the date that the specimen was collected, NOT the date the result was reported or recorded on the form for this visit. A complete date is required.
N. gonorrhea	Select "Positive" or "Negative", or "Not done".
C. trachomatis	Select "Positive" or "Negative", or "Not done".
Was a vaginal sample collected for NAAT for Trichomonas?	Select "Yes" or "No". If "No", then the remaining items for "Was a vaginal sample collected for NAAT for Trichomonas?" do not need to be completed. Proceed to "Was an anorectal swab collected for NAAT for GC/CT?"
Date of collection	Record the date that the specimen was collected, NOT the date the result was reported or recorded on the form for this visit. A complete date is required.
Trichomonas test	Select "Positive" or "Negative", or "Not done".
Was an anorectal swab collected for NAAT for GC/CT?	Select "Yes" or "No". If "No", then the remaining items for "Was an anorectal swab collected for NAAT for GC/CT?" do not need to be completed. Proceed to "Was an anorectal swab collected for HSV-1/2 detection?"
Date of collection	Record the date that the specimen was collected, NOT the date the result was reported or recorded on the form for this visit. A complete date is required.
N. gonorrhea	Select "Positive" or "Negative", or "Not done".
C. trachomatis	Select "Positive" or "Negative", or "Not done".
Was an anorectal swab collected for HSV-1/2 detection?	Select "Yes" or "No". If "No", then the remaining items for "Was an anorectal swab collected for HSV-1/2 detection?" do not need to be completed. Proceed to "Was the participant diagnosed with asymptomatic BV?"
Date of collection	Record the date that the specimen was collected, NOT the date the result was reported or recorded on the form for this visit. A complete date is required.
HSV test result	Use the dropdown menu to select the HSV test result.
Was the participant diagnosed with asymptomatic BV?	Select "Yes" or "No".
Was the participant diagnosed with asymptomatic candida?	Select "Yes" or "No".

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.

Item-specific Instructions:

Field	Instructions
Date of study exit	A complete date is required.
Primary reason for completion/discontinuation	Select the appropriate reason from the dropdown menu if the participant did not complete the study. If "If 'Other', specify" is selected, use the text box provided.
If withdrawal of consent by participant, investigator decision, or other, specify	If the primary reason is "Withdrawal of consent by participant", "Investigator decision", or "Other", then provide additional details in the text field provided.
If "Death", enter date of death	If the primary reason for study non-completion is "Death", provide the date of death. A complete date is required.
If "Adverse event", select applicable adverse event	Select the applicable Adverse Event from the list of AE's in the dropdown menu. In situations where more than one AE is associated with termination, record the AE that most strongly influenced the decision to terminate.

Syphilis Serology

Purpose:

This form is used to document Syphilis Serology test results performed by the local laboratory.

General Instructions:

Complete this form at the V1.0 - Screening Visit, V7 - PUEV and as indicated during the study.

If any or all of the lab tests listed on this form are repeated (re-drawn) between the Screening and Enrollment Visit, document the repeated results on the same Syphilis Serology form. If the participant enrolls, the updated results should be submitted into the study database.

At Screening, record Syphilis Serology on the Medical History Log form when applicable. During follow-up, if a test result recorded within this form indicates that the participant has a new (or increased severity) laboratory-confirmed infection or diagnosis, this infection/diagnosis must be recorded as an adverse event in the Adverse Event Log eCRF as applicable.

Item-specific Instructions:

Field	Instructions
Was a sample collected for syphilis testing?	Select "Yes" or "No". If "No", end of form.
Collection date	Record the date that the specimen was collected, NOT the date the result was reported or recorded on the form for this visit. A complete date is required.

Syphilis test (EIA)	Use the dropdown menu to select “Positive”, “Negative”, “Indeterminate”, or “Not done”
Syphilis test (RPR)	Check “Non-Reactive”, “Reactive”, or “Not done”.
Syphilis titer	Record the titer in the format 1: XXXX. When completing this form in Medidata Rave, please include the “1:” in the same field for the syphilis titer.
Syphilis confirmatory test	If the result of the Syphilis screening test is “Reactive,” complete the Syphilis confirmatory test results (either “Positive”, “Negative,” or “Indeterminate” or “Not done’).

Vital Signs

Purpose:

This form is used to document the participant’s vital signs.

General Instructions:

Complete this form at V1.0 - Screening, V2.0 - Enrollment, and when clinically indicated during follow-up.

Item-specific Instructions:

Field	Instructions
Were vital signs done?	Select “Yes” or “No”.
Date of assessment	A complete date is required.
Height	Enter the participant’s height in centimeters. The value should be rounded to the nearest whole number (e.g. 180 cm). Per protocol, height is required only at the Screening Visit and this item will be displayed on the Vital Signs eCRF in the V1.0 – Screening Visit only.
Weight	Enter the participant’s weight in kilograms. The value can be reported up to one decimal (e.g. 70.1 kg).
Body temperature	Enter the participant’s temperature in Celsius. The value can be reported up to one decimal (e.g. 37.2˚ C).
Systolic BP*	Enter the participant’s systolic blood pressure in mmHg (e.g. 120 mmHg).
Diastolic BP*	Enter the participant’s diastolic blood pressure in mmHg (e.g. 80 mmHg).
Pulse	Enter the participant’s pulse in beats per minute (e.g. 60 beats/min).
Rate of Respiration	Enter the participant’s respiratory rate in breaths per minute (e.g. 14 breaths/min).

* In Medidata Rave, the most recent BP reading that is used for clinical management should be recorded on the Vital Signs eCRF. In instances where the BP has already been entered within Medidata Rave, these fields (Systolic BP and Diastolic BP) can be updated within the form and re-saved.

SUMMARY OF CHANGES

Version		CRF Name	Summary of Changes
Number	Date		
0.1	11/01/2018	N/A	Draft CCGs
1.0	11/08/2018	N/A	Finalized and versioned.