

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-036/IPM 047 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-036/IPM 047 team members, along with their job role and e-mail address, are listed below.

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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-036/IPM 047 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-036/IPM 047 Atlas webpage: <https://atlas.scharp.org/cpas/project/MTN/036/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-036/IPM 047 Atlas web page: <https://atlas.scharp.org/cpas/project/MTN/036/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	Direct number
1-866-MEDIDATA (633-4328)	1-973-659-6780

Toll-free fax	Direct fax
1-877-743-2350	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.
- 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 of Record (IoR) 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 IoR 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.

I certify that I have ensured the accuracy and completeness of the data reported in the Case Report Forms.
Melissa Peda 05 Aug 2016 17:37:50 Pacific Daylight Time

medidata

Username

Password

eSign

12.2 CRF Completion

12.3 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, such as behavioral and product (ring) use data.
- 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.

12.3.1 Screening and Enrollment/Randomization

- Data entry into the study database begins at the Screening Visit. Queries will fire at the time of data entry.
- For participants who screen but do not enroll in MTN-036/IPM 047, data entry is required for the Eligibility Criteria eCRF. Other eCRFs that were completed during the failed screening attempt may remain in the study database, and will not undergo QC review. Screening form queries will be closed by the SCHARP Data Manager once the Eligibility Criteria CRF has been completed.
- For participants who enroll in MTN-036/IPM 047, enter data for the Eligibility Criteria eCRF, along with all required Screening and Enrollment Visit CRFs. Screening form queries will be addressed by the site.
- **Randomization:** Participants will be randomized to a treatment arm (25 mg, 100 mg, or 200 mg) and to an IDI group (considered for IDI, not considered for IDI)
 - Randomization to a treatment arm will be done through Medidata. The first step in the ring randomization process is for site staff to complete the Eligibility Criteria eCRF with all responses indicating that the participant is eligible for study participation. Once this is done, the Randomization CRF may be completed. To randomize a study participant, site staff mark the “Yes” response box (shown in the image below) for the question “Is the participant ready to be randomized?” on the Randomization eCRF. Once this response is saved, the database (via the Medidata Balance module) will assign the participant to a treatment arm 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.

- After a participant is randomized to a treatment arm by Medidata Balance, each participant's randomization ID will be provided on the Randomization CRF within the participant's RAVE casebook. In addition, the ring strength the participant is randomized to will appear automatically on the Enrollment eCRF. At this point, the participant will be randomized to an IDI group. Randomization to an IDI group will be done outside of the Medidata system. The first step in the IDI randomization process is for site staff to locate the three-digit Randomization ID on the Randomization CRF. Next, site staff will locate the Randomization ID in the Randomization ID column on the IDI Sampling List provided by SCHARP.
 - If the value in the Considered for IDI column is "no", the participant will not be invited to participate in an IDI. On the Enrollment CRF, enter "No" for "Was the participant randomized to participate in IDI (In Depth Interview)?"
 - If the value in the Considered for IDI column is "yes", the participant will be considered for participation in an IDI. On the Enrollment CRF, enter "Yes" for "Was the participant randomized to participate in IDI (In Depth Interview)?"
 - The next step is to review the Demographics CRF completed at the Screening Visit for this participant.
 - If the response to "In the past 12 months, with whom did the participant have vaginal sex?" is "Exclusively female partners" or "NA (no sex partners)," then the participant will not be invited to participate in an IDI. On the Enrollment CRF, enter "No" for "Was the participant invited to participate in IDI?"
 - If the response to "In the past 12 months, with whom did the participant have vaginal sex?" is "Both male and female partners" or "Exclusively male partners" site staff will invite the participant to participate in an IDI. On the Enrollment CRF, enter "Yes" for "Was the participant invited to participate in IDI?" Sex with a male partner is defined as having penile-vaginal sex, including with a transman with a reconstructed penis.
 - If the participant declines the invitation to participate in the IDI or be audio-recorded, enter "no" for "Will this participant participate in IDI?". If the participant agrees to participate in the IDI and be audio-recorded, enter "yes" for "Will this participant participate in IDI?"

Page: Randomization - V2.0 - Enrollment

Is the participant ready to be randomized?

Yes No

Randomization Date and Time

12.3.2 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

12.4 Study-specific Data Collection Information

12.4.1 Participant Identification Numbers (PTIDs)

As described in each site's Data Management SOP, each participant who provides written informed consent to be screened in MTN-036/IPM 047 will be assigned an MTN-036/IPM 047 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 her assigned PTID. For study purposes, the act of MTN-036/IPM 047 PTID assignment is defined as completion of an entry on the MTN-036/IPM 047 PTID-Name Linkage Log for a given participant.

The MTN-036/IPM 047 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.

12.4.2 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: <http://www.mtnstopshiv.org/node/7711>.

Screening Attempts (Re-screens)

If a participant's first screening attempt is unsuccessful, she may re-screen once if she chooses. If she 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 that in this case, the Eligibility 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-036/IPM 047 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.

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.

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 the Day 91 visit (Visit 10/PUEV) will appear. The visit window for Visit 11/Final Contact is contingent on the actual visit date of Visit 10/PUEV. The visit window for Visit 11/Final Contact will not be calculated until the actual visit date of Visit 10/PUEV is entered. The calendar can be printed, added to the participant’s study notebook, and updated as needed.

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 the Screening, Day 3, Day 7, Day 14, Day 28, Day 56, Day 91 (PUEV) or Final Contact (24 – 72 hours after PUEV) visit. All other study visits (Enrollment, Day 1, and Day 2) may not be split. (Refer to the SSP Section 5 for more information regarding visit procedures and timing). For example, a participant comes in on her Day 3 target day and completes most of the required evaluations. She comes back the next day and completes 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.

Table 12-1: Visit Timing Requirements

Visit	Visit Code	Target Day	Window Opens	Window Closes
Visit 1 - Screening	1.0	N/A	N/A	
Visit 2 - Day 0 Enrollment	2.0	0	Up to 45 days after screening informed consent date	

Visit 3 - Day 1	3.0	1	no window	
Visit 4 - Day 2	4.0	2	no window	
Visit 5 - Day 3	5.0	3	3	4
Visit 6 - Day 7 / Week 1	6.0	7	6	8
Visit 7 - Day 14 / Week 2	7.0	14	13	15
Visit 8 - Day 28 / Week 4	8.0	28	26	30
Visit 9 - Day 56 / Week 8	9.0	56	54	58
Visit 10 - Day 91 / Week 13 Product End Use Visit (PUEV)	10.0	91	89	93
Visit 11 - Day 92/93/94* Final Contact	11.0	24 - 72 hours after PUEV (Visit 10)		

*NOTE: Visit 11 must occur between 24-72 hours after the PUEV (Visit 10); schedule within visit window accordingly.

Missed Visits

In 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 her Day 7 visit until 9 days after enrollment. Per Table 12-1, the Day 7 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 10-Day 91/PUEV/Early Termination Visit procedures due to an early product use end. For example, if a participant permanently discontinues study product use at Day 10, she would complete Day 91 visit procedures on Day 10, if she is 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-036/IPM 047, 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 her Day 7 visit until Day 9. Per SSP Section 5 Study Procedures, an interim visit is conducted on Day 9 to make up certain missed Day 7 visit procedures.

Why is this an interim visit? The Day 7 visit is considered a missed visit, as the visit window has closed. The visit on Day 9 is being conducted outside of the visit window – that is, between when the Day 7 visit window closed and when the Day 14 visit window opens. The interim visit is assigned an interim visit code as new CRFs will be completed (Interim Visit Summary, Cervical Specimen Storage, Follow-up Summary, Pelvic Exam, Specimen Storage, Vital Signs, and possibly others, per site consultation with the study management team).

2. A participant completes all required evaluations for her Day 7 visit on the target day. She then returns to the clinic 4 days later to request a new ring.

Why is this an interim visit? The participant has already completed all Day 7 visit procedures, and it is too early (and not in the visit window) for the Day 14 visit. This is an interim visit, conducted between the Day 7 and Day 14 visits, and is assigned an interim visit code as new CRFs will be completed (Interim Visit Summary, and Ring Insertion and Removal).

3. A participant completes her Day 3 visit as scheduled. Her Day 7 visit window opens on August 15th, and she is scheduled to complete the Day 7 visit 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 Day 7 visit window, but site staff decide not to conduct Day 7 visit procedures for this participant on August 15th (e.g., the participant already has her Day 7 visit 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).

4. A participant completes all required evaluations for the Day 56 visit on the target day, October 3rd. She returns to the site complaining of pregnancy symptoms on October 31st. The site clinician requests a pregnancy test and the result is positive. Per protocol section 9.3, the participant is permanently discontinued from further use of the study vaginal ring. Per Protocol Section 7.5.3, Day 91/PUEV visit procedures are conducted as part of the October 31st interim visit.

Why is this an interim visit? On October 31st, a pregnancy test is conducted, representing new data collection, the participant is being instructed by study staff to permanently discontinue use of the study vaginal ring, and Day 91/PUEV visit 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 the Day 91 visit are completed.

5. A participant completes her Day 3 visit on the target day. The next day, she calls the clinic to report a new mild genital symptom.

Why is this an interim visit? During the phone contact, the participant reported a new symptom which will result in completion of a new CRF (AE Log). Since new CRFs are completed (AE Log and Interim Visit Summary), an interim visit code is assigned.

12.4.3 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). With the exception of the Medical History Summary and Log eCRFs, which are housed in the Screening Visit folder, all log forms (i.e., AE Summary and Log, Concomitant Medications Summary and Log, Protocol Deviations Summary and Log, and Product Hold Summary and Log) are housed in the “Ongoing Logs” folder within the study database. The Product Discontinuation eCRF and Study Discontinuation eCRF are housed within the “Discontinuations” folder; each of these forms is completed once for each participant to document her permanent product discontinuation and study exit, respectively. The Pregnancy Report eCRF, Pregnancy History eCRF, and Pregnancy Outcome eCRF are housed within the “Pregnancy forms” folder. The Pregnancy Report eCRF and Pregnancy History eCRF are completed if a participant falls pregnant during the study. The Pregnancy Outcome eCRF is completed once for each pregnancy outcome.

Table 12-2 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
V1 - Screening	1.0
V2 - Enrollment	2.0
V3 - Day 1	3.0
V4 - Day 2	4.0
V5 - Day 3	5.0
V6 - Day 7 / Week 1	6.0
V7 - Day 14 / Week 2	7.0
V8 - Day 28 / Week 4	8.0
V9 - Day 56 / Week 8	9.0
V10 - Day 91 / Week 13 (PUEV)	10.0
V11 - Final Contact (24 – 72 hours after Visit 10)	11.0

Visit codes for Split Visits

See SSP 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 Day 28 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 “8.0” and are housed within the Day 28 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, 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 her Day 7 visit (visit code = 6.0) on the target day. She returns to the site one day later to report a new genital symptom. This interim Visit is assigned a visit code of 6.1.

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

1. A participant has a family emergency and is unable to come into the clinic to complete her Day 7 visit until Day, 9, which is outside the visit window. An interim visit is conducted on Day 9 to make up certain missed Day 7 visit procedures.
visit code = 6.1
2. A participant completes all required evaluations for her Day 7 visit on the target day. She then returns to the clinic 5 days later to request a new ring.
visit code = 6.1
3. A participant completes her Day 3 visit as scheduled. Her Day 7 visit window opens on August 15th, and she is scheduled to complete the Day 7 visit on August 16th. The participant reports to the clinic unexpectedly on August 15th to report new genital AE symptoms.
visit code = 5.1
4. A participant completes all required evaluations for the Day 56 visit on the target day, October 3rd. She returns to the site complaining of pregnancy symptoms on October 31st. The site clinician requests a pregnancy test and the result is positive. Per section 9.3 of the protocol, the participant is permanently discontinued from further use of the study vaginal ring. Per protocol section 7.5.3, Day 91/PUEV visit procedures are conducted as part of the October 31st interim visit.
visit code = 9.1
5. A participant completes her Day 3 visit on the target day. The next day, she calls the clinic to report a new mild genital symptom.
visit code = 5.1

12.4.4 Form Supply

SCHARP will post a CRF (pdf) file, representing output from the study database eCRFs, on the following MTN-036/IPM 047 Atlas web page:

<https://atlas.scharp.org/cpas/project/MTN/036/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 should they choose to perform paper CRF completion.

12.4.5 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 12-3) 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, the ongoing log forms, discontinuation forms, and pregnancy forms.

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

Visit	Form Name
Visit 1 - Screening	Eligibility Criteria
	Baseline Medical History Summary
	Demographics
	Hematology
	HIV Test Results
	Local Laboratory Results
	Pelvic Exam
	Physical Exam
	Pregnancy Test Results
	Screening Date of Visit
	STI Test Results
	Vital Signs
	Pelvic Exam Diagrams (non-Medidata Rave)
Visit 2 - Enrollment	Behavioral Summary and CASI Tracking
	Baseline Medical History Summary
	Cervical Specimen Storage
	Enrollment
	HIV Test Results
	Pelvic Exam
	Pharmacy Dispensation (completed by and accessible to site pharmacists only)
	Physical Exam

	Pregnancy Test Results
	Randomization
	Ring Insertion and Removal
	Specimen Storage
	Vital Signs
	Pelvic Exam Diagrams (non-Medidata Rave)
Visit 3 – Day 1	Cervical Specimen Storage
Visit 4 – Day 2	Follow-up Visit Y/N and Summary
Visit 5 – Day 3	Pelvic Exam
Visit 6 – Day 7	Specimen Storage
Visit 7 – Day 14	Pelvic Exam Diagrams (non-Medidata Rave)
Visit 8 – Day 28/Week 4 Visit 9 – Day 56/Week 8	Behavioral Summary and CASI Tracking
	Cervical Specimen Storage
	Follow-up Visit Y/N and Summary
	Pelvic Exam
	Pharmacy Dispensation (for participants randomized to 25 mg VR) (completed by and accessible to site pharmacists only)
	Pregnancy Test Results
	Ring Adherence Y/N and Ring Adherence
	Ring Insertion & Removal (for participants randomized to 25 mg VR)
	Specimen Storage
Pelvic Exam Diagrams (non-Medidata Rave)	
Visit 10 – Day 91/Week 13 (Product Use End Visit (PUEV)/Early Termination)	Behavioral Summary and CASI Tracking
	Cervical Specimen Storage
	Follow-up Visit Y/N and Summary
	Hematology
	HIV Test Results
	Local Laboratory Results
	Pelvic Exam
	Pregnancy Test Results
	Ring Adherence Y/N and Ring Adherence
	Ring Insertion & Removal
	Specimen Storage
	Product Discontinuation
	Pelvic Exam Diagrams (non-Medidata Rave)

Visit 11 – Day 92-94	Cervical Specimen Storage
	Follow-up Visit Y/N and Summary
	Specimen Storage
	Study Discontinuation
As needed	Additional Study Procedures
	CASI Tracking
	Cervical Specimen Storage
	Follow-up Visit Y/N
	Follow-up Visit Summary
	Hematology
	HIV Test Results
	HIV Confirmatory Test Results
	Interim Visit Summary
	Local Laboratory Results
	Missed Visit
	Pelvic Exam
	Physical Exam
	Pregnancy Report
	Pregnancy History
	Pregnancy Test Results
	Ring Adherence Summary
	Ring Adherence
	Specimen Storage
	STI Test Results
Study Discontinuation	
Product Discontinuation	
Vital Signs	
Ongoing Logs	Adverse Event Summary
	Adverse Event Log
	Concomitant Medications Summary
	Concomitant Medications Log
	Protocol Deviations Summary
	Protocol Deviations Log
	Product Hold Summary
Product Hold Log	
Discontinuations	Study Discontinuation
	Product Discontinuation

Pregnancy forms	Pregnancy Report
	Pregnancy History
	Pregnancy Outcome Log

12.4.6 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.

12.4.6.1 MTN-036/IPM 047 QC Review Step #1 (completed during visit)

- Review visit checklist and pelvic 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
 - Enrollment Visit: Medical History Log, Concomitant Medications Log, Behavioral Summary
 - Follow-up visits, when present: Ring Adherence, Behavioral Summary, Adverse Event Log, Ring Insertion and Removal

12.4.6.2 MTN-036/IPM 047 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 Ring Insertion and Removal, Pelvic Exam, Physical Exam, Vital Signs, Local Laboratory Results, Hematology, Pregnancy Test, HIV Tests and STI Tests forms, 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) full pelvic exam is performed during screening, make sure a new pelvic exam source document [e.g., Pelvic Exam Diagrams (non-Medidata Rave)] is completed, and update the Pelvic Exam eCRF in the Screening Visit folder to document the 2nd screening pelvic exam.
- Review the Specimen Storage and Cervical Specimen Storage eCRFs 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 Eligibility Criteria eCRF is completed and entered into the study database. Other eCRFs that were completed as part of the failed screening attempt may remain in the study database, but will 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).

Electronic CRFs that are completed based on other source documents (e.g., paper CRFs 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.

12.5 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.

12.6 Case Report Forms

The current version of the MTN-036/IPM 047 case report forms can be found at the MTN-036/IPM 047 Atlas web page, link provided below.

<https://atlas.scharp.org/cpas/project/MTN/036/begin.view??>