PAPER DRUG FORM 1 VISIT 62

MACSID: ____ _____ _____ _____ _____

Drug name: _____ **Drug code:** ____ _____ _____

Ask the participant for the names of the antiretroviral drugs taken since last visit and fill out one form for each reported drug. If this is a person to person interview, show the drug list hand-out (Appendix 1). Identify the drug codes in the attached drop down list (Appendix 2).

If the participant has taken the drug both as part of a research study and not part of research study (regular prescription care under his doctor) then fill out two forms: first, for non-research use and then follow for research use.

Mark each bubble next to the selected response.

1. A. Did you take (INSERT DRUG NAME) since your last visit as …

READ EACH OPTION.

- ☐ 1. Not part of a research study (non-research use only)
- ☐ 2. Part of a research study only
- ☐ 3. Both non-research and research study

If Q1.A = 1, go to Q2 to ask about taking the drug as not part of a research study.
If Q1.A = 2, go to Q1.B to ask about taking the drug as part of a research study.
If Q1.A = 3, fill out two forms; first for non-research use, starting at Q2; then for research use start at Q1.B.

1. 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?

- ☐ 1. No
- ☐ 2. Yes

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

- ☐ 1. No
- ☐ 2. Yes
- ☐ 3. Don't know

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

- ☐ 1. No ⟶ ***Go to Q1.E***
- ☐ 2. Yes ⟶ **GO TO *Q4*, IF UNBLINDED (*Q1.B* = NO). STOP, IF BLINDED (*Q1.B* = YES).**

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Drug name: _____ **Drug code:** ____ _____ _____

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

____ ____ ____ ____
month *year*

GO TO *Q2*, IF UNBLINDED (*Q1.B* = NO)
STOP, IF BLINDED (*Q1.B* = YES).

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

☐ 1. No ⟶ ***GO TO Q3.***
☐ 2. Yes ⟶ ***GO TO Q4.***

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

____ ____ ____ ____
month *year*

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

☐ 1. By mouth (pill or liquid)
☐ 2. Injection ⟶ ***GO 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
☐ Week
☐ Month

Select day, week or month and fill in number of times taken by mouth.

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

Number of times: ____ ____

If take drug by mouth, GO TO Q8

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Drug name: _____ **Drug code:** ____ _____ _____

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

Number of times: ____ ____

per….

☐ Day

☐ Week

☐ Month

Select day, week or month and fill in number of times inject drug.

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

☐ 1. No ⟶ ***GO TO Q10.***

☐ 2. Yes ⟶

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

____ ____ ____ ____

month *year*

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]

☐ 1. No ⟶ ***GO TO Q13.***

☐ 2. Yes ⟶

MACSID: ____ _____ _____ _____ _____

Drug name: _____ **Drug code:** ____ _____ _____

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) ☐ Diarrhea ☐ 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 the number of pills or dosing frequency ☐ Study ended ☐ Other, specify:	

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Drug name: _____ **Drug code:** ____ _____ _____

Other reasons for stopping medications:

1. _____

2. _____

3. _____

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

Adherence questions:

1.a How many times did you actually take (DRUG)?

When referring to 2 days ago, 3 days ago, and 4 days ago, name the respective day of the week.
Note: If what is actually taken is greater than prescribed dosage in the drug form, please verify.

Yesterday _____

2 days ago _____

3 days ago _____

4 days ago _____

1.b Is this pattern typical of your recent use of [medication]?

- ☐ 1. No
- ☐ 2. Yes
- ☐ 3. Refused

1.c Was there any time in the last 4 days that you took fewer pills per dose (time) than were prescribed?

- ☐ 1. No
- ☐ 2. Yes
- ☐ 3. Refused

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