



Airways Clinical Research Centers (ALA-ACRC)
Trial of Roflumilast in Asthma Management (TRIM)

TRIM

Reference #:	_____		
a) Clinic ID:	_____ Clinic _____		
b) Participant ID:	T	ID	_____
c) Alpha ID code:	_____ NameCode _____		
d) Date:	_____ VisitDate _____		
	day	month	year
e) Visit ID:	_____ VisitID _____		
f) Form version date:	2	AS100fA	R - 2 0 1 8
	day	month	year
g) Language:	(☒)	(☐)	AS100g
	English	Spanish	

Asthma Symptom Utility Index

Purpose: To collect data on participant's frequency and severity of asthma symptoms.

When: V1 - V7, all visits.

Who: Coordinator to administer questionnaire to participant.

Instructions: Ask all questions as written. Clinic coordinator should review the completed questionnaire for missing responses and resolve any problems **before** the participant leaves the clinic. Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

Read as written: *"I would like to ask you some questions about different symptoms of asthma and how often you were bothered by these symptoms in the past 2 weeks."*

- AS101 1.** How many days were you bothered by coughing in the past 2 weeks (*check only one*):
- (☐) Not at all → Skip to item 3
 (☐) 1-3 days
 (☐) 4-7 days
 (☐) 8-14 days
- AS102 2.** On average, how severe was your cough during the past 2 weeks (*check only one*):
- (☐) Mild
 (☐) Moderate
 (☐) Severe
- AS103 3.** How many days were you bothered by wheezing during the past 2 weeks (*check only one*):
- (☐) Not at all → Skip to item 5
 (☐) 1-3 days
 (☐) 4-7 days
 (☐) 8-14 days
- AS104 4.** On average, how severe was your wheezing during the past 2 weeks (*check only one*):
- (☐) Mild
 (☐) Moderate
 (☐) Severe

- AS105** 5. How many days were you bothered by shortness of breath during the past 2 weeks (*check only one*):
- (₁) Not at all → Skip to item 7
(₂) 1-3 days
(₃) 4-7 days
(₄) 8-14 days
- AS106** 6. On average, how severe was your shortness of breath during the past 2 weeks (*check only one*):
- (₁) Mild
(₂) Moderate
(₃) Severe
- AS107** 7. How many days were you awakened at night by your asthma during the past 2 weeks (*check only one*):
- (₁) Not at all → Skip to item 9
(₂) 1-3 days
(₃) 4-7 days
(₄) 8-14 days
- AS108** 8. On average, how much of a problem was being awakened at night during the past 2 weeks (*check only one*):
- (₁) Mild
(₂) Moderate
(₃) Severe
- AS109** 9. How many days were you bothered by side effects of your asthma medication during the past 2 weeks (*check only one*):
- (₁) Not at all → Skip to item 11
(₂) 1-3 days
(₃) 4-7 days
(₄) 8-14 days
- AS110** 10. On average, how severe were the side effects of your asthma medication during the past 2 weeks (*check only one*):
- (₁) Mild
(₂) Moderate
(₃) Severe

For Clinic Staff use only:

11. Form completed by PIN: **AS111** _____

12. Signature (*do not key*): **AS112** _____

13. Who administered the questionnaire (*check only one*): **AS113**

Participant (*self-administered*)..... (₁)
Clinic coordinator. (₂)
Other (*specify*)..... (₃)

AS113s

relationship to participant

14. Who responded to the questionnaire (*check all that apply*)

a. Participant (*self-administered*):..... **AS114_a** (₁)
b. Other (*specify*):..... **AS114_b** (₁)

AS114_bs

relationship to participant

Baseline Asthma and Medical History

Purpose: To collect baseline information concerning participant's asthma and medical history.

When: V1.

Instructions: Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

A. Clinical center, participant, and visit identification

1. Clinical center ID: Clinic _____

2. Participant ID: T ID _____

3. Alpha ID code: NameCode _____

4. Date completed:

VisitDate
day month - year

5. Visit ID: VisitID V 1

6. Form version date: **BA106**

1 4 - F E B - 2 0 1 9
day month year

10. If multiple races are indicated in item 9, please check what is considered to be the primary race (*check only one*):

BA110

American Indian/Alaskan Native (1)

Asian (2)

Native Hawaiian or other Pacific Islander (3)

Black or African American (4)

Caucasian (5)

Other (*specify*) (6)

BA110s

race

11. Date of birth:

BA111 - day month - year

12. Age:

BA112
years

B. Demographic information

BA107 7. Gender (*check only one*):

Male (1)

Female (2)

BA108 8. Ethnicity (*check only one*):

Hispanic/Latino/Spanish (1)

Not Hispanic/Latino/Spanish (2)

9. Race (*check all that apply*):

BA109_a a. American Indian or Alaskan Native (1)

BA109_b b. Asian (1)

BA109_c c. Native Hawaiian or other Pacific Islander (1)

BA109_d d. Black or African American (1)

BA109_e e. Caucasian (1)

BA109_f f. Other (1)

BA109_fs
race

C. Asthma history

13. Age of onset of asthma symptoms (*years; if onset before first birthday record as "01"*):

BA113
years

14. In the past 12 months, how many times have you had to visit a doctor, emergency department, or hospital because of an asthma attack:

BA114
times

15. In the past 12 months, how many times have you required a course of prednisone (or other systemic steroid) for treatment of an asthma attack:

BA115
times

16. Do you have allergies that make your asthma worse:

BA116 Yes No
(1) (2)

BA117 17. When were you last seen by a doctor for urgent care because of breathing problems (*check only one*):

- Never (1)
Within the last year (2)
Greater than one year ago (3)

BA118 18. When did you last visit a hospital emergency room or urgent care facility because of breathing problems (*check only one*):

- Never (1)
Within the last year (2)
Greater than one year ago (3)

BA119 19. When did you last spend a night in the hospital because of breathing problems (*check only one*):

- Never (1)
Within the last year (2)
Greater than one year ago (3)

BA120 20. When did you last have an Intensive Care Unit (ICU) admission because of an asthma attack (*check only one*):

- Never (1)
Within the last year (2)
Greater than one year ago (3)

BA121 21. Do you have a history of asthma in your blood relatives (parents, brothers/sisters, or children):

- Yes (1)
No (2)
Don't know (3)

D. Weight loss history

22. Weight loss in the last 6 months

a. Have you lost weight:

- BA122a**
Yes No
(1) (2)
23

b. How much weight did you lose:

BA122b
lbs

23. Weight gain in the last 6 months

a. Have you gained weight:

- BA123a**
Yes No
(1) (2)
24

b. How much weight did you gain:

BA123b
lbs

24. Have you ever tried any of the following self-guided weight loss plans (*check all that apply*):

- a.** DASH: **BA124_a** (1)
b. South Beach: **BA124_b** (1)
c. Calorie counting: **BA124_c** (1)
d. Atkins: **BA124_d** (1)
e. Paleo: **BA124_e** (1)
f. Other (*specify*): **BA124_f** (1)

BA124_fs

specify other self-guided weight loss plan

g. None of the above: **BA124_g** (1)

25. Weight Watchers

a. Have you ever enrolled in Weight Watchers:

- BA125a** Yes No
(1) (2)
26

b. How many times:

BA125b
times

26. Jenny Craig

a. Have you ever enrolled in Jenny Craig:

- BA126a** Yes No
(1) (2)
27

b. How many times:

BA126b
times

27. Have you ever enrolled in any of the following weight loss programs (*check all that apply*)

- a. Nutrisystem: **BA127_a** (☐)
b. Personal Trainer Food: **BA127_b** (☐)
c. AdvoCare: **BA127_c** (☐)
d. Medifast: **BA127_d** (☐)
e. Herbalife: **BA127_e** (☐)
f. Other (*specify*): **BA127_f** (☐)

BA127_fs

specify other weight loss program

- g. None of the above: **BA127_g** (☐)

E. Exercise history

28. In the past 4 weeks, how many days have you exercised (*including day-to-day walking*) for at least 5 minutes or more (*if no exercise, record "00"*):

- a. 5-30 minutes: **BA128a**
days
b. 31-60 minutes: **BA128b**
days
c. > 60 minutes: **BA128c**
days

29. Have you ever used MyFitnessPal: **BA129**
Yes No
(☐) (☐)

30. Have you ever used an activity monitor (e.g., Fitbit, Apple Watch, pedometer, etc.): **BA130**
Yes No
(☐) (☐)

BA130s

specify activity monitor

31. Do you have a current gym/health club membership: **BA131**
Yes No
(☐) (☐)

F. Cigarette smoking history

32. Smoking status (*check only one*): **BA132**
Current (☐)
Former (☐)
Never (fewer than 20 packs in lifetime) (☐)

36

33. How many years in total have you smoked (*use decimal value for less than 1 year*):

BA133

years

34. On average, how many packs of cigarettes per day did you smoke:

BA134

of packs

35. Total number of pack-years (*pack-years = years smoked times number of packs per day; multiply item 33 x item 34*):

BA135

pack years

G. E-cigarette use history

36. Have you ever used e-cigarettes (*check only one*): **BA136**

Current (☐)

Former (☐)

Never (used fewer than 5 times cumulatively) (☐)

38

37. How often, on average, do/did you use e-cigarettes/vaporizers (*check only one*): **BA137**

Every day (☐)

Most days, but not every day (☐)

1-3 days per week (☐)

Less than once per week (☐)

H. Current smoking exposure

38. Are you exposed to second hand smoke in your home or work place:

BA138

Yes No
(☐) (☐)

39. Do you frequently go places other than your home or work place where you are exposed to second hand smoke:

BA139

Yes No
(☐) (☐)

I. Symptoms

40. In general, over the last 3 months, how often did you have the following symptoms:

		Never	Once a month	1-2 times per week	3-6 times per week	Daily	Twice a day or more
BA140a	a. Cough - deep, chest, chronic:	(1)	(2)	(3)	(4)	(5)	(6)
BA140b	b. Sputum - phlegm or mucus while coughing:	(1)	(2)	(3)	(4)	(5)	(6)
BA140c	c. Chest tightness - difficulty taking a deep breath or pressure in the chest:	(1)	(2)	(3)	(4)	(5)	(6)
BA140d	d. Wheezy, whistling, or musical sound in chest:	(1)	(2)	(3)	(4)	(5)	(6)
BA140e	e. Shortness of breath:	(1)	(2)	(3)	(4)	(5)	(6)
BA140f	f. Nighttime asthma symptoms - includes waking from sleep, nighttime use of albuterol, early morning chest tightness:	(1)	(2)	(3)	(4)	(5)	(6)

J. General medical conditions

41. Have you ever been diagnosed with diabetes mellitus:

BA141 Yes No
(1) (2)
43

42. Age of onset:

BA142
years

43. Has a doctor ever told you that you have any of the following conditions

		Yes	No
BA143a	a. COPD (Chronic Obstructive Pulmonary Disease):	(1)	(2)
BA143b	b. Gastroesophageal reflux (GERD):	(1)	(2)
BA143c	c. Eczema:	(1)	(2)
BA143d	d. Hay fever or allergic rhinitis:	(1)	(2)
BA143e	e. Food allergies:	(1)	(2)
BA143f	f. Other allergies (<i>specify</i>):	(1)	(2)

BA143fs

allergies

BA143g	g. Cancer (<i>other than skin cancer; specify</i>):	(1)	(2)
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BA143gs

cancer

BA143h	h. High cholesterol:	(1)	(2)
BA143i	i. Thyroid disease:	(1)	(2)
BA143j	j. Coronary artery disease:	(1)	(2)

Item 43 continued...

	Yes	No	
k.	(1)	(2)	BA143k
l.	(1)	(2)	BA143l
m.	(1)	(2)	BA143m
n.	(1)	(2)	BA143n
o.	(1)	(2)	BA143o
p.	(1)	(2)	BA143p
q.			Generalized anxiety disorder, major psychiatric disorder, Major Depressive Disorder, Bipolar Disorder, PTSD, suicidal idealization (<i>specify</i>): (1) (2) BA143q

BA143qs

specify disorder

r.	Irritable bowel syndrome (IBS):	(1)	(2)	BA143r
s.	Inflammatory bowel disease (IBD):	(1)	(2)	BA143s
t.	Other condition(s) (<i>specify</i>):	(1)	(2)	BA143t

BA143ts

other condition not previously mentioned

BA143ts2

other condition not previously mentioned

K. Health and development questions

44. What was (is) your approximate weight at the age of 18 years:

BA144
_____ lbs

- BA145** 45. What was your age of first menstrual period (answer a, b, or c)

- | | | |
|--------------------|---------------|-------------|
| a. Age: | BA145s | (BA145='1') |
| | _____ years | |
| b. Don't know: | (1) | (BA145='2') |
| c. Not applicable: | (1) | (BA145='3') |

L. Background information

Provide cue cards to participant for items 46-50.

- BA146** 46. What is your current marital status (check only one):

- | | |
|---|-------|
| A - Married | (1) |
| B - Single, living with significant other | (2) |
| C - Single, not living with significant other | (3) |
| D - Separated | (4) |
| E - Divorced | (5) |
| F - Widowed | (6) |
| Declined to answer | (7) |

- BA147** 47. Which of the following categories best describes the total income for the last year for the household where you live (please include income from all sources such as wages, public assistance or investments; check only one):

- | | |
|-----------------------|-------|
| A - \$30,000 or less | (1) |
| B - \$30,001 - 50,000 | (2) |
| C - \$50,001 - 75,000 | (3) |
| D - Over \$75,000 | (4) |
| E - Don't know | (5) |
| Declined to answer | (6) |

48. Educational attainment

Ask participant: "What is the highest level of education **you** have COMPLETED" (check only one): **BA148**

- | | |
|---|-------|
| A - Eighth grade or less | (1) |
| B - More than 8th grade, but not a high school graduate | (2) |
| C - High school graduate or equivalent | (3) |
| D - Some college | (4) |
| E - Graduate of two-year college or technical school | (5) |
| F - Graduate of four year college | (6) |
| G - Post-graduate studies | (7) |
| Declined to answer | (8) |

49. How do you pay for your prescription drugs (check only one): **BA149**

- | | |
|--|-------|
| A - Out of pocket (pay entire amount with own money) | (1) |
| B - Co-pay (insurance pays some and family pays the rest) | (2) |
| C - Pay nothing (insurance pays for all cost of prescriptions) | (3) |
| D - Don't know | (4) |
| E - Other (specify) | (5) |

BA149s

other payment

- | | |
|--------------------|-------|
| Declined to answer | (6) |
|--------------------|-------|

50. Which of the following best describes your daily work schedule (check only one): **BA150**

- | | |
|--------------------------|-------|
| A - Full-time employment | (1) |
| B - Part-time employment | (2) |
| C - Student | (3) |
| D - Household work | (4) |
| E - Disabled | (5) |
| F - Retired | (6) |
| G - Not working | (7) |
| H - Other (specify) | (8) |

BA150s

daily work schedule

- | | |
|--------------------|-------|
| Declined to answer | (9) |
|--------------------|-------|

Participant ID: T _____

Visit ID: V 1

M. Administrative information

51. Form completed by PIN: BA151 _____

52. Signature (*do not key*):

BA152

Biospecimen Collection Form

Purpose: To document information about biospecimen collection. If participant does not consent to banking specimens, skip this form.

When: V2 and V7.

Instructions: Write the participant alpha ID code on each barcode label. In section B indicate "Yes" if biospecimen was available OR indicate "No" if biospecimen was NOT available. For each sample, attach the specified barcode label on the sample and its matching barcode in appropriate box below. Scan barcode. Key into TRIM data system at www.cctri-als.org/alaacrc within **10 working days**.

A. Clinical center, participant, and visit identification

1. Clinical center ID: **Clinic** _____

2. Participant ID: **T ID** _____

3. Alpha ID code: **NameCode** _____

4. Date specimens collected: **VisitDate**
____ day ____ month ____ year

5. Visit ID: **VisitID** _____

6. Form version date: **BC106**
____ day ____ month ____ year

B. Blood collection

7. Specimens

a. Serum aliquot 1 available: **BC107a**

Yes No
(1) (2)

BC107as
Serum
Aliquot 1
barcode
here

b. Serum aliquot 2 available: **BC107b**

Yes No
(1) (2)

BC107bs
Serum
Aliquot 2
barcode
here

c. Serum aliquot 3 available: **BC107c**

Yes No
(1) (2)

BC107cs
Serum
Aliquot 3
barcode
here

d. Serum aliquot 4 available: **BC107d**

Yes No
(1) (2)

BC107ds
Serum
Aliquot 4
barcode
here

e. Serum aliquot 5 available: **BC107e**

Yes No
(1) (2)

BC107es
Serum
Aliquot 5
barcode
here

f. Serum aliquot 6 available: **BC107f**

Yes No
(1) (2)

BC107fs
Serum
Aliquot 6
barcode
here

Participant ID: T _____

Visit ID: V _____

Item 7 continued

g. Blood sent to lab for glucose BC107g
Yes No
(1) (2)

8

h. Glucose result: BC107h
mg/dL

C. Administrative information

8. Form completed by PIN: BC108 _____

9. Signature (*do not key*):

BC109

Clinic Visit Form

Purpose: To record information about diary entries, asthma symptoms, and other procedures.

When: V2-V7.

Instructions: Complete form at clinic visit. Key into TRIM data system at www.cctrials.org/alaacrc within 10 working days.

A. Clinical center, participant, and visit identification

1. Clinical center ID: **Clinic**

2. Participant ID: **T ID**

3. Alpha ID code: **NameCode**

4. Date completed:

VisitDate

____ - ____ - ____
day month year

5. Visit ID: **VisitID**

6. Form version date: **CV106**

0 8 - M A Y - 2 0 1 8
day month year

B. Diary Cards

7. Number of Diary Cards not returned since the last study visit:

CV107
of diary cards

Review Diary Card with participant during visit.

8. Reason for missing Diary Cards (*check all that apply*):

CV108_a a. None missing: ()

CV108_b b. Participant forgot to return: ()

CV108 c c. Did not complete: ()

CV108_d d. Lost or destroyed: ()

CV108_e e. In the mail: ()

CV108_f f. Other (specify): ()

CV108_fs
specify

C. Interim medical history

9. Since your last visit, rate the severity of the following symptoms (*ask about ALL symptoms listed*):

Mild: Just noticeable and considered unpleasant, but does not interfere with usual activities or sense of well-being.

Moderate: Interferes with usual activities or sense of well-being, but does not limit the participant.

Severe: Prevents activities or participant seeks medical care.

		None	Mild	Moderate	Severe
CV109a	a. Headaches:	(0)	(1)	(2)	(3)
CV109b	b. Congestion, runny nose, sneezing:	(0)	(1)	(2)	(3)
CV109c	c. Acute upper respiratory tract infection:	(0)	(1)	(2)	(3)
CV109d	d. Chest discomfort:	(0)	(1)	(2)	(3)
CV109e	e. Chest pain:.....	(0)	(1)	(2)	(3)
CV109f	f. Bloating/gas:.....	(0)	(1)	(2)	(3)
CV109g	g. Acid reflux/GERD:	(0)	(1)	(2)	(3)
CV109h	h. Nausea:.....	(0)	(1)	(2)	(3)
CV109i	i. Diarrhea:.....	(0)	(1)	(2)	(3)
CV109j	j. Abdominal pain:.....	(0)	(1)	(2)	(3)
CV109k	k. Skin rashes:.....	(0)	(1)	(2)	(3)
CV109l	l. Muscle pain/aches:.....	(0)	(1)	(2)	(3)
CV109m	m. Other (<i>specify</i>):.....		(1)	(2)	(3)
	<u>CV109ms</u> symptom				
CV109n	n. Other (<i>specify</i>):.....		(1)	(2)	(3)
	<u>CV109ns</u> symptom				
CV109o	o. Other (<i>specify</i>):.....		(1)	(2)	(3)
	<u>CV109os</u> symptom				
CV109p	p. Other (<i>specify</i>):.....		(1)	(2)	(3)
	<u>CV109ps</u> symptom				

- CV110** 10. Are you pregnant (*check only one*):
- Yes (1)
- No (2)
- Not applicable (3)

- CV111** 11. Are you currently using adequate birth control methods (abstinence, combination barrier and spermicide, or hormonal) (*check only one*):
- Yes (1)
- No (2)
- Not applicable (3)

- CV112** 12. Are you currently using a CPAP machine (*check only one*):
- Yes (1)
- No (2)

13. Since the last study visit, have you had any of the following **new diagnoses** (*check all that apply*):

- CV113_a** a. Hypertension: (1)
- CV113_b** b. Pneumonia: (1)
- CV113_c** c. Bronchitis: (1)
- CV113_d** d. Strep throat: (1)
- CV113_e** e. Acute sinusitis: (1)
- CV113_f** f. Diabetes: (1)
- CV113_g** g. Other new diagnosis (*specify*): (1)

CV113_gs

specify

- CV113_h** h. No new diagnosis: (1)

14. Serious adverse events
- a. Since the last study visit, have you experienced a serious adverse event or been hospitalized:

CV114a Yes No
(1) (2)

15

- b. Specify event(s): **CV114b**

- c. Number of hospitalizations (*if none enter 00*):

CV114c

For hospitalization(s) or other serious adverse events that occurred after participant enrolled in the study, complete a Serious Adverse Event (SR) form for each event.

15. Since the last study visit, how many times have you seen or contacted a health care provider for asthma or asthma treatment (*if none enter 00*):

CV115

16. Since the last study visit, how many times have you seen or contacted a health care provider for upper airway symptoms (*cold, sinusitis, rhinitis*) (*if none enter 00*):

CV116

17. Other significant medical events or illnesses since the last visit:

CV117

Yes No
(1) (2)

If "Yes," specify:

CV117s

For significant medical events that occurred after the participant enrolled in the study, complete an Unanticipated Problem Report (UP) form for each event.

D. Exit procedures

18. Is this the final study visit:

CV118

Yes	No
(1)	(2)
21	

19. Exit materials distributed

	Yes	No
CV118a a. Exit letter:	(1)	(2)
CV118b b. Final spirometry test results:	(1)	(2)
CV118c c. Treatment unmasking:	(1)	(2)

20. Drug returned:

CV120

Yes	No
(1)	(2)

E. Administrative information

21. Form completed by PIN:

CV121

 22. Signature (*do not key*):

CV122 _____

Drug Dispensing

Purpose: To document distribution of study drug and provide time sensitive tracking of study drug supply.

When: V2, V3, V4, V5 and V6 or any time study drug is dispensed.

Instructions: This form should be filled out by a certified TRIM Clinic Coordinator, Study Physician or PI. Key into TRIM data system at www.cctrials.org/alaacrc **at the time of the visit.**

A. Clinical center, participant, and visit identification

1. Clinical center ID: Clinic _____
2. Participant ID: T ID _____
3. Alpha ID code: NameCode _____
4. Date study drug dispensed:

VisitDate
 _____ - _____ - _____
 day month year
5. Visit ID: VisitID _____
(If not associated with a particular study visit, record as "N")
6. Form version date: **DA106**

0 7 - M A Y - 2 0 1 8
 day month year

B. Medication details

7. Was study drug dispensed **DA107**
 Yes No
 (1) (2)

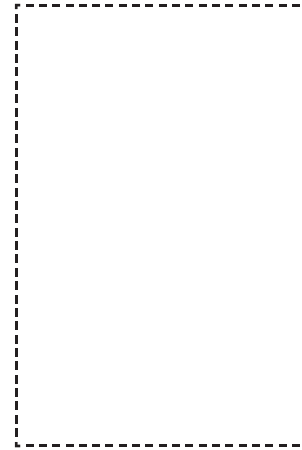
9
8. Why was study drug not dispensed (specify)
DA108 _____
specify

If drug not dispensed, skip to item 13.

9. Bottle ID: T **DA109** _____
 bottle ID#

Note: Bottle ID assignment is to be printed and stored in participant's record.

10. Tear off label from dispensed bottle: **DA110**



Bottle ID to be keyed at data entry.

Note: Label to be affixed to form at the time bottle given to participant.

11. Expiration date of dispensed bottle:
DA111
 _____ - _____ - _____
 day month year

12. Study drug bottle dispensed for following reason (check all that apply)
 - a. Randomization (V2): (1) **DA112_a**
 - b. Scheduled drug refill (V3-V6): (1) **DA112_b**
 - c. Replacement of lost drug: (1) **DA112_c**
 - d. Other (specify): (1) **DA112_d**

DA112ds

reason

C. Administrative information

13. Form completed by PIN: **DA113** _____

14. Signature (do not key):

DA114

TRIM Diary Card

Fill out information inside the box each morning and evening. If information is missing, leave that item blank.

	Mon DC101_Grd1	Tue DC101_Grd2	Wed DC101_Grd3	Thur DC101_Grd4	Fri DC101_Grd5	Sat DC101_Grd6	Sun DC101_Grd7
MORNING	1. Date (month/day):						
	2. Morning peak flow (highest of 3, before bronchodilator):						
	For item 3 check (✓) if occurred						
EVENING	3. Awakened by asthma last night:						
	4. Drug use for quick relief of asthma symptoms (do not count uses to prevent symptoms, for example before exercise; if none record as "0")						
	a. # puffs per day by metered dose inhaler:						
	b. # uses per day by nebulizer:						
	For items 5 - 8 check (✓) if occurred today						
	5. Used oral or IV prednisone/steroids for asthma:						
	6. Used inhaled corticosteroid (e.g. daily controller meds, albuterol, advair):						
	7. New or increased dose of asthma medicine other than drugs listed in 4a, 4b, 5, or 6:						
	8. Urgent unscheduled healthcare contact for asthma (ED/hospital/clinic or doctor visit):						
	9. Asthma score: 0 = No asthma episodes 1 = 1-3 asthma episodes, each lasting 2 hours or less -- all mild 2 = 4 or more mild asthma episodes, or 1 or more asthma episodes that interfered with activity, play, school, or sleep for less than 2 hours 3 = 1 or more asthma episodes which last longer than 2 hours, or result in shortening normal activity, seeing a doctor, or going to a hospital						

To be completed by clinic

10. Date diary started (first entry in item 1):

DC110

____ day ____ month ____ year

15. Date diary returned:

DC115

____ day ____ month ____ year

11. Clinical center ID:

Clinic

16. Clinic coordinator PIN:

DC116

12. Participant ID:

ID

17. Clinic coordinator signature (do not key):

13. Alpha ID code:

NameCode

DC117

14. Form version date:

DC114

____ 0 ____ 3 - M ____ A ____ Y - 2 ____ 0 ____ 1 ____ 8
day month year

Sequential diary card # for this participant (optional):

SeqN

Drug Return/Capsule Count Form

Purpose: To document adherence with study drug and return of study drug bottle.

When: V3, V4, V5, V6, and V7.

Instructions: This form should be completed by certified TRIM Clinic Coordinator. Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

A. Clinical center, participant, and visit identification

1. Clinical center ID: A **Clinic** _____

2. Participant ID: T **ID** _____

3. Alpha ID code: _____ **NameCode** _____

4. Date completed: _____ **VisitDate**
_____ day _____ month _____ year

5. Visit ID: _____ **VisitID**
(If not associated with a particular study visit,
record as "N")

6. Form version date: _____ **DR106**
 1 4 - F E B - 2 0 1 9
day month year

B. Medication details

7. Bottle ID #1: T **DR107** _____

8. Date bottle dispensed: _____ **DR108**
_____ day _____ month _____ year

9. Number of tablets remaining: _____ **DR109**
tablet(s)
If no other bottles returned, skip to item 13.

10. Bottle ID #2: T **DR110** _____

11. Date bottle dispensed: _____ **DR111**
_____ day _____ month _____ year

12. Number of tablets remaining: _____ **DR112**
tablet(s)

13. How often is the participant taking study drug (*check only one*): **DR113**

Every other day: (1)

Every day: (2)

No longer taking (*complete a treatment termination form*): (3)

Other (*specify*): (4)

DR113s

14. Participant took study drug (*check only one*): **DR114**

As expected: (1)

16

More than expected
(too few tablets returned): (2)

Less than expected
(too many tablets returned): (3)

15. Why is participant not taking study drug as expected (*check all that apply*):

a. Forgot to take study drug: (1) **DR115_a**

b. Forgot to escalate study drug: (1) **DR115_b**

c. Lost study drug: (1) **DR115_c**

d. Did not have study drug on hand: (1) **DR115_d**

e. Side effects: (1) **DR115_e**

f. Too busy: (1) **DR115_f**

g. Other (*specify*): (1) **DR115_g**

DR115_gs

specify

C. Administrative information

16. Form completed by PIN: _____ **DR116**

17. Signature (*do not key*): _____ **DR117**

Eligibility Form

Purpose: To document verification that participant meets all eligibility criteria for randomization.

When: V2 after all other forms and activities are completed.

Instructions: If participant still meets all eligibility criteria, key into TRIM data system at www.cctrials.org/alaacrc. This form and the Screening form (SC) must be keyed prior to obtaining treatment assignment. **It is recommended that the responsible study physician sign this form prior to randomization. However, if that is not logistically possible, the physician should sign this form within a prudent period of time after randomization.** If any item checked is marked with , participant is ineligible for randomization; complete and data enter the Early Study Exit (EE) form.

A. Clinical center, participant, and visit identification

1. Clinical center ID: Clinic
2. Participant ID: T ID
3. Alpha ID code: Clinic
4. Date of randomization:

VisitDate
 day - month - year
5. Visit ID: VisitID V 2
6. Form version date: EL106

0 6 - J U L - 2 0 2 0
day month year

B. Inclusion criteria for randomization

- EL107** 7. Previous (within five years) evidence of at least a 12% increase in FEV₁ after inhaling 2-4 puffs of albuterol or a positive methacholine challenge test or patient reported improvement of asthma symptoms with use of corticosteroids:

Yes No
(1) (2)


- EL108** 8. On regular prescribed asthma controller therapy for at least 3 months:

Yes No
(1) (2)


9. Participant has signed informed consent:

Yes No
(1) (2)


EL109

C. Exclusion criteria for randomization

10. History of bariatric surgery:

Yes No
(1) (2)


EL110

11. Participation in an investigational study within the past 4 weeks:

Yes No
(1) (2)


EL111

12. Use of theophylline in the past 4 weeks:

Yes No
(1) (2)


EL112

13. Use of roflumilast in the past 4 weeks:

Yes No
(1) (2)


EL113

14. *For women of child bearing potential:* currently pregnant, lactating, or unwilling to practice effective contraception for the duration of the study (*check only one*):

Yes (1)

No (2)
Not applicable (3)

EL114

EL115 15. Physician diagnosis of chronic obstructive pulmonary disease (COPD):

	Yes	No
	(1)	(2)
		

EL116 16. Diagnosis of liver cirrhosis:

	Yes	No
	(1)	(2)
		

EL117 17. Smoker: current (within the last 6 months) or former (greater than 20 pack years):

	Yes	No
	(1)	(2)
		

18. Does the participant take any of the following drugs that are metabolized by Cytochrome P450:

- | | | | |
|--|---|-------|---------------|
| | Yes | No | |
| a. Rifadin® (rifampicin): | (1) | (2) | EL118a |
| |  | | |
| b. Luminal® (phenobarbital): | (1) | (2) | EL118b |
| |  | | |
| c. Carnexiv®, Tegretol (carbamazepine): | (1) | (2) | EL118c |
| |  | | |
| d. Dilantin® (phenytoin): | (1) | (2) | EL118d |
| |  | | |
| e. Ery-Tab® (erythromycin): | (1) | (2) | EL118e |
| |  | | |
| f. Nizoral® (ketoconazole): | (1) | (2) | EL118f |
| |  | | |
| g. Tagamet® (cimetidine): | (1) | (2) | EL118g |
| |  | | |
| h. Luvox® (fluvoxamine): | (1) | (2) | EL118h |
| |  | | |
| i. Penetrex® (enoxacin): | (1) | (2) | EL118i |
| |  | | |
| j. Femodene® (oral contraceptives containing ethinyl estradiol with gestodene): | (1) | (2) | EL118j |
| |  | | |
| k. Other (<i>specify</i>): | (1) | (2) | EL118k |
| |  | | |

EL118ks

specify

E. Final check

28. Participant meets all eligibility criteria for randomization:

EL128

Yes No

(1) (2)



If answer to item 28 is "No," complete Early Exit (EE) form.

F. Administrative information

29. Form completed by PIN: EL129

30. Signature (*do not key*):

EL130

31. Study physician PIN: EL131

32. Study physician signature (*do not key*):

EL132

33. Date study physician signed:

 - - EL133
day month year

After data entering this EL form, return to TRIM Data System Main Menu and select TRIM Treatment Assignment link to complete randomization process.

Note:

Print treatment assignment from data system and store in participant's record.

G. Randomization data (*generated by TRIM data system*)

34. Treatment assignment:

T -
Bottle ID

Reference #:	_____										
a) Clinic ID:	_____	Clinic		_____							
b) Participant ID:	T	ID		_____							
c) Alpha ID code:	_____	NameCode		_____							
d) Date:	_____	VisitDate		_____							
	day	month	year								
e) Visit ID:	_____	VisitID		_____							
f) Form version date:	1	0	EV100f	L	-	2	0	1	8		
	day	month	month	year	year	year	year	year	year		

STUDY EVALUATION

Purpose: To evaluate a participant's experience in TRIM and record distribution of exit materials.

When: V7 or earlier as needed.

Completed by: Participant with coordinator assistance if needed.

Instructions: Complete at end of V7 or as needed if participant terminates earlier. Key into TRIM data system at www.cctrials.org/alaacrc **within 10 working days**.

Study Evaluation

Please take a few minutes to evaluate the TRIM pilot study. Your feedback will be used to improve TRIM in the future.

A. Exit questions for participants

1. Why did you participate in the study
(check all that apply):

EV101_a a. To improve my asthma: (1)

EV101_b b. To help lose weight: (1)

EV101_c c. Medical care: (1)

EV101_d d. Contribution to science: (1)

EV101_e e. Other (specify): (1)

EV101_es

- EV102 2. How would you rate your experience as a participant in the study (check only one):

Excellent (1)

Good (2)

Fair (3)

Poor (4)

- EV103 3. Do you have any idea which study medication was assigned (check only one):

Roflumilast (1)

Placebo (2)

Don't know (3)

4. Would you want to continue with this treatment: EV104

Yes No
(1) (2)

5. Since starting the study, how do you think your asthma has changed (check only one): EV105

Improved (1)

Worsened (2)

Stayed the same (3)

Unsure (4)

6. Comments about my asthma: EV106

7. Did you try any of the following weight loss plans in the last 6 months (*check all that apply*):

EV107_a Weight Watchers: ()

EV107_b Jenny Craig: ()

EV107_c DASH: ()

EV107_d South Beach: ()

EV107_e Calorie counting: ()

EV107_f Atkins: ()

EV107_g Paleo: ()

EV107_h Other (*specify*): ()

EV107_hs

EV107_i None of the above: ()

8. Did you enroll in any of the following weight loss programs (*check all that apply*):

EV108_a Nutrisystem: ()

EV108_b Personal Trainer Food: ()

EV108_c AdvCare: ()

EV108_d Medifast: ()

EV108_e Herbalife: ()

EV108_f Other (*specify*): ()

EV108_fs

EV108_g None of the above: ()

9. Did you join a gym/health club in the last 6 months: EV109

Yes No
() ()

10. Did you use MyFitnessPal in the last 6 months: EV110

Yes No
() ()

11. Did you use an activity monitor (for example, FitBit, pedometer, etc.): EV111

Yes No
() ()

If no, skip to item 13.

12. Was it helpful: EV112

Yes No
() ()

13. Did you lose weight: EV113

Yes No
() ()

If no, skip to item 15.

14. If you lost weight, was it as much as you hoped: EV114

Yes No
() ()

If yes, skip to item 16.

EV115 15. If you did not lose weight or lose as much as you hoped, why do you think that was:

EV116 16. I would recommend this program to a friend with asthma (*check only one*):

- Strongly disagree: (1)
 Disagree: (2)
 Neither agree nor disagree: (3)
 Agree: (4)
 Strongly agree: (5)
 Not applicable: (6)

EV117 17. Please provide any comments or recommendations you have about TRIM (for example, likes, dislikes, suggestions, etc.):

To be completed by a member of clinical center staff:

B. Exit procedures

18. Exit materials distributed

- | | Yes | No | |
|---------------------------------|-------|-------|---------------|
| a. Exit letter for participant: | (1) | (2) | EV118a |
| b. Exit letter for physician: | (1) | (2) | EV118b |
| c. Unmasking envelope: | (1) | (2) | EV118c |

C. Administrative information

19. Date reviewed: **EV119**
 _____ day _____ month _____ year

20. Clinic coordinator PIN: **EV120** _____

21. Clinic coordinator signature (*do not key*):

EV121

22. Who administered the questionnaire (*check only one*): **EV122**

- | | |
|--------------------------|-------|
| Participant | (1) |
| Clinic coordinator | (2) |
| Other (<i>specify</i>) | (3) |

EV122s

relationship to participant

23. Who responded to the questionnaire (*check all that apply*):

- | | | |
|-----------------------------|----------------|-------|
| a. Participant | EV123_a | (1) |
| b. Other (<i>specify</i>) | EV123_b | (1) |

EV123_bs

relationship to participant

Reference #:			
a) Clinic ID:	_____	Clinic	_____
b) Participant ID:	T _____	ID	_____
c) Alpha ID code:	_____	NameCode	_____
d) Date:	_____	VisitDate	_____
	day	month	year
e) Visit ID:	_____	VisitID	_____
f) Form version date:	2/8/2018	GS100f	R - 2/0/18
	day	month	year
g) Language:	(✓) English	() Spanish	GS100g

GASTROINTESTINAL SYMPTOM RATING SCALE (GSRS)

These questions should not be used, copied or distributed in any form without permission from
from AstraZenca R&D, HEOR, SE-431 83 Mölndal, Sweden, PROinformation@astrazeneca.com

Purpose: To assess gastrointestinal symptoms.

When: V1-V7, all visits.

Who: Participant to complete.

Instructions: Clinic coordinator to hand to participant to complete. Clinic coordinator should review the completed questionnaire for missing responses and resolve any problems **before** the participant leaves the clinic. If score on any item is ≥ 6 , indicative of severe or very severe discomfort, discuss this with the study PI or doctor immediately. Refer to MOP for further instructions. Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

Gastrointestinal Symptom Rating Scale (GSRS)

Please read this first:

This survey contains questions about how you have been feeling and what it has been like **DURING THE PAST WEEK**. Mark the choice that best applies to you and your situation by circling the number below.

- GS101** 1. Have you been bothered by PAIN OR DISCOMFORT IN YOUR UPPER ABDOMEN OR THE PIT OF YOUR STOMACH during the past week?

Circle one

- No discomfort at all. 1
- Minor discomfort. 2
- Mild discomfort. 3
- Moderate discomfort. 4
- Moderately severe discomfort. 5
- Severe discomfort. 6
- Very severe discomfort. 7

- GS102** 2. Have you been bothered by HEARTBURN during the past week? (By heartburn we mean an unpleasant stinging or burning sensation in the chest.)

Circle one

- No discomfort at all. 1
- Minor discomfort. 2
- Mild discomfort. 3
- Moderate discomfort. 4
- Moderately severe discomfort. 5
- Severe discomfort. 6
- Very severe discomfort. 7

- GS103** 3. Have you been bothered by ACID REFLUX during the past week? (By acid reflux we mean the sensation of regurgitating small quantities of acid or flow of sour or bitter fluid from the stomach up to the throat.)

Circle one

- No discomfort at all. 1
 Minor discomfort. 2
 Mild discomfort.. . . . 3
 Moderate discomfort. 4
 Moderately severe discomfort. 5
 Severe discomfort. 6
 Very severe discomfort. 7

- GS104** 4. Have you been bothered by HUNGER PAINS in the stomach during the past week? (This hollow feeling in the stomach is associated with the need to eat between meals.)

Circle one

- No discomfort at all. 1
 Minor discomfort. 2
 Mild discomfort.. . . . 3
 Moderate discomfort. 4
 Moderately severe discomfort. 5
 Severe discomfort. 6
 Very severe discomfort. 7

GS105 5. Have you been bothered by NAUSEA during the past week? (By nausea we mean a feeling of wanting to throw up or vomit.)

Circle one

- No discomfort at all. 1
 Minor discomfort. 2
 Mild discomfort. 3
 Moderate discomfort. 4
 Moderately severe discomfort. 5
 Severe discomfort. 6
 Very severe discomfort. 7

GS106 6. Have you been bothered by RUMBLING in your stomach during the past week?(Rumbling refers to vibrations or noise in the stomach.)

Circle one

- No discomfort at all. 1
 Minor discomfort. 2
 Mild discomfort. 3
 Moderate discomfort. 4
 Moderately severe discomfort. 5
 Severe discomfort. 6
 Very severe discomfort. 7

GS107 7. Has your stomach felt **BLOATED** during the past week?(Feeling bloated refers to swelling often associated with a sensation of gas or air in the stomach.)

Circle one

- No discomfort at all. 1
 Minor discomfort. 2
 Mild discomfort. 3
 Moderate discomfort. 4
 Moderately severe discomfort. 5
 Severe discomfort. 6
 Very severe discomfort. 7

GS108 8. Have you been bothered by **BURPING** during the past week?(Burping refers to bringing up air or gas from the stomach via the mouth, often associated with easing a bloated feeling.)

Circle one

- No discomfort at all. 1
 Minor discomfort. 2
 Mild discomfort. 3
 Moderate discomfort. 4
 Moderately severe discomfort. 5
 Severe discomfort. 6
 Very severe discomfort. 7

GS109 9. Have you been bothered by **PASSING GAS OR FLATUS** during the past week?
(Passing gas or flatus refers to the need to release air or gas from the bowel, often associated with easing a bloated feeling.)

Circle one

- No discomfort at all. 1
Minor discomfort. 2
Mild discomfort.. . . . 3
Moderate discomfort. 4
Moderately severe discomfort. 5
Severe discomfort. 6
Very severe discomfort. 7

GS110 10. Have you been bothered by **CONSTIPATION** during the past week? (Constipation refers to a reduced ability to empty the bowels.)

Circle one

- No discomfort at all. 1
Minor discomfort. 2
Mild discomfort.. . . . 3
Moderate discomfort. 4
Moderately severe discomfort. 5
Severe discomfort. 6
Very severe discomfort. 7

GS111 11. Have you been bothered by DIARRHEA during the past week? (Diarrhea refers to a too frequent emptying of the bowels.)

Circle one

- No discomfort at all. 1
- Minor discomfort. 2
- Mild discomfort.. . . . 3
- Moderate discomfort. 4
- Moderately severe discomfort. 5
- Severe discomfort. 6
- Very severe discomfort. 7

GS112 12. Have you been bothered by LOOSE STOOLS during the past week? (If your stools(motions)have been alternately hard and loose, this question only refers to the extent you have been bothered by the stools being loose.)

Circle one

- No discomfort at all. 1
- Minor discomfort. 2
- Mild discomfort.. . . . 3
- Moderate discomfort. 4
- Moderately severe discomfort. 5
- Severe discomfort. 6
- Very severe discomfort. 7

GS113 13. Have you been bothered by **HARD STOOLS** during the past week? (If your stools(motions)have been alternately hard and loose, this question only refers to the extent you have been bothered by the stools being hard.)

Circle one

- No discomfort at all. 1
- Minor discomfort. 2
- Mild discomfort.. . . . 3
- Moderate discomfort. 4
- Moderately severe discomfort. 5
- Severe discomfort. 6
- Very severe discomfort. 7

GS114 14. Have you been bothered by an **URGENT NEED TO HAVE A BOWEL MOVEMENT** during the past week?(This urgent need to go to the toilet is often associated with a feeling that you are not in full control.)

Circle one

- No discomfort at all. 1
- Minor discomfort. 2
- Mild discomfort.. . . . 3
- Moderate discomfort. 4
- Moderately severe discomfort. 5
- Severe discomfort. 6
- Very severe discomfort. 7

GS115 15. When going to the toilet during the past week, have you had the SENSATION OF NOT COMPLETELY EMPTYING YOUR BOWELS?(This feeling of incomplete emptying means that you still feel a need to pass more stool despite having exerted yourself to do so.)

Circle one

- No discomfort at all. 1
- Minor discomfort. 2
- Mild discomfort.. . . . 3
- Moderate discomfort. 4
- Moderately severe discomfort. 5
- Severe discomfort. 6
- Very severe discomfort. 7

PLEASE CHECK THAT ALL QUESTIONS HAVE BEEN ANSWERED!

THANK YOU FOR YOUR CO-OPERATION.

For Clinic Staff use only:

16. Form completed by PIN: **GS116** ____
17. Signature (*do not key*): **GS117** _____
18. Who administered the questionnaire (*check only one*): **GS118**
 Participant (*self-administered*)..... (1)
 Clinic coordinator. (2)
 Other (*specify*). (3)
- _____
 relationship to participant
19. Who responded to the questionnaire (*check all that apply*)
 a. Participant (*self-administered*):..... **GS119_a** (1)
 b. Other (*specify*):. **GS119_b** (1)
- GS119_bs** _____
 relationship to participant

Reference #:	_____
a) Clinic ID:	____ Clinic ____
b) Participant ID:	T ____ ID ____
c) Alpha ID code:	____ NameCode ____
d) Date:	____ VisitDate ____ day month year
e) Visit ID:	____ VisitID ____
f) Form version date:	0 5 - HQ100f V - 2 0 1 9 day month year
g) Language:	(☒) (☐) HQ100g English Spanish

PATIENT HEALTH QUESTIONNAIRE

(PHQ-9 and GAD-7)

Purpose: To document information about anxiety and depression.

When: V1-V7, all visits.

Who: Participant to complete.

Instructions: Clinic coordinator to hand to participant to complete. Clinic coordinator should review the completed questionnaire for missing responses, compare scores from previous visits, and resolve any problems **before** the participant leaves the clinic. Refer to the MOP for more detailed instructions and additional participant materials.

- Calculate total scores for PHQ-9 and GAD-7 before end of visit.
- If the answer on item 9 is greater than 0, complete a SSW form.
- If the total score in item 10 is greater or equal to 15 or the total score of item 19 is greater or equal to 10, give the participant the mental health resource information.
- Scores exceeding the threshold score, (see worksheet on back), or minimal changes in scores when compared to V2, should be considered an adverse event. See MOP.

Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

Patient Health Questionnaire (PHQ-9 and GAD-7)

A. PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use “✓” to indicate your answer)

		Not at all	Several days	More than half the days	Nearly every day
HQ101	1. Little interest or pleasure in doing things:	(0)	(1)	(2)	(3)
HQ102	2. Feeling down, depressed, or hopeless:	(0)	(1)	(2)	(3)
HQ103	3. Trouble falling or staying asleep, or sleeping too much:	(0)	(1)	(2)	(3)
HQ104	4. Feeling tired or having little energy:	(0)	(1)	(2)	(3)
HQ105	5. Poor appetite or overeating:	(0)	(1)	(2)	(3)
HQ106	6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down:	(0)	(1)	(2)	(3)
HQ107	7. Trouble concentrating on things, such as reading the newspaper or watching television:	(0)	(1)	(2)	(3)
HQ108	8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual:	(0)	(1)	(2)	(3)
HQ109	9. Thoughts that you would be better off dead or of hurting yourself in some way:	(0)	(1)	(2)	(3)

Administrative use only

HQ110 10. Total PHQ-9 score (add up sub-item values in items 1 through 9): _____

HQ111 11. If you indicated any problems in items 1-9, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people:

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult	Selected “Not at all” for items 1-9
(0)	(1)	(2)	(3)	(4)

B. GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

(Use “✓” to indicate your answer)

		Not at all	Several days	More than half the days	Nearly every day
HQ112	12. Feeling nervous, anxious or on edge:	(0)	(1)	(2)	(3)
HQ113	13. Not being able to stop or control worrying:	(0)	(1)	(2)	(3)
HQ114	14. Worrying too much about different things:	(0)	(1)	(2)	(3)
HQ115	15. Trouble relaxing:	(0)	(1)	(2)	(3)
HQ116	16. Being so restless that it is hard to sit still:	(0)	(1)	(2)	(3)
HQ117	17. Becoming easily annoyed or irritable:	(0)	(1)	(2)	(3)
HQ118	18. Feeling afraid as if something awful might happen:	(0)	(1)	(2)	(3)

Administrative use only

HQ119 19. Total GAD-7 score (add up sub-item values in items 12 through 18): _____

To be completed by a member of clinical center staff:

20. Form reviewed by PIN: HQ120
21. Signature (do not key): HQ121
22. Who administered the questionnaire (check only one): HQ122
- Participant (self-administered)..... (1)
- Clinic coordinator..... (2)
- Other (specify)..... (3)
- HQ122s
- relationship to participant
23. Who responded to the questionnaire (check all that apply):
- a. Participant (self-administered):..... HQ123_a (1)
- b. Other (specify):..... HQ123_b (1)
- HQ123_bs
- relationship to participant

HQ Worksheet (do not key):

Worksheet does not need to be completed until V2

TRIM coordinator to review scores on HQ form from V2, and current visits, starting at V3-V7. Any changes in score totaling 5 or more, from baseline (V2), should be considered an Unanticipated Problem (UP) and refer to MOP for further instructions.

24. Current visit:
- a. Score from item #9: ____
- b. Score from item #10: ____
- c. Score from item #19: ____
25. Is the participant at high risk for depression (i.e. score of ≥ 15 on item 10 on the PHQ-9)?
- Yes () No ()
26. Is the participant at high risk for anxiety (i.e. ≥ 10 on Item 19 on the GAD-7)?
- Yes () No ()
27. Does the participant have suicidal ideation (i.e. score of > 0 on item 9 on the PHQ-9)?
- a. Yes () No ()
28. If yes, was the SSW administered?
- Yes () No ()
28. V2 scores:
- a. Score from item # 9: ____
- b. Score from item #10: ____
- c. Score from item #19: ____
29. Comparing V2 to the current score for depression (item 10) and anxiety (item 19), has there been a change ≥ 5 :
- Yes () No ()
- If yes, offer the participant mental health resource information.

Methacholine Challenge Test Worksheet
Instructions: Complete this worksheet before starting methacholine procedure.

 Participant ID: T _____

Visit ID: _____

	Yes	No
Absolute contraindications		
Is participant pregnant:	()	()
Has participant had a stroke or heart attack in the last three months:	()	()
Does participant have a known aortic aneurysm:	()	()
Does participant have uncontrolled hypertension (<i>i.e.</i> , SBP > 200, DBP > 100):	()	()
Has participant had eye surgery within the past 3 months:	()	()
<i>If any items in the above section are checked "Yes", do not perform test.</i>		
Relative contraindications - Does the participant have any of the following conditions?		
Any cardiovascular disease accompanied by bradycardia (slow heart beat):	()	()
Current use of cholinesterase-inhibitor medication (for myasthenia gravis):	()	()
Other serious illness in the last four weeks:	()	()
Is participant wheezing or showing other signs of asthma:	()	()
Medication holds - Has the participant taken any of the following medications or substances within the indicated time period?		
Alcohol within the past 4 hours:	()	()
Smoked a cigarette, cigar, or pipe within the past hour:	()	()
Short-acting bronchodilator within past 6 hours (<i>e.g.</i> , albuterol, Ventolin, Proair, Proventil, Xopenex, isoproterenol, metaproterenol):	()	()
Medium-acting bronchodilator within past 12 hours (<i>e.g.</i> , ipratropium, atrovent):	()	()
Oral theophylline within past 24 hours (<i>e.g.</i> , Theodur, Uniphyll):	()	()
Long-acting bronchodilator within past 36 hours (<i>e.g.</i> , salmeterol, formoterol, Advair, Serevent, Symbicort, Dulera):	()	()
Ultra-long-acting bronchodilator within past 48 hours (<i>e.g.</i> , indacaterol, vilanterol, olodaterol):	()	()
Long-acting anti-muscarinic agents within past 7 days (<i>e.g.</i> , tiotropium):	()	()
<i>If any items in Relative contraindications or Medication holds are checked "Yes", consult with the study physician before conducting the test.</i>		
Other		
Were vials of methacholine prepared and handled according to TRIM MOP guidelines:	()	()
Do you have ALL of the following equipment: EasyOn spirometer, AeroEclipse BAN II nebulizer, precision flow meter, mouthpieces for nebulizer cups, and spirette:	()	()
Is a supervising physician immediately available in case of emergency:	()	()
Are oxygen, stethoscope, pulse oximeter, and sphygmomanometer available in case of emergency:	()	()
Is albuterol (both via MDI and nebulizer) immediately available:	()	()
Is atropine or equivalent anticholinergic medication (<i>e.g.</i> , ipratropium) immediately available:	()	()
<i>If any items in above section are checked "No", do not proceed until all items can be checked "Yes."</i>		

Methacholine Challenge Testing

Purpose: Record results of methacholine challenge testing.

When: V2 and V7.

Instructions: Complete the worksheet at the beginning of the form before completing sections A-F. If any items in **Absolute contraindications** are checked "Yes," do not perform test. If any items in **Relative contraindications** or **Medication holds** are checked "Yes," consult with the study physician before conducting the test. If any items in **Other** are checked "No," do not proceed until all items can be checked "Yes". Methacholine challenge test should be administered at the same time of the day, preferably in the morning. Key into TRIM data system at www.cctrials.org/alaacrc within 10 working days.

A. Clinical center, participant, and visit identification

1. Clinical center ID: Clinic

2. Participant ID: T ID

3. Alpha ID code: NameCode

4. Date of methacholine challenge:
____ day - ____ month - ____ year **VisitDate**

5. Visit ID: VisitID

6. Form version date: **MC106**
1 3 - M A R - 2 0 1 9
day month year

Obtain at least 3 and no more than 8 efforts to achieve acceptability and reproducibility criteria as set by ATS guidelines.

8. Pre-diluent FEV₁: _____ . _____ **MC108**
liters

9. Was the spirometry maneuver acceptable and reproducible: **MC109**
Yes No
(1) (2)
42

10. Is pre-diluent FEV₁ less than 1.5 liters: **MC110**
Yes No
(1) (2)
42

11. Pre-diluent FVC: _____ . _____ **MC111**
liters

12. Predicted FEV₁ (calculated online at www.cctrials.org/alaacrc): **MC112**
_____ . _____
liters

13. Pre-diluent FEV₁ % predicted (100* item 8 / item 12): **MC113**
_____ %

14. Is pre-diluent FEV₁ % predicted less than 60%: **MC114**
Yes No
(1) (2)
42

B. Pre-diluent lung function

If participant is unable to perform acceptable and reproducible spirometry test during pre-diluent session, the methacholine challenge test should not be conducted.

MC107 7. Did you complete the Methacholine Challenge Test Worksheet:

Yes No
(1) (2)

If "No," complete worksheet.

D. Methacholine administration

Items 20-27: Administer methacholine vials in order shown. For each step: Perform spirometry about 30 seconds after methacholine dose. Repeat spirometry about every minute (minimum 2 attempts; maximum 5 attempts), until 2 acceptable spirometry tests obtained. Report the highest FEV_1 . If none of the 5 spirometry tests meets acceptability criteria, then report the highest FEV_1 . STOP if FEV_1 less than or equal to Target FEV_1 . Consult MOP for details on methacholine administration and spirometry.

19. Target FEV_1 (from worksheet #2): STOP testing if highest FEV_1 following a dose drops below this number.					<u> </u> . MC119 liters
	a. Vial	b. Dose (Concentration mg/mL)	c. FEV_1 (Liters)	d. FVC (Liters)	e. Is column c less than or equal to target FEV_1?
20.	J	0.03125 MC120b	<u> </u> . MC120c	<u> </u> . MC120d	Yes No (<u> 1 </u>) (<u> 2 </u>) MC120e Go to item 32
21.	I	0.0625 MC121b	<u> </u> . MC121c	<u> </u> . MC121d	Yes No (<u> 1 </u>) (<u> 2 </u>) MC121e Go to item 32
22.	H	0.125 MC122b	<u> </u> . MC122c	<u> </u> . MC122d	Yes No (<u> 1 </u>) (<u> 2 </u>) MC122e Go to item 32
23.	G	0.25 MC123b	<u> </u> . MC123c	<u> </u> . MC123d	Yes No (<u> 1 </u>) (<u> 2 </u>) MC123e Go to item 32
24.	F	0.5 MC124b	<u> </u> . MC124c	<u> </u> . MC124d	Yes No (<u> 1 </u>) (<u> 2 </u>) MC124e Go to item 32
25.	E	1.0 MC125b	<u> </u> . MC125c	<u> </u> . MC125d	Yes No (<u> 1 </u>) (<u> 2 </u>) MC125e Go to item 32
26.	D	2.0 MC126b	<u> </u> . MC126c	<u> </u> . MC126d	Yes No (<u> 1 </u>) (<u> 2 </u>) MC126e Go to item 32
27.	C	4.0 MC127b	<u> </u> . MC127c	<u> </u> . MC127d	Yes No (<u> 1 </u>) (<u> 2 </u>) MC127e Go to item 32

Items 28-30 left blank intentionally.

Calculation worksheet #3 (do not key):

Target post-test FEV₁ - 90% of pre-diluent FEV₁ (item 8):

_____ x 0.90 = _____
item 8 (liters) liters

- MC131 31.** Is vial C FEV₁ (item 27c) greater than or equal to 90% pre-diluent FEV₁ (from worksheet #3):

Yes No
(1) (2)
└─ **38**

E. Recovery

Administer 2 puffs albuterol via MDI or nebulizer and wait 10 minutes, per protocol.

- MC132 32.** Post-BD FEV₁: _____
liters

- MC133 33.** Post-BD FVC: _____
liters

- MC134 34.** Is post-BD FEV₁ (item 32) greater than or equal to 90% pre-diluent FEV₁ (from worksheet #3):

Yes No
(1) (2)
└─ **38**

Administer 2 additional puffs albuterol via MDI or nebulizer and wait 10 minutes, per protocol.

- MC135 35.** 2nd Post-BD FEV₁: _____
liters

- MC136 36.** 2nd Post-BD FVC: _____
liters

- MC137 37.** Is 2nd post-BD FEV₁ (item 35) greater than or equal to 90% pre-diluent FEV₁ (from worksheet #3):

Yes No
(1) (2)

If "No," consult physician before releasing the participant.

- 38.** Did participant experience any complications of the methacholine challenge:

MC138
Yes No
(1) (2)
└─ **40**

- 39.** Specify complications:

MC139

- 40.** Participant's FEV₁ was less than or equal to Target FEV₁ following the administration of any concentration of methacholine (i.e., are any responses in column e, items 20-27, checked "Yes"):

Yes No
(1) (2)
└─ **42**

Calculate PD₂₀ for FEV₁ as directed in protocol or using calculator online at www.cctrials.org/alaacrc.

- 41.** PD₂₀ FEV₁: _____
μg McCh **MC141**

- 42.** Person administering test

a. Name:

MC142a

b. PIN:

MC142b

F. Administrative information

- 43.** Form completed by PIN: _____ **MC143**

- 44.** Signature (do not key):

MC144

Missed Data

Purpose: Record information about missed study data.

When: After a visit window has closed for a participant and visit/contact forms were missed. Complete a separate Missed Data (MD) form for each visit that is missed or that has missing data.

Instructions: Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

A. Clinical center, participant, and visit identification

1. Clinical center ID: _____ **Clinic**
2. Participant ID: _____ **T** _____ **ID**
3. Alpha ID code: _____ **NameCode**
4. Date form completed:
- _____ - _____ **VisitDate**
- day month year
5. Visit ID: _____ **VisitID**
6. Form version date: _____ **MD106**
- _____ - _____
- day month year

B. Missed visit information

MD107 7. Was the visit missed completely:

Yes No
(1) (2)
└─┬─┘
 10

8. Forms missed [expected at visit]

(check all that apply):

- | | |
|--|-------------|
| a. BC (Biospecimen Collection)
[V2, V7]: | (1)MD108_a |
| b. CV (Clinic Visit) [V2-V7]: | (1)MD108_b |
| c. DA (Drug Dispensing) [V2-V6]: | (1)MD108_c |
| d. DR (Drug Return/Capsule Count)
[V3-V7]: | (1)MD108_d |
| e. MC (Methacholine Challenge test)
[V2, V7]: | (1)MD108_e |
| f. PE (Physical Exam) [V1]: | (1)MD108_f |
| g. PM (Physical Measurements)
[V1-V7]: | (1)MD108_g |
| h. PF (Pulmonary Function)
[V1, V3-V6]: | (1)MD108_h |
| i. EV (Study Evaluation) [V7]: | (1)MD108_i |
| j. TT (Treatment Termination) [V7]: | (1)MD108_j |
| k. UM (Unmasking) [V7]: | (1)MD108_k |
| l. Other (<i>specify</i>): | (1)MD108_l |

MD108_Is

form

- m. N/A, no forms missed:** ()MD108 m

9. Questionnaires missed [expected at visit]
(check all that apply):

- MD109_a a. TA (Asthma Control Test) [V1-V7]: ()
- MD109_b b. AS (Asthma Symptom Utility Index) [V1-V7]: ()
- MD109_c c. GS (Gastrointestinal Symptom Rating Scale) [V1-V7]: ()
- MD109_d d. MQ (Marks Quality of Life Questionnaire) [V1-V7]: ()
- MD109_e e. HQ (Patient Health Questionnaire) [V1-V7]: ()
- MD109_f f. SF (Quality of Life by RAND Health) [V1-V7]: ()
- MD109_g g. Other (specify): ()
- MD109_gs
- questionnaire
- MD109_h h. N/A, no questionnaires missed: ()

MD109_i 10. Any Asthma Diary Cards missing:

Yes No
() ()

13

If "Yes," list start and end dates for the interval(s)
with missing Asthma Diary Cards.

11. First interval missed

- MD111a a. Start date:
- day - month - year
- MD111b b. End date:
- day - month - year

12. Second interval missed

- MD112a a. Start date:
- day - month - year
- MD112b b. End date:
- day - month - year

13. Reason for missed visit or data (check all that apply):

- a. Participant ill: () MD113_a
- b. Participant was temporarily away from the area: () MD113_b
- c. Participant has permanently moved from area: () MD113_c
- d. Participant refused: () MD113_d
- e. Unable to contact participant: () MD113_e
- f. Participant forgot: () MD113_f
- g. Problem at facility (specify): () MD113_g

MD113_gs

problem

- h. Other (specify): () MD113_h

[no data]

i. Additional notes/explanation:

[no data]

C. Administrative information

14. Form completed by PIN: MD114

15. Signature (do not key):

MD115

Reference #:			
a) Clinic ID:	___	___	Clinic
b) Participant ID:	T	___	ID
c) Alpha ID code:	___	___	NameCode
d) Date:	___	___	VisitDate
	day	month	year
e) Visit ID:	___	___	VisitID
f) Form version date:	0	8	MQ100f
	day	month	year
g) Language:	(☒)	(☐)	MQ100g
	English	Spanish	

MARKS ASTHMA QUALITY OF LIFE QUESTIONNAIRE

This version of the Marks Asthma Quality of Life Questionnaire (MAQL) has been reprinted with the permission of Guy Marks.

Purpose: To document information about quality of life.

When: V1- V7, all visits.

Who: Participant to complete.

Instructions: Clinic coordinator to hand to participant to complete. Clinic coordinator should review the completed questionnaire for missing responses and resolve any problems **before** the participant leaves the clinic. Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

MARKS ASTHMA QUESTIONNAIRE

Thank you for taking this questionnaire. It is part of a research project to learn about the way asthma affects people's lives. All your answers will be treated confidentially.

What follows is a series of statements describing the way in which asthma (or its treatment) affects some people. You are asked to tick the response to each statement which most closely applies to you over the last four weeks.

		Not at all	Mildly	Moder- ately	Severely	Very Severely
MQ101	1. I have been troubled by episodes of shortness of breath:	(1)	(2)	(3)	(4)	(5)
MQ102	2. I have been troubled by wheezing attacks:	(1)	(2)	(3)	(4)	(5)
MQ103	3. I have been troubled by tightness in the chest:	(1)	(2)	(3)	(4)	(5)
MQ104	4. I have been restricted in walking down the street on level ground or doing light housework because of asthma or shortness of breath:	(1)	(2)	(3)	(4)	(5)
MQ105	5. I have been restricted in walking up hills or doing heavy housework because of asthma or shortness of breath:	(1)	(2)	(3)	(4)	(5)
MQ106	6. I have felt tired or a general lack of energy:	(1)	(2)	(3)	(4)	(5)
MQ107	7. I have been unable to sleep at night:	(1)	(2)	(3)	(4)	(5)
MQ108	8. I have felt sad or depressed:	(1)	(2)	(3)	(4)	(5)
MQ109	9. I have felt frustrated with myself:	(1)	(2)	(3)	(4)	(5)

		Not at all	Mildly	Moder- ately	Severely	Very Severely
MQ110	10. I have felt anxious, under tension or stressed:	(1)	(2)	(3)	(4)	(5)
MQ111	11. I have felt that asthma or shortness of breath is preventing me from achieving what I want from life:	(1)	(2)	(3)	(4)	(5)
MQ112	12. Asthma or shortness of breath has interfered with my social life:	(1)	(2)	(3)	(4)	(5)
MQ113	13. I have been limited in going to certain places because they are bad for my asthma:	(1)	(2)	(3)	(4)	(5)
MQ114	14. I have been limited in going certain places because I have been afraid of getting an asthma attack and not being able to get help:	(1)	(2)	(3)	(4)	(5)
MQ115	15. I have been restricted in the sports, hobbies or other recreations I can engage in because of my asthma or shortness of breath:	(1)	(2)	(3)	(4)	(5)
MQ116	16. I have felt generally restricted:	(1)	(2)	(3)	(4)	(5)
MQ117	17. I have felt that asthma is controlling my life:	(1)	(2)	(3)	(4)	(5)
MQ118	18. I have been worried about my present or future health because of asthma:	(1)	(2)	(3)	(4)	(5)
MQ119	19. I have been worried about asthma shortening my life:	(1)	(2)	(3)	(4)	(5)
MQ120	20. I have felt dependent on my asthma inhalers:	(1)	(2)	(3)	(4)	(5)

Protocol Deviation

Purpose: To document a protocol deviation (PD). This includes any change, divergence or departure from the IRB-approved research protocol except as noted.

- **Any protocol deviation that increases the risk of harm for the participant, is unexpected and related to the research** must be submitted on an Unanticipated Problem Report (UP) form.
- Out of window visits are determined based on data entered and are not reported to the DCC on a PD form.

Examples of protocol deviations: Not obtaining an expected specimen or test result, enrolling a participant that does not meet eligibility requirements, loss of specimens or data, breach of confidentiality (see MOP for additional examples).

Instructions: Form is submitted to the DCC when it has been keyed into the TRIM data system **within 10 calendar days** of event being identified. In addition,

- *Item 4* - Date of report is to reflect the date site identified or became aware of the deviation (this date may or may not be the same as item 9 - Date of the deviation)
- *Item 16* - Corrective Action Plan - describe the action(s) taken at site to prevent the same or similar deviation in the future. Examples of corrective action include training of staff or a change in operating procedure for the site.
- Submit additional information by editing this form.

A. Clinical center, participant and visit identification

1. Clinical center ID: Clinic

a. Does event affect a single participant:

Yes () No ()

4.

2. Participant ID: T ID

3. Alpha ID code: Name Code

4. Date deviation reported to or identified by site:

Visit Date
day month year

5. Visit ID: Visit ID

If not associated with a particular study visit record as "N".

6. Form version date: PD106

2 6 - J U N - 2 0 1 8
day month year

7. Sequential number of this PD report: SeqN

Sequence number is 01 unless more than one PD is reported on the same day for the same participant(s); then number additional forms sequentially (e.g., 02, 03).

B. Event

8. Did event involve multiple participants: PD108

Yes () No ()

9.

If "Yes", complete only a or b.

a. All participants at the site in date range:

i. PD108ai
day month year

to

ii. PD108bi
day month year

b. Multiple participants:

i. T PD109bi

ii. T PD109bii

iii. T PD109biii

iv. T PD109biv

v. T PD109bv

PD109 9. Date of deviation:

____ day ____ month ____ year

PD110 10. Type of deviation (*check only one*):

- Loss of samples or data (1)
- Breach of confidentiality (2)
- Ineligible at enrollment (3)
- Consent irregularity (4)
- Other deviation (*specify*) (5)

PD110s

deviation

PD111 11. Did the protocol deviation place the participant at greater risk of physical or psychological harm than previously known:

Yes (1) No (2)

PD112 12. Was this event unexpected:

Yes (1) No (2)

PD115 15. Describe protocol deviation:

PD116 16. Corrective Action plan:

PD113 13. Was this event related to this research study (*check only one*):

- Definitely related (1)
- Probably related (2)
- Possibly related (3)
- Not related (4)

*Note: If event placed participant at greater risk (item 11), was unexpected (item 12) and was at least possibly related, it is an **Unanticipated Problem**. Complete UP form and report to the DCC within 5 calendar days.*

PD114 14. Does the protocol deviation require expedited reporting as an Unanticipated Problem:

Yes (1) No (2)



If “Yes”, report on UP form.

17. Follow-up (*as needed*)

PD117a

a. Date of current status:

____ - ____ - ____
day month year

PD117b

b. Narrative:

PD118

18. Is the event IRB reportable:

Yes No
() ()
20. ←

PD119

19. Date reported to IRB:

____ - ____ - ____
day month year

Leave blank until reported.

C. Administrative information

PD120

20. Form completed by PIN: ____ ____ ____

PD121

21. Signature (*do not key*):

Physical Exam

Purpose: Use form if participant has not seen a physician within last 12 months.

When: V1.

Instructions: Completed by certified study physician or designee. Items marked with an “*” are mandatory. Note abnormalities and briefly describe; use extra sheets if necessary. Key into TRIM data system at www.cctrials.org/alaacrc within 10 working days.

A. Clinical center, participant and visit identification

1. Clinical center ID: **Clinic**

2. Participant ID: T ID

3. Alpha ID code: _____ **NameCode** _____

4. Date of exam: **VisitDate**

_____ day _____ month _____ year _____

5. Visit ID: **VisitID** V 1

6. Form version date: **PE106**

$$\frac{0}{\text{day}} - \frac{\text{M}}{\text{month}} - \frac{\text{A}}{\text{year}} - \frac{\text{Y}}{\text{year}} - \frac{2}{\text{year}} - \frac{0}{\text{year}} - \frac{1}{\text{year}} - \frac{8}{\text{year}}$$

B. Physical exam

*7. Blood Pressure

a. Systolic: _____ **PE107a**
mmHg

b. Diastolic: _____ **PE107b**
mmHg

*8. Heart Rate: **PE108**

beats/min

*9. Temperature: °C °F
 (PE109₁)(u₂) _____ PE109

*10. Respiration Rate: **PE110**
breaths/min

* 11.	General appearance:	<u>PE111t</u>	Normal (1)	Abnormal (2)	PE111
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* 12.	Chest:	PE112t	Normal (1)	Abnormal (2)	PE112
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* 13.	Heart:	PE113t	Normal (1)	Abnormal (2)	PE113
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* 14.	HEENT/Neck:	PE114t	Normal (1)	Abnormal (2)	PE114
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* 15.	Respiratory: <u>PE115t</u>	Normal (1)	Abnormal (2)	PE115
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16.	Abdomen:	PE116t	Normal (1)	Abnormal (2)	Not Examined (3)	PE116
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17.	Extremities:	PE117t	Normal (1)	Abnormal (2)	Not Examined (3)	PE117
-----	--------------	---------------	-----------------	-------------------	--------------------------	--------------

18. Skin: PE118t Normal (1) Abnormal (2) Not Examined (3) **PE118**

- | | | | | | |
|------------|---|-----------------|-------------------|--------------------------|--------------|
| 19. | Neurological: <u>PE119t</u> | Normal
(1) | Abnormal
(2) | Not
Examined
(3) | PE119 |
| <hr/> | | | | | |
| 20. | Other (<i>specify</i>): <u>PE120t</u> | Normal
(1) | Abnormal
(2) | Not
Examined
(3) | PE120 |
| <hr/> | | | | | |

C. Physician signature

PE121 21. Is examiner a TRIM certified study physician:

Yes No
 (1) (2)
23.

*If "No," then form must be countersigned by
overseeing TRIM certified Study Physician.*

22. Examiner

PE122a a. Examiner signature:

PE122b b. Examiner name (*print*):

PE123 23. TRIM certified study physician PIN:

PE124 24. TRIM certified study physician signature
(*do not key*):

D. Administrative information

PE125 25. Form completed by PIN:

PE126 26. Signature (*do not key*):

Pulmonary Function Testing

Purpose: To record results of pulmonary function tests.

When: V1 - Spirometry pre- and post-bronchodilator.

V3, V4, V5 and V6 - Spirometry pre-bronchodilator only

Instructions: Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

A. Clinical center, participant, and visit identification

1. Clinical center ID: Clinic

2. Participant ID: T ID

3. Alpha ID code: NameCode

4. Date completed: VisitDate

____ day - ____ month - ____ year

5. Visit ID: VisitID

Indicate "N" as visit ID if testing is not associated with a particular visit.

6. Form version date: PF106

1 5 - M A Y - 2 0 1 8
day month year

B. General PFT data

PF107 7. Choose one predominant ethnicity category as identified by participant (*used to calculate predicted values*):

Caucasian (1)

African-American (2)

Latino/Hispanic (3)

Asian (4)

Other (*specify*) (5)

PF107s

specify

8. Did participant take any of the following medications before visit

Yes No

a. Short-acting bronchodilator within last 4 hours: (1) (2) **PF108a**

b. Long-acting bronchodilator within last 12 hours: (1) (2) **PF108b**

9. Mini-Wright peak flow measurement (*highest of 3 at clinic*):

PF109

Liters/min

C. Pre-bronchodilator data

10. Start time:

PF110 (1) (2) **PF110u**
hour minute am pm

11. Pre-bronchodilator FVC: PF111
Liters

12. Pre-bronchodilator FEV₁: PF112
Liters

13. Predicted FEV₁ (*as calculated online at www.cctrials.org/alaacrc*):

PF113
Liters

14. Percent predicted pre-bronchodilator (BD) FEV₁ (*from online calculator*):

PF114
%

D. Post-bronchodilator data

PF115 15. Was post-bronchodilator testing done:

Yes No
(1) (2)

20

All participants should have post-BD testing at V1.

PF116 16. Post-bronchodilator FVC: _____
Liters

PF117 17. Post-bronchodilator FEV₁: _____
Liters

E. Reversibility data

PF118 18. Percent predicted post-bronchodilator FEV₁
(from online calculator):

%

PF119 19. Percent reversibility (from online calculator):

%

F. Examiner information

PF120 20. Name of pulmonary function examiner:

specify

PF121 21. Examiner PIN: _____

G. Administrative information

22. Form completed by PIN: _____ **PF122**

23. Signature (*do not key*): **PF123**

Physical Measurements Form

Purpose: To record anthropometrics.

When: All clinic visits.

Instructions: Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

A. Clinical center, participant and visit identification

1. Clinical center ID: Clinic

2. Participant ID: T ID

3. Alpha ID code: AlphaCode

4. Date of exam: FormDate

____ day - ____ month - ____ year

5. Visit ID: VisitID

If not associated with a particular study visit, record as "N".

6. Form version date: PM106

0 3 - A P R - 2 0 1 8
day month year

10. Waist circumference (measured; enter only a or b)

a. Inches: _____ inches **PM110a**

b. Centimeters: _____ cm **PM110b**

11. Blood pressure reading (participant should be seated, and relaxed, for 10 minutes before blood pressure is measured; For consistency, please use the same arm at each visit)

a. Systolic: _____ mmHg **PM111a**

b. Diastolic: _____ mmHg **PM111b**

c. Heart rate: _____ bpm **PM111c**

d. Arm used for blood pressure: **PM111d**

Right arm (1)

Left arm (2)

B. Height, weight and vital signs

7. Height (measured; enter only a or b; only at V1)

PM107a a. Inches: _____ inches

PM107b b. Centimeters: _____ cm

8. Weight (measured; enter only a or b)

PM108a a. In pounds: _____ lbs

PM108b b. Kilograms: _____ kg

9. Hip circumference (measured; enter only a or b)

PM109a a. Inches: _____ inches

PM109b b. Centimeters: _____ cm

C. Administrative information

12. Form completed by PIN: _____ **PM112**

13. Signature (do not key): **PM113**



SC110

Clinic



ID

SC111



AlphaCode

FormDate

SC112a

SC112b

VisitID

SC106



SC107

SC113a

SC113b



SC108

SC113c

SC109

SC113d



SC113e

SC114



SC121



SC115



SC122



SC116



SC123a



SC117



SC123b



SC123c



SC118



SC123d



SC123e



SC119



SC123f



SC123g



SC123h



SC123i



SC120



SC123j



SC123k



SC123ks



SC133



SC134

SC135

SC136

Reference #:		
a) Clinic ID:	_____ Clinic _____	
b) Participant ID:	_____ T _____ ID _____	
c) Alpha ID code:	_____ AlphaCode _____	
d) Date:	_____ FormDate _____	
	day month year	
e) Visit ID:	_____ VisitID _____	
f) Form version date:	_____ SF100f _____	
	day month year	
g) Language:	(☒) SF100g (☐)	
	English Spanish	

SF-36™ Version 1.0

Purpose: To collect data to determine participant's view on their health.

When: V1 - V7, all visits.

Who: Participant to complete.

Instructions: Clinic coordinator to hand to participant to complete. Clinic coordinator should review the completed questionnaire for missing responses and resolve any problems **before** the participant leaves the clinic. Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

RAND 36-Item Health Survey 1.0 Questionnaire Items

Choose one option for each questionnaire item.

SF101 1. In general, would you say your health is:

- (1) Excellent
 - (2) Very Good
 - (3) Good
 - (4) Fair
 - (5) Poor
-

SF102 2. Compared to one year ago, how would you rate your health in general now?

- (1) Much better now than one year ago
 - (2) Somewhat better now than one year ago
 - (3) About the same
 - (4) Somewhat worse now than one year ago
 - (5) Much worse now than one year ago
-

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
SF103 3. Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports:	(1)	(2)	(3)
SF104 4. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:	(1)	(2)	(3)
SF105 5. Lifting or carrying groceries:	(1)	(2)	(3)
SF106 6. Climbing several flights of stairs:	(1)	(2)	(3)
SF107 7. Climbing one flight of stairs:	(1)	(2)	(3)
SF108 8. Bending, kneeling, or stooping:	(1)	(2)	(3)
SF109 9. Walking more than a mile:	(1)	(2)	(3)
SF110 10. Walking several blocks:	(1)	(2)	(3)
SF111 11. Walking one block:	(1)	(2)	(3)
SF112 12. Bathing or dressing yourself:	(1)	(2)	(3)

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

	Yes	No
SF113 13. Cut down the amount of time you spent on work or other activities:	(1)	(2)
SF114 14. Accomplished less than you would like:	(1)	(2)
SF115 15. Were limited in the kind of work or other activities:	(1)	(2)
SF116 16. Had difficulty performing the work or other activities (for example, it took extra effort):	(1)	(2)

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	Yes	No
SF117 17. Cut down the amount of time you spent on work or other activities:	(1)	(2)
SF118 18. Accomplished less than you would like:	(1)	(2)
SF119 19. Didn't do work or other activities as carefully as usual:	(1)	(2)

SF120 20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- (1) Not at all
 - (2) Slightly
 - (3) Moderately
 - (4) Quite a bit
 - (5) Extremely
-

SF121 21. How much **bodily** pain have you had during the **past 4 weeks**?

- (1) None
 - (2) Very Mild
 - (3) Mild
 - (4) Moderate
 - (5) Severe
 - (6) Very Severe
-

SF122 22. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- (1) Not at all
 - (2) A little bit
 - (3) Moderately
 - (4) Quite a bit
 - (5) Extremely
-

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks**:

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
SF123 23. Did you feel full of pep?	(1)	(2)	(3)	(4)	(5)	(6)
SF124 24. Have you been a very nervous person?	(1)	(2)	(3)	(4)	(5)	(6)
SF125 25. Have you felt so down in the dumps that nothing could cheer you up?	(1)	(2)	(3)	(4)	(5)	(6)
SF126 26. Have you felt calm and peaceful?	(1)	(2)	(3)	(4)	(5)	(6)
SF127 27. Did you have a lot of energy?	(1)	(2)	(3)	(4)	(5)	(6)
SF128 28. Have you felt downhearted and blue?	(1)	(2)	(3)	(4)	(5)	(6)
SF129 29. Did you feel worn out?	(1)	(2)	(3)	(4)	(5)	(6)
SF130 30. Have you been a happy person?	(1)	(2)	(3)	(4)	(5)	(6)
SF131 31. Did you feel tired?	(1)	(2)	(3)	(4)	(5)	(6)

SF132 32. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc.):

- (1) All of the time
- (2) Most of the time
- (3) Some of the time
- (4) A little of the time
- (5) None of the time

How TRUE or FALSE is **each** of the following statements for you:

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
SF133 33. I seem to get sick a little easier than other people:	(1)	(2)	(3)	(4)	(5)
SF134 34. I am as healthy as anybody I know:	(1)	(2)	(3)	(4)	(5)
SF135 35. I expect my health to get worse:	(1)	(2)	(3)	(4)	(5)
SF136 36. My health is excellent:	(1)	(2)	(3)	(4)	(5)

For Clinic Staff use only:

37. Form reviewed by PIN: **SF137**

38. Signature (*do not key*): **SF138**

39. Who administered the questionnaire (*check only one*): **SF139**

Participant (*self-administered*)..... (1)

Clinic Coordinator..... (2)

Other (*specify*)..... (3)

SF139s

relationship to participant

40. Who responded to the questionnaire (*check all that apply*)

a. Participant (*self-administered*):..... **SF140_a** (1)

b. Other (*specify*):..... **SF140_b** (1)

SF140_bs

relationship to participant

Serious Adverse Event Report

Purpose: To report a serious adverse event (SAE).

Definition of SAE: Any event that results in any of the following outcomes:

- death
- life threatening (i.e., places a participant at immediate risk of death)
- hospitalization (inpatient stay; initial or prolonged)
- persistent or significant disability/incapacity
- congenital anomaly/birth defect

Important medical events that may not result in death, be life threatening, or require hospitalization may be considered a serious adverse event when, based upon appropriate medical judgment, they may jeopardize the patient or subject and may require medical or surgical intervention to prevent one of the outcomes listed in this definition.

An event may also be classified as “unexpected.” This is any event, the specificity (nature or frequency) or severity of which is not consistent with the risk information described in the protocol, consent, or package insert.

Examples of events to be reported as an SAE:

- Allergic bronchospasm (e.g., anaphylaxis) **requiring intensive medical treatment** in an emergency room
- A medical event **requiring medical or surgical intervention** to prevent one of the serious outcomes listed above:
 - Blood dyscrasia (e.g., leukemia) requiring outpatient treatment
 - Cerebrovascular accident (i.e., stroke) requiring intervention
 - Drug overdose

When: Submit report **within 5 calendar days** of a clinical center learning of a serious adverse event, even if some information is missing.

Respondent: Participant, family member (spouse) or both.

Instructions: Form is submitted to the DCC when it has been keyed into the TRIM data system. In addition the site must:

- Email the DCC if receipt of this report is not confirmed within 3 calendar days, email JHSPH.ala-acrc@jhu.edu; indicate Serious Adverse Event in subject line and indicate high priority.
- Submit as much information as is known with initial submission (within 5 calendar days).
- Submit new information and/or follow-up information by editing the form, including resolution of event (items 20-22). For emergencies, the PI or study physician should contact the DCC central office at (443) 287-3170 during office hours; during non-office hours, contact Robert Wise, MD at (410) 905-5688.

A. Clinical center, participant, and visit identification

1. Clinical center ID: Clinic _____

2. Participant ID: T ID _____

3. Alpha ID code: AlphaCode _____

4. Date event reported to site: **FormDate**
____ day - ____ month - ____ year

5. Visit ID: VisitID
If not associated with a particular study visit, record as “N”.

6. Form version date: **SR106**
0 4 - A P R - 2 0 1 8
day month year

7. Sequential number of this SR form: SeqN
*Sequence number is 01 unless more than one SAE is reported on the **same day for the same participant**; then number additional forms sequentially (e.g., 02, 03).*

B. Participant information

SR108 8. Age: _____
years

SR109 9. Sex: _____
Male Female
(1) (2)

10. Height (*from last study visit; complete **only a or b***)

SR110a a. Inches: _____
inches

SR110b b. Centimeters: _____
cm

11. Weight (*from last study visit; complete **only a or b***)

SR111a a. Pounds: _____
lbs

SR111b b. Kilograms: _____
kg

C. Event information

SR112 12. Date of event onset: _____
day month year

SR113 13. Event (*e.g., heart attack*):

14. Event criteria (*check all that apply*)

SR114_a a. Death: (1)

SR114_b b. Life threatening event
(*immediate risk of death*): (1)

SR114_c c. Medically significant, requiring
hospitalization (*inpatient stay;*
initial or prolonged): (1)

SR114_d d. Severely or permanently disabling: (1)

SR114_e e. Medically significant but not
requiring hospitalization: (1)

SR114_f f. Congenital anomaly: (1)

SR114_g g. Event requiring medical or
surgical intervention: (1)

SR114_h h. Other (*specify*): (1)

SR114_hs

specify

15. Was adverse event unexpected (*check only one*): **SR115**

Yes (1)

No (2)

16. Relationship of adverse event to study as determined
by study PI/physician (*check only one*): **SR116**

Not related (1)

Possibly (2)

Probably (3)

Definitely (4)

17. Which of the following body systems are involved
(*check all that apply*)

a. Cardiovascular: (1) **SR117_a**

b. Dermatological: (1) **SR117_b**

c. Gastrointestinal: (1) **SR117_c**

d. Hematological: (1) **SR117_d**

e. Metabolic: (1) **SR117_e**

f. Musculoskeletal: (1) **SR117_f**

g. Neurological: (1) **SR117_g**

h. Psychological: (1) **SR117_h**

i. Pulmonary/Respiratory: (1) **SR117_i**

j. Renal/Urologic: (1) **SR117_j**

k. Hepatobiliary: (1) **SR117_k**

l. Other (*specify*): (1) **SR117_l**

SR117_Is

18. What action was taken (*check all that apply*)

a. None: (1) **SR118_a**

b. Hospitalization/prolonged
hospitalization: (1) **SR118_b**

c. Remedial therapy:
non-pharmacological: (1) **SR118_c**

d. Remedial therapy: pharmacological: (1) **SR118_d**

e. Study exit: (1) **SR118_e**

19. Hospitalization

SR119a

a. Was the participant hospitalized (*for inpatient overnight stay*):

Yes No
(1) (2)

20

SR119b

b. Reason for hospitalization:

SR119c

c. Date admitted:

day month year

SR119d

d. Date discharged:

day month year

SR120 20. Current status of the adverse event (*check only one*):

Ongoing

(1)

23

Resolved without sequelae
(*complete item 22*)

(2)

22

Resolved with sequelae
(*complete items 22 and 29f*)

(3)

22

Death (*complete item 21*)

(4)

21. Death information

SR121a

a. Date of death:

day month year

b. Was autopsy performed:

Yes No
(1) (2)

SR121c

c. Probable cause of death:

Skip to item 23.

22. Date resolved:

SR122

day month year

D. Principal Investigator (PI) signature

I have reviewed the SR form and verify that all information is complete.

23. PI PIN:

SR123

24. PI signature (*do not key*):

SR124

25. Date signed:

SR125

day month year

E. Administrative information

This SR form must be data entered within 5 calendar days of receipt of information.

26. Form completed by PIN:

SR126

27. Signature (*do not key*):

SR127

28. Date reported to DCC:

SR128

day month year

For all events complete description of event in Section F. Updates are to be recorded in Section G.

F. Adverse event narrative

29. Description of serious adverse event

SR129a

a. General description of event:

SR129b

b. Current medications at time of event (*from logs*):

SR129c

c. Symptoms:

SR129d

d. Course/duration:

SR129e

e. Treatments/procedures:

SR129f

f. Sequelae:

SR129g

g. Relevant lab/diagnostic tests:

G. Update on status of adverse event

30. Follow-up #1

SR130a a. Date of current status:

____ - ____ - ____
day month year

SR130b b. Narrative:

31. Follow-up #2

SR131a a. Date of current status:

____ - ____ - ____
day month year

SR131b b. Narrative:

32. Follow-up #3

SR132a a. Date of current status:

____ - ____ - ____
day month year

SR132b b. Narrative:

Reference #:	_____
a) Clinic ID:	____ Clinic ____
b) Participant ID:	____ T ____ ID ____
c) Alpha ID code:	____ AlphaCode ____
d) Date:	____ FormDate ____ - ____ ____ ____ day month year
e) Visit ID:	____ VisitID ____
f) Form version date:	0 ____ 8 ____ TA100f R - 2 ____ 0 ____ 1 ____ 8 ____ day month year
g) Language:	(☒) TA100g () English Spanish

ASTHMA CONTROL TEST™ (ACT)

Purpose: To collect data on your asthma symptoms.

When: V1 - V7, all visits.

Who: Participant to complete.

Instructions: Clinic coordinator to hand to participant to complete. Clinic coordinator should review the completed questionnaire for missing responses and resolve any problems **before** the participant leaves the clinic. Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

Asthma Control Test™

This survey was designed to help you describe your asthma and how your asthma affects how you feel and what you are able to do. To complete it, please mark an ☐ in the one box that best describes your answer.

TA101 1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
				
☐ ₁	☐ ₂	☐ ₃	☐ ₄	☐ ₅

TA102 2. During the past 4 weeks, how often have you had shortness of breath?

More than once a day	Once a day	3 to 6 times a week	Once or twice a week	Not at all
				
☐ ₁	☐ ₂	☐ ₃	☐ ₄	☐ ₅

TA103 3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week	2 to 3 nights a week	Once a week	Once or Twice	Not at all
				
☐ ₁	☐ ₂	☐ ₃	☐ ₄	☐ ₅

TA104 4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as Albuterol, Ventolin®, Proventil®, or Maxair®)?

3 or more times per day	1 or 2 times per day	2 or 3 times per week	Once a week or less	Not at all
				
☐ ₁	☐ ₂	☐ ₃	☐ ₄	☐ ₅

TA105 5. How would you rate your asthma control during the past 4 weeks?

Not Controlled at all	Poorly Controlled	Somewhat Controlled	Well Controlled	Completely Controlled
				
☐ ₁	☐ ₂	☐ ₃	☐ ₄	☐ ₅

For Clinic Staff use only:

TA106

6. Total (sum of items 1-5): _ _ _ _

TA107

7. Form reviewed by PIN: _ _ _ _

TA108

8. Signature (do not key): _____

TA109

9. Who administered the questionnaire (check only one):
Participant (self-administered) (1)
Clinic coordinator. (2)
Other (specify). (3)

TA109s

relationship to participant

TA107_a

TA107_b

10. Who responded to the questionnaire (check all that apply):
a. Participant (self-administered):. (1)
b. Other (specify):. (1)

TA107_bs

relationship to participant

Treatment Termination

Purpose: Record permanent termination of study drug.

When: At end of treatment (V7) or earlier if treatment terminated prior to V7.

Instructions: Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

A. Clinical center, participant, and visit identification

1. Clinical center ID: Clinic

2. Participant ID: T ID

3. Alpha ID code: AlphaCode

4. Date completed: FormDate
____ day - ____ month - ____ year

5. Visit ID: VisitID
(If not associated with a particular study visit, record as "N")

6. Form version date: TT106
____ day ____ month ____ year

B. Termination

TT107 7. Type of termination (check only one):
Study drug permanently stopped before end of trial (1)
End of trial (2)

TT108 8. Date study drug last taken:
____ day - ____ month - ____ year

TT109 9. Last dose taken was (check only one):
One tablet every day (1)
One tablet every other day (2)

10. Main reason(s) for treatment termination (check all that apply)

a. Participant completed study: (1) **TT110_a**

b. Adverse event (specify): (1) **TT110_b**
TT110_bs
specify event

c. Participant unable to tolerate (specify): (1) **TT110_c**
TT110_cs
specify reason

d. Participant request: (1) **TT110_d**

e. Lost to follow-up: (1) **TT110_e**

f. Other (specify): (1) **TT110_f**
TT110_fs
specify

11. Was all study drug collected from participant at this time: **TT111**
Yes No
(1) (2)

If "Yes", complete the Drug Return/Capsule Count (DR) form and skip to item 13.

If "No", proceed to question 12:

12. Why drug was not returned and plan of action to retrieve drug (specify): **TT112**

Note: If unmasking required, complete the Unmasking (UM) form.

C. Administrative information

13. Form completed by PIN: _____ **TT113**

14. Signature (do not key): _____ **TT114**

Unmasking

Purpose: Record unmasking of study treatment.

When: V7 or when study treatment is unmasked.

Instructions: Key into TRIM data system at www.cctrials.org/alaacrc within **10 working days**.

A. Clinical center, participant and visit identification

1. Clinical center ID: _____

2. Participant ID: T _____

3. Alpha ID code: _____

4. Date of report:

_____ day - _____ month - _____ year

5. Visit ID: _____

Indicate "N" as visit ID if not associated with a scheduled visit.

6. Form version date:

1 0 - 0 C T - 2 0 1 8
 day month year

B. Unmasking

7. Date unmasked:

_____ day - _____ month - _____ year

8. Type of unmasking (*check only one*):

Unscheduled unmasking (*before V7*) (☐)

Scheduled unmasking at end of trial (*at V7*) (☐)

10

9. Reason for unscheduled unmasking (*specify*):

10. Treatment assignment revealed from (*check only one*):

Standard unmasking envelope
 (*complete item 11*): (☐)

DCC: (☐)

Emergency unmasking: (☐)

Other (*specify*): (☐)

 specify

11. Unmasking envelope

a. Envelope ID: _____

b. Verification code: U _____

12. Were any TRIM staff unmasked:

Yes No
 (☐) (☐)

14

13. TRIM staff member(s) unmasked (*specify*):

C. Exit questions for study staff

14. *For Study Coordinator:* Do you have any idea which study medication was assigned (*check only one*):

Roflumilast: (☐)

Placebo: (☐)

Don't know: (☐)

Unmasked: (☐)

15. *For Study Physician:* Do you have any
idea which study medication was assigned
(*check only one*):

Roflumilast:	(☐ 1)
Placebo:	(☐ 2)
Don't know:	(☐ 3)
Unmasked:	(☐ 4)

D. Administrative information

16. Form completed by PIN:

17. Signature (*do not key*):

Unanticipated Problem Report

Purpose: To report an unanticipated problem (UP), an event that meets the following 3 criteria:

- Is unexpected **and**
- Places participant(s) at greater risk of harm (physical or psychological) **and**
- Is at least possibly related to the research study

Note:

- *SAEs are reported on the Serious Adverse Event Report (SR) form*
- *Protocol deviations that do not meet all 3 criteria noted above are reported on the Protocol Deviation (PD) form*

When: Form is to be completed and submitted to the DCC **within 5 calendar days** of event being reported to or identified by the site.

Instructions: Form is submitted to the DCC when it has been keyed into the TRIM data system.

In addition the site must:

- E-mail DCC if receipt of this report is not confirmed within 3 calendar days. Email JHSPH.ala-acrc@jhu.edu; indicate Unanticipated Problem in subject line and indicate high priority
- Submit as much information as is known with initial submission (within 5 calendar days)
- Submit new information and/or follow-up information by editing this form, including resolution of event (items 12 and 13)

A. Clinical center, participant, and visit identification

B. Event

UP101 1. Clinical center ID: _____

8. Did event involve multiple participants: **UP108**

UP101a a. Does event affect a single participant:

Yes (1) No (2)
4.

Yes (1) No (2)
9.

If "Yes", complete **only a or b**.

UP102 2. Participant ID: T _____

a. All participants at the site in date range:

UP103 3. Alpha ID code: _____

i. **UP108aj** _____
day month year

UP104 4. Date deviation reported to or identified by site:

____ day ____ month ____ year

to

ii. **UP108ajii** _____
day month year

UP105 5. Visit ID: _____

If not associated with a particular study visit record as "N".

b. Multiple participants:

UP106 6. Form version date:

0 4 - A P R - 2 0 1 8
day month year

i. T _____

UP108bi

ii. T _____

UP108bii

iii. T _____

UP108biii

iv. T _____

UP108biv

v. T _____

UP108bv

UP107 7. Sequential number of this UP report: _____

*Sequence number is 01 unless more than one UP reported on the **same day for the same participant(s)**; then number sequentially (e.g., 02, 03).*

UP109 9. Event:

UP110 10. Date of onset for event/unanticipated problem:
_____-_____-_____
day month year

11. Type of unanticipated problem (*check all that apply*)

- UP111_a** a. Protocol deviation: ()
UP111_b b. Noncompliance: ()
UP111_c c. Unanticipated medical problem: ()
UP111_d d. Other (*specify*): ()

UP111_ds

type of UP

UP112 12. Status of event (*check one*):

Ongoing ()
14. Resolved without sequelae ()
Resolved with sequelae ()
(*specify sequelae in narrative*) ()

UP113 13. Date resolved:
_____-_____-_____
day month year

14. Which of the following body systems are involved (*check all the apply*)

- UP114_a** a. Cardiovascular: ()
UP114_b b. Dermatological: ()
UP114_c c. Gastrointestinal: ()
UP114_d d. Hematological: ()
UP114_e e. Metabolic: ()
UP114_f f. Musculoskeletal: ()
UP114_g g. Neurological: ()
UP114_h h. Psychological: ()
UP114_i i. Pulmonary/Respiratory: ()
UP114_j j. Renal/Urologic: ()
UP114_k k. Hepatobiliary: ()
UP114_l l. Other (*specify*): ()

UP114_ls

specify

UP114_m m. None/Not applicable: ()

C. Principal investigator to complete

15. Did/does the event place the participant(s) at greater risk of physical or psychological harm than previously known: **UP115**

Yes () No ()

16. Was the event unexpected: **UP116**

Yes () No ()

17. Was the event related to this research study (*check one*): **UP117**

Definitely related ()
Probably related ()
Possibly related ()
Not related ()

Reminder - by definition an unanticipated problem:

- increases risk of harm
- is unexpected
- is at least possibly related to the study

I have reviewed the UP form (including narrative)

18. PI PIN: _____ **UP118**

19. PI signature (*do not key*): _____ **UP119**

20. Date of signature: _____ **UP120**

_____-_____-_____
day month year

D. Administrative information

21. Form completed by PIN: _____ **UP121**

22. Signature (*do not key*): _____ **UP122**

23. Date reported to the DCC: _____ **UP123**

_____-_____-_____
day month year

Note: All UPs require narrative (item 24). Any UP which is a protocol deviation or non-compliance requires a Corrective Action Plan (item 25).

UP124 24. Description of event/unanticipated problem:

Note: report of an unanticipated medical event should include participant's age and sex as well as diagnosis, intervention(s), concomitant medications, and indicate if participant was on study intervention at the time of the event.

25. Corrective Action Plan (*required when protocol deviation or non-compliance reported*)

UP125a a. Date plan implemented:

 - -
day month year

UP125b b. Detailed plan:

26. Follow-up #1

UP126a

a. Date of current status:

____ - ____ - ____
day month year

UP126b

b. Narrative:

27. Follow-up #2

UP127a

a. Date of current status:

____ - ____ - ____
day month year

UP127b

b. Narrative: