

## Section 8. Adverse Event Reporting and Safety Monitoring

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### Table of Contents

8.1	Definitions and General Reporting Guidance .....	1
8.1.1	Adverse Event (AE) .....	1
8.1.2	Reporting Adverse Events .....	2
8.1.3	Serious Adverse Events (SAEs) .....	2
8.1.4	Reporting Adverse Events in an Expedited Manner (EAE Reporting) .....	3
8.2	Adverse Event Terminology .....	6
8.2.1	Reporting Genital, Genitourinary, Reproductive System AEs .....	7
8.2.2	STIs/RTIs .....	10
8.2.3	Reporting Abdominal Pain as an AE .....	11
8.2.4	Reporting Laboratory Abnormalities as AEs .....	11
8.3	Adverse Event Severity Grading .....	12
8.4	Adverse Event Relationship Assessment .....	13
8.5	Adverse Event Outcomes and Follow-Up Information: During Study Participation .....	14
8.6	Adverse Event Outcomes and Follow-Up Information: After Study Termination .....	14
8.6.1	Reporting Recurrent Adverse Events .....	15
8.7	Social Harms .....	15
8.8	Safety Distributions from DAIDS .....	16
8.9	Safety Monitoring, Review, and Oversight .....	16
Appendix 8-1: MTN-029/IPM 039 Protocol Safety Review Team .....		18

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This section presents information related to adverse event (AE) reporting and participant safety monitoring in MTN-029/IPM 039. Please also refer to Section 8 of the protocol and the following resources relevant to AE assessment and reporting:

- DAIDS Table for Grading Adult and Pediatric Adverse Events (Toxicity Table)
- Addendum 1-DAIDS Female Genital Grading Table for Use in Microbicide Studies (FGGT)
- Manual for Expedited Reporting of Adverse Events to DAIDS
- DAERS Reference Guide for Site Reporters and Study Physicians
- Investigator’s Brochure for Dapivirine Vaginal Ring

#### 8.1 Definitions and General Reporting Guidance

##### 8.1.1 Adverse Event (AE)

The International Conference on Harmonization Consolidated Guidance for Good Clinical Practice (ICH-E6) defines an AE as any untoward medical occurrence in a clinical research participant administered an investigational product and that does not necessarily have a causal relationship with the investigational product. As such, an AE can be any unfavorable and unintended sign (including an abnormal laboratory finding), symptom, or disease temporally associated with the use of an investigational product, whether or not related to the investigational product.

For MTN-029/IPM 039, this definition applies to each and every participant, beginning at the time of enrollment through when she terminates from the study. Study staff must document in source

documents and case report forms all AEs reported by or observed in study participants, regardless of severity and presumed relationship to study product.

Ongoing medical conditions, problems, signs, symptoms, and findings identified prior to enrollment are considered pre-existing conditions. Such conditions should be documented on the Pre-Existing Conditions case report form. Pre-existing conditions must be graded and are assigned severity grades just as AEs. If a pre-existing condition worsens (increases in severity or frequency) after enrollment, the worsened condition is considered an AE and is reportable on the AE Log CRF. If a pre-existing condition resolves after enrollment, but then recurs at a later date, the recurrence is considered an AE.

### 8.1.2 Reporting Adverse Events

Per Section 8.3 of the MTN-029/IPM 039 protocol, study staff will report on the AE Log CRF all AEs reported by or observed in enrolled study participants regardless of severity and presumed relationship to study product. Expected AEs must also be captured on the AE Log CRF. However, bleeding at the time of speculum insertion or specimen collection that is judged by the clinician to be within the range of normally anticipated bleeding for that procedure *will not be* reportable as an AE. Bleeding of greater quantity or longer duration than typically associated with those procedures will be reported as an AE.

Of note, changes in genital bleeding judged to be related to a woman's contraceptive use or return of menstruation postpartum *will not be* considered an AE, nor will a pelvic exam be required for follow-up.

Each site's SOP for source documentation should define the extent to which the AE Log CRF will be used as the source document for the data elements.

Documentation of site-specific delegation of duties should designate study staff authorized by the IoR to complete the AE Log CRF. Regardless of who initially completes these forms, a clinician listed on the site's FDA Form 1572 should review each AE Log CRF to ensure the accuracy of the data reported and to help maintain consistency of reporting across clinicians.

If, at any time, site staff has questions about participant safety or reporting clinical events, they should send an email to the MTN-029/IPM 039 Safety Physicians at [mtn029safetymd@mtnstopshiv.org](mailto:mtn029safetymd@mtnstopshiv.org).

### 8.1.3 Serious Adverse Events (SAEs)

ICH-E6 defines a serious adverse event (SAE) as any untoward medical occurrence that at any dose:

1. Results in death,
2. Is life-threatening,  
NOTE: The term "life threatening" refers to an event in which the participant was at risk of death at the time of the event; it does not refer to an event which hypothetically might have caused death if it were more severe. A grade 4 severity grading on the Toxicity Table does not necessarily mean that an event is life-threatening. When determining whether a grade 4 event meets the ICH definition of "life threatening", consider the event in the context of any related symptoms the participant may have experienced.
3. Requires inpatient hospitalization or prolongation of existing hospitalization,  
The following types of hospitalizations are not considered Adverse Events, serious or otherwise: any admission unrelated to an AE (e.g., for labor/delivery) or admission for diagnosis or therapy of a condition that existed before randomization (i.e., enrollment for MTN-029) AND has not increased in severity or frequency since baseline.
4. Results in persistent or significant disability/incapacity,
5. Is a congenital anomaly/birth defect,

6. Is an important medical event that may not be immediately life-threatening or result in death or hospitalization but may jeopardize the patient or may require intervention to prevent one of the other outcomes listed in the definition above.

ICH guidance (E2A) also states that medical and scientific judgment should be exercised in deciding whether other adverse events not listed above should be considered serious and that “important medical events that may not be immediately life-threatening or result in death or hospitalization, but may jeopardize the participant or may require intervention to prevent one of the outcomes listed in the definition above” should also be considered serious. SAEs are a subset of all AEs. For each AE identified, an authorized study clinician must determine whether the AE meets the definition of SAE. The AE Log CRF includes an item to record this information.

**All AEs that meet the definition of “serious” (SAEs), regardless of relationship to study product, are expedited adverse events (EAE). EAEs require additional reporting for rapid review and assessment by DAIDS.**

#### 8.1.4 Reporting Adverse Events in an Expedited Manner (EAE Reporting)

Expedited Adverse Events (EAEs) should be reported per the Manual for Expedited Reporting of Adverse Events to DAIDS, version 2.0; January 2010. For MTN-029/IPM 039, the “SAE (Serious Adverse Event) Reporting Category” will be used to report EAEs.

All EAEs must be reported to the DAIDS Regulatory Support Center (RSC) using the internet-based DAIDS Adverse Experience Reporting System (DAERS). All EAEs must be reported within three reporting days of site awareness of the EAE. The definition of a “reporting day” is as follows:

- Monday through Friday
- Saturday and Sunday are not considered reporting days.
- Any holiday (U.S. or in-country/local) that occurs on a Monday through Friday
- A reporting day starts at 12:00 AM (midnight) and ends at 8:59 PM local time (in the site’s time zone).
- The day site personnel become aware that an AE has met the definition of an EAE shall count as day 1 if that day occurs on a reporting day (i.e., Monday through Friday). This is true, regardless of the time of the day site personnel become aware of the EAE. If the day site personnel become aware of the EAE is a non-reporting day (i.e., Saturday or Sunday), then the next reporting day shall count as day 1.

For questions or other communications regarding submission of EAE Reports, see below.

Website:	<a href="http://rsc.tech-res.com">http://rsc.tech-res.com</a>
Office Phone:	301-897-1709 or toll free in the US: 800-537-9979
Office Fax:	301-897-1710 or toll free in the US: 800-275-7619
Office Email:	<a href="mailto:DAIDSRSCSafetyOffice@tech-res.com">DAIDSRSCSafetyOffice@tech-res.com</a>
Office Hours:	Monday through Friday, 8:30 AM to 5:00 PM ET

All EAEs must also be reported on the AE Log CRF. The AE Log CRF includes an item to record if the AE is also being reported as an EAE. When completing AE Log CRF and DAERS report or EAE form, study clinicians should carefully review all documentation of the event to ensure accuracy, completeness and consistency. All AE descriptions and details (e.g., AE verbatim term, onset date, severity grade, relationship to study product, and status/outcome) must be recorded consistently across all documents. All EAEs submitted to the DAIDS Safety Office will be compared with AE Log CRFs received at the MTN SDMC to ensure that all reports that should have been received by both DAIDS Safety Office and the SDMC have been received and that the

details recorded on each form are consistent. If an EAE that was previously reported to the DAIDS RSC resolves and then later recurs at a level requiring expedited reporting, the second occurrence must be reported as a new EAE report (and a new AE-1 CRF, if not already completed).

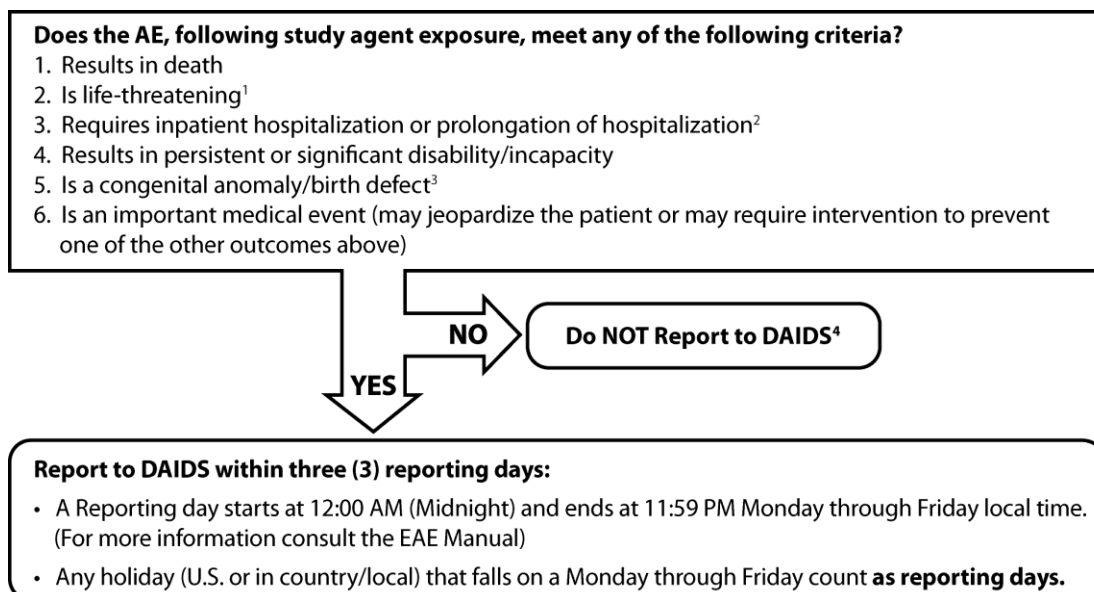
In the event that DAERS cannot be accessed (e.g., due to poor internet connectivity), paper-based EAE reporting should be used, per instructions provided in the Manual for Expedited Reporting of Adverse Events to DAIDS. Completed paper EAE Forms may be faxed or digitally scanned and emailed to the DAIDS RSC via email. The EAE Form and form completion instructions are available on the DAIDS RSC web site (<http://rsc.tech-res.com>). Contact details for submission of EAE Forms to the RSC are provided in the Manual for Expedited Reporting of Adverse Events to DAIDS.

For each EAE reported to DAIDS, sites are required to submit an updated report to DAIDS as soon as significant additional information becomes available. Note that updates made to EAE reports should also be made to the corresponding AE Log CRF documenting the AE, as applicable. Similarly, any updates made to an AE Log CRF should also be made to the corresponding EAE report, as applicable. EAE follow-up information should be reported to the DAIDS RSC, using the update function in DAERS, under the following circumstances:

- Requests from DAIDS for additional information
- A change in the relationship between the AE and study product by the study physician
- Additional significant information that becomes available for a previously reported AE (this is particularly important for new information addressing cause of death if the initial assignment was “pending”)
- Any change in the assessment of the severity grade of the AE
- An update including the final or stable outcome, unless the initial SAE submitted had a final or stable outcome noted already.
- Results of re-challenge with the study product, if performed

Note: A new EAE form does not need to be submitted for any change in the assessment of the severity grade or the relationship between the AE and the study product. However, the increase in severity must be reported as a new AE to the SDMC.

**Figure 8-1**  
**Expedited Adverse Event Reporting Requirements for MTN-029/IPM 039**



**Contact Information for the DAIDS Safety Office:**

**Website:** <http://rcc.tech-res.com> • **E-mail:** [RCCSafetyOffice@tech-res.com](mailto:RCCSafetyOffice@tech-res.com)  
**Office Phone:** 1-800-537-9979 (U.S. only) or +1-301-897-1709 • **Fax:** 1-800-275-7619 (U.S. only) or +1-301-897-1710  
*(Office Phone and Fax are accessible 24 hours per day)*  
**Mailing Address:** DAIDS Safety Office 6500 Rock Spring Drive, Suite 650, Bethesda, MD 20817

<sup>1</sup> “Life-threatening” refers to an event in which the patient was at risk of death at the time of the event. It does NOT refer to an event that hypothetically might have caused death if it were more severe.

<sup>2</sup> Per the ICH SAE definition, hospitalization is NOT an adverse event (AE), but is an outcome of the event. **DO NOT REPORT:** Any admission unrelated to an AE (e.g., for standard labor/delivery, cosmetic surgery, administrative or social admission for temporary placement for lack of a place to sleep); protocol-specified admission (e.g., for a procedure required by protocol); admission for diagnosis or therapy of a condition that existed before receipt of study agent(s) **and** has not increased in severity or frequency as judged by the clinical investigator. (**NOTE:** A new AIDS-defining event in a subject already known to be HIV-infected would be considered an increase in severity of a pre-existing condition [HIV infection] and **would be reportable**.)

<sup>3</sup> Clinically insignificant physical findings at birth, including those regarded as normal variants, do NOT meet reporting criteria. If a clinically significant anomaly is reported, all findings (including those of no individual significance) should be included in the same report. For example, do NOT report an isolated finding of polydactyly (extra fingers or toes) or Mongolian spot in an infant. But if either finding occurred with a major cardiac defect, report all findings in the SAE Report.

<sup>4</sup> Please ensure that any other protocol-specific reporting requirements are met.

## 8.2 Adverse Event Terminology

Study staff must assign a term or description to all AEs identified in MTN-029/IPM 039. The guidance below should be followed when assigning AE terms/descriptions:

- Whenever possible, a diagnosis should be assigned. Document associated signs and/or symptoms related to a diagnosis in the comments section of the AE Log CRF.
- When it is not possible to identify a single diagnosis to describe a cluster of signs and/or symptoms, each individual sign and symptom must be identified and documented as an individual AE.
- Whenever possible, use specific terms to indicate the anatomical location of the AE (e.g., “vaginal” instead of “genital” or “uterine cervix” instead of “cervical”).
- Use medical terms (e.g., “ulcers” instead of “sores”).
- Ensure correct spelling
- Do not use abbreviations, unless the abbreviations are for accepted laboratory findings (e.g., “AST increased”, “SGOT decreased”)

Procedures per se should not be reported as adverse events; rather the underlying condition which leads to a procedure may be considered an adverse event. Any associated procedures may be considered treatments for the adverse event. For example, while “appendectomy” would not be considered an adverse event, “appendicitis” would, with “appendectomy” documented as a treatment provided for the adverse event. In addition, any event that occurs as a result of a study-related procedure should be recorded as an AE. Specify in AE text description (item 1) if the AE is related to a procedure (iatrogenic). For example, if a participant experiences dizziness from a blood draw, then “dizziness due to blood draw” should be submitted as an AE.

Do not include information on relatedness to study product or timing of study product use in the AE term/description. Limit the AE text to the medical description and anatomical location, when needed. Including text such as “after ring insertion” or “at site of ring placement” affects the way the AE is MedDRA-coded, and thus, how it will appear in safety reports.

When reporting AEs which are due to ring removal or insertion, please follow the guidance below:

- If the AE is **due to the act** of study ring insertion or removal, include this information in item 1. For example, use AE text of “pelvic pain due to ring removal” or “vulvar laceration due to ring insertion” rather than just “pelvic pain” or “vulvar laceration.”

It is important to clearly identify in item 1 AEs that are due to the act of study ring insertion or removal, as these AEs are assigned unique coding terms within the standardized MedDRA coding system.

If the AE is **not** due to the act of study ring insertion or removal, do not include mention of the ring in item 1.

- If text is present in the “Comments” field that the AE is due to the act of ring insertion or removal, this same text needs to be in item 1. If not, this may result in a Clinical Query asking that this information be added to item 1 so that the AE is described completely and accurately.

Sites should include text in the “Comments” field explaining why the AE has been judged “related”.

When reporting an AE that is associated with an underlying condition, include the underlying condition in the AE term or description. For example, if a participant is experiencing pain related to an underlying cancer diagnosis, include the cancer diagnosis in the AE term or description.

## 8.2.1 Reporting Genital, Genitourinary, Reproductive System AEs

Vaginal Discharge: Vaginal discharge by participant report and vaginal discharge as observed by the clinician should be graded per the appropriate rows in the FGGT (see below). The verbatim term from the FGGT should be used to distinguish if vaginal discharge was clinician observed versus participant reported.

PARAMETER	Grade 0 NORMAL	Grade 1 MILD	Grade 2 MODERATE
Vaginal discharge by participant report	Participant's usual amount of discharge, regardless of color or quantity	Mild-moderate increase in amount above participant baseline - no sanitary protection required	Profuse increase in discharge requiring pad use or other hygienic intervention
Vaginal discharge as observed by clinician (red or brown discharge should be reported under bleeding, not discharge)	Slight amount of discharge, any color	Mild-moderate increase in amount	Significant increase in amount with pooling in vagina on examination

Note – if vaginal discharge is present both by history and on examination, only report the one with the most severe grade. Grade 3 and 4 vaginal discharge is listed as “NA” in the FGGT and is not pictured here. If they are the same grade, report ‘vaginal discharge by participant report’ as the AE term.

Genital bleeding: Genital bleeding other than menstrual bleeding, often referred to as intermenstrual bleeding (IMB) is a common occurrence among reproductive age women, and often is of physiologic or benign etiology. Some women normally experience mid-cycle bleeding or pre-menstrual bleeding. IMB is common in hormonal contraceptive users, particularly new and/or inconsistent users. These types of genital bleeding events, associated with contraceptive use, are considered a common occurrence and are not reportable as adverse events.

During follow-up, the following types of genital bleeding are reportable as adverse events on an AE Log CRF:

- In women who have re-established regular menstrual cycles postpartum, each new instance of heavy or prolonged menstrual bleeding or intermittent bleeding (as compared to the participant’s baseline bleeding pattern)
- Post-coital bleeding (bleeding associated with sexual intercourse) should be reported if not present at baseline

Note that the above conditions are consistent with the parameters set out in the FGGT under the heading ‘abnormal uterine bleeding unrelated to pregnancy’. Heavy, prolonged or intermittent bleeding episodes during follow-up that are consistent with a participant’s baseline bleeding pattern are considered expected and are not reportable as AEs. Note that shorter than baseline menses is not included in the FGGT, and should not be considered an adverse event.

**Vaginal and/or cervical bleeding associated with study procedures**: Vaginal and/or cervical bleeding associated with speculum insertion and/or specimen collection judged to be within the range of normal according to the clinical judgment of the IoR or designee is not considered to be an adverse event. If the bleeding exceeds the amount considered normal by the clinician, it should be considered an AE and should be documented and reported if applicable using the term

'post procedural bleeding'. The severity of the AE should be graded per the vaginal abrasion row of the FGGT.

Bleeding that is associated with an observed abnormal pelvic exam finding should be considered an AE and should be documented and reported if applicable using the term associated with the exam finding, with the anatomical location noted. For example, if a vaginal laceration is observed on exam, and there is bleeding attributable to the laceration, the term "vaginal laceration" should be used to document the AE. The fact that blood or bleeding was present should be documented on the Pelvic Exam Diagrams form and the Pelvic Exam CRF, and may also be noted in the comments section of the Adverse Experience Log CRF. The term "metrorrhagia" should not be used to document the AE.

If a newly-identified bleeding episode is determined to be different from a participant's baseline bleeding pattern (i.e., longer, heavier, more frequent), and not associated with an observed abnormal pelvic exam finding, contraceptive use, or return to menstruation postpartum, record the episode on an Adverse Experience Log (AE-1) CRF. One of four terms to describe the bleeding event should be used:

- menorrhagia
- metrorrhagia [Note: This term refers to bleeding of variable amounts occurring between regular menstrual periods and should be used to report non-menstrual bleeding such as spotting between menses, ovulation bleeding, and breakthrough bleeding. This term should also be used to report blood-tinged discharge and blood observed in the vagina with no identified source.]
- menometrorrhagia
- post coital bleeding

Note that a shorter than baseline menses is not considered an AE per the FGGT, though infrequent genital bleeding may be an AE. Grade the episode per the applicable row of the FGGT provided below. If both Menorrhagia and Metrorrhagia are present, a single adverse event should be reported as "Menometrorrhagia" and graded per the Menorrhagia row of the FGGT.



PARAMETER	GRADE 0 NORMAL	GRADE 1 MILD	GRADE 2 MODERATE	GRADE 3 SEVERE	GRADE 4 POTENTIALLY LIFE- THREATENING
<b>ABNORMAL UTERINE BLEEDING UNRELATED TO PREGNANCY</b>					
Menorrhagia <sup>2</sup> (prolonged and/or heavy menstrual bleeding)	Participant report of normal bleeding relative to her baseline	Increase from usual with no or minimal interference with usual social & functional activities (including sexual functioning)	Increase from usual with moderate interference with usual social & functional activities (including sexual)	Incapacitating or severe interference with usual social & functional activities (including sexual functioning), transfusion indicated	Life threatening hemorrhage with or without shock
Metrorrhagia <sup>2</sup> (intermenstrual or frequent bleeding)	None or any expected nonmenstrual bleeding	Increase from usual with no or minimal interference with usual social & functional activities (including sexual functioning)	Increase from usual with moderate interference with usual social & functional activities (including sexual)	Incapacitating or severe interference with usual social & functional activities (including sexual functioning), transfusion indicated	Life threatening hemorrhage with or without shock
Postcoital bleeding	None	Occasional (< 25% of coital acts) OR Increase from usual with no or minimal interference with usual social functioning (including sexual functioning)	Frequent (25-75% of coital acts) OR Increase from usual with moderate interference with usual social functioning (including sexual)	Consistent (> 75% of coital acts) OR Incapacitating or severe interference with usual social functioning (including sexual functioning), transfusion indicated	Life threatening hemorrhage with or without shock

**Recurrent bleeding AEs in follow-up:** Once a bleeding AE has been reported, each subsequent bleeding episode should be assessed to determine whether the episode is consistent with previously reported bleeding AEs, or if it is the first of its kind. Clinician discretion should be used to determine if a new AE needs to be documented or if a previously reported AE is ongoing.

- As needed, update the AE Log CRF to be 'continuing'. The dates of each irregular bleeding episode do not need to be recorded on the AE Log CRF, but should be captured in source documentation.
- If reviewing files in retrospect, mark for deletion any AE Log CRFs completed for bleeding episodes that can be subsumed under the AE that was initially reported for the event. When/if any AEs are deleted, clearly document the rationale in the relevant source documents.
- If applicable, review the CM-1 CRF "Taken for a reported AE?" and "AE Log page" to ensure that no deleted AEs are reflected on the form.
- If a participant has an ongoing (recurrent) bleeding adverse event, a pelvic exam is not required each time the participant reports the same ongoing bleeding, provided that the clinician assesses the bleeding to be consistent with the bleeding captured by the ongoing adverse event. If the AE increases in severity, a new AE Log CRF should be completed to document this change in severity.

## 8.2.2 STIs/RTIs

The following terminology should be used only if STI diagnosis is based on clinical evaluation and confirmed, when appropriate/possible, by laboratory result(s). For example, symptomatic bacterial vaginosis and symptomatic vulvovaginal candidiasis should not be reported as AEs based on participant symptoms alone.

- **Bacterial vaginosis:** Only report symptomatic infections that are confirmed with saline wet mount testing and fulfilling Amsels criteria as AEs, using the term “symptomatic bacterial vaginosis.”
- **Candidiasis:** Only report symptomatic infections that are confirmed with KOH wet prep and/or culture as AEs, using the term “vulvovaginal candidiasis.”
- **Chlamydia:** Report all infections using the term “genitourinary chlamydia infection.”
- **Gonorrhea:** Report all infections using the term “genitourinary gonorrhea infection.”
- **Suspected genital herpes outbreaks:** Because herpes testing is not required in MTN-029/IPM 039, each suspected genital herpes outbreak should be reported using the term marked on the Pelvic Exam CRF describing the lesion together with the anatomical location (e.g., vulvar ulceration, vaginal blister).
- **Genital herpes:** The criterion for diagnosing genital herpes per the FGGT is below. Note that laboratory testing is required in order to use the term “genital herpes” for AE reporting. Such testing is not required per protocol and should only be done if clinically indicated. Any new lesion/ulcer observed during the study should be reported as an AE even if it thought to be due to prior herpes diagnosis/infection.

PARAMETER	Grade 0 NORMAL	Grade 1 MILD	Grade 2 MODERATE	Grade 3 SEVERE	Grade 4 POTENTIALLY LIFE- THREATENING
Genital herpes	No lesions	Characteristic ulcerative or vesicular lesions confirmed by culture, PCR, Tzanck prep or other diagnostic test of lesion or previous type-specific serology, covering < 25% of vulva, vagina, or cervix	Same criteria as mild but covering 25-50% of vulvar, vaginal, or cervical surface	Same criteria as mild but covering > 50% of vulvar, vaginal, or cervical surface	Symptoms of significant systemic involvement, e.g., encephalitis, hepatitis

- **Genital warts:** Report all outbreaks of genital warts as AEs, regardless of whether infection with HPV was known to be pre-existing before enrollment. Report the AE using the term “condyloma” and include the anatomical location of the warts (e.g., cervical, vaginal, vulvar, perianal). Grade according to the “Condyloma” row of the FGGT.
- **Syphilis:** Per the FGGT, a Grade 2 Syphilis adverse event is defined as a positive treponemal test along with a positive non-treponemal test and no previous treatment OR a four- fold rise in titer on the non-treponemal test after previous treatment regardless of symptoms or non-oral lesions positive by darkfield exam for treponemes. Report all syphilis adverse events, using the term “syphilis infection” (no anatomical location is required when reporting syphilis infections).
- **Trichomoniasis:** Report only Grade 2 infections per FGGT, using the term “vaginal trichomoniasis”. Trichomoniasis may be diagnosed by positive wet mount, culture, PCR, rapid Trichomoniasis or other licensed test (excluding Pap smear), showing T. vaginalis, regardless of symptoms.

In the absence of a laboratory-confirmed STI or RTI diagnosis, use the term “vulvovaginitis” when 2 or more of the genital/vaginal signs or symptoms listed below are present. Comment on the individual signs/symptoms in the “Comments” field of the AE Log CRF.

- pain
- itching
- erythema
- edema
- rash
- tenderness
- discharge

Similarly, use the term “cervicitis” when 2 or more of the genital/vaginal signs or symptoms listed below are present in the absence of a laboratory-confirmed STI/RTI. Comment on the individual signs/symptoms in the “Comments” field of the AE Log CRF.

- dyspareunia
- erythema
- edema
- tenderness
- discharge

### 8.2.3 Reporting Abdominal Pain as an AE

When reporting abdominal pain as an AE, pain that is gastrointestinal in nature must be differentiated from pain that is genitourinary or reproductive in nature.

If abdominal pain is assessed as gastrointestinal in nature and no other overarching or unifying diagnosis is available, the term “abdominal pain” or “lower abdominal pain” should be used on item #1 on the AE Log CRF.

If the pain is assessed as genitourinary and a specific anatomic location is known, the term reported on the AE Log CRF should be described as such (i.e., “bladder pain”).

If the pain is assessed as reproductive in nature and a specific anatomic location is known, the term reported on the AE Log CRF should be described as such (e.g., “uterine adnexal pain”, “ovarian pain”).

If the pain cannot be localized to a specific organ, it should be described on the AE Log CRF using terms that identify a reproductive or genitourinary anatomical location (e.g., “pelvic pain”, “urinary tract pain”).

### 8.2.4 Reporting Laboratory Abnormalities as AEs

If an abnormal laboratory test result is reported as an AE, separate from any clinical diagnosis associated with the result, the type of test performed and the direction of the abnormality should be reported (e.g., elevated ALT). The specific value or the severity grade of the result should not be reported as part of the AE term. Laboratory values that fall outside of a site’s normal range but are below severity grade 1 are not considered AEs. These out of range but below grade 1 values are not documented as pre-existing conditions or adverse events on the PRE-1 CRFs unless requested by the Investigator of Record (IoR) or designee. When assigning severity grades, note that some sites may have normal reference ranges that overlap with the severity grade ranges. Thus, it is possible for a participant to have a result that falls within the site’s normal range, but is still gradable per the Toxicity Table. Assign the severity grade based on the Toxicity Table severity grade ranges, regardless of whether or not the lab result falls within the site’s normal reference range.

The IoR or designee should carefully review all laboratory abnormalities relevant to the participant's health to identify any adverse events or health problems. Documentation of this review is required by initialing and dating each page of lab results. The severity of all lab abnormalities will be graded and recorded in the source documentation. Results of protocol-specified local laboratory results will also be reported on the Laboratory Result DataFax CRF. Sites should document other results if any, in visit chart note, or in other designated site-specific documents. Through the participant's study involvement, lab abnormalities that meet the criteria for expedited reporting to DAIDS will be reported separately on the AE Log CRF and reported to DAIDS via the DAERS Reporting System.

### 8.3 Adverse Event Severity Grading

The term severity is used to describe the intensity of an AE. The severity of all AEs identified in MTN-029/IPM 039 must be graded on a five-point scale:

- Grade 1 = Mild
- Grade 2 = Moderate
- Grade 3 = Severe
- Grade 4 = Potentially life-threatening
- Grade 5 = Death

Severity is not the same as seriousness, which is based on the outcome or action associated with an event, as described in Section 8.1.3.

The severity of all AEs identified in MTN-029/IPM 039 will be graded using:

- DAIDS Female Genital Grading Table for Use in Microbicide Studies (FGGT)
- If not identified there, the DAIDS Table for Grading Adult and Pediatric Adverse Events (Toxicity Table), Version 2.0, dated November 2014

The DAIDS Toxicity Tables can be accessed on the DAIDS RSC web site (<http://rsc.tech-res.com/safetyandpharmacovigilance/>).

AEs listed in both the FGGT and the Toxicity Table should be graded according to the FGGT. AEs not listed in the FGGT should be graded according to the Toxicity Table. AEs not listed in the FGGT or the Toxicity Table should be graded according to the "estimating severity grade" row of the Toxicity Table:

<b>Grade 1 Mild</b>	<b>Grade 2 Moderate</b>	<b>Grade 3 Severe</b>	<b>Grade 4 Potentially Life-Threatening</b>
Symptoms causing no or minimal interference with usual social & functional activities	Symptoms causing greater than minimal interference with usual social and functional activities	Symptoms causing inability to perform usual social and functional activities	Symptoms causing inability to perform basic self-care functions OR Medical or operative intervention indicated to prevent permanent impairment, persistent disability, or death

Further clarifications, guidelines, and tips for grading the severity of AEs are as follows:

- Genital petechiae and genital ecchymosis should be considered Grade 1 as neither requires treatment.

- If the severity of an AE falls into more than one grading category on the Toxicity Table, assign the higher of the two grades to the AE.
- If a single AE term is used as a unifying diagnosis to report a cluster of signs and symptoms, and the diagnosis is not specifically listed in the Toxicity Table, assign the AE the highest severity grade among each of the associated signs and symptoms. Record the diagnosis as the AE term and record each associated sign and symptom in the AE Log comments section.
- Seasonal allergies should be graded according to the “Estimating Severity Grade for Parameters Not Identified in the Grading Table” row of the Toxicity Table (not the “acute systemic allergic reaction” row).
- When grading using the ““Estimating Severity Grade for Parameters Not Identified in the Grading Table”” row of the Toxicity Table, note that if the condition requires treatment, it must automatically be graded at Grade 2 or higher.
- Urinary tract infections (UTI), may be graded according to the ““Estimating Severity Grade for Parameters Not Identified in the Grading Table”” row of the Toxicity Table if diagnosed on the basis of symptoms. If culture and/or microscopy are done per site standard of care, Grade 1 and Grade 2 UTI can be graded per the UTI row of the FGGT.
- It is preferable that abnormal Pap smear findings are reported and graded based on results of a biopsy, using the “Intraepithelial Neoplasia by biopsy” row of the FGGT (below). However, if further evaluation of the Pap smear finding is not performed, or is scheduled to be performed at a later date, then abnormal Pap smear findings should be graded according to the “Pap” row of the FGGT (see below).

**Note:** AGC and AGC-favor neoplastic are not specifically mentioned in the “Pap” row, but should be assigned severity grades 1 and 2, respectively.

PARAMETER	GRADE 0 NORMAL	GRADE 1 MILD	GRADE 2 MODERATE	GRADE 3 SEVERE	GRADE 4 POTENTIALLY LIFE- THREATENING
Intraepithelial Neoplasia by biopsy (VIN, CIN, VAIN)	None	Intraepithelial Neoplasia 1 (IN1)	Intraepithelial Neoplasia 2 (IN2)	Carcinoma in situ (CIS)	Invasive carcinoma
Pap (use this category <u>only</u> if treatment performed without diagnostic testing, otherwise use biopsy category above)	nl PAP	ASCUS or LSIL	HSIL	Carcinoma in situ or Carcinoma	NA

#### 8.4 Adverse Event Relationship Assessment

One of the following relationship categories must be assigned to each AE:

- Related: There is a reasonable possibility that the AE may be related to the study product.
- Not related: There is not a reasonable possibility that the AE is related to the study product.

Please note that where no cause for the event is apparent, the relationship does not default to “related”. There must be at least a reasonable possibility of a causal relationship. In addition, if the AE is **due to the act** of study ring insertion or removal, then the related category should be utilized.

Study staff should give a reason for their determination of the relationship of the AE to the study product. When an AE is assessed as “not related” to the study products, an alternative etiology, diagnosis or explanation should be provided in the “Comments” line on the AE Log CRF. When an AE is assessed as “related”, recording “no other cause identified” is not adequate. Although an AE’s relationship status defers to clinician discretion, some clinical explanation is helpful in understanding the nature of the adverse event and in determining a more complete safety profile of the study product.

If new information becomes available, the relationship assessment of any AE should be reviewed again and updated as required. When recording an AE that is the result of a study-related procedure other than study ring insertion or removal, mark the “Relationship to study product” as “Not Related” and provide an explanation in the “Comments” section that the event is a ‘result of a study-related procedure’.

## **8.5 Adverse Event Outcomes and Follow-Up Information: During Study Participation**

### **8.6 Each AE identified in MTN-029 must be followed clinically through study participation until the AE resolves (returns to baseline) or improves to a Grade 2 or lower assessment.**

At each follow-up visit, an authorized study clinician should review all previously identified ongoing AEs and evaluate and document its current status. Outcomes must also be reported on the AE Log case report form. In many cases, the final outcome of an AE will not be available when the AE Log CRF is first completed and faxed to DataFax. In such cases, the form should be updated when the final outcome becomes available and re-faxed to DataFax at that time.

As noted above, “resolution” of an AE is generally defined as returning to the condition or severity grade that was present at baseline (i.e. at the time of enrollment). For clinical events that are AEs, clinical management and follow-up of the AE should proceed per the specifications of section 9 of the protocol. If, however, a clinical AE is not addressed in section 9 of the protocol, at a minimum, follow-up evaluations should be performed at scheduled study visits until resolution, or condition has improved to a Grade 2 or lower assessment. More frequent evaluations may be performed at any time if required to properly monitor and/or manage participant safety, at the discretion of the IoR or designee. It is acceptable for AE follow-up/evaluation to be conducted over the phone, as clinically appropriate.

If an AE increases in severity or frequency (worsens) after it has been reported on an AE Log CRF, it must be reported as a new AE, at the increased severity or frequency, on a new AE Log CRF. In this case, the outcome of the first AE will be documented as “severity/frequency increased.” The outcome date of the first AE and the onset date of the new (worsened) AE will both be the date upon which the severity or frequency increased.

## **8.7 Adverse Event Outcomes and Follow-Up Information: After Study Termination**

For AEs that are ongoing at the termination visit, the status/outcome of the AE should be updated to “continuing at end of study participation” and the AE Log CRF should be re-faxed to DataFax. The IoR or designee must establish a clinically appropriate follow-up plan for the AE.

A subset of AEs must be followed after a participant's termination visit. AEs that require reassessment after the participant's termination visit include the following:

- AEs that are found to have increased in severity at the termination visit
- AEs deemed related to study product
- All Grade 3 or higher AEs that are ongoing at the termination visit
- SAEs/EAEs

At a minimum, the above listed AEs must be re-assessed by study staff within 30 days after the termination visit; additional evaluations also may take place at the discretion of the IoR or designee. The requirements for submission of follow-up information on EAEs are specified in

Section 4.3 of the *Manual for Expedited Reporting of Adverse Events to DAIDS (Version 2.0 dated January 2010)*.

If not resolved or stabilized at the time of reassessment, additional assessments should occur at the following frequency:

- If the study is ongoing, continue to reassess at least once per month while the study is ongoing until resolution/stabilization
- If the entire study has ended (not only participant participation), all AEs requiring re-assessment will be re-assessed at least once within 30-60 days after the study end date. The site is to send an informational query regarding the case to the Protocol Safety Review Team (PSRT) (see Appendix 8-1) at the time of reassessment. The MTN-029/IPM 039 PSRT also may advise on whether any additional follow-up is indicated on a case by case basis.

For AEs that are re-assessed after the termination visit, information on the status of the AE at the time of re-assessment will be recorded in chart notes, and may be communicated to the PSRT, if applicable; however, no updates should be made to any case report forms based on the re-assessments.

### **8.7.1 Reporting Recurrent Adverse Events**

If an AE previously reported on an AE CRF resolves and then recurs at a later date, the second occurrence must be reported as a new AE on a new AE CRF.

Regular occurrences of the same adverse event that are expected in follow-up are not typically considered separate adverse events.

## **8.8 Social Harms**

In addition to medical AEs, participants may experience social harms — non-medical adverse consequences — as a result of their participation in the study. For example, participants could experience difficulties in their personal relationships with partners, family members, and friends. They also could experience stigma or discrimination from family members and members of their community.

In the event that any social harms occur, study staff should fully document the issues or problems and make every effort to facilitate their resolution as described in this section. There is no CRF for the reporting of social harms. The IoR will report any social harm that is, in his/her judgment, deemed serious or unexpected, to the PSRT and IRB according to local requirements. Study sites may engage their Community Advisory Boards in exploring the social context surrounding instances of social harm.

Prior to study initiation, study staff teams at each site should discuss as a group, and with community representatives, what issues and problems are most likely to be encountered by participants at their site, and should agree upon how these issues and problems should be handled if reported. Roles and responsibilities should be defined for all staff members, such that each staff member is aware of what actions he/she can appropriately take, and what actions should be referred to other members of the team.

During study implementation, staff teams at each site should continue to discuss actual participant experiences, successful and unsuccessful response strategies, and other lessons learned among themselves and with community representatives. Based on these discussions and lessons learned, procedures for responding to issues and problems should be reassessed and updated as needed throughout the study.

The following are suggested strategies for responding to social harms that may be adapted and tailored to best meet participant needs at each site:

- When first responding to an issue or problem, actively listen to the participant's description of the problem and ask questions to elicit as much detail as possible about the problem, including the participant's perception of the severity of the problem. Record all pertinent details in signed and dated chart notes.
- Ask the participant to articulate her thoughts on what can/should be done to address the problem, including what she would like study staff to do in response to the problem (if anything).
- Discuss with the participant any additional or alternative strategies that you might suggest to address the problem and collaborate with her to develop a plan to try to address the problem. Document the plan in signed and dated chart notes.
- Take all possible action to try to address the problem, per the plan agreed upon with the participant. Document all action taken, and outcomes thereof, in signed and dated chart notes.
- As with medical AEs, follow all problems to resolution or return to baseline.
- Provide referrals as needed/appropriate to other organizations, agencies, and service providers that may be able to help address the problem.
- If the reported social harm is associated with an AE, report the AE on an AE Log CRF. If the social harm is associated with an AE that meets criteria for expedited reporting to the DAIDS RSC, report it as an EAE. Also report the issue or problem to all IRBs/ECs responsible for oversight of MTN-029/IPM 039, if required per IRB/EC guidelines.
- Consult the Protocol Safety Review Team (PSRT) for further input and guidance as needed.

## **8.9 Safety Distributions from DAIDS**

Study sites may receive product- and safety-related information throughout the period of study implementation. This information will be distributed by DAIDS, through its RSC and/or the MTN Leadership and Operations Center, and may include:

- Updated Investigators Brochures
- IND Safety Reports
- Other safety memoranda and updates

Each distribution will include a cover memo providing instructions on how the document is to be handled. In all cases, a copy of the distribution must be filed in on-site essential document files. Also in all cases, study staff responsible for clinical oversight of study participants should be made aware of any newly available safety information. In many cases, the distribution will need to be submitted to site IRBs/ECs. Safety distributions do not require IRB/EC approval; however acknowledgement of receipt is desirable. Submission letters/memos for IRB/EC submissions should specify the name and date of all documents submitted.

## **8.10 Safety Monitoring, Review, and Oversight**

Please refer to Section 8 of the MTN-029/IPM 039 protocol for a complete description of the participant safety monitoring procedures in place for MTN-029/IPM 039. Section 13 of this manual is a reference for a description of the reports prepared by the MTN SDMC in support of MTN-029/IPM 039 safety monitoring procedures.

Participant safety is of the utmost importance in MTN-029/IPM 039. Primary safety monitoring and safeguarding of individual study participants is the responsibility of study staff, under the direction of the IoR. The IoR and designated study staff also are responsible for submitting case report forms to the MTN SDMC and EAE reports via DAERS to the RSC, such that relevant



safety data are available in a timely manner for other study-specific safety monitoring procedures, as follows:

- Clinical Affairs staff at the MTN SDMC will review clinic and laboratory data received at the SDMC and apply clinical data quality control notes (queries) to data requiring confirmation, clarification, or further follow-up by site staff. These queries will be issued to site staff for resolution on an ongoing basis throughout the period of study implementation. In addition, Protocol Safety Physicians may contact site staff directly, if needed, for additional clarification of safety data.
- The DAIDS RSC, DAIDS RAB Safety Specialist, and DAIDS PSB Medical Officer, will review all EAE Forms received for MTN-029/IPM 039 and follow up on these reports with site staff, the MTN-029/IPM 039 Protocol Team, and drug regulatory authorities when indicated.
- The Protocol Safety Review Team (PSRT) will routinely review safety data reports prepared by the SDMC for the study. The PSRT will meet monthly conference call to discuss cumulative study safety data and any potential safety concerns.
- The MTN Study Monitoring Committee (SMC) also will periodically review study data with a focus on performance indicators such as participant accrual and retention, protocol adherence, and data quality. While site staff are not typically involved in these reviews, site staff should be aware that the SMC may make recommendations to DAIDS and/or the MTN leadership that could affect the study and sites in significant ways. These decisions are based on a detailed review of the available study data and careful consideration of ongoing participant safety.

## Appendix 8-1: MTN-029/IPM 039 Protocol Safety Review Team

### Roles and Responsibilities of the PSRT

The roles and responsibilities of the MTN-029/IPM 039 Protocol Safety Review Team (PSRT) are to:

1. Conduct regular reviews of standardized study safety data reports. Once the SDMC begins receiving follow-up safety data, the PSRT will convene via regularly scheduled monthly conference calls. The frequency of calls may be adjusted throughout the period of study implementation as agreed upon by the PSRT. Should any safety concerns be identified by the PSRT, these will be referred to the Protocol Team and MTN Study Monitoring Committee (SMC) as appropriate.
2. Respond to queries regarding product use management including temporary hold or permanent discontinuation of study product.

*The protocol specifies a number of situations in which study product use should be temporarily held, permanently discontinued and/or resumed; designated site staff may implement these holds, discontinuations, and/or resumptions in the absence of consultation with the PSRT. In other situations, however, product use management must be undertaken in consultation with the PSRT. (Protocol Section 9.3 -9.9)*

3. Respond to queries regarding adverse event (AE) assessment, reporting, and/or management.
4. Respond to investigator notification of participant withdrawal from the study
5. Respond to queries regarding study eligibility and/or re-joining of study participant's which previously withdrew consent
6. Respond to queries about product resupply, in the event that a ring cannot be reinserted during study follow-up

### PSRT Composition

The following individuals comprise the MTN-029/IPM 039 PSRT:

- Lisa Noguchi, Protocol Chair
- Rich Beigi, Protocol Co-Chair
- Katie Bunge, MTN Protocol Safety Physician
- Devika Singh, MTN Protocol Safety Physician
- Ken Ho, MTN Protocol Safety Physician
- Jeanna Piper, DAIDS Medical Officer
- Annalene Nel, IPM Medical Officer
- Ning Jiang, SDMC Clinical Affairs Safety Associate (CASA)

Ideally, all members of the PSRT will participate in routine conference calls. At a minimum, the DAIDS Medical Officer (or designee if DAIDS MO is not available), the Protocol Chair or Protocol Co-Chair, and a MTN Safety Physician, must take part in all calls to reach quorum.

If these members are not present, the call may be deferred until the next scheduled call time unless a PSRT member requests an immediate call. MTN LOC (FHI 360) Clinical Research Managers, SDMC Project Managers, Statistical Research Associates, and Site Investigators and study coordinators may attend PSRT calls as observers and/or discussants.

### **PSRT Communications**

A group email address ([mtn029psrt@mtnstopshiv.org](mailto:mtn029psrt@mtnstopshiv.org)) will be used to facilitate communication with the PSRT.

Site consultation with the PSRT will be facilitated using the MTN-029/IPM 039 PSRT Query Form, which is available in the Study Implementation Materials section of the MTN-029/IPM 039 web page. Site staff will email completed query forms to the Protocol Safety Physicians ([mtn029safetymd@mtnstopshiv.org](mailto:mtn029safetymd@mtnstopshiv.org)) who will work with the PSRT to prepare a consensus response to the query, and then email the final response to the site. This process is expected to occur within three business days. When necessary, site requests for responses within one business day can usually be accommodated. All members of the PSRT are encouraged to review the information provided by the site in the query form and to contribute to the response; however, final determination rests with the Protocol Chair(s).

An emergency safety telephone number (412-641-8947) is also available to site staff. This telephone is carried by the Protocol Safety Physicians 24 hours a day, seven days a week. It is intended for use in emergencies only, in which immediate consultation with a Protocol Safety Physician is needed. If the Safety Physician does not answer, a voicemail should be left with the call back number. Questions that can wait for email communication should be handled using the PSRT query process described above.