Section 12. Data Collection

12 Introduction

The purpose of this document is to provide site staff with the information they need to successfully complete and submit MTN-034 Case Report Forms. For questions about this section or about general data collection policies, procedures, or materials, please contact the SCHARP Clinical Data Manager for the study as listed below.

The SDMC (Statistical and Data Management Center) for this study is SCHARP (the Statistical Center for HIV/AIDS Research and Prevention). SCHARP is located in Seattle, USA, and is in the US Pacific Time (PT) time zone. The SCHARP MTN-034 team members, along with their job role and e-mail address, are listed below.

Role	Name	Email Address
Protocol Statistician	Elizabeth Brown	erbrown@fhcrc.org
Statistical Research Associate	Daniel Szydlo	dszydlo@scharp.org
Lead Clinical Data Manager	Jennifer Schille	jens@scharp.org
Clinical Safety Associate	Ning Jiang	Njiang2@scharp.org
Clinical Programmer	Chun Zou	czou@scharp.org
LDO Data Coordinator	Dana Tupa	dtupa@scharp.org

12.1 Medidata Rave Overview

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

The MTN-034 study database in Medidata Rave may be accessed at www.imedidata.com.

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

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

Each site's Data Management SOP designates the site staff members responsible for entering data into the study database. SCHARP grants designated site staff access with specific user permissions to the study database. They are required to complete eLearning modules in Medidata, as assigned by SCHARP, before access is granted and data can be entered into the study database. For more detailed information, see the iMedidata Access Guide, posted on the MTN-034 Atlas webpage: https://atlas.scharp.org/cpas/project/MTN/034/begin.view?

Detailed guidance on data collection, entry, navigation and general use of Medidata Rave is provided in the Medidata Rave Electronic Data Capture (EDC) Training Manual, which is posted on the MTN-034 Atlas web page: https://atlas.scharp.org/cpas/project/MTN/034/begin.view?

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

For service in English

Toll-free	**Direct number**
1-866-MEDIDATA (633-4328)	1-973-659-6780
Toll-free fax	**Direct fax**
1-877-743-2350	1-973-954-5621

Email
helpdesk@mdsol.com

Hours
24 hours a day, 7 days a week

12.2 Data Entry/Quality Control

Once a CRF is completed and saved in the study database, the following may occur:

- A system query may be automatically triggered in Medidata Rave (e.g., denoting incomplete or inconsistent data).

- Review may be required for certain forms and/or fields by the SCHARP Clinical Data Managers and/or Clinical Safety Associate, and manual data queries may be placed.

- Review may be required for certain forms and/or fields by the site monitor (i.e., PPD), and data queries may be placed.

- MedDRA coding will be required for AE Log CRFs, and coding queries may be placed.

- WHO coding will be required for the Concomitant Medication Log CRF and coding queries may be placed.

- AE-EAE reconciliation will occur and inconsistency queries may be placed.

- QCs are listed in the Medidata Rave Task Summary on the study home page of designated site users. Designated site staff members are responsible for routinely checking the Task Summary and correcting/updating study data to resolve any outstanding queries.

- When site staff correct/update study data and/or enter a query response to address a manual or coding query, SCHARP staff review the updated data and/or response, and resolve the query or re-query, as needed.

- When site staff correct/update study data and/or enter a query response to address a monitoring query, the site monitor (i.e., PPD) reviews the updated data and/or response and resolves the query or re-queries as needed.

- In the rare event that a site utilizes paper CRFs as source documents, any changes to the paper CRFs **must** be entered into the Medidata Rave study database.

12.3 Electronic Signatures by Investigators

Each site investigator or designee is expected to complete a single sign-off of a participant's study data (one sign-off for each participant at his/her site) once the participant terminates from the study and site staff have resolved all data queries for the given participant. SCHARP will inform site investigators when investigator sign-off of participant data should be completed at the end of the study. By completing this participant-level sign-off in the Medidata Rave study database, the investigator or designee attests that the data has been reviewed and is deemed to be accurate. iMedidata users will use their login credentials as their electronic signature (see Figure 1 below). Please refer to the "Electronic Signature" section of the Medidata Rave Electronic Data Capture (EDC) Training Manual and/or the Investigator e-Learning module for specific instructions.

Figure 1: Example of Investigator of Record or Designee Sign-off Pop-Up Window

12.4 CRF Completion

12.4.1. General Guidelines

- To the extent possible, site staff should utilize direct data entry into the Medidata Rave study database so that the CRF serves as the source document. Direct data entry is especially encouraged for data collection based on participant self-report, such as behavioral and product use data.

- When direct data entry is not possible due to the nature of the source data - for example, when the source data is a local lab results report - site staff are encouraged to enter study data into the Medidata Rave study database based on the site-specific source document (in this case, the local lab results report).

  o Site staff are encouraged to avoid paper CRF completion, as it represents an additional, intermediate step of data management and QA/QC review into site data management workflows. In addition, paper CRF completion introduces the risk of data transcription errors and could contribute to database data entry errors.

- When completing an CRF, refer to the current version of the MTN-034 CRF Completion Guidelines (CCGs) document, posted on ATLAS, for detailed instructions on data collection pertaining to the given form and fields on that form.

- Complete CRFs as soon as possible once the data is available and has undergone internal QC review, as applicable. Ideally, completion of all required CRFs for a given visit will occur within 1–2 business days of the visit, though up to 7 days is acceptable.

12.4.2 Screening and Enrollment/Randomization

- Data entry into the study database begins at the Screening Visit. Once a participant is determined to be eligible, enrolls, or fails a screening attempt, study eligibility data should be entered into the study database as follows:

- For participants who screen out of MTN-034: data entry is required for the Eligibility Criteria CRF. Other CRFs that were completed with data collected during the failed screening attempt may remain in the study database and will not undergo QC review.

- For participants who enroll in MTN-034: data entry is required for the Eligibility Criteria CRF, along with all required Screening and Enrollment Visit CRFs. All CRFs will undergo QC review.

Randomization: Participants will be randomized to study product sequence (Sequence A or Sequence B) and to serial In Depth Interviews (IDI). Randomization to a study product sequence will be done through Medidata. Randomization to IDI group will be done outside of the Medidata Rave database. For more information regarding randomization to IDI group, please refer to SSP Section 11. The following steps outline the study product sequence randomization process for clinic staff:

1. Complete the **Eligibility Criteria CRF** with all responses indicating that the participant is eligible for study participation.

2. Navigate to the Enrollment folder and complete the **Randomization CRF**. To randomize a study participant, mark the "Yes" response box (see Figure 2) for the question "Is the participant ready to be randomized?" Once this response is saved, the database (via the Medidata Balance module) will assign the participant to a study product sequence and the Randomization Date and Time will appear automatically on the Randomization CRF.

   Note: If a CRS clinic staff attempts to randomize a participant via the Randomization CRF without having indicated that the participant is eligible on the Eligibility Criteria CRF, Medidata Rave will not allow the participant to be randomized, and an error message will appear.

Figure 2: Participant randomization via the Randomization CRF

3. A participant is considered officially enrolled in the study once the Randomization CRF is completed and saved, as evidenced by the appearance of a Randomization Date and Time on the Randomization CRF.

   The product sequence will be auto-populated on the Enrollment CRF in the Enrollment Visit folder (see Figure 3). Upon completion of the Randomization CRF, the clinic staff will navigate to the Enrollment CRF to view the participant's randomized sequence and complete the MTN-034 Prescription.

Figure 3: Participant randomization via the Enrollment CRF

12.4.3 Site Data Management SOP

As a condition for study activation, each study site must have a site or study-specific SOP for Data Management. A template Data Management SOP is available on the MTN-034 study webpage. This SOP should be reviewed and followed in combination with the information contained in the study protocol, this SSP Manual, and the site's Clinical Quality Management Plan (CQMP).

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

• Participant ID (PTID) assignment

• Participant study file organization

- Participant confidentiality

- Site data quality control (QC) processes

- Timing of data entry into the study database

- Data storage

- Data security

- Contingency plans in case of interrupted access to the study database.

- Management of site user account permissions for access to the study database

12.5   Study-specific Data Collection Information

12.5.1   Participant Identification Numbers (PTIDs)

As described in each site's Data Management SOP, each participant who provides written informed consent to be screened in MTN-034 will be assigned an MTN-034 PTID. To do this, site staff will generate in Medidata Rave a participant number (called "Subject ID" in Medidata Rave) within the electronic study and site folder; this number will serve as the participant's PTID. Refer to the "Creating Subjects" section of the Medidata Rave Electronic Data Capture (EDC) Training Manual and the CCG for specific instructions.

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

SCHARP will provide sites with a Microsoft Excel PTID-Name Linkage Log and site staff will maintain this document, which will be used to link a participant's name with her assigned PTID. For study purposes, the act of MTN-034 PTID assignment is defined as completion of an entry on the MTN-034 PTID-Name Linkage Log for a given participant. The PTID-name link log is an essential document, and site staff should ensure that each PTID on the link log is assigned to 1 participant name only. No PTID or name should appear on the log twice, and no PTID or name should appear on the log without a corresponding name or PTID, respectively.

The MTN-034 PTIDs are nine digits and formatted as "XXXYYYYYZ". The PTID consists of three parts: the site number (XXX), the participant number (YYYYY), and a numerical check digit (Z). The check digit (Z) is a number generated by SCHARP within the participant number and helps ensure that the correct PTID is recorded/entered.

12.5.2   Study Visit Timing

Screening and Enrollment

The initial screening visit is defined as the day the participant provided written informed consent to be screened for the study. The Enrollment Visit will be scheduled to take place within 70 days of the initial Screening Visit. The date the participant is enrolled/randomized is Study Day 0 for the participant. SCHARP will provide sites with a visit window calendar tool in Microsoft Excel that can be used to calculate the allowable window for study enrollment based on the participant's screening date (i.e., date informed consent provided for the current screening attempt). The tool will be posted online at: https://www.mtnstopshiv.org/research/studies/mtn-034/mtn-034-study-implementation-materials.

Screening Attempts (Re-screens)

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

If a participant re-screens and enrolls, all previously completed CRFs (from the original, failed screening attempt) must be updated, as needed, to reflect only data from the successful Screening and Enrollment Visit. Note that the Eligibility Criteria CRF completed during the failed screening attempt must be updated to reflect the participant's final eligibility status and enrollment into the study.

Follow-Up Visits

For each MTN-034 follow-up visit, the visit type, visit code, target visit day, and visit window are listed in Table 1. Target days and windows are listed in days, with the day of enrollment/randomization as study day 0.

Target Days and Visit Windows

Whenever possible, visits should be completed on the target day. If it is not possible to complete the visit on the target day, the visit should be completed within the visit window.

SCHARP will provide sites with a spreadsheet tool that may be used to generate individual participant follow-up visit calendars. The spreadsheet requires that the participant's Enrollment (i.e., randomization) date be entered. Once the enrollment date is entered, the target day and visit window for each required follow-up clinic visit up through Visit 23 – Week 72: PUEV will appear. The visit windows for the three phone call visits (Visits 10, 17, and 24) are contingent on the actual visit date of the previous visit (Visits 9, 16 and 23). The calendar can be printed, added to the participant's study notebook, and updated as needed.

Split Visits

Whenever possible, all required follow-up visit evaluations should be completed on the same day. In those cases where this is not possible, the participant may come back and complete the remaining evaluations on another day, as long as that day is within the visit window. The Enrollment Visit may not be split. (Refer to the Study Procedures section of this manual for more information regarding visit procedures and timing). For example, a participant comes in on her Visit 4 target day and completes most of the required evaluations. She comes back the next day and completes the remaining required procedures. While not ideal, this is allowed as needed, and is referred to as a "split" visit; meaning, the participant completed all required visit evaluations on two separate days, both days being in the visit window.

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

Table 1: Visit Timing Requirements

MTN-034 Visit Windows

All windows are in days; Enrollment date = Day 0 PUEV=Product Use End Visit

Visit	Visit Code	Target Day	Window Opens	Window Closes
Screening	1.0	NA	70 days prior to Enrollment	
Enrollment Period 1: Study Product Initiation	2.0	0	NA	70 days after Screening Visit
Visit 3: Visit/Phone Contact - Week 1	3.0	7	1	13
Visit 4 - Week 4	4.0	28	14	41
Visit 5 - Week 8	5.0	56	42	69
Visit 6 - Week 12	6.0	84	70	97

Visit 7 - Week 16	7.0	112	98	125
Visit 8 - Week 20	8.0	140	126	153
Visit 9 - Week 24 Period 1 Study Product Use End/ Period 2 Study Product Initiation	9.0	168	154	181
Visit 10: Visit/Phone Contact - Week 25	10.0	175	161	188
Visit 11 - Week 28	11.0	196	182	209
Visit 12 - Week 32	12.0	224	210	237
Visit 13 - Week 36	13.0	252	238	265
Visit 14 - Week 40	14.0	280	266	293
Visit 15 - Week 44	15.0	308	294	321
Visit 16 - Week 48 Period 2 Study Product Use End/ Period 3 Study Product Initiation	16.0	336	322	349
Visit 17: Visit/Phone Contact - Week 49	17.0	343	329	356
Visit 18 - Week 52	18.0	364	351	377
Visit 19 - Week 56	19.0	392	378	405
Visit 20 - Week 60	20.0	420	406	433
Visit 21 - Week 64	21.0	448	434	461
Visit 22 - Week 68	22.0	476	462	489
Visit 23 - Week 72 Period 3 Study Product Use End Visit (PUEV)	23.0	504	490	518
Visit 24: Visit/Phone Contact - Week 76 Study Exit/Termination	24.0	532	14 days after PUEV (Visit 23)	42 days after PUEV (Visit 23)

Missed Visits

In those cases where a participant is not able to complete any part of a required follow-up visit within the visit window, the visit is considered "missed". For example, an enrolled participant does not report to the clinic for Visit 5 until 70 days after enrollment. Per Table 1, Visit 5 visit has been missed. The missed visit is documented by completion of a Missed Visit CRF.

Interim Visits

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

- Additional study procedures and/or data collection are conducted outside of what is specified in the protocol for a required study visit. For example, an interim visit may occur via a phone contact if the participant reports a new AE. Required follow-up visit procedures are not done, either because the

required follow-up visit has already been completed, the participant is in between visit windows, or it is too early in the visit window to complete the required visit.

- Required study visit procedures are conducted outside the visit window, either to make up certain procedures from a missed visit, or to conduct an Early Termination Visit procedures.

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

For MTN-034, an Interim Visit Summary CRF is completed for interim visits/contacts as needed.

The following are some examples of interim visits:

1. A participant completes all required evaluations for her on the Visit 4 – Week 4 target day. She then returns to the clinic 4 days later to request a new ring.

   Why is this an interim visit? The participant has already completed all Visit 4 procedures, and it is too early (and not in the visit window) for Visit 5 to be conducted. This is an interim visit, conducted between Visits 4 and 5, and is assigned an interim visit code as new CRFs will be completed.

2. A participant completes her Visit 3 phone call as scheduled. Her Visit 4 visit window opens on July 13, and she is scheduled to complete Visit 4 on July 14. The participant reports to the clinic unexpectedly on July 13 to report new genital AE symptoms.

   Why is this an interim visit? The participant is in the Visit 4 visit window, but site staff decide not to conduct Visit 4 visit procedures for this participant on July 13th (e.g., the participant already has Visit 4 scheduled for the next day (on the target date) and has a history of reliably showing up for scheduled study visits, and/or there is limited staff time availability on July 13). An interim visit code is assigned as new CRFs will be completed (Interim Visit Summary, AE Log, others as needed).

3. A participant completes all required evaluations for Visit 9 on the target day, September 20. She returns to the site on October 8 and informs the clinic that she wishes to withdraw from the study. As such, Visit 23 – Week 72 PUEV visit procedures are conducted as part of the October 8 interim visit.

   Why is this an interim visit? On October 8, the participant wishes to withdraw from the study and an early termination visit is conducted. As Visit 9 has been completed, the early termination visit should be assigned an interim visit code. CRFs required at the Visit 23 – Week 72, PUEV visit are completed.

4. A participant completes her Visit 20 – Week 60 visit on the target day. The next day, she calls the clinic to report a new mild genital symptom.

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

12.5.3 Visit Folders and Visit Codes

The CRFs in the study database are set up within pre-defined study visit folders, so the visit name and visit code automatically appear (and do not need to be entered for required study visits).

With the exception of the Product Discontinuation Log CRF and the Pharmacy Dispensation Log CRF, all log forms (i.e., AE Summary and Log, Baseline Medical History Log, Concomitant Medications Summary and Log, Protocol Deviations Summary and Log, Social Impact Log, Social Benefit Log, Family Planning, and Product Hold Summary and Log) are housed in the "Ongoing Logs" folder within the study database.

The Product Discontinuation Log CRF and Study Termination CRF are housed within the "Discontinuations" folder; The Study Termination form is completed once for each participant to document study termination and the Product Discontinuation Log CRF is completed whenever each of

the study product is discontinued.

The Pharmacy Dispensation log CRF is housed within the "Pharmacy" folder. This form is completed at each visit when study product is dispensed. The Pharmacy folder is viewable and data can be entered by the Pharmacy role and the Investigator role only. The CRC role (i.e., site clinic) cannot view the Pharmacy folder.

The Pregnancy Report CRF and Pregnancy Outcome eCRF are housed within the "Pregnancy" folder. The Pregnancy Report CRF and Pregnancy Outcome CRF are completed for every pregnancy reported for a participant during the study. The Pregnancy History CRF is added to a participant casebook via the "Add Event" menu on the participant's homepage and is completed when the first pregnancy for a participant is reported.

Table 2 below lists the visit codes assigned to each required follow-up visit.

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

Visit	Visit Code
V1 - Screening	1.0
V2 - Enrollment	2.0
Visit 3: Visit/Phone Contact - Week 1	3.0
Visit 4 - Week 4	4.0
Visit 5 - Week 8	5.0
Visit 6 - Week 12	6.0
Visit 7 - Week 16	7.0
Visit 8 - Week 20	8.0
Visit 9 - Week 24 Period 1 Study Product Use End/ Period 2 Study Product Initiation	9.0
Visit 10: Visit/Phone Contact – Week 25	10.0
Visit 11 - Week 28	11.0
Visit 12 - Week 32	12.0
Visit 13 - Week 36	13.0
Visit 14 - Week 40	14.0
Visit 15 - Week 44	15.0

Visit 16 - Week 48 Period 2 Study Product Use End/ Period 3 Study Product Initiation	16.0
Visit 17: Visit/Phone Contact - Week 49	17.0
Visit 18 - Week 52	18.0
Visit 19 - Week 56	19.0
Visit 20 - Week 60	20.0
Visit 21 - Week 64	21.0
Visit 22 - Week 68	22.0
Visit 23 - Week 72, PUEV	23.0
Visit 24: Visit/Phone Contact - Week 76 Study Exit/Termination	24.0

Visit codes for Split Visits

See Section 12.3.2 for a definition of split visits. When split visits occur, the CRFs completed for the visit are all assigned the same visit code, even though the dates will differ between some of the CRFs. For example, a participant comes in on her Visit 4 - Week 4 target day of 23-AUG-18 and completes all required visit evaluations except vital signs. She returns on 24-AUG-18 (still within the visit window) and her vital signs are collected. All CRFs dated 23-AUG-18 and 24-AUG-18 are assigned the same visit code of "4.0" and are housed within the Visit 4 – Week 4 visit folder in the study database.

Visit codes for Interim Visits

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

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

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

- To the right of the decimal point:

    - #.1 = the first interim visit after the most recently-required visit,

    - #.2 = the second interim visit after the most recently-required visit,

    - #.3 = the third interim visit after the most recently-required visit, and so on.

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

1. A participant completes all required evaluations for her on the Visit 4 – Week 4 target day. She then returns to the clinic 4 days later to request a new ring.

   i.   *visit code = 4.1*

2.   A participant completes her Visit 3 phone call as scheduled. Her Visit 4 visit window opens on July 13, and she is scheduled to complete Visit 4 on July 14. The participant reports to the clinic unexpectedly on July 13 to report new genital AE symptoms.

   i.   *visit code = 3.1*

3.   A participant completes all required evaluations for Visit 9 on the target day, September 20. She returns to the site on October 8 and informs the clinic that she wishes to withdraw from the study. As such, Visit 23 – Week 72 PUEV visit procedures are conducted as part of the October 31st interim visit.

   i.   *visit code = 9.1*

4.   A participant completes her Visit 20 – Week 60 visit on the target day. The next day, she calls the clinic to report a new mild genital symptom.

   visit code = 20.1

12.5.4   Case Report Form Completion Schedule

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

Some SCHARP-provided forms are required to be completed at each visit, while other forms are required only at one visit or only when specifically indicated. The following table (Table 3) lists the forms that are required to be completed at each study visit, as well as the forms that are completed on an "as needed" basis, the ongoing log forms, discontinuation forms, and pregnancy forms.

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

Visit	Form Name
Visit 1 – Screening Visit (1.0)	*Eligibility Criteria Complete and submit at Screening Visit only if it is determined the participant will not enroll in MTN-034
	Concomitant Medications Summary, Concomitant Medications Log
	Demographics
	Local Laboratory Results
	Baseline Medical History Summary, Baseline Medical History Log
	Family Planning History
	Pelvic Exam
	Physical Exam
	Screening Date of Visit
	Screening Menstrual History
	STI Test Results

	Vital Signs
	Pelvic Exam Diagrams (non-Medidata Rave)
Visit 2 – Enrollment Visit (2.0)	Adherence Counseling
	ACASI Summary
	ACASI Tracking
	Enrollment
	Enrollment Menstrual History
	Family Planning Summary
	Pelvic Exam
	Pharmacy Dispensation (completed by and accessible to site pharmacists only)
	Randomization
	Specimen Storage
	STI Test Results
	Ring Insertion and Removal OR PrEP Provisions and Return *based on sequence randomization
	Pelvic Exam Diagrams (non- Medidata Rave)
Visit 3 - Phone Contact	Follow-up Visit Yes/No, Follow-up Visit Summary
Visits - 4-9 (4.0-9.0) Visits - 11-16 (11.0-16.0) Visits - 18-22 (18.0-22.0)	Follow-up Visit Yes/No, Follow-up Visit Summary
	HIV Test Results
	Pharmacy Dispensation
	Physical Exam
	Pregnancy Test Result
	Ring Insertion and Removal, OR PrEP Provisions and Return *based on sequence randomization
	Specimen Storage
	Vital Signs
	Adherence Counseling

	Required at Visits 6, 9, 13, 16 & 20 only:
	ACASI Summary
	ACASI Tracking
	Pelvic Exam
	Social Benefits and Impacts
	STI Test Results
	Local Laboratory Results (**Required at Visits 9 & 16 only**)
	Product Preference and Acceptability (**Required at Visits 9 & 16 only**)
	Product Choice (**Required at Visit 16 only**)
	Pelvic Exam Diagrams (non-Medidata Rave)
Visits 10, & 17 - Phone Contact	Follow-up Visit, Yes/No, Follow-up Visit Summary
Visit 23 PUEV (23.0)/ Early Termination	ACASI Summary
	ACASI Tracking
	Follow-up Visit Yes/No, Follow-up Visit Summary
	HIV Test Results
	Local Laboratory Results
	Physical Exam
	Pelvic Exam
	Pregnancy Test Result
	Product Preference and Acceptability
	Social Benefits and Impacts
	Specimen Storage
	STI Test Results
	Ring Insertion and Removal, OR PrEP Provisions and Returns *based on sequence randomization
	Vital Signs
	Pelvic Exam Diagrams (non-Medidata Rave)

Visit 24 – Final Phone Contact (24.0)	Follow-up Visit Yes/No, Follow-up Visit Summary
	Study Termination

As needed	ACASI Summary
	ACASI Tracking
	Additional Study Procedures
	COVID-19 Behavioral Assessment
	HIV Confirmatory Results
	HIV Test Results
	Interim Visit Summary
	Local Laboratory Results
	Missed Visit
	Participant Transfer
	Participant Receipt
	Pharmacy Dispensation (completed by and accessible to site pharmacists only)
	Physical Exam
	Pelvic Exam
	Pregnancy Test Result
	Pregnancy Report
	Pregnancy History
	Pregnancy Outcome
	PreP Provision and Return
	Ring Insertion and Removal
	Product Change
	Product Hold
	Product Discontinuation
	Ring Assessment
	Ring Insertion and Removal
	Seroconverter Laboratory Results

	Social Benefits
	Social Impact
	Specimen Storage
	STI Test Results
	Tablet Assessment
	Vital Signs
	Pelvic Exam Diagrams (non-Medidata Rave)

Other Medidata Rave Folders

	Adverse Event Summary
	Adverse Event
	Concomitant Medications Summary
	Concomitant Medications
	Family Planning Summary
	Family Planning
Ongoing Logs, as needed	Protocol Deviations Summary
	Protocol Deviations
	Product Hold Summary
	Product Hold
	Social Benefits Summary
	Social Benefits
	Social Impact Summary
	Social Impact

Discontinuations	Study Termination
	Product Discontinuation Log

Pharmacy	Pharmacy Dispensation Log

Pregnancy	Pregnancy Report
	Pregnancy Outcome Log

12.5.5 Site Review (Quality Control) of CRFs

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

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

MTN-034 QC Review Step #1 (completed during visit)

- Review visit checklist and pelvic exam checklist (if used) to ensure all required procedures were completed

- Review eligibility checklists/worksheets to ensure completeness and verify participant eligibility

- Review LDMS Specimen Tracking Sheets to ensure completeness and accuracy

- Review completed CRFs based on participant responses to ensure completeness:

  o Screening Visit: Demographics, Baseline Medical History Log, Concomitant Medications Log, Screening Menstrual History, Family Planning History

  o Enrollment Visit: Baseline Medical History Log, Concomitant Medications Log, Adherence Counseling, Enrollment Menstrual History, ACASI Summary, Ring Insertion and Removal or PrEP Provision and Return

  o Follow-up visits, when present: Adherence Counseling, Adverse Event Log, Ring Insertion and Removal, PrEP Provision and Return, Ring Assessment, Tablet Assessment, Product Preference and Acceptability, Product Choice, Product Change, ACASI Summary, Social Benefits and Impacts

MTN-034 QC Review Step #2 (completed after visit)

General QC #2 procedures for all visits:

- Review visit checklist to ensure all required procedures were completed

- Ensure the PTID is correct, is recorded correctly on all paper source documents (including paper CRFs, if used), and is the same on the paper source documents and the CRFs for a given participant.

- Ensure that no participant identifiers other than the PTID are present on paper source documents, including paper CRFs (if used).

- Ensure that the assigned visit code is correct, and is consistent between the paper source documents, including paper CRFs (if used), the CRFs, the LDMS Specimen Tracking Sheet, and LDMS for a given participant visit.

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

- Review the Ring Insertion and Removal, PrEP Provision and Return, Pelvic Exam, Physical Exam, Vital Signs, Local Laboratory Results, and STI Tests forms, and ensure that medical conditions are recorded appropriately on the Baseline Medical History Log. Refer to the CCG for further guidance.

- Ensure that all CRFs used to document lab test results have the correct Specimen Collection Dates entered. If any lab tests were repeated, update the appropriate CRF(s) to reflect the repeat test result(s).

- If a second (repeat) full pelvic exam is performed during screening, make sure a new pelvic exam source document [e.g., Pelvic Exam Diagrams (non-Medidata Rave)] is completed, and update the Pelvic Exam CRF in the Screening Visit folder to document the 2nd screening pelvic exam.

- Review the Specimen Storage and the Ring Insertion and Removal (if applicable) CRFs and make sure they match information documented on the visit checklist and Enrollment Visit LDMS Specimen Tracking Sheet (or local lab requisition sheet).

- If a participant screens but does not enroll in the study, make sure the Eligibility Criteria CRF is completed and entered into the study database. Other CRFs that were completed as part of the failed screening attempt may remain in the study database, but will not undergo QC review.

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

- Concomitant Medications Log CRF: if a medication is taken for an AE, select the on the Concomitant Medications Log CRF, and ensure the AE Log CRF for the AE has "Medication(s)" entered for "Other action(s) taken".

QC #2 for Paper CRFs (if used)

This QC review step should occur before forms are data-entered into the study database. Ideally, this review will happen once all lab results are available, so that all forms for a particular visit can be reviewed for consistency across documents.

The goal, as outlined in the site's Data Management SOP, is to correct data inconsistencies/errors prior to entering data into the study database, so that data is accurate, complete, and available at the time of data entry, thus minimizing the likelihood of data queries.

QC #2 procedures for paper CRFs - all visits:

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

- If a response box with "other", "specify", or "describe" line is present, ensure text is present on this line.

- Make sure text responses are clearly recorded.

- For paper CRFs that are not source documents, make sure the data recorded on the paper CRFs matches or is consistent with the source documents.

QC #2 for Electronic CRFs (eCRF)

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

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

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

12.6   Form-Specific Completion Instructions

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

The current version of the MTN-034 CCGs is located on the MTN-034 ATLAS webpage:

https://atlas.scharp.org/cpas/project/MTN/034/begin.view?

12.7   Case Report Forms

SCHARP will post a CRF (pdf) file, representing output from the study database CRFs, on the following MTN-034 Atlas web page:

https://atlas.scharp.org/cpas/project/MTN/034/begin.view?

The pdf file represents the current and complete set of study CRFs and may be used by site staff for local IRB submission as needed. Should the Medidata Rave study clinical database become unavailable (i.e., offline) during the study, the Rave CRF pdf should be used to perform paper CRF completion.