

# 51 FORM 1—ANTIRETROVIRAL DRUGS

ID Number MACSID	Visit No. VISIT_51	DATE	
0 0 0 0	0 0	Jan	DAY YEAR
1 1 1 1	1 1	Feb	AVQM_51
2 2 2 2	2 2	Mar	AVQD_51
3 3 3 3	3 3	Apr	AVQY_51
4 4 4 4	4 4	May	20 2 11
5 5 5 5	5 5 5	June	30 3 12
6 6 6 6	6 6	July	4 13
7 7 7 7	7 7	Aug	5 14
8 8 8 8	8 8	Sept	6 15
9 9 9 9	9 9	Oct	7 16
		Nov	8 17
		Dec	9 18

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

- |  |  |
|--|--|
| <input type="checkbox"/> abacavir (Ziagen) (218)                               | <input type="checkbox"/> lamivudine (Epivir, 3TC) (204)                      |
| <input type="checkbox"/> atazanavir (Reyataz) (243)                            | <input type="checkbox"/> lopinavir/ritonavir (Kaletra, LPV) (217)            |
| <input type="checkbox"/> Atripla (efavirenz + emtricitabine + tenofovir) (262) | <input type="checkbox"/> nelfinavir (Viracept) (216)                         |
| <input type="checkbox"/> Combivir (zidovudine & lamivudine) (227)              | <input type="checkbox"/> nevirapine (Viramune) (191)                         |
| <input type="checkbox"/> d4T (Zerit, Stavudine) (159)                          | <input type="checkbox"/> ritonavir (Norvir) (211)                            |
| <input type="checkbox"/> delavirdine (Rescriptor) (194)                        | <input type="checkbox"/> saquinavir (Invirase, Fortovase) (210)              |
| <input type="checkbox"/> didanosine (Videx) (147)                              | <input type="checkbox"/> tenofovir (Viread) (234)                            |
| <input type="checkbox"/> efavirenz (Sustiva) (220)                             | <input type="checkbox"/> tipranavir (Aptivus, TPV) (238)                     |
| <input type="checkbox"/> emtricitabine (Emtriva, FTC) (239)                    | <input type="checkbox"/> Trizivir (abacavir + lamivudine + zidovudine) (240) |
| <input type="checkbox"/> enfuvirtide (Fuzeon, T-20, pentafuside) (233)         | <input type="checkbox"/> Truvada (emtricitabine + tenofovir) (253)           |
| <input type="checkbox"/> Epzicom (abacavir + lamivudine) (254)                 | <input type="checkbox"/> zidovudine (Retrovir, AZT) (092)                    |
| <input type="checkbox"/> fosamprenavir (Lexiva) (249)                          |  |
| <input type="checkbox"/> indinavir (Crixivan) (212)                            | <input type="checkbox"/> 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\_51

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\_51

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

- NO  DON'T KNOW  
 YES ACTF1\_51

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\_51

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
01	02	03	04	05	06	07	08	09	10	11	12

AVRSM\_51  
AVRSY\_51

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\_51

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
01	02	03	04	05	06	07	08	09	10	11	12

AVRM\_51  
AVRY\_51

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

- by mouth (pill or liquid) DORIN\_51  
 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\_51  
PREST\_51

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

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

NPILT\_51  
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\_51  
INJDU\_51

Please continue on the other side.

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

NO (GO TO Q10)  YES **START\_51**

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	<b>AVSM_51</b>
	01	02	03	04	05	06	07	08	09	10	11	12	<b>AVSY_51</b>

10. Since your last visit in (MONTH), how long have you used (DRUG)? **LENAV\_51**

- 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\_51**

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

- Low white blood cells (low neutrophils) **STWBC\_51**
- Anemia (low red blood cells/low hemoglobin) **STANE\_51**
- Blood in urine **STBLU\_51**
- Bleeding **STBLD\_51**
- Dizziness/Headaches **STHED\_51**
- Nausea/Vomiting **STVOT\_51**
- Abdominal pain (pancreatitis/abdominal bloating) **STABP\_51**
- Diarrhea **STDIA\_51**
- Muscle pain or weakness (myopathy/myositis/m) **STMPW\_51**
- cramps/spasms) **STBTE\_51**
- Burning/tingling in extremities (neuropathy/neuritis/numbness) **STKID\_51**
- Kidney stones **STREN\_51**
- Kidney failure **STRAS\_51**
- Rash **STDM\_51**
- High blood sugar/Diabetes **STCHO\_51**
- High cholesterol/High triglycerides **STURN\_51**
- Painful urination **STHBP\_51**
- High blood pressure **STFAT\_51**
- Abnormal changes in body fat **STNVD\_51**
- Vivid nightmares or dreams **STLTX\_51**
- Liver toxicity (abnormal liver function test) **STIPS\_51**
- Insomnia or problems sleeping **STFTG\_51**
- Fatigue **SINVL\_51**
- Increased viral load **SDCVL\_51**
- Decreased viral load **STHOS\_51**
- Hospitalized **STPER\_51**
- Personal decision **STDOC\_51**
- Prescription changes by physician **STEXP\_51**
- Too expensive **STINC\_51**
- Too much bother, inconvenient (ran out/vacation to fill prescription) **STCGD\_51**
- Changed to another drug in order to decrease the number of pills or dosing frequency **STEND\_51**
- Study ended
- Other, specify:

1) _____	<b>STOT1_51</b>	_____
2) _____	<b>STOT2_51</b>	_____
3) _____	<b>STOT3_51</b>	_____

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

- 100% of the time **MDPRE\_51**
- 95–99% of the time
- 75–94% of the time
- <75% of the time