### Complete the following for each drug listed in question 15B(3).

<table>
<thead>
<tr>
<th>Drug Code</th>
<th>Name of Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>DRAV_47</td>
</tr>
<tr>
<td>40</td>
<td>DRGA_47</td>
</tr>
<tr>
<td>11</td>
<td>AVRM_47</td>
</tr>
<tr>
<td>41</td>
<td>AVRY_47</td>
</tr>
<tr>
<td>21</td>
<td>AVRSM_47</td>
</tr>
<tr>
<td>22</td>
<td>AVRSY_47</td>
</tr>
</tbody>
</table>

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

1. Did you take this drug as part of a research study?
   - [ ] NO (GO TO Q2)
   - [X] YES (RESF_47)

2. Are you currently taking this drug (not as part of a research study)?
   - [ ] NO (GO TO Q3)
   - [X] YES (AVNW_47)

3. [Since your last visit] In what month and year did you most recently take this drug?
   - [ ] Jan
   - [X] Feb
   - [ ] Mar
   - [X] Apr
   - [ ] May
   - [X] Jun
   - [ ] Jul
   - [ ] Aug
   - [ ] Sep
   - [ ] Oct
   - [X] Nov
   - [ ] Dec

4. Do you take this drug by mouth or receive it by injection?
   - [ ] by mouth (pill)
   - [X] 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]
   - [ ] Day
   - [ ] Week
   - [ ] Month

6. According to your doctor, how many pills should you take each time?
   - [ ] Day
   - [ ] Week
   - [ ] Month

7. How many times per day, week, or month do you inject this drug?
   - [ ] Day
   - [ ] Week
   - [ ] Month

**Please continue on the other side.**
8. Did you start taking this drug since your last visit?  
   ○ NO (GO TO Q10)  ○ YES  START_47

9. [Since your last visit] In what month and year did you start taking this drug?  
   [AVSM_47] AVSY_47

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  

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_47

12. Why did you stop taking this drug?  
   (MARK ALL THAT APPLY)  
   ○ Low white blood cells (low neutrophils)  
   ○ Anemia (low red blood cells/low hemoglobin)  
   ○ Blood in urine  
   ○ Bleeding  
   ○ Dizziness/Headaches  
   ○ Nausea/Vomiting  
   ○ Abdominal pain (pancreatitis/abdominal bloating/cramps/spasms)  
   ○ Muscle pain or weakness (myopathy/myositis/muscle cramps/spasms)  
   ○ Burning/tingling in extremities (neuropathy/neuritis/numbness)  
   ○ Kidney stones  
   ○ Kidney failure  
   ○ Rash  
   ○ High blood sugar/Diabetes  
   ○ High cholesterol/High triglycerides  
   ○ Painful urination  
   ○ High blood pressure  
   ○ Abnormal changes in body fat  
   ○ Vivid nightmares or dreams  
   ○ Liver toxicity (abnormal liver function test)  
   ○ Insomnia or problems sleeping  
   ○ Fatigue  
   ○ 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 number of pills or dosing frequency  
   ○ Study ended  
   ○ Other, specify:  
     1) ________________________  STOT1_47  
     2) ________________________  STOT2_47  
     3) ________________________  STOT3_47

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  

CC# 4

GO TO Q10