Section 3. Documentation Requirements

Study staff is responsible for proper collection, management, storage, quality control, and quality assurance of all study-related documentation. This section contains information on the Essential Documents that each study site must maintain throughout the study. It also contains information related to establishing adequate and accurate participant research records — commonly referred to as participant "case history records" — for HPTN 059.

3.1 Essential Documents

The Division of AIDS (DAIDS) Standard Operating Procedure (SOP) for Essential Documents (see Section 17) specifies the essential documents that study sites must maintain for DAIDS-sponsored studies, including HPTN 059. When required documents are modified or updated, the original and all modified or updated versions must be maintained. Although all required documentation must be available for inspection at any time, all documents need not be stored together in one location.

Section Appendix 3-1 presents a suggested essential documents filing structure for HPTN 059. The suggested structure incorporates guidance received from the DAIDS Prevention Science Branch Clinical Operations Group and the DAIDS Clinical Site Monitoring Group (PPD). Study sites are not required to adopt the suggested structure, but are encouraged to consider it when developing their filing approach for HPTN 059. Study sites also are encouraged to establish an SOP to document their filing approach. Further clarifications of the suggested filing structure are as follows:

- Essential documents may be stored in files and/or in binders. The files/binders listed in Section Appendix 3-1 may be further subdivided, consolidated, and/or re-organized if desired.

- It is recommended that a contents sheet be maintained and inserted as the first page(s) of each file/binder. Within each file/binder, it is recommended that documents be filed in ascending date order (most recent documents in front).

- To preserve blinding, certain documents related to the investigational study products will be stored in site pharmacies. A listing of essential documents to be maintained in the pharmacies is provided in Section 3.4, rather than Section Appendix 3-1.

- To facilitate routine inspection by study monitors, certain laboratory-related essential documents should be stored in the main study essential documents files/binders (see items 26-28 in Section Appendix 3-1). Other lab-related essential documents (e.g., lab SOPs) may be filed in the site's laboratory files.

- The suggested filing structure assumes that HPTN 059 participant case history records will be stored separately from the other essential documents listed in Section Appendix 3-1. Section 3.3 below provides information on the required contents of these records. The suggested filing structure also assumes that the HPTN 059 Screening and Enrollment Log, Participant Name-ID Number Link Log, and Clinic Randomization Envelope Tracking Record (which are described in Section 4 of this manual) will be stored in the study clinic or data management area, and not necessarily with the other essential documents listed in Section Appendix 3-1.

3.2 Site Activation Requirements

The Protocol Specialist (PS) will work closely with the sites toward completion of the activation requirements. Study sites can refer to Appendix 3-2 for a checklist of site activation requirements. Prior to site activation, the PS will ensure that the site has met all HPTN study activation requirements. Once DAIDS approval has been obtained, the PS will add the approval date to the Activation Checklist and complete the HPTN Site Specific Activation Notice. The Activation Notice and Checklist will then be emailed to the site PI, the site Study Coordinator, and the Protocol Chair. In addition to the email notification, a hard copy along with the completed Site Activation Checklist and all of the supporting documentation will be sent to the study site in a Site Activation Notebook.

3.3 Participant Case History Documents

Study sites must maintain adequate and accurate participant case history records containing all information pertinent to HPTN 059 for each study participant.

3.3.1 Case History Contents

Participant case histories should contain all of the following elements:

- Basic participant identifiers.
- Documentation that the participant provided written informed consent to screen for and participate in the study prior to the conduct of any screening or study procedures, respectively.
- Documentation that the participant met the study's selection (eligibility) criteria.
- A record of the participant's random assignment.
- A record of the participant's exposure to the investigational study products.
- A record of all contacts, and attempted contacts, with the participant.
- A record of all procedures performed by study staff during the study.
- Study-related information on the participant's condition before, during, and after the study, including:
  - Data obtained directly from the participant (e.g., interview responses and other self-reported information)
  - Data obtained by study staff (e.g., exam and lab findings)
  - Data obtained from non-study sources (e.g., non-study medical records)

In addition to the above, DAIDS requires that all protocol events (departures/deviations/violations) be documented in participant records, along with reasons for the events and measures taken to prevent or correct them, if applicable.

Note: *In addition to documenting all protocol departures/deviations/violations on site, HPTN 059 study sites also must report protocol events to DAIDS and others per HPTN Operating Policy 015-00, which can be found at the following web site:*

http://www.hptn.org/network_information/policies_procedures.htm

3.3.2 Concept of Source Data and Source Documentation

The International Conference on Harmonization Consolidated Guidance for Good Clinical Practice (ICH-E6) defines the terms source data and source documentation as follows:

Source data: All information in original records and certified copies of original records of clinical findings, observations, or other activities in a clinical trial necessary for the reconstruction and evaluation of the trial. Source data are contained in source documents (original records or certified copies).

Source documents: Original documents, data and records (e.g., hospital records, clinical and office charts, laboratory notes, memoranda, subjects' diaries or evaluation checklists, pharmacy dispensing records, recorded data from automated instruments, copies of transcriptions certified after verification as being accurate and complete, microfiches, photographic negatives, microfilm or magnetic media, colposcopic images, x-rays, subject files, and records kept at the pharmacy, at the laboratories, and at medico-technical departments involved in the trial, and any other relevant documents that may be considered as participant data or records).

Source documents are commonly referred to as the documents —paper-based or electronic — upon which source data are first recorded. All study sites must adhere to the standards of source documentation specified in the DAIDS SOP for Source Documentation (see Section 17). The DAIDS SOP specifies both requirements and recommendations. Study sites must comply with all requirements and are encouraged, but not required, to comply with all recommendations.

For HPTN 059, it is expected that participant case history records will consist of the following source documents:

- Narrative chart notes
- Clinic randomization envelopes and prescriptions documenting participants' random assignments
- Visit checklists and/or other site-specific flowsheets
- Local laboratory testing logs and result reports
- DataFax and Non-DataFax forms provided by the HPTN Statistical and Data Management Center (SDMC)
- Colposcopic images (if applicable)
- Other source documents (e.g., site-specific worksheets, non-study medical records)

As a condition for study activation, each study site must establish an SOP for source documentation that specifies the use of the above-listed documents as source documents. Although it is the responsibility of each site to determine the most appropriate source document for each required case history element, Section Appendix 3-3 provides a guide that sites may follow for this study. Supplemental information on the use of chart notes, visit checklists, and forms provided by the HPTN SDMC is provided below. Detailed information on proper completion, maintenance, and storage of participant randomization and product dispensing documentation is provided in Sections 4, 6, and 9 of this manual. Detailed information on proper completion of DataFax and Non-DataFax forms provided by the HPTN SDMC is provided in Section 13 of this manual.

Chart Notes: Study staff must document every contact with a study participant in a signed and dated chart note specifying the date, type, purpose, and location of the contact, and the general status of the participant. The time and location at which a contact takes place, as well as which particular procedures take place, should be specified when necessary to document adherence to protocol requirements. Chart notes also must be used to document the following:

- The screening and enrollment informed consent processes (see also Section 5)
- Procedures performed that are not recorded on other source documents
- Pertinent data about the participant that are not recorded on other source documents
- Protocol events that are not otherwise captured on other source documents

Study sites are strongly encouraged to adopt a common format — such as the Subjective-Objective-Assessment-Plan (SOAP) format — for all chart notes, to help ensure adequacy and consistency of note content and maximize adherence to GCP standards. Further information on the SOAP note format can be found in Appendix 11 of the HPTN Manual of Operations. Several sample notes in SOAP format are provided in Section Appendix 3-4.

Visit Checklists: The checklists in Section 7 of this manual represent convenient tools to fulfill the requirement of documenting all study procedures performed with each study participant. Note, however, that checklists alone may not be sufficient for documenting all procedures. For example, chart notes may be required to document procedures performed at unscheduled study visits, and/or to explain why procedures in addition to those listed on a checklist may have been performed or why procedures listed on a checklist were not performed. Chart notes also may be required to document the content of counseling sessions and/or other in-depth discussions with participants (e.g., related to adherence to protocol requirements).

DataFax and Non-DataFax Forms Provided by the HPTN SDMC: The case report forms for this study are designed for use with the DataFax data management system described in Section 13 of this manual. The SDMC will provide these forms to each site. The SDMC also will provide several study-specific non-DataFax forms to each site. See Section Appendix 3-5 for a listing of all DataFax and non-DataFax forms to be provided for this study.

The SDMC will provide all forms in batches by CRF (e.g. sites will receive a shipment containing a stack of Enrollment Behavior forms, another stack of Screening Eligibility forms, etc.).Stacks of other "as needed" forms also will be provided. The CRFs will be printed at a US-based printing company, and will be shipped from the printing company to each study site. For the Pune, India site, forms will be printed on A4 paper and two-hole

punched. For the US sites, forms will be printed on letter size paper and three-hole punched. For each site, forms that are administered directly to participants will be available in local languages relevant to the site.-Sites are responsible for assembling the forms into Screening files (containing Screening and Enrollment Visit forms) and Participant Study Notebooks (with separate visit tabs containing the forms needed for a given participant and study visit). As shown in Section Appendices 3-5 and 3-6, many of the DataFax and non-DataFax forms provided by the SDMC have been designed to serve as source documents. Before the study starts, each study site must identify the forms that routinely will be used as source documents in its SOP for source documentation, and must follow the specifications of this SOP consistently for all study participants. In the event that study staff is not able to record data directly onto forms designated as source documents per the site Source Documentation SOP, the following procedures should be undertaken:

- Record the data onto an alternative source document
- Enter the alternative source document into the participant's study chart
- Transcribe the data from the alternative source document onto the appropriate form
- Enter a chart note stating the relevant study visit date and the reason why an alternative source document was used

3.3.3 Document Organization

All information pertaining to the participants (including a case history) must be stored in the same manner for all study participants. Study staff must store all study records securely and confidentially in areas with access limited to authorized study staff only (see Protocol Section 8.6 Participant Confidentiality). Study staff is responsible for purchasing file folders, binders, storage cabinets, and any other equipment or supplies needed to properly store all records.

Study-related documentation collected during the screening process should be stored in file folders or thin notebooks for each potential participant. All screening documentation — for potential participants who eventually enroll in the study as well as for those who do not enroll — must be maintained and available for monitoring throughout the study. This documentation must also be available for reference should participants present to the site for re-screening. For participants who enroll in the study, screening documentation (from successful screening attempt that led to enrollment *only*) should be transferred into large ring binders that will serve as participants' study notebooks for the duration of their participation in the study.

All documents contained in participant case history records must bear a participant identifier, which generally will consist of either the participant identification number (PTID) or the participant name. To maximize participant confidentiality, the PTID should be used whenever possible, and records that bear names or other personal identifiers, such as locator forms and informed consent forms, should be stored separately from records identified by PTID. Any documents transferred or transmitted to a non-study site location — including DataFax forms and Expedited Adverse Event Forms — must be identified by PTID only.

Regardless of whether the identifier on a particular document consists of the participant name or PTID, the original identifier may not be obliterated or altered in any way, even if another identifier is added. When necessary to maintain confidentiality, identifiers may be obliterated on copies of original source documents. For example, if medical records obtained from a non-study health care provider bear the participant's name, the original documents bearing the name must be stored unaltered with other study documents bearing the name. However, a copy of the original documents could be made, the PTID could be entered onto the copies, and then the participant name could be obliterated from the copies. Copies handled in this way could then be stored in participants' study notebooks and/or transferred or transmitted to the DAIDS Medical Officer.

Copies of source documents may not be transferred to any other non-study site location without prior authorization from the DAIDS Medical Officer or the CORE Protocol Specialist (or their designees).

All on-site databases must be secured with password-protected access systems. Any lists, logbooks, appointment books, or other documents that link PTIDs to other participant identifiers must be stored securely in a location separate from records identified by either participant name only or PITD only. When in use, these documents must not be left unattended or otherwise accessible to study participants, other study clinic patients, or any other unauthorized persons.

As a condition for study activation, each study site must establish an SOP for data management. This SOP minimally should contain the following elements:

- Procedures for assigning PTIDs, linking PTIDs to participant names, and storing the name-PTID link log
- Procedures for establishing participant files/charts/notebooks
- During-visit participant chart and case report form review procedures
- Post-visit participant chart and case report form review procedures and timeframes
- Data transmission procedures, including timeframes, case report form storage locations before and after faxing, and mechanisms for identifying when forms have been transmitted
- Procedures for resolving data quality control notes from the SDMC
- Procedures for handling and filing field workers' logs, worksheets, etc.
- Storage locations for blank case report forms
- Storage locations for documents identified by participant names or other personal identifiers
- Storage locations for documents identified by PTID
- Procedures for back up of electronic study data (if applicable)
- Handling of participant study records for off-site contacts and visits
  (*Note:* For HPTN 059, study visits may **not** be conducted off-site).
- Confidentiality protections
- Other ethical and human subjects considerations
- Staff responsibilities for all of the above (direct and supervisory)
- Staff training requirements (if not specified elsewhere)
- QC/QA procedures related to the above (if not specified elsewhere)

3.4 Study Product Accountability, Chain of Custody, and Dispensing Documentation

The following essential documents should be maintained in study site pharmacies:

- Current HPTN 059 protocol
- Current Investigator's Brochure (IB) Tenofovir Gel (if IB on file in the clinic essential document files are not easily accessible to pharmacy staff)
- Current HPTN 059 FDA Form 1572
- Current list of authorized prescribers and staff authorized to sign HPTN 059 Study Product Request Slips (names and signatures)
- Pharmacy Establishment Plan
- HPTN 059 pharmacy and product-related SOPs
- HPTN 059 PTID list (provided by the HPTN SDMC)
- HPTN 059 product import documentation
- HPTN 059 product shipping and receipt documentation
- HPTN 059 product storage temperature logs
- HPTN 059 investigational agent accountability records
- HPTN 059 Pharmacy Treatment Assignment List
- HPTN 059 participant-specific records (including prescriptions, product re-supply slips, dispensing records, and DataFax forms as applicable)
- HPTN 059 monitoring visit reports
- HPTN 059 communications with site clinic staff
- HPTN 059 communications with the DAIDS Pharmaceutical Affairs Branch (PAB) and the NIAID Clinical Research Product Management Center
- HPTN 059 communications with the HPTN Coordinating and Operations Center (CORE)
- HPTN 059 communications with the HPTN SDMC
- Other HPTN 059 communications
- Other locally-required administrative, operational, and/or regulatory documentation

Pharmacy staff will document the receipt, dispensing, and final disposition of the investigational products used in the study (i.e., tenofovir gel, and placebo gel). Pharmacy staff also will maintain in the study pharmacies Participant-Specific Pharmacy Dispensing Records containing information on product dispensations and returns for all enrolled participants. Study clinic staff will contribute to the documentation of product dispensation and chain of custody as described in Sections 4, 6, and 9 of this manual.

The specifications related to document security and participant confidentiality described in Section 3.3.3 also apply to records maintained in the study pharmacies. All records must be stored securely in the pharmacies with access limited to authorized study pharmacy staff only.

To preserve the blinding of all protocol team members (with the exception of designated site pharmacy staff) to participants' random assignments to study gel (Tenofovir versus placebo gel), neither the study clinic staff, study participants nor the HPTN 059 team members will be provided access to product-related documentation maintained in the study pharmacies. Sites will develop and follow an SOP documenting how site pharmacy staff will maintain blinding to study gel. Pharmacy staff may provide copies of some participant-specific documentation maintained in the study pharmacies (e.g., chart notes) to clinic staff for purposes of communication and operational coordination. However, decisions to provide such documentation to clinic staff will be made by pharmacy staff only, and under no circumstances will documentation released from the pharmacy include participants' product dispensing records or other unblinded information related to participants' random assignments (see also Section 9.1 of this manual).

Note: Double blinding of non-pharmacy site staff will only to pertain to random assignment of study felt, and not frequency of study gel use. All site study staff will remain unblinded to participants' frequency of study gel use.

3.5 Record Retention Requirements

All study records must be maintained for at least two years following the date of marketing approval for the study product for the indication in which it was studied. If no marketing application is filed, or if the application is not approved, records must be retained for two years after the US Food and Drug Administration is notified that the Investigational New Drug application for the product(s) is discontinued. All records must be retained on-site throughout the study's period of performance, and for at least three years after completion or termination of the study. Study product records must be stored in the study pharmacies, with access limited to authorized study pharmacy staff only, until the study is unblinded. DAIDS will provide further instructions for long-term storage of study records after the study is completed.

Section Appendix 3-1
Suggested Filing Structure for HPTN 059 Essential Documents

File/Binder #1: HPTN 059 Protocol and Current Informed Consent Forms 1. HPTN 059 Protocol (including copy of signed and dated protocol signature page): Version 1.0, and any subsequent protocol Clarification Memos, Letters of Amendment, and Amendments issued after Version 1.0 2. Currently-approved HPTN 059 informed consent forms
File/Binder #2: Regulatory Authority Documentation (if applicable) 3. Regulatory Authority Correspondence/Authorization/Approval/Notification of Protocol (if applicable; if more than one regulatory authority has oversight responsibility for research performed at the study site, include subsections for each authority)
File/Binder #3A: IRB/EC Documentation for [IRB/EC A] 4. FWA documentation for IRB/EC A 5. Roster of IRB/EC A (if available) 6. Relevant IRB/EC A Submission Requirements/Guidelines/SOPs 7. IRB Correspondence for IRB/EC A: File complete copies of all correspondence to and from the IRB/EC; include all enclosures/attachments for all submissions, even if copies of the enclosures/attachments are filed elsewhere; include all approval documentation.
File/Binder #3B: IRB/EC Documentation for [IRB/EC B] 8. FWA documentation for IRB/EC B 9. Roster of IRB/EC B (if available) 10. Relevant IRB/EC B Submission Requirements/Guidelines/SOPs 11. IRB Correspondence for IRB/EC B: File complete copies of all correspondence to and from the IRB/EC; include all enclosures/attachments for all submissions, even if copies of the enclosures/attachments are filed elsewhere; include all approval documentation.
File/Binder #4: Product Safety Information 12. Investigator's Brochure for Tenofovir Gel: current version and any subsequent updates 13. Product Safety Information/Reports/Memos Notes: • It is assumed that expedited adverse event reports will be stored in participant study notebooks. • It is assumed that documentation of IRB/EC submission of above-listed documents (if applicable) will be maintained in the relevant IRB/EC Files/Binders (i.e., File/Binder #3A and #3B).
File/Binder #5: HPTN 059 Study-Specific Procedures (SSP) Manual 14. Final version 1.0 (when available) and any subsequent updates Notes: • For this reference copy of the SSP Manual, do not discard out-dated pages or sections when updates are issued; retain all versions of all pages as a complete historical record. • The SSP Manual contains reference versions of all study case report forms, therefore additional (blank) copies of the case report forms need not be stored elsewhere in the essential document files.
File/Binder #6: HPTN 059 Study-Specific Standard Operating Procedures 15. Final approved version of each SOP, and any subsequent updates to each

Section Appendix 3-1
Suggested Filing Structure for HPTN 059 Essential Documents

File/Binder #7: HPTN 059 Staffing Documentation

16. FDA Form 1572 (copy of original and dated form submitted to the HPTN CORE for Protocol Registration, and any subsequent updates)
17. HPTN 059 Investigator of Record CV (copy of CV submitted to the HPTN CORE for Protocol Registration; ensure that the CV is current prior to initiating HPTN 059; it is recommended that CVs be signed and dated to document at least annual updating)
18. Financial Disclosure Forms (original signed and dated forms, and any subsequent updates)
19. Study Staff Roster (original submitted to FHI for study activation, and any subsequent updates)
20. Study Staff Identification and Signature Sheet (if not combined with staff roster; original and any subsequent updates)
21. Study Staff Delegation of Duties (if not combined with staff roster; original and all updates)
22. CVs for Study Staff other than the IoR (ensure that all CVs are current prior to initiating HPTN 059; it is recommended that CVs be signed and dated to document at least annual updating)
23. Study Staff Job Descriptions
24. Documentation of Study Staff Training

File/Binder #8: Local Laboratory Documentation

25. Local Laboratory Certification(s), Accreditation(s) and/or Validation(s): file documentation current at time of study activation and all subsequent updates
26. Local Laboratory Normal Ranges: file documentation of relevant normal ranges for all protocol-specified tests current at time of study activation and all subsequent updates
27. Laboratory Manager CV (or cross-reference to CV contained in File/Binder #7)

Note:

- It is recommended that a cross-reference be included in this file/binder specifying the storage location(s) of other lab-related essential documents filed in the local lab(s).

File/Binder #9: Monitoring Visit Documentation

28. Monitoring Visit Log
29. Initiation and Monitoring Visit Reports and Documentation of Response to Visit Findings

File/Binder #10: Documentation of Other HPTN Site Visits

30. (Non-Monitoring) Site Visit Log
31. HPTN CORE Site Visit Reports and Documentation of Response to Visit Findings
32. HPTN SDMC Site Visit Reports and Documentation of Response to Visit Findings
33. HPTN Central Lab Site Visit Reports and Documentation of Response to Visit Findings
34. Other Site Visit Reports and Documentation of Response to Visit Findings

File/Binder #11: Study-Related Sponsor Communications

35. Study-Related Communications to and from DAIDS
36. Communications to and from DAIDS RCC (includes copies of all submissions to the DAIDS Protocol Registration Office, which will be prepared and copies provided by the HPTN CORE, as well as the current monthly DAIDS IB/PI listing and year-end and current monthly DAIDS Comprehensive Safety Distribution Report)

Notes:

- Communications should be filed beginning from the date of the HPTN 059 site specific Training.
- Communications related to individual HPTN 059 study participants will be filed in individual participant study records.
- As needed to preserve blinding, product-related communications with DAIDS PAB (and its contractors) will be stored in the study pharmacy.

Section Appendix 3-1
Suggested Filing Structure for HPTN 059 Essential Documents

File/Binder #12: Other Study-Related Communications

37. Study-Related Communications to and from HPTN CORE
38. Study-Related Communications to and from HPTN SDMC
39. Study-Related Communications to and from HPTN Central Lab
40. Other Study-Related Communications

Notes:

- Communications should be filed beginning from the date of the HPTN 059 site specific training.
- Communications related to individual HPTN 059 study participants will be filed in individual participant study records.
- As needed to preserve blinding, product-related communications with DAIDS PAB (and its contractors) will be stored in the study pharmacy.

File/Binder #13: Study Site Staff Meeting Documentation

41. HPTN 059 Staff Meeting Agendas, Participant Lists/Sign-In Sheets, and Summaries

Note:

- Meeting documentation should be filed beginning from the date of the HPTN 059 site specific training.

File/Binder #14: Conference Call Documentation

42. HPTN 059 Protocol Team and Protocol Co-Chairs Conference Call Summaries
43. Summaries of Other HPTN 059 Conference Calls

Note:

- Conference call summaries will be filed beginning from the date of the HPTN 059 site specific training.

File/Binder #15: DAIDS and Other Reference Documentation

44. DAIDS SOP for Source Documentation (Version 2.0 and any subsequent updates)
45. DAIDS SOP for Essential Documents (Version 2.0 and any subsequent updates)
46. DAIDS Protocol Registration Policy and Procedures Manual (August 2004 and any subsequent updates)
47. Manual for Expedited Reporting of Adverse Events to DAIDS
48. US Regulations Applicable to Conduct of HPTN 059 (45 CFR 46; 21 CFR 50, 54, 56, and 312)
49. Any other relevant manuals or reference documents

File/Binder #16: Site-Specific Study Activation Documentation

50. Site-Specific Study Activation Documents

Study Number and Full Title: HPTN 059 Phase II Expanded Safety and Acceptability Study of the Vaginal Microbicide 1% Tenofovir Gel

Protocol Chair(s):

Site Principal Investigator:
Performance Site Name(s):
Performance Site Number(s):

Requirement	Yes*	App. Date	Comments
Current FWA on file with OHRP			
RCC Protocol Registration approval based on: • Approvals from all responsible IRBs/ECs for protocol and all informed consent forms • Signed FDA Form 1572 or DAIDS Investigator of Record Agreement • Curriculum Vitae (CV) of the Investigator of Record			
Financial Disclosure Forms			
Protocol Signature Form (page ix of the protocol)			
Other local regulatory authority approval of protocol, e.g., Ministry of Health, drug controller/regulatory agency (if applicable)			
Applicable study product import approvals (if applicable)			
Applicable study product export approvals (if applicable)			
DAIDS PAB approval of Pharmacy Establishment Plan			
General Pharmacy SOPs			
PAB Study Specific SOPs			
Staff signature log for authorized prescribers			
Study staff signature sheet, roster, and delegation of duties			
Human Subjects training for all "key" staff (as defined by NIH policy)			
GCP training by at least one staff with on-site oversight responsibility (i.e., Investigator, Study Coordinator, Lead Clinician, Data Manager)			

•			
SCHARP approval of site readiness for data management based on following: • Installation of required data transfer equipment • SOP for data management, including QC/QA Availability of SCHARP-provided materials (e.g. DataFax forms, instructions, etc) on site			
Required Site Specific SOPs (refer to Figure 10-5 of MOP)			
Required Study Specific SOPs • SOP for source documentation • SOP for obtaining informed consent from potential study participants • SOP for participant eligibility determination • SOP for safety monitoring and AE reporting (if applicable) • Participant accrual plan • Participant retention plan • Documentation of local HIV counseling procedures • Contraception Counseling • Positive Pregnancy Test Counseling • SOP for abnormal PAP • SOP for writing prescriptions • SOP for Participant Tracking Database • SOP for Departure of Key Staff and Training of New Staff (Include that you have to contact CL when new lab staff are hired) • SOP for Gel Resupply • SOP for Study Gel Administration			

Section Appendix 3-2
Sample HPTN 059 Protocol Activation Checklist

Conduct of, and approved (by DAIDS) site response to, CSMG Study-Specific Initiation Visit			
Completion of on-site study specific training and/or other site preparation/initiation activities (e.g., PPD site initiation visits)			
Resolution of action items identified in study-specific training and/or other site preparation/initiation activities (e.g., PPD site initiation visits)			

Other activation requirements as needed (site- and study-specific), specify _____			
Final approval of DAIDS PSB Chief for activation, based on request from PS following completion of all other activation requirements as specified above			

* check (√) when received in-house, if applicable to protocol; if not applicable, put N/A

I hereby confirm that all of the above requirements have been met. Subject screening and enrollment may begin on or after the date indicated below.

_____ _____

Clinical Research Manager Date

Section Appendix 3-3
Guide to Required Case History Elements and Source Documents for HPTN 059

Required Case History Element	Source Documents*
Basic participant identifiers.	Locator form; Demographics forms.
Documentation that the participant provided written informed consent to screen for and participate in the study.	Signed and dated informed consent forms; signed and dated chart notes stating that informed consent was obtained prior to initiating study procedures.
Documentation that the participant met the study selection (eligibility) criteria.	Demographics form, site-specific Demographics forms, locator form; Screening Eligibility form (non-DataFax); Screening Summary (non-DataFax); Clinical Eligibility form (non-DataFax); Safety Laboratory Results form; STI Laboratory Results form; (non-DataFax) Baseline Medical History form; Concomitant Medications Log form; Physical Exam form (non-DataFax); Screening and Enrollment Pelvic Exam form; Repeat Screening Pelvic Exam form (if indicated); (non-DataFax) Pelvic Exam Diagrams; Pelvic Laboratory Results form; Enrollment Eligibility form (non-DataFax); Enrollment form; Pre-Existing Conditions form; local lab logs and result reports[§]; signed and dated chart notes.
A record of the participant's random assignment.	HPTN 059 prescription; HPTN 059 Participant-Specific Pharmacy Dispensing Record; Enrollment form; dispensed gel chain of custody logs.
A record of the participant's exposure to the investigational study products.	HPTN 059 Gel Re-Supply Worksheet, HPTN 059 Study Product Request Slip, HPTN 059 Participant-Specific Pharmacy Dispensing Record; dispensed gel chain of custody logs, visit checklists.
A record of all contacts, and all attempted contacts, with the participant.	Signed and dated chart notes, and/or other worksheets or site-specific documents if designated in site SOPs.
A record of all procedures performed by study staff.	Completed visit checklists; signed and dated chart notes detailing (i) procedures performed in addition to those contained on the checklist and/or (ii) the reason why procedures contained on the checklist were not performed.

Information on the participant's condition before, during, and after the study.	All documents listed above; Enrollment Behavior Assessment form, Follow-up Behavior Assessment form; Acceptability Assessment form; Study Exit Acceptability Assessment form; (non-DataFax) Follow-up Medical History form; Genital Bleeding Assessment; Follow-up Pelvic Exam form; (non-DataFax) Pelvic Exam Diagrams; (non-DataFax) History of Genital Symptoms form; Baseline Genital Symptoms form; Follow-up Genital Symptoms form; Pharmacokinetics form; Pelvic Laboratory Results form; Safety Laboratory Results form; STI Laboratory Results form; HBV laboratory Results form (if applicable); Adverse Experience Log form; HIV Test Results form; Product Hold/Discontinuation form; Pregnancy Report and History form; Pregnancy Outcome form; Missed Visit form; Follow-Up Visit form; Interim Visit form; CHBV Visit form; Female Study Burden form; End of Study Inventory form; local lab logs and result reports from the local lab[§]; results of information pertinent to the study obtained from non-study sources; signed and dated chart notes.

*Other site-specific source documents also may be used.
[§]A clinician must review all local laboratory reports and document this review by signing and dating all reports.

Section Appendix 3-4
Sample Chart Notes for HPTN 059 in Subjective-Objective-Assessment-Plan (SOAP) Format

Sample Chart Note for a Screening Visit:

15 AUG 2005: Participant presented for HPTN 059 screening. Obtained written informed consent for screening before initiating any procedures. Procedures were completed per protocol, visit checklist and SOPs.

S: Participant reported no current health problems.

O: Pregnancy test negative, participant behaviorally eligible per the Screening Eligibility form, tested HIV negative.

A: Participant is eligible for the study thus far.

P: Screening Enrollment scheduled for 06 SEP 2005.

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Sample Chart Note for a Screening Visit:

15 AUG 2005: Participant presented for HPTN 059 screening. Obtained written informed consent for screening before initiating any procedures. Procedures were completed per protocol, SOPs and visit checklist, with the additions listed here.

S: Participant complained of current genital itching and yellowish discharge, no other current health problems.

O: Participant behaviorally eligible per the Screening Eligibility form, tested negative for pregnancy and HIV.

A: Other than genital symptoms, participant appears eligible for the study thus far. Syndromic treatment provided [insert details here], participant must have completed treatment and be symptom free at next visit in order to enroll in study.

P: Enrollment scheduled for 29 AUG 2005, participant counseled to contact site if symptoms do not resolve in 5-7 days.

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Sample Chart Note for Screening:

15 AUG 2005: Participant presented for HPTN 059 screening. Obtained written informed consent for screening before initiating any procedures. Procedures were completed per protocol, SOPs and the visit checklist, with the additions listed here.

S: Participant complained of current genital itching and yellowish discharge.

O: Participant behaviorally eligible per the Screening Eligibility form, tested negative for pregnancy and HIV. Pelvic exam completed to assess genital symptoms. Discharge noted, but no abdominal tenderness or other signs present. Wet prep was positive for trichomonads, negative for whiff test, clue cells, and yeast.

A: Participant appears eligible for the study thus far, but trich. must be treated and symptoms resolved before enrollment. Treatment provided [insert details here].

P: Enrollment scheduled for 29 AUG 2005, participant counseled to contact site if symptoms do not resolve in 5-7 days.

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Sample Chart Note for Enrollment:

29 AUG 2005: Participant presented for HPTN 059 Enrollment visit. Procedures completed per protocol, visit checklist and SOPs. Participant was confirmed eligible and willing to take part in study. Written informed consent obtained for enrollment before initiating any study procedures. Participant was not willing to consent to specimen storage for possible future research.

S: Participant reported that itching and discharge reported at initial Screening Visit resolved 3-4 days after treatment given at last visit. No current genital symptoms reported today.

O: Screening GC and CT tests were negative. Today's pregnancy test was negative. Pelvic exam and wet mount were normal (see findings on DataFax forms). Participant behaviorally eligible per Screening Eligibility form. Screening documentation reviewed and eligibility confirmed by [insert name]. {counter-signature}

A: Participant is eligible for the study.

P: Participant was enrolled in study. Week 4 visit scheduled for 26 SEP 2005.

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Sample Chart Note for Enrollment Visit:

29 AUG 2005: Participant presented for HPTN 059 Enrollment visit. Procedures completed per protocol, SOPs and visit checklist. Enrollment procedures were was discontinued at this visit due to participant ineligibility.

S: Participant reported no current health problems.

O: Screening GC and CT lab tests were negative, but today's pregnancy test was positive. Enrollment discontinued upon finding this result.

A: Participant is pregnant — not eligible for study.

P: Participant informed that she is pregnant and referred to [clinic name] for antenatal care. Participant informed that she can return to find out about study participation when she is no longer pregnant.

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Sample Chart Note for Follow-up Visit:

26 SEP 2005: Participant presented for HPTN 059 at Week 4 visit. Procedures completed per protocol, visit checklist and SOPs.

S: No issues/problems reported since last visit.

O: Pregnancy test negative.

A: No issues of concern.

P: Week 8 visit scheduled for 24 OCT 2005.

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Section Appendix 3-5
HPTN 059 DataFax and Non-DataFax Forms

HPTN 059 DataFax Forms		HPTN 059 Non-DataFax Forms
Screening Consent		Screening Eligibility
Demographics		Enrollment Eligibility
Site-specific Demographics		Baseline Medical History
STI Laboratory Results		History of Genital Symptoms
Safety Laboratory Results		Physical Exam
Screening and Enrollment Pelvic Exam		Pelvic Exam Diagrams
Pelvic Laboratory Results		Clinical Eligibility
Repeat Screening Pelvic Exam		Screening Summary
HBV Laboratory Results		Follow-up Medical History
Baseline Genital Symptoms		
Pre-Existing Conditions		
Concomitant Medications Log		
Enrollment		
Enrollment Behavior Assessment		
Follow-up Visit		
Follow-up Behavior Assessment- Coitally Dependent Arm		
Follow-up Behavior Assessment- Daily Use Arm		
Follow-up Pelvic Exam		
Follow-up Genital Symptoms		
HIV Test Results		
Acceptability Assessment		
Study Exit Acceptability Assessment		
Pharmacokinetics		
Female Study Burden		
Product Hold/Discontinuation		
Adverse Experience Log		
Pregnancy Report and History		
Pregnancy Outcome		
CHBV Visit		
Genital Bleeding Assessment		
Interim Visit		
Missed Visit		
Termination		
End of Study Inventory		

Section Appendix 3-6
Use of HPTN 059 DataFax Forms as Source Documents

Form Name	Acronym	Source?	Comments
Screening Consent	SC-1	[Mixed]	Form [may be] source for items 1 and 3. Items 2 and 2a are based on source data recorded in participant chart notes and on participant informed consent forms.
Demographics	DM-1,2	Yes	Form is interviewer-administered; participant responses are recorded directly onto the form.
Site-specific demographics	DMU-1 and DMI-1	Yes	Form is interviewer-administered; participant responses are recorded directly onto the form.
STI Laboratory Results	SLR-1	[No]	Items 1e-4d require local/central lab documentation as source. For items 1a-1e, form may serves as source in cases where results are not documented on a local lab report, but are recorded directly onto the form. Otherwise, the local laboratory report may serve as source.
Safety Laboratory Results	SL-1-2	No	Local laboratory report is source.
Screening and Enrollment Pelvic Exam	SPE-1-2	[Yes]	[It is expected that this form routinely will serve as a source document, with supplemental information recorded on the Pelvic/Colposcopy Diagrams, and in participant chart notes if needed. If, instead, other documents such as participant chart notes routinely will serve as the source document for pelvic exam information, this should be specified.]
Repeat Screening Pelvic Exam	RSP-1	[Yes]	[It is expected that this form routinely will serve as a source document, with supplemental information recorded on the Pelvic/Colposcopy Diagrams, and in participant chart notes if needed. If, instead, other documents such as participant chart notes routinely will serve as the source document for pelvic exam information, this should be specified.]
Pelvic Laboratory Results	PLR-1	[Mixed]	For items 1a-1f, form may serve as source in cases where results are not documented on a local lab report, but are recorded directly onto the form. Otherwise, the local laboratory report may serve as source. Local laboratory report is source for item 2.
HBV Laboratory Results	HLR-1	[Mixed]	Central laboratory report is source for item 1. Form may serve as source for item 2.
Baseline Genital Symptoms	BGS-1	Yes	Form is interviewer-administered; participant responses are recorded directly onto the form.

Section Appendix 3-6
Use of HPTN 059 DataFax Forms as Source Documents

Form Name	Acronym	Source?	Comments
Pre-Existing Conditions	PRE-1	No	All items are based on source data recorded on the Baseline Medical History, Physical Exam, Screening and Enrollment Pelvic Exam forms, Pelvic Exam Diagrams, Baseline Genital Symptoms, and/or participant chart notes.
Concomitant Medications	CM-1	[Yes]	[It is expected that sites will record concomitant medication information directly and initially onto this form. If instead other documents such as participant chart notes routinely will serve as the source document for this information, then this form is not considered a source document, and the actual source document should be specified here.]
Enrollment	ENR-1	No	Items 1 and 1a are based on source data recorded in participant chart notes and on participant informed consent forms. For items 2, 2b-2c, this form may serve as source, or the Clinic Randomization Envelope Tracking Record may serve as source. Items 2a, 2d and 2e are based on source data recorded on the prescription contained inside a participant's randomization envelope. Items 3-5 are based on source data documented on the Participant-Specific Pharmacy Dispensing Record (stored in the site pharmacy). Item 6 requires local /central laboratory report as source. Form may serve as source for items 7-8.
Enrollment Behavior Assessment	EBA-1-4	No	Form is interviewer-administered; participant responses are recorded directly onto the form.
Follow-up Visit	FV-1	[Mixed]	Form may serve as source for item 1 if result is not documented on a local lab report, but is recorded directly onto the form. Form may also serves as source for items 1a and 5-6. Participant chart notes and/or AE Log forms are source for items 2-2a, and the Gel Resupply Worksheet is source for items 3 and 4.
Follow-up Behavior Assessment- Coitally Dependent Arm	FBC-1-8	No	Form is interviewer-administered; participant responses are recorded directly onto the form.
Follow-up Behavior Assessment- Daily Use Arm	FBD-1-8	No	Form is interviewer-administered; participant responses are recorded directly onto the form.

Section Appendix 3-6 continued Use of HPTN 059 DataFax Forms as Source Documents			
Follow-up Pelvic Exam	FPE-1-3	[Yes]	[It is expected that this form routinely will serve as a source document, with supplemental information recorded on the Pelvic/Colposcopy Diagrams, and in participant chart notes if needed. If, instead, other documents such as participant chart notes routinely will serve as the source document for pelvic exam information, this should be specified.]
Follow-up Genital Symptoms	FGS-1	Yes	Form is interviewer-administered; participant responses are recorded directly onto the form.
HIV Test Results	HTR-1	[Mixed]	Local laboratory report is source for all items 1-5. Form may serve as source for items 6-6a.
Acceptability Assessment	AA-1-5	No	Form is interviewer-administered; participant responses are recorded directly onto the form.
Study Exit Acceptability Assessment	SAA-1-4	No	Form is interviewer-administered; participant responses are recorded directly onto the form.
Pharmacokinetics	PK-1	[Yes]	Form may serve as source for items 1, 4 and 5. Form may also serve as source for items 2-3 if height and weight are re-assessed at the time of the PK visit, and recorded directly onto this form. The Physical Exam form and/or participant chart notes may also serve as source for items 2-3.
Female Study Burden	FSB-1	Yes	Form is interviewer-administered; participant responses are recorded directly onto the form.
Product Hold/Discontinuation	PH-1	Mixed	Form may be source for all items EXCEPT item 2. Participant chart notes, the PR-1 form, HTR-1 form, and/or AE Log form may serve as source for item 2.
Adverse Experience Log	AE-1	Yes	Form may be source for all items.
Pregnancy Report and History	PR-1	Mixed	Form may be source for item 2. All other items are based on source data recorded on the Baseline and Follow-up Medical History forms.
Pregnancy Outcome	PO-1	Yes	Form may be source for all items if medical records are not available and the data recorded on the form are based on participant self-report.
CHBV Visit	CHB-1	[Mixed]	AE Log forms and/or participant chart notes are source data for items 1-1a. Form may be source for items 2-3.

Section Appendix 3-6 continued Use of HPTN 059 DataFax Forms as Source Documents			
Genital Bleeding Assessment	GBA-1-3	Mixed	Form may be source for items 4-11g, 12a-12b, and 13a-14b. The non-DataFax Follow-up Medical History form is source for items 1-3. The Concomitant Medications Log is source for items 12 and 13.
Interim Visit	IV-1	Mixed	Form may serve as source for items 1, 2a, 3 and 6-7. Form may serve as source for item 2 if result is not documented on a local lab report, but is recorded directly onto the form. The Gel Resupply Worksheet is source for items 4-5 *for interim visits that occur prior to Week 24*. Form or chart notes may be source for items 4-5 *for interim visits that occur after Week 24*.
Missed Visit	MV-1	Yes	Form may be source to document that the visit was missed; source data on the reason why the visit was missed also may be recorded on this form.
Termination	TM-1	No	All items are based on source data recorded on other documents.
End of Study Inventory	ESI-1	No	All items are based on source data recorded on other documents.

Section Appendix 3-7
Use of HPTN 059 Non-DataFax Forms as Source Documents

Form Name	Source?	Comments
Screening Eligibility	Mixed	Screening Informed Consent form is source for item 1. The Screening and Enrollment Log is source for item 2. Form may serve as source for item 3 if documentation of a normal Pap result (in the 90 days prior to screening) is NOT available. Form is source for items 4-23; items are interviewer-administered. Form may be source for item 24 if result is not documented on a local laboratory report, but recorded directly onto the form.
Enrollment Eligibility	Mixed	Enrollment Informed Consent form is source for item 1. Form is source for items 2-10a; items are interviewer-administered. Form may be source for item 11, if results is not documented on a local laboratory report, but recorded directly onto the form. Form may be source for item 12.
Baseline Medical History	Yes	Form may be source for all items. Data recorded on this form is based on participant self-report, and may also be supplemented with data recorded on other source documents (e.g., non-study medical records).
History of Genital Symptoms	Yes	Form may be source for all items. Data recorded on this form is based on participant self-report, and may also be supplemented with data recorded on other source documents (e.g., non-study medical records).
Physical Exam	Yes	Form may be source for all items.
Pelvic Exam Diagrams	Yes	Form may be source for all items.
Clinical Eligibility	No	All items are based on data recorded on other documents as source.
Screening Summary	No	All items are based on data recorded on other documents as source.
Follow-up Medical History	Yes	Form may be source for all items.