

45 FORM 1—ANTIRETROVIRAL DRUGS

ID Number

Visit No.

DATE

| | | | | |
|--------|---|---|---|---|
| | | | | |
| MACSID | | | | |
| 2 | 2 | 2 | 2 | 2 |
| 3 | 3 | 3 | 3 | 3 |
| 4 | 4 | 4 | 4 | 4 |
| 5 | 5 | 5 | 5 | 5 |
| 6 | 6 | 6 | 6 | 6 |
| 7 | 7 | 7 | 7 | 7 |
| 8 | 8 | 8 | 8 | 8 |
| 9 | 9 | 9 | 9 | 9 |

| | | |
|----------|---|---|
| 4 | 5 | 0 |
| 0 | | |
| VISIT_45 | | |
| 3 | 3 | |
| 4 | 4 | |
| 5 | | |
| 6 | 6 | |
| 7 | 7 | |
| 8 | 8 | |
| 9 | 9 | |

| | | |
|----------------------------|-----|------|
| <input type="radio"/> Jan | DAY | YEAR |
| <input type="radio"/> Feb | | |
| <input type="radio"/> Mar | | |
| <input type="radio"/> Apr | | |
| <input type="radio"/> May | | |
| <input type="radio"/> June | | |
| <input type="radio"/> July | 4 | 04 |
| <input type="radio"/> Aug | 5 | 05 |
| <input type="radio"/> Sept | 6 | 06 |
| <input type="radio"/> Oct | 7 | 07 |
| <input type="radio"/> Nov | 8 | 08 |
| <input type="radio"/> Dec | 9 | 09 |

COMPLETE THE FOLLOWING FOR EACH DRUG LISTED IN QUESTION 15.B(3).

- abacavir (Ziagen) (218)
- amprenavir (Agenerase) (219)
- atazanavir (Reyataz) (243)
- Combivir (zidovudine & lamivudine) (227)
- d4T (Zerit, Stavudine) (159)
- delavirdine (Rescriptor) (194)
- didanosine (Videx) (147)
- efavirenz (Sustiva) (220)
- emtricitabine (Emtriva, FTC) (239)
- enfuvirtide (Fuzeon, T-20, pentafuside) (233)
- Epzicom (abacavir, lamivudine) (254)
- fosamprenavir (Lexiva) (249)
- indinavir (Crixivan) (212)
- lamivudine (EpiVir, 3TC) (204)
- lopinavir (Kaletra) (217)
- nelfinavir (Viracept) (216)
- nevirapine (Viramune) (191)
- ritonavir (Norvir) (211)
- saquinavir (Invirase, Fortovase) (210)
- tenofovir (Viread) (234)
- tipranavir (238)
- Trizivir (abacavir + lamivudine + zidovudine) (240)
- Truvada (emtricitabine + tenofovir) (253)
- zidovudine (Retrovir, AZT) (092)

Other →

Name of Drug:

Drug Code

| | | | | | | | | | |
|---|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| 0 | 100 | 200 | 300 | 400 | 500 | 600 | 700 | 800 | 900 |
| 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

You said you were taking (DRUG) since your last visit:

1.A. Did you take this drug as part of a research study?

NO (GO TO Q2) YES RESF1_45

B. Was this study one in which you may have taken a placebo (not the actual drug) or in which you were blinded to the treatment?

NO YES PLCF1_45

C. Was this part of the AIDS Clinical Trial Group (ACTG) study?

NO DON'T KNOW ACTF1_45

YES

D. Are you currently taking this drug as part of the research study?

NO (GO TO E.) YES STOP, IF BLINDED. GO TO Q4, IF UNBLINDED. RNWF1_45

E. [Since your last visit] In what month and year did you most recently take this drug as part of the research study?

| | | | | | | | | | | | |
|----|----|----|----|----|----|----|----|----|----|----|----|
| J | F | M | A | M | J | J | A | S | O | N | D |
| 95 | 96 | 97 | 98 | 99 | 00 | 01 | 02 | 03 | 04 | 05 | 06 |

AVRSM_45
AVRSY_45

IF BLINDED, STOP. GO TO NEXT DRUG.
IF UNBLINDED, GO TO Q2.

2. Are you currently taking this drug [not as part of a research study]?

NO (GO TO Q3) YES (GO TO Q4) AVNW_45

IF YES, BUT DRUG WAS PREVIOUSLY TAKEN AS PART OF A STUDY, YOU MUST COMPLETE THIS FORM FOR RESEARCH USE AND COMPLETE ANOTHER FORM FOR NON-RESEARCH DRUG USE.

3. [Since your last visit] In what month and year did you most recently take this drug?

| | | | | | | | | | | | |
|----|----|----|----|----|----|----|----|----|----|----|----|
| J | F | M | A | M | J | J | A | S | O | N | D |
| 95 | 96 | 97 | 98 | 99 | 00 | 01 | 02 | 03 | 04 | 05 | 06 |

AVRM_45
AVRY_45

4. Do you take this drug by mouth or receive it by injection?

by mouth (pill) DORIN_45

injection IF BY INJECTION, SKIP TO Q7.

5. According to your doctor, how many times per day, week, or month should you take (DRUG)? [IF NOT CURRENTLY TAKING DRUG, USE MOST RECENT TIME]

NUMBER OF TIMES PER Day or Week or Month

| | | | | | | | | | |
|---|----|----|----|---|---|---|---|---|---|
| 0 | 10 | 20 | 30 | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

PRES1_45
PREST_45

6. According to your doctor, how many pills should you take each time?

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|----|

NPILT_45

IF BY MOUTH, SKIP TO Q8.

7. How many times per day, week, or month do you inject this drug?

NUMBER OF TIMES PER Day or Week or Month

| | | | | | | | | | |
|---|----|----|----|---|---|---|---|---|---|
| 0 | 10 | 20 | 30 | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

TINJD_45
INJDU_45

8. Did you start taking this drug since your last visit?

NO (GO TO Q10) YES

START_45

9. [Since your last visit] In what month and year did you start taking this drug?

| | | | | | | | | | | | | |
|--|----|----|----|----|----|----|----|----|----|----|----|----|
| | J | F | M | A | M | J | J | A | S | O | N | D |
| | 95 | 96 | 97 | 98 | 99 | 00 | 01 | 02 | 03 | 04 | 05 | 06 |

AVSM_45

AVSY_45

10. Since your last visit in (MONTH), how long have you used (DRUG)?

- One week or less
- More than 1 week but less than 1 month
- 1–2 months (includes 2 months and longer, but less than 3 months)
- 3–4 months (includes 4 months and longer, but less than 5 months)
- 5–6 months
- More than 6 months

LENAV_45

11. Did you stop taking this drug, for 2 days or longer, at any time since your last visit? [DOES NOT INCLUDE ALTERNATING DRUG USE]

NO (GO TO Q13) YES

DECAV_45

12. Why did you stop taking this drug? (MARK ALL THAT APPLY)

- Low white blood cells (low neutrophils) STWBC_45
- Anemia (low red blood cells/low hemoglobin) STANE_45
- Blood in urine STBLU_45
- Bleeding STBLD_45
- Dizziness/Headaches STHED_45
- Nausea/Vomiting STVOT_45
- Abdominal pain (pancreatitis/abdominal bloating) STABP_45
- Diarrhea STDIA_45
- Muscle pain or weakness (myopathy/myositis/muscle cramps/spasms) STMPW_45
- Burning/tingling in extremities (neuropathy/neuritis/numbness) STBTE_45
- Kidney stones STKID_45
- Kidney failure STREN_45
- Rash STRAS_45
- High blood sugar/Diabetes STDM_45
- High cholesterol/High triglycerides STCHO_45
- Painful urination STURN_45
- High blood pressure STHBP_45
- Abnormal changes in body fat STFAT_45
- Vivid nightmares or dreams STNVD_45
- Liver toxicity (abnormal liver function test) STNVD_45
- Insomnia or problems sleeping STLTX_45
- Fatigue STIPS_45

SINVL_45

SDCVL_45

STHOS_45

STPER_45

STDOC_45

STEXP_45

STINC_45

STCGD_45

STEND_45

- Increased viral load
- Decreased viral load
- Hospitalized
- Personal decision
- Prescription changes by physician
- Too expensive
- Too much bother, inconvenient (ran out/vacation/unable to fill prescription)
- Changed to another drug in order to decrease the number of pills or dosing frequency
- Study ended
- Other, specify:

| | | | |
|----|-------|----------|-------|
| 1) | _____ | STOT1_45 | _____ |
| 2) | _____ | STOT2_45 | _____ |
| 3) | _____ | STOT3_45 | _____ |

13. On average, how often did you take your medication as prescribed?

- 100% of the time
- 95–99% of the time
- 75–94% of the time
- <75% of the time

MDPRE_45