

NCI MULTICENTER HEMOPHILIA COHORT STUDY

HIV DISEASE-RELATED MEDICATION USAGE FORM
 MHCS FORM 28 December 17, 1998

PLACE SUBJECT ID LABEL HERE

PART A - HIV-RELATED DRUGS

1. HAS THIS SUBJECT RECEIVED ANY HIV-RELATED MEDICATIONS (INCLUDING THOSE BEING CONTINUED) SINCE THE LAST TIME THE SUBJECT WAS SEEN OR THAT HAS NOT BEEN REPORTED TO RTI PREVIOUSLY?

YES . . . 01

NO 02

2. HAS THE SUBJECT PARTICIPATED IN ANY CLINICAL TRIALS NOT YET REPORTED TO RTI IN WHICH THE DRUGS GIVEN TO SUBJECT ARE NOT KNOWN?

YES 01

NO02-----> SKIP TO PART B.

3. LIST ACTG NUMBER(S) BELOW IF SUBJECT HAS PARTICIPATED IN A DRUG TRIAL AND IT IS UNKNOWN WHICH MEDICATION(S) WAS OR WERE TAKEN. *IF A DRUG(S) IS KNOWN, DO NOT LIST BELOW. RATHER, LIST IN NEXT SECTION (PART B) ONLY.*

	TOTAL # MONTHS	MONTH/YEAR Started Trial	MONTH/YEAR Last Participated in Trial
Trial 1. <u>1-3 H28A3-1</u>	<u>H28A3-17</u>	<u>H 28 A3 / MS</u>	<u>H 28 A3 / MS</u>
Trial 2. <u>H 28 A3-2</u>			
Trial 3. <u>H 28 A3-3</u>			
Trial 4. <u>H 28 A3-4</u>			

PART B - MEDICATIONS USED

IN THIS SECTION, FOR EACH MEDICATION STARTED OR CONTINUED SINCE THE LAST TIME SUBJECT WAS SEEN (OR THAT HAS NOT BEEN PREVIOUSLY REPORTED TO RTI) ENTER THE TOTAL NUMBER OF MONTHS DRUG RECEIVED AND THE DATES WHEN FIRST AND LAST RECEIVED. NOTE: (IF THE SUBJECT WAS OFF MEDICATION FOR > 6 MONTHS, GIVE MOST RECENT START AND STOP DATES AND TOTAL NUMBER OF MONTHS SINCE MOST RECENT START DATE).

1. HAS THE SUBJECT RECEIVED ANY ANTIRETROVIRAL NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)?

YES 01

NO02----->SKIP TO QUESTION 2.

	Months on Medication	Date Started on Rx MONTH/YEAR	Date Last Received Rx MONTH/YEAR
1. Abacavir	[][]	[][][][]	[][][][]
2. AZT (Retrovir, Zidovudine)	[][]	[][][][]	[][][][]
3. Combivir (AZT and 3TC)	[][]	[][][][]	[][][][]
4. ddC (Hivid, Zalcitabine)	[][]	[][][][]	[][][][]
5. ddl (Videx, Didanosine)	[][]	[][][][]	[][][][]
6. d4T (Zerit, Stavudine)	[][]	[][][][]	[][][][]
7. 3TC (Epivir, Lamivudine)	[][]	[][][][]	[][][][]
8. Other NRTI Drugs, Specify:			
1) <u>9</u>	[][]	[][][][]	[][][][]
2) _____	[][]	[][][][]	[][][][]
3) _____	[][]	[][][][]	[][][][]

2. HAS THE SUBJECT RECEIVED ANY ANTIRETROVIRAL PROTEASE INHIBITORS?

428-62

YES 01

NO02----->SKIP TO QUESTION 3.

	Months on Medication	Date Started on Rx MONTH/YEAR	Date Last Received Rx MONTH/YEAR
1. Fortovase (Saquinavir SGC)	H28B2-1M	H28B21MS H28B21YS	H28B21ML H28B21YL
2. Indinavir (Crixivan)	H28B2-2M	H28B22MS H28B22YS	H28B22ML H28B22YL
3. Ritonavir (Norvir)	H28B2-3M	[][][][]	[][][][]
4. Nelfinavir (Viracept)	H28B2-4M	[][][][]	[][][][]
5. Saquinavir (Invirase)	H28B2-6M	H28B25MS H28B25YS	H28B25ML H28B25YL
6. Other Protease Inhibitor Drugs, Specify:			
1) <u>H28B26IS</u> <u>7</u>	H28B26M	H2826MS H2826YS	H2826ML H2826YL
2) <u>H28B26IS</u>	H28B26M	H2826MS H2826YS	H2826ML H2826YL
3) <u>H28B26IS</u>	H28B26M	H2826MS H2826YS	H2826ML H2826YL

Amplivir (Zalcitabine)

3. HAS THE SUBJECT RECEIVED ANY ANTIRETROVIRAL NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)?

YES 01

NO02----->SKIP TO QUESTION 4.

	<u>Months on Medication</u>	<u>Date Started on Rx MONTH/YEAR</u>	<u>Date Last Received Rx MONTH/YEAR</u>
1. Delavirdine (Rescriptor)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
2. Efavirenz (DMP-266, Sustiva)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
3. Loviride	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
4. Nevirapine (Viramune)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
5. Other NNRTI Drugs, Specify:			
1) <u>6</u>	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
2) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
3) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _

4. HAS THE SUBJECT RECEIVED ANY ANTIRETROVIRAL NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS?

YES 01

NO02----->SKIP TO QUESTION 5.

	<u>Months on Medication</u>	<u>Date Started on Rx MONTH/YEAR</u>	<u>Date Last Received Rx MONTH/YEAR</u>
1. Adefovir	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
2. PMPA	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
3. Other Nucleotide RTI Drugs, Specify:			
1) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
2) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
3) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _

5. HAS THE SUBJECT RECEIVED ANY OTHER ANTIVIRAL MEDICATIONS?

YES 01

NO 02----->SKIP TO QUESTION 6.

	<u>Months on Medication</u>	<u>Date Started on Rx MONTH/YEAR</u>	<u>Date Last Received Rx MONTH/YEAR</u>
1. Acyclovir (Zovirax)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
2. Famciclovir (Famvir)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
3. Ganciclovir (Cytovene, DHPG)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
4. Valacyclovir (Valtrex)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
5. Cidofovir (Vistide)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
6. Other Antiviral Drugs, Specify:			
1) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
2) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
3) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _

6. HAS THE SUBJECT RECEIVED ANY ANTIFUNGAL MEDICATIONS?

YES 01

NO 02----->SKIP TO QUESTION 7.

	<u>Months on Medication</u>	<u>Date Started on Rx MONTH/YEAR</u>	<u>Date Last Received Rx MONTH/YEAR</u>
1. Amphotericin B (Fungizone)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
2. Clotrimazole (Mycelex)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
3. Fluconazole (Diflucan)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
4. Itraconazole (Sporanox)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
5. Ketoconazole (Nizoral)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
6. Other Antifungal Drugs, Specify:			
1) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
2) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
3) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _

7. HAS THE SUBJECT RECEIVED ANY ANTIPNEUMOCYSTIS/TOXOPLASMA AGENTS?

YES 01

NO 02----->SKIP TO QUESTION 8.

	<u>Months on Medication</u>	<u>Date Started on Rx MONTH/YEAR</u>	<u>Date Last Received Rx MONTH/YEAR</u>
1. Atovaquone (Mepron)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
2. Dapsone	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
3. Pentamidine	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
4. Pyrimethamine (Daraprim)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
5. Sulfadiazine	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
6. Trimethoprim	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
7. Trimethoprim-Sulfamethoxazole (Bactrim, Septra)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
8. Other Antipneumocytis/toxoplasma Drugs, Specify:			
1) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
2) _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _

Cladribine (Gleevec); Primaquine

8. HAS THE SUBJECT RECEIVED ANY ANTIMYCOBACTERIAL (TB AND MAC) AGENTS?

YES 01

NO 02----->SKIP TO QUESTION 9.

	<u>Months on Medication</u>	<u>Date Started on Rx MONTH/YEAR</u>	<u>Date Last Received Rx MONTH/YEAR</u>
1. Azithromycin (Zithromax)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
2. Ciprofloxacin (Cipro)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
3. Clarithromycin (Biaxin)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
4. Clofazimine (Lamprene)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
5. Ethambutol (Myambutol)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
6. Isoniazid (INH)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
7. Ofloxacin (Floxin)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
8. Pyrazinamide (PZA)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
9. Rifabutin (Mycobutin)	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _

- 10. Rifampin (Rifadin, Rimactane) |_|_| |_|_|_|_|_|_|_| |_|_|_|_|_|_|_|
- 11. Rifamate capsules |_|_| |_|_|_|_|_|_|_| |_|_|_|_|_|_|_|
- 12. Rifater tablets |_|_| |_|_|_|_|_|_|_| |_|_|_|_|_|_|_|
- 13. Other Antimycobacterial (TB and MAC) Drugs, Specify:
 - 1) _____ |_|_| |_|_|_|_|_|_|_| |_|_|_|_|_|_|_|
 - 2) _____ |_|_| |_|_|_|_|_|_|_| |_|_|_|_|_|_|_|
 - 3) _____ |_|_| |_|_|_|_|_|_|_| |_|_|_|_|_|_|_|

9. HAS THE SUBJECT RECEIVED ANY OTHER HIV-RELATED MEDICATIONS?

YES 01-----> SPECIFY BELOW.

NO02-----> SKIP TO END.

	<u>Months on Medication</u>	<u>Date Started on Rx MONTH/YEAR</u>	<u>Date Last Received Rx MONTH/YEAR</u>
1. _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
2. _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
3. _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
4. _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
5. _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
6. _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
7. _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
8. _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
9. _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _
10. _____	_ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _