

Section 12. Data Collection

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12 Introduction

The purpose of this document is to provide site staff with the information they need to successfully complete and submit MTN-039 Case Report Forms (CRFs). For questions about this section or about general data collection policies, procedures, or materials, please contact the SCHARP Clinical Data Manager for the study as listed below.

The SDMC (Statistical and Data Management Center) for this study is SCHARP (the Statistical Center for HIV/AIDS Research and Prevention). SCHARP is located in Seattle, USA, and is in the US Pacific Time (PT) time zone. The SCHARP MTN-039 team members, along with their job role and e-mail address, are listed below.

MTN-039 Statistical and Data Management Center (SDMC) Staff

Job Role	Name	Email Address
Protocol Statisticians	Elizabeth Brown Cliff Kelly	erbrown@fredhutch.org cwkelly@scharp.org
Clinical Data Manager	Julie Ngo	jhngo@scharp.org
Lab Data Coordinator	Sara Aranda	saranda@scharp.org
Statistical Research Associate	Hanjie Shen	hshen2@scharp.org
Clinical Programmer	Chun Zou	czou@scharp.org
Clinical Safety Associate	Lena Kemel	lkemel2@fredhutch.org

12.1 Medidata Rave Overview

Medidata Rave is the data management system used by SCHARP to receive and manage study data collected at study sites. Each site completes study electronic case report forms (eCRFs) by entering data into the Medidata Rave study database. As specified in each site's Source Documentation SOP, data may be entered directly into the study database (i.e. eCRF is source), collected first on paper CRFs and then entered into the study database, and/or entered into the study database based on other non-CRF source documents (e.g., lab reports, testing logs, chart notes, etc.)

The MTN-039 study database in Medidata Rave may be accessed at www.imedidata.com.

When using Medidata Rave, the internet browser chosen and connectivity quality will be the most critical factors affecting functionality, as Medidata is accessed via a URL using a web browser. Users using outdated browsers will see a new warning banner on the log-in page of iMedidata. This warning will inform them that their browser does not support security features that are being implemented in future iMedidata releases and to upgrade their browser. Users will see this warning banner if they use any of the following browsers:

- Internet Explorer - Versions older than 8.0
- Chrome - Versions older than 30.0
- Firefox - Versions older than 24.0
- Safari - Versions older than 7.0
- Opera - Versions older than 17.0.

Each site's Data Management SOP designates the site staff members responsible for entering data into the study database. SCHARP grants designated site staff access with specific user permissions to the study database. They are required to complete eLearning modules in Medidata, as assigned by SCHARP, before access is granted and data can be entered into the study database. For more detailed information, see the iMedidata Access Guide, posted on the MTN-039 Atlas webpage: <https://atlas.scharp.org/cpas/project/MTN/039/begin.view?>

Detailed guidance on 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-039 Atlas web page: <https://atlas.scharp.org/cpas/project/MTN/039/begin.view?>

Site staff should contact the study Clinical Data Manager with any questions related to study data collection and management. A representative from Medidata Solutions may be contacted (see contact information below) any time a site has technical questions or problems related to access or use of the Medidata Rave software.

For service in English

Toll-free

1-866-MEDIDATA (633-4328)

Direct number

1-973-659-6780

Toll-free fax

1-877-743-2350

Direct fax

1-973-954-5621

Email

helpdesk@mdsol.com

Hours

24 hours a day, 7 days a week

Data Entry/Quality Control

- Once an eCRF is completed and saved in the study database, the following may occur:
 - A system query may be automatically triggered in Medidata Rave (e.g., denoting incomplete or inconsistent data).
 - Review may be required for certain forms and/or fields by the SCHARP Clinical Data Manager, and manual data queries may be placed.
 - Review may be required for certain forms and/or fields by the site monitor (i.e., PPD), and data queries may be placed.
 - MedDRA coding will be required for AE Log CRFs, and coding queries may be placed.
 - AE-EAE reconciliation will occur and inconsistency queries may be placed.
 - WHO coding will be required for CM Log CRFs, and coding queries may be placed.
- QCs are listed in the Medidata Rave Task Summary on the study home page of designated site users. Designated site staff members are responsible for routinely checking the Task Summary and correcting/updating study data to resolve any outstanding queries.
- When site staff correct/update study data and/or enter a query response to address a manual or coding query, SCHARP staff review the updated data and/or response, and resolve the query or re-query as needed.
- When site staff correct/update study data and/or enter a query response to address a monitoring query, the site monitor (i.e., PPD) reviews the updated data and/or response, and resolves the query or re-queries as needed.
- If a site utilizes paper CRFs as source documents, any changes to the paper CRFs **must** be entered into the Medidata Rave study database.

Electronic Signatures by Investigators

Each site investigator or designee is expected to complete a single sign-off of a participant's study data (one sign-off for each participant at his/her site) once the participant terminates from the study and site staff have resolved all data queries for the given participant. By completing this participant-level sign-off in the Medidata Rave study database, the investigator or designee attests that the data has been reviewed and is deemed to be accurate. iMedidata users will use their login credentials as their electronic signature (see image below). Please refer to the "Electronic Signature" section of the Medidata Rave Electronic Data Capture (EDC) Training Manual and/or the Investigator e-Learning module for specific instructions.



12.2 CRF Completion

12.2.1 General Guidelines – eCRF Completion

- To the extent possible, site staff should utilize direct data entry into the Medidata Rave study database so that the eCRF serves as the source document. Direct data entry is especially encouraged for data collection based on participant self-report.
- When direct data entry is not possible due to the nature of the source data - for example, when the source data is a local lab results report - site staff are encouraged to enter study data into the Medidata Rave study database based on the site-specific source document (in this case, the local lab results report).
 - Site staff are encouraged to avoid paper CRF completion, as it represents an additional, intermediate step of data management and QA/QC review into site data management workflows. In addition, paper CRF completion introduces the risk of data transcription errors, and could contribute to database data entry errors.
- When completing an eCRF, refer to the CRF Completion Guidelines (CCG) document, posted on ATLAS, for detailed instructions on data collection pertaining to the given form and fields on that form.
- Complete eCRFs as soon as possible once the data is available and has undergone internal QC review, as applicable. Ideally, completion of all required eCRFs for a given visit will occur within 1–2 business days of the visit, though up to 7 days is acceptable.

12.2.2 Screening and Enrollment/Randomization

- Data entry into the study database begins at the Screening Visit. Once a participant is determined to be eligible, enrolls, or fails a screening attempt, study eligibility data should be entered into the study database as follows:
 - For participants who screen but do not enroll in MTN-039, data entry is required for the Inclusion Exclusion Criteria eCRF (located in the Enrollment folder). (Some eCRFs that were completed during the failed screening attempt may remain in the study database, but may not undergo QC review).
 - For participants who enroll in MTN-039, enter data for the Inclusion Exclusion Criteria eCRF, along with all required Enrollment Visit CRFs.
- **Randomization:** The first step in the randomization process is for site staff to complete the Inclusion Exclusion Criteria CRF with the first two responses indicating that the participant is eligible for study participation. Once these two questions are completed and the form is saved, the Randomization form may be completed. To randomize a study participant, site staff must mark the “Yes” response box (shown in the image below) for the question “Is the participant ready to be randomized?” on the Randomization eCRF in the Enrollment Folder. Once this response is saved, the database (via the Medidata Balance module) will assign the participant to a sample collection schedule assignment (Group 1 or Group 2) and the Randomization Date and Time will appear automatically on the Randomization eCRF. A participant is considered officially enrolled in the study once this step takes place; that is, a randomization assignment is generated for the participant in Medidata Balance, as evidenced by the appearance of a Randomization Date and Time on the Randomization eCRF. The sample collection schedule assignment will autopopulate on the Enrollment eCRF after randomization has occurred.

Page: Randomization - V2.0 - Day 0/Enrollment

Is the participant ready to be randomized?

Yes No

Randomization Date and Time

12.2.3 Replacement Participants

- If it has been determined by the Management Team that a participant needs to be replaced, a Participant Replacement Assessment CRF must be completed for the participant exiting the study. In order to populate the Participant Replacement Assessment CRF, “Were any additional study procedures or forms completed outside of the scheduled study visit” must be marked on the Follow-up Visit Summary CRF. Select “Participant Replacement” from the available CRFs on the Additional Study Procedures form.
- An email will be sent to notify the SDMC to deactivate the replaced participant. Once this occurs, the CDM will email the site to inform them if the next enrolled participant is the replacement participant.
- Please note that the next available enrolled participant might not be the replacement participant.
- When the replacement participant is randomized, please enter the PTID of the replaced participant (the PTID being replaced) on the Enrollment CRF.

12.2.4 Site Data Management SOP

As a condition for study activation, each study site must have a site or study-specific SOP for Data Management. This SOP should be reviewed and followed in combination with the information contained in the study protocol, this SSP Manual, and the site's Clinical Quality Management Plan (CQMP).

The Data Management SOP outlines site staff responsibilities and contains information on several data topics, including:

- Participant ID (PTID) assignment
- Participant study file organization
- Participant confidentiality
- Site data quality control (QC) processes
- Timing of data entry into the study database
- Data storage
- Data security
- Contingency plans in case of interrupted access to the study database.
- Management of site user account permissions for access to the study database.

12.3 Study-Specific Data Collection Information

12.3.1 Participant Identification Numbers (PTIDs)

As described in each site's Data Management SOP, each participant that provides written informed consent to be screened in MTN-039 will be assigned an MTN-039 PTID. To do this, site staff will generate in Medidata Rave a participant number (called "Subject ID" in Medidata Rave) within the electronic study and site folder; this number will serve as the participant's PTID. Refer to the "Creating Subjects" section of the Medidata Rave Electronic Data Capture (EDC) Training Manual and the CCG for specific instructions.

Each PTID is unique. It will be assigned to a single participant only at a given site, and not assigned to any other participant at any site or in any study (e.g., MTN, HVTN, HPTN) for which SCHARP is the Statistical and Data Management Center (SDMC).

SCHARP will provide sites with a Microsoft Excel PTID-Name Linkage file and site staff will maintain this document, which will be used to link a participant's name with his/her assigned PTID. For study purposes, the act of MTN-039 PTID assignment is defined as completion of an entry on the MTN-039 PTID-Name Linkage Log for a given participant.

The MTN-039 PTIDs are nine digits and formatted as "XXXYYYYYZ". The PTID consists of three parts: the site number (XXX), the participant number (YYYYY), and a numerical check digit (Z). The check digit (Z) is a number generated by SCHARP within the participant number and helps ensure that the correct PTID is recorded/entered.

12.3.2 Study Visit Timing

Screening and Enrollment

The initial screening visit is defined as the day the participant provided written informed consent to be screened for the study. The Enrollment Visit will be scheduled to take place within 45 days of the initial Screening Visit. The date the participant is enrolled/randomized is Study Day 0 for the participant. SCHARP will provide sites with a visit window calendar tool in Microsoft Excel that can be used to calculate the allowable window for study enrollment based on the participant's screening date (i.e., date informed consent provided for the current screening attempt). The tool will be posted on-line at <https://mtnstopshiv.org/research/studies/mtn-039/mtn-039-study-implementation-materials>.

Multiple visits may be conducted to complete screening procedures.

Screening Attempts (Re-screens)

If a participant's first screening attempt is unsuccessful, s/he may re-screen once if s/he chooses. If s/he does re-screen, all screening procedures must be repeated with the exception of PTID assignment. Once a PTID is assigned to a participant that PTID is used for the re-screening procedures and forms completed for that participant (do not assign a new PTID).

If a participant re-screens and enrolls, all previously completed eCRFs (from the original, failed screening attempt) must be updated to reflect only data from the successful Screening and Enrollment Visit. Note however, the Inclusion Exclusion Criteria eCRF completed during the failed screening attempt should be updated to reflect the participant's final eligibility status and enrollment into the study.

Follow-Up Visits

For each MTN-039 follow-up visit, the visit type, visit code, target visit day, and visit window are listed in Table 12-1. Target days and windows are listed in days, with the day of enrollment/randomization as study Day 0.

Note that scheduled visits cannot occur on weekends, which means the day of the week must also be taken into account when scheduling the Dose Administration Visits and PK/PD sampling visits (Visits 3-10).

If an interim safety visit has occurred due to an extended pause in the study, the follow-up visit must be within 45 days of the safety visit.

Target Days and Visit Windows

Whenever possible, visits should be completed on the target day. If it is not possible to complete the visit on the target day, the visit should be completed within the visit window. Note that only certain visits have a window; many visits must be completed on the day specified in the visit window calendar tool.

SCHARP will provide sites with a spreadsheet tool that may be used to generate individual participant follow-up visit calendars. The spreadsheet requires that the participant's Enrollment (i.e., randomization) date be entered. Once the enrollment date is entered, the target day and visit window for each required follow-up visit up through Visit 11 will appear. The calendar can then be printed and added to the participant's study notebook.

Split Visits

Whenever possible, all required follow-up visit evaluations should be completed on the same day. In those cases where this is not possible, the participant may come back and complete the remaining evaluations on another day, as long as that day is within the visit window **AND** as long as the visit is NOT the enrollment visit. (Refer to SSP Section 5: Study Procedures for more information regarding visit procedures and timing). For example, a participant comes in on their Visit 3 target day and completes most of the required evaluations. They come back the next day and complete the remaining required procedures. While not ideal, this is allowed as needed, and is referred to as a "split" visit; meaning, the participant completed all required visit evaluations on two separate days, both days being in the visit window.

Note that for split visits, the "Visit Date" on the Follow-up Visit Summary form within the applicable visit folder is the date of the first part of the split visit. See Section 12.3.3 for more information on assigning visit codes to split visits.

Please ensure that:

- HIV pre- and post-test counseling and HIV testing should all occur on one day if rapid testing is performed.
- CASI questionnaire and behavioral forms completion should also occur all on one day.
- PK/PD specimens are collected on the same day of the split visit to avoid complicating interpretability of the data.

Table 12-1: Visit Timing Requirements
MTN039 Study Visit Schedule 1.0

Visit code	Visit type	Target Day	Visit Window
1.0	V1 - Screening Visit	No more than 45 days prior to Enrollment	N/A
2.0	V2 - Enrollment	Day 0	+45 days after 1.0
3.0	V3 – Dose 1	Day 10 ≥ 7 days after Enrollment Visit	≥ 7-30 days after Enrollment Visit
4.0	V4 - 24 Hr Post-dose Visit	Day 11 24 hours after V3	+22-26 hours after Visit code 3.0
5.0	V5 - 48 Hr Post-dose Visit	Day 12 2 days after V3	+44-52 hours after Visit code 3.0
6.0	V6 – 72 Hr Post-dose Visit	Day 13 3 days after V3	+66-78 hours after Visit code 3.0
7.0	V7 – Dose 2	Day 33 ~20 after Visit 6.0	+7-49 days after Visit code 6.0
8.0	V8 - 24 Hr Post-dose Visit	Day 34 1 day after V7	+22-26 hours after Visit code 7.0
9.0	V9 - 48 Hr Post-dose Visit	Day 35 2 days after V7	+44-52 hours after Visit code 7.0
10.0	V10 - 72 Hr Post-dose Visit	Day 36 3 days after V7	+66-78 hours after Visit code 7.0
11.0	V11 – Final Contact	Day 41 ~5 days after V10	+3-7 days after Visit code 10.0

***If the participant permanently discontinues study product use early (i.e. prior to Visit 7), conduct the study procedures for Visit 11 at the participant's last clinic visit. This will be considered an Early Termination Visit.

Missed Visits

In those cases where a participant is not able to complete any part of a required follow-up visit within the visit window, the visit is considered “missed”. For example, an enrolled participant does not report to the clinic for Visit 6 until 5 days after Visit 5. Per Table 12-1, Visit 6 visit has been missed. The missed visit is documented by completion of a Missed Visit CRF.

Interim Visits

An interim visit is a contact with a study participant that meets one of the following criteria:

- Additional study procedures and/or data collection are conducted outside of what is specified in the protocol for a required study visit. For example, an interim visit may occur via a phone contact if the participant reports a new AE. Required follow-up visit procedures are not done, either because the required follow-up visit has already been completed, the participant is in between visit windows, or it is too early in the visit window to complete the required visit.
- Required study visit procedures are conducted outside the visit window, either to make up certain procedures from a missed visit, or to conduct Visit 11/Early Termination Visit procedures due to an early product discontinuation (for reasons other than HIV infection

or pregnancy). For example, if a participant permanently discontinues study product use at Visit 5, s/he would complete Visit 11 visit procedures at Visit 5, if able and willing.

All interim visits/contacts with the participant should be documented in a chart note. Additionally, if the interim contact results in at least one newly-completed eCRF, the interim visit is assigned an interim visit code (visit number ending in something other than “.0”). All phone contacts that meet interim visit criteria as specified above are also assigned interim visit codes. See section 12.3.3 for information on how to assign visit codes to interim visits.

For MTN-039, an Interim Visit Summary CRF is completed for interim visits/contacts as needed.

The following are some examples of interim visits:

1. A participant has a family emergency and is unable to come into the clinic to complete Visit 4 until Day 20 (3 days after the window has closed). Per section 5 of this manual (Study Procedures), an interim visit is conducted on Day 20 to make up certain missed procedures from Visit 4.

Why is this an interim visit? Visit 4 is considered a missed visit, as the visit window has closed. The visit on Day 20 is being conducted outside of the visit window – that is, between when the Visit 4 window closed and when the Visit 5 window opens. The interim visit is assigned an interim visit code as new CRFs will be completed (Interim Visit Summary, Hematology, Chemistry Panel, Specimen Collection and Storage, Anorectal Specimen Storage; possibly others, per site consultation with the study management team).

2. A participant completes Visit 6 as scheduled. Their Visit 7 visit window opens on August 15th, and they are scheduled to complete Visit 7 on August 16th. The participant reports to the clinic unexpectedly on August 15th to report new genital AE symptoms.

Why is this an interim visit? The participant is in the Visit 7 visit window, but site staff decide not to conduct Visit 7 visit procedures for this participant on August 15th (e.g., the participant already has Visit 7 scheduled for the next day (on the target date) and has a history of reliably showing up for scheduled study visits, and/or there is limited staff time availability on August 15th). An interim visit code is assigned as new CRFs will be completed (Interim Visit Summary, AE Log, possibly others).

3. A participant completes all required evaluations for Visit 6 on the target day, August 15th. She returns to the site on August 18th and has a positive pregnancy test. Per section 7.5.2 of the protocol, Visit 11/Early Termination procedures are conducted as part of the August 18th interim visit.

Why is this an interim visit? On August 18th, a pregnancy test is done, representing new data collection, and the participant is being instructed by study staff to permanently discontinue use of the study drug, and Visit 11/Early Termination procedures are conducted. An interim visit code is assigned, as data collection is occurring between regularly scheduled study visits and outside of the visit windows. CRFs required at Visit 11 are completed, along with a new Pregnancy Test and Pregnancy Report and History.

12.3.3 Visit Folders and Visit Codes

The eCRFs in the study database are set up within pre-defined study visit folders, so the visit name and visit code automatically appear (and do not need to be entered for required study visits). All log forms (i.e., AE Y/N and Log, Concomitant Medications Y/N and Log, Protocol Deviations Y/N and Log, Medical History Y/N and Log, and Product Hold Summary and Log) are housed in the “Ongoing Logs” folder within the study database. The Discontinuation of

Study Product eCRF and Study Termination eCRF are housed within the “Discontinuations” folder; each of these forms is completed once for each participant to document his/her permanent product discontinuation and study exit, respectively. Pharmacy Dispensation is housed within its own Pharmacy folder. In addition, the Pregnancy Report, Pregnancy History, and Pregnancy Outcome eCRFs are housed within the Pregnancy folder (if applicable). Table 12-3 below lists the visit codes assigned to each required follow-up visit.

Table 12-2: Visit Code Assignments for Required Follow-up Visits

Visit	Visit Code
Screening (1.0)	1.0
Enrollment (2.0)	2.0
Dosing Visit (3.0)	3.0
24-hour Post-Dosing Visit (4.0)	4.0
48-hour Post-Dosing Visit (5.0)	5.0
72-hour Post-Dosing Visit (6.0)	6.0
Dosing Visit (7.0)	7.0
24-hour Post-Dosing Visit (8.0)	8.0
48-hour Post-Dosing Visit (9.0)	9.0
72-hour Post-Dosing Visit (10.0)	10.0
Final Contact (11.0)	11.0

Visit codes for Split Visits

See Section 12.3.2 for a definition of split visits. When split visits occur, the CRFs completed for the visit are all assigned the same visit code, even though the dates will differ between some of the CRFs. For example, a participant comes in on her Visit 3.0 target day of 23-AUG-17 and completes all required visit evaluations except pregnancy testing. She returns on 24-AUG-17 (still within the visit window) and provides a urine sample for pregnancy testing. All CRFs dated 23-AUG-17 and 24-AUG-17 are assigned the same visit code of “3.0” and are housed within the Day 3.0 visit folder in the study database.

Visit codes for Interim Visits

Note that interim visit codes are not used for visits/contacts between the Screening Visit and Enrollment Visit, as these contacts are considered part of the screening process.

For interim visits occurring after the Enrollment Visit and onwards, interim visit codes are assigned using the following guidelines:

- To the left of the decimal point, record the visit code of the most recently required follow-up visit, even if the visit was missed and/or if the participant is within the next visit’s window.

- To the right of the decimal point:
 - #.1 = the first interim visit after the most recently-required visit,
 - #.2 = the second interim visit after the most recently-required visit,
 - #.3 = the third interim visit after the most recently-required visit, and so on.

Example #1: A participant completes Visit 6 on the target day. S/he returns to the site four days later to report a new genital symptom. This interim Visit is assigned a visit code of 6.1.

The examples below are from section 12.3.2, where interim visits are defined. These examples now have visit code information added to each example.

1. A participant completes Visit 6 as scheduled. Her/his Visit 7 visit window opens on August 15th, and s/he is scheduled to complete Visit 7 on August 16th. The participant reports to the clinic unexpectedly on August 15th to report new genital AE symptoms.

visit code = 7.1

2. A participant completes all required evaluations for Visit 4 on the target day, August 15th. She returns to the site on August 18th and has a positive pregnancy test. Per section 7.5.2 of the protocol, Visit 11/Early Termination procedures are conducted as part of the August 18th interim visit.

visit code = 5.1

3. A participant completes Visit 4.0 on the target day. The next day, she calls the clinic to report a new mild genital symptom.

visit code = 4.1

12.3.4 Form Supply

SCHARP will post a CRF (pdf) file, representing output from the study database eCRFs, on the following MTN-039 Atlas web page:

<https://atlas.scharp.org/cpas/project/MTN/039/begin.view?>

The pdf file represents the complete set of study CRFs and may be used by site staff for local IRB submission as needed, as well as for printing their own paper CRF supplies as back-up in the case completing eCRFs in Medidata is not possible.

12.3.5 Case Report Form Completion Schedule

The SCHARP-provided forms for this study include all forms that are completed and entered into the study database, as well as the Pelvic Exam Diagrams, which is an optional tool sites may use to source document pelvic exam findings for data entry into the Pelvic Exam eCRF.

Some SCHARP-provided forms are required to be completed at each visit, while other forms are required only at one visit or only when specifically indicated. The following table (Table 12-4) lists the forms that are required to be completed at each study visit, as well as the forms that are completed on an “as needed” basis.

Table 12-3: Schedule of Forms – CRFs Required to be Completed at Each Visit

Visit	Form Name
Screening	Screening Date of Visit
	Demographics
	Physical Exam
	Anorectal Exam
	Vital Signs
	STI Tests
	Hematology
	Chemistry Panel
	HIV Test Results
	Pregnancy Test Result (female participants only)
V2 - Enrollment Visit	Randomization
	Inclusion Exclusion Criteria
	Enrollment
	Behavioral Assessment, CASI Tracking
	Physical Exam
	Vital Signs
	Anorectal Exam
	HIV Test Results
	Specimen Collection and Storage
	Pregnancy Test Result (female participants only)
V3, V7 – Dosing Visits	Follow-up Visit Yes/No, Follow-up Visit Summary
	Pharmacy Dispensation
	Dose Administration
	Anorectal Exam
	Specimen Collection and Storage (Group 1 or Group 2)
	Pregnancy Test Result (female participants only)
V4, V8 – 24 Hours Post-Dosing Visits	Follow-up Visit Yes/No, Follow-up Visit Summary
	Behavioral Assessment, CASI Tracking
	Anorectal Exam
	Specimen Collection and Storage (Group 1 or Group 2)
	Discontinuation of Study Product (<i>Visit 8 only</i>)
V5, V6, V9, V10 – Other Post-Dosing Visits	Follow-up Visit Yes/No, Follow-up Visit Summary
	Behavioral Assessment, CASI Tracking (<i>Visit 10 only</i>)
	Anorectal Exam
	Hematology (<i>Visit 10 only</i>)
	Chemistry Panel (<i>Visit 10 only</i>)
	HIV Test Results (<i>Visit 10 only</i>)
	Specimen Collection and Storage (Group 1 or Group 2)
V11 – Final Contact/Early Termination	Follow-up Visit Yes/No, Follow-up Visit Summary
	Study Termination

As needed (Additional Study Procedures/Interim Visits Procedures)	Interim Visit Summary
	Additional Study Procedures
	HIV Test Results
	HIV Confirmatory Tests
	Chemistry Panel
	Hematology
	Physical Exam
	Vital Signs
	Anorectal Exam
	Specimen Collection and Storage
	STI Test Results
	Missed Visit
	Pharmacy Dispensation
	Dose Administration
	Product Hold Summary
	Product Hold Log
	Participant Replacement Assessment
	Pelvic Exam (female participants only)
	Pelvic Exam Diagrams – non RAVE form (female participants only)
	Pregnancy Test Result (female participants only)
Pregnancy Report (female participants only)	
Pregnancy History (female participants only)	
Pregnancy Outcome Log (female participants only)	
As needed, Ongoing Logs	Adverse Event Y/N
	Adverse Event
	Concomitant Medications Y/N
	Concomitant Medications
	Medical History Y/N
	Medical History
	Protocol Deviations Y/N
	Protocol Deviations Log
	Product Hold Summary
	Product Hold Log
Discontinuations	Study Termination
	Discontinuation of Study Product

12.3.6 Completing Interviewer-administered Forms

In order to standardize interviewer-administered data collection from site to site and to maximize quality, it is critical that participant interviews be conducted with a non-biased, non-judgmental approach. Study staff should help a participant feel comfortable sharing personal

information and opinions while asking the study questions in a consistent manner from participant to participant.

Site staff are encouraged to practice direct data entry when administering the interviewer-administered forms (i.e. Demographics), to the extent possible, so that the eCRFs serve as the source documents. Skip patterns are documented in the CRF Completion Guidelines (CCG) document, which site staff should reference when administering the forms. The CCG will be posted on the Atlas web site along with the complete set of study CRFs (pdf file – see above section 12.3.4). The skip patterns are also programmed into the data checks within the study database, and system queries will be generated in real-time, as data is saved within the database, if required items are missed and/or inconsistent responses are entered. This real-time feedback will allow the interviewer to clarify participant responses and update/correct participant self-reported data during the participant interview, yielding accurate, consistent, and complete study data. Site staff who will conduct the participant interviews and complete the interviewer-administered behavioral and product adherence forms are encouraged to practice conducting the interviews, completing/updating the eCRFs by entering test data, and familiarizing themselves with the eCRF questions, skip patterns, and system queries prior to conducting actual participant interviews.

12.3.7 Site Review (Quality Control) of CRFs

As described in the site's Data Management SOP [and referenced in the site's Clinical Quality Management Plan, (CQMP)], each site must perform Quality Control (QC) review steps, especially for paper CRFs (if used) prior to their data entry into the study database. While paper CRFs are being reviewed, it is important that they are stored and tracked systematically.

Below are specific review guidelines that should be followed for these QC review steps.

12.3.7.1 MTN-039 QC Review Step #1 (completed during visit)

- Review visit checklist and genital exam checklist (if used) to ensure all required procedures were completed
- Review eligibility checklists/worksheets to ensure completeness and verify participant eligibility
- Review LDMS Specimen Tracking Sheets to ensure completeness and accuracy
- Review completed CRFs based on participant responses to ensure completeness:
 - Screening Visit: Demographics, Medical History Log, Concomitant Medications Log, Anorectal Exam
 - Enrollment Visit: Anorectal Exam, Specimen Collection and Storage, Concomitant Medications Log
 - Follow-up visits, when present: Anorectal Exam, Specimen Collection and Storage (Group 1 or Group 2), Behavioral Assessment and CASI Tracking, Adverse Event Log

12.3.7.2 MTN-039 QC Review Step #2 (completed after visit)

General QC #2 procedures for all visits:

- Review visit checklist to ensure all required procedures were completed

- Ensure the PTID is correct, is recorded correctly on all paper source documents (including paper CRFs, if used), and is the same on the paper source documents and the eCRFs for a given participant.
- Ensure that no participant identifiers other than the PTID are present on paper source documents, including paper CRFs (if used).
- Ensure that the assigned visit code is correct, and is consistent between the paper source documents, including paper CRFs (if used), the eCRFs, the LDMS Specimen Tracking Sheet, and LDMS for a given participant visit.

Additional QC #2 procedures for Screening and Enrollment Visit documents:

- Review the Physical Exam, Vital Signs, Hematology, Pregnancy Test, HIV Tests, STI Tests, and Anorectal Exam forms, and Pelvic Exam forms (if applicable) and ensure that medical conditions are recorded appropriately on the Medical History Log. Refer to the CCG for further guidance.
- Ensure that all eCRFs used to document lab test results have the correct Specimen Collection Dates entered. If any lab tests were repeated, update the appropriate eCRF(s) to reflect the repeat test result(s).
- If a second (repeat) anorectal and/or pelvic/male genital exam is performed during screening, make sure a new anorectal/pelvic exam source document [e.g., Pelvic Exam Diagrams (non-Medidata Rave)] is completed, and update the Anorectal exam/Pelvic Exam eCRF in the Screening Visit folder to document the second screening genital exam.
- Review the Specimen Collection and Storage eCRF and make sure they match information documented on the visit checklist and Enrollment Visit LDMS Specimen Tracking Sheet (or local lab requisition sheet).
- If a participant screens but does not enroll in the study, make sure the Inclusion Exclusion Criteria eCRF is completed and entered into the study database, along with all other required Screening forms. Other eCRFs that were completed as part of the failed screening attempt may remain in the study database but may not be QC'd.

Additional QC #2 procedures for follow-up visit documents:

- Concomitant Medications Log CRF: if a medication is taken for an AE, make sure the AE is entered on the Concomitant Medications Log eCRF, and make sure the AE Log CRF for the AE has “Medication” entered for “Other action(s) taken”.

QC #2 for Paper CRFs (if used)

This QC review step should occur before forms are data-entered into the study database. Ideally, this review will happen once all lab results are available, so that all forms for a particular visit can be reviewed for consistency across documents. The goal, as outlined in the site’s Data Management SOP, is to correct data inconsistencies/errors prior to entering data into the study database, so that data is accurate, complete, and available at the time of data entry, thus minimizing the likelihood of data queries.

QC #2 procedures for paper CRFs - all visits:

- Make sure a response has been recorded for each item, as required. Make sure skip patterns have been followed correctly, per instructions in the CRF Completion Guidelines (CCG) document.

- If a response box with “other”, “specify”, or “describe” line is present, ensure text is present on this line.
- Make sure text responses are clearly recorded.
- For paper CRFs that are not source documents, make sure the data recorded on the paper CRFs matches or is consistent with the source documents.

QC #2 for Electronic CRFs (eCRF)

When data is entered into the study database and an eCRF is saved, system queries are automatically generated in response to inconsistent or incomplete data. Unlike the paper CRFs, which require manual review, eCRFs have the advantage of having the study database itself provide a real-time QC review to ensure data completeness and consistency. In addition, the database design and system queries ensure skip patterns are followed, per instructions in the CCG.

No additional QC #2 review steps are required for eCRFs that are source (i.e., the data is directly entered into the study database, rather than entered based on a separate paper CRF or other paper source document).

eCRFs that are completed based on other source documents (e.g., paper CRFs, SMS data, or lab reports) should be reviewed to ensure that the data entered matches or is consistent with the source documents. The site’s Data Management SOP provides additional details and specifies which staff members will perform this review.

12.4 Form-Specific Completion Instructions

Detailed form completion instructions for each form are provided in the CRF Completion Guidelines (CCG) document. The instructions document skip patterns and include guidance on completion of eCRFs in the study database. Some items on forms are straightforward and do not require specific instructions. Therefore, you will not see all form items listed in the CCG, but rather only those items needing detailed explanation.

12.5 Case Report Forms

The current version of the MTN-039 case report forms can be found at the MTN-039 Atlas web page, link provided below.

<https://atlas.scharp.org/cpas/project/MTN/039/begin.view?>