

**CLINICAL AND LABORATORY
ADVERSE EVENTS**

Subject ID: _____ - _____ - _____

Subject Initials: _____

Visit Number: _____

(Clinic Coordinator completed)

Complete this log if the subject experienced any clinical adverse events (including intercurrent events) since the last visit. Check the "None" box and instruct the subject to initial and date the source documentation box if the subject has not experienced any clinical adverse events since the last visit.

None

Subject's Initials: _____

Date: ____ / ____ / _____

* Please complete a Serious Adverse Event Reporting (SERIOUS) form.

** Please complete the appropriate Change in Medications form.

*** Please complete the Concomitant Medications (CMED) form.

DESCRIPTION OF ADVERSE EVENT (1000)	1. ICD9 CODE (1010)	2. DATE STARTED (Top Line) (1020)	4. ONGOING at current visit (1040)	5. TYPE (1050)	6. SEVERITY (1060)	7. SERIOUS (1070)	8. LIKELIHOOD OF RELATIONSHIP TO STUDY DRUG(S) (1080)	9. CHANGE IN STUDY DRUG(S) (1090)	10. OUTCOME (Skip if #3 is missing.) (1100)	11. TREATMENT REQUIRED (1110)	12. ONGOING at final visit (1120)
		3. DATE STOPPED (Bottom Line) (1030) MONTH / DAY / YEAR		1 - INTERMITTENT 2 - CONTINUOUS	1 - MILD 2 - MODERATE 3 - SEVERE	1 - YES * 0 - NO	1 - NONE 2 - UNLIKELY (REMOTE) 3 - POSSIBLE 4 - PROBABLE	1 - UNCHANGED 2 - ALTERED **	1 - COMPLETELY RECOVERED 2 - RECOVERED, BUT WITH LASTING EFFECTS 3 - DEATH *	1 - NONE 2 - MEDICATION *** 3 - HOSPITALIZATION * 4 - OTHER	
---	---	__ / __ / ____	<input type="checkbox"/>								<input type="checkbox"/>
---	---	__ / __ / ____	<input type="checkbox"/>								<input type="checkbox"/>
---	---	__ / __ / ____	<input type="checkbox"/>								<input type="checkbox"/>
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---	---	__ / __ / ____	<input type="checkbox"/>								<input type="checkbox"/>



**ASTHMA EVALUATION
QUESTIONNAIRE**

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____/____/____
 Month Day Year
 Coordinator ID: _____

(Subject Interview Completed)

Coordinator Instructions: *Before administering this questionnaire, give the subject his or her diary cards from the two weeks immediately preceding the visit. The subject should refer to the diary cards when answering each question. The AEQ must be the last asthma questionnaire completed at a given visit.*

Subject Instructions: *Please consider your last two weeks of asthma control in answering these questions. Check the box next to the response that best describes your average weekly asthma symptoms, rescue use and nighttime awakenings in the past two weeks.*

- | | |
|---|---|
| <p>1. In the past <u>two weeks</u>, how often have you experienced asthma symptoms?</p> | <p><input type="checkbox"/>₀ Less than or equal to 2 days a week</p> <p><input type="checkbox"/>₁ 3 to 5 days per week</p> <p><input type="checkbox"/>₂ 6 or more days per week, but not continual</p> <p><input type="checkbox"/>₃ Continual (multiple times every day) (1000)</p> |
| <p>2. In the past <u>two weeks</u>, how often have you used your rescue beta-agonist medicine (e.g., albuterol (Proventil, Ventolin)), aside from preventative use prior to exercise?</p> | <p><input type="checkbox"/>₀ Less than or equal to 2 days per week</p> <p><input type="checkbox"/>₁ 3 to 5 days per week</p> <p><input type="checkbox"/>₂ 6 days per week</p> <p><input type="checkbox"/>₃ At least once per day (daily) (1010)</p> |
| <p>3. In the past <u>two weeks</u>, how often have you awakened at night due to asthma symptoms?</p> | <p><input type="checkbox"/>₀ No awakenings or awakened 1 night during the 2 weeks</p> <p><input type="checkbox"/>₁ 1 night per week</p> <p><input type="checkbox"/>₂ 2 or 3 nights per week</p> <p><input type="checkbox"/>₃ 4 or more nights per week (1020)</p> |

Subject Source Documentation

Subject's Initials: _____ (1030)

Date: ____/____/____ (1040)

Time: _____ (based on a 24-hour clock) (1050)



(Technician completed)

1. Serial Number of AM1[®] being tested _____ (1000)
2. Serial Number of turbine being tested _____ - _____
(1010) (1020)
3. Test date _____ / _____ / _____ (1030)
month day year
4. Is a new AM1[®] device being tested for this subject? ₁ Yes ₀ No (1040)
 If **YES**, indicate the primary reason. ₁ First issuing ₅ "Old" device was recalled
₂ "Old" device failed QC testing ₆ "Old" device was lost
₃ "Old" device had display problems ₇ Other (1050)
₄ "Old" device experienced battery failure

	AM1 [®] (L/Min)	Jones FVC (L/Min)
5. Trial 1 (1060/1070)	_____	_____ . _____
6. Trial 2 (1080/1090)	_____	_____ . _____
7. Trial 3 (1100/1110)	_____	_____ . _____
8. Trial 4 (1120/1130)	_____	_____ . _____
9. Trial 5 (1140/1150)	_____	_____ . _____

Clinic Use Only	
Relative Bias <small>(AM1 - Jones FVC) * 100 % Jones FVC</small>	Rank <small>smallest to largest</small>
_____ . _____ %	_____
_____ . _____ %	_____
_____ . _____ %	_____
_____ . _____ %	_____
_____ . _____ %	_____

Clinic Use Only

Median Relative Bias _____ . _____ % **Inter-quartile Range** _____ . _____ %

The Median Relative Bias is the third largest value of the 5 measures of relative bias.

The Inter-quartile Range is determined by subtracting the relative bias of rank 2 from the relative bias of rank 4.

When a subject receives a new AM1[®] or turbine for the first time, the median relative bias must be between -15% and +15%, AND the inter-quartile range must be less than 10%.

When a subject returns to the clinic with a used AM1[®]: (i) subtract the original median relative bias (the median relative bias when the AM1[®] or turbine was first dispensed) from the current median relative bias, and (ii) subtract the original inter-quartile range (the inter-quartile range when the AM1[®] or turbine was first dispensed) from the current inter-quartile range. The difference for (i) must be between -5% and +5% and the difference for (ii) must be less than +5% for the AM1[®] to be reissued to the subject.

10. Did the AM1[®] pass? ₁ Yes ₀ No (1160)
11. If **NO**, is this the second test with this turbine at this visit? ₁ Yes ₀ No (1170)
 ➔ If **NO**, retest the AM1[®] with the same turbine and complete another AM1[®] Quality Control form.
 ➔ If **YES**, issue a new turbine and complete another AM1[®] Quality Control form. If 2 turbines have been tested with this device, issue a new device and turbine and complete another AM1[®] Quality Control form.



**ASTHMA
CHARACTERIZATION
QUESTIONNAIRE**

Subject ID: _____ - _____ - _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: _____ / _____ / _____
Month Day Year
 Coordinator ID: _____

(Subject Interview completed)

ASTHMA HISTORY

1. Approximately how old were you when chest symptoms suggesting asthma first appeared? _____ years (1000)
(Enter '00' if subject was under 1 year.)
- 1a. Did these symptoms appear immediately after or as a result of a respiratory infection such as a cold or pneumonia? ₁ Yes ₀ No ₈ Don't Recall (1010)
2. How old were you when a doctor first diagnosed you with asthma? _____ years (1020)
- 2a. What caused you to seek medical care? ₁ Acute Symptoms
₂ Chronic Symptoms
₃ Other _____ (1030)
3. Have any of your immediate blood relatives been told by a physician that they have asthma?
(Check the 'N/A' box if the subject does not have biological siblings or children.)
- 3a. Mother ₁ Yes ₀ No ₈ Don't Know (1040)
- 3b. Father ₁ Yes ₀ No ₈ Don't Know (1050)
- 3c. Brother(s) or Sister(s) ₁ Yes ₀ No ₈ Don't Know ₉ N/A (1060)
- 3d. Child(ren) ₁ Yes ₀ No ₈ Don't Know ₉ N/A (1070)

ASTHMA SYMPTOMS

4. On average, over the last 4 weeks, how often have you experienced each of the following asthma symptoms:
- 4a. Cough (deep chest) ₀ Never
₁ Less than or equal to twice a week
₂ More than twice a week but not daily
₃ Daily
₄ Continuously (1080)
- 4b. Sputum (phlegm or mucous from the lungs) ₀ Never
₁ Less than or equal to twice a week
₂ More than twice a week but not daily
₃ Daily
₄ Continuously (1090)



**ASTHMA
CHARACTERIZATION
QUESTIONNAIRE**

Subject ID: _____ - _____ - _____

Visit Number: _____

- 4c. Chest tightness (difficulty taking a deep breath, pressure in the chest)
- ₀ Never
₁ Less than or equal to twice a week
₂ More than twice a week but not daily
₃ Daily
₄ Continuously (1100)
- 4d. Wheezing (whistling or musical sound in the chest)
- ₀ Never
₁ Less than or equal to twice a week
₂ More than twice a week but not daily
₃ Daily
₄ Continuously (1110)
- 4e. Shortness of breath
- ₀ Never
₁ Less than or equal to twice a week
₂ More than twice a week but not daily
₃ Daily
₄ Continuously (1120)
- 4f. Nighttime symptoms (waking due to asthma)
- ₀ Never
₁ One or two nights a month
₂ More than two nights per month but at most one night a week
₃ More than one night a week but not frequently
₄ Frequently (1130)
5. How often do you use your rescue beta-agonist medicine (e.g., Albuterol (Proventil, Ventolin)) other than to pretreat prior to exercise?
- ₀ Less than or equal to twice a week
₁ Greater than twice a week but not daily
₂ Daily but not four times a day
₃ Greater than or equal to four times a day (1140)
6. How do you categorize your asthma symptoms throughout the course of the year?
- ₁ Relatively the same all year
₂ Vary by season(s) (1150)
- If 'Vary by season(s)', do your asthma symptoms worsen during the...
- 6ai. Winter? ₁ Yes ₀ No (1160)
- 6aii. Spring? ₁ Yes ₀ No (1170)
- 6aiii. Summer? ₁ Yes ₀ No (1180)
- 6aiv. Fall? ₁ Yes ₀ No (1190)



ASTHMA CHARACTERIZATION QUESTIONNAIRE

Subject ID: _____ - _____ - _____

Visit Number: _____

7. In the last 12 months, how many... (Enter '00' if none)
- 7a. Asthma episodes have you had that required emergency care or an unscheduled office visit? _____ (1200)
- 7b. Hospitalizations have you had due to asthma? _____ (1210)
- 7c. Courses of oral corticosteroid therapy (e.g., Prednisone) for asthma have you taken? _____ (1220)
- 7d. Days of work, school or housework have you missed due to asthma? _____ days (1230)
- If Question #7d > 0, complete Question #7di.
- 7di. In the past 3 months, how many days of work, school, or housework have you missed due to asthma? _____ days (1240)

ASTHMA TRIGGERS

8. Do any of the following currently provoke your asthma?
- 8a. Exercise/Sports ₁ Yes ₀ No ₈ Don't Know (1250)
- 8b. Menstrual cycle (If subject is male or postmenopausal, check N/A) ₁ Yes ₀ No ₈ Don't Know ₉ N/A (1260)
- 8c. Aspirin or non-steroidal anti-inflammatory drugs (e.g., Aleve, Motrin) ₁ Yes ₀ No ₈ Don't Know (1270)
- 8d. Colds, upper respiratory infections, sinus infections ₁ Yes ₀ No ₈ Don't Know (1280)
- 8e. Irritants (e.g., smoke, pollution, odors, perfumes, chemicals) ₁ Yes ₀ No ₈ Don't Know (1290)
- 8f. Weather conditions (e.g., cold, humidity) ₁ Yes ₀ No ₈ Don't Know (1300)
- 8g. Emotional stress ₁ Yes ₀ No ₈ Don't Know (1310)
- 8h. Food additives/preservatives (e.g., MSG, etc.) ₁ Yes ₀ No ₈ Don't Know (1320)
- 8i. Other (please specify) _____ ₁ Yes ₀ No (1330)



ASTHMA CHARACTERIZATION QUESTIONNAIRE

Subject ID: _____ - _____ - _____

Visit Number: _____

ALLERGIES

9. Do you have allergies to pets, pollen, dust, etc.? ₁ Yes ₀ No ₈ Don't Know (1340)

If **YES**,

9a. Do your allergies provoke your asthma? ₁ Yes ₀ No ₈ Don't Know (1350)

9b. Were your allergies diagnosed by a doctor? ₁ Yes ₀ No (1360)

9c. How do you categorize your allergies?
₁ Relatively the same all year
₂ Vary by season(s) (1370)

→ If 'Vary by season(s)', do your allergies worsen during the...

9ci. Winter? ₁ Yes ₀ No (1380)

9cii. Spring? ₁ Yes ₀ No (1390)

9ciii. Summer? ₁ Yes ₀ No (1400)

9ciii. Fall? ₁ Yes ₀ No (1410)

10. Have you ever had eczema (i.e., prolonged itchy, scaly, weepy skin rash)? ₁ Yes ₀ No ₈ Don't Know (1420)

10a. If **YES**, was your eczema diagnosed by a doctor? ₁ Yes ₀ No (1430)

11. Have any of your immediate blood relatives been told by a physician that they have allergies/eczema/hay fever?
(Check the 'N/A' box if the subject does not have biological siblings or children.)

11a. Mother ₁ Yes ₀ No ₈ Don't Know (1440)

11b. Father ₁ Yes ₀ No ₈ Don't Know (1450)

11c. Brother(s) or Sister(s) ₁ Yes ₀ No ₈ Don't Know ₉ N/A (1460)

11d. Child(ren) ₁ Yes ₀ No ₈ Don't Know ₉ N/A (1470)

SMOKING HISTORY

12. Were you ever a smoker? ₁ Yes ₀ No (1472)

12a. If **YES**, how many years did you smoke?
 (total number of years) _____ years (1474)

13. Did you grow up in a household where you were exposed to tobacco smoke? ₁ Yes ₀ No (1480)

14. In an average week, approximately how many hours are you exposed to other people's tobacco smoke in all environments?
 _____ hours (1490)

Subject Source Documentation

Subject's Initials: _____ (1500)

Date: ____ / ____ / _____ (1510)



**CONCOMITANT
MEDICATIONS FOR
ASTHMA/ALLERGY AND
ADVERSE EVENTS**

Subject ID: _____ - _____ - _____
Subject Initials: _____
Visit Number: _____

(Coordinator completed)

Instructions: Since signing the informed consent or last study visit, list all prescription and over-the-counter (OTC) concomitant medications used to treat asthma/allergy symptoms and adverse events. Do not list routine use of study drugs or rescue medications. Check the “None” box if the subject has not started taking any medications since signing the informed consent or last study visit. If the medication is not related to an adverse or laboratory event, leave the event number missing and check the “N/A” box. If the subject is still taking the medication at the end of the current visit, check the “ongoing at current visit” check box and leave the stop date missing. All ongoing medications should be reviewed at subsequent visits to document the stop date of a medication. At the last study visit or an early termination visit, review all ongoing medication and indicate a stop date or check the “ongoing at final visit” check box on the data collection form and update the medication data in the ACRN data entry application.

At the final study visit or early termination visit, forward all concomitant medications for asthma/allergy-related medications and adverse events forms to the DCC.

None

NAME OF MEDICATION (1000)	CODE (1010)	RELATED EVENT (1020)	DOSE (1030)	UNITS (1040)	FREQUENCY (1050)	ROUTE	START DATE (MM/DD/YYYY) (1060)	STOP DATE (MM/DD/YYYY) (1070)	ONGOING AT CURRENT VISIT (1080)	ONGOING AT FINAL VISIT (1090)
___		Event ___ <input type="checkbox"/> NA					___/___/___	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
___		Event ___ <input type="checkbox"/> NA					___/___/___	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
___		Event ___ <input type="checkbox"/> NA					___/___/___	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
___		Event ___ <input type="checkbox"/> NA					___/___/___	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
___		Event ___ <input type="checkbox"/> NA					___/___/___	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
___		Event ___ <input type="checkbox"/> NA					___/___/___	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>



UNITS and FREQUENCY CODES FOR CONCOMITANT MEDICATIONS

Codes for Units	
Code	Units
1	mg
2	mcg (μ g)
3	ml
4	mg/ml
5	mEq
6	g
7	U
8	teaspoon
9	patch
10	puffs (oral inhalation)
11	nasal spray
12	no units
13	packet
14	1 drop
15	mm
16	other

Codes for Frequency		
Code	Frequency	
1	QD	1 time a day
2	BID	2 times a day
3	TID	3 times a day
4	QID	4 times a day
5	q4h	every 4 hours
6	q5h	every 5 hours
7	q6h	every 6 hours
8	q8h	every 8 hours
9	q12h	every 12 hours
10	q24h	every 24 hours
11	hs	every night at bedtime
12	PRN	as required
13	qod	every other day
14	qw	once a week
15	biw	2 times per week
16	tiw	3 times per week
17	5 times per week	
18	every 5 days	
19	once a month	
20	taper dose	
21	other	



**EXHALED BREATH
CONDENSATE
COLLECTION**

Supervisor ID: _____

Subject ID: _____ - _____ - _____

Subject Initials: _____

Visit Number: _____

Visit Date: _____ / _____ / _____
Month Day Year

Technician ID: _____

(Technician Completed)

1. Has the subject had anything other than water to drink or eat in the past hour?

₁ Yes ₀ No (1000)

→ If YES, STOP HERE. Subject is ineligible to continue with ebc collection. If possible, wait until the full hour has passed, then proceed with collection.

2. Was ebc collection attempted at this visit?

₁ Yes ₀ No (1010)

→ If NO, complete Question #2a and STOP.

→ If YES, proceed to Question #3

2a. Check the primary reason ebc collection was not attempted.

- ₁ Subject Refusal
₂ Equipment Unavailable
₃ Clinic Oversight
₄ Other _____ (1020)

3. Time ebc collection started (based on 24-hour clock).

_____ (1030)

4. Time ebc collection stopped (based on 24-hour clock).

_____ (1040)

→ If collection time exceeds ten minutes, please provide an explanation below.

5. Did the subject experience any of the following during the collection process...

5a. Sneezing?

₁ Yes ₀ No (1050)

5b. Coughing?

₁ Yes ₀ No (1060)

5c. Burping?

₁ Yes ₀ No (1070)



EXHALED BREATH
CONDENSATE

Subject ID: _____ - _____ - _____

Visit Number: _____

6. Were six eppendorf tubes aliquoted at this visit? ₁ Yes ₀ No (1080)

If YES, proceed to Question #7.

6a. Which of the following explain why six tubes were not collected?

Equipment Malfunction ₁ Yes ₀ No (1090)
If YES, explain _____

Low Yield ₁ Yes ₀ No (1100)

Subject could not tolerate procedure ₁ Yes ₀ No (1110)

Other ₁ Yes ₀ No (1120)
If YES, explain _____

6b. Record the number of tubes aliquoted. _____ tubes (1130)

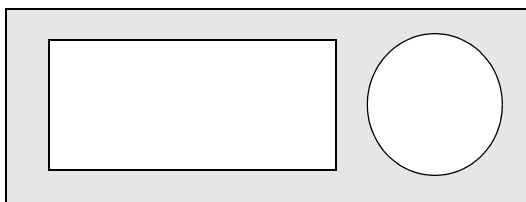
→ If '0', STOP HERE.

7. Was nitrogen gas layered on the tubes before closing them? ₁ Yes ₀ No (1150)

8. Were the tubes stored immediately at -70° Celsius or colder? ₁ Yes ₀ No (1160)

8a. If **NO**, at what temperature were the tubes stored? _____ ° C (1170)

9. Attach one barcode label/dot pair from the subject's visit-specific strip here. Write the barcode number from the label in the spaces provided.



_____ (1180)

Comments: _____



**EXHALED
NITRIC OXIDE**

Supervisor ID: _____

Subject ID: _____ - _____ - _____

Subject Initials: _____

Visit Number: _____

Visit Date: _____ / _____ / _____
Month Day Year

Technician ID: _____

(Technician completed)

Complete this form only if the subject is eligible according to the appropriate Pulmonary Procedures Checklist (PULMONARYCHK) form.

1. Was the exhaled nitric oxide (ENO) procedure performed?

₁ Yes

₀ No (1000)

→ If NO, complete Question #1a and STOP.

→ If YES, proceed to Question #1b.

1a. What was the reason the ENO procedure could not be performed?

₁ Equipment failure, please specify

₂ Equipment not calibrated

₃ Subject refusal

₄ Clinic oversight

₅ Other _____ (1010)

1b. Was the exhaled nitric oxide (ENO) procedure performed on the NIOX Mino?

₁ Yes

₀ No (1015)

→ If YES, do not complete Question #11 on the next page since only 1 acceptable maneuver was obtained.



For each maneuver, record the time and FE_{NO} value. If the maneuver was not accepted by the NIOX machine, record the time and select the 'Maneuver Not Acceptable' check box.

For a procedure done on the ACRN NIOX Machine, when TWO reproducible measurements are achieved, select the 'Reproducible Measurements' check box for both maneuvers. The two measurements are considered reproducible when they are within 5% of their mean or 1.25 ppb of their mean.

		Time (based on 24 - hour clock)	Measured FE_{NO}	Maneuver Not Acceptable	Clinic Use Only Reproducible Measurements
2.	Maneuver #1	_____ (1020)	_____. ____ ppb (1030)	<input type="checkbox"/> 1 (1050)	<input type="checkbox"/>
3.	Maneuver #2	_____ (1060)	_____. ____ ppb (1070)	<input type="checkbox"/> 1 (1090)	<input type="checkbox"/>
4.	Maneuver #3	_____ (1100)	_____. ____ ppb (1110)	<input type="checkbox"/> 1 (1130)	<input type="checkbox"/>
5.	Maneuver #4	_____ (1140)	_____. ____ ppb (1150)	<input type="checkbox"/> 1 (1170)	<input type="checkbox"/>
6.	Maneuver #5	_____ (1180)	_____. ____ ppb (1190)	<input type="checkbox"/> 1 (1210)	<input type="checkbox"/>
7.	Maneuver #6	_____ (1220)	_____. ____ ppb (1230)	<input type="checkbox"/> 1 (1250)	<input type="checkbox"/>
8.	Maneuver #7	_____ (1260)	_____. ____ ppb (1270)	<input type="checkbox"/> 1 (1290)	<input type="checkbox"/>
9.	Maneuver #8	_____ (1300)	_____. ____ ppb (1310)	<input type="checkbox"/> 1 (1330)	<input type="checkbox"/>
10.	Maneuver #9	_____ (1340)	_____. ____ ppb (1350)	<input type="checkbox"/> 1 (1370)	<input type="checkbox"/>

11. Did the subject achieve two reproducible outcomes? 1 Yes 0 No (1380)
 If **NO**, explain _____



**METHACHOLINE
CHALLENGE
TESTING**

Supervisor ID: _____

Subject ID: _____ - _____ - _____

Subject Initials: _____

Visit Number: _____

Visit Date: _____ / _____ / _____
Month Day Year

Technician ID: _____

(Technician completed)

Complete this form only if the subject is eligible according to the Methacholine Challenge Testing Checklist (METHACHK) form.

Clinic Use Only (Technician completed)

Use the FEV₁ value from the appropriate spirometry testing form as the baseline reference.

- A. Baseline FEV₁ prior to methacholine challenge ____ . ____ ____ L
- B. Methacholine Reversal Reference Value (Question A x 0.90 = ____ . ____ ____ L)
- C. Diluent FEV₁ Reference Value (Question 1000 x 0.8049 = ____ . ____ ____ L)

1. Post Diluent FEV₁ ____ . ____ ____ L (1000)
2. Did the subject drop \geq 20% at the diluent stage? ₁ Yes ₀ No (1010)
 → If **YES**, proceed to Question #5 and record 0 for Question #5a.
3. Last concentration of methacholine administered ____ . ____ ____ mg/ml (1020)
4. FEV₁ after last concentration of methacholine administered ____ . ____ ____ L (1030)
5. Did the subject achieve a PC₂₀? ₁ Yes ₀ No (1040)
 → If **NO**, proceed to Question #6.
- 5a. PC₂₀ ____ . ____ ____ mg/ml (1050)
6. Time methacholine challenge ended (based on 24-hour clock) ____ (1060)
7. Subject's FEV₁ after standard reversal from methacholine challenge
If subject is continuing with sputum induction, standard reversal = 4 puffs albuterol.
If subject is not continuing with sputum induction, standard reversal = 2 puffs albuterol.
- 7a. FEV₁ ____ . ____ ____ L (1070)
- 7b. Time of FEV₁ in Question #7a (based on 24-hour clock) ____ (1090)
- 7c. Was the FEV₁ from Question #7a \geq the methacholine reversal reference value (B) in the gray box above? ₁ Yes ₀ No (1100)
 → If **YES**, **STOP HERE** and continue with remaining visit procedures.
 → If **NO**, proceed to the Additional Treatment for Methacholine Challenge Testing (METHA_ADD_TRT) form.



**ADDITIONAL TREATMENT
POST METHACHOLINE
CHALLENGE TESTING**

Supervisor ID: _____

Subject ID: _____ - _____ - _____

Subject Initials: _____

Visit Number: _____

Visit Date: _____ / _____ / _____
Month Day Year

Technician ID: _____

(Technician completed)

Complete this form only if the subject did not reverse to 90% of baseline FEV₁ after the first post-challenge treatment of albuterol.

1. Was an additional treatment used in the first hour? ₁ Yes ₀ No (1000)
→ If NO, skip to Question #3.
 - 1a. Additional albuterol by MDI ₁ Yes ₀ No (1010)
→ If NO, skip to Question #1b.
 Number of additional puffs of albuterol administered ₁ two ₂ four ₃ > four (1020)
 - 1b. Nebulized Beta-agonist ₁ Yes ₀ No (1030)
 - 1c. Subcutaneous epinephrine ₁ Yes ₀ No (1040)
 - 1d. Implementation of clinic emergency protocol or algorithm ₁ Yes ₀ No (1050)
 - 1e. Other (specify) _____ ₁ Yes ₀ No (1060)

2. Subject's FEV₁ after additional treatment within first hour.
 - 2a. FEV₁ _____ . _____ L (1070)
 - 2b. FEV₁ (% predicted) _____ % predicted (1080)
 - 2c. Time of FEV₁ in Question #2a (based on 24-hour clock) _____ (1090)
 - 2d. Was the FEV₁ from Question #2a ≥ the methacholine reversal reference value (B) in the gray box on the Methacholine Challenge Testing (METHA) form? ₁ Yes ₀ No (1100)
→ If YES, STOP HERE and continue with remaining visit procedures.
→ If NO, proceed to Question #3.



**ADDITIONAL TREATMENT
POST METHACHOLINE**

Subject ID: _____ - _____ - _____

Visit Number: _____

3. Was additional treatment used after one hour? ₁ Yes ₀ No (1110)
→ *If NO, skip to Question #4.*
- 3a. Additional albuterol by MDI ₁ Yes ₀ No (1120)
→ *If NO, skip to Question #3b.*
Number of additional puffs of albuterol administered ₁ two ₂ four ₃ > four (1130)
- 3b. Nebulized Beta-agonist ₁ Yes ₀ No (1140)
- 3c. Subcutaneous epinephrine ₁ Yes ₀ No (1150)
- 3d. Implementation of clinic emergency protocol or algorithm ₁ Yes ₀ No (1160)
- 3e. Treatment in the emergency room ₁ Yes ₀ No (1170)
- 3f. Overnight hospitalization ₁ Yes ₀ No (1180)
→ *If YES, please complete the Serious Adverse Event (SERIOUS) form.*
- 3g. Other (*specify*) _____ ₁ Yes ₀ No (1190)
4. Subject's final FEV₁ after methacholine challenge.
- 4a. FEV₁ _____ . _____ L (1200)
- 4b. FEV₁ (% predicted) _____ % predicted (1210)
- 4c. Time of FEV₁ from Question #4a (*based on 24-hour clock*) _____ (1220)
- 4d. Was the FEV₁ from Question #4a ≥ the methacholine reversal reference value (B) in the gray box on the Methacholine Challenge Testing (METHA) form? ₁ Yes ₀ No (1230)
→ *If NO, complete the source documentation box below.*

Physician Source Documentation
Physician's signature: _____ (1240)
Date: ____ / ____ / _____ (1250)
Time: _____ (<i>based on 24-hour clock</i>) (1260)



**METHACHOLINE
CHALLENGE
TESTING CHECKLIST**

Supervisor ID: _____

Subject ID: _____ - _____ - _____

Subject Initials: _____

Visit Number: _____

Visit Date: _____ / _____ / _____
Month Day Year

Technician ID: _____

(Technician completed)

Complete this form only if the subject is eligible according to the appropriate Pulmonary Procedure Checklist form and successfully completed baseline spirometry session(s).

1. Has the subject had any severe acute illness in the past 4 weeks? ₁ Yes ₀ No (1000)
- If **YES**, has the subject received permission from the supervising physician to proceed with the methacholine challenge testing?
Physician's Signature: _____ (1015) ₁ Yes ₀ No (1010)
2. Does the subject have a baseline (pre-diluent) FEV₁ less than 55% of predicted?
Use the FEV₁ value from the appropriate spirometry testing form as the baseline reference. ₁ Yes ₀ No (1020)
3. Does the subject have a history of urinary retention? ₁ Yes ₀ No (1030)
- ➔ If **NO**, proceed to Question #4.
- 3a. If **YES**, is the subject randomized? ₁ Yes ₀ No (1040)
- ➔ If **NO**, proceed to Question #4 and complete the appropriate Termination of Study Participation form.
- 3b. Was written medical clearance obtained from the study physician? ₁ Yes ₀ No (1050)
- If **YES**, obtain physician's signature:
_____ (1055)
4. Is there any other reason the subject should not proceed with the methacholine challenge testing? ₁ Yes ₀ No (1060)
- If **YES**, explain _____

5. Is the subject eligible to proceed with the diluent (solution #0) spirometry testing for the methacholine challenge? ₁ Yes ₀ No (1070)
- If any of the shaded boxes are completed, the subject is NOT eligible for the methacholine challenge.**
- ➔ **If YES, proceed to the Methacholine Challenge Testing (METHA) form.**



BASALT/TALC RUNIN
ALLOCATION
CHECKLIST

Subject ID: 1 6 - _____ - _____
Subject Initials: _____
Visit Number: 3
Visit Date: _____ / _____ / _____
Month Day Year
Coordinator ID: _____

(Clinic Coordinator completed)

1. Since Visit 1, has the subject experienced a significant asthma exacerbation as defined in the protocol? ₁ Yes ₀ No (1000)
2. Since Visit 1, has the subject received treatment with any excluded medications (P16_EXCLDRUG)? ₁ Yes ₀ No (1010)
3. Using the history stored in the DOSER™, did the subject take at least 75% of the required puffs from his or her QVAR inhaler during the interval between Visits 2 and 3?
→ Use Question #3 from P16_COMPLY to answer this question ₁ Yes ₀ No (1020)
4. Using the history stored in the DOSER™, did the subject take 4 puffs per day (correct daily dose) on at least 75% of the days during the interval between Visits 2 and 3?
→ Use Question #6 from P16_COMPLY to answer this question ₁ Yes ₀ No (1030)
5. Did the subject record both AM and PM peak flow measurements and symptoms on his or her Diary Cards (P16_DIARY) on at least 75% of the days during the interval between Visits 2 and 3? ₁ Yes ₀ No (1040)
6. Did the subject measure his or her AM and PM peak flow on schedule and accurately transcribe the measurements on his or her Diary Cards (P16_DIARY) on at least 75% of the days during the interval between Visits 2 and 3? ₁ Yes ₀ No (1050)
7. Is the subject's prebronchodilator FEV₁ > 40% of predicted? ₁ Yes ₀ No (1060)
8. Does the subject wish to withdraw consent from the study? ₁ Yes ₀ No (1070)
9. Is there any new information that makes the subject ineligible according to the eligibility criteria?
If **YES**, describe: _____ ₁ Yes ₀ No (1080)
10. Is there any other reason why this subject should not be allocated to the BASALT or TALC study?
If **YES**, describe: _____ ₁ Yes ₀ No (1090)



ALLOCATION CHECKLIST

Subject ID: 1_6 - _____ - _____Visit Number: 3

11. Is the subject eligible for allocation? ₁ Yes ₀ No (1100)
If any of the shaded boxes is completed, the subject is ineligible.

- ➔ *If YES, continue with rest of form.*
- ➔ *If NO, complete the BASALT/TALC RUNIN Termination of Study Participation (P16_TERM) form.*

12. Is the subject's prebronchodilator FEV₁ > 70% of predicted? ₁ Yes ₀ No (1110)
➔ If **NO**, skip to Question # 14.

13. Did the subject answer 0 or 1 for each of the three questions on the ACRN Asthma Evaluation Questionnaire (AEQ) at this visit? ₁ Yes ₀ No (1120)
➔ If **YES**, skip to Question # 15. Subject should be allocated to the BASALT study.

14. Does the subject have any medical contraindications for tiotropium use (i.e., narrow angle glaucoma, prostatic hypertrophy, bladder-neck obstruction, renal insufficiency)? ₁ Yes ₀ No (1130)
➔ If **YES**, subject is ineligible to continue in the BASALT/TALC studies. Complete a BASALT/TALC RUNIN Termination of Study Participation (P16_TERM) form.
➔ If **NO**, subject should be allocated to the TALC study.

15. Indicate the study into which the subject is enrolling. ₁₇ BASALT
₁₈ TALC (1140)

16. Record the date on which the subject originally signed the informed consent document for the study to which he or she has been allocated. _____ / _____ / _____ (1150)
Month Day Year

After study allocation, complete the following procedures:

- ➔ *Record study to which the subject was allocated (P16_LOG).*
- ➔ *Enroll subject in appropriate protocol.*



BASALT/TALC RUNIN
COMPLIANCE
CHECKLIST

Subject ID: 1 6 - -
Subject Initials:
Visit Number:
Visit Date: / /
 Month Day Year
Coordinator ID: - -

(Clinic Coordinator completed)

Check the following compliance criteria at Visits 2 and 3.

DOSER™ Compliance for QVAR MDI

1. Total number of scheduled puffs since the last visit ___ ___ ___ puffs (1000)
 ➔ Value obtained from Question #1 on P16_COMPLY_WKS

2. Total number of puffs in DOSER™ history ___ ___ ___ puffs (1010)
 ➔ Value obtained from Question #2 on P16_COMPLY_WKS

3. Percent compliance = $\frac{\text{Question \#2}}{\text{Question \#1}} \times 100$ ___ ___ . ___ % (1020)
 ➔ ***If the subject took less than 75% of the scheduled QVAR puffs, re-emphasize the importance of maintaining the daily dosing schedule.***

4. Total number of full days since the last visit ___ ___ (1030)
 ➔ Value obtained from Question #4 on P16_COMPLY_WKS

5. Total number of compliant days ___ ___ (1040)
 ➔ Value obtained from Question #5 on P16_COMPLY_WKS

6. Percent compliance = $\frac{\text{Question \#5}}{\text{Question \#4}} \times 100$ ___ ___ . ___ % (1050)
 ➔ ***If the subject took the correct daily dose less than 75% of the days, re-emphasize the importance of maintaining the daily dosing schedule.***



**BASALT/TALC
RUNIN DIARY CARD**

Subject ID: 1 6 - _____ - _____
 Subject Initials: _____
 Return Visit Number: _____
 Return Visit Date: _____ / _____ / _____
 Month Day Year

Subject's Initials: _____
 Date: ____ / ____ / _____

To the subject: If your peak flow is below _____ (1000) liters/minute, use your RESCUE albuterol inhaler as instructed in the handout "If Your Asthma Gets Worse." Contact study personnel if your peak flow does not increase to this value after 1 hour of RESCUE use, or if you are experiencing extreme symptoms. If you have taken at least 10 puffs/24 hours for the past 48 hours from your RESCUE inhaler, contact study personnel.

Please use black ink to complete.	Day 1: ____	Day 2: ____	Day 3: ____	Day 4: ____	Day 5: ____	Day 6: ____	Day 7: ____
Date (ddate)	____ / ____ month day	____ / ____ month day	____ / ____ month day	____ / ____ month day	____ / ____ month day	____ / ____ month day	____ / ____ month day

MORNING EVALUATION (Between 5 AM and 10 AM)

1. Number of times you woke up last night due to asthma (1010)	____	____	____	____	____	____	____
2. Time of AM Peak Flow (within 15 minutes of awakening) (1020)	____ : ____	____ : ____	____ : ____	____ : ____	____ : ____	____ : ____	____ : ____
3. AM Peak Flow (liters/min)** (1030) / (1035)	____	____	____	____	____	____	____
4. Total number of puff(s) from QVAR Inhaler (AM) (1040)	____	____	____	____	____	____	____
Symptoms⁺⁺ during the night	5. Shortness of Breath (1050)	____	____	____	____	____	____
	6. Chest Tightness (1060)	____	____	____	____	____	____
	7. Wheezing (1070)	____	____	____	____	____	____
	8. Cough (1080)	____	____	____	____	____	____
	9. Phlegm/Mucus (1090)	____	____	____	____	____	____

NIGHT-TIME EVALUATION (Between 8 PM and 1 AM)

10. Time of PM Peak Flow (between 8 PM and 1 AM) (1100)	____ : ____	____ : ____	____ : ____	____ : ____	____ : ____	____ : ____	____ : ____
11. PM Peak Flow (liters/min)** (1110) / (1115)	____	____	____	____	____	____	____
12. Total number of puff(s) from QVAR Inhaler (PM) (1120)	____	____	____	____	____	____	____
Symptoms⁺⁺ since you woke	13. Shortness of Breath (1130)	____	____	____	____	____	____
	14. Chest Tightness (1140)	____	____	____	____	____	____
	15. Wheezing (1150)	____	____	____	____	____	____
	16. Cough (1160)	____	____	____	____	____	____
	17. Phlegm/Mucus (1170)	____	____	____	____	____	____

24 HOUR EVALUATION

18. Total number of puffs from albuterol (RESCUE) inhaler during past 24 hours. (Do not record preventive use.) (1180)	____	____	____	____	____	____	____
19. Total number of times you dosed from your albuterol (RESCUE) inhaler during past 24 hours. (Do not record preventive use.) (1190)	____	____	____	____	____	____	____

** Record the best of three attempts. Circle the value if you have taken any medication from your RESCUE albuterol inhaler in the last 2 hours.

0 = Absent No symptom
 1 = Mild Symptom was minimally troublesome, i.e. not sufficient to interfere with normal daily activity or sleep.
 2 = Moderate Symptom was sufficiently troublesome to interfere with normal daily activity or sleep.
 3 = Severe Symptom was so severe as to prevent normal activity and/or sleep.

++ Symptom Severity Rating Scale



**BASALT/TALC RUNIN
ELECTROCARDIOGRAM
REPORT**

Subject ID: 1 6 - _____ - _____
 Subject Initials: _____
 Visit Number: 3
 Visit Date: _____ / _____ / _____
Month Day Year
 Coordinator ID: _____

(Clinic Coordinator completed)

The subject should rest quietly for at least five minutes before the electrocardiogram.

- | | | |
|---|-------|---------------------|
| 1. Time electrocardiogram started <i>(based on 24-hour clock)</i> | _____ | (1000) |
| 2. Ventricular heart rate | _____ | beats/min (1010) |
| 3. Cardiac cycle measurements | | |
| 3a. P - R Interval | _____ | milliseconds (1020) |
| 3b. QRS Duration | _____ | milliseconds (1030) |
| 3c. Q - T Interval | _____ | milliseconds (1040) |

Physician Source Documentation	
Physician's signature: _____	(1050)
Date: ___ / ___ / _____	(1060)



**BASALT/TALC RUNIN
ELIGIBILITY
CHECKLIST 1**

Subject ID: 1 6 - ____ - ____
Subject Initials: ____
Visit Number: 1
Visit Date: ____ / ____ / ____
 Month Day Year
Interviewer ID: ____

(Subject Interview completed)

1. **Did the subject sign either (or both) of the BASALT/TALC Informed Consent(s)?**

₁ Yes ₀ No (1000)

If **YES**, record the date the form(s) was (were) signed.

____ / ____ / ____ (1010)
 month day year

→ **Consent should be reviewed and signed on the day Visit 1 is performed.**

2. Are you planning to move away from this clinical center in the upcoming year such that your ability to complete the study will be jeopardized?

₁ Yes ₀ No (1020)

3. Have you had a respiratory tract infection in the past **4 weeks**?

₁ Yes ₀ No (1030)

4. Have you experienced a significant asthma attack in the past **4 weeks**?

₁ Yes ₀ No (1040)

5. Do you work the night shift or have an altered day/night cycle for other reasons?

₁ Yes ₀ No (1050)

6. Is the subject eligible to proceed?

₁ Yes ₀ No (1060)

If any of the shaded boxes are completed, the subject is ineligible.

→ *If YES, proceed with remaining Visit 1 procedures.*

Subject Source Documentation

Subject Initials: ____ (1070)

Date: ____ / ____ / ____ (1080)



**BASALT/TALC RUNIN
ELIGIBILITY
CHECKLIST 2**

Subject ID: 1 6 - ____ - ____
 Subject Initials: ____
 Visit Number: 1
 Visit Date: ____/____/____
Month Day Year
 Coordinator ID: _____

(Clinic Coordinator completed)

1. Is the subject 18 years of age or older? ₁ Yes ₀ No (1000)
2. Does the subject have current evidence of any of the conditions listed on the Exclusionary Medical Conditions (P16_EXCLMED) reference card?
 If **YES**, describe _____
₁ Yes ₀ No (1010)
- 2a. Does the subject have unstable or severe coronary artery disease or a history of myocardial infarction within 6 months of Visit 1?
₁ Yes ₀ No (1020)
3. Has the subject taken any medications listed on the Exclusionary Drugs (P16_EXCLDRUG) reference card within the specified time periods?
 If **YES**, describe _____
₁ Yes ₀ No (1030)
4. Is the subject currently taking prescription or over-the-counter medication(s) other than those listed on the Allowed Medications (P16_MEDALLOW) reference card?
 If **YES**, describe _____
₁ Yes ₀ No (1040)
5. Based on input from the subject and the study physician, will the subject need to use intranasal steroids at any time during the study?
₁ Yes ₀ No (1050)
- 5a. If **YES**, is the subject willing to use a single intranasal steroid at a stable dose continuously for the duration of the study?
₁ Yes ₀ No (1060)
6. Is the subject regularly using inhaled corticosteroids?
₁ Yes ₀ No (1070)
 → If **NO**, skip to Question #7 and complete rest of form.
 → If **YES**, answer Questions #6a and 6b, then skip to Question #8.
- 6a. Has the subject been on a stable dose of inhaled corticosteroids for at least **2 weeks**?
₁ Yes ₀ No (1080)
- 6b. Has the subject been using greater than the equivalent of 1000 µg inhaled fluticasone daily?
₁ Yes ₀ No (1090)
 → Refer to the ICS Equivalency (P16_ICS_EQUIV) reference card.



ELIGIBILITY CHECKLIST 2

Subject ID: 1 6 - ____ - ____
Visit Number: 1

- | | | | | |
|---|--|-----|--|-----------|
| 7. Has the subject used or received a prescription for an asthma controller (inhaled corticosteroids, leukotriene modifier, and/or long-acting beta-agonist) during the past year? | <input type="checkbox"/> ₁ | Yes | <input type="checkbox"/> ₀ | No (1100) |
| 7a. If NO , does the subject report experiencing asthma symptoms more than twice a week? | <input type="checkbox"/> ₁ | Yes | <input checked="" type="checkbox"/> ₀ | No (1110) |
| 8. Is the subject currently receiving hyposensitization therapy (e.g., allergy shots) other than an established maintenance regimen implemented continuously for a minimum of 3 months ? | <input checked="" type="checkbox"/> ₁ | Yes | <input type="checkbox"/> ₀ | No (1120) |
| 9. Has the subject experienced a life-threatening asthma exacerbation requiring treatment with intubation and mechanical ventilation in the past 5 years ? | <input checked="" type="checkbox"/> ₁ | Yes | <input type="checkbox"/> ₀ | No (1130) |
| 10. Has the subject smoked cigarettes, a pipe, cigar, marijuana, or any other substance in the past year? | <input checked="" type="checkbox"/> ₁ | Yes | <input type="checkbox"/> ₀ | No (1140) |
| 11. Record smoking history in pack-years. (Enter 00.0 if subject never smoked.) | ____ . ____ (1150) | | | |
| Is Question #11 \geq 10? | <input checked="" type="checkbox"/> ₁ | Yes | <input type="checkbox"/> ₀ | No (1160) |
| 12. Is the subject potentially able to bear children?
<i>(If subject is male, check N/A and go to Question #13.)</i> | <input type="checkbox"/> ₁ | Yes | <input type="checkbox"/> ₀ | No |
| 12a. If YES , is the subject using one of the approved methods indicated on the Birth Control (BIRCTRL) reference card? | <input type="checkbox"/> ₁ | Yes | <input checked="" type="checkbox"/> ₀ | No (1180) |
| 12b. If YES , is the subject currently pregnant or lactating? | <input checked="" type="checkbox"/> ₁ | Yes | <input type="checkbox"/> ₀ | No (1190) |

- | | | | | |
|---|---------------------------------------|-----|--|-----------|
| 13. Is the subject eligible to proceed?
<i>If any of the shaded boxes are completed, the subject is ineligible.</i>
<i>→ If YES, proceed with remaining Visit 1 procedures.</i> | <input type="checkbox"/> ₁ | Yes | <input checked="" type="checkbox"/> ₀ | No (1200) |
|---|---------------------------------------|-----|--|-----------|

Subject Source Documentation

Subject Initials: ____ (1210)

Date: ____ / ____ / ____ (1220)



**BASALT/TALC RUNIN
ELIGIBILITY
CHECKLIST 3**

Subject ID: 1 6 - ____ - ____
 Subject Initials: ____
 Visit Number: 1
 Visit Date: ____ / ____ / ____
Month Day Year
 Coordinator ID: _____

(Clinic Coordinator completed)

Section 1

1. Is the subject's prebronchodilator FEV₁ > 40% of predicted? ₁ Yes ₀ No (1000)

➔ If **NO**, **STOP** here. Subject is ineligible for the study.

2. Does the subject have valid source documentation for a methacholine challenge (ACRN systems and procedures only) within the past 6 months? ₁ Yes ₀ No (1001)

➔ If **NO**, skip to Question #3.

➔ If **YES**, record values below:

PC₂₀: _____ mg/ml (1002)

Source Documentation Date: ____ / ____ / ____ (1003)

Technician ID: _____ (1004)

Supervisor ID: _____ (1005)

2a. Was the subject using ICS regularly at the time the challenge was performed? ₁ Yes ₀ No (1006)

➔ If **YES**, complete Question #2b and skip to Question #2d.

➔ If **NO**, complete Question #2c and continue with rest of form.

2b. Does the subject have source documentation of a methacholine PC₂₀ ≤ 16 mg/ml? ₁ Yes ₀ No (1007)

2c. Does the subject have source documentation of a methacholine PC₂₀ ≤ 8 mg/ml? ₁ Yes ₀ No (1008)

2d. Is the subject eligible to proceed? ₁ Yes ₀ No (1009)
If either shaded box in Question # 2b or 2c is completed, the subject must complete testing at Visit 1 to confirm eligibility.

➔ ***If YES, continue with remaining visit procedures and complete Section 4.***

➔ ***If NO, complete Question #3 on the next page and proceed accordingly.***



ELIGIBILITY CHECKLIST 3

Subject ID: 1 6 - ____ - ____
Visit Number: 1

3. Is the subject's prebronchodilator FEV₁ ≥ 55% of predicted and he/she qualifies for methacholine challenge? ₁ Yes ₀ No (1010)
- If **YES**, complete Section 2.
- If **NO**, complete Section 3.

Section 2

4. Is the subject regularly using ICS at this time? ₁ Yes ₀ No (1020)
- If **YES**, complete Question #5 and skip to Question #7.
- If **NO**, complete Question #6 and continue with rest of form.
5. Does the subject have a methacholine PC₂₀ ≤ 16 mg/ml? ₁ Yes ₀ No (1030)
6. Does the subject have a methacholine PC₂₀ ≤ 8 mg/ml? ₁ Yes ₀ No (1040)

7. Is the subject eligible to proceed? ₁ Yes ₀ No (1050)
- If either shaded box in Section 2 is completed, the subject is ineligible at this point.***
- ***If YES, continue with remaining visit procedures and complete Section 4.***
- ***If NO, the subject may return at a later date for a continuation visit to perform albuterol reversibility testing to qualify. Complete Question #8 and proceed accordingly.***

8. Will the subject complete reversibility testing? ₁ Yes ₀ No (1060)
- If **NO**, STOP here. Subject is ineligible for the study.
- If **YES**, continue with visit procedures on the P16_VISITA checklist and complete Section 3.

Section 3

9. Did the subject's FEV₁ improve ≥ 12% in response to four puffs of albuterol? ₁ Yes ₀ No (1070)
- ***If YES, continue with remaining visit procedures and complete Section 4 on the next page.***
- ***If NO, STOP here. Subject is ineligible for the study.***



**ELIGIBILITY
CHECKLIST 3**

Subject ID: 1 6 - _____ - _____

Visit Number: 1

Section 4

10. Is the subject able to use the AM1[®] device correctly, as evidenced by achieving a satisfactory rating on the AM1[®] Performance Checklist (PERF_AM1)? ₁ Yes ₀ No (1080)

11. Is the subject able to use a metered dose inhaler (MDI) properly, as evidenced by achieving a score of 6 on two consecutive, separate inhalations using the MDI Inhalation Technique Checklists (SCORE, TECH_MDI)? ₁ Yes ₀ No (1090)

12. Is the subject eligible to proceed? ₁ Yes ₀ No (1100)

If either shaded box in Section 4 is completed, the subject is ineligible.

→ *If YES, continue with remaining visit procedures.*

→ *If NO, STOP here. Subject is ineligible for the study.*



**BASALT/TALC RUNIN
LABORATORY
MEASUREMENTS**

Subject ID: 1 6 - ____ - ____

Subject Initials: ____

Visit Number: 2

Visit Date: ____ / ____ / ____
Month Day Year

Coordinator ID: ____

(Clinic Coordinator completed)

1. Eosinophils (absolute count)

____ /mm³ (1000)



**BASALT/TALC RUNIN
MEDICAL HISTORY**

Subject ID: 1 6 - ____ - ____
 Subject Initials: ____
 Visit Number: 1
 Visit Date: ____ / ____ / ____
Month Day Year
 Coordinator ID: ____

(Subject Interview completed)

COLD HISTORY

1. On average, how many respiratory tract infections/colds do you experience per year? _____ (1000)
2. How severe are your colds usually?
₁ Extremely severe
₂ Very severe
₃ Severe
₄ Moderate
₅ Mild
₆ Extremely mild (1010)
3. When you get colds, how often do they make your asthma worse?
 → *If NEVER, skip to Question # 5.*
₁ Always
₂ Usually
₃ Sometimes
₄ Rarely
₅ Never (1020)
4. When colds make your asthma worse, how severe does your asthma usually get?
₁ Extremely severe
₂ Very severe
₃ Severe
₄ Moderate
₅ Mild
₆ Extremely mild (1030)

PRIOR ASTHMA TREATMENT

I will read a list of medications. Indicate if you have ever used each medication. If you have, please indicate, to the best of your knowledge, the date last taken.

If Yes, indicate date medication was last taken
 month / day / year

5. Non-long-acting Inhaled Beta-Agonists ₁ Yes ₀ No ₈ Unknown _____ / _____ / _____
(Bronkaid Mist, Duo-Medihaler, Medihaler-Epi, Primatene Mist, Alupent, Brethaire, Brethine, Bronkometer, Maxair, Metaprel, Proventil, Tornalate, Ventolin, Xopenex and others)
 (1040) (1050) (1060) (1070)
- 5a. If **YES**, indicate average daily puffs in the past month. (Enter '00' if none used.) _____ puffs (1080)
6. Long-acting Inhaled Beta-Agonists ₁ Yes ₀ No ₈ Unknown _____ / _____ / _____
(Serevent, Foradil, Advair Diskus Symbicort Turbuhaler)
 (1090) (1100) (1110) (1120)



MEDICAL HISTORY

Subject ID: 1 6 - _____ - _____

Visit Number: 1

If Yes, indicate date
medication was last taken
month / day / year

- | | | | | |
|---|---|--|---|---|
| 7. Asthma medication via a Nebulizer Machine | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1130) | ___ / ___ / _____
(1140) (1150) (1160) |
| 8. Oral Beta-Agonists
(Alupent, Brethine, Bricanyl, Metaprel,
Proventil, Ventolin, Repetabs, Volmax
and others) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1170) | ___ / ___ / _____
(1180) (1190) (1200) |
| 9. Short-acting Oral Theophylline
(Aminophylline, Slo-Phyllin and others) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1210) | ___ / ___ / _____
(1220) (1230) (1240) |
| 10. Sustained release Oral Theophylline
(Slo-bid, Theo-Dur, Uniphyl and others) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1250) | ___ / ___ / _____
(1260) (1270) (1280) |
| 11. Inhaled Anticholinergic
(Atrovent, Combivent, Spiriva) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1290) | ___ / ___ / _____
(1300) (1310) (1320) |
| 12. Anti-allergic Inhaled Medications
(Intal, Tilade and others) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1330) | ___ / ___ / _____
(1340) (1350) (1360) |
| 13. Anti-allergic Nasal Medications
(Nasal crom, Astelin and others) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1370) | ___ / ___ / _____
(1380) (1390) (1400) |
| 14. Anti-allergic Oral Medications
(Allegra, Claritin, Zyrtec,
Chlor-Trimeton and others) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1410) | ___ / ___ / _____
(1420) (1430) (1440) |
| 15. Leukotriene Antagonist / 5LO Inhibitors
(Accolate, Zflo, Singulair) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1450) | ___ / ___ / _____
(1460) (1470) (1480) |
| 16. IgE Blocker
(Xolair) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1490) | ___ / ___ / _____
(1500) (1510) (1520) |
| 17. Topical Steroids - Prescription
(Synalar, Lidex, Dermacin, Fluocinonide
and others) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1530) | ___ / ___ / _____
(1540) (1550) (1560) |
| 18. Topical Steroids - OTC
(Hydrocortisone - multiple strengths
and products) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1570) | ___ / ___ / _____
(1580) (1590) (1600) |
| 19. Nasal Steroids
(Beconase, Vancenase, Flonase, Nasacort,
Nasalide, Nasarel, Rhinocort, Nasonex
and others) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1610) | ___ / ___ / _____
(1620) (1630) (1640) |
| 20. Oral Steroids
(Prednisone, Medrol and others) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown
(1650) | ___ / ___ / _____
(1660) (1670) (1680) |



MEDICAL HISTORY

Subject ID: 1 6 - _____ - _____

Visit Number: 1

If Yes, indicate date medication was last taken month / day / year

21. Inhaled Steroids ₁ Yes ₀ No ₈ Unknown _____ / _____ / _____
(1690) (1700) (1710) (1720)
(Azmacort, Beclovent, Vanceryl, AeroBid, QVAR, Flovent, Pulmicort, Advair Diskus and others)

→ If NO or unknown, skip to Question #22.

→ If YES, complete Questions #21a - 21c.

21a. Indicate most recent type of inhaled steroid taken

- ₁ beclomethasone MDI (1 puff = 42 µg) (e.g., **Beclovent, Vanceryl**)
- ₂ beclomethasone MDI (1 puff = 84 µg) (e.g., **Vanceryl-DS**)
- ₃ beclomethasone HFA (1 puff = 40 µg) (e.g., **QVAR**)
- ₄ beclomethasone HFA (1 puff = 80 µg) (e.g., **QVAR**)
- ₅ budesonide DPI (1 puff = 80 µg) (e.g., **Symbicort Turbuhaler**)
- ₆ budesonide DPI (1 puff = 160 µg) (e.g., **Symbicort Turbuhaler**)
- ₇ budesonide DPI (1 puff = 200 µg) (e.g., **Pulmicort Turbuhaler**)
- ₈ budesonide DPI (1 puff = 320 µg) (e.g., **Symbicort Turbuhaler**)
- ₉ flunisolide MDI (1 puff = 250 µg) (e.g., **Aerobid, Aerobid - M**)
- ₁₀ fluticasone MDI (1 puff = 44 µg) (e.g., **Flovent**)
- ₁₁ fluticasone MDI (1 puff = 110 µg) (e.g., **Flovent**)
- ₁₂ fluticasone MDI (1 puff = 220 µg) (e.g., **Flovent**)
- ₁₃ fluticasone DPI (1 puff = 50 µg) (e.g., **Flovent Rotadisk**)
- ₁₄ fluticasone DPI (1 puff = 100 µg) (e.g., **Advair Diskus**)
- ₁₅ fluticasone DPI (1 puff = 250 µg) (e.g., **Advair Diskus**)
- ₁₆ fluticasone DPI (1 puff = 500 µg) (e.g., **Advair Diskus**)
- ₁₇ mometasone DPI (1 puff = 220 µg) (e.g., **Asmanex Twister**)
- ₁₈ triamcinolone acetonide MDI (1 puff = 100 µg) (e.g., **Azmacort**)
- ₁₉ other _____ (1730)



MEDICAL HISTORY

Subject ID: 1 6 - _____ - _____

Visit Number: 1

- 21b. Indicate number of daily puffs used _____ puffs (1740)
- 21c. Indicate how long you used the inhaled steroid (duration of use)
- ₁ less than 1 month
 - ₂ 1 - 6 months
 - ₃ greater than 6 months (1750)

PRIOR CHOLESTEROL TREATMENT WITH STATIN DRUGS

Indicate if you have ever used statin medications. If you have, please indicate, to the best of your knowledge, the most recent drug taken, date last taken, and the total daily dose.

If Yes, indicate date medication was last taken
month / day / year

22. Statin medications ₁ Yes ₀ No ₈ Unknown _____ / _____ / _____
(Lipitor, Baycol, Lescol, Advicor, Mevacor, Pravachol, Vytorin, Zocor and Crestor) (2030) (2040) (2050) (2060)

→ If NO or unknown, skip to Question #23.
→ If YES, complete Questions #22a - 22b.

- 22a. Indicate most recent type of statin medication taken
- ₁ atorvastatin (e.g., Lipitor)
 - ₂ cerivastatin (e.g., Baycol)
 - ₃ fluvastatin (e.g., Lescol)
 - ₄ lovastatin (e.g., Advicor, Mevacor)
 - ₅ pravastatin (e.g., Pravachol)
 - ₆ simvastatin (e.g., Vytorin, Zocor)
 - ₇ rosuvastatin (e.g., Crestor) (2070)

- 22b. Indicate the total daily dose used _____ . _____ mg (2080)
(If dosage is unknown enter '999')

PRIOR DISEASES, ILLNESSES AND SURGERIES

Have you had any diseases, illnesses, conditions or surgeries related to the following areas?

- | | | | If Yes, Comment |
|---|---|--|---|
| 23. Skin | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | _____ (1760) |
| 24. Blood, Lymph, or Immune Systems | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | _____ (1770) |
| 25. Eyes | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | _____ (1780) |
| 26. Ears, Nose, or Throat | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | _____ (1790) |
| 26a. Have you ever had nasal polyps? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉ Don't know (1800) |
| 26ai. If YES, have you ever had any nasal polyps removed? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | (1810) |
| 26b. Do you have chronic or recurrent sinusitis (treated with antibiotics)? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉ Don't know (1820) |



MEDICAL HISTORY

Subject ID: 1 6 - _____ - _____

Visit Number: 1

- 27. Breasts ₁ Yes ₀ No _____ (1830)
- 28. Endocrine Systems ₁ Yes ₀ No _____ (1840)
- 29. Lung - other than asthma ₁ Yes ₀ No _____ (1850)
 - 29a. Have you ever had pneumonia? ₁ Yes ₀ No ₉ Don't know (1860)
 - 29b. Have you ever had bronchitis? ₁ Yes ₀ No ₉ Don't know (1870)
- 30. Heart and Blood Vessels ₁ Yes ₀ No _____ (1880)
- 31. Liver or Pancreas ₁ Yes ₀ No _____ (1890)
- 32. Kidneys or Urinary Tract System ₁ Yes ₀ No _____ (1900)
- 33. Reproductive System ₁ Yes ₀ No _____ (1910)
- 34. Stomach or Intestines ₁ Yes ₀ No _____ (1920)
 - 34a. Do you have gastroesophageal reflux disease (GERD)? ₁ Yes ₀ No ₉ Don't know (1930)
- 35. Muscles or Bones ₁ Yes ₀ No _____ (1940)
- 36. Nervous System ₁ Yes ₀ No _____ (1950)
- 37. Psychiatric ₁ Yes ₀ No _____ (1960)
- 38. Other _____ ₁ Yes ₀ No _____ (1970)
- 39. Drug Allergies ₁ Yes ₀ No _____ (1980)

- 40. Food Allergies ₁ Yes ₀ No _____ (1990)

SUBJECT'S WEIGHT

(Clinic Coordinator completed)

41. Weight (without shoes or heavy clothing) _____ . _____ kg (2000)

Subject Source Documentation

Subject's Initials: _____ (2010)

Date: ____ / ____ / _____ (2020)



**BASALT/TALC RUNIN
PULMONARY
PROCEDURE CHECKLIST
(Visits 1-3)**

Subject ID: 1 6 - _____ - _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: _____ / _____ / _____
Month Day Year
 Coordinator ID: _____

(Subject Interview completed)

Please reference the Drug Classifications list for a complete list of examples for the questions below. If any medications other than study QVAR or rescue albuterol were used, record the medication(s) on the Concomitant Medications for Asthma/Allergies and Adverse Events (CMED) form.

1. Have you consumed caffeine in the past 6 hours? ₁ Yes ₀ No (1000)
Examples: Pepsi, Coke, Coffee, Mountain Dew, Tea, Rootbeer, Red Bull
2. Have you used medications with caffeine in the past 6 hours? ₁ Yes ₀ No (1010)
Examples: Anacin, Darvon compound, Esgic, Excedrin, Fiorinal, Fioricet, No Doz, Norgesic, Vivarin
3. Have you used any weight loss medications in the past 6 hours? ₁ Yes ₀ No (1020)
Examples: bitter orange, Xenadrine EFX, Thermorexin
4. Have you consumed any food containing alcohol or beverages containing alcohol in the past 6 hours? ₁ Yes ₀ No (1030)
5. Have you used any oral antihistamines in the past 48 hours? ₁ Yes ₀ No (1040)
Examples: Allegra, Chlor-Trimeton, Claritin, Tylenol PM
6. Have you used any nasal antihistamines in the past 6 hours? ₁ Yes ₀ No (1045)
Examples: Astelin, Livostin, Patanase
7. Have you used any oral decongestants or cold remedies in the past 48 hours? ₁ Yes ₀ No (1050)
Examples: pseudoephedrine (Sudafed), Tylenol Allergy
8. Have you used any nasal decongestants in the past 6 hours? ₁ Yes ₀ No (1060)
Examples: oxymetazoline (Afrin)
9. Have you used any cough medicines, anti-tussives, or expectorants in the past 48 hours? ₁ Yes ₀ No (1070)
Examples: guaifenesin, dextromethorphan, Duratuss, Benlyn, Triaminic expectorant, Dayquil Anti-Cough
10. Have you used a rescue intermediate-acting inhaled beta-agonist in the past 6 hours? ₁ Yes ₀ No (1080)
Example: albuterol (Ventolin or Proventil), study RESCUE
11. Have you used any nasal steroids in the past 48 hours? ₁ Yes ₀ No (1090)
Examples: Flonase, Rhinocort, Nasonex



**PULMONARY PROCEDURE
CHECKLIST**

Subject ID: _____ - _____ - _____

Visit Number: ____

12. Have you used any smokeless tobacco products today? ₁ Yes ₀ No (1095)
Examples: chewing tobacco, snuff

13. At this time, is your asthma worse because of recent exposure to triggers? ₁ Yes ₀ No (1100)
Examples: cold air, smoke, allergens, recent exercise, a recent respiratory tract infection, or other pulmonary infection

14. Is there any other reason you should not proceed with spirometry testing? ₁ Yes ₀ No (1110)
If **YES**, explain _____

15. Is the subject eligible to proceed with the spirometry testing? ₁ Yes ₀ No (1120)
If any of the shaded boxes are filled in, the subject is ineligible for spirometry and exhaled nitric oxide testing.
➔ If YES, proceed to Question #16 or the next form/procedure listed on the visit procedure checklist.

Complete for all subjects at Visit 1.
If subject is less than 21 years old, complete Question #16 at each visit.

16. Height (without shoes) _____ cm (1130)



**BASALT/TALC RUNIN
SIGNIFICANT ASTHMA
EXACERBATION
(Visits 1-3)**

Subject ID: 1 6 - _____ - _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: _____ / _____ / _____
Month Day Year
 Coordinator ID: _____

(Clinic Coordinator completed)

This form must be completed each time a subject experiences an asthma exacerbation according to the definition below.

1. Did the subject experience an increase in cough, phlegm/mucus, chest tightness, wheezing, and/or shortness of breath? ₁ Yes ₀ No (1000)

2. Did the subject require an increase in asthma medications (oral, inhaled, and/or intravenous corticosteroids or other controller medications) as a result of rescue intervention or by the opinion of the treating physician? ₁ Yes ₀ No (1010)

→ If YES, please complete the CMED form.

3. Did the subject experience a significant asthma exacerbation? ₁ Yes ₀ No (1020)
If BOTH of the shaded boxes are completed, the subject has experienced a significant asthma exacerbation.

→ If YES, complete this form, then STOP. The subject is ineligible for the study. Please complete the P16_TERM form.

→ If NO, STOP HERE. DO NOT SUBMIT THIS FORM TO THE DCC.

4. Date significant asthma exacerbation occurred _____ / _____ / _____
month day year (1030)

5. Did the subject seek care for the asthma exacerbation? ₁ Yes ₀ No (1040)
→ If NO, skip to Question #8.



**SIGNIFICANT ASTHMA
EXACERBATION**

Subject ID: 1 6 - ____ - ____

Visit Number: ____

6. What type of care was sought?
6a. Study Investigator? ₁ Yes ₀ No (1050)

If **YES**, indicate type of contact.

₁ Scheduled clinic visit
₂ Unscheduled clinic visit
₃ Phone contact (1060)

6b. Primary Care or Other Physician? ₁ Yes ₀ No (1070)

If **YES**, name of physician: _____

If **YES**, indicate type of contact.

₁ Scheduled clinic visit
₂ Unscheduled clinic visit
₃ Phone contact (1080)

6c. Emergency Room visit? ₁ Yes ₀ No (1090)

If **YES**, name of hospital: _____

7. Was the subject hospitalized? ₁ Yes ₀ No (1100)

→ **If YES, please complete the Serious Adverse Event Reporting (SERIOUS) Form.**

If **YES**,

7a. Duration of hospital stay? ____ . ____ days (1110)

7b. Was intubation or ventilation assistance required? ₁ Yes ₀ No (1120)

7c. Name of hospital: _____

8. Please indicate whether the following medications were used to treat the asthma exacerbation:

8a. Albuterol rescue inhaler (RESCUE) ₁ Yes ₀ No (1130)

8b. Nebulized beta-agonist ₁ Yes ₀ No (1140)
→ **If YES, please complete the CMED form.**

8c. Inhaled corticosteroids ₁ Yes ₀ No (1150)
→ **If YES, please complete the CMED form.**

8d. Oral corticosteroids ₁ Yes ₀ No (1160)
→ **If YES, please complete the CMED form.**

8e. Intravenous corticosteroids ₁ Yes ₀ No (1170)
→ **If YES, please complete the CMED form.**



**SIGNIFICANT ASTHMA
EXACERBATION**

Subject ID: 1 6 - ____ - ____ - ____

Visit Number: ____

9. Was the asthma exacerbation treated as outlined in the protocol?
If **NO**, explain _____

₁ Yes ₀ No (1180)

10. Was the asthma exacerbation related to routine pulmonary function testing, including the collection of exhaled nitric oxide?
(Check one box only)

₁ Definitely related
₂ Probably related
₃ Relationship undetermined
₄ Probably not related
₅ Definitely not related (1190)

11. Was the asthma exacerbation related to the collection of exhaled breath condensates? (Check one box only)

₁ Definitely related
₂ Probably related
₃ Relationship undetermined
₄ Probably not related
₅ Definitely not related (1200)

12. Was the asthma exacerbation related to methacholine challenge testing? (Check one box only)

₁ Definitely related
₂ Probably related
₃ Relationship undetermined
₄ Probably not related
₅ Definitely not related (1210)

13. Was the asthma exacerbation related to sputum induction?
(Check one box only)

₁ Definitely related
₂ Probably related
₃ Relationship undetermined
₄ Probably not related
₅ Definitely not related (1220)



**BASALT/TALC RUNIN
TERMINATION OF
STUDY PARTICIPATION
Visits 1-3**

Subject ID: 1 6 - ____ - ____
Subject Initials: ____
Visit Number: ____
Visit Date: ____ / ____ / ____
 Month Day Year
Coordinator ID: ____

(Clinic Coordinator completed)

Complete this form only for subjects who have successfully completed Visit 1 and have been terminated or deemed ineligible prior to the completion of Visit 3.

1. Who initiated termination of the subject? ₁ Subject
₂ Clinical Staff (1000)
→ *If subject withdrew due to impending clinical staff termination, please indicate termination by clinical staff.*
→ *If Clinical Staff, skip to Question #3.*

2. Indicate the **primary** reason the subject has withdrawn from the study.

- ₁ no longer interested in participating *
₂ no longer willing to follow protocol *
₃ difficult access to clinic (location, transportation, parking)
₄ unable to make visits during clinic hours
₅ moving out of the area
₆ unable to continue due to personal constraints *
₇ unable to continue due to medical condition unrelated to asthma *
₈ side effects of runin study medications *
₉ dissatisfied with asthma control during the runin
₁₀ other * (1010)

*** Additional explanation required:**

(1020)

→ *Skip to the SIGNATURES section.*



**TERMINATION OF
STUDY PARTICIPATION**

Subject ID: 1_6 - _____ - _____

Visit Number: _____

3. Did clinical staff terminate the subject due to ...
- 3a. pregnancy? ₁ Yes ₀ No ₉ N/A (1030)
(Check N/A if the subject is male.)
- 3b. loss to follow-up? * ₁ Yes ₀ No (1040)
- 3c. an asthma-related adverse event? * ₁ Yes ₀ No (1050)
- 3d. a medication-related adverse event? * ₁ Yes ₀ No (1060)
- 3e. an adverse event not related to asthma or medications? * ₁ Yes ₀ No (1070)
- 3f. non-compliance with QVAR dosing? * ₁ Yes ₀ No (1080)
- 3g. non-compliance with diary completion? * ₁ Yes ₀ No (1090)
- 3h. non-compliance with visit attendance? * ₁ Yes ₀ No (1100)
- 3i. non-compliance with peak flow monitoring? * ₁ Yes ₀ No (1110)
- 3j. significant asthma exacerbation? ₁ Yes ₀ No (1120)
- 3k. ineligibility during the BASALT/TALC common
runin period for reasons other than compliance
or exacerbation? * ₁ Yes ₀ No (1130)
- 3l. subject allocated to TALC prior to study start date ₁ Yes ₀ No (1132)
- 3m. subject allocated to TALC after recruitment closed ₁ Yes ₀ No (1134)
- 3n. subject allocated to BASALT after recruitment closed ₁ Yes ₀ No (1136)
- 3o. other reason? * ₁ Yes ₀ No (1140)

*** Additional explanation required:**

(1150)

- 3p. Indicate the letter corresponding to the primary reason the
subject was terminated. _____ (1160)



**TERMINATION OF
STUDY PARTICIPATION**

Subject ID: 1_6 - _____ - _____

Visit Number: _____

SIGNATURES

Please complete the following section regardless of the reason for termination of study participation.

I verify that all information collected on the ACRN BASALT/TALC RUNIN data collection forms for this subject is correct to the best of my knowledge and was collected in accordance with the procedures outlined in the study protocol.

_____ (1170) ____ / ____ / ____ (1180)
Clinic Coordinator Signature month day year

_____ (1190) ____ / ____ / ____ (1200)
Principal Investigator Signature month day year



**POST-ALBUTEROL
(4 puffs)
SPIROMETRY TESTING**

Supervisor ID: _____

Subject ID: _____ - _____ - _____

Subject Initials: _____

Visit Number: _____

Visit Date: _____ / _____ / _____
Month Day Year

Technician ID: _____

(Technician completed)

Complete this form only if the subject is eligible according to the appropriate Pulmonary Procedure Checklist form and successfully completed baseline spirometry session(s).

➔ **Administer 4 puffs of albuterol and wait 15 minutes, then perform spirometry.**

1. Time albuterol administered (*based on 24-hour clock*) _____ (1000)

2. Time post-albuterol spirometry started _____ (1010)
(*based on 24-hour clock*)

The best effort reflects the trial where the sum of FEV₁ and FVC is maximized.

3. Results of best effort post-albuterol:

3a. FVC _____ L (1020)

3b. FEV₁ _____ L (1030)

3c. FEV₁ (% predicted) _____ % predicted (1040)

3d. PEF_R _____ L/S (1050)

3e. FEF₂₅₋₇₅ _____ L/S (1060)

4. In your judgment, was the subject's spirometry technique acceptable? ₁ Yes ₀ No (1070)

4a. If **NO**, why was it unacceptable?

Inadequate inspiratory effort ₁ Yes ₀ No (1080)

Inadequate expiratory effort ₁ Yes ₀ No (1090)

Inadequate duration of expiration ₁ Yes ₀ No (1100)

Cough during procedures ₁ Yes ₀ No (1110)

Other (*specify*) _____ ₁ Yes ₀ No (1120)



**POST-IPRATROPIUM
(4 Puffs)
SPIROMETRY TESTING**

Supervisor ID: _____

Subject ID: _____ - _____ - _____

Subject Initials: _____

Visit Number: _____

Visit Date: _____ / _____ / _____
Month Day Year

Technician ID: _____

(Technician completed)

Complete this form only if the subject is eligible according to the appropriate Pulmonary Procedure Checklist form and successfully completed baseline spirometry session(s).

Note: Ipratropium should NOT be administered to subjects who have a hypersensitivity/allergy to soy or peanuts.

→ **Administer 4 puffs of ipratropium and wait 30 minutes, then perform spirometry.**

1. Time ipratropium administered (based on 24-hour clock) _____ (1000)

2. Time post-ipratropium spirometry started _____ (1010)
(based on 24-hour clock)

The best effort reflects the trial where the sum of FEV₁ and FVC is maximized.

3. Results of best effort post-ipratropium:

3a. FVC _____ L (1020)

3b. FEV₁ _____ L (1030)

3c. FEV₁ (% predicted) _____ % predicted (1040)

3d. PEF_R _____ L/S (1050)

3e. FEF₂₅₋₇₅ _____ L/S (1060)

4. In your judgment, was the subject's spirometry technique acceptable? ₁ Yes ₀ No (1070)

4a. If **NO**, why was it unacceptable?

Inadequate inspiratory effort ₁ Yes ₀ No (1080)

Inadequate expiratory effort ₁ Yes ₀ No (1090)

Inadequate duration of expiration ₁ Yes ₀ No (1100)

Cough during procedures ₁ Yes ₀ No (1110)

Other (specify) _____ ₁ Yes ₀ No (1120)



**URINE
PREGNANCY
TEST**

Subject ID: _____ - _____ - _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____/____/____
Month Day Year
 Coordinator ID: _____

(Clinic Coordinator Completed)

Complete this form for female subjects only.

1. Is the subject unable to bear children due to any of the following reasons?

1a. Post-menopausal (at least one year since last menses)

₁ Yes ₀ No (1000)

1b. Hysterectomy

₁ Yes ₀ No (1010)

1c. Tubal ligation

₁ Yes ₀ No (1020)

→ ***If any of the shaded boxes are filled in, a pregnancy test is not required. Proceed to the source documentation box.***

2. Pregnancy test results

₁ Positive

→ ***If pregnancy test results are positive, the subject must be terminated from study participation. Complete the appropriate Termination of Study Participation form and follow study termination procedures.***

₂ Negative (1030)

Subject Source Documentation

Subject's Initials: _____ (1040)

Date: ____/____/____ (1050)



"Attach Registry Form Label Here"

ACRN REGISTRY

Subject's Last Name: _____

Subject's First Name: _____

Subject's Initials: _____

Social Security Number: _____
(Last 4 digits)

Coordinator ID: _____

(Clinic Coordinator/Subject Interview Completed)

Search the ACRN Registry. If the subject is either incomplete or not found in the Registry, complete the Registry form and enter/update the subject's information appropriately.

ADMINISTRATIVE

1. Did the subject sign an ACRN Protocol Informed Consent and HIPAA Authorization form? ₁ Yes ₀ No (1000)

If **NO**, stop here. Data cannot be entered into the ACRN Registry.

If **YES**, record the signature date.

____ / ____ / ____ (1010)
Month Day Year

DEMOGRAPHICS

2. Subject's date of birth ____ / ____ / ____ (1020)
(Ask the subject his/her date of birth.)
Month Day Year

3. Subject's gender ₁ Male ₂ Female (1030)

4. Subject's Race and Ethnicity

4a. Subject's ethnic background ₁ Hispanic or Latino ₂ Not Hispanic or Latino (1040)
(Ask the subject to identify his/her ethnic background.)

4b. Subject's racial background *(Ask the subject to identify all that apply.)*

American Indian or Alaskan Native ₁ Yes ₀ No (1050)

Asian ₁ Yes ₀ No (1060)

Black or African American ₁ Yes ₀ No (1070)

White ₁ Yes ₀ No (1080)

Native Hawaiian or Other Pacific Islander ₁ Yes ₀ No (1090)

Other *(specify)* _____ ₁ Yes ₀ No (1100)



REGISTRY

Subject's Initials: _____

5. Subject's primary racial identification
(This identification will be used for spirometry testing. Ask the subject which category best describes him or her and check only one box.)

- ₁ American Indian or Alaskan Native
- ₂ Asian or Pacific Islander
- ₃ Black, not of Hispanic Origin
- ₄ White, not of Hispanic Origin
- ₅ Hispanic
- ₆ Other _____ (1110)

Subject Source Documentation

Subject's Initials: _____

Date: ____ / ____ / _____

Administrative Use Only

Does the subject recall participating in any of the ACRN I protocols? *(Circle all that apply)*

BAGS (1)

CIMA (2)

SOCS/SLIC (3)

DICE (6)

MICE (7)

BARGE (8)

IMPACT (9)

SMOG (10)

SLiMSIT (11)

PRICE (12)

Registry Form Storage Instructions:

Upon printing the subject's label sheet, print the subject's name on the upper right hand label. Attach the Registry form label to the upper left hand corner of the form. Lastly, attach the Registry Log label to the next available row on the Registry Log and complete the required fields. The Registry form should be stored alphabetically by subject's last name in the ACRN Registry Binder. The label sheet should then be filed directly behind the Registry form.

REGISTRY FORMS SHOULD NOT BE SENT TO THE DCC.



**SLEEP AND DAYTIME
ALERTNESS
QUESTIONNAIRE**

Subject ID: _____ - _____ - _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____/____/____
 Month Day Year
 Coordinator ID: _____

(Subject completed)

ABOUT YOUR SLEEP

The questions below apply to the last 6 months.

Some people work the night shift or rotating shifts. Other people have a bedtime that changes a lot. If these apply to you, then questions about the time of day refer to the time when you awaken from your longest sleep and become active. Questions about time of night refer to the time when you have your longest sleep.

Please check only one box for each question.

	Never	Rarely	Sometimes	Usually	Always
1. I am told I snore loudly and bother others.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅ (1000)
2. I am told I stop breathing ("hold my breath") in sleep.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅ (1010)
3. I awake suddenly gasping for breath, unable to breathe.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅ (1020)
→ If this <i>never</i> happens to you, please skip to question #4.					
→ If this happens to you <i>even rarely</i> , please answer questions #3a and 3b.					
3a. It takes just a couple of breaths to fully recover.	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	(1030)		
3b. It happens when I have chest tightness, wheezing, or cough and takes more than a couple of breaths to fully recover.	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	(1040)		
4. I sweat a great deal at night.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅ (1050)
5. I have high blood pressure (or once had it).	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅ (1060)
6. I have a problem with my nose blocking up when I am trying to sleep.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅ (1070)
7. My snoring or my breathing problem is much worse if I sleep on my back.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅ (1080)
8. My snoring or my breathing problem is much worse if I fall asleep right after drinking alcohol.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅ (1090)



ABOUT YOUR DAYTIME ALERTNESS

9. Do you feel that you are excessively (overly) sleepy during the day? ₁ Yes ₀ No (1100)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Please check one box that best represents the likelihood of your dozing off in each situation.

	Likelihood of Dozing			
	Never	Slight	Moderate	High
10. Sitting and reading	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ (1120)
11. Watching TV	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ (1130)
12. Sitting, inactive in a public place (for example, a theater or a meeting)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ (1140)
13. As a passenger in a car for an hour without a break	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ (1150)
14. Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ (1160)
15. Sitting and talking to someone	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ (1170)
16. Sitting quietly after a lunch without alcohol	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ (1180)
17. In a car, while stopped for a few minutes in traffic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ (1190)
18. During the past 2 months, on average, how many hours of <i>actual sleep</i> (including daytime naps) did you get in a 24-hour period? This may be different than the number of hours you spent in bed.				_____ hours (1200)

CURRENT WEIGHT

19. What is your current weight in pounds? _____ pounds (1205)

Subject Source Documentation

Subject's Initials: _____ (1210)

Date: ____ / ____ / _____ (1220)



SERIOUS ADVERSE EVENT REPORTING FORM

Subject ID: _____ - _____ - _____
 Subject Initials: _____
 Visit Number: _____
 Current Date: ____ / ____ / ____
 Month Day Year
 Coordinator ID: _____

(Clinic Coordinator completed)

This form and a final resolution report (including relevant documents) written by the Principal Investigator should be faxed to the DCC at (717) 531-4359 within 72 hours of notification of a serious event. Also fax the Clinical Adverse Events form (AECLIN), the appropriate Concomitant Medications for Asthma and Allergies (CMED) form, and any relevant source documents.

1. Date of Adverse Event _____ / _____ / _____ (1000)
Month Day Year

2. Description of Adverse Event (ICD9 Code) _____ (1010)
 Describe: _____

3. Time interval between taking the study drug (last dose before symptoms) and subsequent onset of symptoms. _____ (1020)

4. Unit of time for above interval
 ₁ second(s)
 ₂ minute(s)
 ₃ hour(s)
 ₄ day(s) (1030)

5. Why was the event serious?
 - 5a. Fatal Event ₁ Yes ₀ No (1040)
 - 5b. Life-threatening event ₁ Yes ₀ No (1050)
 - 5c. Inpatient hospitalization required
 → If NO, skip to Question #5d.
 Admission date _____ / _____ / _____ (1070)
Month Day Year
 Discharge date _____ / _____ / _____ (1080)
Month Day Year
 - 5d. Hospitalization prolonged ₁ Yes ₀ No (1090)
 - 5e. Disabling or incapacitating ₁ Yes ₀ No (1100)
 - 5f. Overdose ₁ Yes ₀ No (1110)
 - 5g. Cancer ₁ Yes ₀ No (1120)
 - 5h. Congenital anomaly ₁ Yes ₀ No (1130)
 - 5i. Serious laboratory abnormality with clinical symptoms ₁ Yes ₀ No (1140)
 - 5j. Other (specify) _____ ₁ Yes ₀ No (1150)



SERIOUS ADVERSE EVENT

Subject ID: _____ - _____ - _____

Visit Number: _____

6. What, in your opinion, caused the event?

6a. Toxicity of study drug(s)

₁ Yes

₀ No (1160)

6b. Withdrawal of study drug(s)

₁ Yes

₀ No (1170)

6c. Concurrent medication

₁ Yes

₀ No (1180)

If **YES**, describe _____

6d. Concurrent disorder

₁ Yes

₀ No (1190)

If **YES**, describe _____

6e. Other event

₁ Yes

₀ No (1200)

If **YES**, describe _____

DO NOT ENTER QUESTIONS #7 - 8: FOR REPORTING PURPOSES ONLY.

7. If subject died, cause of death: _____

8. Was an autopsy performed?

₁ Yes

₀ No

If YES, attach report or send as soon as possible.

REPORTING INVESTIGATOR:

Comments (discuss any relevant laboratory data or other assessments which help explain the event):

Name: _____

Signature: _____

Date: ___ / ___ / _____



**ALLERGY SKIN
TEST RESULTS**

Subject ID: _____ - _____ - _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____ / ____ / ____
Month Day Year
 Coordinator ID: _____

(Clinic Coordinator completed)

1. Since August 2004, has the subject had an acceptable skin test for an ACRN protocol within three years of the visit date?

₁ Yes ₀ No (1000)

→ If **NO**, proceed to Question #2.

1a. Date of previous skin test

____ / ____ / ____ (1010)
month day year

1b. Coordinator ID who performed the skin test

____ (1020)

1c. Time test sites pricked/punctured *(based on 24-hour clock)*

____ (1030)

1d. Time test sites evaluated *(based on 24-hour clock)*

____ (1040)

→ **STOP HERE** and attach a photocopy of pages 3 and 4 from the previous Allergy Skin Test Results (SKIN) form to this page for data entry purposes.

2. Has the subject had dermatographia **or** a significant adverse reaction to skin testing previously (e.g., anaphylaxis, angioedema, asthma, hypotension, etc.)?

₁ Yes ₀ No (1050)

→ If **YES**, do not proceed with allergy skin testing.

→ If **YES**, and the subject has acceptable ACRN skin testing results from a prior ACRN protocol (ACRN I or II), record Subject ID associated with the most recent acceptable test.

____ - ____ - ____
 (1052) (1054) (1060)

3. Has the subject taken any of the medications listed in the ACRN Skin Testing MOP within the exclusionary periods?

₁ Yes ₀ No (1070)

→ If **YES**, the allergy skin testing procedure should be rescheduled.



**ALLERGY SKIN
TEST RESULTS**

Subject ID: _____ - _____ - _____

Visit Number: _____

4. Was the subject's most recent FEV1 below 60% predicted? ₁ Yes ₀ No (1072)

→ If **NO**, proceed to Question #5.

4a. Has the subject received permission from the supervising physician to proceed with the skin testing? ₁ Yes ₀ No (1074)

→ If **YES**, obtain physician's signature:

_____ (1076)

→ If **NO**, allergy skin testing procedure should be rescheduled.

5. Is the subject eligible for allergy skin testing? ₁ Yes ₀ No (1080)

If any of the shaded boxes are completed, the subject is ineligible for allergy skin testing. STOP HERE.

→ Allergy Skin testing may be rescheduled for the next visit if the subject is ineligible due to Question #3 or Question #4a.

6. Time test sites pricked/punctured (*based on 24-hour clock*) _____ (1090)

7. Time test sites evaluated (*based on 24-hour clock*) _____ (1100)



ALLERGY SKIN TEST RESULTS

Subject ID: _____ - _____ - _____

Visit Number: _____

Transfer the tracing of each measurable wheal and record the longest diameter and the diameter at the perpendicular midpoint in mm. If the wheal is not measurable, record '0' for both diameters.

1. Positive Control	Largest Wheal Diameter: _____ mm (1110) Perpendicular Wheal Diameter: _____ mm (1120)	2. Negative Control	Largest Wheal Diameter: _____ mm (1130) Perpendicular Wheal Diameter: _____ mm (1140)
3. Mite Mix	Largest Wheal Diameter: _____ mm (1150) Perpendicular Wheal Diameter: _____ mm (1160)	4. Cockroach Mix	Largest Wheal Diameter: _____ mm (1170) Perpendicular Wheal Diameter: _____ mm (1180)
5. Mouse	Largest Wheal Diameter: _____ mm (1190) Perpendicular Wheal Diameter: _____ mm (1200)	6. Rat	Largest Wheal Diameter: _____ mm (1210) Perpendicular Wheal Diameter: _____ mm (1220)
7. Penicillium	Largest Wheal Diameter: _____ mm (1230) Perpendicular Wheal Diameter: _____ mm (1240)	8. Alternaria	Largest Wheal Diameter: _____ mm (1250) Perpendicular Wheal Diameter: _____ mm (1260)



ALLERGY SKIN TEST RESULTS

Subject ID: _____ - _____ - _____

Visit Number: _____

9. Aspergillus	Largest Wheal Diameter: _____ mm (1270) Perpendicular Wheal Diameter: _____ mm (1280)	10. Cladosporium	Largest Wheal Diameter: _____ mm (1290) Perpendicular Wheal Diameter: _____ mm (1300)
11. Cat	Largest Wheal Diameter: _____ mm (1310) Perpendicular Wheal Diameter: _____ mm (1320)	12. Dog	Largest Wheal Diameter: _____ mm (1330) Perpendicular Wheal Diameter: _____ mm (1340)

13. Is the mean diameter for the 'Negative Control' < 3 mm? ₁ Yes ₀ No (1350)

➔ If **YES**, go to Question #14.

➔ If **NO**, administer the negative control on the opposite hand and complete Question #13a and #13b.

13a. Record the measurements for the 'Negative Control' administered on the opposite hand:

Largest Wheal Diameter: _____ mm (1352)

Perpendicular Wheal Diameter: _____ mm (1354)

13b. Is the mean diameter calculated from the measurements in Question #13a < 3 mm? ₁ Yes ₀ No (1360)

➔ If **NO**, go to Question #15. The subject has dermatographia and therefore, do not repeat skin testing on this subject.

14. Is the mean diameter for 'Positive Control' ≥ 3 mm more than the mean diameter from the 'Negative Control'? ₁ Yes ₀ No (1370)

15. Was this test acceptable? ₁ Yes ₀ No (1380)

If any of the gray shaded boxes are checked, this test was not acceptable.

➔ *Allergy Skin testing may be rescheduled for the next visit if the subject's test was unacceptable due to the use of exclusionary medications.*



SPIROMETRY TESTING

Subject ID: _____ - _____ - _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____ / ____ / ____
Month Day Year
 Technician ID: _____

Supervisor ID: _____

(Technician completed)

Complete this form only if the subject is eligible according to the appropriate Pulmonary Procedure Checklist form.

1. Time spirometry started *(based on 24-hour clock)* _____ (1000)

The best effort reflects the trial where the sum of FEV₁ and FVC is maximized.

2. Results of best effort:

2a. FVC _____ L (1010)

2b. FEV₁ _____ L (1020)

2c. FEV₁ (% predicted) _____ % predicted (1030)

2d. PEFr _____ L/S (1040)

2e. FEF₂₅₋₇₅ _____ L/S (1050)

3. In your judgment, was the subject's spirometry technique acceptable? ₁ Yes ₀ No (1060)

3a. If **NO**, why was it unacceptable?

Inadequate inspiratory effort ₁ Yes ₀ No (1070)

Inadequate expiratory effort ₁ Yes ₀ No (1080)

Inadequate duration of expiration ₁ Yes ₀ No (1090)

Cough during procedures ₁ Yes ₀ No (1100)

Other *(specify)* _____ ₁ Yes ₀ No (1110)

